ATTACHMENT, SELF DEVELOPMENT AND TRAUMA RECOVERY IN STRATEGIC INTEGRATIVE PSYCHOTHERAPY

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ABSTRACT: Attachment is a fundamental safety net for the exploration, development, and evolution of a relationship, but also for the growth and development of an authentic, autonomous, stable self. The premise for attachment is one's need to maintain contact with the significant individuals that surround us considering the vulnerability and complete helplessness that humans are facing since birth. The hypothesis of this study consists in presenting trauma and therapeutic intervention methods from the perspective of the integrative strategic model of the self.

The objectives are: creating a trauma intervention plan on the emotional axis of the integrative strategic model of the self and analyzing the therapeutic relationship in trauma psychotherapy. the data are presented and interpreted in a relationship with the content relating to the basic, central, plastic and external self of the afore mentioned model. From the perspective of integrative strategic psychotherapy, trauma involves a complex assessment of the client who is to be positioned on the emotional axis. The therapeutic relationship aims to create a secure attachment experience with the client.

KEYWORDS: attachment, trauma, emotional axis, strategic integrative psychotherapy.

1. INTRODUCTION

Fonagy (2000, cited in Wallin, 2010, p. 303) considers that trauma and attachment involve the internalization of a "false self" representation as a substitute of the "constitutional" self (the real one), as a consequence of the responses to an abusive attachment figure.

Thus, Fonagy also explains why some people who suffer from active traumas resort to self-sabotage behaviours, even self-mutilation, because of the need to keep the connection with the original persecutor. If there is no one available to assume the persecutor role, the person tends to persecute itself.

Wallin (2010) observes the act transposition phenomenon – in terms of re-experiencing the trauma symbolically, a fact noticed in the behaviour manifested by the victim in ulterior relationships.

From an attachment point of view, trauma is described at this stage, as traumatizing the child's need for attachment. Franz Ruppert (2012, p. 178) calls this phenomenon "attachment trauma", which he explained as a result of the relationship with an emotionally unavailable mother since attachment is necessary for the child's survival.

The author describes attachment trauma using an eloquent metaphor to show that for a child with an emotionally inaccessible mother it is as if "the wall where the child should hang the emotional rope does not have any hooks and it is smooth and inaccessible.

The attachment trauma occurs when, due to feelings reflected by an insecure attachment, the child develops his own survival strategy, often based on inner withdrawal and the development of his own phantasmal world, hence the incongruity with a reality difficult to accept.

The feeling of inner emptiness and the inability to achieve a genuine contact with another person become central experiences in these individuals' lives.

When associated with traumatic experiences of any kind, these are far more intense and difficult to overcome because the person does not have a solid and healthy attachment basis and is not autonomous and emotionally available to manage the trauma.

The same author considers that other types of trauma related to attachment are existential trauma - the trauma caused by loss and the attachment system trauma.

2. THE EMOTIONAL AXIS: EVALUATION, DIAGNOSIS, THERAPEUTICAL INTERVENTION METHODS

EMOTIONAL AXIS - *CHARACTERIZATION*

On the Emotional Axis, the Basic Self contains internal working models or neural maps for the attachment and emotional structure. Depending on the relationship with one's environment, these IWMs

become active and develop into a set of central beliefs (the Central Self); the Central Self characterizes on the Emotional Axis the attachment style, the repression or expression of basic and primary emotions, emotions categories and value conditions.

These are maintained by the mechanisms of the Plastic Self which is responsible for a certain style of attachment, emotional regulation and a continuity of values. Their related behaviours and emotional expression characterize the External Self.

Inter-subjectivity is an important aspect of the emotional domain. Inter- subjectivity refers to the perceptions and representations that people build when relating to one another and the individual's resources to interpret the meaning of socio-cultural life elements. Inter-subjectivity is a social, cognitive and affective phenomenon that occurs early and depends on how the individual's environment experience is structured from a neurobiological perspective (Ginot, 2007).

Inter-subjectivity is defined as the manner in which a person understands another person and resonates with this other. Wallin (2010, p. 77) defines inter-subjectivity as the "interface between two minds", an innate capacity "to reveal our mind in the minds of others when we turn to others to find out more about our own mind." For children, the ability to inter-subjectivity is innate.

It starts to take shape during childhood, as the child interacts with others and begins to understand thoughts and emotions.

Stern defines emotional relatedness as the process by which we, as persons, have similar feelings as the other and we allow this other person to understand that we felt the same; the other sees this emotional relatedness as the intersubjectivity core, not just as a communication possibility, but as an "interpersonal communion" - being together and sharing without trying to change the other (Stern, 2004, cited in Smith, Vîşcu, 2016). It might be useful at this point to develop a general model for the evaluation, diagnosis and therapeutic intervention of a traumatic situation.

As previously discussed, traumas are caused by various factors and fall into different categories.

The common trait is the traumatic process characterized by the existence of a traumatic event, the neurophysiologic changes set (reactions) which occur after the trauma and symptomatically persist and what one could call the potential stimulus trigger (those situations or contexts that recall the trauma and often trigger abnormal reactions even if there is no the threat).

The evaluation and diagnosis of a trauma must imply the analysis of all the psychological axes. The Emotional Axis is special because any kind of trauma will directly influence the emotional Self.

In order to proceed with a therapeutic intervention on the Emotional Axis, it is necessary to make a prior analysis of the trauma implications as per the four domains of the Self.

A possible structured description of a traumatized Self is presented in Table 1.

Table 1 The Emotional Axis in current trauma situations

The Basic Self	**The Central Self**	**The Plastic Self**	**The External Self**
IWM attachment (secure/insecure)	The pattern/attachment style (Building the attachment) Early experiences in relationship with the mother: the mother's response to the child's needs the mother's emotional stability as an emotional adjustment factor for the child. Usually not sufficiently structured!	Mechanisms that maintain the poor attachment style/pattern: There is no IWM for secure attachment, thus the same actions that somehow ensure the "illusion" of protection are repeated.	The manifestation of attachment patterns Congruent behaviours with the attachment style/pattern Dependent or avoidant Insecure / Undecided (Ambivalent)
IWM basic emotions: fear, anger, sadness, joy, surprise Primary emotions Instability and vulnerability in emotion management	Repression / no repression of primary / basic needs Basic emotions / Emotions categories Being centred on sadness, repressed anger, guilt building up inside the circle of devaluing cognition, a negative orientation / a pessimistic view of reality	Emotional disturbance: Neurotic guilt Fear of being left Fear of death Unrequited love Impotent rage Shame General emotional weakness	Emotional expression: Anxious Hyper-vigilant Fearful Sad Emotionally paralyzed (anhedonia, insensitive to others' emotions) Weeping Desperation

The Basic Self	The Central Self	The Plastic Self	The External Self
	The value conditions altered by the incapacity to control the de facto reality so that the trauma wouldn't have occurred or subsequently the incapacity to help oneself overcome trauma	Mechanisms that maintain value conditions Avoidance Assurance and reassurance behaviours	External locus of evaluation Blame, exaggerated response to stimuli that evoke the trauma or are similar to conditions when the trauma occurred The feeling of helplessness
IWM inter-subjectivity /intra-subjectivity	Inter-subjectivity / intersubjectivity: Discontinued contact	Mechanisms that maintain the relational patterns: Withdrawal	The behavioural expression of relational patterns Distrust Repressed social need Blame Renunciation and isolation

In terms of emotional therapeutic intervention on the Emotional Axis, there are several benchmarks that should be taken into account. According to several authors the following interventions may be useful (Vanderkerckhove et al., 2000; Wilkins, 2010, as cited in Smith, Vîşcu, 2016, p. 201):

- Managing client incongruence through unconditional acceptance;
- Congruent answers with the client's condition: empathy, the therapist's attention to their own reactions, triggered by the client's confession and the answer they provided to the client;
- Therapist self-disclosure;
- Communicating empathic understanding;
- Restoring the attachment patterns (second order attachment in therapy);
- Recognizing emotions;
- Supporting the client's emotions expressions;
- Supporting the client in adjusting emotion intensity: identifying and labeling emotions, allowing and tolerating emotions, establishing a professional distance, increasing positive emotions, reducing vulnerability to negative emotions, self-adjustment;
- Reassessment: creating a new meaning for the client;
- Positive Imagery;
- Reflecting on emotions: developing new explanatory stories for past experiences
- Corrective emotional experience.

While working with the client, the therapist must go through the following 7 emotional levels (Bridges, 2006 as cited in Smith, Vîşcu, 2016):

- level 1: the client intellectualizes and there is no evidence of emotional significance for the events described;
- level 2: the client provides verbal or nonverbal evidence regarding the personal relevance of the material, but does not refer particularly to his or her internal emotions or reactions
- level 3: the client focuses mainly on external events, focusing occasionally on his or her own feelings;
- level 4: the client begins to focus on the internal experiences of emotions in relationship with their own level of comprehension;
- level 5: the client starts to question and explore questions about himself or herself;
- level 6: expressing positive feelings of relief; and
- level 7: gaining a greater understanding.

3. THE THERAPEUTICAL RELATIONSHIP AND THE EMOTIONAL AXIS IN TRAUMA PSYCHOTHERAPY

Siegel (1999, p. 2 cited in Wallin, 2010, p. 99) states that "the genetically programmed growth of the nervous system is shaped by interpersonal experience." The theories concerning attachment show how strong is the influence of the relationship between the primary attachment figure and the child on its socio-emotional development.

Wallin (2010) extends the attachment theories to the therapist-client relationship and shows how the therapist can provide the therapeutic change by cultivating a relationship similar to the secure attachment one, by appropriately containing the client. Mentalization and inter-subjectivity are essential ingredients of a successful therapeutic relationship that aims to fulfil such objectives.

Erskine, Moursund, and Trautmann (1999, as cited. Popescu, Vîşcu, 2016) define as the "contact key in a relationship" the basis of the therapeutic process, consisting in the agreement between therapist and client. The authors state that the clients coming to therapy encounter problems whose difficulties reside in a series of "internal contact disruptions".

These may also serve as defence mechanisms that the clients are not aware of, with the potential to hinder

the psychotherapeutic process. The denial, disengagement, desensitization, depersonalization and dissociation may be considered such contact interruptions.

Denial implies memories and emotions repression: the client has issues and cannot find a solution to the problems he or she faces, or they do not see the problem or fail to make connections.

Disengagement refers to the inability to tolerate emotions, especially the painful ones. Desensitization is a loss of contact with the bodily self at a sensory level. Depersonalization describes a psychic abandonment of the body and the sense of self. Dissociation is a defence mechanism in which the consciousness is divided into separate parts functioning separately. Depending on the level where the contact has been interrupted, the therapist must intervene specifically and help the client in a restoration process.

It seems that "the way in which the client perceives the therapeutic alliance and the therapeutic relationship is the most important factor contributing to successful therapy." (Popescu and Vîşcu, 2016, p. 47).

As seen in the previous chapters, I must highlight the therapist-client relationship as a space for emergence and reciprocity at the level of "mind's theory" and inter-subjectivity; the therapist is taking a leadership role in this process by spotting the key moments and managing them so that the client can feel safe, emotionally connected, and aware of everything that involves his or her own of therapy.

The dissociation phenomenon is defined early by Pierre Janet (cited in Riedesser, Fischer, 2007) as the result of an overwhelming of consciousness when developing a traumatic situation, which has a striking impact. The authors mentioned see the term dissociation as per Pierre Janet's original interpretation, that is: "the memory of a traumatic experience will often fail to be properly elaborated; it will, therefore, be divided from conscience, cleaved, dissociated, in order to reappear at a later time, either as an emotional state, a physical state or in the form of representations, images or behaviour re-enacting."(p. 37).

It is also important to recall that "regression is the partial restoration of an individual's previous functional fixations, thus protecting its own vital economy." (Stora, J., B., cited. Wildöcher, Braconnier, 2006, p. 377).

Initially, dissociation is necessary in order to cope with trauma. One technique that helps the client to manage dissociation is the "bubble" technique developed by Alden (Popescu and Vîşcu, 2016, p. 275). The clients are invited to observe the trauma as if they were inside a bubble preventing any harm. When the person 'solves the trauma" by stepping out of the dissociation or regression circle the corrective emotional experience also occurs.

A corrective emotional experience is an action of the therapist that aims to provide the client with a positive experience, corrective because it contrasts with what the clients is used to experience (Knight, 2005 as cited in Popescu and Vîşcu, 2016).

From a neurobiological point of view, Wallin (2010, p. 104) specifies that the person who is involved in a psychotherapy process manages to re-evaluate the traumatic experiences and thus generate new connections (associations) in the mind and brain, due to the attachment relation with the therapist. This means that from an integrative strategic point of view, the nervous system, due to its inherent plasticity, forms new schemes and internal action models; these are generated by the safe and deeply transformative relationship created during the therapeutic process: reaching the emotional corrective experience becomes thus possible.

Wildöcher D., Braconnier A. (2006, p. 27) describe the "emotional corrective experience concept" as being more than interpretation and insight, but also an emotional climate described by "neutrality and availability", both provided by the therapist. The perspective is, however, psychoanalytic.

The authors describe it as "a determining process during the treatment which is based on re-evaluating the object choices and triggered purposes according to the analyst's feedback". On the other hand, the treatment or psychoanalytic treatment aims to repair (therapeutic change through the corrective emotional experience) through the he fusion experience of the patient with the analyst (the mother). This emulates the original fusion relation between infant and mother, but in the therapeutic context, this fusion always expresses trust and confidence" through the therapist's emotional response." (Wildöcher, Braconnier, 2006, p. 161)

In other words, the therapist generates in the client the therapeutic change ("the idea of repairing") by confronting them with their own imbalanced drives, in regression stage, while ensuring in their person and role (as an analyst) a secure environment. On the other hand, Judith Lewis Herman (cited in Goleman, D., 2001, p. 258) believes that patients should not be deprived of the feelings related to trauma. The solution does not lie in sparing the victim, but rather in encouraging them tactfully and professionally to express their overwhelming feelings. Dealing with one's own overwhelming emotionality enables a

recycling process of the trauma until the person can detach from it, being capable to accept the feelings associated with the traumatic memories. The symptoms are gradually reduced and the person can move on to living a normal life as the trauma belongs to the past.

In the "Purdy" case, reported earlier by D. Goleman (2001), an example of corrective emotional experience for children who have chosen to change the theme of the game by killing "Purdy" can be observed, thus returning to the natural order dominating before the incident occurred. This example represents a therapeutic way of dealing with trauma, because the newly discovered perspective releases the victim from the emotional blockage produced by the traumatic event.

Talking about affective adjustment and attachment strategies, David Wallin (2010, p. 137) points out the "primary strategy of attachment" developed by researchers (Fonagy, Main) as a model of safety responsible for how the child learns, by looking into the "adult's mirror ", how to regulate their emotions and to understand the world.

Regarding the safety model, Wallin states that "emotional adjustment is the process by which the child manages to associate the initial involuntary emotion expressions with the responses of the person who cares for him or her using social "bio-feedbacks". Wallin explains in the second part of the book that psychotherapy functions similarly: the therapist has the duty to help the client to adjust his or her affectivity in relationship with the trauma, based on the provided safety model (II order attachment).

This model aims to link the posttraumatic Self to resilience, ultimately empowering the Self to a position outside or above the experienced trauma.

According to Riedesser and Fischer (2007, p. 169-170), there are three sequences in the trauma process: the shock phase, the action phase, and the recovery phase. In order to produce effective and lasting results, the recovery phase should include the resilience development act.

Resilience is described in relationship with the idea of *dynamic adaptive process in terms of "resistance to psychological deconstruction" and empowerment in face of significant adversities.* (Turliuc, Măirean, 2014). According to the authors mentioned, resilience can be achieved at an an individual, family or community level. Turliuc and Măirean (2014, p. 108) define resilience as "the ability of a person to cope with suffering and continue to develop, the greatest challenge being the ability to avoid passing on the suffering to the next generation."

David J. Wallin (2010, p. 89) defines the Self as a "relatively stable internal reference point" generated by the interaction of body-brain-mind, where the "part of the human being that lives life but at the same time informs it both unconsciously and consciously" can be found.

Goleman (2001) considers that emotional intelligence is an important factor in acquiring resilience and *developing the posttraumatic self.* The author talks about *re-educating the emotional brain* by learning that life should not be lived as a permanent crisis and that one can gain autonomy and control in fighting the consequences of a trauma.

According to psychiatrist Judith Lewis Herman (as cited Goleman, 2001, p. 255), trauma recovery involves several *phases*. Firstly, it is necessary to focus on ways that calm the emotional neural circuits responsible for the emotional alert. The patient will learn through practice and self-education the nature of the discomfort state relating to the trauma and that it is part of the specific symptoms accompanying traumatic disorders. Thus, knowing where he or she stands, the patient will feel less frightened by their own stormy symptoms.

Another phase consists in helping the patient to develop a supportive and effective control strategy, discarding the impression of complete helplessness caused by trauma.

For example, the person affected by trauma can learn to think positively, stay focused and always look for resources, instead of focusing on the problem, or to involve in his or her life supportive people.

Another support strategy is using specific medication. Drug treatment does not erase trauma consequences but it can help by ensuring a physiologically calm state enabling the emotionally injured circuit to relearn the sense of safety and control existing before trauma.

In another phase of trauma therapy, by talking about the trauma and reconstructing it, the patient learns to experience the memories without experiencing the associated horror or strong sensations. In other words - in the therapist's company- that is in a safety environment the patient verbalizes and gradually gets used to evoke the trauma, which is consequently removed from the conscious present (dissociated) and transformed into words. Thus, the emotional circuit changes by understanding that safety, not horror, can be felt in tandem with the traumatic memories.

Referring to trauma, Tedeschi and Calhoun (1996, as cited Turliuc, Măirean 2014, p. 200) identify three change areas: the clients acquire a new self-perception and a high self-esteem; then redefine their interpersonal behaviour in a positive way and another

change is related to the life philosophy and the meaning attributed to aspects related to world and life. Basically, the clients acquire a posttraumatic Self in the light of a new existential understanding, where a new spiritual knowledge invested with power and self-responsibility intervenes.

Apparently, an essential role in acquiring resilience and developing the posttraumatic Self consists into developing a "mentalizing capacity," in the terms suggested by Wallin (2010). For a person who is right in the middle of trauma, in dissociation state, trauma therapy seems almost impossible. Once the person is assisted and taught to reflect, to see new perspectives, to actively seek solutions and give up its helpless victim position, an improvement and a favourable therapeutic outcome can be observed, which remains effective on the long-term.

Mentalizing represents a "conversation about conversations", that determines a reframing of those IWM (Internal Working Models) helping the traumatized person to "live" their world (initially caught between dissociation and suffering). Furthermore, mentalizing allows or unveils "more than just a single perspective on existence" in a context where the therapist invites the patient to self-monitoring their own states of mind, thoughts and actions, and thus bringing the patient into the present moment – an objective and potentially different one (Wallin, 2010, p. 259).

It can be thus understood without a doubt why the posttraumatic Self, that is the new Self- the one which is formed during the therapeutic process, becomes resilient: because it obtained a new skill: the capacity to mentalize or reflect outside the traumatic experience! On the other side, "the hurt aspects of the self are formed as an answer to trauma and negative relationships with abusive, neglecting, rejecting or over involved role models" (Frederick, 2005, apud. Popescu, Vîșcu, 2016, p. 216).

According to John Bowlby, "the therapist's role is analogous with the role of a mother ensuring for her child a safety base to explore the world" (1988, p. 140 apud. Wallin, 2010). This explains why a quality therapeutic relationship has the capacity to dislocate the person from their traumatic blockage by creating that secure, non-invasive environment where the person affected by trauma can grow, holding on to the therapist's wing until they learn how to fly by themselves and manage to lift up and encompass the trauma.

From a strategic integrative perspective, resilience and the posttraumatic Self can be reflected by several changes: psychosomatic problems disappearing (biological axis, External Self), acquiring control over trauma related dysfunctional thoughts, a change of perspective through a consolidated set of decontaminated beliefs (cognitive axis, Central Self), a restored emotional balance (Emotional Axis), emerging out of some psychodynamic blockages (psychodynamic axis), interaction and social life, as well as renewed interpersonal contacts, a new life meaning and purpose (family and existential axis).

4. CONCLUSIONS

Trauma is to be put in relation to a series of factors and potentially traumatic events, the person's pattern for understanding and representing oneself, life and the world, as well as with a process like development. One aspect with a special importance is dealing with trauma through a strategic integrative approach, structured into two components: dealing with trauma through the modelling of a therapeutic relationship, followed by analysis and working with trauma from the perspective of the plural approach described by psychological axes and the four domains of the Self.

The first aspect – the therapeutic relationship makes possible the recovery from trauma by rebuilding a safe attachment, developing self reflection skills and an enlarged point of view, centred on resources and facilitating emotional corrective experiences, recovering self-esteem and confidence in the other persons.

In order to build a favourable therapeutic relationship, the therapist must express empathy, accept the objective reality lived by the client, their defence mechanisms developed as a reaction to the problem the person is fighting with. But the therapist must also pay attention to their own supervising needs.

A positive therapeutic relationship offers the emotional support necessary to the client in order to detach them from the past and recover their hurt Self. The client must have the conviction of not being rejected but accepted as they are. In creating a therapeutic relationship there a few elements that matter: the degree of therapist involvement, the honesty, non-verbal communication, their capacity to mentalize / reflect, the consciousness in repairing possible or even necessary disruptions in the therapeutic process.

The second component is represented by a rigorous study framework for the trauma, involving evaluation, diagnosis and specific intervention. This framework should have as benchmark the internal reference system of the client, which in a trauma situation becomes rigid, blocked and dysfunctional.

From an axial and multifaceted perspective, trauma can be analyzed and comprehended into a much more complex way, which leads to an elaborate therapeutic intervention.

It has been seen that the integrative-strategic model of the Self integrates the psychotherapy theories accepted nowadays about the Self, as well as neurobiological research about the human brain and the interaction between the two cerebral hemispheres, neuronal plasticity and the mapping of information into neuronal networks. The integrative-strategic model also integrates research on attachment theory – the basis on which therapeutic relationship and second order attachment are structured.

Integrative-strategic psychotherapy is based on the theory of a Self in continuous development, starting in early childhood to adulthood, through internal working models connecting the nervous system plasticity with the individual's environment, where they live their own life experience and give it a subjective meaning.

The Self evolves under the influence of multiple factors: biological, cognitive, emotional, existential, psychodynamic, and cultural as well as factors concerning family attachment.

The integrative-strategic model of the Self defines these factors, and the way in which they are interconnected to the Self according to the six psychological axes concept. With regard to the Self, there are four aspects through which it manifests, functioning on a verbal and non-verbal level, in continuous interdependence and resulting into a personal way of understanding one's life experience and of acting accordingly to the beliefs of this standpoint.

These four aspects are defined as the Basic Self, the Central Self, the Plastic Self and the External Self. The Basic Self hosts the non-verbal experience domain, assimilated into an early stage of life; at this stage, pre-established neuronal networks are in a state of expectancy, as a series of potential software, waiting to be accessed and activated by experiences.

Depending on the degree, quality and intensity of received stimulation, the individual may develop certain patterns of behaviour and understanding of life experiences. The Central Self is the host of beliefs or "laws" resulting from the Basic Self's experiences. The Plastic Self is the territory of action, containing mechanism meant to sustain and support the central set. The External Self represents the interface, which is expressed thorough our behaviour.

Am integrative strategic psychotherapeutic intervention based on the internal working model of the Self and framed according to the six psychological axes offers the therapist an approach finely tuned to the specific needs of the client.

When synthesizing the ideas exposed in the paper, it should be remembered that in approaching trauma from the perspective of integrative strategic psychotherapy, the following aspects are essential: a complex client evaluation (not just as life history but also including the psychological aspects involving biology, cognition, family, the emotional, psychodynamic and existential spheres), as well as building a quality therapeutic relationship and maintaining it at a high quality standard which guarantees the achievement of the psychotherapy objectives.

It is compulsory for trauma evaluation and diagnosis to take into account an analysis of all psychological axes. The Emotional Axis is particular as trauma of any kind affects in a direct manner the emotional Self. It has been seen how important it is the manner in which the attachment internal working model and its implications get structured throughout life in relation to trauma.

While a safe, secured attachment represents a resource in working with trauma, an unsafe attachment can provide us some reasons for understanding the traumatized self and the resilience deficit. In relation to the attachment type is also developed the capacity for emotional regulation, as well as the contact with the self and the world, which is translated into the inter-subjectivity concept. During the therapy process it is necessary to develop for the client facing a trauma those reaction models activating resources and not blockages. Confrontation and the emotional corrective experience describe the key element in the therapeutic process of overcoming trauma; these use as a resource the dissociation state, which further enables the access to resilience.

In the light of the above elements, one can conclude that integrating all the available trauma knowledge in the context of strategic integrative psychology is more than welcomed; this permits a valuing of the emergent self model and elaborated from the axial point of view.

The integrative strategic schema in the trauma treatment must include a specific work done on every axis and at different levels of the self, without neglecting the importance of the therapeutic relationship and the main axis profoundly affected: the emotional one.

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