Trauma Treatment

Factors Contributing to Efficiency

Edited by
Agnieszka Widera-Wysoczańska

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Agnieszka Widera-Wysoczańska

INTRODUCTION

EFFECTIVELY COPING WITH TRAUMA THROUGHOUT A PERSON'S LIFE SPAN

AGNIESZKA WIDERA-WYSOCZAŃSKA

Trauma surrounds us. Throughout the course of human lives, individuals have to confront sudden terrible events and chronic stressful hardships. People can experience acute trauma, for example, in the form of the loss of someone close through sudden death, divorce or breakup, the loss of a job and long-term unemployment, involvement in a traffic accident, experience of a natural disaster or war and its consequences in terms of the loss of a loved one, health and home, or volunteering to do recovery work after a natural disaster or helping a person to cope with a chronic, complex trauma which is often lifelong.

Among the chronic and interpersonal injuries are described, for example, a personal serious illness or that of relatives; dysfunctional or pathological relationships with family members or issues arising from emotional, physical, sexual and/or substance abuse, as well as long-term stressful situations including prolonged lawsuits, which may be related to family matters, in the course of which both adults and children suffer. We should also pay attention to the stressful situations experienced by old people, such as interpersonal events, when the closest of relations are dying; social events, retirement, both natural and pathological biological consequences such as diminished health, tackling existential events, namely one's death and the fear of it.

Suffering people are looking for different ways to effectively deal with stressful situations in order to return to a better psychological state. They read books, seek individual support, look for intervention, for crisis counsellors or psychotherapists and go to various support groups or prefer to speak to a priest from their church or talk to a friend instead. Amongst the procedures which enable the recovery of mental health after trauma, therapeutic alliance, attachment, narratives, catharsis, and the unity of the group should also be mentioned (Garmezy, Master, 1986). It was noted

that a person recovers faster when, in the course of receiving professional help, a sense of security is built and strengthened, when there is a sense of control, emotional awareness, expansion of consciousness, behaviour control, imitation, interpersonal learning, similarity and altruism.

These factors relate to the phenomenon of resilience, as the ability to self-help in order to change living conditions, adequate adaptation and involvement in everyday life matters. The ability to perform tasks is constantly being developed and improved, often in difficult, stressful living experiences. Resilience is the use of internal forces, so that despite the suffering a balance in stressful or traumatic events can be found. It helps to creatively resist the pathogenic impact of the nearest environment (Sheehy, 1981; Uchnast, 1997).

Resilience is not an innate trait. It develops as a result of difficult life experiences and threats to fundamental values such as life or health. It also develops as a result of participating in psychotherapy. It may be formed when we confront risks and take various actions, which aids an increase in our immunity resources. The main role in this resistance is the ability to break away from negative experiences and induce positive emotions in ourselves.

Grossarth-Maticek and Eysenck (1995), Eysenck and Grossarth-Maticek (1991) and Flach, (2004) described the close relationship between personality type and illness or ability to recover. The first two personality types reveal a significant lack of resilience. The first is characterised by vulnerability to cancer, the second type to heart attack or stroke. People of the first type of personality manifest a strong need to be close to another person emotionally, or to achieve some highly valued goal. However, the object of their need or pursuit is permanently withdrawn and therefore they feel worthless, hopeless, depressed, and helpless. Those of the second type have an intense need to distance themselves from disturbing persons or situations, but they cannot. This causes them irritation, anger, a feeling of being trapped, and helplessness.

Studying these types of personalities leads researchers to wonder what reduces our resistance to stress and hinders recovery.

This is influenced by life history and the conditions of a particular family in which he/she was raised, with the resulting internal characteristics of a person and his/her understanding of interpersonal skills; this affect is also due to biological factors. Anti-resilient family environments are overly rigid or extensively disorganised (Flach, 2004). Rigidly organised living conditions are very resistant to change. They are characterised by totalitarianism, violence, alcoholism and substance abuse, childhood physical and/or sexual abuse, or early separation from a parent

or both parents. The impact of the weakening of resource persons is also a family history of anxiety, punishment, excessive demands, destructive values, secretiveness, aversion to innovations, intolerance of conflict, pathological principles and family attitudes. In contrast, chaotic conditions are characterised by inconsistency and transience, lack of authority, over-indulgence, excessive forbearance, unclear expectations, absence of defined values, indiscretion, opposition to anything traditional, continuous turmoil, and vindictiveness.

Among personal characteristics, the following particularly stand out: dependence, low flexibility, pessimism, panic response to stress, loss of self-control or control of their environment, intense fear quite out of proportion to a particular stress, and inflexibility increase the risk of panic. In addition, during extreme or traumatic situations long-term personal traits can become frozen. Research literature also suggests biological dysfunctions that could be genetically conveyed, or the impact of stressful events on the functioning of the brain.

Two types of personality which are resilient, each in their own way, have been described by Grossarth-Maticek and Eysenck (1995). The most important characteristic of people in the first category is the awareness of their ambivalent feelings about close relationships (they want to be close but are afraid of it) and they seek help during the course of psychotherapy or counselling to resolve the ambivalence. They may experience episodes of anxiety or aggressiveness, but they are not depressed and do not suffer from helplessness. People with the second type of resilient personality are in touch with their emotions and express them. They have a healthy sense of self-confidence and autonomy; they like themselves and other people. They learn from experience. They handle their relationships with others easily, knowing whom to trust. They have effective coping mechanisms to counteract helplessness and deal more capably with various stresses and interpersonal inadequacies. They seem to be resilient.

What are the determinants of resilience that have been identified? Just as in the case of the factors which reduce the ability to self-heal, the profiles of the resilient personality include inner psychological, spiritual and interpersonal strengths as well as the family conditions in which a person grew up (Flach, 2004; Henderson, 1999; Siebert, 2005). Not all resilient people have all of the following characteristics developed to the same extent.

The psychological inner attributes include autonomy, a sense of self-esteem, self-confidence and capabilities, a high level of personal discipline and a sense of responsibility, recognition and development of one's talents, creativity, focus and a commitment to life and a dream of what

they wish to accomplish in their lives. They have a sense of humour as well as the ability to maintain a distance from themselves or their surrounding reality and give it a new and surprising interpretative framework. These people are very tolerant of uncertainty and distress, but it is not too severe, and for a reasonable length of time. They are capable of achieving insights into problematic situations. They have the ability to identify sources of distress in life situations or in inner conflicts, which brought them to a crisis point. They can transform unpleasant occurrences into learning experiences, which consists of drawing positive lessons from bad events. They look at old problems in new ways, integrate new perspectives and patterns of behaviour into effective approaches of coping with trauma, and choose more suitable, workable solutions for various dilemmas. They accept emotional states, react emotionally, creatively manage pain; they cry, express anger, share their emotions and control their states. An important element that describes resilient people is innate optimism and hope for a better tomorrow.

Their understanding of life is based on faith or philosophy, and spirituality. This allows them to have hope in the most difficult situations.

Positive interpersonal attributes involve high social competence and the reactions of others towards us. A person with social competence can think and act independently, without being unduly reluctant to rely on others. He/she has the ability to give and take during human interactions, to create a favourable, well-established network of understanding family and friends, including one or more who serve as confidants, with respect, patience, empathy, open communication, and with appropriate feedback. These people are capable of forgiving others and themselves. They are proficient in setting limits, generosity, and freedom from their own selfishness and protection against the selfishness of others, and are able to give and receive love. They tolerate conflict and different opinions (Greff, Human, 2004), and are helpful in resilience and are empathetic and open in expressing feelings and the needs of others. People recovering from serious physical and emotional disorders do much better if they are surrounded by friends and family members than if they emerge from their troubled times to be greeted by hostility, rejection, or indifference. Many people consult therapists to receive this kind of deep feeling and such healing relationships.

People who quickly return to health experience or have experienced resilience in family life in childhood (Flach, 2004; Rutter, 1999; Walsh, 2003). A resilient family is elastic, shares common goals and realistic expectations, expresses empathy, and communicates meaningfully. Action is based on the values of self-respecting people, with kindness, courtesy,

and mindfulness. Resilient parents teach their children resilience through big and small examples in everyday life. They learn to perceive reality realistically and adapt to this reaction. Stress or traumatic situations give opportunities to develop and strengthen the attributes of self-healing. Resilience is not a-once-and-for-all thing, nor is any one particular resilient attribute a static ingredient of our personalities. The presence of one or more strengths does not guarantee the presence of others.

Resilience can be developed through a course of educational programmes, through workshops and psychological or psychotherapeutic training. During these processes, participants learn about themselves (personal understanding), express themselves (articulation) and transform (customisation). The development of resilience (self-help) is both preventative and therapeutic. The main idea is to develop and support these life skills that strengthen and enrich the individual and prepare us to face the inevitable challenges of life. Uses for these development strategies are based on the support and training of participants in decision-making, consensus building, planning activities and the practical implementation of these skills. The application of reframing opens up new meanings for situations experienced. People talk about their strengths, which focus on capabilities which are an inseparable part of the personality to be sought and given. The experience of trauma is a time to reflect on life, goals, values and relationships. Therefore, it is important to present the research and reflection of practitioners about healing factors applicable to different forms of professional assistance for adults who have experienced various types of acute and interpersonal trauma in childhood, adulthood and old age. Discussing the healing factors occurring during the process of helping enables effective programmes to be built and develops the capacity to cope with destruction and trauma. Healing factors, the characteristics of a counsellor, personality determinants of recovery, and techniques for recovery, are analysed in this book, because its purpose is to provide readers with information setting out directions in psychological conduct for persons harmed.

Who can benefit from this book?

It is intended for researchers, especially for professionals, who are looking for effective ways of dealing with people who have been hurt in life, that is, for psychologists, social workers, therapists, sociologists, nurses, doctors, therapists and students in these fields. This book is also for survivors themselves, who could find ways of approaching problems relevant to them. It is a continuation of the issues that were discussed in

the book "Interpersonal trauma and its consequences in adulthood" (Widera-Wysoczańska, Kuczyńska, 2010).

What are the contents of the book?

This book is divided into three parts. The first part characterises the issues related to the phenomenon of trauma. In the second part, the chapters' focus is on descriptions of factors that influence intervention and support. Then the third part concerns factors in effective therapy of people after trauma. The book as a whole is intended to provide expertise that can facilitate effective help and treatment for trauma survivors, and it shows which factors enhance a person's ability to heal.

In the First Chapter of Part I, Agnieszka Widera Wysoczańska describes the types of trauma: interpersonal and simple experienced by people who professionals specialising in this area have to deal with. The author compares the qualities which are characteristic for both traumatic occurrences which underlie the different ways of effective treatment of people experiencing interpersonal and simple traumatic stress.

In the Second Chapter of Part II, Alice Strzelecka-Lemiech and Alice Kuczyńska show that it is easier to get support when it comes to domestic violence from people who are professionally involved in helping than from non-professionals. It describes the factors relating to the effective delivery of assistance by social workers. These factors include amongst others a sense of responsibility and appropriate theoretical knowledge of the effects of domestic violence and, above all, knowledge of how to proceed against abuse. Of great importance is the level of empathy of professionals, which affects the assessment of domestic violence, the degree of personal responsibility for intervention and how to respond. An important role is played by social skills, such as the ability to be assertive: refusal, gaining favour within the social environment, the expression of both positive and negative feelings, and the ability to initiate and maintain a conversation.

Anna Bokszczanin, in the Third Chapter, describes the role of social support in reactions to the stress of flooding among adolescents. On the basis of quantitative research on 262 students of secondary schools she examined the relationships between distress (PTSD symptoms), and growth (stress-related growth symptoms), disaster trauma exposure, and social support. Post-flooding social support exchanges (support received plus support provided) were associated with both more PTSD symptomatology and further accounts of growth. On the other hand, young people’s positive attitudes in mutually helping were associated with less PTSD symptoms and were seen more as endorsements of stress-related

growth items. The consequences of experiencing traumatic events are the effects, both negative and positive (autogenesis), including spiritual growth, greater understanding of themselves and others, and improving relations with others. An affirmative attitude to help, feeling close contact with other people, affects the ability to effectively cope with trauma. A positive attitude towards helping other people is a protective factor against the development of PTSD.

Żurek Alina, Dąbrowska Grażyna, and Żurek Grzegorz in Chapter Four present difficult situations in old age and opportunities for providing psychological help. Psychologically, old age abounds in various events that carry the experience of loss, defined as difficult situations. These are interpersonal events (close relations dying), social events (retirement), both natural and pathological biological consequences (loss of health), approaching existential events, namely one's death and fear of it; and finally, the consequences of all the aforementioned events: negative self-evaluation, losing the meaning of life, the negative balance of life, feeling alienated, being misunderstood by others, and desolation (Steuden 2011). The events listed above, related to losses, present a strongly negative image of old age. Seniors experiencing old age in a positive way accept the passing of time and the irreversible changes in their lives. Among the persons examined are some who experience their old age negatively; they need support and psychological help in order to survive their old age. V. E. Frankl's logotherapy can be one psychotherapeutic method of help.

The issue of predictors of the effectiveness of therapy for women subjected to violence in close interpersonal relationships is discussed by Ewa Miturska in Chapter Five, which begins the third part of the book. The criterion for therapy effectiveness was changed with the sense of coherence level. A sense of coherence is understood in accordance with Antonovsky's concept of salutogenesis as a cognitive-motivational human personality construct. Another aim of the study was to investigate selected predictors of therapy effectiveness, namely emotional intelligence, the sense of control, and personality features. The results verified both individual and group therapeutic effectiveness conducted with the subjects, as well as the significance of the subjects' features in the process.

In Chapters Six and Seven, Agnieszka Widera-Wysoczańska tracks interpersonal trauma suffered in childhood, based on qualitative research which shows the factors facilitating and impeding the therapeutic process. The research conducted concerns the factors which influence the changes effected in people from dysfunctional families, aged between 21 and 53 during an 8-month course of therapy. Those participating in the therapy suffered from chronic interpersonal trauma in their childhood, including

emotional, physical, sexual and substance abuse. The healing factors, which, in the subjective experience of the examined persons, allowed them to enhance resilience, solve their problems, make changes and reach set goals. During the analysis of research material obtained, the following categories were created: the flow of time; feeling that one is a member of the group; revealing traumatic events in the presence of others; relationships with the therapist; support from persons from beyond the group; insight into the past; conferring meanings and looking from a new perspective; experimenting with expressing one's emotions; disclosure of being a perpetrator; insight into the thus-far existing relationships and learning to construct creative relationships with others, and learning to build oneself. During therapy, factors that impede recovery were established: negative evaluation of people in the group; fear and shame of revealing one's life; negating the meaning of his/her own experiences; the negative impact of others' stories on their condition; escape from remembering negative attitude towards oneself; toxic loyalty towards destructive parents; the mutual impact of therapy, and life situations, such as the influence of the therapy on one's life situation and influence of the life situation on the therapy; the perpetrators' accusations; dealing with other people's problems during the group therapy and beyond it in order not to deal with one's own problems; not taking risk; hiding the fact that one is a perpetrator of abuse; not revealing erotomania.

In Chapter Eight, Marilyn Korzekwa describes Eye Movement Desensitisation and Reprocessing (EMDR) created in 1987 by Francine Shapiro as a therapeutic process for the different types of trauma such as the stress of war, and natural disasters or traumatic events during childhood, including the experience of sexual abuse.

Finally, a general approach to treatment of post-traumatic disorders by a Croatian expert is put forward by Rudolf Gregurek in Chapter Nine. Post-traumatic stress disorder (PTSD) presents an important medical and social problem in the Republic of Croatia with a prevalence of 10-30 %, depending on the population. On the basis of his 15-year clinical experience in treating PTSD and a detailed analysis of related literature, Gregurek and a special team at the Clinic for Psychological Medicine, University Hospital Zagreb, compiled guidelines for diagnosis and treatment of PTSD. The established guidelines were independently developed, clinically proven at his clinic, and in terms of a custom-made procedure are unique worldwide. The essential feature is psycho-analytical comprehension and an approach to the etiopathogenesis of PTSD, although it also applies to other psychotherapeutic techniques (cognitive-behavioural, relaxation, existential). The diagnostic model is based upon a

structured clinical interview (DSM-IV, ICD-10), but also complies with the principles of psychotherapeutic interview. The therapeutic interventions as proposed are divided, according to therapeutic goal, into symptomatic and etiological.

PART I:

OVERVIEW OF TRAUMATIC STRESSORS

CHAPTER ONE

FEATURES OF SIMPLE AND COMPLEX TRAUMA THROUGHOUT A HUMAN LIFE SPAN

AGNIESZKA WIDERA-WYSOCZAŃSKA

When analysing the factors contributing to efficiency during trauma treatment it is important to recognise both types of traumatic events: simple and complex, and compare them by distinguishing similarities and differences.

Defining traumatic events

The opinions concerning traumatic events which result in serious consequences for a person have been formed most intensely since WWII. In the 1950s, according to international and American classification, traumatic events were described as huge stress appearing in the life of a person who did not report mental disorders, resulting in the occurrence of transient situational syndrome (Bret, 2007). In the 1970s the foundations of more contemporary knowledge were laid down. During this period Mardi Horowitz (1978, 1979) described a way of reacting to acute experiences threatening her life. At this time Lenore Terr (1979) outlined a development context of research concerning traumatic experiences on children who survived the school bus kidnapping (Chowchilla in California, 1976). Henry Krystal (1978) described the impact of trauma on ways of verbalising internal experiences and their somatisation. Charles Figley (1978) wrote a book on the trauma of war (combat trauma), which followed his service in the war in Vietnam.

Two basic types of traumatic events have an influence on human life and are described in literature in various ways. Traditional approaches concerning trauma perceive fear as the most important reaction which classifies a specific event as traumatic. Jennifer Freyd (2001; DePrince, Freyd, 2002) suggested that, depending on the context of their occurrence, traumatic events can be characterised by various degrees of fear and

feelings of betrayal. She deemed traumatic events to be the ones which can cause such strong feelings of betrayal and various levels of fear. Quite a low level of fear and a high level of betrayal arise from single occurrences of emotional or sexual abuse perpetrated by a stranger. Sadistic violence of all kinds caused by the closest ones is characterised by both the feeling of fear and that of betrayal. As opposed to the above situations, there are also traumatic events of high and very high levels of fear and with or without a low level of betrayal, such as natural catastrophes (e.g. hurricanes) and traffic accidents. A low level of betrayal and a low level of fear experienced during a particular event do not make it traumatic. In this way Freyd (2002) divided traumatic events into natural ones (predominantly connected only with fear) as well as interpersonal (combined with various levels of fear and betrayal). On the basis of the analysis, I divided the last group into interpersonal trauma in a family, perpetrated by a close person, and the trauma suffered by a third person important to the victim or by complete strangers. Table 1-1 presents them as chronic interpersonal complex trauma (acts committed by family members) and interpersonal simple trauma (acts committed by strangers).

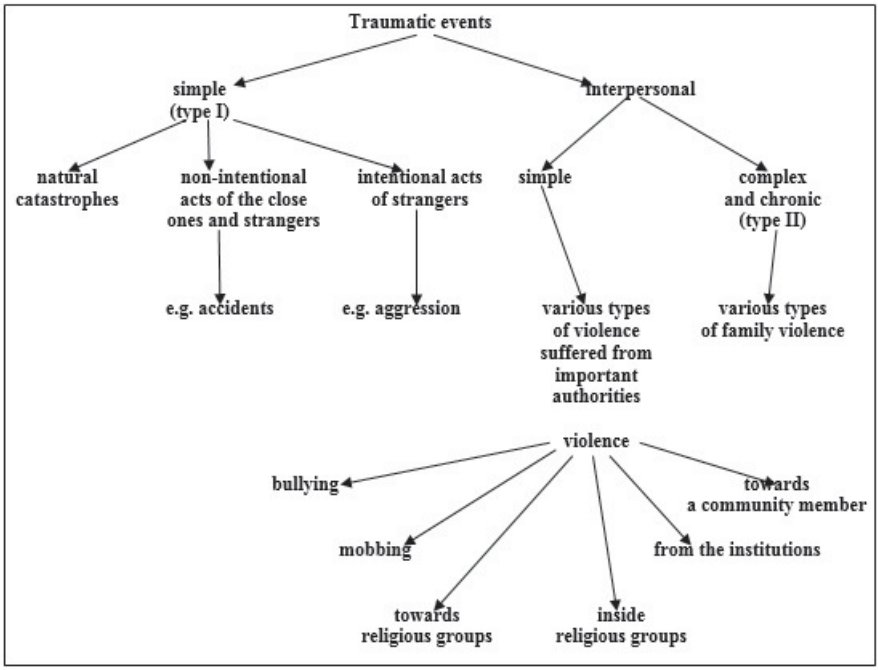
Table 1-1. Division of traumatic events according to fear and the sense of betrayal

- high level of fear - little or no sense of betrayal	Simple trauma: - natural catastrophes - traffic catastrophes
- high level of fear - high level of betrayal	Complex and chronic interpersonal trauma suffered from: - parents (guardians) - other family members (sadistic violence) - holocaust
- various (rather lower) levels of fear - various (rather high) levels of betrayal	Simple interpersonal trauma: - various interpersonal relations, including strangers in roles of authority - aggression from strangers, not known personally (sexual abuse, emotional abuse)

Source: elaborated from Freyd's (2001) basis by Widera-Wysoczańska (2011).

Another breakthrough in defining traumatic events shifting from a single situation to repeated occurrences was described by Lenor Terr (1991, 1994) as two types of trauma. Type I covers single occurrences already presented in the paper, single sudden and unexpected or not normative events, which make it impossible for a person to satisfy their daily needs and distort their points of reference. They include natural catastrophes, wars or rape or deeds caused by unintentional human acts such as road accidents or plane accidents. Type II trauma (chronic and complex) relates to repeated harm, which can be foreseen and expected by a person and which results from the intentional and conscious actions of another person. These types of traumatic events were described by Terr in order to show the specificity of traumas suffered by a child from his/her closest ones. Traumatic events of Type II include, according to Terr, various types of abuse and negligence in a family. In this way a division into simple and interpersonal traumatic events was made. Its expanded characteristics are presented in Fig. 1-1.

Figure 1-1. Types of traumatic events



Source: own research (Widera-Wysoczańska, 2011).

Simple traumatic events

Simple traumatic events i.e. Type I trauma could contribute to the occurrence of a "simple" PTSD in a person (DSM III, 1980; DSM-IV-TR, APA, 2000 and DSM-V-TR, http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf; 2015). A description of objective qualities was included in criterion A of this disorder, where a traumatic event is a situation in which a person experiences, is a witness to or hears about the event in which death or closeness of death occurred or physical health was endangered, or there was a danger of serious harm, and can bear the consequences of a catastrophic event or be its witness in another person, although he/she himself/herself has never been under threat. It can also occur when a person confronts a life threat involving a close person. This constitutes DSM-V-TR, without the requirement that the individual must experience intense subjective distress, such as fear, helplessness, or horror during or soon after the event.

Types of simple traumatic events

Table 1-2 presents examples of simple traumatic events. They are called simple as they do not typically involve abuse, aggression (natural or traffic catastrophes) or conscious intention to cause harm such as an attack by an animal (for example a dog) or one-time abuse in the form of drastic aggression suffered from a stranger (assault, rape on the street). They do, however, include acts of terrorism, kidnapping, torture, wars waged by strangers from whom the victim does not expect help or support, although long-lasting torture, being a prisoner of war or an inmate of a concentration camp is also considered a chronic trauma (Briere, Scott, 2006).

Table 1-2. Simple traumatic events

PTSD criterion "A"	Examples
In order to be able to speak of a traumatic event, a person must experience an event defined by criterion A1.	Simple traumatic events.
A 1.1. Being informed about a violent or accidental death or a threat of death that happened to a close relative or friend.	Natural catastrophes: earthquakes, floods, volcanic eruptions;

	Man-made catastrophes: traffic accidents with numerous victims: aeroplane or ship crashes, train or bus accidents; traffic accidents with one or several victims: car crashes, motorcycle crashes; house or other building fires; building collapse; Interpersonal violence is perpetrated on a single occasion by strangers: rape, assault, physical attack, battery; Animal attack, e.g. by a dog; Warfare; Torture; Terrorism; Kidnappings.
A 1.2. A person was subjected to the consequences of a catastrophe, although he/she was not endangered in person.	Seeing the corpses of people who died: e.g in a car accident, or in an earthquake; Seeing a beaten man; Rescuers exposed to trauma.
A 1.3. A person is confronted by the consequences of an occurring threat to the life of someone close.	The information that someone we love, someone important to us was seriously injured or died in unexplained circumstances, it is unknown what happened to their body; Kidnapping, the disappearance of a close person or lack of information about him/her.

Source: A. Widera-Wysoczańska (2010a; 2011) based on: APA, DSM-IV-TR (2000) and DSM-V-TR; Allen (2001); Briere, Scott (2006); van der Kolk, McFarlane, Weisaeth (2007).

In turn, according to a reaction to serious stress (F43) described in ICD-10 (1998, pp. 96–97) a traumatic event is an occurrence or a stress situation, long-term or short-term, of exceptionally life-threatening or catastrophic character, which would evoke serious reactions in almost everybody (Table 1-3).

Table 1-3. Simple traumatic events according to ICD-10

In order to recognise the disorder category: "Reaction to serious stress" one of the following circumstances must occur:
1. Severe reaction to stress or post-traumatic stress disorder occurs as delayed or extended reaction to an exceptionally stressful event or short-term / long-term situation with features that are exceptionally threatening to life or catastrophic such as: natural disaster or a man-made catastrophe, war, assault, serious accident, presence at somebody's violent death or torture, terrorism, rape, crimes or sudden, threatening changes of social position, multiple orphaning over a short period of time, a house fire which might result in an intense feeling in almost everybody (criterion A). 2. A significant change in life is a permanent, unpleasant situation which leads to adjustment disorders. 3. Genesis and escalation of an acute reaction to stress depend first of all on personal sensitivity and the ability to cope with stress.

Source: ICD-10 (1998, p. 96-97).

The same event does not need to be traumatic for everyone, which is why in DSM-IV-TR (2000) and ICD-10 (2003) it was stressed that an objective description of a traumatic event is not sufficient and should take into account "individual sensitivity" i.e. the way it is subjectively interpreted by a person. It is assumed that traumatic stress can follow from a real external threat or from somebody's subjective interpretation of these events as well as their ability to cope with stress.

Features of a simple trauma

Simple traumatic events occur in human life as one-time or repeated situations. They last over a limited (usually short) period of time; yet some social groups are exposed to the permanent hazard of recurring natural catastrophes. Such events go beyond everyday human experiences, and thus cause significant fear. It can happen (start and finish) at various ages. The condition before and after the trauma is always known, despite the fact that it can last for some time and can be repeated (e.g. a flood). These traumatic events are sometimes predictable (e.g. an earthquake in a place of high seismic activity), but more frequently their occurrence is unpredictable for a person (e.g. road accidents, terrorism, sudden acts of aggression). Therefore they cannot possibly be controlled. Some of these occurrences are not caused by man, such as, for example, natural

catastrophes (e.g. earthquakes, tornadoes, hurricanes, floods or fires). Others are of an interpersonal character and the perpetrator could be a stranger, from whom one does not expect safety and who commits a single act (such as rape or street assault, torture, war) or when a human error occurs, for example when a house collapses or a dam bursts due to faulty construction, or information was not provided concerning the approaching catastrophe, although it was available. Simple traumatic events are of a direct character, when a person's life or health is threatened, e.g. through a traffic accident or a natural catastrophe. Indirectness is their characteristic quality. When a person is a witness to an event and its consequences, for example they see their close ones or strangers whose health and lives are endangered or witness their death; the consequences, i.e. effects of the traumatic event are observed. A dramatic event causes a traumatic interpersonal effect in the form of the loss of a close person or the loss of a house, for example, due to fire.

The features of a simple trauma can have consequences and influence factors affecting the effectiveness of healing a person who suffers from them.

Interpersonal traumatic events

Definitions presented in DSM and ICD do not include complex and chronic interpersonal events, which is why for numerous researchers, especially for clinicians, these events were insufficient and led to further research concerning the second type of trauma.

Types of interpersonal traumatic events

The author of this chapter divided interpersonal trauma into the following factors (as in Table 1-4; after Widera – Wysoczańska, 2011):

1) type of a person who commits an act:
   - a complete stranger
   - a familiar person
   - a close person
2) duration:
   - single occurrence
   - lasting for a short specific period of time
   - chronic, long-lasting, often for the whole period of one's life
   - since childhood

3) structure:
   - simple (experiencing one type of abuse)
   - complex (experiencing various types of abuse during the same period of time)
4) reasons:
   - accidental and non-intentional
   - conscious bravery without a direct intention to harm
   - purposeful and intentional
5) traumatic interpersonal consequences which violate the social points of reference of a person:
   - before the traumatic event
   - after the traumatic event
   - mourning after a loss.

Table 1-4. Types of interpersonal events

Type of person	Duration	Structure	Reasons	Traumatic interpersonal consequences
a complete stranger	single	simple	non-intentional, accidental	before the trauma
a familiar person	short-term	complex	conscious bravado	after the trauma
a close person	long-term chronic		purposeful and intentional	mourning

Source: Widera-Wysoczańska, 2011.

Among single or specified-in-time interpersonal traumatic events the following are differentiated (Widera-Wysoczańska, 2011):

1) a single act of aggression experienced directly (one is harmed) or indirectly (another person is harmed in our presence or we can see the consequences of harm) e.g. rape, beating, assassination,
2) abuse lasting for a longer, but specific period of time e.g.: mobbing, bullying, cyberbullying, kidnapping, war, torture.

These acts can be committed by complete strangers or people not related but important to a victim such as friends and acquaintances, school

colleagues, neighbours, superiors at work, officials in institutions, people belonging to religious groups, people representing a political system or family members – although in such situations the traumatic events are rarely single instances.

Complex and chronic interpersonal events lasting for a long period to be specified are the following (Widera-Wysoczańska, 2010c):

1) attachment trauma (Bowlby, 1980, 1984; Allen, 2001), which includes various destructive models (anxious/ambivalent, avoidant, disorganised) of a child relationship with his/her guardian;
2) various types of family abuse: partner – partner, parent – child, child – parent, siblings, uncles, aunts, grandparents and others;
3) various types of aggression between family members, most frequently being an element of violence mechanisms.

They are perpetrated mainly by persons from the closest and also more distant family: biological, adoptive, or foster care. Abusers can also be a man who are particularly important to the harmed person, for example, concubines or partner of a parent.

Interpersonal trauma can have various structures. In relation to the above, the author of this chapter described traumatic simple events i.e. composed of one type of abuse, as well as complex ones when a person suffers from various types of violence over the same period of time.

Three main causes of interpersonal traumatic events are observed (Widera-Wysoczańska, 2011):

1) non-intentional, resulting from an accidental occurrence or another person's inattention, e.g. a traffic accident (an aeroplane, or a car), an accident caused by the faulty construction of a building;
2) a result of irresponsibility, conscious bravado without intention to hurt anybody e.g. a car accident, aeroplane crash caused by an inexperienced pilot, the collapse of a building caused by a conscious change of construction plan or changing the construction materials without the constructor's consent;
3) intentional, deliberate acts: e.g. family violence; street violence (battery), abuse at work (mobbing).

Simple non-interpersonal and interpersonal trauma (natural catastrophes or aggressive assaults) and complex trauma can have a negative impact on relationships with others, as they violate the existing

system of social reference. They produce traumatic interpersonal consequences, constituting another stressful situation, which takes on a traumatic character. These consequences are grouped as follows (Widera-Wysoczańska, 2010c):

1) distortion of an individual's social reference system after experiencing trauma:
   - worsening of relationships with people from social groups,
   - loss of support from the family or social group,
   - feeling of being under threat from others;
2) mourning caused by loss and following change of the status quo:
   - mourning after a loss of a close relative (parting, separation, divorce, death),
   - mourning after the loss of a home or house (as a result of a catastrophe or domestic violence),
   - mourning after the loss of a job;
3) distortion of an individual's social reference system before and after a traumatic event:
   - loss of trust related to lack of protection from non-interpersonal trauma (e.g. wrong decisions or their lack of concern for protection from catastrophes),
   - loss of trust due to lack of protection from interpersonal trauma (e.g. escalating domestic violence, at school or at work).

Abuse as a chronic interpersonal traumatic event

Abuse is perceived as each non-accidental act exceeding the social norms of mutual contacts, attacking an individual's personal freedom and forcing him/her (e.g. by manipulating people and their environment or influencing their feelings through emotional and physical aggression) to acts inconsistent with his/her own needs or will. Violence is an advantage taken in order to impose one's will on others, to force something on them or to unlawfully impose authority on others. According to the dictionary of phraseology, (Muldner-Nieckowski, Muldner-Nieckowski, 2004) violence is a person's decision to use force, emotional or physical constraint and to brutally threaten others. It is an intentionally presented threat, occurring in specific social interactions.

In dysfunctional and pathological families numerous traumatic events may occur, which comprise complex, chronic trauma. In a family, traumatic interpersonal events take various forms. They can be experienced from early childhood and throughout a whole human lifetime.

The following can be enumerated (Widera-Wysoczańska 2010a, 2010c, 2011) as instances:

a) insecure attachment (anxious/ambivalent, avoidant and disorganised) parents with children,
b) emotional abuse and neglect,
c) being abandoned by parents leaving for work abroad e.g. euro-orphans,
d) physical abuse and neglect,
e) child sexual abuse with intimate physical touching (e.g. fondling, penetration, rape, production of child pornography), sexual abuse without touching (e.g. inappropriate nudity, sexual intercourse of an adult in the presence of a child, pornography), emotional sexual abuse (e.g. vulgar insults and jokes, sexual evaluation of the child's body, intergenerational shift of roles - a child is a partner of a parent),
f) sexual abuse between partners,
g) homophobic abuse, between, for example, family members,
h) child over-protection, which can be at the same time emotional and sexual abuse; also Münchausen syndrome by proxy (MSBP) was included in this category,
i) a parent's / partners' addictions, e.g. alcohol, medicines, drugs, pornography, sex, work,
j) separation or emotional/ physical divorce of guardians,
k) economic abuse,
l) medical abuse,
m) kidnap by one of the parents,
n) pathological experiencing of grief after losing a close person,
o) pathological reactions of guardians to child or other family member's chronic diseases,
p) persecuting and stalking by a partner or another close (or strange) person,
q) family violence during the court proceedings.

Beyond the family, numerous interpersonal traumatic events towards children and adults can also occur, which are isolated events or which last for some time. These include, among others, the following:

a) peer violence (bullying), emotional, physical or sexual, at school, kindergarten or in the playground,

b) abuse from teachers at school: (a) ignoring, excluding, neglecting students in the situations when a threat is present in the peer group and (b) active verbal, emotional and physical or sexual abuse,
c) homophobic abuse,
d) mobbing and discrimination at a place of work: economic abuse, emotional, sexual (sometimes physical) abuse at work from superiors or colleagues,
e) abuse in religious groups: emotional, physical or sexual,
f) abuse in sects: emotional, physical or sexual,
g) abuse in various institutions,
h) persecuting various social, religious or other groups,
i) persecuting members of social or religious groups,
j) violence against children as a result of court proceedings.

The World Health Organisation distinguishes one more very important category: "violence carried out on oneself", including self-harm and suicidal behaviour as well as addiction to self-destruction.

Active and passive perpetrators

Abuse and aggression are performed by "active perpetrators" and "passive perpetrators". These are persons from the family or the environment, such as school, work, religious groups, offices or strangers (Salter, 1995; Widera-Wysoczańska, 2010c, 2011).

An "active" perpetrator deliberately and intentionally uses violence towards another person in order to feel satisfaction from harm or pain caused, to reduce unpleasant and haunting emotional stress and to satisfy their needs. They force their victims to focus on them. This mechanism is progressive and its immanent quality is its specific dynamics, typical for these forms of abuse. With premeditation the perpetrators manipulate children or adults, seduce or intimidate them in order to affect them emotionally or materially and subordinate them for the purpose of later betrayal with the use of emotional behaviour, physical or sexual abuse or violence caused by addiction. The perpetrator's way of acting is not accidental. It is controlled, considered and adjusted to the way in which the victim functions, the time it takes place, the location and manner of impact, in such a way that it is the most effective and the least risky for the attacker. The active perpetrator is supported by lack of activity on the part of a passive perpetrator.

"Passive" perpetrators passively observe and do not react to the active perpetrator's behaviour; they do not help the victim, do not protect or

support them and do not report this fact to proper authorities or institutions. Therefore, abuse takes on the form of an action of abandonment. It is done on purpose, in order to satisfy their need for peace, security, belonging to a partner or to the institution at issue (Widera-Wysoczańska, 2005). Passive perpetrators are most frequently mothers, fathers or other adults from a family who do not protect a child or an adult, do not take care of them, do not care about his/her safety, or lie that there is no violence.

They can also be people from the environment who know about the harm being done but do not react: teachers at school, doctors who pretend not to see signs of violence on a child's body or state that they cannot determine their causes; employees who do not react when their colleague is harmed; neighbours who hears a child's screams through a wall and do not report it to the proper authorities; a hired babysitter who sees a mother or father's criminal activity but does not want to interfere with his/her employers' lives.

Aggression as a simple interpersonal traumatic event

Aggression (Latin aggresio – attack), is generally a violent act directed towards a person or institution or towards oneself, motivated by anger, annoyance or frustration and aimed at causing physical or emotional harm. If someone is aggressive, we can say they are truculent, aggressive, and hostile in certain situations or circumstances, dangerous to something or someone (Muldner-Nieckowski, 2004).

The following types of aggression can be differentiated:

a) enemy – aggression with the aim of hurting or causing pain,
b) instrumental – aggression for a purpose other than hurting or causing pain, e.g. intimidating, or removing competition,
c) pro-social – protecting social interests, defensive,
d) induced – arising as a result of psycho-manipulation,
e) auto-aggression – aggression directed against oneself,
f) transferred aggression – moved from an unavailable object to an available object,
g) passive – a method of exposing negative emotions through mental harassment of another person; passive aggression occurs when through cultural norms a person is forced to withhold physical abuse; it happens on purpose and is a conscious act.

Aggressive behaviour is a special kind of relation taking place in a specific social interpersonal situation of people interacting with one another, directed against a person or people.

Aggression criteria

When deciding whether a specific type of behaviour is aggressive, numerous criteria have been listed. It was determined that these are forms of behaviour of various structures (Rode 2010):

a) simple reactive reactions - constituting the organism's aggressive responses to external and internal incentives eliciting aggression,
b) aggressive actions - more complex and lasting for longer time sequences of behaviour,
c) aggressive operations - long-term forms of human activity,
d) distortions in the sphere of forms of asocial behaviour (ICD-10, 2000), constantly repeated dissocial behaviour and nasty, aggressive behaviour.

All these forms of behaviour are directed against oneself or against a group of people and they lead to a certain result, which harms others and oneself.

On this basis, apart from the notion of aggression, a notion of aggressiveness was distinguished which can be: (a) an acquired property formed in the course of one's own experiences, (b) learned disposition – readiness to react with aggression or as a habit. Aggressiveness is characterised by a high frequency of forms of aggressive behaviour combined with inadequate reaction to incentives, unskilled control of aggressive behaviour and constant hostility towards others.

The following types of aggression can be distinguished (Rode, 2010):

a) due to type of action – physical and verbal,
b) due to the perpetrator's activity – active (active impact) or passive (indirect impact),
c) due to the subject – direct (open, visible attack on a person or their values, the perpetrator is known) and indirect (attack on a placeholder object, where the aggression is transferred to other people; frequently the perpetrator and the actual victim are not known),
d) behavioural (against specific victims) and symbolic (against people or things symbolising the object).

The Aggressor's goals

Aggressive behaviour plays a psychological function and serves the perpetrator. In the case of hostile aggression it is the will to harm another person, because causing pain and suffering gives pleasure to the perpetrator. In instrumental aggression the aggressor strives to reduce negative emotional stress, to seek pleasure, to satisfy their biological and social needs. When aggression is connected with a social role (e.g. a policeman) the tasks following from that kind of aggression causes brutal action and negative consequences (Krahe, 2005; Rode, 2010). Aggressive behaviour results from subjective, conscious intention or motivation of a perpetrator and is aimed at harming and hurting someone. They include intentional aggressive lack of action, when not providing help is harmful (Tedeschi, Smith and Brown, 1974). Aggression can be assumed on the basis of the characteristics of types of behaviours and their circumstances. Similarly, as in the case of abuse, it is difficult to objectively state whether a specific aggressive form of behaviour was conscious and intentional or not. An intention to harm is not directly apparent in one's behaviour, but we can assume it from the context.

How is abuse different from aggression as an interpersonal traumatic event?

Both phenomena have an interpersonal character. Abuse seems to be based on complex mechanisms of building the relationship of dependency and intimidation, calculated by the perpetrator, keeping secrecy, tolerating possession of its own dynamics depending on the type of violence. Aggression is either simple or a more complex reaction, state or feature of a person, on a single occasion or repeated. Abuse is launched usually as deliberate actions by the perpetrator; aggression can also be a sudden reaction to an incentive. Aggression can function separately (as a one-time reaction) or it can be one of the tools used in violence mechanisms, visible mainly in its acute phase. Abuse is not always aggressive if we understand aggression as a sudden physical attack; or it is always aggressive if we understand it as causing emotional, physical, or sexual harm to another person, who bears its consequences. Aggression is typically perceived by the victim as violence. Abuse can be unnoticed by a victim for a longer period of time or can be treated as a daily standard and it is an interpersonal traumatic event which is chronic and complex. Aggressive behaviour is an interpersonal simple traumatic event (Widera – Wysoczańska, 2011).

Features of complex and chronic interpersonal trauma

Interpersonal psychological trauma perpetrated by close relatives arises in relation to repeated, chronic and complex stressful situations, which follow from the behaviour of their closest ones, whom they love and who are authorities for their victim, on whom their victim depends.

This trauma is also connected with people from beyond the family, often with someone with whom we have a relationship as a colleague (e.g. at school) or in a professional (e.g. employer) context. Trauma can also be suffered from complete strangers, when one experiences a long-term confinement due to kidnapping, or imprisonment. People who survived the holocaust have also suffered from this type of trauma (Widera – Wysoczańska, 2011).

Interpersonality

Traumatic events in a family are caused by the actions of close relatives, people important for a victim, from whom they expect love and security. Apart from the family, such behaviour can occur in relations with complete strangers or strangers who are important and in a position of authority.

Complexity

Interpersonal trauma in a family is decidedly more often considered a complex stressful event. The complexity of traumatic events means that in the same period of life a person experiences at the same time, on the same day, in the same week, over the same period – various types of abuse e.g. neglect, emotional, physical, sexual or alcoholic abuse. Sybil, whose story was described in the book Sybil (Schroeiber, 1973), experienced a sadistic emotional, active and passive physical abuse as well as sexual abuse with touching (under the pretext of taking care) by the mother for many years of her childhood, whereas her father neglected his daughter, abandoned her emotionally and did not protect her from serious violence. A similar reaction was observed amongst other persons: a doctor or a grandmother, who had contact with her, had evidence that she was being hurt and could have protected her, but did not.

Apart from the family, strangers frequently perform “simple” traumatic acts when a person experiences violence of one type (e.g. exclusion by their peers at school or in the backyard or emotional humiliation by the employer).

Chronicity and inevitability

A chronic series of interpersonal traumatic events in a family means that events such as rows, silence (i.e. emotional abuse), beating (i.e. physical abuse), intergenerational exchange of roles (emotional or sexual abuse), exceeding intimate borders, acute sexual abuse (sexual abuse) and parent's alcoholism are frequently repeated over a certain period of a person's life or for many years. Such traumatic events become the inevitable experience of a child or an adult, because various types of violence are experienced day by day. A person who lives in such an atmosphere every day has nowhere to escape. A child beaten or sexually abused is not able to pack his/her things and move out.

Abuse from important people from outside the family can be one-time or repeated and then it occurs for a limited period in a person's life. A victim does not live with the perpetrator 24 hours a day and could make a decision not to see the perpetrator.

The chronic behaviour of active and passive perpetrators in a family could cause grievous emotional stress and general fear as well as creating cognitive distortions of perceptions of violence as "normal" and "daily", typical for all families. A man who is harmed for a specific time by other family members or others outside the family does not treat this as "normal daily life" but as something difficult to accept and continuing, frequently cruel "inconvenience" or social pathology.

Normality

Abuse resulting from repetition is "normality" in human daily life. Many people who have experienced abuse in a family since early childhood treat it as normal and do not realise the fact that in other families similar behaviour does not exist (e.g. eroticisation of family life). When a perpetrator is from beyond the family, a lack of feeling of the normality of abusive behaviour occurs most frequently. Violence at school (in Poland), in the current pathology of social life, is more and more frequently treated as the norm. In their development, adolescents treat it as a norm: "exclusion" of some students, cyber-violence, pornography, drug addiction, self-highs or self-destruction (mutilation, tattoos, also on the whole body). Both those victimised as well as the perpetrators cannot imagine a different style of relationship.

Family and social secret

Abuse in the family is kept secret between the perpetrator and the victim or becomes a family secret known to everyone. Nobody is interested in revealing it. In social life the secret is known to all the people in the community. All "initiated" people pretend that violence does not take place (e.g.: in the case of bullying, it is known by other students and teachers, and similarly in the case of mobbing co-workers). In each case this strengthens the offender and increases in the victim's feelings of inevitability and of being trapped and helpless (Widera – Wysoczańska, 2006).

Repetitiveness and unpredictability

Trauma in the family is predictable, as it is repeated. The person is certain that harm will be committed again but does not know exactly when, in what way and to what degree. So they live in an atmosphere of constant threat. Their incapacity to predict danger (which takes place also outside the family) leads to generalised fear. It is connected with a compulsive need for recognition by the child and gives other family members signals of the coming violence. This releases a constant cautiousness to the aggressor's behaviour as well as non-verbal signals they provide. The exact time when another traumatic event occurs as well as the degree of brutality are impossible to predict, therefore a person reveals a lack of internal control and a feeling of learnt helplessness. A lack of control can lead to a general feeling of threat extending to the whole family and the external environment.

Escalation

A complex trauma is prone to escalation. If more than one traumatic event occurs in the family and it involves, for example, emotional abuse, it is highly probable that the events will escalate and as a result there will occur other, more drastic forms of violence, including beating. Physical abuse starts with e.g. shaking, which consequently may lead to threatening family members and creating constant fear and helplessness. Sexual abuse usually starts with the emotional seduction of a child and addicting him/her; afterwards erotic touching appears which can finally lead to aggravated rape. Watching pornography starts with pornography for adults and then the perpetrator needs more and more drastic incentives, moving on to watching, for example zoophilia and child pornography.

Directness and indirectness

A complex trauma is direct when a child or other person is personally harmed, and indirect, when observed - as a witness of abuse of their relatives, siblings, parent(s) or the consequences following on the abuse. Direct roles include: a person who harms and a person who is being hurt. Adults or peers being harmed indirectly become active participants in the circle of violence: "wrongdoer - the person directly harmed - witness". Roles people play when they witness abuse include (Besag, 1989; Cardemil, Cardemil & O'Donnell, 2010):

a) a person who assists: does not start the abuse or lead in hurtful behaviour, but may encourage the abusive action and occasionally join in;
b) a person who reinforces: not directly involved in hurtful behaviour but acts as the audience and provides different support for the abuser (e.g. laughter) and this way encourages the offender to continue;
c) an outsider: remains separate from the hurtful situation, he neither reinforces hurtful behaviour nor defends the person being abused, also does not provide feedback about the situation to show he is on anyone's side, however, as an unresponsive witness, he encourages the perpetrator of the abuse;
d) a person who defends: this one actively gives support to the person being abused and may defend the victim against violence.

The role of the victim is apportioned to all of them receive and they all experience abuse indirectly, while an assistant, outsider and instigator assumes the role of a passive perpetrator. Outside the family, direct violence has consequences for them, whereas indirect violence seems less significant.

The degree of a perpetrator's reflexivity

A feature of traumatic events is the reflexivity of passive and active perpetrators (Widera-Wysoczańska, 2010a, 2011). The lower the reflexivity of people responsible for violence against the child and other family members, the more doubtful the chances of improving the situation in a dysfunctional and pathological family and stopping the harmful behaviour of the perpetrator. Rigid thinking and behaviour as well as being directed with destructive myths strengthen violence (Table 1-5).

Table 1-5. Features of interpersonal traumatic events in a family and outside it

In a family	Outside the family
1	2
Complex: a person suffers various types of abuse and neglect at the same time.	Simple: a person suffers one type of violence at a time.
Chronic: traumatic events are repeated numerous times a) over the same period of time b) for many years of the person's life.	Once only or repeated: lasting for a specific, limited period of time.
Inevitability: a child who lives with perpetrating parents and has nowhere to escape to, a beaten wife who lives with an aggressive partner and has nowhere to move to.	Certitude: a person can choose not to come back to a place where they are abused.
Daily: a person experiences traumatic events (various types of abuse) day by day.	Temporary and non-daily.
Normality: as a result of the repetition it becomes a "normal" daily experience.	Lack of feeling of normality: unless the social pathology is treated as normal.
Family secret: known only to the perpetrator and victim or known to the family, but not people from outside the family.	Social secret: known to many people from a particular social group.
Interpersonal: traumatic events are the actions perpetrated by close people who are important to a harmed person.	Interpersonal: relationship with others a) unknown strangers, b) strangers who are important, authority figures.
Deliberate and intentional: abuse is perpetrated on purpose and intentionally.	Deliberate and intentional: abuse is perpetrated on purpose and intentionally.

Predictability – unpredictability: a person knows that he/she will be harmed again, but does not know how and when.	Predictability – unpredictability: he/she predicts that traumatic events can recur, but does not know when and how.
Loss of control: over oneself, over one's environment, generally over one's life.	Loss of control: over fragments of one's life, in a specific sphere: relationships with peers or at work, broadly no generalisation.
Escalation: a specific type of violence is escalated and subsequently other forms of violence occur, becoming more and more grievous.	Escalation of a specific type of abuse: a specific type of violence is escalated most frequently, violence can recur, each time more severe (e.g. from peers or employers).
Directness and indirectness: a child or another person is hurt personally or (as a witness) observes as their close ones are hurt and bears the consequences of that.	Directness: a person is harmed; Indirectness: depending on the circumstances they observe other's harm.
Reflexivity: the lower the reflexivity of active and passive perpetrators, the lower the chances of changing the situation in a family and the greater the chances of an escalation in violence.	Reflexivity: the lower the reflexivity of active and passive perpetrators, the lower the chances of changing the situation in a family and the greater the chances of an escalation in violence
Feeling of betrayal: high.	Feeling of betrayal: low or high.

Source: Widera-Wysoczańska, 2010a; 2011.

Betrayal and fear

Interpersonal trauma both in a family and beyond it can be experienced by a person in various periods of their life: in childhood, youth, or in adult life. It is related to staying in a relationship with people playing various roles in our lives. Trauma occurs most frequently in dysfunctional and pathological families. Particularly painful is the behaviour of people who are authority figures, whom one trusts and from whom one expects love, protection and safety. These are the persons who play the role of our guardians in our childhood: mother, father, grandfather, grandmother, uncle, aunt and other family members. Such a type of interpersonal trauma is called "betrayal trauma" (Freyd, 2001). Betrayal follows from

squandering or breaking the trust. The closer and more important the relationship, the greater the degree of betrayal experienced. A reduced feeling of betrayal appears when people from outside the family hurt others. In adult life trauma is related to the behaviour of our partners whom we love and from whom we expect attachment, understanding, co-operation and honesty, as long as the relationship lasts and after it is finished.

Betrayal trauma occurs mainly in relationships in a family, but it also appears in social structures, which we should trust: the school (bullying), place of work (mobbing), in a shop or inside religious groups or in a country's economic or political system. The behaviour of teachers, educators, priests or doctors as authority figures for others can be difficult as we expect wisdom, justice, appreciation and rational actions from them. A child treated unfairly by a teacher who does not appreciate his/her true abilities can feel betrayed and lose the will to learn. We expect responsibility, honesty, balanced and lawful behaviour from our superiors at work. However, every relationship is different and even these short-term events can be traumatic, if they are not consistent with the commonly binding rules of social life.

A student treated unfairly by a teacher who is the authority for him/her by definition can feel rejected, not accepted and can experience feelings that the principles of justice have been betrayed, especially if everybody pretends that nothing has happened and the teacher is entirely right. Unfortunately, a student has limited possibilities for changing the situation and releasing him/herself from such a relationship. The employee depending on their employer feels betrayed in a way, when they are treated in an unjust, unreliable and unfair way or when they are subject to mobbing. Nobody reveals the fact that they see the employee's difficult situation. It seems that they can resign from work, as they are not emotionally related to their employer, but they are dependent financially. A member of a particular religious community shows limitless trust to his/her leader, therefore not understanding exclusion or persecution from the group members becomes a traumatic event for them. A person cheated in a shop can either complain about the salesman's behaviour or stop shopping there, but they will be more cautious in the future.

One can also feel betrayed when someone whom we must trust does not inform us about the probable hazard to life i.e. aeroplanes or buses, or the management of a dangerous mine where miners still work.

Differences and similarities of simple and interpersonal traumatic events

The features of a "simple" and interpersonal trauma described in this chapter show differences between these two occurrences. The differences arise from differing (after Widera – Wysoczańska, 2011):

(a) sources of traumatic events
(b) internal structure
(c) starting time
(d) relationships with active and passive perpetrators and people from their environment
(e) influence on a person.

Sources

Trauma occurs as a result of acts of Nature, and as hazards or the aggression by a stranger. Interpersonal trauma, chronic and complex, arises in a family due to the impact of close and important persons. Interpersonal simple trauma or trauma lasting for some specified time arises as a result of acts committed by strangers who are important to us.

Structure

Interpersonal trauma in a family is complex, composed of numerous types of abuse which last for a long time in a person's life. Their repetition results in the fact that such a traumatic event becomes a "normal" experience inscribed on a person's life.

Interpersonal trauma experienced from a stranger familiar with a victim can be simple or complex, once only or repeated, lasting for some time, yet it does not become a normal life experience.

A simple traumatic event is non-interpersonal and concerns a situation lasting a limited time and therefore it exceeds a daily, normative experience of a person. A natural catastrophe in a person's life occurs typically not more than once or several times in a life (e.g. in land areas with high seismic activity) and many people have never experienced it.

Both traumas are characterised by their directness and indirectness. The difference consists in the sources of these qualities. In the case of interpersonal complex trauma, the health or life of a person is threatened by purposeful and intentional acts of a close person, from whom we expect love and security; the acts are directed towards us, e.g. one is shouted at,

beaten or sexually abused, or indirectly when someone is a witness to the behaviour directed against close ones or their results, e.g. one can see their mother or siblings being beaten as well as see physical marks of abuse on their body along with psychological consequences. Due to violence existing between family members one can lose a close person (separation, divorce, death) and experience related mourning. One can lose a home (the need to move out whereas the perpetrator stays there), and not receive social support or lose close relationships. The consequences described become other traumatic occurrences.

During the simple trauma a person's life or health is directly threatened due to natural forces (natural catastrophes), a mistake committed by a person (traffic accident) or a stranger's aggression who was indifferent to us (battery in the street, a terrorist attack or war). A person can directly experience a traumatic event being a witness to a natural catastrophe, a traffic catastrophe or a building disaster caused by a human mistake or by the aggression of a stranger and as a witness to consequences following these events for others, they see close people and strangers, whose lives and health are threatened and they observe their death.

Due to the forces of nature, a human mistake or the physical aggression of a stranger or a chronic interpersonal trauma one can suffer from traumatic interpersonal effects [Allen, 2001] taking on such forms as: traumatic bereavement after losing a close person (splitting up, death) or after losing one's home (e.g. due to a flood or fire or the necessity to move out), losing support from the social system or in the form of a threat from strangers.

Starting time and duration

Interpersonal traumatic chronic events in a family usually start during the first weeks, months or years of a person's life, in their family of origin. It is difficult to observe the person's condition "before" this event as well as its chronicity "after" it. It happens that in the current family in the adult person's life it appears in the form of long-lasting domestic violence.

Interpersonal "simple" events last for a longer or shorter period of time in a person's life and they start at a time possible to be observed. Dealing with "simple" interpersonal events or acute simple events (natural catastrophes) can happen in various periods of one's life; therefore there is typical awareness of the condition "before" and "after" the event.

When a person experiences interpersonal chronic events, problems can occur concerning the possibility of diagnosing the child's or adult's mental condition before its occurrence as well as determining the fact when

specific emotional, physical or sexual abuse occurred. In the case of simple and acute interpersonal trauma we can diagnose the psychological or somatic condition before the stressful event and after its termination.

Relationships with others

Interpersonal complex and chronic trauma is connected with the relationship(s) with an active and passive perpetrator and with people from the environment. It usually happens in an original or current family. It is caused by close ones, important persons whom one trusts and loves and from whom one expects security, love, support and protection. The closer the person, the greater the feeling of betrayal and the greater the consequences in a person's life. The relations with people from the environment are also important as they often see the harm but do not support the victim. These people become passive perpetrators.

"Simple" interpersonal trauma caused by a person from outside the family who became important for a child or for the adult.

A simple trauma can have an interpersonal character, when it is caused by a stranger from whom we do not expect love and safety (a single attack: battery, rape, outside a family environment, a terrorist attack, war) or by a stranger or a close person who committed a mistake causing, for example, a coach accident or a car crash; or the structure of a building that collapsed. In the case of natural catastrophes, trauma is not of the interpersonal background (Table 1- 6).

Table 1-6. Comparison of traumatic events

		Interpersonal	
Features	Simple, acute	Complex, chronic (Type II)	Simple
Sources	Forces of nature. A hazard resulting from a human act. A stranger's aggression.	Violence from: - close persons from a family, - strange but important persons;	Violence from: - important strangers, - peers, - institutions, - employer, - environment, - religious communities;
Structure	Without violence. Unpredictable: -when and to what degree; Predictable: -it is known it will occur again (seismic activity areas); Uncontrolled: -a stranger's aggression unpredicted and uncontrolled;	Complex: -several types of abuse at the same time, Predictable: -a person knows the violence will recur, and -they know it will be escalated; Uncontrolled: -one cannot control when it happens, -does not know its form, or -the degree of escalation;	Simple: -one type of violence; Complex: -several types of abuse at the same time; Predictable: -one can assume it will happen; Unpredictable: -one does not know exactly when, -what form and -in what escalation;

	Directness: -health or life is threatened due to forces of nature or a stranger's aggression Indirectness: -one is a witness or hears about a natural catastrophe caused by human error or a stranger's aggression, -one hears or sees the consequences appearing among their closest ones or strangers, whose health and life is threatened or one sees their death;	Directness: -a person's life or health is threatened by the acts of a close person e.g. one is beaten; Indirectness: -one is a witness of events or -their results caused by actions of a close person (one can see the fact of violence against somebody close or physical marks and mental consequences);	Directness: -the mental and physical condition of a person is exposed to acts of important strangers Indirectness: -one is a witness to violence, -one does not observe long-term mental and physical consequences, -one can hear about mental and physical consequences appearing in a person, including suicide;
Traumatic interpersonal effect	Losing a close person, Mourning, Home loss;	Losing a close person, Mourning, Losing a house due to the need to move out, while the perpetrator can stay in it, Lack of social support, Lack of relationship with the family;	Lack of social support, Losing one's job, Changing school;
Starting time	People of various ages;	Most frequently in childhood and adolescence, but also adult life (violence between the partners) or old age (violence between the partners or violence from children);	All moments of life;

Duration	"Dose": -lasts a limited time, -often, -once only; "Permanent exposure": -recurring catastrophes (e.g. earthquakes in California);	Chronic: -lasts for a long period of time, - sometimes over a person's whole life;	"Dose": -happens once for a limited time -repeated; "Over a longer period of time but not chronic": - mobbing, - bullying;
Relationship with passive and active perpetrator	Interpersonal: - a perpetrator is a stranger from whom one does not expect security or love, - their actions are intentional and purposeful; A person's mistake: - e.g. poor construction of the house which collapsed, faulty structure of a dam which burst, no information about the upcoming catastrophe; Non-interpersonal: -natural catastrophes (floods, earthquakes, fires, hurricanes etc.);	Interpersonal: - a perpetrator is a close person from whom one does expect security and love, - his/her actions are intentional and deliberate;	Interpersonal: -a perpetrator is a stranger from whom one does not expect love or safety from one's environment (shop, school, work, playground), - his/her actions are intentional and deliberate;

Betrayal and fear	Fear; Intimidation: - from a stranger's aggression (terrorism, war, attack); Lack of feeling of betrayal: - at natural catastrophes, - a stranger's attack;	The phenomenon of "a deep act of betrayal", intimidation or threats from the perpetrator; Fear;	Feeling of betrayal: -various degrees of betrayal depending on the level of relationship; Fear and various degrees of fear;
Isolation and secret	Contact with the environment: - talking to a victim, - a third party asks questions, - conversations of third parties concerning the event; Visibility of events: a victim usually knows the environment - knows what happened (car crashes, natural catastrophes, kidnaps), - the public is informed about that;	Isolation and secret: - lack of conversations during violence and afterwards, - lack of sources of knowledge concerning normality; Compulsion to keep it secret for many years after the event and even for an entire life;	Isolation: -a person is afraid to tell, due to expected negative consequences (violence at school and at work, violence in a religious sect); Openness: - a person can speak about what happened without emotional and social consequences (e.g. about a fraud in a shop, life threat on a plane);

Environment reaction	They are looking for: - ways of help and rescuing the victims;	Lacking or limited: - searching for ways of help from people from outside to people hurt in the family, - during the events (due to keeping secrecy) and after its termination;	Lacking or limited: - searching for ways of bringing help to people hurt at school, work or in the sect; They are looking for: - ways of help and rescuing the victims;
Settling in a person's experience	Extends beyond daily experiences;	Becomes "normality": -as a result of repetition and keeping secrecy and lack of knowledge about other families;	Extends beyond daily experiences;
The conditions "before" and "after"	Known psychological and physical conditions: - from before the trauma, - after the trauma, - it is a once only event despite the fact that it can last for some time and is repeated (e.g. volcanic eruption);	We frequently do not know psychological and physical conditions: - from before the trauma, - after the trauma due to its chronicity and very early occurrence in a person's life;	Known psychological and physical conditions: - from before the trauma, - after the trauma;
Cognitive distortions	The fact of occurring influences changing the attitude concerning: - own indestructibility, - predictability of the world, - trust and feeling of safety towards people (terrorist attack);	It influences the creation of cognitive distortions in a victim concerning him/herself, others and what is just in the world;	It can influence the creation of cognitive distortions in a victim concerning him/herself, others and what is just in the world;

	The degree of help received can influence the way people are perceived;		
Consequences	"Simple" PTSD, Co-existing disorders.	Emotional trouble, "Simple" PTSD, "Complex" PTSD, Co-existing disorders.	Emotional trouble, "Simple" PTSD, "Complex" PTSD, Co-existing disorders, Specific symptoms for specific violence, Accumulated symptoms from childhood to adulthood, Symptoms concerning current stress, Symptoms related to the crisis.

Source: Widera-Wysoczańska, 2010a; 2011.

Summary

Traumatic events can be divided into acute simple and interpersonal and these two can be further divided into complex interpersonal and chronic and simple interpersonal. Simple traumatic events can follow from natural catastrophes, unintentional actions of close ones and of strangers as well as the intentional activity of strangers. The criteria for dividing interpersonal traumatic events can include the following: a type of person who commits this act, the duration, the structure, reasons, and traumatic consequences violating the social reference system of a victim. The trauma can be divided, depending on its level of fear and anxiety. The more a person experiences the feeling of betrayal, the more traumatic the events that take on the character of interpersonal trauma caused by a person we depend on.

Simple interpersonal events include various types of violence and aggression suffered from strangers and from important ones. Interpersonal complex events include violence and aggression committed by close and important ones, often lasting for a longer period of time which can only be specified with difficulty.

Complex and chronic trauma possesses specific qualities such as: daily routine and normality, interpersonality, deliberateness and intentionality, predictability, loss of control, escalation, directness and indirectness, reflexivity and a feeling of betrayal. Their escalation is different depending on whether the trauma was suffered inside the family or outside it.

Violence and aggression are forms of interpersonal traumatic events and can be decided due to their occurrence in a family and in the environment as well as when directed by a person against herself/himself. They are performed by active and passive perpetrators. Violence is based on intentionally long-term mechanisms, whereas aggression is an intentional, sudden, attacking, hostile act caused by external and internal incentives.

Between the simple trauma – acute and interpersonal – there exist differences and similarities following various sources of stressful events, their course, internal structure, starting time, relationship with the active and passive perpetrator as well as with people from their environment and its influence on a person.

Both groups of events: simple and complex, can be described by means of objective qualities and their subjective perception by the persons experiencing them. Every person reacts differently to stressful events in their life and these reactions are defensive mechanisms and a way to cope

with the trauma. Giving individual meaning to stress events follows from the story of life preceding the events as well as a person's life situation during the time the events last. The sum of objective and subjective reception of stress events contributes to symptoms arising which are experienced by a person as a result of undergoing traumatic events. Early interpersonal trauma causes a more comprehensive psychopathology than later interpersonal traumatisation. Simple trauma causes different consequences compared with interpersonal complex trauma. Simple, acute events can lead to the creation of a simple PTSD; interpersonal events can contribute to the creation of complex PTSD (DESNOS). Both lead to numerous symptoms and co-assisting disorders. In relation to the above the process of psychological help to people experiencing a simple or an interpersonal trauma is different.

PART II:

FACTORS THAT INFLUENCE INTERVENTION AND SUPPORT

CHAPTER TWO

SUBJECTIVE DETERMINANTS OF WILLINGNESS TO GIVE SOCIAL WORKERS ASSISTANCE IN SITUATIONS OF DOMESTIC VIOLENCE*

ALICJA STRZELECKA–LEMIECH
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Abuse is a destructive phenomenon, both in the personal lives of all those involved (i.e. victims and perpetrators) and in the context of social life. Thus it seems justified and in the best interest of us all to create a statement that reacts to any indications of domestic violence.

There is a growing environment of people involved in counteracting violence in Poland. New legal forms regulating proceedings related to victims and perpetrators have been created in recent years, including definitions of duties that apply in particular social welfare services. Social welfare has become one of the significant elements in counteracting violence in our country, and thus every welfare worker is obliged to react within his/her competence to any sign of violence. Moreover, 82% of society expects help primarily from municipal and communal social welfare centres in difficult social situations (Szczepańska, 2008).

Welfare workers are the direct executors of social services, which, according to the Social Assistance Act, are supposed to help families with violence-related problems to return to social functioning. This professional group is an important link in the chain of victim support and may increase the number of diagnoses of violence, as well as initiate further steps for intervening. Because of its work (for instance possibly contacting the whole family and not just one person, creating an ongoing rather than a one-off contact, working in the environment of the person in need), the

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welfare staff is not only able to take up specific external actions, but also to motivate its clients to fight the problem, coordinate the actions of various institutions, and to actively support counteraction against violence (Malara, 2002; Strzelecka-Lemiech, 2008).

However, various studies indicate that victims and perpetrators, as well as professionals, repeatedly experience difficulties in distinguishing elements of upbringing from violence (Firestone, 2007) and marital quarrels from abuse. It also happens that marital rape is punished according to domestic violence laws (a lower level of sentencing) (Jabłońska, Nowakowska, 1998). Different definitions of violence used by various social groups are also noticeable, as are inadequate evaluations of some violent outcomes, compared with the current state of psychological knowledge. Also, victims and perpetrators receive unequal treatment depending on their gender, age and reaction to harm. Studies show, for instance, that victims who are not held responsible for the violence receive more help than those who are judged responsible (Bateson, 1998, cited in West and Wandrei, 2002).

The Psychology Health Institute in Warsaw (Instytut Psychologii Zdrowia, IPZ) conducted a project including a study of professionals dealing with violence in their work. Participants included teachers, healthcare professionals, police officers, and social welfare centre employees, as well as people providing psychological-pedagogical support. Their attitudes towards violence were studied, as well as their relevant professional work with victims of violence, skills in helping people touched by violence, and their subjective evaluation of work conditions. The replies given by healthcare professionals, teachers and, to a degree, policemen revealed that some shared unfavourable stereotypes, according to which domestic violence is justifiable in certain situations (5.9%, 4.8% and 10.6% respectively) and parents are free to select their methods of upbringing, including physical punishment (7.5%, 11.3% and 10.2%). These groups knew less about violence and did not perceive its intensification to the same degree as employees from other studied professional groups (Riahi, 2005). The research also revealed differences in frequency in intervention between representatives of individual services. Policemen interviewed by IPZ most often said that they always intervene in cases of violence, but one in five healthcare professionals did not intervene in any cases of violence to children. Also, less than half the teachers admitted they intervened in all cases they encountered of family-abused children. In each professional group there were representatives who never intervened (Riahi, 2005).

Studies conducted in other countries among social welfare workers dealing with child protection (Howe, Herzberger and Tennen, 1988; Herzberger, 2003) revealed that they also evaluated child punishment according to gender. Female professionals, compared with men, evaluated parental punishment as more severe. Male professionals said that physical punishment administered by the father was more severe than that administered by the mother. Professionals also evaluated the punishment administered to boys as more severe and less adequate than that administered to girls. Other studies revealed that nurses called cases with female victims violent more often than cases with male victims. Women involved in mental health matters, compared with men, more often evaluated the same indicators (for instance sexual mistreatment of children) as proof of abuse (O'Toole, O'Toole, Webster and Lucal, 1994, as cited in Herzberger, 2003).

The current studies of welfare professionals in Poland have focused first of all on analysing general attitudes and experiences related to domestic violence, only distinguishing the type of violence towards children. Aspects examined include the general effectiveness of actions taken, the difficulties in carrying out actions (Kuna-Broniowska, Łysenko, 2003), welfare employees' beliefs relating to domestic violence, professional experience with victims of violence, and competence in supporting such people, as well as subjective evaluations of work conditions (Riahi, 2005). However, there still is a lack of studies to determine the welfare workers' readiness (and the readiness of non-professional people) to intervene in situations of domestic violence.

Only a few years have passed since responsibilities and obligations relating to counteract domestic violence were imposed on social welfare in Poland; hence the psychological knowledge about the determinants of welfare workers' readiness to give support in situations of violence is still incomplete. As results from studies conducted by Szczepańska (2008) indicate, 82% of Polish society expect support from local authorities - municipal and communal social assistance centres - in difficult situations. These expectations do not mean just any support, but effective support. The latter, however, largely depends on professional competence and appropriate strategies resulting from constantly updated knowledge and reality-related experience (see Daro and Cohn Donnelly, 2004). There is also a lack of data regarding the readiness of ordinary citizens to help.

Therefore, learning about the welfare workers' readiness and the readiness of non-professionals to intervene in domestic violence, as well as learning the factors that may determine this readiness, may contribute to

an increase in social awareness in this area, in people's readiness to actively oppose and, consequently, limit any forms of violence.

This article will present research results concerning subjective determinants of readiness to intervene in situations of domestic violence.

Subjective determinants of helping – a short overview of various studies available

Many currently available studies have focused on helping victims of violence, including either the type of violence (Follingstad, Rutledge, Berg, Hause and Polek, 1990, as cited in Langhinrichsen-Rohling, Shlien-Dellinger, Huss and Kramer, 2004; Kuczyńska and Strzelecka-Lemiech, 2010), the relationship between supporter and supported (Karyłowski, 1975, as cited in Wojciszke, 2000; Simon, 1995, as cited in Langhinrichsen-Rohling, Shlien-Dellinger, Huss and Kramer, 2004; Kuczyńska and Strzelecka-Lemiech, 2010), or the availability and actions of other people (as cited in Wojciszke, 2000).

However, the impact of subjective factors on perceiving violence and readiness to help also seems considerable. An overview of such studies is presented below.

Emotional state of the helper

Feeling guilty significantly intensifies the disposition to help (Szuster, 2004), this disposition increases if others know about our guilt and we diminish it when we try to rid ourselves of it (for instance confessing it) (Regan, Williams and Sparling, 1972, as cited by: Wojciszke, 2000).

Furthermore, a positive mood increases the chances of helping others (Isen, 1984, as cited in Wojciszke, 2000). An improvement in mood prevents such forms of support that might destroy the mood. A negative mood intensifies the inclination to help only in particular situations: when helping is easy and does not require much effort, when reasons exist to believe that help will improve the mood, if other forms of mood improvement are unavailable, and if the initial poor mood is not too strong (Berkowitz, 1987, as cited in Wojciszke, 2000; Szuster, 2004).

Characteristics of the supported

According to the social responsibility norm we are more willing to help people who are more dependent than we are; thus older people and children have a higher chance of receiving help than adults. However, if

the critical situation in which the victim finds himself/herself is perceived by the supporter as one the victim can control, then any sort of intervention raises rather anger and dislike than sympathy, inhibiting any help (Wojciszke, 2000).

People are more willing to help those they like rather than dislike, who are more attractive, and above all – who are similar to themselves (considering personality traits, clothing, appearance) (Wojciszke, 2000).

Age of the victim of violence

When studying signs of violence towards children, the context has to be considered - social consent exists for physical punishment of children. Some 41% of Polish society accepts the following statement: "parental spanking has never done any harm" and almost half (49%) of Poles say spanking children is an ordinary method of upbringing (Roguska, 2008). Almost 90% of adults in Poland say that you should intervene when an adult family member or a child is beaten and humiliated, but in cases of harming children within a family, the consent for intervention by outsiders or institutions depends on the type of harm. If it is sexual abuse, 100% of professionals admit the necessity for external intervention, but only 10% think this way regarding a spanking (Sajkowska, 2001). A majority of adult Poles (51%) are against a legal ban on beating children, while 41% support such a ban (Roguska, 2008).

Gender

Gender differences in giving help:

Eagly and Crowley (as cited in Hyde and Frost, 2002) have analysed brief meetings of people who did not know each other but that provoked "unusual acts of help" (p. 300). Gender differences in giving help were higher in favour of men:

> "in natural environments rather than in lab conditions, with other people around who could become witnesses of the help provided, when other people could participate and when the appeal for help was rather an expression of a need than a direct request." Eagly and Crowley (as cited in Hyde and Frost, 2002)

The impact of the help requester's gender has also been analysed (Eagly and Crowley, 1986, as cited in Hyde and Frost, 2002). It turned out that men were more eager to help women, but received help from both genders to the same degree. Women, on the other hand, helped women and

men to the same degree, but received support more often from men than from women.

The study also revealed that men reporting the harm they experienced are treated less seriously than women. Police in such cases less frequently file a report, less frequently direct the victim to a social welfare institution, and less frequently give support on how to protect oneself (Tjaden and Thoennes, 2000, as cited in Herzberger, 2003). At the same time, in cases of domestic violence, men are more reluctant to call for help than women – they rather select non-legal methods (Kelly, 2003).

Gender differences in perceiving violence

Many studies confirm that people perceive situations of violence differently through the genders involved. Both the observer's as well as the victim's and perpetrator's gender may affect the evaluation of the level of violence. Experiments concerning the evaluation of punishment used towards children yielded the following dependencies: according to women, punishment of children is more severe than according to men; also, women more often assess child punishments as acts of violence (observer's gender). A daughter's punishment is evaluated as more severe, more violent and emotionally harmful than a son's (victim's gender). Punishment administered by fathers on daughters was more often perceived as violence than the same punishment administered by mothers on their daughters (perpetrator's gender) (Herzberger, 2003).

Attitude studies all over the world have revealed that students far more readily accept a woman slapping a man in his face than a man slapping a woman (Straus, 2006). In general, female physical aggression is socially tolerated to a higher degree than that of a male (Straus, 1997, as cited in Capaldi, Kim and Shortt, 2007).

Men accused of domestic violence are arrested three times more often by the police than are women; they are more often threatened with arrest or thrown out of the house (Heleniak, 2005, as cited in Hamel, 2007; Gelles and Straus, 1988, as cited in Kelly, 2003). Of those who are convicted of spousal murder, men are more often sentenced to prison (94%, men; 81% women). Among all those sentenced to prison, men more often receive life sentences (16%, men; 5% women) (Herzberger, 2003). These results indicate that male-inflicted domestic violence is treated as more severe and is seen to deserve higher social sanctioning than violence inflicted by women (Capaldi, Kim and Shortt, 2007).

Men are more inclined to accuse the victims of aggression than women are (Summers and Feldman, 1984, as cited in Langhinrichsen-Rohling,

Shlien-Dellinger, Huss and Kramer, 2004; Harris and Cook, 1994, as cited in West and Wandrei, 2002). Women less often believe that husbands have the right to apply force towards their wives (Cook and Harris, 1995, as cited in Langhinrichsen-Rohling, Shlien-Dellinger, Huss and Kramer, 2004), and assess domestic violence as more severe than men (Mangold and Koski, 1990). Also, women perceive perpetrators less favourably, have a more positive image of the victim and more acutely evaluate physical assaults than men do (Pierce and Harris, 1993, as cited in Langhinrichsen-Rohling, Shlien-Dellinger, Huss and Kramer, 2004). More often than women, men perceive domestic violence stereotypically (IPZ, 2004) and are more permissive in directing violence towards their partner in a partner relationship (West and Wandrei, 2002; Beyers, Leonard, Mays and Rosen, 2000, as cited in West and Wandrei, 2002).

In the case of different types of assault and various forms of violence, female victims are burdened with greater responsibility than male victims. The "guilt" of women and men assaulted during jogging was evaluated in one study: Howard, 1984, (as cited in Unger and Saundra, 2002). The situation is different in cases of domestic violence – a woman's aggressive behaviour towards her partner is most often said to be a response to the spouse's current or past violence (not necessarily physical violence) and is treated as self-defence (Swan and Snow, 2003, as cited in Capaldi, Kim and Shortt, 2007; Dekeseredy, 2002, as cited in Hamel, 2007; Kelly, 2003; Corry, Fiebert and Pizzey, 2001).

Proprietary research

The purpose of this study is to check the contribution of such factors as:

(a) violence-observers' emotional empathy and social competence levels
(b) their age
(c) their self-assessments as persons actively reacting in situations where others need help
(d) self-assessments as persons actively reacting in situations of violence in the
(e) welfare workers' willingness to help and in the willingness to intervene of people who do not professionally help others

Theoretical background

A majority of previous studies concentrated on demonstrating how specific factors impact on attitudes towards violence - among them, its intensity, effects, beliefs concerning the right to react, the number of acts of violence, evaluating a victim's responsibility for the violence. However, in order to better understand why witnesses of violence decide whether to help or not, the contribution of additional specific factors should be tracked. Taking the above into account, Latane and Darley's decisive model for crisis intervention (1970) has been selected to provide the theoretical basis for the study. This model facilitates a better understanding of factors affecting why the decision of whether to intervene (or not) is made.

This results in a more detailed appreciation concerning the problem of reacting to situations of violence. The approach adopted makes it possible to obtain results that may indicate the areas of action needed to correct the way professional groups think about, and behave toward giving, support, and may indicate areas of social education.

The model, as previously mentioned, was proposed by Latane and Darley (1970), whose inspiration to undertake research came from their observations that the number of witnesses to a critical event decreases the probability that the victim will receive help. According to the researchers, five conditions must be fulfilled before help is given. Fulfilling only one leads to a failure to act. Decisions about possible support are taken on a step-by-step basis:

I. Noticing the event

In order for the decision process to start, the situation has to be noticed. A few factors may influence not noticing, including the observer being hasty or lost in thought. Haste makes us less interested in what is happening around us and thus lowers the probability of helping others. This factor is more important even than personality-related factors (for instance the level of our religiousness) (Darley and Batson, 1973).

II. Interpretation of the event as a crisis situation

Just noticing the situation is not sufficient. The witness has to decide how serious the situation is and how necessary the help is. It is important for the situation to be unambiguous - the more complex the situation is, the more inclined the witnesses are to look on as just other observers of the event. Witnesses of a sudden event look at the recipient and if they do not

notice signs of anxiety or any aggressive action, they ascertain that the situation does not require any intervention (this phenomenon has been called the accumulation of ignorance or the ignorance of many) (Latany and Darley, 1970). Research has revealed that the higher the number of witnesses of a critical event, the lower the chance of helping the victim. This dependence, called the phenomenon of the indifferent passer-by, disappears when the situation turns unambiguous and cannot be interpreted other than as an incident (Latane and Darley, 1968).

III. Assuming responsibility

Interpreting a situation as critical and requiring intervention is associated with a decision to assume personal responsibility to intervene and help the victim. Crucial factors at this stage are the number of witnesses and knowledge if or someone has already intervened. If there are many witnesses to an incident, the diffusion of responsibility appears – an individual loses his/her feeling of responsibility, because there are other people present. Dispersion of responsibility decreases guilt and shame (Kubacka-Jasiecka, 2004). Some social roles, however, may inhibit these phenomena – for instance the role of a group leader (Wojciszke, 2000). At this stage, people enjoying respect and authority may be essential. Our subjection to regulations or orders relieves us from responsibility: acting under an authority's influence may be stronger than the feeling of justice or individual value (Zimbardo and Ruch, 1997). Research indicates that casual witnesses in natural conditions have a higher readiness to help than in laboratory conditions. This probably results from the passive attitude adopted by study participants, as well as by renouncing responsibility in favour of the researcher and subjecting oneself to the rules of the experiment. Being responsible requires situational analysis, activating norms and rules commanding help, and turning on control mechanisms. A conflict between the necessity to react and the will to avoid costs - manifested in a hope that someone else will act instead (Kubacka-Jasiecka, 2004) might also lead to transferring responsibility to others.

IV. Awareness of the appropriate form of support and ability to provide it

Knowledge about what form of support is appropriate, as well as the ability to use it, is conducive to readiness to intervene in crisis situations.

V. Deciding to help

Even if a witness knows the appropriate form of help, other circumstances might occur that prevent him/her from acting. S/he may fear ridicule or making the victim's situation even worse. S/he might also fear for his/her own safety. Ridicule decreases if witnesses can discuss the event with each other, settle on its meaning, agree on a plan, and justify the plan after it has been seen to be put into effect.

Purpose of the study

The study had a number of goals:

1. to compare the level of readiness to intervene in situations of domestic violence declared by welfare workers and lay persons;
2. to determine if such reactions depend on a person's age, level of emotional empathy and social competence, and self-assessment of one's actively reacting to situations where others need help.

Three basic research questions have been formulated:

Are there differences between welfare workers and lay persons in their readiness to intervene in domestic violence?

What is the contribution resulting from previous decision stages (evaluating the level of violence, feeling responsible for and aware of the correct form of support) in evaluating the probable cause for intervention in the case of welfare workers and lay persons?

Does intervention depend on age, emotional empathy, social competence and self-assessment as a person who can actively react where others need help in situations of violence?

The following hypotheses have been formulated:

I) Readiness to intervene in cases of domestic violence (general and at each stage of decision-making) should be higher in the case of welfare workers than in the control group (lay persons) because of the welfare workers' profession (having undergone training and having gained professional experience) as well as because welfare workers have been examined at their workplace.

Knowledge should be the best predictor of intervention in the case of welfare workers, and of responsibility in the control group. Moreover, it

may be assumed that the meaning of evaluation of the level of violence might differ between those groups. If lay persons evaluate their abilities to help as lower and the situation as more severe, they may desist from active involvement because of fear of defeat or fear of threat to themselves. Welfare workers, on the other hand, because of their professional responsibilities, might try to intervene.

A person's characteristics play an important role in readiness to intervene.

Readiness to intervene depends on the subjects' age (younger people may feel more responsible and competent about reacting because they are physically fitter);

Empathy, an altruistic form of behaviour, will also be a differentiating factor - readiness to intervene significantly depends on its level;

Social competence determines the ability to cope; so its level is significant in the decision to intervene;

Participants want to maintain a consistent image of themselves. They perceive themselves as persons who actively react to situations where someone needs help and as persons who actively react to situations of violence.

Description of the study group

The study was conducted using two groups: welfare workers and lay persons.

Welfare workers employed in the Municipal Social Welfare Centre in Wrocław, who agreed to participate anonymously, constituted the target study group. One hundred and thirty-eight social workers decided to participate and 14 refused. One hundred and twenty questionnaires were used in the study; 18 were rejected due to inappropriate or incomplete responses. The welfare workers whose replies are included in the analysis, consisted of 111 women and nine men aged 23 to 54 (M = 41.6), working in their current positions from one year up to 32 years (M = 14.7).

The control group consisted of adult Wrocław residents, characterised by secondary, incomplete higher or higher education (a secondary education is the minimum required to work in welfare), with ages compatible with those in the study group. One hundred and forty-eight people decided to participate, 21 refused, including four who withdrew while completing the tests. One hundred and twenty questionnaires were used in the study and 28 were rejected due to inappropriate or incomplete responses. The control group included in the analysis consisted of 61 women and 59 men aged 20 to 60 (M = 36.9).

The Wrocław model, based in one of Poland's largest cities, seems interesting both because of the large number of social issues arising in large groups and because of the complexity of the local Social Welfare Centre - thanks to this complexity, the local centre includes elements characteristic of smaller units (for instance those functioning in rural areas). And besides, the Municipal Social Welfare Centre in Wrocław is one of few such institutions that have introduced specialist units responsible for supporting welfare workers in solving specific social issues (including domestic violence, addictions or mental illness).

Tools

Seventy-two short stories describing situations of domestic violence were used to measure readiness to intervene. The accuracy and comprehensibility of the stories had previously been assessed by competent judges. The stories included types of violence (psychic, physical, and sexual) and relations between the victim and the perpetrator (divided into: family - the perpetrator was a family member - that is, a person with consanguine or marital ties to the victim; or non-family, an outsider). The subjects' goal was to take an attitude towards each of the stories based on four questions referring to the intervention stages, according to the Latane and Darley model - excluding stage 1 (noticing the event). The questions referred to evaluating the level of violence (conviction that it requires intervention), degree of one's own responsibility to react, degree of awareness about the appropriate form of help, and evaluation of the probability to intervene. When answering, the subjects used a 5-grade scale, with 1 being the lowest the appropriate variable level and 5 the highest.

The Social Competence Questionnaire (SCQ) by A. Matczak (Kwestionariusz Kompetencji Społecznych) was used to gauge the participants' social competencies. The total points for all the diagnostic items were used to indicate social competence.

The SCQ measures social competence understood as complex skills acquired by individuals in social training that determine the effectiveness of coping in specific social situations. The total number of items is 90, with 60 of them diagnostic, comprising three factor scales:

1. competence determining effectiveness of behaviour in intimate situations
2. competence determining behavioural effectiveness in social exposure situations, and

3. competence determining required assertiveness.

The total result (between 60 and 240 points) is the sum of points received for replies to all diagnostic questions (Matczak, 2001).

The emotional empathy level was measured using the Emotional Empathy Scale developed by Mehrabian A. Epstein (Rembowska, 1989). The sum of points for all scale items was used as the indicator of the empathy level. This technique measures emotional empathy perceived as emotional sensitivity to surroundings, understanding the feelings of unknown people, extreme emotional sensitivity, a tendency to be touched by positive and negative emotional reactions, and a tendency to sympathise with a willingness to contact with people who experience problems. The questionnaire includes 33 statements for which the respondents are asked to select an attitude using a 9-grade scale. Their replies are gauged on a scale of 0 to 8 with 0 being the questionnaire's lowest possible totalled result and 264 the highest.

Self-assessment is based on the participant's replies marked on a scale of 1-5, where 1 means never reacts and 5 always reacts.

Self-assessment of the participant's reaction to violence is measured by the participant's replies marked on a scale of 1-5, where 1 means never reacts and 5 always reacts.

The participant's age is given in years.

Course of the study

Examination of the target group was conducted on the premises of the Municipal Social Welfare Centre in Wrocław, in the work places of ten Social Field Work Teams. Each participant filled in tests during his/her work hours, at his/her work place, in silence, in the presence of other employees of the same team, as well as a study co-ordinator. Control group participants received the questionnaire by e-mail and sent them back completed, using the same channel or completed the questionnaire in direct contact with those conducting the study.

The participants' task was to take an attitude towards six different situations of violence (described in a story), by answering four questions assigned to each of the situations. They selected the digit out of 5 available that best reflected their opinion on the given matter.

Results and interpretation

Readiness to intervene in cases of domestic violence, presented by welfare employees and people not related professionally to helping others.

Consistent with expectations (hypothesis 1), welfare workers declared a higher general readiness to intervene (M = 3.68), compared with lay persons (M = 3.28; F (1.236) = 23.36; p = 0.001).

The correctness of this hypothesis is also confirmed by the analyses of the individual stages of the intervention decision process (Table 2-1).

Table 2-1. Comparison of the level of readiness to intervene in cases of domestic violence, as presented by social services employees and people not dealing professionally with helping others in situations of violence

Stages of readiness to intervene	Welfare workers M	SD	Control group lay persons M	SD	t
Level of violence	4.33	0.15	3.99	0.15	-3.94***
Responsibility	3.57	0.16	3.1	0.16	-4.91***
Knowledge	3.47	0.17	3.07	0.17	-4.05***
Probability of intervention	3.35	0.16	2.97	0.16	-3.95***

Note *$p < 0.05$; **$p < 0.01$; ***$p < 0.001$

The results also indicate a similar attitude among the participants in both groups towards violence, whereby all participants evaluated the level of violence they could possibly witness as the highest, with significantly weaker assessments for feeling responsible to intervene and being aware of appropriate support ($p < 0.001$), followed by the weakest assessment for intervening (the difference between stages two/three and four is significant in both groups at $p < 0.05$). These results prove that if violence is noticed (this condition was met in the study, as the participants referred to specific descriptions of events), it is usually evaluated as requiring intervention. On the other hand, the high results of violence, indicating the necessity to help, were greatly disproportionate to an individual's own sense of responsibility to intervene as well as to knowing which form of support

was appropriate. These results prove that the process leading to intervention is complex, and suggest that different contributions need to be made at individual stages before deciding to intervene. Also there are probably other factors that were not included in Latane and Darley's theoretical model. When explaining why social welfare employees declared a higher readiness to intervene in crisis situations compared to lay persons, it should be recalled that such employees are one of the "first contact" professional groups (other groups include probation officers, healthcare professionals, and police officers) - professionals who work directly with the client and his/her family. Social welfare services employees' basic assignments, described in laws concerning social welfare and counteracting domestic violence, include support to families with problems of violence. Thus, reacting to violence is not only an issue of morality or personal choice - which might be said about the control group's decisions to intervene or desist from intervention - but is a legally regulated duty. Of particular importance (and thus expected of them by other groups) is that welfare workers, because of their relatively regular and direct contact with families, may play the role of co-ordinators for teamwork between separate institutions that care for the family. This distinguishing role explains their greater readiness to declare support in situations of violence, as compared with the control group.

At the same time, welfare workers (and particularly employees of the Municipal Social Welfare Centre in Wrocław, our study group) are a relatively well-trained group regarding domestic violence: considerable internal training in this area took place between 2004 and 2006; subsequently, in 2007 there was the "Comprehensive Education - Effective Support" project). This group not only more willingly participates in training sessions (seminars, conferences) compared with other "first contact" groups, but also sees the most sense in participation (OBOP - Centre for Public Opinion Research, 2007). Such training sessions also cover definitions and forms of violence, and thus social welfare employees are able to recognise violence more easily and more often than the control group. Learning about methods to help, they might also feel competent to actually help, as well as feeling more responsible - than those who are professionally prepared to do so. Knowing the appropriate methods of support (see below) is the main predictor for social welfare employees to intervene in crisis situations. Such results confirm the importance of training as one of the most effective measures in counteracting violence. It is also worth remembering that the obligations related to the professional role, as well as good training in reacting to situations of violence, may result in the costs of refraining from support being higher for such people

than for the control group (for instance the predicted expectations of the society or superiors or the predicted stronger feeling of guilt resulting from the greater feeling of duty related to the profession).

Results of the study regarding differences in declarations of readiness to intervene supplement the theoretical model assumptions and facilitate the model's practical use in preventive measures against violence. It turns out that if there are social welfare employees among witnesses of an event, they might be determined to show a greater openness to help. Assuming that the social worker's more frequent declaration of will to intervene results from his/her professional training, a conclusion may be drawn that it is possible to increase the motivation of people to help. The order of processes leading to intervention, described by Latane and Darley, indicates a range of important issues which, if discussed, might significantly increase the effectiveness of educational programmes (for instance education regarding the identification of violence as an event that requires help) In order to better understand the decision-making process, additional calculations have been made. A multiple regression analysis has been conducted for each group studied (social welfare employees and non-professionals) in order to verify the contribution of individual decision stages to the final decision to intervene. Table 2-2 presents results of those analyses.

Table 2-2. Summary of regression for the dependent variable "Probability of intervention" in the groups studied, depending on the earlier stages of the help process

Variables	Beta	t (116)	*p*
Welfare workers R square =.820 F (3.116) = 176.59; $p < 0.001$			
Level of violence	-.085	-1.839	.068
Responsibility	.382	5.383	.001
Knowledge	.608	8.501	.001
Control group R square =.812 F (3.116) = 166.72; $p < 0.001$			

Level of violence	- .113	-2.113	.037
Responsibility	.610	9.902	.001
Knowledge	.439	7.464	.001

In line with this study's second hypothesis, knowledge about appropriate forms of support (Knowledge) turned out to be the best predictor of intervention by welfare workers. In the case of lay persons, it was a feeling of responsibility.

Welfare employees were asked at their workplace and during work hours - a fact that might have had an impact on the Knowledge factor. It might have activated their self-image as employees of the Municipal Social Welfare Centre. They could have thus evaluated the reasonableness of their reactions based on whether the reaction would be effective (which is what both clients and superiors would have expected), and not only based on moral or ethical selections, where the "I want to help" factor would be important. Consequently, anxiety concerning the evaluation of one's own support actions may induce social workers to refrain from giving support. It would thus be important to include this fact in training provided to this group, as well as to study other factors that decrease social workers' readiness to intervene in situations of violence.

Share of subjective factors in the decision process

In order to verify what the share of individual subjective factors is in the successive stages of support decision-making, regression analysis was performed on both groups. The results are presented in Tables 2-3, 4, 5 and 6.

Table 2-3. Regression summary for the dependent variable "Level of violence" (reflecting stage II in the decision-making process) in the groups studied, depending on tested subjective variables

Variables	Beta	t (112)	*p*
Welfare workers R square =.141 F (7.112) = 2.634; $p < 0.015$			
Reaction to situations of violence	.214	2.075	.040
Reaction to situations where help is needed	.001	.008	.993
Social competence - I scale	-.137	-1.175	a
Social competence - ES scale	.139	1.088	.279
Social competence - A scale	.181	1.402	.164
Empathy level	.190	2.077	.040
Age	.116	1.262	.210
Control group R square =.157 F (7.112) = 2.980; $p < 0.007$			
Reaction to situations of violence	.145	1.218	.223
Reaction to situations where help is needed	.105	.916	.362
Social competence - I scale	.097	.781	.436
Social competence - ES scale	-.103	-.838	.404
Social competence - A scale	.053	.367	.714
Empathy level	.204	2.161	.033
Age	-.067	-.758	.450

Table 2-4. Regression summary for the dependent variable "Responsibility" (reflecting stage III in the decision-making process) in the groups studied, depending on tested subjective variables

Variables	Beta	t (116)	*p*
Welfare workers R square = .201 F (7.112) = 4.019; $p < 0.001$			
Reaction to situations of violence	.105	1.051	.296
Reaction to situations where help is needed	.201	2.001	.047
Social competence - I scale	.130	1.153	.251
Social competence - ES scale	.096	.834	.406
Social competence - A scale	.123	.987	.326
Empathy level	.046	.518	.605
Age	.132	1.491	.138
Control group R square = .296 F (7.112) = 6.724; $p < 0.001$			
Reaction to situations of violence	.193	1.769	.080
Reaction to situations where help is needed	.197	1.875	.063
Social competence - I scale	.071	.624	.534
Social competence - ES scale	-.250	-.222	.028
Social competence - A scale	.232	1.772	.079
Empathy level	.226	2.618	.010
Age	-.090	-1.126	.263

Table 2-5. Regression summary for the dependent variable "Knowledge" (reflecting stage IV in the decision-making process) in the groups studied, depending on tested subjective variables

Variables	Beta	t (112)	*p*
Welfare workers R square = .320 F (7.112) = 7.536; $p < 0.001$			
Reaction to situations of violence	.125	1.366	.174
Reaction to situations where help is needed	.222	2.404	.018
Social competence - I scale	.157	1.151	.133
Social competence - ES scale	.210	1.976	.051
Social competence - A scale	.325	.989	.325
Empathy level	.031	.387	.697
Age	.133	1.634	.105
Control group R square = .235 F (7.112) = 4.906; $p < 0.001$			
Reaction to situations of violence	.016	.139	.889
Reaction to situations where help is needed	.194	1.765	.080
Social competence - I scale	.098	.825	.411
Social competence - ES scale	-.037	-.314	.754
Social competence - A scale	.290	2.124	.036
Empathy level	.177	1.964	.052
Age	.007	.082	.935

Table 2-6. Regression summary for the dependent variable "Probability of intervention" (reflecting stage V in the decision-making process) in the groups studied, depending on tested subjective variables

Variables	Beta	t (112)	*p*
Welfare workers R square = .298 F (7.112) = 6.799; $p < 0.001$			
Reaction to situations of violence	.017	.178	.859
Reaction to situations where help is needed	.344	3.671	.001
Social competence - I scale	.184	1.745	.084
Social competence - ES scale	.117	1.081	.281
Social competence - A scale	.117	1.002	.318
Empathy level	-.020	-.243	.808
Age	.080	.961	.339
Control group R square = .279 F (7.112) = 6.177; $p < 0.001$			
Reaction to situations of violence	.049	.442	.659
Reaction to situations where help is needed	.280	2.635	.009
Social competence - I scale	.024	.205	.808
Social competence - ES scale	-.180	-1.586	.115
Social competence - A scale	.343	2.589	.011
Empathy level	.230	2.631	.010
Age	-.002	-.027	.978

Age and readiness to help

The study conducted demonstrated that the subjects' age does not significantly explain intervention decision-taking on any stage (hypothesis 3.1).

Currently available results were taken into account when formulating this hypothesis to indicate that older people more often acquiesce to children's physical punishment (Roguska, 2008), and subjects over 60 years of age significantly less frequently admit that violence towards children is common (Nowakowska, Paluch, Zarębińska-Szczodry, 2001). It was thus assumed that older subjects will also less frequently perceive behaviour as violent and as a result will rarely declare intervention. However, it should be noted that the research was conducted in 2007 - the first year since 2003 that a decrease in the number of domestic victims of violence was noted (according to the "Blue Card"), as well as the year when the number of police interventions decreased (according to statistics provided by the Main Police Headquarters, 2008). This may indirectly confirm an increasing social awareness of domestic violence - and maybe violence in general. A hypothesis may thus be stated: the decline in domestic violence is a result of a few years of social campaigning (for instance, the annual "16 Days Against Violence Towards Women"; "Violence-free Childhood", 2006; and "Spank 2005") that refutes various myths and stereotypes and that clearly names previously accepted forms of behaviour as violent. The Counteracting Domestic Violence Act, introduced in 2005, should also not be forgotten. Social awareness related to domestic violence may thus be equally seen in all age groups.

Empathy level and readiness to help

The study revealed that the level of empathy plays a significant part in evaluating not only the violence level but also the sense of responsibility and the probability of intervention in the welfare workers' group. Also, this variable makes a significant contribution in evaluating the violence level, one's own responsibility to react, and the probability of intervening in the control group (hypothesis 3.2).

This result is consistent with the hypothesis according to which empathy is a mediating mechanism in altruistic behaviour, as explained by the empathy-altruism hypothesis model proposed by Bateson (1991). According to this model, the empathy felt by witnesses with an event affecting the person in trouble is the basic factor that persuades people to help. Empathic stimulation motivates the onlooker to help such a person

regardless of whether it is in the interest of the witness and even if the costs the witness incurs outweigh the possible benefits. According to Bateson, people may also help others when they do not feel empathy towards the person in need, but in such cases the benefits deriving from helping usually have to outweigh the possible loss (this hypothesis is consistent with the study results indicating that the level of empathy is only one of a number of factors that explain the probability for intervention).

Results indicate that the level of empathy is related to the evaluation of the level of violence in a given event - greater empathy probably facilitates noticing violence and/or increases sensitivity to its perceived intensity. The ability to empathise and understand the other's reactions may be of particular importance in this area (the easier it is for the witness to feel that the victim is undergoing distress/pain, the more willingly he will determine that the situation is violent).

It should, however, be remembered that empathy contributes significantly in explaining one's own responsibility to react in violent situations only in the case of the control group. Possibly other factors influenced social welfare employees' declarations to help in violent situations. As previously noted, support to families stricken with violence is one of the basic assignments of welfare employees, thus, reacting to domestic violence is this group's legal duty. This factor probably has a far more significant impact than empathy. Also, a person's self-image in performing social work may be an explanation. This is probable particularly because the study was done at the employees' workplace at the Municipal Social Welfare Centre, during their work hours and in the presence of their colleagues. In line with the social-context primacy theory (Markus and Kunda, 1986, as cited in Forgas, Williams and Wheeler, 2005), the "I" concept currently available within operational memory is influenced by the social situation that the given person finds himself/herself in. The part of the self-image that is cognitively more accessible at the given moment determines one's self-definition and is superior to other self-image elements. Thus it is possible that the situation's characteristics determine the social welfare employees' way of thinking about themselves as people who are supposed to help others.

Another interpretation is also possible - the social welfare employees' empathy level facilitated noticing violence in the stories, but only imagining oneself as an observer of the violent situation activated the welfare employee's self-image.

However, regardless of the group, the participants' empathy level does not significantly explain how to react in situations of violence. Empathy

towards the victim is not related to knowledge of possible actions in such situations. Moreover, it should be remembered that emotional empathy, being an affective reaction, might not only facilitate but also hinder support. In the case of someone suffering greatly, high levels of empathy may result in so much stimulation that the observer will focus on himself rather than on the actual victim (Eliasz, 2006). To deal with such high tensions, the person will not always want to help the victim, but may also try to relieve the tension by avoiding information about the sufferer or by denying signals of suffering (Kliś, 1994) - for instance by belittling the perpetrator's behaviour. Also the witness may accuse the victim of being responsible for the situation (Hoffman, 2006).

However, some level of empathy is necessary in professions related to helping others - the more we understand the feelings or the situation of others, the more willing we are to help (as cited in Eliasz, 2006). Simultaneously, the study revealed that introducing empathy-increasing training might enhance empathy.

The results presented, apart from their importance in preventing violence, seem also to contribute significantly to the decision model itself. Not only can other witnesses' reactions interpret a particular event as an emergency, but so can such personality traits as the level of empathy. It would be interesting to examine, in further research, in what conditions this particular factor has significant meaning and in what situations we judge an event based mainly on the reactions of other witnesses. Also, it would be interesting to verify what the dependencies are between those two factors.

Social competences and readiness to help

Research has indicated that the level of social competences (Social Exposure scale) has a significant share in evaluating one's own responsibility to react in situations of violence only in the control group. The same relation was observed in the level of social competences (Assertiveness scale): in evaluating one's own knowledge of how to react, and in evaluating the probability of reacting (hypothesis 3.3).

Overall, it may be stated that deciding to react is related to various elements of social competences. A detailed analysis demonstrates that deciding to intervene is related first of all to assertiveness-related abilities - the ability to refuse, to gain favour in the social surroundings, express positive and negative emotions, and to initiate and maintain conversation (Lazarus, 1974, as cited in Starostka, 2008). These abilities are particularly important when helping in situations where the aspirations and needs of

participants may be opposed - and violence is such a situation. These abilities are important during the stage of evaluation where our knowledge about how to react is appropriate and then at the stage where we decide whether or not to react. Thus it may be supposed that more assertive people will more often know the correct forms of support to be used and will more often be able to use them. Assertive people are able to find a solution that satisfies both sides of a conflict, using discussion and compromise (as cited in Starostka, 2008). Such people are able to reconcile their self-interests with the interests of others (Król-Fijewska, 1993).

It should of course be remembered that only declarations to help were studied - the subjects could thus be convinced that their abilities would effectively cope with violence and could more willingly declare their readiness to help. However, this does not mean that assertiveness makes an effective reaction easier (from the point of view of the victim).

The remarkable meaning of the social exposure scale results is worth noting - these results have an impact only during one's own evaluation to react responsibly in the control group. This part of social competence relates to presenting oneself from the best possible point of view and to adjusting one's image based on the recipient's expectations (Borkowski, 2003). Thus it may be possible that the subjects with the prior level of this competence presented themselves as particularly moral and responsible concerning the suffering of others (this would be one of the strategies helpful in creation of an image - the moral perfectness strategy) (Jones and Pittman, 1992, as cited in Starostka, 2008). Of course it may also be true that people with higher auto-presentation skills actually do more frequently feel responsible to help others, because, for instance, they have a stronger feeling of their own effectiveness or feel they can exert pressure on others and in this way can acquire respect or gain others' trust.

Neither social competence element had a share in explaining the welfare workers' readiness to intervene, which may be related to the fact that they had been trained to react to violence (as previously noted, a number of training programmes had been conducted in recent years in the Wrocław Municipal Social Welfare Centre). Thus, perhaps welfare workers, regardless of their personal social skills, had both the knowledge and competences needed to react to violence.

Social competences that determine effectiveness of coping in interpersonal situations (for instance being able to recognise and name emotions, read others' emotions, react to the interlocutor's needs and abilities, and being sensitive to and understanding others) (Starostka, 2008) did not impact on any of the stages. Therefore, specific skills related

to coping in difficult social situations (behavioural components of the social competences) probably have a stronger impact on the witness's behaviour than on his ability to react empathically, or on his sensitivity to emotions (any impact of the latter on reactions to violence may be ambiguous).

Nonetheless, the conclusion may be drawn that it would be good to include social competence workshops in prevention-related activities, since some of those competences may strengthen the readiness to help.

Moreover, it should be stressed that the authors of the decisive crisis-intervention model focused on evaluating situational factors (including, for instance, the number of witnesses or their response time) in order to decide whether to intervene. The results presented above extend these considerations to allow for personality factors (including the observer's social competences).

Evaluating oneself as a person actively reacting to someone needing help and being ready to help in situations of violence

The hypothesis according to which subjects, if they value themselves more as persons, would be more willing to help in situations where someone needs help, and in situations of violence (hypothesis 3.4).

The image of oneself as a person who actively reacts in situations of violence plays a considerable part in explaining the control group’s probability of intervening. In the social workers’ group this variable significantly relates to the level of violence, one’s own responsibility to react, and knowledge about how to react.

The image of oneself as a person actively reacting to violence is therefore consistent with the subjects' reaction to specific situations of violence - it may be stated that the subjects were able to evaluate themselves in this area accurately and coherently.

However, perhaps these evaluations were reactions to situations before reading the examples of violence and before answering the questions regarding support, and therefore had an impact on the replies. We may assume that the information given at the beginning of the study was an important aspect of the subjects' self-image. According to the theory of cognitive dissonance, the subjects would probably feel discomfort if the initial information about themselves was inconsistent with further declarations relating to help (see Aronson, Wilson and Akert, 1997, p.82). Subsequent replies, therefore, could be influenced by a motive to maintain coherence between their self-image and their replies referring to specific examples of violence. Such an interpretation seems particularly interesting

in the context of research conducted by Darley and Batson (1973, as cited in Aronson, Wilson and Akert), where it is suggested that neither the religiousness of subjects nor their attention directed to the issue of helping others impacted their decisions to intervene. Such a conclusion inspires further research into this area.

However, the variable “evaluation of oneself as a person actively reacting to situations where others need help” did not significantly explain the subjects' replies to the question about the probability of intervening in situations of violence. Why? Perhaps help in such situations requires specific abilities or predispositions (compared to other situations where help is needed). Violence is usually characterised by some level of danger. Participants have conflicting needs and at least one of them uses psychic or physical strength; so help may mean using strength or making use of one's superiority, which would not be necessary if, for instance, help is required because someone has dropped their shopping.

Limitations

The study has a number of drawbacks:

- it is concerned with only subjects' declarations of readiness to intervene and not actual behaviour
- readiness was measured using questions asked directly, allowing for biased replies
- the welfare workers’ group was asked in their workplace, during their work hours, which could have impacted their replies

Summary

Despite its drawbacks, the study made it possible to answer the research question. Among other things, the study revealed that if a witness is a social welfare employee, the result may be a greater openness to want to help. Assuming that the welfare workers' declarations result from their professional training, it may be concluded that this possibly reinforces their actual readiness to help. Such actions, however, should be wider than just focusing on what sort of violence requires social reaction. Above all, actions should concentrate on providing knowledge about how to determine the level of violence, on directly and indirectly supporting the victims, and on acquiring skills that would enable the best possible use of such methods.

CHAPTER THREE

DISTRESS AND GROWTH IN ADOLESCENTS AFTER A FLOOD: THE ROLE OF SOCIAL SUPPORT

ANNA BOKSZCZANIN

Catastrophes and natural disasters (e.g. hurricanes, earthquakes, floods, avalanches, and droughts) are events that result in serious property damage, severe anxiety, and traumatic experiences. Several studies suggest that the extreme stress experienced during a disaster can be dangerous to the proper development of children and adolescents and create the risk of mental disorders (Eth, Silverstein, and Pynoos, 1985; Green et al., 1991; Groome and Soureti, 2004; Lonigan et al., 1994; La Greca et al., 1996; Nader et al., 1990; Vernberg et al., 1996). Due to the serious risk of adverse health effects stemming from disasters, the need exists to study young people's reactions (Norris et al., 2002) as well as potential positive effects among young people. A growing number of studies have documented that traumatic events can lead not only to negative psychological distress, but also to positive outcomes in the form of growth.

Many people may experience benefits after a trauma, most often referred to as post-traumatic growth (PTG) (Tedeschi and Calhoun, 1996) or stress-related growth (Park, Cohen, and Murch, 1996). Assessments of growth usually involve an increase in searches for changes in relationships with other people (better understanding of others, improved relationships with other people, and a greater sense of closeness) and positive changes related to self (values, priorities, attitudes, opinions, or behaviour). Symptoms of positive growth, along with harmful traumatic health-stress symptoms (e.g. PTSD) (e.g. Adams and Boscarino, 2005; Anthony, Lonigan, and Hecht, 1999; Bokszczanin, 2007; La Greca, Silverman, and Wasserstein, 1998; Madrid et al., 2006), have been observed in many populations, including adolescents, after different types of traumatic events such as natural disasters (Cryder, Kilmer, Tedeschi, and Calhoun,

2006; Milam, Ritt-Olson, and Unger, 2004). The manifestation of both positive and negative phenomena can be observed even in time periods after the stressful events. Although the growth formation and its long-term effects are not clear, experiencing severe stress and trauma is regarded as a catalyst for growth.

Information on natural disasters can mobilise the wider community to provide broad tangible, emotional, and informative assistance to victims. The beneficiaries are all survivors, including children and adolescents. However, natural disasters often result in young people being not only recipients, but also providers of social support. Teenagers often work together with adults to secure property against imminent catastrophe, rescue their own and others' personal belongings, and provide first aid or care for younger children and older people. After the crisis (i.e. the passage of floods, hurricanes, or avalanches), youth also take an active part in cleaning and removing the debris. Receiving and providing support during and after disasters manifest themselves as participation in a support network or exchange of social support (Kaniasty, 2003). Social support during natural disasters serves as a protective factor and reduces the negative consequences of traumatic experiences (Bokszczanin, 2008; Compas and Epping, 1993; Prinstein et al., 1996). Both receiving support and help from the community and struggling with the disaster can evoke positive changes, such as growth and the learning of more valid communal defences and solidarity during the common misery (Kaniasty and Norris, 1996; Kaniasty, 2003).

The present study is part of a larger research project focusing on how young people deal with stress as well as their reactions after experiencing a natural disaster. The purpose of this study is to explore the relationship between negative and positive flood outcomes (distress and growth), exposure to traumatic experiences during the disaster, involvement in exchanging social support, and beliefs about mutual assistance. It is expected that young people who have experienced greater exposure to trauma during the disaster and suffered greater losses will have both higher PTSD levels and more growth symptoms (Solomon and Dekel, 2007). People who were more involved in social support exchange will have higher levels of distress and growth symptoms. This expectation is consistent with the rules of helping people emerge from most natural disasters. More affected individuals receive more assistance. It is also observed that people who have experienced major losses and threats during a disaster are also more helpful to other victims (Kaniasty and Norris, 2008). Thus, it is also expected that adolescents who highly appreciate the value of support provision will experience more growth.

Kaniasty's (2003, p. 181) longitudinal studies demonstrated the positive correlation between stress-related growth and affirmative attitude toward provision of help. In this study, adult flood survivors who appreciated the value of the assistance also experienced an increased closeness in relations with other people. Therefore, it would be expected that positive beliefs about the value of mutual help as well as positive beliefs about the benevolence of people and the world (Janoff-Bulman, 1989) will be factors facilitating adaptation after a trauma.

Method

Participants and procedure

The study was conducted eight months after a flood that occurred in the municipality of Piechowice (Dolnoslaskie voivodship, Poland) in August 2006. The study involved 266 students from one middle school (grades 7-9) and one high school (grades 10-14) located in the flood-affected area, with an average age of 16.23 years (Standard Deviation = 2.04). After obtaining consent from the schools' administration, students were informed about the study aim and the voluntary nature of participation. They completed questionnaires in the presence of trained university students involved in the research project. The statistical analysis was based on data from 262 people who completed a questionnaire without missing data, comprising 165 boys and 97 girls.

Measurement of variables

The students answered questions about traumatic experiences during the flood, help received and given to others during and after the disaster, their attitudes regarding helping, observed traumatic stress symptoms, and symptoms of growth. They were also asked about their gender and age.

Exposure to trauma. The items dealing with exposure to disaster stressors were derived from the scale used by Vernberg et al. (1996) and Bokszczanin (2007; 2008). Students answered no (0) or yes (1) to 12 specific questions assessing their experiences during the flood (e.g. Did you see anyone drowning or in danger of drowning during the flood?). Totals of the 12 items ranging from 0 to 12 were tabulated. Higher scores indicated higher exposure to disaster stressors, alpha = 0.74.

PTSD symptoms. PTSD symptoms were measured using a scale created from the eight questions relating to the presence of the intrusion (RCMS, Norris and Perilla, adapted by Kaniasty, 2003). The scale ranged

from eight to 40, with alpha = 0.91. A higher score indicated more PTSD symptoms.

Growth symptoms. To measure interpersonal and intrapersonal changes experienced by the respondents due to flood-related stressors, a 22-question scale was used (Park, Cohen, and Murch, 1996 adapted by Kaniasty, 2003). For example, I learned to be nicer to others as a result of the flood. Did such a change occur in your life as a result of flooding? Respondents chose one of four answers: (0) a change did not occur, (1) there has been only a small change, (2) an average change occurred, and (3) change occurred to a great extent. The scale ranged from 22 to 66 (alpha = 0.96).

Participation in the mutual exchange of social support. The scale for measuring young people's participation in a support network during the flood was built using nine items (cf. Kaniasty, 2003). This measure consisted of three items and assessed social support received by the participants (e.g., Did anyone try to cheer you up or reassure you during the flood?). A six-item measure was used to assess social support given by adolescents. These items referred to help-providing behaviour (e.g. Did you help anyone to protect their property from being flooded, for instance, by erecting sandbag barriers?). Respondents answered the question by selecting one of four answers: never (0), once or twice (1), several times (2), or many times (3). A higher score indicated greater involvement in the network of mutual support. The scale ranged from 0 to 27 (alpha = 0.80).

Belief in the efficacy of help. The scale on belief in the effectiveness of helping was built using seven items (cf. Kaniasty, 2003); e.g. Success in coping with one's difficulties largely depends on help and support from others. Respondents chose one of four answers: (1) I strongly disagree, (2) I disagree, (3) I strongly agree, or (4) I agree. The scale ranged from seven to 28, with an alpha = 0.64.

Results

Statistical analyses of the data were presented in a correlation Table using Pearson's r (Table 3-1) and two hierarchical regression analyses (Table 3-2).

Table 3-1. Pearson r correlations between the analysed variables

Variables	1	2	3	4	5	6
1. Gender[a]						
2. Age	–0.25***					
3. Exposure to trauma	0.24***	–0.21***				
4. PTSD symptoms	0.01	–0.30***	0.44***			
5. Growth symptoms	0.17**	–0.21***	0.48***	0.42***		
6. Participation in the mutual exchange of social support	0.19**	–0.21***	0.59***	0.46***	0.60***	
7. Belief in the efficacy of help	0.15**	0.03	0.04	–0.09	0.28***	0.18***

[a]1 - boys, 2 - girls; ** $p < 0.01$; *** $p < 0.001$ (own research).

The correlations presented in Table 3-1 indicate that girls experienced more stress during the flood than the boys. More symptoms of growth were observed among the girls. The girls were also more involved in the exchange of social support than boys and exhibited greater belief in the efficacy of help. Younger respondents experienced more stress during the flood as well as more PTSD symptoms and growth than older respondents. Younger participants were also more involved in the network of social support during and after the flood than their older colleagues.

As expected, those who experienced more PTSD symptoms also demonstrated more symptoms of growth. The PTSD symptoms were positively correlated with greater participation in the exchange of social support. Similarly, the greater the respondent's participation in the exchange of social support, the more often symptoms of growth were observed. Young people who experienced more growth symptoms after the flood also had a higher level of belief in the efficacy of help. Participation in the exchange of social support was positively correlated with belief in the efficacy of help.

Table 3-2 shows the results of two hierarchical regression analyses with the PTSD and growth symptoms as dependent variables. Variables were introduced for each equation in the following steps. In the first step,

the variables of age and sex were simultaneously introduced, followed by exposure to trauma (the second step); in the third step, the variable reflected the exchange of social support, and the fourth variable showed the levels of belief in the efficacy of help. The results of the statistical analyses indicated that, after the introduction of all independent variables, both equations were statistically significant (F). Entered variables explained a significant part of the variance (R2). The regression coefficients (β) showed that younger respondents and those who experienced more stressful events during the flood had higher levels of PTSD symptoms. In addition, students who were more involved in the exchange of social support and those with lower levels of belief in the effectiveness of helping demonstrated more PTSD symptoms. More growth symptoms were observed in girls, in respondents more exposed to trauma, in students more involved in social support networking, and in students with higher levels of belief in the effectiveness of helping.

Table 3-2. Predictors of PTSD symptoms, and growth. Hierarchical regression analysis

Predictors	PTSD symptoms β	Growth symptoms β
Gender[a]	–0.07	0.13*
Age	–0.32***	–0.19**
Exposure to trauma	0.42***	0.45***
Participation in the mutual exchange of social support	0.29***	0.48***
Belief in the efficacy of help	–0.13*	0.20*
Final tests statistic		
R2	0.33***	0.43***
F	5.79*	16.23***

[a] 1 - boys, 2 - girls; * $p < 0.05$;** $p < 0.01$; *** $p < 0.001$ (own research).

Discussion

The aim of this study was to examine the relationship between distress and growth and the social support role in adolescents after experiencing a natural disaster exposure to trauma. The results of the study showed that those young people who had more PTSD symptoms eight months after the flood also had more growth symptoms. This result is not surprising as it is consistent with reports from other studies with children and adolescents

after a natural disaster (Milam, Ritt-Olson, and Unger, 2004). The positive correlation between PTSD symptoms and growth suggests the co-existence of negative and positive reactions to severe stress. A literature review also indicates that the consequences of traumatic events may include experiencing both negative psychological states (e.g. intrusive thoughts, nightmares related to the disaster) and growth (e.g. improved relationships with others and a sense of personal enrichment) (Tedeschi and Calhoun, 1996). This may imply that the presence of harmful PTSD symptoms does not exclude psychological growth and maturation. In the light of our study, both phenomena - distress and growth - emerge as separate factors and do not exclude processes (cf. Solomon and Dekel, 2007).

Attention should also be focused on possible alternative interpretations of the results, which suggests that positive changes after the trauma do not necessarily mean improvement or better health. Several studies found some harmful effects of growth after experiencing trauma. For instance, a study conducted by Cheng, Wong, and Tsang (2006) demonstrated that people who had coped with acute respiratory syndrome (SARS) and observed only beneficial changes in their lives had worse psychological well-being and experienced greater loss of resources than those who were aware that - in addition to the benefits - they also experienced adverse changes caused by the disease. This example suggests that post-traumatic growth may be accompanied by cognitive distortions arising from coping with trauma. From this perspective, the observed growth symptoms in trauma victims can be explained as a defensive compensation that protects the person before becoming aware of losses and damage caused by the traumatic event itself (cf. Solomon et al., 1999). According to this interpretation, growth is understood as a kind of stress-coping strategy that creates “positive illusions” that improve one’s welfare after the trauma. This illusion only improves well-being; it does not mean real recovery (Taylor, 1989).

The results indicating greater growth among girls than boys and more among younger than older respondents are consistent with the results of other studies, showing a positive correlation between distress and the level of exposure to stress (Milam, Ritt-Olson, and Unger, 2004). It is commonly believed that girls and younger adolescents are more susceptible to the consequences of traumatic events. Increased susceptibility is associated with different educational practices used for girls and those for boys in managing their feelings and in controlling their behaviour. Both girls and younger adolescents use less adaptive ways for coping with problems than boys and older adolescents do (Grant, 2003). It was also expected that

higher levels of distress and growth symptoms would be evident among people who were more involved in the exchange of social support. This expectation was confirmed and is consistent with the social support distribution rules emerging after most natural disasters. According to the rules, more affected individuals get more assistance. In addition, people more affected by disaster-related stress are also more helpful in providing support to other people (Kaniasty, 2003; Kaniasty and Norris, 2008). Greater participation in mutual social support may also cause a sense of growth in young people arising from the fact that one is perceived as important and necessary for communities struggling with calamitous effects (Kaniasty, Norris, 1996; Kaniasty, 2003).

It was also predicted that people who believe more in the value of mutual aid would experience more growth. This expectation was confirmed over and above the variance responsible for individual differences (i.e. gender and age), traumatic experience from the time of the disaster, and activity in the exchange of social support. Young people who had more positive attitudes toward helping others had better health and fewer PTSD symptoms. This result may suggest that a positive attitude toward help is a protective factor against the development of PTSD. Social support routinely fulfils its role in protecting young people against distress and generating growth. Our results also indicate that post-traumatic growth in adolescents is salutary in contrast to the distress symptoms which are strongly associated with a negative perception of the world. Our study also demonstrates that positive attitudes toward helping are an important factor in psychological adaptation after traumatic events (cf. Janoff-Bulman, 1989).

A small number of empirical reports concerning growth and social support in adolescents and natural disaster survivors suggest that this study, conducted after the flood in Piechowice, should be treated as an initial exploration of the problem. Knowledge related to the reactions - both positive and negative - may be useful for clinicians and other professionals to help children and adolescents after a trauma.

CHAPTER FOUR

DIFFICULT SITUATIONS IN OLD AGE: POSSIBILITIES OF PROVIDING PSYCHOLOGICAL HELP

ŻUREK ALINA, DĄBROWSKA GRAŻYNA AND ŻUREK GRZEGORZ

Increasing interest in old age is related to the rising rate of aging in highly developed nations, including Poland. Data provided by GUS (Main Polish Institute of Statistics) prove that after 2025, the proportion of Poles aged over 65 will be greater than the number of young people under 18 (cf. Straś-Romanowska 2000b). According to WHO (2002), already in 2020 the elderly will constitute 30% of the whole population. It should be added that the World Health Organization regards age 6o as the beginning of old age (Krzymiński, 1993).

In these circumstances, the number of studies devoted to various aspects of old age has increased. While previous works assumed the negative consequences underscoring aging, contemporary works focus on its positive aspects and successful aging (Hill, 2005). English Language literature for some time has taken the view that so-called successful aging is possible when an accurate diagnosis of resources is made so that an elderly person can find satisfying activities that personally influence his/her development (Chodzko-Zajko and Schwingel, 2010; Fisher and Specht, 1999; Schultz and Heckhausen, 1996; Wong, 1989) .

Undoubtedly in the light of this widening positive approach, specialists working with the elderly cannot omit the clinical aspect, full of problems faced in everyday life by an elderly person. A lot of attention is given to the somatically, mentally, and neurologically ill. However, the medical, psychosocial, as well as existential sense which describes only an elderly person's mental and physical abilities and excludes the whole range of

problems resulting from diseases, the weakening of nearly all bodily organs, or experienced loss through demise, is false.

The process of aging can be examined physiologically or pathologically (Bień, 1997; Duthie et al., 2007; Stuart-Hamilton, 2000). Physiological aging considers the lowered efficiency of almost all bodily functions and organs; the process is not pathological as it does not rule out unaided coping with these typical old age problems. Physiological aging applies to all the elderly, it is inevitable and depends on external as well as internal circumstances, for instance one's health, other biological factors, how active a person is, or the way one deals with life events. Biological aging becomes visible in a person's physical picture and functions; its symptoms can affect skin, hair, face, muscles, and bodily movements. The efficiency of many systems worsens: the nervous system (the demand for sleep and rest increases, mental activity decreases; lassitude and irritability increase, and moods worsen), the endocrine system (reproductive hormones -- estrogen, progesterone, and testosterone levels, as well as the growth hormone level, are lowered), the cardio-vascular system (heart capacity decreases by 30%), the urinary system (decrease in renal blood flow rate by 50%), the respiratory system (60% decrease in maximum breathing capacity and 70% decrease in oxygen consumption) among others (Bień, 1997). Changes concerning the capabilities of sense organs occur, in particular sight and hearing (Duthie et al., 2007), and in cognitive functions, and personality (the latter is hard to explicitly assess as positive or negative). It should be emphasised that within cognition both regression and development are observed; some features disappear, some appear (Straś-Romanowska, 2000ab; Trempała, 1989, 1997). Considerable research has proven that elderly people can properly function cognitively on condition that they maintain both intellectual and physical activity (Baltes and Baltes, 1993; Kowalik, 2000; Trempała, 1989, 1997; Ułaszewska-Żuk, 2000). Sometimes it is difficult to differentiate between biological aging and chronic illnesses among seniors. When the range and pace of physical deterioration and mental incapacity increase and visibly impede everyday functioning, the existence of developing pathological processes can be suspected.

Pathological aging consists in a rapid, extensive decrease of physical and mental abilities, which results in extensive ailments, namely dementia, depressive disorders (ICD-10, 1997), and mobility disability. Dementia results from brain illnesses and various factors damaging the brain, for instance circulatory system conditions, poisoning, and diabetes (Bilikiewicz and Parnowski, 2002). Some most frequently appearing medical conditions are Alzheimer's disease and vascular dementia. The

risk of these illnesses increases in relation to central nervous system conditions regardless of the age at which they appear. The characteristic symptoms encompass memory and cognitive functions disorders, various psychic disorders (delusions, hallucinations, mood disturbances, and difficulties in recognising people), behavioural disorders (aggression, psychomotility and neuro-vegetative disorders) and personality changes (Leszek, 2003). Depressive disorders, besides the dementia syndrome, are the most frequent mental disorders from which elderly people suffer. Depression symptoms include ailments connected with somatic disease, loss of one's closest relations, and observing negative changes in life (cf. Steuden, 2011). Depression symptoms are usually related to solitude (no close relations – an objective fact) or loneliness (no satisfying social connections – a subjective perception) (Pafał-Struzik, 2000).

Psychologically, old age abounds in events bringing the experience of loss. They are often interpersonal events like losing one dearest to you, especially a spouse; social events, namely retirement and losing socio-professional and economic status, no longer feeling needed, losing social support, sometimes being deprived of a house, flat, or financial means, which forces one to abandon one's former living standard; natural and pathological biological consequences, for example deterioration of health, physical attractiveness, and overall ability; oncoming existential events, in other words, the approaching perspective of one's death and the fear it brings (Straś-Romanowska, 2000b, p.267). Finally, the consequences stemming from all the above-mentioned events: negative self-evaluation, illness or deprivation of full ability, having lost meaning in life, undergoing a negative life balance, feeling isolated, feeling misunderstood and suffering loneliness (Steuden, 2011, p.25). All these events connected with the loss of the picture in old age, regarded as an undoubtedly negative stage.

Worsening physical ability coexists with difficult experiences located in time. The time relates to the present, the past, and the future. Sometimes a deprivation may relate to a very distant future but the need to reconcile oneself to it is still present. The experienced loss of the perspective on time – the future above all related to an awareness that your demise is approaching – becomes very real, even tangible (Steuden, 2011).

So old age emerges as a picture of critical or even traumatic events, characterised by definitely negative emotions. According to Straś-Romanowska (2000b), such critical events may cause a crisis in transitioning from adulthood to old age, compelling one to adapt to old age and its revaluations, by changing one's life concepts or life philosophy, and changing one's lifestyle. In such a situation it is justifiable to ask: Is

old age a solely traumatic period, abounding in existential crises? Are there any means for adapting oneself to old age by avoiding existential problems resulting from the experience of loss?

Answers to these questions may be derived from many research results. Authors specialising in this problem (cf. Straś-Romanowska, 2000b; Steuden, 2011) distinguish two ways to adapt; the first one is connected with forming an attitude towards critical life events, and is expressed in so-called (internal) adjustment; the other is related to solving problems deriving from these events, and is expressed in so-called (external) adaptation. Many theories explaining how to adapt oneself to old age have been formulated. Among classical theories functioning in psycho-socio-pedagogical literature are: Cumming and Henry's disengagement theory (1961); Neugarten, Havighurst and Toby's age-stress theory (1968), and activity theory by the same authors. The disengagement theory emphasises that withdrawing from social life is the most natural need in old age, and the lifestyle fulfilling this need is called the "rocking chair style", conducive to having retrospective memories and analysing unsolved conflicts. The age-stress theory underscores critical life events acting as stressors. As a consequence, the factors that were most important in early childhood – physiological well-being, feeling safe, and the need for general stimulation – continue to be most significant. The "elevator" hypothesis, used by the authors, pictures a typical reaction-to-stress pattern as learning new behavioural forms (levelling up) and returning to already acquired, old forms and schemes (levelling down). In the third above-mentioned theory – the activity theory – it is assumed that despite progressively aging an elderly person can remain active, but in an altered way. Replacement activities – recreation and hobbies, socio-political, integrative, receptive activities (watching television, reading books, listening to the radio) – fill the time previously occupied with one's professional job.

Also newer theories, called theories of constructive old age - stating that life is a task of continuous searching for knowledge and acquiring new skills - offer various ways to adapt actively to old age.

The choice-of-aging theory emphasises independent decision-making; seniors choose the optimum kind of activity for themselves (Steuden, 2011, p.88). The competency theory links old age to an elderly person's full responsibility for themselves, for acquiring the ability to cope with difficulties (through education about aging and old age, and trying to better understand themselves and others) (Halicki, 1997). Csikszentmihalya's flow theory (1998) emphasises that the quality of life is influenced by accepting one's old age, which is expressed by means of

everyday thoughts and emotional states related to everyday life experiences, in other words, to illness, pain, disability, suffering, and fear. Czerniawska's lifestyle theory (1996) stresses educational activity to maintain an elderly person's mental ability. Every intellectual effort slows the pace of memory and learning deterioration.

A common characteristic of the above-mentioned active-adaptation theories is that the elderly person must have some knowledge about potential changes occurring during aging, both biological and mental, or social. Good preparation for these potential changes, even if only through prevention, at least offers some protection from the negative consequences of old age (Steuden, 2011).

Elderly people's active adaptation to old age can be characterised by their lifestyle. The two most frequently occurring adaptations are passive lifestyle (less desirable, connected with a somatic disease, decrease in locomotion, and decreased physical strength), and active lifestyle (connected with the family, physical activity, and social activity, thus focusing on home, religion and education) (Czerniawska, 1998). In constructive old-age adaptation, the educational lifestyle, allowing a broadening of interests, gaining new skills or making new acquaintances and friendships is crucial. It is expressed by the elderly taking part in various forms of education. One possible educational lifestyle is the University of the Third Age.

UTA has two aims: educational and recreationally-integrative (Drożdż, 2009; Marczuk, 2006; Wnuk, 2008). The educational aims are realised through engaging the elderly in studies that enable them to learn new science disciplines, chosen by the participants themselves, which express their needs and interests. The effort devoted to learning new things broadens both one's world view and the learner's understanding of the people in that world. It benefits the senior, who gains a better understanding of herself/himself and others, and strengthens his/her ability to solve existential dilemmas thanks to deep reflection on past events and their significance in his/her personal life.

The second UTA aim – recreationally-integrative – is realised through creating opportunities for people to meet; through common interests, maintaining contact with one another, and creating friendships the elderly are protected against apathy, and feeling lonely and helpless. For retirees it exerts a positive influence on their functioning in a family, society, and intergenerational communication; it creates a sense of independence and at the same time a sense of belonging to a social group; it provides an opportunity to spend one's time usefully. Czerniawska (1998) underscores the fact that various forms of activation offered by UTA (which motivates

in cognitive, physical, family-life, social, and cultural activities) result in positive self-evaluation and self-esteem; they destroy the socially functioning old-person stereotype and, as a consequence, counteract marginalisation.

Integrating life experience with newly acquired knowledge, reinterpreting the meaning of past events and accompanying experiences in confrontation with the experiences of other people met through UTA is part of the cognitively-active positive-aging model that enables elderly persons to discover new qualities in life (Steuden, 2011).

Description and methodology of research

The research was carried out using Grant no. ZP05D08227 from the State Committee for Scientific Research and was conducted by a psychologist from the University of Wrocław (UWr) and a team of workers from AWF (University of Physical Education) in Wrocław in teaching facilities of the Third Age University within UWr. Those examined were at least annual UTA participants. Before beginning the research they gave their written consent to taking part in the research; they were informed of its aims and could withdraw from it in case the need arose. The psychologist discussed the rules for answering questions posed in the research and the rules for completing sentences in the projected part adapted from some of the applied methods. Altogether 132 UTA members aged 60-89 and living in Wrocław were examined. Various research devices were employed. Data selected for the present analysis were obtained by applying part of C. Crumbaugh and L. T. Maholick's PIL (PLT) test (1981), translated into Polish by Z. Płużek and known under the term Sense of Life Test (Popielski, (1987). The point of reference used by its authors for constructing this device was V. E. Frankl's Existential Frustration Symptoms Questionnaire (1959); its aim was to qualitatively describe existential frustration symptoms. Crumbaugh and Maholick focused quantitatively on having or lacking a sense of meaning in life; in other words, they quantitatively captured what Frankl described as existential frustration to establish if there is a neurosis diagnostically different from other neuroses – a noogenic neurosis. Through empirical studies the authors tried to prove that what is measured by their scale corresponds to what Frankl termed existential frustration and a noogenic neurosis. They also tried to demonstrate that the etiology and symptomatology of this noogenic neurosis, characteristically felt by those who experience no purpose in life, is different from traditionally distinguished neuroses and that the scale measures how intense one feels

about purpose in life, and differentiates between persons' pathological and normal functions (Popielski, 1987).

The sense of life scale comprises three parts marked as A, B, and C, while – as the paper focuses on the qualitative aspect – the data analysis involves part B (incomplete sentences). Subjects completed the following sentences: My life is…, In my life I have already achieved…, Life is for me…, Death is…, The thought of suicide…, and Illness and suffering… Their answers were analysed.

The research aim was to characterise the way UTA listeners experience old age.

The fundamental issue was the answer to the following question: How do UTA members experience their old age? There were also attempts to answer two detailed questions:

Are there among the UTA members any persons experiencing their old age negatively?
Are there among the UTA members any persons experiencing their old age positively?

The authors assume that the way in which one experiences old age is determined by the following factors:

attitude towards one's life (My life is…),
positive or negative balance of life (In my life I have already achieved…),
attitude towards life in general (Life is for me…),
attitude towards death (Death is…),
having suicidal thoughts or accepting suicide as a fact (The thought of suicide…),
attitude towards illness and suffering (Illness and suffering can be…).

The above-mentioned categories, characterised negatively, determine old age as a negative experience. In contrast, positive experiences are determined by the same factors, but characterised positively. Utterances were obtained by means of the judgment method. Having utterances evaluated by competent judges is a way to gain objective interpretations. Two competent independent judges were invited to assess the completed expressions according to categories specified by the authors:

negative expression (the subject describes a given phenomenon , e.g. death, in negative terms),

positive expression (the subject describes a given phenomenon in positive terms, expresses a positive, accepting attitude towards it or states that it does not occur to him/her, e.g. suicidal thoughts),
neutral expression (the subject describes a given phenomenon in terms neither positive nor negative but rather interprets them neutrally; the subject's utterance does not render his personal relationship to a given phenomenon or to the judges a unanimously defined utterance about the category in question).

The items characterised as impossible to assign to one category were specified and added to unfinished sentences (omitted by the subjects). As a consequence a certain number of sentences were disqualified from interpretation (Table no. 1 – rejected items).

Research findings

It can be observed that the majority of subjects defined the categories specified as old age experiences (Table 1) positively. This situation occurs in four such categories: attitude towards one's life (positive 59.1%, negative 12.9%), balance of life (positive 72.7%, negative 6.1%), attitude towards life in general (positive 59.9%, negative 6.1%), occurrence of suicidal thoughts (no occurrence 57.6%, occurrence 4.5%). In the remaining two categories (attitude towards death and attitude towards illness and suffering), the situation is reversed: negative opinions prevail, which shows that a higher proportion of the persons questioned feared death, illness, and suffering. It is noteworthy that most neutral opinions were related to death; it proves that death is difficult but is easier to interpret than relate to it personally.

The competent judges were least unanimous when evaluating the occurrence of suicidal thoughts category. As a consequence, this category is characterised by the highest proportion of rejected items (31.1%).

In the paper's further parts, examples of subject utterances assessed as positive, negative, and neutral are presented. Only positive and negative utterances will be discussed (Tab. 4-2).

In the attitude towards one's life category (Tab. 4-2) over half of the analysed utterances were positive (59.1%). The subjects used designations underscoring joy, diversity, a wealth of experiences accompanying their lives; they emphasised its value and usefulness. In contrast, in the utterances characterising life negatively the following experiences were stressed: hardships, monotony, cheapness, feeling defeated, and no

purpose to life. These subjects accounted for nearly 13% of all participants in the survey.

Table 4-1. Table presenting the competent judges' assessments

Question	% of unanimous assessments			% of rejected assessments
	positive	negative	Neutral	
My life is…	59.1	12.9	12.1	15.9
In my life I have already achieved…	72.7	6.1	6.1	15.1
Life is for me…	59.9	6.1	13.6	20.4
Death is…	5.8	18.9	59.1	16.2
The idea of suicide…	57.6	6.8	4.5	31.1
Illness and suffering can be…	31.1	36.4	11.4	21.1

Source: authors' own study based on data from PIL (PLT) C. Crumbaugh and L. T. Maholick.

Table 4-2. Examples of the completed sentence My life is… in the three categories according to competent judges' assessments

My life is…	Positive	Joyful Diverse and interesting Valuable Successful Abounding in positive experiences
	Negative	Quite monotonous, because lonely Difficult Third-rate A defeat, I think Not very meaningful
	Neutral	Peaceful and monotonous Active Full of work As it is Normal

Source: authors' own study based on data from PIL (PLT) C. Crumbaugh and L. T. Maholick.

Balance of life (Tab. 4-3) is a positive category characterised by the highest proportion of persons (72.7% of the subjects). Among their achievements they enumerated job satisfaction, joy in family life, and also goals. Some provided general statements saying that they had achieved everything or a lot. There is a relatively small group (6.1%) of those who assessed their life balance as negative. Although this is not a large group, its existence cannot be ignored. Subjects from this group stated that in their lives they had achieved nothing, not much or less than they intended. In order to minimise the risk of mood disturbances or even suicides among the elderly the UTA member environment should be carefully diagnosed to find persons who experience discomfort connected with a negative life balance.

Table 4-3. Completed examples of "in my life I have already achieved…" in the three categories assessed by competent judges'

In my life I have already achieved…	Positive	Everything I could Joy in my family A lot and I want to develop further Satisfaction in working with people My set goals
	Negative	I have achieved nothing Few of those things I intended to achieve Nothing Less than I wanted Not much
	Neutral	The end of my possibilities Not everything yet A lot and nothing Happiness and unhappiness Success but also failure

Source: authors' own study based on data from PIL (PLT) C. Crumbaugh and L. T. Maholick.

In attitude towards life in general (Tab. 4-4) almost 60% present this relation as positive, describing life as interesting, valuable, precious. Concepts they listed were, for example joy, wealth, value and a gift. Similar to the case of the balance of life, only 6.1% of members examined

associated life with negative notions, for instance burden, duty, fight, passive existence.

Table 4-4. Completed examples of "Life is for me …" in the three categories assessed by the competent judges

Life is for me...	Positive	Interesting and precious A joy A priceless value A wonderful gift Wealth
	Negative	A difficult lesson Hard Full of responsibilities and self-sacrifice A constant fight A passive existence
	Neutral	Indifferent; it exists Difficult to define Waiting, a path A constant mystery/riddle Full of unknowns

Source: authors' own study based on data from PIL (PLT) C. Crumbaugh and L. T. Maholick.

In the area attitude towards death (Tab. 4-5) very few utterances were qualified by the competent judges as unambiguously negative or unambiguously positive. Thus one must be very careful about making generalisations derived from this part. Only 5.8% of the subjects expressed positive views on death. The positive utterances were characterised by religious content; death is associated with redemption, a transition to eternal life, and the beginning of a better life. Negative utterances abounded in expressions of death's pointlessness (death is meaningless/pointless), of sadness, fear, and despair (death is horrible, death is the worst, death is a great tragedy). Death is negatively described by 19% of the subjects.

Table 4-5. Completed examples of "Death are …" in the three categories by the judges

Death is...	Positive	One of the stages of life Sometimes redemptive A bridge to meeting one's close relations Transition to eternal life The beginning of one's life
	Negative	Horrible The worst A great tragedy Sad Meaningless / pointless
	Neutral	Departure from this world A man's natural biological cycle Given to everyone Inevitable The destination to which everyone is heading

Source: authors' own study based on data from PIL (PLT) C. Crumbaugh and L. T. Maholick.

In occurrence of suicidal thoughts (Tab. 4-6) almost 60% did not have suicidal thoughts. Almost 7% confessed, however, that they would allow suicide as a last resort or during an incurable sickness. Some of them used to have suicidal thoughts.

Table 4-6. Completed examples of "The thought of suicide …" in the three categories dealt with by competent judges

The thought of suicide...	Positive	Never comes I never thought about Is absent in me Doesn't exist Is foreign to me
	Negative	Can be allowed as a last resort Is an extremity I would allow in the case of incurable sickness Was a life jacket for me I had in the past
	Neutral	Is a tragic matter Not at all Is something I don't have such thoughts about Is born out of difficult mental experiences Is difficult to assess; it is either courage or escape from problems

Source: authors' own study based on data from PIL (PLT) C. Crumbaugh and L. T. Maholick.

In attitude towards illness and suffering (Tab.4-7) the difference between positive and negative utterances is only 5%. Illness and suffering viewed in a positive light (by 31.1%) are described as possible to overcome, cured or dealt with; faith and religion enable one to find their meaning (…can be getting closer to God, a time of deep reflection). Negative descriptions (36.4%) underscore torment, hopelessness, cruelty, or evil.

Table 4-7. Completed examples of "Illness and suffering can be …" in the three categories assessed by competent judges

Illness and suffering can be…	Positive	Getting closer to God A time of deep reflection Possible to overcome Cured Dealt with
	Negative	A necessary evil My torment Hopeless for people Cruel Tiring and overwhelming
	Neutral	Difficult, but one has to find strength A normal stage in life of the elderly Something natural Are things I don't have Conditions that one has to go through with meekness

Source: authors' own study based on data from PIL (PLT) C. Crumbaugh and L. T. Maholick.

Analysis and interpretation of results

Old age is the last stage of every person's life. The processes that take place at the time have an individual course (Susułowska, 1989) and are conditioned by various biological, psychological and social as well as spiritual factors. Old age as described by the subjects constitutes symptoms of existential frustration, whose main factor is pointlessness in life. Their utterances: My life is meaningless…third-rate…a failure, In my life I have achieved nothing, Life is for me a passive existence, Death is meaningless/pointless… is a great tragedy, constitute Frankl's qualitative indicators of existential frustration. If we add suicidal thoughts or allow suicide as a last resort, an alarming psychological and spiritual image emerges. This image is characterised by negative emotions, fear of death, and existential senselessness.

A conclusion can be drawn from this analysis: among the UTA seniors in Wrocław, a group of members were diagnosed as experiencing old age as a traumatic period full of difficult events. They are not protected from experiencing old age as traumatic even by the cognitive activities performed in the classes organised at the University of the Third Age.

There is a reason why psychologists call this period adulthood/old age crisis (Straś-Romanowska, 2000b), in which natural critical developments related to failure to accept old age could be combined with the situational crises connected with various traumas – crises, related for instance, to death in the immediate family. In old age, often when change for the better is lacking, critical situations have a particularly stressogenic influence (Zielińska-Więczkowska et al., 2008). Critical situations always constitute worry and struggle, and in old age they especially cause frustration or depression. Old age is inseparably connected with death and, accompanying it (or not), fear of death. This topic was reflected upon by the persons examined in one of the factors, namely the attitude towards death. Fearing death is rather common and concerns almost all people, especially the elderly, who face the prospect of edging closer to their own demise. A person cannot rationally refute this fear and mentally always experiences the threat of death (Żurek and Dębska, 2006). Death's approaching prospect often releases the most traumatic parts of the human experience which have been previously marginalised or denied due to high mental costs. The vision of death unblocks these contents and introduces them into the consciousness; only as a result of this process can their new meaning emerge as well as the meaning of life as it is. Becoming aware that one did not fulfil important developmental tasks in an earlier period can be an additional experience resulting in frustration, existential neurosis or mood decline. Quality old age, according to gerontologists, mostly depends on life's previous stages (especially in adulthood); it, therefore, results from past events (Zielińska-Więczkowska, 2008 after Zych, 1999). Entering old age with a burden of negative experiences results in psychological problems. The picture of one's own old age depends mostly upon the particular person, on his attitude towards life and death, health, and illness and suffering. It compels every person to take responsibility for the quality of one's old age. According to Dąbrowski's (1979) theory, integrating traumatic experiences and consciously accepting unfulfilled developmental tasks can lead to a higher consensual level and to an emerging new form of mental life. When death is accepted, and regret and sadness connected with negative evaluations of earlier life are expressed, it then becomes possible to enter into a deeper dimension of existence, to grant a more complete meaning to one's life (cf. Żurek, Dębska, 2006), suffering, illness, and old age.

Evaluating one's life balance conducted as losses and profits is an important indicator of how old age experiences will be accepted. If the negative pole prevails (Erikson, 1997), an elderly person will perceive facts that will not allow him/her to accept his/her current state. The senior

will claim that it is too late to change or correct anything. This perception "trap" (Baumann, 2008) condemns a person to constant dissatisfaction or even despair. In extreme cases, persons can function as though they have descended to the lowest development level, where the most important things are to satisfy one's physiological needs and the need for safety (according to Maslow's theory). Simultaneously life-balance is inseparably connected with the need to seek meaning in life's earlier stages as well as in the illness and suffering that one later experiences (Straś-Romanowska, 2000a, 2002). According to Frankl, the need to find meaning in life is crucial to the elderly, and its fulfilment is significant according to psychologists, who underscore the role of mental balance in experiencing old age. Undoubtedly experiencing meaning in one's life, even if it is devoid of good health and full of suffering, helps to overcome the old age crisis. As old age is the period conducive to reflection over the value of one's earlier life, people at this stage perform the final calculation. Awareness that transition is inevitable and that the end is approaching allows a person to see various everyday problems in a different light. Returning to the past, according to Jung or Erikson (1997; in Straś-Romanowska, 2001), can serve to naturally integrate the psyche, allotting the right portions to things and events. As a consequence, accepting one's death as inevitable becomes an important challenge, especially when death becomes a close proximity, as happening in one's immediate family, or among friends and acquaintances. Seeing sense in earlier events and adding to a positive balance of life can alleviate fear of death, which is after all a great unknown for everyone.

According to the researchers' own investigations, what helps the elderly to alleviate fear of death, illness, and suffering is faith in God and eternal life after death. After conducting an analysis of subject utterances, the presence of religious contents can be observed. Faith is a value esteemed gradually higher with age (Zielińska-Więczkowska et al., 2008; Zych, 2000) and less so in life's earlier stages. Frankl (1984; in Popielski, 1987) states that a person will search for the meaning of his/her life in a heavenly reality. Christianity alleviates the tragedy of human existence in a special way by providing hope for eternal life in the presence of God (Mesjasz, 2006). Apparently for many subjects, such a prospect proves to be helpful in understanding, ascribing meaning to, and as a consequence, accepting, aging - and death.

A significant problem for old age is, however, the risk of suicide (Tucholska, 2006). As it turns out, the suicide rate increases with age. Among people aged 65+ it is 50% higher than among younger people. Statistically the number of suicide attempts decreases with age, while the

number of suicides committed increases (Osgood, 1991). Maris (after: Tucholska, 2006) enumerates various suicidal risk factors; among others there are alienation, loneliness, loss of support, hopelessness, somatic diseases, bad financial situation, difficult life experiences. The list is completed by Pilecka (2004) who continues with stress, fear, chronic diseases, mental diseases, difficult economic situation resulting from entering retirement, lowered self-esteem resulting from loss of family position, and negative life balance. Many of the factors listed above prevail in old age, making this period especially exposed to suicidal risk. This research team's analysis confirms this fact. Although attitude towards suicide was characterised by having the highest proportion of rejected items (the competent judges lacked unanimity in their evaluation), still a certain group of persons examined accepted suicide as a possible act.

The mutual category used to describe both old age and trauma is a loss. The aforementioned events like the sudden death of a spouse, gradual passing away of one's closest relations, widowhood and loneliness, the necessity of dealing with everyday obstacles unaided, and finally illness and non-adjustment to it mean that old age is sometimes identified, both cognitively and emotionally, as a difficult situation. Cognitively, without the support expected from one's closest relations, it is difficult for an elderly person to come to terms with the inevitable end of many social relations; emotionally this social displacement in a way justifies the occurrence of many pathological mental reactions resulting from non-adjustment to randomly occurring changes, requiring treatment or at least professional advice and support. In this particular period – with losses in health and strength, closest relations, job, prestige, and one's own approaching demise – counselling and psychological support made available through institutional networks specialised in providing psychological help to the elderly become all the more significant (Wnuk, 2002). Contemporary counselling provided for persons at this age is an integral part of life counselling for adults in the trend toward lifespan development psychology. Meanwhile situational counselling, the need for which emerges the moment problematic situations appear, implies the necessity for its application especially in old age with its undoubted abundance of existential problems (Straś-Romanowska, 1996; Wnuk, 2002). Creating psycho-gerontological clinics providing existential support for the elderly would meet their expectations. Undoubtedly there is an increase in the number of senior clubs in our country, as well as good-practice circles, senior volunteer stations, and parish counselling services by the church. However, even the existing network of medical

counselling clinics (termed geriatric) does not solve all the problems faced by the elderly (Wnuk, 2002).

Therefore, a question arises: what determines the specifics of psychogerontological counselling? According to Czerniawska (1996), counselling for the elderly is concentrated on three categories of help: first, on help with problems derived from changes that follow the aging processes and the perception that one is an old person; secondly, on help with reorganising one's life as a widow, constructing a new life plan, choosing a life activity for the retirement period; thirdly, on help with maintaining intellectual ability, physical fitness, and socio-moral development.

Straś-Romanowska (1996, 2002) emphasises, moreover, the significance of giving help when an elderly person has spiritual dilemmas connected with worldly values and the search for life's meaning. Therefore, while not belittling instrumental counselling that deals with living in transforming social conditions, the author(s) indicate(s) the importance of existential counselling derived from spiritual problems. The importance of existential counselling is underscored by problems experienced in later old age, that is, by emptiness, no joy in life, enmity towards the world or towards oneself, conflicts with the closest family, existential frustration related to no longer wanting to live and to act, by feeling that life has no purpose. The fears experienced from internal suffering and death brought about by close relations dying prove that an elderly person cannot adapt to these problems that arise. A complementary clinical approach is necessary (Wnuk, 2002). This approach considers the different psychological sources involved (biological, social, mental, and spiritual) and takes into account that in counselling practice it is often difficult to distinguish between instrumental and existential problems. The necessity to answer the question "What should I do?" or "How should I do it?" in order to cope co-exists with the fundamental question every person has to answer for themselves: "What do I live for?"

One of the many therapeutic methods especially useful in identifying existential problems which thwart the striving for sense and which intensify existential fears is Frankl's logotherapy (Popielski, 1987). As a professional psychological tool, it can be used with seniors in their crises related to development, as well as in situational crises caused by other traumas. If a professional counsellor in existential counselling focuses his/her attention on problems about life's meaning, suffering, illness, or death, the patient can be directed to the world of values and spirituality. In practice, however, introducing a person to the problem of meaning is possible also in other psychotherapeutic currents -- with the proviso that

they do not reduce a human being to a psycho-biological dimension, depriving him/her of the spiritual sphere. Such services do not have to be strictly psychotherapeutic; they should rather be developed as existential counselling or a kind of psychological support.

Living in the contemporary world exposes many people to difficult circumstances – some are traumatic events that transcend one's abilities to adapt. They can be wars, earthquakes, catastrophes, numerous family migrations searching for ways to earn a living, and added to these traumas the loneliness of those who do not migrate, who suddenly lose their loved ones or sustain bodily damage or disability caused by traffic accidents.

As reactions to these events, many people undergo serious psychological crises, chronic stress, post-traumatic stress disorder, various addictions, or even suicidal attempts. Also, old age and losing one's immediate family member, experiencing loneliness, desolation, losing social functions and prestige, becoming gravely ill, and having to deal with your own impending death become traumatic problems concerning a large proportion of society. Some people go through old age with its abounding losses with full awareness, and they consciously come to terms with the passing of time and with irretrievable changes in their lives. For some, traumas activate – instead of destroy – the will to live and the desire to cope. There are among us, however, people who need support and psychological help in their desolation – and very often despair – in order to survive throughout their old age.

Conclusion

The UTA members examined mostly experienced their old age in a positive way. The positive experience of old age comprises a positive attitude towards one's life, towards life in general, towards death, illness, and suffering, a positive balance of life and non-occurring suicidal thoughts.

Among the UTA members examined there were persons who experienced old age negatively. For them old age is connected with treating illness and suffering evils, having a negative balance of life, a negative attitude towards one's life, towards life in general, and towards death; they allow suicidal thoughts.

The seniors experiencing old age negatively require psychological support aimed at helping one discover meaning in life.

An important social support can be by developing a network of counselling clinics specialising in existential counselling.

Existential counselling focuses on problems experienced in late old age, namely, emptiness in life, no joy in life, enmity towards the world or towards oneself, conflicts with the closest family, and existential frustration related to the lack of meaning in life.

One method to help support elderly persons could be V. E. Frankl's logotherapy.

PART III:

FACTORS OF EFFECTIVE THERAPY ON PEOPLE AFTER TRAUMA

CHAPTER FIVE

PREDICTORS OF THERAPY EFFECTIVENESS FOR WOMEN SUBJECTED TO VIOLENCE

EWA MITURSKA

Violence is one of the most important contemporary problems, an issue poorly documented for many years. It was believed that it manifested itself sporadically and concerned mainly pathological environments in a strict sense. It is now known that violence appears in all social groups and is independent of race, culture, social background, financial situation, education or health status (Dobrzynska-Mesterhazy, 1999; Herzberger, 2002; Lipowska-Teutsch, 1993, 1998). Recent work has brought about a significant breakthrough in the area of family violence, the problem becoming more visible both in public opinion and in the activities of particular institutions. Violence started to be equated in public awareness with the family environment, until then it was assessed as safe.

The problem continues to be a "taboo" subject, not to be discussed much, and where society remains rather helpless. Therefore further empirical research and work on coherent, clear policy is required to counteract this phenomenon (Browne and Herbert, 1999). The outcomes of empirical research are to modify certain activities conducted so far and to collect the "best practices" in the area of psychological support provided to specific client groups.

Research shows that violence is a phenomenon causing considerable damage among those subjected to it. The consequences can be legal, economic, or social as well as personal: in both physical well-being and in a mental sense. The effects of violence in relation to the mental sphere can be very extensive, ranging from anxiety disorders, depression and neurosis to post-traumatic stress syndrome and psychosomatic diseases. Pathological patterns exhibited by a person subjected to long-term violence concern the following areas: cognitive, emotional, behavioural, biological and interpersonal (Akerman, Pickering, 2004; Pospiszyl, 1994, 1999; Seligman, Walker and Rosenhan, 2003). Those who experience

violence often require professional assistance in the form of therapy or other assistance (Herman, 2007).

However, the literature on this subject contains very little data relating to psychotherapy provided for violent persons. There is no information about psychotherapeutic effectiveness in treating patients. The research presented attempts to fill this gap; the results could become the basis for clinical psychology.

The objective inference concerning psychotherapy and its results is extremely difficult. This is due both to their therapeutic complexity and to the lack of equivocal understanding about the therapy's effectiveness. Since there is no generally accepted definition of psychotherapy, its goals are also variously expressed. Depending on patient needs, on his/her deficiencies and recognised pathogenetic mechanisms, the goals could be broadly understood as improving one's well-being, removing disease symptoms, and alleviating suffering or change in the patient's behaviour, attitude or emotion. Psychotherapeutic principles depend to a great extent on how "improvement" is understood in the various schools of psychotherapy (Grzesiuk, 2006; Prochaska and Norcross, 2006; Rakowska, 1998; Sek, 2001), while psychotherapy's complex process makes it more complicated. Psychotherapeutic change is multi-dimensional in character and is caused by many processes. The transparent interaction between a therapist and a patient is a difficult task. Despite such methodological difficulties, a number of studies on psychotherapy have been conducted over the last twenty years. The results mainly show that psychotherapy is effective: from a health perspective it can remove symptoms, develop patient potential and change behaviour. There is also significant improvement in a patient's psychosocial functioning (Garfield and Bergin, 1990; Rakowska, 1996).

It is already known that psychotherapy is effective, but we it is not exactly known why. Each psychotherapy school points toward different, specific curative (therapeutic) factors. At the same time there is existing research confirming positive therapeutic results in relation to so-called common factors. According to many researchers, psychotherapy depends on multiple variables, among which are psychotherapeutic characteristics, namely those of a therapist and a patient. The feedback between these variables conditions how psychotherapy proceeds (Grzesiuk, 1998, 2000). The interaction is influenced by a patient's different characteristics, in particular his personality, temperament, the type of disorder exhibited and its intensity, motivation to participate in therapy, readiness to co-operate, activity during treatment, general living conditions, and other determinants in the cognitive, emotional and behavioural spheres. A patient's socio-

demographic characteristics are also significant (Czabala, 2006; Grzesiuk, 2006; Rakowska, 2005).

In order to study therapy's effectiveness for women experiencing violence, quantitative analysis was selected as the means to measure psychotherapeutic results. An increased sense of coherence was regarded as a measure, indicating a possible change caused by the treatment.

The "sense of coherence" is a theoretical formulation described by A. Antonovsky as a part of the salutogenesis concept. It is understood as

> "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; the resources are available to one to meet the demands posed by these stimuli; and these demands are challenges, worthy of investment and engagement" (Antonovsky, 1995, p.34).

Sense of coherence (SOC) is a general and constant belief in the predictability and rationality of the world that surrounds us and in our everyday life. On the basis of having done considerable empirical research, Antonovsky concluded that there are three components of SOC: comprehensibility, manageability and meaningfulness. At present it seems that SOC is a so-called meta resource that a person has that manages the other, generalised resistance resources of a human being (Antonovsky, 1995; Heszen and Sęk, 2007). Antonovsky assumed that the stronger the sense of coherence, the easier it is for a human being to stay out of danger. For such persons, who value their own lives, their health becomes a priority, being too precious to be treated lightly. Cognitively the chances of such persons adopting positive health behaviour and other activities beneficial for their personal growth are made greater with SOC. Also, the author believes that the stronger the sense of coherence, the greater the chance such persons have of interpreting stimuli that reach them, not as being stressful and dangerous, but as being challenging: they redefine dangers in such a way as to maintain personal control. It will be easier for them to reduce the fear and anxiety that accompany changing circumstances. The third way in which sense of coherence impacts health is exemplified by persons with high SOC levels who, despite having numerous resources, attempt to maximise SOC and make the best use of it in order to cope with stress. Therefore they seek some potentially accessible ways to solve the problem, while still believing in their own abilities (Antonovsky, 1979, 1984, 1997). The theoretical salutogenesis model has been verified by many research studies, with very promising

results, since almost every piece of research confirms the significant role that the sense of coherence plays. SOC also impacts the life satisfaction level and sense of confidence in the social roles performed.

A significant negative dependency between high SOC and susceptibility to various psychic and somatic disorders was confirmed (Mroziak, 1994; Pasikowski, 2000; Sęk and Pasikowski, 2001). Therefore it seems that SOC could be regarded as a good way to measure changes caused by psychotherapy.

The question remains of how to select predictors. Research on patient treatment is based on a search for a human being's potentials that would condition the adaptation process. In other words, does a person have such traits that allow him to maintain his health status at a level sufficient to fulfil his needs and to reach goals or develop the organism, but first of all, to overcome all obstacles? Such resources improve human adaptation to reality requirements and prevent stress from transforming into a chronic form. They impact the motivation to develop, promote pro-health behaviour and counteract other dangers originating in the risky behaviour area (Poprawa, 2001). A review of personal psychosomatic resistance allows us to select such predictors, such as emotional intelligence, the locus of control and personality traits.

Emotional intelligence according to Salovey and Mayer is "the ability to perceive emotion, integrate emotion to facilitate thought, understand emotions and to regulate emotions to promote personal growth" (Salovey, Bedell, Detweiler and Mayer, 205, p. 637). It concerns the human ability to use emotions to cope with difficult life situations (Salovey and Meyer, 1990), and consists of four types of abilities: 1) perceiving, assessing and expressing emotions, 2) facilitating thought with the help of emotions, 3) comprehending and analysing emotions, and 4) regulating emotions.

The literature on this subject suggests emotional intelligence has a great impact on human psychological functioning. Initial research indicates that emotional intelligence is connected to the intra-psychic ability to manage and accept one's emotions. It also has a great impact on the interpersonal abilities of assertiveness, conflict resolution, maintaining ties, or expressing empathy (Goleman, 1997, 1999; Mayer, Caruso, Salovey, 2000, 2004). This factor performs a significant role in the capacity to cope with stress, and in particular in perceiving and selecting coping strategies during problematic situations. Emotional intelligence should not be underestimated when prioritising goals and determining their effectiveness, or the skilfulness in delaying a reward in case of difficulties (Bedell, Detweiler and Mayer, 2005; Salovey, Sluyter, 1999; Salovey).

The other tested predictor - the locus of control - is understood by J. B. Rotter as a generalised expectation on the location of control reinforcements. As he himself puts it:

> "When a reinforcement is perceived by the subject as following some actions of his own but not being entirely contingent upon his action, then, in our culture, it is typically perceived as the result of luck, chance, fate, as under the control of powerful others, or as unpredictable because of the great complexity of the forces surrounding him. When the event is interpreted in this way by an individual we have labelled this a belief in external control. If the person perceives that the event is contingent upon his own behaviour or his own relatively permanent characteristics, we have termed this a belief in internal control" (Drwal, 1979; Rotter, 1966, p.1).

Existing extensive empirical studies allow one to conclude that the locus of control is a proper factor explaining many aspects of human behaviour, both in life or in the laboratory. The research shows that the locus of control interacts with a sense of self-efficacy. It was proved that those with internal locus of control trust their abilities to impact events and more accurately assess the probability of success when they undertake actions (Drwal, 1978, 1985, 1995). Persons with the locus of control have confidence in their potential and are characterised by higher aspiration levels. Also they are active and independent during decision-making (Rotter, 1954, 1975). They are characterised by a high degree of responsibility. The research results show that the locus of control is closely related to numerous physical and mental health indicators. The persons with an internal locus of control seem to be better equipped to cope with life's hardships than those who assume that they have no impact on how events play out (Galdowa, 1999; Rotter, 1960, 1965).

The last of the verified predictors was personality traits. According to P. Costa and R. McCrae's five-factor model, personality consists of the following dimensions: neuroticism, extraversion, openness to experience, agreeableness and conscientiousness.

"The Big Five" is the basic format used to describe human personality (Oles, 2003). These traits are the basis for predicting many successes in one's personal and professional life, and are significant determinants of mental and physical health. They explain many individual human traits such as coping with stress, functioning cognitively and emotionally, or using defensive mechanisms (Costa, McCrae, 1992, 2005; Zawadzki, Strelau, Szczepaniak, Sliwinska, 1997). Empirical studies so far have proven to be of great significance in adapting Costa and McCrae's NEOAC factors to psychosocial events (Galdowa, 1966 b; Oles, 2003).

These and other selected predictors enable one to expect that they constitute a person's essential resources, allowing for better and more successful responses during therapy which, in turn, could result in a possible growing sense of coherence.

Study objectives

The research goal was to measure the effectiveness of psychotherapy provided to women who experienced violence in close, interpersonal relations. Additionally, the research was to verify selected health predictors in their impact on psychotherapeutic results. On the basis of such analysis, potential health correlates were prepared: emotional intelligence, the locus of control and selected personality traits. The study based itself on the assumption that empirical verification of the above-mentioned predictors would assist in identifying essential human resources. It seemed important to check whether a dependency existed between them and the growth of sense of coherence, and by the same token, between the patient's perception of reality as being more comprehensible, manageable and meaningful.

Research tools

While taking into consideration the research goals and their specificity, a decision was made to conduct the research using questionnaires, five being employed, as follows:

1. - SOC-29 questionnaire by Antonovsky (1979) adapted to Polish conditions by teams at the Institute of Psychiatry and Neurology in Warsaw, the Institute of Psychology at Adam Mickiewicz University in Poznan, and the Institute of Occupational Medicine in Lodz.
2. - Emotional Intelligence INTE questionnaire by N. S. Schutte and others, adapted by A. Ciechanowicz, A. Jaworska and A. Matczak.
3. - Locus of Control Scale I-E by J.B. Rotter, adapted by J. Karylowski.
4. - NEO-FFI questionnaire by P. Costa and R. McCrae (1992), adapted by B. Zawadzki, J. Strelau, P. Szczepaniak and M. Sliwinska.
5. - Self-completion questionnaire (APZP – Measurement of Violence Phenomenon Questionnaire).

Sampling plan

Purposive sampling was used to select respondents, the selection criteria being: 1) that a respondent was experiencing / had experienced violence committed by someone close either currently or in the past, and 2) a respondent participating in therapy dealing with destruction caused by her having experienced violence. Such criteria were met by the patients participating in the therapeutic activities as part of the project "Work and worthy life for women - victims of violence", conducted in Warsaw between 2006 and 2008 by the Centre for Women's Rights NGO.

Research procedure

The research was conducted in three stages. Stages I and II concentrated on measuring psychotherapeutic effectiveness, and, during Stage III, an impact analysis of selected predictors on psychotherapy effectiveness was conducted on the results of treatment. The effectiveness of the therapy had two phases: the pre-test and post-test. The measurement post – test was conducted after a period of approximately eight months.

Sample group characteristics

Statements made by the 55 women interviewed indicate that most were subjected to violence, both as members of a generational family as well as of their own family, over several years or longer. The respondents experienced different degrees of violence, including physical, psychological, economic and sexual violence.

Concerning physical violence, it can be stated that of all the women, 92.7% were at least beaten or injured once by someone close to them, and almost 40% (38.2%) experienced multiple acts of acute violence committed by the perpetrators. Similarly the majority of women (more than 60%) were physically pushed or shaken numerous times. Psychological violence was extreme, with almost all respondents being humiliated through insults or abuse (96.4%), or forced to perform some humiliating activities (83.6%). On numerous occasions most of them were also isolated by the perpetrators (90.9%). A high percentage (89.1%) were subjected to threats and blackmail. Only a low percentage did not confirm experiencing emotional violence. More than nine-tenths (94.5%) experienced negligence and economic violence, being deprived of financial means by the perpetrators. As many as 65.5% confirmed that at least once they were forced to perform unwanted sexual acts.

The picture of violence is not complete without saying something about the perpetrator. In 90.9% of the cases, the family-violence perpetrator was a husband or a partner. Almost 30% (29.1%) of the respondents experienced violence from their parents.

In addition, in some families (10.9%) the perpetrators were adult children. Some of the respondents (10.9%) experienced violence outside the family environment, at work or in another social milieu. Violence was rarely a one-time event. In principle it would affect many people. In the majority of families (63.6%) the victims of violence were children. There were also incidents where the respondents' parents were subjected to violence (16.4%).

The assistance provided by the project was multi-faceted. The aim in providing psychological help was to strengthen and restore psychic control, and assist in improving parental performance or strengthening social bonds. Psychological assistance was accessible in both individual consultations and group activities, which included: support, therapeutic, theatrical, and workshops: wendo (women's self-defence), assertiveness, and coping with stress. In addition the assistance programme took into consideration how women function in the labour market, by offering professional re-adaptation support. An important part in providing help was to give assistance in solving the legal issues that could impact respondents' lives. In addition the women could use such forms of assistance as legal consultations, occupational counselling, training, education and professional work experience. It should be emphasised that among the respondents there were no persons who would not benefit from different forms of psychological assistance provided in the project.

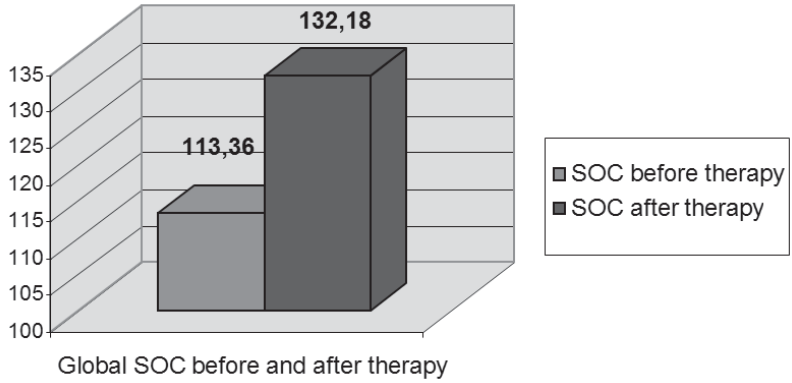
Results

Effectiveness of psychotherapy

The research project assumed that the difference between the sense of coherence, prior to therapy and after, would indicate how effective the psychological impact had been on the patients. Indirectly, the change in SOC was to be proof of the respondents' improved quality of life, since, according to salutogenesis, increased SOC indicates that reality is perceived in a more comprehensible, meaningful and manageable way. Statistical analysis proves that the average sense of coherence measured prior to therapy was 113.36 points and after therapy 132.18 points. Obviously, differences in the global level reflect the partial results of the SOC components: comprehensibility, manageability and meaningfulness.

The mean sense of comprehensibility in the tested group prior to therapy was 37.51 points and after therapy 45.55 points. Similarly, the sense of manageability prior to the treatment was 39.16, and after the treatment 46.07 points. Also, the sense of meaningfulness increased from 39.69 points to 40.56 points.

Figure 5-1. Sense of coherence before and after therapy



Source: own research, 2010.

Use of the t-test for dependent samples proved that the null hypothesis was to be rejected, since it assumed there was no difference between the average sense of coherence prior to and after therapy. The t-test was t (54) = − 7.566; the number of degrees of freedom df = 54 and the level of significance p = 0.00. The correlation coefficient is relatively high at 0.718, and indicates the high correlation level between the results obtained during both measurements. The data indicate that in the tested group the mean sense of coherence level is indeed higher after therapy. The differences concern both the global SOC and the three partial SOC dimensions: comprehensibility, manageability and meaningfulness. The data are presented in Table 5-1.

Table 5-1. SOC and its components before and after therapy. Statistics of t-test for dependent samples

Variables	SOC before therapy	SOC after therapy	t	df	p
Global SOC	113.36	132.18	−7.566	54	0.00
Comprehensibility	37.51	45.55	−7.055	54	0.00
Manageability	39.16	46.07	−6.480	54	0.00
Meaningfulness	36.69	40.56	−4.036	54	0.00

Source: own research, 2010.

Predictors of therapy effectiveness

The next research stage included testing the factors influencing therapy effectiveness. This assumption required empirical verification that was conducted with multi-variable regression analysis. The dependent variable in this model was a change in the sense of coherence level, i.e. the difference registered between two measurements: the first and the second SOC measurements. The independent variables, so-called predictors of therapy, were emotional intelligence, the locus of control and personality traits.

Regression analysis conducted for the selected predictors confirms the existence of dependencies between the women's selected characteristics levels and the SOC levels at the end of their treatment. The change in the mean coherence level was 18.82 points. The mean level of the particular variables is presented in Table 5-2.

In order to test the dependencies between predictors and a change in the coherence level, a hierarchical analysis of multi-variable regression was control (beta = −0.387; $p < 0.05$), and 4) extraversion (beta = 405; $p < 0.05$).

Table 5-2. Level of measured variables

Variables	Mean
Global SOC before therapy	113.36
Global SOC after therapy	132.18
Emotional intelligence	127.67
Sense of control (Locus of control)	10.02
Neuroticism	20.84
Extraversion	31.24
Conscientiousness	29.98
Agreeableness	30.80
Openness to experience	25.22

Source: own research, 2010.

Other significant predictors include conscientiousness (beta = 0.359; $p < 0.05$) and agreeableness (beta = − 0.144; $p < 0.05$). No such significant dependency was found with the variable openness to experience.

Table 5-3. Statistics for regression analysis of therapy effectiveness predictors

Variables	Beta	p
Emotional intelligence	0.510	0.04
Sense of control (Locus of control)	– 0.387	0.033
Neuroticism	– 0.307	0.032
Extraversion	0.405	0.036
Conscientiousness	0.359	0.037
Agreeableness	– 0.144	0.042
Openness to experience	0.202	0.197

Source: own research, 2010.

Discussion

Research was based on verifying therapy effectiveness, which included assessing the significance of particular predictors. For research purposes such patient traits were selected as were regarded as significant human resources. It was assumed that the traits would reveal the interaction between a given form of treatment and its specific results registered at the SOC level. This was followed by a verification of such characteristics as: emotional intelligence, the locus of control and human personality traits.

The results seem to be very promising, the research having proved that an increase in the sense of coherence level is possible. This actually confirms that the therapy provided is effective. Statistics used as part of the regression model confirmed the predictor's significance. Similar to emotional intelligence, the locus of control and specific personality traits proved to be highly significant in relation to the therapy results. An increased sense of coherence could be observed among those who possessed certain ability levels in coping with stress, emotions or in assessing reality. High emotional intelligence and internal locus of control levels supported the increase in the sense of coherence. In addition, personality traits had an impact on the treatment results. There were positive correlations between SOC levels and extraversion and conscientiousness, while there were negative correlations between neuroticism and agreeableness. No correlations between level of openness to experience and the final therapy result were confirmed.

The results serve not only to explain some less well-known phenomena, but also have some practical applications. The results obtained from the measurement of the effectiveness of the predictors of therapy can help in the design of therapeutic agents systematic activities. It should be emphasised that the effectiveness of therapy depends to a great extent on a patient's initial cognitive, emotional and motivational resources. Therefore, without taking into consideration these traits, it is difficult to arrive at the therapeutic results significant for patients. It seems important to use knowledge about an individual patient's characteristics to design a programme of therapeutic activities. Matching therapy with a patient's potential and abilities is a guarantee for obtaining significantly better final results.

CHAPTER SIX

METHODOLOGY OF RESEARCH ON FACTORS INFLUENCING THE RECOVERY OF PEOPLE DURING THERAPY AFTER INTERPERSONAL TRAUMA

AGNIESZKA WIDERA-WYSOCZAŃSKA

Adults who experienced interpersonal, complex and chronic trauma in their childhoods search for various ways of effectively coping with the consequences of the trauma they suffered. They have experienced traumatic situations caused by their loved ones, the caregivers and authorities on whom they were dependent. Traumatic events constitute various kinds of abuse (described in Chapter One). Being subject to abuse leads to the occurrence of severe and chronic problems and disorders in life (Widera-Wysoczańska, 2010; 2011). In order to regain their mental health, aggrieved persons read books, seek individual support, look for intervention, visit crisis counsellors, go to various support groups or talk to a priest from their chu rch or a friend. Participation in individual and group psychotherapy is one of the most important paths to recovery and involves various factors that might impede or facilitate recovery.

The most fundamental obstacles impeding the process of recovery are the events taking place within a family. Victims of emotional, physical and sexual abuse, children of alcoholics and people who do not receive support from people they see as important assess themselves and their environment in very negative terms.

The symptoms are more difficult to remove if a perpetrator is a child's parent or caregiver and the relationship is long-lasting; the intrusiveness of offender behaviours increases. In these situations, the sense of betrayal results in a lack of trust towards others and leads to isolation. Such people's recovery is hindered if they have an internal attributional style whereby they blame themselves for the abuse, view their experiences as

threatening and use wishful thinking as a coping strategy; they experience a sense of helplessness (Berliner, Elliott, 1996). Factors which hinder recovery that might occur within a therapeutic group relate to the relationships between the group members as well as an individual's health condition. Relationships and emotions that are present at the start of a group are of particular importance. The most characteristic dynamics are difficulty coping with the lack of the group and the therapist's interest in the person and difficulty coping with questions addressed to the person during the session.

Thoughts and feelings that hinder progress include jealousy of other participants, discouragement and fear (Wajda, 2014). Primitive defensive mechanisms are active in the recovery process such as splitting oneself and the environment into good and bad objects, introjections and projection. The influence of abuse dynamics on the therapeutic process of women who were victims of sexual abuse has been described in professional literature. One important dynamic is transference on to the therapist and therapy participants activated by betrayal, traumatic transference, shame, low self-esteem, intimacy difficulties, and guilt, locus of responsibility, defences, accommodation mechanisms, learned responsibility, loss, grief and anger. The second type of dynamic is the counter-transference arising in the therapist who includes reactions such as: dread, horror, denial, avoidance, shame, pity, disgust, guilt, rage, grief, everyone is a victim, contact victimisation, privileged voyeurism, and sexualisation of the relationship (Courtois, 1988; 2013).

Factors which facilitate recovery constitute a phenomenon called resilience. Children and adults coming from dysfunctional and pathological families search for sources of resilience mainly outside the family: in surrogate relationships, or in relationships with distant family, teachers, and friends, or in a relationship with a psychotherapist (Walsh, 1998). The phenomena occurring in the abusive family that facilitate the creation of a better quality of life have also been described (Sheinberg, Fraenkel, 2001). One of the most important factors contributing to a faster recovery is the supportive reaction of caregivers and the environment to the disclosure of abuse and their constructive attitude towards a child after such a disclosure. Thus, a network of supporting persons becomes an external resource. The caregivers' support is the best predictor of freedom from clinical symptoms and maintenance of social competence (Spaccarelli and Kim, 1995). The parent's cohesion and warmth in helping the child with the stressful situation (Walsh, 1998), as well as their permanent emotional and physical presence (Van der Kolk et al., 1996) and closeness, especially in the mother-child relationship, are all important

factors (Williams and Finkelhor, 1995). At least one warm and supportive parent is enough for a fast recovery (Spaccarelli and Kim, 1995).

Resilient persons are able leave home early and distance themselves from the family atmosphere. This enables them to live independently of their family pathology and relieve their feelings of guilt (Rubin, 1996), which contributes to a more effective recovery. Resilient persons with good social skills are able to find a surrogate environment such as a church, friends or distant family. Spiritual development becomes a resource, the inner feeling of control and strength gives some distance to traumatic experiences. It gives the feeling of independence and allows more objective and less distorted understanding of traumatic experiences. Resilient persons have awareness of their feelings and they do not block the past from their memory. Such persons are oriented to action, reaching their goals and achievements. However, one must be careful to determine whether a person is resilient or if they are simply concealing their feelings under the mask of "well-functioning".

As we see, there are many pathways to resilience. One of them is participation in individual and group psychotherapy. The phenomenon which is described is common for all types of therapy and includes such categories as: the patient's characteristics, the therapist's qualifications, and group processes. The following characteristics of the patient were pointed out, for example: hope, a sense of security, and the feeling of being stronger, emotional awareness, catharsis, and expansion of consciousness, behaviour control and eagerness to seek help. The therapist's qualifications are described as follows: for example, warmth, positive expectations, emphatic understanding, specialisation, inspiring trust, non-assessment and acceptance of all aid resilience. Numerous researchers share the opinion that the therapist-patient relationship is a key factor facilitating the recovery. Group processes provide therapeutic alliance, support, learning factors, unity of the group, attachment, narratives, similarity, altruism and a sense of control (Garmezy, Master, 1986; Grencavage and Norcross, 1990; O'Brien, Houston, 2000; McLeod, 1993).

It is worth noticing that the descriptions of the obstacles that impede as well as the resources which facilitate recovery in reference to literature relate to difficult life situations, without not specifying which qualities follow which type of stress or trauma experienced.

Methodology

In order to obtain a more profound understanding of the phenomenon under investigation a qualitative psychological study was employed. Adults from dysfunctional families were interviewed about the factors which influenced their mental health during the eight-month psychotherapy.

The research problem

The psychotherapy of persons who suffered from chronic, complex and interpersonal trauma in their childhood is difficult and long-lasting. Therefore, I have examined the factors in the group therapy which impede treatment as well as the factors which initiate resources necessary for recovery (resilience). The following research questions were formulated:

What are the groups of factors that facilitate or impede recovery?
What phenomena impede recovery?
What phenomena facilitate recovery?
What internal capabilities does a person develop under the influence of factors facilitating their recovery?

The answers to these questions provide a basis for establishing a proposed model of therapeutic factors which impede or facilitate the recovery of persons who suffered from interpersonal trauma.

The examination of the factors mentioned was expected to assist with planning a more effective recovery process and with dealing with crises that occur during therapy for persons who experienced interpersonal trauma in their childhood. The study is expected to provide practical knowledge about:

Which objectives recommended during therapy serve the healing?
Which principles facilitate the process of recovery?
Which therapeutic methods / approach contribute to the building up of a person's resources?

The research participants

The participants in the study were selected by criterion-based purposeful sampling, from among persons seeking outpatient treatment.

Therapy was conducted in the Institute of Psychotherapy Trauma, Development and Training.

Using purposeful sampling, individuals who sought out therapy voluntarily because of problems tormenting them in their lives and wished to change the quality of their lives, were chosen. They endorsed having experienced emotional, physical and / or sexual abuse and / or substance abuse by parents during their childhood or / and youth. In all cases the abuse were to be perpetrated by their mother (or stepmother) and / or father (or stepfather). In subjects should not occur mental illness. The survivors should had at least secondary education.

One hundred and nine people filled in questionnaires, and fourteen were rejected due to incomplete responses. Ultimately, a total of 95 adults were examined, comprising 66 (69,47%) women and 29 (30,52%) men aged from 21 to 53, with a mean of 31.7 years. All individuals were informed about the procedure of the examination and agreed to it.

Research methods

All the subjects prior to therapy agred to complete three research interviews. To obtain information about various types of abuse (emotional, physical, sexual, addictions), the Abuse Questionnaire (AQ) was used (see: Appendix 1 of this chapter). The qualitative structured interview Intimate Situations Questionnaire (ISQ), version for women (ISQ – F, Appendix 2 of this chapter) and the version for men (ISQ – M, Appendix 3 of this chapter) provided information about direct and indirect sexual abuse experienced by the subject, about the perpetrators, and about the duration and frequency of abuse (Widera-Wysoczańska, 2010c). Direct sexual abuse contains various types of actions: a. sexual abuse with touching, sexual abuse without touching and emotional sexual abuse. Indirect sexual violence is divided into: bringing the child to the perpetrator, consciously allowing the child to be harmed, not reacting to the sexual abuse of the child when the caregiver knows of it and does not accept this.

In order to obtain answers concerning the respondents' life problems, the goals they strived to achieve, factors facilitating and impeding recovery, the changes that were reached, and the resources that were developed, a structured interview composed of open-ended questions concerning the process of psychotherapy (IPP, see: Appendix 4 of this chapter) was conducted. Appendix 4 contains some of the questions from the entire interview, which deals with the present study.

The afore-mentioned research methods were developed for a multi-stage study on family violence risk factors and on the treatment of people after childhood trauma according to the rules of qualitative method preparation. The questions included in the interviews have been formulated based on the literature, the researcher's practical knowledge, numerous pilot studies and also with the help of competent research raters.

Research procedure

Subjects participated in integrated "life span" psychotherapy. Initially they received 5 individual sessions which prepared them for the group therapy. This was followed by 180 hours of group therapy in the form of two-day sessions (twelve hours each) taking place twice a month. Concurrently, individual sessions were continued once a month. Treatment was conducted in groups of 12 people. Group therapy and parallel individual sessions lasted about 8 months. The process of psychotherapy is presented in a more detailed way in the chapter Multifaceted Integrative Therapy following Chronic Childhood Trauma to be found in the book "Interpersonal Trauma and Its Consequences in Adulthood" (Widera-Wysoczańska, Kuczyńska, 2010).

Integrated through-life-span psychotherapy used in the study consists of stages divided with respect to its process, presented in Table 6-1 (Briere, Scott, 2006; Courtois, 1988; Salter, 1988; Widera-Wysoczańska, 2007, 2010) and structure, presented in Table 6-2 (Widera-Wysoczańska, 2007, 2010).

Then, introduce the five steps of an integrated "life-span" psychotherapy with regard to its structure (Table 6-2).

Table 6-1. The stages of life-span psychotherapy with reference to the process

Stages:			
	Initial impact	Processing consequences	Reintegration
	Recollection and disclosure	Processing of the consequences of trauma	
Goals:			
Understanding symptoms as biological and psychological adaptation and ability.	Reminding and disclosing (narration).	Reduction or elimination of post-traumatic consequences.	Building the present and future life and prevention activities. Integration of the past, present and future (using the results of stages I to III).
Phases:			
Identification and diagnosis of: - the person, - her/his situation in life (environment, family). Stabilisation, security, confidence: - building a mature therapist-patient relationship, - a contract with supporters from outside of the family (social support, - stabilisation of life, e.g. progressive distancing from the family of origin. Safety for loved ones: - children, partner,	Reminders from the general to the particular: - organising the memory: what, where, when, how. Revealing the mystery about: - the course of traumatic events, - the behaviour of passive and active perpetrators, - other people abused, -authentic feelings, - facts and particular concerns coming from a dysfunctional family (rules, roles, mechanisms, myths), - the form of abuse experienced, - symptoms from childhood to	Processing the consequences of abuse (verbal and non-verbal) experienced in the dysfunctional family: - identifying and abreacting emotions, - identifying and changing beliefs (distortions), - confronting the active perpetrator and other family members (passive abusers), - becoming aware of and accepting the positive aspects of one's own past and the parents'/caregivers' behaviour.	Awareness of the symptoms and knowing how to deal with them. Learning to build healthy mechanisms of their self-esteem, sense of power and relationships with others: - child-parent attachment, - upbringing, - partnership, - intimacy, sexuality, - social functioning,

- gradual work on their own parenthood, partnership, - making a partner aware of "hardships" in therapy. Possible pharmacological treatment. Setting treatment priorities and contact with specialists: - the mental state of the person, such as suicide, committing a crime, addiction to drugs or, alcohol, sexoholism, pornography), - co-occurring disorders: e.g. depression, aggression, eating disorders, panic attacks, - co-occurring problems, e.g. the crisis in the family/ marriage/ job that requires immediate intervention.	adulthood (particuraly important when people do not remember the traumatic events exactly, they are afraid they are only imagining the symptoms and the reality of the trauma experienced). An awareness of how the people's internal mechanisms hindered their functioning in the past and in the present.	Identification of oneself as a perpetrator of abuse: - recognises one's own abusive behaviour towards own, children, partner, parents, and other people, -make the changes in one's own behaviour for the better. Help mothers/ caregivers support children after abuse: - explore their understanding of abuse, - analyse the process of abuse, - understand the reactions to the disclosure, - analyse the denial, - take responsibility for the child's safety, - build new secure relationships with children, - establish boundaries, stable rules, child protection. The self-realisation and release of authentic emotions (previously suppressed).	- skills in interpersonal relations, assertiveness, - planning and realising goals, making decisions, -work. Recognising and building a new quality of life. Integration of the changes of the present and the "projection" into the future.

Source: Widera Wysoczańska, 2010; 2010b.

Table 6-2. The stages of the integrated through-life – span psychotherapy with regard to structure

Stage	The sequence of forms of therapy	Methods of therapy
Stage I Preparation and stabilisation	*preparation and stabilisation* sessions	individual
Stage II Basic	*basic therapy:* -for survivors from dysfunctional families and those who have experienced violence, -identifying themselves as perpetrators and stopping or reducing of violent behaviours, -building a parent – child relationship, -building a relationship with a partner,	 group + individual sessions group + individual sessions individual + with a child individual + with a partner
Stage III Advanced	*advanced therapy:* -for people experiencing sexual violence, -for perpetrators of family violence, -for parents to support children, -for partners to build a relationships,	 group + individual group + individual individual + group individual
Stage IV Thematic	*thematic developmental:* -e.g.: child-parent attachment, upbringing; partnership, -intimacy, sexuality; skills in interpersonal relations, -assertiveness; planning and realising goals, making decisions; femininity, masculinity,	 group workshops individual sessions
Stage V Crisis intervention	*crisis intervention:* -occasional sessions in crisis.	 individual

Source: own research, Widera – Wysoczańska, 2010; 2010b.

The present study concerns Stage I and Stage II. Research interviews were conducted before Stage I and after Stage II. Before starting the group therapy the subject completed the Abuse Questionnaire (AQ), Intimate Situations Questionnaire (ISQ) as well as open-ended questions from the Interview about the Process of Psychotherapy (IPP). The IPP inquires into life problems that patients wanted to resolve during treatment, the goals they wanted to achieve, and the factors which would show that these goals had been achieved. Following the treatment, participants responded to questions on the IPP concerning the factors impeding and facilitating recovery, the changes that were achieved, and the resources (skills and capabilities) that were developed.

Analysis Procedure

First, the information obtained from the Abuse Questionnaire, and the Intimate Situation Questionnaire was subject to descriptive statistical analysis. Demographic data were established as well as the kinds of abuse experienced by the examined group. Next, the data from the IPP was subject to qualitative psychological analysis (Widera-Wysoczanska, 2000). The goal was to obtain answers to the main research questions. Initially, open-ended questions on the course of the psychotherapy, the factors facilitating or impeding recovery, and achieved changes were analysed separately for each person. The information obtained was put on a table, separately for each respondent. In order to get answers to research questions on a more general level, cross-portrait analysis was conducted (Tesch, 1990; Widera-Wysoczańska, 2000). Then, answers to questions which gave insight to issues relating to the research problem were analysed for all the cases. The factors that impede and / or facilitate recovery as well as the categories comprising the phenomena which lead to the development of internal resources were created. The factors were formed from a combination of several or several dozen cases. This resulted in a model of factors that influence recovery in the course of psychotherapy. The resulting categories were rephrased on the basis of citations emanating from the patient's reports. The rules of validation of qualitative studies were respected. When using the criterion of persuasiveness, quotes from subjects' data substantiated the researcher's interpretations and proved that this is a trustworthy approach. To assess the reliability of the types and categories, contents assigned to them by the investigator were checked by three competent raters, working independently of one another (Widera – Wysoczańska, 1995).

Results

The participants' demographic data as well as the types of abuse experienced by the examined group are presented below with the aid of descriptive statistics. Next, in Chapter Seven, the model of factors created by qualitative analysis that influence the recovery in psychotherapy from the subject's perspective, will be described.

Demographic data

The ninety-five people who participated in the therapy were adults who experienced different types of abuse in childhood. The research sample comprised 66 (69%) women and 29 men (31%). In terms of level of education, 68 (72%) persons had received higher education and 18 (19 %) persons had received secondary education. Thirty nine (41%) people were married and 15 (16%) were cohabiting while thirty seven (39%) participants were single and four (4%) divorced (Table 6-3).

Table 6-3. Demographic data

Demographic feature		n = 95	%
Sex	Women	66	69.47
	Men	29	30.52
Education	Higher	68	71.57
	Incomplete higher	9	9.47
	Secondary	18	18.94
Marital status	In a marital Relationship	39	41.05
	Cohabiting	15	15.78
	Single	37	38.94
	Divorced	4	4.21

Source: own research, 2010.

Types of childhood abuse

The persons experienced interpersonal complex trauma. One person suffered only from different kinds of emotional abuse. Other respondents described from 2 to 9 different types of abuse (Table 6-4).

All participants (100%) reported that they had experienced intra-familial emotional abuse. They also reported the following types of abuse:

physical (84% of participants); emotional sexual abuse (77%), including listening to or being given vulgar insults (77%); sexual abuse with touching (65%), such as touching the genitals (52%), being forced to touch the genitals of other people (19%), and rape (28%); sexual abuse without touching (36%), i.e. being forced to watch intercourse between adults (23%) and being shown pornography (29%). In 61% of cases the father and in 29% the mother were addicted to alcohol or /and drugs or pornography.

Table. 6–4. Traumatic events and perpetrators in the therapeutic group

Type of abuse	Perpetrator	n = 95	%
Emotional abuse		95	100
	Mother	68	71.50
	only by mother	11	11.58
	mother + other person	3	3.15
	mother + stepfather	3	3.15
	Father	75	78.95
	only by father	24	25.26
	Mother and father	51	53.68
	Siblings	2	2.11
	Others	1	1.05
Physical abuse		80	84.21
	Mother	35	36.84
	only by mother	11	11.58
	mother + siblings	4	2.11
	mother + uncle	1	1.05
	Father	62	65.26
	only by father	39	41.05
	Mother and father	19	20.00
	father + siblings	4	4.21
	Stepmother	1	1.05
	Stepfather	1	1.05
Addicted father		58	61.05
alcoholic father		52	54.74
father addicted to drugs		4	4.21
to sex / pornography		9	9.47
Addicted mother		28	29.47
alcoholic mother		26	27.37
mother addicted to drugs		3	3.16
Emotional sexual abuse		73	76.84
vulgar insults		73	76.84
	Father	56	58.95
	only by father	25	26.32

	father + siblings	5	5.26
	Mother	35	36.84
	only by mother	7	7.37
	mother + other person	2	2.11
	Mother and father	26	27.37
	Others	8	8.42
Sexual abuse with touching		62	65.26
other person(s) sexually touched the genitals		49	51.58
	Father	16	16.84
	only by father	11	11.58
	father + other person	4	4.21
	Mother	6	6.32
	only by mother	3	3.16
	mother + other person	2	2.11
	Mother and father	1	1.05
	Siblings + stepsiblings	12	12.63
	Uncle + aunt	2	2.11
	Strangers	6	6.32
	Others	8	8.42
being forced to touched the genitals of others		18	18.95
	Father	7	7.37
	Mother	2	2.11
	Others	9	9.47
rape		27	28.42
	Father	6	6.32
	Mother	1	1 05
	mother + woman	1	1.05
	Stepfather	2	2.11
	Stepsiblings and cousin	9	11.58
	Stranger	3	3.16
	Aunt	3	4.21
	Others	2	2.11
Sexual abuse without touching		34	35.78
being forced to watch intercourse between adults		22	23.15
	Mother and father	16	16.84
	Stepfather and mother	2	2.11
	Others	4	4.2
pornography		28	29.47
	Father	11	11.57
	Colleagues	17	17.89

Source: own research, 2010.

Perpetrators of violence

Mothers alone were the emotional abusers in eleven (12%) persons' cases, and fathers alone in twenty-four cases (25%). Fifty-one people (54%) were abused by both the mother and the father (Table 6-4).

Eleven (12%) people experienced physical violence only from their mother and thirty-nine (41%) people only from their father. Physical violence from both parents was experienced by nineteen people (20%). Fifty-two (55%) participants described having alcoholic fathers and twenty-six (27%) alcoholic mothers.

Emotional sexual abuse was experienced by thirty-five (37%) people from their mother and fifty-six people (59%) from their father.

Sexual abuse with touching was experienced amongst sixteen (17%) people as perpetrated by the father and six (6%) people by the mother. Among those who were forced to touch the genitals of others, seven (7%) by the father and two (2%) by the mother. Among the people who reported rape, six (6%) of them pointed to the father, two (2%) to the mother and two (2%) the stepfather.

Of the people who witnessed sexual intercourse, sixteen (17%) of them saw the intercourse between their parents and two (2%) witnessed the step-father with the mother. Mainly colleagues (18%) and fathers (12%) provided pornography.

Duration of chronic trauma

The persons experienced interpersonal chronic trauma. A distinct majority of persons had experienced abuse since from early childhood ("since I can remember") until they left home.

Emotional abuse. Sixty-four people (67% from n=95) who experienced emotional abuse said that they had experienced it as long as they could remember. Eight (8%) people started to experience emotional abuse between about the ages of 3 and 6, another nineteen (20%) people between 7 and 13, and four (4%) between 14 and 17 years of age. Twenty-nine (30%) persons reported that they experienced it until 14 to 18. Furthermore, sixty-six (89%) persons reported that they had experienced it to about 19 to 30 years of age.

Physical abuse. Thirty-two people (40% from n=80) reported that they had experienced physical violence as long as they could remember, thirty-four (42%) from ages 3 to 7, ten (12%) between the ages of 8 and 13, and four (5%) between the ages of 14 and 20. Physical violence for six (7%) people lasted to the ages of 6 and 8; for eighteen (22%) persons it

continued until 9 to 13, for thirty-nine (49%) to 14 to 18 years of age, for sixteen (20%) lasted up to between 19 and 26, while for one (1%) until 40 years of age.

Addiction of parents. The father was perceived as an addict as long as the person could remember in fifty-two (90% from n=58) cases, from 5 to 6 years of age in three (5%) cases and 10-12 years of age in three (5%) cases. Fifty-three (91%) people reported that the father abused alcohol into their (the participants') adulthood, which is up to 18 - 39 years of age; for five (9%) asted up to between 14 and 18.

Twenty-three (82% from n=28) people were raised by an addicted mother 'as long as they could remember', three (11%) since the ages of 6-8 and two (7%) from 12-15 years of age. According to two (7%) people, their mother's alcohol abuse lasted until they were 8-10 years, for (7%) two participants up to 17-19 years, for six (21%) people up to 20-24 years, for sev en (25%) people up to 25 to 29 and for eleven (39%)people up to 30 - 40 years of age.

Sexual abuse. Thirty-four (47% from n=73) people were vulgarly called names from earliest childhood and do not remember a time without insults. Twelve (16%) people reported that the vulgar insults began at about 4 to 7 years of age, eighteen (25%) people from 8 to 13 and nine (12%) from 14 to 18. In the lives of nine (12%) people, vulgar insults lasted until 15 years of age, for approximately twenty-six (36%) people up to 19 years of age, for twenty-eight (38%) up to 26 years of age and for ten (14%) people up to 30 – 40 years of age.

For twenty-three (47% from n=49) people, the touching of genitals started between 9 and 15 years of age, for fourteen (29%) between 4 and 7 years of age and twelve (24%) people reported it 'as long as they could remember'. Five (10%) people experienced such sexual abuse up to 8 years of age. Nineteen (39%) people reported that the abuse ended when they were between 9 and 13 years of age. At the age of 15, the abuse ended for seven (14%) people. For seven (14%) persons it ended between 16 and 18 years of age. Eleven (22%) people were touched on the genitals against their will up to 24 years of age.

People were forced to touch the genitals of other people: three (17% from n=18) people 'since they could remember', six (33%) people since 3 to 5 years of age; six (33%) people since 6 to 8 years of age; and for three (17%) between 11 and 17. Five (28%) people said that the violence against them ended when they were nine years old, four (22%) people, when they were between 10 and 12 years old, and nine (50%) people when they were between 15 or 21 years of age.

Subjects reported being raped at various ages: four (15% from n=27) people at 5-6; five (18%) people at 8-9 years, four (15%) people at 10-12 years; seven (26%) people at 15-16 years; four (15%) people at 17-18 years; and three (11%) people at 22 years of age. Some persons were raped more than once and by more than one perpetrator.

The first time people were forced to watch sexual intercourse between adults: seven (32% from n=22) people 'since they can remember', nine (41%) people between 5 and 7 years of age; five (23%) people between 10 and 12; and one (5%) aged 15. According to six (27%) people this abuse lasted up to age 9 to 12 years, for eleven 58%) persons up to 14 and 17, and for five (23%) people it lasted up to the age of 22.

Four (14% from n=28) people were shown pornography between 5 and 6 years of age; five (18%) between 7 and 8; eight (28%) people between 10 and 12 years of age; four (14%) between 13 and 17 and seven (25%) people from the age of maturity, i.e. between 18 and 27 years of age.

Summary

The study group was heterogeneous. Subjects had mainly higher education (81%) or secondary one (19%). A similar percentage of people in the course of the study were in a relationship with a life partner (57%) or lived alone (43%). All individuals from the test group had experienced complex intra – familiar interpersonal trauma that was a chronic one and affected their daily life. Most of the subjects stated that they had experienced it, "ever since they could remember" which means from early childhood until the age of teenage or young adulthood. Parents, stepparents and siblings were the most commonly indicated perpetrators.

The results presented are intended to describe the experience of people surveyed, in order to understand the factors influencing the process of recovery during the childhood trauma treatment. The next chapter will describe the factors that according to the subjects had a positive or negative impact on the success of therapy.

Appendix 1:

Abuse Questionnaire

Prepared at the Institute of Psychology, Wrocław University, Department of Clinical Psychology (2001) by Agnieszka Widera-Wysoczańska.

Please answer the following questions or underline the correct (i.e. sincere or true) answer. All responses are completely anonymous. Please be attentive and answer all the questions, no omissions, please.

Part A

Date:
1. Sex: (1) Woman ____ (2) Man____

2. Age:

3. Your education:
(1) primary school, (2) vocational, (3) technical, (4) secondary,
(5) incomplete higher, (6) higher, (7) a student of …… year.

4. Marital status:
(1) single, (2) married, since: ……, (3) divorced, since: ……,
(4) in an open relationship, since: ……, (5) widow(er), since: ……

5. Religion you were brought up in:
(1) Protestant, (2) Roman Catholic, (3) Greek Catholic, (4) Atheist
(5) other: ……

6. In what region (province) were you brought up as a child:
a. until the age of: ……
b. Was it: (1) an out-of-the-way house, (2) a village, small town (up to 100 th`ousand inhabitants), (3) an average town (between 100 thousand to 500 thousand inhabitants), (4) a big city (over 500 thousand inhabitants).

7. Were you brought up by?
   a. (1) mother and father, (2) only mother, (3) only father, (4) stepmother, (5) stepfather, (6) grandmother, (7) other people: ……
   b. until the age of: ……

8. I was witness to or I experienced emotional abuse:
   YES NO
   a. Quarrels and shouting
   YES NO
   b. Insults
   YES NO
   c. Offences
   YES NO
   d. Assessing
   YES NO
   e. Long-term silence
   YES NO
   f. Embarrassing
   YES NO

8.1. Who behaved in this way: ……
8.2. Towards whom: ……
8.3. Since what age (yours): ……
8.4. How did it end, how old were you: ……
8.5. How often: (1) rarely, (2) sometimes, (3) frequently, (4) almost always.

9. I or another person was required to:
   a. Satisfy the adult persons' needs
   YES NO
   b. Listen to parent's problems which were too adult
   YES NO
   c. Care for younger siblings
   YES NO
   d. Care for the whole house (e.g. permanent cleaning, cooking, washing)
   YES NO

9.1. Who behaved in this way: ……
9.2. Towards whom: ……
9.3. Since what age (yours): ……

9.4. How did it end, how old were you: ……
9.5. How often: (1) rarely (2) sometimes (3) frequently
(4) almost always

10. I or another person was forbidden to contact:
a. I was isolated from my family
YES NO
b. I was isolated from my colleagues
YES NO
c. I was isolated from my interests
YES NO
10.1. Who behaved in this way: ……
10.2. Towards whom: ……
10.3. Since what age (yours): ……
10.4. How did it end, how old were you: ……
10.5. How often: (1) rarely (2) sometimes (3) frequently
(4) almost always

11. Nobody revealed towards me or towards another person:
a. warm feelings
YES NO
b. support in difficult situations
YES NO
11.1. Who behaved in this way: ……
11.2. Towards whom: ……
11.3. Since what age (yours): ……
11.4. How did it end, how old were you: ……
11.5. How often: (1) rarely (2) sometimes (3) frequently
(4) almost always

12. Various situations and behaviours at home were described in another way than I perceived them (e.g. when father was drunk it was said that he was just tired.)
YES NO
12.1. Who behaved in this way: ……
12.2. Towards whom: ……
12.3. Since what age (yours): ……
12.4. How did it end, how old were you: ……
12.5. How often: (1) rarely (2) sometimes (3) frequently
(4) almost always

13. I was witness to or I experienced physical abuse:
YES NO
a. beating
YES NO
a. pushing
YES NO
b. aggressive jabbing
YES NO
c. being jerked round
YES NO
d. hit in the face
YES NO
e. aggressively kicked
YES NO
f. other
YES NO
13.1. Who behaved in this way: ……
13.2. Towards whom: ……
13.3. Since what age (yours): ……
13.4. How did it end, how old were you:
13.5. How often: (1) rarely (2) sometimes (3) frequently (4) almost always

14. My father abused:
a. alcohol
YES NO
b. drugs
YES NO
c. medicines
YES NO
d. pornography
YES NO
e. other
YES NO
14.1. Since what age (yours): ……
14.3. How did it end, how old were you: ……

15. My mother abused:
    a. alcohol
    YES NO
    b. drugs
    YES NO
    c. medicines
    YES NO
    d. pornography
    YES NO
    e. other
    YES NO
15.2. Since what age (yours): ……
15.3. How did it end, how old were you: ……

16. I or another person was insulted in a vulgar way:
    YES NO
16.1. Who behaved in this way: ……
16.2. Towards whom: ……
16.3. Since what age (yours): ……
16.4. How did it end, how old were you: ……
16.5. How often: (1) rarely (2) sometimes (3) frequently
    (4) almost always

17. Someone touched my genitals against my will:
    YES NO
17.1. By whom: ……
17.2. How old were you when this started: ……
17.3. How old were you when this finished: ……
17.4. How often this happened (1) rarely, (2) sometimes,
    (3) frequently, (4) almost always.

18. I was forced to touch another person's genitals against my will:
    YES NO
18.1. By whom: ……
18.2. How old were you when this started: ……
18.3. How old were you when this finished: ……
18.4. How often did this happen? (1) rarely (2) sometimes
    (3) frequently (4) almost always

19. I was shown pornographic photos, films, papers
YES NO
19.1. Which of them: ……
19.2. By whom: ……
19.3. How old were you when this started: ……
19.4. How old were you when this finished: ……
19.4. How often this happened (1) rarely (2) sometimes
(3) frequently (4) almost always.

20. I saw sexual intercourse between adults:
YES NO
20.1. Between whom: ……
20.2. How old were you when this started: ……
20.3. How old were you when this finished: ……
20.4. How often did this happen (1) rarely (2) sometimes
(3) frequently (4) almost always.

21. I was raped
YES NO
21.1. By whom: ……
21.2. How old were you then: ……

22. I am addicted to:

1. Alcohol	YES	5. Medicines	YES	9. Coffee	YES
	NO		NO		NO
2. Drugs	YES	6. Sex	YES	10. Coca-cola	YES
	NO		NO		NO
3.Cigarettes	YES	7. Hazard	YES	11. Food	YES
	NO		NO		NO
4. Sweets	YES	8. Accepting others		12. Pornography	YES
	NO	YES NO			NO

Other: ……

Appendix 2:

Intimate Situations Questionnaire version for women (ISQ-F)

Prepared at the Institute of Psychology, Wrocław University, Department of Clinical Psychology (2001) by Agnieszka Widera-Wysoczańska

HOW TO REPLY TO THE FOLLOWING QUESTIONS?

This questionnaire is completely anonymous.

To answer the following questions please read each of them carefully and think whether such situations happened in your life even once. Answer the questions: YES .... NO: please circle the correct answer. If the answer is NO, please move to the next question below. If the answer is YES, please move to the next question in the table next to it.

When answering the questions, please provide an answer which in your opinion reflects your situation in the best way.

I would like to emphasise that there are no good or bad answers in this questionnaire. Each sincere, true answer is correct. Everybody is different and has other experiences in life.

On a separate page there are two supplementary charts. Please refer to them when it is difficult for you to determine a person with whom the described situations below are connected and how long these situations lasted in your life. When answering the questions please do not use only the information provided in the table.

The last part of the questionnaire includes open-ended questions in which you can write everything that is important to you in relation to the subject discussed, but not included in the questionnaire.

PART I

Date: .....

1. Your age ..... CODE .....

2. When answering the following questions, please provide answers to all the questions.

Have you ever, in the past or in your present life, (in childhood, in youth, in adulthood) been induced to experience or perform in any of the following situations?		Who behaved in this way and what was this person's approximate age when did this person behave like this for the first time? Please use Table 1 to determine this person.	How old were you when situations of that type started?	How often did such a situation occur in your life? Please use Table 2 to determine frequency and duration.	How old were you when situations of that type finished?
1). I heard unpleasant remarks concerning my gender, for example "you are so fat", "nobody will want you", "big blue eyes".	YES NO Which?	.....	.....	.....	.....
2). During my childhood and adolescence period I saw naked adults and this was embarrassing for me.	YES NO	.....	.....	.....	.....

3). An adult person bathed together with me at the age of three or later.	YES NO	.....	.....	.....	.....
4). I was encouraged to watch pornography.	YES NO	.....	.....	.....	.....
5). I was told that all women are whores or saints.	YES NO	.....	.....	.....	.....
6). I was told I was a whore.	YES NO	.....	.....	.....	.....
7). I experienced vulgar remarks concerning the development of my breasts, hips, buttocks, genitals.	YES NO	.....	.....	.....	.....
8). Someone touched my breast or bottom in a shameful way.	YES NO	.....	.....	.....	.....
9). I was slapped in the face.	YES NO	.....	.....	.....	.....
10). I was expected to take the side of one of the parents when they argued.	YES NO	.....	.....	.....	.....
11). A person older than me entered my room any time, without knocking, even when I was getting dressed.	YES NO	.....	.....	.....	.....
12). A person older than me suddenly entered the bathroom or a toilet when I was using it without asking.	YES NO	.....	.....	.....	.....
13). I was coerced to sleep with one of my parents while the other parent was sleeping elsewhere.	YES NO Under what circumstances?	.....	.....	.....	.....

14). An adult controlled me when I wanted to meet my peers.	YES	NO	.....	.....	.....	.....
15). I was spied on by somebody.	YES	NO	.....	.....	.....	.....
16). When I was a child or an adolescent someone touched my genitals, for example in bed.	YES	NO	.....	.....	.....	.....
17). Someone touched my genitals in an erotic way without my consent.	YES	NO	.....	.....	.....	.....
18). Someone exhibited his/her genitals to me without my consent.	YES	NO	.....	.....	.....	.....
19). I was forced to handle the sexual organs of another person.	YES	NO	.....	.....	.....	.....
20). I was kissed in an erotic way when I did not want that.	YES	NO	.....	.....	.....	.....
21). I was forced to caress another person's body.	YES	NO	.....	.....	.....	.....
22). I was forced to masturbate in the presence of another person.	YES	NO	.....	.....	.....	.....
23). I was raped or forced into sexual intercourse against my will.	YES	NO	.....	.....	.....	.....
24). I was forced to have oral sex (caressing the penis with lips or touching the clitoris with lips)	YES	NO	.....	.....	.....	.....

25). I was forced to watch the intimate behaviour of others, for example sexual intercourse	YES NO	.....	.....	.....	.....
26). Someone washed my private parts when I was older than 7.	YES NO	.....	.....	.....	.....
27). I was forced to describe my intimate experiences in detail.	YES NO	.....	.....	.....	.....
28). I started my sexual life early and now I feel bad about it.	YES NO	.....	.....	.....	.....
29). When I was a child or an adolescent someone put a finger or another object into my vagina or anus.	YES NO	.....	.....	.....	.....
30). Someone videoed my body against my will.	YES NO	.....	.....	.....	.....
31). Someone recorded my sexual behaviour / my behaviour with my body against my will.	YES NO	.....	.....	.....	.....
32). When I was a child or an adolescent, someone forced me to have sexual intercourse between my thighs.	YES NO	.....	.....	.....	.....
33). My body was presented in a sexual manner on the internet without my permission.	YES NO	.....	.....	.....	.....

34). I experienced other situations of an intimate character not listed above, which were troubling for me. These were the following:	YES NO	.....	.....	.....	.....

PART II
(It applies both to the ISQ for women and for men.)

3. Did a person who committed the above behaviour (circle the applicable answer):

a) intimidate you?
YES NO
If yes, in what way? ……
b) offer you sweets:
YES NO
c) threaten that they would hurt somebody you loved (or your pet):
YES NO
d) put pressure on you:
YES NO
e) buy you gifts:
YES NO
f) behave nicely:
YES NO
g) behave in another way:
YES NO

4. If the above situations occurred in your life please described how you felt then:

a) towards yourself: ……
b) to a person who performed the above acts: ……
c) to a guardian (for example mother): ……

5. Did you tell anybody about these abuses?
YES NO

If the answer is: YES - to whom?
If the answer is NO - please say why: ……

6. Have you ever sought help due to the described situations?
YES NO

If the answer is: YES - please state where: ……
If the answer is NO - please state what the reasons were: ……

7. Has somebody ever noticed your problems, found out about the situations related to described intimate situations?
YES NO

If the answer is YES - please state who: ……
How were these situations revealed? ……
Did this person help you?
YES NO

If yes, in what way? ……

8. How often did you see your parents drunk? (please state frequency on the basis of Table 2)

Who was drunk the most often? ……
Was either of your parents on detox? ……
Which of them? ……

9. How often was someone in the house beaten? (please state how often on the basis of Table 2)

Who did the beating? ……
Who was beaten? ……

10. What (or who) helped you the most to go through these difficult intimate situations from the past? ……

11. What feelings do you experience now when you recall embarrassing intimate situations? Please underline the appropriate emtions:

a). involving you:

feeling of guilt	humiliation	astonishment
hatred	anger	neglect
emotional pleasure	loneliness	helplessness
sense of being betrayed	fear	physical pleasure
shame	disgust	shock
aggression	humiliation	other:
sense of being noticed	sense of being protected	
disgust	powerlessness	
sense of being important	escaping problems	

b). a person who performed the above acts:

guilt	fear	powerlessness
hatred	disgust	escaping problems
love	missing	shock
being betrayed	helplessness	anger
shame	gratitude	indignation
wrath	sense of being important	pleasure
being noticed	astonishment	abandonment
other:		

c). to a guardian (for example mother):

guilt	humiliation	sense of being important
hatred	fear	loneliness
grief	indignation	anger
being betrayed	sense of being protected	shock
shame	abandonment	other:
wrath	helplessness	
sense of being noticed	disgust	

12. What would you advise a person who experiences any of such described violent behaviour?

13. Do you feel that the situations described have or had an impact on your life? YES NO

If the answer is YES, please describe in detail the influence of these behaviours on your life and the problems arising from that? Please underline the spheres which were influenced by them:

relationships with men	relationships with partner	contacts with your own children
relationships with women	sexual sphere	addictions
attitude towards your body	self-esteem	intellectual sphere
other spheres:		

14. How do you currently cope with problems resulting from the past situations?

15. If you did not experience the situations described above, please describe what problems you do encounter in your life.

16. Would you like to add something related to the topic of sexual abuse or your family?

17. Please give at least 10 opinions concerning yourself, other people, the world: ……

If, after completing this Sexual Abuse Questionnaire, you would like to talk to a psychologist or use psychological help we will provide you with professional institutions which aim to solve such problems in order to improve your life.

Tables helpful in providing answers to the Intimate Situations Questionnaire: version for women and men

Table 1 (people)	Table 2 (frequency and duration)
father mother stepfather stepmother brother stepbrother sister stepbrother cousin uncle aunt grandfather grandmother brother-in-law friend / acquaintance / mother's colleague friend / acquaintance / father's colleague mother's friend father's friend teacher alien woman alien man playmate priest doctor other persons:	never once several times in my life several times a year several times a month several times a week everyday several times a day still it's over other people:

Source: own research.

Appendix 3:

Intimate Situations Questionnaire version for men (ISQ M)

Prepared at the Institute of Psychology, Wrocław University, Department of Clinical Psychology (2001) by Agnieszka Widera-Wysoczańska

HOW TO REPLY TO THE FOLLOWING QUESTIONS?

This questionnaire is completely anonymous.

To answer the following questions please read each of them carefully and think whether such situations happened in your life even once. Answer the questions: YES.... NO: please circle the correct answer. If the answer is NO, please move to the next question below. If the answer is YES, please move to the next question in the table next to it.

When answering the questions, please provide an answer which in your opinion reflects your situation in the best way.

I would like to emphasise that there are no good or bad answers in this questionnaire. Each sincere, true answer is correct. Everybody is different and has other experiences in life.

On a separate page there are two supplementary charts. Please refer to them when it is difficult for you to determine a person with whom the described situations below are connected and how long these situations lasted in your life. When answering the questions please do not use only the information provided in the table.

The last part of the questionnaire includes open-ended questions in which you can write everything that is important to you in relation to the subject discussed, but not included in the questionnaire.

PART I2

Date:.....

1. Your age.... CODE.....

2. When answering the following questions, please provide answers to all the questions.

Have you ever, in the past or in your present life, (in childhood, in youth, in adulthood) been induced to experience or perform in any of the following situations?		Who behaved in this way and what was this person's approximate age when did this person behave like this for the first time? Please use Table 1 to determine this person.	How old were you when situations of that type started?	How often did such a situation occur in your life? Please use Table 2 to determine frequency and duration.	How old were you when situations of that type finished?
1). I experienced vulgar remarks concerning my sex, e.g. "you male virgin", " you queer", "innocent", other:	YES NO Which?	.....	.....	.....	.....
2). In my childhood or adolescence I used to see an adult undress.	YES NO	.....	.....	.....	.....
3). In my childhood or adolescence I found male or female lingerie scattered in the house.	YES NO	.....	.....	.....	.....
4). An adult person bathed together with me at the age of five or later.	YES NO	.....	.....	.....	.....

5). My naked buttocks were bitten.	YES	NO	.....	.....	.....	.....
6). In my childhood I was shown pornographic photos, films or papers.	YES	NO	.....	.....	.....	.....
7). Adults used vulgar words concerning another sex in my presence e.g. I was told that all women are either "saints or whores".	YES	NO	.....	.....	.....	.....
8). I was given erotic presents by a person older than me.	YES	NO	.....	.....	.....	.....
9). When I was adolescent I experienced embarrassing or vulgar remarks concerning my physical development or my genitals.	YES	NO	.....	.....	.....	.....
10). When I was a child someone touched my genitals in a sexual way.	YES	NO	.....	.....	.....	.....
11). I was slapped in the face.	YES	NO	.....	.....	.....	.....
12). I was expected to take the side of one of the parents when they argued.	YES	NO	.....	.....	.....	.....
13). When I was a child or an adolescent an adult person made remarks concerning the size of my penis	YES	NO	.....	.....	.....	.....
14). A person older than me entered my room any time, without knocking, even when I was getting dressed.	YES	NO	.....	.....	.....	.....

A person older than me suddenly entered the bathroom or toilet when I was using it.	YES NO	.....	.....	.....	.....
15). I was forced to sleep with one of my parents while the other one slept in another bed.	YES NO Under what circumstances?	.....	.....	.....	.....
16). An adult seriously restricted my contact with my peers	YES NO	.....	.....	.....	.....
17). In my youth or adolescence, I was forced to sleep with an adult in one bed at their insistence.	YES NO	.....	.....	.....	.....
18). My sexual initiation took place under the pressure from the environment, against my own will.	YES NO	.....	.....	.....	.....
19). When I was a child someone touched my genitals, e.g. in bed.	YES NO	.....	.....	.....	.....
19). Someone caressed my body without my consent.	YES NO	.....	.....	.....	.....
20). I was kissed on my lips by an adult in a way that aroused my disgust or embarrassment.	YES NO	.....	.....	.....	.....
21). Someone exhibited his/her genitals to me without my consent.	YES NO	.....	.....	.....	.....
22). An adult confided in me, or in my presence talked about their sexual life.	YES NO	.....	.....	.....	.....
23). I was forced to manually stimulate another person's sex organs.	YES NO	.....	.....	.....	.....

24). Sexual intercourse was presented to me as a physicl phenomenon, not requiring an emotional relationship with the second person	YES NO	.....	.....	.....	.....
25). My relationship with a girl was laughed at.	YES NO	.....	.....	.....	.....
26). I was forced to caress another person's body.	YES NO	.....	....	.....	....
27). I was forced to watch another person's masturbation.	YES NO	.....	.....	.....	.....
28). I was forced to masturbate in the presence of another person.	YES NO	.....	.....	.....	.....
29). Someone tried to rape me.	YES NO	.....	.....	.....	.....
30). I was raped.	YES NO	.....	.....	.....	.....
31). An adult ridiculed my body at the age of puberty.	YES NO	.....	.....	.....	.....
32). I was forced to see sexual intercourse between others.	YES NO	.....	.....	.....	.....
33). An adult person asked me for details of my meetings with a girl.	YES NO	.....	.....	.....	.....
34). I was undressed against my will (for example someone took off my trousers and pants in the presence of other people).	YES NO	.....	.....	.....	.....
35). I started my sexual life early and now I feel bad about it.	YES NO	.....	.....	.....	.....

36). I was forced to have anal (anus) intercourse.	YES NO	.....	.....	.....	.....
37). I was forced to commit oral intercourse (someone put their penis in my mouth).	YES NO	.....	.....	.....	.....
38). In my childhood or adolescence I saw a woman taking off her bra or pants (e.g. getting changed).	YES NO	.....	.....	.....	.....
39). I was forced to have sexual intercourse with a younger child or my peer.	YES NO	.....	.....	.....	.....
40). I was forced to touch the private parts of younger children or my peer.	YES NO	.....	.....	.....	.....
41). I was forced to watch the sexual behaviour of other children towards themselves.	YES NO	.....	.....	.....	.....
42). Someone recorded my sexual behaviour against my will.	YES NO	.....	.....	.....	.....
43). I experienced other situations of an intimate character not listed above, which were troubling to me. as follows:	YES NO	.....	.....	.....	.....

Appendix 4:

Interview about the Process of Psychotherapy prepared by Agnieszka Widera Wysoczańska

Please provide answers to the following questions concerning the process of psychotherapy. Appendix 4 contains only some of the questions from the entire interview, which deals with the present study. This study is part of a larger work on the treatment of people after childhood trauma.

I. Demographic data:

1. Code: ……
2. Date of birth: ……
3. Education: ……
4. Marital status: ……
5. Children, their age: ……
6. Attending physician's name: ……
7. Directed to therapy by: ……
8. Individual therapy duration: ……
9. Group therapy duration:

II. Questions about the motivation (asked before the therapy):

1. What problems in your life persuaded you to undertake the therapy? 2. What goals do you want to achieve during the therapy? 3. How can you recognise that the goals have been achieved?

III. Questions about the course of treatment (posed after the termination of the therapy):

1. What new goals appeared during the therapy?
2. Describe the degree of achievement for each of the set goals?
   a. How do you recognise that you have achieved a goal?
3. What elements of group therapy influenced the recovery process and in what way?
   a. At the beginning of the therapy:
   b. During the therapy:
   c. At the end of the therapy:
4. What relationships in the therapy group influenced the recovery process?
   a. At the beginning of the therapy:
   b. During the therapy:

c. At the end of the therapy:

5. What elements of the therapy/ method influenced your recovery?
   a. At the beginning of the therapy:
   b. During the process of therapy:
   c. At the end of the therapy:
6. How did your activity in the group influence the recovery process?
   a. At the beginning of the therapy:
   b. During the process of therapy:
   c. At the end of the therapy:
7. What mechanisms did you use to avoid emotional contact with difficult situations in your childhood?
   a. At the beginning of the therapy:
   b. During the process of therapy:
   c. At the end of the therapy:
8. What mechanisms did you use to avoid solving difficult situations in your life?
   a. Before the therapy:
   b. During the therapy:
   c. At the end of the therapy:
   d. What feelings does it arouse in you?
9. What mechanisms did you use to solve difficult situations in your life?
   a. Before the therapy:
   b. During the therapy:
   c. What feelings does it arouse in you?
10. Describe your feelings / thoughts connected with talking about your childhood and abuse, which appeared during:
    a. The initial sessions:
    b. The middle session:
    c. The last session:
11. What happened when you were talking about your past?
12. What was helpful for you in going through the fear in order to get better?
    a. Before the therapy:
    b. During the therapy:
    c. At the end of the therapy:
13. What was not helpful to you in building safety and trust in life?
    a. Before the therapy:
    b. During the therapy:
    c. At the end of the therapy:

14. What was helpful to you in building safety and trust in life?
    a. Before the therapy:
    b. During the therapy:
15. How do you want to build safety in your life in the future and from now on?
16. What did you realise concerning your life during the therapy relating to:
    a. situations?
    b. relationships?
    c. feelings?
    d. beliefs?
    e. behaviour?
    f. other?
17. How does this awareness help you in building:
    a. situations?
    b. relationships?
    c. feelings?
    d. beliefs?
    e. behaviour?
    f. other?
18. From whom did you emotionally part during the therapy?
    a. If and how is this parting affects your life?
19. From whom did you physically part during the therapy?
    a. If and how is this parting affects your life?
20. From whom did you build relationships with during the therapy?
    a. If and how is this new relationships beneficial to you?
21. How did your relationship with your family change:
    a. With your mother?
    b. With your father?
    c. With your siblings?
    d. With your partner?
    e. With your children?
    f. other?
22. How did this change influence your life?
23. What important things did you manage to realise during the therapy?
24. What do you plan after the therapy?
    a. What are your plans?
    b. What goals do you have?
    c. What values do you want to implement?

25. In what way did the internal and external changes influence your mood?
    a. The awareness of what is most important to you?
26. How did your mental state improve during the therapy?
    a. not at all:
    b. a little:
    c. on a medium level:
    d. very much:
    e. I feel I am a different person:
    f. other:
27. How do you feel now?
    a. Describe your daily emotions:
    b. Describe your daily thoughts:
    c. What mental problems are bothering you currently?
28. How did your physical health change?
    a. How did your way of taking care of physical fitness change?
    b. What physical problems are bothering you currently?
29. What further goals in self-improvement do you wish to achieve?
    a. How do you want to achieve them?
30. What would your life look like if you did not take part in therapy?
31. How do you keep fit now?

I give my consent that the questionnaires can be anonymously used during the therapy and may be used by therapists conducting the therapy for research purposes YES / NO.

CHAPTER SEVEN

MODEL FACTORS INFLUENCING HEALING AFTER TRAUMA IN GROUP PSYCHOTHERAPY: FROM PARTICIPANTS' SUBJECTIVE PERSPECTIVE

AGNIESZKA WIDERA-WYSOCZAŃSKA

On the basis of a qualitative analysis I have selected proposed model factors that contribute to the quality of recovery during the process of intergenerational group psychotherapy of people who suffered from interpersonal trauma in their childhood (described in Chapter Six). The model was generalised for the examined group of 95 persons. It contains a "theoretical" and a "practical" part. The elements presented in the "theoretical" part are factors impeding and / or facilitating the process of recovery. These factors were described with the use of interpersonal or extra-personal "phenomena" which contribute to the process of recovery in a negative or positive way. Factors facilitating recovery include descriptions of "benefits" i.e. internal and external resources activated by specific phenomena in the form of capabilities and skills.

The "practical" part of the model includes a description of objectives, principles of treatment and presents recommended methods, whose application is justified as factors that facilitate recovery.

Factors impeding the healing process – traps to recovery

Individuals who have suffered from interpersonal, chronic and complex trauma build up mechanisms that allow them to endure the duration of the abuse experienced. These mechanisms protect them from grievous harm experienced at the hands of the perpetrator. Chronic and complex trauma is typically so overwhelming for a person that it limits his or her capability of processing and gaining relief from the horrific events. The trauma remains "blocked" inside the person, causing emotional,

cognitive, social and somatic problems. If a person finds herself or himself in situations where there is no violence these mechanisms still function despite the fact that they have ceased to have their protective function. Then they become factors that impede the process of recovery.

On the basis of conducted research, I have defined factors which impede recovery as a group of mechanisms in the way a person functions, which began developing in early childhood, throughout the period of adolescence and into present-day life. These mechanisms have a huge impact on feelings, thinking, and perceiving oneself and others, as well as on interpersonal relationships, ways of behaving, solving conflicts, and coping with the crises and stress that accompanies them. They cause distortions in the reception of reality.

They have a destructive impact on a person both when they stay in their natural family or professional environment as well as when the person is undergoing individual and group therapy during which they should reach their internal resources and re-construct them.

Factors hindering recovery occurring during group treatment concern the ways both the psychotherapist and therapy participant function. The traps on the road to recovery, according to the persons examined include: negative evaluation of people in the group; fear and shame of revealing one's life; negating the meaning of his/her own experiences; the negative impact of others' stories on their condition; escaping from remembering; a negative attitude towards oneself; toxic loyalty towards destructive parents; the mutual impact of therapy and life situations, such as the influence of the therapy on one's life situation and the influence of the life situation on the therapy; the perpetrators' accusations; dealing with other people's problems during group therapy and beyond it in order not to deal with one's own problems; not taking risks; hiding the fact that one is a perpetrator of abuse (Table 7-1).

Negative evaluation of the people in the group

Negative assessment of the relationship in the group was indicated by sixty-nine (73%) people. It is connected with broken trust in people, a lack of feeling safe or a lack of faith in the good intentions of others. As a consequence such people were convinced that the group or the therapist was against them, and / or did not accept them and rejected them as well as misjudged them because of not dealing with a person through their own problems. Some of them thought that they were the only ones with such concerns. This has been captured in these ways:

> "I separated myself from the group", "I was depressed all over again when inventing the reasons why the group would reject me and why the therapist does not like me", "I thought that I was the only one to fear being rejected by the group. I was afraid to speak, as I feared I would be ridiculed or treated like a leper", "I feared not being accepted by people in the group or that they would reject me", "I thought that people feel aversion to contact with me as a person with problems and unable to cope with her affairs", "In my head I shot whole movies about what others were thinking about me."

These people isolated themselves from the group and avoided contact with people:

> "I didn't talk to people about myself." They were closed towards others: "I closed myself in my own world." They negated others: "I was looking for bad qualities in people and always found something I could use."

They were characterised by little activity during group sessions, because they were afraid of revealing their emotions, thoughts and problems. Due to a lack of trust, they were afraid that the information revealed by them would be used against them. This is confirmed by the words:

> "As a very closed person I thought there was no need to share the situations from my life, especially about my feelings, with strangers", "I was not actively participating", "I did not trust anyone I was afraid that afterwards somebody could use this information against me."

They had a feeling of not being understood by others. In some people this resulted in chaotic behaviour and way of speaking. Such behaviour is caused by emotional chaos, which disorganises their thinking and impedes speaking about difficult topics.

Fear and shame of revealing one's life

Before making the decision to reveal their history and when sharing the story aloud, ninety-five (100%) people felt fear and shame. They feared being ridiculed, they feared negative assessment, disregard, lack of understanding and lack of interest or belief in what had happened in their childhood and the consequences they bear. The situations experienced were too painful to admit and too shameful to talk about. People said:

> "I was ashamed of speaking in front of others and I was sure they would assess me negatively and would not respect me - that they would condemn me", "I was afraid that what I have to say is not interesting to others", "I feared that nobody would believe that I had had such a horrible childhood", "I was afraid that others would not perceive negative things in my childhood which could explain my bad physical and mental state", "I was afraid that people would think that I am complaining about myself", "I was so ashamed that I could cry."

Due to anxiety, many people experienced somatic symptoms such as physical tension, a sensation of heat, sweaty hands, increased heartbeat, headaches, abdominal pain, shaky voice, vomiting. "I wanted to tell the story of my life, but because of fear I suffered such a headache and abdominal pain that I thought I would vomit when I started talking."

Negating the meaning of his/her own experiences

Sixty-nine (73%) group members denied the meaning of their own traumatic life experiences. This followed from their compulsion to maintain the secrecy imposed by the perpetrator, their denial on behalf of the perpetrator and people from the environment that there had been any abuse at all, minimising the significance of facts that took place or the resulting symptoms or rationalisation of the perpetrator's behaviour. These individuals have a distorted image of themselves, their lives, environment and the perpetrator. It differed significantly from the objective facts.

They revealed a feeling of competition as to who suffered from "worse" and more dramatic situations in life and it was always a different person from the narrator of the story. Some of them feared that they experienced too little harm to justify their right to feel bad. Others proved that nothing bad had happened in their lives, so they did not need to change anything. The trauma suffered was chronic, so it became a daily "standard" and due to that they were convinced that they were not harmed. They deemed that what happened to them was typical for the majority of families and meant nothing. Therefore, there was nothing to speak about. The subjects said:

> "I thought that my problems are not so terrible", "Nothing so terrible has happened", "I feared that the group would think that I had invented the story of my life and that it is nothing when compared to others who have experienced more numerous, much more terrible, situations", "I found out that others had had a worse childhood than me", "They could think that my story was not so bad at all. In the end I thought so myself because my parents and grandma told me that I had had a good childhood", "I feared

that others would not perceive in my childhood anything that would excuse my bad condition."

Negative impact of others' stories on the condition of the person

Thirty-nine (41%) respondents felt a negative impact from others' stories on their physical and mental condition. People's stories activated renounced memories of traumatic events and difficult emotions pertaining to them.

"First, some drastic aspects in the stories of other people from the group scared me", "I didn't want to listen to them and I thought I could not bear it any more." "I feel the same emotions as in my childhood. Sadness and anxiety was unbearable."

They identified with other people's stories (e.g. transferring emotions) because life in a dysfunctional environment had distorted the process of creating identity, that is, of the sense "who I am" and what life experiences have constructed me: separation from others, building separateness, a feeling of autonomy and individualisation. These people had difficulties with finding their own identity. They had a limited feeling of "I". They were too prone to determine themselves through who they were in a relationship with others, instead of what they were truly like. Through their symbiotic tendencies, their identity was "permeated by" others. Identifying oneself with other people's stories was also related to the creation of the false "I" which arises as a result of excessive focus on the needs of the perpetrator in order to feel safer in a relationship with him or her. This is confirmed by the words of participants:

"I overreacted to dramatic stories told by others in the group and I identified with them", "I thought that I had experienced the same thing, that I had felt the same in the past and at present, although I had never felt like that before", "I reacted in this way every time one person after another was talking about their emotions. As if I became this person. I had difficulties distinguishing what is mine and what is theirs. This was very tiring."

Table 7-1. Factors impeding recovery after the trauma experienced in childhood

Groups of factors impeding recovery	n = 95 n %	Phenomena impeding the changes and causing losses
Negative evaluation of the people in the group	69 72,63%	Conviction that others are biased against person, reject, do not accept, assess negatively Isolating oneself from the group Clamming up Avoidance of speaking Avoiding people Negating people Little activity Fear of revealing one's emotions, thoughts and problems Lack of trust in others Feeling of not being understood Fear that the revealed information will be used
Fear and shame of revealing one's life story	95 100%	Physical tensions manifesting themselves as sensations of heat, sweaty hands, increased heartbeat, headache, abdominal pain, shaky voice, vomiting Fear of being rejected Fear of being ridiculed Fear and shame of not being understood Fear and shame of negative assessment Fear of being disregarded Fear of evoking lack of interest or belief
Negating the meaning of his/her own experiences	69 72,63%	Competing about the gravity of the situations which happened in the past Negating one's own harm Blocking rational assessment of events Minimising the significance of facts Rationalisation of the abuser's behaviour Being brought up in accordance with the rule that nothing that happened in the family can come to light
Negative impact of others' stories on person condition	39 41,05%	Negative impact of others' stories on one's physical and mental condition Identification with other people's stories

Escape from remembering	51 53,68%	Fear of confronting with difficult emotions from the past Pain and fear accompanying increasing awareness and recall Resignation from reaching for memories to block feelings (sorrow, guilt, pain, anxiety, growing depression) and thoughts delaying tactics
Negative attitude towards oneself	71 74,73%	Self-delusion Clamming up Destructive convictions about oneself Blaming oneself for harm incurred Blaming oneself for everything Lack of empathy towards oneself Compulsion to be strong Lack of faith in one's intuition Criticising oneself for everything Making oneself believe one is a bad person Distorted self-esteem Excessive demands of oneself Criticising oneself for slow changes Resting on one's laurels when one gets better
Toxic loyalty towards destructive parents (offender)	65 68,42%	Feeling of guilt that one is hurting one's parents by speaking negatively about them and accusing them Protecting the parents Justifying the parents' behaviour Compulsion to take care of one's family, but not of oneself
Mutual impact of therapy and life situations on each: Influence of the therapy on their life situation	53 55,78%	 Fear that the therapy will have a negative influence on one's relationship with a partner or children, Fear that somebody might use gained information against them Isolating oneself from people from beyond the group

Influence of their life situation on therapy		Contact with parents during process of the therapy: -stress connected with the relations with parents -stress due to parents' manipulations (e.g. very frequent phone calls) -visiting parents right after sessions -working with the family -engaging in the family/ parents' problems -living together with their parents Stress in the current life: -the current situation of the family -atmosphere at work -attack by the boss -lack of time Contact with a destructive partner / husband -who did not accept the changes -and did not want to understand the sense of therapy -who used gained knowledge against the person Conversations with a partner/ other about the course of therapy with no limits and boundaries Contact (conversations) with people who deny that harm experienced during their childhood
The perpetrators' accusations	72 75,78%	Living with the perpetrator Accusations by the perpetrators of a change in the behaviour of people recovering Constant manipulation by the perpetrator
Dealing with other people's problems during the group therapy and beyond it in order not to deal with one's problems	64 67,36%	Surrounding oneself with weak people Striving to be accepted by others (being nice, solving problems for others) Controlling others Analysing other people's problems Making others emotionally addicted to oneself Not being able to say "no" Making excuses in front of other people Transferred aggression, passive or verbal
Not taking risks	51 53,68%	Putting off decisions Expecting that everything will solve itself Not undertaking activity Diminishing problems Not noticing problems Not assuming responsibility

Hiding that one is a perpetrator	39 41,05%	Not disclosing that this person was an abuser of neglect or rejection of own children / partners / other adults / of emotional, physical, sexual abuse Unrevealed erotomania Unrevealed addiction to pornography The fear that it comes to light that this person physically, sexually hurt others Not revealing how much harm was done to their loved ones Shifting responsibility on to wife/children

Source: own research, 2007; 2010.

Escape from remembering

Fifty-one (54%) participants were afraid that the memories of the past would lead to feeling those very difficult emotions experienced in childhood once again, such as shame, guilt, and sorrow. They said that:

> "I was afraid of recalling the memories from the past, I feared the past feelings and making myself aware of the influence they have on my present life", "While telling the story I experienced fear of my own emotions, especially grief and sorrow and for some time I did not have the courage to cope with them", "I felt worse than others because of my history; I was ashamed of it. That is why recalling the past was difficult. I wanted to escape from the sorrow which appeared", "I blamed myself for what had happened in the past."

They also escaped from depression, compassion, anxiety, and grief, which appeared as a result of current recall of the past. Many people therefore gave up trying to reach their memories in order to, as they claimed, block the pain, anxiety and growing depression and the thoughts accompanying the increasing awareness.

Negative attitude towards oneself

A negative attitude towards oneself impeded seventy-one (75%) people's recovery. An important factor in this connection was self-blame for the harm suffered from parents in one's childhood and for everything that happened in their life. These people deemed that screams, beating or rapes were a proper punishment for their bad behaviour. A typical expression was:

> "I thought that I was beaten and raped because I behaved badly towards my parents. It was all my fault. As a punishment they could hurt me any way they wanted", "I had a tendency to attack myself because I lacked the courage to see that someone was hurting me and I needed to defend myself. I was afraid to protect myself", "Blaming myself slowed down my work. How could I be angry at the perpetrator and say what he did to me, if I was the guilty one. It was all because of me", "I was afraid that others would see that what happened was my fault. Therefore I could not speak about everything", "I was afraid that I was inventing problems from my childhood in order to find someone guilty of my own failures."

Some of the participants did not feel empathy towards themselves. "I didn't feel compassion for myself, I don't like to think of myself as a baby girl, and it made me angry. She allowed herself to be hurt. She was hopeless."

In the case of men, the conviction that they have to be strong impeded their recovery. "I thought that men do not speak about such things and they do not feel sorry for themselves."

A factor impeding recovery was lack of trust in oneself and in one's intuition. It was accompanied by criticism of oneself and of one's behaviours and disturbed self-esteem. "I had a feeling of being a loser in life and I was convinced that I would not manage anyway." "I didn't believe my own feelings." These people had excessive demands on themselves and assessed themselves negatively "I am a bad mother, a bad wife and a bad daughter." "I am of no value." "I am useless." "I am worth nothing." They criticised themselves for slow changes during the therapy and when at last they felt better they tended to "rest on their laurels".

Destructive convictions concerning themselves caused permanent depression, bad moods, a lack of hope, a lack of the will to live, feelings of being of no value, not liking oneself, anger towards oneself, and stomach aches or other somatic symptoms.

Toxic loyalty towards destructive parents

Problems with recovery also resulted from toxic loyalty towards one's parents. In the case of sixty-five (68%) therapeutic group members this impeded revealing harm suffered in their childhood from the perpetrator who was active in using abuse (usually the father) as well as passivity and not protecting the person from abuse (usually the mother). They experienced fear and feelings of guilt that someone is hurting their parents by speaking negatively about them and accusing them. According to subject, it has been captured in these ways:

> "I feared that by talking about my childhood I would hurt my parents", "I felt guilty, because I said bad things about my loved ones", "I was afraid to say bad things about my mother more than about my father for I was addicted to my mother", "Blaming my parents did not help, I did not feel safe", "I could not say bad things about my father and mother and this meant that I did not have anything to work with."

The patients protected and justified their harming parents. They had an inner compulsion to deal with their family and not with themselves, hoping that finally they would receive safety, closeness and love. Here are the statements of the respondents:

> "I thought I don't have the right to say bad things about my parents, because they were my parents and they were harmed too", "I was ashamed to say bad things about my parents and I defended them", "I have always hidden difficult topics from my childhood, I knew that one does not talk about them, because one shouldn't say bad things about the parents who brought them up. Instead, I only smiled", "I can see only the good in my parents, I feel gratitude and huge empathy towards them and this does not release me from them, I let myself am seduced by them", "I was hoping all the time that my father would change, that is why I justified him", "Mum had to behave the way she did for our sakes."

This caused the feeling of disappearance, resignation from oneself, resentment, a physical feeling of choking and taking one's anger out on others in the form of redirected and passive aggression.

Mutual impact of therapy and life situations on each other

In the cases of fifty-three (56%) patients, the recovery process was impeded by the fear that the therapy would have a negative impact on their current relationship with their own child or partner. Some people, tired of feelings experienced during the therapy, isolated themselves from people from outside the group: "I closed myself in at home." "I acted only in the professional area", therefore they did not receive support and did not learn to construct safe relationships. Some people revealed fear that somebody might use gained information against them.

According to many participants their life situation influenced the therapy. The recovery process was hindered especially by contacting their parents during the whole duration of the therapy and the manipulation the parents exercised upon them. Living with their parents, visiting parents and siblings, especially right after the sessions, frequent phone calls, working with the family, worrying and taking the parents' problems on themselves had particular impact. "Stress was related to my view of my

parents. I was scared of their manipulation, frequent phone calls. I didn't have their emotional support."

Another factor impeding recovery was contact with a destructive partner / husband who did not accept the changes and did not want to understand the sense of therapy. Talking to such a partner resulted in experiencing a lack of understanding, a lack of support and the feeling of being betrayed.

> "I haven't received emotional support from my husband", "I talked too much with my partner about the course of my new therapy. When, after such conversations, he did not satisfy my needs or he used gained knowledge against me, I felt misunderstood and betrayed", "There were too many talks about myself, I didn't take care of my space and of the fact that I have the right not to speak about something", "I didn't take care of the boundaries that would give me safety and intimacy."

Contact (conversations) with people who deny harm experienced during their childhood was also destructive for treatment. "Conversations with my sister and her statements that I exaggerate when it comes to my grudges against my parents made my working over my past and current problems more difficult."

Recovery was hindered when stress in current life appeared related to the situation in the current family or with the atmosphere at work, boss attacks or lack of time because of excessive duties, which limited the time meant for "therapeutic reflection" on oneself.

The perpetrators' accusations

In seventy-two (76%) people, a vast amount of anxiety and will of escape from the therapy was aroused by the perpetrators' accusations that the person had changed his/her previously existing behaviour to, according to the perpetrator, something worse and ungrateful. Such accusations were made especially when the "victim" started to express his or her feelings related to the perpetrator's behaviour, objected to the perpetrator's demands, became more independent and autonomous, ceased to assume responsibility for the perpetrator's behaviour and started to control his or her life.

Dealing with the problems of other people in the group and from outside the group

In the sixty-four (67%) cases among the group therapy patients, a factor hindering recovery was dealing with others' problems and sticking to details instead of facing one's own problems. Such a person was nice to others. They surrounded themselves with weak people, unable to put up with their lives so that she or he could manage their affairs. Such a person advised others and controlled weaker people. In this way, these people made others addicted to them and it gave them a sense of security that they would receive help from others and also did not have to deal with their own problems. Subjects were told about it this way:

> "I'm starting to analyse other people's problems, cavilling, instead of solving own problems", "I tried to be nice to everybody", "I surrounded myself only with people who accepted me or were not brave enough to hurt me", "I made relationships with weak people", "I controlled others. I manage other people's affairs instead of my own", "I was nice to everybody and I smiled. I got people emotionally addicted to me which made me feel safe, gave me the feeling that I could rely on them."

As a result "I could not say 'no" and then I was so burdened that I reacted with verbal aggression." This resulted in inactivity concerning their own problems.

Not taking the risk

Fifty-one (54%) participants of the therapy put off the decision to deal with their own problems. "I will think later what to do and how to do it, because tomorrow is a better day for that". They expected that everything would solve itself or be solved via the therapist and they did not undertake any action. "I didn't stick my neck out", "I tried to be transparent and absent". Some of the people diminished or didn't notice their problems or didn't take responsibility for their solving their problems. In relation to such behaviour these persons felt helpless and angry.

Hiding that one is a perpetrator

A factor that significantly impeded the process of recovery was not revealing the fact that one is a perpetrator of harm to others. Thirty-nine (41%) people feared that it would be revealed that they harm their own children or partners emotionally, physically or sexually. This group

comprised both men and women. They were hiding erotomania, including being addicted to pornography. They used denial mechanisms, renounced, minimised, transferred responsibility onto their relatives, said they were not such types of people who could act in this way, and justified that they weren't there. They also did not speak at all about destructive actions. So, during the therapy they had to control their speech and reactions so that it would not be revealed that they are perpetrators themselves.

> "I didn't say that I hurt my family. I rejected my own son, didn't talk to him. I accused my wife of everything."

Such individuals were focused on maintaining secrecy and defending the mechanisms of violence instead of being interested in making changes. The disclosure which took place just before the end of the therapy, if any, caused a very limited scope of inner changes.

What helped people to deal with destructive mechanisms impeding the recovery described by them?

Factors facilitating recovery after trauma

When a person is in a traumatic situation which lasts too long and is terrifying, it becomes so overwhelming that dealing with it merely by means of time and support is not enough. When trauma is constantly present in one's life, it overwhelms the person's capabilities of experiencing strength, self-confidence and safety. Such a person loses the chance of dealing internally with the trauma and its consequences. They do not build strength and power. Chronic trauma symptoms and mechanisms are so active that their consequences cannot be solved by means of internal or external resources. In order to be able to go back and resolve the trauma, an individual first needs to build a sense of support and strength inside and outside. Building resources that enable recovery processes provides the basis to healing from the consequences of trauma.

Factors facilitating the recovery process are a set of intra and interpersonal phenomena that support the development of internal resources (capabilities). These resources help in properly adapting to changing conditions and in engagement in daily issues. They arise when a person is forced to deal with difficult, stressful and traumatic life experiences and threats to fundamental values such as life or health. They help to creatively resist the pathogenic impact of the nearest environment (Uchnast, 1997; 1998; Janoff-Bulman, 2004). One of the main capabilities is to break away from negative experiences, induce positive emotions in

themselves and build up the sense of value, control and strength. These resources are not only inherent qualities (genes), but they are mainly created during one's life by means of the phenomena in which a person is engaged. They are also developed as a result of the influence of factors facilitating recovery during participation in psychotherapy.

Group therapy patients who suffered from interpersonal trauma point to factors appearing during the therapy which facilitate recovery and the regaining of harmony. The healing phenomena enable problems to be solved and a set of goals to be achieved. They are arranged in types which take the course of time into consideration; feeling that one is a member of the group; revealing traumatic events in the presence of others; relationships with the therapist; support from persons from beyond the group; insight into the past, conferring meaning and looking from a new perspective; experimenting with expressing one's emotions; disclosure of being a perpetrator; insight into current relationships and learning to construct creative relationships with others; learning to build oneself (Table 7-2).

Flow of time in the group

Together over the course of time, thirty-one (33%) group therapy members experienced the feeling of safety and motivation to change something inside them. These people took more and more risk of opening up before other participants. They were aware of the therapy time passing by, and the diminishing opportunity for change. We find it in words:

> "With every session it was becoming easier, as the time passed I started to feel that I am recovering and finally I realised that there is a method in it and this only deepened my motivation to introduce further changes (…)."

Just as the time flow influenced the gradual building of internal resources in the form of feelings of safety, the courage to take the risk and the motivation to change arose.

Feeling a member of the group

Feeling a member of the group for people with similar past experiences in eighty-eight (93%) cases increased together with the sense of acceptance, support, compassion, sympathy, warmth and mutual engagement as well as with the group's faith in the person, that he or she is capable of change. This enhanced the trust in the group and decreased the

fear of being rejected after telling one's life story. It appears in these words:

> "I was not rejected by the group and I could feel their acceptance while telling my story", "I received many warm words from the group, people showed me they wanted to offer me warmth and support", "The group's support and positive reactions of people soothed my fear", "The group gave me so much. I felt supported in all that I said, I felt safe and accepted. The warm statements of the group allowed me to accept myself and believe in my history. This helped me to express my anger towards my parents."

The feeling of loyalty towards other members of the group who took the risk of revealing their lives and inner selves was helpful: "Other people said their stories, I will do that too", "Others' courage to talk about themselves helped me" as well as the group's feedback:

> "It helped me to hear that what I have experienced was not bad, it confirmed that I haven't invented it and I am not responsible, that I am not guilty", "The feedback of the group was helpful. They listened and they accepted", "The group helped me with their support and remarks."

The feeling of being a member of the group helped to build resources such as trust in participants, diminished fear of speaking about one's life, strengthened self-acceptance and made one aware that he/she is not guilty or responsible for the perpetrator's actions. Expressing anger at the perpetrators was helpful.

Revealing traumatic events in the presence of others

Listening to the stories from the lives of others for eighty-four (88%) members of the group contributed to building the courage to reveal one's own traumatic history: "It was much easier for me to talk about what was happening in my home because I heard others' stories." "It was important for me to see that others had the courage to talk about themselves."

People were becoming more and more aware of the fact that others experienced similar traumas in their childhood and in their adult lives suffer from similar problems resulting from the trauma. People describe it in such a way:

> "I realised that others' stories are in my opinion even more dramatic than mine. It helped me that others had had similar experiences to mined and they also face various problems and they were talking about them", "Many people opened themselves and talked about their traumatic childhood. All

were a great support for each other, each of us had a difficult childhood and many problems in life and this brought us closer to one another... ."

During the therapy, participants gradually gained the certainty that the group believed their story because the majority of participants did not deny, did not minimise or rationalise events in the life of the teller but accepted them as fact. This allowed diminishing cognitive distortions concerning the very fact of existing traumatic events, behaviours and one's own "participation" in experienced violence. "I knew that the group believes in what I say that I don't have to prove anything to anybody at any cost and I knew I would not be rejected."

They regained the ability to gradually eliminate various mechanisms of denial that they had suffered as a result of the violence experienced in the past: "I was not able to keep that inside any more", "I was more and more focused on emotions, I allowed myself to cry during the group sessions, I ceased controlling my emotions so much."

Denials impeded the revelation of their situation. The liquidation of the denials allowed participants to construct the conviction that memories reflect the truth.

Revealing traumatic experiences in the presence of others aroused courage, increased awareness and gave relief that one is not the only person who suffered from interpersonal trauma. Furthermore, it influenced the elimination of cognitive experience and treating suffered violence as the truth.

Table 7-2. Factors facilitating recovery during therapy for people after childhood interpersonal trauma

Types of factors facilitating recovery	n=95 n %	Categories of phenomena constructing the resources	Benefits – activated internal and external resources
Flow of time	31 32,63%	Gradually undertaking activity in the group Awareness of time passing at the herapy for which a person has paid	Increased feeling of safety Increased motivation for changes Increased courage to take risks and open to others
Feeling a member of the group	88 92,63%	The group's acceptance Incentives from the others to talk	Increased trust in group members Trust that other people in the group want to

		Support, commitment, engagement, compassion, sympathy and warmth of the group members Talking about one's fear Feeling of loyalty Feedback The group's faith in a person's capability to change	help, not to reject Relief Feeling that a person is needed Experiencing that one can count on others Decreased fear of being assessed Decreased fear of speaking about one's life Decreased fear of being rejected Strengthened self-acceptance Becoming aware that one is not responsible or guilty of the perpetrator's acts Expressing anger at the perpetrators
Revealing traumatic events in the presence of others	84 88,42%	Listening to others' life stories Increasing awareness: that others suffered similar traumas during their childhood and have similar problems resulting from that in their adult lives The group's belief in the story told Treating violence as Fact	Courage to reveal Relief that one is not the only one Decreasing mechanisms of denial Decreasing cognitive distortions Increasing the feeling of acceptance
Relationship with the therapist and his / her professionalism	51 53,68%	Attachment: -building trust in the therapist -feeling of being accepted by the therapist -building secure attachments Manner of dealing with violence:	Increasing the feeling of safety in relationships with people in the group and from beyond the group Strengthening trust in others Strengthening security

		-therapist's professionalism -respect for interpersonal boundaries -naming the perpetrator's actions as violence by the therapist -therapeutic exercises, mainly working with the inner child, fantasies concerning anger towards the perpetrators from the childhood	
Support from people outside the group	36 37,89%	Receiving warmth Receiving closeness Talks Others' faith in Changes	Trust Safety
Insight into the past, conferring meaning and looking from a new perspective	95 100%	Revealing the secret(s) of one's life Accurate recall of new facts from one's life Conferring meaning on perpetrator's behaviour Naming the harming behaviour as violence Awareness that in the past one experienced "things that shouldn't have happened" Real assessment of the perpetrator's behaviour Increasing awareness that destruction was then perceived as "normal" in life	Decreased fear concerning the past Decreased cognitive distortions Conferring realistic meanings to experienced violence Trauma from the past and present problems resulting from it are arranged into a logical wholeness Acknowledging violence as truth not fantasy Insight into renounced feelings Anger towards the perpetrator Diminished redirected aggression and passive aggression Obtaining a look into the

		Confronting the Aggressor	past (I was treated badly) and the present, which gives relief and strengthens Increasing self-acceptance
Experimenting with expressing one's emotions	76 80%	Learning to receive feedback concerning one's feelings in a constructive way Learning to show feelings and transfer information concerning the feelings within the group Learning to express feelings constructively, both towards the family and friends Learning to control one's emotions	Releasing oneself from shame, the feeling of guilt, responsibility, anger Courage to express feelings Relief Recovering life energy Increasing control over one's feelings and the form of their expression
Disclosure of being a perpetrator	48 50,52%	Disclosing their perpetration and neglect of their own children / partners / other adults: emotional, physical, sexual abuse Revealing being addicted to pornography Realising and revealing how much harm was done to their loved ones Awareness of the phenomenon of projection of feelings	Reducing the fear of uncontrolled disclosure that she / he is the aggressor Increase the courage to talk about their lives Increased motivation to change their behaviour Reducing the frequency of abuse
Insight into the so-far existing relationships and learning to construct	84 88,42%	Learning to consciously choose constructive relationships in one's life	Conversations solving the problems Establishing borders Building a healthy distance to people

creative relationships with others		Separation from people who pose a threat Breaking contact with parents Not being involved in other people's problems Learning to build adult relationships with parents and life partners Learning to care for Others Watch personal Boundaries	Obtaining satisfying relationships with others
Learning to build oneself now and in the future	92 96,84%	In the cognitive sphere: -learning to draw conclusions from problems and errors -fear of being stuck in one point -learning to choose, plan and build objectives -trusting oneself -strengthening one's value -thinking of liking oneself In the emotional sphere: -learning to draw pleasure from the small things in life -learning to enjoy yourself and others' minor pleasures -giving yourself the right to do nothing -learning to take care of oneself -learning to notice one's needs -learning to take care of one's inner child	Satisfying one's needs Experiencing pleasure Pleasing oneself with small things Joy and peace Better mental condition Energy and strength Feeling valuable and important Trust oneself Values in life Making choices Planning Objectives Achieving goals

		In the behavioural sphere: -learning to take life into one's own hands -learning to make decisions for oneself -allowing oneself to make mistakes	

Source: own research, 2007, 2010.

Relationship with the therapist and his/ her professionalism

For fifty-one (54%) participants the following factors facilitated recovery: the therapist's actions aimed at building trust in her; by asking questions about emotions, their reasons, and who exactly is concerned with accepting the participant's feelings; the therapist's experience and professionalism and reactions following from it such as referring to the perpetrator's behaviour as abuse, proposed therapeutic exercises, mainly working with the inner child, fantasies concerning anger towards perpetrators from one's childhood. This resulted in increased trust and the feeling of safety in relationships with others. "The therapist's expressions gave me the feeling of safety", "Individual meetings helped me, conversations with the therapist and also a better understanding of my life. It allowed me to feel."

Support from persons from outside the group

A factor contributing to recovery in thirty-six (38%) cases was obtaining support from the closest ones outside the group. "Hugging my boyfriend", "Talking to my friend" or "The faith and motivation of other people – friends or colleagues, who believed in me and saw the changes taking place inside me. This constructed trust."

Insight into the past, conferring meanings and looking from a new perspective

In ninety-five (100%) persons revealing the secret, frequently for the first time, of their difficult past was helpful in recovering. These people realised that their better condition was connected with this very process. People wrote:

> "I realised that I will be troubled by that if I do not speak about my past and that without speaking about it I will not be able to go any further. When I revealed something, other feelings and other perceptions of the facts appeared. I preferred overcoming the fear and saying something, as afterwards it did not lay heavy in my mind and I felt a great relief", "I thought that what I have to say will help me, I was speaking about that for the first time", "Telling what I have experienced, what I witnessed and what my family was like diminished my fears from the past", "Showing myself in the true light and getting that off my chest really helped me", "Most effective was telling the truth about my life aloud and reaching what my feelings related to."

When telling their story at "their own pace" patients remembered new facts from their lives in more and more detail. They acquired a more complete picture of the past events, which by then had been driven out of their memory. This allowed a gradual reduction of cognitive distortions relating to the perpetrator's behaviour and conferring a more realistic meaning upon them. "Naming various behaviours and specifically calling them abuse or violence by the therapist when people told their story in detail was important...."

Thanks to this trauma from the past and present, problems resulting from it were arranged into a logical wholeness. Individuals acquired the conviction that what they have experienced is true, that it was not invented and they did not fantasise about suffered abuse. They understood more and more that in the past they experienced "things that should not have happened" and conferred an adequate, real meaning on them. "I realised that the cruelty of childhood affects my adult life", "I realised that my mother knew that I was abused by my stepfather and grandmother and she did nothing about it."

The therapy participants became aware that abuse was treated by them and their environment as a standard in daily life. Real assessment of the perpetrators' behaviour led to enhanced self-acceptance: "what he did to me was bad, it is not true that I am a bad person."

Becoming aware of the past activated insight in the thusfar renounced or frozen feelings. People started to experience renounced anger towards perpetrators who had hurt them more and more clearly and gradually aggression redirected from the perpetrator to others as well as passive aggression diminished. Various ways of confronting the aggressor "during the group" by reporting the case to the police or talking to the perpetrator were healing.

Insight into the past, conferring realistic meanings and looking from a new perspective diminished fear of the past, liquidated cognitive

distortions and caused conferring realistic meanings to experienced abuse. Trauma from the past and present problems resulting from it became arranged into a logical wholeness. Patients acknowledged that what they had experienced was true. They became aware of their anger towards the perpetrator; their redirected aggression and passive aggression diminished. Their self-acceptance increased.

Experimenting with expressing one's emotions

Conferring real meanings on traumatic events facilitated insights into one's feelings. Seventy-six (80%) therapy group members became aware that they were experiencing irrational shame, feelings of guilt and responsibility, fear and anger as well as realising that they were revealing passive aggression. "I felt relieved from shame and responsibility", "It was important to say what I was feeling, wondering about - to reach the causes of fear and other feelings."

Receiving and providing feedback showed that one does not need to be afraid of expressing one's feelings and this in turn enhanced the will to experiment with expressing one's feelings, including sadness, sorrow or anger. Group members were taught how to show their feelings in a constructive way. It brought positive effects; having expressed their emotions, patients felt relief. They learned to express their feelings in such a way as not to harm the ones whom they addressed. These new abilities were transferred to their relationships in their daily lives. Showing one's feelings allowed them to regain energy and the will to live. "During recovery, it was helpful to experiment with expressing one's feelings during the therapy and take the risk of expressing them towards my loved ones." The connection with learning how to increase control over one's feelings and associated behaviour limited hysteria or bursts of anger.

Experimenting with one's feelings resulted in relief from shame, fear, responsibility and anger. It encouraged the constructive expression of feelings, and helped to regain energy for action. At the same time the patients increased control over their feelings and their forms of expression.

Disclosure of being a perpetrator

For forty-eight (50%) people, it was important to realise and admit to emotional, physical, sexual abuse in relationships with loved ones and to learn to create a constructive bond with others. People disclosed their perpetration and neglect of their own children / partners / other adults. They revealed being addicted to pornography. They realised and revealed

how much harm they had done to their loved ones. The awareness of the projection of feelings following harm suffered in childhood from the parents to "innocent" persons in adult life was very helpful. The subjects believed that:

> "I realised how much I hurt my family", "I can see the mistakes that I have made, and I am still making mistakes towards loved ones. I try to avoid it whenever possible", "I don't accuse my wife. I try to help my son so that he feels he is important for me", "I yell at the children but far less often, I don't call them names, and I don't spank them", "I try not to pick a fight with my husband", "Now I know that by frequent crying I blackmailed him, and I am trying to avoid it now."

Patients with decreased fear of uncontrolled disclosure that they were the aggressors were increasingly encouraged to tell the truth about their lives, about being both the victim and the perpetrator. Motivation grew to make changes in life, especially in order to build healthy relationships with loved ones. The patients wondered how to apologise and make amends to those who were wronged.

Insight into the ongoing existing relationships and learning to construct creative relationships with others

Eighty-four (88%) people were learning to consciously choose constructive relationships in life. It was another healing factor along with learning to build adult relationships with parents and life partners, engaging in talks in order to solve the problems (instead of escaping from them) and establishing personal borders.

> "I tried to protect myself from my parents. I didn't engage in other people's problems. I isolated myself from the people who threatened me. I refused any discussion about my parents", "I broke off contact with my mother", "I needed to determine my own boundaries and I asked my husband to abide by them."

People have learned that conversations solve problems and should help to establish borders; one should avoid threatening people as one obtains new ways of behaviour in order to create more satisfying, safer relationships with others.

Learning to build oneself now and in the future

Ninety-two (97%) people were of the opinion that they had learned to build themselves up: "I took my life into my own hands". Learning to draw conclusions from one's own actions as well as from problems and mistakes the patients had committed gave them feedback concerning further actions. Some of them at some point of recovery felt fear that if they did not engage themselves in therapy, they would not be able to introduce changes into their lives.

> "Eventually I was desperate to be in better condition", "My stubbornness pushed me forward and the fear that if I do not do anything, my development will be arrested, I want it to be better and I know that I am the only person who can help myself", "I thought about the fact that I don't want to be stuck in the mud anymore. I didn't want to go back to depression. I knew that I have to act."

They gained the knowledge that they have "the right to live their own lives" and can take care of themselves. Acquiring the skills of drawing small pleasures from life was important, noticing one's needs and satisfying them, pleasing oneself with small things such as sitting in the armchair and reading a book, playing sports or giving oneself the right to do nothing. Participants wrote:

> "I became aware that I have the right to my own life, my own decisions, to call a spade, even when it is difficult", "I am learning to reach my own needs and make choices in accordance with them, starting from whether I want to go to the cinema to decisions concerning my choice of profession. Thanks to this I feel more joyful and peaceful", "I am learning to please myself with small things such as time for a cup of tea or going to the cinema as well as those more important ones such as everyday jogging in order to acquire a better physical condition. I have more energy and I am more important for myself."

Learning how to take care of our inner child, give him or her warmth, support, safety, feeling that he or she counts were important in building oneself. It was connected with strengthening one's value and building trust in oneself. Finally they learnt to make choices, to plan and set objectives.

> "I think I like myself. I allow myself to make mistakes. I can ignore them", "I am able to express myself and ask others to respect my needs."

Learning to build activated the ability to draw information from one's own actions, energy, joy, peace, strength and internal power. It enhanced

one's self-esteem, helped to build self-confidence, make choices and set objectives for the future.

Factors increasing the effectiveness of changes and growth in psychotherapy following childhood trauma

During the process of recovery it was helpful to recognise the mechanisms which sustain difficult states and life problems, learning to cope with them with the use of phenomena activating the resources and build mature strategies of problem solving applying newly acquired skills. Gained changes and growth appeared across such domains as: mental and emotional changes of a person; more real perceptions of past and contemporary events from life; their activity in relationships with participants of the group as well as with persons from their environment; a greater appreciation of life and a shift in priorities; a greater sense of personal strength and recognition of new possibilities or paths for their lives.

On a personal level

On a personal level the phenomena that facilitated extracting resources included expanding the awareness of one's life and in relation to that gaining a more accurate picture of what happened in the past as well as noticing past and current problems are the consequence of their traumatic childhood, "… consequences of qualities, properties and behaviours acquired in childhood". It was necessary to reveal difficult events from one's past in the presence of other supporting group members as well as to experience lack of consent for denying what happened in the past. It diminished cognitive disorders concerning traumatic facts from the person's life and constructed conviction that these memories were true. A real assessment of the perpetrator's active and passive behaviours was healing and related to becoming aware that they are guilty and responsible for used violence. Conferring real meaning on the past enables insight into one's thusfar renounced feelings. They set themselves free from irrational shame, guilt and responsibility. "I feel relieved from responsibility for what (violence) I haven't done". There was a gradual release (catharsis) of fear, sorrow, and anger, the end of redirected or passive aggression. They learned to accept and express feelings in a constructive way, first in the presence of people from the group and afterwards in their own environment. Another benefit was learning to increase control of one's own feelings and behaviours following from that, as well as to make

choices. The frozen energy now giving the strength to act was activated. A decision was made that in order to reach something and build, one must take risks. Finally, it was very important that in order to recover it is necessary to make oneself aware of the fact that one is a perpetrator to others, gradual resignation from using emotional, physical, sexual abuse (e.g. violations of intimate boundaries) and establishing healthy present relationships with one's children, partner, friends or siblings. A healing factor was becoming aware of what kind of person one is and what one's identity is. Building oneself and one's authentic "I", a person gets to know the needs and desires as well as motives of their behaviour better. They feel their value more clearly along with their right to love, friendship, happiness and others' attention. Also, to experience joy and be "happy with small things". Participants find support in themselves and build self-respect. They build the present and plan the future.

At the group level

At the group level it was important to become aware of the quality of interpersonal functioning in the group and gradual learning of new ways of establishing relationships which are used to build contacts in the person's environment. Among the healing group factors, the influence of such phenomena was observed as similarity, and a sense of belonging, dissimilarity and mutuality, reciprocity and support. Initially it was important to build and experience the feeling of similarity, which diminishes experiencing uniqueness of one's misery and problems. It also helps to build the feeling of membership in a group of people who are in a congruent situation. This ensures safety and trust. Mutuality and support in a therapeutic group are important, consisting of listening to others and sharing one's experience(s) and feelings. This conveyed important information to people who were afraid to ask for help, who thought they have to cope with their problems themselves and felt despair that nobody needed them. These people found that others want to be helpful, they are needed by others in the group and they can rely on one another. When the feeling of safety and trust increases, a very important factor which enables healing results in the diversity and otherness of life stories and behaviour of people in the group as well as feedback offered to one another. Such information was not only supported but was also criticised in a constructive way. These phenomena facilitating recovery diminish the fear of being assessed by others and show trauma from various perspectives. The therapist and persons from the group are a "model" teaching new ways of behaviour and a "mirror" showing another person's behaviour.

This leads on one side to more courageous functioning among people and on the other, it confers real meaning to traumas experienced in one's life. Thanks to interpersonal learning one meets new ways of acting in relationships with others, different from the currently existing ones and can test them in safe conditions.

A person who is not able to, or cannot, obey the described principles built in the group has a problem with going through the process of recovery. From the research it also follows that when compared to other factors in subjective reception of the group participant, the therapist plays a relatively minor role in the recovery process.

Clinical Applications
Planning of the therapeutic process

What conclusions from the research of factors that impede or facilitate recovery can be drawn in relation to their influence on objectives set by the therapist concerning the therapeutic process and introduced methods?

Objectives

The important objectives of a psychotherapeutic group to be implemented at the individual level relates to revealing the secret while sharing her/his history of life and problems resulting from that story, in the presence of others from the group, who experienced abuse (Table 7-3). A person has to learn to look at the same stressful situation from various perspectives; to change the meanings conferred to abuse into the real ones, based on facts reminded. It is to lead to expanded awareness, recognise thoughts, feelings and needs that have been renounced so far, to make past events real and reconstruct one's faith in one's own intuition. The realisation of repressed feelings, following from traumatic events is important. The goal of the therapy is to reveal that one is a perpetrator of abuse, to resign from abuse being used and learn constructive behaviour towards children, partners and other people. Then the person is recognising and constructing one's identity, the authentic "I" and setting objectives in one's life. All the changes are to be projected in the future. Forgiving the perpetrators is not the purpose of the therapy.

Table 7-3. The objectives in the therapeutic process on an intrapersonal level into the factors affecting recovery

Disclosure of the secret, talking about her/his life history and problems of the past and current life, in the presence of other survivors of abuse
Developing a coherent narrative
Looking at the same situation from various perspectives
Changing the meanings conferred to abuse into real ones, based on facts
Expanded awareness
Recognising thoughts, feelings and needs
Making events real
Reconstructing trust to one's own intuition
Abreaction from suppressed feelings (experience of repressed feelings resulting from traumatic events)
Revealing that one is a perpetrator of abuse, and resigning from abuse used
Learning constructive behaviours
Recognising and constructing one's authentic identity
Setting objectives in one's life
Setting values in one's life
Pacing into the future

Source: own research, 2010.

Because people who were traumatised in childhood have problems with building attachment, a therapeutic group helps in achieving objectives related to the interpersonal functioning of a person (Table 7-4). People learn relations with people from the group and transfer these skills to their environment(s). They need to learn to express their feelings in a constructive manner and to respect themselves and others. People deal with others' shame. A person gains the feeling of being needed and helpful for others, learns cooperation, to take and give support as well as honestly and openly provide feedback, using similarities and differences between people. Feeling of similarity to other people reduces the feeling of the uniqueness of one's own misfortune and insolubility of problems in favour of affiliation to a wider group of people in the same situation, coping with trauma. Different views of life situations provide knowledge of how to cope with the problems or fear of not being accepted in another way.

Table 7-4. The objectives in the therapeutic process on an interpersonal level, based on own research on the factors affecting recovery

Learning to establish relationships with people in the group
Transferring these skills to the environment
Dealing with one's shame in the presence of the group
Accepting and providing support
Providing an honest and open feedback
Constructing the skill of co-operation
Using similarities and differences in establishing relationships with people
Gaining the feeling of being needed and helpful for others (altruism)
Learning to express one's feelings in a constructive manner

Source: own research, 2010.

It is important to introduce principles concerning the forms of relationships with people from outside the group, especially with family members both during and after the therapy. Participants receive support from the people outside the family, with whom they discuss the rules of this contact. During the therapy it is helpful not to talk with persons not belonging to the group about its course, the emotions released, the problems tackled and the effects gained. Contact with destructive relatives is limited or totally suspended for the time of the therapy. Permanent contact with them causes constant recurrence of destructive mechanisms. Stressful situations are avoided to as great an extent as possible. The introduction of adaptive strategies is aimed at solving problems: striving to be together with other people; searching for acceptance in order to satisfy the need of safety. In this way therapy participants have a chance to learn how to use mature defensive mechanisms based on altruism, humour and distance from themselves. These adaptive strategies are to be practised during participation in the group therapy and introduced into daily life.

Fundamental rules concerning the forms of relationships with people from the group emphasise that all group members must be respected and that each of them makes their own decisions concerning the time, form and amount of their activity in the group. In order to cope with one's shame in therapeutic groups a fact must be observed that people have a sense of self-esteem and should respect the esteem of others. They can get irritated (without becoming aggressive) when their own honour or that of others is violated.

Approaches and methods

In relation to the presented purposes following the analysis of factors impeding and facilitating recovery one must consider psychotherapeutic approaches which will contribute to their implementation (Table 7-5).

In therapeutic work with persons who suffered from chronic interpersonal trauma in childhood (physical, emotional, sexual, substance abuse), an approach is adopted which assumes that abuse, including sexual abuse of children and adults, is a fact. If a person speaks about it, this is not her or his imagination, unsatisfied needs or projections. A perpetrator is always responsible for the violence (Brickman, 1984; Brownmiller, 1975). No approaches are applied which would accuse the victim or ignore the consequences of abuse. In applied methods abuse is named as it is, without minimising the behaviour of the perpetrator or diminishing its influence on the victim. The perpetrator's behaviour is assessed (Herman, 1992).

Applied psychotherapeutic methods deal with the quality of one's life and not with the reconstruction of a family. They do not strive to recreate traditional roles according to which the father is to be dominant, the mother is to be subordinate and helpless and the child is to respect parents irrespective of what they do.

Therapy should be conducted separately for the survivors and perpetrators from one family. Therapists do not conduct a system of therapy in the family where abuse takes place because a harmed person is deprived of a chance to react in accordance with his/her own feelings, intuition and thoughts. Sufferers are emotionally and cognitively helpless in the face of the perpetrator sitting next to them and still manipulating the child and the whole family (even only by means of their gaze). First, each person participates in individual therapy: the aggrieved person in order to build their strength and real perception of reality, the perpetrator to admit the guilt and assume responsibility for harm done, to learn how to control their behaviour (fantasies) and to stop manipulating the victims. Only when a harmed person expresses their fully conscious consent it is it then possible for a general meeting of family members to take place.

Especially during the initial stages of the therapy it is important to use narrative methods which allow the suffered harm to be spoken about loudly, not the ones based on work with the use of symbols without the content. The process of revealing the past, sometimes for the first time in their lives, allows disclosure of difficult events and "breaking through" the mechanisms of denial and silence imposed by the perpetrator. During a recall of the past we avoid methods based on trance, hypnosis or other suggestive techniques. Instead, we adopt methods which allow the

individuals to consciously regain control. The loud story-telling methods reveal the secret, liquidating the destructive mechanisms of silence and denial of the violence used by the perpetrator and eliminating the subordination of individuals.

Dance and movement are used instead of methods based on touching the body. If a safe touch is to take place, it is introduced in further stages of therapy, after detailed recognition of suffered abuse (e.g. sexual) and its consequences. The patient's consent is necessary so that he or she learns to control the situation and determine his/her personal borders.

A common assumption in psychotherapy has been that change is gradual and linear (Collins and Sayer, 2000; Hayes, Laurenceau, Feldman, and Strauss, 2007). The described approach assumes that psychotherapy of the traumatised persons runs mainly in a discontinuous and non-linear manner. It concerns post-traumatic internal growth and dynamic ways of running psychotherapy. An important predictor of transition is a type of discontinuity called critical fluctuations (Kelso, 1997; Schiepek, Eckert and Weihrauch, 2003). Due to a co-operation of factors which both hinder and facilitate the healing process in this period of fluctuation, the system is destabilised but also open to new information and to the exploration of potentially more adaptive configurations. It oscillates between old patterns that are less viable and new patterns that are emerging, until the system settles into a new dynamically stable state (Kelso, 1997; Vallacher et al., 2002). Traumatic events and major life challenges can cause significant emotional arousal and distress and shake up a person's worldview to leading to dramatic life transition, called post-traumatic growth (Linley and Joseph, 2004; Tedeschi and Calhoun, 2004). Some individuals can positively re-interpret, make meaning of adversity, and after a period of destabilisation and distress, be transformed by their struggles with traumatic life events. The factors facilitating recovery during psychotherapy provide a stable environment and increase patients' readiness and resources for change, but they also introduce a variety of interventions to interrupt, challenge, and destabilise old patterns. During the non-linear, dynamic processing of change one moves forward and backward to complete beginning, middle and end.

Finally, the application of methods which will enable the conscious creation of present behaviours and projection of changes made into the future is important. Individuals learn to use new, more adaptive mechanisms of functioning; to maintain improved conditions, in order to be grounded, to store difficult emotions in themselves, to establish borders and sustain internal harmony as well as to strengthen the feeling of their bodies. They are not able to maintain the changes by themselves and after

some time they will come back to behaviour based on the primary mechanisms of coping with their lives, especially with stressful situations. Methods that will support the changes, plan the future, place one's own objectives and implement them are necessary.

Table 7-5. Recommended and not recommended rules for methods which implement the objectives of psychotherapy following the analysis of factors impeding and / or facilitating recovery

Recommended approaches	Not recommended approaches
Recognition that violence exists. If a person speaks of abuse suffered in their childhood it means that it had taken place.	Children and women fantasise on the theme of suffered violence and project their needs.
Recognition of a perpetrator's responsibility. The perpetrator is the only one responsible for abuse.	The child and woman are responsible for the abuse, as they e.g. seduce; they should apologise to the perpetrator and thank him or her for care.
Conduct of the offender is assessed.	Do not judge the perpetrator.
Abuse hurts. Suffered abuse does not bring benefit to a person, in fact it can diminish their capabilities.	It is acknowledged that abuse has taken place, but it is seen as natural even bringing benefit to the child (he grew up as a decent man because he was beaten).
One act of abuse is abuse.	One act of any form of abuse is not abuse.
A single act of violence hurts. A person incurs the consequences even when he/she suffers from abuse only once.	It is deemed that abuse has taken place but the consequences suffered by the child / woman as a result of it are ignored.
Traditional roles are a risk factor for abuse. A person can object to the roles existing in their families; traditional roles deeming a man as the ruler and a woman as a subordinate are a risk factor for the occurrence of abuse.	It is important to build traditional roles (often based on religion) and on family principles.
Therapy is conducted separately for the survivors and perpetrators from one family. Perpetrators manipulate family members e.g. with their sight, mimicking, body – they do not have to say anything.	Using the family system therapy for all family members, in families where abuse has taken place, without considering the dynamics of abuse and manipulation used by the perpetrator.

Revealing the secret and liquidating mechanisms of silence. The loud story-telling methods reveal the secret, liquidating the destructive mechanisms of silence and denial of abuse used by the perpetrator and eliminating the subordination of individuals.	At the stage of remembering the traumas using symbolic techniques "without content" without telling about abuse suffered, using hypnosis.
Narrative methods to regain internal control. Narrative methods in which a person feels s/he is regaining a conscious internal control over what s/he is saying and how s/he is saying it, when s/he reveals facts from his/her lives and how s/he interprets them.	Using hypnosis and other suggestive methods at the stage of remembering trauma, significantly limiting the control over the pace and content of recall and expression.
Non-linear and dynamic processing of change. Non-linear processing for moving forward and backward to complete beginning, middle and end. Non-linear emotional arousal and distress leading to life transition.	Change is gradual and linear. Intra-individual variability has been viewed as an error.
No touching. Movement, dance without touch; safe touch in further stages of therapy, after diagnosing the person's life and problems.	Techniques of working with the body and touch without adequate diagnosis of the individual's mental condition and earlier preparation.
Further development. Learning and exercising new behavioural modes such as e.g. educational skills or assertiveness.	Ending the process of therapy at the stage of insight into the past, without further development.
Transferring introduced changes into the future.	Ending the process of therapy at the stage of insight.

Source: own research, 2007, 2010.

"Second line" methods are introduced after the termination of basic psychotherapy. They include meditation and yoga, visualisation and relaxation. They enhance the feeling of strength, joy and pleasure, as well as helping to comfortably experience emotions and all inner experiences.

It was found that, based on the analysis conducted, certain kinds of strategies (and techniques resulting from the strategies) seem to be most effective in the treatment of people who have suffered interpersonal

trauma. All the strategies described below are to be put in order in a person's internal and external life to avoid repeating previous chaos. These are the strategies:

- Relational, building a secure attachment between therapist and patient (therapeutic bond), between people in the group and resulting in building relationships with people from outside the therapy;
- Narrative, enabling a person to speak about his/her life experiences, focussing on insight to understand the meaning of traumatic events;
- Retrospective and exploratory, affecting the process of memory, recall and disclosure of their harm;
- Changing meanings (making it real) to get a realistic meaning of the events of life. The research has shown that insight into the past, conferring meanings and looking from a new perspective is one of the most important factors in recovery;
- Rebound and overworked emotions aimed at regulating emotions (e.g. re-experiencing, avoidance, arousal);
- Changing beliefs (cognitive restructuring) and eliminating cognitive distortions that destructively affect mood and behaviour;
- Confrontational, directed at opposing the views and behaviour of abusive people, presenting their own views, in the presence of witnesses or without them, in an atmosphere of respect. Having space to make a choice and find their own solutions, with hope for an internal change and opening a new perspective;
- Coping with stress and relaxation strategies;
- Working with values for establishing the important things in life;
- Reaching resources focused on building resources and development (metaphors, trans);
- Learning new behaviour (e.g. assertiveness, child care);
- Pacing in to the future to design the changes in the future;
- Planning and goal setting for execution in the future;
- Dealing with crises in life.

These strategies in various configurations are described in many approaches to the therapy of traumatised persons. In this paper they are arranged in a sequence, enabling a person to "dispose of" a past, reduce the influence of traumatic symptoms in the present life, build a strong "me", shape a good life in the present and design the future.

Summary

In order to achieve these goals, the therapist has to take care of the selection of people to the group in such a way that they can derive mutual benefit from being with one another. It is important to select persons with both similar and different stories of life. Thanks to similarities one gains the feeling of being a member of the group and diminishes the feeling of being exceptional. The differences provide various points of view, allowing access to new perspectives and conferring constructive and rational meanings on one's experiences. They also allow people to learn from their relationships with others who have a different way of functioning and to learn how to confront difficult persons. At the beginning of the therapy, similarities are important; however for a person to develop diversified resources throughout the therapy, diversification is also needed. Differences might actually be more important. In subject literature I have not encountered such a perspective on factors activating changes and building resilience. It follows from the fact that it is important that there are persons in the group who suffered from various forms of abuse (e.g. not only adult children of alcoholics) as well as both victims and perpetrators. Most of the objectives presented have already been described in subject literature, yet so far nobody has pointed to the fact that their implementation is connected with factors facilitating recovery. Such a description allows an understanding of their deeper sense and we may plan ways for them to gain in a wise way.

CHAPTER EIGHT

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR): AN INTRODUCTION

MARILYN I. KORZEKWA

Eye Movement Desensitisation and Reprocessing (EMDR) is a psychotherapeutic approach to treating symptoms caused by disturbing or traumatic events. Examples of such events include combat stress, assaults, natural disasters, and upsetting childhood events. EMDR is a complex method that incorporates aspects from psychodynamic, cognitive, behavioural, body-based and client-centred therapies.

In 1987, psychologist Francine Shapiro discovered, while walking in a park, that her voluntary eye movements (left-right) reduced the intensity and validity of negative, disturbing thoughts. After extensive testing, Shapiro developed a comprehensive eight-stage protocol for the treatment of psychological trauma (Shapiro, 2001). The first published research study examined the efficacy of EMDR in treating traumatised Vietnam combat veterans, and victims of sexual assault. EMDR significantly reduced the symptoms of post-traumatic stress disorder (PTSD) in these research subjects (Shapiro, 1989).

Although EMDR's efficacy in the treatment of PTSD is well-established in numerous research trials, positive therapeutic effects with EMDR have also been reported in a wide range of pathologies. The disturbing event underlying the pathology does not necessarily have to meet criterion A for PTSD as in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; American Psychiatric Association [APA], 1994). In other words, the event does not have to involve actual or threatened death or serious injury in order to be amenable to treatment with EMDR. Furthermore, although EMDR was originally developed with lateral eye movements as a core feature of the method, other forms of bilateral stimulation are now being used. These include alternate right-left auditory tones and taps on the client's hands.

The Adaptive Information Processing Model

Shapiro believes that the brain is oriented towards health and has the ability to achieve healing. The adaptive information-processing (AIP) model postulates that there is an innate information processing system in the brain that "metabolises" new experiences. Incoming sensory information is integrated and connected to related information that is already stored in memory networks, allowing us to make sense of our experience. This is "adaptive resolution". Normally, this information processing occurs during thinking, talking, or dreaming (Shapiro, 2001). For example, a conflict with a playmate ("me first") and its resolution ("we can share") is accommodated and assimilated into memory networks having to do with relationships and conflict resolution (Solomon and Shapiro, 2008).

Traumatisation has been described as a disruption of the inherent information processing system that normally leads to integration and adaptive resolution following upsetting experiences (van der Kolk and Fisler, 1995). In trauma, because of the strong emotions involved, the memory is "frozen" in its state-specific form and its neuro-physiological network is isolated. This traumatic network is unable to connect with memory networks that hold adaptive information. In other words, the natural information processing system has malfunctioned.

The AIP model postulates that dysfunctionally-stored traumatic memories lead to symptoms such as persistent intrusive thoughts, nightmares, negative emotions, negative beliefs about self, unpleasant body sensations, and maladaptive responses. According to the AIP model, conditioned responses and negative self-beliefs are not the cause of present dysfunction; they are seen as symptoms of an unprocessed earlier life experience. Past events retain their power because they have not been assimilated over time into adaptive networks (Solomon and Shapiro, 2008). For example, a conditioned response such as a fear of dogs might be related to a memory from the age of 2 of a big dog growling at a toddler. A negative self-belief such as, "I am not good enough", might be related to a memory from the age of 10 of receiving a beating because the potatoes were not peeled when the mother returned home.

According to the AIP model, EMDR exerts its therapeutic effects in a number of steps. First, traumatic material is specifically targeted in the EMDR protocol. Then this "frozen" material is processed (desensitised) in a focused manner. EMDR also activates neurophysiologic networks in which appropriate and positive information is stored. This allows

connection of the traumatic material to positive networks. This leads to the resolution of the traumatic memories.

What Happens during EMDR?

During EMDR, the therapist works with the client to identify the specific problem that will be the focus of treatment. Utilising a structured protocol, the client describes a disturbing memory related to his or her presenting problem. The client is asked to identify the image, cognitions, emotions, and somatic distress associated with the traumatic memory.

The client is then asked to hold the image, negative cognitions, emotions and sensations together in his/her mind. While the client is engaged in eye movements or another form of bilateral stimulation, he or she is experiencing various aspects of the initial memory. The therapist pauses the eye movements or bilateral stimulation at regular intervals to ensure that the client is processing adequately on his or her own. The therapist guides the process, making clinical decisions about the direction of the intervention.

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The client may process the memory at cognitive, affective, and/or somatic levels over the course of a given session. The goal is the client's rapid processing of information about the negative experience, bringing it to an "adaptive resolution." This is defined as a reduction in the symptomatology, a shift in the negative belief to the client's new positive belief, and the prospect of functioning better (Shapiro, 2001).

Not only does EMDR look for cognitive shifts of concepts relating to responsibility for the trauma in the past, but also the client is asked to consider positive cognitions around safety in the present and desired thoughts and actions for the future.

EMDR treatment may involve one to three sessions for single incident traumas. Childhood origin trauma or more complex problems may require treatment of a year or longer.

For many clients, EMDR provides more rapid relief from emotional distress than conventional therapies. Several research studies have shown

that the number of treatment sessions required to resolve a trauma with EMDR is lower than in cognitive-behavioural approaches. The bilateral stimulation in EMDR triggers a parasympathetic relaxation response that assists with the client's ability to tolerate trauma work. EMDR is also a client-centred approach in that the therapist facilitates the stabilisation of the client's own brain's innate healing mechanism (i.e., information processing system). The EMDR model also acknowledges the physiological component in emotional difficulties and strives to reduce the client's distress level to zero by the end of the session (EMDR Presentation Packet, 2007).

Before being considered for EMDR treatment, clients require careful assessment for suitability, readiness for trauma work, and safety factors (such as emotional and environmental stability, affect tolerance, and the absence of unstable medical problems, substance abuse, suicidal or homicidal ideation, self-mutilation, and severe personality disorders). Failure to identify high levels of dissociation can prematurely break down the clients' defences and flood them with emotion that he or she may not be able to handle. The therapist should also be experienced in treating the type of problem to be targeted with EMDR and the therapist should have completed the EMDR training workshop. The 8 stages of EMDR treatment comprise:

1. Client History and Treatment Planning
2. Client Preparation
3. Assessment
4. Desensitisation
5. Installation
6. Body Scan
7. Closure
8. Re-evaluation. (Shapiro, 2001).

The details of the protocol are covered in EMDR training workshops.

A childhood trauma case example: The client is a 35-year-old woman who reports she was sexually abused as a child by her alcoholic father. Her presenting problems include nightmares, flashbacks, avoidance of trauma-related trigger situations, hyper-vigilance, guilt, self-hatred, mistrust of others, and feeling hopelessness and helplessness. The "picture" she has chosen to focus on is of her father appearing at the bedroom door late at night and telling her to take off her clothes. She is about 5 years old. He smells of alcohol. Her negative cognitions about the memory include: "It was my fault. I'm bad. I'm always vulnerable and in danger. I have no

control." The positive cognitions she would like to believe about this memory are: "I did the best I could. I'm a good person. It's over. I'm safe now. I have choices and a reasonable degree of control now." Her emotions when thinking about the memory are fear, sadness, and anxiety at a level of 8/10. She feels tension in her neck and shoulders, knots in her stomach, and palpitations in her chest.

Possible information processing shifts related to concepts of responsibility, safety, and choices are:

1. Responsibility: The client recognises that she was an innocent child betrayed by the person who was supposed to love and protect her. She mourns the loss of her "innocence" and expresses anger towards her father for the first time. She experiences a greater sense of compassion for herself and an increased sense of self-respect as a survivor.

2. Safety: The client experiences a dramatic decrease in her distress level as her memories of abuse are desensitised and reprocessed. She recognises (at a cognitive, affective, and somatic level) that the abuse is truly over and that her father can no longer hurt her.

3. Choices: The client begins to acknowledge the choices she has made in her adult life (establishing boundaries with her family of origin, connections with supportive people, and a commitment to therapy). She begins to consider new possibilities for the future. She expresses a desire to initiate new friendships and activities and acknowledges a renewed sense of hope and confidence (EMDR Presentation Packet, 2007).

How Does EMDR Work?

Theories as to why EMDR works are currently only speculations - and will probably remain so for many years. Fortunately, we do not have to know why a demonstrably effective treatment works before using it (Shapiro, 2001).

In PTSD, there is a dysfunction of episodic memory. The episodic memory system, which is located in the hippocampus, stores "episodic" memories, the memories of actual events in our lives. Episodic memories are encoded in the left hemisphere but retrieved in the right hemisphere. The traumatic memory is inappropriately, incompletely or incoherently encoded at the time of the trauma. The dysfunctional episodic traumatic memory then intrudes on wakefulness with flashbacks and sleep with nightmares (Stickgold, 2008).

Recovery from trauma depends on the processing of traumatic memories from their episodic form into general semantic memories. The semantic memory system, which is located in the neo-cortex, stores

general semantic (verbal) information. Semantic memories are encoded and retrieved in the left hemisphere. There is evidence in PTSD of dysfunction in the inter-hemispheric connection and a smaller corpus callosum. Thus, in PTSD, processing of traumatic memories from episodic into semantic memories is prevented (Propper and Christman, 2008).

Stickgold, a sleep researcher, suggests that EMDR may help in the treatment of PTSD by activating the memory processing system similar to what occurs during rapid eye movement (REM) sleep. The rapid eye movements during sleep facilitate the making of previously unrecognised connections between apparently unrelated memories (Stickgold, 2008). EMDR repetitively redirects attention, which activates brain systems similar to that of RE M sleep. Any alternating stimulation (eye movements, tapping, or sound) activates these systems by forcing the brain to constantly reorient attention to new locations in space. In this manner, EMDR can 'push-start' the broken-down REM machinery that is required for the brain to effectively process traumatic memories.

Two other theories contribute to the above mechanism. Horizontal eye movements (2 cycles per second) have been shown to induce a state in which the accuracy of episodic memories is improved and the amount of inter-hemispheric interaction is increased (Propper and Christman, 2008). There is also an “investigatory reflex” that results in a relaxation response, when it is clear that there is no threat. The “investigatory reflex” may be stimulated by bilateral alternating stimuli (MacCulloch and Feldman, 1996).

Brain Activity Scanning and EMDR

SPECT Scanning: Six subjects with PTSD were asked to recall their traumatic memories during SPECT (Single Photon Emission Computed Tomography) brain activity scanning before and after three sessions of EMDR treatment. After EMDR treatment, two areas of the brain had increased activation compared to before treatment: the anterior cingulated gyrus (which differentiates real from perceived threats; an increase in activity signifies reduced hyper-vigilance and the ability to react appropriately to current threats) and the left frontal lobe (which processes information, so sense is made of the memories [Levin, Lazrove, and van der Kolk, 1999]).

There were two studies of resting SPECT scanning before and after EMDR:

1. Six police officers with PTSD who received 10 hours of EMDR (Lansing et al., 2005) and

2. Two PTSD subjects who received 6 sessions of EMDR (Oh and Choi, 2007). Results revealed that post-EMDR, compared with pre-EMDR; there was an increase in perfusion in the left dorso-lateral prefrontal cortex (working memory and cognition; logic) and a decrease in perfusion in other brain lobes and areas involved with traumatic imagery and emotion. This is consistent with an increase in logical over emotional reasoning. In the second study, the SPECT scan showed a change from a PTSD pattern pre-EMDR to an almost normal pattern post-EMDR.

Functional MRI: Functional magnetic resonance imaging (fMRI) was carried out on a single subject during an EMDR session. The improvement with EMDR paralleled a number of brain changes which represented the recruitment of a large network of cortical neurons (Richardson et al., 2009). Specifically, during EMDR, there was an increase in ventro-medial prefrontal cortical (which links sensory and emotional parts of memory) blood flow and a decrease in the right lateral frontal lobe, right posterior cingulate cortex and right para-hippocampal gyrus blood flow.

Are the Eye Movements Critical to the Efficacy of EMDR?

EMDR with eye movements is slightly better than EMDR without eye movements; however results in early studies were not statistically significant. These studies are flawed (insufficient number of sessions, inadequate statistical power, and failure to use the entire EMDR protocol). However, when EMDR protocols using a fixed gaze have been compared with the same EMDR protocol using eye movements, the results are inconclusive (EMDR Presentation Packet, 2007).

Several laboratory studies have demonstrated the following effects of eye movements on memories in “normal subjects”: reduced vividness of memory images and related thoughts; reduced emotionality related to the memory images; increased cognitive flexibility; and increased episodic memory retrieval (Propper and Christman, 2008).

Clinical subjects with traumatic memories demonstrated the following physiologic responses to eye movements (EM): decreased heart rate and blood pressure; increased finger temperature (signifying increased blood flow and a relaxation response); decreased skin conductance (relaxation); increased respiratory rate which synchronised with EM; and increased heart rate variability (signifying increased parasympathetic tone [Sondergaard and Elofsson, 2008]).

What is the Research Indicating the Efficacy of EMDR?

EMDR is accepted as an effective treatment for PTSD by the following organisations: the American Psychiatric Association Practice Guideline (2004); the U.S. Department of Veterans Affairs and Department of Defense (2004); the Cochrane Database of Systematic Reviews (2007); the American Psychological Association (1998); and the International Society for Traumatic Stress Studies (2000).

The following government agencies have accepted EMDR as an effective treatment for PTSD: the French National Institute of Health and Medical Research; the United Kingdom Department of Health (2001); the Israeli National Council for Mental Health (2002); the Dutch National Guidelines Mental Health Care (2003); and the Australian Centre for Post-traumatic Mental Health (2007) [EMDR Presentation Packet, 2007].

EMDR's efficacy in the treatment of PTSD has been established in well-designed randomised, controlled PTSD studies. The effect sizes were generally moderate to large effect sizes compared with the waiting list (Jensen, 1994; Wilson, Becker and Tinker, 1995; Rothbaum, 1997) and other treatments (Vaughan et al., 1994; Marcus, Marquis, and Sakai, 1997; Carlson et al., 1998; Scheck, Schaeffer, and Gillette, 1998; Chemtob, Nakashima and Carlson, 2002).

EMDR has been compared with the antidepressant, fluoxetine, and with placebo for 8 weeks in adult-onset and childhood-onset trauma survivors with PTSD. EMDR was more successful in achieving sustained reductions in PTSD and depression symptoms than either fluoxetine or placebo. At a six-month follow-up, 75% of the adult-onset as opposed to 33% of child-onset trauma subjects achieved asymptomatic end-state functioning (compared with none in the fluoxetine group). Results for EMDR were not only maintained at the 6-month follow-up, but the subjects' level of functioning increased (Van der Kolk et al., 2007).

Research Comparing EMDR to CBT/PE for PTSD

Six studies directly compared EMDR with cognitive behavioural therapy (CBT) or prolonged exposure (PE) PTSD treatment protocols. All the studies found that both types of treatment were effective. In five of six studies, EMDR was found to be more efficient than CBT/PE. EMDR either required fewer sessions, less homework, or the magnitude of the treatment effects were greater for EMDR at follow up (Ironson et al., 2002; Jaberghaderi et al., 2004; Lee et al., 2002; Power et al., 2002,

Rothbaum, Astin and Marsteller, 2005). In the sixth study, the reverse was found (Taylor et al., 2003).

Meta-analyses of PTSD treatments have concluded that EMDR is equivalent to exposure and CBT (Seidler and Wagner, 2006) but that exposure therapy uses one to two hours of daily homework and EMDR uses none (Davidson and Parker, 2001; Bradley et al., 2005) and that the more rigorous the EMDR study, the larger the dimension of the treatment effect (Maxfield and Hyer, 2002).

Is EMDR an Exposure Therapy?

Contrary to the theory behind flooding (which involves prolonged, sequential, directive, and anxiety-focused exposure), EMDR involves very brief (20-30 second) exposures. Clients are first asked to focus on the most distressing picture, and then they are allowed to free-associate within the memory or between memories. The client's attention is split between the feared stimulus and a motor task; he/she is allowed to use cognitive avoidance (skipping elements and image distortion). The focus can be on any distressing emotion. Importantly, EMDR is more effective for the emotions of shame and guilt than CBT. Also, in EMDR, corrective information can come from the client, not only the habituation effect or the therapeutic situation. In contrast with systematic desensitisation, EMDR is ineffective when paired with relaxation procedures (Rogers and Silver, 2002).

Reconsolidation of memory is a neurobiological process hypothesised to underlie EMDR's effects. The process of reconsolidation includes both assimilation (new information is integrated into existing cognitive schemas) and accommodation (existing cognitive structures are modified to accommodate the new experience). In EMDR, desensitisation is postulated to be the result of information processing, and not a result of habituation (Rogers and Silver, 2002). During EMDR, changes in cognition, affect and sensation appear to occur concurrently (Shapiro, 2001).

In conclusion, the evidence classifies EMDR as an information-processing therapy rather than an exposure therapy (Rogers and Silver, 2002).

Published case studies or case series of the effectiveness of EMDR in treating other problems

The usefulness of EMDR has also been described in PTSD following accidents, surgery, or severe burns, symptoms after a natural catastrophe, and crisis intervention. EMDR is effective in anxiety disorders: panic disorder and agoraphobia, choking phobias, simple phobias, blood and injection phobias, and test anxiety. EMDR is also effective in treating other problems such as the loss of a sibling, body dysmorphic disorder, body image anxiety specific to congenital anomaly and disability, conduct disorder, and restoring performance at work (EMDR Presentation Packet, 2007).

EMDR has also been shown to be effective in treating chronic pain (Ray and Zbik, 2002), complicated grief (Sprang, 2001), chemical dependency (Vogelmann-Sine et al., 1999), and complex PTSD (Korn and Leeds, 2002).

Conclusions

The efficacy of EMDR in the treatment of PTSD has been demonstrated in several well-designed, randomised, controlled studies compared with a waiting list, fluoxetine, CBT, and PE. Meta-analyses of the data suggest that not only is EMDR equivalent in efficacy to CBT/PE, but EMDR requires fewer sessions and less homework. Numerous organisations and governments around the world have accepted EMDR as an effective treatment for PTSD. Although the eye movements produce interesting physiological responses such as increased parasympathetic tone and a detached, distanced stance, studies that examine EMDR without eye movements are inconclusive about the role of eye movements.

However, EMDR is more than just eye movements; the treatment involves a comprehensive protocol. The client is carefully assessed for suitability and contra-indications, and subsequently the protocol is used to access the dysfunctionally stored traumatic information. The brain's innate processing system is stimulated using the protocol and bilateral stimulation (visuals, taps, or sounds) and this facilitates dynamic linkages to adaptive memory networks (Solomon and Shapiro, 2008). The body scan ensures complete processing and the cognitive reassessment of the installation phase promotes full integration of the gains. Brain neuro-imaging before and after EMDR treatment demonstrates a reduction in the activity of PTSD fear and imagery circuits and an increase in prefrontal

cortical logical, verbal processing circuits that parallels recovery from PTSD.

Clients find that their distress is relieved; their associations with the traumatic memory become positive, related cognitions become realistic and adaptive. Their transformation is often accompanied by global changes in their sense of self, others, and the world, and in behaviour and lifestyle (Maxfield, 2007).

Acknowledgements

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CHAPTER NINE

A GENERAL APPROACH TO THE TREATMENT OF POST-TRAUMATIC DISORDERS: THE CROATIAN EXPERIENCE

RUDOLF GREGUREK

Post-traumatic stress disorder presents an important medical and social problem in the Republic of Croatia with a prevalence of 10-30% depending on the population, mostly total victims of traumatic experiences during the Croatian War. Post-traumatic stress disorder, for Croatian medicine and the public in general is not just one of a number of diagnostic categories, it is much more than that. It is, one could say, something like war for itself, a kind of War Trauma. This kind of disorder in Croatia has become some kind of national particularity, and war created and is still creating new victims (Gregurek, 2000).

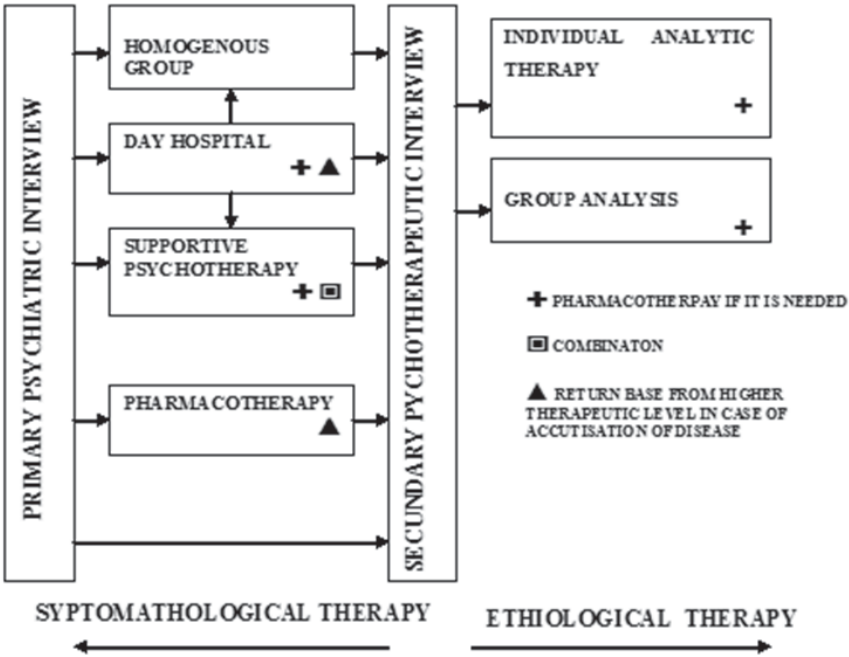
In the beginning of the 90s, knowledge about PTSD in Croatia was somewhat poor and medical textbooks on psychiatry only contained a few lines about that particular diagnostic category. That's why there are therapeutic approaches based on the experiences of psychiatrists and their ability to be specially educated as fast as possible, using various foreign literature. During those times we tried to combine our own psychiatric experience with theorised knowledge from overseas (Gregurek, 2002).

Therapeutic work, as well as direct experience of relationships with patients who had PTSD, motivated us to try to define our own therapeutic approach based on our experience or possibilities (one could say education) that psychiatrists in Croatia have. One particular motive was the fact that society stigmatised this kind of patients.

On the basis of our 15-year clinical experience in treating PTSD and detailed analysis of related literature our team compiled the proposed guidelines for treatment of PTSD. The established guidelines were independently developed and clinically proven at our clinic. Their essential feature is psychodynamic comprehension and an approach to the etiopathogenesis of PTSD, although it also applies to other

psychotherapeutic techniques (cognitive-behavioural, relaxation). The therapeutic approach is based upon structured clinical interview, but also complies with the principle of psychodynamic interview (Figure 9-1.).

Figure 9-1. Guidelines for psychotherapy – PTSD without comorbidity



Source: own research.

Primary psychiatric interview

The purpose of a psychiatric diagnostic interview is to gather information that will enable the examiner to make a diagnosis (Gregurek, 2002.). Having established a diagnosis, the clinician can then make predictions about the future course of a disorder and the likely response to treatment. As with all areas of medicine, treatment decisions are guided by diagnosis (Spitzer, 1990; Robins, 1981; Watson, 1991; Coltart, 1988).

A psychoanalytic interview is less concerned with establishing a diagnosis than with surveying psychological functions as they have evolved over an individual's lifetime. It describes personality structure in terms of ego strengths (including principal defence mechanisms, regulation

of drives, relationships with other people, and reality testing), principal psychological conflicts, and developmental history, with particular emphasis on early childhood (McWilliams, 1994).

The psychodynamic formulation is not intended to produce a diagnosis but rather to describe an array of psychological and adaptive capacities (Connors, 1997; Resnick, 1992; Wilson, 1989; Kean, 1992). These descriptions allow the analytic psychiatrist to formulate a theoretical model that explains current symptomatic behaviour and interpersonal or functional limitations. It serves as the template for the conduct of psychoanalytic therapy by anticipating unconscious intrapsychic conflicts and unacknowledged developmental arrests or delays.

The treatment of PTSD begins with a primary psychiatric interview, which a psychiatrist, the professional in the field of psycho trauma, conducts over two or three sessions, each lasting 45 minutes. The goals of the interview are:

1. To diagnose and to exclude other co-morbid conditions or disorders
2. To determinate symptoms and the advancemans' of disorder
3. To determinate the ego-capacity of the patient's personality

A therapeutic model is chosen on the basis of the primary interview, concerning any symptoms and the advance of the disorder, and the ego-capacity of patient's personality. Therapeutic possibilities - techniques put at the disposal of PTSD treatment could be divided in two basic groups – symptomatic and etiological.

Therapeutic approach according to symptoms

The therapeutic approach according to symptoms includes many therapeutic techniques, we split into two subgroups: A) pharmacotherapy; B) the superficial psychotherapy approach (suggestive, supportive, cognitive-behaviour, relaxation therapy, autogenic training, EMDR). This model included hospital therapy (in-patient and partial day hospital) and all models of counselling and self help PTSD patients groups. It is important to stress that, there is no excluding border curtailing other therapeutic approaches between these therapeutic models, and it was even possible to form different combinations and interactions (Caroll, 1992; Bradley, 2005).

The aim of the therapeutic approach according to symptoms is to relieve pain or even remove troubles and create a pre-morbid psychological equilibrium. The therapeutic approach according to

symptoms processes topics which are on the conscious symptom level: causes of behaviour, experiences and human relations. Relieving or removing symptoms can be achieved by using medicaments and their effect on the transmitter, deregulated by psychotherapy for the purpose of strengthening the ego. For the patient with a relatively weak ego this is the main purpose, and in the case of a patient with a relatively strong ego, which is only acutely decompensated as a result of bad outer influence, the aim of the treatment is to establish a natural balance. In this case the therapist takes over the function of the substitute ego, actually encouraging or criticising certain actions or even making decisions in some serious situations. The strengthening ego can focus on the demands of reality more successfully, and can withstand anxiety from the id and the superego.

Homogeneous Trauma Groups

Early in treatment, group psychotherapy is most helpful when groups of post-traumatic stress disorder patients are homogeneous. This type of therapy often occurs at an in-patient unit of a psychiatric hospital and is relatively brief. The processes could conceivably be conducted in out-patient settings as well. However, this early treatment stage is often chaotic and filled with crises, so the support of hospitalisation is desirable.

Sitting in a room with others who experience stress is the most powerful way for the patient to begin winning the battle against the sense of isolation and alienation that accompanies these disorders. Yalom (1985) referred to this concept as "universality." At last, the stress experiences are "speakable"; the notion that "going away" was a creative response to unspeakable traumatisation signals the beginning of the attenuation of the fear that has hovered in the patient's mind for years - the fear that he or she really is "crazy."

The group traversed a developmental process in which the primary issue was divided into three phases:

(1) making a connection with the group
(2) focusing on feelings of entitlement, and
(3) providing a period of resolution when feelings of sadness, pain, and loss were central.

Members of the group learn that talking helps, not only because it soothes but also because it illuminates cause and effect, thereby facilitating self-understanding and insight. Various alters and dissociative states were created to make psychological survival possible during the

traumatic experience. As the function of this defence becomes clearer, rationality begins to prevail and the aura of "craziness" starts to abate (Gregurek, 1998).

1. Short-term crisis intervention groups

This was successful for victims of disasters, shooting incidents, and other acute trauma.

The essence of the groups is:

1. To provide a place where people can feel safe from physical harm
2. To regain a sense of communality and interpersonal belonging
3. To work out exactly what has happened
4. To start giving voice to the meaning of the experience.

2. Self-help groups

Self-help groups focus on the development of serenity, which can be understood as a state of autonomic stability and of being at peace with one's surroundings. They promote interdependence by relearning to trust, by surrendering, by making contact, and by developing interpersonal commitments.

3. Time-limited homogeneous groups

The members undertake to be present for the duration of the group, usually 10 to 12 sessions, and the therapist asks them to specify a particular, realistic task that they will attempt to accomplish during that period; the therapist frequently gives them specific homework assignments. The members are actively encouraged to fully share their self-imposed tasks with the group (Weis, 1993).

Partial (day) hospital

Day treatment programmes provide short-term, crisis-stabilisation services as an alternative to in-patient care. Day treatment programmes serve the needs of patients with moderate-to-severe disorders who require interventions focused on improved level of functioning, skill-building, and disease management. Intensive out-patient programmes function as intermediate or step-up programmes from out-patient psychotherapy (Creamer, 2002).

Supportive psychotherapy

Supportive psychotherapy offers the patient support by an authority figure during a period of illness or temporary decomposition (Schwartz, 1984). It also has the goal of restoring and strengthening the patient's defences and integrating capacities that have been impaired. The goal of supportive therapies is the soothing or removal of difficulties and establishment of «pre-morbid» equilibrium. Supportive psychotherapy means a series of individual and group therapy techniques and their combinations, whose main characteristic is that they help patients to recover from some symptoms using the established capacities of personality and copying mechanisms. Supportive techniques don't enter into the etiology of symptoms and can be successfully combined with psychoactive drugs (Bryant, 1998).

Psycho-pharmacotherapy

The symptoms of PTSD could be linked with corresponding clinical conditions using clinical analogy (see Table 9-1). For example, reliving traumatic events as well as the symptoms of hyper-arousal, are followed by anxiety, and the symptoms of avoidance could be linked with depressive elements, even with social phobia. After a good clinical interview it is important to define if the symptoms of PTSD exist independently or are related to some other disorder. In the case of when patients have only PTSD symptoms, the pharmacological approach specified in the psychopharmacological algorithm for the PTSD treatment is recommended. In the cases of existing co-morbidity, including appropriate pharmacotherapy understanding dominant co-morbidity symptoms is indicated (Davidson, 2000; Alarcon, 2000; Brady, 2000; Friedman, 2000).

Table 9-1. Symptom – oriented adjuvant pharmacotherapy of PTSD

Dominant symptom	Clinical analogy	Focused therapy
Intensified arousal	ANXIETY	Benzodiazepines, buspirone, SSRI (selective serotonin reuptake inhibitors)
Reliving	ANXIETY (similar to generalised)	Antipsychotic drugs, atypical antipsychotic drugs, tryciclical antidepressants, SSRI, nafazodon, beta-blockers
Explosivity		Anticonvulsive drugs, atypical antipsychotic drugs
Nightmares		Benzodiazepines, nafazodon, ciproheptadine
Flashback	SIMILAR TO PSYCHOSIS	Antipsychotic drugs, atypical antipsychotic drugs, anticonvulsive drugs, lithium
Dissociation	ANXIETY	Benzodiazepines, buspirone
	SIMILAR TO PSYCHOSIS	Antipsychotic drugs, atypical antipsychotic drugs
	DEPRESSION	SSRI, tryciclical antidepressants
Avoidance	PHOBIA	SSRI, benzodiazepines
	DEPRESSION	SSRI, tryciclical antidepressants
Insomnia		Hypnotic drugs (benzodiazepines) Trazodone (well combined with SSRI)

Source: own research.

Etiological therapy approach

After this symptomatic therapy and control of symptoms, patients could choose etiological therapy. Then they attend a secondary

psychotherapeutic interview, conducted by a psychiatrist-psychotherapist, to evaluate that it is possible, bearing the symptomatology and the patient's personality maturity in mind. It is necessary to conduct this secondary psychotherapeutic interview before the patient is given any psychoanalytical (etiological) psychotherapy, regardless of whether the patient has been given any kind of psychotherapeutic treatment or not.

Etiological therapy includes psychoanalytical psychotherapy which can be either an individual or a group therapy approach (sometimes both). The aim of etiological therapy is to gain an insight into actions, attitudes and the perception of personality, by which the person partially changes. Changes do not appear on the level of behaviour, but the person becomes more mature, the ego responds to the environment in relation to principles of reality. Objective relations are enhanced and pathogenic defence mechanisms are weakened. The patient's subjective symptoms disappear or are relieved, which is the side-effect of the change in personality of a patient (McWilliams, 2004).

Individual analytical therapy

The aims of individual analytical psychotherapy are to recover the emotional aspects of early experiences and memories, as well as the emotional components of current relationships, and to achieve change in the anxiety response through processes such as reliving and catharsis (Schottenbauer, 2008). Individual analytical psychotherapy may be viewed as a long-term rebuilding and reconstruction of the memories and emotional responses that were embedded in the limbic system.

At the end of this therapy the patient can confront the conflicts and instead of suppression he can find more constructive solutions, or unfold his adjustment abilities.

Group analysis (Heterogeneous group therapy)

People whose reactions to early traumas have become integrated into the totality of their personalities are apt to repeat aspects of the trauma and defensive reactions to it in their relationships with other people. In heterogeneous, transference-oriented trauma groups, the social expressions of those trauma-related affects and cognitive schemata are inevitably expressed on a social level and become readily observable.

Long-term heterogeneous groups can be particularly helpful to people with previous individual therapy, where they had an opportunity to develop a language in which to identify their feelings and a basic curiosity

about how they themselves may contribute to their problems in interpersonal relationships (Nicholas, 1999; Gregurek, 1999).

Patients suitable for group analysis should have the ability to observe their own problems, the ability to react emotionally and the capacity for insight.

The group realises the environment, which enables the training of different roles. Members of the group alternate passive and active positions. Group conductors should encourage mutual support, but should also work out resistances, sometimes taking the active position, and helping the patient to work out the suppressed materials with other patients (Ford, 1997).

The therapeutic environment should be created in a way that enables individuals who are similar in some way to understand and feel with others, but are at the same time different enough so they can watch and help other group members from different perspectives and positions. The best group composition is if the members are similar in terms of ego-development and different in terms of interpersonal style.

Groups that focus on the relationships between the members allow new losses to be experienced as object losses with concomitant grief and sadness, rather than as narcissistic injuries with the accompanying feelings of helplessness, numbing, and vengeful rage. As heterogeneous trauma groups mature, they gradually make that transition. When that happens, the group members start accessing the full benefit of the strengths that traumatised persons have developed to survive catastrophic trauma.

The role of the therapist is to support group members in becoming independent. The therapist's function is in controlling, containing, and analysing the destructive, regressive part and in encouraging the healthy parts of the patient. With the integration of good therapeutic processes, the healthy parts of the patient gain control over his or her regressive parts.

In the beehive of group activity, the role of the therapist is to support members to become independent. However, a desire on the part of the therapist to ward off feelings of loss related to lessened dependency of members upon him may easily interfere with this role. At this stage, the therapist is very much at risk of feeling unimportant to the group. If the therapist cannot tolerate a complementary identification with members' somewhat abandoned objects, due to an overvaluation of the centrality of his role, then the therapist may become excessively active in an attempt to reclaim his former role, much like a mother who continues to prop the child up after the child has learned to walk.

Working with people who have been traumatised confronts therapists, as well as patients, with intense emotional experiences; it forces them to

explore the darkest corners of the mind, and to face the entire spectrum of human glory and degradation. Sooner or later, those experiences have the potential to overwhelm the therapists. Repeated exposure to their own vulnerability becomes too intense, the display of the infinite human capacity for cruelty too unbearable, and the enactment of the trauma within the therapeutic relationship too terrifying (Wilson, 1994; Gregurek, 2007).

The psychiatrist must be taught to think first about the whole person, and to appreciate that each one is interesting and unique, not simply a composite of symptoms that are used to make an ICD or DSM diagnosis and provide treatment according to a standard algorithm.

The ability to provide psychological help for a traumatised person demands the appropriate medical and psychological knowledge about normal and pathological reactions, but at the same time appropriate empathetic capacity and the ability to contain trauma.

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