Trauma Treatment:

Factors Contributing to Efficiency

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Edited by

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Cambridge Scholars Publishing

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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 Wysoczań ska 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).

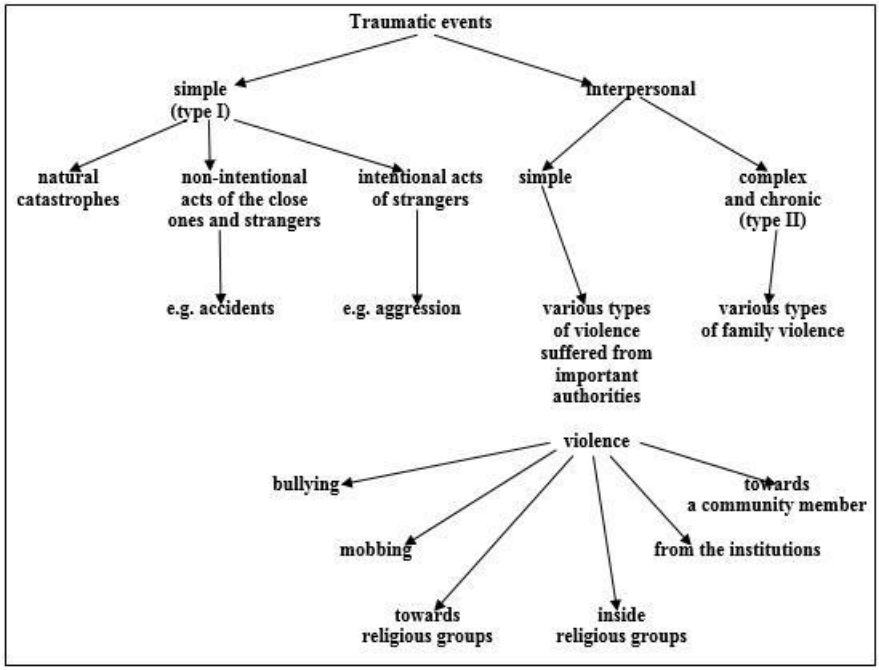
Table 1-1. Division of traumatic events according to fear and the sense of betrayal

- 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

CHAPTER SEVEN

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

AGNIESZKA WIDERA-WYSOCZAŃSKA

On the basis of a hermeneutical 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 Influence of their life situation on therapy	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 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 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 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	Increased trust in group members Trust that other people in the group want to 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	Courage to reveal Relief that one is not the only one Decreasing mechanisms

		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	of denial Decreasing cognitive distortions Increasing the feeling of acceptance
Relationship with the therapist and 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: -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	Increasing the feeling of safety in relationships with people in the group and from beyond the group Strengthening trust in others Strengthening security
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	Decreased fear concerning the past Decreased cognitive distortions Conferring realistic

		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 Confronting the aggressor	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 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:	Reducing the fear of uncontrolled disclosure that she / he is the aggressor Increase the courage to

		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	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 creative relationships with others	84 88,42%	Learning to consciously choose constructive relationships in one's life 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	Conversations solving the problems Establishing borders Building a healthy distance to people 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	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

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

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 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
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	At the stage of remembering the traumas using symbolic techniques "without content" without telling about

the secret, liquidating the destructive mechanisms of silence and denial of abuse used by the perpetrator and eliminating the subordination of individuals.	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) 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.