**Psychiatr. Pol. ONLINE FIRST Nr 307: 1–11**
Published ahead of print 12 April 2023
www.psychiatriapolska.pl
ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
DOI: https://doi.org/10.12740/PP/OnlineFirst/156722

# Relational trauma

Dorota Draczyńska

First Department of Psychiatry, Institute of Psychiatry and Neurology in Warsaw

**Summary**

The aim of this paper is to briefly present the current knowledge on the definition of relational trauma, place in classifications, prevalence, consequences, and applied therapeutic methods. Reports from many countries indicate that in the relationship with adults, usually parents, on whom the child is dependent for many years, various forms of abuse may occur, related not only to violence, but also to emotional, physical, and intellectual neglect. Behind them, the unregistered area of aversive experiences of children who enter adulthood with the experience of relational trauma is hidden. These adverse childhood experiences significantly affect overall functioning in adulthood. For years, researchers of the phenomenon have been paying attention to the existence of a separate diagnosis related to relational trauma. The 11th edition of the International Classification of Diseases (ICD-11) introduces a new diagnosis: complex post-traumatic stress disorder (Complex PTSD, cPTSD). New methods of therapeutic interventions emerge, and the validation of these methods and explanation of the mechanisms of action is research work for the coming years.

**Key words:** childhood trauma, adverse childhood experiences, PTSD

*He felt his suffering not as a part of himself,*
*he himself certainly, deep down, remained pure joy.*

**Czesław Miłosz, The Issa Valley**

Trauma, according to international classifications of mental disorders ICD-10 and DSM-5, is a mental trauma caused by a violent and stressful event associated with a life or health threat or being a witness of such an event. It is not difficult to imagine situations which are overwhelming for an individual and go beyond this definition. Especially, when this individual is a child who later becomes an adult.

The researchers dealing with the phenomenon of trauma differentiate between a trauma associated with a single event from a trauma resulting from early childhood traumatic experiences defined as developmental trauma [1] or as relational trauma [2]. They introduce the definition of Trauma with a capital T for overstraining single

experiences (PTSD, Post Traumatic Stress Disorder) and for a relational trauma the idea of trauma with a small t – understood as a bad experience objectively less dominant but able to bring about serious results if repeated [3]. From the perspective of an adult person these events may seem not meaningful but very often have significant impact on the mood of a child, building self-image and the patterns of relationships with the world [4]. For instance, the contact with a mentally unstable caregiver, the experience of parentification, which is parent – child role reversal when a child observing weak, helpless, emotionally unavailable or/and addicted parent takes their role caring for a parent or other family members. As well as, demeaning, criticizing, experiencing of name calling, verbal threats and unfair punishment [4].

Other researchers indicate type I trauma for single extreme events caused by natural disasters, intentional and non-intentional human acts or type II trauma for repetitive events, occurring in a close relationship. Type I is described as simple and one-time, and type II as chronic and complex [5].

In the literature we may find the term ‘‘childhood trauma’’, also written ‘‘Childhood Trauma’’ [6; p. 35]. It is defined according to the suggestion of WHO (1999) as ‘‘all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or […] other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power” [7; p. 8].

This short review indicates that the phenomenon of relational trauma does not have a univocal name. This may be associated with dilemmas of a clinical nature in terms of specifying and understanding the symptoms of people with complex trauma, differentiating them from the symptoms of personality disorders, especially borderline personality disorder, as well as difficulties in incorporating into social awareness thinking about childhood trauma and its consequences.

## The place in ICD-10, ICD-11, DSM-IV, DSM-V classifications

Lack of nosological entry for relational trauma is reflected in classification of mental disorders. As far as the conceptualization of PTSD does not bring about any doubt, the identification and indication of disorders associated with experiences of relational trauma is subjected to constant changes. The diagnostic criteria of PTSD have been pointed out by the phenomena’s researchers as not containing the full spectrum of difficulties of people dealing with experiences of relational trauma. It was confirmed that the reaction to traumatic stress goes beyond the symptoms of PTSD, comprising of somatization, dissociation and alteration in affect regulation [8].

In the late 80s of the 20$^{th}$ century, Herman [9] outlined the existence of separate nosological entity associated with traumatic experiences in childhood and relations with child’s caregivers. She called it complex Post-Traumatic Stress Disorder (cPTSD). This concept was reflected in the diagnosis coded F62 according to ICD-10: ‘‘enduring personality changes, not attributable to brain damage and disease” [10; p. 39], describing personality and behavioral disorders in adults who endured strong and prolonged stress. However, this codification was not accepted by researchers and clinicians, mainly

because according to ICD-10 such diagnosis in children or adults who experienced trauma in the developmental stage of life is not allowed, as their personality has not yet been formed [8].

The next attempt at classification of relational trauma is "disorders of extreme stress, not otherwise specified" (DESNOS). DESNOS concept encompasses symptoms not contained in PTSD. Six groups of symptoms have been defined [11]:

(1) Alteration in Regulation of Affect and Impulses (A and 1 of B–F required):
   A. Affect Regulation
   B. Modulation of Anger
   C. Self-Destructive
   D. Suicidal Preoccupation
   E. Difficulty Modulating Sexual Involvement
   F. Excessive Risk-taking

(1) Alterations in Attention or Consciousness (A or B required):
   A. Amnesia
   B. Transient Dissociative Episodes and Depersonalization

(2) Alterations in Self-Perception (Two of A–F required):
   A. Ineffectiveness
   B. Permanent Damage
   C. Guilt and Responsibility
   D. Shame
   E. Nobody Can Understand
   F. Minimizing

(3) Alterations in Relations with Others (One of A–C required)
   A. Inability to Trust
   B. Revictimization
   C. Victimizing Others

(4) Somatization (Two of A–E required):
   A. Digestive System
   B. Chronic Pain
   C. Cardiopulmonary Symptoms
   D. Conversion Symptoms
   E. Sexual Symptoms

(5) Alterations in Systems of Meaning (A or B required):
   A. Despair and Hopelessness
   B. Loss of Previously Sustaining Beliefs.

DESNOS was incorporated into DSM-IV. DSM-V does not contain definitions of cPTSD nor DESNOS due to insufficient number of studies showcasing their differences from PTSD [8].

ICD-11 classification introduces diagnosis of "complex post-traumatic stress disorder" – cPTSD (6B41) making it a separate from PTSD (6B40) nosological entity. cPTSD consists of two groups of symptoms: PTSD and disturbance of self organization (DSO) [8].

According to ICD-11 (2022) PTSD's diagnostic criteria consist of three groups of symptoms:

1. re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares;
2. avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event(s);
3. persistent perceptions of heightened current threat, for example, as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises.

cPTSD's diagnostic criteria comprise of three groups of symptoms from the spectrum of self-organization (DSO, disturbance of self organization) causing impairment in functioning in personal, familial, social, educational or professional life:

1. problems in affect regulation (emotional lability, difficulty returning to normal functioning);
2. beliefs about oneself as diminished, defeated, or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event;
3. difficulties in sustaining relationships and in feeling close to others.
4. To make diagnosing cPTSD easier, Cloitre and co-workers [12] developed the International Trauma Questionnaire (ITQ), which was clinically confirmed [12, 13].

The introduction of relational trauma as a new diagnosis by the World Health Organization, is the result of several decades of epidemiological and clinical research. They confirmed that adverse childhood experiences may be the basis for the development of complex PTSD and personality disorders in adulthood.

### *The prevalence*

Abuse, neglect and maltreatment of children as well as relational trauma caused by them is a common problem on a global scale. It is found in countries of high, low and medium income [14]. The number of cases is hard to estimate as there is no universal system of data collection. Some types of violence are of a hidden or a stigmatizing nature or there are differences in their defining [15]. The way to estimate relational trauma is to refer to official reports of child abuse and neglect.

In 2020 in Poland [16], 71.5 thousand children were housed in foster care and 12 thousand were found to be experiencing domestic violence. The report states that 6% of interviewed teenagers experienced parental neglect (lack of care and physical neglect).

Another indicator showing the extent of parental neglect and abuse of parental power is the number of interventions of court into parental power. In the year 2020, 2,590 minors, including 1,238 girls and 1,352 boys, were victims of physical or psychological abuse of a minor or a physically dependent person (Article 207 section 1 of the Criminal Code) [17].

Data from Empowering Children Foundation research [18] suggest that in the opinion of Polish people child abuse is common in families. 41% of young people faced violence from the hands of adults they were close to.

A third of respondents (33%) experienced physical violence, and one in five respondents – psychological violence. The perpetrators of both kinds of violence were most often the victim's parents. 13% of interviewed schoolchildren witnessed domestic violence (between the parents or an adult abusing another child). Seven out of ten teenagers (72%) between the ages of 11 to 17 were victims of at least one out of seven categories of abuse: violence at the hands of trusted adults, physical neglect, witnessing domestic violence, peer violence, burdening sexual experiences, sexual abuse, experience of a conventional crime (vandalism, robbery, assault).

Globally the situation is similar. A report conducted in the USA concerning child maltreatment [19] shows that in the year 2020 Child Protective Services received 3.1 million reports of child maltreatment (which makes it 4% of the population). 76.1% of children experienced physical neglect, 6.5% – physical maltreatment, 9.4% – sexual abuse, and 0.2% were victims of human trafficking for sexual purposes.

WHO's regional office in Europe reported in 2013 [20] that 18 million children in Europe experience sexual harassment, 44 million – physical abuse and 55 million – emotional abuse.

Besides the official data, there is the unregistered hidden area of aversive experiences of children who enter adulthood with past experiences of relational trauma. A solution in preventing and reducing the consequences of adverse childhood experiences in relations with their caregivers, usually parents, could be to include families in preventive programs, support therapies that help build bonds between the parent and the child. Helping parents understand their child's needs, emotions and behaviors, as well as themselves as parents. A coherent system of educating social services responsible for creating care and upbringing environments would be recommended. Such actions would help to minimize the psychosocial and medical costs incurred as a consequence of traumatic development.

## *Consequences of relational trauma*

### Neurobiological consequences

The research results indicate that the experience of relational trauma negatively influences the development of the central nervous system, causes the disturbance of cognitive and affective processes and upsets the nervous system [21, 22]. Prolonged childhood trauma induces completely different mental and somatic adaptational reactions than a single traumatic experience in adult life [23]. In aversive situations a child experiences helplessness towards the fear or agitation, which upsets their psychological potential and emotional stability [24].

From the biological point of view, a stressful situation activates the sympathetic nervous system and hypothalamic-pituitary-adrenal axis. When it is a reaction to a stressful event – it is an adaptational mechanism, but when there is a situation of prolonged stress, and that is when a child suffers from abuse or/and neglect, it leads to impairment of numerous physiological processes and hormonal dysregulation. It also causes attention deficit hyperactivity disorder [25] as well as symptoms of obsessive-compulsive disorder [21].

The authors [21] claim that in terms of affective functioning, aversive experiences – chronic stress – lead to reward system causing disorder in dopaminergic transmission. It may result in two opposing consequences: 1) anhedonic behavior, which might increase the risk of mood disorders and 2) compensatory reward-seeking behavior, which might increase the risk of maladaptive behaviors, including substance abuse. The further consequence of relational trauma is attention selectivity and emotional hyperactivity. People with experience of relational trauma react to negative stimuli faster than to neutral or positive ones. They have some difficulties in recognizing and understanding emotions.

Oversensitivity to nonverbal or negative stimuli as well as emotional hyperactivity lead to the development of psychopathology in adulthood, including, for example, anxiety. Moreover, under the influence of harmful experiences some biochemical mechanisms are released leading not only to functional but also anatomical changes. The brains of children suffering from relational trauma are smaller, have thinner cerebral cortex in the area of temporal and frontal lobes as well as higher amount of grey matter in comparison with the children without such an experience [21]. It can be assumed, that relational trauma is 'saved' in the brain and nervous system, and 'frozen' in the in the body.

## Psychological consequences

John Bowlby's attachment theory explains how the relationship between a caregiver and child affects health. Research into attachment patterns has led to identification of secure and three insecure attachment styles: anxious-ambivalent, avoidant and disorganized [26]. Adverse situations in early life, experienced by a child in a relationship with a guardian (neglect, rejection, mistreatment, abuse) lead to development of an insecure attachment pattern [1, 27, 28], characterized by anxiety, anger, guilt, shame, and harm [28]. According to authors [29], disordered attachment patterns mean disordered brain development, in which the brain 'focuses' on survival instead of developing.

Disturbance of the relationship in childhood and 'emotional freeze', which are proceeded by experiencing abuse and/or neglect, result in the lack of ability to begin relationships, form bonds and feel empathy. Emotional dissonance or unavailability of the primary caregiver, mainly the mother, negative feedback given to the child 'program' their emotional memory [27]. Collecting negative experiences, a child builds a negative beliefs about himself, others and the world, for example: "I'm weak, others are better, the world is dangerous" and enters adulthood with them. The beliefs start functioning autonomously and distort the perception of self, others and the world. They distort reality. Individuals, who are not aware of them, start to treat those beliefs as facts not as beliefs originating from their relationship with their caregivers. Parental "you are" turns into "I am" which cannot be outgrown.

It has been confirmed that there is a strong relationship between repetitive experiences of traumatic character in childhood and affective disorders and identity disorders [28]. The consequence of developmental traumas is also alexithymia ("no words for emotions") [27] and dissociation, the 'side effect' of which is the disorder of physi-

cal Self [27]. Traumatized children may perceive mind and body as separate beings. Self (mind) stays not incarnated. And 'Divided Self' is created [30]. The body is not regarded as own, beautiful, worth caring, protection and love. An individual is 'stuck' in experienced harms, rendings and resentments which determine the quality of their life [25].

The person who experienced relational trauma may feel the lack of ontological security understood as the sense of being in a particular place and time [25]. In consequence they obscure this lack with information overload, entertainment without any intellectual effort, overburdening professional requirements, and drugs. They may have some problems with assertiveness, drawing the lines and overreacting. They project destructive schemas which leads to transgenerational transmission of trauma – – the one in which own psychological traumas are handed down to next generations [25]. Adverse childhood experience may result in abusing power as an adult towards own children and neglecting children in the way they used to be neglected. The victim becomes the executioner and passes violent patterns to next generations [31].

It can be said that thinking about themselves in the words of their parents, adult children may feel like failures, be filled with a sense of shame, guilt, failure. They may compensate negative beliefs with various coping strategies. Develop a false self without knowing who they are and where they are going.

It is worth mentioning that attachment to other important adults, e.g., grandparents, may have a corrective influence on the experience of traumatic development [32]. It can mitigate the negative impact of trauma and improve the ability to resolve the effects of trauma in adulthood.

### *Psychotherapy*

Reports from numerous European countries indicate the need to develop a unified standard concerning the therapy of trauma [33].

At present prevailing treatments are those applied to post-traumatic stress disorder therapy: CBT (Cognitive Behavioral Therapy) and those originating from cognitive-behavioral approach: BEPP (Brief Eclectic Psychotherapy for PTSD) [34], PE (Prolonged Exposure) [35] and CPT (Cognitive Processing Therapy) [36]. The above-mentioned methods focus on the reduction of symptoms and coping with anxiety, avoidance and security strategies. Van der Kolk [23] claimed that CBT is not effective enough for people with the experience of relational trauma.

Another method is EMDR (Eye Movement Desensitization and Reprocessing) and integrating (incorporating) the memories to the line of life [37]. However, a small number of studies does not allow to prove its efficacy explicitly [38]. Next method – a psychodynamic psychotherapy, contributed to understanding the idea of trauma by multidimensional view of personality and it may be indicated in the therapy together with other techniques [39].

Treatment of the consequences of relational trauma should differ from treating PTSD. PTSD therapy focuses on psychological consequences of traumatic experience

and specific traumatic memories. However, the therapy of relational trauma, apart from those mentioned above, is supposed to retrieve the ability to control emotions, ability to build relationships and help in finding the sense of existence. While looking for existential fulfillment [40] it is essential to find the answer to four fundamental questions concerning meaning of human existence: 1) "I am – can I be here?", 2) "I am alive – do I like this fact?", 3) "I am myself – may I be like this?" And 4) "Why do I live?", as taking responsibility for oneself with regard to the sense of meaning and future. It often happens that the 'burden of the past' obscures the present. That is why the very crucial element of recovering is consciously existing in the present with reference to the future and future shape of life, for which one should take responsibility. This aspect of relational trauma seems to be especially significant. It nearly always turns out that someone looking for help among the other people hoping they will be able to steer their life, does not realize their own abilities, competences and resources. And these are the keys to finding the existential meaning and taking responsibility for one's life [40].

For relational trauma there is no 'first-choice treatment' because it is holistic, multidimensional and concerns nearly all the areas of human functioning [23]. In practice it is advised [23] to go beyond the conversation, to use experimental techniques, breath, movement, touch, and action. The therapy should motivate to take responsibility for one's life and talk somebody out of thinking about me as a victim. It should help to find the sense of existence and in such a context construct the agency of people with the experience of relational trauma.

The techniques such as 'the third wave' of CBT – ACT (Acceptance and Commitment Therapy), Schema Therapy, DBT (Dialectical Behavior Therapy), Existential Therapy, and SE (Somatic Experiencing) may be helpful while treating relational trauma. However, explaining the mechanisms of its functioning and validation of efficiency is the research for the coming years [23].

The therapy of relational trauma is like the Japanese art of kintsukuroi (golden repair). It consists of multi-method, multi-interventions to create an integrated therapeutic approach. Japanese art teaches that what has been destroyed and then repaired is more valuable than a new thing [41]. In Japanese art, it is repairing broken ceramics with gold, and in the therapy – the Self divided by trauma.

## References

1. Heller L, LaPierre A. *Leczenie traumy rozwojowej. Wpływ wczesnej traumy na samoregulację, obraz samego siebie i zdolność do tworzenia związków*. Publishing House of the Institute of Psychosomatic Therapy, 2018.
2. Howell EF. *The dissociative mind*. New York, NY, USA: Routledge, 2013.
3. Wilson G, Farrell D, Barron I, Hutchins J, Whybrow D, Kiernan MD. *The use of Eye-Movement Desensitization Reprocessing (EMDR) therapy in treating Post-traumatic Stress Disorder — a systematic narrative review*. Front Psychol. 2018; 6(9): 923.

4. Chen R, Gillespie A, Zhao Y, Xi Y, Ren Y & McLean L. *The efficacy of Eye Movement Desensitization and Reprocessing in children and adults who have experienced complex childhood trauma: A systematic review of Randomized Controlled Trials*. Front. Psychol. 2018; 9: 534.
5. Pietkiewicz IJ, Tomalski R. *Zaburzenia związane z traumą– perspektywa teoretyczna. Czasopismo Psychologiczne 2018*; 24(2): 261–268.
6. Nelson CA, Bloom FE, Cameron JL, Amaral D, Dahl RE, Pine D. *An integrative, multidisciplinary approach to the study of brain-behavior relations in the context of typical and atypical development*. Dev. Psychopathol. 2002; 14(3): 499–520. DOI: 10.1017/s0954579402003061.
7. *Report of the consultation on child abuse prevention*. WHO, Geneva, 1999WHO/HSC/PVI/99.1.
8. Tomalski R, Pietkiewicz I. *Złożony zespół stresu pourazowego – przełom w leczeniu zaburzeń osobowości*. Psychiatr. Psychol. Klin. 2020; 20(1): 54–60.
9. Herman JL, Perry JC, Van der Kolk BA.). *Childhood trauma in borderline personality disorder.* Am. J. Psychiatry 1989; 146(4):490–495.
10. *Międzynarodowa Statystyczna Klasyfikacja Chorób i Problemów Zdrowotnych* – X Revision, Vol. I, 2008. Center of Health Information Systems, 2012.
11. Luxenberg T, Spinazzola J, van der Kolk BA. *Complex trauma and disorders of extreme stress (DESNOS) diagnosis, part one: assessment*. Dir. Psychiatry 2001; (21): 373–392.
12. Cloitre M, Hyland P, Prins A, Shevlin M. *The international trauma questionnaire (ITQ) measures reliable and clinically significant treatment-related change in PTSD and complex PTSD*. Europ. J. Psychotraum. 2021; (12): 1930961.
13. Gelezelyte O, Roberts NP, Kvedaraite M, Bisson JI, Brewin CR, Cloitre M, Kairyte A, Karatzias T, Shevlin M, Kazlauskas E. *Validation of the International Trauma Interview (ITI) for the Clinical Assessment of ICD-11 Posttraumatic Stress Disorder (PTSD) and Complex PTSD (CPTSD) in a Lithuanian Sample*. Eur. J. Psychotraumatol. 2022; 13(1): 2037905, DOI: 10.1080/20008198.2022.2037905.
14. van Berkel SR, Prevoo MJL, Linting M, Pannebakker FD, Alink LRA. *Prevalence of child maltreatment in the Netherlands: An update and cross-time comparison*. Child Abuse & Neglect 2020; (103): 104439.
15. Saunders BE, Adams ZW. *Epidemiology of traumatic experiences in childhood*. Child Adolesc. Psychiatr. Clin. N. Am. 2014; 423(2): 167–184.
16. Central Statistical Office of Poland: https://stat.gov.pl/obszary-tematyczne/dzieci-i-rodzina/dzieci/piecza-zastepcza-w-2020-roku,1,5.html, 2021.
17. Report on the implementation of activities under the National Program for Counteracting Domestic Violence for the years 2014–2020 for the period from 1 January to 31 December 2020. Ministry of Family and Social Policy, 2021
18. Włodarczyk J, Makaruk K, Michalski P, Sajkowska M. *Ogólnopolska diagnoza skali i uwarunkowań krzywdzenia dzieci. Raport z badań*. Fundacja Dajemy Dzieciom Siłę, 2018.
19. Child Maltreatment 2020, Children's Bureau (Administration on Children, Youth and Families, Administration for Children and Families) of the U.S. Department of Health and Human Services, 2022.
20. *European report on preventing child maltreatment*. Summary. World Health Organization, The Regional Office for Europe, 2013.
21. Pechtel P, Pizzagalli DA. *Effects of early life stress on cognitive and affective function: an integrated review of human literature*. Psychopharmacol. (Berl.) 2011; 214(1): 55–70. DOI:10.1007/s00213-010-2009-2.

22. van Berkel SR, Prevoo MJL, Linting M, Pannebakker FD, Alink LRA. *Prevalence of child maltreatment in the Netherlands: An update and cross-time comparison*. Child Abuse & Neglect 2020; (103): 104439.
23. Van der Kolk B. *Strach ucieleśniony. Mózg, umysł i ciało w terapii traumy*. Warsaw: Czarna Owca Publishing House; 2018.
24. Vetulani J. *Trauma dziecięca a rozwój mózgu*. https://www.youtube.com/watch?v=tZkBZxqZUlY [retrieved: 2017].
25. Simon W. *Psychoterapia NEST. Teoria i praktyka*. Warsaw: NEST Association; 2020.
26. Włodarczyk E. *Znaczenie wczesnodziecięcego przywiązania w diadzie matka/opiekun – dziecko*. Adam Mickiewicz University Press, Educational Studies 2016; 39: 377–394. https://hdl.handle.net/10593/17657.
27. Zdankiewicz-Ścigała E. *Trauma wczesnodziecięca i lękowe style więzi*. https://www.youtube.com/watch?v=GlvsYebSu9Q [retrieved: 2017].
28. Liotti G, Farina B. *Traumatyczny rozwój. Etiologia, klinika i terapia wymiaru dysocjacyjnego*. Bledzew: Przyjaciele Martynki Foundation; 2016.
29. Nelson CA, Bloom FE, Cameron JL, Amaral D, Dahl RE, Pine D. A*n integrative, multidisciplinary approach to the study of brain-behavior relations in the context of typical and atypical development*. Dev. Psychopathol. 2002; 14(3): 499–520. DOI: 10.1017/s0954579402003061.
30. Laing RD. *Podzielone ja*. Poznan: Rebis Publishing House; 1995.
31. Kowalczyk MH. *Transgeneracyjne wzory przemocy seksualnej w genezie zachowań kobiet wykorzystujących seksualnie dzieci. In: Współczesne problemy resocjalizacji. W poszukiwaniu nowych rozwiązań*. Educational Publishing House AKAPIT; 2015.
32. Strong DD, Bean, RA, Feinauer LL. *Trauma, attachment, and family therapy with grandfamilies: a model for treatment*. Child. Youth Serv. Rev. 2010; (32): 44–50. DOI: 10.1016/j.childyouth.2009.06.015.
33. Schäfer I, Hopchet M, Vandamme N, Ajdukovic D, El-Hage W, Egreteau L et al. *Trauma and trauma care in Europe*. Eur. J. Psychotraumatol. 2018; 9(1):1556553. DOI: 10.1080/20008198.2018.1556553.
34. Nijdam M, Meewisse M-L, Gersons B, Olff M. *Treatment protocol Brief Eclectic Psychotherapy for PTSD (BEPP). Third English version*. Amsterdam: B.P.R. Gersons, 2011.
35. van Minnen A, Harned MS, Zoellner L, Mills K. *Examining potential contraindications for prolonged exposure therapy for PTSD*. Eur. J. Psychotraumatol. 2012; 3. DOI: 10.3402/ejpt.v3i0.18805.
36. Resick PA, Monson CM, Chard KM. *Terapia przetwarzania poznawczego w zespole stresu pourazowego (PTSD) Podręcznik dla klinicystów*. Jagiellonian University Press, 2019.
37. Wilson G, Farrell D, Barron I, Hutchins J, Whybrow D, Kiernan MD. *The use of Eye-Movement Desensitization Reprocessing (EMDR) therapy in treating Post-traumatic Stress Disorder — a systematic narrative review*. Front Psychol. 2018; 6(9): 923.
38. Chen R, Gillespie A, Zhao Y, Xi Y, Ren Y & McLean L. *The efficacy of Eye Movement Desensitization and Reprocessing in children and adults who have experienced complex childhood trauma: A systematic review of Randomized Controlled Trials*. Front. Psychol. 2018; 9: 534.
39. Spermon D, Darlington Y, Gibney P. *Psychodynamic psychotherapy for complex trauma: targets, focus, applications, and outcomes*. Psychol. Res. Behav. Manag. 2010; (3): 119–127.
40. Längle A. *Analiza egzystencjalna — poszukiwanie zgody na życie*. Psychoterapia 2003; 125(2): p. 33–46.

41. Kumai C. *Życie według kintsugi*. Bialystok: Wydawnictwo Kobiece Łukasz Kierus; 2019.
42. Miłosz Cz. *Dolina Issy*. Krakow: Wydawnictwo Literackie; 2000, p. 12–13.

Address: Dorota Draczyńska
Institute of Psychiatry and Neurology in Warsaw
Sobieskiego Street 9, 02-957 Warszawa
e-mail: ddraczynska@ipin.edu.pl