

Interpersonal Trauma and its Consequences in Adulthood

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Edited by

Agnieszka Widera-Wysoczańska
and Alicja Kuczyńska

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P U B L I S H I N G

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INTRODUCTION

ALICJA KUCZYŃSKA
AND AGNIESZKA WIDERA-WYSOCZAŃSKA

In this book we present studies on the influence of various forms of abuse experienced in childhood on the personal functioning of that individual in adulthood, including resulting life problems and personality and neurobiological disorders.

The source of this interpersonal psychological trauma is a traumatic event that is repetitive, chronic and complex in nature, and is caused by the action of a closely related person. Along with these traumatic events are included various types of neglect and violence, which a person may be subjected to from early childhood - in those times which are developmentally important for her/him - and then through the juvenile years, often up to the current moment of her/his life. Complex interpersonal psychological trauma occurs most frequently in a dysfunctional and pathological family. This causes the appearance of various types of symptoms, which can be very broadly divided, on one hand, into short and long term and, on the other, specific and unspecific. These symptoms, with their causes and consequences, can be either internal or external depending upon the extent to which they can be seen on the outside. The nature of these symptoms varies over one's entire life-span. They can accumulate, leading to secondary problems in life. When a person experiences extremely dramatic trauma they can lead to various personality disorders (e.g. borderline personality disorders, dissociation and psychopathic personality disorders) and to Complex Posttraumatic Stress Disorders (CPTSD). Interpersonal characteristics - chronic and complex traumatic events - go far beyond stressful events described in the classic PTSD (Criterion A). Traumatization of this type is extreme, often being life-threatening, emotionally horrifying, and physically and sexually violating. Symptoms of CPTSD also go beyond the triad of symptoms (intrusive reexperiencing, Criterion B; avoidance, Criterion C; and hyperarousal, Criterion D) described in PTSD. These include core problems such as affect dysregulation, structural dissociation, somatic

dysregulation, an impaired self-concept and self-development, and disorganized attachment patterns as well as many other symptoms which are still the subject of scientific research and discussions.

We also describe psychotherapeutic issues connected with interpersonal trauma in our book. The issues contained in this part concern the sexologist experiences from work with perpetrators of sexual violence, problems connected with treatment of alcohol addicted people, partners remaining in conflicted relationship as well as parents who harm their children.

Since most of the presented studies are primarily concerned with the Polish population, the book may be an interesting example of the discussed issues as seen from the perspective of a society subject to a complex system and its mental transformations.

The book consists of five parts.

Part 1. The paper by Alicja Kuczyńska is a short introduction to interpersonal trauma issues. Analyzing the individual and social aspect of trauma, the author brings readers closer to understanding this phenomenon, gives some examples of factors that cause these kinds of experiences, and indicates sequels to them. The analysis will serve also to describe the general potential for trauma prevention and to help traumatized people, with particular consideration aimed at the psychologist's role.

Agnieszka Widera-Wysoczańska describes the main features and consequences of complex and chronic trauma and compares these features with simple trauma. She presents some examples of this kind of disorder from her practice. The author takes also a subject of intergenerational transmission of violence.

Part 2, "Dysfunctional relationships in adulthood" is devoted to events which affect the quality of relationships in adulthood. These events, which amount to chronic complex trauma, take place within the family and community in early childhood, adolescence, and adulthood. The article by Jowita Wycisk presents theoretical discussions about interpersonal traumatic events in their past and in their current life which cause young girls to become mothers too early.

The article by Irena Pospiszyl, based on empirical studies, describes past behaviors of women who are currently being beaten by their partners. It concerns extra-familial ways of functioning from childhood and adolescence - interests, social activities, and number of friends. The results confirm literature data which indicate that women who are beaten in relationships were socially passive in the past, although being

professionally active in adult life. The article by A. Widera-Wysoczańska presents results of a qualitative study on the influence of the attachment of overprotective and non-protective mothers with their children on those children's partner selection in adulthood. This is placed in the context of emotional, physical, and sexual childhood abuse and over protectiveness.

Part 3, "The development of personality disorders", is devoted to the causes of the origin of borderline interpersonal disorders (BDP) and of their psychopathic structures.

The theoretical article by Lidia. Cierpiałkowska presents the causes of BDP, seen in traumatic relationships during childhood. The time of their appearance is considered.

The empirical article by Marylin. Korzekwa examines the causes of the appearance of dissociation in BPD and finds it in childhood abuse, parental addictions, the child's own addictions, disturbed relationships, and neurological problems with their neurobiology, etiology and treatment.

The article by Beata Pastwa-Wojciechowska describes what kinds of childhood traumatic experiences occur in the lives of women and men with psychopathic personality structures which condemn them to domestic abuse. The influence of disturbed ties with the mother on the development of this disorder is highlighted.

Part 4, "Neurobiological disorders", deals with the influence of interpersonal trauma on a person's neurobiological functioning. The article by R. Gregurek presents research on the influence of war trauma (the war in Croatia) on brain functions in persons with PTSD. That by Olga Sakson-Obada demonstrates the influence of domestic abuse on physical numbness and sensitivity.

Part 5, "Psychological trauma treatment" focuses on practical questions about people who experienced interpersonal trauma. Most of the articles were devoted to trauma survivors. In the article by Alicja Kuczyńska and Alicja Strzelecka-Lemiech examine situational determinants of readiness for intervention by social workers and people who are not professionally involved in helping with domestic violence. The article by Agnieszka Widera-Wysoczańska presents the multiaspect principles concerning the philosophy and its methods of dealing with persons who experienced childhood interpersonal trauma and are suffering its consequences in adulthood. Dorota Dyjakon in her article presents the psychotherapy of alcoholics-perpetrators of domestic violence as a proposal which enriches the therapeutic offer for addicted people. It also gives attention to the special nature of problems which arise in an alcoholic family in relation to using violence by addicted people not only in an active phase of the

disease but also after starting treatment. Finally, in the article by Maria Beisert we turn our attention to what kind of victimization persons who assist perpetrators of sexual abuse might be subjected to.

We thank Cambridge Scholars Publishing very much for the proposal to prepare a book devoted to interpersonal trauma and confidence shown to us in this manner. We were very honored and pleased for his opportunity to present the Polish thought to a wider reader on the issue. We give special thanks to the representative of the Cambridge Scholars Publishing, Carol Koulikourdi, for very kind cooperation and patience shown during the process of its preparation.

We invited many prominent authors to co-operate with us in the creation of the book.

There were three reviewers - prof. Grazyna Dolińska-Zygmunt, prof. Barbara Pilecka and prof. Kinga Lachowicz-Tabaczek - whose suggestions and comments have contributed greatly to the book. All these people we thank very much for such successful cooperation and commitment.

PART I

WHAT IS TRAUMA?

CHAPTER ONE

INDIVIDUAL AND SOCIAL ASPECTS OF TRAUMA

ALICJA KUCZYŃSKA

The paper is a short introduction to interpersonal trauma issues. Analyzing the individual, social and cultural aspect of trauma, the author brings readers closer to understanding this phenomenon, gives some examples of factors that cause these kinds of experiences, and indicates sequels to them. The analysis will serve also to describe the general potential for trauma prevention and for helping traumatized people, with particular consideration aimed at the psychologist's role.

The aim of this presentation is to introduce the problem of trauma. I would like to describe in short the types of traumatic events, the likelihood of experiencing them and reactions to them, as well as the general potential for helping people who have experienced trauma. I found it would be convenient to look at the issues both from the perspective of the individual as well as from the social aspects of trauma.

The notion of trauma stems from the Greek word *trauma* meaning a wound, and is colloquially regarded as referring to a psychological (traumatic) or bodily injury. Although the term appeared in published papers on psychology and medicine as early as the nineteenth century, systematic work aiming at establishing its definition and a more detailed role that experiences of this nature may play in the development of mental problems or disturbances was undertaken as late as the 1970's. The work concentrated on listing events that could potentially trigger adverse outcomes for the participants, characterizing these events and describing their psychological consequences. The result was the addition of a new category of mental disorders, - *Posttraumatic Stress Disorder* or PTSD - into the 1980 edition of the diagnostic classification system DSM-III. The major defining criteria was the notion of trauma understood as an unusually intensive and unwanted experience that involves actual or felt danger to one's life or health, evoked by direct contact of the individual

with extreme, atypical life events (APA, 1980, p. 236). The experience results in a persistent re-experiencing of the traumatic event, avoidance of situations/stimuli associated with the trauma and persistent symptoms of increased arousal and anxiety. The official distinction of this new category of disturbances laid a good foundation for reviving the discussion on the essence and meaning of trauma, and undertaking intensive empirical attempts to explore this phenomenon. The results gathered from these studies brought two important findings. First, they proved that trauma is not such an infrequent phenomenon as had been previously assumed (Kessler et al., 1995; Breslau et al., 1998)¹, which resulted in a revised definition of trauma in the recent edition of classification DSM-IV-TR. The DSM-IV-TR refers to trauma as: 1) an experience of an event that involves actual or threatened death, serious injury to oneself or others, and 2) a response involving intense fear, helplessness, or horror (Oltmanns, Emery, 2007, p. 217). The findings also pointed to a wide range of traumatic events, including not only warfare, natural disasters, accidents or dramatic chance incidents, but also violence inflicted by others, rejection or betrayal, which in turn lead to an intensified revival of the trend of research on the kind of trauma that comes from another person, which is most frequently described as relational or interpersonal trauma.

The types of potentially traumatizing events

The number of events that are a potential source of human misfortunes is actually unlimited. They include not only natural disasters (flood, hurricanes, earthquakes), events caused by humans (plane or rail crashes, ship sinking or serious traffic accidents), acts of terror and warfare (such as participation in battle, imprisonment or being taken as a hostage, and torturing), but also interpersonal traumas. Although the term suggests that it encompasses all traumatic events (the source of which is another human being (including the death of a close person or threat to his or her life))² most researchers restrict the range of events under the heading of interpersonal trauma to ones where the perpetrator is another close person. They also pinpoint the intentions of the perpetrator, whose motivation is either the desire to hurt the other and/or the desire to pursue his or her own goals, irrespective of harm and costs to other people. Examples of this kind of phenomenon may be assault, battery, mutilation, rape or sexual abuse.

Although the subject of this monograph is interpersonal trauma, I would like to draw your attention to the fact that an attempt to describe the intentions of people participating in other traumatic events could have

significance for better understanding the reactions of trauma victims and determining responsibility shared by the perpetrators of the events. For example, active participation in warfare or practicing harmful customs or rituals does not necessarily have to be originally related to the desire of hurting others. Usually such activities are associated with the intention of pursuing the goals of a group or with sustaining ways of functioning arising from the desire or necessity to belong to the group, and secure oneself appropriate, advantageous or at least fundamental living conditions within the group. Nevertheless, the intention is fulfilled irrespective of the harm and cost to other people.

The likelihood of experiencing trauma

At first it would seem that traumatic events are accidental by nature. However, the frequency of experiencing trauma by various people is not by chance and depends on many individual, social and cultural variables. It is more likely for people with a history of behaviour disorder, and for those who are anxious or poorly educated, but it is also likely for those coming from families where mental disorders occurred in the past or are present. Groups that are particularly at risk of traumatic events include people from social minorities and persons living in dangerous environments or areas of civil conflicts. Also, sex is found to be an important differential variable. The degree of exposure of women and girls, men and boys to a potential traumatic event depends on the type of event. A review by Tolin and Foa (2006) of 290 publications devoted to this problem proved that men and boys, more so than women and girls, frequently report experiences involving assaults, accidents, warfare, disasters and fire, serious illness, non-specific injuries or witnessing death and the wounding of others. On the other hand, women and girls more often than men experience assaults, sexual violence and abuse in childhood. Here, a question obviously arises as to what extent biological sex actually differentiates the likelihood of exposure to traumatic events, and what the role is of factors or mechanisms pertaining to biological sex, but accounting for its circumstances that are of a social and cultural nature.

Reactions to potential traumatic events and their consequences

Not everyone reacts to extreme events with such intense sensations as the trauma definition assumes. However, experiencing trauma involves the

risk of acute stress disorder (ASD), posttraumatic stress disorder (PTSD) or complex posttraumatic stress disorder (CPTSD).

Diagnostic criteria of acute stress are in essence very similar to the above-described symptoms typical of PTSD, with the difference being that they also include dissociative symptoms (such as emotional numbness, derealisation, depersonalisation or dissociative amnesia) and should not persist longer than four weeks.

CPTSD is actually a new diagnostic unit proposed as a result of the study of people who survived multiple trauma of a cumulative nature. The prototype of the diagnostic criteria for this category of disorders stems from research on the consequences of a prolonged, recurrent trauma originating in childhood. The consequences of this kind of trauma influence the following aspects of functioning:

- a) affect regulation (including difficulties in the regulation of anger as well as self-destruction)
- b) alterations in attention and consciousness (dissociative symptoms)
- c) alterations in self-perception (self-blame, guilt)
- d) alterations in perception of the perpetrator (acceptance of the perpetrator's belief system)
- e) alterations in relations with others (inability to trust others and lack of comfort/intimacy in relationships)
- f) somatisation and/or medical conditions
- g) alterations in the systems of meaning (sense of helplessness resulting from the impossibility of being understood by anyone) (Herman, 1992a, 1992b, in: Courtois (2008).

Although it is assumed that no one is able to develop symptoms characteristic of ASD or PTSD without having experienced considerably intensive trauma, the experience of trauma itself is not a sufficient condition of PTSD. There have been attempts to predict depersonalization and emotional numbness (Bryant et al., 2000), on the basis of ASD symptoms, especially the ones that relate to re-experiencing the traumatic event. However, it is usually assumed that PTSD results from a combination of many factors, including pre-traumatic biological and personality features, the severity of the experienced harm, the manner in which emotional processing of the experience takes place, or the fact of having or not having received appropriate social support (Oltmanns, Emery, 2007). A meta-analysis of 68 publications by Ozer and her colleagues (2003) showed seven important predictors of the risk of PTSD. Most of the analysed factors are of an individual character, but the authors also considered one indirect factor and one social factor. These analysed factors are: experiencing at least one traumatic event, psychological

adaptation before the examined trauma (including mental problems or disorder, such as depression or anxiety disorders), perception of life endangerment while experiencing trauma, a high level of emotional arousal during the stressful event and immediately afterwards, dissociative experiences, perceived social support after the experienced trauma, and the occurrence of mental illness in the family history.

Referring again to the results of the analysis by Tolin and Foa (2006), it could be added that, although they are less likely to be exposed to a potentially stressful event, the reactions of women are more intense, and as a result they more frequently develop symptoms of PTSD than do men.

Helping trauma survivors

Exposure to a potentially traumatic event does not always have to result in mental disorders. Many researchers believe that mental disorders may be prevented through appropriate resilience training and immediate crisis intervention. Obviously, the specificity of interpersonal trauma makes employment of the first form of prevention impossible. Hence crisis intervention is used, and in general it consists in describing or reenacting the painful experience for the victim of a traumatic event, and providing him or her with professional support. Although most studies show that immediate help reduces the risk of disorders occurring, the efficiency of one-time interventions has been challenged (Oltmanns, Emery, 2007). There is no evidence that escaping ASD or PTSD is truly the result of the intervention itself or is due to personality traits of the person subject to the potentially traumatic event - such as high self-esteem (Bryant et al., 2007; Stinson et al., 2008), self-efficacy (Leszczyńska et al., 2009), one's ability to cope in stressful situations or ego resiliency (Bonanno, 2008; conf. Staub et al., 2008).

The principal aim of therapy of ASD and PTSD patients is restoring them to the level of functioning in the period preceding the traumatic event. Peterson, Prout and Schwarz (1991: in Lis-Turlejska, 2002, p.102) distinguished four strategies common to all therapeutic proceedings. They include:

1. supporting adaptive abilities of coping
2. „normalization” of what the person perceives as disturbed
3. reduction of avoidance
4. changing the alteration of/changing the attribution of the meaning of trauma

Due to the specificity of CPTSD, the goal of therapy is bringing the person to the best possible way of functioning that may potentially be achieved in the face of prolonged and serious symptoms of sickness. The course of therapy is sequential, and consists in three stages (Courtois, 2008 p. 5-6):

1. The first step is devoted to the building of therapeutic alliance, working on affect regulation, education, providing security and achieving the ability to cope.
2. The achievement of the above-goals makes it possible to move to the second stage - that is, to the analysis and processing of the traumatic material, enabling the person to function in a less disturbed way.
3. The third step aims toward the consolidation and restructuring of life, allowing personal and social development to be reinforced by everyday life events.

Conducting therapy with trauma survivors involves many difficulties. They pertain both to the person who is the therapist, and the one who is in therapy. The major factor making therapy difficult on the part of the patient is the nature of his or her experience, especially when it concerns trauma experienced in the family (Herman, 1998; Briere, 1986, 1998; Suchańska, 1998; Courtois, 2008). The symptoms of the principal disorders themselves may hinder communication and excessively increase vigilance or sensitivity to the therapist's behavior. There are also frequent co-occurrences of somatic conditions (vascular circulation, gastroenterological problems, diabetes, and oncological diseases) and mental illness (depression, substance abuse disorders, antisocial symptoms, and borderline personality disorders) (conf. Lis-Turlejska, 2002; Oltmanns, Emery, 2007; Elhai et al., 2007; Kendall-Tackett, 2009).

The basic factor hindering therapy on the part of the therapist is the necessity of being very competent, as lack of competence brings about the risk of re-victimisation of the client. Such a lack is brought about by still quite limited possibilities of attaining necessary therapeutic skills. Therefore, the major challenge that the psychologists are confronted with is acquiring knowledge on trauma, on the experiences of people who have suffered it, and on the possibilities of helping them, as well as spreading information and generously sharing it with everyone who is willing to receive it (conf. Miller, 2007; Kazdin, 2009).

In presenting the individual and social aspects of trauma, I wished to show that the science of trauma is first of all a science regarding humans. While it is humans who experience traumatic events (and often directly or indirectly are also the perpetrators of them), it is also only humans who can help others in overcoming the consequences of dramatic experiences

and act towards creating a better world. The words of a Romanian philosopher, Emile Cioran (2004, p.126) may guide us in doing so:

„I am reflected in your eyes, and so are you in mine. Each of us is reflected in the eyes of the other. The whole world is looking at itself in the tears of each of us. As in the faces of old icons, we remain devoutly bent over our cloudy clearness - radiating, but not transparent.

Let the tears become our true mirror. There our suffering and ecstasies will unite. Is there anything better than a shed tear for being the mirror of the one who has lost his paradise?

It is in tears only that we regain our face.

And since the tears flow out from the depth of the human being, they are like a calling from another paradise, the one we will enter after our final moment, after our second tear”.

Notes

¹ Research findings suggest that trauma is experienced by people living in various countries (e.g. Japan [Allard, 2009], Mexico [Norris et al., 2003], Sweden [Frans et al., 2005] or Poland [Statystyka Sądowa i Penitencjarna Ministerstwa Sprawiedliwości, 1998]), irrespective of age (Herzberger, 2002; Badura-Madej et al., 2000; Dobrzyńska-Mesterhazy, 1996; Czapczyńska, 2007; Courois, 2009).

² The review by Cabizuc and colleagues (2009) of sixteen papers showed that there is an increased risk of PTSD among parents of children who are chronically ill or subject to intensive medical procedures. Since one of the consequences of PTSD may also be a restriction of parental competence in the caretaking role during this difficult period for the parents and their children, the authors postulate the necessity of early diagnosis of parental functioning in order to prevent extremely important negative outcomes.

CHAPTER TWO

INTERPERSONAL TRAUMA AS CHRONIC AND COMPLEX

AGNIESZKA WIDERA-WYSOCZAŃSKA

Interpersonal trauma belongs to complex and chronic injuries, and it arises in connection with experiencing different types of abuse. In this article I wish to show the characteristics of chronic and complex trauma and compare them with those of a simple trauma. I describe the types of families which provide environments for interpersonal trauma and the types of abuse which contribute to complex interpersonal suffering. The perpetrator, usually close to the person wronged, is responsible for the abuse. Specific consequences (that a person suffered a specific type of abuse) and non-specific symptoms (that a person suffered some abuse) resulting from trauma depends on the age at which a person experiences it. These sufferers change over time (*life-span*); their traumas lead to secondary problems of life, while the accumulation of complex interpersonal traumas can lead to various disorders, including complex Post-Traumatic Stress Disorder (CPTSD). These consequences become an intermediary in the transmission of violence from generation to generation, and require specific therapy.

Psychological traumatic stressor events

To more clearly understand the concept of "trauma" a distinction was made between the traumatic event and the person's subjective reaction to it. The reaction is made during one's lifetime or in the immediate aftermath of the experience (peritraumatic) or as post-traumatic (occurring weeks, months, years afterwards) (Weathers, Keane, 2007). In trauma specialists opinion, the word "psychological trauma" applies only to events that are stressful and negative for the person. Responding to this event is defined as post-traumatic consequence occurring in the form of reactions, problems

and disorders. Let me begin with a description of psychological characteristics of types of traumatic events.

1. Simple traumatic events

The definition of a traumatic event, presented in PTSD A criterion contained in DSM-IV-TR (APA, 2000), shows a traumatic event as one which threatens health, life or the physical integrity of the person directly involved or of someone who is closely related. A person can experience the event, be a witness of it or hear about it. He/she can bear the consequences of the event or be a witness of its consequences, but not be threatened (Criterion A1). In addition, the reaction of the person is accompanied by anxiety, helplessness and horror (Criterion A2). Potentially traumatic events include natural disasters, including earthquakes, hurricanes, floods, or man-made disasters, such as car or aircraft accidents, a ship sinking, an explosion, and wars and diseases as well as physical or sexual assault by stranger, robbery, kidnapping, or being held hostage (Briere, Spinazzola, 2005; Briere, Scott, 2006; Van Hooff, Mc Farlane, Baur, Abraham, Barnes, 2009).

Table 2-1. Simple traumatic event according to PTSD, Criterion A "exposure to trauma" (DSM-IV-TR: APA, 2000).

The criterion of "A" with PTSD	Examples
A 1.1. A person who has witnessed or experienced events in which death or a threat of death occurred, where there is a threat to physical health or serious injury to a person.	<p>Natural disasters:</p> <ul style="list-style-type: none"> - earthquakes - floods - volcanoes <p>The catastrophe caused by a human being:</p> <ul style="list-style-type: none"> - Transport accidents with multiple victims: aviation, railway, ship, bus - Transport accidents with one or more victims: auto-mobile, motorcycle - Fires of houses or other buildings - Collapse of buildings <p>Military actions:</p> <ul style="list-style-type: none"> - War - Torture <p>Interpersonal abuse (occasional) made by foreigners:</p> <ul style="list-style-type: none"> - Rapes - Physical attack

	<ul style="list-style-type: none"> - Beatings Attack by an animal: - e.g. a dog
A 1.2. A person was a witness of the consequences of catastrophic events, but he/she was never threatened.	<ul style="list-style-type: none"> - Seeing bodies of people who died in a transport accident or during natural disasters - Watching a man being beaten - Exposure of emergency staff to the trauma
A 1.3. A person confronted with the consequences of a threat to the life of a close relative.	<ul style="list-style-type: none"> - Information that somebody we love or someone who is important to us was seriously injured or died in unknown circumstances, it is not known what happened to his/her body - Kidnapping, loss of the beloved one, and lack of knowledge of his/her fate

According to the response to severe stress (F43) described in ICD-10 (International Classification of Diseases) (2000) a traumatic event is described as a stressful event or situation, either short or long, of an exceptionally threatening or catastrophic nature which produces a severely negative experience for almost everybody (Tab.2-2).

Table 2-2. Simple traumatic events according to ICD-10 (2000).

In order to recognise the "reaction to severe stress" disorder category, it is necessary to experience one of the following causal factors:
<ol style="list-style-type: none"> 1. extremely stressful life event, physical or psychological, caused by a severe reaction to stress 2. significant life change leading to permanent and painful situations that causes adaptation disorders 3. genesis and severity of acute stress depend mainly on onto-genetic sensitivity and one's ability to cope with stress 4. stressor causing disorder, which disorganises the social reference frame of an individual (bereavement, separation), or interferes with wider social support systems and values (migration, refugee status) 5. stressor can be associated with a significant stage of development for an individual or with a crisis of development (parenting, retirement, etc.).

The same event need not be traumatic for everyone. The objective description of a traumatic event presented in the A criterion should be supplemented by a subjective interpretation of the event made by the person. The element of this subjective interpretation refers to the inclusion

of an emotional reaction in the form of fear, helplessness and horror in the A criterion of PTSD (DSM-IV–TR: APA, 2000). It was therefore concluded that reaction to traumatic stress can come from real emotional or physical abuse, and from external threats due to the subjective interpretation of those events.

The description by Lenore Terr (1991, 1994) of two types of traumatic events was a landmark step in defining traumatic events, ranging from a one-off situation to recurring events. Type I includes a single-incident trauma, which is sudden and unexpected. By contrast, type II is a complex or repetitive trauma for a chronic, recurrent, and accumulating experience, which can be anticipated and expected by the person. This type of traumatic event was described by Terr (1988) to show the specificity of interpersonal trauma experienced by a person in his/her childhood in the family.

According to ICD-10 (ICD-10, 2000), type II trauma is described as less severe psychosocial stresses called "life events" which can contribute to a number of abnormalities found in various categories of ICD-10 (particularly for adjustment disorders, F43.2). The very occurrence of a life event is not sufficient to explain the emergence of the disorder, as formation of its clinical picture also depends on the patient's own sensitivity.

The foundations for more precise defining interpersonal, complex and chronic, traumatic events were established in the following manner.

2. Interpersonal, complex and chronic traumatic events

Psychological interpersonal trauma incurs in connection with experiencing different types of abuse and negligence, and most often occurs in a dysfunctional and pathological family. This event is *interpersonal* and is connected with a specific type of bond, mainly a dysfunctional one (ambivalent, avoidant, disorganised, dissociative: Bowlby, 1973). It is the result of people who are close and important to the person wronged; moreover, the abuse being traumatic event is done deliberately and intentionally. Such an active (direct) perpetrator hurts the person manipulating him/ her, seducing, addicting emotionally, and subjecting the sufferer in order to use - secretly and with impunity - other abuse (e.g. emotional, physical, and sexual). Causing harm to the person, the perpetrator evokes a feeling of betrayal and undermines trust in primary relationships. The passive offender, the second parent, care-giver or person on whom the child depends, and does not offer protection and support. This situation causes a second injury: loss of basic confidence and a feeling of betrayal from the care-giver (betrayal trauma). The closer the