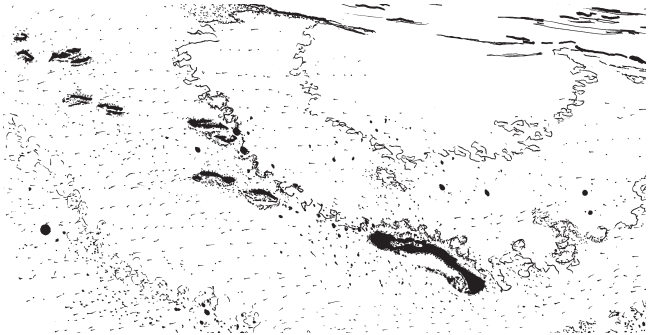
# Post-traumatic stress disorder in the women leaving a violent relationship and its treatment in counselling practice

(A methodological manual)



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**Title: Post-traumatic stress disorder in the women leaving a violent relationship and its treatment in counselling practice**

Compiled by: Pola Sejková, Nicole Fuchsová, Monika Kolcúnová, Ľudka Vysocká



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Home must be a safe place for everybody.

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„Those who enter discussions under the texts about violence survivors too often forget that they comment on the life of concrete people. When considering concrete human beings and their suffering, it is hard to be radical and aggressive.“

Sme, 21. Oct 2013,  Hana Vojtová

# Introduction

It is very difficult to work with the women who have experienced violence. The first acute phase requires crisis counselling and solving "technical" matters, such as divorce, a criminal complaint, children custody, alimony, housing, job, the status of a single parent, a new relationship ... All this happens in an unsettled situation to a woman with a wounded soul and a lot of unprocessed traumatic experiences. Moreover, the woman has to cope with new rules of an independent life and the care for children in a single-parent household, eventually with a new partner. Unless post-trauma is healed, psychosomatic problems might occur as well as repetitive violent relationships and a deterioration of the relationship with the children and other relatives and friends.

Leaving a violent relationship and searching for life without violence, the woman often suppresses the pain of her soul, dislikes herself and cannot forgive herself and the world, which influences the quality of her life. In our counselling work we most commonly deal with the first phase – acute solution. The following post-trauma treatment is a weak point of our work so far, and the clients themselves rarely ask about it. Why is it so? There are more answers to this question. Women want to forget and believe that if they suppress the experience with violence in an intimate relationship, they will be able to protect themselves against failure later on. Counsellors do not offer such services as they lack the experience with a long-term counselling relationship, and in our conditions, they also lack examples of good practice.

This manual will empower counsellors to help women with post-traumatic stress disorder. Its compilation resulted from sharing the experience with the Norwegian partners from the town of Kirkenes and the

Crisis Centre in the Glåmdal district, which was collected within the Safe Women's House MyMamy project, supported from the SK09 Domestic and Gender-based Violence Programme. The project was approved in 2015 and implemented by April 2017. Its main outcome is the safe women´s house with the capacity for 11 families and the counselling and social services staff (crisis counsellors, social workers, lawyer, psychologist, special pedagogists). Our professional capacities have improved also thanks to the new knowledge and skills gained from the cooperation with our Norwegian partner organisations. When compiling the manual, we used the knowledge from literature and the experience of counsellors from all three partners' organizations - WeMothers, Norasenteret, and Crisis Centre in Kongsvinger (Glåmdal district).

Pola Sejková, WeMothers, o.z.chairwoman

# 1. THEORETICAL BACKGROUND

## 1.1. Key Concepts

The word „***trauma***" generally refers to any injury, a physical or mental shock. The term was used as early as in Ancient Greece and meant wounds, injuries, but also defeats. It referred to injuries of the soldiers whose shields had been penetrated. Similarly, our current understanding of trauma refers to the penetrating of one´s psychic self-defence.

Further in the text ***psychic trauma*** will be discussed, which means a mental injury causing not only functional disorders but also organic changes. Psychic trauma might be caused either by single events, such as death of a close person or rape or by a less significant but repeating unfavourable situation, such as family quarrels, an arrogant boss or a traumatising teacher. It is important to know that the same event can have different consequences in different individuals. Each human is a unique being, and the same is true about an individual copying with traumatising influences. While one woman might be hit by trauma also on the level of organic changes; another woman takes the same situation more easily and does not experience any negative effects when it is over. Therefore, it is difficult to find a uniform rate for assessing the severity of certain behaviour in couple relationships. This is a problem of much expert psychological evidence provided for criminal proceedings against a person suspicious of psychological abuse.

**Post-traumatic stress disorder (PTSD)**

***Post-traumatic stress disorder*** (hereon as PTSD) is a complex of psychological symptoms caused by an extraordinary traumatising event. A post-traumatic stress response includes mainly the repetition of a traumatic event in ideas, dreams and imagination; nevertheless, these memories of a concrete horrible event have been partly discontinued. The person suffering from PTSD avoids the places and situations that are somehow connected to the event or that might remind of it. Being anxious and too watchful, such person cannot concentrate, starts to isolate herself from her family and friends and tends to react in an inappropriate, panicking or aggressive way. A person who has experienced extreme trauma can be diagnosed PTSD provided that certain symptoms from each of the three groups of symptoms occur in her / him: re-experiencing, evasive behaviour and irritability. The given symptoms must persist as long as one month and must cause serious problems or difficulties in personal or professional life. The most efficient help can be provided by psychotherapy...

***Post-traumatic stress disorder* is** also present in the women experiencing violence in couple relationships. Much research into PTSD mostly observes the men whose problems were caused by war; nevertheless, general population studies show that PTSD is more frequent in women.

Further research shows that post-traumatic stress disorder (PTSD) may be a consequence of acute or long-term domestic violence that keeps occurring even after a woman abandons a dangerous relationship. The same disorder may develop in the children who have experienced domestic violence.

Traumatic stressors have been recorded in 50% of adults and 40% of children. This concerns mainly the people who have witnessed a serious injury or death or the people who have experienced a situation

in which their life was in danger. The statistics is from the USA, but similar results have been found also in other developed countries. Traumatic stressors included in the domestic violence category are less commonly represented, but they present a higher risk for PTSD development than for example, natural disasters or the situations when a person has witnessed a traumatic event.

Since the 19th century several authors have tried to describe PTSD and have searched for its causes. Some authors think that it is a consequence of a physical trauma and a physical injury, but according to new findings PTSD might develop as a consequence of a life threatening event that does not have to be accompanied only by a physical injury. In the mid-20th century the term war neuroses was used. Its content and criteria are not specific enough. The term post-traumatic stress disorder (PTSD) is relatively new. It was introduced by American psychiatrists after war experience in Korea and Vietnam. The soldiers in both conflicts were accompanied not only by surgeons but also by psychiatrists and psychologists directly on the front lines. They could describe and try to treat a variety of mental problems that soldiers and later veterans experienced. They also discovered that after outrageous front line incidents some soldiers experienced the states of fear, anxiety, resignation, hostility or hidden aggressiveness, which are generally known and understood as a more or less common acute response to stress in the given situation. After some time some ill-disposed soldiers showed quite new symptoms. It was a surprise that such symptoms do not develop immediately after the event but are developing often without warning over several days or weeks, and it might happen even in an asymptomatic period, when an acute stress response stops. PSTD might develop

even six months after the experienced trauma. In the past many people believed that only soldiers or other people having experienced war could suffer from PTSD. Therefore, PTSD was commonly called "combat exhaustion" or "bomb shock". PTSD can hit anybody. New research shows that all types of people from different environments can suffer from traumatic experiences that sometimes lead to PTSD.

The PTSD diagnosis has been a lengthy process, which still continues. In the 1960s and 1970s the civil rights movement and feministic movement drew attention to a psychological effect of rape and the battered woman syndrome.

In the 1980s the Post Vietnam Syndrome was described in soldiers returning from war. All these states and syndromes led to the creation of the PTSD diagnostic unit in the DSM-III in 1980. The opponents of the concept claim that PTSD develops only in a small number of people with traumatic experience and most of them do not need any specific treatment.

Such a statement is not fair to victims and we can oppose that other medical diagnoses are not doubted either, even if some people do not fall ill. An example: not all the people with the HIV virus develop AIDS...

**Difference between stress, traumatic stress, PTS and PTSD**

Stress is a non-specific response of the body to any demand made upon it. (Selye, 1984). The most extreme form of stress is the stress resulting from a traumatic event - traumatic stress. Post-traumatic stress (PTS) continues also after a traumatic event.

**Types of trauma**

- type I trauma includes unexpected accidents or natural disasters as well as terroristic attacks, a single episode of an attack, etc. It is a simple and rare trauma.
- type II is a complex or repeating trauma, such as permanent abuse or domestic violence. A typical feature is its high frequency and the accumulation of other difficulties. It usually causes the loss of trust in primary relationships as it is often triggered by a person close to the victim.

Complex trauma is more risky for PTSD development than type I trauma. It can also affect biological, psychological and socioemotional development of human beings, especially if trauma occurs in a critical period of development. Such a critical period is mainly childhood, when important components of one´s personality are formed, such as self-control and creation of the boundaries of „me“. Trauma breaks the basic feeling of safety in children and causes fear, disruption, and vulnerability. The child cannot control his/her feelings and achieve the feeling of integrity.

Traumatic events are exceptional because they are far beyond normal human adjustment to life. They evoke absolute helplessness and horror. There is no quantifying rate as it leads to absurd comparison of experienced events.

## 1.2. Traumatic events and the impact of trauma on human mind

The most common causes of PTSD are exceptional and catastrophic events, such as:

- surviving a serious car accident,
- surviving a natural disaster or terroristic attack
- death of a close person (or just mere information on the death of a beloved person),
- physical or psychological abuse,
- rape.

When experiencing or noticing a threating situation, it is natural to feel fear, anxiety, anger, helplessness (and other emotions). These emotions cause a whole range of psychological and physical changes. Almost everybody experiences similar responses to such events and is deeply upset. And this is one of the diagnostic criteria that help characterise the event as a traumatic one.

Trauma occurs not only as a result of catastrophic events, such as sexual abuse or violence but also as a result of seemingly less striking events, such as divorce, car accident or surgery. These experiences are often taken as common events and their traumatic consequences are not considered. Whatever the cause, the good news is that trauma can be treated by using right procedures, and it can even be prevented.

The repeated trauma distorts the already formed personality of an adult, but it forms and deforms the child´s personality. Family is a place where one experiences love and safety. Unfortunately, it is also a place

of violence, hatred and fear. If women are exposed to their violent partner's behaviour, violence concerns also their children who witness it; thus, becoming both witnesses and victims at the same, time.

Observing violence against the mother has the same serious impact on her children as violence committed upon children themselves.

Violence against women is an important traumatic event in the life of women and their children. Judith Lewis Herman (2001, p. 110) compares violence against women (VAW) to war, concentration camps or political imprisonment and claims that the women facing VAW experience small hidden concentration camps created by bullies ruling over their homes. *„The cases of domestic violence captivity usually do not include physical barriers that would prevent the victim from escaping. The barriers that prevent the victim from escaping are mostly invisible, but they are so strong that victims do not know how to break them.*" The barriers are about man having total power over woman. The author explains that man in order to have power over woman uses methods based on causing systematic and repeated psychological trauma. The abuser' s tactics are devised and carried out precisely to control woman and make her powerless, isolated, horrified, with a destroyed feeling of her own self and destroyed feelings to others. These patterns of violence include isolation, distorted woman´s perception, trivial demands, depletion, humiliation, defamation, intimidation, total control and occasional favours. *„The ultimate goal of all these techniques is to show the victim that the perpetrator is so powerful that her resistance is useless and her life fully depends on his kindness to her, which she cannot achieve unless she is slavishly devoted. The perpetrator´s aim is not only to evoke fear of death in his victim but also to evoke gratitude to him as he lets her live.*" (Herman, 2001, p. 114). By applying fear and control the

abuser makes the woman docile and makes her responsible for his violent behaviour. At the same time his occasional kindness keeps her hope that he will change.

Herman (2001, p. 132) maintains that the contradictory feelings of terror and relief in the isolation of an intimate relationship can result in the extreme dependence of the woman on the abuser´s authority. *„The victim can live in constant fear of his anger but at the same time she can perceive him as the source of strength, her guide and counsellor…"* This is also related to a self-destroying reaction, which is, according to M. A. Douglas (in: Čírtková, 2006, p. 61) one of the three basic symptoms of the women experiencing VAW. The others are Stockholm syndrome and a post-traumatic stress disorder, which is analysed in more details.

## 1.3. Post trauma as a state, PTSD

PTSD can be defined as a delayed, lingering response to a stressful event of a short-term or long-term duration, which is of extremely dangerous and catastrophic nature and which would cause deep upset almost in anybody.

PTSD signs start after a traumatic event and after a latency period, which may last from several weeks to several months. People suffering from PTSD should know that it is a health problem, an illness that is as serious as, for example, diabetes or arthritis (inflammation of joints). The given problem is not a sign of personal weakness. The symptoms of this disease are not "only in your head" or "imagination ". A post-traumatic stress disorder (PTSD) starts when PTS escalates to such a level that it evokes the symptoms stated in DSM-IV. Post-traumatic stress disorder is often wrongly explained and diagnosed despite its

very specific symptoms that form a syndrome. PTSD falls into a big group of anxiety disorders, having its acute and chronical forms. This anxiety disorder typically develops after an emotionally difficult, stressful event, whose severity goes beyond common human experience and is traumatising for most people. It occurs after sudden, outrageous, personal integrity limiting or life threatening events, which a person has experienced or witnessed.

PTSD diagnosis requires meeting the following criteria:

1. exposure to a traumatising event,
2. overwhelming memories, flashbacks, dreams, experiencing anxiety when facing the situations reminding of the stressor or linked to the stressor,
3. avoiding ideas and feelings connected to the trauma and activities reminding of the trauma,
4. at least one of the following criteria must be present: partial or complete traumatic amnesia, difficulty falling asleep and concentrating, flushes of anger, irritation, etc.
5. the criteria 2, 3 a 4 must be met within 6 months from the trauma or the stressful period. Sometimes the diagnosis can be made also after the given period, but the reasons must be clearly stated.

PTSD can be diagnosed in a person who has experienced an extreme trauma if certain symptoms from each of the three groups are present: reliving the traumatic event as if it were happening again, dumbness and distress. These symptoms must pervade for at least one month and cause serious problems in personal and professional life.

*A person must re-experience one or more of the following symptoms:*

- Common, sudden and sorrowful memories of the event, including ideas and images.
- Repeated stressful dreams about the event.
- Reliving the traumatic event.
- Strong emotional or mental pain when encountering people, places or things related to the event.
- Physical reactions, for example, shiver, fever, pounding heart), when encountering people, places or things related to the event.

*Avoidance must include three or more of the following symptoms:*

- Avoiding ideas, feelings or conversations related to the event.
- Avoiding activities, places or people related to the event.
- Inability to remember important details of the event.
- Inability to enjoy or participate in the activities that we liked to do before.
- A sense of *isolation* or even alienation from family members and friends.
- Certainty that some important life objectives will not be met, for example, marriage, parenthood or aging.

*Distress must include two or more of the following symptoms:*

- troubles falling asleep or sleeping,
- outbursts of irritation or anger,

- troubles concentrating,
- always being on guard for danger,
- being easily startled or frightened .

### Occurrence of PTSD symptoms

PTSD symptoms usually start within several weeks after the traumatic events. Nevertheless, some people might lack symptoms even several months or years after the traumatic events.

Although the PTSD diagnosis has its criteria and is precisely defined, it might differ in women experiencing violence in an intimate relationship. The diagnosis is based on the observation of the people who have experienced big traumatic events, such as war or natural disasters. It means that some people experience typical personality changes in relations and in one's own identity in response to a long-term and repeating trauma (for example, abuse or violence in relationship). People who experienced trauma in childhood are most vulnerable.

As already stated, PTSD usually develops after a complex type II trauma, whose symptoms are as follows:

1. extreme emotional instability and distress,
2. pathological dissociation,
3. health problems (somatic), which classical medicine cannot cure,
4. negative self-evaluation (perception of oneself as aggrieved and wrong) in relations (expecting betrayal, abuse or desertion) and in spirituality (the loss of hope and belief).

PTSD is often accompanied with other illnesses and disorders, which makes the diagnosis more difficult. Research findings claim that more than 80% of adults with PTSD meet diagnostic criteria for at least one more psychiatric diagnosis, such as mood and anxiety disorders, addictions, somatoform disorders, eating disorders and dissociative disorders. People with PTSD can also have somatic problems, especially in domestic violence cases, with different injuries, gynaecological and other problems.

As a consequence of violent intimate relations, complex PTSD has its specific features, which are observed as complex changes in many areas of the victim's perception and behaviour. *(Herman 2001, 170-171)*:

1. Changes in emotions:

- Persistent dysphoria
- Chronic suicidal thoughts
- Self-harming
- Bursting or extremely subdued anger
- Obsessive or extremely subdued sexuality

2. Changes in Consciousness:

- The loss of memory or hypermnesia for traumatic events
- Temporary dissociation episodes

- Depersonalisation, loss of the sense of reality
- Recurrent experiencing of the trauma in the form of obsessive memories and ideas

3. Changes in self-perception:

- Feeling of helplessness and paralysis of initiative
- Feelings of shame, guilt and self-blaming
- Feeling of dirt and stigmatisation
- Feeling of being completely different from other people

4. Changes in perceiving the abuser:

- Excessive dealing with the relation with the abuser
- Unrealistic passing of total power on the abuser
- Idealisation and paradoxically, gratitude
- Feeling of a strange or supernatural relationship
- Accepting the abuser´s beliefs or accepting his way of making the whole situation rational

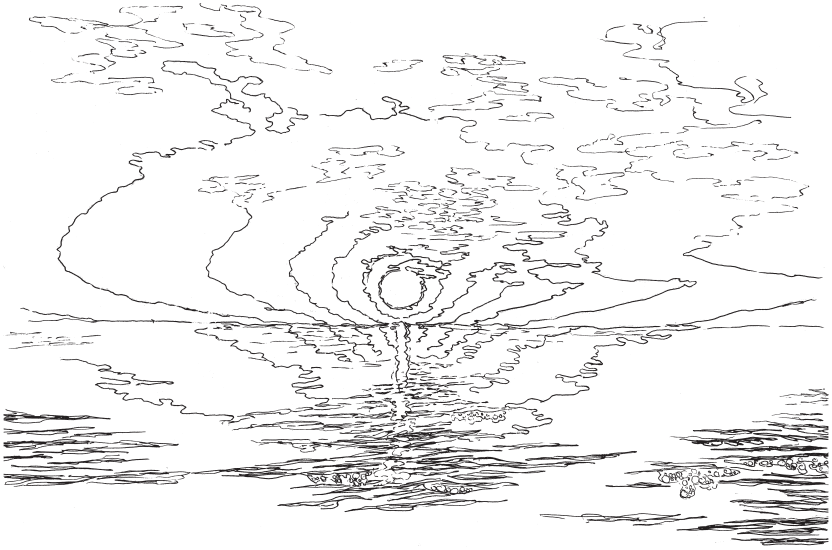
5. Changes in the relation to the others

- Isolation and alienation
- Interruption of intimate relationships

- Repetitive searching for a rescuer
- Constant distrust
- Repetitive failure in self-defence

6. Changes in meaning systems:

- Loss of belief
- Feeling of helplessness and despair



## 2. PTSD THERAPY

### 2.1. Basic therapeutic principles

As we have already mentioned, each human being is unique and responds to the same input in a unique way. Some people who have survived extreme life threatening situations are able to handle the situation themselves or with the help of the family and friends.

Others search for a helping "crutch" in the substances that make them feel they can cope with a difficult situation at least for a while. If one cannot cope with the trauma using her / his own sources, it is recommended to address a professional therapist and choose one of the effective approaches. It seems that psychotherapy is most effective, although pharmacotherapy should be also considered, but under the supervision of a psychiatrist. In this case antidepressants are used; anxiolytics are not so efficient. It is interesting that placebo is almost as efficient as common drugs with guanfacine or clonidine.

What is most important, though, is a psychotherapeutic approach. The main objectives of psychotherapy in PTSD treatment are as follows:

- to integrate trauma into one´s own personal experience,
- to soothe or remove negative impacts on one´s physical and mainly mental health.

The therapy goes on in an atmosphere of a trustworthy counsellor patient relation. There are several therapeutic methods that professionals use; therefore, the victim should always consider what to choose.

Therapists use different approaches, which might not suit everybody. While certain method is very good for one client it does not have to suit another.

It is also important to consider a necessity of a different approach to children and adults. Children often suffer when adults do not speak about their unhappiness and hope that the children will sooner forget about it. Nevertheless, supressed emotions cause suspense, and the children have to cope with it, anyway. They understand that the parents, mother or other adults do not want to talk to them about the experienced event. Therefore, the psycho therapist has to analyse the situation very carefully and choose the right way of the treatment. A psychotherapeutic approach is based on an emphatic dialogue, which consists of three parts, supposing the client is a child:

1. Opening – the child expresses the nature of the trauma through play or drawing, children drawings are easily readable especially in preschool and younger school age.
2. Trauma – a talk about the event gradually develops
3. Closing – presents a summary of the whole therapy; copying with the event; the therapist ensures the child that he / she is safe and his / her feelings are understandable and only temporary.

A dialogue with adults is slightly different in its structure, although it is also divided into three parts:

1. Assessment of the current state – focusing on depression, anxiety, trauma flashbacks, startle responses, etc.
2. The period before the trauma – questions aim at discovering eventual mental disorders in the family.
3. Discussion about the trauma itself.

The psychotherapist should strive to be emphatic, calm and pleasant. Using appropriate questions she gets to the details and discusses them with the client. She should never force her own opinions; on the contrary, the client reaches her own conclusions. The client should not supress her emotions (anger, helplessness, cry…), and it is good to support her in showing her emotions as it is an excellent way of getting rid of tension and understanding one's own attitude to the trauma; eventually, formulating one´s life objectives later on.

If PTSD is not treated with suitable psychotherapy and it is only a general practitioner who prescribes antidepressants, the personality can be permanently harmed, with psychosomatic disorders that other experts might have difficulty solving.

One of the methods used for treating trauma consequences is **cognitive behavioural therapy**. It focuses on the correction of problematic ways of thinking and behaviour that result in suffering, which have developed due to the experienced trauma and have formed a vicious circle. It is necessary to explain the client that there is a direct relation between her symptoms and the traumatic event and that it is all related to PTSD. The client is then exposed to triggering moments (most commonly in a form of a dialogue about the event, which should be repeated approximately 10 times). As a result, emotional tension alleviates.

The exposure to fear and anxiety stimuli, which are triggers of stress reaction, in combination with relaxation in the safety of a therapeutic situation leads to desensitization and to the reduction of anxiety. Sensitivity to the given stimuli is lowered, which results in behavioural changes, especially to the removal of evasiveness. The treatment also includes stereotypically repeating and demoralising ideas and a dis-

turbed attitude of a person to herself, to her future and to other people and the world. It is important to learn new skills that are inevitable for copying with problems and situations connected with trauma.

Another therapeutic method used for healing trauma is **supportive psychotherapy**. It aims at achieving inner stabilisation and peace. The therapist listens to the client with understanding and encourages sharing negative emotions (the feeling of fear, sadness, anger, guilt, etc.). The therapist also encourages the client to describe what haunts and bothers her and to recall the details of a traumatic event. He /she helps the client understand the context and together they try to solve the problems connected to trauma consequences. The therapist strives to involve the people who are important for a traumatised person and secures also the involvement of relevant institutions and services.

During a traumatic event personal values are often violently attacked. **Psychodynamic psychoterapy** helps a traumatised person explore her / his personal values and the rate of their violation during a traumatised event. It aims at solving conscious and subconscious conflicts that the person experiences due to a violent event. The therapy also tries to restore and increase self-respect and self-control, and to restore the feeling of integrity and personal self-esteem.

Another helpful method is **family therapy**. Due to the PTSD of a person also her / his family members suffer – the partner, children. They often say that their husband / wife / mother does not talk to them,

does not show emotions and interest and does not contribute to the family life. The therapy helps family members understand emotions that each of them experiences and teaches them how to cope with these emotions. They learn about better ways of communication, parenting care and stress-copying techniques.

Another efficient treatment is **discussion groups or groups focused on counselling**, that consist exclusively of the people suffering from PTSD. This method encourages the people who have experienced a similar traumatising event to share their experiences and their responses to the event. If one learns that there are more people who have experienced a similar terrible event and have experienced similar feelings, he / she starts to understand that his / her feelings of guilt and unworthiness are not unique.

A special psychotherapeutic technique of healing post-trauma and its consequences is provided also by **Katathym imaginative psychotherapy**, which uses guided mental imagery.

**EMDR (Eye Movement Desensitization and Reprocessing)** is a new and very promising method of processing traumatic memories. It often happens that the information on hurtful events remains in the nervous system (all the images, sounds, ideas, emotions and all the other impressions. When treated by this method, the client creates the vivid visual image related to the memory while the therapist directs lateral eye movement. According to a neurophysiological hypothesis, this movement opens an access to neural networks with the "stranded" information on trauma and enables brain to process this information. Thus, the emotional charge bearing traumatic memories decreases and unpleasant physical symptoms also

disappear. Moreover, the therapist works with the client also on the change of her / his self-esteem, which is due to traumatic experience negative and very low.

**EMDR is a relatively new therapeutic method. The method of processing traumatic experiences with the help of eye movement includes elements of psychodynamic and cognitive behavioural therapy.** EMDR is one of the most effective psychotherapeutic approaches. Post-traumatic stress disorder is its main indication. EMDR focuses on the processing of traumatic experiences and is globally acknowledged as one of the first choice methods in PTSD treatment. EMDR makes it possible to work with both simple and complex trauma. Simple trauma refers to single or short-term traumatic events, such as accidents. Complex trauma includes repeated serious trauma with a lot of symptoms, which limits one´s life in society. EMDR has the tools that help the client get rid of the burden of the past memories.

EMDR therapy consists of eight phases, which aim at the processing of traumatic experiences. The first 3 phases (a history-taking session, equilibrium searching and assessing) represent the diagnosis and preparation phase; the next 3 phases (desensitisation, installation and body scan) enable the processing itself. The last two phases (closure and re-evaluation) lead to the integration and reorientation. The phases are relatively independent, but they are closely interwoven and enable gradual processing of serious post-traumatic stress disorders without destabilising a person and disturbing her / his everyday life.

While classical therapy is mostly verbal, EDMR focuses directly on distressing events and enables their processing. The unprocessed events are dysfunctionally stored in the brain in the same way as they were experienced during the traumatic period. EMDR is generally known as a therapy that can reach the same

effect faster than other therapies. Psychotherapy is usually a long distance run, especially if it is supposed to process also past traumatic experiences. EMDR is about one third shorter than other psychotherapeutic approaches.

## 2.2. Specific features of post-trauma therapy for women after violent events in an intimate relationship

Post-traumatic stress disorder is a major topic of interest of J. L. Herman (2001, p. 56), who claims that traumatic events are extraordinary not because of their rare occurrence but because they exceed the human ability to adjust to life. People respond to danger by a series of physical and mental reactions that mobilise them to act, attack or escape. If one cannot do anything, traumatic reactions develop. *„If you can neither resist nor escape, your protective system becomes overloaded and collapses. Traumatic events cause deep and permanent changes in physiological excitability, emotions and cognitive and memory abilities.“* Herman further claims that the people exposed to repeated long-term trauma, which is true about women experiencing violence, develop a malignant progressive form of post-traumatic stress disorder that disrupts their personality. *„The very basic structure of the Me is damaged in traumatised people. They lose trust in themselves, in other people, in God. Their self-esteem is damaged by the experience of degradation, guilt and helplessness“* (Herman, 2001, p. 85). Jana Cviková and Jana Juráňová (2001) consider several symptoms of post-traumatic stress disorder: excessive excitability (constant fear and expectation of new danger, which persists not only when awake but also when sleeping), intrusion (obsessive ideas and images, live memories) and constriction

(mental and emotional numbness and evading the situations that the person considers threatening)[1]. The women who have experienced violence and suffer from PTSD are sometimes diagnosed with a completely different disorder that does not consider the influence of chronic trauma on a woman. *„Victims are often prescribed drugs that cure anxiety disorder or depressions, but the real cause of their problems remain hidden.“* (Logar, 2003, in: Vargová, Vavroňová, 2006, p. 39). Herman (2001) provides other wrong diagnoses – somatization disorder, borderline personality disorder and multiple personality disorder, and she claims that the symptoms present in a woman are not considered a consequence of long-term violence, but rather character personality features that make the woman predestined to violence. Herman (2001, p. 168) also emphasises that PTSD diagnosis is not sufficiently accurate as the criteria are often based on the people who have experienced a specific traumatic event (war, a natural disaster, rape), but the people who have experienced chronic abuse exhibit a much more complicated set of symptoms. *„Chronic abuse results in the changes of personality features, including deformation of family relations and identity. A common formulation of PTSD includes neither changing and multiple symptoms of chronic and repeated trauma nor deep deformation of the personality that develops in captivity.“*

Violence against women affects women in a very serious way. It not only severely violates their rights and freedoms and devastates the safe home environment but also continuously diminishes their self-es-

[1] J. L. Herman (2001) claims that perception can be damaged or deformed, and even partial anamnesis can be present or loss of other perceptions, eventually, with a restricted recollection deprived of emotion and meaning. The given facts can be questionable in the talks of women about the experienced violence; therefore, their statements can be considered doubtful.

teem and affects their life in different fields. Moreover, as research results from 2008 show, most women experiencing violence live in a household with at least one child (76 %).

Herman (2001) writes also about the principle of providing assistance and mentions the already stated empowerment principle and the neutrality in relation principle. She emphasises the need of impartiality and neutrality of the assisting counsellor, but calls also for moral neutrality as it is important that the counsellor adopts a moral attitude. It means that she is supposed to confirm her solidarity with the client and understand that the client has experienced a traumatic event of absolute injustice and needs the support that will help her restore the feeling of justice, at least to some extent. We can conclude that a moral attitude is somehow related to the already mentioned supportive counselling. Herman also points out the necessity of creating a healing relationship between counsellor and client. She enumerates the stages of the client´s healing, which should be considered when providing psychotherapeutic assistance. Nevertheless, due to the severity of violence consequences, mainly the presence of PTSD, the given stages must be considered also by other assisting professionals. Therefore, we select the signs and principles of individual stages that should be taken into account and respected by all the involved assisting professionals.

According to Herman (2001, p. 218) the first healing stage is providing women and their children with safety – *„this crucial task is prior to all the others, as no therapeutic work can be successful unless adequate safety is provided to the person who has experienced trauma.*“ Safety provision consists of three main principles – naming the problem clearly, restoring control and creating safe environment. The author claims that if the woman can name the problem she has the knowledge and if she has the knowledge she has also the power.

*„Once the person is not imprisoned in the solitude of her trauma, she finds out that there is a language that can describe her experience. She finds out that she is not alone; many others have suffered in a similar way. Later she finds out that she is not crazy; traumatic syndromes are normal human reactions to extreme circumstances"*(Herman, 2001, p. 216). Restoring control includes the need of control over one's own body (restoring one's physical integrity), and gradually includes also the control of the environment, i.e. safe life situation, financial provision, mobility and self-protection. Herman emphasises the need of social support. The creation of safe environment means a safe shelter for the woman and her children and writing a plan of their future protection. It is the basis for the next work with the woman and her children, especially in relation to the steps she wants to make against the abuser.

When a traumatised person gradually gets the basic feeling of safety or predictability of her life, when she again finds out that she can rely on herself and other people, then the second healing stage starts – recollection and grieving. It is a reconstruction of the story, which the author compares, due to the consequences of post-traumatic stress disorder, to building of a very complex puzzle consisting of plentiful interlocking small parts. The objective of this stage is to transform traumatic memories so that they can be included in the life story of the woman. It is a so-called story telling act because a traumatic memory is, according to Herman (2001, p. 263), without words and static. *„Trauma has become part of the experience of a person … the story has become a memory like all the other memories…."* Another principle is grieving, which is important as each trauma brings some losses. The author points out that some women might conscientiously refuse grieving because this would mean a victory of the abuser. Therefore, it is important that the

assisting professional re-formulates the act of grieving of a humiliated person to the act of courage. When the person mourns for a traumatic event, she can suddenly find out that the abuser is not interesting for her and she is not interested in him anymore.

Herman (2001, p. 264) maintains that the stage is completed once the woman processes her history and feels new hope and energy so that she can start living again. *„At this point a person who has survived trauma meets the task to rebuild his / her life at present and deal with own challenges in the future.“* Now the third stage starts, which focuses on restoring contacts with close people and a wider community and on making new contacts. As a result, psychological capabilities are restored, which traumatic experience have damaged or deformed. The woman starts to trust other people again; she can be autonomous and more initiative and is able not only to preserve her own opinion, borders and intimacy but also to respect the borders and autonomy of other people. Herman (2001) also claims that this is the stage when women are ready to share their secrets, cope with the ignorance or mistrust of strangers and blame those who have hurt them.

Herman points out that the given healing stages are “abstract concepts” and cannot be literally understood. They aim at bringing order into the processes that are by their nature complex and turbulent. That is why we want to draw the attention of assisting professionals to these stages so that they know what the woman who has experienced VaW needs in order to heal. It is important that they know that women and children need safety, they need to name the problem clearly, to take a moral attitude and make the abuser responsible for his deeds. Assisting professionals should provide their clients with the space for grieving, empower them and build on their strengths, so that they enter the third stage, which is starting a new life.

It is important to know the principles aiming at the empowerment of women, their children and their mutual relationship. It is important to create an adequate system of assistance and support in an acute crisis period and in a following period, responding to the needs of women and children.

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