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TRAUMA – CONTROVERSIES SURROUNDING THE CONCEPT, DIAGNOSIS, AFTERMATH, AND PRACTICAL IMPLICATIONS

The way of understanding trauma still remains a crucial issue in both theoretical and practical terms (in diagnosis and therapy). In this article, we discuss the controversies around the definition, the process of diagnosing, and the consequences of trauma. The subject of analysis is the current diagnostic criteria for trauma (the narrow and broad approaches to trauma), including those set out in the current classifications of mental disorders: ICD-10 and DSM-5. We discuss posttraumatic stress disorder syndromes as well as the impact of traumatic events on mental health and psychosocial functioning. The principles of support for people who have experienced trauma are also suggested.

Keywords: trauma; trauma assessment; posttraumatic disorders; implications for practice.

Introduction

Among many events and stressful situations, those of particular importance are traumatic events threatening health or life, during which a person experiences intense fear and a sense of helplessness (Lis-Turlejska, 1998, 2005). After the American Psychiatric Association distinguished a disease entity called "post-

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traumatic stress disorder" (PTSD; DSM-III, 1980), maintained in subsequent editions (DSM-IV and DSM-5) and subsequently by the World Health Organization (ICD-10, 1997), interest in the characteristics, scale, and aftermath of traumatic events began to increase. The key element in these reflections is the concept of trauma, whose definition changed over the years.

Initially, trauma was defined as a kind of stressor beyond the range of ordinary human experience and distinguished from other, weaker stressors such as everyday worries or critical life events. Empirical studies showed that there are considerable individual differences in the experience of traumatic events (Lis-Turlejska, 2005; Popiel & Pragłowska, 2009; Zawadzki & Strelau, 2008). Numerous studies also prove that strongly stressful events with traumatic potential are a frequent phenomenon in the general population (Lis-Turlejska, 2005; Norris & Slone, 2007).

There is no consensus regarding the frequency of the occurrence of traumatic events; the earliest studies conducted in the United States suggested a rare occurrence of traumatic events (about 1%) and posttraumatic disorders (Helzer, Robins, & McEvoy 1987; Breslau, Davis, Andreski, & Peterson, 1991). Since that time, a constant increase in the occurrence of traumatic events has been observed, which may stem from actual increase in exposure to such events (civilizational, technological, and social changes) as well as from progress in the methodology of research devoted to these events and their effects. It is estimated that exposure to a traumatic event during the lifetime in western countries varies from 25% to 92% for men and from 18% to 87% for women (Breslau et al., 1998), while in the USA these percentages are 60.3% for men and 51.3% for women (Kessler, Sonnega, Bromet, Hughens, & Nelson, 1995). In Poland, studies devoted to these issues have been few; one of them is the study conducted by Lis-Turlejska (2005) on a sample of students, in which 75.6% of the participants reported having experienced at least one traumatic event (according to DSM-IV criteria), the mean number of such events being significantly higher among men than among women.

The need for in-depth reflection on the issue of trauma stems from several causes: greater demand for professional support in the face of increasing risk factors for trauma, difficulties related to its diagnosis and results, and the differentiation of the clinical symptoms of trauma from reactions to normative experiences. What is also important is the need to take into account the legal regulations pertaining to the victims of traumas and sometimes to their perpetrators (e.g., violence, traffic accident). The understanding of the magnitude of trauma

and the assessment of its severity is important in the assessment of its results and in planning support.

The faces of trauma and difficulties in defining and diagnosing it

Definitional controversies mainly concern the question of which events are traumatic and which ones are not. Generally speaking, there are two ways of understanding trauma, based on its essence, frequency of occurrence, and consequences: a broad one and a narrow one.

In the broad sense, the term "trauma" can be used to refer to all psychological injuries occurring at different stages of human life (crises, conflicts, chronic somatic and well as mental diseases threatening life) that involve a risk of emotional, cognitive, or social disorders. This understanding of trauma is close to the concept of a stressful situation. In the narrow sense, trauma is treated as a kind of severe stressor that exposes a person to the threat of losing life or sustaining a serious bodily injury, usually has a sudden, uncontrolled character, and may concern many people simultaneously. This also refers to situations of witnessing such an event (Folkman, 2011; Skinner & Zimmer-Gembeck, 2011; Solomon & Heide, 1999; Terr, 1991).

Special controversies concern the diagnosis of traumas occurring in childhood. Terr (1991) distinguishes two main types of trauma experienced in this period of life: Type I and Type II. The former is a result of an individual event of short duration (e.g., kidnapping, witnessing a murder), while the latter encompasses long-term situations and repeated situations of exposure to external traumatic factors.

Observations concerning the negative consequences of prolonged traumatic events have been confirmed in numerous studies. It has been shown in those studies that the percentage of people exhibiting PTSD or depression increases with the increase in the number of traumatic events experienced. The highest likelihood of PTSD in women is connected with extremely traumatic experiences of sexual violence, while in men it is connected with diseases or accidents threatening life or with witnessing a tragic death or an assault (Lis-Turlejska, 2005).

In DSM-5 (APA, 2013), the concept of trauma appears mainly in the description of PTSD and acute stress syndrome (ASD). The concept of trauma has been more specifically defined here and the diagnostic categories of PTSD and ASD have been moved from the group of anxiety disorders to the group of disorders stemming from an injury or a stressor. This highlights the role of a traumatic

event as an etiological factor in these and related disorders, in contrast to other anxiety disorders, for which the presence of such an event is not necessary. In DSM-5, trauma is understood as a special type of event (stressor); the following are enumerated as events of this kind: (1) exposure to actual death, (2) exposure to threatened death, (3) exposure to actual or threatened serious injury, and (4) exposure to actual or threatened sexual violence. Moreover, this classification specifies the conditions relating to the circumstances of such events, of which at least one must be met for the event to be recognized as traumatic. These conditions are:

(1) direct experience of a traumatic event;

(2) being a direct witness to a traumatic event;

(3) indirect experience by receiving information that a close family member or a friend was in danger of an injury. If the traumatic event involved death or a threat to life, it must have been a violent one or an accident.

(4) multiple or extreme exposure to aversive details of traumatic events, usually in the course of professional activities (e.g., emergency services). Indirect exposure in the nonprofessional context (electronic media, television, movies, or photographs) is excluded here.

It is worth noting that the criterion of subjective emotional response (fear, helplessness, terror) to the traumatic event, which had been present in the previous edition of the DSM manual, was removed from DSM-5. The authors of DSM stressed that detecting the presence of this criterion posed practical difficulties since it did not have an objective character and could be based solely on the subjective experience of the person exposed to traumatic events and on their individual ability to interpret the emotions experienced. This criterion was also problematic with regard to victims of traumatic events (e.g., victims of car accidents) who had lost consciousness in the course of the event (e.g., as a result of skull and brain injury). Such people were later unable to give an account of their subjective reactions to the events because the details of how the event happened were shrouded by amnesia. The removal of this criterion from the list of criteria necessary for trauma to be diagnosed enables greater objectivity in diagnosing PTSD and ASD. Additionally, some empirical studies yielded results challenging the legitimacy of including this criterion in PTSD assessment. An example is a study of over 900 war veterans, in which the criterion of subjective emotional reaction to the traumatic event turned out to not be a statistically significant predictor of PTSD, although it was associated with the intensity of PTSD symptoms in those individuals in whom this disorder occurred (Osei-Bonsu et al., 2012). In a study of PTSD syndrome stemming from the experience of sexual violence it

was found that the presence of subjective emotional reaction to the traumatic event did not have predictive value for psychological, professional, and somatic functioning (Palmieri, 2002). A different study, conducted on three different samples, also revealed no relationship between the subjective criterion for trauma and its consequences in the form of PTSD symptoms (Bedard-Gilligan & Zoellner, 2008). In further research, scholars questioned the validity of the criterion of subjective emotional reaction to the event, since they found that other emotional reactions to the event had similar predictive value with regard to the level of PTSD symptoms as reactions with contents listed in DSM-IV criteria (fear, helplessness, terror; Hathaway, Boals, & Banks, 2010). The changes visible in DSM-5 mark a trend towards greater objectivity in the definition of trauma.

In the literature on the subject, the concept of a potentially traumatic event (or a potentially traumatic stressor) is sometimes used, which highlights the distinction between the objective event and an individual way of reacting to it. In this kind of approach, an event has a traumatic character when it causes post-traumatic symptoms in a person (Lis-Turlejska, 2000). This understanding of trauma seems controversial, though, due to the fact that it makes the recognition of an event as traumatic dependent on the occurrence of psychopathological consequences: when these are absent, the event remains only potentially traumatic. This may imply the controversial conclusion that there are no objectively traumatic events. It seems, however, that an event may have a traumatic character even when a particular person's reaction to that event is within the norm and when the person has effectively coped with the stress resulting from that event. The authors of the present article believe that trauma has a dual nature, comprising the occurrence of a traumatic event and a strong subjective emotional reaction to it; the reaction may but does not have to evolve into a psychopathological condition.

The solutions applied so far make it possible to conclude that, in practice, trauma diagnosis is not simple and that difficulties in this regard can concern the following issues:

– The subjective vs. objective character of trauma – there are considerable individual differences in the perception of the traumatic nature of certain events; consequently, the subjective perception of the traumatic character of the same event may differ across individuals.

– Despite attempts to systematize traumatic events and distinguish them from other, nontraumatic stressors, the borders of the concept of trauma may differ across social and cultural communities.

– A difficulty in trauma assessment may arise in the evaluation of events that took place in a distant past, for example in childhood. Their retrospective evaluation is exposed to distortions connected with memory processes and with the change in their evaluation from the perspective of passing time.

– Trauma superimposed on previously existing disorders can significantly hinder recognizing the actual significance of events with traumatic potential.

– In some cases of assessment or therapy as well as in some legal circumstances, there is a risk of "suggesting" a trauma to a person who did not evaluate a particular event as traumatic before. As a result, the person may evaluate his or her past experiences as traumatic, harmful, and qualifying for legal claims.

– What is important in this regard is the individual system of values that determines what significance is attributed to various events, including traumatic ones (diminishing or magnifying their subjectively perceived traumatic character).

Additionally, it is possible to identify a number of factors (cultural factors, the model of family functioning, individual and social perception of difficult situations, health condition, situational and social context) that are important to understanding and assessment. What is also of significance is legal aspects, such as the penalization of certain acts or the motivation to make legal claims.

In the process of assessment, trauma can be underestimated or overestimated. The causes behind this state of affairs are numerous; they concern the way of diagnosing trauma, the way of analyzing and assessing the relations between the person's resources and the traumatic experience, the individual way of perceiving and evaluating the situation, and the availability of support. It should be stressed that the consequences of underestimating or overestimating a trauma significantly affect the person's functioning, quality of life, health condition, and social functioning.

Trauma underestimation can be a risk factor for many forms of disorders in the traumatized person's functioning: a sense of loneliness and social isolation, a sense of harm, self-destructive behaviors, a sense of guilt, the consolidation of generalized negative cognitive schemata and beliefs, establishing unsafe relationships, the development and maintenance of mental and somatic disorders, as well as PTSD syndrome.

Trauma underestimation can be related to the risk of identification with the role of a victim, stigmatization (e.g., adult children of alcoholics, ACOA; adult children of divorced parents, ACODP), populational (e.g., national, professional, community-related) or transgenerational (generational – the "second generation syndrome") generalization of trauma (connected with terror and persecution), identity change, a low sense of personal dignity and value, manipulation using

the "status of being a victim," and deriving indirect benefits or activating an overcompensation mechanism (e.g., contempt for people who function worse).

Disorders resulting from the experience of a traumatic event

The experience of a traumatic event is accompanied by a high risk of mental and behavioral disorders. In the context of diagnosis, it is important to consider whether a particular reaction to a traumatic event has a normative character (normal reaction to a non-normal situation) or significantly diverges from the norm. In a majority of people, the symptoms that dominate in the first period after a traumatic event include: anxiety, discomfort, excessive agitation, and the avoidance of contacts, which can be considered normative reactions (appropriate to the situation).

According to Alarcon, Deering, Glover, Ready and Eddelman (1997), it is possible to distinguish six types of disorders being the clinical aftermath of traumatic experiences: affective (depressive), dissociative, somatomorphic, psychomotor, cognitive, and neurotic-like; many people exhibit symptoms representing various types of disorders.

In the ICD-10 manual (1997), the World Health Organization lists the following complexes of mental disorders causally related to exposure to traumatic events:

(1) acute stress reaction – defined as a transient disorder of considerable intensity that develops in an individual without any other apparent mental disorder in response to exceptional physical and mental stress. It occurs within minutes of the impact of the stressful event in order to subside and disappear within several hours (24-48 hours).

(2) posttraumatic stress disorder – arises as a delayed and/or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (sexual violence, brutal death, warfare, serious accident). Typical symptoms include repeated reliving of the trauma – in intrusive memories or returns of the stressor in the form of "flashbacks," vivid memories, or recurring dreams, or in the form of worse well-being in a situation of encountering circumstances reminiscent of the stressor. Other characteristic symptoms are: partial or total inability to recollect certain important circumstances of encountering the stressor as well as persistent symptoms of excessive psychological sensitivity and agitation (difficulties in initiating and maintaining

sleep, irritability or outbursts of anger, concentration problems, hypervigilance, an enhanced startle reaction). The symptoms must occur within six months after the stressful event or after the end of the stressor's activity period.

(3) Adjustment disorders – these are states of emotional disturbance, usually interfering with social adjustment and effective performance, arising in the period of adaptation to a significant life change or a stressful life event. In the case of this diagnostic category, the stressor does not necessarily have an extreme character (trauma in the broad sense).

(4) Enduring personality change after catastrophic experience (after experiencing an extreme situation) – this diagnosis can be made only when there is a marked and lasting change in the way of perceiving, relating to others, or thinking about oneself and the environment. The personality changes should be significant and involve maladjusted or rigid behaviors that did not occur before the pathogenic experience.

In the latest edition of the DSM-5 classification, the American Psychiatric Association distinguishes a separate group of disorders, referred to as trauma- and stressor-related disorders, comprising:

(1) Acute stress disorder (ASD) – the necessary condition of diagnosing this disorder is the experience of a severe traumatic event and the persistence of the symptoms for between three days and a month after the trauma. The classification lists 14 symptoms of this disorder, grouped into the following categories: intrusive symptoms (e.g., recurring memories, dreams); negative mood; dissociative symptoms (derealization, dissociative amnesia); avoidance symptoms (e.g., avoiding memories, thoughts, or places connected with the trauma), and hyperarousal symptoms (e.g., sleep disorders, irritability, hypervigilance). At least nine of them have to be found for ASD to be diagnosed. An important change from the DSM-IV criteria for this disorder is the possibility of diagnosing it when there are no dissociative symptoms, which used to be treated as necessary before. In the DSM classification, ASD is not the equivalent of acute stress reaction from ICD-10. Acute stress reaction according to ICD-10 is a transient disorder, lasting for a few hours to a few dozen hours after the trauma, whereas acute stress disorder according to DSM can last for up to 30 days after the trauma; if the symptoms persist for a longer time, the diagnosis of PTSD should be considered.

(2) PTSD syndrome – as in the case of ASD, the experience of a traumatic event is necessary for a person to be diagnosed with this syndrome, and the symptoms must persist for at least a month. The symptoms are divided into four categories: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. For the diagnostic criteria to be met, symp-

toms from each of these categories must be present. An important change present in DSM-5 compared to the criteria for this disorder in the previous edition of the DSM is the addition of a previously absent category of symptoms, referred to as negative alterations in cognitions and mood.

(3) Adjustment disorders – understood similarly to adjustment disorders in ICD-10 and defined as a heterogeneous group of stress reaction syndromes, occurring after exposure to a stressful event. The classification allows for the possibility of the stressor having a traumatic (trauma in the narrow sense) or nontraumatic character.

Additionally, the DSM-5 classification distinguishes two specific disorders occurring in childhood, connected with the experience of a specific type of traumatic events in this developmental period:

(4) reactive attachment disorder (RAD) – characterized by persistent divergences from the norm in terms of the patterns of forming relationships (attachment) in the child, which stem from emotional disorders (a lack of social and emotional reactivity to others, a decrease in positive affect, episodes of unfounded irritability, sadness, or anxiety).

(5) Disinhibited social engagement disorder (DSED) – characterized by less or no inhibition in establishing relations with adult strangers.

Apart from the most typical disorders connected with posttraumatic stress, discussed above, there is the complex posttraumatic stress syndrome connected with a prolonged or repeated trauma rooted in childhood. The basic elements of this syndrome are: a sense of guilt, stigmatization, disturbances of personal identity (of self-continuity – difficulty in integrating the past with the present) and social identity (Herman, 1998; Solomon & Heide, 1999).

A special type of syndrome observed in some people who have experienced traumatic events is the so-called survivor syndrome. This concept was introduced by Niederland (1968) to refer to a complex of symptoms that are present in people who have survived highly traumatic events (e.g., the Holocaust, catastrophes, traffic accidents). The main symptoms include: a sense of guilt, chronic depression, insomnia, a sense of identity change, anxiety symptoms, a tendency to withdraw, a tendency to meditate in solitude, uncontrolled outbursts of anger, depressive states, and states of emotional indifference. The joy of life in these people is intertwined with the experience of negative emotions, of which the sense of guilt is particularly intense (Lis-Turlejska, Szumiał, & Okuniewska, 2012; Prot, 2009; Popiel, 2014).

The significance of the sense of guilt in posttraumatic stress disorder has found expression in its description in DSM-5 (2013), pointing to the posttrauma-

tic fixed negative beliefs about oneself and other people, distorted beliefs about the causes or consequences of the traumatic event that lead to blaming oneself or others, and a sense of shame and terror (DSM-5, APA, 2013; Popiel, 2014).

Apart from disorders that are causally related to the experience of traumatic events, there remains a wide group of disorders in which a relationship can be found between their symptoms and exposure to a traumatic event. In the case of these disorders, diagnosis does not require proving a link with a trauma, but they may sometimes constitute the psychological consequences of a trauma. Such disorders include: anxiety disorders, mood disorders, mixed anxiety-depressive disorders, dissociative disorders, or personality disorders resulting from traumas experienced in childhood. Many data point to a relationship between sexual abuse in childhood and borderline personality disorders (Briere & Elliot, 2003; Klatkiewicz, 2011).

It should be stressed that the mechanisms of the emergence of the disorders listed above and their links with a traumatic event can be explained by various theories (in various paradigms).

The consequences of trauma for psychosocial functioning

The experience of trauma is accompanied by negative emotions and sometimes releases the clinical syndromes described above. However, the occurrence of a spectrum of negative experiences or even disorders does not determine the further consequences of trauma for psychosocial functioning. Subsequently, these consequences can include either aggravation and intensification of disorders or positive resolution (independent or as a result of the support received). For many years, the aftermath of traumatic events has been considered mainly in terms of the psychopathological model, with a focus on disorders and their negative personal as well as social consequences. The experience of trauma has been associated with strong negative emotions and with difficulties in coping with the symptoms of avoidance, reliving, or agitation. Attention has also been drawn to consequences such as low self-esteem, lack of self-respect, withdrawal from social contacts, learned helplessness, and a sense of guilt (Herman, 1998; Lis-Turlejska, 2005; Popiel, 2014). The focus in this paradigm was on the traumatic character of interpersonal relationships and the lack of support, which can increase the sense of helplessness and the risk of self-destructive behaviors, particularly in the case of chronic trauma. Focus on the negative social and personal results of trauma led to a situation in which people who coped with it effectively

were seen as characterized by extraordinary strength, psychological resistance, will to survive, hope for success, and sense of meaning in life (Frankl, 1976).

In research conducted towards the end of the 1990s, scholars began to emphasize that traumatic events do not cause negative consequences only but may in fact be a source of more adequate personal, social, and professional functioning (Peterson, Park, & Seligman, 2006). Significant positive changes as a result of trauma are referred to as posttraumatic growth (PTG), positive psychological change, or stress-induced growth (Tedeschi, Park, & Calhoun, 1998). These changes are usually distant in time from the traumatic event, occur in all age groups, and concern between 40% and 70% of people (Tedeschi & Calhoun, 2004). Positive changes are observed in three areas of the person's functioning:

– self-perception – greater resistance to difficult situations, greater confidence in oneself and one's abilities, a desire to change the current way of life in a positive direction, a greater awareness of one's limitations and weaknesses that protects the person from wasting energy in inefficient activities;

– interpersonal relations – openness to other people, strengthening the bonds with others, more rational behavior, an ease of sharing one's experience with others, an increase in empathy, the understanding of other people's suffering, greater ease in showing emotions;

– philosophy of life – a growth of existential awareness, a change of life priorities, an increase in the significance of spiritual matters, finding new opportunities to fulfill one's life (Tedeschi et al., 1998; Tedeschi & Calhoun, 1995, 2004).

In a situation of positive changes in personality, trauma plays the role of a catalyst in the development of new identity; the person can start a new life with a clear meaning, value, and purpose. PTG is both the outcome and the process of inner struggle with the results of trauma – a process in which the person returns to the traumatic event, making an attempt to understand it and incorporate it into their life (integrate it in the self). This process involves both growth and distress, since trauma always involves not only some kind of loss but also the person's effort to cope with it (Calhoun & Tedeschi, 2004). The essence of trauma lies in the fact that it confronts the person with reality of death and the possibility of losing their life; as a result of a reinterpretation of trauma and the processing of its negative aspects, it becomes possible to discover the meaning of life in the situation changed by the trauma. The posttraumatic growth phenomenon has been widely discussed in the Polish literature on the subject in relation to various clinical and nonclinical populations, with various modifying factors taken into account (Ogińska-Bulik, 2010, 2013, 2015; Zdankiewicz-Ścigała, 2009).

Implications and challenges for clinical practice

The understanding of trauma is particularly important for psychologists performing clinical assessment as well as for therapists working with people who have experienced a traumatic event. Both underestimating a trauma and overestimating its significance in the assessment process may result in negative consequences for the functioning of the person with this kind of experience. This makes it important in therapeutic work with people who have experienced a trauma to take into account the multiple factors that determine the correct diagnosis of traumas and the consequences of such a diagnosis. It is important to adopt a particular theory pertaining both to trauma and to its aftermath. What is of particular importance here is to refer to the pathogenic or salutogenic model. On the other hand, it is important to ensure the professional training of people providing psychological support in objectively assessing the significance of the event and its possible consequences. No less important is the ability to accurately predict the direction of the aftermath of trauma in the context of individual and sociocultural determinants of trauma in a particular person's life as well as in the context of the person's flexibility and coping skills.

Despite the attempts made by scholars to refine the definition of trauma, this issue still requires further resolutions and remains a challenge both for assessment practice and for therapy. The authors of the present paper propose certain general suggestions that, if taken, may help to give the right direction to diagnostic and therapeutic work with people who have experienced trauma.

Focus on trauma vs. coping with its consequences. What is of great importance in working with a client burdened with the experience of a traumatic event is the patient's/client's general impression, connected with the main focus of the therapeutic work. Undoubtedly, concentration on the very experience of trauma may have a therapeutic character to some extent, making it possible to experience it again in safe conditions, but it does not liberate the person from the negative experience and does not contribute to the release of personality potential. What we believe to be more important from the point of view of the person's further development and functioning is the process of looking for ways of coping with the consequences of trauma. This process enables changing the current view of the experienced trauma as impossible to resolve to one that it is possible to cope with, and frequently to one whose consequences can be positive. A clear confirmation of this is provided by research on the phenomenon of posttraumatic growth, which is not a direct consequence of trauma but an effect of the person's

struggle with its consequences (Peterson et al., 2006; Tedeschi & Calhoun, 2004).

Reworking the status of "being a victim" into the status of "being a survivor." Traumatic events have a considerable impact on the sense of identity. According to Kozielecki (1986), identity is a complex multidimensional personal judgment, depends on various areas of self-knowledge and on the temporal integration of its elements (the past self, the present self, and the future self), and has an influence on behavior. It is a personality construct integrating various aspects of self-experience, characterized by continuity and consistency; it can be violated as a result difficult and traumatic events. As a result of trauma, the sense of identity may undergo reorganization; some of its aspects may become dominant, which minimizes the significance of others. An example of such changes in the sense of identity is the intensified sense of "being a victim," leading to self--victimization – to experiencing oneself as a victim and concentrating on the harm suffered. Therapeutic work with the patient/client after an experience of a traumatic event should be aimed at processing the status of "being a victim" into the status of "being a survivor," which broadens the perspective from which various circumstances and consequences of the traumatic event are seen.

Work on the integration of the past self and the hurt self (the actual self) with the future self in order to achieve the status of "being a survivor." This makes it possible to integrate the traumatic event and the related experiences with the previous and current experiences, as well as with the experiences that have reference to the future. The traumatic event usually constitutes a dramatic disruption of self-continuity, and the person perceives it as the border separating the "better" life before the trauma from the "worse" life after the trauma. In this situation, the main aim of the therapeutic process is to restore the continuity of the sense of identity in the person's life, which requires incorporating the traumatic event, as one of many different events, into their life history. In the process of therapy, "the hurt self" should be incorporated into the sense of identity in order to be an element integrating rather than separating "the past self" and "the future self."

Work on maintaining self-consistency despite trauma. Therapeutic efforts should focus on restoring not only the continuity but also the consistency of the sense of identity. This is because traumatic events can cause a disintegration of the sense of identity into elements that, in the person's experience, lose connection with one another, resulting in a sense of inner split, a sense of behavioral inadequacy, and a sense of isolation and alienation. In practice, this manifests itself in the person introducing a strong internal distinction between the various

life roles he or she performs (e.g., "As a mother, I cannot show to my child that I am suffering," "At work I must smile, but in fact I feel like crying"). The disrupted consistency of identity can be restored by developing an acceptance of the overlapping of various aspects of identity that the person distinguishes from one another (e.g., "My child will notice one day that I suffer, anyway, so I had better explain it to him/her before that happens," "If I feel bad at work, I can find a way to show it").

Looking for the meaning of trauma for the current life. Traumatic events are usually perceived by the person as meaningless, accidental, unexpected, uncontrollable, and unpredictable. The result of such attribution is that the traumatic experience goes beyond the ordinary mechanisms that give meaning to events due to their importance and, frequently, their far-reaching consequences. The aim of therapeutic work should therefore be to look for the meaning of trauma for the person's current life, but without a simplifying negation of the importance of such an event. This search for meaning should not directly focus on finding "positive" aspects of the trauma but on finding its negative as well as positive meanings for the person's further life. This reduces the tendency to think in black-and-white terms and enables a more balanced assessment of the trauma.

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