KARTU GALIME
APSAUGOTI IR PADĖTI

PSYCHOLOGICAL HELP FOR ABUSED CHILDREN

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PROKURATŪRA

Paramos vaikams centras
Children Support Centre

Funded by the European Union's Rights, Equality and Citizenship Programme (2014–2020 m.)

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CONTENT

INTRODUCTION

Many children and adolescents face traumatic experiences every day. One of the most prevalent traumatic experiences is domestic violence. As the war in Ukraine began, thousands of families and children that have arrived in Lithuania also have experienced the horrors of war. It is important for the mental health-care specialists to be properly prepared to help the children with traumatic experiences and their families. These recommendations have been prepared in order to provide necessary information and to strengthen the competencies of the specialists helping the children who have experienced violence.

The publication "Psychological Assistance to Children with Experiences of Violence" has been prepared as part of the project "Kartu galime apsaugoti ir padėti", carried out by the Prosecutor General's Office of the Republich of Lithuania and the NGO Children Support Centre, and funded by the European Commission. The aim of the project is to encourage early recognition of children suffering from violence, to ensure their protection, to acknowledge the specific needs of children during criminal proceedings as well as to provide them with complex assistance required for coping with the effects of violence.

VIOLENCE AGAINST CHILDREN AND ITS PSYCHOLOGICAL EFFECTS

Erna Petkutė, psychotherapist, Children Support Centre

As the phenomenon of violence against children, like all forms of violence against children, is widespread and has significant negative consequences on children's physical, mental health and development, it requires joint efforts of officers and professionals to effectively identify, stop and assess the consequences of violence and provide assistance to child victims. Another important role of all professionals involved in criminal investigations and those indirectly involved in the investigation is to raise public awareness, sensitivity and sense of responsibility, thereby reducing the level of crime against children and increasing the safety of children in the society.

According to the World Health Organisation (WHO, 2016), 1 in 4 children experience physical abuse and 1 in 5 children experience sexual abuse. High prevalence of violence against children has also been confirmed by research conducted in Lithuania. According to a study conducted by the Vilnius University Centre for Psychotraumatology, 71% of adolescents aged 12-16 years who participated in the study reported having experienced some form of violence (Zelviene et al. 2020). Among the types of violence, psychological violence (47%), physical violence (34.6%) and online sexual abuse (31.4%) predominated. Adult sexual abuse of children accounts for 9.9% and peer sexual abuse – for 17.1% (Zelviene et al. 2020). These results reflect the extent of the harm suffered by a large proportion of young people under the age of majority. The findings also suggest that only a small proportion of children who are abused are known or reported. According to the data of the State Child Rights Protection and Adoption Service under the Ministry of Social Security and Labour, ~0.52% of the country's children were victims of violence in 2021. These statistics, unfortunately, do not reflect the real extent of the problem of violence against children in Lithuania, based on scientific research and professional practice, and should be thoroughly investigated.

Below are important concepts enshrined in the Law on Fundamentals of Protection of the Rights of the Child that give rise to the concept of child abuse:

- **Violence against a child** means direct or indirect intentional physical, psychological or sexual impact on a child, whether by act or omission, if this has resulted in the death of

the child, or has impaired child's health or normal development, or has resulted in pain or danger to the child's life, health or normal development, or has adversely affected the child's dignity and/or honour. Violence against a child also includes neglect of a child (...).

- **Physical violence** means a deliberate physical act or acts against a child, including physical punishment, if the act or acts have resulted in the death of the child, or have impaired the child's health or normal development, or have caused pain or danger to the child's life, health or normal development, or have violated the child's honour and/or dignity.
- **Physical punishment** means the disciplining of a child by means of a physical act that is used to inflict physical pain, however slight, or to physically torture the child, or to violate the child's honour and/or dignity (...).
- **Neglect** means a persistent failure or neglect by parents or other legal representatives of a child or the person responsible for the child's care to meet the child's basic physical, emotional and social needs, which has resulted in the death of the child, or in the impairment of the child's health or normal development, or in a danger to the child's life, health or normal development. Poverty for objective reasons shall not be considered neglect.
- **Sexual violence** means intentional criminal acts, as defined in Chapter XXI of the Criminal Code of the Republic of Lithuania "Crimes and criminal offences against the freedom and inviolability of sexual self-determination of a human being", committed against a child, as well as profiting from the prostitution of a child, the involvement of a child in prostitution or in a pornographic event, the showing of pornography to a child, the forcing of a child into prostitution, the exploitation of a child in pornography or the possession of pornographic material depicting a child or a person as a child, or the involvement of a child in sexual slavery, and any other forms of sexual exploitation of a child.
- **Psychological violence** means the intentional systematic violation of a child's right to identity, humiliation, bullying, intimidation, interference with the child's normal development, encouragement of antisocial behaviour or other non-physical contact behaviour (acts or omissions), which has led to the death of the child, or to the impairment of the child's health or normal development, or to the endangerment of the child's life, health, normal development or the humiliation of the child's honour and/or dignity. Psychological abuse shall not include appropriate and reasonable assessment of a child's knowledge and abilities and other actions to assess the child's normal development.

The types of violence against children discussed may be single factors, but often several

forms of violence against children are revealed at a time (Briere & Runtz 1988, Ney et al. 1994). A study by Claussen & Crittenden (1991) highlighted that among children who experienced physical abuse and neglect, 90% have also experienced psychological abuse. The authors of this study also found that psychological abuse is a factor that has a stronger impact on a unsuccessful development of a child than the extent of physical abuse.

It is important to stress that psychological abuse is defined as persistent contact with a child by adults, i.e. parents/guardians and others, which causes long-term negative changes in the child's emotional state and self-esteem, and can lead to physical health problems and mental disorders. Psychological abuse includes adult actions directed at the child, such as frequent aggressive statements and comments towards the child, and inaction, where parents emotionally reject the child, withdraw, or fail to show sympathy or support when the child is in desperate need. Various terms are used in the literature to describe this phenomenon, including 'psychological abuse', 'psychological violence', 'emotional abuse', 'emotional neglect' or 'emotional violence'. These terms are often used synonymously.

Psychological abuse can be used against children not only by their parents or guardians, but also by other related persons. Psychological abuse or neglect is indicated by specific, frequently repeated patterns of parenting and behaviour towards children by adults, which can be observed in the adult's interactions with a child. The way adults treat a child may also be reflected in the child's own behaviour, interactions with other children or adults, his/ her game playing, posture and changes in his/ her well-being. According to definitions by Glaser (Glaser & Prior, 2012; Glaser, 2002), psychological abuse can be divided into several types according to the nature of the adult's behaviour towards a child:

1. **Persistent negative adult attitudes towards a child.** Parents or other adults who influence a child blame, criticise, humiliate and reject the child because they believe the child deserves it. Adults convey the message to the child that whatever the child does, he/ she is bad, guilty, a loser, a problem and a burden.
2. **The expectations and demands of the adults responsible for a child are not in line with the age and maturity of the child.** Parents and other adults make demands on children that are too high or too low for their age and maturity. Adults demand that a child, who is not yet able to do so, assesses threatening or difficult situations, takes responsibility for circumstances beyond his/ her control, such as being able to look after

younger siblings, protect them from dangers, and provide help. Adults can also overprotect their children in non-threatening situations, limiting their own initiative, doing everything for them and thus preventing the development of independence.

3. Parents or other adults overly restrict a child's socialisation and prohibit interaction with others, or distort the child's social adaptation. Adults responsible for the child do not help or create opportunities for the child to develop his/her communication and cognitive skills: they do not allow him/her to attend classes, extracurricular activities, training sessions, and unreasonably prohibit him/her from socialising with peers. Some adults may involve children in anti-social activities, such as drug and alcohol use, stealing and other inappropriate activities.

4. Adults responsible for a child do not protect him/her from traumatic experiences, and the child becomes a witness of violence. A child is left alone as a bystander in traumatic situations that are not age-appropriate, especially in cases of physical violence or psychological abuse between parents/guardians.

5. Parents or other adults responsible for a child do not recognise the child's individuality and psychological limits. Adults use children to meet their own psychological needs, fail to separate their own expectations from the child's abilities and needs, and ignore the child's unique temperament and character - for example, adults persist in trying to make a withdrawn and shy child open, sociable and unafraid of public speaking, or force a child to play sports competitively even though the child has a talent for the arts and feels clumsy in sports.

Of all the types of violence, psychological violence against children is the most difficult to identify. Psychological abuse is difficult to identify because it does not leave physical signs, and its negative effects can be felt later in a child's development, affecting the child's personality. The main challenge for professionals working with children in this respect is to distinguish between the problems which adults encounter in parenting and psychological violence. It is not easy to distinguish between manifestations of inappropriate parenting, such as excessive demands, unjustified fears for the child's safety, verbal punishments and criticism, and emotional violence. Adult behaviour that is psychologically abusive to a child is defined as a persistent failure to meet the child's emotional needs and to make the child feel worse becoming a parenting style and a systematic pattern of adult behaviour towards the child. Such adults constantly blame children for their own (as parents/guardians or other important people) failures, illnesses, suicides or divorces, for a child having some characteristics typical of their spouses, a "bad parent" or other people that adults do not like. Children suffering from other difficulties from other back-

grounds and emotionally abused children may behave in similar ways and show similar symptoms or behaviours. However, observing the behaviour of parents or other adults towards children with different backgrounds can help to distinguish what has affected the child's well-being, behaviour and development. Parents of children with other backgrounds are more likely to acknowledge the existence of a problem, to notice when their child is feeling unwell and to seek help for their child. On the other hand, parents who emotionally abuse their children are more likely to deny the problem and the impact of their behaviour on their child's well-being, to blame the child, to refuse the help offered, to be unconcerned about their child's psychological well-being, to take no interest in their child's well-being, and to refuse to cooperate with professionals.

Another problem that arises when assessing possible psychological violence against a child is the aspect of "intentional misbehaviour" formulated in the definition. The behaviour of psychologically abusive adults is not always conscious and pre-planned. Such behaviour may be influenced by the social problems they experience, their psychological well-being and mental health, their limited knowledge of children's emotional needs and their lack of skills of relationship-building with their children. For this reason, in cases of psychological abuse, it is important to give consistent attention to the adults responsible for a child and to target them with all the forms of influence and assistance that help them develop their safe behaviour towards their children.

CONSEQUENCES OF VIOLENCE AGAINST CHILDREN

Violence affects a child's physical, emotional, social, cognitive and behavioural areas. Research in various countries also shows that violence can have significant adverse consequences on a child's development and functioning. There is a distinction between short-term and long-term consequences of violence against children. The short-term consequences of child-harming behaviour include physical injuries, mental disorders or emotional difficulties resulting from abuse. Long-term consequences are personality traits that may have developed as a result of childhood abuse or neglect, which become apparent as the child grows up and interfere with the child's favourable adaptation. Some types of child-damaging behaviour do specific harm, for example, physical abuse may cause brain damage, children who have been sexually abused may exhibit sexualised and/or sexually inappropriate behaviour, also children may develop post-traumatic stress disorder after experiencing or witnessing rape or inter-parental violence (Children's Aid Centre, 2008). Some of the consequences of violence may manifest later in a child's life, for example, depression may develop after a child experiences sexual abuse, and

anxiety disorders may develop after long-term emotional abuse. It is important to stress that a significant damage can be done to a child even when parents or other adults do not consciously intend to harm the child.

Below is information on the consequences of violence on specific areas of a child's functioning:

- **Attachment issues.** Secure attachment is crucial for a child's early emotional and social development. Secure attachment protects a child's developing brain from damaging effects of stress, whereas if a child's attachment is insecure, his/ her brain is more susceptible to these effects. Infants and young children who are exposed to constant screaming, shaking or neglect are at a greater risk of developing insecure disorganised attachment (Hildyard & Wolf, 2002; Jordan & Sketchley, 2009).
- **Physical health problems.** Physical injuries are a direct result of physical abuse and/or neglect. These are specific bone fractures, scars, burns, concussion, recurrent and unrelated somatic illnesses and other health problems. Physical injuries, impaired growth and cerebral palsy, which are incurable or irreversible, can be the long-term consequences of physical abuse of a child. Infants are particularly vulnerable in this respect. Shaking an infant can cause brain damage, spinal and spinal cord injuries, blindness and/or deafness, speech impairment and death (Child Welfare Information Gateway, 2008). Having suffered such injuries, infants are often unable to recover and reach the physical and mental health levels of their peers (Goldman et al., 2003). Extreme physical and emotional neglect, shortage of full-fledged nutrients, lack of physical stimulation and social isolation also disrupt brain development of an infant and a young child – the affected child's brain may be smaller in volume, less active and have less hemispheric differentiation. Longitudinal studies on the consequences of child abuse show a strong association between childhood abuse and the development of serious illnesses in adulthood, such as cardiovascular disease, diabetes and cancer (Flaherty et al., 2013).
- **Psychological problems.** Violent behaviour by adults has a comprehensive impact on a child's psychological well-being and can have a significant impact on his/ her personal development and self-esteem. A child who is constantly subjected to psychological, physical or sexual violence by the people closest and most important to him/ her develops a distorted view of the world around him/ her, "learns" that the world around him/ her is unpredictable and threatening, and that the people who care for him/ her can suddenly turn cruel, angry, impatient, irritable, depressed and indifferent, and can exploit the child for their own needs. Living with abusive adults, the child may perceive himself/ herself as "bad", inadequate, guilty, often experiencing feelings of helplessness and

depression, shame and guilt.

- **Difficulties in interpersonal relations.** Victims of childhood violence do not have the opportunity to experience a healthy, loving and trusting relationship with the adults who take care of them. Relationships with key people, based on violence and abuse, horror and helplessness, persist throughout life as a fundamental pattern of relationships in which the child may unconsciously identify and involuntarily become a "victim" or a "perpetrator". The psyche of the abused child has to adapt in order to survive physically and psychologically. In order to cope with these difficult experiences, a child often uses a variety of coping strategies and immature psychological self-defence mechanisms that may persist into later life or adulthood. Children who are chronically abused may also become "desensitised" to pain. They may not "feel" pain when they are injured and often do not realise that other people may be in pain. Children who suffer such consequences may find it difficult to recognise and name their own feelings or the feelings of other people. They may lack empathy and compassion that are essential in relationships and may avoid any psychological closeness. Children who have been abused in emotionally difficult situations may feel as if they are out of their body and thus "absent" in actual situations, watching what is happening from aside, psychologically detaching themselves from the event in order to survive. Children who have been abused may also "forget" specific events or whole periods of their lives. Painful experiences that the child cannot integrate into his/ her psyche are pushed into the unconscious and can emerge at any time when the child does not expect them.
- **Behavioural problems.** Growing up in a threatening environment, constantly exposed to physical and emotional abuse, children learn that the world is unsafe and that adults are a source of threat and pain. The younger the age at which a child is exposed to abuse and the longer it lasts, the more serious the behavioural problems that can be observed in their childhood, adolescence and adulthood. The behavioural difficulties observed may be internalised, i.e. manifesting by withdrawal, disengagement and/or passivity, or externalised, i.e. manifesting by increased excitability, impulsivity and/or aggressiveness. Children who have been physically abused may be prone to misinterpret the motives of another person's behaviour, perceive it as aggressive and react with exaggerated defensiveness or offensiveness. Children who have been sexually abused and molested may have serious sexual behavioural problems in adulthood. Examples of such difficulties include involvement in prostitution, frequent partner changes, denial of sexuality, gender confusion, gender denial, teenage pregnancy, sexually transmitted diseases, unsafe sexual behaviour, and increased risk of rape (Corby, 2006; Merrick et al., 2008).

Physical abuse and emotional humiliation in childhood is also a major risk factor for the use of violence and humiliation of others in adulthood. Gilbert and et. al. (2009) found a strong correlation between the experience of abuse and future criminal behaviour. According to the study, children who had experienced abuse and neglect were eleven times more likely to be arrested for criminal behaviour than children who had not.

- **Cognitive and learning problems.** Abuse and neglect in infancy and early childhood significantly impairs the development of a child's cognitive functions, especially language development, the ability to act in a purposeful and planned manner, and to focus. Research shows that children who have been exposed to abuse and neglect often have learning difficulties and significantly lower academic achievement compared to other groups of children (Gilbert et al., 2009; Mills, 2004; Veltman & Browne, 2001). Emotional difficulties resulting from violence may also affect children's learning opportunities. Children who are anxious and stressed or who have acquired organic brain damage often find it difficult to fit in with others, behave impulsively and hostile, and are more likely to be bullied.
- **Mental health issues.** Certain mental health problems can be a result of violence. Post-traumatic stress disorder is one example of such disorders. A child with post-traumatic stress disorder may experience vivid, unexpected and uncontrollable flashbacks that force the child to seemingly relive the traumatic event, even years later. Children may also suffer from sleep disturbances, nightmares, fears, startle reactions and avoidance of certain places and/or people. In their longitudinal study, Brown, Cohen, Johnson and Smailes (1999) found that abused children were three times more likely to suffer from depression and anxiety disorders than those who had a positive upbringing. Research found (Brodsky & Stanley, 2008) that children who have been abused are twice as likely to engage in suicidal behaviour, and young people who have been sexually abused are eight times more likely to attempt suicide than others. Eating disorders are also often associated with childhood abuse. When researching the background of young people with anorexia and/or bulimia, they are often found to have experienced childhood sexual abuse and/or psychological violence. The use of psychoactive substances in childhood and beyond is also strongly associated with all types of violent behaviour affecting the child.

As violence can seriously affect child's development, physical and mental health, interpersonal relationships, behavioural problems, cognitive impairment and educational success, it is important to assess the harm done to the child correctly and to provide timely and effective support. It is important to take into account that violence against a child has

not only short-term but also long-term consequences, and to distinguish between the possible consequences of different types of violence. Knowledge of the consequences of violence against children also contributes significantly to the detection of a potential crime and to the accurate and efficient planning of the investigation and interrogation process.

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DOMESTIC VIOLENCE

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Domestic violence is a breach of human rights and liberties prevalent throughout the world. Lithuania is no exception: according to the data of the Lithuanian Department of Statistics, the police received 55,815 reports of domestic violence in 2021, 58,553 in 2020, and 53,075 in 2019. However, these numbers only reveal a part of the problem, because a lot of people who experience violence do not find the courage to ask for any kind of help. It is confirmed by the representative survey of Lithuanian residents (2020) regarding domestic violence, which indicates that 60 % of the people who experienced domestic violence did not seek any help.

According to the official statistical data, it is also been recorded year after year that the vast majority of the suspects (perpetrators) of domestic violence are men, and the victims are mostly women. In 2021, 78.9 % of adult victims were women (80.5 % of them were abused by their intimate partner), and 87.1 % suspects (perpetrators) were men (Lietuvos statistikos departamentas, 2022).

The gravity of the problem of domestic violence increases upon taking into account the harm from the violence, which can be long-lasting, repeated and causing negative effects of the person's physical and mental health. Doubtlessly, the experience of violence is also often related with physical injury, gynecological problems, etc. However, the experience of violence also hurts a person's psychological state, self-esteem, ability to function and adapt in the society, and is related to the emergence, duration and recurrence of mental health problems. The most frequent mental health effects of violence by an intimate partner are depression and PTSD (Campbell, 2002). The results of a study by WHO carried out in 2013 have revealed that women who have experienced physical or sexual violence by their intimate partner suffer from anxiety and depression almost twice as often as women who have no experience of violence.

Due to the prevalence and effects of the problem of domestic violence, care-giving specialists should be able to recognize violence, understand the dynamics of violent relationships, and once violence is recognized, act in order to prevent its recurrence.

DEFINITION AND TYPES OF DOMESTIC VIOLENCE

In order to protect persons from domestic violence, quickly react to the emerging threat of violence, to prevent it, to apply means of protection and provide suitable assistance, the Seimas of Lithuania passed the Protection from Domestic Violence Law of the Republic of Lithuania in 2011.

The law indicates that violence is "a deliberate physical, psychological, sexual, economic or other effect of actions or inactivity due to which the person experiences physical, material or non-pecuniary harm", whereas "domestic" refers to persons who are currently or have been in the past connected by domestic ties, i. e., marriage, partnership, in-law, etc. relationships, as well as those who reside and manage their household together.

The notion of violence as defined by the law also contains for main types of domestic violence:

- **Physical violence** – illegal, deliberate physical effect on a person's organism carried out against his or her will, aiming to take his or her life, harm his or her health, restrict his or her freedom, cause a helpless state, physical pain or any other physical suffering (for instance, hitting, pushing, pulling hair, preventing from leaving the house, throwing objects, etc.)
- **Psychological violence** – deliberate, intentional effect on another person's psyche (for instance, constant criticisms, deprecation, humiliation, limiting communication with others, disrespect of needs, manipulations, etc.)
- **Sexual violence** – exploiting another person for fulfilling own sexual needs (for instance, forced intercourse, forced kissing, touching, undressing, forcing another to watch and / or repeat pornographic actions, etc.)
- **Economic violence** – humiliating another due to economic dependence and (or) incurring economic damage due to the abuser's violence (for instance, preventing from employment, taking money away, financial control, forcing to ask for money for own and children's needs, etc.)

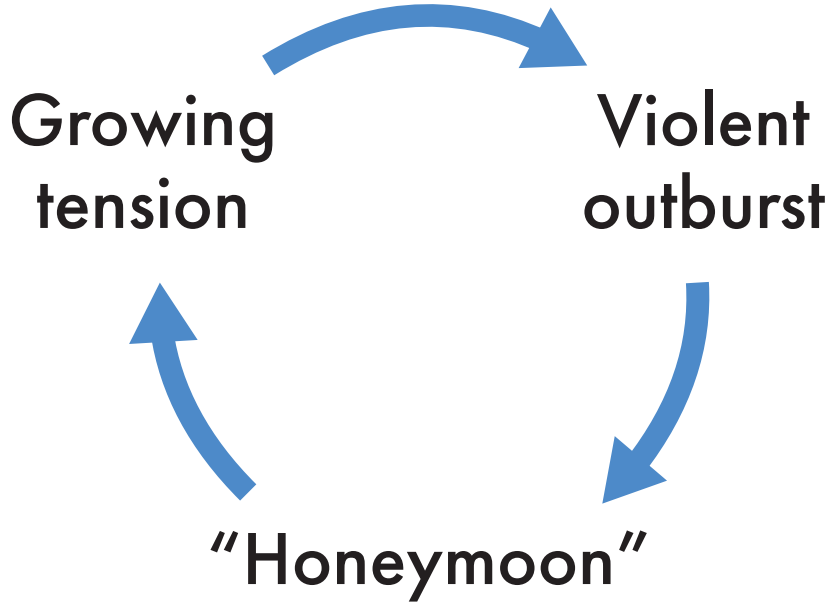
THE DYNAMICS OF DOMESTIC VIOLENCE

Domestic violence tends to recur. The cycle of recurrent violent actions is called the circle of violence and consists of three stages:

- **Growing tension** – the violent person becomes more and more aggressive, controlling, isolating, communication with family and friends is forbidden. The victim of abuse attempts to adjust to the requirements, avoid possible conflicts in order to prevent

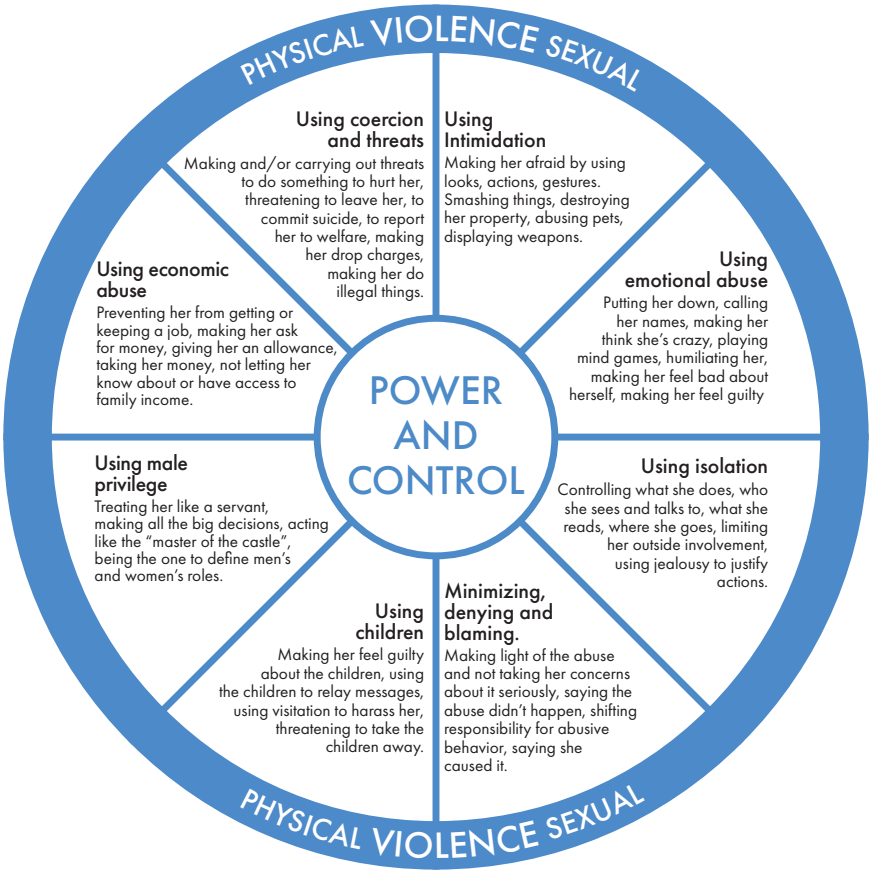
the violent outburst, but the situation does not improve, the tension grows. This stage may last for weeks, months or even years.

- **Violent outburst** – as the abuser's tension becomes unbearable, the violence breaks out. It may be blows, threats, sexual violence or other types of harmful actions. This stage may last from several minutes to several hours.
- **"Honeymoon"** – the abuser apologizes for their actions, promises to change, to not do that again, as long as the other person will "be good" and not "provoke" them. However, eventually the first stage is entered again – tension, humiliation, control continue until the next violent outburst, which again ends in apologies and promises. Gradually, the first stages become longer, their effects more serious, while the "honeymoon" stage grows shorter.



Picture 1. The circle of violence.

Abusers have many ways to keep their victim near. These ways are best represented in the "Power and Control Wheel", which lists the most prevalent strategies that the abusers employ in order to scare and control another person.



Picture 2. Power and control wheel.

RECOMMENDATIONS

- Apply the principle of zero tolerance to violence throughout the process of providing assistance – violence is not excusable in any case.
- Sharing a violent experience with close ones is not easy, because it is an especially sensitive and humiliating experience, therefore the assisting specialists must establish a respectful relationship with the victim with no place for judgment, reproach or blame.
- Upon recognizing violence, action must be taken in order to prevent the recurrence of any expression of violence, and necessary services (e. g., the police, local child protection service) must be consulted as needed.
- The victim must be aided and / or informed about other possible assistance (for instance, emotional support hotlines, specialized complex support centers, crisis centers, etc.)
- Awareness of the Protection from Domestic Violence Law of the Republic of Lithuania

which defines not only the concept of domestic violence, but also the rights and responsibilities of the subjects of domestic violence, the applications of the tools and projects of prevention, assistance and protective measures for the victim of abuse.

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DISCLOSURE OF SEXUALLY ABUSED CHILDREN

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The scientific data indicates that 1 in 5 children in Europe has experienced sexual abuse before their 18th birthday. However, the real numbers of sexual abuse of children are not known, because some of the victims have still not told anyone about it. There are also adults who were sexually abused as children, but have never opened up about it to anyone. Studies of adults have shown that only 1 in 5 informants had disclosed their sexual abuse before taking part in the study, and half of the informants remained silent for longer than 5 years before disclosure. According to the data of various authors, the victims wait on average 2 years before they disclose their sexual abuse (Hebert, Tourigny, Cyr, McDuff, Joly, 2009; Karayianni, Fanti, Diakidoy, Hadjicharalambous, Katsimicha, 2017; Mathews, Bromfield, Walsh, Cheng, Norman, 2017). Disclosure of sexual abuse is a multi-layered process. It means that the sexually abused children often do not speak up about it immediately, their story may lack detail, coherence and cohesion. Also in some cases, if children experience negative effects of the disclosure, they recant their initial statement during the proceedings or start minimizing the extent of the actions of sexual nature that had been performed with them. Research data show that precisely because the disclosure of sexual abuse is so complicated, the victimized children often face doubt or disbelief (Ney, 1995; Pipe, Lamb, Orbach, Cederborg, 2007; O'Donohue, Fanetti, 2016).

It is important that the mental health professionals working with sexually abused children focus not on judging the truthfulness of the disclosure and the facts presented, but instead on understanding the reasons why the child has chosen to make the disclosure at this particular moment and under these circumstances. A child's disclosure is also influenced by the nature of the relationship with the abuser (how close they are with the child, how they treat the child in order to ensure the child's submission) as well as the environment in which the child is growing (where he or she lives and with whom, what his or her relationships with non-violent adults and peers are). The more inner and outer resources a child has, the sooner he or she is able to make the disclosure of sexual abuse, and his or her story is more likely to be coherent, detailed and containing more significant elements

(Ney, 1995; Pipe, Lamb, Orbach, Cederborg, 2007; O'Donohue, Fanetti, 2016). Next follows more detailed information about the various factors mentioned above and their influence on children's disclosure.

THE CHILD'S AGE AND KNOWLEDGE OF THE ACTIONS OF SEXUAL NATURE PERFORMED WITH THEM. Research indicates that adolescents aged 12-17 experience sexual abuse more often, but the results of the studies analyzing the connection between the age of the victims and the disclosure of sexual abuse vary. According to some authors, younger children take longer to disclose sexual abuse, because they lack the knowledge about the implications of the actions performed with them and fail to understand what is expected of them during the interviews, as well as due to the more limited language development. Other researchers emphasize the opposite, that adolescents are more likely to delay their disclosure, because they are more aware of the effects of the disclosure (they know that a police investigation will begin, which will be stressful to family members, that their peers will talk about it, etc.), therefore they employ silence to protect themselves and others from these effects. It has also been observed that younger children are more likely to make their disclosure unexpectedly, by accident, for instance, by casually speaking up during a game. On the other hand, adolescents are more likely to make their disclosure intentionally, meaning they choose who to talk to and how, and are more likely to speak up to their peers first (Barth, Bermetz, Heim, Trelle, Tonia, 2013; O'Donohue, Fanetti, 2016; Karayianni, Fanti, Diakidoy, Hadjicharalambous, Katsimicha, 2017).

THE CHILD'S LINGUISTIC AND COGNITIVE DEVELOPMENT AND HIS OR HER OTHER INDIVIDUAL FEATURES. Research indicates that the less skilled children, especially boys with behavioral difficulties, are at a greater risk of sexual abuse. The abusers tend to pick the children who are more easily manipulated, who experience communication difficulties and form attachments more easily (Black, Heyman, Slep, 2001; Kucuk, 2016). The paradox is that while the children with emotional and behavioral difficulties are more likely to be sexually abused, they are also the most doubted in courts, because witnesses are more likely to describe them as disobedient, uncontrollable, evasive, manipulative and liars. The children who have linguistic problems may simply fail to verbalize their experience, and the victims with diagnosed intellectual disabilities may not even comprehend that the actions performed with them are inappropriate, especially in the cases where the abusers show them exceptional attention like giving money, buying things, repeatedly speaking nice words. There are other inner characteristics that make children different from one another, for instance, some are bolder and more resolute at

asking for help, others are more reserved and likely to doubt themselves, and all that may also contribute to the timeliness of their disclosure. They are also significantly influenced by other mental problems diagnosed to children, for instance, adolescents with depression may speak less of their sexual abuse at an interview, because they may disbelieve that others may be capable of helping them, and children with the ADHD may not be able to tell a coherent and cohesive story, because during an interview they usually do not manage to stay put, fail to hear the questions, are easily distracted by irrelevant triggers (O'Donohue, Fanetti, 2016).

THE CHILD'S RELATIONSHIP TO THE ABUSER. Children are usually sexually abused by someone they know or are close with. That makes the timely disclosure of children especially difficult, as they experience contradictory feelings regarding their abuser. Besides, in order to gain the trust and submission of children, to prevent them from telling anyone about what is happening, the abusers employ varied means of pressure – not just physical violence, but also threats of different negative effects, for instance, that the family would break down or suffer financially, and the child would be to blame, that no one would believe the child and would stop loving them, that the abuser will go to jail, kill themselves, etc. Also the children may be affected by special attention and exceptional privileges, and in such cases it is even more difficult for them to recognize that the actions of sexual nature performed with them are inappropriate, and to disclose them in time. If the victims fail to understand the significance of the actions performed with them, they not only delay their disclosure, but also blame themselves and believe to have contributed to those actions (Hébert, Tourigny, Cyr, McDuff, Joly, 2009; Reitsema, Grietens, 2016; O'Donohue, Fanetti, 2016).

THE CHILD'S IMMEDIATE ENVIRONMENT AND HIS OR HER RELATIONSHIPS WITH NON-VIOLENT PEOPLE AROUND. Whether the children who have experienced sexual abuse will be ready to talk about it or not also depends on the surrounding environment, and especially the position of adults who are important to the child. Research distinguishes the characteristics of the family in which the abused children live. Families in which children experience sexual abuse tend to be socially isolated, conflicting within, less capable of coping with stress, poor at adapting to their circumstances and lacking in communication skills (Reitsema, Grietens, 2016). Cases of physical, emotional abuse and neglect of children are also more prevalent in such families (Karayianni, Fanti, Diakidoy, Hadjicharalambous, Katsimicha, 2017). Sexually abused children whose parents live

together have been identified to make their disclosure sooner than those whose parent are divorced or separated. Literature unequivocally acknowledges that a close and trusting relationship between the child and a non-violent adult is one of the most important factors that define not only the child's readiness to speak up, but also the disclosure of the facts of abuse to the law enforcement. Non-disclosure of sexual abuse or a delay in speaking up to the non-violent closest adult is often dependent on a disturbed relationship between the child and the parent / caregiver (Schönbucher, Maier, Mohler-Kuo, Schnyder, Landolt, 2012). Authors of the studies especially focus on the relationship between the child and the mother, as it is especially significant to disclosures. The mother's belief in her child is the basis from which any assistance to the child is launched. The knowledge that mom is going to believe and protect not only hastens the disclosure, but also helps dealing with the trauma. If a mother actively defends her child, he or she provides more details significant to the case in his or her interview. If, on the contrary, the mother is unsupportive and helpless, the risk that the child's statement will be incoherent and vague increases (O'Donohue, Fanetti, 2016; Proulx, Cyr, 2016). Research indicates that mothers of sexually abused children claim to experience more stress and more feelings of tension, sadness, anger, loss and helplessness compared to mothers whose children have not suffered from sexual abuse (Black, Heyman, Slep, 2001).

In conclusion, the disclosure of sexually abused children is a complicated process defined by varied and complex factors. Knowing these factors, a specialist is not only more capable of understanding the situation of the child and their family, but also to properly identify the fields where the help must be focused – for instance, if an adolescent has an intellectual disability, lives in an institution and faces the risk of sexual abuse in the future, it is important to teach him or her the correct behavior, what to do and what not to do, who to ask for help and so on. In this case it is also important to train the caregiving staff in the specifics of communication with the child regarding the characteristics of his or her development. In the cases, for instance, when the disclosure of the victim is complicated by the fact that the mother became helpless, confused and doubtful of her child upon learning of the abuse, it is important to provide psychological assistance not just to the victim, but to the mother as well, i. e., to strengthen her psychologically in order for her to be able to take care of the child and help him or her deal with the trauma. Thus, a broader understanding of the disclosure of the sexual abuse of children not only allows to better respond to the needs of the victimized children, but also prevents the specialists from making too hurried, partial and categorical judgments in the face of sexual abuse of children.

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PSYCHOLOGICAL HELP TO CHILD AND ADOLESCENT VICTIMS OF SEXUAL VIOLENCE

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A case of sexual violence may occur in the practice of every psychologist working with children and adolescents. The psychologist working with a child may be the first specialist to suspect or learn about sexual abuse of the child. This chapter provides recommendations for psychologists who work with child victims of sexual violence. We will review the preparations for work with child and adolescent victims, collaborations with specialists in other fields, planning the psychological help in a particular case, the aims and the methods to achieve them.

The text uses the term "child" to include children and adolescents of various ages up to 18. The recommendations may also be useful for work with older clients, depending on the needs of their development and social maturity.

PREPARING FOR WORK WITH CHILD AND ADOLESCENT VICTIMS OF SEXUAL VIOLENCE

Encountering a case of sexual violence usually is very emotional for any specialist, causing anxiety, fear, anger, helplessness, etc. Difficult feelings may arise due to the reality of facing the phenomenon of sexual violence, identification with the feelings of the child victim or another family member, connections to personal experience. It is important for the psychologist to maintain their emotional balance, to accept and understand own feelings, to control them and to act based not on the feelings, but on the professional knowledge of the phenomenon of sexual violence.

The consulting psychologist requires professional knowledge about the stages of child development, the human psychosexual development, the phenomenon of sexual violence, the help provided in cases of sexual violence, the work with child and adolescent victims of trauma, the legal and child rights context. The psychologist must be prepared to constantly improve their competencies of working with child victims of sexual abuse, attend professional supervisions, especially when facing a complicated case.

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The psychologist must also be prepared to work not only individually with the child, but also with his or her family / caregivers, as well as collaborate with the other specialists participating in the intervention of the case. The psychologist must be attentive towards conflicts arising in the group of the specialists and try to perceive them as a reflection of the processes taking place in the family in which sexual abuse has been disclosed (Furniss, 2013).

The psychologist working with a child victim of sexual violence must realize that he or she is meeting a child whose needs and feelings have been disregarded, who has been exploited in order to satisfy sexual needs of another person, who maybe did not receive support and protection, and who is currently experiencing strong feelings of helplessness, guilt and shame. The psychologist must be able to respond to the often ambivalent emotions of the child and also to be open, honest, friendly, reliable and respectful of the child's needs and expressed opinions. The psychologist must also bear in mind the child victim's sensitivity to physical contact and difficulty in maintaining boundaries in interpersonal relationships. Qualities like creativity, freedom, flexibility, ability to maintain boundaries and sense of humor are helpful in working with child and adolescent victims of sexual abuse (Cohen, Mannarino & Deblinger, 2016).

THE CONTEXT OF PROVIDING PSYCHOLOGICAL HELP TO A CHILD VICTIM

Psychological help / psychotherapy provided to a child victim of sexual abuse should always be part of a complex intervention by specialists. There are several reasons for that.

Sexual violence is a serious breach of child rights and a crime that must be stopped. The main condition for an effective help for the child is first of all to ensure the safety of the child. No psychological help is useful if the child continues to be sexually abused. Therefore the main reason why the psychologist must collaborate with the specialists in other fields – especially child rights and the law – is ensuring the child's safety. The psychologist cannot ensure the child's safety alone.

Collaborating with other specialists, the psychologist may acquire important information about the means to ensure the child's safety, the stage of the criminal investigation and the proceedings in which the child client may need to participate. If the child has to participate in the legal proceedings, the consulting caregivingpsychologist may help the child prepare for them emotionally. It is important to note that the consulting psychologist may only assist the child in preparing for the legal proceedings, but not help in his or her inter-

view for the criminal process. The consulting psychologist has a different function than the one who helps carry out the interview. Confusing these roles may be harmful to the process of psychological healing.

Most importantly, during an intervention in the case of child sexual abuse, the psychologist and any other participating specialist must primarily focus on the interests of the child (Paramos vaikams centras, 2012).

PLANNING THE PSYCHOLOGICAL HELP

The plan of the psychological help assigned to a child must be based on the assessment of the child's psychological condition and family situation. It is important to assess the psychological difficulties the child experiences, the post-traumatic symptoms and the level of their expression, the extent to which the trauma interrupts the child's adjustment to everyday life. In assigning the help, the specialist needs to collect the information not only about the child's condition, but also about the characteristics of the disclosure of sexual violence, the reactions of the child's family to the violence disclosed, the characteristics of the family's interactions with the specialists. The decisions about the provision of the help for the child must always be made in the context of the family. Also, a specialist must always be aware of their general role in the network of the specialists and the intervention.

In planning the provision of the psychological help to a child victim, the following factors must be taken into account (see Zmarzlik & Pawlak-Jordan, 2010):

- the child's age;
- the nature of the sexual abuse;
- the duration and frequency of the sexual abuse;
- other forms of violence accompanying the sexual abuse;
- the role of the abuser in the child's life;
- the nature of the child's emotional connection with the abuser;
- the reactions of the environment to the disclosure of the fact of sexual abuse;
- the support provided by the nonviolent parent;
- the child's life experience and inner resources;
- history and disturbances of the child's family;
- positive experience and resilience of the child's family.

In conclusion, the psychological help must be planned individually in each case of the child and the family. It is important to note not only the negative experiences and risk

factors of the child (the difficulty of the symptoms, the duration of the abuse, etc.), but also the present protective factors and the positive experience of the child (psychological resilience, the psychological defense mechanisms employed, the support of the loved ones, absence of negative disturbances before the abuse, etc.)

THE FORMS OF HELPING THE CHILD AND THEIR FAMILY

Helping the child victim of sexual abuse is only effective when the help is provided to both the child and the parents / caregivers / family members. It is especially relevant when the child experiences abuse in his or her own family, but it is also important in the cases of abuse outside the family. Usually the disclosure of sexual abuse in every case causes a crisis in the family and leaves no family member untouched.

Psychological help to the child victim of sexual abuse and his or her family may be provided in the following forms (Zmarzlik & Pawlak-Jordan, 2010):

- providing help in a crisis;
- individual psychological counseling / psychotherapy for the child;
- children's group therapy;
- individual psychological counseling / psychotherapy for the parent;
- parents' group therapy;
- educational classes for parents;
- support groups for parents.

The form of help must be selected individually in each case, depending on the needs, state and of the child and the family as well as on what is locally available. The choice of the form and duration of the help also depends on the child's age. When very young children experience sexual abuse, it is worth considering the possibility of focusing on the ways of help that would enable the adults in charge of the child's wellbeing to be properly supported and provide assistance to the child.

THE GOALS AND AREAS OF PSYCHOLOGICAL HELP

The main goal of the psychological counseling for a child victim of sexual abuse is to help the child restore their psychological balance. Accompanying the child during a difficult moment, the psychologist must help the child regain the sense of security, control, confidence in oneself and in others, to strengthen proper use of defense mechanisms and thus reduce the expression of symptoms and to ensure the child's better functioning in the future (Cohen et al., 2016; Nyman & Svensson, 1997; Söderström, 2013; Zmarzlik & Pawlak-Jordan, 2010). The most important goals of psychological help and areas of

work are described next.

Restoring the sense of security and trust in adults.

A child victim of sexual violence has a special need to feel safe again – both physically and psychologically. In trying to restore the child's safety, it is necessary to ensure that the child is not sexually abused again. The collaborations of specialists in ensuring protection for the child has already been discussed in a previous chapter. The psychologist may play the most significant role in restoring the child's psychological security. The psychologist must treat the child in a way that is helpful to the child in building trust – be predictable, keep commitments, maintain boundaries during counseling sessions, respect the child's opinions, be sensitive to the child's needs and empathetic to his or her emotional state. The physical environment during counseling must also increase the child's sense of security. The psychologist may pay attention not only to establishing their own connection with the child, but also in rebuilding the child's connection to the nonviolent parent.

Acknowledging the reality of sexual abuse.

Sexual violence causes confusion and feelings of unreality in its victims. Some children develop symptoms of amnesia and dissociation. The children need a psychologist's help to acknowledge what happened and to confirm that the abuse is over. It is important that the horrible and painful experience that the child wants to delete from their life gradually becomes a part of the child's life story, which may be painful, but has been survived and integrated.

It is recommended to speak about the abuse experienced as clearly and directly as possible. E. g., to say not "that event", but rather, "the time when Uncle put his penis in your bottom". If the psychologist feels embarrassed to discuss the abuse, it is worth practicing with some colleagues.

Not all the children find it easy to verbalize the sexual abuse they have experienced. It is recommended to use drawing tools or toys that would help the child tell his or her story. A conversation about good and bad secrets may also be helpful in getting children to start talking. However, if a conversation about the abuse experienced is too stressful, the psychologist may help the child by telling what he or she knows about abuse from other sources and then work with the child's reaction. It is also important to pay attention to the topic of abuse coming up in later stages of the work.

The child victims of sexual abuse are often misled and tricked by the abuser(s). The child may be confused as to what happened and what is allowed. The child may maintain false

convictions. Therefore the psychologist has a very significant task of bringing the child's experience back to reality by responding to the child's condition and helping to comprehend what happened. It is important for the child to understand what sexual abuse is, who is responsible for it, what is and is not allowed in dealing with the child's body, etc. The psychologist must be prepared to directly reply to the child's questions and provide necessary information.

Strengthening feeling recognition and expression skills.

Child victims of sexual abuse find it difficult to understand and express their often contradictory feelings. The experience of sexual abuse usually causes strong anxiety and fear. The helplessness and anger the child experiences may be mixed with love and longing. Usually children experience strong feelings of guilt, "their own sinfulness" and responsibility, which may interfere with the child's social functioning. Strong feelings of shame due to the experience of abuse prevents the child from talking about the abuse and is accompanied by anxiety that others may reject or punish the child if they learn about the experience of abuse.

Soderstrom and colleagues (2013) describe two ways in which children usually process the experience of abuse. Some present with intense experiences of anxiety, fear, panic, accompanied by recurrent flashbacks, nightmares, strong avoidance. Other children lean more towards emotional isolation and dissociation. The psychologist must help the former to deal with the strong emotions that they experience, and the latter, to gradually approach the painful experience and withstand the difficult feelings. In both cases, the goal is to approach the trauma-related feelings.

The work of the psychologist is to help the child accept and experience all the feelings that arise: by reflecting the child's feelings and by teaching him or her that it is understandable to feel like that in a situation like this.

Strengthening the child's autonomy.

Sexual abuse is often an experience of helplessness, lack of options, absence of power and the right to make decisions, feelings of victimhood, conviction that it is impossible to protect and defend one's body. Therefore a very important goal of psychological assistance is to help the child overcome their feelings of helplessness and victimhood and to acquire experience that the child's choices and decisions matter, that the child is in control of their body and that the child may ask for help when needed.

Strengthening the child's autonomy should begin at the first session by telling the child openly and in a comprehensible way what the goal of the session is and what is going to be done during it.

Acceptance and providing hope.

Often child victims of sexual abuse are disappointed in themselves, the world around them and the future that awaits them. The psychologist should help the child understand that the abuse is over, and hope may be regained. Restoring or strengthening the relationship with the nonviolent parent is also very significant to long-term recovery. Also it is useful for the children to hear how other children feel and behave, and what has helped other children to regain hope.

Sexual abuse may not be deleted from memory. It is part of the child's history even after the psychological treatment is over, and the child may continue to experience feelings related to the abuse. It is important that both the child and his loved ones do not get stuck in the situation of the victim.

Building up the child's self-esteem and self-confidence.

Child victims of sexual abuse may experience low self-esteem and feelings of helplessness. The psychologist should constantly aim at building up the client's self-esteem by emphasizing his or her strengths, positive experiences and achievements observed during counseling: the ability to express opinions and feelings, to say no, etc. The psychologist should also try to enlist the child's loved ones who spend a lot of time with the child to also help build up the child's self-esteem.

Child victims of sexual abuse usually underrate both their personality and their body. They find it hard to accept their body, may hate it, feel disgust with it, consider it sinful and dirty, sometimes children even feel that they have no connection to their body. The child victims find it difficult to understand what physical closeness is healthy and what boundaries should be maintained. They may avoid any touch at all, treat every touch as sexual or the opposite, act in a sexual and enticing way when they seek a close connection. The psychologist has an important task to help the child to appropriately interpret the signals sent by their body and by other people and to respond to them in a non-harmful way.

Strengthening interpersonal relationship skills.

Child victims of sexual abuse often feel different, marked. It interferes with their ability to connect with their peers, to belong to a group of peers and to participate in age-appropriate social activities. The psychologist's task is to help the child restore correct convic-

tions about oneself and others. In ensuring the child's social adaptability, the psychologist should also enlist the help of the child's non-violent loved ones.

Correcting inappropriate sexual behavior.

Not all child victims of sexual abuse present with symptoms of sexualized behavior. In some cases the sexual behavior is insignificant, does not interfere with the child's functioning and fades in time. Sometimes sexualized behavior disappears while providing the psychological help oriented towards the goals listed above. However, in some cases sexualized behavior grows more prominent and interferes with the child's relationships with peers and adults. In such cases sexualized behavior should be corrected directly, by strengthening the child's self-control skills. If the child's sexual behavior turns into criminal behavior towards other children, termination and correction of such behavior must be a priority in the psychological work. In such cases, collaboration with other services is also necessary: child rights specialists, social workers. In order to protect the safety of other children, the compilation and application of safety plans in the family or institution is recommended.

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PSYCHOLOGICAL HELP FOR PEOPLE AFFECTED BY THE DIFFICULTIES OF WAR

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The war in Ukraine has touched a lot of people throughout the world, therefore it is very important to deal with that. The people experiencing direct military actions now or having experienced them in the past can be categorized into five groups: those present in the action zone; volunteers; people at the rear; people who have experienced traumatic events and left the war zone; people who were abroad as the war began.

The first group is the people in the military action zone. Everything around them is acute and complicated, they are under a lot of stress, and their feelings and experiences are different from those of volunteers or refugees.

Panic, freezing, breathing difficulties, stomach spasms, lack of appetite, helplessness, heavy sleepiness – these are all details of the everyday life of the people in the first group.

Recommendations

This group requires work applying the crisis scheme (which may be found in any textbook on counseling people in crisis).

The main task when working with the members of the first group is to bring them back to reality, help them see what is besides them, around them, what may help, for instance, where there is a bathroom that may serve as shelter during bombings etc.

These people may benefit from physical practices. Slow deep breaths, progressive flexing and relaxation of different body parts, grounding, i. e., observing the body parts that touch the ground, like the feet when standing, or the back when lying down. The goal is to notice what is around, finding a "thread" connecting to the outside world, something to hold on to. It is important to rest systematically, as constant anxiety is exhausting. Sitting back to back with another person may help feel oneself and the other. Stroking the stomach, placing a hand between the shoulderblades, gently hugging, avoiding unnecessary words. Repeating positive statements may also be helpful. Phrases to be repeated should be like these: "I have done all I could", "I am in a safe space", "I have water and papers". These statements will help prevent unconsidered actions that may be provoked by particularly strong anxiety.

If you are next to a person in panic, ask them to slow down their breathing, tell them to breath in, breath out, breath in, breath out, put their palms in a tube by their mouth, blow into a bag or perform any other action that would help restore the rhythm of their breath. Ask the person to describe what they are wearing, what they see, if there are other people nearby – that will help to draw the attention from their inner state to the outside.

The second group of people is very special: the volunteers. Doing something useful is a good way to reduce anxiety. Tired volunteers experience discomfort, irritation, but once they realize that they are taking their irritation out on the people who need help, they feel guilty and again try their best to provide assistance. Sometimes the distinction between "me" and "them" disappears in the mind of a volunteer. These people keep telling themselves: "Who if not me?", but it is a straight path to burnout. It is important to understand that it is impossible to do everything. "Do not choose who to save: help the first victim, then come back to rescue another. Just save those you can save, and that's it."

Recommendations

If the volunteers do not allow themselves any rest, if they get involved in the vicious circle, it is important to point that out. They must understand what is happening to them. It is important to learn to say "ENOUGH". If such people continue to disregard their basic need, they burn out and can no longer do their job satisfactorily. Every hour, five minutes should be spent for oneself. For example, plunging hands in cold water, hugging oneself, shaking. The volunteers need to remember who they talked to, come back to themselves, and then help another, and thus slowly make their way ahead.

The third group consists of the people at the rear, where it is relatively safe. On the one hand, they are safe enough, but on the other hand, the security is not absolute.

This group characteristically is greatly disoriented and confused, feels helpless and experiences waves of anxiety. It is influenced by the amount of attention the person pays to following the news and the number of interactions with people in panic. After such interactions, it is difficult to regain inner balance. When others tell scary things, the mind produces horrible images, and anxiety drives to action. Such people seek safety, but sometimes an exhausted person decides to stay, because he or she lacks energy to leave. If they decide to stay, they believe they will fail, and it may greatly influence their decisions. This group of people is characterized by emotions like insecurity, doubt, helplessness, increased inner locus of control, constant tension, tense mimics, chaotic eye movements, inability to focus, freezing. Physical signs: increased arousal, changes in breathing

patterns, increased blood pressure, increased heart rate, sleep disturbances, sudden reactions, anxiety, difficulty falling asleep, failure to differentiate between dreams and reality, increased nightmares, increased sweat, chest spasms, muscle aches, decreased cognitive, memory, attention, reasoning abilities, constantly growing irritation towards others, forgetfulness, fear.

Such people are very vulnerable, they tend towards high levels of perfectionism and may experience neurotic problems.

Recommendations

Eating well and taking good care of oneself. Not judging oneself. Some people experienced anxiety and panic attacks even before the war, they engaged in self-harm or in "eating their problems". Therefore it is important to help such people distinguish their inner state and anxiety about the real situation, recognize senses of reality, build up resilience against the unknown (seek novelty and enjoy it). During therapy, "turn" the image towards everything being all right here and now. Anxiety is a frustration due to disregard of one's needs and feelings. Question: "How can I take care of myself?" Constant balancing – loss of balance leads to panic, the person will submerge in his or her fears. It is important to regain the ability to adapt creatively. Appreciate more what is there. Allow oneself to eat, laugh, be happy.

The fourth group consists of the people who experienced traumatic events and went abroad. Their circumstances are different, but no less significant. To such people, the priority is ensuring safety, renting a home, making friends, finding ground, rediscovering what matters.

They are plagued by PTSD, nightmares, exaggerated reactions to loud noises, depression, sadness, lots of experiences and numerous losses.

Recommendations

Working according to the scheme for PTSD treatment.

Practicing mindfulness, returning to the here and now, help in realizing one's breathing, observing one's reactions, sitting down, distracting. Repeating: "I breathe, I live" – after that, the anxiety-inducing thoughts are mentalized. It is important to realize: "These are my thoughts, I may or may not think them". The words "I want to discover myself" are helpful in thought control. This practice is required to help the client stop struggling, pick up what they need and leave.

Grounding methods help reduce anxiety and other intense emotions. They are also used in early therapy in order to stabilize flashbacks of the traumatic event (they are one of the symptoms of PTSD), distract from traumatic thoughts, memories and experience, and transport into the present moment.

The fifth group consists of the people who were abroad (studying, working, vacationing) when the war started. They are the ones who learned about the start of military actions and began worrying, blaming themselves, feeling shame about their luck in escaping it. It may be difficult to understand their experiences, because these people have homes, quiet lives, jobs. But all that only makes the situation more difficult, because it may seem like their experience is devalued.

Recommendations

It is important to work with this group carefully and provide them with the opportunity to talk about and process their experience.

EXAMPLES OF METHODS TO OVERCOME ANXIETY

5-4-3-2-1

This method requires engaging the organs of senses to help focus on details in the environment. It may be sounds or the texture of something. For instance, name five objects that you can see; four things that you can touch (clothes touching the body, rays of sun of the skin, the chair that you sit on, the weight, structure and other characteristics of an object that you feel when you hold it in your hands); three sounds you can here (like traffic, birdsong, the ticking of a clock); two things you can smell (air freshener, perfume or oil) and one thing you can taste (candy, chewing gum, water).

A variation is observing and counting (listing) things of the same color, shape or category (own choice).

Categories

Choose at least three of the categories listed below and think of as many elements of each of them as possible. Take several minutes for each category in order to come up with more elements.

Categories: movies, countries, books, grains, sports teams, colors, cars, fruit and vegetables (together or separately), animals, cities, TV shows, famous people.
If you want to make the task more difficult, try listing the elements alphabetically.

Body perception

The aim of this method is to focus on bodily senses and thus to mentalize the present moment.

Take five deep breaths in through the nose, out through the mouth (open your lips a little and make a tube shape).

Stand with both your feet on the ground. Wiggle your toes. Lift and lower them several times. Focus briefly on your feet, try to feel them.

Stamp the ground or floor several times. Pay attention to the sensations in your feet and what you experience as you put them down or as they touch a surface.

Squeeze and release your fists. Repeat ten times.

Press your palms together. Press even harder and hold for 15 seconds. Focus on the sense of tension in your arms.

Rub your hands energetically. Focus on the sound and the warm sensation.

Stretch your arms above your had like reaching for the sky. Stretch like that for five seconds. Drop your arms and let them relax.

Take five more deep breaths and focus on the sensation of stillness in your body.

Cognitive exercises

These methods help to distract from unpleasant thoughts and feelings. They may be performed anytime and anywhere. Experiment and discover what suits you best.

List all the things you can see.

Think of a task that you know well and describe all the actions or processes that it involves in detail. For instance, tell how you cook your favorite dish.

Take an object and describe it: color, texture, size, weight, smell and any other characteristics that you can observe.

Spell your own name and three other names backwards.

List all your family members, their ages and one favorite activity.

Read something backwards.

Think of a thing or an object and "draw" it in your mind or by tracing your finger in the air.

For instance, try "drawing" your home, car or pet.

SURVIVOR'S GUILT

Survivors experience the sense of guilt. It is the "survivor's guilt". It emerges when it feels that you have survived, left, saved everyone you could, dealt with all the problems, overcome panic, taken care of your family, helped or not helped your loved ones. It seems like you did everything right and everything you could do, and after all the horror there must come the sense of satisfaction, joy and security. Maybe such sense does emerge, but it does not stay long or may not be experienced at all.

The person is visited upon by disappointment and guilt, because now they are safe, but others remain in danger. The thoughts may vary greatly, because each person thinks and experiences guilt in unique ways.

The feeling of guilt may emerge in every case, regardless of whether the person left or stayed. It is important to learn to live with this feeling. If the person had not left, they would feel guilty that they did not take the opportunity that they had, did not save those they could save, they would feel guilty about their children, wife, mother, brother, sister, father and others that they could have taken to a safe place.

It is recommended to start working, to find some activity: volunteer, help people find homes, accept, care, love and dream about things to do after the war, about where, with whom and how one might live. Someone might have always dreamed of living abroad, and now they have the opportunity to do so – of course, it is not happening according to the dreams, but still it is happening. Someone might have wanted to try living in another country, and now they have tried it and found out for sure that they want to go home, and they realize that home is the only place where they feel safe. Yet another person might now know for sure that they will not leave their country even if it means losing their life.
It is different for everyone. It is important to accept the guilt and learn to live with it, to take on the responsibility for one's own life.

STAGES OF GRIEF

People experience the different stages of grief at different times and may also return to the stages that they seem to have already left. Elizabeth Kuebler-Ross (1973) states that the stages of grief may last differently and replace each other or occur at the same time. It would be ideal to believe that everyone will achieve the stage of acceptance of all the changes that they are facing, but often some people get stuck in one stage and are

unable to move on.

The person's behavior in each of the five stages of grief:

1. Shock or disbelief. "I can't believe it!", "It's impossible!", "Not to me!", "Not again!"

2. Denial. It is often a temporary protection that buys some time to learn more about the changes before moving on to the next stage. It is the initial stage of shock and freeze. We do not want to believe that the changes are happening. It seems that if we pretend that nothing is changing, if we distance ourselves from the event, maybe it will go away. It is somewhat like the ostrich hiding its head in the sand.

3. Anger. "Why me? It's not fair!" "No! I cannot accept it!". Once we realize that the changes are real and we cannot avoid them, denial turns into anger. We are angry about what is happening to us, and blaming someone or something. Interestingly, our anger may be directed towards completely different things. People may be angry with their boss, themselves or even God. When times are rough economically, the economy is to blame for everything. The government or some high authority is responsible for all the troubles, they should have foreseen and calculated everything. Also people may become more irritable with their colleagues or family members, for instance, start picking up fights over insignificant details.

4. Negotiations. "Let me live until the children finish school!", "I'll do anything, just give me some more time. A few more years." Negotiations are an attempt to delay what cannot be avoided. People often engage in them when they undergo changes. We begin negotiating, trying to somehow delay the changes or find a solution to our situation. We usually attempt making deals with God, with other people, with life. We say: "If I promise to do this, you will prevent this change from happening." Speaking of work, some people start working even harder, often take on extra time, hoping to avoid being fired.

5. Depression. "I'm so unhappy, how can I care about anything else?", "It's no longer worth trying." When we realize that the negotiations were in vain, the approaching change becomes real. We understand the losses that it will bring, and everything we will have to leave behind because of it. This understanding drives to depression, weighs down, sucks out the energy. The depression stage is often observed in the working environment. When people face change at work, they reach the point where they feel demotivated and very uncertain about their future. In practice this stage is expressed as frequent absences from work. For instance, people often take sick days off.

6. Acceptance. "Everything will be all right", "I cannot overcome this, but I can be well prepared for it."

When people realize that it is pointless fighting the change, they move on to the stage of acceptance. It is not a state of happiness, but rather, a humble acceptance of the change and the sense that it must be faced. For the first time people attempt to assess their perspectives. It is like a train entering a tunnel. "I don't know what's waiting behind the corner, but I must move along the trail. I'm scared, but I have no choice, so I hope for a light at the end of the tunnel..."

Such an attitude may turn into a creative state, because it forces people to explore and seek new opportunities. People discover something new in themselves, besides, it is important to realize that accepting the change required courage.

Kuebler-Ross (1973) says that we may fluctuate between the different stages of change. For instance, one day we may have reached the stage of acceptance, but then we hear some news at work, and it casts us back into anger. It is normal. Although Kuebler-Ross does not include hope in the list of the five stages, she says that hope is precisely the significant thread that connects all the stages.

Hope gives faith that the changes will eventually turn out for the better, and everything that happens has a special meaning that we will realize in time.

This is an important indicator of our ability to successfully adapt to change. There are possibilities for growth and improvement even in the most difficult situations. Every change comes to an end. Such reasoning creates the hope or meaning that Victor Frankl (1959) spoke about and that Kuebler-Ross agrees with. The model of the stages of grief provides people with calm and relief: they realize the stage of accepting change they are in at the moment and the stages they were in in the past.

How to inform a child about a death

It is important for a child not only to be aware of the fact that a loved one has died, but also to talk about it. But such a conversation takes some preparation. What to recommend to a grown up who needs to correctly inform a child that a loved one has died?

Try to find a quiet and peaceful place for the conversation with the children, think well what you are going to tell them. Ask the children to sit beside you. If your child is young and he or she has a favorite object that he or she always carries around (a toy, a warm scarf or a blanket), allow the little one to have the object nearby. Speak slowly and pause

often, so that the child has time to understand what he or she hears, and that you could process your own feelings.

Be empathetic and honest with children of different ages, and if you speak to young children, use the language they can understand, talk clearly and avoid euphemisms. If you say "we lost someone", you may confuse the child even more, because he or she will fail to understand what it means.

In a warm and soft voice, say: "I have some very sad news that I want to tell you. Your dad has died (was killed). It means that his body is no longer working, and we will not see him again."

It may be difficult to use such straightforward language, but it is very important to be honest and direct.

It is important to give the children time to process this information. Young children may pretend that they are not listening to you – it may be their reaction to the news. Be patient and wait until you have their attention. Also be prepared that younger children will keep asking the same questions both during the initial conversation and over the following days and weeks.

Make sure that children are not perceiving some things "magically": they may be concerned that the death of a loved one was caused by something they said or did. Children of any age may feel guilt, therefor you should figure out if they do not feel responsible for what happened.

For instance, you may ask: "Are you worried that dad might have died because of something you said or did?" In simple words, explain to the children what happened, and reassure them that they have nothing to blame themselves for. You may tell the child: "Relax, you did nothing wrong. Only war is to blame that dad stopped breathing. No one else did it."

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THE ROLE OF THERAPEUTIC RELATIONSHIPS IN HELPING ABUSED CHILDREN

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It is often observed that the cognitive and behavior therapists do not focus enough on the therapeutic relationships and the factors associated with the therapist. In this paper, I examine the effect of the therapeutic relationships in providing care for the child victims of violence, and especially the influence of the therapists' convictions to the quality of their work.

I provide an analysis of a supervised therapy case and, based on it, I reveal how the therapist's conviction in his lack of competence affects the process of diagnosing sexual abuse in children. In the analysis I reveal that such a conviction causes a great anxiety to the therapist, which results in reduces empathy. The therapist' self-protecting behavior (focus on the goal or the means of diagnosis) interferes with establishing the necessary therapeutic relationship. Based on my experience in supervision and training, I provide a list of convictions that may interfere with caring for the child victims of violence (typically, such convictions are related to own competence and certain difficulties in caring for child victims of violence).

Since the convictions of therapists affect the process of treatment, they deserve a lot of attention during supervisions and therapeutic training. Not only must the falls convictions about violence against children be corrected, but convictions about the lack of competence and fears of the therapists themselves must be addressed. Supervisions should provide the therapists not only with factual knowledge, but emotional support as well.

KEYWORDS:
Cognitive behavior therapy, work with child victim of violence, therapeutic relationships, main convictions of therapists

Treat other people the way you want to be treated by others.

Nicholas Ladany, Myrna L. Friedlander, Mary Lee Nelson

Work with children victims of violence is considered to be especially difficult and to take a great emotional toll. That is often the case. In such work, we face the traumas of young people, which may have a traumatizing effect on the therapists themselves (Adams, Riggs, 2008; Figley, 1995). We know that providing care to such clients tends to be more stressful and lead to professional burnout. Besides we must face the patients' feelings of helplessness, and as we work with heavily traumatized victims of violence who experience difficult feelings, we feel helpless ourselves. That may strengthen the convictions that we the therapists have about the injustice present in the world and how we disapprove of it. In such cases we often experience anger and desire for revenge the perpetrators and abusers. Usually all the therapist's emotions and strengthening convictions are an adequate response to the news of violence against a child. On the other hand, such convictions may strongly influence the therapeutic relationships and the results of the therapy itself. By learning our own cognitive and emotional reactions to violence against children, and the ways we act when faced with them, we can greatly improve the quality of our work and thus care for our clients more effectively. Lack of knowledge about the mechanisms that come into play with the experience of violence may also reduce the quality of therapy (or psychological help in the broader sense), and in radical cases, even make it impossible.

In this article I analyze the influence of the therapists themselves on their work with child victims of violence, and the emotions that arise in the therapeutic relationship due to a contact with violence. I employ the declarative-procedural-reflective (DPR) model suggested by Bennett-Levy and Thwaites (2007). After that I provide an example of the concept of therapeutic relationship. Based on this example, I reveal the difficulties that may arise in therapeutic relationships due to the therapist' idiosyncratic convictions about the work with a child victim of violence. It seems that studying therapeutic relationships is useful for at least two reasons. One, it helps us realize the vicious circles in which we may spin with our clients. Being stuck in such a vicious circle often interrupts the therapeutic process, may cause resistance on the part of the client, and in extreme cases even encourage him or her to terminate therapy. If we acknowledge that we are stuck in a vicious circle, we may break out of it. Besides, according to Safran, Muran, Stevens and Rothman (2007) and other authors, realizing and discussing with the patient(s) the difficulties in the therapeutic relationships may also strengthen the therapeutic relationship. Two, understanding therapeutic relationships may reveal how the patient(s) act(s) in their other relationships. Thus, discussing such a concept with the patient may often have a therapeutic aspect (Ladany, Friedlander, Nelson, 2005).

In the next chapter of this paper I will provide examples of convictions related to the therapy of child victims of violence and unpleasant emotions that these convictions may cause. I will describe how such convictions affect therapy and indicate ways to deny the truthfulness of such convictions. The goal of this part of the text is self-help for the therapists who experience difficulty in establishing therapeutic relationships due to too high standards, self-blaming and judgmental tendencies as well as unrealistic and incorrect ideas about the therapy of child victims of violence. At the end I will attempt to make some more general conclusions about helping people who work directly with child victims of violence and the supervisors who assist them. I will also provide suggestions about training the specialist to work in this field in the future.

In the text I use the words client and patient interchangeably. I do that because each of them is to some extent inconvenient. It feels like a simplification to consider therapeutic relationships as just one of many types of relationships in which one person provides the other with a service (as implied by the word "client"). The "service" of therapy is a lot more than just a simple service to another person, it is too emotionally involving for both sides of the process and raises a lot more ethical questions than any other service relationships, and it stems from different values than simply desire for profit. On the other hand, the word "patient" too strongly connects psychotherapy with the medical context. On the one hand, many of the therapeutic procedures are considered medical services and are intended for the treatment of particular illnesses (for instance, second wave cognitive behavioral therapy). On the other hand, more and more researchers are focusing on the need for a holistic understanding of mental disorder and declare the need for therapy models based on transdiagnostic premises. More and more researchers are attempting to construct models of psychological wellbeing and psychological disorder that would help turn the focus away from particular mental disorders and be able to explain them (Hayes, Strosahl, Wilson, 2013; Villatte, Villatte, Hayes, 2016). It may seem easy to miss these aspects of therapy if using the word "patient" exclusively.

DECLARATIVE-PROCEDURAL-REFLECTIVE MODEL

Safran et al. (2007) define the human relationships as a system of subjective interpersonal negotiations among the participating people (in the context of therapeutic relationships it is a negotiation between the therapist's subjectivity and the client's subjectivity). By defining relationships like this, the authors recall the general definition which was used, among others, by Gordon who stated that human communication defines their shared

meaning and understanding. In other words, one person knows what the other has in mind, and vice versa. Of course, obstacles and misunderstandings abound in the process of communication. First of all, maybe I did not express my idea clearly enough and only clarified it during the conversation. Then, my listener may misunderstand what I am saying, because I am not making myself clear enough, o he or she is not hearing it right. Eventually, even if my words are heard well and good, they can always be misinterpreted. My words may be understood differently, or my attitude towards what I am saying may be misconstrued (for instance, I may be trying to inform, saying something ironically, sharing my experience, seeking comfort, etc.). All such misunderstandings also occur in therapeutic relationships, which differ from other kinds in that they should, by definition, provide a safe space to examine obstacles in communication (Miller, Rollnick, 2014).
In analyzing therapeutic relationships, Bennett-Levy and Thwaites (2007a) mostly focused on the therapist's personality and asked what characteristics of the therapist influence therapeutic relationships. The authors have defined three general systems that influence therapeutic relationships. The first is the declarative system of knowledge. It consists of all the information applied in therapy that therapists have acquired not only in their training, but in life as well. The declarative system of knowledge consists of knowledge of interpersonal relationships, the concept of the case (knowledge of the diagnosis, psychological functioning, life story, etc.) and particular therapeutic interventions adjusted to the produced concept of the case.

The second system that the authors define is procedural. Everything that takes place in a particular therapy session depends on the procedural system, it controls the therapist's behavior. It includes the ability to observe the clients' behavior and reactions. We learn that from birth by participating in the various social relationships as well as in therapeutic training. The skills to observe clients' behavior and reactions include the ability to identify with the client's emotions, to mentally distance oneself from the experience of the client and to understand what the client is experiencing from the perspective of the therapist, to associate emotions with the therapist's interpretations and cognitive schemes, to focus on the here and now (applying mindfulness skills), which allows to focus on the session and makes the dual perspective easier: on the one hand, identifying with the inner world of the client's experiences, and on the other hand, understanding what is happening from the point of view of the therapist.

Besides the cognitive skills, the therapist's behavior is controlled by two schemes – the self as a person and the self as a therapist. The schema of the self as a person consists of all

the convictions, emotional reactions and behavior modes that have been shaped throughout our lives. These are convictions that are closely related to our own story. Working with child victims of violence, the therapist's own experience of trauma and violence is especially pertinent. The experience of violence may affect the therapist's behavior in numerous ways. First, the experience of trauma may encourage avoidance. Conversations of trauma and violence may cause painful memories that the therapist would rather avoid. Second, the fact that the person himself or herself has experienced violence may put the opposite mechanism in play. The therapist who has experienced violence may be especially sensitive to the various signs of violence. It seems that sometimes it may be useful in his or her work (especially when violence is disclosed). However, it may also cause him or her to overemphasize some signs of violence and overinterpret the events described. Even if such interpretations are not exaggerated, the therapist may seek his or her own interpretations due to the personal experience, i. e., to assign to the patients his or her own helplessness, anger or other feelings towards the perpetrator, even if the patients have not experienced similar emotions. Third, studies of people with addictions who abstain and who are also addiction therapists indicate that they tend to encourage the decisions that helped them overcome addiction during therapy (Miller, Rollnick, 2014). It seems that a similar mechanism may be at play in treating child victims of violence, when the therapist who has been a victim of violence recommends to his or her clients such ways of dealing with trauma that brought relief to himself or herself. Essentially, cognitive fusion with own traumatic memories and cognitive schemes that have emerged as a result of violence may result in a lesser focus on the person in therapy and make it a lot more difficult, and in extreme cases impossible (Hayes, Strosahl, Wilson, 2013). For this reason, personal therapy is especially important and necessary for the therapists who have encountered violence themselves and want to help other victims of violence.

The scheme of the self as a therapist takes shape during the therapeutic training and practice. It includes all the convictions about oneself as a therapist and ways in which the therapist emotionally reacts and acts in different therapeutic situations. Its important parts are convictions of own competence or lack thereof, assumptions about therapy and patients (for instance, assumptions: "therapy should be pleasant", "I must be a specialist of all the areas of psychological care", "some patients are especially sensitive, and the experience of strong emotions may ruin their lives"), attitudes and values of the therapist (for instance, "I must help everyone", "therapy is a mission, and I must not accept pay for it"). Of course, sometimes it is difficult to precisely differentiate between the scheme of

oneself as a person and oneself as a therapist. Some convictions intersect between different schemes – for instance, we often choose the caring professions because of our strong desire to help others, and this desire stems from personal schemes. On the other hand, modifying certain convictions and schemes during clinical work may influence the scheme of the self as a person. For instance, if we started our therapeutic work with a dysfunctional conviction that when someone experiences unpleasant emotions while interacting with us, it means we are hurting that person, and because of that we have tried to be nice to everyone and very attentive to their emotions, therapeutic work may adaptively correct this conviction (the way others feel when interacting with us does not always depend on us, and sometimes in communication with another person other values are more important than being nice).

Important parts of the procedural system are interpersonal skills, the ability to conceptualize problems and apply therapeutic methods. Those are the skills to act in a certain way that we first apply consciously and with some effort, and over time, as the therapeutic mastery increases, they become automatic. These skills are related to the declarative knowledge about therapy and interpersonal strategies, but their concept cannot be understood too narrowly (like the theory of driving a car cannot be narrowed down to the ability to drive). The therapist's skills, his or her schemes as a person and a therapist, the concept of the patient's behavior during the session are transformed into the therapist's own behavior. For instance, if the client talks about a trauma he or she has experienced and stops talking at a particular moment, the therapist may focus on the difficulties that the client is experiencing based on his or her natural curiosity (personal scheme), confidence in own abilities (therapist's scheme), knowledge of trauma therapy (talking about trauma is difficult and clients want to escape it, but at the same time it is healing and helps reduce anxiety), and having enough technical skill to control the therapy, he or she may verbalize the patient's difficulties ("I can see that you find it difficult to talk"), normalize them ("a lot of people aren't too fond of talking about their difficult past) and encourage further conversation ("I will help you remember the difficult moments").

The third scheme is reflective. In therapeutic work, especially as we observe difficulties in therapy, we begin reflecting on why these difficulties arise and how they may be overcome. If that happens, it is a sign that the reflective system is functioning. In order for reflection to happen, we must focus on the problematic situation, create a mental image of the problem (i. e., describe and conceptualize it) and carry out cognitive operations that allow reflection (for instance, explain the situation providing a broader context,

apply problem solving methods, accept the present situation). The reflective system is applied both in the declarative system (when we consider the knowledge we are acquiring and assess it critically) and the procedural system (when the particular events that happen during the therapeutic work challenge us and provide us with a possibility of reflection). The connections between the systems described is presented in Figure 1 .

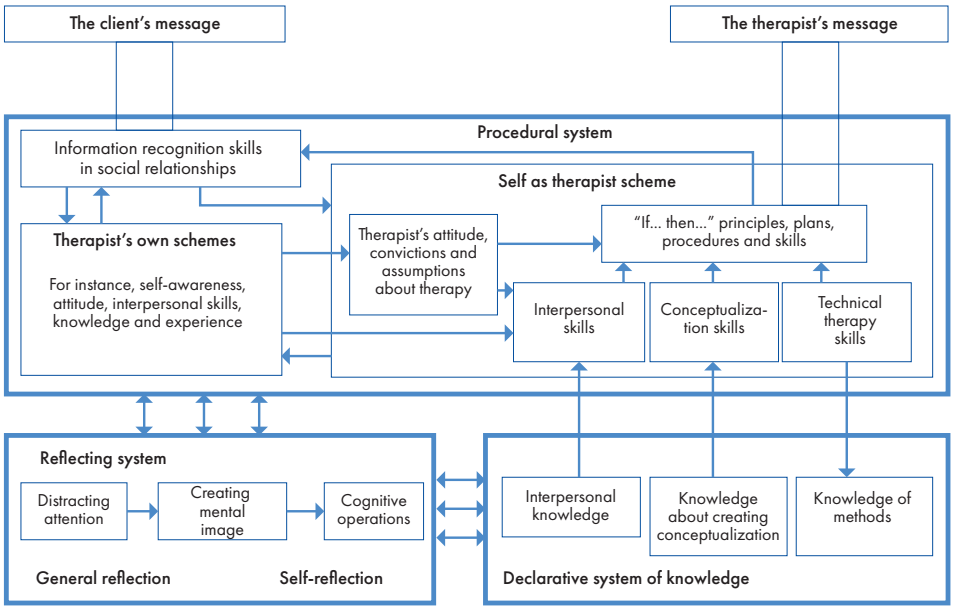

Figure 1. Declarative-procedural-reflective system

There is a particularly significant issue associated with the relation between the scheme of self as a person and self as a therapist. During therapy we often wonder whether our reaction is caused more by our scheme as a person (i. e., our history, convictions and attitudes), or is it connected to our scheme as a therapist.

In the first case it must be considered whether what the therapist does will have a therapeutic effect. For instance, a patient in therapy tells about his father who abused alcohol. The therapist, whose father was violent towards the son and the mother, may presume that the patient's father was also violent. Such assumption may have such a strong effect that the therapist might not even pause to check it, instead believing that the patient has an enhanced model of harm. Meanwhile, the patient's father in fact would seize communication with the family when drunk and shut himself in his room. The therapist's false assumption will likely be checked during the therapy, but it may have a harmful effect on the therapeutic relationship, because it may cause misunderstandings or resistance. Our

partialities may also be transferred into the therapeutic process. For instance, a therapist with strong conservative convictions may guide a woman in a violent relationship with her husband towards strengthening the marriage. Whenever there occurs a value conflict between our convictions that stem from our personal schemes and the attitudes of our clients, the decisions should always be made with regard to the clients' wellbeing and not our own desire to realize our attitudes.

During therapeutic training, personal therapy or supervisions therapists improve their ability to reflect. It is associated with personal improvement, reflection on interpersonal relationships, self-knowledge and therapeutic skills. Various schools of therapy place different emphases on the need for therapy or work on oneself during the therapeutic training. Some methods require it, while others only recommend individual work. The usual arguments for personal therapy are as follows. First, realizing own personal schemes allows for a better understanding whether whatever is happening in the therapeutic relationship is associated with our own life story and schemes that the patient's behavior arouses in us, or if it is rather the result of the patient's behavior. Second, research indicates that trying out therapeutic methods oneself helps learning to apply them and memorize their theoretical rationale more easily. Third, therapists with better self-reflection skills are more empathetic, better at adapting interventions to stages of therapy, more understanding, less judgmental and listen more than talk. It was found in a comparative study of the therapists who learned mindfulness themselves and those who did not (Bennett-Levy, Finlay-Jones, 2018; Bennett-Levy, Lee, 2014; Kohrt et al., 2015). Bennett-Levy and Thwaites (2007a) have also conceptualized the concept of the therapist's empathy and its role in the therapeutic relationship, based on the model associated with the relationship between the declarative, procedural and reflective systems. They observed that empathy consists of four basic skills. First, the ability to identify with the patient's experiences (i. e., to observe what he or she is experiencing, and find similar emotions in own experiences). Second, empathetic knowledge and understanding what situations and what interpretations of such situations are associated with the emotions experienced. Third, empathetic communication skills that therapists use to show their patients that they are heard and understood. Fourth and last, empathetic view of the patient's wellbeing. Bennett-Levy emphasizes the importance of an empathetic attitude and, following Gilbert, considers the paradox of the empathetic criminal. A regular criminal will use a gun to extract information from his or her victim. In the same situation, an empathetic criminal would point the gun at the victim's child's head. Similarly, the focus on the value system in which truly empathetic responses are based is emphasized by Miller

and Rollnick (2014), who in the third edition of their Motivational Interviewing introduce the concept of compassion in the spirit of motivational dialogue. This concept defines the attitude of active encouragement of the other's wellbeing (it is a concept explaining the main principles and premises of this therapeutic style of interview) in order to differentiate the therapeutic method from manipulative techniques to achieve private goals.

The researchers emphasize that strong therapeutic schemes (or, to use another term, cognitive fusion with the schemes, i. e., identification with own convictions and regard to them rather than experience) may greatly interfere with empathetic understanding of patients. For instance if a therapists has strong convictions about experiencing negative emotions ("one should not experience unpleasant emotions", "no need to be sad", "action should be taken"), facing a despairing client, may start applying coping techniques to distract him or her from painful experiences or memories. By doing this, the therapist may unconsciously indicate that he or she fails to understand the patient, and diminish his or her experience. Such behavior may cause the client's anger and resistance, and thus interfere with the therapy in process (Safran et al., 2007).

Empathetic attitude of therapists is especially important in the stage of assessing and diagnosing traumatized persons, as they reveal especially embarrassing facts from their past or share embarrassing thoughts or behaviors. The feeling of being understood increases the patient's sense of security and thus makes disclosing uncomfortable information easier (Bennett-Levy, Thwaites, 2007a). Empathetic and warm attitude is also appreciated. Such an attitude towards clients indicates that they matter and that we are interested in their opinions. Miller and Rollnick (2014) have distinguished four main processes taking place during a psychological conversation. The first, on which all others depend, is the process of engagement. During this process, the client checks his or her own feelings when talking with the therapist, decides whether the therapist can be trusted and whether it is possible to continue working. The next process is focusing i. e., directing the conversation towards the problematic areas in which the client wants to make changes. The next process is evoking, when we together consider the benefits and difficulties of change in order to help cope with it as well as delineate inner motivation to change. The last process is planning, during which particular action plans associated with the areas of difficulty and suffering are established. The sense of being understood and accepted has defining influence on the process of engaging in therapeutic contact, and all the other processes taking place in therapy depend on engagement in the therapeutic relationship (Miller, Rollnick, 2014).

EXAMPLE OF ANALYSIS OF A PSYCHOLOGICAL RELATIONSHIP: AVOIDANCE AND CORRECTING REACTION

In this part of the paper, the theoretical considerations deserve an illustration. So let us examine the problems that the therapist has observed in his therapeutic relationship to a six year old female patient, who was brought in by her mother because of increased anxiety. The girl attended school and was experiencing great difficulty in adaptation. She did not want to go to school, sometimes cried a lot when separated from her mother, could not sit in class, stood up from her desk and walked around the classroom, sometimes seemed to explode with anger while at school. Until then, the girl had no educational problems or emotional difficulties.

In the conversation with the mother the therapist learned that the girl has a little sister, aged one. The mother said that she and her husband did not know how to tell the girl that a new baby is coming. They were afraid that she might react negatively of feel threatened. So the parents only talked to her when the mother's pregnancy was already advanced and visible. The girl did not appear worried. Now that the sister is born, she also seems happy that there is a younger child in the family, tries to be involved, approach the baby sister, kiss her. The patient's mother is on maternity leave, and the father supports the family, therefore their financial situation has deteriorated. Besides, six months ago, the patient's mother's brother has moved into the house where the family lives. He was in a crisis, having ended a long-term relationship and had to move out of the apartment where he had lived with his partner in another town. He is currently unemployed and looking for work.

During the first meeting, the girl was friendly with the therapist, easily established contact and was interested in the situation. The therapist asked her to draw her family. The girl pictured all the family members. She drew her parents in the middle, her sister next to mom, and herself next to dad. When the therapist asked her if she would like to draw someone else, the girl nodded and drew the last figure with marked genitalia. When asked "Who is that?", she replied that it is her uncle. Further questioned, she said that she drew "the willy", because "boys have willies", and she has once seen her uncle's "willy". During the conversation she was calm and did not express increased fear or anxiety. Towards the end of the session the therapist thanked the girl for her honesty and said that they would most likely return to this conversation when they meet the next time.

The therapist began the next session by showing the girl her family picture and asking if

she remembered it. The girl nodded. The therapist asked if they could talk about the uncle. He asked if the uncle spends a lot of time with her, how they play, how she likes playing with her uncle and which games she avoids. He asked her to show dolls playing together. The girl refused. Then the therapist asked her to draw the games with her uncle that she does not like. The girl, already disengaged from the contact, took a piece of paper, a black crayon and started drawing. She seemed angry. When the therapist asked how she feels and if she is all right, she said that she was fine and ripped up the paper. The therapist tried to calm the girl down, therefore he suggested playing a game towards the end of the session. After the session, he told the patient's mother that he wants to meet her to talk about her daughter.

After the second session with the girl, the therapist contacted me for a supervision, asking what he should do. He suspected that the girl could have been sexually abused, and did not know what to do next. Together we identified two problematic questions. First, the therapist wanted to come up with a plan for the future: how to arrange the meeting with the mother, how to inform her of his suspicions without blaming the girl's uncle, what questions to ask the mother in order to establish sexual abuse and how to work with the mother in establishing sexual abuse, and how to continue working with the girl herself. Second, he was concerned about what happened during the second session. He wanted to figure out why the girl, who at first was open and interested in communicating, during the second meeting seemed so disturbed, scared, and finally reacted in open anger, which the therapist tried to calm down. The second question is related to the therapeutic relationship, or rather, to the difficulties encountered in it.

In order to analyze the difficulties in the therapeutic relationship, we applied the scheme suggested by Safran et al. (2007), in which four stages of maintenance analysis of a therapeutic relationship were identified:

1. identifying the factor which caused the difficulty in the relationship;
2. describe, recognize and distance oneself from the events of the therapeutic relationship;
3. examine the possible assumptions of the client;
4. reveal the hidden desires or needs.

Such analysis of therapeutic relationships is especially important, because obstacles in therapeutic relationships occur when the client notices certain aspects in the behavior of the therapist that confirm his or her dysfunctional assumptions about relationships with

people. Often clients respond to such an explanation of the therapist's behavior with open anger and confrontation, or distance themselves from the relationship (both responses may be understood to be forms of resistance). Such behavior may cause an adversarial or anxious reaction in the therapist, and the therapeutic relationship starts spinning in a vicious cycle.

Having recognized such a vicious cycle, it is possible to break out of it. Sometimes this phenomenon may be analyzed during a session by asking if similar situations tend to occur in the client's life.

Let us look at an excerpt of the supervision conversation, where the supervisor and the therapist verbalize the difficulties in the therapeutic relationship:

Supervisor:

- How did you feel and what did you think when the girl drew her uncle in the family picture and added his genitalia?

Therapist:

- At first it wasn't that bad. I was surprised, but not worried. I think I asked what it was calmly enough, and could talk to her freely. The girl also did not seem concerned. It became worse when she left the office. I realized that her behaviors, her outbursts of fear and anger coincided with the uncle moving in to live with them. I thought that they could be symptoms of sexual abuse. And I have no experience in working with children like this.

Supervisor:

- And what did you do then? How did such concern affect you?

Therapist:

- I tried hard to prepare for the session. I reviewed my notes from a training in care for sexually abused children. I reminded myself the questions to be asked in diagnosing. I even wrote down the list and compiled a list of techniques I will use in talking to the girl. Still, I was nervous. I couldn't get rid of the thought that I shouldn't ask her something that might hurt her, make her remember something scary and not let her calm down.

What is notable in this conversation is the hypotheses that the therapist comes up with about the way the girl's behavior may be connected to the uncle's looks and, bearing in mind the sexual content revealed in the drawing, about the possibility of sexual abuse.

It is a testament to the therapist's openness and ability to conceptualize the patients' problems. It is also notable that the therapist becomes anxious, and his thought turn to his own lack of competence. The scheme of himself as a therapist becomes highly activated. On the one hand, he is a beginner therapist, on the other hand, he has participated in a specialized psychotherapy training and a course in working with children and specifically with child victims of violence. Anxiety causes the activation of cognitive assumptions: "If I feel anxious, I must prepare well for the session." Due to such assumptions, the therapist engaged in a behavior that may be understood as protective: he read his notes and prepared a detail scenario for the session. Of course, it is good behavior: at work we often face situations where it is useful to apply literature or supervisions. What is worse is the fact that the main goal of such behavior is to get completely rid of fear and anxiety. Paradoxically, then we can strongly identify with convictions of own incompetence, and our level of anxiety will increase and not decrease.

Cognitive synthesis and engaging in self-preserving behaviors may reduce our ability to recognize information in social relationships. Our focus is on our own experiences and the desire to proceed with our own agenda, and not on the client's behavior (Hayes, Strosahl, Wilson, 2013). Our ability for compassion also decreases: we have more difficulty recognizing the clients' emotions, accepting their attitude, and our ability to communicate empathically decreases. We often notice that the scenario we prepared is no longer working, and our anxiety level increases. Then we may start pressuring the patients to conform to our scenario, ask them more and more questions to acquire necessary information, etc. We start acting under the influence of correcting reaction: we try to affect the person we work with so that he or she maintains the direction of our choice. Then we turn to the directive style of conversation, which may cause resistance in the client (Miller, Rollnick, 2014).

Having recognized these difficulties, the supervisor offered the therapist to roleplay the situation so that the supervisor plays the therapist, and the therapist plays the patient. Often such roleplays help the therapist better understand the client's perspective and break out of his or her own typical models and habits. During the imitated conversation, the supervisor attempted to be very bossy and pressuring. The supervisor directed the whole conversation towards the uncle personally. After enacting the situation, he asked the therapist how he felt after this exercise and what conclusions he has arrived at.

Therapist:

- It felt really unpleasant. I thought you are not listening to me at all and have no interest

in me. You asked me questions that I definitely could not answer. And I still could not understand why you were asking me that. I was confused, lost. I was also angry. During the conversation I remembered that the girl really wanted to tell about her little sister, and I completely ignored he. I only inquired about the uncle.

After this conversation, the therapist and the supervisor tried to analyze the convictions and assumptions that might be the cause of such a reaction. Based on the information from the conversation with the mother, it is possible to assume that the patient's parents try to avoid talking on more difficult or unpleasant topics (they delayed telling her that she would have a younger sister to keep her from worrying too much). However, the girl observed that the relationships in the family are changing, and she saw the changes in her mother's appearance. For this reason, the girl might have formed the conviction in her mind that grownups have secrets and cannot be trusted. Once the younger child was born, the mother's attention naturally turned towards satisfying the infant's needs. At the same time, due to the second child in the family and his wife's leaving of her job, the patient's father carried a heavier burden and a greater commitment to work. The girl might have felt more and more lonely and misunderstood. Maybe she started thinking that her own needs are unimportant and no one is paying attention to her? The situation was made worse by the arrival of the uncle, which caused an even greater confusion in the family. Besides, the patient was about to begin her pre-school year, and that might have strengthened her convictions about her own helplessness even more. During the session, while talking to the therapist controlled by the correcting reaction, all these convictions became activated and caused a strong resistance in the girl. If we add the possibility of sexual abuse to the mix – an experience that usually results in a strong mistrust of adults, feeling of helplessness and unpredictability of the world – the girl's resistance during the session seems even more understandable.

The girl's resistance (angry scratching of the paper, tearing it up) was interpreted by the therapist through negative automatic thoughts – "something bad is happening", "I'm not helping". These thoughts strengthened his own fear and anxiety. On the one hand, these thoughts told the therapist that such behavior confirms the hypothesis of the girl's experience of sexual abuse (according to the principle "if a child is acting so emotionally, it is very likely that something bad has happened to her"). On the other hand, they activated the scheme of himself as the therapist who talks about his own therapeutic incompetence. It was associated with the assumptions that clients should not experience unpleasant or difficult emotions during a session, and if such emotions arise, the therapist should imme-

diately intervene and help clients to stop experiencing them (such assumptions may be associated with the scheme of himself as a person, which may include a conviction that a person should be nice and helpful). Due to such convictions, the therapist suggested to the girl playing Memo. Of course, there is nothing wrong with the suggestion. During the therapy of children and adolescents, part of the time is often devoted to playing an involving game together or doing another activity that is not directly related to the therapy. However, working with the patient described, it is worth considering the hypothesis that her parents deal with difficult emotions by avoiding the situations in which they may arise, or by avoiding conversations on difficult or painful topics.

Thus, such a strategy of avoidance may strengthen the conviction that unpleasant emotions are dangerous and that they are best avoided and not expressed. If this hypothesis is correct, further therapy should be directed towards learning to experience emotions, to express them, and eventually, it may improve the ability to accept unpleasant emotions and experiences. By maintaining avoidance strategies, you may only encourage problem behavior (like uncontrollable outbursts of anger). The vicious circle of the therapeutic relationship is depicted in Figure 2 .

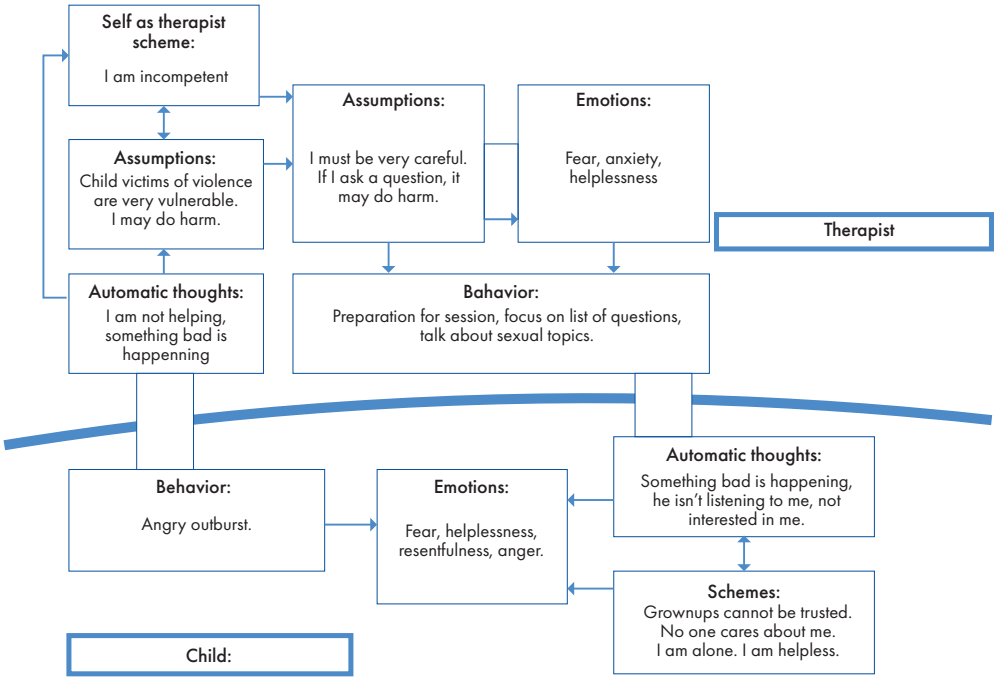

Figure 2. An example of a vicious circle in a therapeutic relationship.

Due to negative automatic thoughts and the activation of the scheme of his incompetence, the therapist considered redirecting the girl to a more experienced person. Participating in the supervision, he could reflect whether such behavior would be useful or harmful to his client.

As a positive thing, he observed that it would be a possibility to receive more professional care. However, it was likely that sending the girl away would mean a long wait for a diagnosis (due to lack of specialists), and also it would have required going to another town (in the town where the therapist practices there are no specialized centers for child victims of sexual abuse, nor people with a lot of experience in working with such children). As a negative thing, the therapist noted that the girl has started establishing a relationship with him, was very open and willing to talk during their first session. Redirecting her to another specialist may be an experience that strengthens her model of distrusting grownups, for instance, the idea that maybe she needs protection, and that she cannot talk to grownups about complicated things (which is probably the way the girl's parents behave).

Strategically considering all that has been said, the decision to redirect the girl for an assessment seemed wrong. At the same time, active schemes of one's incompetence may easily harm the result of the therapeutic work and the assessment. These schemes needed to be discussed on the cognitive level during the supervision. The therapist was asked to considered if the fact that he has acquired a specialized education in therapy and trained in caring for child victims of violence is a sign of his incompetence? Does the fact that he knows and notices signs of violence against children indicate his incompetence? Finally, the therapist's convictions about the special vulnerability of child victims of violence and the special danger of the topic of violence needed to be discussed. These convictions are most likely part of the therapist's system of declarative knowledge, which was formed based on spoken language judgments about violence against children. On the one hand, these convictions may lead to avoiding the topic of violence (it is a natural reaction to avoid unpleasant situations or experiences). Such avoidance is expressed as unwillingness to talk about sexual or trauma-related topics and often diminishes the ability to recognize concerning signs. On the other hand, such convictions may lead to overalertness or encourage too much discussion on sexual violence. The therapist considered how to tell the girl's mother that sexual abuse might have taken place. Obviously, such interpretation is more related to the therapist's sensitivity to the problem of abuse and not with real evidence. What really becomes clear from the conversations with the girl and her

mother is that first, the girl is experiencing some emotional difficulty, and second, that sexual content appearing in her family drawing may encourage thoughts of rejecting (or confirming) the assumption of sexual abuse. It is probably worth discussing the drawing with the mother and assessing her reaction, and also discussing the family's sexual habits (what the attitudes towards sex are among the family members, do the father, mother and mother's brother differ in this regard, how they behave at home, for instance, do they walk around naked). It is also useful to learn the girl's daily routine and risk factors for sexual abuse. However, at this stage of the psychological work it is yet too early to form the assumption that sexual abuse really did happen. The difficulty in the therapeutic relationship was associated to certain convictions of the therapist: creating the scheme of himself as a therapist, possibly also himself as a person, and compiling the system of declarative knowledge. The convictions that create the schemes of the self as a person and the self as a therapist interfered with the functioning of the procedural system, which caused the difficulty in the therapeutic relationship.

PREJUDICES, MALADAPTIVE CONVICTIONS AND MODELS THAT MAY INFLUENCE THE THERAPEUTIC PROCESS OF CHILD VICTIMS OF VIOLENCE

Researchers emphasize that the therapeutic work may be influenced by the convictions from three main areas. The first conviction is associated with the therapist's self-confidence (mostly with the image of themselves as a therapist). The second area of convictions is associated with emotional exhaustion and various traumas. This field may be related to the therapist's personal state (for instance, emotional exhaustion due to difficulties in the therapist's own life or traumas experienced in the personal life) and his or her professional situation (for instance, exhaustion due to work with difficult patients, secondary trauma from listening to the stories of traumatized patients). Finally, the third area is related to the therapist's personality traits (Ladany, Friedlander, Nelson, 2005). The first area may be discussed during oversight or specialized training, the second area is often examined in personal therapy and may be discussed at a supervision for clinical work, and the third area may be improved during personal therapy. Later in this paper I will discuss suggestions for supervisions and training for those who care for child victims of violence. Meanwhile, I would like to discuss the main convictions of the therapists, mostly related to their own feelings of incompetence, and also certain convictions about working with victims of violence and prejudices about experiencing emotions.

The maladaptive models described are often a part of the model of the self as a therapist

or the self as a person, declarative knowledge or the rules that control a therapist's behavior. Regardless of the place we assign them in the Bennett-Levy's conceptualization, a strong cognitive fusion with these models may cause the difficulties described earlier in analyzing the example of the vicious circle in the therapeutic relationship. Essentially, cognitive fusion diminishes the therapist's cognitive ability, reduces his or her empathy and dictates behavior that may negatively affect therapeutic relationships. Reflection of these convictions (mentalizing them and attempting to discuss them) may relieve cognitive diffusion and improve the quality of the therapeutic work. The following convictions have been observed in my own clinical, training and supervising practice.

The first conviction states that only highly qualified people with a great life and professional experience are capable of working with child victims of violence. We have seen how this conviction may interfere with the work according to the example above. If the therapist focuses on his or her own feeling of incompetence, his or her ability to empathically understand his or her clients and follow their guidance, to create a precise concept of the problem, and sometimes even to diagnose the problems correctly may be very limited.

This conviction often encourages self-protecting behavior, like excessive preparation for the sessions, strict adherence to established therapy goals or session scenarios prepared in advance, or succumbing to excessive correcting strategy. From the cognitive perspective, it is worth noting that some studies show that more experienced therapists create better therapeutic relationships and have better skills at empathically responding to their client's needs if they have attended personal psychotherapy (Branson, Shafran, Myles, 2015). At the same time, the competence of applying the methods of, say, cognitive and behavioral therapy is built up over four or five years of training consisting of 450 hours of activity[1]. The therapists who have finished such training or who have finished two years of it and constantly attend supervisions are considered capable of providing psychological care. It is not worth to advice the therapists without experience or training on treatment of victims of violence to work clinically with abused children. On the other hand, it is worth remembering that even the most experienced therapists once had to gain their experience. Every representative of this profession once received his first patients. In general, it seems that the young therapists who have finished or are finishing their training should be

[1]Guidelines of European Association for Behavioral and Cognitive Therapy, https://eabct.eu/ wp-content/uploads/2014/02/Thomas-Kalpakoglou-Training-and-Accreditation-2002-2013.pdf.

encouraged to care for child victims of violence. Especially at the beginning it is a good idea to attend frequent supervisions, work in a team or collaborate with colleagues.

The second conviction is that working with a child victim of violence takes a special psychological toll and requires incredible psychological resilience. In fact, the phenomenon of secondary traumatization, when people encounter trauma indirectly by engaging with trauma victims and their stories, has been widely described and recognized (Adams, Riggs, 2008; Figley, 1995). Besides, people who have experienced violence as children themselves and have not dealt with their own trauma may have bad reactions to working with trauma victims. It is likely that our individual resilience to stories about human pains and suffering varies. However, the assumption that working with child victims of violence requires a certain special inclination or resilience seems very much an exaggeration. By providing psychological care, we encounter various expressions of suffering: we work with people grieving a loss, accompany those who are sick, often fatally, meet people who have lost all their possessions and often their loved ones due to natural disasters and cataclysms, work with war victims, etc. Our usual work with people means numerous encounters of traumas. That is a feature of the psychological work. It is useful to recognize this risk in order to protect ourselves from it or to better control it. It is important to mind our own boundaries and values (some of us find it easier to care for cancer patients, and others, child victims of violence). In doing this work, it is also useful to take care of our own psychological state. Many people find consolation in spiritual practices (often pain and suffering is a motive in a religious conversion). Our psychological resistance also varies over time and with life experience. Some therapists find it especially difficult to work with child victims of violence when they are themselves parents of young children. All of that must be taken into account. However, the difficulty of this work should not be overestimated. Violence against children is one of the injustices of this world. But such cases still occur in this world, and there are children who require help from grownups. If we have chosen a caring profession, it is not worth running away from it (besides, often it is not even possible).

The conviction that violence against children is an insignificant phenomenon which only occurs in pathological situations, unrelated to neither me nor my working environment may occlude the problem of violence and abuse, encourage rationalization of observable facts, increase desire to avoid talking about the violence with a child who has experienced it and thus to make the disclosure difficult or even impossible. All it takes to get rid of this conviction is familiarizing oneself with the usual statistical data on violence against

children (like Krzywdzenie dziecka. Analiza zjawiska. (2012). Dziecko Krzywdzone. Teoria, badania, praktyka, 11(2)). This conviction is also often changed by training in recognizing violence against children.

The last group of convictions, associated with the perception of the self as a therapist, may especially interfere with the work with the parents of child victims of violence and in some cases to prevent legal intervention when abuse of children is disclosed. These convictions are based on principles: "I must help everyone", "I must satisfy everyone's needs". If a therapist follows such strict convictions, it may be especially difficult, say, to provide information that would help correct the parents' attitude towards children, or to inform the caregivers about violence against children. Often such convictions may have a negative influence on the therapist. Let us imagine that a young therapist with such a conviction will try, on the one hand, to listen to a mother's complaint about her child's inappropriate behavior, and on the other hand, to confirm and understand the child's emotions that have been caused by the fact that the mother does not completely understand her state and behavior to which it leads. In such conflicts, it is useful to realize who our primary client is and whose interests and wellbeing should primarily be supported. Sometimes supporting the child's wellbeing may briefly contradict the parents' wellbeing and vice versa. For instance, we know that working with the history of trauma may temporarily spoil a client's mood and activity. The return of the difficult past may be painful. However, it is in the interest of the client. At the same time the parents may be interested in the child's doing well at school. This produces a conflict of interests that must be solved by only working with one person.

Related to "I must help everyone" may be the conviction that legal intervention in the cases of violence against children may harm the possible abuser or that a 100 per cent certainty that violence against children occurred is necessary for a legal intervention. In discussing such convictions, it is useful to understand several things. First, no psychologist or another person caring for child victims of violence will ever have enough knowledge to be 100 per cent precise in identifying whether violence did occur or not. He or she has no tools to help identify the facts (he or she will not visit the location, cannot send the child for a medical assessment if the parents do not agree, often does not have the possibility to question the possible abuser and witnesses of abuse). These tools are written into laws and are the competence of prosecutors and courts. The court's task is to identify the facts (i. e., whether or not a law has been breached). Besides, like in every area of life, it is necessary to bear in mind some uncertainty and risk. The task of a psychologist, peda-

gogue or teacher is not to identify the facts, but to ensure the protection of the children's rights. Thus, upon a suspicion that a child may have experienced violence, the specialists should recourse to legal means. It is clearly stated in the Polish (Podlewska, Trocha, 2010) and international (e. g., American: Miller, Dove, Miller, 2007) guidelines of working with child victims of violence. Second, if we recognize these attitudes in ourselves, it is worth realizing that a report on a suspected crime passes no judgment on the suspect and therefore may not harm him or her. The court may find the suspect not guilty, or the prosecutor may reject the case in an earlier stage of the investigation. If that does not happen, it is worth answering the question which good is more worth seeking: the child's safety, protection, justice, or the freedom of the abuser?

Another group of convictions is associated with child victims of violence and the work with them. In general, this group of convictions may be narrowed down to the conviction that child victims of violence are especially vulnerable and may be very easily hurt. In fact, a traumatic experience often causes emotional difficulty and can be a source of great suffering. Victims of violence may develop PTSD, other anxiety disorders, depression, behavior or eating disorders. However, it is important to remember that these children have already been really hurt, they are already harmed. No conversation aimed at helping them may not harm them more. Paradoxically, lack of conversation may be more harmful than anything else. If violence is met with silence, the victims may easily draw the conclusion that it is better to never talk about it at all, because no help can be found. They may feel even more helpless. Often silence may lead to self-blame (since others do not talk about it, maybe it is not a problem, and I really deserved what happened to me). Not talking about violence prevents its disclosure.

Besides, when violence is disclosed, only talking about it with a supportive adult allows to process this experience, deal with unpleasant emotions caused by memories, and understand what really happened. Let us not forget that the children who have experienced violence have already experienced something horrible. It is likely that even a not entirely successful psychological intervention will not be worse than that. Of course, we can imagine words that would be really hurtful to such children (like blaming them for the violence they experienced, making the violence public, diminishing or dismissing the harm done to them, etc.) It seems like it takes a lot of ill will and very little knowledge to desire to say such words.

An especially important conviction is that child victims of violence are extremely vulnerable, that it is best not to talk with them about their trauma, because it may cause unpleas-

ant memories to return and be too painful. On the contrary, the majority of therapeutic methods agree that only a review of the painful past may reduce the pain and eventually help accept it. Trying to escape the memories only makes them more powerful. It may also be a problem because it involves us in something that cannot be achieved. This conviction is often connected to a whole bunch of convictions about experiencing feelings. Of course, everyone who works in the field of psychological care knows that there are no good or bad feelings (which is the first myth about feelings). Often this distinction is replaced by the distinction between easy and difficult feelings. However, such language also disguises the point.

Feelings are definitely not difficult the same way math problems or mountain climbing are. In the latter cases, the word "difficult" means, among other things, that these are tasks that we may fail at and that require special skills. A difficult math problem is something that few people can solve, because only they have the special skills. A difficult slope is one that a person without physical training and specialized gear cannot climb, and the attempt itself may cause a very serious accident. In this sense one cannot talk about "difficult feelings": it is impossible to not experience feelings or not have the special skills to process them.

Feelings are like certain events that begin and end. The whole art is to know what to do with them. Sometimes the problem is what we do under their influence (get angry, hurt ourselves, resort to drugs, etc.) However, usually problems are caused not by feelings, but by the behavior that attempts to quell them. Therefore I suggest to talk about pleasant and unpleasant feelings instead of difficult ones (of course, experiencing some feelings is unpleasant).

One of the most widespread convictions about unpleasant feelings among beginner therapists is that therapy must be pleasant. Of course, such a conviction may lead us to avoid talking about painful topics that induce anxiety or anger. None of these feelings are pleasant. Such convictions undermine the very essence of psychological counseling – discussing topics that cause the patients difficulty. If these topics cause difficulty, we may assume that talking about them will not be "pleasant". Some researchers and practitioners even point out that a therapeutic conversation that causes unpleasant feelings helps the clients calm down, learn to tolerate tension and effectively regulate their emotional reactions (Leahy, Tirch, Napolitano, 2014). Some therapists, convinced that therapy must be pleasant, have great worries about the situations when a client leaves a session and still experiences unpleasant feelings. In order to avoid that, sometimes the

therapists attempt to devote the last minutes of the session for the quelling of emotions. It is a suitable strategy (especially when planning a session to discuss a traumatic experience, it is useful to devote some time to calm down the unpleasant feelings). However, it is important to make sure that such behavior does not contribute to the patient's own convictions about intolerance to own feelings (for instance, "strong feelings should not be experienced", "having feelings is a sign of weakness", etc.) The main principle in working with feelings should be their acceptance and the acknowledgment that any person who experiences difficult events or talks about them may have unpleasant feelings. There is nothing wrong in such feelings, all feelings are welcome in therapy.

HOW TO HELP THOSE WHO WORK WITH CHILD VICTIMS OF VIOLENCE? – SEMINARS, TRAINING AND SUPERVISIONS

Knowledge about the problem of violence against children primarily comes from seminars and training. We have already mentioned that many false assumptions about working with child victims of violence may occur due to the lack of knowledge about this phenomenon. When specialists are provided with factual knowledge, they often understand the phenomenon of violence against children better and become more sensitive to the problem. Sometimes after training about cases of violence the participants say that they knew before that "such things happen", but were positive that this problem does not concern them directly. After the training they change their mind and begin to acknowledge that every specialist working with children may encounter a victim of violence.

The types of training, seminars and supervision are greatly dependent on the level of experience of the participants. At the beginning of training, imparting concrete knowledge is the main goal. Training for people who have no knowledge about a particular field must follow a more didactic method[2]. Therapeutic training often provides knowledge about particular therapeutic protocols and scenarios for solving particular problems. The training also provides knowledge about working with child victims of violence, especially in terms of trauma and post-traumatic disorders. As the level of knowledge and involvement increases, the form of the training changes from strictly didactic and led by a trainer to a seminar (or Socratic type of training). The trainers then not so much share their knowledge, but acquire it from the participants, and group work, sharing of experience, talking

[2]I use the term "didactic method" in the sense of direct transfer and provision of knowledge, which I contrast with the "Socratic method", which involves acquiring knowledge from students. The specialists of didactics understand this term as a teaching method (lecture, presentation, etc.)

about convictions, doubts and assumptions is more prevalent. If it is a therapeutic training, the focus is not on learning particular actions, but on changing protocols, deepening the understanding of the patients' problems, understanding the therapeutic relationships, their effects and applications in therapy itself. Such training transfers the focus from the question "what to do?" to the question "how to do it?" (Törnquist, Rakovshik, Carlsson, Norberg, 2017).

The importance of experiential learning is emphasized. Bennet-Levy in this text discuss a learning model based on self-education and self-reflection. During the training, the participants are encouraged to try certain methods of conversation, diagnostic tools or therapeutic techniques themselves and use the experience to draw conclusions for their practice of care. The main questions in this context are related to what they experienced (self-analysis) and how the experience affects their work and understanding of problems (self-reflection; Bennett-Levy, Lee, 2014). When learning to work with a child victim of violence (both in terms of diagnostics and therapy), in the context of self-education it is also important to realize own convictions and attitudes towards the problem of violence against children, and how these convictions may affect the therapeutic work. Work with a child victim of violence, especially at the beginning, may be a source of great anxiety and fear. One of the functions of the training is allowing people to experience their anxiety and to talk about their fears. We know that people get used to anxiety-inducing situations: the more often we do what we fear, the more the anxiety decreases (behavior therapists call this process habituation). One of the functions of training in work with child victims of violence is adapting the specialists to the anxiety this work induces.

Another important function of the training is increasing the ability to empathically understand the situation of people we care for. It is especially important to understand the view of a child victim of violence "from the inside". In order to acquire such a skill, we need to employ our own experience (thus, ourselves as persons and not just as therapists), enrich our theoretical knowledge about violence against children and improve our skills of treating them (Bennett-Levy, Thwaites, 2007a). Employing our own experience, we may also observe and comprehend how your own experience and convictions and feelings stemming from it may influence counselling.

Research shows that in terms of longer specialist training about care for child victims of violence, it is useful to include elements of mindfulness or self-compassion (compassion-oriented therapy methods). On the one hand, they help withstand unpleasant feelings due to memories about the violence experienced in the past and encourage

mindfulness of them in the therapeutic work, and on the other hand, as the therapists themselves employ mindfulness techniques, their psychological consciousness expands, and they are better able to recognize the states of the client's psyche, listen attentively and accompany their clients. Learning mindfulness techniques increases:

- empathy for the clients and willingness to talk about their difficult experiences;
- ability to choose appropriate therapy methods based on the stage of the therapy;
- ability to refrain from advice and questions and to withstand silence;
- ability to talk about childhood memories;
- ability to understand own compensatory models and behaviors influencing the course of the therapy.

Learning mindfulness techniques also allows the therapists to handle stress better, therefore it is an effective method of preventing professional burnout or secondary traumatization (Bennett-Levy, Finlay-Jones, 2018).

We can easily observe that training based on methods of self-education and self-reflection are, on the one hand, more engaging for the participants, and on the other hand, more exhausting and more charged emotionally. A lot of fear, anxiety and worry may arise during it. It is usually associated with the fear of losing control of the feelings experienced and the judgment of other participants. It is useful to discuss such fears with the participants and to normalize them. It is often a good idea to include some elements of psychoeducation about feelings (for instance, the experience of even the strongest of feelings cannot induce sensory losses or madness) and to show the similarities between the fears that the trainees are experiencing and the fears that child victims of violence experience when they encounter the specialists. In this context, it is also important to create a safe space for the participants and to carefully discuss the rules that apply during the training (confidentiality, non-judgment, speaking from own perspective and from that of others). In discussing the specialists' work with themselves, it is worth distinguishing between reflections on own feelings or examined personal models (that the participants may keep to themselves) and the reflections on the learning process and lessons that they may apply in their clinical work (which they are encouraged to share; Bennet-Levy, Lee, 2014).

The observations regarding training methods discussed so far may also be applied to supervision of people caring for child victims of violence. The supervisions of beginner therapists tend to be more targeted, providing concrete instructions for work and feed-

back. On the other hand, the supervisions of more experienced therapists follow the Socratic method and are directed towards the reflection of the work and self-reflection. They also are more likely to discuss applying therapeutic protocols to the work with particular patients or problems related to therapeutic relationships (Branson et al., 2015). The supervisions of specialists working with violence should also include elements of professional burnout prevention. It is useful to discuss with the specialists the feelings that the therapists experience when working with child victims of violence and to normalize them. A supervision may employ exercises of mindfulness or compassion-oriented therapy, which allow the supervised therapist to view their work and emotions from a distance and to accept them. It is also useful to examine the specialists' convictions about their competence and lack thereof at supervisions. We have seen that a strong cognitive fusion with the conviction of one's incompetence may result in a weaker response to the clients' needs, and in extreme cases to cause the therapists to avoid such clients. The therapists may avoid working with child victims of violence or redirected such clients to more experience colleagues. I have described this problem earlier. In supervising the people who work with child victims of violence, it is important to focus on appreciating the specialists' strengths. First, it builds up the relationship established during a supervision: we prefer spending time with the people who support and respect us. Second, the supervisor's behavior models the therapist's behavior, and working on low self-esteem is an important part of the therapy for child victims of violence. Third, a strong conviction of one's incompetence may result in overemphasizing the obstacles of therapy and ignoring achievements. That may result in false clinical assessments. Values also improve self-esteem. When working with child victims of violence, it is often necessary to engage in legal interventions, work with people at increased risk of suicide, sometimes make decisions quickly, and that requires self-confidence and competence (Törnquist et al., 2017). The therapists who work with child victims of violence and their caregivers should have the attitude that a problem can be solved and that therapy is often successful. In order to do it sincerely and correctly, it is worth believing in oneself.

Some studies in supervision efficiency indicate that therapists' self-esteem and the possibility of successful intervention may be improved by allowing the therapists to choose further course of action and apply particular therapeutic methods at supervisions. Often a supervisor's bossy instruction on following his or her directions turns out to be ineffective and reduces the therapist's ability to apply such intervention (Törnquist et al., 2017). Directing, instructing or forced application of solutions increase resistance. If we feel a

threat to our autonomy, we put a lot of effort in protecting it (Miller, Rollnick, 2014). Such a mechanism may also activate in a supervision. It should also be noted that forming own autonomy is an important part of the therapy for child victims of violence. Therefore the therapists who work with such children can use a possibility to participate in supervisions where there self-sufficiency is respected. Such behavior of supervisors often models the behavior of therapists.

Safran et al. (2007) emphasize that it is important for therapists to be able to accept themselves. It allows them to reflect on their reactions, emotions and thoughts that arise during therapeutic relationships more deeply. Such skills allow to establish a genuine dialogue with the client. Self-acceptance is especially important when working with people who have been badly hurt in life. Obviously such people bring out strong emotions in us. In order to accept (and withstand) them, we must learn to accept ourselves, especially our sensitive and vulnerable parts. Therapists should be assisted in training this skill (Safran et al., 2007).

CONCLUSIONS

Psychological work with children who have suffered from violence is often very interesting and challenging. In this process, the help provider's behavior schemes are touched, and strong convictions and feelings aroused. These models influence the therapeutic process. Child victims of violence are often very sensitive to interpersonal signals, they look for signs of danger and often misinterpret them. When working with such a client, therapists should especially carefully observe their own reactions during therapy. An important element of self-reflection is asking oneself if my emotional reaction corresponds to the situation and if revealing it to the client will have therapeutic value. For this reason it is especially advisable at training and supervisions to draw the attention of people who work with such children to the aspect of therapeutic relationships. It is also useful to take care of those who work with this type of clients and to teach them the skills of effective self-care. I began this paper with the quote: "Treat other people the way you want to be treated by others" (Ladany et al., 2005). Since we often recognize that child victims of violence are especially vulnerable clients who deserve care and protection, we should provide the people who help them with the same.

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