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Trauma as a Component of the Self-Concept of Undergraduates

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Abstract

The article deals with trauma of undergraduates. It focuses on the context of a lived-through trauma and its reflection in self-concept of undergraduates, with an accent on study issues. The related aim is to detect the impact of trauma on the self-concept of an individual. Trauma has a significant impact on the self-concept of an individual and it causes lower self-acceptance, self-image, and self-esteem. It is the source of anxiety and depressive symptoms of some individuals.

Keywords: Trauma; Individual; Self-concept; PTSD; Complex PTSD; Pesso Boyden System Psychomotor

1. Theoretical background

Traumatic experience from childhood predispose subsequent emergence of mental disorders. Posttraumatic stress disorder (PTSD) is often found at adults, who lived through trauma in childhood (Bremner et al., 1993 in Grawe, 2007). We have seen people with such experience that they have higher hormonal reaction on the same stress situation than population which did not go through such trauma (Heim et al., 2000 in Grawe, 2007). The same
author found out that at adult females who were abused in childhood had a high stress reaction on average social stress.

The impact of external factor causes destruction of mental and biological adaptation mechanisms – in this context as internal or external sources are not able to cope with the threat. Traumatic experiences paralyse and flood the system of self-defence, interfere with the internal sense of control and competence. Therefore individual is experiencing helplessness (Vizinová & Preiss, 1999) „Traumatické události vyvolávají hluboké a trvalé změny v behaviorální, kognitivní a emocionální oblasti.“ (Vizinová & Preiss, 1999, p. 17) “Traumatic events cause deep and permanent changes in behavioural, cognitive and emotional area.” Towards examples of traumatic events we can more generally include: (Levine, 2002; Höschl, Libiger, & Švestka, 2002) a fetal trauma (intrauterine, prenatal), birth trauma (perinatal), loss of a parent or a close person (especially in childhood and growing up), sexual and emotional abuse, rape, physical abuse, diseases (particularly serious and long-term), physical injuries, accidents, presence of a violent act, natural disasters, fires, medical interventions, anaesthesia, long-term immobility.

Currently there are many professional discussions about developmental trauma, or complex posttraumatic stress disorder (hereinafter complex PTSD). In MKN-10, DSM-V there is not complex PTSD included. ICD prepares inclusion of complex inclusion of complex posttraumatic stress disorder in the year 2015 into 11 version. The WHO International Classification of Diseases, 11 version (ICD-11) prepare including complex PTSD in 2015. (Maercker et al., 2013) Cloitre et al. (2013) points out the compliance and differences of PTSD and complex PTSD. Within PTSD re-experiencing, avoidance, sense of threat appears. The complex PTSD is connected with re-experiencing, avoidance, sense of threat, dysregulation, negative self-concept and interpersonal disturbances.

The reaction on traumatic event can have three types (Czapiga, undated): rapid reaction – disruption of normal behaviour with the consequences in form of problems with the control of self-evaluation and identity, irrational, compulsive or impulsive behaviour; a slow reaction – during a process of traumatic event a clinical disorder unfolds; reaction in a form of chronic disease. For a special result of trauma a posttraumatic stress disorder may be considered. (Czapiga, undated) Psychiatric trauma can have three forms: primary trauma – an individual is directly an object of aggression; secondary – individual’s experience with trauma of a close person; tertiary – individual is in a contact with primary or secondary traumatized person.

Events after trauma events have decisive influence for formation and development of PTSD. Except power and circumstances of trauma based on research that significant important reaction of social environment plays a big role. (Raboch & Sovák, 1995) By Praško et al. (2003) last researches point out that at 25% people who meet with a catastrophic event later on develop PTSD. The percentage significantly increases when the event is caused by other people (rape, torture, abuse, attack, war events, and crimes). (Ulrichová, 2013)

Equally important is the age, in which the trauma happened. In accordance with the opinion of Pesso (Pesso, Boyden-Pesso, & Vrtbovská, 2009) we can say that the most serious consequences of trauma connected with early developmental phases, where individual yet does not have firmly established structure of personality. However, implicit constructs of normality exist in the cognitive area of an individual. (Havigerová, 2012) The Self-concept is formed through the experience with the environment and influenced mainly by the environment and the significant others. (Shavelson, Hubner, & Stanton in Blatný & Plháková, 2003) Trauma deforms structure of personality. Ego (self-concept) is therefore developed as “traumatized”. In this context Pesso speaks about a developmental trauma.

By Höschl et al. (2002) at PTSD psychotherapy plays a big irreplaceable role, especially at negative symptomatology PTSD (avoidance behaviour and falling back). Apart from short dynamic therapy and CBT there can be successfully used a constraint induced therapy (CIT) and in the recent year also Pesso Boyden System Psychomotor (PBSP). Bonne et al. (2004) speaks in a similar vein – according to him it is necessary to look for new therapeutic procedures which can mitigate accompanying symptoms of PTSD (e.g. depressions, fear and sleep disorders). Pesso Boyden System Psychomotor (PBSP) offers specific approach towards a client with PTSD. According to just an unique research – study about PBSP therapy’s impact on neurobiological changes of brain through functional magnetic resonance made by a department of neurobiology of Charles University Prague, can be stated that PBSP is an effective method during treatment of PTSD. At the same time the study showed that PBSP has measurable effect for brain activity in areas which generate repetitive persistent symptoms and strengthens centres which manage strong emotional impulses. The results of fMR were supported by other testing methods – Hamilton Anxiety test (HAM-A), Hamilton Depression test (HAM-D), Beck Depression Inventory test (BDI) and a test for posttraumatic syndrome (IES). (Pesso, Boyden-Pesso, & Vrtbovská, 2009)
2. Research questions

Our aim was to describe and analyse experience of undergraduates with trauma and further more to find out how the trauma influenced their self-concept. Based on study aims and with regard to the basis of research there were set research questions: What experience do undergraduates have with trauma? How does trauma affect the self-concept of undergraduates?

3. Purpose of the study

The objective of the study was to describe and analyse experience with trauma of undergraduates. The related aim was to detect the impact of the trauma on the self-concept of an individual. The acute trauma, the chronic trauma, the physical trauma and the psychological trauma will be differentiated, with particular attention to the impact of the trauma on the further life of an individual.

4. Research methods

In the research there was employed the qualitative research strategy. The data were collected by casuistries and by interviews. On the first was deliberate with using the phenomenological research, but in view of significant events during the life of respondents, in the end, the data analysis had been based on the method of the narrative reconstruction of life story. We worked with topics: Life issues, Representation of actions, Plots, Values and beliefs, Reflexion and perspective, The images of oneself and the others (Chrz, 2004; Miovský, 2006). During one or two years ten in-depth interviews have been realised (during psychotherapy) with students, who had repeatedly met with trauma events in the period of childhood or who had met with isolated trauma event in the period of finishing late adolescence or early adulthood. Five representative interviews were chosen for the purpose of this study.

5. Findings

Selected respondents’ stories (4 females and 1 male in the period of late adolescence and early adulthood) were first analysed by using narrative reconstruction. In the following analysis there are represented crucial moments, topics and life events of clients’ stories and a process of PBSP therapy.

- **Life issues**
  R1 – comes with learning difficulties, feels energy loss to learn, inability to be a part of a study group. During the next sessions (after several months) there are issues which emerge: humiliations from father’s side, sexual abuse from a close friend side.
  R2 – comes with learning difficulties, feelings of loneliness, worthlessness. After several weeks more issues are found – humiliation and beating from father’s side, the urge to stay away from home at an early age.
  R3 – comes with interpersonal problems, mainly intimate relationships. Little by little we come up with other issues – aggressive behaviour from the side of male parental persons, ignoring behaviour from mother’s side.
  R4 – comes with learning difficulties, feelings of isolations (in a peer group) and inability to break away from a mother. The core issue shows up after a while aggressive behaviour in a form of beating and shouting from father’s side.
  R5 – comes with recurring nightmares, with feeling of helplessness, inability to manage him/herself and the study.

  In further sessions we gradually reveal the context of abuse from the step father’s side and a picture of posttrauma. From stories can be seen occurrence of a negative self-image – self-discrepancy (Higgins, 1987). In the period of childhood and also adolescence there was lack of positive idols, adults, mainly parenting persons, they were intrusive or on the contrary evasive.

- **Representation of actions**
  R1 – at the beginning she tried to emerge from targeted attacked by herself and then she asks mother for help. The mother has no capacity to change this consistently. Her school results are getting worse. She cannot fight back, she
lacks support. After completing secondary school she goes to study far away from home.

R2 – she fought back in her childhood mainly by arguing with her father that she was not useless. When she lived away from home she behaved bravely but when her close ones arrived, she especially did not want to go to her mother, she refused her. She passed primary and secondary school but she felt very lonely. She is studying at university and she suffers from anxiety and depressive symptomatology and studying difficulties.

R3 – she felt lonely in her childhood, she missed warm motherly love with no doubt, father and step father were rude to her (shouting, beating, ignorance). She starts a relationship with a boy very soon, where she seeks support and unconditional acceptance. During study depressive symptomatology occurs.

R4 – in nursery school he understood behaviour of his father as a great anger, he was very afraid. Father discredited his wife, he constantly insulted her in front of her son.

R5 – a client describes when she was small that she did not understand behaviour of her father, how he treated her, he undertook her silence, she was afraid to speak. Later on she intimated her mother but she did not believe her, she belittled the situation. The client missed support and assurance of safety, she experienced unlimited acting of her step father. Anxiety appears. The abuse ended when she left to a boarding school and found a boy.

Depressive and anxiety symptomatology is present, a doctor recommended medication. There is also an emerging trend to seek basic developmental needs at vicarious persons. The emotional function of family there was not sufficient (Žumárová, 2012). Studying difficulties are the results of trauma events, negative self-concept. Eventual success is disparaged, failures appear as big, uncontrollable, they exactly fit into a framework of experience of helplessness, decrease of self-esteem and reduced self-assessment.

- **Plots**

R1 – experience with abuse from close friends’ side, absence of safety assurance. In addition of deficits in basic needs there was repeated occurrence of traumatization, where R1 was not able to face. Consequently during her life she entered risky relationships and interpersonal contacts. For another crucial plot can be described leaving home and beginnings of study at college.

R2 – experience with disparaging conduct from her father’s side and exclusion from a peer group meant for R1 the (perception of helplessness and vanity). From this period she wished to be invisible. The experience of separation from the loved ones firstly evoked an easy leaving home to college but during the time it had a strong tendency to return home and seek for support.

R3 – experience of ignorance, physical violence and lack of support partly lead towards a creation of so called self-self structure and also towards anxiety-depressive symptomatic. There is an effort to prove to be that R3 is a better person than mother. Unconditional mother’s love is sought by other objects.

R4 – aggressive behaviour of father escalated up to the time when he became sick, thereafter physical aggression changed into disparage of the son and also the wife. Towards the end of secondary school there was a clear made coalition between the son and the mother. Nowadays they call each other several times a day. R4 speaks about his mother as “we”.

R5 - the study at secondary school was without any problems, at present she studies at university and with excellent results. Even though she is afraid that she is not able to manage the study (does not deserve it), lacks energy, has anxiety in the evenings. Wish her new boyfriend are rather just friends, she is not able to have intimate contact.

As for supporting method there had been chosen psychotherapy, specifically Pesso Boyden Psychomotor System. Sufficient space is given to create safe therapeutic space, explanation of the trauma theory by Pesso and Boyden, extrastructural dialogue. (Pesso, Boyden_pesso, & Vrtbovská, 2009; Šifinek, 2014) We gradually include emotional awareness with the use of witnessing, we uncover pathogenic believes (principle of a close person’s voice identification, who passes the belief), we offer so called reversals/bookmarkers of negotiation and communications of real characters, then (very individually at each client with considerable respect towards his/her possibilities to enter into scenic symbolic level of work) we continue with therapeutic structure.

- **Values and beliefs**

R1 – she described her family as the greatest value. She wants to have a safe and a happy family.

R2 – she considers a membership in a society as a value, especially in the family, in fact in a group of friends. Study means the next value for her.

R3 – a life with a boyfriend she perceives as a value, in a loving partnership, where intimacy has its place. Professional orientation is important.
R4 – education is the value – mother is also university graduate. A life with a girlfriend is the next value in the future horizon (but such a girlfriend who would like his mother).
R5 – there is again occurrence of fundamental value which is a safe family. The future is seen with hope and at the same time with doubts.

From casuistries it is clear that respondents wish to make their dreams come true what they did not live through in their primary family. There appears the desire to find a safe place, support. They also find lasting relationships (Taliánová, 2011). We focused on saturation of basic developmental needs in the therapy by symbolic ideal parental figures during structures. Specifically by those who would provide home as a good and a safe place where is inter alia enough support.

• Reflexion and perspective
R1 – a family, where there was violence, R1 perceives as a place full of uncertainty. At the beginning she was covered in anger towards parental persons. She saw herself with despect, she considered herself as an abnormal and a strange girl.
R2 – she rates her place in the family as uncertain, she does not know if they count with her. Often enters into a conflict, than she feels sorry that she is “the black sheep”. She is the organizer of family gatherings, feels the need to be a part of a wider family. She seeks her good place.
R3 – has a feeling that she no longer belongs to a closer family. Sees her family more likely as relatives who support and she feels safe with them and confident. Likewise a relationship with her boyfriend is a promise of a family who she wished to have when she was little.
R4 – relationship towards mother is with caring love, he does not like father. About father he says: ”We do not want him at home.” This respondent has a gap in a topic of roles.
R5 – speaks about a great confusion, ambivalent feelings towards mother and also to a step farther.

Traumatized people enter the therapy very often full of confusion, feeling of guilty, anger and helplessness. It appears that either the therapist uses any method or an approach the client needs safe space also with the fact that the therapist represents a safe figure. Respect is necessary towards client’s pace and the offer of a pilot saturation. Without any strengthening of conscious functions the effect of such therapy is usually not, the client is still confused, does not feel anything or experiences but does not understand his/her emotions.

• Pictures of self and others
R1 – at the beginning she saw herself with a despect – as shed had accepted personal standards transmitted by her father. She spoke about herself as about a useless, fat, ugly and a stupid one. Perceives father as an aggressor. Looking back she sees her mother as a victim, who had not change to save her. She does not blame her nor has grudge. She accepted traumatic experience as a part of herself, she has integrated it. Does not feel glutted, takes part of interpersonal relationships and cares about her safety.
R2 – at first her big aim was to be invisible, she did not want to bother anyone by her presence. She did not want to talk about her strong points, she highlighted her weak ones. Her study situation became better, at present she perceives herself as ”she had a few moment of success”. Surprisingly, but not with reluctance, responds to compliments. She discovers her artistic talents. She feels very uncertain sometimes.
R3 – in the childhood she saw herself as a lost child. She lacked emotionally engaged mother and a strong but a kind father. Now she is aware of her study success and also that despite all the difficulties she lives in a stable relationship. She is determined to live according to her and her partner, who is her certainty. She perceived the difference between certainty which is brought by her partner into their relationship and she had missed it from her parents.
R4 – he perceives himself as a student who is not successful while he has all conditions. His mother is seen as caring, loving, and father as an aggressor.
R5 – at the beginning she looked herself from a balcony in a theatre, gradually she was coming closer. Still she is not sure of herself, but she is aware of her origin accepted that she does not take the blame for her father’s behaviour. She is able to distinguish support and safety by her boyfriend, in exaggeration she calls him as her assurance.

During therapeutic process there has been individual understanding of interaction experiences and actions. Experiences have not been forgotten, but became readable, clearer, grasped by a conscious pilot’s hand. They do not
interfere into personal and study life of clients enough to tie them down essentially. Positive changes in the area of self-concept are evident – in the level of self-respect and self-evaluation, in self-belief and self-acceptance.

In stories of respondents traumatic events occurred which had points of contact – they concerned with the early stages, they affected individual’s personality with imperfect personal structure and therefore they became a component of self-concept. Consequently they brought apart from depressive and anxiety symptomatology also risk behaviour, based mainly on tendention to face risk situations and interpersonal contacts – and therefore at least in one case of acute trauma.

In the process of PBSP therapy there had been a significant space given in the initial phase which took place during extrastructural dialogue, furthermore strengthening of conscious functions (according to PBSP’s pilot). Which followed by a gradual process of traumatic events during therapeutic sessions (structures). At this point we want to emphasize, that it was a long-term therapy, not a short intervention or solitary sessions.

6. Conclusions

Trauma has a significant impact on the self-concept of an individual and it causes lower self-acceptance, self-image, and self-esteem. It is a source of anxiety and depressive symptoms of some individuals – there is no significant difference between the acute and chronic forms of trauma; identically there is no difference between physical and psychological trauma.

During therapeutic process was confirmed that as Pesso, Boyden-Pesso, & Vrtbovská (2009) write that while trauma therapy the aim is to create conditions which enable the Ego to regain control and to create such framework where the client can his repressed and strong feelings and impulses get to the surface if his/her mind and behaviour and offer interactions with the help of ego creating characters of ideal parents. This allows that reactions which relate to trauma experience to be understood, became conscious, were named and were given a shape, space and were accepted and therefore its ego was made available for internalization. We add that it is necessary to proceed with significant consideration towards individual client’s capacity and to be engaged in the therapy process.

As seen the developmental trauma is a bearer of a high-risk behaviour and often subconscious tend to potential dangerous, traumatic situations in the period of adulthood. We are aware of the fact that for further investigation it is necessary to expect more case studies and a detailed process. There is also a comparison of PBSP approach for example with CBT in the context of work with trauma.

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