Psychiatr. Pol. 2018; 52(3): 471–486
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/66124

Resilience in persons with affective and anxiety disorders and the experience of early trauma – pilot studies

Małgorzata Teresa Talaga[1], Iwona Marta Sikorska[1], Mirosława Jawor[2]

[1] Institute of Applied Psychology, Jagiellonian University
[2] Department of Adult, Juvenile and Adolescent Psychiatry, University Hospital in Krakow

Summary

Aim. The primary goal of the study was to examine the role of ego resilience as a factor contributing to the relationship between early trauma and the incidence of psychopathology in adult life; and to make an attempt at identifying the relationship between resilience and personality traits and the early experience of trauma and the incidence of psychopathology in adult life in persons with affective and anxiety disorders.

Method. The study involved 30 patients of the Day Care Emotional and Mood Disorder Treatment Unit, University Hospital in Krakow, Poland, who were asked to complete the following inventories: the Early Trauma Inventory – Self Report, the NEO-PI-R, the Resilience Scale for Adults, and the Beck Depression Inventory.

Results. The vast majority of the participants (97%) experienced interpersonal trauma in childhood, mostly of physical (96.67%) and emotional (83.33%) type. The personality traits that would most frequently resurface in the participants were: Agreeableness (50%), Neuroticism (43.34%) and low Extraversion levels (36.67%). The highest score for resilience was obtained in Perception of Future (24.8 points) and the lowest in Personal Strength (9.73 points). The average level of the symptoms of depression in the sample was characteristic of mild depression ($M = 22.83$).

Conclusions. The outcomes fail to confirm the relationship between depressive tendencies and childhood trauma, and depressive tendencies and personality traits. The analysis allows the conclusion that the incidence of mental disorders is not dependent on childhood trauma, but rather on resilience levels. Resilience may be a predictor of a positive personality profile and a protective factor against the incidence of the symptoms of depression.

Key words: resilience, affective disorders, trauma

Introduction

Resilience has been explored in psychiatry, health psychology, crisis intervention, and positive psychology for more than 50 years now [1]. The term resilience is derived

from Latin verb *resilire* meaning "to bounce back, to swerve, to go back to the beginning, to regain equilibrium" [2]. There is a number of Polish translations of this term, such as "prężność osobowa" [3], "prężność ego" [4], "prężność" [5], "sprężystość" [6, 7], "odporność psychiczna" [8–10], or "rezyliencja" [11].

An interest in resilience has grown eight times over the last twenty years. The number of scientific publications on resilience that are listed by ERIC, PsychArt, and Medline grew from 2,000 to 40,000 between the years 1990–2010 [12].

The outcomes of longitudinal studies in children growing up in adverse conditions reveal that a large number of the children, despite unfavorable circumstances, are in good health, have life skills that are adequate to their age, and complete their developmental tasks accordingly. They also turn out to be successful in adult life. The outcomes contributed to the understanding of resilience that explains positive adaptive skills in children and young people despite growing up in adverse conditions or when confronted with chronic stress or traumatic experiences [1, 13, 14]. The longitudinal studies that span over 40 years (Kauai Longitudinal Study) [15], 25 years (Michigan State University Longitudinal Study) [16], and over 10 years (*Die MannheimerRisikokinderstudie* and Swedish Longitudinal Study on Ego–Control and Ego-Resiliency) [17] contributed to the identification of risk factors, on the one hand, and mental health protective factors, on the other [10].

Although the focus of resilience research is primarily on children, separate studies exist that concentrate on adults and the ways they cope with adversity in the light of traumatic experiences they experienced in childhood.

These childhood-related experiences, which due to the time of their occurrence are also referred to as early trauma, reflect two different types of trauma: type 1 – simple and singular, and type 2 – complex and chronic. The former demonstrates the impact of natural disasters or events that are not intentional, as well as war and terrorism, on the functioning of the exposed persons. The latter's focus is on the implications that intentional and conscious abuse by other people has on the individual. Since trauma is usually inflicted by people from the victim's immediate environment, this type of suffering is usually referred to as interpersonal trauma [18].

Research projects in disaster psychiatry or clinical psychology focus on the formation of PTSD, and identify factors that protect against its development. The meta-analysis of 15 projects investigating the impact of natural disasters (hurricanes, earthquakes, floods), man-made catastrophes (war, terrorism) and epidemics exemplify the basic range of research and the obstacles to carrying it out successfully [19]. This can be exemplified by researches investigating young people in the wake of hurricanes, tsunamis, or earthquakes (e.g. [20–22]); the situation of children soldiers in Africa (e.g. [23, 24]); the impact of war experiences on young people (e.g. [25]); or the implications of the World Trade Center attack in 2001 (e.g. [26]).

An extensive body of research was carried out to verify the hypothesis that people who experienced trauma in childhood may be prone to psychological or functional disorders in adulthood [18, 27]. It was pointed out that the experience of early trauma may predict a variety of short – and long-term mental disorders in adulthood (National Research Council, 1993; Wekerle and Wolfe, 1996; as cited in:

[28]), sometimes leading to the incidence of serious psychological or psychiatric symptoms [28–30].

Weber et al. [31] investigated the relationship between the experience of stress in developmental age and disorder symptomatology in adult life in a group of 96 hospitalized patients (severe depressive episodes, schizophrenia, drug dependence, personality disorders) by examining their entire stress-related life history. The sample was compared against a group of 31 people without mental health problems. Additionally, a relationship was revealed between the number of behavioral concerns in childhood (before reaching the age of six), as well as prior to puberty and adulthood, and the incidence of psychopathology. It was demonstrated that heavy exposure to stress in childhood and prior to puberty had a negative effect on all the participants in the study. High levels of stress in hospitalized patients were related to the incidence of the symptoms of PTSD, depression and personality disorders. The outcomes seem to confirm the hypothesis that periods of exposure to stress occur throughout development, and they may interact with genetic factors and vulnerability factors, which in turn determines the incidence of mental disorders [31].

In their study, Chu et al. [32] identified the role of early trauma in predicting the symptoms of depression and anxiety in a non-clinical group of adults. The study involved 1,209 people between 18 and 70 years of age, 45% of whom were male. The analysis demonstrated that early exposure to a stressful experience significantly increased the incidence of the symptoms of depressive and anxiety disorders against the group of people who had failed to report the experience of trauma in childhood. The multiple regression analysis of the five stressors (interpersonal trauma, family break-up, disaster/war, health problems or death in the family, personal health problems), demonstrated that interpersonal trauma was more likely to provoke the symptoms of depression and anxiety than any other stressors both in men and women [32].

Leenarts et al. [33] revealed the direct relationship between the incidence of interpersonal trauma and mental health problems such as PTSD and complex PTSD. The outcomes reported by Janovic et al. [34] indicated the impact of long-term trauma effect (abuse in childhood) on the risk of the incidence of psychopathology in adult life [34]. Polish researchers revealed a significant positive correlation between the incidence of anxiety and depression and emotional abuse in patients with mental health problems. The studies demonstrated the relationship between the symptoms of depression and abuse experienced in childhood. It was also pointed out that subsequent severe or chronic stressors add to the incidence of mental health disorders in the participants [35].

Although childhood trauma had a significant effect on the participants and their mental health, it was also observed that a large number of people who experienced trauma in childhood remain in good mental health throughout their adult lives. These people were defined as resilient [18]. The paper derives inspiration from the studies that demonstrate that resilience as a personality trait plays a significant role in predicting the relationship between trauma and three types of mental health problems – anxiety disorders, affective disorders, and self-destructive behaviors [20].

The main purpose of the study was to examine the role of ego resilience as a factor contributing to the relationship between trauma and the symptoms of psychopathology

in adult life. Additionally, an attempt was made at identifying the relationship between resilience and personality traits, and the early experience of trauma and the incidence of psychopathology in adult life in persons with affective and anxiety disorders.

Method

Participants

The study was conducted in a sample of patients at the Day Care Emotional and Mood Disorder Treatment Unit, University Hospital in Krakow ($N = 30$) who completed the entire 12-week therapeutic treatment program between August 2013 and March 2014. In order to be selected for the study, the participants had to meet the following criteria: they had to be referred to treatment and complete a 12-week therapeutic program at the Day Care Emotional and Mood Disorder Treatment Unit, University Hospital in Krakow. The sample was described using the following data: gender, age, education, medical diagnosis (according to the *Classification of mental and behavioral disorders in ICD-10*). The participants ranged from 22 to 56 years of age, mean age in the group was 42.4 years. The remaining characteristics are represented in Table 1.

Table 1. **Study group characteristics**

		Study group	
Characteristics		N	%
Gender	Female	21	70
	Male	9	30
Education	Vocational	2	6.67
	Secondary	12	40
	Higher	16	53.33
Medical diagnosis	Neurosis	6	16.67
	Personality disorders	3	10
	Affective disorders	21	73.33
Severity of the symptoms of depression	None	4	13.33
	Mild	16	53.33
	Moderate	9	30
	Severe	1	3.33
Early trauma	General Trauma	1	
	Physical Abuse	29	96.67
	Emotional Abuse	25	83.33
	Sexual Abuse	13	43.33

N = total number of participants; % = percentage

Research tools

The following tools were used in the study: the Early Trauma Inventory – Self Report (ETI) [36] in the Polish adaptation by Bożena Śpila, Maria Chuchra and Anna Grzywacz (2005) [37]; the NEO Personality Inventory (NEO-PI-R) (Costa and McCrae, 2005) in the Polish adaptation by Jerzy Siuta (2009) [38]; the Resilience Scale for Adults (RSA) [39] in the Polish adaptation by Irena Jelonkiewicz, Katarzyna Kühn-Dymecka and Marek Zwoliński (2010) [40]; and the Beck Depression Inventory (BDI) [41].

Early Trauma Inventory (ETI)

The Polish adaptation of the Inventory by B. Śpila, M. Chuchra and A. Grzywacz [37] serves as a tool for retrospective measurement of various types of violence experienced from adults in childhood. The inventory covers four factors: General Trauma, Physical Abuse, Emotional Abuse, Sexual Abuse. A self-report scale was used in the study.

NEO Personality Inventory

The Inventory is used in diagnosis of the Big Five personality traits. The tool provides a detailed personality description to define individual adaptive styles displayed by each participant. The outcomes obtained with the Inventory can help in predicting the overall adaptive style of each participant and their social involvement; it can also help interpret their recurring patterns of behavior, which are displayed in the majority of the situations in which they are involved [38].

Resilience Scale for Adults (RSA)

The Resilience Scale for Adults (RSA) is used to assess factors that protect against the incidence of a disorder and predict positive adaptive styles in individuals, despite the incidence of various risk factors and stressors in their lives at a variety of levels – intrapersonal and interpersonal ones [39].

The Scale covers six different factors, including: (1) perception of Self ($\alpha = 0.70$); (2) perception of future ($\alpha = 0.66$); (3) social competence ($\alpha = 0.76$); (4) structured style ($\alpha = 0.69$); (5) family cohesion ($\alpha = 0.78$); and social resources ($\alpha = 0.69$) [39].

Perception of Self reflects a participant's belief in their own capabilities, their sense of agency, and realistic expectations. Perception of future marks the ability to plan the future and a positive future time perspective, which implies that an individual is also target-oriented. Social competence is related to being kind and flexible with other people, the ability to make friends with other people, and a sense of humor. Structured style refers to the ability to maintain and follow a routine and having clearly defined goals and plans before taking up an activity. Individuals with high scores on structured style can be described as "well organized". Family coherence is used to assess whether a family have shared values, spend time together, how they define loyalty in the fam-

ily, their future perspective, or whether family members trust and are supportive of one another. Social resources reflect access to social support. The above-mentioned factors are considered to be resilience-promoting factors [39].

The Polish RSA adaptation was developed by researchers from the Clinical Psychology Lab at the Department of Psychology and Mental Health Promotion, Institute of Psychiatry and Neurology, Warsaw. The surveys were based on the narrow understanding of resilience as ego resilience, characteristics of Self in relation to stressors. The Polish adaptation of the Resilience Scale for Adults was given the following title "Ty i Twoje Życie" ("You and Your Life"). The Polish adaptation is shorter, and has been designed for adults and young people [40]. The items of Polish adaptation measure the following factors: personal strength (perception of self and perception of future), structured style, social competence, and total ratio. The reliability of the scale was $\alpha = 0.77$, while the reliability of sub-scale was as follows: personal strength $\alpha = 0.74$, perception of Self $\alpha = 0.64$, perception of future $\alpha = 0.69$, social competence $\alpha = 0.77$, and structured style $\alpha = 0.49$. The internal consistence of the Polish RSA adaptation resembles that of the original one. However, a reservation might be made concerning structured style, which is much lower in reliability than that of the original one [40].

Beck Depression Inventory

The Inventory is an accurate measurement tool, and it provides a reliable description of the clinical state in patients with depression. It serves as a valuable addition to psychiatric examination, and it also allows a comparison between the assessments obtained in various psychiatric treatment centers [41]. The above tool provided a measurement of the subjective perception of the incidence of affective, motivational, behavioral, somatic, and cognitive symptoms in depression.

Study procedure

The participants were asked to complete the above-presented inventories individually. Each survey was completed by the participants at the Day Care Emotional and Mood Disorder Treatment Unit, University Hospital in Krakow, Poland, in individual therapy room. The survey took two hours to be completed by each participant. Each survey began by a word of introduction from the researcher, who assured the participant that the study was anonymous, and that they can stop in case the participant feels any emotional discomfort when filling in the questionnaire. The participant was also asked to provide consent to be involved in the study and the outcomes to be processed for scientific purposes in accordance with the principles of informed consent.

The researcher remained present throughout the survey to dispel any potential technical concerns and, more importantly, to support in difficult moments related to childhood trauma. After the survey, each participant was offered a chance to speak to the researcher to alleviate stress and calm down.

Results

Traumatic experience

Each of the 30 participants involved in the study experienced trauma in childhood. Only one participant experienced non-interpersonal trauma (General trauma) without any form of abuse. While the most frequently reported trauma was physical abuse, more than half of the participants experienced emotional abuse. 43.33% of the participants reported sexual abuse (Table 1).

The data obtained in the study suggest the co – occurrence of various types of abuse. The majority of those participants who experienced physical abuse were also exposed to emotional abuse (44.83%). Three patients were affected by physical abuse exclusively (10.34%) whereas 12 participants were exposed to all the three types of abuse in childhood (41.38%). Only one person experienced both physical and sexual abuse without having any exposure to emotional abuse (3.45%) (Table 2).

Table 2. **Co-occurrence of various types of trauma**

		Type of trauma			
		PA	EA	SA	All
Type of trauma	PA	3*	13	1	
	EA	13	-	0	
	SA	1	0	-	
	All				12

N = 30 participants; * – persons who experienced physical abuse only; PA – physical abuse; EA– emotional abuse; SA – sexual abuse

Most frequently, both physical and emotional abuse was perpetrated by the family members – parents/carers, brothers or sisters. Mothers/carers were increasingly more likely to resort to physical and emotional abuse against the child than other people. Other women from the family or female strangers were least likely to inflict physical abuse on the child. Emotional abuse was reported to have been perpetrated by the family members exclusively.

Perpetrators of sexual abuse usually differed from those who resorted to physical or emotional abuse. Sexual abuse was usually inflicted by a male stranger, while sisters or female strangers were reported the least frequently. Other male family members were not reported as perpetrators of sexual abuse.

First experiences of abuse were most frequently reported to have occurred at the age of 6–12 years, and least frequently at the age of 13–18 years. In the latter, sexual abuse turned out to occur more frequently than the other two types of abuse. The age of 0–5 years was exposed to all types of abuse as the initial traumatic experience.

Personality traits

The personality traits that would most frequently resurface in the participants included high Agreeableness and low Extraversion levels. No participant reported to have low Openness to Experience and Agreeableness levels combined. The largest number of the participants scored high on Neuroticism. Accordingly, the smallest number scored low or extremely low on Neuroticism. Openness to Experience would most frequently yield high or average scores, and only rarely extremely high scores would be obtained in this respect. 30% of the participants scored extremely low on Conscientiousness, while 10% of the participants scored extremely high (Table 3).

Table 3. **Level of personality traits in the study group**

Level	Personality trait									
	N		E		O		Agr		C	
	n	%	n	%	n	%	n	%	n	%
Very high	9	30	4	13.33	3	10	2	6.67	3	10
High	13	43.34	5	16.67	10	33.33	15	50	5	16.67
Moderate	6	20	4	13.33	10	33.33	8	26.66	7	23.33
Low	1	3.33	6	20	7	23.34	5	16.67	6	20
Very low	1	3.33	11	36.67	0	0	0	0	9	30

Total number of participants = 30; N – Neuroticism; E – Extraversion; O – Openness; Agr – Agreeableness; C – Conscientiousness; *n* = number of participants; % – percentage of participants

Resilience

Given the absence of Polish standardized norms, only raw outcomes were used in the analysis of the scores on resilience. The outcomes obtained in the sample were set against the data obtained in a study involving young adults that was carried out by the Institute of Psychiatry and Neurology [6] (Table 4).

Table 4. **Comparison of resilience component factors in the study group and the control group**

Factor	Study group		Controls		Possible maximum result
	M	SD	M	SD	
Perception of Self	15.07	5.47	19.67	4.67	30
Perception of future	24.80	9.47	15.04	3.18	20
Personal strength	9.73	4.58	34.71	6.94	50
Structured style	13.20	3.20	13.40	3.42	20
Social competence	19.43	5.39	23.11	4.42	30
Resilience	57.43	15.03	71.15	11.27	100

N = 30; M – arithmetic mean; SD – standard deviation

Comparative analysis demonstrates that the highest score for resilience was obtained in Own perception of future (24.8 points out of 30) and the lowest in Personal strength (9.73 points). Average scores on other factors range from 13.20 to 19.43 points. Total RSA was 57.43 points. The analysis of both each factor and Total RSA suggests that the participants are significantly less resilient than the control group.

Symptoms of depression

16 and 9 participants obtained a result that was indicative of the symptoms of mild and moderate depression, respectively. Only one person displayed the symptoms of severe depression, while four participants reported no symptoms of depression at all. However, it must be pointed out that the Beck Depression Inventory measures the subjective perception of depression (Table 1).

The role of ego resilience as a factor contributing to the relationship between trauma and the symptoms of psychopathology in adult life

Regression analysis reveals that a correlation between Early trauma and Depressive tendencies is only ostensible ($\beta = 0.16$) and statistically insignificant ($p > 0.40$). For Depressive tendencies, only 2% of the variance can be explained by Early trauma ($R^2 = 0.02$). The result suggests that the incidence of Early trauma cannot explain the variance of Depressive Tendencies in the participants. A low and statistically insignificant ($\beta = -0.25$; $p > 0.10$) correlation was established between Early trauma and Resilience. For the latter, 6% of the variance can be explained by Early trauma ($R^2 = 0.06$). That being said, the correlation between Resilience and Depressive tendencies turned out to be moderate ($\beta = -0.50$) and statistically significant ($p < 0.05$). For Depressive tendencies, 25% of the variance can be explained by Resilience ($R^2 = 0.25$). The strength of relationship between Early trauma and Depressive tendencies with reference to Resilience yielded a result that verged on zero ($\beta = 0.04$), while the percentage of explained variance remained the same ($R^2 = 0.25$).

Correlations between resilience, personality traits and early trauma and symptoms of psychopathology

Statistical analysis (using Pearson's r coefficient and Spearman's ρ coefficient) failed to reveal any statistically significant correlations between Depressive tendencies and four Early trauma factors, Depressive tendencies and personality traits, Early trauma and personality traits, and Early trauma and Resilience. However, a negative correlations between Depressive tendencies and Resilience was observed, which allows us to hypothesize about the relationship between these variables (Table 5).

Table 5. **Correlations between Depressive tendencies and Resilience (Pearson's *r*)**

Variables	r	P
Resilience	**-0.50**	**0.005**
Perception of Self	**-0.50**	**0.005**
Perception of future	**-0.49**	**0.005**
Personal strength	**-0.53**	**0.003**
Structured style	**-0.39**	**0.034**
Social competence	-0.24	0.21

N = 30; statistically significant coefficients are marked in **bold**

The analysis also revealed a moderate negative correlation between 1/Neuroticism and Resilience as well as 2/Neuroticism and Perception of Self and Personal Strength; and a positive correlation between Perception of Self and Extraversion, Conscientiousness and Openness to experience, and between Structured style and Conscientiousness, Personal Strength and Openness to experience and Conscientiousness, Extraversion, Openness to experience, Social competence and Conscientiousness, Openness to experience, Agreeableness and Extraversion. The results are presented in detail in Table 6.

Analysis showed that Resilience correlated negatively with Neuroticism, while positively with Extraversion, Openness to experience and Conscientiousness. In turn, the Perception of Self also correlated negatively with Neuroticism and, like the previous factor, positively with Extraversion, Openness to experience and Conscientiousness. Personal strength showed a negative relationship with Neuroticism and positive with Openness to experience and Conscientiousness. Structured style correlated positively only with Conscientiousness, at moderate level. Social competence correlated positively with Extraversion and Openness to experience (Table 6).

Table 6. **Correlations between personality traits and Resilience (Pearson's *r*)**

Variables	N	E	O	Agr	C
Resilience	-0.47**	0.47**	0.55**	0.22	0.46**
Perception of Self	-0.52**	0.39	0.48**	0.14	0.41
Perception of future	-0.35	0.13	0.35	0.18	0.26
Personal strength	-0.47**	0.29	0.45	0.17	0.36
Structured style	-0.23	0.21	0.19	0.18	0.56**
Social competence	-0.34	0.67***	0.63***	0.14	0.32

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$; $N = 30$; N – Neuroticism; E – Extraversion; O – Openness; Agr – Agreeableness; C – Conscientiousness

Discussion

Explorative in nature, the study was aimed at defining an area for future research and more in-depth analysis. The outcomes failed to confirm the relationship between depressive tendencies and early trauma, and depressive tendencies and personality traits. The analysis allows the conclusion that the incidence of mental disorders is not dependent on childhood trauma, but rather on resilience levels. The obtained outcome is far from definitive, which may be due to a small number of people in the sample. It nonetheless opens an intriguing area for further research.

The outcome corresponds with the results obtained by Hjemdal et al. [42] who conducted research on resilience. They demonstrated that resilience is a significant predictor of mental health, together with individual differences in tolerance to stress. They also pointed out a negative correlation between neuroticism and resilience, and positive correlations between extraversion and resilience and social competence; Openness to experience and resilience; agreeableness and resilience, personal strength and structured style [39, 42].

The analysis concerning personality traits took into account only the Big Five factors. excluding all the others due to a small number of people in the sample. Qualitative analysis was nonetheless applied and it demonstrated a correlation with extraversion components such as: – Cordiality and Positive emotions, Openness – Action and Values, and Agreeableness – Altruism. The outcome calls for further exploration, and it also requires in-depth research to investigate personality components and their correlations with resilience, which is due to the already established relationship between the Big Five factors and resilience factors. The above-mentioned component factors imply that an individual has a social support network, maintains contact and close relations with other people, is optimistic, and knows how to go beyond the stereotypical patterns of cognition and activity [38].

Similarly, Cooper et al. [43] underline the relationship between resilience and positive emotions, with particular emphasis on the nature of these correlations. Resilience can be treated as an outcome of positive emotions that are experienced when coping with challenging situations. However, having certain resilience levels can also play a significant role in experiencing positive emotions. Furthermore, they also point out that those individuals who experience positive emotions more often are also more likely to use stress coping styles that are focused on active dealing with difficulties and are characterized by higher flexibility in thinking [43].

The outcomes of our own studies demonstrate that the project in hand is limited in scope, and should be continued in a larger sample that is also uniform in age and gender. A study involving a larger sample entails certain difficulties due to the fact that the patients tend to terminate their therapy. This is corroborated by Herman [44], who emphasizes that therapy, as it progresses, is fragmentary and incomplete, largely due to the large number and complexity of the symptoms and the difficulty the patients have in developing close relations with other people.

Further research is required to investigate the relationship between particular diagnoses and the incidence of mental health problems in patients that score high on

resilience. One of the possible explanations might be that the measurement tool used in the study primarily focuses on positive aspects and protective factors. The resulting state of affairs can be explained by the following hypothesis: seeking help, which for the patients of the Day Care Emotional and Mood Disorder Treatment Unit means joining group therapy, is a manifestation of health and internal strength. Additionally, a large number of academic papers and journal publications discuss difficulties in estimating the real impact of trauma, a response to trauma, factors that determine the way in which the response is described (denying the real impact of trauma on life), the impact of cultural and social norms on coping, and social contexts. Szwajca [45] points out that the analysis of the above variables fails to yield unequivocal results. He also adds that the subjective perception of the traumatic event, being an important variable, is nonetheless very difficult to measure in a reliable way.

Also, a question arises whether persons considered to be resilient should be able to cope in many areas, or excel in one area and be average in others. Additionally, persons with traumatic experiences might be successful throughout the survey, but their functioning can become less adaptive over time. Research suggests that persons who were exposed to trauma often fail to report it in the survey, and they evince higher levels of conformity (than the controls), a higher need for being socially attractive, focus on the assessment made by others and seeking reassurance that they are normal from the researcher. For persons affected by interpersonal trauma, the positive redefinition of their resources and resilience might be a form of self-delusion, denial in the face of difficulty, wishful thinking, or defending self-esteem in the face of the aggravating symptoms of psychopathology [45]. The above conclusions can be made only tentatively. They are intended to point out the need for a deeper insight into the individual situation of the patient, including their heightened willingness to report their personality traits in detailed clinical surveys or projective measurements. It is worth noting that measurement tools are not able to bring out human experience in its complexity.

Sikorska [46] also points out that the emotional cost of a successful adaptation process should be investigated in more detail. Some researchers in resilience are more inclined to believe that children who complete developmental tasks in threatening circumstances are susceptible to internal suffering [46]. The above approach emphasizes the importance of successful coping with everyday tasks and the developmental process at the behavioral level in patients who experience emotional difficulties, which can lead to depression or other mental health problems. Difficult, unpleasant emotions in the face of adversity hardly preclude successful coping with everyday tasks and obligations. Tyszkowa emphasizes that the essence of resilience consists in being able use informative or compensatory function of emotions that emerge in challenging situations. This enables the person in this situation to continue to move towards the intended goal [47].

Conclusions

1. The vast majority of the participants (97%) experienced interpersonal trauma in childhood, most frequently of physical and emotional type, which demonstrates the frequency and co-occurrence of various types of abuse.
2. Most frequently, both physical and emotional abuse was perpetrated by the family members – women being more likely to resort to violence against children.
3. The participants displayed average levels of the traits that are characteristic of resilience. The obtained outcomes allow the conclusion that resilience may be considered a predictor of a positive personality profile and a protective factor against severe symptoms of depression.
4. The obtained outcomes require further verification and more detailed analysis. Research should be continued to explore the relationship between early childhood trauma and mental disorders, especially the symptoms of depression. Although verified by other studies, this relationship was not verified by the project in hand.
5. Subsequent research should be carried out in larger samples to provide a comparison of selected variables against various groups.

References

1. Kolar K. *Resilience: Revisiting the concept and its utility for social research*. Int. J. Ment. Health Addict. 2011; 9(4): 421–433.
2. De Florio V. *On resilient behaviors in Computational Systems and Environments*, https://www.academia.edu/11736157/ (dostęp: 24.05.2015).
3. Uchnast Z. *Prężność osobowa a egzystencjalne wymiary wartościowania*. Roczniki Psychologiczne 1998; 1: 7–27.
4. Oleś P. *Psychologia przełomu połowy życia*. Lublin: Scientific Society of the Catholic University of Lublin; 2006.
5. Heszen I, Sęk H. *Psychologia zdrowia*. Warsaw: Polish Scientific Publishers PWN; 2007.
6. Jelonkiewicz I, Kuhn-Dymecka A, Zwoliński M. *Właściwości psychometryczne Skal Kwestionariusza „Ty i Twoje Życie" w próbie maturzystów i w części próby studentów z 2009 roku*. Annex to the Report on the statutory subject of the IPiN entitled *Proces adaptacji do doświadczeń życiowych a zdrowie u dorastających, młodych dorosłych i osób z problemami zdrowia psychicznego*; 2009.
7. Ogińska-Bulik N, Juczyński Z. *Prężność u dzieci i młodzieży – charakterystyka i pomiar. Polska skala SPP-18*. Polskie Forum Psychologiczne 2011; 16(1): 7–28.
8. Pilecka W, Fryt J. *Teoria dziecięcej odporności psychicznej*. In: Pilecka W ed. *Psychologia zdrowia dzieci i młodzieży. Perspektywa kliniczna*. Krakow: Jagiellonian University Press; 2011. P. 48–68.
9. Grzegorzewska I. *Odporność psychiczna dzieci alkoholików*. Warsaw: Scholar Publishing House; 2013.

10. Sikorska I. *Odporność psychiczna w okresie dzieciństwa*. Krakow: Jagiellonian University Press; 2016.
11. Junik W. red. *Resilience. Teoria, badania, praktyka*. Warsaw: PARPA Media; 2011.
12. Ager A. *Annual Research Review: Resilience and child well-being – public policy implications*. J. Child Psychol. Psychiatry 2013; 54(4): 488–500.
13. Cichetti D, Cohen DJ. ed. *Developmental psychopathology*. New York: Wiley; 2006.
14. Masten A, Obradović J. *Competence and Resilience in Development*. Ann. NY Acad. Sci. 2006; 1094; 13–27.
15. Werner EE, Smith RS. *Journeys from childhood to midlife: Risk, resilience, and recovery*. Ithaca: Cornell University Press; 2001.
16. Wustmann C. *Resilienz: Widerstandsfähigkeit von Kindern in Tageseinrichtungen fördern*. Weinheim, Basel: Belt; 2004.
17. Chuang SS, Lamb ME, Hwang CPh. *Personality development from childhood to adolescence: A longitudinal study of ego-control and ego-resiliency in Sweden*. Int. J. Behav. Dev. 2006; 30(4): 338–343.
18. Widera-Wysoczańska A, Kuczyńska A. red. *Interpersonalna trauma. Mechanizmy i konsekwencje*. Warsaw: Difin Publishing House; 2011.
19. Masten AS, Osofsky JD. *Disasters and their impact on child development: Introduction to the special section*. Child Dev. 2010; 81(4): 1029–1103.
20. Catani C, Gewirtz AH, Wieling E, Schauer E, Elbert T, Neuner F. *Tsunami, war, and cumulative risk in the lives of Sri Lanken schoolchildren*. Child Dev. 2010; 81(4): 1176–1191.
21. Fernando GA, Miller KE, Berger DE. *Growing paints: The impact of disaster-related and daily stressors on the psychological and psychosocial functioning of youth in Sri Lanka*. Child Dev. 2010; 81(4): 1192–1210.
22. Celebi Oncu EC, Wise AM. *The effects of the 1999 Turkish earthquake on young children: Analyzing traumatized children's completion of short stories*. Child Dev. 2010; 81(4): 1161–1175.
23. Klasen F, Oettingen G, Daniels J, Post M, Hoyer C, Adam H. *Posttraumatic resilience in former Ugandan child soldiers*. Child Dev. 2010; 81(4): 1096–1113.
24. Betancourt TS, Borisova II, Williams TP, Brennan RT, Whitfield TH, Soudiere de la M et al. *Sierra Leone's former child soldiers: A follow-up study of psychological adjustment and community reintegration*. Child Dev. 2010; 81(4): 1077–1095.
25. Layne CM, Beck CJ, Rimmasch H, Southwick JS, Moreno MA, Hobfoll SE. *Promoting "resilient" posttraumatic adjustment in childhood and beyond: "Unpacking" life events, adjustment trajectories, resources, and interventions*. In: Brom D, Pat-Horenczyk R, Ford J. ed. *Treating traumatized children: Risk, resilience and recovery*. New York: Routledge; 2009. S. 13–34.
26. Gershoff E, Aber JL, Ware A, Kotler J. *Exposure to 9/11 among youth and their mothers in New York City: Enduring associations with mental health and sociopolitical attitudes*. Child Dev. 2010; 81(4): 1142–1160.
27. Briere J, Scott C. *Podstawy terapii traumy. Diagnoza i metody terapeutyczne*. Warsaw: Institute of Health Psychology; 2010.

28. Philippe FL, Laventure S, Beaulieu-Pelletier G, Lecours S, Lekes N. *Ego-Resiliency as a mediator between childhood trauma and psychological symptoms*. J. Soc. Clin. Psychol. 2011; 30(6): 583–598.

29. Herman JL. *Przemoc, uraz psychiczny i powrót do równowagi*. Gdansk: Gdansk Psychological Publishing House; 2004.

30. Perry BD, Pollard RA, Blakely TL, Baker WL, Vigilante D. *Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits"*. Infant Ment. Health J. 1995; 16(4): 271–291.

31. Weber K, Rockstroh R, Borgelt J, Awiszus B, Popov T, Hoffmann K et al. *Stress load during childhood affects psychopathology in psychiatric patients*. BMC Psychiatry 2008; 8: 63.

32. Chu DA, Williams LM, Harris A, Bryant RA, Gatt JM. *Early life trauma predicts self-reported levels of depressive and anxiety symptoms in nonclinical community adults: Relative contributions of early life stressor typesand adult trauma exposure*. J. Psychiatr. Res. 2013; 47(1): 23–32.

33. Leenarts LE, Vermeiren RR, Ven van de PM, Lodewijks HP, Doreleijers TA, Lindauer RJ. *Relationships between interpersonal trauma, symptoms of posttraumatic stress disorder, and other mental health problems in girls in compulsory residential care*. J. Trauma. Stress 2013; 26(4): 526–529.

34. Jovanovic T, Blanding NQ, Norrholm SD, Duncan E, Bradley B, Ressler KJ. *Childhood abuse is associated with increased startle reactivity in adulthood*. Depress. Anxiety 2009; 26(11): 1018–1026.

35. Śpila B, Makara A, Chuchra M, Pawłowska B. *Związek stresujących wydarzeń życiowych z zaburzeniami stanu psychicznego*. Psychiatr. Pol. 2005; 39(1): 115–123.

36. Bremner JD, Vermetten E, Mazure CM. *Development and preliminary psychometric properties of an instrument fort the measurement of childhood trauma: The Early Trauma Inventory*. Depress. Anxiety 2000; 12(1): 1–12.

37. Śpila B, Makara A, Chuchra M, Grzywa A. *Polska adaptacja Inwentarza Wczesnej Traumy (ETI)*. Wiadomości Psychiatryczne 2005; 8(1): 19–24.

38. Siuta J. red. *Diagnoza osobowości. Inwentarz NEO-PI-R w teorii i praktyce*. Warsaw: Psychological Test Laboratory of the Polish Psychiatric Association; 2009.

39. Friborg O, Barlaug D, Martinussen M, Rosenvinge JH, Hjemdal O. *Resilience in relation to personality and intelligence*. Int. J. Methods Psychiatr. Res. 2005; 14(1): 29–42.

40. Zwoliński M. Annex No. 17 to the report on the subject of the IPiN, nr 26/2008.

41. Parnowski T, Jernajczyk W. *Inwentarz depresji Becka w ocenie nastroju osób zdrowych i chorych na choroby afektywne (ocena pilotażowa)*. Psychiatr. Pol. 1977; 4: 417– 421.

42. Hjemdal O, Friborg O, Stiles TC, Rosenvinge JH, Martinussen M. *Resilience predicting psychiatric symptoms: A prospective study of protective factors and their role in adjustment to stressful life events*. Clin. Psychol. Psychother. 2006; 13(3): 194–201.

43. Cooper C, Flint-Taylor J, Pearn M. *Building resilience for success: A resource for managers and organizations*. London: Palgrave Macmillan; 2013.

44. Herman JL. *Przemoc. Uraz psychiczny i powrót do równowagi*. Gdansk: Gdansk Psychological Publishing House; 2004.

45. Szwajca K. *Sprężystość (resilience) i odpowiedzi na doświadczenia urazowe – fascynujący i trudny obszar badań*. Psychiatr. Pol. 2014; 48(3): 563–572.

46. Sikorska I. *Odporność psychiczna i poczucie jakości życia sportowców z niepełnosprawnością*. In: Kubacka-Jasiecka D, Mudyń K ed. *Kryzysy i zaburzenia posttraumatyczne. Problemy interwencji oraz pomocy psychologicznej*. Torun: Adam Marszałek Publishing House; 2014.

47. Tyszkowa M. *Problemy psychicznej odporności dzieci i młodzieży*. Warsaw: Nasza Księgarnia; 1972.

Address: Małgorzata Teresa Talaga
Institute of Applied Psychology
Jagiellonian University
30-348 Kraków, Łojasiewicza Street 4