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# Children as victims of domestic violence: Effective CBT strategies for treating trauma[1]

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*Violence is not a sign of strength but of weakness.*

*Blessed Father Jerzy Popiełuszko*

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**Abstract:** A child's experience of domestic violence can be considered interpersonal trauma, as they are harmed by someone they know and are close to. On the other hand, domestic violence is associated with severe and chronic stress, which in the long term can have devastating effects on the child's physical and mental health. The aim of this review paper is to present the problem of domestic violence against children, signaling modern methods of cognitive-behavioral psychotherapy that are highly effective in treating psychological trauma. The article consists of two parts: the first part provides characteristics and a scale of the phenomenon of domestic violence against children, its determinants and its consequences. The second part reviews effective CBT strategies in the treatment of post-traumatic disorders. The subject matter for the first part of this article relates to theoretical models of the causes of violence, in terms of its determinants, and in particular the GAM (General Aggression Model), Albert Bandury's social learning theory, and the theory of intergenerational transmission of violence. As part of the characterization of the consequences of domestic violence, numerous studies confirming the relationship between relation trauma and a range of diverse disorders are cited. In particular, the etiology of PTSD is discussed. The second part of the article addresses effective methods of trauma treatment based on the cognitive-behavioral paradigm. Trauma-focused cognitive-behavioral psychotherapy (TF-CBT), as a practice based on reliable scientific evidence (EBP – evidence-based practice), has been recognized as the first-line therapy for the treatment of post-traumatic stress disorders. The text presents Edna Foa's prolonged exposure method, Patricia Resick's cognitive processing therapy, along with a discussion of the neurobiological basis of PTSD and CPT. The paper also includes a description of an innovative process-based approach. An important research task for the future remains to conduct further scientific research on predictors of the effectiveness of PTSD treatment, with particular emphasis on the therapeutic alliance and factors protecting children from developing trauma.
**Keywords:** child, domestic violence, cognitive-behavioural psychotherapy, interpersonal trauma, posttraumatic stress disorder (PTSD).

## Introduction

The United Nations Convention on the Rights of the Child was adopted by the UN General Assembly on 20 November 1989 and was the first international treaty to stipulate that children have the right to protection, help and special care. The preamble to the Convention, which was ratified in Poland in 1991, states that "the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding".[2]

1 Article in Polish language: https://stowarzyszeniefidesetratio.pl/fer/63P_Fedo.pdf
2 Sejm Rzeczypospolitej Polskiej. Konwencja o prawach dziecka przyjęta przez Zgromadzenie Ogólne Narodów Zjednoczonych dnia 20 listopada 1989 r. [Convention on the Rights of the Child adopted by the United Nations General Assembly on 20 November 1989]. Dz.U. 1991 nr 120 poz. 526. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=wdu19911200526

Family experts claim that violence experienced by children from strangers is not only rarer but also far less harmful than violence experienced from closest family members (Młyński, 2012; Pospiszyl, 2000).

The terms "trauma" and "post-traumatic stress disorder" are often associated with the experiences of military veterans, as they were first defined in relation to wartime experiences (Holiczer, Gałuszko, Cubała, 2007; Zawadzki, Popiel, 2014). In fact, there are many types of trauma, among which relational/interpersonal trauma is of particular significance (Greenberg, 2018). Relational trauma arises as a result of negative childhood experiences related to such things as the experience of family violence, emotional neglect or abandonment by a parent (Froń, Lewandowska, 2023). As a rule, it is associated with exposure to terrifying, life-threatening or dangerous event, and also recurring, prolonged or extreme stressors, and therefore, it can cause PTSD or *complex* PTSD (C-PTSD) (Kowalski, Blaut, Dragan, Farley, Pankowski, Sanna, Śliwerski, Wiśniowska, 2024; Popiel, Pragłowska, 2022; Gałecki, Szulc, 2023b).

## 1. Characteristics of violence against children in the family

Domestic violence is still present in all societies, regardless of the level of their economic and cultural development. It is alarming to see the prevalence of domestic violence, *strictly speaking*, among the closest relatives. Especially alarming is the fact that violence against children is mostly committed by their parents (Lubińska-Bogacka, 2019b; Młyński, 2012).

Doctors who recognised injuries as the consequence of the cruel treatment of children by their parents played a significant role in identifying the harm caused by acts of violence against children. In 1953, radiologist F. Silverman introduced the term *battered child syndrome*, which was defined as the clinical condition of a small child experiencing serious physical injury that results in permanent damage to the body. In 1961, H. Kempe, President of the American Academy of Pediatrics, organised the first academic conference with the battered child syndrome as the leading theme. A few years later, a new term was coined: *maltreated child*. It meant a child who has suffered various forms of violence, e.g., physical violence, psychological violence or sexual abuse. Today, literature and the media also use the term *child abuse and neglect*; however, *violence against children* remains the most popular one (Lisowska, 2005; Lubińska-Bogacka, 2019a; Młyński, 2012).

According to the amended Act on Counteracting Domestic Violence of 9 March 2023 (Article 2(1)),[3] domestic violence, formerly referred to as family violence, is defined as a single or recurring wilful action or negligence, using physical, psychological, or economic superiority, which infringes upon the personal rights or wellbeing of persons experiencing domestic violence, in particular:

1. exposing that person to the risk of losing their life, health, or property,
2. violating their dignity, bodily integrity or freedom, including sexual freedom,
3. causing harm to that person's physical or psychological health, causing suffering or injury to that person,
4. limiting or depriving that person of access to financial resources or the ability to work or become financially independent,
5. significantly violating that person's privacy or causing them to feel threatened, humiliated, or distressed, including with the use of means of electronic communication.[4]

There are four main types of behaviour classified as violence against children: physical violence, psychological (emotional) violence, sexual violence and neglect. Moreover, violence against children sometimes takes such forms as, for example, giving

3 Sejm Rzeczypospolitej Polskiej. (2023, March 9). *Ustawa z dnia 9 marca 2023 r. o zmianie ustawy o przeciwdziałaniu przemocy w rodzinie oraz niektórych innych ustaw* [Act amending the Act on counteracting family violence and certain other acts]. Dz.U. z 2023 r. poz. 535. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20230000535

4 Sejm Rzeczypospolitej Polskiej. (2005, July 29). *Ustawa z dnia 29 lipca 2005 r. o przeciwdziałaniu przemocy domowej* z późn. zm. [*Act of 29 July 2005 on counteracting domestic violence, as amended*]. Dz.U. z 2024 r. poz. 424. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20240000424

children psychoactive or harmful substances, or substances not intended for children; Münchhausen syndrome *per procuram*/*Münchhausen syndrome by proxy* or exposure to domestic violence (witnessing domestic violence) (Bryńska, 2020; Lubińska-Bogacka, 2019b; Młyński, 2012).

Contrary to popular belief, violence is perpetrated not only by members of dysfunctional families; rather, it occurs in various families. It is committed by all kinds of people regardless of their age, socioeconomic status, education and profession. Families with low social status are more likely to use corporal punishment and neglect children, while families with higher social status apply a wider range of punishments, with emotional punishment being more common (Lubińska-Bogacka, 2019b; Młyński, 2012).

Prosecutorial or court statistical forms include a long list of crimes that may be classified as domestic violence, e.g., abuse, causing bodily harm, unlawful threats, etc. (Lewoc, 2024). It is acause for concern that crimes against the family are among the most frequently committed crimes. They rank third in the overall crime scale (after crimes against property and crimes against life) (Pospiszyl, 2000). It is important to remember that violent behavior is not always a criminal offense under the law, but it is always driven by the perpetrator's intentions and needs, and it always infringes upon the other person's rights to respect, dignity, rest, privacy, or autonomy (Michalska, Jaszczak-Kuźmińska, 2014; Młyński, 2012).

## 2. Data on the extent of domestic violence against children

It is difficult to assess the actual scale of domestic violence against children in Poland. According to data on the initiation of the *Niebieska Karta* (*Blue Card*) procedure by the Polish Police between 2012 and 2024, presented in Table 1, women constitute the largest group of victims of domestic violence, while minors are the second largest group affected by domestic violence. If we compare the number of minors affected by domestic violence in 2012 and 2024, it is easily noticeable that the number of victims among children went up by about 34%. The number of children found to be affected by domestic violence in 2024 was the highest in the last twelve years. This can certainly be attributed to the change in the reporting criteria in the SEPol system operated by the Police. Since 2012, the only violence-affected minors included in reports were those who were targets of violence (Mende, 2015). Since 2024, minors who witness family violence have also been registered as victims of family violence, pursuant to the amended Act of 6 September 2023 on the *Blue Card* procedure and *Blue Card* form templates[5].

Table 1. Number of victims of domestic violence according to the "Blue Cards" procedure, based on police statistical data from 2012 to 2024. Source: Portal of the Polish National Police and the National Police Headquarters.

| Year | *Blue cards* issued | Total number of victims | Women | Men | Minors |
|---|---|---|---|---|---|
| 2012 | 51 292 | 76 993 | 50 241 | 7 580 | 19 172 |
| 2013 | 61 047 | 86 797 | 58 310 | 9 233 | 19 254 |
| 2014 | 77 808 | 105 332 | 72 786 | 11 491 | 21 055 |
| 2015 | 75 495 | 97 501 | 69 376 | 10 733 | 17 392 |
| 2016 | 73 531 | 91 789 | 66 930 | 10 636 | 14 223 |
| 2017 | 75 662 | 92 529 | 67 984 | 11 030 | 13 515 |
| 2018 | 73 153 | 88 133 | 65 057 | 10 672 | 12 404 |
| 2019 | 74 313 | 88 032 | 65 195 | 10 676 | 12 161 |
| 2020 | 72 601 | 85 575 | 62 866 | 10 922 | 11 787 |
| 2021 | 64 250 | 75 761 | 55 112 | 9 520 | 11 129 |
| 2022 | 61 645 | 75 761 | 55 112 | 9 520 | 11 129 |
| 2023 | 62 170 | 77 832 | 51 631 | 9 162 | 17 039 |
| 2024 | 59 174 | 86 920 | 50 638 | 10 559 | 25 723 |

The wide range of published statistics relating to children affected by family violence is puzzling. Some sources report that the percentage rates are low, while others claim that the percentage of children experiencing domestic violence may be as high

5 Rada Ministrów. (2023, September 6). Rozporządzenie Rady Ministrów z dnia 6 września 2023 r. w sprawie procedury "Niebieskie Karty" oraz wzorów formularzy "Niebieska Karta" [Regulation on the "Blue Card" procedure and "Blue Card" form templates]. Dz.U. 2023 poz. 1870. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20230001870

as 90% (Młyński, 2012). On the one hand, data documenting legal interventions against perpetrators of violence reveal only the tip of the iceberg; based on this data, one might assume that child abuse in the family is a marginal phenomenon. Police and court records generally cover only serious cases of child abuse. On the other hand, sociological studies, revealing violence that is not included in official statistics and often constitutes an element of parenting practices, argue that violence (though in its less drastic forms) is a rather common childhood experience (Siejak, 2016).

The extent of the "dark figure" of undisclosed cases of violence against children remains largely dependent on socio-cultural factors. The society at large still shows a high level of acceptance for corporal punishment. For centuries, educational tradition has recognised children's obedience to adults as a value. In addition, individualism embedded in the European culture makes many modern families embrace the principle of non-interference in their lives and the lives of other families. Yet, the most difficult obstacles to overcome in combating domestic violence seems to be the sense of shame, helplessness and fear in adults. As the child's environment tends to systematically avoid conversations about the trauma, it reinforces the child's belief that he or she has to deal with this area of life alone. Moreover, it reinforces the coping mechanisms based on cognitive, emotional and behavioural avoidance of difficult experiences (Bryńska, 2020; Konowałek, 2020; Lisowska, 2005; Popiel, Pragłowska, 2022; Zagórski, 2017).

## 3. Risk factors for domestic violence

Academic literature provides numerous theoretical models of the causes of violence against children: psychological, sociological and integrative models (e.g., R. Gelles' model, K. Browne's multifactorial model), the socio-situational model, the exchange theory and social control theory and the concept of violence as the source of gratification (Lisowska, 2005, Pospiszyl, 2000). It is worth mentioning that the phenomenon of violence is inseparably linked to aggression. This is because aggression is the main characteristic of perpetrators of violence. Moreover, studies show that family violence is the most common form of interpersonal aggression (Filipek, 2014; Pospiszyl, 2000). The concept of violence is associated with aggression, brutality, crime and cruelty, while aggression is associated with violent behaviour, hostility, audacity, destructiveness and animosity (Lubińska-Bogacka, 2019b; Młyński, 2012).

According to the *General Aggression Model* (GAM), aggression arises due to social, cognitive, developmental and biological factors. Distal processes provide the basis for an aggressive personality, dependent on the influence of biological factors (e.g., hormones) and environmental factors (dysfunctional family, exposure to violence, difficult living conditions, etc.). At the level of proximal processes, the emergence of aggressive behaviour is determined by the interaction of personal factors (e.g., biological predispositions, temperamental traits, moral justification of violence, violent self-image, personality disorders like narcissism, etc.) and situational factors ( including social rejection, provocation, frustration, bad mood, watching violence in the media, intoxication with alcohol, etc.), which impact internal states – thoughts, emotions, arousal – and subsequently influence judgements and decisions. Each cycle of proximal processes, ending in impulsive action, may contribute to the development of an aggressive personality due to multiple repetitions (Allen, Anderson, Bushman, 2018; Huesmann, 2018).

This mechanism of developing a "cognitive script" – a mental record of the course of an event, consolidated as a result of its multiple repetitions – is also described by the theory of social learning developed by Albert Bandura. According to this theory, a child learns new behaviours by observing other people who serve as models. The *intergenerational violence transmission* theory also proves that experiencing parental violence in childhood or witnessing family violence increases the likelihood of aggressive and violent behaviour towards one's children. Sometimes patterns of violence become generalised, which leads an individual to perpetrate multiple types of violence. Statistical data indicate that between 20% and 80% of perpetrators of violence experienced violence in

their families of origin (Bandura, Huston, 1961; Bandura, Ross, Ross, 1961; Bryńska, 2020; Filipek, 2014; Lisowska, 2005; Widera-Wysoczańska, 2010).

It is worth mentioning that, in spite of all, the intergenerational transmission of violence is conditioned by a combination of various factors: social and environmental, familial, personal, biological and genetic. Research and practice in the field of domestic violence prevention emphasise that domestic violence may be the cause as well as the effect of family dysfunction. In addition, therapeutic experience shows that if victims undertake to work to change their behaviour, they can break the chain of violence being passed on to next generations (Allen et al., 2018; Bryńska, 2020; Filipek, 2014; Huesmann, 2018; Lisowska, 2005; Widera-Wysoczańska, 2010).

Family violence is a complex phenomenon influenced by multiple factors. It is important to remember that a family is a group of people who differ in terms of age, gender, temperament, personality, needs, preferences, interests and experiences. Such situations naturally give rise to conflicts (Lubińska-Bogacka, 2019b; Pospiszyl, 2000). The foundation of the family is love, which, nevertheless, requires family members to embrace personal development and acquire various skills, such as skills related to dialogue, correct communication and effective cooperation, solving problems related to the care and upbringing of children, as well as managing negative emotions and stress.

Aaron T. Beck, the founder of cognitive psychotherapy, developed a structured, short-term, and present-oriented psychotherapy for depression, focused on the resolution of current problems and changing dysfunctional (inadequate or unhelpful) thinking and behaviour. He dedicated his professional career to researching disorders of the thinking process and discovered that couples struggling with marital problems exhibited the same thinking aberrations as patients suffering from depression and anxiety. In his book for married couples titled *Love is never enough. How Couples Can Overcome Misunderstandings, Resolve Conflicts, and Solve Relationship Problems*, he referred to the cognitive revolution and suggested that developing the skills of clear thinking and clearly expressing one's thoughts would help prevent misunderstandings from arising (Beck, 2020; Beck, 2021).

## 4. Consequences of domestic violence against children

The development of psychology (showing that the essential foundations of the future personality are shaped through early family interactions and emotional bonds) and knowledge about traumatic stress contributed to the shift away from the traditional thinking about victims of family violence in terms of individual psychopathology (Resick, Monson, Chard, 2019).

Many researchers describe early attachment as the prototype of all close relationships that an individual will form, also in adult life. Attachment is defined as a *long-term emotional relationship with a specific person* (Schaffer, 2009).

Secure, trusting attachment develops when caregivers provide a child with protection, security and love, which, at the same time, support the development of all physical and psychological functions of the child. Insecure attachment (anxious-ambivalent, anxious-avoidant, disorganised-disoriented) develops in children who experience physical or emotional abuse, neglect or other forms of inappropriate treatment from the caregiver. The most concerning manifestation of insecure attachment is the disorganised pattern, which reflects the child's inconsistent relationship with caregivers. The child's strategy for interacting with others is then disrupted; at times, the child may seek closeness with the parent; at other times, the child may be avoiding closeness or resisting it while experiencing a range of negative emotions, with fear being the most dominant. The child's relationships with peers are often also conditioned by the *fight or flight* principle, which means that they are dominated by a high level of aggression or avoidance and withdrawal (Schaffer, 2009).

In her in-depth study on domestic violence, Professor Irena Pospiszyl highlighed that harming a child has a negative impact on the child's development and is particularly detrimental to his or her emotional well-being. The child's direct reaction to harmful behaviour involves increased aggression, low self-esteem, emotional instability, inability to form interpersonal relationships and hostility towards the environment, combined with a strong attachment to caregivers.

Children who experience harm are often described as:

- unable to relax,
- having no sense of humour,
- unruly,
- prone to entering a state of *frozen watchfulness,*
- or heightened vigilance (Pospiszyl, 2000).

A family in which violence occurs is classified as a dysfunctional family. Domestic violence destroys bonds and has particularly negative consequences for the child's developing personality. The traumatic experiences of children who suffer violence from their parents are associated with chronic tension and emotional overload. Firstly, the parent's aggression directed at the child causes suffering, fear and disintegration of the sense of security and stability in life. Repeated verbal attacks that humiliate, devalue and destroy a child's identity and self-image are equally painful (Mellibruda, 2015; Młyński, 2012; Polok, 2021).

Secondly, a child witnessing frightening and repeated incidents of a parent's aggression towards other household members experiences a paralysing fear for the lives of loved ones and a desperate helplessness in the face of this threat while, at the same time, wanting to protect the relatives against it (Mellibruda, 2015; Młyński, 2012; Polok, 2021). The behavior patterns of children in families with violence are similar to the ways children function in families with alcohol-related problems. Having their needs constantly ignored, children learn to suppress their emotions and adopt a task-oriented approach to problems. They often take on various roles, such as that of a hero, rescuer, mascot, scapegoat or invisible child, which are reinforced by the parents. These children very frequently feel inferior and different (alienated) among their peers at school or even in society at large. Maltreated children lose trust in other people, display feelings of helplessness and anger, show a tendency toward emotional and social isolation, and struggle with problem-solving skills, which stems from low self-esteem (Lubińska-Bogacka, 2019a; Mellibruda, 2015; Młyński, 2012; Polok, 2021, Szmyd, 2008).

There are numerous clinical indications to believe that mistreatment at an early age leads to psychopathology in later life. Results collected from numerous scientific studies prove that negative childhood experiences (e.g. childhood trauma, domestic violence, relational trauma) predispose individuals to somatic and mental health problems (Froń, Lewandowska, 2023). Modern handbooks of clinical psychology and child and adolescent psychiatry cite a long list of mental health issues that arise as a consequence of violence experienced in childhood or adolescence (Bryńska, 2020; Dąbkowska, 2022; Gałecki, Szulc, 2023b; Grzegorzewska, 2020; Konowałek, 2020). The diversity of the psychopathologies that arise from traumatic stress in childhood is striking.

Persons who were mistreated in childhood are more likely to suffer from depression, susceptibility to stress, high emotional sensitivity, eating disorders and suicide attempts (especially as a consequence of sexual abuse), behavioural disorders, addictions or criminal activity. The most common disorder diagnosed as a consequence of experiencing family violence is post-traumatic stress disorder (PTSD), and recently, also *complex* PTSD (C-PTSD) (Greenberg, 2018; O'Connor, Thayer, Vedhara, 2021; Schaffer, 2009; Widera-Wysoczańska, 2010).

In the latest edition of the *International Statistical Classification of Diseases and Related Health Problems* – ICD-11 of 11 February 2022, the *World Health Organization* (WHO) identified the *complex* post-traumatic stress disorder (C-PTSD). The new diagnosis – analogous to DESNOS –was defined as a repeated interpersonal trauma, which is difficult or impossible to escape from, e.g., as in the situation of prolonged domestic violence, repeated sexual or physical abuse in childhood, a genocide campaign, torture, or enslavement (Kowalski et al., 2024; Popiel, Pragłowska, 2022; Gałecki, Szulc, 2023b).

Experts of the American Psychiatric Association (APA) developed the initially theoretical concept of the *disorder of extreme stress non otherwise specified* (DESNOS). However, in the diagnostic system for mental disorders published by APA (*Diagnostic and Statistical Manual of Mental Disorders*, DSM-5), DESNOS ultimately did not obtain the status of a nosological entity (Gałecki, 2024).

Some specialists do accept the diagnosis of complex PTSD. Others believe that the cognitive, emotional and behavioural problems experienced

by children who were victims of adverse experiences result from a pathomechanism other than PTSD. Attempts are still being made to establish the structure of symptoms that distinguish C-PTSD from other disorders, especially PTSD and borderline personality disorders (Cloitre, Garvert, Brewin, Bryant, Maercker, 2013; Cloitre, Garvert, Weiss, Carlson, Bryant, 2014; Konowałek, 2020; Merecz-Kot, 2021; Resick, Bovin, Calloway, Dick, King, Mitchell, Suvak, Wells, Stirman, Wolf, 2012).

The *Traumatic Stress Personality Disorder* (Tr-SPD) and the *Posttraumatic Personality Disorder* (PPD), as well as the *Developmental Trauma Disorder* (DTD) diagnosed in children, are also recognised as consequences of chronic interpersonal trauma experienced in childhood. Moreover, complex PTSD often coincides with dissociation and conversion disorders, affective disorders in the form of depression, dysthymia and dysphoria or borderline personality disorder (Widera-Wysoczańska, 2010).

In his influential work titled *"Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic",* Professor David H. Barlow outlined the model of PTSD aetiology. The starting point for his work was the search for an answer to the question about differences between patients in terms of their susceptibility to PTSD following a traumatic life event. It was found that not all people experience PTSD in response to strong stressors. Risk factors for PTSD include the following: generalised biological susceptibility (constitutional and congenital factors, temperament), generalised psychological susceptibility (e.g. a sense of powerlessness and lack of control), as well as the level of exposure to the stressor, number of exposures, strategies for coping with stress (e.g. avoidant behaviours) and access to social support (e.g. weak bonds with significant others) (Keane, Barlow, 2002; Popiel, Pragłowska, 2022; Zawadzki, 2024).

Children are considered more susceptible to all kinds of traumatic life events, due to their limited ability to satisfy their existential needs, and consequently, also to defend themselves and change their situation. In addition, the likelihood of developing PTSD after a trauma is greater in children than in adults; it affects about ¼ of children and adolescents (according to various studies, this percentage amounts to between 15% and 27%). It is also known that whether a child will develop PTSD depends on the type of trauma experienced. Usually, 50–75% of children experience long-term consequences of trauma, and their symptoms persist until adulthood (Dąbkowska, 2022; Gałecki, Szulc 2023a; Konowałek, 2020).

## 5. Evidence-based CBT strategies for treating trauma

*Trauma-focused cognitive-behavioural therapy (TF-CBT*) is the dominant therapeutic approach, included in international recommendations as the first-choice psychotherapy for the treatment of PTSD in people of all ages – not only adults but also children and adolescents. The term TF-CBT combines different approaches, based on the cognitive-behavioural model, which simultaneously recognise the significance of processing the traumatic experience. This group includes E. Foa's prolonged exposure; P. Resick's cognitive processing therapy, A. Ehlers' cognitive-behavioural therapy and F. Neuner's narrative exposure therapy (Gałecki, Szulc, 2023b; Kowalski et al., 2024; Popiel, Pragłowska, 2022; Popiel, Zawadzki, 2023).

The latest meta-analysis review of studies on the effectiveness of cognitive-behavioural therapy in relation to PTSD confirms the effectiveness of CBT based on a huge number of studies conducted on adults, as well as on children and adolescents. Recognised international associations, such as the American Psychological Association (APA), the American Psychiatric Association (APA), the National Institute for Health and Care Excellence (NICE), the Australian Psychological Society (APS) and the European Society for Traumatic Stress Studies (ESTSS), clearly point to the verified effectiveness of TF-CBT in the treatment of children, adolescents and adults with PTSD after an experience of incidental trauma. TF-CBT proved to be an effective therapy for children and adolescents with a complex trauma diagnosis. However, it has been recommended that more empirical data be collected, as is the case with third-wave CBT therapies (Kowalski et al., 2024).

Edna Foa i Michael Kozak underline, that PTSD mechanisms are largely related to mechanisms of fear conditioning, sensitisation and calming. The fear structure has an adaptive function, as it prompts us to flee from danger. However, under the influence of trauma, the fear network undergoes modification, turning into a pathological fear structure. In this situation, neutral stimuli can be misinterpreted and associated with threat, which triggers the flight response. The relationships between the different elements of the pathological fear structure are fragmented and incoherent. Avoidance makes it impossible to access that structure, which plays the key role in the persistence of anxiety and PTSD symptoms. Only exposure and emotional processing of fear can help silence false anxiety alarms (Foa, Kozak, 1986; Gałecki, Szulc, 2023b; Pineles, Mostoufi, Ready, Street, Griffin, Resick, 2011; Popiel, Pragłowska, 2022).

At present, there is a single PTSD treatment programme for adolescents in Poland, which is based on the method of prolonged exposure and emotional processing, named *Odzyskaj życie po traumie: przedłużona ekspozycja w terapii PTSD nastolatków. Poradnik pacjenta (Reclaiming your life after a trauma: prolonged exposure in the treatment of PTSD in teenagers. Patient's handbook)* and *Przedłużona ekspozycja w terapii PTSD nastolatków. Emocjonalne przetwarzanie traumatycznych doświadczeń. Podręcznik terapeuty (Prolonged Exposure Therapy for Adolescents with PTSD. Emotional Processing of Traumatic Experiences. Therapist Guide)* by Edna Foa, Eva Gilboa-Schechtman and Kelly Chrestman (Chrestman, Gilboa-Schechtman, Foa, 2014; Foa, Gilboa-Schechtman, Chrestman, 2014). It is worth remembering that the therapy of a child who experienced interpersonal trauma requires establishing the therapeutic alliance via taking multiple aspects into account, including acknowledging the victim's experience, understanding the changes that occurred due to the traumatic event; restoring trust; reinforcing the victim's autonomy; developing a sense of strength and control and shaping a healthy personality (Dąbkowska, 2022; Foa et al., 2014; Resick et al., 2019).

If children or teenagers who experienced trauma undertake therapy in adulthood, they may, for many years, rely on cognitive processes shaped at a time when their executive functions were not fully developed. Neurobiology can help us understand why younger people are more likely to suffer from PTSD. The prefrontal cortex (which is the centre for decision making and control over the amygdala, which triggers strong emotions) can only reach full development in persons older than 20. Young people are often not only more susceptible to trauma but, above all, have fewer resources to deal with it (Johnson, Blum, Giedd, 2009; Resick et al., 2019).

Professor Patricia A. Resick and her team researched traumatic stress over many years, developing the *cognitive processing therapy* (CPT). The biological model of PTSD proposed by the author reflects the latest research on how the brain responds to psychological trauma (Resick et al., 2019).

PTSD symptoms co-occur with changes in the neurochemical functioning of the entire brain or its specific structures. Studies involving individuals with PTSD have shown that the amygdala exhibits increased reactivity, while the prefrontal cortex demonstrates significantly reduced activity. According to S.B. Johnson and his colleagues, the prefrontal cortex coordinates higher-level cognitive processes. Executive functions are a set of cognitive processes that oversee goal-directed behaviour and include planning, response inhibition, working memory and attention. These abilities allow an individual to pause for long enough to make an accurate assessment of a situation, consider potential options, plan a course of action and then act. Poor cognitive functioning leads to difficulties in planning, concentrating, taking feedback into account and a lack of mental flexibility, which can hinder judgment and decision making (Gałecki, Szulc, 2023b; Johnson et al., p. 217).

This is likely why so many PTSD patients who experienced psychological trauma in childhood hold extreme beliefs – especially if they experienced the trauma multiple times. CBT practitioners emphasise that people with exceptionally rigid cognitive patterns are predisposed to develop PTSD. One of the objectives of cognitive therapy is to teach patients to think in more flexible ways (Foa et al., 2014; Popiel, Pragłowska, 2022; Resick et al., 2019).

One significant discovery confirmed by neuroimaging studies was the positive impact of CPT on brain neurochemical processes: an increase in prefrontal cortex activity, which interrupts the fight-or-flight response modulated by the amygdala. As expected, it was proven that CPT can help individuals develop affect (emotion) regulation, increase cognitive flexibility and alter many assumptions and beliefs that were developed during the period of cognitive immaturity and were never verified due to avoidance symptoms (Resick et al., 2019, p. 31).

Work is still ongoing to understand and clarify the neurophysiological mechanisms linked to PTSD. Its progress will determine the possibilities for effective prevention and treatment of disorders related to traumatic stress (Gałecki, Szulc, 2023b).

Cognitive-behavioural therapy focuses on processes that perpetuate the disorder. For a long time, post-traumatic stress disorder was categorised as an anxiety disorder. Current classifications, both DSM-5 and ICD-11, distinguish a group of disorders specifically related to stress. It has been found that various negative emotions experienced by patients with PTSD, such as guilt, anger, shame, disgust and sadness, mean that PTSD goes beyond an anxiety disorder (Gałecki, Szulc, 2023b; Popiel, Pragłowska, 2022; Resick et al., 2019).

The dynamically developing knowledge of psychopathology, as well as on the processes and mechanisms determining the effectiveness of therapy, has been reflected in the concept of process-based cognitive-behavioural psychotherapy. For example, the inability to regulate emotions is considered one of the fundamental processes maintaining psychopathological symptoms of not only PTSD but also many other disorders. Leading representatives of the process-based approach within the "third wave" of CBT, Steven Hayes and Stefan G. Hofmann, postulate that psychological processes are not connected in a linear way, and therefore, effective treatment should take into account multilevel connections. The authors emphasize that the main assumption of process-based therapy is the combination of strategies tailored to achieving specific, intended goals (Hofman, Curtiss, Hayes, 2020; Ong, Hayes, Hofmann, 2022; Popiel, Pragłowska, 2022).

Violence is recognised as a complex and chronic traumatic event. Apart from therapy for the child, psychological treatment often involves crisis intervention, individual therapy for the caregivers and/or addiction treatment, family psychotherapy and participation of the perpetrators of violence in therapeutic programmes, for example, on developing social skills and conflict resolution, aggression management, etc. (Widera-Wysoczańska, 2010). Dysfunctional couples may also benefit from couples therapy.

Research on the predictors of the effectiveness of PTSD treatment is ongoing. Considering the three dimensions: cognitive, emotional and behavioural, the way the individual experiences events and difficulties, the way the individual cognitively processes and interprets information related to them and what actions the individual takes in response to them, we need to conclude that all these factors taken together condition the individual's level of psychological resilience (Cyniak-Cieciura, Zawadzki, 2019; Dąbkowska, 2022; Franczok-Kuczmowska, 2022). Identifying the sources of children's resilience to the experience of violence, interpersonal trauma and chronic stress remains a research challenge for the future (Lisowska, 2005).

## Conclusions

On the one hand, this paper is concerned with identifying the characteristics of domestic violence against children. On the other hand, it includes a review of CBT strategies that are empirically proven to be effective in treating traumatic experiences. Due to the broad scope of the topic, the article presents selected CBT strategies, focused chiefly on the treatment of PTSD and C-PTSD.

Diagnosing PTSD/C-PTSD in children and adolescents causes multiple problems for a variety of reasons. The main reasons include differences in diagnostic criteria identified in current classifications. Moreover, the symptoms of PTSD and C-PTSD often overlap with other disorders, such as GAD. Furthermore, developmental changes characteristic of a specific age and the developmental stage that the young patients are at play a significant role,

too, and may make diagnosis more difficult. It is worth remembering that symptoms of PTSD and C-PTSD in children and adolescents may take the form of non-specific manifestations. In many cases, it is not easy to link a child's ailments to trauma and diagnosing PTSD, as the patient, unless asked by the clinician about particular symptoms, will avoid recalling unwanted memories (Dąbkowska, 2022; Gałecki, Szulc 2023a; Konowałek, 2020; Popiel, Pragłowska, 2022).

While planning a psychotherapeutic intervention for a child who is a victim of domestic violence, one needs to remember that the child is closely attached to his or her family. Helping a child entangled in family problems requires a comprehensive approach, as it is usually the parents – the child's legal guardians – who need help and support in various areas. As in the case of a natural disaster, effective help and protection for children in cases involving domestic violence depend on the engagement and coordinated cooperation of specialist services. Educational activities that raise public awareness and knowledge about the threat of domestic violence and ways of combating it are extremely important in this regard. The most important thing is to help a child with interpersonal trauma restore trust and faith in people.

## References


Allen, J. J., Anderson, C. A., & Bushman, B. J. (2018). The General Aggression Model. *Current Opinion in Psychology, 19*, 75–80. https://doi.org/10.1016/j.copsyc.2017.03.034

Bandura, A., Huston, A. C. (1961). Identification as a process of incidental learning. *Journal of Abnormal and Social Psychology, 63*(2), 311–318. https://doi.org/10.1037/h0040351

Bandura, A., Ross, D., & Ross, S. A. (1961). Transmission of aggression through imitation of aggressive models. *Journal of Abnormal and Social Psychology, 63*(3), 575–582. https://doi.org/10.1037/h0045925

Beck, A. T. (2020). *Miłość nie wystarczy. Jak rozwiązywać nieporozumienia i konflikty małżeńskie* (Andrzej Jankowski Trans.). Poznań: Media Rodzina. (Original work published 1989 as *Love is never enough: How couples can overcome misunderstandings, resolve conflicts, and solve relationship problems through cognitive therapy.* HarperCollins.).

Beck, J. S. (2021). *Cognitive behavior therapy: Basics and beyond* (3rd ed.). New York, NY: Guilford Press.

Bryńska, A. (2020). Przemoc w rodzinie, przemoc seksualna wobec dzieci, postępowanie wobec ofiar przemocy [Domestic violence, sexual violence against children, procedures for victims]. In B. Remberk (Ed.), *Zaburzenia psychiczne u dzieci i młodzieży* [Mental disorders in children and adolescents] (pp. 609–630). Warszawa: PZWL Wydawnictwo Lekarskie.

Chrestman, K. R., Gilboa-Schechtman, E., & Foa, E. B. (2014). *Odzyskaj życie po traumie: przedłużona ekspozycja w terapii PTSD nastolatków. Poradnik pacjenta* [Reclaim your life after trauma: Prolonged exposure therapy for adolescents with PTSD. Patient guide]. Sopot: GWP.

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European Journal of Psychotraumatology, 4*, 1–12. https://doi.org/10.3402/ejpt.v4i0.20706

Cloitre, M., Garvert, D. W., Weiss, B., Carlson, E. B., & Bryant, R. A. (2014). Distinguishing PTSD, complex PTSD, and borderline personality disorder: A latent class analysis. *European Journal of Psychotraumatology, 5*, 1–10. https://doi.org/10.3402/ejpt.v5.25097

Cyniak-Cieciura, M., & Zawadzki, B. (2019). The relationship between temperament traits and post-traumatic stress disorder symptoms and its moderators: Meta-analysis and meta-regression. *Trauma, Violence, & Abuse, 20*(1), 1–15. https://doi.org/10.1177/1524838019876702

Dąbkowska, M. (2022). Zaburzenie stresowe pourazowe [Post-traumatic stress disorder]. In M. Janas-Kozik & T. Wolańczyk (Eds.), *Psychiatria dzieci i młodzieży* [Child and adolescent psychiatry] (Vol. 2, pp. 15–44). Warszawa: PZWL.

Filipek, A. (2014). Przemoc w rodzinie a realizacja ról rodzicielskich [Domestic violence and the implementation of parental roles]. In J. Szymanowska (Ed.), *Wyzwania współczesnego dzieciństwa i rodzicielstwa* [Challenges of contemporary childhood and parenting] (pp. 95–111). Toruń: Wydawnictwo Adam Marszałek.

Foa, E. B., Gilboa-Schechtman, E., & Chrestman, K. R. (2014). *Przedłużona ekspozycja w terapii PTSD nastolatków. Emocjonalne przetwarzanie traumatycznych doświadczeń. Podręcznik terapeuty* Sopot: GWP. (Original work published 2008 as *Prolonged exposure therapy for adolescents with PTSD. Emotional processing of traumatic experiences. Therapist guide*).

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*(1), 20–35.

Franczok-Kuczmowska, A. (2022). Adults' resilience in the light of measurement methods. *Developmental Psychology, 27*(1), 9–26. https://doi.org/10.4467/20843879PR.22.001.16676

Froń, O., & Lewandowska, A. (2023). Złożony zespół stresu pourazowego u dzieci i młodzieży – walidacja nowego zaburzenia w ICD-11 [Complex post-traumatic stress disorder in children and adolescents – validation of a new disorder in ICD-11]. In A. Lewandowska (Ed.), *Monografia. Psychiatria wieku rozwojowego* [Monograph. Developmental psychiatry] (pp. 75–80). Warszawa: Medical Tribune.

Gałecki, P. (2024). *Kryteria diagnostyczne DSM-5-TR* [Diagnostic criteria DSM-5-TR]. Wrocław: Edra Urban & Partner.

Gałecki, P., & Szulc, A. (2023a). *Psychiatria. Rozpoznania według ICD-1.* [Psychiatry: Diagnoses according to ICD-11] Vol. 2. Wrocław: Edra Urban & Partner.

Gałecki, P., & Szulc, A. (2023b). Zaburzenia swoiście związane ze stresem [Stress-related disorders]. In P. Gałecki & A. Szulc (Eds.), *Psychiatria. Rozpoznania według ICD-11* [Psychiatry: Diagnoses according to ICD-11]. Vol. 1 (pp. 345–372). Wrocław: Edra Urban & Partner.

Greenberg, M. (2018). *Mózg odporny na stres* [The stress-proof brain]. Poznań: REBIS. (Original work published 2017).

Grzegorzewska, I. (2020). Terapia dzieci po urazach psychicznych [Therapy for children after psychological trauma]. In I. Grzegorzewska, L. Cierpiałkowska, & A. R. Borkowska (Eds.), *Psychologia kliniczna dzieci i młodzieży* [Clinical psychology of children and adolescents] (pp. 869–877). Warszawa: PWN.

Hofmann, S. G., Curtiss, J. E., & Hayes, S. C. (2020). Beyond linear mediation: Toward a dynamic network approach to study treatment processes. *Clinical Psychology Review, 76*, 101824. https://doi.org/10.1016/j.cpr.2020.101824

Holiczer, A., Gałuszko, M., & Cubała, W. J. (2007). Zaburzenie stresowe pourazowe – opis ewolucji koncepcji zaburzenia i podejść terapeutycznych [Post-traumatic stress disorder: Evolution of the concept and therapeutic approaches]. *Psychiatria, 4*(1), 25–32.

Huesmann, L. R. (2018). An integrative theoretical understanding of aggression: A brief exposition. *Current Opinion in Psychology, 19*, 119–124. https://doi.org/10.1016/j.copsyc.2017.04.015

Johnson, S. B., Blum, R. W., & Giedd, J. N. (2009). Adolescent maturity and the brain: The promise and pitfalls of neuroscience research in adolescent health policy. *Journal of Adolescent Health, 45*(3), 216–221. https://doi.org/10.1016/j.jadohealth.2009.05.016

Keane, T. M., & Barlow, D. H. (2002). Posttraumatic stress disorder. In D. H. Barlow (Ed.), *Anxiety and its disorders: The nature and treatment of anxiety and panic* (pp. 418–452). New York, NY: Guilford Press.

Komenda Główna Policji (KGP). (2025, April 6). *Przemoc domowa – dane za 2024 rok* [Domestic violence – data in 2024]. Retrieved from https://statystyka.policja.pl/st/wybrane-statystyki/przemoc-domowa/50867,Przemoc-domowa-dane-od-2023-roku.html

Komenda Główna Policji (KGP). (2025, May 15). *Przemoc w rodzinie – dane od 2012 roku* [Violence in family – data since 2012]. Retrieved from https://statystyka.policja.pl/st/wybrane-statystyki/przemoc-domowa/201373,Przemoc-w-rodzinie-dane-od-2012-do-2022-roku.html

Konowałek, Ł. (2020). Zaburzenie stresowe pourazowe [Post-traumatic stress disorder]. In B. Remberk (Ed.), *Zaburzenia psychiczne u dzieci i młodzieży* [Mental disorders in children and adolescents] (pp. 199–206). Warszawa: PZWL Wydawnictwo Lekarskie.

Kowalski, J., Blaut, A., Dragan, M., Farley, D., Pankowski, D., Sanna, K., Śliwerski, A., & Wiśniowska, J. (2024). *Systematyczny narracyjny przegląd metaanaliz badań nad skutecznością psychoterapii poznawczo-behawioralnej i zaleceń terapeutycznych opublikowanych między 2010 a 2023* [A systematic narrative review of meta-analyses on the effectiveness of cognitive-behavioral therapy and therapeutic recommendations published between 2010 and 2023]. Warszawa: Polskie Towarzystwo Terapii Poznawczej i Behawioralnej im. Prof. Zdzisława Bizonia.

Lewoc, M. (2024). Prawo a przemoc domowa w 2023 roku [Law and domestic violence in 2023]. *Niebieska Linia, 6*, 1–9. Retrieved June 7, 2025, from https://www.niebieskalinia.pl/aktualnosci/artykuly-niebieskiej-linii/prawo-a-przemoc-domowa-w-2023-roku-61552024

Lisowska, E. (2005). *Przemoc wobec dzieci – rozpoznawanie i przeciwdziałanie* [Violence against children – identification and prevention]. Kielce: Wydawnictwo Akademii Świętokrzyskiej.

Lubińska-Bogacka, M. (2019a). *Stosowanie przemocy wobec dziecka – przyczyny, skutki, diagnozowanie i profilaktyka* [Use of violence against a child – causes, consequences, diagnosis, and prevention]. Kraków: Petrus.

Lubińska-Bogacka, M. (2019b). *Wybrane problemy przemocy w rodzinie: krótkotrwałe i wtórne skutki dla ofiar* [Selected issues of domestic violence: short-term and secondary consequences for victims]. Kraków: Petrus.

Mellibruda, J. (2015). *Rany i blizny psychiczne* [Psychological wounds and scars]. Warszawa: Instytut Psychologii Zdrowia PTP.

Mende, W. (2015). 16 lat procedury „Niebieskie Karty" z perspektywy danych statystycznych [16 years of the "Blue Card" procedure from the perspective of statistical data]. *Kwartalnik Policyjny, 3*, 15–20. Retrieved June 7, 2025, from https://kwartalnik.csp.edu.pl/kp/archiwum-1/2015/nr-32015/2819,16-lat-procedury-Niebieskie-Karty-z-perspektywy-danych-statystycznych.html

Merecz-Kot, D. (2021). Diagnoza zaburzeń w stanie zdrowia po doświadczeniach traumatycznych – perspektywa historyczno-kulturowa [Diagnosis of health disorders after traumatic experiences – historical-cultural perspective]. In M. Dragan & M. Rzeszutek (Eds.), *Z badań nad traumą psychiczną w Polsce* [Research on psychological trauma in Poland] (pp. 17–39). Warszawa: Wydawnictwo Naukowe SCHOLAR.

Michalska, K., & Jaszczak-Kuźmińska, D. (2014). *ABC przeciwdziałania przemocy w rodzinie – diagnoza, interwencja, pomoc* [ABC of counteracting domestic violence – diagnosis, intervention, help]. Warszawa: Fundacja ETOH: Wydawnictwo Edukacyjne Remedium.

Młyński, J. (2012). Przemoc w rodzinie – skala zjawiska, ofiary przemocy i formy pomocy pracowników socjalnych [Family violence – the scale of the phenomenon, its victims and social workers' forms of help]. *Studia Socialia Cracoviensia, 4*(2), 141–156. https://doi.org/10.15633/ssc.416

O'Connor, D. B., Thayer, J. F., & Vedhara, K. (2021). Stress and health: A review of psychobiological processes. *Annual Review of Psychology, 72*, 663–688. https://doi.org/10.1146/annurev-psych-062520-122331

Ong, C. W., Hayes, S. C., & Hofmann, S. G. (2022). A process-based approach to cognitive behavioral therapy: A theory-based case illustration. *Frontiers in Psychology, 13*, 1002849. https://doi.org/10.3389/fpsyg.2022.1002849

Pineles, S. L., Mostoufi, S. M., Ready, C. B., Street, A. E., Griffin, M. G., & Resick, P. A. (2011). Trauma reactivity, avoidant coping, and PTSD symptoms: A moderating relationship? *Journal of Abnormal Psychology, 120*(1), 240–246. https://doi.org/10.1037/a0022123

Polok, G. (2021). *Rozwinąć skrzydła* [Spread your wings]. Katowice .

Popiel, A., & Pragłowska, E. (2022). *Psychoterapia poznawczo-behawioralna. Teoria i praktyka* [Cognitive-behavioral therapy: Theory and practice] (2nd expanded edition). Warszawa: Wydawnictwo Naukowe PWN S.A.

Popiel, A., & Zawadzki, B. (2023). Psychoterapia – quo vadis? [Psychotherapy – quo vadis?]. *Kwartalnik Nauka, 3*, 61–85. https://doi.org/10.24425/nauka.2023.147311

Pospiszyl, I. (2000). *Przemoc w rodzinie* [Domestic violence in the family]. Warszawa: WSiP.

Rada Ministrów. (2023, September 6). *Rozporządzenie Rady Ministrów z dnia 6 września 2023 r. w sprawie procedury "Niebieskie Karty" oraz wzorów formularzy "Niebieska Karta"* [Regulation on the "Blue Card" procedure and "Blue Card" form templates]. Dz.U. 2023 poz. 1870. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20230001870

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., Mitchell, K. S., Suvak, M. K., Wells, S. Y., Stirman, S. W., & Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: Implications for DSM-5. *Journal of Traumatic Stress, 25*(3), 241–251. https://doi.org/10.1002/jts.21699

Resick, P. A., Monson, C. M., & Chard, K. M. (2019). *Terapia przetwarzania poznawczego w zespole stresu pourazowego (PTSD): podręcznik dla klinicystów* [Cognitive processing therapy for PTSD: A comprehensive therapist manual]. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego. (Original work published 2017)

Schaffer, H. R. (2009). *Psychologia dziecka* [Introducing child psychology]. Warszawa: PWN. (Original work published 2004).

Sejm Rzeczypospolitej Polskiej. (2005, July 29). *Ustawa z dnia 29 lipca 2005 r. o przeciwdziałaniu przemocy domowej* z późn. zm. [Act of 29 July 2005 on counteracting domestic violence, as amended]. Dz.U. z 2024 r. poz. 424. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20240000424

Sejm Rzeczypospolitej Polskiej. (2023, March 9). *Ustawa z dnia 9 marca 2023 r. o zmianie ustawy o przeciwdziałaniu przemocy w rodzinie oraz niektórych innych ustaw* [Act amending the Act on counteracting family violence and certain other acts]. Dz.U. z 2023 r. poz. 535. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20230000535

Sejm Rzeczypospolitej Polskiej. *Konwencja o prawach dziecka przyjęta przez Zgromadzenie Ogólne Narodów Zjednoczonych dnia 20 listopada 1989 r.* [Convention on the Rights of the Child adopted by the United Nations General Assembly on 20 November 1989]. Dz.U. 1991 nr 120 poz. 526. Retrieved from https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=wdu19911200526

Siejak, A. (2016). *"Kocham, nie biję"?: przemoc wobec dzieci w dyskursie publicznym* ["I love, I don't hit": Violence against children in public discourse]. Warszawa: Biuro Rzecznika Praw Dziecka.

Szmyd, B. (2008). Rola Poradni Psychologiczno-Pedagogicznej w rozwiązywaniu kryzysów wieku dziecięco-młodzieżowego [The role of the Psychological-Pedagogical Counseling Center in resolving child-adolescent crises]. In I. Kurlak & A. Gretkowski (Eds.), *Pomoc dziecku i rodzinie w sytuacji kryzysowej* [Helping children and families in crisis] (pp. 115–124). Stalowa Wola – Sandomierz: Wydawnictwo Diecezjalne i Drukarnia.

Widera-Wysoczańska, A. (2010). *Mechanizmy przemocy w rodzinie: z pokolenia na pokolenie* [Mechanisms of domestic violence: From generation to generation]. Warszawa: Difin.

Zagórski, B. J. (2017). Wsparcie duchowe w rodzinie z przemocą – praktyka duszpasterska [Spiritual support in families with violence – pastoral practice]. In A. Lewicka-Zelent (Ed.), *Przemoc rodzinna. Aspekty psychologiczne, pedagogiczne i prawne* [Domestic violence: Psychological, pedagogical, and legal aspects] (pp. 161–169). Warszawa: Difin.

Zawadzki, B. (2024). Temperament traits as predictors of the effectiveness of different methods of posttraumatic stress disorder (PTSD) therapy. Keynote presented at the International Scientific Conference: *'Tailor-made. Cognitive Behaviour Therapy'*, 18 May 2024, Warsaw.

Zawadzki, B., & Popiel, A. (2014). Na rozstaju dróg: struktura objawów stresu pourazowego (PTSD) po DSM-5, a przed ICD-11 [At the crossroads: Structure of PTSD symptoms after DSM-5 and before ICD-11]. *Kwartalnik Nauka, 4*, 69–86.