PSYCHOTERAPIA 3 (210) 2024
PAGES: 33–44
DOI: 10.12740/PT/192215

Agnieszka Nowakowska[1], Dorota Draczyńska[2]

BECOMING MYSELF – EXISTENTIAL ANALYSIS IN PSYCHOTHERAPY OF A PERSON WITH RELATIONAL TRAUMA

[1] XX Psychiatry Division, Nowowiejski Hospital
[2] First Department of Psychiatry, Institute of Psychiatry and Neurology

I'm not sure what I'm looking for anymore
I just know that I'm harder to console
I don't see who I'm trying to be instead of me
But the key is a question of control

Martin Gore, A Pain That I'm Used To,
Santa Barbara, California, 12.12.2005

existential analysis
relational trauma
4FM

Summary

The aim of the article is to present the process of individual psychotherapy according to existential analysis, in the paradigm of four fundamental motivations (4FM), and to indicate the changes that occurred in each of the 4FM in a patient, Mrs. K., a 25-year-old woman, an only child, who after living abroad for three years and ending a relationship returned to her parents' home. She wanted to feel safe, but this did not happen. She did not understand her reactions, suppressed anger, and was unable to set boundaries. In the relationship with her parents, she felt "like she used to". As a result, anxiety symptoms appeared (security deficits in 1FM) and depression (2FM – relationship to life). Feeling despair, she activated an internal, critical narrative (3FM – lack of understanding of oneself, lack of consent to be oneself). As a result, she did not find meaning in her current life, and thoughts of resignation and fleeting suicidal thoughts appeared (difficulties in the area of the fourth 4FM, i.e., searching for the meaning of life, and in the three previous ones). During the therapy, she gradually got to know herself, her symptoms, and learned self-regulation. She built her autonomy. Her parents' home became the harbor from which she set sail into the world. At the helm stood Mrs. K., accepting her family of origin and the influence her family had on her. She learned to distance herself from her thoughts (1FM), understand her emotions, express them and regulate them (2FM) and set boundaries (3FM). She got to know herself and recognized that she has the right to her own boundaries, beliefs and needs (3FM), and she found meaning (4FM), without waiting for reality to be in line with her expectations, which — as she knows — is not possible. In everyday life she finds her "yes" to life.

Introduction

Theoretical background

Alfried Längle, a student of Viktor Frankl, the creator of existential analysis (EA), indicates its main goals: supporting people in a full cognitive and emotional experience of themselves and the world, teaching them to make decisions in harmony with themselves and taking responsibility for their lives. EA assumes the weakening of blocks that prevent from taking action, as a result of which a person has the opportunity to discover the unique meaning of his or her existence understood as a specific, individual way of being [1–4]. According to EA, existence takes place in dialogue, in a personal encounter with another person and with oneself. In a personal encounter we see individuality. This requires maintaining a phenomenological attitude and readiness to be emotionally moved.

Personal encounter is an important concept of existential analysis referred to as personal existential analysis (German: *Persönliche Existenzanalyse* – PEA) [5, 6]. PEA, combined with the 4FM model (four fundamental motivations) and diagnoses classified in the ICD/DSM diagnostic systems, creates a diagnostic and therapeutic scheme [4]. It takes into account the conceptualization of relational trauma as “emotional freezing” in the area of four fundamental motivations (4FM) as a result of experienced violence and/or neglect, understood as the lack of internal consent in each of the 4FMs [7].

Aim and method

Mrs. K.’s psychotherapy conducted according to EA indicates the process of changes taking place in each of the 4FMs, which led to the integration of the experiences of relational trauma, symptomatic improvement, unlocking the ability to pursue one’s own life goals and taking up life in harmony with oneself, in specific conditions of reality, with respecting the importance of personal beliefs regarding the values that guide a person in life [6], in this case herself.

Mrs. K. entered the office as a person with experience of relational trauma, who developed depressive and anxiety symptoms and personality difficulties resulting from the fear and suffering she experienced. “I can’t”, “I don’t know if I’m allowed to”, “when I set boundaries, when something doesn’t suit me, people get angry with me”, “I don’t want to hurt people”, “it’s either them or me”. She felt helpless and resorted to developed ways of coping with reality. She withdrew from relationships: “people scare me,” she said. She suppressed her emotions and constantly tried to control reality and herself. Perfectionism made it difficult for her to function on a daily basis. Excessive doubts about one’s own choices and future life made it difficult to make decisions. The lack of contact with one’s own emotions was a facade for the experienced reluctance and anger, expressed in negative self-narratives. As a result, anxiety, uncertainty and feelings of guilt appeared. Many traumatic situations from her childhood came back to her in her memories and dreams.

There were "just like back then" reactions. The image of an aggressive, intimidating father who criticized, threatened and used unfair, often cruel punishments returned. Mrs. K. was delegated to calm him down in order to protect her younger sister and mother. "Only I could manage his anger," she said.

Mrs. K.'s mother forbade anyone to talk about the situation at home. Both parents, after medical studies, held high positions and externally created the image of a happy, well-functioning family.

At the beginning of therapy, the patient's symptoms were consistent with the diagnosis of complex PTSD according to ICD-11. Re-experiencing, avoidance, a sense of threat (PTSD cluster, post traumatic stress disorder, area of post-traumatic stress disorder) with accompanying symptoms of affect dysregulation, negative self-image and impairment in relationship functioning (DSO cluster, Disturbances in Self Organization, area of personality organization). Two years later, a self-aware woman emerged from the office, accepting reality and finding meaning in everyday life.

The criterion of symptomatic improvement and the existential perspective are complementary to each other and contribute to the response to psychotherapy. In the presented description of the psychotherapy process, emphasis is placed on the primacy of the criterion – freedom – responsibility – decision-making.

Therapeutic factors according to existential analysis

Existential analysis focuses on practicing the ability to take a stand towards reality: giving or withholding inner consent, and developing one's own ability to decide. The following healing factors are involved:

- the phenomenological openness of the psychotherapist, who directs the patient towards a subjective understanding of values and emotions, helps to get acquainted with them and illuminate them in a specific context, so that it becomes clear not only what the patient felt, but also why he felt that way in a specific situation,
- being with the patient, confronting, working with paradoxes that strengthen the patient in forming opinions, recognizing the connections between his own experiences and the requirements of a given situation, adopting new attitudes, taking a position in harmony with himself and, consequently, understanding himself,
- remaining in an accepting relationship – enables self-expression, connecting with external or internal values and rebuilding the connection with life**.**

Four fundamental motivations

Taking an attitude towards reality is based on four foundations (4FM), which somehow sustain our existence [6] and, together with the questions asked, help in the search for individual answers. Certain conditions, if met, are an element of internal consent and

acceptance of reality. Its denial is related to the patients' experience of suffering, which blocks the ability to accept reality, understood as the recognition of conditions, which intensifies psychopathological symptoms. The condition for a fulfilled existence is to find your own "yes" to life in each of the four areas of 4FM: reality, relationships, yourself and a sense of meaning. The key questions of 4FM are presented in Figure 1 along with the conditions that are necessary to find your "yes" to life at various stages of existence. The next figure (Fig. 2) shows the distribution of acceptance for each of Mrs. K.'s FMs at the beginning of the therapy and at its end.

I CAN "BE", EXIST, LIVE (1FM)	I LIKE TO LIVE (2FM)
1. Am I healthy? 2. Do I have anything to eat? 3. Do I have a place to sleep? 4. Do I have a place where I feel safe? Conditions: distance, protection, support	1. Am I giving myself time? 2. Do I feel liked? 3. Do I feel loved? 4. Do I understand my emotions? 5. Is my life good and valuable? 6. Do I have a balance in giving and taking? Conditions: time, relationships, closeness
I AM MYSELF (3FM)	**MY LIFE HAS MEANING (4FM)**
1. Do I appreciate myself? 2. Do I like myself? 3. Do I support myself? 4. Do I see myself? 5. Do I respect myself? 6. Do I speak well of myself? Conditions: respect, acceptance, appreciation	1. What good comes from me being alive? 2. What can I do today to make my life meaningful? 3. Am I taking actions that make sense? 4. Do I have values that guide me in life? Conditions: all of the previous three, individual meaning

Figure 1. **Key questions and terms of 4FM: Authors' own elaboration**

Diagnosis and process analysis

At the beginning of psychotherapy, the reactions and internal experiences of 25-year-old Mrs. K. were not understandable to her. She did not connect the anxiety and tension in her body with traumatic experiences and learned reactions from childhood, or with her return

to her family home. She had no control over the severity of her symptoms, and adequately experiencing the present was a problem for her. As an adult, she felt defenseless in the face of her parents' orders and prohibitions, shouting and insults towards her, each other and her sister. In many unplanned situations, she experienced the activation of an emotional state originating from childhood, related to traumatic experiences in the relationship with her parents. The symptoms she described were consistent with difficulties regulating affect in most people with relational trauma. What she reported was dominated by descriptions of being in a state of constant readiness and vigilance on a daily basis, or alternatively – of being emotionally frozen and cut off. As a preventive measure, she preferred to keep her distance from people, seeing herself as inferior and worthless.

During psychotherapy, Mrs. K., by building a safe bond with the psychotherapist, was able to create continuity of experience and coherence within herself, and found a safe ground in the current reality. In other words, she was able to come back to herself on an emotional and cognitive level. At the same time, she built and strengthened her relationship with herself and the outside world. She accepted reality in the area of each 4FM. She found her own meaning and purpose in life. She recognized her biography. She integrated traumatic experiences from her family home into her experience.

The duration of therapy is 60 hours of sessions, with 15 in the office and 45 online, due to the patient's move to another city. As time passed and psychotherapy progressed, weekly meetings were changed to biweekly sessions.

The begining of psychotherapy, diagnosis, therapy plan and goals

Mrs. K. was 25 years old when she started psychotherapy. She had just ended her 3-year relationship with her partner and returned to Poland, where she moved back into her family home. Although the problem she reported concerned the ability to set boundaries and build confidence in her own choices, the clear tension in her body was visible in the foreground. Mrs. K. was sitting on the edge of the chair, practically not moving. She spoke quickly, without pausing. She often, unconsciously, checked whether she had turned off her phone. She was unaware of the body-emotions and thoughts-emotions-behaviors connection.

The conceptualization of the difficulties reported by Mrs. K. was shaped at the diagnosis stage and updated along with the implemented therapy plan. The process of diagnosis and psychotherapy was dynamic and interdependent. The EA psychotherapist looked for and understood Ms. K.'s internal inhibitions, blockages and resources, as well as her own. The psychotherapist approached the patient's subjective world of experiences and updated the diagnosis and treatment plan to effectively predict treatment outcomes.

The therapy plan at the first stage included supporting Mrs. K. in moving back to live with her parents, re-experiencing traumatic experiences and coping with the loss of her previous life. This was a challenge similar to the psychotherapy of minors who were not separated from their family of origin. Mrs. K.'s parents did not respect Mrs. K.'s boundaries, including physical ones, e.g., the boundary of the room door, and Mrs. K. was unable to set

these boundaries. She regressed and had to cope with the loss of freedom she experienced after moving out of her family home a few years earlier. The parents demanded information about who Mrs. K. was meeting and where. They reacted with verbal aggression to attempts to set boundaries, as well as to Mrs. K.'s opposition and rebellion against these practices.

During psychotherapy, Mrs. K. decided to continue her studies, leave home and start working. Her goals motivated her to act in accordance with Frankl's idea – those who have a 'why' to live, can bear with almost any 'how'[8].

After Mrs. K. moved to another city to study, psychotherapy became less interventional. Therapy goals were updated and focused on:

- building trust in reality, distinguishing things, phenomena and situations over which Mrs. K. has influence from those over which she does not, and learning to distinguish thoughts from emotions,
- learning the meaning of emotions and connecting them with body reactions,
- modification of maladaptive strategies for coping with emotions,
- symptoms of freezing, cutting off, experiencing traumatic events in the present, i.e., reacting "just like then and there."

Mrs. K. learned about the role of boundaries and how to set them. The therapy goals were dynamic and changed depending on Mrs. K's life contexts. This is consistent with the phenomenological approach: we start from "what is given" and follow the patient's lead. The role of the EA psychotherapist is to understand the current, holistic picture of the patient with a specific system of resources and deficits within 4FM and to ensure that the conceptualization is constantly updated with what the patient brings [7]. The main goal, which was often returned to, was the patient's gaining autonomy, reflecting, discovering and accepting herself, as well as strengthening positive internal dialogue as opposed to a critical monologue. In other words, the focus was on building a good, caring and understanding relationship between Mrs. K. and herself.

Working with 4FM – struggles during psychotherapy

The topic that came to the forefront was anxiety – working in the 1FM area. Mrs. K.'s experiences were dominated by fears of rejection, fears of embarrassment, but also fear as a state in which the whole body is tense, on alert: the patient reported that she had to be awake all the time. Of course, it was understandable from a developmental perspective – an unpredictable, aggressive father and a mother who perceived a threat at every turn and in every person, isolating the family according to the principle that 'we cannot talk about what happens at home'. There was also an uncontrolled flood of catastrophic thoughts. For Mrs. K., the very fact of coming to psychotherapy and talking about her experiences from her family home was an intense, destabilizing experience, filled with doubts. Gradually, the patient accepted the psychotherapist's feedback. She learned to name what was happening in her home and tried to understand what impact it had on her.

She made sure that she could feel what she felt and that what she felt was appropriate to the situation.

After addressing topics related to anxiety and Mrs. K. acquiring the skills to cope with it, the topic of 2FM, i.e., relationships and attitude towards life, emerged. Mrs. K. spoke about the need to control and manage relationships, presenting great rigidity in her beliefs that people need to be managed in such a way that they do not pose a threat to her. The issue of feeling safe, including physical safety, continued to arise – the apartment she occupied after moving out from her parents' home was not safe enough. She checked the door locks when she left the house, making sure they were locked, and while she was at work, she thought about it. She did not allow herself to maintain a balance in giving and receiving, assuming that she owed people something for wanting to have anything to do with her at all. She periodically reported a lack of energy and a high need for sleep.

Symptoms from the 2FM area appeared: depression and a feeling of exhaustion, while blaming herself for this condition. For Mrs. K. maintaining relationships was difficult. There were constant thoughts that she was doing something wrong. She was very meticulous in her relationship with the psychotherapist for the first few months. She wanted to describe as best as she could what she was experiencing, convinced that making a mistake was not an option, as it could threaten the continuity of the relationship.

In the 3FM area, Mrs. K. discovered that she had anger inside her. She learned that this emotion has specific functions. It was difficult for Mrs. K. to combine the functions of anger appearing in specific situations in her life. It was associated with the belief that setting boundaries would hurt others, which would mean that she was a bad person, and she did not want to be like that.

It should be noted that in the EA therapeutic process, the therapist also analyzes his own resources and blockages in the 4FM paradigm [7]. In the initial phase of Mrs. K.'s psychotherapy, the psychotherapist faced a blockade due to the patient's reluctance to undergo the recommended psychiatric consultation for initiating pharmacotherapy, which had been suggested alongside the intensification of symptoms of anxiety and depression, destabilizing her functioning. The patient's determination and persistence, as well as her rejection of the possibility of obtaining relatively quick help, were incomprehensible to the psychotherapist. What helped the psychotherapist to find ground was the agreement with Mrs. K. that she would monitor her symptoms and return to the topic of initiating pharmacotherapy if the symptoms became more severe, i.e., a multitude of catastrophic thoughts that were difficult to stop, difficulty falling asleep or waking up, deterioration of mood that would continue to be disturbing. Fear for the patient and feeling responsible for her ability to be (1FM) was a fear from the 3FM area of the psychotherapist: "will I be able to help", "if I am myself, as I am, am I a competent therapist". The key was to give up decision-making and recognize Mrs. K.'s (3FM) autonomy, which was proper and the subject of therapeutic work, combined with the observation of symptoms and the improvement that slowly occurred. Additionally, supervision and the fact that the supervisor works in a similar modality, in the spirit of respect, understanding and acceptance (3FM), provided invaluable support to the psychotherapist.

Within 4FM – cognitively and declaratively – Mrs. K. felt the strongest of all motivations. This is consistent with the specificity of this motivation, which does not refer to the person, but to existence. It assumes a distance in which a person experiencing dissociative states can find themselves – focus on work, learning, areas where they experience success, and from there build meaning and a plan for the future. The psychotherapist's 4FM was satisfied from the first meeting. The psychotherapist felt that accompanying the patient in this psychotherapy process made sense. The sense of meaning and importance of the relationship was also visible in the fact that Mrs. K. and the psychotherapist did not miss a single session together.

Results

Working with the 4FM paradigm – changes during psychotherapy

During the last session, Mrs. K. summarized her therapy process and her change, saying that what stuck with her the most was the psychotherapist's repeated statement: "you always have a choice" (4FM). The choice meant recognizing the right to make her own decisions in harmony with herself – for example, telling her father that if he shouted at her, she would end the conversation, or that she did not want to host her parents in her new place of residence, but could "meet them for coffee, in a public place". Mrs. K. experienced that having a choice means giving yourself the right to your emotions and needs, even if it does not suit everyone. "I have the right not to be in relationships, but also to be in them on my own terms," she said. Ultimately, according to the existential perspective, choice refers to how a person responds to a situation and what attitude he takes towards the situation he is in.

Even though anxiety recurred in the patient's experiences in many situations, she was able to cope with it in an understanding way – soothe the condition, understand why it appeared and connect it with the tension in her body (1FM and 2FM). Mrs. K. learned emotional self-regulation by conducting supportive internal dialogue. She acquired the skills of working with thoughts, being in the body and returning to herself (1FM – the ability to build distance from her thoughts, 3FM – knowing her own boundaries and feeling herself). She incorporated self-regulation exercises into her regular techniques for finding safety and grounding (1FM). Mrs. K. accepted reality, learned to regulate her emotions and have positive relationships, allowed herself to be herself and found meaning. She achieves her goals and takes on professional challenges. She successfully completed her studies and excelled as a group leader. She stopped waiting for life to perfectly match her expectations (1FM – ground, 4FM – meaning, broader context, 2FM – taking care of her own energy resources, giving herself the right to rest, accepting the dissatisfaction of others in relationships, experiencing the joy of water sports). Also within 2FM there was an understanding that if she does not feel, she cuts herself off, and perhaps she loses then important information about the situation and context.

The big change was the recognition that validated feelings do not have to be rational, in the sense that not everything needs to be rationalized. Recognizing that the dissatisfaction of others in relationships is acceptable, and that people do not automatically know what Mrs. K. feels, she has the right to communicate (3FM). As part of 3FM, Mrs. K. found it revealing to allow herself to feel anger, a suppressed and fearful emotion. She connected it with childhood and the topic of feeling like yourself and setting boundaries, which had not been possible before. In the past, she cognitively analyzed what she should say. Now, she recognizes emotions (2FM) and knows how to address them properly, which results in a feeling of connection (2FM) and the ability to decide and be herself (3FM).

Figure 2 shows the distribution of Mrs. K.'s acceptance of each FM at the beginning and end of therapy. It is important to note that despite the relatively smallest improvement in 1FM (anxiety and a sense of insecurity returned, which required Mrs. K.'s conscious work and self-regulation), the areas of 2FM, 3FM and 4FM were significantly expanded. The joy of life, savoring it, respect and appreciation for yourself, the ability to set boundaries, giving meaning to your life. This is consistent with what is expected from existential psychotherapy; symptoms do not block a person from living a full life [9].

Benefits of the case study

Case studies significantly contribute to "insight into the psychotherapy process" [10, p. 42]. This was also the idea behind this description: to present the way a psychotherapist works according to the EA modality and the 4FM paradigm. From the point of view of the psychotherapy process, it is important that anxiety symptoms did not completely disappear from Mrs. K's life. Anxiety still appeared in many situations. However, it stopped attracting her attention and did not stand in the way of living life to the fullest. EA indicates that the essence of anxiety often manifests itself in a deep feeling that one has not "really lived" [9]. The implication of this approach for psychotherapy is that its goal is not to reduce symptoms in itself, but to help the patient be himself in the situation in which he finds himself. In such a situation, a decrease in the severity of symptoms becomes a side effect [9]. In the case of relational trauma, repeated situations of violence or neglect make the individual helpless and terrified [11]. They lose confidence in the world and generate fear (1FM). When faced with trauma, a person experiences a pervasive loss of trust in himself, people and the world, and is unable to cognitively respond to the situation. During psychotherapy, Mrs. K. was able to gradually rebuild her ability to respond to reality, starting with recognizing her own right to respond to it in harmony with herself, respecting her conditions and those of others. This was helped by the rebuilt sense of agency and self-worth, and thus the experienced sense of security. Mrs. K. understood that this is not a permanent state, so in various destabilizing situations (difficult, surprising, crisis), anxiety may return, but it is no longer the enemy. In the words of Längle in the context of anxiety: "according to Freud: dreams are the royal road to the unconscious, in AE anxiety is the

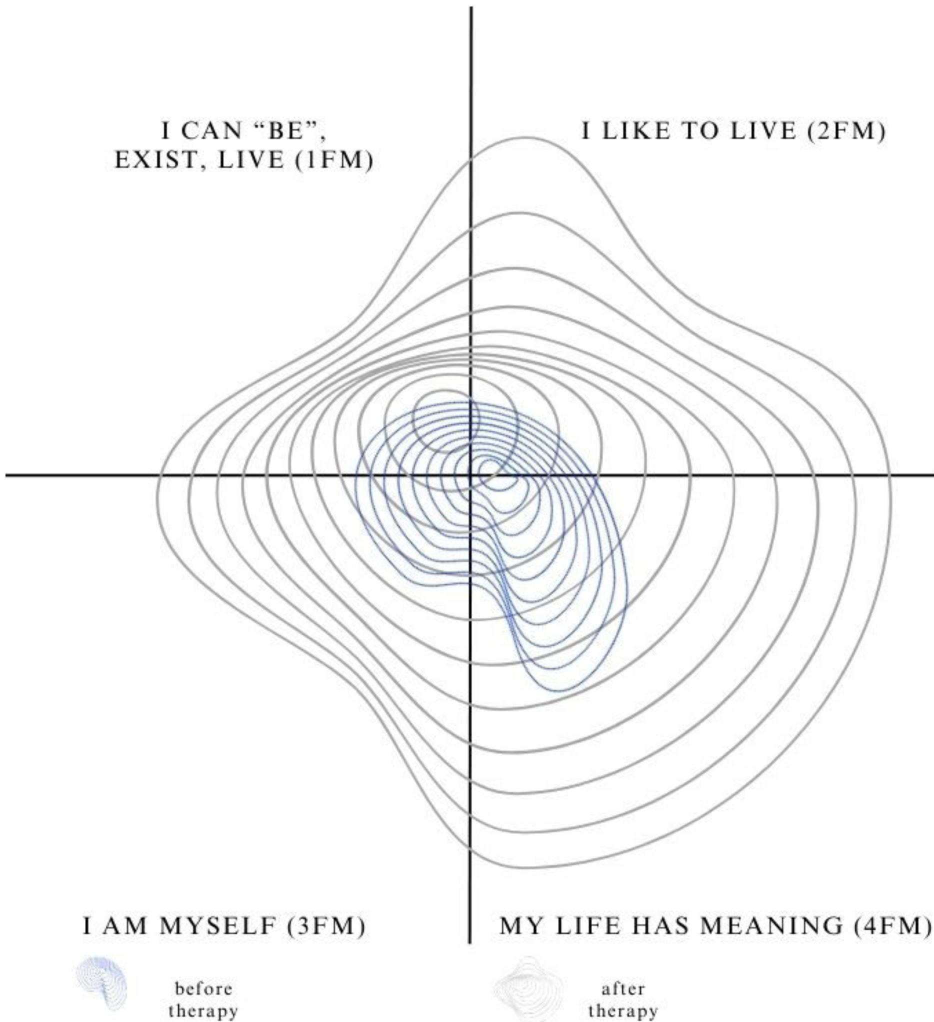

Figure 2. **Distribution for each FM of Mrs. K. at the beginning of therapy and at its end 4FM. Authors' own elaboration**

royal road to the depth of existence, to the essence of life" [12]. So, fear can point to what needs to be discovered and understood. In the described case, for Mrs. K., it was a journey back to childhood and the discovery that her mother's fear had likely accompanied her in fetal life, which she had no influence on. However, it has an impact on how she can take care of her space today, provide protection and support for herself, and create conditions to simply be here and live.

There are still few known case reports of EA psychotherapy in Poland – although training in this method has been possible for almost 18 years. This description of the exis-

tential analysis psychotherapy process is the third to appear in the journal Psychotherapia. The first was the text by Längle "Therapeutic conversation as a way of self-discovery" published in 2003 [6], which is a record of an excerpt of psychotherapy with a theoretical introduction. The second and first description of conducting EA psychotherapy in Polish conditions involves the psychotherapy of a patient addicted to psychoactive substances in a prison setting [13]. While in the case of Karaś's work [13], it is known that the effects of psychotherapy persisted over time (seven years after the end of psychotherapy, the patient maintained abstinence, got married and led a fulfilled professional and family life), in the case we described, it is only known that the effects persisted at the scheduled follow-up visit one month after completing psychotherapy.

Summary

The aim of psychotherapy according to EA is to equip the patient with tools related to building or strengthening relationships with oneself and the world, in internal dialogue, teaching and supporting acceptance of reality, giving meaning and purpose to life and recognizing one's biography [1-4]. The aim of the article was to present what the postulated [7] diagnostic and therapeutic model of EA in the treatment of relational trauma may look like in practice. Exploring topics related to 4FM – cognitively and experientially, both in the "here and now" and in work with biography, seems to be a well-suited treatment in the therapy of relational trauma. It enables the integration of experiences, causes the individual to regain their natural dispositions to be, act, feel and enter into relationships, remain in harmony with themselves and the outside world, as well as give purpose and meaning to their own lives.

References

1. Längle A. Analiza egzystencjalna — poszukiwanie zgody na życie. Psychoter. 2003; 2(125): 33–46.
2. von Kirchbach G. General introduction to logotherapy and existential analysis. Europ. Psychother. 2003; 4(1): 33–46.
3. Opoczyńska M. Psychologia egzystencjalna a podstawowe zagadnienia psychoterapii. In: Opoczyńska M, ed. Wprowadzenie do psychologii egzystencjalnej. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 1999. pp. 193–210.
4. Längle A. Von der sinnzentrierten Behandlung zur existenzanalytischen Psychotherapie. Markierungen zum Unterschied von Logotherapie nach Frankl und der modernen Existenzanalyse. Existenzanalyse 2022; 39(1): 73–78.
5. Längle S. Voraussetzungen zu erfülltem Sinnerleben. Elemente der existentiellen Haltung. Existenzanalyse 2000; 17(2): 28–32.
6. Längle A. Rozmowa terapeutyczna jako droga odkrywania samego siebie. Psychoter. 2003; 11(24): 41–54.

7. Nowakowska A, Draczyńska D, Anczewska M. Analiza egzystencjalna jako metoda pracy z pacjentami z doświadczeniem traumy relacyjnej. Psychoter. 2023; 3(206): 41–54.
8. Frankl VE. Człowiek w poszukiwaniu sensu. Warszawa: Czarna Owca; 2009.
9. Längle A. Existenzanalyse. In: Längle A, Holzhey-Kunz A, eds. Existenzanalyse und Daseinsanalyse. Wiedeń: Wydawnictwo UTB; 2008. pp. 29–180.
10. Janusz B, Czapkiewicz K, Wolska M, Bierzyński K, Müldner-Nieckowski Ł, Furgał M. Zasady konstrukcji klinicznego studium przypadku w psychoterapii. Psychoter. 2019; 191(4): 41–56.
11. Draczyńska D. Relational trauma. Psychiatr. Pol. 58(3): 529–539. https://doi. org/10.12740/PP/OnlineFirst/156722.
12. Längle A. Informacja ustna w trakcie seminarium szkoleniowego. Warszawa, 2011.
13. Karaś A. „Something empty has been filled" – individual psychotherapy of a patient addicted to psychoactive substances, conducted in the prison and based on the existential analysis paradigm. Psychoter. 2018; 184(1): 51–63.

E-mail address: ddraczynska@ipin.edu.pl