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VICTIMISATION – CAN BEING A VICTIM BE LEARNT? MALADAPTIVE SCHEMAS AS A WAY OF COPING WITH DIFFICULT EXPERIENCES

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Abstract. Victimization is the process of assuming the role of a victim. Even early criminological theories indicated how important an individual's personality can be in this process. In contemporary theories of the psychopathology, the causes of vulnerability to becoming a victim lie in maladaptive schemas, i.e. dysfunctional patterns of thinking, behaviour and experiencing emotions. Research indicates that, in particular, the area of disconnection / rejection that develops in early childhood in relationships with parents and / or peers promotes susceptibility to victimization. The article describes the cases of three patients who were diagnosed with the indicated patterns in the area of disconnection / rejection, as a result of experiencing direct violence in their childhood. Their examples show how the tendency to become a victim continues in adulthood. It seems important to recognize maladaptive schemas, also in the context of the victimization process. Proper work with the victims of crime can be the basis for environmental change, which will be important both for avoiding victimisation in the future, but also for stabilizing the negative behaviour of the perpetrators themselves.

Key words: maladaptive schemas; victimisation; security science; schema therapy; case study; victim, crime

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1. Introduction

Victimisation, or a process of assuming the identity of a victim, is a phenomenon that criminology has been dealing with for a long time. In search for victim characteristics, we quite often refer to socio-economic factors. This means, among other things, that people with fewer financial resources, and thus poor living conditions, less access to medical care, power, privileges, etc. are more likely to experience situations in which they become victims of crime (Burgess et al., 2010, Daigle, 2012, Niedobecka, 2014). Therefore, when we think in a colloquial sense about victims of crimes, especially those that take place in the public domain, i.e. assault in the street, we usually think that such situations, more often than not, affect people who are socially excluded or function on the margins of social life, or if we exclude these factors, we conclude that the probability of experiencing such situations is the same for most 'normal' passers-by. However, empirical research shows that such events do not affect individuals in the same way. There are individuals who are more predisposed to experience such events, and these analyses indicate that victims of such crimes are not at all distinguished by visible, external characteristics, yet they are more likely to experience similar negative situations (Bonomi, et al., 2006, Kunst and Van Wilsem, 2013, Mirska, 2009)

2. Criminal victimology

Criminal victimology addressed the personality traits of individuals that predispose them to be victims as early as in the 1950s. According to the concept developed by Von Hentig and continued by Ellenberger (Hołys, 1997), which had a reference to homicide cases, one might distinguish three types of victims:

- depressive type: people in a state of low mood signal weakness, inability to defend themselves and passivity with their attitude and behaviour. In addition, the state of low mood most often appears in people who experience loneliness, social isolation, and therefore are less likely to receive support and help;
-greedy type: individuals who are greedy and seek financial gain regardless of the situation, they are keen to accumulate material goods regardless of moral and ethical principles; due to their behaviour they often become victims of people who are similar to them in their behaviour;
-bully: individuals who like to have an advantage and power over other people. They often use their advantage and bully others. They are aggressive, and their behaviour often provokes aggression towards them and fosters their own victimisation.

In developing this typology, Ellenberger defined victims of crime by referring to their personality as:

- masochistic tendencies: people who seek sensations that allow them to experience suffering. When entering such situations, they often fail to notice the potential danger;
- 'Abel syndrome': in line with the reference to a biblical figure, these are individuals who tend to bully and show aggression towards family members or people with whom they are emotionally involved;
- apathetic tendencies: people with such traits are withdrawn, discouraged with life, and thus present themselves to their environment as weak individuals who lack the will to defend themselves, showing that the harm inflicted on them is not associated with greater consequences.

These and other theories about victims of crime have been developed in criminology to explain why certain individuals are more predisposed to experience crime. Their propensity reveals itself despite having socio-economic conditions similar to the people in their immediate surroundings. Some of the very first of these theories sought reasons for becoming a victim of crime in individual personality traits. They showed that certain characteristics and ways in which victims function are conducive to behaviour that favours or provokes negative environment reactions towards them. They indicate that some actions against another person result from passive attitudes and withdrawal of the victim, while for others it is their active behaviour that puts them at risk of being a victim.

3. Schema therapy theory and being a victim

Young's schema therapy theory points out that manifestations of the tendency to be a victim appear as early as during childhood. This may be related to the fact that a child functions in different environments - both in relationships with parents, siblings and peers. However, it absolutely applies to a situation when a child experiences violence from his/her environment and, due to his/her age and abilities, is not able to cope with the situation on his/her own or defend himself/herself. The experience of victimisation may threaten the sense of security and foster the formation of maladaptive emotional schemas (Hankin et al., 2013).

Maladaptive emotional schemas are defined in schema therapy as broad, pervasive and dysfunctional patterns that involve thoughts, feelings, behaviours, memories, bodily sensations and the way we relate to others, which are conducive to the emergence of negative experiences in the individual on an ongoing basis. They act as a trigger that activates intense and unpleasant feelings, particularly anger, sadness and anxiety (Young and Klosko, 1994, Young et al., 2003, Zeigler-Hill et al., 2011). The authors of the model proposed to identify five broader categories of these schemas (areas), which link unmet needs into larger groups. These are: disconnection and rejection, impaired autonomy and lack of achievements, damaged boundaries, other-directedness, and excessive vigilance and inhibition (McKay et al., 2018, Martin and Young, 2010, Arntz and Jacob, 2013).

Previous research shows that disconnection and rejection is an area that is particularly often identified in victims of violence. This is formed in the family (Gay et al., 2013) or school environment (Calvete et al., 2015) which is emotionally stunted, cold, unpredictable, rejecting, creating loneliness, bad tempered or abusive. An individual who has developed these patterns feels that their needs to experience security, stability, support, care, empathy, understanding feelings and respect will not be met (Young et al. 2003, Martin and Young, 2010).

Maladaptive schemas emerge during childhood on the basis of the child's temperament, as the best form of adaptation for the child (with certain characteristics) to the conditions in which he/she is functioning. In spite of the fact that in adulthood the schemas are often no longer appropriate, making it difficult to satisfy the needs, in the absence of other, more appropriate ways or patterns of reaction, the individual continues with the previously learned reactions. This way of acting is supported by the human tendency to maintain consistency (Young et al., 2003). It allows the individual to avoid the anxiety associated with new situations or putting themselves to the test.

In trying to understand a person's behavioural picture, it is important to consider that most patients use a combination of schemas and coping styles. While schemas remain rather fixed, coping styles are used in different ways depending on the context, situation and environment (Martin & Young, 2010). Observation of patients during clinical work and while accompanying them in the process of change shows that coping styles of emotionally disturbed people tend to take extreme forms in response to different circumstances. The authors of schema theory indicate that there are three basic coping styles: surrender, avoidance and overcompensation. When an individual surrenders, it means that they accept the schema and what it entails. They do not try to avoid or fight the schema, but accept all the emotional consequences of the schema. Referring here to the phenomenon of victimisation one may indicate an adolescent with a rejection schema who, either in their family or peer reactions (often both these environments act simultaneously in a similar way), have learned that they cannot count on support or acceptance. As the schema continues, they start to project negative attribution onto their peers, so that even in neutral situations they react with excessive tension and aggression (Calvete and Orue, 2012). Signals sent in this way are easily interpreted by those around them as hostile and aggressive, and a negative opinion of such an adolescent easily becomes a reason for their subsequent rejection. Such behaviours and reactions often occur in boys diagnosed with ADHD (Philipsen et al., 2017). The avoidance of the rejection schema, on the other hand, will involve the incorporation of cognitive, behavioural and emotional responses designed to result in the avoidance of schema activation. An adolescent that uses this style of coping will seek to avoid closer relationships and contact with peers, as a consequence of which they themselves may feel that they do not have people close to them around, or peers will find them unpleasant and will not want to have them as friends. Last but not least, the style of coping that consists in overcompensation refers to behaviours, thoughts and reactions which are aimed at hiding one's own deficits or weaknesses from the surroundings. It is often aggressive and may manifest itself in various forms, i.e. behaviours of an intellectual, emotional, verbal or physical nature. The underlying belief that often underpins such reactions is "own them before they do it to you" (Young et al., 2003). Adolescents with such schemas in their peer environment will often present themselves as smarter and will ridicule other children, or will use physical superiority over their peers. Such attitudes may, however, in the long term, arouse resentment and aggression from those around them, and thus promote secondary victimisation. This is consistent with the criminology theories cited above, but also with research data (Dodge et al, 1990, Schwartz et al, 1998, Yang, Salmivalli, 2015). At the same time it has been shown that individuals who are only aggressive and do not enter the role of victim are better adapted in terms of psychosocial characteristics than individuals who experience both these roles simultaneously (Schwartz, 2000, Schwartz, Proctor, Chien, 2001).

The aim of the research is to contribute to the current literature that relates to the search for factors which facilitate the occurrence of crime. The analysis made use of the theory of maladaptive emotional schemas (Young, et al. 2003), which in this case focuses on the search for the causes of victimising behaviour. Previous research shows that in this group of individuals, schemas from the area of disconnection and rejection are most commonly identified (Calvete, et al., 2015, Gay et al., 2013). Three cases of female patients undertaking therapy based on Young's schema theory will be described. They will focus primarily on the analysis of emotional

schemas using the Polish adaptation of the YSQ-S3 tool. Descriptions will be made of how patients behave, think and experience emotions that may be related to the experience of being a victim.

4. Research procedure

Young's early maladaptive schemas questionnaire YSQ-S3 in a shortened version was used to examine the intensity of maladaptive emotional schemas. The Polish translation was done by Justyna Oettingen. The questionnaire consists of 90 statements. The person examined refers to each of them on a six-point scale where 1 stands for 'completely untrue about me' and 6 means 'describes me perfectly'. On the basis of the questionnaire, 18 maladaptive emotional schemas are diagnosed, which are grouped into five areas. These include disconnection and rejection (abandonment/instability, emotional deprivation, mistrust/abuse, defectiveness/shame, social isolation), impaired autonomy and performance (dependence/incompetence, vulnerability to harm or illness, emotional enmeshment, underdeveloped self, failure), impaired limits (entitlement/grandiosity, insufficient self-control and self-discipline), other-directedness (subjugation, self-sacrifice, recognition-seeking and approval-seeking), and overvigilance and inhibition (negativity/pessimism, emotional inhibition, unrelenting standards, hypercriticalness, punitiveness). According to the data, reliability analysis by Cronbach's alpha for the test shows varying internal consistency of the subscales from 0.62 to 0.94 (Staniaszek, Popiel, 2017, Oettingen et al., 2018)

The descriptions of the three cases were selected from a group of 115 people – patients that report for therapy on their own (they were not referred by a doctor or institution) – aged 21-60 years. The exclusion criteria were symptoms of psychotic disorders of antisocial personality, manic-depressive disorder and addictions. Prior to treatment, the patients were tested using the Minnesota Multiphasic Personality Inventory MMPI-2. They had not previously undergone therapeutic interventions and had not taken mood-altering drugs during psychotherapy. They established normal contact, were able to actively participate in interactions based on a cognitive-behavioural orientation in the structure of schema therapy (according to the tenets of Young's therapy) (Young, 1996). The patients participated in the interactions for one year (they attended 40 psychotherapeutic sessions and 15 booster sessions – in the following year). The therapist was trained in cognitive-behavioural and schema therapy.

5. Case studies

Referring to the above theory, I wanted to present the cases of three adult female patients who exhibit victimization traits and whose functioning is associated with the development of maladaptive behavioural patterns. All the patients are adults. In order to change the maladaptive schema, techniques of the schema therapy were used while working with them:

Olga, 25 years old, a student. She came to the therapy because of an eating disorder. During the intervention, she was also diagnosed with social anxiety and avoidant personality traits. According to the patient, her first experience of being a victim occurred in her pre-school years. As an overweight child she was ridiculed by her peers in kindergarten. She did not feel that she received support from adults and quickly learned to withdraw from social interactions. Another experience of abuse as a child came in primary school, when she became a victim of violence from her classmates - verbal abuse, but also physical attacks. According to the patient, she has never experienced physical violence in her family environment, but her mother noticeably used emotional blackmail on her (she often vented her own anger and frustration on her). As the youngest child, she did not react to her mother's behaviour and took on the emotional consequences of this relationship. The patient's grandmother also played an important role in shaping her schemas, by making frequent references to Olga's appearance and thus humiliating her.

On the basis of the YSQ-S questionnaire, the patient was diagnosed with maladaptive schemas of abandonment/relationship instability (the strongest) and excessive demands/excessive criticism, self-sacrifice. The primary coping styles observed in the patient were those of avoidance and submission. In order not to be nega-

tively evaluated and rejected, she easily experiences feelings of being overloaded, overwhelmed, and unable to cope. At such moments, she withdraws from a given situation (she skipped exams, did not meet with friends). At other times, when exposed to relationships with other people, she often submits to them by often ridiculing difficulties, keeping a low profile, speaking in a quiet voice.

A few years ago, during her high school years, while being at a party with her friends, she found herself in a situation she describes as rape. The patient does not remember the exact circumstances - she even suspects that she might have been given some pills, but in the morning she woke up next to her male- and female- friend on the bed. Being sober she would never have allowed such a situation to take place. Despite the fact that the patient does not remember the circumstances of the incident, there is no evidence that her private sphere was violated, she interprets it as abuse and therefore experiences emotions similar to those of a trauma. Again in her experience she has the feeling of being a victim. From the therapist's point of view, this situation is difficult to define and categorise. It is impossible to determine whether the patient has actually experienced a form of violence or not, but there are certainly emotions and behaviours associated with experiencing trauma and the reappearance of a sense of powerlessness and exploitation.

Halina, 38, clerk. The patient came for a therapy with symptoms of agoraphobia. She was pharmacologically supported and was on sick leave due to being unable to get to work on her own. During her childhood, the patient had good relationships with her peers, although her circle of friends was limited due to family relationships and difficulties inviting friends home. The patient's mother was verbally aggressive towards her, often belittled her, neglected her needs, and showed negativity to her suggestions, without thinking about the consequences of such treatment. Moreover, the woman used manipulation towards the patient's brother, which caused the boy to engage in physical aggression towards Halina. In such situations the mother assisted her son or verbally encouraged the patient's brother to continue such behaviour. Due to her age and position in the family, Hania was not able to defend herself. Her father did not react to such behaviour of his wife and son. His position in the family was weak. The patient's mother belittled him and was not interested in his opinion.

The YSQ-S questionnaire identified the emotional deprivation schema to be the strongest in the patient, the other two being self-sacrifice and subordination schemas. The patient uses each of the three basic coping styles considered in the theory, namely surrender, avoidance and overcompensation, as her basic coping styles at different times. Halina is able to stay within the schema with people close to her for a long time, maintaining the schemas while experiencing negative emotions from this. When the emotions accumulated in this way start to overwhelm her, she develops overcompensation which is associated with strong tension, as well as aggression directed at the people around her. Avoidance is the last of the coping styles that she uses, and it appears both in the form of anxiety reactions and avoidant behaviour, as well as in the tendency to isolate from challenges and people.

Halina was married to a man with dominant traits who had manipulative and aggressive tendencies. Initially, as she describes, their relationship was good, she felt respected and treated well. In retrospect, she notes that right from the beginning she took on a lot of responsibilities and took her husband's critical remarks too personally. She admits that she tried to change her behaviour and adapt, but her husband did not appreciate her efforts and constantly demanded more. Over time, his comments became demeaning and punitive, and she began to feel worse. Her descriptions imply that the husband used psychological violence towards her. Over time Halina became afraid of her husband and at the same time she withdrew from social interaction, as she did not feel worthwhile enough. She felt increasingly worse, and started to develop anxiety. After some time she decided to leave her husband and eventually the spouses divorced. However, the patient still feels she was hurt. Now during her therapy, she demonstrates strong tension and aggression in her personal interactions with people, because, as she points out, 'she will not allow to be treated in a negative way anymore'. She perceives the world and above all people as threatening. At the same time she still has symptoms of anxiety disorder.

Karolina, age 42, freelancer. The patient came to therapy due to low mood and eating disorders (compulsive overeating). The primary stimulus to take up a therapy was a significant, in her opinion, weight gain. Her de-

scriptions imply that she was brought up in an intellectual family background. Both father and mother were employed. Her description of her parents implies that they are both individuals who have difficulty with showing emotions. The father does not recognise emotional states and avoids any confrontation with them. He interprets the experienced internal states as anger and transfers it to the people around. The mother is constantly experiencing emotional tension, which she herself fails to notice, therefore she engages in compulsive activities; in her behaviour one can often notice a tense and raised voice, excessive vocalisation and self-centeredness. The patient's descriptions imply that she has features of neurosis. Her parents were physically abusive towards her, especially her father, who used corporeal punishment using both his hand and his belt. Similar behaviour on their part continued into early adulthood, until the patient met her present husband. Karolina admits that it was not uncommon for her to have marks on her body. According to her descriptions, her mother and father mutually reinforced each other in their violent behaviour and she had no one to protect her. The patient had no difficulties in her relationship with her peers.

After Karolina had completed the YSQ-S questionnaire, she was diagnosed with elevated scores in several schemas. The highest of these were vulnerability to being hurt, emotional deprivation, negativism and pessimism. The patient uses surrender and overcompensation as her primary coping styles. When confronted with the demands and expectations from those around her, the patient adapts and meets the expectations of the other person. She does not think about her own needs at a given moment. She is also overly kind in such situations and her behaviour indicates that there is nothing wrong with given circumstances. In this way other people learn that in a relationship with Karolina they can satisfy their own needs without much contribution on their part. Over time, these situations and the inability to meet their own needs cause the patient to become increasingly frustrated and angry. Such moments cause her to display overcompensating behaviour - raised voice, flooding the people around her with emotions, making decisions that do not take other people into account, or rejection.

A few years ago Karolina started working for a corporation. Initially she felt very good in it – she was engaged in her duties. According to her, she felt comfortable with her colleagues and initially had a good relationship with her supervisor. But as she continued working for this company, she noticed over time that she was given more tasks to do compared with her colleagues in the same position. She says that this made her very nervous, so she decided to talk to her supervisor and explain the situation. This conversation did not go as she would have expected. The supervisor did not accept her arguments and started to list the mistakes she had made. The situation escalated over time. According to her, she continued to receive a large number of tasks, perhaps even more than before. She also began to feel that her supervisor mistreated her – he belittled her work, cut off her bonuses, avoided talking to her and did not share all information, which caused her to develop feelings of guilt and helplessness. The patient's description implies that she was harassed in the workplace. The patient remained at work under these conditions for some time, but eventually decided to quit.

Conclusion

As shown by the studies cited at the beginning of the paper, but also by the author's own observations and analyses in his work with individual patients - the situations of being a victim of aggressive behaviour by peers or parents experienced during childhood result in the formation of feelings, behaviours and cognitive components of behaviour which are characteristic of maladaptive emotional schemas, above all the rejection schema (Calvete et al., 2017). These schemas cause individuals to continue a particular way of functioning in their environment in adulthood, which causes them to continue to experience distress in their interactions with their environment, experience negative consequences of their own actions, and they are more predisposed to re-experience victimisation. This repetition of patterns of action and re-exposure to negative experiences is a mechanism for deepening psychopathology and exacerbating mental health, which is perceived as a feeling of helplessness (Hankin et al. 2013, Stevens and Roedger, 2019).

Due to the possibilities of shaping and changing behaviour, emotional reactions and ways of thinking with the use of psychotherapy, especially schema therapy, it seems particularly important to deepen the knowledge

of how an individual creates and then reactivates maladaptive schemas. For if the victim of a crime does not change his or her own way of behaving and thinking, this increases the likelihood that the chain of events in the perpetrator-victim relationship will be re-activated. This does not justify the wrong attitudes and actions of the person doing the wrongful or unlawful act, but it provides the ground for activating his/her maladaptive ways of thinking and reacting. By enhancing the victim's social skills, we can make the environment to which the perpetrator returns more stable and having flexible boundaries, and thus reduce the likelihood of his negative actions. At the same time, working on maladaptive schemas can enable a person who has become a victim of crime to gain self-confidence, the ability to take care of themselves and to respond appropriately to their environment. It can therefore become part of the environmental influence on the perpetrator.

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