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Mental Health of Educators: A Pilot Study on Personality and Physical Activity as Correlates of Teachers' Occupational Burnout

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Abstract

The study explores burnout among 73 school teachers, examining associations with personality, physical activity, and differences based on age, gender, and specialization. Utilizing the NEO-FFI Personality Inventory, Maslach Burnout Inventory, and International Physical Activity Questionnaire, it revealed significant correlations between personality traits (excluding openness) and all burnout dimensions. Notably, younger teachers exhibited higher depersonalization levels than their older counterparts. Given teachers' pivotal role in student development, researching occupational burnout is crucial – especially in the post-pandemic era. Understanding these dynamics is essential for fostering a healthy educational environment and ensuring overall student well-being.

Keywords: teachers, occupational burnout, physical education, personality, physical activity

Introduction

The concept of stress and occupational burnout has been addressed in the psychology literature for many years. Though metaphorical, the term "burnout" accurately captures the experience of an individual whose strength and power are exhausted due to highly stressful conditions in the workplace. Freudenberger and Richelson (1980) proposed the idea that this phenomenon develops gradually under the influence of chronic stress, which depletes energy reserves, induces negative thinking, limits motivation, and alters

behavior. Importantly, burnout more frequently affects individuals who are professionally engaged in helping others. Moreover, a person affected by burnout not only sees no prospects for further development, but also lacks satisfaction from work and even joy in everyday life (Schaufeli & Buunk, 2002). Currently, the dominant concept of burnout is the three-dimensional model created by Maslach and Jackson (1986). According to them, burnout should be defined as a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment, which may occur in individuals working with others in a specific way. According to Sęk (2001), occupational burnout is a complex set of relationships influenced not only by factors within the individual, but also by the surrounding environment.

Nevertheless, certain personality aspects can play a protective role, while others can make an individual more susceptible to burnout. Jędryszek-Geisler and Izdebski's (2018) research on Polish elementary- and secondary-school teachers showed negative correlations between emotional exhaustion and openness to experience and extraversion, agreeableness, and the burnout dimension of depersonalization. The research also revealed a positive correlation between extraversion and conscientiousness and the dimension of personal achievement. It found that extraversion and openness to experience are predictors: the former of depersonalization and personal achievement and the latter of exhaustion and personal achievement. Additionally, the intensity of neuroticism along with openness to experience explained the degree of emotional exhaustion. Furthermore, conscientiousness turned out to be a predictor of high personal achievement. Similar dependencies were found in studies on elementary school teachers in Cyprus. Neuroticism proved to be a significant predictor of all burnout dimensions. It was also found that dealing with students' inappropriate behavior and time constraints had a protective value against burnout (Kokkinos, 2007). Other studies also report that teachers exhibited elevated levels of stress and burnout in comparison to their counterparts in various human services and other occupations (Johnson et al., 2005) and that when juxtaposed with other professional cohorts, educators displayed heightened levels of both exhaustion and cynicism, key dimensions of burnout syndrome (Maslach et al., 2001).

Teaching is recognized as a challenging profession; inherent psychosocial risks and the educational environment are emerging as primary contributors to work-related accidents or illnesses. The International Labour Organization (ILO) highlights the growing prevalence of chronic stress, anxiety, exhaustion, and depression in this field. The prevalence of overall burnout among physical education teachers is notably higher when compared to teachers of other school subjects, which could be due to various factors: the curriculum, a lack of adequate facilities and equipment, low status of physical education teachers, and students' behavior and discipline problems (Alsalhe et al., 2021; González-Valero et al., 2019; Puertas-Molero et al., 2018).

The aforementioned burnout syndrome is characterized as a prolonged state of stress and a psychosocial indicator that directly impacts mental health and physical well--being (Melguizo-Ibáñez et al., 2020; Metlaine et al., 2017). Nevertheless, educators must exhibit resilience to navigate these challenges and effectively cope with adversity within contemporary education systems (Ellison & Woods, 2019). A factor that can undoubtedly influence emotion regulation and foster resilience is physical activity (Barquero, 2015). The World Health Organization (WHO, 2022), in its global recommendations on physical activity for health, asserts that adults (18–64 years) practicing a minimum of 150 minutes per week of moderate or 75 minutes of vigorous aerobic physical activity witness improved muscle and cardiorespiratory function, along with a reduced risk of non-communicable diseases and mental health issues. Failing to adhere to these recommendations and maintaining a sedentary lifestyle negatively impact health and contribute to the development of psychological illnesses such as depression, anxiety, and stress (Callow et al., 2020; Raza et al., 2020). A significant amount of research indicates that physical activity is one of the main factors positively affecting the psychological well-being of teachers, regardless of their age or the subject they teach (Corbett et al., 2022; Troy et al., 2022). Kowalczyk and Kostorz (2017) point out in their literature review that physically active teachers, especially women and physical education teachers, have low scores in individual dimensions of burnout such as emotional exhaustion, personal accomplishment, and cynicism. Among female teachers who exercise regularly, the level of burnout on individual scales was lower than that in teachers declaring no physical activity. However, no significant differences were observed in the level of life satisfaction between these groups. The results lead to the conclusion that physical activity can have a beneficial impact on mental states, reducing the effects of perceived work stress. Exercise may indirectly prevent the occurrence of undesirable emotions and the consequences of emotional exhaustion, thus reducing the intensity of occupational burnout.

Taking into account the above considerations, the aim of this article is to describe the phenomenon of occupational burnout among physical education teachers and teachers of other subjects. The research goal is to characterize differences in occupational burnout, personality, and physical activity levels between physical education teachers and other teachers, considering age and gender, and to measure the relationships between individual dimensions of occupational burnout (depersonalization, emotional exhaustion, and personal accomplishment), personality traits, and the level of physical activity in the study group.

Material and Methods

Study Design

In this study, an online survey served as the primary research method for investigating teachers' well-being and associated factors. The survey encompassed four essential components: general and demographic information, a burnout questionnaire, a personality questionnaire, and a physical activity inventory. The study design involved distributing the survey to a diverse sample of teachers, who participated by completing the aforementioned questionnaires and inventory through an online platform. Before doing so, the teachers signed an informed consent form. The burnout questionnaire gauged the prevalence and intensity of burnout symptoms, providing insight into the psychological well-being of the participants. The personality questionnaire aimed to explore individual traits and characteristics that might influence one's susceptibility to burnout. Lastly, the physical activity inventory captured data on the participants' engagement in physical activity, allowing for an examination of the potential relationship between physical activity level and burnout.

The study was conducted between March and June 2019 among school teachers from Pomeranian Voivodeship.

Participants

A total of 73 individuals (N=73) participated in the study, including 42 elementary-school teachers (57.53%), 16 secondary-school teachers (21.92%), and 15 teachers working in both types of schools (21.55%). The majority of the surveyed teachers (n=47) were employed in public schools (64.38%), while 12 worked in private schools (16.44%) and 14 worked in both types of schools (19.18%). For the purpose of analysis, the teachers were grouped according to the subjects they teach, distinguishing between physical education (PE) teachers (n=34; 46.58%) and teachers of other subjects (mathematics, Polish, natural sciences, biology, physics, chemistry, music, and art; n=39 [53.42%]). Among the respondents (aged 18–64), there were 58 women (79.45%) and 15 men (20.55%). The above data is presented in Table 1.

Table 1. Descriptive statistics

N=73		
	n	**%**
Age (years)		
18–25	4	5.48%
26–35	17	23.29%

N=73		
	n	%
36–64	52	71.23%
Gender		
Women	58	79.45%
Men	15	20.55%
City		
Village	18	24.66%
City with 20,000–100,000 inhabitants	20	27.40%
City with 100,000–500,000 inhabitants	15	20.55%
City with 500,000+ inhabitants	18	24.66%
Mixed	2	2.73%
Subject		
Physical education	34	46.58%
Others	39	53.42%
Level of school		
Elementary	42	57.53%
Secondary	16	21.92%
Elementary and secondary	15	21.55%
Type of school		
Private	12	16.44%
Public	47	64.38%
Private and public	14	19.18%

Secondary school – high school or technical college

The mean, minimum, and maximum values of the parameters measured for the entire group are presented in Table 2. The mean values of the parameters from the NEO-FFI inventory for the entire group of teachers were as follows: 22.97 (SD=5.98) for neuroticism, 32.10 (SD=4.19) for extraversion, 22.60 (SD=4.29) for openness, 26.03 (SD=5.10) for agreeableness, and 29.96 (SD=3.77) for conscientiousness. The mean values for the burnout scales were 27.64 (SD=12.59) for emotional exhaustion, 27.38 (SD=6.53) for the professional efficacy scale, and 7.70 (SD=5.58) for the depersonalization scale. The average value of physical activity (IPAQ total) expressed in min/week (METs) for the group was 5,655.33 (SD=6,311.66), with a minimum value of 0 and a maximum value of 35,031 METs.

Table 2. Mean, minimum, and maximum values for the study group

	N=73		
	M±SD	**Min.**	**Max.**
Neuroticism	22.97±5.98	6	36
Extraversion	32.10±4.19	20	42
Openness	22.60±4.29	13	35
Agreeableness	26.03±5.10	14	41
Conscientiousness	29.96±3.77	19	39
Emotional exhaustion	27.64±12.59	0	54
Personal accomplishment	27.38±6.53	10	41
Depersonalization	7.70±5.58	0	27
IPAQ total [METs]	5,655.33±6,311.66	0	35,031.00

Research Tools

NEO-FFI Questionnaire (Neuroticism-Extraversion-Openness Five Factor Inventory)

This questionnaire assesses personality traits according to the Big Five model. It was developed by Costa and McCrae (1992); the Polish adaptation and translation were done by Zawadzki et al. (2005). The questionnaire measures five traits: *neuroticism* – a tendency to worry, experience anxiety, and anticipate failure; *extraversion* – characterized by rational action and being active, energetic, sociable, and optimistic; *openness to experience* – a positive evaluation of life experiences, curiosity, and openness to novelty; *agreeableness* – trust, cooperation, and willingness to help; and *conscientiousness* – perseverance, reliability, and dutifulness in working toward goals. Each trait is assessed by 12 questions, totaling 60 statements. Participants rate each statement on a five-point scale, where "0" means "strongly disagree" and "4" means "strongly agree." The reliability of the NEO-FFI Personality Inventory was estimated using Cronbach's α, a coefficient for internal consistency.

Maslach Burnout Inventory (MBI)

This questionnaire, developed by Maslach (1993), measures burnout in the workplace. The Polish adaptation and translation were carried out by Chirkowska-Smolak and Kleka (2011). The questionnaire consists of 22 questions rated on a seven-point Likert scale, with "0" meaning "never" and "6" meaning "daily." It comprises three subscales with reverse scaling: Emotional Exhaustion (nine questions), Depersonalization (five

questions), and Personal Accomplishment (eight questions). The Cronbach's α for the subscales were 0.91, 0.67, and 0.81, respectively.

International Physical Activity Questionnaire (IPAQ)

The short version of the questionnaire was used. It includes seven questions related to physical activities in daily life, work, and leisure (Craig et al., 2003). Participants provide responses in days/week, hours/day, or minutes/day. The Cronbach's α was 0.48.

Ethical Issues

This research was performed according to the principles of the WMA Declaration of Helsinki and with the approval of the Bioethics Commission at the District Medical Chamber in Gdańsk (project no. KB-13/17).

Data Analysis

Descriptive statistical analysis was conducted using Microsoft Excel 365. Correlation analysis and tests for independent variables were performed using Statistica version 13.

Results

Associations between occupational burnout, personality traits, physical activity, and professional seniority

The correlation analysis between personality traits, burnout dimensions, physical activity, and seniority (Table 3) revealed several statistically significant relationships ($p<0.05$). Neuroticism intensified symptoms of emotional exhaustion (0.457) while it lowered the sense of professional efficacy (-0.511). Extraversion positively correlated with the sense of personal accomplishment (0.420) and reduced symptoms of emotional exhaustion (-0.240). Agreeableness intensified symptoms of depersonalization (0.484). The last of the NEO-FFI traits, conscientiousness, slightly intensified symptoms of depersonalization (0.235) and increased the sense of personal accomplishment (0.350).

Table 3. Correlation between personality traits, burnout dimensions, physical activity, and professional seniority

Variable	O	C	E	A	N
EE	0.116	0.088	-0.240*	0.068	0.457*
PA	0.108	0.350*	0.420*	-0.070	-0.511*
D	0.156	0.235*	0.007	0.484*	0.337
IPAQ	-0.062	0.082	0.057	0.016	-0.065
S	-0.068	0.011	0.147	-0.125	-0.059

*p<0.05; *NEO-FFI Scales: N – Neuroticism; E – Extraversion; O – Openness; A – Agreeableness; C – Conscientiousness; MBI Scales: EE – Emotional Exhaustion; PA – Personal Accomplishment; D – Depersonalization; IPAQ – total score; S – Seniority*

Differences in occupational burnout, personality traits, and level of physical activity according to gender, age, and specialization

A between-group analysis was conducted, as shown in Table 4. There were no significant differences between the women and men. However, several statistically significant differences were identified. There was a significant difference between teachers of physical education (PE) and teachers of other subjects on the scale of Emotional Exhaustion. The PE teachers exhibited a lower level of emotional exhaustion (M=23.21; SD=10.35) than the teachers of other subjects (M=31.51; SD=13.21). Other statistically significant differences were found when comparing teachers in different age groups. A statistically significant difference was observed for the scale of Professional Achievement between teachers in the age ranges of 18–25 versus 26–35 and of 18–25 versus 36–64. Teachers in the youngest age group showed higher scores in Professional Achievement (M=35.00; SD=7.12) than teachers in the 26–35 (M=26.94; SD=5.38) or 36–64 (M=26.94; SD=1.17) age groups. On the other hand, teachers in the middle age range exhibited a higher level on the Depersonalization scale (M=20.24; SD=6.46) than individuals in the oldest age group (M=7.10; SD=1.37).

Table 4. Group differences in personality traits, burnout dimensions, and physical activity

		Neuroticism		Extraversion		Openness		Agree-ableness		Conscien-tiousness		Emotional Exhaustion		Personal Accom-plishment		Deperson-alization		IPAQ Total Score [METs]	
	n	M±SD	p	M±SD	p	M±SD	p	M±SD	p	M±SD	p	M±SD	p	M±SD	p	M±SD	p	M±SD	p
GENDER																			
Women	58	23.16±5.71	0.611	31.95±4.19	0.558	22.43±4.01	0.505	25.72±4.85	0.321	29.72±3.54	0.299	27.67±12.07	0.970	27.05±6.50	0.397	7.52±5.15	0.588	5438.93±6706.86	0.568
Men	15	22.27±7.11		31.67±4.30		23.27±5.35		27.20±5.99		30.87±4.57		27.53±14.93		28.67±6.71		8.40±7.18		6492.07±4559.75	
SUBJECT																			
Physical Education	34	23.35±5.59	0.615	32.41±4.06	0.551	22.56±4.30	0.936	26.21±5.22	0.782	29.94±3.57	0.970	23.21±10.35	0.004*	28.09±6.06	0.393	7.68±4.94	0.185	6708.99±6903.06	0.185
Others	39	22.64±6.35		31.82±4.33		22.64±4.34		25.87±5.05		29.97±3.98		31.51±13.21		26.77±6.94		7.72±6.15		4736.74±5677.96	
AGE																			
18–25	4	20.50±5.20	0.402	33.00±4.24	0.729	21.25±2.63	0.428	24.50±3.11	0.351	30.75±0.96	0.734	20.25±18.84	0.552	35.00±7.12	0.020*	4.75±5.91	0.138	3693.88±3437.11	0.506
26–35	17	23.29±5.98		33.29±3.98		23.00±4.08		27.35±5.69		29.94±4.59		24.47±10.95		26.94±5.38		10.24±6.46		5315.74±4451.80	
18–25	4	20.50±5.20	0.418	33.00±4.24	0.538	21.25±2.63	0.564	24.50±3.11	0.637	30.75±0.96	0.648	20.25±18.84	0.184	35.00±7.12	0.023*	4.75±5.91	0.380	3693.88±3437.11	0.534
36–64	52	23.06±6.09		31.64±4.24		22.58±2.92		25.71±4.49		29.90±14.56		29.25±2.29		26.94±1.17		7.10±1.37		5917.23±6994.14	
26–35	17	23.29±5.98	0.889	33.29±3.98	0.160	23.00±4.08	0.732	27.35±5.69	0.261	29.94±4.59	0.973	24.47±10.95	0.163	26.94±5.38	0.999	10.24±6.46	0.042*	5315.74±4451.80	0.741
36–64	52	23.06±6.09		31.64±4.24		22.58±2.92		25.71±4.49		29.90±14.56		29.25±2.29		26.94±1.17		7.10±1.37		5917.23±6994.14	

*p<0.05

Discussion

In the realm of education, understanding the intricate interplay between teacher occupational burnout, personality traits, and physical activity is paramount for fostering a sustainable and thriving teaching environment. The demanding nature of the profession often places educators at risk of burnout, prompting a critical examination of how individual personality traits may influence susceptibility. The decision to focus on a sample of Polish teachers with different specializations – in particular, distinguishing physical education teachers from others – adds a nuanced layer to the discussion. This approach allows for a more refined analysis, recognizing that the unique demands and characteristics of various teaching specializations may impact the experience of burnout differently. Additionally, delving into the role of physical activity in mitigating or exacerbating teacher burnout unveils a holistic perspective on well-being within the educational landscape (Corbett et al., 2022; Jędryszek-Geisler & Izdebski, 2018). Therefore, we decided to measure the above components among a Polish sample of teachers of different specializations (physical education vs. others).

There were a few associations between the characteristics of burnout and personality traits. We observed that those teachers who had higher emotional instability (neuroticism) also had higher emotional exhaustion with their work. Also, teachers identified as more extraverted exhibited a positive correlation with a heightened sense of personal accomplishment, indicating that their outgoing and sociable nature may contribute to greater fulfillment in their professional achievements. Additionally, these extraverted teachers experienced fewer symptoms of emotional exhaustion, suggesting that their energy and enthusiasm positively correlates with emotional well-being within the teaching context. On the contrary, teachers characterized by higher levels of agreeableness displayed an interesting dynamic: while their agreeable nature fosters positive interpersonal relationships, it was found to intensify symptoms of depersonalization. This implies that, despite their amiable and cooperative demeanor, agreeable teachers may be more prone to feelings of detachment in their interactions within the educational environment.

Higher negative affectivity increases a person's difficulty in coping with stressful events and the probability of burnout developing. Mosa-Kaja et al. (2015) showed in their study that Polish teachers dealing with burnout reported a greater sense of incongruence between themselves and their work environment than their engaged counterparts, who exhibited a more harmonious alignment. The engaged teachers displayed lower levels of negative affectivity and higher levels of self-directedness compared to those experiencing burnout. The study suggests that negative affectivity may serve as a predisposing risk factor, while self-directedness emerges as a protective element against burnout.

A comparison between age groups on the aspects of occupational burnout confirmed earlier research indicating that younger workers tend to experience higher levels

of burnout, particularly in terms of depersonalization. This is evidenced by the comparison between the 26–35 and 36–64 age groups, in which the younger teachers were characterized by significantly higher depersonalization. Therefore, employers should pay attention to younger employees, especially their adaptation to the environment (Lubrańska, 2016). The current study also showed that PE teachers experience less emotional exhaustion than teachers of other specializations. However, there were no significant differences in the level of physical activity and no associations between the level of physical activity and the characteristics of burnout, which was the authors' assumption. On the other hand, we think the fact that physical education teachers exhibited lower emotional exhaustion may be linked to physical activity (METs). Teachers who practice sports on a daily basis are consequently more physically active, dedicating significantly more time to sports activities than teachers of other subjects. The association between physical activity and burnout, however, did not yield significant results. Nonetheless, the study underscores the potential protective role of physical activity, which has also been confirmed by González-Valero et al. (2023), that physical activity significantly reduces symptoms of burnout among physical education teachers.

In summary, the study provides valuable insight into the intricate interplay between personality traits and different facets of teacher well-being, contributing to a deeper understanding of occupational burnout issues within socially imperative professions, particularly among educators. However, there are limitations to this study. It exclusively outlines correlations and differences in certain variables without delving into an exploration of the predictors of burnout among the educators in question, a crucial next step in the analysis of this specific group. Also, the sample size should be much larger in order to more thoroughly investigate the problem of burnout among Polish teachers. Furthermore, future research should concentrate on formulating specific mental health recommendations or activities aimed at alleviating burnout among teachers. Educational institutions should consider implementing tailored support programs that take into account the personality traits specifically associated with burnout. Providing resources and interventions aligned with individual teacher profiles can contribute to the prevention and mitigation of burnout. Tailored support programs for younger teachers that would equip them with coping mechanisms and stress management skills could be particularly beneficial. Schools and educational authorities should establish mechanisms for ongoing monitoring of teacher well-being, especially in the post-pandemic era. Early identification of burnout risk factors and timely interventions can contribute to a healthier and more sustainable teaching environment. Encouraging and facilitating physical activity among teachers may have positive implications for mitigating burnout. Institutions could consider initiatives that promote regular exercise and well-being, recognizing the interconnectedness of physical health and occupational stress.

Conclusion

The findings of this study shed light on the intricate relationship between personality traits, physical activity, and occupational burnout among school teachers and provide insight into the factors associated with burnout in the educational setting. The key points of the study are as follows:

1) Personality traits and burnout: The study emphasizes the significance of personality traits in understanding burnout among teachers. Notably, all dimensions of burnout except for openness showed significant correlations with specific personality traits. This underscores the need for tailored interventions and support based on individual personality profiles.
2) Age disparities in burnout: The identification of higher levels of depersonalization among younger teachers highlights a critical aspect of burnout dynamics. This insight prompts a closer examination of the unique challenges faced by early-career educators and the development of targeted strategies to mitigate burnout risk in this demographic.

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When Shame Becomes Part of the Self: How Chronic Shame Shapes Personality

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Abstract

This article explores the origins and significance of shame from both developmental and relational perspectives within medical and psychotherapeutic contexts. Shame deeply embeds itself in one's personality and can influence various aspects of human behavior. Approaches to tackling and managing a patient's shame differ based on their background and specific issues. A doctor's strategy in a single patient encounter will differ significantly from the long-term approach taken in psychotherapy. The authors highlight the psychological intricacies of shame and present various methods for addressing it in therapeutic settings.

Keywords: shame, doctor-patient relationship, psychotherapy, personality psychology

Introduction

In an interview for the book *Czując* [Feeling] by Agnieszka Jucewicz (2019), Anna Król-Kuczkowska recounts a story about a lecturer who, after delivering one of his early talks on shame, was advised by a colleague to change his focus. The colleague said, "That's all well and good, but why not choose another topic? Shame won't advance your academic career" (Jucewicz, 2019). Lewis offers further insight into the discomfort of experiencing shame. She suggests that shame is contagious and that, just as those who experience shame are inclined to conceal it, observers of shame often have a natural tendency to turn away from it (Lewis, 1971). Interestingly, this creates an opportunity to research this emotion, its significance, and its impact on all of us. Although experiencing shame

is common, its effects on human health and well-being have only recently begun to be explored in depth by scientists.

Mentions of shame appear in the diagnostic criteria for post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (CPTSD) in the American Psychiatric Association's DSM-V, classified under persistent negative emotional states, and in the ICD-11 classification (Taylor, 2015, as cited in Dolezal & Gibson, 2022). This recognition highlights the role of shame among the emotions (such as fear, terror, anger, and guilt) that individuals experience due to trauma. Its significance has become a key factor in the success of treatment and has extended beyond theoretical discussions in psychotherapy to being included in medical diagnostic manuals (Dolezal & Gibson, 2022).

A review of the literature and empirical research on shame indicates that this emotion is often considered a co-occurring or mediating factor in the development of psychological difficulties. For instance, studies have explored shame in relation to attitudes toward sexual identity, internalized homophobia, and membership in marginalized sexual minority groups (McDermott, Roen, & Scourfield, 2008; Singer, 2013; Brown & Trevethan, 2010). Other research has examined the link between shame and eating disorders (Keith & Gillanders, 2009; O'Loghlen, Grant, & Galligan, 2022; Wong & Qian, 2016), self-harming behaviors (McDonald, O'Brien, & Jackson, 2007; Sheehy et al., 2019), and PTSD or complex PTSD (Lee, Scragg, & Turner, 2001; Saraiya & Lopez-Castro, 2016; Wong & Cook, 1992).

These examples demonstrate that shame frequently appears in psychopathology studies as a co-occurring or mediating factor. However, investigating shame as a variable that influences the structure of human personality remains challenging, likely due to the difficulties in methodologically defining and measuring shame.

Shame in a developmental perspective

Erik Erikson (1950), a pioneering psychologist in human development, identified the genesis of shame in the second of his eight stages of psychosocial development, occurring around age 2. After resolving the initial crisis of developing basic trust in themselves and others, children encounter the next developmental challenge centered on autonomy versus shame and doubt.

During this phase, children begin to develop self-awareness and navigate issues related to boundaries, differentiation, and early mastery of their bodily functions, including physiological needs. This stage is marked by a fascination with self-discovery and bodily control, alongside a heightened sensitivity to unclear boundaries, confusion, and setbacks. The way caregivers and the community respond to a child's assertions of independence and the challenges of toilet training plays a crucial role in shaping their sense of autonomy and potential feelings of shame.

Using a developmental perspective, Erikson highlighted the crucial role of parents in shaping their children's sense of self-worth. Parents who use control, punishment, and shaming can inadvertently instill feelings of worthlessness and submissiveness in their children. As these children grow into adulthood, they are likely to perpetuate this cycle of shame with their own offspring. By inducing feelings of guilt and contempt in their children, they attempt to avoid the sense of failure they associate with parenting and protect themselves from re-experiencing the shame rooted in their own childhoods. Thus, the cycle of shame continues, now repeated by the former children in their new role as parents.

Erikson's theory sheds light on how negative experiences of shame in early childhood can have long-lasting effects. He links feelings of shame and doubt with struggles for autonomy – like the "terrible twos," where toddlers push for independence and express their separateness. According to Erikson, these early experiences of shame are ingrained in the very pre-verbal stages of self-formation. When children successfully navigate these early struggles for autonomy, they develop a strong and coherent sense of self. However, if they face intrusive parenting and shaming as a means of control, they might grow up feeling deeply insecure, inadequate, or defective, which can then interfere with their ability to take initiative, feel competent, or build healthy relationships in later stages of development.

The significance of shame

Shame is a ubiquitous human experience that affects interpersonal relationships. It shapes our self-perception, self-esteem, identity, ability to form and sustain relationships, and social standing. Concurrently, shame is intricately linked to mechanisms of social control and power dynamics, delineating the boundaries of what is deemed normative and acceptable within a society and culture versus what is not (Dolezal & Gibson, 2022). Generally understood as an aversive emotion, shame emerges from concerns regarding others' perceptions and judgments. Individuals experience shame when they perceive themselves as being seen by others – whether those others are physically present, imagined, or internalized – as flawed, or when aspects of their self are viewed as inadequate, inappropriate, or immoral.

Shame overlaps with other emotions like embarrassment, bitterness, excessive worry, and humiliation. It often serves as an umbrella term that encompasses a variety of feelings, including "feelings of being slighted, insulted, disrespected, dishonored, disgraced, disdained, demeaned, slandered, treated with contempt, ridiculed, teased, taunted, mocked, rejected, defeated, subjected to indignity or ignominy; feelings of inferiority, inadequacy, incompetence; feelings of being weak, ugly, ignorant, or poor; of being a failure, 'losing face,' and being treated as if you were insignificant, unimportant, or worthless" (Gilligan, 2003). Fossum and Mason describe shame as "an inner sense

of being completely diminished or insufficient as a person. It is the self, judging the self. A moment of shame may be humiliation so painful or an indignity so profound that one feels one has been robbed of her or his dignity or exposed as basically inadequate, bad, or worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as a human being" (Cornell, 1994). What all these experiences have in common is the feeling of being negatively judged by others and the sense of being of less worth than others.

On the other hand, while shame is an unpleasant experience, it is also an inevitable and necessary part of human life. Shame can foster adaptive and desirable qualities such as modesty, humility, gratitude, and respect for oneself and others. Anna Król Kuczkowska (as cited in Jucewicz, 2019) refers to this as healthy shame, explaining that "some degree of susceptibility to feeling shame indicates our maturity, sense of responsibility, boundaries, and intimacy. If you were changing your clothes in the bathroom and a stranger walked in, you would be embarrassed rather than say: Please come in. Perhaps you would like to watch?"

This healthy, adaptive shame can drive personal growth and change, and help individuals form harmonious and meaningful relationships with others (Dolezal, Gibson, 2022). It plays an adaptive role by protecting against the overexposure of certain aspects of the self. In a medical context, a patient's shame is understandable because they reveal to a doctor or psychotherapist parts of themselves that they do not show to others, even in intimate relationships.

According to the *Dictionary of the Polish Language* (2024), shame is defined as "an unpleasant feeling caused by awareness of wrongdoing, … usually combined with fear of losing one's good reputation." Interestingly, the Polish word *srom* [vulva], aside from its anatomical meaning (referring to the external genital organs of women and female mammals), was once used as a synonym for shame, disgrace, and failure. This linguistic connection adds a layer of negativity to nudity and carnality, especially in a sexual context. For example, a nurse in a gynecology ward might tell a patient to "please cover your shame." In this context, the protective aspect of shame becomes blurred.

The significance of chronic shame

"Healthy shame," which has the potential to protect relationships and support personal growth, can easily become distorted and turn into "unhealthy," "toxic," or "destructive" shame (Sanderson, 2015). Toxic shame, according to Sanderson, "paradoxically severs connections, destroys social bonds and can lead to antisocial behaviour." John Bradshaw adds that "shame as a healthy human emotion can be transformed into shame as a state of being … [which] is to believe that one's being is flawed, that one is defective as a human being. [Shame] becomes toxic and dehumanizing" (Bradshaw, 2005).

This kind of shame evolves into a deep-seated sense of inferiority, inadequacy, and defectiveness, coupled with the belief that one does not deserve love or relationships. It becomes a chronic experience that distorts one's sense of self, life, the world, and others, profoundly affecting the individual's life chances. This is consistent with Goldberg's (1991) distinction, which clearly separates guilt ("How could I have done **THAT**?") from shame ("How could I have done that?"). This shift focuses on the person rather than the act, effectively preventing the reparative and restorative measures typically involved with guilt.

Patricia DeYoung (2015) offers another definition of "chronic shame" as the "an experience of one's felt sense of self disintegrating in relation to a dysregulating other." This perspective centers on the relational aspect of shame, emphasizing that shame requires a spectator (whether real, imagined, or internalized) who fails to emotionally mirror the person in an attuned way, instead intensifying the shame with their reaction. This often leads to a desire to hide, disappear, or psychologically "sink into the ground."

This understanding of chronic shame is in keeping with the psychoanalytic view that links early failures in primary relationships – specifically, a lack of parental mirroring and empathic attunement – with present experiences of shame, often marked by a sense of "ruptures in interpersonal bridges" (Lewis, 1971; Kaufman, 1988).

Where does shame hide?

In English-language literature, shame is often described as "hiding in plain sight," which seems to perfectly capture its essence. Patients who seek help from specialists, like psychotherapists, rarely discuss overwhelming shame during initial consultations. Instead, they talk about issues related to self-esteem, low self-worth, and a persistent sense of being damaged or defective. Others focus on relationship difficulties, such as dissatisfaction, unfulfillment in romantic relationships, a lack of respect from their partner, or embarrassment in situations involving sexual intimacy. Some patients also report experiences of abuse and exploitation.

What these various stories and reasons for seeking therapy have in common is the unspoken shame that hides within them, manifesting as symptoms that cause discomfort and distress. As patients build a therapeutic relationship and develop trust and a sense of security, they often gain a deeper understanding of the meaning and function of their symptoms and realize that their past relational experiences share common themes.

Cornell (1994) describes shame as fundamentally feeling invisible. This extends beyond a lack of empathy or parental mirroring to a point where the child feels they hold no real meaning or interest to the parent, except in fulfilling the parent's own desires and fantasies. Many clients express a deep-seated belief that there is something inherently wrong with them, with one client notably stating that they never felt a sense of belonging.

For these individuals, their childhood and adolescence seems irrelevant to one or both parents, resulting in a lack of any external validation of their internal experiences. These people often retreat into fantasies, books, and isolated thought processes. They maintain a sense of internal coherence and security only through isolation, internalizing a belief that they are uninteresting to others. Despite being deeply interested in the world and other people, they do not expect their interest to be reciprocated. Over time, this accumulated lack of validation erodes their sense of self and leaves them with a persistent feeling of inadequacy (Cornell, 1994, p. 8).

As mentioned earlier, shame is often a pre-verbal experience that does not initially lend itself to verbal labeling (Park & Shields, 2023; Hill, 2015). In psychotherapy, especially in the early stages, shame often manifests as a bodily experience triggered by the autonomic nervous system. During these moments, patients may blush, sweat, and feel agitated, expressing their discomfort through actions like wriggling, squirming in their chairs, fidgeting, or having a distracted gaze. Their body language often includes a bowed head, closed eyes, and a body collapsed inward, as if trying to become as small and invisible as possible (Lewis, 1971). At these stages, it is crucial to connect this bodily experience with feelings, thoughts, and behaviors with due sensitivity. This helps to bring the "spilled" bodily experience into states of consciousness where it can be operationalized, labeled, and experienced differently from the initial context.

Shame often hides behind silence. These are the moments in therapy when patients become silent, avoid eye contact, lower their voice, do not respond, or try to change the subject. Silence then becomes a moment in the therapeutic relationship where the patient recreates the experience of not being accepted, feeling scorned, and reliving their past interactions with others. As Cornell (1994) mentioned in a conversation with Lynn Hawker, "I don't think you emphasized enough the silence of shame. The silence keeps the person from telling anyone that they feel shamed, or why and when one feels shamed or embarrassed … one becomes more careful, withdrawn, and covered. You would think that with growing trust, communication, and closeness between therapist and client, some of these issues would finally surface. Not so" (Lynn Hawker, Personal Communication, December 1989).

Psychotherapy has the privilege of allowing ample time and space to work on shame. In a medical context, however, it is vital to sensitize doctors to the multidimensional and deeply destructive nature of chronic shame, as well as the vulnerability to re-traumatization in patients who have experienced humiliation in close relationships. The doctor's role is not to analyze the causes of the patient's shame but to understand its complexity and empathetically acknowledge the patient's difficulty in opening up. For example, a doctor might say to a patient with a ruptured hemorrhoid, "I understand that this is not easy for you to talk about. I respect your willingness to share your concerns, and I will do my best to make you comfortable during the examination."

Recommendations for therapy

In the doctor–patient relationship, it is crucial to develop empathetic understanding, engage in self-reflection on shame, and use language that facilitates communication and eases patients' feelings of shame. In turn, psychotherapists must carefully and consistently engage with patients, providing time, attention, sympathetic interest, and a safe environment. This support helps patients gradually stop trying to prove their worth and avoid experiencing shame. Instead, they can find their voice, recognize their value, and gain a clearer perspective on themselves, which will allow them to create meaning in a narrative that is free of "shaming others." As Cornell (1994, p. 10) notes, "This is quiet work, more often marked by depth of understanding than intensity of expression."

Including group therapy alongside individual treatment can be particularly valuable. Group therapy provides a sense of belonging and a space to talk about oneself, breaking the common rule from shame-based homes that forbids discussing shame. Being listened to, noticed accepted with respect, and made to feel important in a group setting can offer a powerful corrective emotional experience in healing chronic shame.

Kaufman (1988) emphasizes that it is essential for the therapist to genuinely care about the client. For effective restoration to take place, the therapist–client relationship must be authentic, honest, and mutually desired. A secure relationship fosters growth. The increased anxiety that comes with self-exploration and facing dynamic conflicts can only be effectively experienced, understood, and managed within a secure relationship. The therapist and client's joint approach to these conflicts creates this anxiety, and their mutual confrontation of conflict deepens their relationship further. Dependency on the therapist often develops, and this dependency can be permitted without being encouraged. Allowing this dependency and identification, when needed by the client, provides the necessary support, strength, and healing for the wounded or insecure aspects of the self (1998, pp. 120–121).

Conclusion

Given the sensitivity and complexity of how shame affects patients' functioning, along with the societal taboo against discussing it, the authors believe that it is important to discuss the practical approach to chronic shame in doctors' daily interactions with patients. They also aim to demonstrate the potential for deep psychotherapeutic work in treating this condition.

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Supporting the Supporters: The Role of Mentoring and Supervision in Healthcare

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Abstract

Marked by both profound rewards and significant challenges, health professions occupy a unique position in society. These careers offer a deep sense of empowerment and fulfillment, but also involve considerable stress, frustration, and personal sacrifice. Healthcare professionals – such as doctors, nurses, paramedics, and physical therapists – often work at the very limits of their mental and physical capacities, as they deal with the most difficult aspects of human life.

The recent SARS-CoV-2 pandemic has placed additional strain on healthcare systems worldwide, exacerbating existing pressures. Alarming global statistics show an increase in suicide attempts and completed suicides among doctors (Harvey et al., 2021). Consequently, it is essential that all professionals involved in patient care and related support services possess a solid foundation of competencies, alongside access to a readily available support system. Equally critical is the promotion of self-care and attention to the psycho-physical well-being of healthcare workers.

This article explores two underutilized forms of support available to healthcare professionals: mentoring and supervision.

Keywords: professional burnout in the health professions, mentoring in the health professions, supervision, Balint groups, mental health care in the health professions

Introduction

Health professions represent a unique, complex group of careers facing both immense rewards and formidable challenges. These roles offer a powerful sense of empowerment and satisfaction, yet they also entail considerable frustrations and numerous sacrifices. Professionals in these fields, including doctors, nurses, paramedics, and physiotherapists, operate at the very limits of their mental and physical capacities. Their daily work involves engaging with some of the most difficult aspects of human existence – suffering, pain, death, and fear – while dealing with individuals who are entirely dependent on their expertise and actions. They regularly confront the most intimate aspects of patients' lives and bodies.

To practice in these professions, individuals must undergo long and rigorous training, commit to extensive working hours, and accept the demands of night shifts. These professionals are frequently overwhelmed by their responsibilities and duties (Givens & Tjia, 2002; West et al., 2011; Kinowska, 2023). Concurrently, they must cope with their own feelings of frustration, helplessness, powerlessness, exhaustion, anxiety, demotivation, and anger. Despite having a strong sense of professional identity and belonging to a community, they function within an exceptionally demanding and competitive environment (Gerada, 2022).

This combination of factors contributes to higher levels of stress and burnout among health professionals compared to many other occupations. Recent years have been particularly taxing on healthcare systems globally due to the SARS-CoV-19 pandemic. Alarming statistics show an increase in suicide attempts and completed suicides among physicians worldwide (Harvey et al., 2021).

However, there has been a positive shift toward addressing the well-being of healthcare professionals. Increasing attention is being paid to systemic measures aimed at improving working conditions and protecting mental health. The success of these initiatives will depend on effectively raising awareness within the medical community that maintaining one's own psycho-physical well-being is as crucial as patient care, and that seeking professional support is a vital aspect of professional responsibility and work ethic, rather than a sign of weakness or incompetence.

This article examines two forms of support that are commonly available but not always fully utilized by healthcare professionals: mentoring and supervision.

Mentoring: A Pathway for Professional Support and Development in Medicine

Current studies indicate that over 50% of medical professionals experience burnout (Batanda, 2024). Epidemiological data reveal a sharp increase in burnout among physicians in recent years, with a pronounced rise since the COVID-19 pandemic. The prevalence and severity of psychological strain in the medical profession point to the need for effective support mechanisms for healthcare professionals. Occupational Burnout Syndrome frequently affects those who work closely with others, struggling with excessive workloads and constantly operating at the limits of their capacities (Patel et al., 2018). Professional burnout syndrome is defined as "a state of physical, emotional, and mental exhaustion caused by prolonged involvement in emotionally taxing situations" (Antczewska & Roszczyńska, 2004; Henzel-Korzeniowska, 2004; Sęk, 2006).

In medical education, students are comprehensively trained in knowledge, competencies, and professional skills. Increasing emphasis is placed on developing their soft skills and professionalizing their interactions with patients. As a result, students become aware of the importance of mental health care and burnout prevention from the earliest stages of their training. Traditionally, the master–student relationship has played a pivotal role in medical education, aiding in the practical development of occupational skills and the modeling of professional attitudes. Today, mentoring remains an indispensable element in training young medical professionals, nurturing professional expertise, and providing a space for personal growth in self-awareness, reflectiveness, mental resilience, values, and psycho-physical well-being.

As a field of professional interaction, mentoring involves not only sharing practical knowhow but also employing tools and principles grounded in research from psychology, organizational studies, andragogy, and ethics. Modern mentors can receive specialized training to enhance their effectiveness in this role. Mentoring is a multifaceted and complex relationship between senior and junior professionals. When successful, it hones and expands the abilities and competencies of the junior professional, forming an integral part of their professional development (Barondess, 1997). This relationship enables them to learn about the environment they are entering, understand the nature of their duties – including priorities, habits, and crucial aspects of professional identity formation – and develop the personality and attitude necessary for a profession of public trust, such as medicine. Additionally, it plays a major role in shaping and implementing career paths.

Mentoring encompasses the entirety of interactions between the mentor and their mentee. Clutterbuck notes that mentoring aids individuals in guiding their own learning to achieve their full potential, enhance their skills, improve their performance, and reach their personal goals. He describes mentoring as a supportive relationship that facilitates learning and experimentation, with success being evaluated based on the competencies

acquired rather than the amount of material covered (Clutterbuck, 2014). Barczykowska and Dzierzyńska also suggest that "almost from its inception, mentoring has been part of a trend of preventive and corrective interventions" (Barczykowska & Dzierzyńska, 2012). Mentoring is not necessarily defined by an age difference between the mentor, who is typically older, and the mentee, who is younger. Instead, it is defined by the mentor's experience in a specific area. The essence of mentoring lies in partnership, offering mentees support from an experienced individual in a field that the mentee is currently exploring. This relationship is geared toward discovering and developing the mentee's potential, providing guidance to stimulate and accelerate their growth, and enhancing their knowledge and skills.

In this context, mentoring serves a preventive and protective function, as it addresses the professional challenges faced by junior employees. It can be both competency-based, where knowledge and specific skills decide about its strength, and developmental, where the mentor acts as a career guide. For the mentee, mentoring offers opportunities to avoid mistakes, gain new perspectives, and acquire industry-specific expertise. Analyzing the scope of mentoring work, we can distinguish between areas related strictly to professional competence and those concerning soft skills related to the mentee's personal effectiveness. The development of resilience (Dencla, 2020), a sense of self-efficacy, and awareness of available resources are key elements in preventing general psychological distress and counteracting professional burnout.

The effectiveness of the mentoring process depends on the willingness of both parties to engage in this developmental path and, perhaps most importantly, on the characteristics of the mentor. A good mentor should possess skills and qualities that successfully support the mentee, including:

- empathy – to understand the mentee's perspective and tailoring their support to meet those needs
- patience – mentoring is a lengthy process that requires time and persistence
- listening skills – to better understand the needs of the mentee
- openness to change and flexibility – to stay current with the latest trends in the field and to embrace diverse viewpoints
- motivational skills – to inspire and encourage the mentee to grow and maintain a positive outlook
- good manners and professional ethics – to model desirable attitudes and behavior.

This description of the mentor's characteristics and responsibilities emphasizes the multifaceted and potentially significant influence inherent in the mentoring relationship. It underscores the mentor's professional obligation to instill attitudes and behaviors in their mentee that encourage a habit of personal development and mental healthcare. Assuming the role of a mentor offers numerous benefits, such as enriching professional growth and safeguarding the mentor against burnout. The following scientific perspective delves into selected forms of mentoring and examines their application in the cascading

process of training medical professionals, training academic staff, and exploring their interrelationships.

Group Mentoring: A Model of Community Practice in Healthcare

Focusing on the contextual-developmental perspective of the mentoring process, we must stress the reciprocity between mentor and mentee, as well as the transformation of identity experienced by both parties. Research on the primary benefits for the mentor reveals three main categories: generativity, personal growth and reflection, and increased action due to enhanced self-efficacy (Kline, et al., 2022). Sharing personal experiences reinforces the mentor's sense of contributing to others and making a meaningful impact. It stimulates the need to create conditions for growth, share role models, and experience the fresh energy of mentees. In the literature, these values are linked to Erikson's (1958, 1998) construct of generativity, which involves a commitment to future care, to others, and to oneself – a concept filled with creativity, care, and kindness (Jankowska, 2017). Personal transformation, or growth, includes building greater self-confidence, accepting limitations, and developing a positive self-attitude. Additionally, mentors experience a heightened sense of agency: the belief in one's ability to control reality and achieve one's goals through personal effort.

When examining mentoring in terms of participant numbers, we can distinguish group mentoring, multiple mentoring, and hub mentoring. In group mentoring, mentors simultaneously advise and support a group of mentees. Each mentor may interact with multiple students in both collective and individual formats. Reciprocity is key, as mentees can engage with different mentors based on their needs and situations. In contrast, the multiple mentoring model involves a group of mentors with diverse experiences and competencies rotating to provide support to a single mentee. Through this dynamic process, mentees benefit from a variety of perspectives and skills depending on the circumstances and their current needs for growth. In hub mentoring, a single mentor plays a central role, by guiding group discussions and forming developmental pairs. This mentor not only provides individual support, but also coordinates group interactions to ensure their effectiveness and efficiency. The mentor's role includes building strong group bonds and facilitating the exchange of knowledge and experience among participants (Khatchikian, et al., 2021).

In summary, group mentoring forms are characterized by the practice of support and development through access to diverse viewpoints and knowledge resources. They enhance interpersonal skills through group interaction, supporting problem-solving and the achievement of developmental goals. Participants benefit from the motivation and emotional support of the community, which creates an atmosphere of mutual trust and acceptance. Group mentoring also provides a space for interdisciplinary peer mentoring

programs and fosters individual development and the exchange of experiences between experts in different professional fields.

As a final conclusion on mentoring, it is important to highlight a best practice recommendation that underscores the value of a holistic and cascading approach to implementing mentoring programs. This practice involves supplementing traditional mentoring with electronic mentoring (e-mentoring), peer mentoring, and group mentoring. Such an approach reinforces personalized, relevant, timely, and longitudinal support (Ong, et al., 2022). Mentoring plays a significant role in professional identity formation (PIF), shaping how individuals perceive, feel, and behave as professionals (Kim et al., 2023). According to the literature, mentoring supports professional identity formation through a structured approach as a community of practice (CoP) (Krishna, et al., 2023).

The concepts of communities of practice and situated learning, formulated by Lave and Wenger, offer substantial practical value. According to their approach, social interactions among individuals promote learning and a community of practice forms when individuals willing to share a common body of knowledge engage in activities aimed at acquiring knowledge and skills in a specific domain. Learning becomes situated when it occurs within a defined domain and follows a staged process. This process begins with observation, progresses through imitation and the performance of simple tasks, and culminates in the execution of more complex activities. It is a trajectory from peripheral participation to full participation in the community, where it is essential for individuals to acquire an identity associated with the community (Cruess, et al., 2015).

Members of a community of practice come together due to shared interests, professional goals, or passions, which provides a foundation for collaboration and knowledge exchange. They are engaged in a specific area of practice or professional activity and regularly utilize similar methods, techniques, and approaches. Communities of practice serve as forums for sharing experiences, knowledge, and skills, and for supporting each other in problem-solving and professional growth. They also create an environment where members can continually learn from one another, experiment with new ideas, and boost their skills. Experts in medical education strongly emphasize the importance of understanding professionalism, which is continually being developed through research and literature on identity formation. An inspiring and often cited example is the United States Army's use of the Kegan framework as a theoretical construct to monitor the professional identity development of its officer corps (Cruess et al., 2014).

Further important findings underscore the concept of "medicine as a community of practice," which stresses the need for a theoretical framework for the foundations of medical education. Under this approach, communities of practice are recommended as foundational for medical education. Recognizing the potential of these communities is the first step, with subsequent steps including active inclusion, building a welcoming environment, role modeling, mentoring, experiential learning, and reflection (Cruess et al., 2018).

Supervision: Enhancing Professional Skills and Personal Growth for Medical Professionals

Wenger's concept of communities of practice is inextricably linked to development and education as a transformative process for the individuals involved. The main components of this process include learning through experience, action, belonging, and becoming; in other words, making meaning, being active in action, being part of a community, and forming an identity (Hughes et al., 2024). This approach emphasizes ways to support and enhance medical professionals, one of which is mentoring, along with metamentoring, where mentors' reflection on their mentoring practices plays a major role. In addition to mentoring, another valuable source of support and professional development for medical professionals is supervision. While it is a fundamental aspect of the work and development of psychotherapists and other mental health professionals (Gilbert & Evans, 2004), supervision also offers considerable potential for any professional whose efficacy largely depends on the quality of their interactions with care recipients.

While mentoring typically involves professionals from the same field, supervision is a consultative process where the supervisor is a certified expert in psychotherapy, psychological support, or related areas such as organization or education. Importantly, the supervisor may belong to a different profession. The goal of supervision is to offer comprehensive support to professionals in health and assistance fields. Through a specific agreement, the supervisee can enhance soft and diagnostic skills related to mental health, critically examine their work with patients, particularly addressing challenges and obstacles, and process difficult emotions arising from the demanding nature of their work. This process helps maintain mental well-being.

Medical professionals often learn to compartmentalize their emotions to preserve rational thinking. Supervision, however, teaches them to reintegrate emotions and manage their emotional states effectively, while ensuring that work-related stress does not adversely impact their personal and relational lives. Originating in the 1950s in Great Britain, Balint groups, a notable example of support for medical professionals, have since gained traction globally within medical communities. These groups involve regular meetings with both educational and supervisory components (Adams, 2006). By cultivating emotional communication and providing a supportive environment in which to share experiences, Balint groups help physicians develop personal competencies, improve their sense of security, and regain or strengthen their satisfaction with their profession (Benson & Magraith, 2005; Popa-Velea et al., 2019; Kjeldmand & Holmström, 2008).

Conclusion

Presenting mentoring and supervision as accessible and potentially burnout-preventive activities for healthcare professionals may address the increasing need to enhance comfort and support mental health within the medical field.

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Trauma-Oriented Medical Care: Bridging Medicine and Psychotherapy

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Abstract

In the past decade, the issue of trauma has gained significant attention in psychological and medical research. Advances in psychophysiology, neuropsychology, and psychotherapy have greatly improved our understanding of the progression and consequences of psychological trauma. Treatment methods for trauma now boast a high success rate.

Trauma and psychotraumatology are especially critical in emergency and medical services. Recognizing the nature of trauma and applying principles of early intervention can considerably reduce its long-term negative effects (Goldstein et al., 2024). Additionally, understanding how past trauma – sometimes from long ago – affects current psychological and physical health can clarify behaviors often seen as maladaptive, such as excessive anxiety, heightened sensitivity to pain, uncontrollable anger, substance addiction, or self-harm. This insight can enhance the diagnostic and treatment process.

Trauma-informed care in medicine acts as a bridge between medical treatment and psychotherapy. Since trauma affects both the mind and the body, treatment should be grounded in a holistic view of the individual (Mikhail et al., 2018). Understanding trauma mechanisms is also crucial for preventive mental health care professionals (McKann & Pearlman, 1990).

Keywords: trauma-oriented medical care, PTSD, CPTSD, psychological trauma

Introduction

The scientifically accepted definition of psychological trauma originates from Janet's psychodynamic approach, described as an event or series of events that, due to their nature, impact the psyche and risk fragmenting its coherence. According to the American Psychiatric Association, trauma is "any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning. Traumatic events include those caused by human behavior (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes) and often challenge an individual's view of the world as a just, safe, and predictable place" (APA, 2018). Individual trauma results from an event, series of events, or set of circumstances that are perceived as physically or emotionally harmful or life-threatening, leading to a lasting negative impact on mental, physical, social, emotional, or spiritual functioning (SAMHSA, 2014).

This article provides an overview of aspects of trauma-informed care that are relevant to the practice of healthcare professionals. A broader understanding of the impact of psychological trauma on psychophysical functioning significantly boosts the effectiveness of patient treatment and improves the comfort of healthcare providers. Knowledge of the reactions resulting from chronic stress and trauma, as well as specific patterns of patient behavior, helps reduce the potential risk of treatment failures.

Trauma-Oriented Medical Care

People encounter various psychological traumas throughout their lives, but only some experience lasting effects from these traumas. While severe trauma is part of many people's life experiences, not everyone will face its consequences. Epidemiological studies reveal that over 70% of the general population is exposed to stressors that could potentially lead to post-traumatic stress disorder (PTSD; Frans et al., 2005; Kessler, 2017). Trauma can affect any social group, but factors such as social exclusion, migration, and poverty increase the risk. Loneliness and a lack of social support also heighten this risk.

Most people will recover from trauma without long-term effects. However, about 20% may experience significant negative outcomes later in life, such as psychiatric disorders or physical illness. PTSD is notably more common in clinical populations, with symptoms affecting 75% of patients (Breslau & Kessler, 2001; Koenen et al., 2017). It is important to differentiate between one-time trauma and relational trauma experienced in early childhood. The latter, often occurring in the pre-verbal stage, relates to early developmental experiences.

Diagnosing Trauma

According to the latest ICD-11 classification, diagnosing PTSD involves three key elements (Bowin 2021):

1) re-experiencing the traumatic event, as evidenced by intrusive memories, flashbacks, and/or nightmares; 2) avoidance of traumatic reminders, as evidenced by the avoidance of internal and/or external stimuli; and 3) a persistent sense of threat, evidenced by hypervigilance and being prone to startle. One symptom from each category is required, and the symptoms must have persisted for several weeks and cause significant impairment in functioning.

The ICD-11 has also introduced the concept of Complex PTSD (CPTSD). To be diagnosed with CPTSD, a person must meet the criteria for PTSD and also show three additional features related to "disturbances in self-organization" (DSO): 1) affective dysregulation (e.g., trouble calming down or numbing); 2) negative self-concept (e.g., worthlessness); and 3) disturbed relationships (e.g., difficulty feeling close to others). "According to Herman's (1992) original conceptualization of CPTSD the etiology included exposure to prolonged or repetitive events from which escape is difficult or impossible. Although ICD-11 CPTSD does not require the event be prolonged or repetitive, it notes that it often stems from such. Moreover, the developers note that regardless of the nature of the stressor, the diagnosis of PTSD versus CPTSD is determined by the symptom profile" (Cloitre et al., 2013).

These symptoms can often be observed in patients receiving medical care. Understanding them properly can help in interpreting the patient's often subtle reactions. For patients, recognizing and normalizing these symptoms can be an important step toward recovery.

DSO 1: affective dysregulation (e.g., trouble calming down or numbing)

Due to the hyperactivity of the amygdala, patients with PTSD often remain in a constant state of anxiety and can interpret potentially safe situations as threatening. Additionally, because of the dysregulation between the amygdala and the orbitofrontal cortex, triggering the fight/flight response, the body's stress response system (H-P-A axis) might not deactivate properly even after the initial threat has passed. This means the patient continues to feel anxious and is unable to relax. Soothing verbal reassurances or rational explanations that there is no real danger may not bring the intended effect (Zhang, 2018).

PTSD is characterized by persistent, chronic hyperarousal of the autonomic nervous system (AUN). Individuals with PTSD experience continuous stress. When daily life stresses are added on top of an already overloaded AUN, it fails to function properly. Consequently, patients feel – and this perception is valid – that they are unable to manage their stress. Therefore, simple directives from a doctor such as "please calm down" or "try to avoid stress" are counterproductive for these patients, as they are simply unable

to relax. Paradoxically, moments of tranquility and rest, when nothing extraordinary is happening, can actually increase tension because they are interpreted as "the calm before the storm," creating a sense of impending disaster.

Patients may respond with heightened anxiety and express numerous concerns about their diagnosis and treatment process. They often complain of various troubling psychosomatic symptoms, which can be traced back to functional dysregulation of the autonomic nervous system.

This emotional numbness can manifest both mentally and physically and may be mistaken for apparent indifference or a disregard for clinically significant symptoms. Individuals who have experienced trauma frequently report a diminished ability to feel physical sensations. For example, one patient who frequently suffered injuries during manual labor without adequate protection mentioned that he chose not to wear protective gear because it allowed him to "feel something." Another patient recounted sitting on her porch in thin pajamas during a winter snowfall until she no longer felt the cold. She justified this behavior similarly. Some patients describe feeling like zombies – going through the motions, functioning, but devoid of any real emotional or sensory experience.

DSO 2: negative self-concept (e.g., worthlessness)

Although some symptoms may resemble elements of a depressive episode, for traumatized individuals, they are part of a broader picture (Post, 2011). Feelings of worthlessness, inadequacy, and loss of meaning and hope manifest as apathy and negative self-perception. Patients may express that they see no point in seeking treatment and may show limited motivation for it. When PTSD or CPTSD symptoms are severe, there is an increased risk of self-destructive behavior, either actively (e.g., self-harm) or passively (e.g., not taking treatment, abandoning medication). Patients may feel an overwhelming sense of guilt and excessive responsibility for failures, and sometimes prefer to endure their condition rather than seek help (Asarnov, 2020).

DSO 3: disturbed relationships (e.g., difficulty feeling close to others)

This pattern can affect both the patient's personal life (turbulent relationships, divorce, multiple breakups, or living alone) and the doctor–patient relationship. To seek treatment, patients must trust their doctors and medical staff. Trauma, especially in relationships with people, often destroys this trust (Campbell, 2018). A patient may logically accept a doctor's arguments, understand rational explanations, and feel assured about the safety of selected treatments. However, when faced with their own dependence, helplessness, physical proximity (during examinations or treatments), surrender of control, and need to trust another person, they experience inundating anxiety. Deep-seated traumatic experiences cause internal conflict and distrust. From a doctor's perspective, this can lead to frustration due to the patient's inconsistent responses.

One reason for this inconsistency is that logical arguments rely on declarative memory, which is conscious and language-based (semantic), formed after the age of three. In contrast, emotions, trust, or threats related to proximity and pain from trauma are recorded in procedural memory, which is stored from birth in an unconscious, non-verbal way. The lack of synchronization between these two long-term memory systems is typical of psychiatric disorders like PTSD. Therefore, building trust in the patient–doctor relationship is critical (Goldstein, 2024).

One factor that influences the depth and persistence of trauma, as well as the potential for psycho-physical recovery, is the attachment style developed in early childhood (Bryant, 2023). If a child grows up in a safe, predictable environment with reassuring relationships, allowing them to explore the world and develop an inner life safely, they develop a secure attachment style. In adulthood, people with this style can recognize stressful or traumatic situations, seek help when needed, and regulate their emotions effectively. Even if they face a serious crisis or trauma, they can recover. In times of danger or discomfort, they seek support from others. Physical proximity, like touch or a hug, helps their nervous systems to synchronize, reducing anxiety and tension, and returning their physiological responses to normal. Just as a baby calms down in its mother's arms, adults find emotional comfort in the presence of loved ones (Weismann, 2021).

However, if a child experiences prolonged stress due to inconsistent parental care, neglect, rejection, or violence, their developing brain and nervous system are flooded with stress hormones. This causes their forming implicit memory systems to center around fear. According to the principle of "use it or lose it," the most frequently activated synaptic connections become fixed and form pathways for rapid neuronal response. These circuits are easily activated later in life when a person anticipates a threat, which is common in individuals who have experienced trauma (Le Doux, 2017).

Guilt, Chronic Shame, and Trauma

People with trauma often experience chronic shame and a heavy sense of guilt. Sometimes, this feeling is so intense that it influences major life decisions, such as choosing a career path or completely sacrificing oneself for others as a form of atonement for one's guilt. For example, one patient sought therapy for repeated anxiety attacks. During a session, he recounted a traumatic childhood experience: at age seven, he witnessed his younger sister being sexually abused by a neighbor. The boy entered the room and hid under the table, unable to call for help or defend his sister. He wanted to intervene but was paralyzed, feeling glued to the floor.

When the therapist explained the freeze response in extreme danger, the patient felt immensely relieved and moved. He realized his reaction was not within his control; his nervous system reacted in the only way it could to protect him. The neighbor was

a formidable man, weighing over 100 kilograms. Understanding this, the patient could better cope with his gnawing sense of guilt. Similar reactions are seen in survivors of accidents where loved ones died. It is vital to explain that their inability to move and help was not a sign of weakness or cowardice, but an automatic nervous system response aimed at self-preservation (Bub et al., 2017).

This understanding is also therapeutic for victims of violence, especially sexual violence. Immobility and lack of defense are often misinterpreted as acquiescence, while, in reality, freezing is a protective response when fleeing or fighting is not possible. If death or serious injury is imminent, numbing can make potential death painless. Awareness of this mechanism is particularly important in countries where the legal system presumes the culpability of rape victims. There is still a societal belief that a woman who does not scream or defend herself must have consented to intercourse, which retraumatizes victims of sexual violence (Lopez-Castro et al., 2019).

Summary: The Role of Health Care Providers in the Prevention and Treatment of Trauma

This discussion is only an introduction to a very complex problem. Although it focuses on a few selected aspects and provides a general overview, it shows that understanding trauma and integrating this knowledge into medical care is crucial for preventing and treating its effects. Educating patients about the meaning and mechanisms of their symptoms can be therapeutic, restore a sense of control, and help them understand their reactions. Furthermore, normalizing symptoms helps reduce anxiety and feelings of helplessness in the face of difficult experiences. Addressing shame and educating patients about neurophysiological mechanisms can help destigmatize their symptoms. Additionally, awareness of trauma pathomechanisms provides a foundation for healthcare workers to take care of their own mental health.

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Officers of the Wielkopolska Police Department Awarded the Crystal Star for Saving Lives in Situations of Suicidal Behavior

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Abstract

Every day, police officers respond to numerous incidents involving violations of the law and moral norms, demonstrating both professionalism and determination in serving the public. However, their efforts to save lives in situations involving suicidal behavior deserve special recognition. When individuals attempt to take their own lives for various reasons, police officers often risk their own lives and health to intervene and prevent these tragedies. One way this bravery is honored is through the Crystal Star, awarded in Greater Poland to officers who prioritize the life and health of every person.

Keywords: suicide, suicidal behavior, police, saving lives

Introduction

In accordance with Article 27(1) of the Police Act of April 6, 1990, before starting duty, a police officer takes the following oath:

> I, a citizen of the Republic of Poland, aware of the duties undertaken as a police officer, vow to serve the Nation faithfully, protect the legal order established by the Constitution of the Republic of Poland, and guard the security of the State and its citizens, even at the risk of my life. While performing the tasks entrusted to me, I vow to diligently observe the law, to remain faithful to the constitutional bodies of the Republic of Poland, to observe official discipline, and to carry out the orders and instructions of my superiors. I vow to guard the secrets associated

with the service, the honor, dignity, and good name of the service and to observe the principles of professional ethics. (Ustawa o Policji…, 2024)

In the context of this article, the passages in the oath that emphasize guarding the safety of citizens, even at the risk of one's own life, are particularly relevant. Some police officers fully embody these words, sometimes sacrificing their own lives to save others.

Police Officers Saving the Lives of Potential Suicide Victims: Background Information

However, it happens much more often that police officers who intervene are effective in saving people who want to take their own lives. Interventions can be both direct, when people's lives are physically saved, for example, by preventing a person who wants to commit suicide from jumping out of a window, and by reaching out to these individuals via the internet. When information that someone wants to commit suicide appears on an online forum or social networking site, the administrator of the site, informed in advance by those who have such knowledge, reports the matter to the police authorities, who take appropriate action. In 2018, there were 250 such reports, which is more than a fivefold increase compared to 2017, when 48 such reports were recorded. Police data show that in 227 cases, the Police Combating Cybercrime officers determined the personal data of 145 people who intended to commit suicide, 72 of whom were hospitalized. Eighty-three of the reports turned out to be a prank. This does not change the fact that each such report is treated as a priority by the police. A special procedure is launched to determine the IP address of the device from the service provider or social network, followed by a referral to the appropriate field cell to reach the owner of this number to verify the information (Markowski, 2019).

The vast majority of internet users are young people who often face many social and personal problems. It is important to distinguish between the terms "suicide" and "suicide attempt." Suicide refers to an action that results in death, while a suicide attempt refers to an intentional act aimed at ending one's own life, but which results in injury instead (Witkowska, 2021).The most commonly cited cause of suicide is mental illness or behavioral disorders, followed by addictions to alcohol and psychoactive substances, along with psychological, social, moral, religious, and economic factors. To prevent suicide, various measures are being taken in the United States, including education, counseling, and clinical management. These efforts are a crucial part of public health protection.

Prevention initiatives include educational campaigns, school programs, media training to counter suicidal behaviors, and school crisis response plans and teams (National

Center for Injury Prevention and Control, 2006). These targeted efforts primarily reach those at high risk of suicide (Goldsmith et al., 2002). Considering the legal and criminal approach to this problem, the intention of the law is to protect the most precious good, namely human life, while also fostering a sense of social solidarity in individuals facing life-threatening situations. Article 162(1) of the Criminal Code does not mandate the prevention of suicide, but requires every citizen to take action to avert danger when human life or health is at risk (Zoll, 1995). However, even though there is no explicit provision prohibiting suicide, the lawmakers' intent is to treat such acts as prohibited. According to the above-mentioned provision, a third party is obligated to provide assistance, even if it involves facing opposition in any form (Wąsek, 1999).

Given this context, we must consider whether a person who wishes to commit suicide should be prevented or allowed to proceed. These two approaches differ in terms of the factual subject matter, but it is important to consider not only the legal provision, but also the broader social interest and the individual's welfare. Often, a person attempting suicide cannot consciously guide their decision due to emotional agitation, illness, or the influence of alcohol or psychotropic drugs.

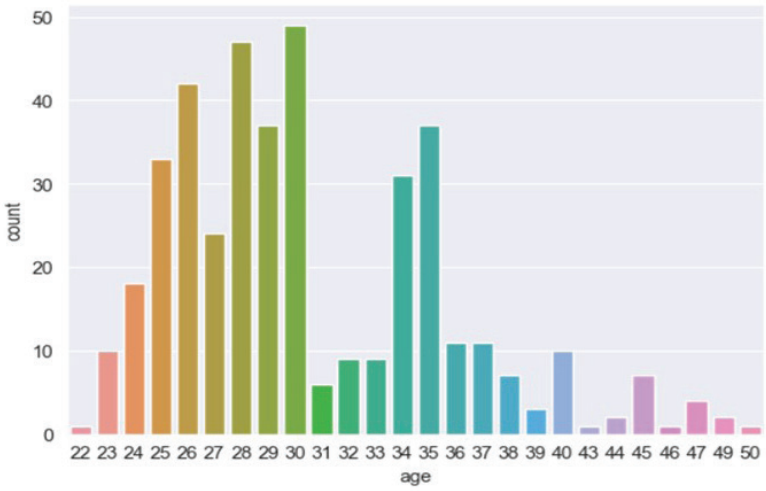
The designer of the Golden Gate Bridge in San Francisco, which opened in 1937, believed it was suicide-proof, but he was wrong. Since then, more than 1,600 people have jumped off the bridge. Could these deaths have been avoided? These are the questions asked by retired police officer Kevin Briggs, who decided to patrol the bridge. Over his years of service, he saved more than 200 people who attempted suicide there. However, he believes that "save" is not the most accurate word, as the decision to commit suicide is an act of desperation. Kevin Briggs tries to listen to people rather than offer empty reassurances that everything will work out.

Who are the Wielkopolska Police Officers Awarded the Crystal Star for Preventing Suicide?

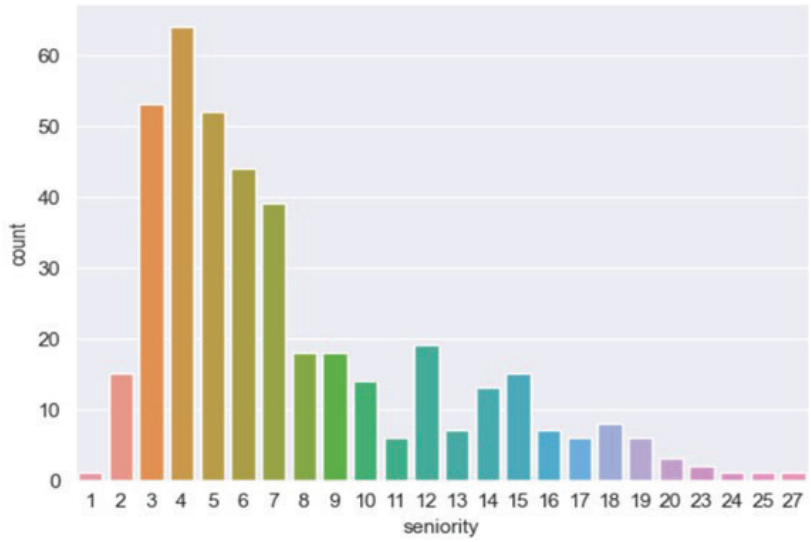
Wielkopolska, a region in Poland, is notable for its recognition of police officers who honor their oath, even at the risk of their own lives. These officers have successfully intervened in suicide attempts, demonstrating courage and determination. For their bravery, they were awarded the Crystal Star.

Photo: I. Liszczyńska

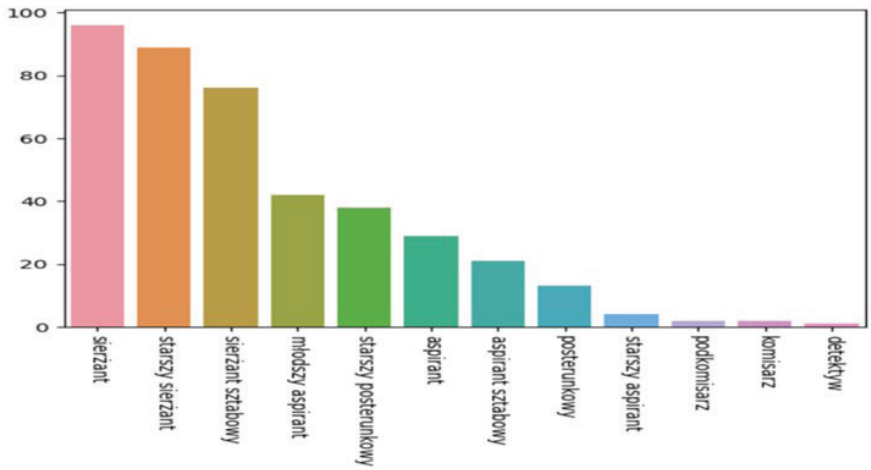
This decoration is awarded to police officers who, whether on or off duty, responded to danger by putting the health and lives of bystanders above their own. Focusing on the issue of suicide, this analysis examines data on life-saving interventions by police officers in situations involving suicidal behavior. From June 2013 to September 2021 in the Wielkopolska voivodeship, 223 suicide attempts were thwarted thanks to effective interventions by 380 policemen and 33 policewomen (Niezależny Samorządny Związek Zawodowy Policjantów woj. wielkopolskiego, 2021). The chart below provides a breakdown by age.



The largest group of police officers rewarded for rescuing would-be suicide victims are those in the age brackets of 25–30 and 34–35. When considering the seniority of these officers, we find that the most numerous group had between 3 and 7 years of service, while the number of officers with over 15 years of service is significantly lower, as shown in the chart below.



Regarding the ranks of the decorated officers (ranging from Senior Constable to General Police Inspector), the majority are from the sergeant ranks (Sergeant, Senior Sergeant, and Staff Sergeant), while the least represented ranks are junior officers and the most senior ranks.

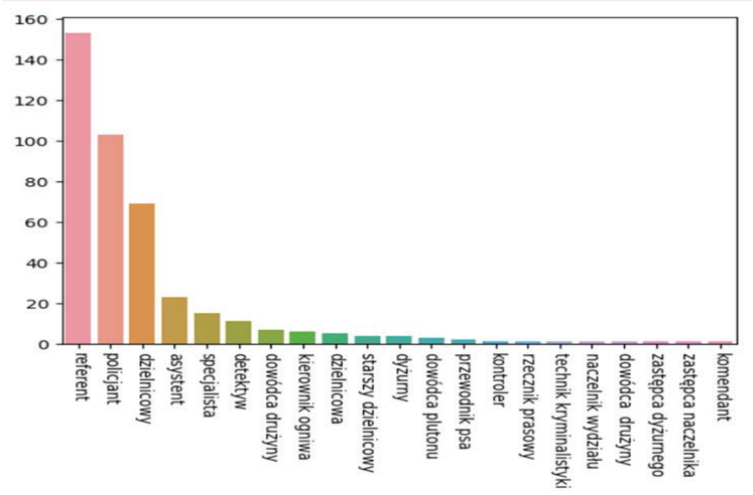


The numerical breakdown by rank is as follows:

- Sergeant: 96
- Senior Sergeant: 89
- Staff Sergeant: 76
- Junior Aspirant: 42
- Senior Constable: 38
- Aspirant: 29
- Staff Sergeant: 21
- Constable: 13
- Senior Aspirant: 4
- Deputy Commissioner: 2
- Commissioner: 2
- Detective: 1

In the police force, besides distinctions by rank, there are also distinctions by official position. Positions range from Trainee, the first grade, to Chief of Police, the 16th grade. The most common grades are from 3 to 6, including roles such as Clerk, Cell Manager, Deputy Duty Officer, Station Manager, District Manager, Duty Officer, Platoon Commander, and Specialist.

This structure is similarly reflected among the officers awarded the Crystal Star.

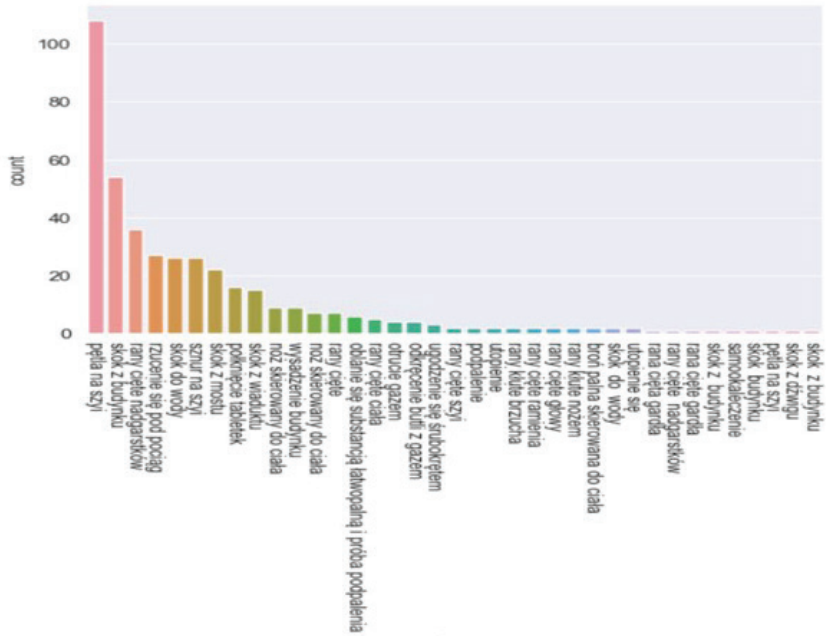


In numerical terms, the breakdown is as follows:

- Police Clerk: 153
- Police Officer: 103

- District Officer: 69
- Assistant: 23
- Specialist: 15
- Detective: 11
- Squad Leader: 7
- Cell Manager: 6
- Senior District Officer: 5
- Duty Officer: 4
- Platoon Commander: 3
- Dog Handler: 2
- Controller: 1
- Press Spokesperson: 1
- Forensics Technician: 1
- Department Head: 1
- Team Commander: 1
- Deputy Duty Officer: 1
- Deputy Chief: 1

Among the most common suicidal behaviors that prompted intervention by police officers awarded the Crystal Star, hanging was the most frequent method, while jumping from a building was the rarest. The detailed breakdown is shown in the chart below:



The numerical breakdown is as follows:

- Hanging (neck noose): 53
- Jumping from a building: 33
- Throwing oneself under a train: 16
- Jumping into water: 12
- Rope around the neck: 12
- Jumping from a bridge: 10
- Jumping off an overpass: 9
- Swallowing pills: 9
- Blowing up a building: 5
- Knife pointed at the body: 5
- Cuts: 3
- Cuts to the body: 3
- Dousing oneself with a flammable substance and attempting to set fire: 3
- Unscrewing a gas tank: 2
- Jumping into water: 1
- Gas poisoning: 1
- Jumping from a crane: 1
- Arson: 1
- Self-harm: 1
- Stabbing oneself with a screwdriver: 1
- Cut wounds to the neck: 1
- Jumping from a building: 1
- Drowning: 1
- Cut wounds to the throat: 1
- Cut wounds to the arm: 1
- Stab wounds to the abdomen: 1
- Firearm pointed at the body: 1
- Cut wounds to the head: 1
- Jumping from a building: 1
- Stab wounds with a knife: 1

The various methods that potential suicide victims use to attempt taking their own lives reveal a predominant trend: hanging by tightening a noose around the neck, which can result in strangulation or cervical spine fracture, severing the spinal cord. This aligns with Anna Nimecunowicz-Janica's analysis, which found that over 60% of men and 12% of women choose this method (Bolechała et al., 2003). When officers respond to such reports, they typically rush to the scene and act quickly to cut the noose or remove it from the victim's neck, followed by cardiopulmonary resuscitation if the spinal cord is not damaged.

In these situations, the officers' decision-making skills, determination, medical training, composure, and experience in handling suicide interventions are crucial (Osteen, 2020). To understand the full scope of what officers face, it is important to consider their psychological profile. They are often deeply committed to their duty, which can lead to stress from the demands of their job, conflicts with superiors, the threat of disciplinary action, lack of support from colleagues, unclear promotion paths, and bureaucratic burdens (Hołyst, 2012).

Additionally, officers deal with personal issues such as marital and family conflicts, low pay, bank debt, low social prestige of their job, high demands, and stress management difficulties (Ogińska-Bulik, 2003). These factors contribute to a higher risk among officers of depression (14.6%), post-traumatic stress (14.2%), and suicidal thoughts (27.7%) (Syed, 2020). Understanding these pressures helps put into perspective the challenges officers face when trying to dissuade someone from committing suicide.

Conclusion

Police officers face a wide range of situations daily, involving chases, thefts, murders, and human corpses, including those of children (Hallenberger, 1998). These experiences expose them to mental strain and tension that often cannot be immediately relieved. Despite these challenges, they continually face their own burdens and limitations while making difficult decisions for which they bear responsibility. Every officer understands the weight of this responsibility, especially when saving a life in a situation of suicide. Between June 2013 and September 2021, there were 223 successful life-saving interventions, each unique with its own set of circumstances and unknowns. During these moments, officers felt pride, joy, and a sense of purpose in their duties. Police officers often face unpredictable and dangerous situations, such as unjustified claims from families if a life is not saved, the risk of being pulled along when someone jumps from a building, or threats from individuals attempting suicide who may be wielding sharp instruments or weapons. Despite the risks to their own lives and health, officers intervene because they prioritize saving another person's life over their own safety. Given these facts, it is only fitting to honor officers who remain faithful to their oath with the Crystal Star decoration.

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Impact of the "Suicidological Library" Series on the Advancement of Polish Suicidology

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Abstract

Since 2021, researchers affiliated with the Polish Association of Suicidology have initiated the publication of multi-author monographs as part of the "Suicidological Library" series. To date, three volumes have been released. This article aims to explore how these monographs have contributed to the field of suicidology. Each volume was produced under the scientific editorship of Prof. Brunon Hołyst and involved a diverse editorial board comprising leading Polish suicidologists as well as experts from the USA, Sweden, Germany, Austria, and Canada. While the "Suicidology" yearbook helped unify the suicidology research community and disseminate knowledge between 2005 and 2018, the "Suicidological Library" series has further strengthened this trend. It not only presents the findings of esteemed Polish suicidologists, but it also showcases the research of emerging scholars in this challenging field.

Keywords: suicide, suicide attempt, suicidal behavior, suicidology

Introduction

The Polish Association of Suicidology, established to promote knowledge on suicidology and to reduce suicide and suicide attempts, has been dedicated to research from its inception. Between 2005 and 2018, their efforts resulted in numerous publications that brought the scientific community together and spread valuable information on suicidology.

In 2020, the Association's scientific community launched the "Suicidological Library," a series of multi-author monographs. This initiative aligns with the Association's Statute, which calls for "initiating and conducting research in the field of suicidology."

Prof. Brunon Hołyst, PhD, the president of the Association, became the series' scientific editor. An editorial board of leading Polish suicidologists was established, including Agnieszka Gmitrowicz, Daria Biechowska, Andrzej Bałandynowicz, Adam Czabański, Antoni Florkowski, Brunon Hołyst, Józef Kocur, Marta Makara-Studzińska, Norbert Malec, Halszka Witkowska, and others. Additionally, renowned international suicidologists such as Nestor Kapusta (Austria), David Lester (USA), Armin Schmidtke (Germany), and Danuta Wasserman (Sweden) joined the editorial board.

The Polish Association of Suicidology funded all monographs in the "Suicidology Library" series. Between 2021 and 2023, three volumes were published, featuring dozens of scholarly works by both prominent Polish suicidologists and emerging researchers in the field.

Publications in the "Suicidological Library" Series, 2021–2023

In 2021, the first volume of the "Suicidological Library" series was published, titled "Suicide Prevention: Motivation of Suicidal Behavior." In the foreword, scientific editor Prof. Brunon Hołyst writes, "[t]his new series aims to fill a gap in the existing literature on preventing suicidal intentions. Its purpose is to analyze motivation and promote new methods to prevent cases of voluntary death." Hołyst also encouraged readers to share comments to further expand on the topics covered.

The first chapter, written by Maria Szyszkowska (2021), explores suicide from a philosophical perspective. In the second chapter, Brunon Hołyst (2021) presents a model for understanding the motivation behind suicidal behavior. Andrzej Bałandynowicz (2021), who authored the third chapter, discusses the phenomenon of pacifism. In the fourth chapter, Włodzimierz Adam Brodniak (2021) examines the erosion of social ties as a risk factor for suicide, and identifies causes such as divorce, family violence, the rise in single-person households, emigration issues, and the impact of new media.

The second part of the volume features eight chapters, each addressing different aspects of suicidology. Norbert Malec (2021) discusses the conditions of imprisonment and the personal safety issues of convicts, highlighting the high incidence of suicide among prisoners. Adam Czabański (2021) explores the motivation and mechanisms behind spontaneous altruistic suicides on the battlefield, with examples from World War II, the Iraq War, and the war in Afghanistan. Chapter seven, authored by Maciej Kijowski (2021), provides detailed data on suicides among sailors on Polish naval vessels. Marta Dora (2021) examines the factors influencing suicide risk in non-heterosexual and transgender individuals, with a focus on risk factors and prevention strategies. In the ninth chapter, Marlena Stradomska (2021) analyzes the use of firearms in suicides. Next, Halszka Witkowska (2021) delves into suicide notes, treating them as a genre of expression and a cultural phenomenon. The penultimate chapter, written by Maria Grzegorzewska (2021), discusses the support that

teachers can provide to students at risk of suicide. Finally, Alexander Ferens (2021) outlines the concept of the position of a suicidologist within a local government institution and describes the role and responsibilities of such a position.

The second volume of the "Suicidological Library," titled "Suicide Prevention: Suicidal Behavior of the Elderly," was published in 2022. It comprises 11 chapters authored by researchers from various scientific centers across Poland. Professor Brunon Hołyst writes, "[o]ld age does not have to mean a voluntary relinquishment of life. While the circumstances of existence at this age often impede daily joy, the belief that life is sacred should deter us from making a tragic choice."

Adam A. Zych (2022) opens the volume with an exploration of attempted suicide, suicide in old age, and parasuicide. Next, Agnieszka Gmitrowicz (2022) examines silent suicide among people over 65. Norbert Malec (2022) follows with a discussion on police statistics regarding suicide attempts by the elderly in Poland. Daria Biechowska's contribution (2022) focuses on the prevalence and risk factors of suicide among the elderly between 2012 and 2021. In the fifth chapter, psychological hygiene and suicidal behavior among seniors are addressed by Andrzej Balandynowicz (2022).

Brunon Hołyst (2022) delves into the etiology of suicide among the elderly, highlighting the negative effects of loneliness and suggesting preventive measures to reduce the incidence of suicide among seniors. Joanna Kufel-Orłowska (2022) contributes insights into the prevention of suicide among the elderly in the seventh chapter. The eighth chapter, co-authored by Adam Czabański and Halszka Witkowska (Czabański & Witkowska, 2022), examines the characteristics of suicidal behavior in the elderly.

Julia Ciołek (2022) provides a review of the literature on the interplay of risk and protective factors in suicide prevention among older adults. Marlena Stradomska (2022) presents a case study on volunteer work with seniors from a suicidological perspective in the tenth chapter. Finally, Natalia Wojak (2022) discusses support and social activation for seniors in the context of suicide prevention.

The third volume of the "Suicidological Library," titled "Suicide Prevention: Suicidal Behavior in Children and Adolescents," is the most extensive in the series to date, featuring 22 chapters. It begins with a thought-provoking statement from Brunon Hołyst:

> Our attitudes toward children and adolescents should be guided by both empathy and reason. We must place the world of their perceptions, views, problems, addictions, sufferings, and daily concerns at the forefront of our attention. A tolerant and understanding approach, particularly from parents, helps to strengthen the mental well-being of children and young people and protects them from making tragic decisions. When a child loses the meaning of life, it is crucial to offer them the hope of a positive future.

The first chapter of this volume focuses on the suicidal behavior of young children aged 7–12. Although this is not a widespread issue, the number of suicides among

children in this age group has been increasing each year, with a rising proportion of these tragedies involving girls (Czabański, 2022). In the second chapter, Norbert Malec (2023) examines suicidal behavior among children and adolescents from 2012 to 2022, drawing on police statistics. The third chapter, authored by Szmajda and Gmitrowicz (2023), presents research on risk factors for suicide attempts among adolescents receiving psychiatric treatment. Following this, Anna Gil (2023) discusses the impact of recent reforms in child and adolescent psychiatry on the rising number of suicide attempts among Polish adolescents. Marta Makara-Studzińska and Daria Biechowska (2023) explore the psychosocial determinants of suicidal behavior in their chapter. Next, Halszka Witkowska (2023) offers a comprehensive look at the etiology of suicidal behavior among children and adolescents from various perspectives.

The seventh chapter by Brunon Hołyst (2023) addresses the motivations behind suicidal behavior, stressing the influence of family dynamics, school environment, and peer interactions. In the eighth chapter, Sowińska, Kamińska, Kołodziej, and Szulczak (Sowińska et al., 2023) examine the youth suicide crisis in Poland in detail.

Andrzej Bałandynowicz (2023) explores the connections between negative parenting and suicidal behavior among children and adolescents in his chapter. Agnieszka Kalwa (2023) describes research on temperament and attachment styles in families of adolescents who have attempted suicide. Finally, Joanna Kufel-Orłowska (2023) discusses juvenile suicide prevention systems in Poland and compares them with those in selected countries worldwide.

The twelfth chapter explores the risk factors associated with self-harming behavior in adolescents (Araucz-Boruc, 2023). Joanna Podemska (2023) then examines preventive measures for children and adolescents in suicidal crises from the perspective of an educator and therapist. The following chapter, focused on suicide risk prevention among minors in postvention, is authored by Rudnik (2023). The fifteenth chapter addresses the significant issue of social media and its connection to self-harming behavior among adolescents (Zalewska, 2023).

The sixteenth chapter outlines the school support system for students following a suicide attempt, contributed by Kicińska and Palma (2023). The role of school psychologists in preventing suicide among children and adolescents is discussed in the seventeenth chapter by Kozłowski and Kozłowska (2023). Kazimiera Pierzchała (2023) describes the Catholic Church's role in preventing juvenile suicide in the eighteenth chapter. Chapter nineteen, by Kazimierz Kopczyński (2023), deals with the precautions needed when using pharmacotherapy to treat depression and somatic diseases. Marlena Stradomska (2023) discusses suicide prevention within the activities of a sociotherapy center for children and adolescents in chapter twenty. The twenty-first chapter presents a case study of child and adolescent suicide by Jabłoński (2023). Finally, the twenty-second chapter, by Sygit-Kowalkowska (2023), describes the role of a forensic psychologist in working with minor witnesses exhibiting suicidal behavior.

Among the 45 publications in these multi-author monographs, there is a blend of theoretical and practical work, contributed by both scholars and practitioners dedicated to reducing suicides and suicide attempts in Poland.

Impact of the "Suicidological Library" Series on the Advancement of Polish Suicidology

The three volumes of the "Suicidological Library" series encompass a total of 45 research papers authored by suicidologists from various generations. These works expose readers from diverse professions related to suicide and suicide prevention to a broad range of important topics. The research comes from scholars across different scientific communities who collaborate with The Polish Association of Suicidology. The contributors include psychiatrists, psychologists, sociologists, educators, lawyers, cultural scholars, and philosophers. Many of these authors have not only engaged in scholarly research, but have also made significant practical contributions to advancing suicide prevention efforts in Poland. Creating monographs on suicidology involves collaboration among suicidologists from across Poland. By bringing together both theoretical and practical experts, this effort facilitates a nationwide exchange of experience. Such academic collaboration enriches the field and significantly advances the field of suicidology.

Looking ahead, the Polish Association of Suicidology plans to develop more multi-author scientific monographs in the "Suicidological Library" series, including contributions from international scholars. These future publications aim to foster a deeper scientific understanding of suicidal behavior and support the development of programs designed to reduce suicides and suicide attempts.

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