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Childhood Trauma and Developmental Processes

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Summary

The importance of childhood trauma on development processes are described in numerous studies. Traumatic childhood experiences have a profound impact on many different areas of child/adolescent functioning - on an emotional, behavioral, physical, cognitive, and thought level.

Clinical entities associated with the traumatic experience in children and adolescents are common in psychiatric practice. Frequent manifestations of these experiences are described as PTSD, but also as depression, as anxiety, or somatization, as behavior disorders or dissociative reactions. In clinical work with children and adolescents, it is necessary to emphasize the importance of understanding traumatic experiences through the dimensions of developmental processes.

This article illustrates the complexity of the clinical presentation of adolescents with a traumatic experience during childhood.

Key words: *child, adolescent, development processes, trauma, psychopathology*

Sažetak

Traume doživljene tijekom djetinjstva i utjecaj trauma na razvojne procese opisani su u brojnim studijama. Traumatska iskustva tijekom djetinjstva imaju intezivan tjecaj na mnoga različita područja funkcioniranja djeteta/adolescenata - na emocionalnoj, bihevioralnoj, fizičkoj, kognitivnoj i misaonoj razini.

Klinički entiteti povezani s traumatskim iskustvom u djece i adolescenata česti su u psihijatrijskoj praksi. Manifestacije ovih iskustava opisuju se kao PTSP, ali i kao depresija, anksioznost ili somatizacija, kao poremećaji ponašanja ili disocijativne reakcije. U kliničkom radu s djecom i adolescentima potrebno je naglasiti važnost razumijevanja traumatskih iskustava kroz dimenzije razvojnih procesa.

Ovaj članak ilustrira složenost kliničkih slika adolescenata s traumatskim iskustvom tijekom djetinjstva.

Ključne riječi: *dijete, adolescent, razvojni procesi, trauma, psihopatologija*

Introduction

The importance of childhood trauma on developmental processes are described in numerous studies. Traumatic childhood experiences have a profound impact on many different areas of child/adolescent functioning - on an emotional, behavioral, physical, cognitive, and thought level. Children and adolescents can experience traumatic situation in family, school, and society, as well as participants in natural disasters, war, terrorism, epidemics and other forms of violence and tragedies.

Clinical practice of child and adolescent psychiatry many times shows that most of childhood trauma begins at home.

Childhood trauma

Isolated but intense traumatic events tend to produce conditioned behavioral and biological responses in children and adolescents, most commonly with the manifestation of a spectrum of PTSD diagnoses. Recurrent traumas have a strong adverse effect on the development of the mind and the brain. Chronic trauma has a pervasive effect on neurobiological development of the child and adolescent.

In conditions of healthy development, child learns to regulate his own behavior by anticipating his caregiver's responses to him. These interactions allow him to create "internal work models," through the internalization of the affective and cognitive characteristics of their primary relationships. As early experiences are gained in the context of the developing brain, neural development and social interaction are inseparably linked. According to Tucker (Tucker, 1992) "For the human brain, the most important information for successful development is conveyed by the social rather than the physical environment. The child's brain must begin participating effectively in the process of social information transmission that offers entry into the culture. "

Early patterns of attachment shape the quality of information processing throughout the life span. Secure infants learn how to trust - what they feel and how they understand the world, that allows them to rely both on their emotions and thoughts to react to any given situation. Their experiences of feelings understood provides them that they can make good things happen, but if they do not know how to deal with difficult situations, they can find people who can help them. Safe children learn words to describe their emotions, learn to communicate and express their feelings. They can describe their physiological states (e.g., when they are hungry or thirsty) as well as emotional states (e.g., when they are sad or happy). Their parents can recognize how their children are feeling and help them when they are in trouble to regain a sense of security and control. Secure attachment relieves suffering caused by trauma.

When trauma occurs in supportive families, the child's reaction is likely to resemble that of a parent. In conditions where the trauma is massive or when the caregivers themselves are the source of the traumatization, children cannot modulate their arousal. This causes a breakdown in their ability to process, integrate and categorize what is happening.

At the core of traumatic stress is a breakdown in the ability to regulate internal states. If the traumatization persists, children dissociate - relevant sensations, affects, and cognitions cannot be connected (separated into sensory fragments) and, as a result, these children cannot understand what is happening or devise and take appropriate action plans.

When caregivers are emotionally absent, inconsistent, frustrating, violent, intrusive, or neglectful, children are liable to become intolerably distressed and unlikely to develop a sense that the external environment can provide relief. Thus, children with insecure attachment patterns have trouble relying on others to help them, while unable to regulate their emotional states by themselves. As a result, they experience excessive anxiety, anger, and longings to be taken care of. These feelings may become extreme and lead to dissociative states or self-defeating aggression. Spaced out and hyperarousal children learn to ignore either what they feel (their emotions), or what they perceive (their cognitions).

When children are unable to achieve a sense of control and stability, they become helpless.

If they are unable to understand what is happening and cannot do anything to change it, they switch from a (stressful) stimulus to a (fight / flight / freeze) response without the ability to learn from experience. In situations after that, when they are exposed to reminders of a traumatic experience
(images, sounds, smells, physiological states, situations, etc.) they tend to behave as if they have been traumatized again – a catastrophic sensations. Many of the problems of traumatized children can be understood as the child's effort to minimize an objective threat in order to regulate emotional stress. Often the environment does not understand the nature of the child's / adolescent's behavior, it could be described as oppositional, rebellious, unmotivated, or antisocial behavior.

Clinical practice

The reactions of the child / adolescent after the traumatic experience serve to change the senses associated with the trauma. Over time, tolerance grows for the experienced traumatic experience that is accepted as a part of life, which does not mean that the traumatic experience was unnoticed. Child / adolescent reactions are normal reactions to abnormal occasions, a set of feelings of thought, and actions aimed at mitigating the effects of the traumatic experience. During further development, psychopathological manifestations may occur that may not directly indicate the traumatic experience.

Clinical entities associated with the traumatic experience in children and adolescents are common in psychiatric practice. Manifestations of these experiences are described as PTSD, but also as depression, as anxiety, or somatization, often as behavior disorders or dissociative reactions. The diagnosis of PTSD is not developmentally sensitive and does not adequately describe the impact of exposure to childhood trauma on the developing child. Currently clinicians have no other diagnostic entity that describes the pervasive impact of trauma on child development. These children are given a range of "comorbid" diagnoses, as if they occurred independently from the PTSD symptoms, none of which do justice to the spectrum of problems of traumatized children, and none of which provide guidelines on what is needed for effective prevention and intervention. Underneath depressive and anxiety states, somatization, behavioral disorders, or dissociative reactions in clinical practice, we often find traumatic experiences.

The examples that follow below illustrate the complexity of the clinical presentation of adolescents with a traumatic experience during childhood.

Vignette 1: ANNA, 17 years
admitted to hospital with a diagnosis of depression

Symptoms at admission were reduced and unstable mood, anger, aggression against things, self-harm behavior. She has been living with her mother for the last 3 years, before she lived with her father and mother in low. Parent divorced when she was 4 years old. Mother's observations about Anna state self-harm from 14 years, last month worse than before, lack of communication, alone, without friends, worried her.

Anna's mother was treated because of depression. Actually she is unstable, confused, try to be supportive, but helpless.

Parents did not notice the traumatic effects of divorce and mother's depression on their child until she became depressed and began to self-harm.

Vignette 2: TINA, 14 years
admitted to hospital with a diagnosis of acute psychosis

Symptoms at admission were suicidal ideation, reduced and unstable mood, anger, aggression against things, screaming without control, problems in school and with pears...

For the last year she has been living with her mother younger brother and father in low, before she lived with her father and grandmother without contacts with mother. Parent divorced when she was 7 years old. Tina describes emotional abuse by her father and grandmother.

Tina's mother was treated because of depression after divorce, actually is stable, supportive, engaged, in stable partner relation. Tina has good relations with father in low.

Tina was discharged from the hospital with diagnoses Adjustment disorder, Short psychotic episode, Psoriasis, Reumatoid artritis. Motivated to continue treatment in the day hospital, which included individual and group psychotherapy and medication.

Vignette 3: MAIA, 13 years
admitted to hospital with a diagnosis of Anorexia nervosa

Symptoms at admission were reduced diet, low body weight, preoccupation with physical appearance, reduced and unstable mood, anger, suicidal ideation, aggression, peer problems.

Maia lives with her father, older brother, and father's parents. Her mother died when she was 7 years old. Her father is often absent due to obligations at work and a new partnership. Maia is not close with brother, he is "in his world". Lack of communication in family. All family members have their own way of dealing with loss. Interactions in family are reduced, focused on facts, without presenting or talking about emotions, non-stable, non-supportive atmosphere.

All patients are adolescents whose developmental processes are ongoing and are shaken by the experience of trauma that was not recognized. They show different ways of dealing with trauma, different levels, and qualities of relationships with family members. There are significant differences in the ability or inability of mothers / fathers to recognize the suffering of a child. Clinicians recognized different diagnoses when assessing hospitalization.

During the diagnostic process, traumatic experiences were found and presented in different ways in the clinical presentation.

Conclusion

Clinical entities associated with the traumatic experience in children and adolescents could be described as PTSD, but also as depression, dissociative reactions understood as acute psychoses, eating disorders or other diagnosis.

Trauma affects the processes of growth and development. Traumatic experiences affect children's expectations of the world, the security of living with others, and a sense of personal integrity. Trauma changes the inner images of the child's world, shapes the understanding of oneself and others, leads to expectations or expectations in relation to the future, affects present and future experiences and behavior.

In clinical work with children and adolescents, it is necessary to emphasize the importance of understanding traumatic experiences through the dimensions of developmental processes.

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