The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 9, Issue 1, January- March, 2021
DIP: 18.01.041/20210901, DOI: 10.25215/0901.041
http://www.ijip.in

Research Paper

A walk through the hall of childhood trauma

Rejoe Mohan[1]*

ABSTRACT

Pervasiveness of childhood trauma is something that necessitates a sense of concern and immediate attention. The immediate exposure to trauma in children and adolescents can have a significant impact on their psychosocial functioning. This article is a walkthrough the childhood trauma and the treatment modalities that are currently used to deal with trauma caused in childhood.

Keywords: *Childhood Trauma*

As Albert Bandura rightly pointed out, children do learn from their environment through observation (Bandura, Grusec, & Menlove, 1966). Therefore, if such learning is caused by traumatic situations, it can be quite problematic, as the childhood days are the times when foundations are being laid for personality development. The effects caused as a result of such emotionally painful experiences faced by the child leading to lasting mental and physical effects on the child are termed as childhood trauma. These experiences that cause traumatic effects on the child are called Adverse Childhood Experiences (ACEs) (Sacks, Murphey, & Moore, 2014), and may include intentional forms of violence such as childhood physical or sexual abuse, or domestic violence, sudden loss, or separation from parents or caregivers, the impact of natural disasters, accidents or war and chronic stress in response to painful medical procedures. These experiences can be exhausting in nature and might take place frequently, causing the children to deal with the stress, even when they are not equipped to deal with it (World Health Organization., n.d.).

Understanding of these experiences began in the mid-1990s when Vincent Felitti, the head of Kaiser Permanente's Department of Preventive Medicine in San Diego, decided to find more about the participants who were dropping out from the Kaiser Permanente's obesity clinic. He conducted interviews with the clients who had left the program to discover that a majority of those clients were sexually abused as children. This made him ponder over the thought that, obesity might perhaps be a coping mechanism for those clients. This was the first breakthrough in disseminating the concept of Adverse Childhood Experiences (Ellen, 2002).

Prevalence of childhood trauma is something that requires a sense of concern and immediate attention. There are international studies that show that childhood trauma is quite common

[1]Registered Clinical Counsellor in British Columbia, Canada
*Responding Author

Received: December 27, 2020; Revision Received: February 18, 2021; Accepted: March 03, 2021

across the world. Bethell, Newacheck, Hawes and Halfon (2014) had opined that nearly half of all children in the United States are exposed to at least one traumatic social or family experience. In another study conducted by UBC, it was noted that roughly one in three Canadians have experienced childhood trauma, with the greatest number of reported traumas being caused due to the exposure to domestic violence (Lake, 2016).

Other than domestic violence, many other ACEs can cause childhood trauma. According to a study that looked into understanding the prevalence of adverse childhood experiences, some of the other significant ACEs are caused due to parental divorce or separation, parental death, parental incarceration, violence among adults in the home, victim or witness to neighborhood violence (can be caused by war or other factors), living with a mentally ill adult, living with someone who has a substance abuse problem, experiencing economic hardship often, such as the family finding it difficult to afford food and housing (Kirk, 2018).

Moreover, when the traumatic experience is due to another person and not an event, it is called interpersonal childhood trauma. This happens when the child is sexually, physically, or emotionally abused either when the caretaker is causing physical or emotional neglect, or the parents of the child are affected by Post-Traumatic Stress Disorder (PTSD). These traumatic situations have the potential to disturb the secure attachment the child is meant to experience in the early days.

John Bowlby's view on Childhood Trauma

John Bowlby, a psychoanalyst, believed that the mental and behavioral concerns faced by an individual could find its source in childhood. And so he formulated his attachment theory around the premise that children are born being "biologically pre-programmed", to form an attachment with others, as it is the only way they could survive (McLeod, 2017). He stated that that the early attachment helps the child in creating experiences with the caregiver, which the child would internalize to create lenses through which the child would see the self and others in close relationships. This perception, in turn, influences how that individual would perceive and cope with stress (Bretherton, 1992).

When a child who is born with a biological expectation to form secure attachments is met with adverse traumatic experiences, the formation of this secure attachment is disrupted(Ogle, Rubin, & Siegler, 2015). Due to such disruption of attachment, the child might not be able to develop a secure parental attachment, which in turn can have adverse consequences on the child, including an increase in the levels of stress hormones, negative self-image, negative view of others, lack of proper regulation of emotions and/or behaviors (Anderson, & Gedo, 2013). Apart from experiencing these consequences, the insecure attachment causes a sense of fearfulness and helplessness which are usually pervasive throughout the lifespan (Lyons–Ruth, Yellin, Melnick & Atwood, 2005). Research indicates that a fearful individual is more likely to perceive and interpret situations as stressful; which increases the vulnerability in that individual to experience adverse psychological symptoms, which can even cause the development of severe psychopathology (Pielage, Gerlsma, & Schaap, 2000). This goes on to show how childhood trauma disrupts the attachments causing severe impacts in the life of the individual.

IMPACT OF CHILDHOOD TRAUMA

The immediate exposure to trauma in children and adolescents can have a significant impact on their psychosocial functioning (Little & Little, 2013; Schoedl et al., 2010). Around 90%

of the adults in the United States have been found to be having exposure to some traumatic event during their lifetime, mostly prior to adolescence. Children exposed to traumatic or stress-provoking events can result in symptoms including intrusive re-experience, avoidance of associated stimuli, negative alterations in cognitions and mood, or marked alterations in arousal and reactivity, etc. characterizing the symptoms of Post-Traumatic Stress Disorder (PTSD). Depressive and anxiety features are also commonly found among the survivors of trauma during the course of life (Lenz & Hollenbaugh, 2015).

From a psychodynamic perspective, early childhood experiences exert a constant influence on the lives of individuals. From cradle to the grave, a person is influenced by the influence of life experiences. Belief systems -as embarked by different perspectives- emerge out of such experiences and act as a resort for the individuals to get hold of their lives. Such beliefs may function as a means to fulfill the psychological needs of the person. But when these beliefs go overboard, a psychopathological concern may arise.

A cross-sectional study conducted to understand the prevalence and clinical impact of Childhood Trauma in Patients with Severe Mental Disorders, with a sample size of 102 patients who were diagnosed with schizophrenia, bipolar disorder, or schizoaffective disorder, had found that around 47.5% of patients had gone through childhood abuse. The findings emphasize the association between childhood abuse and severe mental disorders (Alvarez, et al., 2011).

Another study that looked into understanding the impact of childhood trauma in the development of the brain stated that childhood trauma has a cavernous effect on the emotional, behavioral, cognitive, social, and physical functioning of children. It was indicated that since the child's brain is just developing to consolidate and integrate new information in a "use-depended fashion", the more the traumatic situation the child faces, the more likely they are to have neuropsychiatric symptoms following trauma. This is because the trauma causes the child to be in a state of hyperarousal or dissociation (Perry, Pollard, Blakley, Baker, & Vigilante, 1995).

The experience of traumatic events in childhood has also been associated with the occurrence of severe medical conditions during the life span of individuals. A longitudinal study that investigated the long-lasting impact of trauma had found that around 64% of participants experienced at least one exposure, and of those, 69% reported two or more incidents of childhood trauma. The study was conducted among 17,000 participants ranging in age from 19 to 90 and verified their medical histories over time as well as childhood exposure to abuse, violence, and interruptions in caregiving. The findings also indicated a strong link between childhood trauma exposure, high-risk behaviors (e.g., smoking, unprotected sex), chronic illness such as heart disease and cancer, and early death among the participants (Su, Roberts & Loucks, 2015).

Given the wide-ranging prevalence of traumatic experiences at an early age; identifying, evaluating, and facilitating interventions for the mitigation of symptoms associated with the trauma is a sensible task for therapists (Lenz & Hollenbaugh, 2015).

TREATMENT OF CHILDHOOD TRAUMA

Understanding the impact helps us in comprehending the kind of treatment that might be best suited for individuals exposed to childhood trauma. The common target outcomes for treating individuals with exposure to trauma in childhood and adolescence include reducing

the influence of thinking styles, affective responses, and ineffective behaviors that maintain the symptoms further (Cohen& Mannarino, 2008).

If an individual (be it an adult or a child) walks in for treatment for childhood trauma, the therapist should conduct a risk assessment to understand if the trauma has caused the person to feel suicidal or lead to self-harm behaviors. In the case of a child walking into the session and the therapist finds out that the child might be going through traumatic situations, the therapist must ensure that the child services is informed. The therapist also has the responsibility to inform the caregivers and ensure necessary legal or medical procedures for safeguarding the child.

There are different kinds of therapies that are being used for treatment purposes. The former approach, Component-based Psychotherapy (CBP) is an evidence-informed framework created to guide clinical intervention with an adult who has been victims of childhood trauma. This particular model views eating disorders, addictions, self-harming behaviors, avoiding closeness, depression, and anxiety as ways implemented to manage dysregulation that is happening within the client due to childhood trauma. CBP has four important components namely (a) relationship, (b) regulation, (c) working with dissociated aspects of the self, and (d) the narrative. The relationship component focuses on the therapeutic relationship between the therapist and the client. The regulation component looks into understanding how to increase the self-regulatory capacity of the client without the therapist being overwhelmed. Working with the dissociated aspects of the self involves integrating the concept of self which was disintegrated or not properly developed due to the adverse childhood experiences. The final component, the narrative, involves the therapist working into the development of identity by the integration of the experiences faced by the client. This process involves meaning-making, of the traumatic experiences the client has gone through as a child (Grossman, Spinazzola, Zucker, & Hopper, 2017).

Multi-modality trauma treatment (MMTT) is another therapeutic model that was created in 1998 for helping traumatized adolescents in the mitigation of symptoms. The approach a 14-session format involving psychoeducation, narrative writing (writing about the traumatic experience), exposure and relaxation techniques, and cognitive restructuring. Empirical evidence indicates that MMTT can cause a marked decrease in traumatic symptoms experienced by the child or the individual exposed to traumatic events in childhood (Vitelli, 2012).

Another approach gaining momentum in recent times is the Trauma-Focused Cognitive Behavior Therapy (TF-CBT). This was developed exclusively for children and adolescents who are experiencing PTSD symptoms (Cohen, Mannarino, Kliethermes, & Murray, 2012). The TF-CBT comprises of both trauma-sensitive interventions as well as cognitive restructuring. It is a short treatment modality that spans over 12–16 weeks. The fundamental principle revolves around getting the child exposed to the traumatic experience through the various modes of treatment, including psychoeducation, relaxation training, affective coping skills, cognitive reframing, trauma narration, in vivo exposure, conjoint child and parent sessions, and enhancement of future safety (popularly known by the acronym PRACTICE) and emphasizes on developing the coping skills through various activities (Cohen et al., 2006).

However, while using different therapeutic modalities to assist the client, the therapist needs to make sure that the client does not become re-traumatized due to the narration of traumatic

experiences that happen within the sessions. This is because when clients are re-traumatized within the session, there is a possibility of them resorting back to the maladaptive reactions and behaviors they were indulging in before coming for the session; or they might disassociate from the session and may not come back for the consecutive sessions. Therefore, the therapist needs to regulate the emotions of the client and not make the client feel overwhelmed (Bicknell-Hentges & Lynch, 2009). The client's mind and emotions should not be allowed to wander far away from the "window of tolerance". Dan Siegel, was the first to define "window of tolerance" as an optimal space, in which the emotions and thoughts of the clients are in an optimal amount allowing the client to function. If the client is overwhelmed (hyper-aroused) or becomes emotionally number (hypo-aroused), the session would not be therapeutic (Dezelic, 2003). Therefore, whenever the therapist feels that the client is moving significantly away from the window of tolerance, the client would be given opportunities to engage in exercises that would re-orient the client to the present.

Cultural Sensitivity. Childhood trauma can also occur due to the culture and the society the child is a part of. In other words, cultural trauma can be a contributing factor for the childhood trauma since culture is part of the environment the child is growing up in. Cultural trauma can be defined as a collective feeling of a group of people (such as a society or a country), created as an aftereffect of being subjected to stressful events that had the potential to create wounds in the collective consciousness of that group of people (Alexander, Eyerman, Giesen, Smelser, & Sztompka, 2004). Colonization would serve as a perfect example of a stressful event that has caused cultural trauma. Trauma-related concerns can differ from one culture to another. And therefore, it becomes important for the therapist to alter the therapy to each client's situation keeping in mind the fact that the collective culture of that client and that systems created in that culture maintains and heals the trauma (Schnyder, et al., 2016).

CONCLUSION

This paper was a quick brisk through the hall of childhood trauma. Childhood trauma can be seen as an underlying factor in many psychiatric disorders, including personality disorders. And even if it does not cause such adverse results in everyone, those internal wounds can cause the child to grow old without being able to "self-actualize" or live life in its complete sense.

REFERENCES

Alexander, J. C., Eyerman, R., Giesen, B., Smelser, N. J., & Sztompka, P. (2004). Cultural Trauma and Collective Identity. University of California Press.

Alvarez, M.-J., Roura, P., Oses, A., Foguet, Q., Sola, J., & Arrufat, F.-X. (2011, March). Prevalence and Clinical Impact of Childhood Trauma in Patients with Severe Mental Disorders. *The Journal of Nervous and Mental Disease, 199*(3), 156-161.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of mental disorders* (5th ed.). Arlington, VA: Author.

Anderson, S. M., & Gedo, P. (2013). Relational trauma: using play therapy to treat a disrupted attachment. *Bulletin of the Menninger Clinic, 77*(3), 250-268.

Bandura, A., Grusec, J. E., & Menlove, F. L. (1966, September). Observational Learning as a Function of Symbolization and Incentive Set. *Child Development, 37*(3), 499-506. Retrieved from https://www.jstor.org/stable/1126674

Bethell, C. D., Newacheck, P., Hawes, E., & Halfon, N. (2014, December). Adverse Childhood Experiences: Assessing the Impact on Health and School Engagement and

The Mitigating Role of Resilience. *Health Affairs., 33*(12). Retrieved from https://doi.org/10.1377/hlthaff.2014.0914

Bicknell-Hentges, L., & Lynch, J. J. (2009, March). Everything Counselors and Supervisors Need to Know About Treating Trauma. *American Counseling Association Annual Conference and Exposition*, 19-23.

Bretherton, I. (1992). The Origins of Attachment Theory: John Bowlby and Mary Ainsworth. *Developmental Psychology, 28*, 759-775. Retrieved from http://www.psychology.sunysb.edu/attachment/online/inge_origins.pdf

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.

Cohen, J. A., & Mannarino, A. P. (2008). Trauma-focused cognitive behavioral therapy for children and parents. *Children and Adolescent Mental Health*, *13*, 158–162.

Dezelic, M. (2003). *Window of Tolerance- Trauma/Anxiety: widening the comfort zone for increased flexibility*. Retrieved from www.drmariedezelic.com/#!window-of-tolerance–traumaanxiety-rela/ca9e

Ellen , J. (2002, October 3). *The Adverse Childhood Experiences Study — the largest, most important public health study you never heard of — began in an obesity clinic.* Retrieved from ACES too High: https://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/

Grossman, F. K., Spinazzola, J., Zucker, M., & Hopper, E. (2017). Treating Adult Survivors of Childhood Emotional Abuse and Neglect: A New Framework. *American Journal of Orthopsychiatry., 87*(1), 86-93. Retrieved from http://www.traumacenter.org/products/pdf_files/Treating_Adult_Survivors_Childhood_Emotional_Abuse_Neglect_G0003.pdf

Kirk, M. (2018, February 22). *The demographics of childhood trauma.* Retrieved from https://psmag.com/social-justice/the-demographics-of-childhood-trauma

Lake, S. (2016, September). The lasting effects of childhood trauma on mental health in adulthood: Current knowledge and practical next steps for clinical practice. *UBCMJ*, 46-47. Retrieved from https://med-fom-ubcmj.sites.olt.ubc.ca/files/2017/03/v8i1-news2.pdf

Lenz, S.A., & Hollenbaugh, M.K. (2015). Meta-Analysis of Trauma-Focused Cognitive Behavioral Therapy for Treating PTSD and Co-occurring Depression Among Children and Adolescents. *Counselling Outcome Research,6* (1), 18-32. doi:10.1177/2150137815573790

Little, S., & Little, A. (2013). Trauma in children: A call to action in school psychology. *Journal of Applied School Psychology, 29*, 375–388. doi:10.1080/15377903.2012.695769

Lyons–Ruth , K., Yellin, C., Melnick , S., & Atwood, G. (2005). Expanding the concept of unresolved mental states: Hostile/Helpless states of mind on the Adult Attachment Interview are associated with disrupted mother-infant communication and infant disorganization. *Development and Psychopathology, 17*(1). doi:10.1017/S0954579405050017

McLeod, S. (2017). *Bowlby's Attachment Theory*. Retrieved from www.simplypsychology.org: https://www.simplypsychology.org/bowlby.html

Ogle, C. M., Rubin, D. C., & Siegler, I. C. (2015, July). The relation between insecure attachment and posttraumatic stress: Early life versus adulthood traumas. *Psychol Trauma*, 324–332. doi:10.1037/tra0000015

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits". *Infant Mental Health Journal. , 16*(4), 271-291.

Pielage, S., Gerlsma, C., & Schaap, C. (2000, October 25). Insecure attachment as a risk factor for psychopathology: the role of stressful events. *Clinical Psychology & Psychotherapy, 7*(4), 296-302.

Sacks, V., Murphey, D., & Moore, K. (2014, July). *Adverse Childhood Experiences: National and State level prevalence.* Retrieved from childtrends.org: https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

Schnyder, U., Bryant, R. A., Ehlers, A., Foa, E. B., Hasan, A., Mwiti, G., Yule, W. (2016, July 28). Culture-sensitive psychotraumatology. *European Journal of Psychotraumology*. doi:10.3402/ejpt. v7.31179

Schoedl, A. F., Costa, M. C., Mari, J. J., Mello, M. F., Tyrka, M. F., Carpenter, L. L., & Price, L. H. (2010). The clinical correlates of reported childhood sexual abuse: An association between age at trauma onset and severity of depression and PTSD in adults. *Journal of Child Sexual Abuse, 19*,156–170. doi:10.1080/10538711003615038

Su, S., Jimenez, M. P., Roberts, C. T., & Loucks, E. B. (2015). The role of adverse childhood experiences in cardiovascular disease risk: a review with emphasis on plausible mechanisms. *Current cardiology reports*, *17*(10), 88. https://doi.org/10.1007/s11886-015-0645-1

Vitelli, R. (2012, November 25). *How Can We Treat Traumatized Children?* Retrieved July 2019, from https://www.psychologytoday.com/us/blog/media-spotlight/201211/how-can-we-treat-traumatized-children

What is childhood trauma? (2016). Retrieved from Blueknot Foundation: https://www.blueknot.org.au/Resources/Information/Understanding-abuse-and-trauma/What-is-childhood-trauma

World Health Organization. (n.d.). Retrieved from Adverse Childhood Experiences International Questionnaire (ACE-IQ) :https://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/

Acknowledgement

The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author declared no conflict of interest.

How to cite this article: Mohan R. (2021). A walk through the hall of childhood trauma. *International Journal of Indian Psychology*, *9*(1), 376-382. DIP:18.01.041/20210901, DOI:10.25215/0901.041