Training on Child Psychology

COOPÉ' Sud

12.b. Psychological impact of specific traumatic experiences:
PHYSICAL ABUSE - INCEST & SEXUAL ABUSE

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Psychological impact of traumatic experiences: PHYSICAL ABUSE

According to the Convention on the Rights of the Child (U.N.1989), *"States Parties shall take all appropriate legislative, administrative, social and educational measures to* ***protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse****, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child" (Article 19*)

Trauma at an early age of infancy (particularly during the first two years) alters the brain growth and the neural activity of the baby and compromise, in particular, such brain-mediated functions as attachment, empathy, and affect regulation. Thus, affective disturbances are a hallmark of early trauma.

"Early traumatic environments that induce atypical patterns of neural activity interfere with the organization of cortical-limbic areas and compromise, in particular, such brain-mediated functions as attachment, empathy, and affect regulation. These very same functions are mediated by the frontolimbic areas of the cortex, and because of their dysfunction, affective disturbances are a hallmarkof early trauma. Teicher (1996) reports that children with early physical and sexual abuse show EEG abnormalities in frontotemporal and anterior brain regions. Teicher concludes that stress alters the development of the prefrontal cortex, arrests its development, and prevents it from reaching a full adult capacity" (Allan Shore http://www.allanschore.com/pdf/SchoreIMHJTrauma01.pdf).

a) Psychological impact and mechanism of physical abuse on the child.

Physical abuse: experience of fear + pain + helplessness

Consequences

- trouble of body image the child is unconsciously splitting his body image (and the feelings associated to his/her body), and the inner self (and inner feelings) so as to isolate the physical pain and to protect himself psychologically.
- integration of inner feelings of no protection. Helplessness.

Different kind of coping mechanisms:

- the child is externally well behaving in order to avoid his/her parents' violent reactions.
- the child shows naughty and violent behaviours; this is a way to justify the parents' blows and violent attitude.
- the child is identifying himself / herself with the aggressor, as a reaction to the pain and the fear. This mechanism provokes changes in the child's personality (because of a total surrender to the aggressor's wish, the child integrates the aggressor's guilt). This is the basis of the child's reaction consisting in reproducing his/her own abuse. It is a way for the victim to fight his feelings of helplessness and distress: the child unconsciously "prefers" to identify himself herself to his/her own aggressor, who is the strongest and the most powerful person. That is a way for him/her to feel protected.

Risk of reproduction of the abuse in the future:

- the teenager is violent with other people, generally weakest ones (his peers or younger children).
- the person is physically abusing his/her own children.
- context of violence in the person's couple.

b) Psychic symptoms:

The ability to regulate the intensity of emotions is built in early infancy through the interaction with a "good enough" caregiver. The caregiver actually acts as an external regulator of the intensity of the baby's emotions untill the baby integrates these capacities of regulation. But in an insecure / violent / abusive environment the baby cannot develop the capacity to regulate his/her emotions.

These are commonly observed symptoms, their intensity varies from one case to the other, depending of the severity of abuse and the child's sensitivity.

- Anxiety.
- Identity troubles (disturbance of the body image, confusion of roles and responsibilities).
- Mistrust and fear of other people.
- Learning disability (or learning troubles).
- Depression, feeling of despair.
- Behaviours inducing self-destruction, self-punishment, self-injury... This is a consequence of the identification with the aggressor; these symptoms represent a punishment corresponding to the victim's unconscious guilt about his/her own abuse.

In some cases, only one child within the family is victim of physical abuse, while the other children are not suffering from any violence. The reason of such a situation is related to the child's special place, role and representation within the family. Most of the time, the situation can be understood by analysing what had happened in the child's family and the past generations. The victim might be associated to a bad event, a

danger, he/she might unconsciously represent one parent's own image as a former abused child... Actually, many abusive parents (but not all) are former abused children for whom the mechanism of reproduction of abuse is active (some violent parents might also be suffering from psychiatry troubles, sadism or other perversions).

For all victims of physical abuse, helping them to identify themselves as victims is the first step in the therapeutic process (once this level is reached, these children are able to start understanding their situation, and developing adjusted coping mechanism in order to fight their psychic troubles, their guilt, and to avoid the vicious cycle of traumatic reproduction).

Sexual abuse of children

a) INCEST

PSYCHOLOGICAL IMPACT AND MECHANISM OF INCEST ON THE CHILD.

Incest: sexual abuse upon a child by a family member (incest : any form of sexual contact occuring between family members; incest and sexual abuse of children take many forms and may include sexually suggestive language; prolonged kissing, looking, and petting; vaginal and/or anal intercourse; and oral sex. Because sexual contact is often achieved without overt physical force, there may be no obvious signs of physical harm. In the vast majority of cases (more than 90%), sexual abuse is perpetrated by a family member or close relations; less that 10% of sexual abuse is perpetrated by someone unknown to the child).

the child is manipulated

– the affective relationship with the parent is associated to sexuality. (the child is looking for an affective relationship, what he receives instead is sex, a sexual response to his affective need)

– the affective relationship is used by the aggressor to maintain the incestuous situation.

– -the child's feelings and guilt are manipulated.

– the law of silence and secret is established.

Coping mechanism: adaptation syndrome

The child is forced to adjust to the adult's incestuous system, since the child is dependent on the aggressor who belongs to the victim's own family. Then, the child has no choice but to accept and adjust to this situation passively, because he/she is not able to react to the traumatic situation (too much affective dependence is involved). Because of this passive adaptation to the incestuous context, the child is not able to consider himself/herself as a victim: the child integrates the parent's guilt in order to protect his/her abusive parent, and he/she cannot consider himself herself as a victim. This reaction is called "identification with the aggressor ".

Reproduction of the trauma

Reproducing the trauma is a way for the victim to try understanding, controlling, and to find a solution to the situation. Then, the child is unconsciously placing himself in situations where he might be abused again, in

order to find new ways to react and then to develop effective defence mechanisms. Then, various behaviours are observed:

- seduction.
- aggressive behaviours with sexual manifestations.
- compulsive masturbation.
- sexual plays

Risk for the future: reproduction of abuse

- other experiences of sexual abuse.
- prostitution (60 to 80% of prostitutes were victims of incest or sexual abuse in childhood and 80% of sex-addicts ...)
- for adult women, there is a risk for them to be attracted by potential abusers, with a risk of sexual abuse for their own children.
- identity troubles.

b) Psychic symptoms

These symptoms are commonly observed, their intensity varies from one case to the other depending of the kind and duration of abuse. These symptoms are related to the Post Traumatic Stress Disorders.

- post-traumatic symptoms: flash-backs, hallucinations, emotional instability, sleep disturbances with bad dreams, hyperactivity or withdrawal attitude.
- loss of interest
- difficulty to concentrate or memorize (or important intellectual activities)
- phobic reactions
- depression
- behaviours inducing self-destruction, self-punishment, self-injury... This is a consequence of the identification with the aggressor: these symptoms represent a punishment corresponding to the victim's unconscious guilt about his/her own abuse.
- children often repress their experience of trauma in order to survive; this is a necessary and appropriate coping mechanism

Teenagers with a history of incest might "sleep around" in order to feel accepted, or run away from our homes and communities. Depression is another common response to the abuse, and adult survivors often turn to drugs and alcohol to mask the pain. 30 to 40% of people with anorexia, 60% of drug-addicts were victims of incest or sexual abuse in childhood...These are attemps to survive a childhood that wasn't like a childhood at all. Incest and sexual abuse on children can have lifelong consequences.

o **SEXUAL ABUSE HAPPENING OUTSIDE OF THE CHILD'S FAMILY.**

As seen above, in the vast majority of cases (more than 90%), sexual abuse is perpetrated by a family member or a close relation; less that 10% of sexual abuse is perpetrated by someone unknown to the child.

Psychic symptoms:

Generally, the child is suffering from Post-Traumatic Stress Disorders (PTSD): sleep disturbances and bad dreams, anxiety, phobic reactions, fear to stay alone, attention troubles... Guilt and shame are always observed.

The psychological consequencies of such a trauma depend on the degree of the child's sensitivity, his/her personality and his/her inner feeling of security. The second most important factor is the family members' reaction and the support they are providing the child with. The depth of the traumatic effect also depends on the child identifying himself as a victim or by his family identifying him as a victim. In some cases, the relatives believe that the child had seduced his/her agressor and provoked his/her own abuse.

- **If the family is supportive to the child, and recognizes him/her as a victim:**

Since the child has a clear status of victim, he/she feels supported and understood by his family, it is easier for him/her to fight the psychological difficulties due to the trauma, the guilt... In such a situation, feelings of anger and the wish to punish the aggressor are coming out, the child is able to develop his/her inner strenghts and defence mechanisms. In this case, psychotherapy helps the child stabilize and avoid the development of psychic troubles. Globally, the child has less difficulty to recover.

- **If the family is not supportive to the child, and does not recognize him/her as a victim:**

In such an absence of family support, feelings of guilt and shame persist, and the child integrates the belief that he/she is the one responsible for his/her own abuse, for the pain and confusion associated to the trauma. This situation causes self-depreciation or even identity troubles. Later, if the child had not been given the opportunity to clarify his/her traumatic experience and the idea of guilt, disturbances in terms of socializatïon, relationships and sexuality generally appear. Reproduction of the abuse is then frequently observed.

Appendix

DSM-IV-TR criteria for PTSD

In 2000, the American Psychiatric Association revised the PTSD diagnostic criteria in the fourth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). The diagnostic criteria (Criterion A-F) are specified below.

Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses functioning.

Criterion A: stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

Criterion B: intrusive recollection

The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Criterion C: avoidant/numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma

3. Inability to recall an important aspect of the trauma

4. Markedly diminished interest or participation in significant activities

5. Feeling of detachment or estrangement from others

6. Restricted range of affect (e.g., unable to have loving feelings)

7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: hyper-arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:

1. Difficulty falling or staying asleep

2. Irritability or outbursts of anger

3. Difficulty concentrating

4. Hyper-vigilance

5. Exaggerated startle response

Criterion E: duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criterion F: functional significance

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

Specify if:

With or Without delay onset: Onset of symptoms at least six months after the stressor

References

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders DSM-IV-TR (Fourth ed.). Washington D.C.: American Psychiatric Association.

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