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PERSONALITY DEVELOPMENT PROCESS OF PERSONS WHO EXPERIENCED TRAUMA IN THEIR CHILDHOOD

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Abstract: The aim of this work is to show a relation between trauma – a chronic effect of traumatic stimuli experienced in childhood – and personality development. Childhood is a special period as far as development is concerned: this is when personality foundations are being shaped. Strong unpleasant experiences may cause difficulties and personality deformation manifested in person's activity.
In this work, two aspects have been discussed: the consequences of traumatic stress and the two directions of personality deformation as an effect of child's trauma, namely avoiding social contact (internalizing behavior) and hyperactivity (externalizing behavior). Not all children who experienced trauma develop improper personality pattern. A secure type of attachment to a primary object in childhood can serve as a defense.

Key words: psychic trauma in childhood, traumatic stress results, difficulties in personality development, personality deformation

Traumatic experience in childhood

The term trauma – a strong and negative experience, which has an effect on human mental and physical health – has been known in medicine, and especially in psychiatry, since the nineteenth century. In medical practice in that time, a relation between the nature of mental experience and health or illness has been indicated. Nowadays, the fact that traumatic experience can contribute to clinical and sub-clinical disorders, is clearly stated in Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR, 2000). This indication does not mean the cause – effect relation. Mental disorders development – excluding the states caused by mechanical damages – is a process influenced by many factors. Nevertheless, with its multidimensional diagnosis, DSM-IV suggests that mental and social factors should be considered when defining causes of mental disorders (Bomba 2002; Czapiga 2006; Rutkowski, Turkot, Kurek-Rusin 2007).

Psychic trauma is a type of experience that may cause mental (sometimes also physical) damages of either temporary or permanent nature. Physical harm on

the other hand may be caused by external force: harassing a child or hitting him or her. Psychic trauma is caused by extreme emotional experience resulting from rejection or sexual harassment and causes development and fixation of psychological problems and disorders. Psychic trauma – as understood in such a way – is a term drawn from psychoanalysis. It comprises three elements, such as *rapid shock, wound, and consequence of trauma*, all of which influence current mental organization (Schier 2002, p. 183; Missildine 2004). The danger caused by trauma is strongest in early and late childhood. These periods are most important for the basis of personality being shaped, when child's cognitive, emotional and behavioral system is immature (Obuchowska 1989; Przetacznik-Gierowska, Tyszkowa 1996). As a result of traumatic experiences, a child loses a sense of security, which means that the basic psychological need is being frustrated, a state of helplessness is increasing, and the appropriate mental development of a person is endangered.

In psychological literature there is a differentiation between traumatic stress, which is temporal (in adulthood), and long lasting traumatic experiences in childhood (physical violence, sexual harassment), which cause deeper effects because they disturb the development of many personality dimensions and deepen the forms of inappropriate behavior (Lis-Turlejska 2002; Schier 2002; Herman 2002; Herbert 2004).

Forms of violence against children

Most frequent forms of violence experienced by a child are: physical violence and emotional violence caused by the rejection or domination of a child (all forms of violence include this factor; it is also most frequent form of violence, although most difficult to identify as its consequences are not immediately visible). Neglect, specifically in the field of satisfying basic mental and biological needs, is also a frequent type of violence. Physical violence threatens child's life and corporality, mental integrity or liberty of a person, and it hinders or even warps personality development (Browne, Herbert 1999).

Most severe form of hurting a child is sexual harassment defined by *Standing Committee on Sexually Abused Children* as sexual abuse of a child by a person sexually mature, who either by conscious acting or by neglecting their social duties or duties resulting from a specific responsibility for a child engages a child in every kind of sexual activity, which is aiming at satisfying the other person (Beisert 2004, p. 12; Kembłowski 2006).

J. L. Herman (2002) – who studies the strongest type of trauma, which is sexual harassment in childhood – claims that because of a complex clinical picture of disorders, there is a need for a separate category defining only this kind of trauma, and he proposes the term *Complex Posttraumatic Syndrome*. A part of the symptoms appearing after trauma (I mean personality distortion) cannot be attributed only to stress. What strengthens the impact is recurrent harassment and chronic

fear. The symptoms of a complex posttraumatic syndrome and of other unpleasant experiences can be noticed in emotional, cognitive, behavioral field, and in the field of interpersonal relations; they consist of anxiety, fear, phobia, depression, aggression, etc. They are also similar to the symptoms of other disorders, such as personality disorders, affective disorders, and psychotic disorders. The similarity concerns the type of symptoms, and the difference is in their strength, duration, and permanence of their consequences. That is why the diagnostic and therapeutic process should reveal and then cure the relation between traumatic experiences and the configuration of a person's psychopathological symptoms.[1] The scales and questionnaires worked out by American Academy of Child and Adolescent Psychiatry[2] can be helpful for diagnosis of a child's mental state after trauma.

Diagnosis of a mental state after traumatic experience

External stimuli which have traumatic impact on the child's mind cause disorders included in classifications as separate diagnostic categories. The classification systems of World Health Organization (ICD-10) and American Psychiatric Association (DSM-IV TR) use the following terms to denote those types of disorders which are caused by extremely unpleasant circumstances:

1. *Reaction to severe stress and adjustment disorders* F43. The reaction may be acute (F43.0); symptoms are severe but temporary in this case. *Posttraumatic stress disorder* (F43.1); response is delayed and/or protracted (ICD – 10, pp. 127–130).
2. *Acute Stress Disorder* – ASD, 308.3 (DSM – IV TR, pp. 469–472). The following sets of symptoms have been identified: persistent recurrence of traumatic event, avoidance of stimuli that arouse recollections of the trauma, increased arousal of a person, which has not been noticed before traumatic experience,

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1 The aims and the rules of therapeutic actions, the stages of diagnosis and of therapy of a sexually abused child are described by: A. Widera-Wysoczańska (2003). Psychologiczne pomaganie dziecku wykorzystanemu seksualnie i jego rodzinie, pp. 249–278. [In:] A. Czapiga (ed.), Psychospołeczne problemy rozwoju dziecka. Aspekty diagnostyczne i terapeutyczne. Toruń: Wydawnictwo Adam Marszałek. Information about therapy of persons who experienced psychic trauma can also be found in: James, R.K., Gilliland, B.E. (2005). Strategie interwencji kryzysowej. Warszawa: Wydawnictwo PARPA and Lis-Turlejska, M., Łuszczyńska, A. (2006). Terapia potraumatyczna. [In:] L. Grzesiuk (ed.), Psychoterapia. Praktyka. Podręcznik akademicki. Warszawa: Wydawnictwo Eneteia.

2 PTSD Reaction Index; Trauma Symptom Checklist for Children; Child PTSD Symptom Scale; Checklist of Child Distress Symptoms – Child and Parent Report Versions; Children's Impact of Traumatic Events Scale and the version for adolescents, Impact of Events Scale. More information on this topic can be found in the article: Practice Parameters for the Assessment and Treatment of Children and Adolescents With Posttraumatic Stress Disorder (1998). *Journal of the American Academy of Child and Adolescent Psychiatry*. Volume 37, Issue 10. Supplement. See also: J. Rabe-Jabłońska, *Wiadomości Psychiatryczne,* 1999, II, 2.

and dissociative reactions. The symptoms of traumatic stress persist no longer than one month. In order to diagnose the disorder, symptoms from each set are required (at least one symptom from each set) and three out of five dissociative symptoms (e.g. derealization, depersonalization, dissociative amnesia).[3]

3. *Post-Traumatic Stress Disorder* – PTSD, 309.81 (DSM–IV TR, pp. 463–468).

Post-Traumatic Stress Disorder (PTSD) develops usually out of an acute reaction, which is directly initiated by a devastating experience, such as rape or being orphaned. Such a state can be chronic, especially in the case of persons at risk, because one's specific individual features (configuration and level of personality features and the nature of childhood experience) can make them vulnerable to this kind of disorder. The factors (stressors) having an influence on a person are usually chronic; thus, their effects are extensive and deeply fixed.

The consequences of traumatic experiences

The consequences of violence can be temporal or permanent. They have to be considered with respect to the following criteria:

– time of occurrence of the first effects of violence (immediate or distant)
– specific and non-specific nature of symptoms
– types of symptoms observed in somatic and/or mental sphere (Kmiecik-Baran 2003; Warzocha, Rabe-Jabłońska 1999).

Posttraumatic stress is not the only consequence of violence. The effects of childhood trauma can include:

1. Rapid shock reactions causing disorganization of behavior. Strong emotional agitation in the state of shock disturbs the orientation of the self and surroundings, which results in the problems with control, self-esteem, and identity. The behavior becomes then irrational, compulsive, and often also impulsive.
2. Psychogenic reactions, which develop slowly, in which traumatic experience transforms in the direction of clinical disorders (neurotic or even psychotic in the form of short term reactive psychosis).
3. Reactive psychogenic state as a chronic effect of trauma, e.g. somatization disorder.
4. Developmental disorders manifested in difficulties in intellectual functioning (developmental retardation).
5. Personality disorders manifested in mental disharmony and in the lack of mental integration. It is most crucial to point to the group of disorders denoted as

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3 The introduction of *Acute Stress Disorder* term, a new diagnostic category, to a nosological system was caused by the fact that many patients (according to B. Dudek mainly) who had PTSD diagnosed shortly after traumatic experience within one month had no symptoms of this disorder. This fact has initiated arguments among psychiatrists and psychologists because it has shown up that many people with PTSD diagnosis had not had ASD diagnosis, mainly because of the lack of dissociative reactions (Marshall and team 1999, quoted in B. Dudek 2003, p. 16).

dissociative, among which there are: identity disorder, fugue and dissociative amnesia, conversion and depersonalization disorders.

Long lasting and recurrent trauma often initiates defensive type of coping with traumatic experience through distorting the view of oneself, of the world, and of the relation with the surroundings, which causes pathological forms of behavior, such as obsessions, compulsions, aggression, protest, negativism, and the reactions in the form of "somatic equivalents." As a further reaching consequence of these types of behavior, neurotic disorders can occur with high level of generalized anxiety and panic, which sometimes may transform into phobia.

As a consequence of difficult and traumatic external conditions created by a contact with adults, especially important persons from whom a child is not able to free oneself, a sense of loneliness can occur, which distorts the functioning of a person in every sphere of life: cognitive, emotional, social, and behavioral (Izdebska 2006, Cudak 2001).

Traumatic experiences can lead to anxiety, psychosomatic and even to clinical disorders of a psychotic nature, and to personality disorders. These pathologies will manifest themselves in the form of emotional disorders and improper behavior. Emotional disorders which are effects of psychic trauma may transfer into behavioral disorders because manifestations of hostility or passiveness and withdrawal lead to disorders of adaptation to threatening environment. In order to denote these types of behavior, a T. M. Achenbach's typology can be useful. Achenbach distinguishes two categories of disordered behavior of a child. Internalizing behavior, which is manifested by anxiety, blocking, passiveness, and withdrawal. It is characterized by a high level of control. Children with this pattern of behavior do not cause big difficulties in child upbringing. They submit to adults and to their peers, they do not manifest any willingness to seek help, and they suffer from the problems, but they conceal them instead of revealing.

Externalizing behavior is destructive, aggressive, obstructive, protesting, impulsive, and dominant, often being a demonstration against social norms and rules. It is characterized by a low level of control and a high level of expression.

High level of the above symptoms can serve as a basis for diagnosis of internalizing or externalizing disorders.[4]

My own observations revealed that those children who developed the first pattern of reacting, inhibited children, more often experience support from adults who notice alarming emotional symptoms of anxiety, sadness, harm, and who engage themselves in helping. Those children who developed the second pattern in the form of hyperactivity and aggressive behavior are more often prone to additional negative experiences resulting from rejection, sanctions, and imperative child-rearing.

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4 Child Behavior Checklist, CBCL, drawn up by T. M. Achenbach, can serve as a study tool of internalizing and externalizing disorders. More information can be found at www.aseba .org./

Difficulties and disorders resulting from trauma develop in the case of children in the two directions mentioned above (Glaser, Frosh 1995; Brągiel 1998; Urban 2000). The first direction is withdrawing from contact, which is manifested in inhibitions, passiveness, apathy, and anxiety. Those children who react in this way are at risk from neurotic disorders and from developing the patterns of personality dominated by anxiety (e.g. avoidant, dependent, and obsessive-compulsive); the second pattern is hyperactivity manifested in aggressive behavior, such as aiming at the others or at oneself, expansion, dominance over other people, and in the lack of affective control. This group is prone to develop personality with a tendency to emotional hyper reactivity and instability. How deep, pervasive, and fixed the consequences of trauma will be, depends on many factors, which have been systematized by A. Widera-Wysoczańska (2003, pp. 265–266) on the basis of existing sources. The author distinguishes-three groups of the factors:

1. Objective, related to child's age and to the character of traumatic experience (frequency of traumatic circumstances, trauma degree, type of relation to an offender, and type of family relations, formal consequences for a child after revealing an act of violence).
2. Background, situation, and social factors considered in three perspectives: the past (period before trauma), the present (period of trauma), the future (period after trauma). Support of a family and specialist care, lack of which can deepen and strengthen effects of trauma, play the most important role here.
3. Subjective, that is, biological and personality predispositions to strong psychopathological reactions.

In the case of high level and fixation of a person's improper behavior which can be observed during the further stages of life, that is, in the case of such behavior which prevents fulfilling needs and/or realization of roles and tasks, there can be basis for diagnosis of personality disorders, which are characterized by high level of anxiety:

a) *Avoidant Personality Disorder,* 301.82 – characterized by shyness, uncertainty, low self-esteem, high tension in the case of social exposure; the way of life is reduced to well known people and situations (DSM-IV TR, pp. 718–721).
b) *Dependent Personality Disorder,* 301.6 – a person is characterized by dependence on the others and panic fear from being rejected, helplessness, submissiveness, searching for a decision-making person, hypersensitivity to criticism and disapproval (DSM-IV TR, pp. 721–725).
c) *Obsessive-Compulsive Personality Disorder,* 301.4 – persons with such personality pattern are characterized by perfectionism, and rigid behavior, overconscientiousness, carefulness, inflexible attitude towards rules (DSM-IV TR, pp. 725–729; Kaplan, Sadock 1998, pp. 179–182; Carson, Butcher, Mineka 2003, pp. 1065–1066).

According to DSM-IV TR personality disorders including predisposition to emotional hyperactivity and unstableness form a group of disorders, for which

a deformation of the system of the self is characteristic. This group consists of the following types of personality disorders:

a) *Antisocial Personality Disorder,* 301.7 – is characterized by anomy of social values. It is manifested by disordered behavior, such as irritability, aggressiveness, impulsiveness, and failure to conform to social rules and norms. Also characteristic is having superficial relationships and lack of remorse for hurting others (DSM-IV TR, pp. 701–706).
b) *Borderline Personality Disorder,* 301.83 – persons with this structure of personality have the following features diagnosed: affective unstableness, difficulties in interpersonal relations, from idealization to devaluation, unstable self-image, and chronic feelings of emptiness (DSM-IV TR, pp. 706–710; Kaplan, Sadock 1998, pp. 173–177; Carson, Butcher, Mineka 2003, pp. 1065).
c) *Histrionic Personality Disorder,* 301.5 – strong, dramatic displays of emotions in order to attract attention of other people, demand for admiration, praise, and attention (DSM-IV TR, pp. 711–714).
d) *Narcisstic Personality Disorder,* 301.81, to which the following features are specific: excessive self-esteem, a sense of being unique and holding one's own specific rights, empathy disorders, irritability, treating others like objects (DSM-IV TR, pp. 714–717).

Retardation in personality development, regressions and deformations – all of these are the most crucial aspects of clinical children's psychology because most often they are the cause of social maladjustment, which is noticeable in behavior disorders. Early and recurrent traumas resulting from child abuse impede or even deform personality being developed. The effects of early childhood trauma have been proven and described in the works of such authors as: J. L. Herman (2002), R. C. Carson, J. N. Butcher, S. Mineka (2003), D. Gloser, S. Frosh (1995), A. C. Salter (2003), A. Widera-Wysoczańska (2003). Especially in the case of persons with borderline personality disorders, mental and physical abuse in childhood has been stated as a fact (it concerns about 90% of the researched persons). The effects of these experiences can be described as immediate, that is, observed in childhood, and further-reaching, that is, noticeable in adulthood: improper relations with one's own children, personality disorders, auto destructive behavior as an effect of cumulated, increasing stress, getting addicted to psychoactive substances, committing crimes, and affective disorders (Lis-Turlejska 2002; Glaser, Frosh 1995; Salter 2003).

There is no determining cause-effect relation between traumatic experiences and disorders, but as many empirical studies deduce (Carson, Butcher, Mineka 2003; Meyer 2003), trauma experience underlies a person's difficulties in the form of extreme emotional reactions or disorders mentioned and depicted in classification systems (Arnold, Babiker 2003; Wycisk 2004). It especially concerns personality foundations development in childhood. Personality of a person who experienced violence is created in this case under the influence of trauma, and early childhood conflict is a basic pathogenic factor which deforms this process.

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PROCES OSOBNOSTNÍHO VÝVOJE U OSOB, KTERÉ V DĚTSTVÍ PROŽILY TRAUMA

Cílem této práce je ukázat vztah mezi traumatem – chronickým efektem traumatických podnětů prožívaných v dětství – a osobnostním vývojem. Dětství je výjimečné období vývoje: právě v této době se formují základy osobnosti. Silné nepříjemné zážitky mohou způsobit potíže a deformaci osobnosti projevující se v činnosti člověka.

Tato práce pojednává o dvou aspektech: o následcích traumatického stresu a o dvou směrech deformace osobnosti následkem dětského traumatu, jmenovitě se jedná o vyhýbání sociálnímu kontaktu (internalizační chování) a hyperaktivitu (externalizační chování). U všech dětí, které prožily trauma, se však nevytváří nesprávné osobnostní vzorce. Bezpečný attachment k primárnímu objektu v dětství může posloužit jako obrana.

Klíčová slova: duševní trauma v dětství, následky traumatického stresu, obtíže ve vývoji osobnosti, deformace osobnosti