Copyright © 2019 by David Hosier

All rights reserved. This book or any portion thereof may not be reproduced or used in any manner whatsoever without the express written permission of the publisher except for the use of brief quotations in a book review.

First Edition, 2019

www.childhoodtraumarecovery.com

A Beginner's Guide To Childhood Trauma.

About The Author :

David Hosier BSc Hons; MSc; PGDE(FAHE) was educated at Goldsmiths College, University of London and holds two degrees in psychology as well as a diploma in education. He is the founder of childhoodtraumarecovery.com for which he has written over 700 articles over a period of six years. This book, in response to many readers' requests, represents the culmination of this work by bringing together many of the most important of these articles to provide an overview of the topic of childhood trauma.

His academic interest in childhood trauma and its effects began in 1993 when he wrote his final year university thesis on the effects of childhood depression on academic performance.

He wrote this book in the belief, borne out by his own experience, that knowledge and insight into how one acts and behaves can have a positively transformative effect which exceeds that derived from advice. Because of this belief, he founded childhoodtraumarecovery.com - initially solely as a form of self-therapy and upon which this book is based - to address his own issues relating to a traumatic childhood. The site now comprises over 750 articles.

He has, therefore, both very considerable academic and personal experience of the topic of childhood trauma and the ruinous effect it can have upon our adult lives.

Structure Of Book

Part One - The Introduction, describes, and elaborates upon, the main elements of the seminal Adverse Childhood Experiences Study and elucidates the main ways in which children may experience interpersonal and complex trauma.

Possible negative effects of childhood trauma will be considered in **Part Two** ; whilst most will be assigned their own chapter, some closely related effects will be amalgamated into individual chapters that consider two or more of them together.

Part Three will outline the main therapies that are currently used to treat the adverse effects of childhood trauma and examines aspects of posttraumatic growth.

CONTENTS :

PART ONE : Introduction.

1) Introduction. The Adverse Childhood Experiences Study And Types Of Interpersonal Trauma.

Perhaps the best known study on the effects of adverse childhood experiences on later life was conducted by Felle at Kaiser Permanente from 1995 to 1997 and is known as, not altogether inappropriately, THE ADVERSE CHILDHOOD EXPERIENCES STUDY, abbreviated to the ACE Study.

One of Feletti's main aims in carrying out this study was to increase public and professional awareness of the enormous importance of the impact of childhood on adult lives and, therefore, of course, on society in general.

All too often individuals fail to identify the intimate connection between adult mental and physical problems and the adverse childhood experiences linked to these problems – this is also true of professionals who should know better; frequently, patients who present themselves to doctors and clinicians with conditions such as anxiety and depression are simply palmed off with medication (which often does not work and /or has unwanted side-effects) whilst the possible underlying cause, often a traumatic childhood, is utterly ignored**.**

Indeed, I know this from my own experience; I suffered severe anxiety and depression and for years and years and yet no clinician so much as enquired about my (highly unstable and traumatic) childhood; instead, I was given powerful medication (which, I later discovered, dramatically reduces life expectancy due to its toxicity) and even ECT (which did not work and was traumatic and frightening to undergo ; although it does work very well for some, according to the literature).

When considering the potentially damaging effects our traumatic childhoods may have had upon us, it is highly pertinent to consider the following questions:

1) How old we were when we experienced childhood trauma (for some, of course, sadly, this may encompass their entire childhoods). This is important as various traumatic experiences affect us differently depending upon our age at the time.

2) What support, if any, was there for us from any family members and/or caregivers not involved in causing the trauma?

This is important as the greater our level of emotional support at the time of our traumatic experiences, the more psychologically resilient we are likely to have been - thus potentially reducing the adverse effects of these traumatic events.

3) Was the person/s who caused our trauma related to us and / or supposed to be our caregiver? In general terms, trauma induced by someone who is supposed to be our caregiver, particularly a parent, is very significantly more psychologically damaging to us than had the trauma been inflicted upon us by someone not falling within this category.

4) Did traumatic events occur to us that we do not remember? (For example, because we were so young or because these experiences were so emotionally painful that we have repressed them - i.e. blocked them out from our conscious awareness?). This is important as we may have been significantly psychologically damaged by events that are now not available to conscious access (however, any attempt to 'recover buried memories' must be undertaken with extreme caution as some so-called recovery techniques can lead to the creation of false memories).

Adverse childhood experiences (ACEs) have been split into three categories :

- ABUSE
- NEGLECT
- FAMILY DYSFUNCTION

In the original ACE study (conducted by Kaiser Permanente and the Centers for Disease Control and Prevention between 1995 and 1997), these three categories were further broken down into :

ABUSE : Emotional; physical and sexual

NEGLECT : Physical; emotional

Family Dysfunction :

Witnessing domestic violence; person/s with depression / mental illness in the home; substance abuse in the home ; loss of a parent (e.g. because of divorce / separation / death).

Of course, the child may suffer trauma in many other ways, but the above categories were focused upon in the original ACE study.

The original ACE study found that, overall and on average, the greater the number of ACEs an individual had experienced during childhood, the more likely s/he was to suffer from the following problems later in life :

Psychiatric Problems :

- alcoholism
- depression
- abuse of illegal drugs
- sexually transmitted diseases
- suicidal ideation

Physical Problems :

- ischemic heart disease.
- liver disease.
- sexually transmitted diseases.
- chronic obstructive pulmonary disease.

'Life' Problems :

- health-related quality of life.
- poor work performance.
- financial stress.
- risk for intimate partner violence.
- promiscuity.
- smoking / starting to smoke especially early in life.
- unintended pregnancies.
- poor academic performance.

In this book, I will examine more closely the nature of the association between the above symptoms, illnesses, difficulties and problems and childhood trauma. However, the above list is far from exhaustive, and other research, as we shall see, has linked childhood trauma to many other negative effects that can have on our adult lives and these links, too, will be further elucidated ; they are as follows :

Arrested development ; believing we are an 'intrinsically bad' person ; how feeling of being bad is perpetuated; anxiety; hypervigilance ; being trapped in the fight / flight / freeze response ; borderline personality disorder ; complex PTSD ; dissociation ; problems with controlling intense emotions / dramatic mood swings (also referred to as emotional dysregulation) ; severe relationship difficulties ; reduced life expectancy ; difficulties managing stress ; psychosis ; shame ; self-hatred ; reduced life expectancy.

The Three Types Of Adverse Childhood Experiences : Abuse, Neglect And Family Dysfunction.

Abuse:

Child abuse can take on three main forms :

1) Emotional abuse

2) Physical abuse

3) Sexual abuse

In the past it was generally agreed amongst clinicians that sexual abuse had the most significant adverse impact on the child's subsequent development. However, it is important to point out that more up-to-date research shows emotional and physical abuse can be just as damaging (some children will experience a combination of two or more of the three types).

The exact nature of the abuse will be inextricably intertwined with the developmental problems which emerge in the individual as a result of it.

Neglect :

There is a problem, though, with the categorization method. This is because the three individual categories do not tend to take account of neglect. Neglect may involve a parent or carer doing nothing to intervene to prevent the child from being abused by someone else, or a parent burdening a young child with their own psychological problems which the child is not old or mature enough to cope with. A parent or carer might neglect a child knowingly or unknowingly.

How Common Is Child Abuse?

It is difficult to know the true figures as childhood abuse is often covered up or unreported. Also, accurate figures are hindered by the fact that childhood abuse cannot be precisely defined.

However, current estimates in the UK suggest about 12 % of children experience physical abuse and 11 % experience sexual abuse.

So if you have been abused as a child, you are far from alone.

Personal Meaning :

Whilst it is impossible to precisely define child abuse, what is important is the PERSONAL MEANING the sufferer ATTACHES to it. In other words, recognizing the problems a person has developed as a result of the abuse and providing therapy to help the individual deal with those problems is more important than precisely defining the traumatic experience which caused the problems, and arguing about whether it technically qualifies as abuse or not.

Psychological Abuse May Be Most Damaging :

A major study (Spinazzola et al.) on the effects of child maltreatment provides strong evidence that psychological maltreatment of children is the most harmful form of abuse.

The study analyzed a sample of 5616 young people who had histories of childhood trauma in the form of :

- psychological maltreatment (i.e. emotional abuse / emotional neglect).
- sexual abuse.
- physical abuse.

Each young person who participated in the study was then assessed on whether or not he / she had experienced particular behavioral problems, symptoms and disorders (12 in all) , a list of which I present below :

- substance abuse.
- alcohol abuse.
- other forms of self-harm.
- skipping school or daycare.
- behavior problems in the home.
- criminal activity.
- attachment problems.

- academic problems.
- running away.suicidality.
- behavior problems at school.sexualized behaviors.

Results Of The Study :

The researchers found that those young people who had a history of psychological maltreatment were more damaged by their adverse experiences (as measured by the extent to which they were affected by the above listed behavioral problems, symptoms and disorders) than were those who had suffered physical or sexual abuse.

More specifically, of the above 12 listed behavioral problems, symptoms and disorders, those who had suffered psychological maltreatment were equally likely, or more likely, than those who had suffered physical abuse to have been affected by :

- substance abuse.
- alcohol abuse.
- other forms of self-harm.
- skipping school or daycare.
- behavior problems in the home.
- criminal activity.
- attachment problems.
- academic problems.
- running away.
- suicidality.behavior.
- problems at school.

Furthermore, of the above 12 listed behavioral problems, symptoms and disorders, those who had suffered psychological maltreatment were equally likely, or more likely, than those who had suffered sexual abuse to have been affected by :

- substance abuse.
- alcohol abuse.
- other forms of self-harm.
- skipping school or daycare.
- behavior problems in the home.
- criminal activity.
- attachment problems.
- academic problems.
- running away.
- suicidality.
- behavior problems at school.

Implications Of The Study :

In response to the above findings, the authors of the study emphasized the need for it to become a matter of public policy to develop and implement childhood trauma interventions in ways that recognize just what a devastating effect psychological maltreatment in one's childhood can have upon a person's quality of life.

They also drew attention to the need for the child welfare system to improve their ability to detect cases of child psychological maltreatment (which frequently occurs 'under the radar') so that effective interventions may be implemented.

***

Different researchers tend to define emotional abuse, or, as it is referred to in the USA, 'psychological maltreatment' in different ways. The difficulties with precise definition arise from the fact that several variables need to be considered - including philosophical, scientific, cultural, political and legal factors (Hart et al., 2002).

For example, some researchers differentiate between emotional ABUSE and emotional NEGLECT. Also, whilst some researchers focus upon the ACTIONS OF THE PERPETRATOR (it should be pointed out that 'actions' in this context refer to both acts of COMMISSION and acts of OMISSION - or, to put it another way, both upon what the perpetrator does and FAILS TO DO), others focus more upon THE EFFECTS UPON THE CHILD. A third complicating factor is that there is often a significant delay between the abuse itself and the disturbed behavior which results from that abuse.

In the USA, emotional abuse (or 'psychological maltreatment') is most frequently, formally defined in the following way :

' *A repeated pattern of caregiver behavior or extreme incidents that convey to children that they are worthless, flawed, unloved, unwanted, endangered or only of value in meeting the needs of another. It includes :*

- *spurning*
- *terrorizing*
- *isolating*
- *exploiting/corrupting*
- *denying emotional responsiveness*
- *neglecting mental health, medical needs and education*

The above is the definition is from *The American Professional Society on Abuse of Children (APSAC), 1995*

Let's look at what is meant by each of the six items on the above list.

1) SPURNING - this may be verbal or non-verbal and includes belittling, shaming or ridiculing the child, generally degrading him/her or rejecting/abandoning him/her.

2) TERRORIZING - this includes placing the child in danger, threatening him/her or generally creating a climate of fear.

3) ISOLATING - this can involve placing severe restrictions on the child, preventing developmentally appropriate social interaction and/or separating the child from the rest of the family.

4) EXPLOITING/ CORRUPTING - this includes encouraging the child to develop in inappropriate and/or antisocial behaviors and values, such as stealing, abusing others physically or verbally, breaking into houses etc.

5) DENYING EMOTIONAL RESPONSIVENESS - this involves being emotionally unavailable, ignoring the child, failing to express affection, and becoming distant physically and

emotionally.

6) NEGLECTING MENTAL HEALTH, MEDICAL NEEDS AND EDUCATION - this involves failing to provide and attend to the psychological, medical, cognitive and mental needs of the child.

(1-6 above from *Dorosa Iwaniec*, 2006)

Why Is Emotional Abuse So Harmful?

Emotional abuse not only negatively affects the child at the time it is going on (by lowering his/her self-esteem and causing him/her to live in a constant state of uncertainty and fear, for example), but, if there is no therapeutic intervention, leads to a deeply unhappy adulthood as well.

When a person has grown up in an environment which is emotionally abusive, his/her adult experiences will be viewed through the negative filter which was laid down during his/her childhood. This, in turn, is likely to lead to maladaptive (unhelpful) behaviours in adult life which may well jeopardize his/her career prospects, relationships and physical health, for example.

Effects Of Emotionally Unstable Environment On The Child :

If, as a child, an individual lives in an emotionally unstable environment, as I did with my mother until I was thirteen (when I was made to leave to go and live with my father and step-mother) s/he may, as I did, have felt that s/he was robbed of security and value.

As children, we desperately needed consistency and the knowledge that we were unconditionally accepted and valued by those who were supposed to deeply care for us. But, because an emotionally unstable environment is one which is devoid of consistency, children brought up in such a home never learn what to expect (their parents' / carers' behavior can wildly fluctuate in unpredictable ways) they are never able to feel the environment is under control - they never know what might happen next or what lies ahead; there is constant uncertainty and fear about how they will be treated. Anything seems possible. There exists in such children a permanent state of nervous anticipation, if not outright terror.

Summary Of Main Adverse Effects Of Emotional Abuse :

- a necessity to be in a state of constant hypervigilance; this will often lead to acute sensitivity and easily triggered hostility (attack, in this case, being a form of defense).
- if, as children, we are constantly told we are in the wrong, this can lead to procrastination, indecision and inaction (we become constantly concerned anything we try will turn to disaster).
- if we are constantly provoked, we may start reacting with outbursts of rage.
- being constantly treated in an unfair way can lead us to become obsessed with getting justice.
- the constant psychological strain can lead to a state of emotional exhaustion - this can easily result in apathy and depression (including losing motivation and an inability to derive any pleasure from activities or social interactions).
- intense anger reactions following even minor provocations / outbursts of extreme rage easily triggered.
- recurring feelings that life is not worth living given the intense emotional pain it entails.
- feelings of being incapable of dealing with life's relentless demands.
- frequent and intense feelings of wanting to escape responsibilities.
- regard other people's opinions us far more important than our own (although may not show this on the surface; indeed, outward behavior may suggest to others that the opposite view is held).
- an intense desire to win the approval and admiration of others.
- automatically self-blame when things go wrong.
- inability to control our own emotions.
- highly sensitive to others' emotions.
- fear of never being capable of living up to others' expectations.
- highly indecisive.
- deep fear regarding what the future may hold / a constant sense of imminent doom / always expecting the worst possible outcome.
- an inability to tolerate own failings and weaknesses.
- deep fear of taking risks that most people would regard as worth taking, resulting in not progressing at work, not daring to even attempt to form relationships etc.
- Feelings of being undeserving if good things happen / feelings of guilt about indulging in pleasurable activities as believe we irrationally believe that we 'don't deserve them.'
- when good things do happen, a feeling of suspicion emerges (e.g. 'this is surely too good to be true / too good to last). For example, I used to think that if I won the lottery, it was overwhelmingly probable that I'd drop dead of a heart attack within a month (maximum!) of receiving my financial windfall.
- difficulty keeping as job (often, this may be due to problems interacting with authority figures / extreme difficulty accepting criticism).
- fear of taking a challenging job due to intense concerns about failing at it, thus not fulfilling vocational potential.
- derive comfort / ameliorate emotional pain from such things as cigarettes, drugs, alcohol, gambling, food, frequent casual sex etc. (in its intense form, such behavior is referred to by psychologists as 'dissociating' (I will say more about 'dissociation' later on in this book). Also, a belief that it would be impossible to give up such activities as this would render life utterly intolerable.
- indulgence in hedonistic behaviour as a way of compensating self for childhood suffering.
- fear that, in a relationship, will be taken advantage of and exploited.
- incomprehension regarding what others could possibly see in us, and, therefore, holding a kind of, 'I wouldn't want to join any club that would have me as a member' (Groucho Marx) attitude - only applied to relationships (as expressed by Woody Allen in the opening sequence of his film *Annie Hall*).
- prepared to tolerate being abused in a relationship due to a feeling of 'deserving no better.'
- feel a desperate need to be in a relationship with another person in order to feel 'validated' as an individual ; this is linked to a poor sense of identity which may also result from having suffered childhood emotional abuse.
- a feeling of having to hide 'true self' from others, as this 'true self' is 'utterly unlovable.'
- a feeling of constant physical malaise, but, also, a lack of motivation to do anything about it (e.g. taking more exercise, stopping smoking, eating more healthily etc.).
- constant feelings of anxiety and/or frequent feelings of intense panic.
- deep sense that there must be something profoundly and irredeemably wrong with us.
- being perpetually criticized can lead to feelings of insecurity, shame and guilt.

As one would expect, the worse one's experience of childhood emotional abuse was, the more of the above symptoms one is likely to have, and the more intense such symptoms are likely to be (all else being equal).

Therapies such as cognitive behavioral therapy (CBT) and dialectical behavioural therapy (DBT) can significantly ameliorate such problems (we will look in greater detail at these therapies in Part 2).

The Dysfunctional Family :

A dysfunctional family is one that has at its core destructive and harmful parenting and a lack of concern for the child. The harmful effects on the child may go completely

unacknowledged or be minimized. Often, little or nothing is done to rectify the situati**on** nor to alleviate its adverse effects upon the child.

If the distress caused to the child is severe and long-lasting, s/he may develop a psychiatric condition such as complex posttraumatic stress disorder (complex PTSD) which, if not properly treated, may seriously adversely affect the rest of his/her life. (I will say more about complex PTSD later on in this book).

Types Of Dysfunctional Family :

1) A family in which the mother and/or father are addicted to drugs or alcohol (or who have another psychological addiction).

This may lead to the parent passing out, going missing for extended periods of time, behaving unpredictably, getting out of control or causing the family severe financial hardship.

Children who grow up in such families tend to grow up into distrustful adults who see others as being essentially unreliable.

2) A family in which violence and volatility predominates. Children from such families are at risk of becoming violent and volatile themselves, not least as a result of learned behavior.

3) A family in which the child is forcibly removed from the parents' care (e.g. due to bring taken into care or being sentenced to a period of juvenile detention).

4) A family in which the child is used as a 'pawn' (e.g. divorcing parents each trying to turn the child against the other parent). This may include speaking ill of the other parent, limiting the child's contact with the other parent, preventing the child from seeing the other parent at all or coercing them into rejecting a parent when this is not in the child's interest.

5) A family in which a parent has a mental illness that adversely impinges upon the child's own emotional development

6) A family in which the child is overly controlled and a parent makes excessive use of their power.

Adverse Effects Upon The Child :

Apart from the adverse effects upon the child already mentioned, children brought up in such dysfunctional families are also at risk of developing many other problems and difficulties, including depression, low self-esteem, anxiety, irrational self-blame and self-hatred, alcohol and/or drug dependency, an impaired, or even ruined, ability to both give and receive love.

Furthermore, the child may become rebellious and start to behave in anti-social ways; for example : getting into fights, vandalizing property, indulging in petty theft, committing arson, bullying others, dropping out of school.

They may also start behaving self-destructively, self-harm, develop life-long problems with interpersonal relationships, have an elevated risk of attempting suicide as well as lower life expectancy. Also, if they become parents themselves, they may develop their own parenting problems, thus perpetuating the dysfunctional family cycle.

Dysfunctional families which lead to the child having to take on the role of carer (e.g. before I was a teenager I cared for my mentally unstable mother after the divorce of my parents) can put him/her under extreme stress as s/he does not have the emotional maturity to cope. Such children, in effect, have their childhoods 'stolen' from them.

Children may also attempt to cope with the enormous stress of growing up in a dysfunctional family by becoming withdrawn. Compounding this problem, very sadly, they may also become the victims of bullies at school due to their vulnerability.

As a result of this, they may grow up to be 'loners.'

PART TWO : Adverse Effects Of Childhood Trauma.

2) Childhood Trauma Leading To Need To Self Medicate.

Until a few years ago I consumed excessive amounts of alcohol .Two main reasons for this most ill-advised and, above all, *desperate* behavior are both clichés: *one:* I drank to reduce my social anxiety and, *two:* I drank to numb my intense and intolerable psychological pain.

The root cause of my social anxiety and psychological pain derived, I feel sure, from my traumatic childhood. Indeed, such childhood trauma is very often the root cause of why people in general use alcohol, and other psychoactive substances such as illicit drugs, to self-medicate (ie. attempt to ameliorate their emotional and psychological pain).

A main reason that many find it so hard to stop or reduce their reliance on such self-medication is that they are unaware that the origin of their addictive need to self-medicate lies in their traumatic childhood experiences and that the adverse psychological consequences which they seek to numb by excessive drinking or drug taking are *symptoms* of this trauma.

This lack of insight leads to the root cause of the particular addiction remaining untreated, making it much harder for the individual to recover from his/her reliance on mind-altering substances.

Very sadly, other people, perhaps ill-informed family members, who also are unaware of the true origins of the problem, may, due to their lack of understanding, blame the individual for his/her, as they may erroneously perceive it, *'weakness of character'* and *'selfishness'* (it is *not* selfishness - being addicted to, for example, alcohol is hardly *fun* or *enjoyable;* one does not *choose* to suffer from such an addiction, by definition).

Equally sadly, the addict may blame him/herself, adding to his/her depression and worsening yet further his/her already extremely low self-esteem, thus, in all likelihood, *aggravating still further* his/her addictive disorder.

Whilst the afflicted individual may sometimes enter stages of incipient recovery, if his/her childhood trauma remains therapeutically unaddressed, s/he is likely to relapse when events in his/her life trigger traumatic memories and flashbacks.

It is useful to provide some statistics in connection with the idea of childhood trauma leading to self-medication as an adult: for example, intravenous drug users are 1000% (one *thousand* per cent) more likely to have suffered childhood trauma than non-intravenous drug users. A second example is that (in the USA) female alcoholics are twice as likely to have suffered significant trauma compared to their non-alcoholic counterparts.

The Role Of Adrenaline:

Those suffering from the effects of severe trauma, such as those who have been diagnosed with posttraumatic stress disorder (PTSD) or complex posttraumatic stress disorder (complex PTSD) have been found to produce in their bodies excessive quantities of the hormone adrenaline which significantly contributes to their feelings of deep anxiety and general psychological distress.

It is hardly a coincidence, then, that one of the illicit drugs they can become dependent upon is heroin as this drug is highly effective at shutting down the brain's adrenaline center - the *locus coeruleus.*

Other drugs that have a similar effect are Valium, alcohol and benzodiazepines.

Therapies for those who have experienced significant childhood trauma and are consequently addicted to the sort of substances referred to above are far more likely to be successful if

they do not ignore the root cause of the problem - namely the afflicted individual's childhood traumatic experiences.

3) Arrested Development.

The normal development of self involves the following stages :

1. Approximately 6 months : the capacity for self-observation develops.
2. Approximately 12 months : the capacity for symbolic thinking becomes well established as does a 'sense of self'.
3. Approximately 7 to 11 years : the capacity for concrete operational thinking becomes established, as does an intense emotional life. Also, at this stage, the child becomes increasingly concerned about his / her interaction with his / her peers.
4. Adolescence : the capacity for concrete operational thinking continues to develop as does the ability to negotiate increasingly complex and nuanced social interactions
5. Early Adulthood : concerns turn to intimacy and family.
6. Mid-Life : concerns extend to wider society.
7. Later Life : world view / understanding deepens ; metaphysical concerns may become increasingly profound.

However, those who have experienced significant and protracted childhood trauma FAIL TO DEVELOP A STRONG SENSE OF SELF / SELF-IDENTITY, especially if they developed, due to their upbringing, an ANXIOUS ATTACHMENT STYLE (Main et al., 2002). An anxious attachment style can develop when an emotionally unstable parent (particularly a parent prone to explosive outbursts of rage) causes their child to have to be hyper-alert / hypervigilant regarding this parent's unpredictably changing moods as a form of self-preservation (my own mother's emotions fluctuated wildly which had an effect on me that made me able to sense how she was feeling from the minutest change in her expression, intonation or body language, and, to this day, I am able instantly to pick up on the most subtle of people's changes in mood via tacit signs to which others may be oblivious).

Sadly, too, children brought up by such parents are unconsciously indoctrinated into developing the core belief that their own, personal concerns, worries, anxieties and needs are, at best, secondary to those of their emotionally unstable parent. Whilst, on the surface, the child / young person may appear to be 'coping' with such impossibly onerous responsibilities, there is often an extremely heavy emotional price to be paid in later life.

There are three main ways in which childhood trauma can impair the development of self; these are as follows :

1. No strong sense of self is developed ; instead, a 'false self' is created that tends to take its cues about how to behave from the expectations of others, so lacks autonomy, authenticity and consistency.
2. A less weak sense of self than the above type, but still a very fragile sense of self which is kept hidden due to a sense of shame and of being judged and rejected.
3. The third type of self develops as a result of an emotionally over-involved parent / primary caretaker. The self is undeveloped as the individual has grown up to 'learn' (on an unconscious level) that s/he must be hypervigilant to the parent's / primary caretaker's needs (and, by extension, as s/he gets older, to the needs of others) – such individuals may become 'chronic caretakers' of others whilst remaining neglectful of their own needs and lacking in assertiveness and in a sense of personal boundaries.

4) The False Belief Of Being An 'Intrinsically Bad' Person.

When a child is continually mistreated, s/he will inevitably conclude that s/he must be innately bad. This is because s/he has a need (at an unconscious level) to preserve the illusion that her/his parents are good; this can only be achieved by taking the view that the mistreatment is deserved.

The child develops a fixed pattern of self-blame, and a belief that their mistreatment is due to their 'own faults'. As the parent/s continue to mistreat the child, perhaps taking out their own stresses and frustrations on her/him, the child's negative self-view becomes continually reinforced.

Indeed, the child may become the FAMILY SCAPEGOAT, blamed for all the family's problems.The child will often become full of anger, rage and aggression towards the parent/s because s/he has not yet developed sufficient articulacy to resolve the conflict verbally. A vicious circle then develops: each time the child rages against the parent/s, the child blames her/himself for the rage and the self-view of being 'innately bad' is further deepened.

This negative self-view may be made worse if one of the child's unconscious coping mechanisms is to take out (technically known as 'DISPLACE') her/his anger with the parent/s on others who may be less feared but do not deserve it (particularly disturbed children will sometimes take out / displace their rage against their parent/s by tormenting animals; if the parent finds out that the child is doing this, it will be taken as further 'evidence' of the child's 'badness', rather than as a major symptom of extreme psychological distress, as, in fact, would be more helpful).

The more the child is badly treated, the more s/he will believe (at least at an unconscious level) s/he is bringing the treatment on her/himself, confirming the her/his FALSE self-view of being innately 'bad', even 'evil'(especially if the parent/s are deeply religious, in the case of the latter).

Essentially, what is happening here is that the child is identifying with the abusive parent/s, believing, wrongly, that the 'badness' in the parent/s actually resides within themselves. This has the effect of actually preserving the relationship and attachment with the parent (the internal thought process might be something like: 'it is not my parent who is bad, it is me. I am being treated in this way because I deserve it.' It is worth reiterating that such a thought process may well be, unconscious).

Eventually, the child will come to completely INTERNALIZE the belief that s/he is 'bad' and this false conviction will come to fundamentally underpin the child's self-view, creating a sense of worthlessness and self-loathing (I will discuss this further later on in this book). Often, even when mental health experts intervene and explain to the child it is not her/his fault that they have been ill-treated and that they are, in fact, in no way to blame, the child's negative self-view can be so profoundly entrenched in the unconscious that it is extremely difficult to erase.

In such cases, a lot of therapeutic work is required in order to reprogram the child's self-view so that it more accurately reflects reality. Without proper treatment, a deep (and unwarranted) sense of guilt and shame may persist over a lifetime with catastrophic results (I will examine how irrational, chronic feelings of shame develop in more detail in the chapter entitled : shame).

5) Harmful Effects Of Labelling The Child As 'Bad.'

Many children who have been emotionally hurt and traumatized *'act out'* their intense feelings of confusion, pain, fear, loneliness, isolation and vulnerability, which are too strong and powerful to contain, by expressing these feelings through negative behavior such as getting into fights, extreme verbal aggression, vandalism, getting drunk or numbing themselves with drugs

This is, of course, commonly known as *'acting out'* and children express their pain in this way as they are unable to articulate their feelings, understand the cause of these feelings, or mentally process their traumatic experiences in a meaningful way.

'***Acting out', then, is an unconscious, desperate expression of inner turmoil and of a profound need for help, love, compassion and understanding, however counterintuitive and paradoxical this may sound to some.***

Tragically, instead of receiving the help they so desperately need, such children are all too often criticized, disparaged, rejected and labelled as 'bad' by the very people (i.e. their parents) who are responsible for inducing the child's highly distressed condition, *rather like injecting a person with a cancer causing agent and then blaming them for being ill ; or punching someone in the face and then blaming them for bleeding over you*.

This, of course, can be psychologically crushing for the child, destroying his/her confidence and self-esteem, inducing depression, anxiety, self-harming behaviour and alcohol/drug dependence.

Additionally, the child may go through the rest of his/her life (in the absence of effective therapy) feeling utterly unlovable, intrinsically and irrevocably flawed in terms of character, unable to form healthy relationships, deeply distrustful of others, cynical, pessimistic and intermittently suicidal.

Also, being labelled as 'bad' is likely to intensify the child's sense of injustice, isolation and rejection, increasing his/her feelings of anger ; this anger may then become a protective shield - a thin and flimsy veneer, unconsciously engineered, to conceal deeply entrenched feelings of powerlessness, vulnerability and despair.

Alternatively, the child may try to cope by 'shutting off' emotionally (when this reaches a clinically significant level it is referred to as 'dissociation' - I will say more about 'dissociation later) and may, as a psychological defense, affect a kind of indifferent, insouciant, disinterested, '*couldn't-care-less'* attitude in an attempt to conceal feelings of vulnerability and a fear of being perceived as 'weak'.

The earlier children suffering in this way can be identified, and remedial, therapeutic interventions instigated, the greater the chance that psychological damage is minimized, allowing the individual to go on to live a satisfying, fulfilling and productive life..

6) How False Feelings Of Being 'Bad' Are Perpetuated.

When a child is continually mistreated, s/he will inevitably conclude that s/he must be innately bad. This is because s/he has a need (at an unconscious level) to preserve the illusion that her/his parents are good; this can only be achieved by taking the view that the mistreatment is deserved.

The child develops a fixed pattern of self-blame, and a belief that their mistreatment is due to their 'own faults'. As the parent/s continue to mistreat the child, perhaps taking out their own stresses and frustrations on her/him, the child's negative self-view becomes continually reinforced. Indeed, the child may become the FAMILY SCAPEGOAT, blamed for all the family's problems.

The child will often become full of anger, rage and aggression towards the parent/s and may not have developed sufficient articulacy to resolve the conflict verbally. A vicious circle then develops: each time the child rages against the parent/s, the child blames her/himself for the rage and the self-view of being 'innately bad' is further deepened.

This negative self-view may be made worse if one of the child's unconscious coping mechanisms is to take out (technically known as DISPLACEMENT) her/his anger with the parent/s on others who may be less feared but do not deserve it (particularly disturbed children will sometimes take out their rage against their parent/s by tormenting animals; if the parent finds out that the child is doing this, it will be taken as further 'evidence' of the child's 'badness', rather than as a major symptom of extreme psychological distress, as, in fact,it should be).

The more the child is badly treated, the more s/he will believe s/he is bringing the treatment on her/himself (at least at an unconscious level), confirming the child's FALSE self-view of being innately 'bad', even 'evil' (especially if the parent/s are religious).

What is happening is that the child is identifying with the abusive parent/s, believing, wrongly, that the 'badness' in the parent/s actually resides within themselves. This has the effect of actually preserving the relationship and attachment with the parent (the internal thought process might be something like: 'it is not my parent who is bad, it is me. I am being treated in this way because I deserve it.' This thought process may well be, as I have said, unconscious).

Eventually the child will come to completely INTERNALIZE the belief that s/he is 'bad' and the false belief will come to fundamentally underpin the child's self-view, creating a sense of worthlessness and self-loathing.

Often, even when mental health experts intervene and explain to the child it is not her/his fault that they have been ill-treated and that they are, in fact, in no way to blame, the child's negative self-view can be so profoundly entrenched that it is extremely difficult to erase.

In such cases, a lot of therapeutic work is required in order to reprogram the child's self-view so that it more accurately reflects reality. Without proper treatment, a deep sense of guilt and shame (which is, in reality, completely unwarranted) may persist over a lifetime with catastrophic results.

Any individual affected in such a way would be extremely well advised to seek psychotherapy and other professional advice as even very deep rooted negative self-views as a result of childhood trauma (Known as CORE BELIEFS, see immediately below) can be very effectively treated.

Core Beliefs :

By the time we are adults, most of us have developed very entrenched, deeply rooted, fundamental beliefs about ourselves. Psychologists refer to these as ou**CORE BELIEFS**. Once established, they can prove very difficult to change without the aid of therapeutic interventions (such as cognitive behavioral therapy, or CBT).

A traumatic childhood, especially one that involved us being rejected and unloved by our parents, will very frequently have a very adverse effect on these CORE BELIEFS. However, precisely how our self-concept is warped and distorted by our problematic childhood experiences will depend upon the unique aspects of those experiences (as well as other factors such as our genetic inheritance, our temperament and the support we received (or failed to receive) from others to help us to cope with our childhood difficulties.

Examples of the kind of**false core beliefs our traumatic childhood experiences could have led us to form**are as follows :

OTHERS WILL ABANDON ME - this belief may develop if one/both parents abandoned us during our childhoods, for example

I AM NOT WORTH OTHERS CARING ABOUT - this belief may develop if our parent/s focused far more on their own needs than our own, for example

I MUST BE SELF-SACRIFICING - this belief may develop if our parent/s 'parentified' us, for example

I MUST SUBJUGATE MYSELF TO OTHERS - this belief may develop if our own views and needs were dismissed as unimportant by our parent/s, for example

I AM A SOCIAL PARIAH, UNFIT TO ASSOCIATE WITH OTHERS- this belief may develop if we grew up feeling our childhood experiences set us apart from our contemporaries or if we were in some way 'forced to grow up' too early, so that we developed difficulties relating to those of our own age during childhood (perhaps we were so anxious and preoccupied we couldn't behave in a care-free way join in the 'fun').

I AM INTRINSICALLY UNLOVABLE - this belief may have developed if we were unloved, or PERCEIVED OURSELVES TO BE UNLOVED, by our parent/s, for example

I AM VULNERABLE AND IN CONSTANT DANGER - such a belief can develop if we spent a lot of our childhood feeling anxious, under stress, apprehensive or in fear, for example

I MUST ALWAYS KEEP TO THE HIGHEST OFSTANDARDS - such a belief may develop if our parents only CONDITIONAL LOVED/ACCEPTED us

I AM SPECIALLY ENTITLED - this belief may develop if we feel (probably on an unconscious level) that society in general should compensate us for our childhood suffering or because we are so overwhelmed by our emotional pain that we can't help but to focus almost exclusively upon our own needs (rather as we would, say, if we were on fire).

Unfortunately, such deeply instilled core beliefs are **liable to become self-fulfilling prophecies.** As already stated, they are resilient to change and this state of affairs is seriously aggravated by the fact that, once such beliefs have become deeply ingrained, our view of the world is so coloured that we misinterpret, or 'over-interpret', what is going on around us, specifically :

We selectively attend to, and absorb, information which supports, or, seems to us to support, our negative view of ourselves, while, at the same time, ignoring or discounting anything that contradicts our negative self-view. In so doing, we are likely, often, to grossly overestimate the significance of information that seems to confirm our negative self-view, or simply completely to misinterpret information (eg by thinking/believing : 'he just yawned because I'm boring', whereas, in fact, he yawned because he had not slept for twenty-four hours).

Cognitive behavioral therapy (CBT) can help to address our false core beliefs, as we shall see in Part Three.

7) Anxiety.

It is not at all uncommon for those who have experienced significant childhood trauma to develop anxiety disorders in later life, as a result.

Anxiety disorders include :

1) Generalized anxiety disorder – persistent and intense worry that lasts for at least six months and can relate to a broad range of concerns.

2) Agoraphobia – fear of situations in which it would be difficult or embarrassing to get away/escape – often, the sufferer fears having a panic attack in such a situation.

3) Panic disorder – the sufferer experiences frequent panic attacks and is preoccupied with the fear of such attacks occurring.

4) Phobias – these can be split up into two categories : a) specific phobia and b) social phobia :

a) Specific phobia – fear of a particular situation or object which causes significant, irrational anxiety.

b) Social phobia – excessive fear of interacting with others.

5) Obsessive-compulsive disorder(OCD).

6) Post-traumatic stress disorder (PTSD). :

The experience of anxiety includes both physical and psychological features, examples of which I provide below :

PHYSICAL – increased heart rate ; rapid and shallow breathing (this actually worsens anxiety – if we find ourselves breathing in this way, slowing down the breathing and breathing more deeply often proves helpful) ; a feeling of an urgent need to protect ourselves.

PSYCHOLOGICAL – a feeling of being threatened (although it may not be possible for us to pinpoint the source of such threat) ; a feeling of impending doom and disaster.

If we are not sure what is causing these feelings, it is hard to find a solution and bring them to an end, meaning the anxiety can last for an indeterminate length of time if treatment is not sought.

Other Factors That Increase Our Risk Of Developing Anxiety :

1) Experiences in later life – if we have suffered childhood trauma we are often less able to function as an adult (for example, we may have problems with maintaining relationships, or develop addictions, or find ourselves frequently in conflict with others due to difficulties managing anger). Also (as we saw in the first chapter), severe stress in early life can actually damage the way the brain physically develops in such a way that we become much more susceptible to the effects of stress in our adult lives than we otherwise would have been.

This can lead to further stress which, in turn, increases our chances of developing an anxiety disorder.

2) Genes – if we have anxious parents we may inherit genes from them which make us more susceptible to developing anxiety ourselves.

Also, if we had anxious parents as we grew up, our environment is more likely to have been stressful, and, furthermore, we may have *learned* anxious behaviour due to a psychological process known as '*modelling*.'

3) Our 'thinking style' – those of us who are prone to negative thinking, perhaps due to depression, are more likely to suffer from anxiety.

For example, we may be prone to what psychologists refer to as *'catastrophizing'* (this means we are prone to perceiving events far more negatively than is objectively justifiable and, also, of underestimating our ability to cope).

The more of the above factors that apply to us, the greater is our vulnerability to developing an anxiety disorder.

Impaired Brain Functionality :

Herrings et al., (University of Winconsin-Madison) conducted a study which involved sixty-four adolescent participants. It was a longitudinal study that followed the participants over time (prenatally to the age of eighteen).

The aim of the study was to identify what factors significantly elevate mental health problems in childhood and adolescence, and, in order to ascertain this, each participant was assessed on the extent to which they had suffered childhood trauma. This was achieved by utilizing the Childhood Trauma Questionnaire, which the participants took when they

reached the age of eighteen and which incorporated questions related to the following six types of childhood trauma :

1. VIOLENCE
2. DIVORCE OF PARENTS
3. SEXUAL ABUSE
4. DEATH OF PARENT / PRIMARY CARER
5. SERIOUS ILLNESS
6. OTHER

Results of the study suggested that the greater the extent to which the participant had experienced childhood trauma, the more likely she or he was to develop symptoms of anxiety.

Further investigation suggested that this may be because their traumatic experiences had adversely affected the connection in their brains between three particular regions :

- THE AMYGDALA
- THE HIPPOCAMPUS
- THE PREFRONTAL CORTEX

These three brain areas interact in a way that determines how we perceive and respond to threat and fear.

However, how connections between these brain areas were adversely affected by the experience of childhood trauma differed between boys and girls, as shown below :

- Impaired communication between the HIPPOCAMPUS AND PREFRONTAL CORTEX was found to exist in both boys and girls who had experienced significant childhood trauma.
- Impaired communication between the AMYGDALA and PREFRONTAL CORTEX was found in girls only.

8) Depression.

A study conducted at the University of Cambridge in the UK, involving 238 teenagers between the ages of 15 and 18 years, focused on investigating how GENES AND ENVIRONMENT INTERACT and in what ways this interaction increases or decreases an individual's chances of being. diagnosed with depression in later life.

In the study, the teenagers were put into six different groups; the group they were placed in was determined by two factors :

1) Whether or not they had experienced significant childhood trauma (e.g. exposure to family arguments, stress and other trauma) prior to the age of 6 years.

2) Their particular type of genetic variation in relation to a specific gene involved in the production of serotonin in the brain (serotonin is a neurotransmitter – a sort of chemical messenger which helps cells in the brain communicate with one another – and affects our moods and emotional state).The teenagers all had one of the following 3 types of genetic variation:

- a) SS (two short versions of gene)
- b) SL (one short and one long version of gene)
- c) LL (two long versions of gene)

Results :

- Those who had been exposed to trauma before the age of 6 years were more likely to develop depression later on BUT ONLY IF THEY ALSO HAD A GENETIC VULNERABILITY (genetic vulnerability, the study found, was due to having the SS variation or SL variation of the gene, represented above by categories 'a' and 'b').

Specifically, it was found that exposure to discord between parents and/or neglect led to the individual :

i) having a high level of emotional sensitivity.

ii) having greater difficulty processing their emotions.

iii) having a tendency to respond especially badly to criticism.

iv) being more affected by the emotional tone of other people's voices.

According to the study, these four factors, in turn, make it more likely that the individual will later be diagnosed with depression.

Conclusion :

Having both the SS or SL variation of the gene AND experiencing early trauma is associated with a higher probability of being diagnosed with depression later on in life.

HOWEVER: having the LL variation of the gene and experiencing early trauma is NOT associated with a higher probability of being diagnosed with depression later on.

THEREFORE, WE MAY REASONABLY CONCLUDE : having the SS or SL variation of the gene makes the individual MORE VULNERABLE TO THE EFFECTS OF EARLY TRAUMA, thus making it more likely that the s/he will eventually be diagnosed with depression, whereas, HAVING THE LL VARIATION OF THE GENE SEEMS TO PROTECT THE INDIVIDUAL FROM THE EFFECTS OF EARLY TRAUMA.

It may be inferred, then, that neither early trauma alone, nor genetic vulnerability alone, are sufficient to make it more likely the individual will be diagnosed with depression. It seems, instead, it is how the relevant genes and early life experiences INTERACT that determines the likelihood that a particular individual will develop depression.

Trauma May Alter Genes :

Other recent studies have shown that childhood trauma can actually change the structure of DNA in the person who has suffered it and consequently alter how these genes work (it has been known for some time that how genes express themselves is influenced by their interaction with the environment).

For example, research involving rats has been shown that QUALITY OF MATERNAL CARE HAS A LARGE EFFECT ON GENES RESPONSIBLE FOR THE STRESS RESPONSE IN OFFSPRING:

POOR MATERNAL CARE = ADVERSE EFFECT ON GENES OF OFFSPRING = HIGH SUSCEPTIBILITY TO STRESS IN OFFSPRING.

Indeed, there is a growing body of evidence that psychological abuse of children has BIOLOGICAL effects. Furthermore, research suggests that the effects of abuse on the child's DNA lowers their resistance to stress. This effect can persist throughout life and increases the suicide risk of the individual.

It is thought that trauma / abuse in early childhood (before the age of six) can have a particularly damaging effect on the DNA which controls the individual's stress response.

For those that are interested, environment affects DNA (and thus how it expresses itself) by punctuating it with what are technically known as EPIGENETIC MARKERS. It follows from this that the function of DNA is not permanently fixed from birth, but can be altered by its interaction with the environment).

Childhood Trauma Can Affect Our Genes In Such A Way That Our Ability To Cope With Stress Is Greatly Diminished :

A study led by Seth Pollak (University of Wisconsin) suggests that abuse can adversely affect children at a cellular level, including the turning off or on of particular genes.

The study involved examining the DNA of children who had been identified (by Child Protection Services) as having been abused. Blood samples were taken from each of the children in order to enable this analysis.

It was found that, in each of the children, the same, specific gene (NR3C1) had been damaged. When this gene is working properly, it helps the child to manage stress (i.e. to calm down in a timely fashion after having been upset). It does this, when healthy, by preventing too much cortisol (a major stress hormone) from building up in the body.

However, in the abused children, the damage to this gene means that, under stress, too much cortisol DOES build up in their body. The effect is that the children are unable to calm themselves in the way non-abused children are able to.

This damage to the gene can result, therefore, in the child being in a constant state of hypervigilance (i.e. perpetually tense and in a state of 'red-alert' - I examine this more closely in the next chapter). As a result, the child is likely to perceive threats where, objectively speaking, they do not exist, and frequently become preemptively aggressive and very easily enraged.

Additionally, such children are more likely to suffer from depression and anxiety, to find any kind of significant change difficult to cope with, and, later in life, to develop physical problems such as diabetes 2 and heart disease

Studies of rodents have found that rat pups that are abused in early life also incur damage to the same (NR3C1) gene that, when operating correctly, helps them regulate stress (the same as it does in humans, as described above).

The good news, though, is that it has been found that when these rats are removed from their abusive environments and returned to nurturing mothers, the damage to the NR3C1 gene is reversed.

By extrapolation, we are able to infer that the same reversal of damage may be possible in humans by appropriate interventions. Key to these are likely to be the replacement of the traumatic environment with one which is supportive, loving, stable, safe and relatively stress-free.

Childhood Trauma, Genes And Depression :

Just as trauma can affect genes, pre-existing genes can affect the impact trauma is likely to have on us; it is, to this extent, a two-way street. Indeed, studies now show that the risk of developing depression becomes even greater if the sufferer of childhood trauma has a particular genetic make-up making him or her more vulnerable to the effects of stress.

We can summarize in this way : children who are genetically predisposed to being particularly vulnerable to stress will typically be more adversely affected by their childhood trauma than those children who do not have the genetic vulnerability. THIS HELPS TO EXPLAIN WHY TWO CHILDREN WHO SUFFER SIMILAR TRAUMA MAY BE AFFECTED QUITE DIFFERENTLY FROM ONE ANOTHER.

Further study has shown that the children with the particular genetic variation described above are MORE SENSITIVE TO THE ENVIRONMENT AROUND THEM (they process emotional information differently) than children without the variation. The genes involved are responsible for the production of SEROTONIN (a chemical affecting mood, also known as a neurotransmitter) in the brain.

DISCORD BETWEEN PARENTS and NEGLECT (again, especially if the child is under six) have specifically been linked to the child developing HIGH EMOTIONAL SENSITIVITY and a greater susceptibility to stress. And, once again, if the child has the genetic variation making him or her particularly vulnerable, the adverse effects of the discord or neglect will be increase such vulnerability.

The research producing such findings as illustrated above is still in a relatively early stage and future research is likely to help clarify the complex interactions between our genes and how childhood trauma affects us.

Childhood Trauma, Life Events And Depression :

A recent research study, carried out by Wiersma et. al, focused on possible causes of chronic depression (chronic depression is long-lasting depression which has been continuous for two years or more – 20% of those with major depression suffer from this chronic form of it).

When major depression is also chronic, it is particularly serious; this is because those individuals who are chronically depressed are more likely to be hospitalized and more likely to commit suicide than those who suffer from episodic depression) found that the GREATEST RISK FACTOR LINKED TO THE DEVELOPMENT OF LATER ADULT CHRONIC DEPRESSION WAS CHILDHOOD TRAUMA.

The study ran over a time period of 8 years and involved 1230 participants (two thirds of whom were female). Amongst other factors, the study sought to determine the link between adult chronic depression and:

a) Childhood Trauma (e.g. physical abuse, emotional abuse, sexual abuse).

b) Childhood Life Experiences (e.g. parental loss, parental divorce, parental separation).

Results :

Those who had experienced childhood trauma (physical / emotional / sexual abuse) were significantly more likely to suffer from chronic depression compared to those who had not experienced childhood trauma ; however, Childhood Life Experiences which, according to self-reports from the participants, had NOT involved significant trauma, did NOT significantly increase the likelihood of the later development of adult chronic depression.

Other Results From The Study :

- the more frequent the experiences of childhood trauma were, the greater was the risk that the individual would go on to develop adult chronic depression.
- those who had suffered most severely from childhood trauma were 3 times more likely to go on to develop adult chronic depression compared to those who had not suffered significant trauma. Furthermore, they were found to be at significant increased risk of developing comorbid psychiatric conditions, such as anxiety (this will be examined further in later chapters). Finally, too, it was found that, on average, the age of onset of their depressive condition was earlier.

Conclusions :

- these findings are consistent with previous research findings.
- it can be inferred from the results that IT IS NOT THE LIFE EVENTS, PER SE, WHICH INCREASE THE CHANCES OF THE LATER DEVELOPMENT OF ADULT CHRONIC DEPRESSION; RATHER, IT IS THE QUALITY OF THE CHILD'S HOME ENVIRONMENT WHICH IS CRUCIAL.

Implications For The Treatment Of Depression :

We are able to infer from the above findings that it is quite possible that :

a) depression associated with childhood trauma

and

b) depression NOT associated with childhood trauma

may react differently to particular types of treatment. For example, studies extending on the study described above suggest that depression associated with childhood trauma is more likely to respond well to psychotherapy rather than psycho-pharmacology (treatment with drugs). Therefore, clinicians need to be aware of whether their depressed patients experienced childhood trauma, in order that a more informed decision about appropriate treatment may be taken.

Can Facing Up To Our Childhood Trauma Help Alleviate Our Depression?

Alice Miller (1923 – 2010), the world renowned psychologist and expert on the damage that can be done to individuals during their childhood, as well as its implications for their adult lives, states, unequivocally, that if we are suffering from depression linked to our childhood, traumatic experiences, it is imperative that we start to understand, and to process mentally, the harm that was done to us when we were children.

Miller states that one reason we may not accept and acknowledge our childhood suffering and the responsibility our parents have for having inflicted this, or for having failed to protect us from it, is that we may still be idealising them. She goes on to say that it is necessary for us to overcome this psychological defence mechanism and attempt to recall, as fully as possible (in a therapeutically safe environment), how we were badly treated as children and how this made us feel at the time.

Only by getting in touch with these feelings, Miller explains, and then by acknowledging the psychological suffering our parents caused us when we were young and helpless, and, furthermore, by not being afraid to express, in a healthy manner, our pent up feelings of anger and rage, can we finally, perhaps after decades, free ourselves from our depressive state.

Putting it simply, Miller is of the view that by denying we were ill-treated, out of misguided loyalty to our parents, and by continuing to repress the rage that this treatment caused, we perpetuate our psychological illness. We must, then, according to Miller, unblock our original feelings.

In order to help us to get back in touch with these repressed feelings, we should ask ourselves if our parents would treat us now as they did then. If the answer to this question is 'no', Miller explains, then it begs the question : *'were they taking advantage of our helplessness, vulnerability and dependency to behave as they did, at the time, with impunity?*

As well as getting in touch with our repressed rage, Miller counsels us, we should also try to reconnect with the fear and deep sadness we felt as children, as well as with our childhood sense of helplessness and isolation. Then, by processing these authentic, original feelings, cathartically, under the supervision and with the support, of a suitably qualified and experienced psychotherapist, we may find ourselves in a much better position to recover our mental health and equilibrium.

Childhood Trauma, Depression And Learned Helplessness :

If we suffered a traumatic childhood in which we felt powerless to change our situation for the better, we may have become conditioned to believe that there is no point in trying to improve our situation in life as any such attempt will inevitably be doomed to failure.

Such a state of mind, one of the hallmarks of clinical depression, has been termed 'learned helplessness' by psychologists.

If we are suffering from learned helplessness, we will lack motivation to create positive change, even when it is clearly possible to do so from an objective perspective.

The following experiment, involving dogs, helps to illustrate precisely what psychologists mean by the condition of learned helplessness. It is a controversial experiment which is ethically questionable and I do not think I would feel comfortable carrying out such a research activity myself. However, here are the findings :

Phase One Of Experiment :

The experiment, part of a research study by Martin Seligman, was carried out in the 1960s and involved two sets of dogs. Both sets of dogs were given electric shocks ; however :

- one group of dogs could stop the pain by learning to press a lever.
- the other group of dogs could not escape the pain whatever they did.

Phase Two Of Experiment :

After this unpleasant experience, BOTH groups of dogs were placed in a shuttle box with two sides separated by a short barrier. Again, electric shocks were applied through the floor in the cage. This time, however, IT WAS POSSIBLE FOR BOTH SETS OF DOGS TO ESCAPE THE PAIN by jumping over the short barrier to the other (safe) side of the box.

Results:

The first group of dogs (who had control in the first phase of the experiment by being able to press the lever to stop the shocks) learned to avoid the pain by jumping the barrier in phase 2. However, the second set of dogs (who had no control over the electric shocks in the first phase of the experiment) failed to avoid the punishment (they did not learn they could do so by jumping the barrier) in phase 2.

It is thought, in the same way, that if, as children, we have been in traumatic situations over extended time periods from which we were unable to escape, as adults we might become, like the second group of dogs in the experiment, despondent, depressed and unable to try to help ourselves.

However, also like the second set of dogs in the experiment, we may falsely believe we can't help ourselves (due to our past experiences) when, in fact, we can – it can be our depressed and helpless frame of mind, formed in our childhood, that creates *the illusion* that there is no way out for us when, in fact, there is.

9) Hypervigilance.

A person who is hypervigilant feels constantly 'on edge', 'keyed up' and fearful. S/he experiences a perpetual sense of dread and of being under threat despite the fact that, objectively speaking, there is no present danger. Indeed, the person affected in this way is so intensely alert to, and focused upon, any conceivable imminent danger that s/he may develop paranoia-like symptoms.

The Nervous System :

In physiological terms, the nervous system becomes 'stuck' in an over-activated state and it is very difficult for the hypervigilant individual to calm him/herself sufficiently to enable it to return to a normal level of activation ; instead, it becomes locked into the **'fight or flight'** mode (the hypervigilant person's body is in a continuous state of preparedness to fight or flee because of the anticipation of threat the person feels - I will say more about the 'fight / flight' response in the next chapter)

Hypervigilance is one of the many symptoms of hyperarousal. Hyperarousal, in turn, is a symptom of PTSD /Complex PTSD (considered later on in this book) which are conditions linked to severe and protracted childhood trauma.

Other symptoms of hyperarousal may include :

- insomnia (e.g. constant waking during the night and finding it hard to go back to sleep).
- extremely sensitive startle response.
- problems with concentration and mental focus.
  abiding feelings of irritability and anger**,** perhaps giving rise to outbursts of extreme rage / verbal aggression, or, even, physical violence.
- constant anxiety.
- panic attacks.
- reckless behavior.
- using short-term 'solutions' (such as drinking too much alcohol or using street drugs) to reduce painful feelings which, in the longer-term, ar**e** self-destructive.

It is not difficult to see why the experience of childhood trauma should be linked to increased risk of develop hypervigilance as an adult : if we have lived our early life in an environment that made us feel constantly anxious, under threat and fearful, our very neural development (i.e. the development of our brain) can be adversely affected (as we saw earlier) and it is such negative effects that can leave us so vulnerable and predisposed to developing the disorder - particularly at times when our adult lives expose us to further stressful experience.

10) The 'Fight Or Flight' Response

Most of us are already familiar with the concept of the 'fight or flight' response to perceived danger,
namely that when presented with a threat our bodies respond by preparing us to fight against it or run from it.
This response served our ancestors well if they came face-to-face with a dangerous predator or encountered a similar emergency.

However, there are two other responses to threat which are less well known. These are the freeze response and the fawn response. I will explain what these are in due course.

Collectively, these responses to threat are known as the
4F responses and each of them represents a different response that modern day humans can display if they have been subjected to sustained and repeated trauma during their childhood.

If we have suffered problematic relationships with our main caregivers during our early life,
it is likely that we will grow up to be very suspicious about forming close relationships with others during later life.
The conscious or unconscious reasoning behind this is that if we can't trust and rely upon our parents, we can't trust anyone.

On top of this problem, any relationships we do form, with their inevitable ups and downs,
are prone to remind us of similar relationship problems we had in our early lives with our caregivers. This can trigger upsetting and painful flashbacks.

Non-Traumatized Versus Traumatized Childhood :

Those lucky enough not to have experienced a significantly disrupted childhood only utilize the 4F responses appropriately or, in other words, only when they are faced with real danger.
However, those who were exposed to serious, ongoing trauma during childhood frequently become FIXATED with one, or perhaps two, of the
4F responses and these become DEEPLY INGRAINED and REFLEXIVE.

Unlike those who did not experience a traumatic childhood, these individuals will also tend to over-rely on these responses and use them inappropriately, i.e.
when there is no serious threat. These responses upon which they have become fixated, learned as a defense mechanism during childhood,
tend to remain on a hair-trigger and are therefore easily activated.

Let's look at each of the 4F responses to childhood trauma in turn:

1) THE FIGHT TYPE - The individual who has become fixated, due to his childhood experiences, on the 'fight' response avoids close relationships with others by frequently becoming enraged and by being overly demanding.

It is theorized that s/he is largely unconsciously driven to behave in this way because s/he has a deep-rooted need to alienate others so that an intimate relationship cannot develop.

The largely unconscious reasoning behind this is that such a relationship would make him intolerably vulnerable because it would carry with it the risk of rejection, similar to the rejection experienced in childhood, which would be psychologically catastrophic for him/her.

2) THE FLIGHT TYPE - It is theorized that this type of individual, for the same reasons as above, avoids close relationships with others by immersing him/herself in activities (for example, by becoming a workaholic) which do not leave him the time to build deep, serious relationships with others.

3) THE FREEZE TYPE - This type avoids serious relationships with others by not participating with them socially. Often they will become reclusive and increasingly take refuge in fantasies and daydreams.

4) THE FAWN TYPE - This type will often go out of their way to help others, perhaps by performing some kind of community service, but without building up emotionally close, or intimate, relationships, due to a fear, like the other three types detailed above, of making himself vulnerable to painful rejection which would reawaken intense feelings of distress experienced as a result of the original, highly traumatic childhood rejection.

11) Borderline Personality Disorder.

We can say, with a very considerable degree of confidence indeed, that there exists a strong link between borderline personality disorder and childhood trauma / neglect and there now exists a large body of research suggesting that individuals who have suffered childhood trauma and/or neglect are far more likely to develop this very serious, psychiatric condition as adults than those who were fortunate enough to have experienced a relatively stable childhood.

Before we look at how borderline personality disorder and childhood trauma are linked, it is first useful to briefly describe the main symptoms of this devastating psychological disorder

Borderline personality disorder sufferers experience a range of symptoms which are split into 9 categories. These are:

1) Extreme swings in emotions.

2) Explosive anger.

3) Intense fear of rejection / abandonment, sometimes leading to frantic efforts to maintain a relationship.

4) Impulsiveness.

5) Self-harm.

6) Unstable self-concept (not really knowing ‘who one is’).

7) Chronic feelings of ’emptiness‘ (often leading to excessive drinking/eating etc ‘to fill the vacuum’).

8) Dissociation (a feeling of being ‘disconnected from reality’).

9) Intense and highly volatile relationships.

N.B.For a diagnosis of BPD to be given, the individual needs to meet at least 5 of the above borderline personality disorder criteria.

Borderline personality disorder is an even more likely outcome, if, as well as suffering trauma through dysfunctional parenting, the individual also has a BIOLOGICAL VULNERABILITY.

In relation to an individual’s childhood, research suggests that the 3 major risk factors are:

- trauma / abuse.
- damaging parenting styles.
- early separation or loss (e.g due to parental divorce or the death of the parent/s).

Of course, more than one of these can befall the child. Indeed, in my own case, I was unlucky enough to be affected by all three. And, given my mother was highly unstable, it is very likely I also inherited a biological / genetic vulnerability.

Examples Of Damaging Parent Styles :

1) Dysfunctional and disorganized.

This style can occur when there is a high level of marital discord or conflict. It is important, here, to point out that even if parents attempt to hide their disharmony, children are still likely to be adversely affected as they tend to pick up on subtle signs of tension.

Chaotic environments can also impact very badly on children. Examples are:

- constant house moves.
- parental alcoholism / illicit drug use.
- parental mental illness and instability / verbal aggression.

2) Emotional invalidation.

Examples include:

- a parent telling their child they wish he/she could be more like his/her brother/sister/cousin etc.

- a parent telling the child he is 'just like his father' (meant disparagingly). This invalidates the child's unique identity.
- telling a child s/he shouldn't be upset/crying over something, therefore invalidating the child's reaction and implying the child's having such feelings is inappropriate.
- telling the child he/she is exaggerating about how bad something is. Again, this invalidates the child's perception of how something is adversely affecting him/her.
- a parent telling a child to stop feeling sorry for him/herself and to think about good things instead. Again, this invalidates the child's sadness and encourages him/her to suppress emotions.

Invalidation of a child's emotions, and undermining the authenticity of his/her feelings, can lead the child to start demonstrating his/her emotions in a very extreme way in order to gain the recognition he/she previously failed to elicit.

3) Child trauma and child abuse

People with BPD have very frequently been abused. However, not all children who are abused develop borderline personality disorder due to having a biological/genetic RESILIENCE and/or having good emotional support and validation in other areas of their lives (e.g. at school or through a counselor).

Trauma inflicted by a family member has been shown by research to have a greater adverse impact on the child than abuse by a stranger. Also, as would be expected, the longer the traumatic situation lasts, the more likely it is that the child will develop borderline personality disorder in adult life.

4) Separation and loss.

Here, the trauma is caused, in large part, due to the child's bonding process development being disrupted. Children who suffer this are much more likely to become anxious and develop ATTACHMENT DISORDERS as adults which can disrupt adult relationships and cause the sufferer to have an intense fear of abandonment in adult life. They may, too, become very 'clingy', fearful of relationships, or suffer from a distressing mixture of the two.

Borderline Personality Disorder (BPD) Statistics, Facts And Figures :

- about three quarters of those who suffer from BPD have a history of self-harm.
- about 10% of those who suffer from BPD eventually commit suicide.
- the majority of those who suffer from BPD improve over time (over 70% go into long-term remission).
- about 50 -60% of those with BPD have a history of having been sexually abused.
- one of the main hallmarks of BPD is severe dissociation.
- a diagnosis of BPD does not define the person nor detract from their positive qualities.
- psychotherapy, especially dialectical behaviour therapy (DBT), has been shown by studies to be the most effective treatment.
- if a person suffers from BPD, s/he is likely to have other mental health issues that run alongside it (known as comorbidities). Often, these other conditions include depression, psychotic symptoms and bipolar disorder.
- about half of those who suffer from BPD have experienced a history of having been the victim of violence.
- about 1% of the population suffers from BPD ; whilst it is just as likely to affect men as women, the condition is under-diagnosed in men who are more likely to become caught up in the justice system or to use substance abuse services instead of having their BPD directly addressed.

Neuroimaging And Borderline Personality Disorder (BPD) :

Are the brains of people with borderline personality disorder (BPD) physically different from the brains of those without BPD? Neuroimaging techniques can help to answer this question.

What Is Neuroimaging?

Neuroimaging incorporates various techniques which take images of the brain's structure and functioning. However, there is controversy surrounding just how accurately such images may be interpreted.

Neuroimaging techniques include :

- Magnetic resonance imaging, or MRI (this technique uses magnetic fields and radio waves to produce two or three dimensional images of the brain).
- Positron emission tomography, or PET (this technique also produces two or three dimensional images by measuring emissions from radioactive chemicals that have been injected into the bloodstream).
- Magnetoencephalography (this technique measures the magnetic fields produced by electrical activity in the brain).

Meta-analysis Of Neuroimaging Studies Relating To Borderline Personality Disorder (BPD) :

Researchers at the *University of Freiburg (2006)* conducted a meta-analysis (an overarching analysis of relevant, previously published studies) of all the research to date. They found that all of these studies discovered abnormalities in :

- the limbic system (a region of the brain involved in generating emotions including fear, anger and those connected with sexual behavior and the formation of memories, especially memories connected with intense emotions).
- the frontal lobes (a region of the brain involved in functions including : understanding the consequences of actions, decision making, the regulation and control of emotions and the suppression of unacceptable social impulses, including impulsive aggression).

Conclusion :

The abnormalities in these two regions of the brain, given the functions of those regions, are consistent with symptoms found in individuals suffering from BPD. It can therefore be inferred that the limbic system and frontal lobes are involved with the disorder.

However, research (at the time of writing) is not advanced enough to enable actual *diagnosis of* BPD using neuroimaging techniques.

Common Misunderstandings About Borderline Personality Disorder :

Due to the fact that borderline personality disorder (BPD) is a highly complex condition, there are, notoriously, many misunderstandings and misconceptions surrounding the true nature of this extremely serious psychiatric illness ; they include the following :

1) The condition is untreatable.

Unfortunately, until relatively recently, many of those working in the field of mental health regarded BPD as essentially untreatable. It is very sad that this meant a lot of individuals were left to suffer extreme distress which could, with proper treatment, have been alleviated.

Fortunately, there is now much research showing that, in fact, treatment can be very effective for those suffering from BPD (for example, dialectical behaviour therapy - which I'll consider in more depth later on in this book). Other therapies which may be helpful include :

- STEPP (System Training For Emotional Predictability And Problem Solving).
- Mentalization-Based Therapy (MBT)
- Intensive Short-Term Dynamic Therapy
- Dynamic Deconstructive Therapy (DDT).

Indeed, approximately three-quarters of those who receive proper treatment will improve so significantly that they no longer meet the criteria to be diagnosed with BPD.

2) Stigmatization.

It is true that there is still significant stigma surrounding the diagnosis of BPD, but things are improving.

It used to be the case that many mental health professionals even refused to work with BPD sufferers because they were regarded as too difficult and challenging. This situation has greatly improved due to the much better understanding that now exists surrounding what compels BPD sufferers to behave the way they do and how this behaviour is very often linked to intense feelings of distress and having suffered a deeply painful childhood.

3) Diagnosis.

In the past, psychiatrists frequently did not even like to diagnose their patients with BPD because they did not wish to stigmatize them. Again, now, with the accruing of much greater understanding and knowledge about both the causes and true nature of the condition, psychiatrists are not so likely to be deterred from diagnosing the illness.

There is, in fact, great value in receiving a correct diagnosis of BPD, as it allows the sufferer to understand the source of his/her difficulties and what may have caused them, therefore making it far more likely that these difficulties can be effectively addressed.

4) The misconception that those who suffer from BPD are deliberately manipulative

It used to be claimed by some that individuals with BPD had a tendency to be deliberately manipulative. In fact, however, when BPD sufferers become intensely angry, for example, or otherwise 'act out', it is generally the case that such behaviour is impulsive, spontaneous and completely unplanned.

Indeed, because one of the symptoms of BPD is an impaired understanding of how social interaction operates, they are unlikely to have the necessary skills to plan out the intricacies of how to approach others in a manipulative and self-serving way.

5) The misconception of 'attention-seeking' suicide attempts.

The fact of the matter is that an absolutely astounding ten percent of individuals with BPD ultimately end their lives by suicide. THIS SUICIDE RATE IS ONE THOUSAND TIMES GREATER THAN IN THE GENERAL POPULATION IN THE UK! That statistic speaks most eloquently for itself, I think. Given this horrendous figure, one is left wondering, and deeply bewildered, as to why those with BPD do not demand more attention, left as they are, so often, to fend for themselves with no proper therapeutic intervention.

Study Shows 73% Recover from Borderline Personality Disorder (BPD) :

Until recently, it was frequently suggested that borderline personality disorder (BPD) was very difficult, if not impossible, to treat. During my research for this book, I have been disturbed to discover, also, that in the recent past some clinicians did not regard BPD as an illness at all – instead, they put forward the view that those diagnosed with BPD were not mentally disordered, but, rather, simply 'bad' and 'manipulative' people!

This reminds me of a time I made a very serious and determined suicide attempt and the psychiatrist I saw afterwards (who knew very little about me) tried to make the case that I had not really intended to kill myself but was seeking attention and sympathy. When I protested and tried to explain the attempt had been made very much in earnest (one might even say, 'deadly earnest), he responded (and I quote him verbatim) : *'It sounds like you're talking bullshit to me!'*

Highly professional.

In connection with the cynical and deeply insulting attitude that my psychiatrist displayed, I would also point out that, in my own personal view, some individuals (in my case, certain family members and former friends) like to take the view the BPD sufferer is not really ill as this, in their minds, absolves them of any responsibility to provide help and support.

Despite such pessimism, a study funded by Columbia University found that 73.5% of the participants who took part in their study recovered from BPD within 6 years. Even more encouragingly, it was found in the same study that more than half actually recovered within just 2 years.

Another encouraging finding of the study was that only 6% of those who had recovered relapsed (and, even if they did, this was mainly due to the effects of an extremely stressful event/s).

Further Results From The Study :

- 1.4% of the participants committed suicide in the first 2 years of the study.
- 1.7% of the participants committed suicide in the next 2 years of the study.
- 0.7% of the participants committed suicide in the final 2 years of the study.
- (This gives a total of 3.8%, or about 1 in 25, who committed suicide during the study).
- 65.9% achieved good psychological functioning by the end of the study (32.4% after 2 years, 48.3% after 4 years, 65.9% by the end of study).

Specific Symptoms Of Those In Study That Improved :

- Impulsiveness (this symptom improved best of all).
- Mood / affect (although this improved least well).
- Interpersonal functioning.
- Self-mutilation.
- Suicidal behaviors.
- Psychotic symptoms.

The study also showed that the two factors which most helped the individuals to recover were :

1) Ending a destructive relationship.

2) Determination to get well.

12) Complex Posttraumatic Stress Disorder (Complex PTSD).

There has been some controversy regarding the difference between post traumatic stress disorder (PTSD) and complex PTSD amongst researchers.

During the early 1990s, the psychologist Judith Herman noted that individuals who had suffered severe, long-lasting, interpersonal trauma, ESPECIALLY IN EARLY LIFE, were frequently suffering from symptoms such as the following:

- disturbance in their view of themselves
- a marked propensity to seek out experiences and relationships which mirrored their original trauma.
- severe difficulties controlling emotions and regulating moods.
- identity problems/the loss of a coherent sense of self.
- a marked inability to develop trusting relationships.

and, sometimes:

- adoption by the victim of the perpetrator's belief system.

Furthermore, some may go on to become abusers themselves, whilst others may be constantly compelled to seek out relationships with others who abuse them in a similar way to the original abuser (i.e. the parent or primary caretaker).

It is most unfortunate that, prior to the identification of the disorder that gives rise to the above symptoms, now referred to as complex PTSD, those suffering from such symptoms were NOT recognized as having suffered from trauma and were therefore not asked about their childhood traumatic experiences during treatment. This meant, of course, that the chances of successful treatment were greatly reduced.

Research has now demonstrated that the effects of severe, long-lasting interpersonal trauma go above and beyond the symptoms caused by PTSD.

The main symptoms of complex PTSD are as follows:

1) severe dysregulation of mood.

2) severe impulse control impairment.

3) somatic (physical) symptoms (e.g. headaches, stomach aches, weakness / fatigue).

4) changes in self-perception (e.g. seeing self as deeply defective, 'bad' or even 'evil').

5) severe difficulties relating to others, including an inability to feel emotionally secure or empowered in relationships.

6) changes in perception of the perpetrator of the abuse (e.g. rationalizing their abuse / idealization of perpetrator).

7) inability to see any meaning in life / existential confusion.

8) inability to keep oneself calm under stress / inability to 'self-sooth.'

9) impaired self-awareness / fragmented sense of self.

10) pathological dissociation.

The DSM IV (Diagnostic and Statistical Manual IV) first named complex PTSD as: DISORDER OF EXTREME STRESS NOT OTHERWISE SPECIFIED (DESNOS). Now, however, complex PTSD is listed as a SUB-CATEGORY of PTSD.

Whilst it is certainly true that there is an OVERLAP between the symptoms of PTSD and complex PTSD, many researchers now argue that PTSD and complex PTSD should be regarded as SEPARATE and DISTINCT disorders.

12) Hypersexuality.

Hypersexuality, also referred to as erotomania , or, more straightforwardly, sexual addiction, has been linked to traumatic experiences during the sufferer's childhood. This does not imply, of course, that all those who suffer childhood trauma will go on to become hypersexual in adulthood, nor that there aren't other causes (there are - such as some neurological conditions which it is unnecessary for me to go into here).

Erotomania can be defined as a persistent and enduring, intensely powerful compulsion to indulge in sexual activity, whether that activity be solitary or with another / others. Although it affects females (in such cases, yet another term is sometimes used - 'nymphomania') it is more common amongst men.

Clearly, it is no easy task to judge when a 'normal' sexual appetite escalates to such extremes that it is classified as erotomania ; nevertheless, clinicians generally classify sexual addiction as being a pathological condition when it substantially interferes with day-to-day functioning, including friendships, relationships, work and life-style in general.

Clinicians regard addiction to sex as a coping mechanism which allows the sufferer to 'dissociate' (I explain in detail what psychologists mean by 'dissociation' in a later chapter) or, in other words, to mentally 'escape' from feelings of intense emotional distress (in order to temporarily escape from mental pain more effectively, those suffering from hypersexuality may combine sex with drugs or excessive use alcohol.

Symptoms of hypersexuality include :

- frequent, anonymous sex.

- frequent use of prostitutes.

- obsession with online porn / sexually oriented chat rooms / phone sex.

- view of others as mere sex-objects.

- obsessive masturbation (can be even as much as 10-20 times per day).

and, at the more severe end of the scale, symptoms may include :

- indecent public exposure.

- voyeurism.

- bestiality.

13) Violence.

Research shows that the more ADVERSE CHILDHOOD EXPERIENCES an individual suffered in their early life, the greater their risk of becoming a victim of crime and / or the perpetrator of crime in early life.

ADVERSE CHILDHOOD EXPERIENCES, as defined by the well known Adverse Childhood Experiences Study that we encountered in Chapter Oneare listed below :

- physical abuse.
- emotional abuse.
- sexual abuse.
- witnessing the mother being abused by the father.
- loss / abandonment / rejectionby a parent (including due to separation and divorce).
- living with a parent suffering from a pathological addiction.
- living with a clinically depressed mother
- living with a mother who suffers from another significant mental illness.

As we also saw in Chapter One, the more of the above adverse childhood experiences a person has suffered, the higher their ACE Score. For example, a person who had suffered one of the above adverse childhood experiences would have an ACE score of 1, whereas an individual who had experienced four of them would have an ACE score of 4.

Relationship Between An Individual's ACE Score And Their Likelihood Of Being The Perpetrator And / Or The Victim Of Crime :

Some main examples of the research linking crime / violence to childhood trauma include the following :

- ACE scores of 4 or over increase the risk of being the perpetrator of violence, the victim of violence and of being put in jail by 500 per cent, compared to an individual with an ACE score of zero. (Bellis et al.)
- Females with ACE scores of 5 or more are 14% more likely to suffer domestic violence and 30% more likely to suffer sexual assault, compared to females with an ACE score of zero. (Whitfield et al.).
- Ex-offenders with an ACE score of 5 or above are 11 times more likely to reoffend during their first year of probation and 15 times more likely to reoffend during their second year of probation, compared to individuals with an ACE score of zero (Anda, 2011).
- Children involved in the juvenile justice system have, on average, approximately, an ACE score triple that of children who are not involved in the system (Baglivio et al.).
- As a child's ACE score increases, the risk of him perpetrating violence increases from between 35% and 144% (Duke et al.).

14) Antisocial Personality Disorder.

According to *Meroy* (1988), those who go on to develop antisocial personality disorder as adults have frequently experienced a dysfunctional relationship with their mothers during infancy, including a failure to form a healthy emotional bond with her - this could be for a variety of reasons that include maternal mental illness, emotional deprivation, rejection, abuse and/or neglect.

Stranger Self-Object :

Meroy also suggests that the person suffering from antisocial personality disorder has a self based upon an 'aggressive introject', referred to as a 'stranger self-object.'

An introject can be defined as :*an unconscious defense mechanism in which an individual (especially a child) absorbs , and replicates in himself, the personality traits of another person into his/her own psyche.*

The aggressive introject is referred to as the stranger self-object because it reflects the*child's experience of the parent as a kind of 'stranger' who cannot be trusted and who harbors nefarious intent towards him/her* (i.e. the child).

As a child, the future antisocial personality disorder sufferer perceives his/her primary caregiver (usually the mother) as being unloving, cruel, emotionally distant and cold, unempathetic, uncaring and a threat / aggressive / prone to hurting him/her ; s/he then introjects (see above) these characteristics.

Failure To Develop Meaningful Empathy Or Internalize Rules :

Furthermore, s/he generalizes the negative characteristics s/he perceives to exist in the harmful primary- caregiver onto others so that his/her basic template for relating to other people in general excludes trust, empathy and healthy emotional bonding.

This, in turn, leads him/her to be unable to develop meaningful empathy with others, making it possible for him/her to hurt these others without experiencing feelings of remorse.

According to the theory, failure to identify with parents due to early life dysfunctional relationships with them can also frequently lead to *non-internalization* of rule based systems which, in turn, makes it far more likely that the child will grow up without respect for the rules of society in general (which is, of course, a hallmark of the antisocial personality).

'Sadistic' Attempts To Bond :

Also, according to the theory, because of the failure of emotional bonding in early life with his/her mother, the antisocial personality disorder sufferer, as an adult, becomes essentially emotionally detached from his/her relationships and any attempts s/he does make to bond with others are frequently sadistic (based upon control and other destructive behaviors).

'Superego Lacunae' :

Because those suffering from antisocial personality disorder do not experience remorse when they hurt others, some psychodynamic theorists speculate that they are also unable to experience true depression. Kernberg (1984) suggests that such individuals usually have severely underdeveloped superegos and that even high functioning antisocial individuals, who do, in fact, have some nascent and perfunctory development of their conscience, still have very substantial deficits in relation to it which Kernberg referred to as superego lacunae.

Kernberg also put forward the notion that those who suffer from antisocial personality disorder :

- do not tend to be interested in rationalizing their behavior.
- do not tend to be interested in morally justifying their behavior.

Young Offenders :

A research study (Fonagy et al., 1997) showed that 90% of young offenders had suffered significant childhood trauma, including both abuse and loss (e.g. of a parent through divorce). Neglect in childhood was also a very significant factor in greatly increasing the risk of later violent offending. Violent offending following such trauma is sometimes referred to as ‘acting out’.

The Effects Of Loss During Childhood :

The psychologist Bowlby (1969) studied the effects of loss in childhood (e.g. through parental divorce). He demonstrated that it very often led to the child responding by passing through three stages:

1) PROTEST (due to SEPARATION ANXIETY).

2) DESPAIR (due to grief over the loss. N.B. The loss need not be due to death).

3) EMOTIONAL DETACHMENT (a defense mechanism).

Following loss, if the child is not treated sympathetically and emotionally supported, his or her response to the loss can become pathological.

Types Of Loss :.

Two types of loss that the child might experience are death of a parent or parental divorce. But a feeling of loss can, in fact, be just as damaging (or, indeed, even more damaging) following less overt forms of loss. For example:

- parental rejection.
- parental threats to abandon the child.
- parental neglect / lack of emotional involvement.
- parental abuse.
- parents not giving the child love.

Later work by Bowlby (1979) has shown that children often ‘re-experience’ their childhood loss in later life when faced with further separation and loss, or the threat of it, in their adult relationships. This may be expressed by the individual ‘re-experiencing’ his or her feelings of childhood loss by reacting with violence, anger and hatred.

Furthermore, these dysfunctional response patterns are resistant to change as the individual’s perception of adult relationships becomes distorted by their experience of childhood loss (in essence, leading to error-correcting information being defensively and selectively excluded from consciousness).

Childhood Trauma Leading To Problems Controlling Emotions :

Further research (Van der Kolk et al., 1995) has shown that childhood trauma can lead to the individual experiencing a deep feeling of terror which he or she is unable to articulate; this, in turn, leads to the individual experiencing extreme problems in relation to regulating internal states / emotions, including, of course, feelings of aggression and hostility. Indeed, this dysfunction is biological in origin, as the biological state of the individual has been adversely affected by their childhood trauma.

Habitual And Repetitive Relationship Difficulties (Attachment Disorder) In Adult Life Following Childhood Trauma :

It has also been demonstrated by research that, following loss-related childhood trauma, in later life the individual’s adult relationships very frequently induce intense feelings of insecurity (if this is insecure response is severe and habitual, it is known, according to Bowlby’s theory, as ‘attachment disorder’). This can, and often does, lead the individual to adopt dysfunctional coping strategies including alcohol and drug misuse, violence and crime.

Altered Physiology :

In such individuals, the instinctive, internal ‘fight’ response is far more easily triggered, and, indeed, far more intensely triggered, when the individual who has experienced childhood trauma perceives himself to be faced with a threat. Due to the unresolved trauma, the PHYSIOLOGICAL RESPONSE TO THREAT ALSO REMAINS UNRESOLVED. In fact, the individual’s nervous system is perpetually in a state of HYPERAROUSAL: expecting threat, perceiving threat everywhere, and, on a hair-trigger, ready to fight.

In essence, the individual is trapped in the moment when they did not release the aggressive energy in response to the original trauma/s. This pent-up aggressive energy, then, is condemned, repeatedly, to express itself in adulthood in the form of various types of emotions; these include anger, hatred and rage.

Until the trauma is properly resolved, the individual, unconsciously, becomes trapped in a cycle of attempting to resolve the trauma through compulsive reenactment; we reenact the original trauma in a manner which is closely linked to that original trauma. For example, a child who was exposed to a lot of aggression, hostility or violence is quite likely, as an adult, to be repeatedly drawn into violent situations.

Far from this reenactment resolving the trauma, it actually perpetuates its effects. However, because the behaviour is being driven by largely unconscious motivations, the individual

reenacting the trauma is very often powerless to alter his automatic responses to triggers such as perceived threat (the threat, due to the individual's hyper-aroused nervous system, often being overestimated or, even, imagined).

The Good News :

This is all very depressing. However, despite the fact it has been believed, in the past, that extreme trauma leading to cyclical violence could not be cured, because, it was thought, the brain had been irreversibly damaged by the original emotional trauma (producing constant feelings of depression, anxiety and rage), more up-to-date research is suggesting that pathological symptoms resulting from trauma do NOT have to be caused by actual physical brain damage (i.e. they can be caused by trauma which has not physically damaged the brain) and that when the trauma is effectively resolved through therapy the individual's nervous system can return to normal and, thus, greatly improve the individual's behaviour.

There is most certainly hope, then, for even the most severely traumatized amongst us.

The Case Of Adolf Hitler, According To Miller :

The Swiss psychoanalyst, Alice Miller, was of the view that most people *repress* their memories of childhood trauma and may be in such extreme *denial* about the way their parents mistreated them that they may actually, on a conscious level, *idealize* them rather than castigate them. This acts as a psychological defense mechanism : protecting the individual from the painful truth.

Nevertheless, Miller suggests, the unconscious rage they feel against their parents constantly fizzes beneath the surface looking for an outlet. This outlet takes the form of displacement (redirecting one's rage onto innocent victims).

An exceptionally rare and extreme example of individuals who may act out this process of repression, denial and displacement is that of some serial killers. However, Miller provides an *even more* extreme example, that of the tyrant and fascist dictator, Adolf Hitler.

Hitler's childhood was abusive ; indeed, Adolf Hitler, as a child, was severely physically abused by his father (Alois) who would regularly fly into uncontrollable rages and beat his son. Sometimes, Adolf Hitler's mother would intervene in order to try to physically protect her son, only to be beaten by her husband herself as a consequence.

One effect of this on Adolf Hitler is that he began to bully his sister which took the form of hitting her, just as he was hit by his father.

'The terror of the Third Reich was cultivated in Hitler's own home.'

– Florian Beierl

In modern day terms, then, Adolf Hitler's family was highly dysfunctional, and this had a damaging psychological effect on him as evidenced not only by his bullying of his sister, but also by the fact that in his teens he became increasingly reclusive, resentful and emotionally unstable (particularly when interacting with his father).

According to Miller, Hitler's terrible and horrific actions can be traced back to this dysfunctional childhood in so far as his heinous actions as an adult were driven by a psychotic and deranged lust for *'revenge on the world'* for his childhood suffering.

Miller also argues that many high ranking SS officers had also suffered abusive childhoods, as had other tyrants such as Mao and Stalin.

Miller's ideas have been criticized for being overly simplistic, so she is something of a controversial figure.

School Shooters :

It is *utterly understandable*, of course, that many choose to explain such appalling tragedies as school shootings using phrases such as *'it was simply an act of pure evil'* However, do such explanations (based on *entirely natural* emotional responses with which we all sympathize) prevent us from looking for more complex, deep-rooted causes? And, if there are more complex and deep-rooted explanations, shouldn't they be studied so as to help the prevention of future, similar occurrences?

Langam PhD, in his excellent book, *'Why Kids Kill',* attempts to do exactly this. Based on his research, he has theorized that those individuals whom he terms 'school shooters' fall into three main categories (though he accepts there may well be other categories that his own research has, as yet, not identified).

The three categories of 'school shooters' identified by Langam are as follows :

- Individuals who are psychopathic
- Individuals who are psychotic
- Individuals who are traumatized

Let's look at each of these three categories in turn :

1) Psychopathic 'school shooters' :

Langam describes certain personality features of psychopathic 'school shooters' which may contribute to their lethal behavior. First, he says, they are egotistical, meaning that they consider themselves to be in some way fundamentally and intrinsically superior to 'the *mere mortals'* with whom they are infuriatingly forced live alongside. Second, they are egocentric, meaning they are highly focused on placing their own needs far above the needs of others.

Furthermore, Langam describes this category of 'school shooters' as being, rather unsurprisingly, as amoral, lacking a conscience (including the capacity to feel guilt or remorse), lacking empathy for the feelings of others and as having problems controlling anger.

Also, Langam points out, psychopaths may be superficially charming, thus making their true intentions much more difficult to detect and making it easier for them to manipulate others.

Finally, Langam states that, whilst not all psychopaths are sadistic, those he examined during the course of his own research *were* sadistic. A person with a sadistic personality shows an enduring propensity to indulge in aggressive and / or cruel behavior, enjoys witnessing the suffering of others, and is prone to instil fear in others in order to be better able to manipulate them. They may also enjoy deprecating, demeaning, devaluing, disparaging and humiliating others.

Notwithstanding the above, however, sometimes so-called psychopathic traits in adolescents may be symptomatic of profound feelings of inner, emotional distress.

2. Psychotic 'School Shooters' :

Those suffering from psychotic illnesses lose touch with reality' (although this may only happen occasionally and need not be a permanent state. The main symptoms of psychosis are

delusions and hallucinations.

Hallucinations are most commonly auditory (frequently referred to as 'hearing voices') but may also be visual (self-explanatory), tactile (e.g. feeling as if insects are crawling over one's skin), olfactory ('smelling' odors e.g 'of dead people' when such smells are, in fact, utterly absent), gastatory (sensing 'tastes' in the absence of a physical stimulus e.g. believing one can 'taste poison' in one's food) or proprioceptive (hallucinations of posture e.g. feeling one is floating, flying, having an 'out of body' experience, believing part of one's body to be in a different location or feeling the 'presence' a limb that has been amputated *(phantom limb syndrome)*.

Delusions are blatantly false beliefs that are held with absolute conviction, unalterable (even in the face of powerful counterarguments and contradictory evidence), and, frequently, bizarre and / or patently untrue (Karl Jasper).

Langam states that, amongst 'school shooters', common delusions are :

- DELUSIONS OF GRANDEUR
- PARANOID DELUSIONS

In the group of 'school shooters' which Langam based his research on, he reports that delusions of grandeur held by these individuals included beliefs about being *godlike'* and that the paranoid delusions that they held included believing that '*people, gods, demons, or monsters were intending to harm or kill them.'*

3. Traumatized 'school shooters' :

Langam reminds us that traumatized / abused children frequently suffer consequences that include 'anxiety, depression, hostility, shame, despair and hopelessness' and that they may, too, suffer a 'reduced capacity for feeling emotions' and 'feel cut off and *detached from others…threatened…and paranoid*. And, further, they may suffer from constant hypervigilance, self-destructiveness, self-harm, suicidal ideation and a propensity to behave violently.

It almost goes without saying, therefore, that the above provides yet further compelling evidence for the necessity to therapeutically intervene at the earliest possible opportunity when young people are displaying symptoms of emotional turmoil, traumatization and incipient mental illness (although, of course, it should, equally, hardly need saying that most such individuals are of no danger to others and are *far more likely to be a danger to themselves* due to self-harm (including heavy drinking, binge-eating, drug-taking, heavy smoking, anorexia and suicidal ideation / behavior and general self-destructive behavior).

So-Called Psychopathic Traits In Adolescents Frequently A Sign Of Intense Emotional Distress :

Some teenagers may 'act out' violently and find themselves labelled as incipient psychopaths ; however, a recent study conducted at the *University of Vermount* and published in the *Journal Of Child Abnormal Psychology* by psychological researchers *Gill* and *Stickle* suggests that those in the medical profession who are prone to see young people displaying certain characteristics and behaviours as nascent *psychopaths* may not properly appreciate the complexities involved in the diagnosis of *psychopathy*.

In the *Diagnostic and Statistical Manual of Mental Illness- edition* 5 *(DSM - V), psychopathy* is listed under *antisocial personality disorders.*

Typically, a psychopath is :

- *unconcerned about the rights of others.*
- *highly egotistical / narcissistic.*
- *bold.*
- *disinhibited / impulsive / very poor at delaying gratification.*
- *lacks empathy.*
- *callous, cold and unfeeling- disregards the law (although many psychopaths never break the law).*
- *prone to violence (though, again, many psychopaths are not).*
- *devoid of conscience / does not feel remorse or guilt.*
- *not afraid of punishment.*

The Study *:*

The study referred to in the first paragraph involved 150 participants (both male and female) residing in juvenile detention centers. All of the participants were aged from 11-years-old to 17-years-old and had been classified as :

- *callous.*
- *unemotional.*
- *extremely, behaviourally antisocial.*
- *incipiently psychopathic.*

What Did The Study Find?

Using more sensitive and sophisticated means of testing (especially with regard to examining personality traits) than is usually used to investigate psychopathy and psychopathic characteristics it was found that although, superficially, the young people *appeared* callous, unemotional and pre-psychopathic, their *actual* diagnosis (according to the more accurate and appropriate tests used), in the main, was that they were :

- *severely depressed.*
- *severely anxious.*
- *in a state of high emotionality.*

(In other words, they were not psychopathic but suffering from intense emotional distress).

Implications Of Study :

Due to these findings, the researchers pointed out that young people displaying behavioral problems such as those in this study should not be unthinkingly labelled as incipient psychopaths, punished and stigmatized but, instead, be given appropriate support and treatment such as cognitive behavioral therapy (CBT) and help controlling their intense and volatile emotions.

15) Dissociation.

Those of us who experienced significant childhood trauma are at a far greater risk of developing the psychiatric condition known as DISSOCIATIVE DISORDER in adulthood than are the rest of the population.

Unfortunately, however, it often goes unidentified as it can, not infrequently, be misdiagnosed (most commonly as depression).

Symptoms of dissociation can be viewed as lying on a spectrum ranging from *mild to severe.* I outline examples of such symptoms below:

Mild symptoms include:

- Feeling in a daze (sometimes referred to as 'mind fog'),
- Feeling utterly exhausted, numb and soporific for no obvious reason,
- Finding oneself tongue-tied when trying to talk about difficult experiences (as if experiencing a kind of mental block).

More severe symptoms include:

- Amnesia for certain events, or large periods of time, in one's life (for example, I have no memory whatsoever of large chunks of my childhood). Such 'dissociative amnesia' far exceeds normal forgetfulness.
- Time loss : an individual may suddenly find himself in a particular place, with no memory of how he got there, unable to remember anything that has occurred in the recent past (e.g the last few hours or days).
- Feeling out of control (e.g. experiencing extreme, uncontrollable anger).
- Periods of apparent deafness *(at my first school, when things were at their worst at home between my parents, at times I did not respond to my name being called out in class ; the school thought I was suffering from deafness; in fact, though, the cause was deep psychological trauma. This is certain as it became apparent this 'deafness' only occurred when the class was discussing parents or family matters or associated topics).*

Dissociation And Switching:

Some people dissociate when under extreme stress in a way that almost resembles 'changing personality'; this is referred to by psychologists as *'switching'.*

In fact, it is NOT a literal switch of personality, but a switch of *ego states / states of consciousness* sometimes referred to by psychologists as *'parts'* or *'alters.'*

Studies suggest that nearly all people who suffer such *switching* have experienced severe early life trauma. It is NOT a genetic disorder.

When a person *switches* due to stress, s/he may *switch* from the *ego state* that s/he relies on for his/her day-to-day functioning to the *ego state* that is normally *dissociated or 'kept in a separate compartment'* in the mind ; it is this separation that allows the individual to function daily, by preventing the feelings in the *dissociated* part from interfering in it.

This *dissociated* part contains profoundly painful trauma related feelings such as fear, shame and anger.

According to Dr Harold Kushner, author of *Healing Dissociation,* in order to overcome feelings of dissociation / dissociative disorders it is necessary to :

- Gradually, as part of a therapeutic process, come to terms with, and accept, the reality of one's traumatic childhood experiences (as opposed to being in denial about this, repressing it or suppressing it).
- Firmly recognize the traumatic experiences are now over and in the past.
- Firmly recognize that because the traumatic experiences are over and in the past, how one feels, behaves, thinks and acts no longer has to be constricted by these experiences ; one is free to start making fresh choices and take on a new, more positive approach to life.
- Come to an acceptance that injustice, pain and suffering are inevitable parts of life and that what is of greatest importance is how one responds adapts to this inescapable fact.
- Find meaning in one's experiences of suffering, such as how it has developed one as a person and how it can lead to posttraumatic growth (I will say more about the concept of posttraumatic growth later on in this book).

16) Emotional Dysregulation.

Significant and chronic childhood trauma also increases our risk, as adults, of suffering from 'emotional dysregulation.'

Other terms for 'emotional dysregulation' include 'emotional instability', 'affective volatility' and high 'emotional lability.' In other words, an individual who is emotionally deregulated is prone to experiencing extreme and rapid fluctuations in his/her moods and feelings

Recent research into BPD suggests that, in the case of individuals afflicted by this disorder, *not all* emotions are involved in these dramatic fluctuations of mood. The main emotions that ARE involved have been found to be :

- anger
- anxiety
- depressive feelings

To elaborate a little further, anger appears to be the emotion most strongly associated with BPD, and severe swings between feelings of depression and anxiety have been found to be particularly prevalent in those suffering from the condition.

Anyone who suffers from, or has suffered from, significant emotional dysregulation knows the devastating effects the condition can have on various aspects of one's life - it can ruin friendships, family relationships and intimate relationships ; it can also cause problems at work, including job loss ; it may even lead to legal difficulties (and these examples by no means constitute an exhaustive list).

If, then, we suffer from emotional dysregulation, it is vital, if we wish to reclaim, and establish some semblance of control over our lives, that we reduce our level of emotional dysregulation and, thus, become more emotionally stable.

A study carried out by Bailey and Chambers (2016) found that by undergoing an eight week course in mindfulness meditation, it was possible for an individual to increase the volume of the dentate gyrus, an area of the hippocampus (the hippocampus is the part of the brain responsible for emotional regulation) by 22.8% - this is possible because of a quality of the brain known as neuroplasticity.

And other research has found that mindfulness meditation can also have beneficial effects upon other brain regions and their associated functions. For example, a review of research,

carried out by the researchers Tang, Holzel and Posner (2015) and published in a journal called Nature Reviews Neuroscience focused upon 21 studies on the effects of mindfulness meditation on the brain. Findings of the studies suggest that mindfulness meditation can increase the size of the following brain regions :

- anterior cingulate cortex and striatum (involved in attention control).
- multiple prefrontal regions and limbic region (involved in emotional regulation).
- insula, medial prefrontal cortex (involved in self-awareness).

17) Severe Relationship Difficulties.

As we grow up, we form MENTAL MODELS representing what our relationships with others are like. The term that psychologists often use to refer to such mental models is INTERPERSONAL SCHEMA.

These interpersonal schema develop from early infancy and throughout childhood. Overwhelmingly, the form they take is influenced by the quality of our relationships with our parents / primary caregivers.

Vitally, these interpersonal schema FUNDAMENTALLY AFFECT how we interact with others in later life. Those who suffer mistreatment by parents / caregivers are very likely to form NEGATIVE INTERPERSONAL SCHEMA which ADVERSELY AFFECT their relationships with others as they get older ; problems relating to others may start, for example, at school, and then, later, become apparent at work (or, indeed, in any other context in which it is necessary to interact with others).

Repetition And Re-enactment Compulsion :

The individual who, due to his/her traumatic experiences as a child, has developed negative interpersonal schema very frequently becomes unconsciously compelled to form relationships which lead to a re-experiencing or re-enactment of the original trauma (it is theorized that this occurs as an unconscious attempt to *master the original trauma*).

An example of this would be that of a woman who was physically beaten by her father as a child being unconsciously driven to form intimate relationships with men who are likely to physically abuse her during her adulthood.

Another example would be of someone who was rejected by parents as a child becoming unconsciously driven to ensure s/he is also rejected by those he forms relationships with as an adult.

Self-Sabotage :

In this way, the negative interpersonal schemas which we developed during our traumatic childhoods lead us to sabotage our adult relationships for reasons that are operating below the conscious threshold (until we are made aware of these unconscious mechanisms, for example, through undergoing the appropriate therapy e.g. schema therapy - schema therapy is discussed later on in this book).

Examining The Process By Which Our Negative Interpersonal Schema Develop :

Essentially, the process by which the development of our negative interpersonal schema develop occurs as follows :

1) As infants and children, we are ‘programmed’ by our evolutionary history (for survival reasons) to endeavour to form strong emotional attachments with our primary caregivers; this remains true even if they are ‘bad’ caregivers (bad care is better than no care from an evolutionary perspective).

2) The negative interpersonal schema we learn from our experience of our dysfunctional early relationships PROFOUNDLY INFLUENCE how we behave in our future relationships, and what we expect from them.

3) This will tend to lead to repeated difficulties in the relationships we form as adults – they, too, will tend to be dysfunctional and destructive.

4) This in turn reinforces and strengthens the negative interpersonal schema that we formed during our childhoods, further compounding our already serious problem.

5) These negative schema, and the relationship difficulties which accompany them, can last well into adulthood, or, even, a lifetime, preventing us from ever developing emotionally fulfilling and satisfying intimate relationships.

6) Often, the problem may only be properly resolved by the affected individual undergoing the appropriate therapy (e.g. as already suggested, schema therapy).

Core Beliefs :

If we had dysfunctional relationships with our parents or primary care-givers as children which caused us to experience traumatic distress it is likely that, as a result, we developed negative core beliefs which now may be seriously detrimental to our adult relationships both in terms of forming and maintaining them.

A core belief is one that is deeply entrenched and one that has a powerful effect on how we view the world, ourselves and others. Importantly, most of the time we are not conscious of the fact that this mechanism is at work which, of course, makes it extremely difficult, even impossible, to control (after all, how can we control an unconscious process of which, by definition, we are unaware?).

Indeed, if we are unaware that our negative core beliefs, acquired during childhood, are at the root of our adult relationship difficulties, our lives will continue to be (most unhelpfully) directed by them.

It is only by identifying these negative core beliefs, understanding how, and why, they developed, and becoming aware of how they are ruining our adult relationships, that we may start to make positive changes.

One type of therapy that may be particularly useful in helping us in this regard, many may already be aware, is cognitive behavioural therapy. (CBT).

Negative core beliefs, developed due to our childhood dysfunctional relationships with our parents / primary caregivers, may, for example, include the following (the actual negative core beliefs we develop that harm our adult relationships will, of course, depend upon the exact nature of how we were badly treated by our parents / primary caregivers) :

– people I love will abandon/ reject / leave me.

– people I love will betray and exploit me.

– people I love will emotionally withdraw from me.

– people I love will soon discover I'm unlovable, inadequate and worthless.

– people I love will not protect me.

Core Beliefs Are Easily Triggered :

Such core beliefs are very easily triggered, and, once triggered, can lead to*extremely strong, uncontrolled emotions.*

Very often, too, these easily triggered *core beliefs lead us to jump to false and irrational conclusions* For example, if someone we are meeting for a drink is late, we might assume this is a sign of rejection when, in reality, it is because their car broke down and their mobile phone had a dead battery so they could not contact us to explain their lateness.

Danger Of Revictimization :

Revictimization can be defined as harm done to an individual as a result of his/her inability to self-protect. It has also been viewed as an unconscious form of self-harm.

Survivors of traumatic childhood abuse are at high risk of being revictimized. Indeed, sometimes such individuals seem to actually actively seek out situations within which revictimization is likely to take place (although this is likely to occur on an unconscious level). Why should this be?

Well, several theories have been advanced in an attempt to elucidate this, on the face of it, rather perplexing phenomenon.

Sigmund Freud (1856-1939) proposed that revictimization could be explained by his theory of REPETITION COMPULSION whereby individuals are unconsciously driven to 're-enact' past traumatic experiences in an attempt to 'gain mastery' over them.

Briere (1992) suggests two possible explanations. First, survivors of traumatic abuse have grown up 'getting used to' living in the context of problematic relationships so that, when they experience further dysfunctional relationships with others in later life, *even if these again result in them being on the receiving end of further abuse* they are liable to accept it as 'just the way things are' ; indeed, they may assume that such relationships are an inevitable part of life and can't be escaped (this is a form of 'learned helplessness', discussed earlier in the chapter about depression).

Second, those who have suffered childhood abuse frequently experience low levels of self-esteem which may lead them to develop a false belief that they are somehow unworthy of being part of a healthy, non-exploitative, mutually loving relationship.

It has also been pointed out (e.g. Finkelhor, 1979) - and this would seem a matter of common sense - that those who are abused as children are also at greater risk of being revictimized as they are liable to place themselves in dangerous situations when trying to escape their home environment.

Self-Revictimization :

In a desperate attempt to escape emotional pain , those who have experienced significant childhood trauma may attempt to dissociate (discussed earlier) from their suffering by becoming dependent upon dysfunctional coping techniques such as excessive alcohol intake, gambling or risky, promiscuous sex ; such self-harm may also take on a more direct guide in the form of self-cutting, self-burning etc. (all of these dysfunctional coping techniques are discussed later on in this book).

18) Addictions.

Those of us who have suffered significant childhood trauma are more likely than others to develop addictions (often multiple addictions) during our teens and adulthood. Why should this be?

Experiments involving rats help to cast light upon this. These experiments involve measuring how addicted to cocaine rats become in two different conditions (the psychologist, Professor Bruce Alexander, pioneered these studies). These two conditions are as follows:

Condition One: A solitary rat in an impoverished environment (i.e. one in which there is no stimulation, just an empty cage).
Condition Two: The rat has the company of other rats and has an enriched (i.e. stimulating) environment.

In BOTH conditions the rats were exposed to the availability of cocaine - the drug was added to their water supply.

Results:

- In condition one rats became extremely addicted to cocaine.
- In condition two rats ingested far less cocaine (75% less) and did not become addicted.

If we extrapolate from this research (i.e. apply it to humans) it would be expected that :

Individuals with empty, lonely lives are significantly more likely to become addicts than individuals with full and socially integrated lived. Indeed, there is much research evidence to support this view and a growing school of thought is of the view that a person's life situation plays a more important role in an individual's addiction than the addictive substance itself.

Implications:

It is likely, then, that a person's life circumstances play a vital role in whether or not a person becomes an addict. Therefore, it follows that the most effective way to reduce addiction is to help addicts reconnect with society and gain dependable social support.

Because those who have suffered childhood trauma are more likely to develop chaotic, disenfranchised lives as adults, such people are at greater risk than others of living in the kind of social isolation which fosters drug addiction.

19) Difficulties Managing Stress.

Chronic stress during our childhood can drastically diminish our ability to manage stress when we become adults, making it extremely difficult to cope with the daily stressors that others may easily be able to take in their stride.

We may, for example, become disproportionately enraged if we temporarily mis-place our keys, inadvertently snap a shoe-lace, or are thwarted in our vehicular progress down the street by a succession of obstinately and infuriatingly red traffic lights.

The reason for such overreactions can lie in the fact that our chronically stressful childhoods have disrupted the process in the brain associated with the production of stress hormones.

In particular, levels of the stress hormones adrenaline and cortisol may have become chronically too high.

It follows that, when we experience a minor stressor, too much adrenaline and cortisol are released. Let's look at the effect that these two stress hormones have upon the body:

1) The Effect Of Adrenaline On The Body:

- causes heart rate to increase.
- causes blood pressure to go up.
- causes breathing rate to become more rapid (sometimes leading hyperventilation).

2) The Effect Of Cortisol On The Body:

- transports energy to muscles by diverting it from areas of the body where it is not immediately needed (such as the stomach).

So, the effects of adrenaline and cortisol combined are to prepare the body for *'fight or flight',* as if we were being threatened by a ravenously hungry tiger (when, in fact, we are just stuck in traffic or have mislaid our keys etc.). In such a case, energy builds up in the body which is not dissipated, causing great tension.

In order to attempt to free ourselves from this unpleasant feeling of tension, we may try to partly dissipate it by shouting obscenities or pounding our fists against some wholly innocent inanimate object (this is sometimes referred to by psychologists as a *displacement activity).* In other words: we are responding to minor stressors as if they posed a severe, even life-threatening, danger. Our brain is preparing us for *fight or flight* because it has grossly overestimated the risk the minor stressor poses to us. It is 'fooled' into making this error due to the disruption of the body's system that produces adrenaline and cortisol caused by our chronically stressful childhood.

And, following the same logic, when we're unfortunate enough to experience major stressful events in our adult lives, we may find ourselves going into *a nuclear meltdown, utterly overwhelmed and unable to cope.*

20) Psychosis.

'The psychiatric profession is about to experience an earthquake that will shake its intellectual foundations…there is tectonic, plate-shifting evidence'[for the environmental basis of psychosis]'

Oliver James (leading UK psychologist). Comment in relation to the now overwhelming evidence that psychosis is strongly related to childhood trauma and the need to stop over-focusing on biological causes.

Although there is now a vast amount of research that has been conducted on the link between childhood trauma and the later development of **non-psychotic** disorders, the amount of research that has been conducted on the link between childhood trauma and the later development of **psychotic** conditions has been rather less plentiful ; however, increasingly, researchers are focusing on this, so far, less studied link and in this chapter I will review some of what is currently known or theorized about the association.

Notwithstanding the above, there now exists strong research evidence showing the link between childhood trauma and the affected individual's likelihood of developing PSYCHOTIC ILLNESS in later life.

It is, of course, already well-established that there is a powerful link between childhood trauma and psychiatric conditions which include depression, anxiety, substance abuse, eating disorders, post traumatic stress disorder, sexual dysfunction, personality disorder, dissociation and suicidal ideation. Now, however, it is becoming increasingly apparent that there is also a strong link with psychotic conditions such as BIPOLAR DEPRESSION and SCHIZOPHRENIA. Indeed, asn ever-increasing body of evidence is now demonstrating the very high prevalence of experiences of severe childhood trauma in psychiatric patients who are suffering from such psychotic illnesses

In fact, many leading psychologists are now arguing that researchers have neglected the importance of childhood experiences in relation to psychotic illness in the past. Here, then, in order to help correct this omission, I present some recent research which helps to redress the balance:

Studies About Childhood Trauma And Psychosis :

Read et al. reviewed 51 previous studies on causes of psychotic illness and found that 69% of female psychotic patients and 59% of male psychotic patients had suffered severe childhood trauma. It was also pointed out by the researchers that these figures, although already extremely high, may be UNDERESTIMATES due to the fact that experiences of child abuse are well known to be under-reported.

Furthermore, Bebbington et al, examinined data generated from 8500 individuals and found that those suffering from psychosis were approx. 15 times more likely than the mentally well to have suffered severe childhood trauma.

Also, a Dutch study of 4000 patients found that those who had suffered severe childhood trauma were approx. 11 times more likely to have developed psychotic conditions in later life.

And yet more evidence has been generated by a Californian study that found that those who had suffered severe childhood trauma were 5 times more likely to have gone on to experience HALLUCINATIONS in later life.

Cognitive Theory :

According to COGNITIVE THEORY, adverse childhood experiences, the individual develops what is called a NEGATIVE COGNITIVE TRIAD of beliefs; these are:

- a negative view of self.
- a negative view of others.
- a negative view of the world in general.

More specifically, beliefs such as the following are likely to develop:

- I am vulnerable.
- others cannot be trusted.
- the world is dangerous.

Such beliefs can become so ingrained and severe that they eventually manifest themselves in the guise of psychotic symptoms e.g PARANOIA.

Effects Of Childhood Trauma On The Brain :

As we saw earlier in this book, research is showing that extreme stress in childhood can adversely affect the physical development of vital brain regions responsible for emotional control (e.g the AMYGDALA) which can lead to extreme emotional dysregulation (as we also saw earlier) and concomitant over-sensitivity and emotional over-reactivity. If the problem becomes sufficiently intense psychotic conditions may result.

Implications :

It is thought a new, overarching theory of the causes of psychosis (known in scientific circles as a PARADIGM SHIFT) is likely take root in the field of psychiatric research – namely one that emphasizes the enormous importance of adverse childhood experiences.

It is argued that patients who present with psychotic symptoms should ROUTINELY undergo DETAILED ASSESSMENTS relating to their childhood experiences and that there should be a much greater emphasis upon the importance of psychological therapy.

Early Signs Of Psychosis :

Usually a person does **not** *suddenly* become psychotic. Instead, the onset of psychosis is often a gradual process and sometimes individuals may start to show possible signs of *incipient* psychosis in their teens.

So what are the early warning signs? I provide a list based on the most current research in this area below. However, it is important to realize these symptoms are NOT specific to psychosis - they may also be due to numerous other conditions. Anyone worried that they, or someone else, may be psychotic or may be developing psychosis should seek an expert opinion and NOT attempt an amateur diagnosis based on the symptoms that follow.

Possible Early Signs That A Person May Be Becoming Psychotic:

These signs may be split into six categories as follows:

1) Cognitive symptoms.

2) Neurotic symptoms.

3) Changes in mood.

4) Changes in volition.

5) Behavioral symptoms.

6) Physical symptoms.

Let's look at each of these six categories below:

Cognitive Symptoms:

- problems with concentration / attention / mental focus.
- frequent daydreaming/ retreating into fantasy worlds.
- thought blocking (a sudden lapse into silence during conversation due to the mind*'going blank'*. This most frequently occurs when the individual is asked about something that is, consciously or unconsciously, psychologically disturbing to him/her. It is a psychological defense mechanism and a form of repression.)
- reduced ability to think in abstract terms.

Neurotic Symptoms:

- restlessness / agitation.
- Anger.
- Irritability.

Changes in Mood:

- guilt.
- suicidal ideation.
- depression.
- mood swings.
- anhedonia (an inability to derive pleasure from people, events or circumstances – a feeling of emptiness, flatness and numbness).

Change in Volition:

- Loss of drive.
- Loss of interest in events, activities and people that used to interest one.
- Feelings of apathy and fatigue and a general lack of energy.

Behavioral Symptoms:

- Social withdrawal..
- Drop in standard of school / college work.
- Increase in impulsivity.
- Increasingly odd / strange behavior.
- Aggression.
- Destructiveness.

Physical Symptoms:

- Weight loss.
- Poor appetite.
- Sleep problems.

The Main Types Of Psychotic Delusions :

Psychotic delusions can occur in two conditions linked to childhood trauma :

A) DEPRESSION WITH PSYCHOTIC FEATURES.

B) SCHIZOPHRENIA.

What Is Meant By The Term 'psychotic delusion?'

A PSYCHOTIC DELUSION results from a THOUGHT DISORDER that gives rise to BLATANTLY FALSE BELIEFS. Whilst the belief is clearly and obviously false, the person who holds it has an UNSHAKEABLE BELIEF that the belief is true, even in the face of utterly overwhelming evidence to the contrary.

Classification of delusions:

Delusions can be classified as follows:

A) Bizarre or non-bizarre.

and:

B) Mood-congruent or mood- incongruent.

I define these classifications below:

BIZARRE – extremely strange and odd beliefs that are CLEARLY IMPOSSIBLE. For example, a belief that the birds' singing is really Morse code and they are communicating with each other in such code in order to form a plot to take over the world.

NON- BIZARRE – the belief held is still clearly wrong but, theoretically, not totally impossible. For example, a belief that the government has placed listening devices in every room of one's house.

MOOD – CONGRUENT – the delusion is in line with the mood the person manifests as a result of his/her condition. For example, a depressed individual who believes that aliens have removed the part of his/her brain the used to give rise to the experience of pleasure. Or, a person who is manic may believe s/he has supernatural powers

MOOD – INCONGRUENT – the delusion is not obviously in line with the individual's prevailing mood (e.g. a belief that a newsreader on the TV is talking about him/her). These are sometimes referred to as 'mood-neutral' delusions

Within these classification groups, delusions can also be of a specific type. I list these types below:

- Delusions of jealousy : an all-consuming obsession that one's partner is being unfaithful when there is no evidence that this is the case and there is no objective reason for suspicion.
- Delusions of nihilism : the belief that oneself, other people or the world do not really exist.
- Delusions of grandeur ,: a belief one is a person of massive importance such as Jesus, Emperor of the World etc. Or the belief one has made a great achievement (that the world refuses to recognise) such as a belief one has written plays vastly superior to those of Shakespeare when, in reality, they are barely literate.
- Delusions of control : a belief that one is having one's thoughts and behaviour controlled by an external force e.g. by aliens.
- Delusions of reference : a clearly false belief that people are talking about one or making reference to one when they are not e.g. a belief that the newsreader on the radio is always referring to one in a coded or indirect manner
- Delusions of guilt : a false belief one is responsible for some terrible event (such as a belief one is personally responsible for all the starving people in the world).
- Erotomania : the belief that a famous person or person of high status (normally a person the sufferer of the delusion has never met) is deeply and passionately in love with one. – Delusions of mind-reading : the belief that others are reading one's mind.
- Delusions of persecution : the belief that others are conspiring against one (e.g trying to poison or drug one).
- Religious delusions: delusions with a religious theme e.g .that one is a human incarnation of God
- Somatic delusions : these are delusions about one's body (e.g. that ants are crawling under one's skin).

Study On Childhood Trauma And Schizophrenia :

I remember when I was doing my first degree in psychology at the University of London that, when we studied schizophrenia, in trying to explain its causes we concentrated largely upon examining genetic explanations and, also, explanations based upon the existence of individual differences in brain chemistry and brain biology.

More recently, however, evidence has been accumulating that if an individual suffers childhood trauma then this, too, puts him/ her at greater risk of developing this most devastating and debilitating of psychiatric conditions.

Indeed, a study at the University of Liverpool and Maastricht in the Netherlands lends support to this theory. The study looked at data from three groups of people :

a) individuals who were known to have suffered childhood trauma who were followed up in their adult lives (the study was what is known as *longitudinal* and examined 30 years' worth of data).

b) psychotic individuals who were asked about their childhoods.

c) randomly selected individuals (data obtained from this third group served as a comparison point against which to interpret the data generated from the above two groups). This is also known as the control group.

Findings Of The Study :

- Those who had suffered childhood trauma prior to the age of 16 were **3 times more likely** to develop psychosis in adulthood than were the individuals from the group of randomly selected individuals (group 'c' above).
- The more serious the individuals' experiences of childhood trauma were, the more likely they were to develop psychosis later on during their lives.
- Those who had suffered the most serious types of trauma were found to be up to **50 times** more likely to go on to develop schizophrenia than individuals who had been randomly selected for the study.
- Different kinds of trauma resulted in the development of different types of psychiatric symptoms. For example, those individuals who had spent significant amounts of time in children's homes were particularly likely to develop symptoms of paranoia later on during their lives

Implications:

In the light of these findings, they expert Professor Bengal stressed the importance that those who were responsible for diagnosing psychiatric patients should **ask them about their**

childhood experiences as a matter of routine.

Professor Bengal also drew attention to the need for further research into the effects of childhood experiences on the physical developing brain.

Finally, he called for further research into why symptoms of trauma often do not appear in an individual until years after the traumatic experiences have taken place. For example, a person who suffered childhood trauma between the ages of , say, eight and twelve, may not display overt psychiatric symptoms caused by it until his/her twenties.

BPD And Psychosis :

If we are unfortunate enough to develop BPD following a traumatic childhood, in some cases (NOT all) we may, especially during periods of acute stress, be prone to what psychologists and psychiatrists refer to as brief psychotic episodes.

Such brief psychotic episodes can entail experiencing, for periods of short duration, symptoms such as paranoid delusions and hallucinationsHowever, these are likely to be of relatively minor intensity compared to how they might be experienced by someone suffering from acute schizophrenia.

Psychotic Depression :

The depression which accompanies BPD can become so acute that it leads to psychotic symptoms. Extended dysphoria (the word 'dysphoria' refers to a highly distressing state in which the sufferer feels extreme emotional pain, restlessness, emptiness and agitation) can tip over into psychotic experiences ;These may include : feelings of extreme, irrational guilt and false beliefs about being responsible for things that they are, in fact, in no way responsible for (such as the abuse they suffered).

BPD and reality testing :

Reality testing, a concept originally introduced by Sigmund Freud (1856-1939), can be described as the capacity of an individual perceive the external events going on around him/her objectively, accurately and based on conventional interpretation rather than in a way distorted by internal mental factors. The *Medical Dictionary* defines it as : ***'The objective evaluation of the external world and differentiation between it and the ego or self.'***

Reality testing is most obviously impaired in individuals, such as some schizophrenics, who are in the grip of florid psychotic symptoms such as hallucinations (e.g. hearing voices or seeing things that aren't there) and delusions (e.g. believing one's thoughts are being broadcast / audible to others).

Individuals with borderline personality disorder (BPD) generally do not have such dramatically impaired reality testing (although they can suffer from brief psychotic episodes when experiencing extreme stress). However, their reality testing can fluctuate to a significantly greater degree than is found in relatively 'psychologically healthy' individuals.

For example, particularly when experiencing significant levels of stress, individuals suffering from BPD may lapse into a paranoid style of thinking or experience an impaired ability to self-reflect in a realistic fashion.

The Problems That May Arise As A Result Of Impaired Reality Testing :

An impaired ability to reality test can lead to various problems, including :

- inappropriate judgment of important situations.
- failure to challenge irrational negative thoughts.
- blaming of oneself for / feel shame about things that were not one's fault.
- loss of awareness of one's authentic self, thoughts and feelings(due to defense mechanisms such as denial, repression and suppression).
- a restricted and blinkered view of the world.

Improving Impaired Reality Testing :

Studies (e.g. Landa et al., 2006) suggest that cognitive behavioral therapy (CBT) can be an effective means of improving a person's ability to reality test.

BPD And Hallucinations :

Hallucinations are perceptions that people experience but which are NOT caused by external stimuli/ input. However, to the person experiencing hallucinations, these perceptions feel AS IF THEY ARE REAL and that they are being generated by stimuli / input outside of themselves (in fact, of course, the perceptions are being INTERNALLY GENERATED by the brain of the person who is experiencing the hallucination).

Different Types Of Hallucination :

There are several different types of hallucination and I summarize these below :

- **VISUAL HALLUCINATIONS** - these involve 'seeing' something that in reality does not exist or 'seeing' something that does exist in a DISTORTED / ALTERED form.
- **AUDITORY HALLUCINATIONS** - these, most often, involve 'hearing' voices that have no external reality (though other 'sounds' may be hallucinated, too).
- **TACTILE HALLUCINATIONS** - these occur when an individual feels as if s/he is being touched when, in fact, s/he isn't (for example, feeling the sensation of insects crawling over one's skin).
- **GUSTATORY HALLUCINATIONS** - these occur when a person perceives a 'taste' in his/her mouth in the absence of any external to the person causing the taste.
- **OLFACTORY HALLUCINATION** - this type of hallucination is sometimes also referred to as***phantosmia*** and involves perceiving a smell which isn't actually present.

Mild Hallucinations :

Mild hallucinations are actually not uncommon even amongst people with no mental illness (e.g. believing one has heard the doorbell ring when it hasn't). If the person who has the experience of hallucinations such as those listed above is aware that the sounds, visions etc. are not real but are being generated from his/her own mind then experts do not consider them to be suffering from full-blown psychosis. These kind of experiences are only classified as psychotic if the person is adamant that they are real. As stated already, psychosis of this nature, involving a complete departure from reality, is rare in those with BPD.

Severe Hallucinations :

At the other end of the scale, however, are fully-blown hallucinations that involve the person who is experiencing them being*psychotically detached from reality;* for example, someone experiencing a psychotic episode might hear, very clearly and distinctly, voices that s/he fully believes are coming from an external source (such as 'the devil' or a dead relative). A person suffering from such hallucinations cannot in any way be convinced that the 'voices' are being generated within his/her own head/brain.

It is uncommon for people suffering from borderline personality disorder (BPD) to suffer from the most serious types of hallucinations (as described above); however, under acute stress (and those with BPD are, of course, far more likely to experience acute stress than the average person), the BPD sufferer may experience hallucinations that fall somewhere between the mild and severe types.

For example, if s/he (the BPD sufferer) was constantly belittled and humiliated by a parent when growing up, s/he may, when experiencing severe stress, 'hear' the 'parent in their head' saying such things as *'you're useless'* or *'you're worthless.'*

However, unlike the person suffering *unambiguously* from psychosis, when this occurs s/he is *not* completely detached from reality but is aware the 'voices' are being generated within his/her own mind and are *imaginary as opposed to real.*

Severe hallucinations may be indicative of schizophrenia but can also have other causes which include : delirium tremens (linked to alcohol abuse), narcotics (e.g. LSD) and sensory deprivation.

If a BPD sufferer is unlucky enough to experience a psychotic episode, when is it most likely to occur, and how can that person minimize their risk?

Sufferers of BPD are at greatest risk of experiencing a psychotic episode following a significant stressor which acts as a 'psychosis trigger'. Such experiences are sometimes referred to as 'reactive psychosis.' It follows from this, of course, that those with BPD should avoid stress as far as it is possible.

Psychomotor Agitation :

Another symptom of psychosis, which those suffering from BPD and other serious mental disorders may display, is psychomotor agitation.

We have seen that those who have suffered significant childhood trauma are at an increased risk of developing anxiety disorders in their adult lives. In extreme cases, this may lead to what is known as psychomotor agitation. I explain what is meant by this term below. However, I wish to start by recounting my own experience of this most distressing of psychological conditions.

For at least three years in total, off and on, I could not take a bath. The reason for this was that, when I was in this state (each episode could last several months) I was too agitated to do so - I couldn't relax enough to lie down in the water, or even sit in it, any more so than I could voluntarily immerse myself in molten iron or bathe in volcanic lava.So I showered instead, right? Wrong. I felt too agitated to even indulge in this activity, even though most people find showering extremely relaxing and pleasurable.

Instead, I carried out my ablutions with a damp flannel; however, I confess that even this frequently proved to be a challenge I could not meet. Anti-social? Well, yes, if I saw anyone : but I didn't. I was living as a virtual recluse, only venturing outdoors when absolutely necessary.

Of course, for people who haven't experienced severe agitated depression, it is extremely difficult to imagine how acutely distressing it is to have to endure such psychological torment on a constant and unremitting basis. I couldn't even sit back in an armchair; I was, *quite literally,* always on the 'edge of my seat' (so it seems the expression is not merely a metaphor).

In other words, I existed in a perpetual and unrelenting state of the most intense kind of agitation - permanently distracted and distraught. This led to a suicide attempt which left me in a coma in intensive care for five days, followed by hospitalizations and several courses of electro-convulsive shock therapy (ECT). That's how bad it was - though even these details do not properly convey the absolute horror of the experience.

The name for this kind of profound, and highly distressing, restlessness is, as I have said, psychomotor agitation, and other symptoms it entails include unintentional / involuntary/ purposeless movement driven by an irresistible compulsion to do so, feelings of inner tension, restlessness, anxiety and intense mental anguish and distress. These involuntary movements may include pacing around the room and / or hand wringing.

Psychomotor agitation is found particularly frequently in those with bipolar disorder, substance abusers and those with psychotic depression

Treatment:

Doctors may treat the disorder pharmacologically (i.e. with medication) but it also often treated non-pharmocologically by means other therapies such as meditation, mindfulness, yoga and other relaxation techniques (I consider these treatments more fully later in the book).

21) The Agonizing Effects Of Shame.

Sadly, those who have suffered significant childhood trauma are often left, as adults, with deep and abiding feelings of irrational shame due to the way they have been conditioned as children by the very people who should have instilled in him / her feelings of value, self-worth and self-respect.

Feelings of shame can be excruciatingly painful; at their worst, they can cause us to completely isolate ourselves so that we avoid contact with others to the extent that we may become virtual recluses, perhaps only daring to venture out of our house or flat when absolutely necessary. Indeed, the word '*shame*' derives from the Indian word '*sham*' which means 'to hide.'

What Is Shame?

When we feel ashamed we feel very negatively about ourselves and believe we are, to put it simply, a deeply bad person. We also tend to assume that others are judging us in a similarly disparaging manner. The sensation of shame also frequently involves feelings of inadequacy, inferiority, incompetence, self-disgust, self-hatred, anxiety, anger, bodily tension, nausea and sweating / feeling too hot.

Effects On Relationships :

Because of our own jaundiced and self-lacerating view of ourselves, we assume others will feel the same way about us (or soon will do once they discover' what a 'horrible and disgusting' person we are). We therefore avoid trying to form close relationships, believing such efforts to be futile given that we will 'inevitably be rejected' once the 'real' us is discovered.'

Other Possible Effects Of Shame :

We may also try to psychologically defend ourselves from deep rooted feelings of shame. For example :

- we may become preoccupied with managing a superficial image of ourselves when interacting with others which we desperately hope will keep 'our true badness' concealed; this can lead to the creation of a 'false self' which precludes any chance of authentic or meaningful interaction with others (in other words, we '*become afraid to be who we are*').

- perfectionism / 'workaholism' (in a desperate attempt to compensate for the profound inner feelings of inadequacy and inferiority that may accompany a pervasive sense of shame).'Workaholism' and perfectionism are both *extremely precarious* ways of maintaining some semblance of self-respect and self-esteem as we tend to continually set ourselves targets which, inevitably, we sometimes fail to achieve. We are then highly vulnerable to suffering a catastrophic collapse in our sense of self-worth as it has not been built upon strong enough, nor sustainable, foundations.

Differentiating Between Three Types Of Shame :

We can differentiate between three specific types of shame. These are :

1) INTERNAL SHAME

2) EXTERNAL SHAME

3) REFLECTED SHAME

I define these three types of shame below :

- **Internal Shame :** this is a sense of shame we feel about ourselves.
- **External Shame** : this is when we perceive that others have a very low view of us which makes us feel ashamed.
- **Reflected Shame** : this is when we feel shame vicariously due to how someone else connected to us has behaved, such as a family member or a member of a group with which we identify.

Often, a sense of internal shame and external shame co-exist within the same person. However, in the case of shame related to childhood trauma, we may (irrationally) feel a strong sense of internal shame even though we can accept that others are not negatively evaluating us as a result of what happened to us (i.e. there is an absence of external shame).

The Shame Loop :

Scheff (1990) proposes that in response to a childhood in which we were persistently shamed to a significant degree we can become trapped in a SHAME LOOP in which :

- (Stage one) shame becomes internalized and cannot be discharged which, in turn, leads to :
- (Stage two) feeling shame for feeling ashamed, which results in :
- (Stage three) the feelings of shame intensifying ; this builds up even greater feelings of shame being fed back into the shame loop so that :
- Stage one is reactivated with still greater destructive energy and the cycle, in the absence of effective therapeutic intervention, is reinvigorated.

Reluctance To Seek Treatment :

And, as you might guess, because individuals ***feel shame for feeling ashamed***, they find it very hard indeed to confide in others about what they perceive as their 'dark secret', thus failing to seek professional help and compounding their problems.

Defenses Against Intense Feelings Of Shame :

Nathanson (1992) identified four main ways in which an individual may respond to feelings of shame in an attempt (conscious or unconscious) to defend and protect him/herself from the emotional suffering such feelings can evoke.

Nathanson proposed that the four main defense mechanisms employed against shame (which he believed to be largely learned in early childhood to protect the self from intolerable feelings) are :

- **withdrawal**
- **attack self**
- **avoidance**
- **attack others**

Nathanson also suggests that whilst individuals may employ more than one of the above defenses against shame (depending upon the particular conditions which have given rise to these feelings), they tend to have a kind of 'default mode' (i.e. a specific main defensive strategy against shame) which they most frequently rely upon.

The Compass Of Shame :

Nathanson referred to the above four defenses against shame (*withdrawal, attack self, avoidance, attack others)* as making up what he referred to as '***The Compass Of Shame***'. He further explained that all four defenses were best seen as existing on a continuum running from 'mild' to 'extreme'.

So, for example, a 'mild' enactment of withdrawal is the aversion of one's gaze whereas, at the 'extreme' end of the spectrum, one might withdraw from others completely and live in a wooden hut in the forest as a hermit.

The Continuums :

So now let's briefly look at the four continuums upon which the four shame defenses lie :

1) DEFENSE AGAINST SHAME : WITHDRAWAL :

- **MILD END OF CONTINUUM :** slumped shoulders, looking downwards, blushing, covering mouth with hand, staying silent, averted gaze, chronic loneliness.
- **EXTREME END OF CONTINUUM :** physical, cognitive and emotional withdrawal, isolation, depression, retreat into 'own internal world', chronic loneliness, presentation of only a false and superficial self to the world, hypersensitivity to rejection and criticism (particularly criticism of character).

2) DEFENSE AGAINST SHAME : ATTACK SELF :

- **MILD END OF CONTINUUM :** deferential behavior, modesty, shyness, self-deprecating humor.
- **MIDDLE OF CONTINUUM :** self-sabotage, self-neglect, self-humiliation, self-effacement, obsequiousness, subservience.
- **EXTREME END OF CONTINUUM :** self-hatred, self-disgust, self-contempt, masochism, self-debasement, self-harm (e.g. cutting oneself, burning oneself with cigarettes etc), suicidal ideation / suicidal behavior.

3) DEFENSE AGAINST SHAME : AVOIDANCE :

- **MILD END OF CONTINUUM :** self-deception, disowned shame,self-deprecating charm, impostor syndrome.
- **MIDDLE OF CONTINUUM :** ostentatious behavior / displays of wealth (jewelry, clothes etc.) arrogance,competitiveness, thrill seeking / risk taking, hedonism, perfectionism.
- **EXTREME END OF CONTINUUM :** pathological lying, narcissism,, grandiosity, self-aggrandisement, addictions (e.g excessive use of alcohol, obsessive sexual activity.

4) DEFENSE AGAINST SHAME : ATTACK OTHERS :

- **MILD END OF CONTINUUM :** teasing, put downs, banter.
- **MIDDLE OF CONTINUUM :** bullying, humiliated fury, rage.
- **EXTREME END OF CONTINUUM :** violence.

Whilst some of the above defenses against shame are clearly healthier than others, even these mostly fail to fully alleviate deeply entrenched shameful feelings – in such cases, therapy such as cognitive behavioral therapy and compassion-focused therapy can be of significant benefit.

22) Self-Hatred.

Closely linked to feelings of shame are feelings of self-hatred.

Following a childhood in which we had the experience of neglect, abuse, abandonment or a combination of these, it very frequently follows that we grow up to become intensely self-critical and even consumed by feelings of self-hatred. Indeed, these are both key symptoms of clinical depression and also of complex post-traumatic stress disorder (complex-PTSD) – both of these conditions, as we have already seen, are strongly associated with severe childhood trauma.

When an individual's childhood is traumatic, there is, for him or her, a constant sense of being in danger; lack of emotional support, encouragement and affection from the parents leaves the child feeling perpetually anxious and fearful.

One psychologically defensive reaction to this can be for the individual to develop, as we have seen, is perfectionism– on an unconscious level this is an attempt to finally gain the parents' approval.

However, because perfection is generally impossible to achieve, a sense of constant failure develops which can develop into self-hatred. This is because (again, on an unconscious level) the individual believes it is this 'constant failure' that is the root cause of the parents' rejection (although, of course, this belief is erroneous – the real problem is the inability of the parents to bond in an emotionally healthy way with their son or daughter).

Because the child growing up in a traumatic environment will perceive that environment (either consciously or unconsciously) to be unsafe -or, to put it more bluntly, dangerous – s/he, as a survival technique, will tend to become HYPERVIGILANT (constantly on the alert for any sense of imminent threat).

This tendency, as the child gets older, will tend to become DEEPLY EMBEDDED INTO THEIR PERSONALITY and they are likely to GENERALIZE THEIR CONSTANT SENSE OF DANGER ONTO THE WORLD IN GENERAL.

In other words, s/he is likely to develop a CORE BELIEF that THE WORLD IS A FUNDAMENTALLY UNSAFE AND THREATENING PLACE. This leads to a psychological process that psychologists have termed ENDANGERMENT (projecting a sense of danger onto situations which are, in reality, essentially safe).

All of this means that the individual will have a marked tendency to constantly attempt to analyze how others are reacting to him/her and to then frequently presume that they are evaluating and judging him/her in negative ways (even if there is, in fact, little or no evidence that this is the case).

Also, it is likely that the individual will develop PERFORMANCE ANXIETY; this entails constant self-criticism and self-castigation for 'not doing well enough.'The individual's perceived parental view of him/her ('you are not good enough') becomes INTERNALIZED and transformed into the (false) belief : 'I am not good enough.'

23) Reduced Life Expectancy.

Recent research suggests that significant, chronic childhood trauma can reduce life expectancy by 19 years, though this need not be the case.

Childhood trauma clearly puts the child who experiences it under great stress; the more protracted and intense the trauma is, and the more trauma the child suffers, all else being equal, the more stress is inflicted upon the child.

A recent study has shown that an especially traumatic childhood (in which the child experiences several types of trauma) may reduce life expectancy by about 19 years (from approximately 79 years for those who experienced no significant trauma, to about 60 years for those who experienced many significant traumas).

In the study, the traumas experienced included the following:

- witnessing domestic violence.
- emotional / verbal abuse.
- physical abuse..
- parental alcohol/drug misuse
- parental imprisonment.
- parental separation / divorce.

Specific Details Of Study :

- those who had suffered 6 or more traumas, on average, lost about 19 years of life (dying, on average, at about 60 years, rather than at about 79 years, as was the average age of death of those who had suffered no significant trauma).
- those who had suffered 3 to 5 traumatic events lost, on average, 5.5 years of life, dying, on average, at 73.5 years.
- those who had suffered 2 traumatic events lost, on average, about 3 years of life, dying, on average, at about 76 years.

Possible Reasons For The Link Between Childhood Trauma And Reduced Life Expectancy:

One theory is that childhood trauma can lead to CELL DAMAGE (specifically, inflammation and premature aging of the cells). It is also thought that exposure to high and sustained stress in childhood can also DAMAGE DNA strands; this, in turn, can lead to increased risk of disease and premature death.

Furthermore, extreme stress in childhood (which makes it far more likely the child will go on to have a stressful adult life) leads to greater production in the body of ADRENALINE (a neurotransmitter which prepares the body for 'fight or flight') and also of CORTISOL (a stress hormone); these biochemical effects increase the individual's likelihood of developing disease, including, of course, the diseases identified in the Adverse Childhood Experiences (ACE) study which we encountered at the beginning of this book.

Childhood Trauma Leading To Harmful Adult Behaviors :

Because individuals who suffer childhood trauma tend to have much more stressful adult lives, as adults they are more likely to utilize coping strategies which are, in the long-term, damaging (these are known as MALADAPTIVE COPING STRATEGIES). They include:

- smoking
- drinking alcohol to excess

- illicit drug use
- comfort eating' of junk food

All of these behaviors, linked to childhood trauma, can dramatically reduce life expectancy.

Why Not To Panic :

Although the study shows that there is an association (or correlation) between childhood trauma and lower life expectancy, this does NOT mean that childhood trauma directly and inevitably leads to losing years of life.

Rather, the link is indirect: childhood trauma tends to lead to more stress and harmful behaviors (as already outlined) and it is these which can lower life expectancy, NOT the childhood trauma, in and of itself, taken in isolation.

The good news that follows from this is that we are able to address our stress and harmful behaviours (such as excessive drinking, overeating etc) either through self-help or with the aid of professional therapy; therefore, the childhood trauma we experienced need NOT lead to a shorter life.

24) Impaired Educational Achievement.

A study was carried out by Perez and Wisdom (1994) that examined the effects of childhood trauma on educational achievement.

The study identified a group of eleven-year-old children who had experienced childhood abuse or neglect.

Twenty years after identifying this group the researchers gave these same individuals an I.Q. test and compared their results with those of a control group (individuals of the same social class, age, sex and race but who had NOT experienced abuse or neglect in childhood).

Results Of I.Q. Test :

It was found that :

THE GROUP OF INDIVIDUALS WHO HAD EXPERIENCED CHILDHOOD ABUSE / NEGLECT HAD SIGNIFICANTLY LOWER I.Q.s THAN THOSE IN THE CONTROL GROUP.

Also, as part of this same study, the reading ability of the group of individuals who had suffered childhood trauma was compared to the reading ability of those in the control group.

Results For Reading Ability :

THE GROUP OF INDIVIDUALS WHO HAD EXPERIENCED CHILDHOOD ABUSE / NEGLECT HAD SIGNIFICANTLY LOWER READING ABILITY THAN THOSE IN THE CONTROL GROUP.

(In fact, the individuals who had suffered childhood abuse/neglect had an average reading ability of a child in sixth grade, despite the fact that they were, at the time of testing, thirty-one years of age.)

Other Findings Of The Study :

Significantly more individuals who had suffered childhood abuse / trauma did not complete high school compared to individuals from the control ; this is demonstrated by the figures provided below :

Individuals Who Had Suffered Childhood Abuse / Neglect :

- 58% did not complete high school.

Individuals From The Control Group:

- 34% did not complete high school.

A more recent study, conducted by Porche et al. (2011) also supports the hypothesis that the experience of childhood trauma adversely affects academic performance. This study involved over 2500 young people aged between twenty-one and twenty-nine years and looked at :

- the effects of witnessing domestic violence as a child on educational achievement.
- the effects of having been physically abused as a child on educational achievement.

Results :

- 31% of those individuals who had experienced childhood physical abuse before the age of sixteen dropped out of school.
- 26% of those individuals who had witnessed domestic violence before the age of sixteen dropped out of school.

Compared To :

- 13% of those individuals who had NOT experienced childhood trauma dropped out of school.

25) Suicide.

Research has shown that the experience of childhood trauma and the risk of the individual who suffered it attempting suicide in later life (as a teenager or as an adult) are extremely strongly correlated.

A particular study, carried out by *Dube et al.* (2001), which involved gathering data related to this issue, found that those most seriously affected by childhood trauma were a staggering 51 times (i.e. 5100%) at greater risk of suicide attempts as a teenager compared to those who had experienced a settled childhood. As an adult they were found to be at 30Xs (i.e. 3000%) greater risk of attempting suicide compared to their more fortunate contemporaries.

Other findings in the study by Dube et al. were that about 67% of adult suicide attempts were linked to the experience of childhood trauma, and, also, that about 80% of teenage suicide attempts were connected to the experience of childhood trauma.

The Special Adverse Effects Of Emotional Abuse :

The same study also found that the type of abuse that was most strongly predictive of the individual who experienced it making suicide attempts in later life was emotional abuse.

Other Types Of Abuse :

Dube et al. also found many other types of abuse to be powerfully correlated with increased risk of suicide. These were :

- domestic violence.
- loss of a parent (e.g through divorce or abandonment).
- family member in prison.
- parent with mental illness (e.g. depression).
- parent with addiction.
- physical neglect.
- emotional neglect.
- physical abuse.
- verbal abuse.

Possible Actions To Take In Light Of These Findings :

Given the above facts, it is necessary to ask what may be done to address this tragic problem. I provide some suggestions below :

- more training for those who work with children about the effects of childhood trauma and how best to treat these effects.
- more education to be given to the public in general about the effects of childhood trauma.
- rather than expel or suspend 'difficult' children, schools should keep them in education and provide the appropriate counseling and/or other professional support.
- respond more sensitively and compassionately to 'problem behaviour' (or, 'acting out') by young people, both in schools and other applicable environments.

26) Childhood Trauma And Workplace Performance.

The negative effects of childhood trauma can also seriously impair our work performance as adults. Some obvious examples include:

- low academic achievement.
- .alcoholism.
- drug addiction.
- anger management problems (which may lead to conflict in relations with colleagues and the boss).
- relationship problems (including marital and family difficulties), depression, anxiety, headaches, somatic symptoms (such as back pain and irritable bowel syndrome).

Indeed, research published in the *Permanent Journal* reported that, in the United States, back pain alone is thought to cost businesses just short of 30 billion dollars per year and depression is thought to cost it about 44 billion dollars per year.

However, it is not possible, from these figures, to ascertain what percentage of the above referred to cases back pain and the above referred to cases of depression is directly linked to the adverse effects of childhood trauma.

From these findings, however, it is reasonable to conclude that educating employees about how adverse childhood trauma may have negatively impacted upon their lives is very important as it may allow them to seek more relevant, trauma-informed, treatments and therapies for their difficulties, thus increasing their chances of successful recovery. And, in order for such education to be implemented effectively, business owners, too, need to learn about the possible harmful effects of unresolved childhood trauma on their employees and, therefore, on their business.

27) Did Your Dysfunctional Family Make You The ‘Identified Patient’?

The person [in the family] who gets diagnosed is part of a wider network of extremely disturbed and disturbing patterns of communication'

R.D. Laing

It has been theorized (originally in the 1950s as part of the Bateson Project, led by Gregory Bateson), that in many dysfunctional families an individual within the family is, largely unconsciously, assigned the role of the *'identified patient'.*

Essentially, this process comes about as a result of the dysfunctional family *projecting onto a family scapegoat.*

What Is 'Projection’?

Projection is a psychological defence mechanism by which people avoid facing up to their own unwanted feelings, such as aggressive impulses, by displacing and seeing them in others)

An example of *projection* would be a very selfish person who constantly accuses others of being selfish and, indeed, sees selfishness in others everywhere she or he looks.

In this way it is a type of blame-shifting - the family displaces their own psychological difficulties onto one specific family member, who, as a result, becomes the family scapegoat, diverting attention from the rest of the family's mental and emotional problems.

Often, the *identified patient* is unconsciously selected as she or he is the youngest, most vulnerable, weakest and sensitive member of the family .

If we were made to be the *identified patient* in our family, our family may have:

- constantly belittled, undermined, ridiculed, humiliated and vindictively teased us.
- made us feel inferior and of little or no worth.
- made us feel like the family outsider, disconnected from its other members and unacceptable to them, excluded and 'kept at a distance'.
- made us feel that we were an 'intrinsically bad' person.
- showed little or no interest in us.
- labelled us a 'problem child' and / or 'trouble-maker, ' responsible for all the family's ills.'
- over-emphasized our faults whilst, simultaneously, ignoring or minimizing our strengths, qualities and accomplishments.

As our family will have a vested interest in continuing to keep us in our role of *identified patient* (namely to prevent them from having to face up to their own failings and contributions to the family's dysfunction), they will go to great lengths in order to do so. In fact, if we, the *identified patient* start to recover, they may be unconsciously driven to prevent this recovery, and thus, by such means, maintain the family's *status quo.*

Externalization:

It is likely that, in such families, the identified patient has been psychologically abused by some, or all, other members of the dysfunctional family and that any problematic behaviors she or he does display are, in fact, externalizing behaviors brought on by the family's mistreatment of him or her.

One school of thought has been of the view that in families in which an *identified patient* has been unconsciously designated, it is not the identified patient who is 'mad'; on the contrary - it is the other family members. In relation to this view, R.D. Laing put forward the notion that such families suffered from 'a *distorted and disturbing pattern of communications.'*

And, indeed, the anti-psychiatry movement of which R.D. Laing (see above) was a leading part, suggested that, frequently, it was the family of the identified patient who were 'mad', and the identified patient the 'most sane', having insight that is lacking in the other family members.

It follows from this that therapy, in cases where an *identified patient* seems to have been selected, should involve ALL family members.

28) How Effects Of Childhood Trauma Can Be Delayed.

Delayed onset post traumatic stress disorder (PTSD), ,which can occur as a result of a severely disrupted childhood, is defined by the DSM (Diagnostic Statistical Manual) as PTSD which develops at least six months after the traumatic event/s; however, PTSD can take much longer than this to manifest itself.

One reason why PTSD may not become apparent immediately is that the individual who has been affected by trauma is able, for a period of time, to employ coping mechanisms (either consciously or unconsciously) which keep the condition at bay. During this period, some of the effects of the traumatic experience/s lie dormant.

However, due to the experiencing of further triggers (stress-inducing reminders of the original trauma), the person's neurobiological processes (already harmed by the original trauma) may be further adversely affected until a 'tipping point' is reached, resulting in him / her meeting the criteria for being diagnosed with the disorder.

In other words, there is an interaction between the original damage caused by the trauma and exposure to further stressors later on in life.

It follows from this that the more severe the original trauma, and the more severe the stressors life throws at the individual subsequently, the greater is his / her accumulated risk of developing PTSD. Indeed, this is borne out by the research.

Delayed onset post traumatic stress disorder (PTSD) ,which can occur as a result of a severely disrupted childhood, is defined by the DSM (Diagnostic Statistical Manual) as PTSD which develops at least six months after the traumatic event/s; however, PTSD can take much longer than this to manifest itself.

The original trauma, then, makes the individual more susceptible to being affected adversely by further life stressors. In neurological terms, this is thought to be because the original trauma can damage an area of the brain known as the amygdala; damage to this region makes a person's fear / anxiety response to stressors much more intense than is normally the case.

The more the individual affected by the original trauma subsequently experiences stressful triggers (see above) which cause him / her to mentally and emotionally relive it, the more damaged, and hypersensitive to the effects of further stress, the amygdala (see above) becomes.

Eventually, the amygdala's response to perceived threat and danger (there does not have to be any real threat or danger ; indeed, one of the hallmarks of PTSD is that it causes the sufferer to see threat everywhere, where it does not, in fact, exist) become so exaggerated that the individual finds him / herself living in what amounts to a state of almost constant terror (indeed, I myself was in just such a state for more time than I care to recall).

Vicious Circle :

As the individual starts to perceive, irrationally, threat everywhere, the range of triggers (see above) s / he experiences grows ever wider; this, in turn, yet further sensitizes the amygdala and reinforces the individual's stress response. Thus, a vicious cycle develops.

Critical Period Of Brain Vulnerability :

I will finish with a quote from the psychologist Shalev, which I think speaks for itself and requires no further elucidation from me :

'Following trauma there is a critical period of brain plasticity during which serious neuronal changes may occur in those who go on to develop PTSD.'

PART THREE : RECOVERY.

28) Dialectical Behavior Therapy (DBT).

DIALECTICAL BEHAVIORAL THERAPY (DBT) has been found to be particularly effective in treating those who, due to their childhood experiences, have gone on to develop borderline personality disorder (BPD), although by no means does one have to have been diagnosed with BPD to benefit from it.

Five skills are central to dialectical behavioral therapy (DBT); these are as follows:

1) CORE MINDFULNESS.

2) TAKING THE 'MIDDLE PATH'.

3) DISTRESS TOLERANCE.

4) EMOTIONAL REGULATION.

5) INTERPERSONAL EFFECTIVENESS.

Let's look at each of these five key components in turn :

1) CORE MINDFULNESS:

DBT describes the mind as having 3 components (these are concepts, not actual distinct physical part of the brain, obviously). The 3 components are:

a) the reasonable mind.

b) the emotional mind.

c) the wise mind.

Let's examine each of these in turn:

a) the reasonable mind: this can be summed up, according to DBT, as the part of the brain which acts according to reason, logic and rationality.

b) the emotional mind: according to DBT, this is the part of the brain which operates on the basis of our feelings (when the 'heart controls the head').

c) the wise mind: ideally, according to DBT, we should allow this part of the brain to guide us; it is A BALANCE BETWEEN 1 and 2 above, when the reasonable and emotional brain are operating in effective HARMONY.

If we are able to operate in 'wise mind mode', this will mean we can maintain control and prevent ourselves from becoming a victim of our own intense emotions. In order to see the importance of this, we need only consider times in our lives when our behaviour has been dominated by our emotions and the negative effects this may have led to. Indeed, not learning to control emotions can leave our lives in ruins, not least due to the frequent self-destructive effects of our emotional outbursts.

2) TAKING THE MIDDLE PATH:

This is a metaphor for avoiding the trap of constantly seeing issues in terms of BLACK AND WHITE (e.g. all good/all bad and a marked tendency to perpetually think IN TERMS OF EXTREMES). DBT stresses the importance of teaching ourselves to FOCUS MORE ON THE GREY AREAS and to try to take A BROADER RANGE OF PERSPECTIVES when considering issues, to think more FLEXIBLY and to THINK LESS IN ABSOLUTE TERMS.

Taking the middle path, according to DBT, also involves BOTH VALIDATING OUR OWN THOUGHTS/FEELINGS AND THOSE OF OTHERS. Even if others don't understand, DBT stresses that we need to comfort ourselves when distressed by reminding ourselves that how we are feeling is real and makes sense under the current circumstances we find ourselves in.

We can remind ourselves, too, that no matter what others may think, NOBODY UNDERSTANDS US AS WELL AS WE UNDERSTAND OURSELVES (others can't understand what it is 'to be in our heads'; we should not be ashamed of how we feel). By applying this compassion and understanding to ourselves, as part of 'taking the middle path' it seems fair that we should extend similar understanding to others – we can accept what they feel, as non-judgmentally as possible, irrespective of whether we approve or not.

3) DISTRESS TOLERANCE :

Practitioners of DBT try to instil the view in their clients that sometimes it is easier, and psychologically healthier, to stop struggling against reality, and (they tell us), we need to accept that we, nor anybody else, for that matter, can prevent painful events from occurring in life (sometimes extremely painful ones, if we're going to be up-front about it), nor can the painful emotions they bring with them. It is hardly a new idea, but practitioners of DBT also remind us that some painful things in life cannot be changed and that the only viable option we really have, therefore, is to accept the fact. This, of course, is difficult and requires considerable inner strength. By accepting the things which cannot be changed, though, it is reasoned, we free up energy which could have been wasted (by, say, being angry and bitter about the existence of these unchangeable facts) to deal with what CAN BE CHANGED.

DBT therapists tell us that there are certain skills we may wish to develop which will INCREASE OUR ABILITY TO TOLERATE DISTRESS; these are:

a) distraction / improving the moment.

b) self-soothing.

c) considering the pros and cons of the situation.

d) radical acceptance.

Let's briefly look at each of these in turn:

a) distraction/improving the moment : e.g. distracting ourselves with activities we enjoy, keeping our minds busy ; reminding ourselves of the good things in life ; reminding ourselves that it is better to think clearly and in a focused way about our problems 'after the storm has passed' (rather than try to make decisions when in the middle of an intense crisis which may be over-determined by our emotions) ; remind ourselves that difficult periods will pass

b) self-soothing : e.g. we can use positive self-talk ; meditation/relaxation activities/breathing exercises ; using our imaginations to recall a soothing and comforting memory or place (if recalling a place it can be helpful to imagine, for a while, actually being there) ; thinking of things in life which are meaningful to us and give us the motivation to get through the difficult period.

c) considering the pros and cons of the situation : e.g. we may wish to consider how getting through a very difficult period may benefit us – for example, we may learn from it, it may strengthen us, it may make us more compassionate and sensitive towards others, we may be able to pass on the benefit of our experience to help others, it may even open up completely unexpected avenues in life which may not otherwise have been available to us (bad events do sometimes lead to positive outcomes, however indirectly – it is often worth keeping that in mind).

d) radical acceptance : this might involve trying to view what is happening, however undesirable, from as objective and detached a perspective as possible – a bit like watching the events unfold around somebody else in a movie ; another, perhaps surprising, technique suggested by DBT therapists is to try to, literally, half-smile. This sounds strange and even rather silly, but research shows that just as the mind can affect the body (e.g. thinking about something embarrassing and going red in the face) so too can the body affect the mind – in this case, the idea is that the half-smile 'fools' the brain into 'believing' things aren't as bad as all that. It is obvious, however, that in certain situations this technique would be highly inappropriate (I need hardly list examples).

4) EMOTIONAL REGULATION :

The fourth skill that DBT teaches is how to cope with intense and overwhelming emotions – this skill is referred to by practitioners of DBT as *emotional regulation.*

This skill is made up of three sub-skills : a) increasing one's understanding of one's emotions; b) decreasing one's emotional vulnerability; c) lessening the degree of distress caused by one's negative emotions.

5) INTERPERSONAL EFFECTIVENESS :

The final skill of interpersonal effectiveness helps the person undertaking DBT to communicate with others effectively when interacting with others in a way that helps to improve his/her relationships.

In order to achieve this, s/he is helped to communicate with others in a more controlled manner and to be less prone to speaking impulsively and without forethought due stress or overwhelming emotions (such as anger).

Research Suggests That DBT Can Beneficially Alter Brain Functioning :

Research conducted by *Schnell and Herpertz (2006)* involved looking at the effects of DBT (specifically, *training in emotional regulation, see number 4, above*) on female patients' brain functioning (this was done by taking magnetic resonance images, or MRIs, a type of brain scan) after they had spent 12 weeks undergoing an inpatient treatment program.

Results :

The female, BPD patients who improved following the DBT / emotional regulation skills 12 week inpatient program were found (by analysis of their MRIs) to show:

REDUCED ACTIVITY IN CERTAIN BRAIN REGIONS ASSOCIATED WITH THE GENERATION OF INTENSE EMOTIONS, INCLUDING THE AMYGDALA AND THE HIPPOCAMPUS.

Such a reduction of activity in these brain regions is associated with an increase in the individual's ability to prevent themselves from overreacting to stressful situations (overreacting to stressful situations, also known as impaired emotional regulation, is one of the hallmark features of BPD).

Conclusion :

The above can be interpreted as further evidence for the effectiveness of DBT for treating patients suffering from borderline personality disorder (BPD).

29) Eye Movement Desensitization And Reprocessing (EMDR):

As we have seen, individuals who have suffered severe childhood trauma may, as a result of it, later suffer from complex posttraumatic stress disorder (complex PTSD), or similar condition. Some professionals advocate a relatively new technique which aims to address this; it is known as eye movement desensitisation and reprocessing (EMDR).

What Is EMDR?

The therapist administering EMDR will first examine the issues related to the individual's psychological difficulties and, also, help him/her develop strategies to aid in relaxation and deal with stress. After this, the therapist encourages the individual to recall particular traumas, whilst, simultaneously, manipulating his/her eye movements by instructing him/her to follow the movements the therapist is making with a pen, or similar object, in front of the individual's face). The theory is that this will facilitate the individual in effectively reprocessing his/her traumatic experiences, thus alleviating psychological distress.

THIS SOUNDS A LITTLE ODD; WHAT IS THE RATIONALE BEHIND EMDR AND, HOW, EXACTLY, IS IT THOUGHT TO WORK?

My first reaction to hearing about this particular therapy was that it sounded somewhat strange. However, the rationale behind EMDR is that disturbing memories from childhood need to be PROPERLY PROCESSED by the brain in order to alleviate symptoms associated with having experienced childhood trauma (e.g. complex PTSD, as already mentioned); this is because the view is taken that it is the UNRESOLVED TRAUMA that is the cause of the psychiatric difficulties the individual who presents him/herself for treatment is suffering.

Those professionals who recommend the therapy believe that the EYE MOVEMENTS INDUCED BY THE THERAPIST IN THE INDIVIDUAL BEING TREATED LEAD TO NEUROLOGICAL AND PHYSIOLOGICAL CHANGES IN THE BRAIN WHICH AID IN THE EFFECTIVE REPROCESSING OF THE TRAUMATIC MEMORY, and, in this way, ameliorates psychological problems from which the individual had been suffering.

Stages Of EMDR Therapy :

These are briefly outlined below:

1) The first stage is the identification of the specific memory / memories which underlie the trauma.

2) Next, the individual is asked to identify particular negative beliefs he/she links to the memory (e.g. 'I am worthless').

3) Then, the individual being treated is asked to replace the negative belief with a positive belief (e.g .'I am strong enough to recover' or 'I am a person of value with potential to have a bright future' etc.)

4) In the fourth stage, the therapist moves a pen (or similar object) in various, predetermined motions in front of the individual's face and he/she is instructed to follow the movements with his/her eyes (e.g. repeatedly left and right). Whilst this is going on, the therapist instructs the individual to simply, non-judgmentally observe his/her own thoughts, letting them come and go freely and without trying to influence them in any way – just to accept them, in other words, and let them happen.

5) This procedure is repeated several times.

Each time the process is undertaken, the therapist asks the individual being treated to rate how much distress he/she feels – this continues until his/her self-reported level of distress becomes very low. Similarly, each time the process is undertaken, the individual is asked to report how strongly he/she now feels he/she believes in the positive idea given in stage 3 (see examples provided above); therapy is only concluded once the level of reported belief becomes very high.

N.B. The therapy is actually more involved than this, so the above should only be taken as a brief outline. There are, too, different variations of procedure outlined above which can be employed within the EMDR range of therapies available.

Unblocking Traumatic Information :

As alluded to above, hen we suffer severe trauma we are not able to fully mentally process what it is that has happened to us and the trauma becomes mentally entrenched – in other words, what happened to us becomes locked or 'stuck' in our memory network. The effect of this may include us experiencing various symptoms such as irrational beliefs, painful emotions, anxiety and fears, flashbacks, nightmares and phobias. It may well also cause blocked energy and greatly reduce our self-efficacy.

When we experience events that trigger memories of the trauma, including images, sounds, physical sensations and beliefs which echo the original experience of the trauma, our perception of current events are distorted.

How Does EMDR Actually Work?

EMDR is based on the idea that it is our memories which form the basis of our PERCEPTIONS, ATTITUDES and BEHAVIORS. Because, as we have already established, traumatic memories fail to be properly processed, they lead to these perceptions, attitudes and behaviors becoming DISTORTED and DYSFUNCTIONAL.

In effect, the trauma is too large and too complex to be properly processed so it remains 'STUCK' and DYSFUNCTIONALLY STORED. This often leads to MALADAPTIVE ATTEMPTS TO PROCESS AND RESOLVE THE INFORMATION CONNECTED TO THE TRAUMA SUCH AS FLASHBACKS AND NIGHTMARES (Sharpio, 2001).

Studies On Effectiveness Of EMDR:

A recent meta-analysis of evidence (i.e. an overview of a large number of particular, individual studies of EMDR) supported the claim that it is effective, as have other meta-analyses.

However, some researchers have suggested that it is not the EYE MOVEMENT PART of the therapy which is of benefit, but only the act of repeatedly recalling traumatic memories which is the effective component (based on the idea that these repeated mental exposures, under close supervision and in a supportive and safe environment, of the traumatic memories alone facilitates their therapeutic reprocessing).

Proponents of EMDR, however, maintain that the eye movements induced by the therapy are essential to allow the EFFECTIVE REPROCESSING OF THE TRAUMA; these proponents also emphasize that the therapy only requires short exposures to the traumatic memory/memories, thus giving it an advantage over therapies which utilize far more protracted exposures.

Research into EMDR is ongoing.

30) Cognitive Behavioral Therapy (CBT).

Cognitive behavioral therapy (CBT) was initially devised during the 1970s by Aaron Beck and has since been developed by other psychologists (for example, David Burns, MD) and is now used to treat many conditions that individuals who have experienced significant and protracted childhood trauma are at increased risk of suffering from (especially depression and anxiety).

Put simply, cognitive behavioral therapy (CBT) works on the basic observation that:

1) how we think about things and interpret events affects how we feel.

2) how we behave affects how we feel.

therefore:

3) by changing how we think about things, interpret events and behave will CHANGE HOW WE FEEL.

Research :

CBT is widely used by therapists to treat survivors of childhood trauma and there is now a solid base of research which supports its effectiveness. I myself underwent a course of CBT some time ago and found it very helpful.

What We Think About Things Determines How We Feel ::

Survivors of childhood trauma often develop depression and associated thinking styles that are extremely negative:

Indeed, depressed individuals often develop what is sometimes called a COGNITIVE TRIAD of negative thoughts. These are:

- negative view of self.
- negative view of the world.
- negative view of the future.

The aim of CBT is to change these negative thinking patterns into more positive ones. Or, in other words, it aims to correct FAULTY THINKING STYLES.

Faulty Thinking Styles :

Individuals who suffer from this cognitive negative triad of depressive thoughts, as I did for more years than I care to remember, are generally found to have deeply ingrained faulty thinking styles; I provide the most common ones below and give a very brief explanation of each type (if the examples seem a little extreme, it is merely to illustrate the point):

1) GENERALIZATION:

e.g. someone is rude to us and we conclude: 'nobody likes me or ever will'.

So, here, the mistake is vastly over-generalizing from one specific incident.

2) POLARIZED THINKING:

e.g. 'unless I am liked by everyone, then I am unpopular'.

This is sometimes referred to as 'black or white' thinking i.e. seeing things as all good or all bad and ignoring the grey areas (this type of 'black and white' thinking style is one of the hallmark symptoms of borderline personality disorder (BPD).

3) CATASTROPHIZING:

e.g. 'I know for sure this will be an unmitigated disaster and I'll be utterly unable to cope.'

Here, the mistake is to overestimate how badly something will turn out or to greatly overestimate the odds of something bad happening. It often also involves underestimating our ability to cope in the unlikely event that the worst does actually happen. Also known as 'WHAT IF…' style thinking.

4) PERSONALIZATION:

e.g.. taking an innocent, casual, passing remark to be a deliberate and calculated personal attack. Here, the mistake is thinking everything people do or say is a kind of reaction to us and that people are predisposed to wanting to gratuitously hurt us.

5) SELF BLAME :

e.g. someone says our team at work has not met its monthly target and we then look for ways to convince ourselves it is specifically and exclusively due to something we have done wrong. With this type of faulty thinking style, we blame ourselves for something for which there is no evidence it is our fault. Irrational self-blame is extremely common amongst those who have suffered childhood trauma.

6) MINIMIZATION :

e.g. 'I failed one exam out of ten, therefore I'm stupid and a complete failure'.

Here, the positive (passing nine out of ten exams) is pretty much ignored (minimized) and the negative (failing one exam) completely disproportionately affects our view of ourselves. Individuals who minimize the positive tend to also MAXIMIZE (i.e. make far too much of) the negative.

Conclusion :

What tends to underlie all these faulty thinking styles is that we UNNECESSARILY BELIEVE NEGATIVE THINGS IN SPITE OF THE FACT WE HAVE NO, OR EXTREMELY LIMITED, EVIDENCE FOR SUCH BELIEFS. Therefore, we unnecessarily and irrationally further lower our own sense of self-esteem and self-worth whilst simultaneously aggravating our feelings of inadequacy and depression.

31) Somatic Experiencing Therapy.

Dr Peter Levine's *somatic experiencing therapy* is predicated on the idea that the disturbing symptoms of PTSD are substantially caused by the adverse effect our traumatic experiences have had on the way our body and nervous system works.

In essence, Levine contends that if we are suffering from PTSD it means we have become *'stuck'* in the fight/flight/freeze response.

In order to understand this, consider how wild animals respond to danger; let's use the example of a zebra:

If a zebra is stalked by a tiger, it will enter the flight/fight state and run away. Whilst running away, it is in the fight/flight state, meaning that it will be highly physiologically aroused (e.g. fast heart rate) in order to provide it with the energy to (hopefully) escape.

If it is lucky enough to escape to safety, the zebra's level of physiological arousal will quickly return to normal because the immediate danger has passed.

In other words, the zebra only remains in fight/flight mode for a short period of time to deal with immediate danger.

Getting 'Stuck' In Fight/Flight/Freeze Mode :

However, in sharp contrast, individuals suffering from PTSD have, like the zebra, had their fight/flight response triggered by their traumatic experience but, unlike the zebra, remain stuck in this state of heightened physiological arousal even though the danger has passed; it is this, according to Levine, that causes the distressing symptoms of PTSD.

The Root Cause Of The Symptoms Of Trauma : Trapped 'Survival Energy' :

Levine states that, in those suffering from PTSD, the initial great stress caused by our traumatic experience, whatever this may have been (including the complex, cumulative effects of childhood trauma such as emotional abuse) leads to the production of 'survival energy' which is not discharged once the traumatic experience is over but remains bound up and trapped in the body.

It is this trapped survival energy that, according to *Levine,* is at the root of the debilitating symptoms of trauma.

The Need To Discharge The Trapped 'Survival Energy' :

Levine suggests that discharging the trapped survival energy held in our bodies will allow our heightened physiological state and the operation of our nervous systems to return to normal and thus alleviate our symptoms of trauma.

Levine's somatic experiencing therapy is designed to help us achieve this *therapeutic discharge of survival energy.*

32) Self-Hypnosis.

Research has shown that hypnosis can be of benefit for individuals suffering from trauma related conditions such as post-traumatic stress disorder (PTSD). Hypnosis is not used in isolation to treat such conditions, but in conjunction with other therapies such as cognitive-behavioral therapy (CBT) and psychodynamic therapy.

Research studies have demonstrated that the use of hypnosis as part of the therapy for trauma based conditions can be particularly effective in:

- reducing the intensity and frequency of intrusive, distressing thoughts and nightmares.
- decreasing avoidance behaviors (i.e. avoidance of situations which remind the individual under treatment of the original trauma).
- reducing the intensity and frequency of the mental re-experiencing the trauma.
- reducing anxiety, hypervigilance and hyperarousal that the trauma has caused.
- helping the individual to psychologically INTEGRATE the memory of trauma in a way which reduces symptoms of dissociation.
- helping the individual to develop more adaptive coping strategies.

However, it is not recommended that hypnosis be used to 'recover buried memories of trauma' as this has been shown to be unreliable and it is also likely that the use of hypnosis for this purpose can create FALSE MEMORIES in the person being treated.

Some individuals have been significantly helped by the use of hypnosis as part of their therapy for trauma related conditions such as PTSD in as little as just a few sessions. As one would expect, however, the more complex the trauma related condition is, the longer that effective treatment for it is likely to take.

The psychologist Spiegel states that self-hypnosis may be particularly useful for helping those suffering from PTSD / complex PTSD overcome problems associated with the troubling symptom of disturbing, intrusive memories of the original trauma.

This is because certain qualities of the hypnotic experience have much in common with qualities of the experience of the symptoms of posttraumatic stress disorder (PTSD), examples of which include :

- a feeling of reliving the traumatic event.
- feelings of dissociation (detachment from reality)
- hypersensitivity to stimuli.
- a disconnection between cognitive and emotional experience.

Spiegel argues that this similarity between hypnotic phenomena and the symptoms of posttraumatic stress disorder (PTSD) / complex PTSD make sufferers of this most serious and disturbing disorder *more hypnotizable* than the average member of any given randomly selected population.

It follows from this that those suffering from posttraumatic stress disorder (PTSD) ? complex PTSD*may be particularly likely to be helped by the utilization of hypnotic techniques and procedures*, particularly *'coupling access to dissociative traumatic memories with positive restructuring of those memories'*(Spiegel et al., 1990).

By this statement, Spiegel is suggesting that hypnosis could help bring traumatic memories more fully into conscious awareness and alter the way in which they are stored in memory *by associating / pairing / linking them with feelings of safety*(such as the feeling of being safe and protected in the therapist's consulting room) rather than, as had previously been the case, high levels of distress.

In this way, Spiegel suggests, when these previously disturbing memories are recalled in the future, because they are now associated / paired / linked with feelings of safety, they cease to induce distress.

In effect, then, the traumatic memories have become positively recontextualized and deprived of their previous power to induce feelings of fear, anxiety and terror.

Research Evidence That Hypnotherapy Can Effectively Reduce Symptoms Of PTSD.

There is a growing body of scientific evidence showing that those with PTSD can be helped by taking advantage of hypnotherapy. I briefly examine some of this evidence below:

1) Bryant et al. carried out a research study that showed the more vividly PTSD sufferers experienced flashbacks and nightmares, the more hypnotizable they tended to be.

2) Brom et al. ran an experiment in which PTSD sufferers were split into three groups :

- Group 1 received psychodynamic psychotherapy.
- Group 2 received were treated using systematic desensitization techniques.
- Group 3 received hypnotherapy.

Results :

Whilst all three groups responded equally well, group 3, comprising individuals who underwent hypnotherapy, required the fewest treatment sessions.

Other Research:

- Forbes et al. found hypnotherapy to be an effective means of reducing nightmares and flashbacks in PTSD sufferers.
- Krakow et al. carried out research showing that children who had experienced early life trauma were able to use imagery under hypnosis which reduced their nightmares and intrusive thoughts, as well as reducing their levels of emotional arousal and improving their quality of sleep.

Furthermore, there is good evidence that hypnotherapy can substantially help those suffering from mental health issues linked to PTSD such as depression and anxiety.

33) Mindfulness Meditation.

Mindfulness is an exciting technique, its effectiveness supported by much research evidence, which is now becoming very popular as a tool for the treatment of conditions related to childhood trauma, including depression, anxiety, difficulties regulating emotions and borderline personality disorder (BPD). It derives from Buddhist philosophy.
The technique teaches people to improve their coping ability and resilience by concentrating on :

- how they breathe.
- observing.
- accepting.
- adopting a non-judgmental attitude.

Individuals are encouraged to just accept and observe their thoughts, their physical sensations (perhaps caused by anxiety) and their emotions as they come and go in the mind.

The technique emphasizes the importance of just observing these phenomena in a detached way, stepping back from them, avoiding engaging with them or getting caught up in them. A metaphor for this would be watching leaves on a stream float by.

Mindfulness is also all about being intensely involved in the MOMENT (rather than thinking about the past or future). It is about accepting the moment as it is and being fully involved in it – for example, becoming aware of our breath going in and out, the feel of the temperature on our skin, the feel of the seat we are sitting in, the feel of the clothes against our skin, the colour of the walls – everything, in fact, which is currently impinging upon the senses. By existing in the moment, unconcerned by the past or present, we can just dispassionately, non-

judgmentally 'watch' our concerns and worries as they pass through our mind.

In this way we can detach ourselves from stressors, and, with practice, we can prevent our previously unhelpful, 'automatic responses' to stress. The technique also encourages us, as we simply observe, in a detached manner, thoughts and feelings passing through our minds, to label them. For example, 'worry', 'fear' etc; the reason for this is explained below:

Neurological Explanations For How Mindfulness Works :

As I have already said, there is a lot of evidence showing MINDFULNESS to be a very effective coping technique. In terms of how the brain works, this has been explained in the following way: –

- labelling our emotions rather than engaging with them activates the PREFRONTAL CORTEX (an area of the brain) which reduces anxiety.
- a high level of MINDFULNESS correlates positively with the level of neural activity in the PREFRONTAL CORTEX; this has the effect of damping down activity in the AMYGDALA (high activity in the brain area known as the AMYGDALA is associated with intense emotions); in this way, we become much calmer. –
- the effects of practicing MINDFULNESS, and the subsequent effects on the brain given above, result in us being able to achieve much greater emotional regulation (emotional control).

As well as reducing anxiety, depression and helping us to master our emotions, MINDFULNESS, research has shown, also benefits the immune system, helps people control obsessive-compulsive disorder (OCD) and is also used to help control chronic pain.

Furthermore, people who continue to practice mindfulness have been found to have stronger coping skills and greater resilience than others.

34) Neurofeedback.

It is becoming increasingly recognized that overactivity in the brain's fear circuitry may be of fundamental relevance to not only complex-PTSD and PTSD, but to many other psychiatric disorders as well and it clearly follows, therefore, that damping down the over-intensity of neuronal firing in this part of the brain may be key to effective therapy for the treatment of a whole array of mental health issues.

In relation to this, there is mounting excitement about how NEUROFEEDBACK can benefit many individuals who suffer from acute psychological distress.

According to Mobbs, the brain consists of two areas involved in how we experience fear as shown below :

- the reactive-fear circuit.
- the cognitive-fear circuit.

Let's look at each of these in turn :

The Reactive Fear Circuit :

This circuit deals with threats that are IMMEDIATE and require an instant reaction (namely, activation of the 'fight or flight' response) ; it involves the interconnection between two areas of the brain as shown below :

- the periaqueductal gray.
- midcingulate cortex.

The Cognitive Fear Circuit :

This circuit deals with threats that DO NOT require an immediate response, allowing us time to consciously consider the risk they pose to us and how we should respond to them ; this circuit involves connections between the following brain areas :

- the posterior cingulate cortex.
- the ventromedial prefrontal cortex.
- the hippocampus.

The See-Saw Method :

Mobbs asserts that the relationship between these two brain regions can be compared to the two ends of a seesaw ; in other words, as one goes up, the other comes down, which means :

- The more activated the reactive-fear circuit becomes, the less activated the cognitive-fear circuit becomes.

And the reverse is also true, so :

- The more activated the cognitive-fear circuit becomes, the less activated the reactive-fear circuit becomes.

Relevance To Those Who Have Suffered Childhood Trauma :

As we have seen, if we have suffered severe and protracted childhood trauma we are at increased risk of developing various disorders as adults (such as complex PTSD and borderline personality disorder) which are underpinned by having oversensitive and overactive fear-response circuitry and, correspondingly, underactive cognitive-response circuitry.

What Is Neurofeedback ?

Neurofeedback is biofeedback for the brain and neuro-counsellors can provide their patients with such feedback simply by using special computer software.

The neurofeedback the patients receive allow them to become aware of their brain function frequencies and how these relate to different emotional states.

How Does Neurofeedback Help Adults Suffering From The Effects Of Childhood Trauma?

Armed with this information, and by continuing to learn from the neurofeedback their brains provide them with (via the software mentioned above), the patients can then, gradually, be trained to exercise control over their brain wave activity (for example, by soothing it with visualization techniques, breathing exercises or calming thoughts etc.). Ultimately, with enough training, the patients' dysregulated brains can be helped to heal and to become less fear-driven.

This results in the reactive-fear circuit becoming less sensitive and active which, in turn, provides the cognitive-fear circuit, as it were, 'more room to manoeuvre'. In this way, irrational feelings of fear that were originally being driven by the (unthinking and automatic) reactive-fear circuit can now be more soberly and rationally considered by the (reflective and thinking)

cognitive-fear circuit and, therefore, more easily dismissed as unwarranted, made impotent and deprived of their power to cause us anguish.

It should also be noted, however, that whilst a lot of excitement has been generated around this method of treatment, it is still early days and more research is needed to determine the extent of its effectiveness and to which disorders its application is best suited.

35) Yoga.

Studies into the effectiveness of yoga already suggest that it can help ameliorate both physical and psychological problems including diabetes, arthritis, fibromyalgia, depression and anxiety.

There also now exists evidence (e.g. van der Kolk, 2014, see below)) that it can help to reduce symptoms of Complex posttraumatic stress disorder (Complex PTSD).

Complex PTSD Gives Rise To Both Psychological And Physical Symptoms :

We have already seen how the cumulative effects of exposure to ongoing and repetitive trauma can result in the development of Complex PTSD and that the condition adversely affects the body's physiology leading to impaired functioning of the autonomic nervous system and associated physical problems that can manifest in various ways including :

- hypervigilance.
- dissociation / psychic numbing.
- hyperventilation.
- accelerated heart / pulse rate.
- sweating.
- elevated blood pressure.
- restless, physical agitation.

Furthermore, such symptoms are, in individuals with complex PTSD, if not ongoing, very easily triggered by even relatively minor stressors ; this is because the individual's capacity to tolerate stress is dramatically compromised, especially in relation to stressors that are linked (on either a conscious or unconscious level) to memories of the original traumatic experiences.

Severe Physical Symptoms Of Complex PTSD May Prevent Or Impair Talk-Based Psychotherapy :

If such physical symptoms of complex PTSD are severe, and remain unaddressed, there is potential for them to prevent or impair talk-based psychotherapy. For example, in my own case my physical symptoms were so bad that I frequently either could not attend therapy sessions (as I was unable to leave my flat), or, if I did manage to attend, was unable to focus or concentrate properly.

How Can Yoga Help Those Suffering From Complex PTSD?

Yoga that incorporates physical exercises, breathing exercises and mindfulness can be a more effective treatment of the physiological symptoms of complex PTSD that talk-based psychotherapy because of the fact that it DIRECTLY ADDRESSES SUCH SYMPTOMS THROUGH BREATHING TECHNIQUES AND BODY WORK. Indeed, recent research supports the effectiveness of yoga in this regard – for example, van der Kolk's study (2014), which I briefly outline below :

The Study :

- The participants in the study were adult females with complex PTSD who had not responded to the intervention of traditional psychotherapy
- These same females were then randomly allocated to one of two groups as shown below :

GROUP ONE :

The females who were randomly allocated to GROUP ONE underwent a TEN WEEK COURSE IN TRAUMA SENSITIVE YOGA (a special form of yoga that was developed at the Boston Trauma Center in the U.S.).

GROUP TWO :

The females who were randomly allocated to GROUP TWO did NOT undergo this course.

The Results Of The Study :

The main findings of the study were as follows :

At the end of the ten week period :

- Those in the treatment group (GROUP ONE) were significantly less likely still to meet the diagnostic criteria for complex PTSD than those in the non-treatment group (GROUP TWO).
- Furthermore, those in the treatment group (GROUP ONE) showed a significant reduction in depression and self-harm.

Longer term studies have found similar results (e.g. Rhodes, 2014).

Trauma-Sensitive Yoga (TSY) :

TSY was developed as an adjunct therapy by David Emerson (who founded the Trauma Center in Brookline, Massachusetts) in 2003 and its main goal is to help traumatized individuals control their emotions and associated, dysfunctional behaviors and concentrates on breathing techniques, meditation, specific physical postures and gentle movements.

Conclusion :

Yoga may be an effective complementary treatment option to be used in conjunction with talk-based psychotherapies particularly when physical symptoms of complex PTSD are so severe that they interfere with talk-based psychotherapies.

A major benefit of yoga for the treatment of the physical symptoms of complex PTSD is that it addresses such problems directly.

36) Compassion Focused Therapy.

Therapy which emphasizes self-compassion (as well as compassion for others), not inappropriately named COMPASSION FOCUSED THERAPY (CFT), has become increasingly utilized for the treatment of the effects of childhood trauma over the last decade or so. It is based on 3 main components :

- being mindful of one's own suffering.
- being kind to oneself (with positive internal 'self-talk', for example). and non-self-critical
- being open about own suffering and communicating it without feelings of shame or weakness.

CFT is a particularly useful and effective therapy for those of us who tend to be ashamed of our internal emotional state, prone to severe self-criticism and come from an abusive and neglectful background (i.e. suffered such an environment during our childhood).

CFT motivates and helps individuals to develop a compassionate self-view as well as a compassionate view of others. Research suggests that many of us who suffered disturbed childhoods are fearful of giving compassion to ourselves or receiving it from others.

Neuroscience (the scientific study of the brain) has shown that giving oneself compassion or being self-critical (i.e. where the compassion or criticism is INTERNALLY GENERATED) has very similar biochemical effects upon the brain as would be generated by EXTERNAL STIMULI (i.e. others showing us compassion or criticizing us). For more about this very interesting area of research it is well worth reading the study on EMPATHY AND MIRROR NEURONS by Decety and Jackson (2004).

Because CFT is based on similar theory to cognitive behavioral therapy (CBT) it focuses on reasoning, rumination, behaviors, emotions and motives in a similar way to how CBT does.

EVIDENCE FOR THE EFFECTIVENESS OF COMPASSION FOCUSED THERAPY :

- A study carried out by Lutz et al (2008) demonstrated that showing compassion towards others led to beneficial changes in the PREFRONTAL CORTEX (a specific brain region) and a much increased sense of personal well-being.
- A study by Fredrickson et al (2008) demonstrated that 6, one hourCOMPASSION FOCUSED MEDITATION sessions per week increased POSITIVE EMOTIONS, MINDFULNESS and FEELINGS OF PURPOSE.
- A study by Gilbert and Proctor (2006) focused on individuals with long-term mental health problems and found that COMPASSION TRAINING significantly reduced their feelings of shame, depression and anxiety; it also greatly reduced their previously pronounced tendency towards self-criticism.

37) Steps To Recovery.

Research shows those who suffer childhood trauma CAN and DO recover.

Making significant changes in life can be a very daunting prospect, but those who do it in order to aid their own recovery from childhood trauma very often find the hard work most rewarding.
Some people find making the necessary changes difficult, whereas others find it enjoyable.

The Decision To Change :

Change does not occur instantly. Psychologists have identified the following stages building up to change:

1) not even thinking about it.
2) thinking about it.
3) planning it.
4) starting to do it.
5) maintaining the effort to continue doing it.

The Recovery Process :

Each individual's progress in recovery is unique, but, generally, the more support the trauma survivor has, the quicker the recovery is likely to occur.

Often recovery from childhood trauma is not a steady progression upwards - there are usually ups and downs (e.g. two steps forward...one step back...two steps forward etc.), but the OVERALL TREND is upwards (if you imagine recovery being represented on the vertical axis of a graph and time by the horizontal). Therefore, it is important not to become disheartened by set-backs along the recovery path. These are normal.

Sometimes, one can even feel one at first is getting worse (usually if traumas, long dormant, are being processed by the mind in a detailed manner for the first time). However, once the trauma has been properly consciously reprocessed, although this is often painful, it enables the trauma survivor to work through what happened and to form a new, far more positive, understanding of himself or herself.
Once the trauma has been reworked (i.e understanding what happened and how it has affected the survivor's development) he or she can start to develop a more positive and compassionate view of him/herself (for example, realizing that the abuse was not their fault can relieve strong feelings of guilt and self-criticism).

Once the reworking phase has been passed through, improvement tends to become more consistent and more rapid.

Steps To Recovery :

It is important to remember that, no matter how severe our particular experiences of childhood trauma were, people can, and do, recover from such experiences if they undergo an appropriate form of therapy.

In analysing the recovery process from childhood trauma, it is possible to break it down into seven stages ; I present these stages below :

1) The first very important thing to do is to stop seeing ourselves as abnormal because of the effect our childhood trauma has had on us, but, instead, to see our symptoms and resultant behaviours as **A NORMAL REACTION TO ABNORMAL EVENTS/EXPERIENCES.**

It is very important to realize that it is highly probable that other people would have been affected in a very similar way to how we ourselves have been affected had they suffered the same adverse experiences that we did. Coming to such a realization is, I think, important if we wish to keep up our self-esteem.

2) A very therapeutic effect can often be achieved by opening up about our traumatic experiences and how we feel they have affected us by talking to others we trust about such matters.
3) If at all possible, it is important that, during the recovery process, we are in an environment in which we feel safe and secure, and which is as stress-free as possible.

4) It is also extremely important that we try to resume normal everyday activities and interpersonal relationships as soon as possible, even if this requires some effort at first. Indeed, the research suggests recovery is very difficult if we do not re-establish human relationships. Also, we need to try to build some structure into our daily lives, as this provides a foundation of stability.

5) We need to accept that we may need much more rest than the average person - this is because the brain needs time to recover. In relation to this, getting the correct nutrients and sufficient sleep (I needed far more than 8 hours during my recovery) is also very important.

6) We also need to realize that while our experience of trauma entailed a great deal of suffering, many people not only recover from childhood trauma but develop as a human being in extremely positive ways as a result of it ; this phenomenon is known as **posttraumatic growth**.

7) Therapy should be seriously considered.

LET GO OF THE PAST :

The following six strategies can help us to let go of the past and move on with our lives more effectively :

1) VALIDATION :

According to ***Horowitz,*** if our past childhood trauma and the pain it has caused is, subsequently, invalidated (e.g. denied, ignored, dismissed, minimized, mocked etc.) by those who have harmed us, the psychological harm done to us is amplified. This makes it harder to move forward in our lives.

However, if this is the case, it can be helpful to seek and obtain validation from significant others, such as a therapist who is trained to work with childhood trauma survivors, or from what *Alice Miller (1923-2010)* referred to as an '*enlightened witness.*' Miller defined an *'enlightened witness'* as a compassionate and empathetic person who helps the childhood trauma survivor '*recognize the injustices [s/he] suffered and give vent to {his/her] feelings.'*

2) EXPRESSION OF PAIN :

This pain we have been caused does not necessarily need to be expressed directly to those responsible ; for example, we may describe our experiences and feelings in a journal, or, as *Franz Kafka* did, write a letter to the person/s responsible (in the case of*Kafka,* the letter was to his abusive and narcissistic father) without actually sending it (instead, his biographer informs us that he gave it to his mother to give to his father - he was too frightened to approach his father directly - but she never did, possibly because she believed it wouldn't do any good).

3) CONSCIOUS DECISION :

Because we might have been ruminating, perhaps obsessively, on the trauma and injustice contained in our past, the process of turning things over and over in our minds may have become almost automatic. It is therefore necessary to make a firm, conscious decision to embark upon the journey of *letting go.*

4) ADOPT BENEFICIAL TIME PERSPECTIVE :

According to TIME PERSPECTIVE THERAPY (developed by *Zimbardo, Sword* and Sword, 2013) we should use the past to our advantage (such as learning from previous mistakes and focusing upon good things that have happened rather than dwelling on the bad). Also, we should develop the ability to live in the present and enjoy it, but not in such a heedless and hedonistic way that it endangers our future ; and, also, adopt an optimistic view of the future and plan for it (by setting achievable goals).

5) CULTIVATION OF COMPASSION :

Compassion-Focused Therapy, described in the previous chapter, can effectively help people move on from their traumatic childhood experiences. It can be particularly effective in helping those suffering from feelings of shame resulting from their traumatic experiences (such feelings are a very common response to a traumatic childhood, as we saw in Part Two of this book).

6) REFRAME :

Many people do not realize the damage that their childhood has done to them and may take a sanitized view of it due to what they are taught to believe by those who harmed them or by society more generally By reframing the past, with the help of a psychotherapist, we can start to obtain a *genuine insight into what really happened to us* which, in turn, empowers us and makes us less of a slave to the unconscious forces that may be ruining our lives.

38) Posttraumatic Growth.

Many people, after suffering a terrible trauma, find that, once they have got through it and started to recover from its damaging psychological effects, they eventually reach a stage whereby they are able to use their adverse experiences to develop them as a person in highly positive ways that benefit both themselves and society at large.
This has been termed by psychologists ***posttraumatic growth.***
After experiencing trauma comes a slow process of recovery (assuming effective therapy is sought); the length of time recovery takes will depend both upon the type, intensity and duration of the trauma, as well as the age that the individual was when s/he experienced the trauma, and also the affected individual's personal characteristics, temperament and genetic make-up.

Once the person who experienced the trauma is able to manage his/her painful and distressing emotions more effectively, finds memories of the trauma less difficult to cope with, and is able to function reasonably well on a day to day basis, a **transition** can start to take place **in which the person begins the process of moving on from recovery into posttraumatic growth.**

Ideally, this period of growth and development should be guided and facilitated by an appropriately qualified and experienced therapist.
The process of posttraumatic growth involves taking stock of what happened and analysing its significance.

The American Psychological Association identify ten key elements that the process involves :

1) re-establishing meaningful relationships with other people **(see blow).**
2) accepting that change is an inevitable part of life.
3) setting goals and starting to move towards them.
4) taking decisive action.
5) working on developing a positive self-view.
6) learning from the past.
7) good self-care.
8) developing an optimistic outlook.
9) seeking out opportunities for self-discovery.
10) seeing crises as challenges rather than as insurmountable obstacles.

39) Posttraumatic Growth : The Importance Of Relationships And Social Support.

Human beings are naturally social animals and it is a basic and fundamental instinct for us to try to bond, connect and form attachments with others; the benefits we may gain from such relationships to others when we have experienced trauma include providing us with :

- a greater sense of meaning in life.
- a greater sense of safety.
- a greater sense of belonging.
- a greater sense of affirmation / self-worth.
- someone to confide in.
- someone to advise us about coping strategies.
- someone to help us understand and process what has happened to us.
- someone who can help us look at what has happened from a new and original perspective.
- someone who can help distract us from our negative ruminations and feelings.
- someone who can help to emotionally soothe us.

What Does The Research Say?

Our relationships with others significantly influence how we cope with and respond to trauma ; the researchers Calhoun and Tedeschi (2006) suggested that specific reasons as to why this should be so included the following :

- other people may positively alter how we view the world and how we interpret and perceive events.
- other people may introduce us to additional coping methods.
- other people may provide us with social support.

Other researchers (e.g. Cordova et al., 2001 ; Leopore and Revenson, 2006) suggest that relationships with others in which we feel safe to make emotional disclosures may be of particular value.
Leopore and Revenson also suggest that our relationships with others can help with how we respond to trauma in the following ways :

- weakening the connection between trauma and negative emotional responses and replacing them with positive emotional responses.

- helping us to regulate (control) our negative emotions connected to the trauma by shifting our focus of attention.
- helping us to habituate to negative emotions connected to the trauma.

- facilitating positive cognitive reappraisals in relation to the trauma.

- through his research, *Weiss* (2004) found that those who had suffered traumatic experiences can benefit in particular by having social relations with others who have also lived through trauma and who have not only coped with it, but have also experienced posttraumatic growth in response to their traumatic experiences and can, therefore, act as role-models.

- Schroevers et al., (2010) conducted research suggesting that having other people to help the individual who has suffered trauma cognitively process information connected with the traumatic experience can also be of significant be.
- those with access to good social support systems tend to have both a better sense of general emotional wellness (Henderson and Brown,1988) and lower levels of depression (Lara et al.,1997) when compared to those individuals who lack social support.
- Having good social support not only improves our psychological health, but also has benefits for our physical health, such as strengthening our immune system **(*Kiecolt-Glaser and Glaser, 1992*).**

Perception Of Social Support Versus *Actual* Social Support :

Research has also found that even if, by any reasonable, objective measure, we are receiving adequate social support during and after traumatic periods its benefits will be greatly diminished if we do not *perceive* it as adequate ; for example ; if we perceive someone we are close to as being non-receptive when we confide in him/her information about our traumatic experience - irrespective of whether they actually *are non*-receptive - our sense of emotional well-being will be diminished (Cordova et al., 2001).

From such research we are able to infer that in order for us to have a significantly increased chance of coping with trauma and experiencing posttraumatic growth, it is not necessarily enough to receive adequate social support - we must, too, believe that those providing this support ***genuinely care about us.***

The Importance Of Avoiding Negative And Critical Social Interaction :

Research also suggests that, in the aftermath of trauma, it is at least as important (and, perhaps *even more* important), to **avoid negative and critical social interaction** in the aftermath of trauma as it is to find positive support if one wishes to experience posttraumatic growth.

40) Posttraumatic Growth And Spirituality.

It is not necessary to have a religious faith to be spiritual. But what do we mean by the term SPIRITUALITY?

Being a non - religious but spiritual person means we do not need to 'buy into' particular religious texts, systems of belief or traditions which have been passed on from generation to generation over many, many centuries. Indeed, free from such restrictive shackles, we are liberated to go about our spiritual practice in a way which is unique to us, if we so choose.

Our spiritual belief might involve belief in something far more intelligent than us but which we are so far unable to understand (and we certainly do not need to refer to such an entity as 'god').

People who are spiritual often report that being so :

- helps them to find meaning and purpose in life,
- helps them during periods of suffering,
- helps them to cope with the death of loved ones,
- helps them to come to terms with the prospect of their own death.
- helps them learn and develop in response to mistakes and suffering, rather than being defeated by them.
- helps them recover from traumatic experiences.
- helps with fears concerning the possibility of 'life after death.'
- helps them if they feel the need for forgiveness or the need to forgive others.
- helps them develop their creativity.
- helps them to become kinder, more patient and more compassionate.
- helps them to develop empathy.
- helps them to develop better judgement.

Many people who are spiritual report becoming more aware of the RECIPROCAL element of life (i.e. we tend, to some extent at least, to 'reap what we sow').

Also, those who are spiritual often find that they are more able to draw on their own suffering to effectively help others. Thus, suffering becomes less meaningless.

SPIRITUAL PRACTICES INCLUDE :

- meditation.
- yoga.
- Thi Chi.
- sports that encourage the development of trust and cooperation.
- appreciating nature, its beauty, exquisite complexity and ability to inspire feelings of awe.
- contemplative reading (literature, poetry, philosophy).
- forming deeper relationships/friendships.
- appreciation of the arts.
- creative activities (e.g. painting, gardening, cooking).
- volunteering to help others.

Carl Jung

Carl Jung (1875-1961) was the founder of analytic psychology and regarded spirituality as an essential part of his work. He did not subscribe to any one, traditional religion. Indeed, he believed that fundamentalist and dogmatic religions *inhibit* spiritual growth, rather than enhance it.
Instead, he stressed the importance of the person's **individual experience** in spiritual growth (including the experiencing numinous events) and of discovering one's true self (which Jung regarded as the most complete, fulfilled, integrated, balanced and effective individual that we can be - although, it has to be said, he also stated that very few people were ever able to attain this optimum state, rather as Maslow believed very few could ever ascend to the state of self-actualization in the hierarchy of human needs.

Pain, Suffering And Trauma Can Help Us Discover Our True Selves, According To Jung :

Jung also believed that our discovery of our 'true selves' involved a process of **'individualization'** that was often a very protracted, extremely painful and traumatic experience.

In order to emphasize just how excruciatingly painful this process could be, he compared it to initiation tests that are undertaken by members of shamanic tribes. These initiation tests can be nearly fatal but are intended to bring about a new spiritual awareness, allowing the individuals who endure them to become spiritual teachers and healers.

In essence, Jung viewed such a process as akin to 'death and rebirth' and he points out that such 'death and rebirth' processes are central to many religions and traditions, including the death and resurrection of Jesus ; ancient Egyptian myths in which the god dies and is then reborn ; the mythical process of alchemy in which base metals are broken down and reformed into precious metal.

Related to this latter example (the mythical process of alchemy) is the **SHATTERED VASE THEORY OF POSTTRAUMATIC GROWTH.**
The '**shattered vase**' metaphor was devised by the psychologist, Professor Stephen Joseph. It is based on the idea that after a severely traumatic experience we can feel as if our lives have been 'shattered' and that **our very being has become fragmented.**

However, just as one could rearrange the broken pieces of the shattered vase into a new work of art, such as a mosaic or sculpture, so too, suggests Joseph, may we be able to 'rebuild' ourselves.

Like the shattered vase refashioned into a different art piece, our 'rebuilt' self will also be different from the original, but may well possess new qualities that did not exist in our former selves, such as those listed above.

Indeed, the new, rebuilt self may well be a significant improvement upon the old one and as such would constitute posttraumatic growth.
We can, therefore, draw some solace from the shattered vase metaphor, even if our suffering has been great.

D.H. Brighton, 2019.
childhoodtraumarecovery.com