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Post-Traumatic Stress Disorder and Complex-Post-Traumatic Stress Disorder Caused by Childhood Experience

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Abstract: A distressing incident can lead to PTSD, a mental health condition. However, most trauma starts at home, where parents account for most child abuse (approximately 80% of all cases). There is another trauma called CPTSD. Complex post-traumatic stress disorder (C-PTSD) is a psychological impairment caused by long-term exposure to social and interpersonal trauma in the setting of reliance, confinement, or entrapment (where the sufferer is unable to escape), leading to a loss of control, powerlessness, and a warped sense of self. Of these, the most typical examples include people who have suffered chronic abuse, neglect, or abuse by caregivers. This article focuses on PTSD and CPTSD caused by childhood experiences. It shows the etiology and the effect on children's lives and futures from psychological, sociological, and biological perspectives. Also, it provides some childhood experiences of people living with PTSD to show the significant impact. The article includes the treatment of PTSD and CPTSD. The recommendation, in the end, makes some suggestions to improve these mental illnesses. In conclusion, people can learn more about the impact of childhood experiences on PTSD and CPTSD from this article.

Keywords: post-traumatic stress, terrifying event, etiology, treatment, attachment, early relationship trauma, childhood experiences

1. Introduction

A mental health illness known as post-traumatic stress disorder (PTSD) affects 5–10% of the population and affects women more frequently than males [1]. It develops when people have experienced terrifying events, such as childhood physical abuse, serious accidents, and childbirth experiences. A constant reliving of the experience, avoiding painful reminders, a general numbing of emotional reactivity, and chronic physiological hyperarousal are common symptoms of PTSD.

Children exposed to terrifying events like adults can cause PTSD [2]. Children experiencing PTSD often display the core symptoms of adult PTSD and other symptoms [2]. Loss of previously learned developmental abilities, the appearance of new anxieties or the reawakening of old ones,

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accidents and risky conduct, separation anxiety, and other symptoms may be stomach aches and headaches [2].

Six symptoms fall under the diagnosis of type CPTSD [3]. First, individual mood and impulse control must be modified. Second, the second phenomenon changes in attention or consciousness. Third, a shift in how one views oneself. The fourth is alterations in interpersonal connections. Fifth, somatization symptoms start to manifest. The meaning system is finally modified. This essay primarily focuses on the psychological harm brought on by caregivers' ongoing negligence [3].

Some key characteristics of C-PTSD, such as confinement, psychological disintegration, loss of security, trust, and self-worth, and the propensity to be victimized again, are not well covered in the description of PTSD. Additionally, C-PTSD exhibits characteristics of attachment disorders, particularly parts of generalized insecurity or disordered connection that are not well characterized in the PTSD diagnosis.

2. Methodology

This paper is a review based on research and studies collected using Google Scholar in the post-trauma stress disorder field.

Basic information about PTSD is obtained from the DSM-IV: Diagnostic and Statistical Manual of Mental Disorders. For the etiology section, the primary source is PTSD in Children and Adolescents by Jessica Hamblen, Ph.D. And Post-traumatic stress disorder in children, by Debra Kaminer, Soraya Seeda, and Dan J. Stein. This document also provides the ways of treatment, which shows the different ways to cure PTSD, including Psychotherapy and Pharmacotherapy.

3. Results and Discussion

3.1. Etiology

Whether directly or indirectly, exposure to a stressful incident is the genesis of PTSD. Children who have suffered horrific crimes like parent murder, school shootings, and natural and manufactured disasters like earthquakes and floods may be diagnosed with PTSD [4].

15 to 43% of girls and 14 to 43% of boys in the general population reported experiencing at least one traumatic event in their lifetime. 3% to 15% of girls and 1% to 6% of males who have suffered trauma may be diagnosed with PTSD. Other studies indicate that 100% of children who witness a parental homicide or sexual assault develop PTSD [4].

Like other anxiety disorders, children's reactions to stressful experiences are influenced by parental responses, which are also tied to their inherent propensity to react negatively. Regarding PTSD in childhood, this area has not been sufficiently investigated. The idea that children perceive their parents' reactions is now universally acknowledged. Most kids claim they avoid discussing unpleasant experiences with their parents to avoid upsetting them. Because parents typically underestimate the severity of the stress reactions their children suffer, one cannot make a diagnosis merely based on their reports [5].

From a biological perspective, Hippocampal dysfunction may contribute to the etiology and maintenance of PTSD. According to animal research, the hippocampus is necessary for creating and remembering associations between environmental inputs and unpleasant events. This suggests that impaired hippocampus function may cause the organism to generate a variety of specific habitats where these cues may be present [6].

Most kids with PTSD have likely experienced several traumas, such as being sexually abused in childhood or seeing domestic violence. Youngsters who have been sexually abused as children are the most prevalent. It frequently occurs in secrecy and is repeated over time [5].

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However, there are some differences in etiology between CPTSD and PTSD. C-PTSD is different from PTSD in that the boundary is clear but similar. C-PTSD is a psychological impairment caused by long-term exposure to social and interpersonal trauma in the context of dependency, captivity, or entrapment (where the victim lacks a viable escape route), resulting in lack or loss of control, helplessness, and a distorted sense of identity and self. Of these, the most typical examples include people who have suffered chronic abuse, neglect, or abuse by caregivers; The hostages—concentration camp survivors; And some survivors of religious cults [7].

3.2. Impact

PSTD can alter some people's whole lives. However, according to a 33-year assessment of the Aberfan landslide catastrophe survivors, 29% of those tracked down and questioned still fulfill the criteria for PTSD. It suggests that the long-term repercussions of life-threatening traumatic events in childhood can be severe without adequate rehabilitation.

An experience for person living with PTSD who was involved in an industrial disaster in childhood said: "The physical wounds I received to my head and stomach would eventually heal, but the psychological wounds would last much longer and continue to affect me more than 30 years later [5]." He said that he overcame these problems by learning to live with them. Nevertheless, he will be affected by the catastrophe until he dies [2].

Within a minute, these impacts significantly modified a young boy who had no concerns in the world. Because most of his buddies had left, he could not play. He often experienced nightmares and could not attend school due to his constant worry that a catastrophe might reoccur. His inability to focus was so bad that it impacted his academic achievement. Additionally, he has remorse over the fact that he lived while others perished.

Later, some deep sadness and flashbacks can be brought on by earthquakes. The sadness so immobilizes him that he cannot even reach for a razor. He cannot gaze in the mirror since doing so will make him doubt his existence [5].

PTSD also happens to a woman with a successful career and happy marriage. It was what people could see on the surface. She never told anyone what happened to her until she was 40 because of the difficulty trusting people. Her father sexually abused her from age 10 to 15. Although her father died, she could see, smell, and taste him. She had always been aware that she had experienced sexual abuse, and this awareness left a physical mark on her. Headaches, constipation, back discomfort, gynecological issues, unreasonable fear of thunderstorms, startle response, and insomnia. However, no clinician had inquired whether she had ever experienced sexual abuse as a child, so she was aware that discussing it was inappropriate. Suicidal ideas resurfaced due to her sense of powerlessness, and she believed that suicide was the only way to stop the onslaught of memories [5].

Fortunately, she finally discloses her secret to her GP (general practitioner). Her GP could have had her admitted to the hospital. She had rapid access to trauma counseling from 1994–1995. She made gradual progress and observed a reduction in her symptoms with each new understanding. She suddenly understood how PTSD affected her life, making her a workaholic, fat person with no true friends. The only thing she had going for her was a deep-seated conviction that her attacker would not prevail [5].

The PTSD sufferer's interactions with those close to them, such as family and friends, may be impacted by the condition's emotions and physical symptoms . Some patients may neglect their social and familial circles and retreat from those close to them. These patients believe they are no longer able to relate to their surroundings. They think sharing ordinary events with others is meaningless, but they cannot share the traumatic experience. This feeling that PTSD might produce

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in sufferers leads them to think they are being isolated. Long-term isolation can result in a decline in self-esteem and confidence, eventually leading to severe depressive episodes [8].

CPTSD also has a significant impact on sufferers. It is widely established in the literature that awful childhood experiences and trauma negatively affect a person's health and development. There is currently enough proof to conclude that early exposure to interpersonal trauma hinders children's capacity to master particular developmental tasks, such as emotional regulating and forming stable attachments. This is because they hinder the growth of the brain systems that regulate arousal, emotion, stress response, and reward processing. These essential psychobiological functions are all associated with developing underlying long-term problems in PTSD, mainly manifested as complex PTSD [9].

The way children think about themselves, and the world comes from their childhood experiences . Furthermore, the thinking that comes from their childhood experiences shapes the way they live. For example, children who have long felt neglected in early relationships may perceive hostility in situations. In addition, people who have experienced neglect will often devalue their worth. They may seek, fabricate, and interpret experiences and relationships in ways that are compatible with misrepresented mental images. As a result, they are more likely to be psychologically inclined to avoid and exclude situations that are not the same as psychological reinterpretation [1].

Moreover, children and adults who have experienced chronic neglect often psychologically picture relationships as unpredictable, untrustworthy, and even harmful. These negative thoughts often carry over into every new relationship. In new relationships, they find it difficult to trust others emotionally, or they often distort the cognitive information processing of perceived objects. Emerging evidence suggests that individuals with negative early life experiences (e.g., negative attachment to parents, negative relationships with teachers and relatives, inefficient parenting) are challenging to confer resilience, even in typical situations. Higher probabilities of teen pregnancy and adult social disorder issues were indicated by a lack of family-specific qualities, including maltreatment, reduced closeness, and a lack of loyalty and protection. Additionally, distinctions in culture, gender, color, ethnicity, and geographic borders impacted how an individual's development was affected by a caregiver's perceived rejection in the form of indifference or neglect. However, it was not sufficiently influenced to intervene in these universal relationships.

3.3. Treatment

There are differences in the treatment between children's PTSD and children's CPTSD. There are two treatment modes for children with PTSD: Psychotherapy and Pharmacotherapy.

Psychoeducation, direct trauma exploration, symptom management strategies, exploration, and adjustment of false cognitive attributions about the trauma are common psychotherapy interventions with children [4]. More commonly than other approaches, cognitive-behavioral therapy (CBT) has been experimentally beneficial in treating PTSD in children [4].

The most commonly used is the manual-based CBT protocol for PTSD, TF- CBT. It is suitable for children who suffer from depression, anxiety, or other trauma. The method has been tested in 500 children and shows a positive result. It is much better than the usual treatment. TF-CBT is adapted for childhood traumatic grief, and two studies prove that it has a positive result in treating PTSD and childhood traumatic grief symptoms [10].

There’s another proof that parents in treatment are beneficial in treating children’s trauma. The experiment compares the therapy to parents alone, children alone, and parents and children. The result shows a noticeable improvement in children who have reported PTSD and parents who have been reported as the behavior problem. So, the study proves that parents with a lower level of

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emotional distress and parents with more robust support all show more positive treatment responses during the treatment method of CBT. [10]

Pharmacological treatments for PTSD in children have not received much empirical research [4]. However, the ideally effective pharmacological are: enabling traumatized children to engage with emotionally difficult things and work through their discomfort will help psychotherapy be more effective at treating debilitating symptoms, enhancing the child's quality of life, and facilitating the process [4].

If the trauma is related to society, children can be considered to have a school-based screening. The reason is that it is a high-efficiency way to identify, also treat children who are sufferers of PTSD. The treatment should also consider other factors, for example, family factors such as attitudes about the specific intervention. [10]

Current treatment modalities include psychoeducation of traumatic events and trauma-focused treatment. For example, children enduring caregiver neglect or trauma might benefit from early treatments that introduce them to positive childhood experiences and resources, which can act as a buffer and protective factor for their mental health as adults. In addition, training using emotion regulation and cognitive reorganization techniques appears to prepare children or adults for the review and exposure of traumatic memories during treatment [11].

4. Conclusion

The primary issue with children's PTSD is that psychotherapy treatments are created for traumatized adults rather than children, and there is little empirical data to support the efficacy of these treatments for children. Therefore, we suggest that psychologists pay attention to this problem so that children can get better treatment through psychotherapy. In addition, Parents' behavior also affects children's mental health. Children who live in loving families usually have no mental problems, except the other factors from the outside world. Oppositely, children with evil native family always quickly diagnosed with mental illness. Parents should always pay attention to their behavior because it relates to children's psychology; as the article mentions, a girl who has been sexual abuse by her father has PTSD, and the psychological wounds still exist when she was married.

Long-term childhood trauma shapes personality, identity, and other self-regulatory abilities. Childhood interpersonal trauma exposure affects a child's ability to complete particular developmental tasks effectively. When children feel indifference and neglect from parents or are rejected without discrimination, they will show psychological maladjustment and seven negative personality tendencies mainly manifested as a C-PTSD. To reduce the occurrence of negative emotions in children, it is to be able to develop positively, and appropriate treatment (e.g., medication, family therapy, cognitive behavioral therapy) should be provided to the child or adolescent based on their circumstances.

However, many trauma-based treatments are based on cognitive theories of traumatic stress. According to this hypothesis, the information related to a traumatic incident conflict with the knowledge in a person's fundamental cognitive model. Therefore, when a person is faced with a traumatic event, although he can try to make sense of the experience, it is not easy to fully integrate the experience into existing cognition.

Furthermore, exposure to childhood trauma caused by emotional neglect may induce the occurrence of CPTSD. Either because they lack the emotional support necessary to help them deal with the traumatic experience, which can also be called the ability to regulate stress levels. Either due to emotional neglect or a failure to quickly and effectively acquire the required skills. In trying to prevent and intervene in CPTSD, providing emotional support to gradually exposed children cannot be ignored.

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