Chapter 41

Abandonment trauma from a developmental perspective and its treatment

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Borja Luque Martínez
Psicólogo

ABSTRACT
Human beings are acquiring learning as we live different experiences. These learnings together with biological factors condition our development. In favorable contexts we will achieve greater development of our potential, however, in unfavorable contexts, our capacities may be reduced. Even situations of special impact may occur throughout the life of the person, which leaves their mark and blocks the proper development of the person. These are traumatic situations that reduce learning capacity and generate palpable biopsychosocial damage, something that happens in cases of early abandonment.

1 INTRODUCTION

To contextualize this reality from an evolutionary or developmental perspective, the Attachment Theory is of great interest. This was initially developed by John Bowlby (1969) and highlights the importance of the baby's innate behaviors to attract the attention of her caregivers. In turn, the main caregivers see their care systems activated to respond to the needs of the baby. Thus, their survival depends on their ability to care. These care behaviors favor the calming of stressful states of the baby, thus regulating the different affective states that it may have. It is in this baby-caregiver dyad that the baby learns to interact with other people and to regulate her affective states, initially unconsciously (Dykas & Cassidy, 2011; Pauli-Pott & Mertesacker, 2009).

Therefore, the caregiver becomes the reference point for the baby to explore the world, as well as being the main provider of security for this exploration (Ainsworth, 1989). These first meaningful relationships generate what Bowlby called Internal Working Models, which consist of representations about oneself, the world, and interpersonal relationships. These mental representations make up the internal model of oneself, integrating the self in terms of self-esteem and the model of others in terms of trust, and mark the levels of anxiety and avoidance in relationships (Bartholomew & Horowitz, 1991).

2 DETACHMENT TRAUMA

The infant's or child's brain searches, in interaction with its primary caregivers, for signals that provide a sense of calm and security (Bowlby, 1969; Ainsworth, 1989). If these signals are not emitted by the caregiver and the infant perceives insecurity or threat, his nervous system goes into a state of alert,

producing hyperactivation or hypoactivation. Thus, if there is no synchronicity between the caregiver and the baby or child, there are problems in affective regulation, due to the deregulation of brain rhythms (Schore, 2001, 2002). Therefore, in cases of neglect or abandonment, this state is activated in the brain of the child, which produces a strong impact on development, leaving a neurological trace that affects subsequent affective regulation, assuming a trauma for the subject.

Early abandonment is a traumatic event for children and their intervention is laborious and complex since they lack positive somatosensory experiences. These positive experiences are related to the fact of being present in the mind of another person who reads the needs. For abandoned children, emotional and behavioral expressions are contradictory, confusing, and terrifying. And, in the case of internationally adopted children, their origins involve very different cultures, customs, and family relationships than those of their new adoptive families, this is part of their grief. Children themselves have experienced losses of their primary and secondary attachment figures, as well as the loss of friends who have been left behind (Cortes-Viniegra & Aumeunier-Gizard, 2021).

Thus, the infant's exposure to traumatic situations, such as the loss of primary attachment figures and subsequent international adoption, has a clear influence on the overall functioning of the individual and the appearance of externalizing and internalizing traumatic symptoms (Juffer et al., 2005; Fernández Rivas et al., 2014) that even becomes chronic in adolescence and adulthood (Gould et al., 2012; Ballard et al., 2015).

Among the internalizing symptoms suffered by children who experience abandonment, we find denigration and somatic and depressive symptoms and among the externalizing ones, disruptive behaviors and aggression towards oneself and others can be observed. In addition, immobilization, paralysis, and dissociation can be observed (Levine and Kline, 2016). It has also been found, in a recent meta-analysis, that young subjects who have experienced trauma show low levels of performance in executive functions (Op Den Kelder, 2018). And is that, psychosocial deprivation in childhood is associated with a worsening of executive functions and with the appearance of attentional, behavioral, and socio-emotional problems (Bos et al., 2009; McDermott et al., 2013). In addition, another recent meta-analysis has shown significant effects on neurocognitive functioning after a traumatic event, on information processing speed, verbal, attentional, and working memory (Scott et al., 2015).

A large part of these symptoms is due to the affective disorganization just mentioned. And, it is that the abandonment by the main caregivers and the perception that infants may have about this treatment leads to the development of dysfunctional attachment models (Hesse and Main, 2006). In fact, on numerous occasions, these infants show symptoms of Reactive Attachment Disorder (Minnis & Cols., 2009), as well as Post-Traumatic Stress Disorder (Hoksbergen et al., 2003; Linda et al., 2006; Onyiriuka, 2018). Both disorders converge symptomatologically in what some authors call Developmental Traumatic Disorder (Van der Kolk, 2005).

3 POST TRAUMATIC STRESS DISORDER (PTSD)

It is an anxiety disorder produced by a traumatic event that exceeds the coping abilities of the individual. So much so, that after a while it continues to generate anxious symptoms and re-experiencing the event (American Psychiatric Association, 2014).

When post-traumatic stress is triggered by a repeated experiences over time, such as mistreatment, repeated abuse, neglect, or abandonment, the sequelae and symptoms generate suffering and adaptation problems in the individual. However, on numerous occasions, the symptoms presented do not meet the criteria proposed for PTSD, resulting in an underdiagnosis of traumatic disorders. With the purpose of a better differential diagnosis, some authors propose the inclusion, in the current diagnostic manuals, of the diagnosis of Complex PTSD (PTSD-C). Specifically, this diagnosis is included in the International Classification of Diseases ICD-11 (World Health Organization, 2018).

Complex PTSD is the result of repeated traumatic experiences over time and includes a negative self-concept and difficulties in emotional regulation and interpersonal relationships. It should be noted that, although rare, C-PTSD can develop with a single exposure to a traumatic event (Elliott et al., 2021).

Table 1. PTSD and C-PTSD symptoms. Adapted from American Psychiatric Association (2014) and World Health Organization (2018)

PTSD Symptoms (DSM-5)	Symptoms of Complex PTSD (ICD-11)
Traumatic experience (Criterion A) Re-experiencing the traumatic experience. This may include having nightmares or flashbacks (Criterion B). Avoidance of situations or activities that are reminiscent of the traumatic event (Criterion C). Negative and persistent cognitive and mood disturbances (Criterion D). Hyperarousal, overarousal, alertness (Criterion E). Somatic symptoms that have no medical cause (Criterion H).	The symptoms of PTSD. Problems in emotional regulation. Changes in the state of consciousness, such as forgetfulness of the traumatic event or dissociation. Negative self-perception: Feelings of guilt or shame. Difficulty in interpersonal relationships, avoiding them, or seeking relationships with harmful people Distorted perception of the abuser Loss of sense and meaning of life and hopelessness.

Among the differences that exist between PTSD and PTSD-C are their differential clinical and behavioral correlates. And it is that higher levels of dissociation, depression, Borderline Personality Disorder, anxiety, self-harm, and suicidal ideation can be observed in those subjects diagnosed with PTSD-C, although it is true that the diagnosis of PTSD is more frequent (Hyland et al., 2018). Additionally, those with PTSD-C show higher levels of psychiatric burden (prevalence and associated costs, mortality, disability, and impairment) and lower levels of psychological well-being (Cloitre et al., 2019).

Concerning adoption processes, some studies show a high incidence of PTSD in adopted children who have previously been abandoned and have lived temporarily in orphanages, places where situations of social and physical neglect sometimes occur (Hoksbergen et al., 2003). In addition, there is evidence that separation from parents (or primary caregivers), even briefly, during childhood when a traumatic

experience has been experienced, predicts insecurity in attachment style and post-traumatic stress disorder, which is maintained in adulthood (Bryant, 2017).

4 REACTIVE ATTACHMENT DISORDER (TRA)

Collected in the DSM-5 (American Psychiatric Association, 2014) and the ICD-10 (World Health Organization, 2000). This disorder is characterized by inadequate and persistent socialization skills that can present in two forms:

TRA Inhibited. Defined by an inability to initiate social interactions and respond appropriately, presenting special affective and behavioral withdrawal. In addition, unexplained episodes of irritability, sadness, or fear may occur. The child is inhibited, hypervigilant, ambivalent, and presents contradictory behaviors.

TRA Uninhibited. Defined by the presence of altered behaviors when interacting with strange adults, being especially close with unknown people, and making little or no use of the caregiver after a risky exploration.

In both cases, the infant is at least nine months old and has suffered an extreme pattern of insufficient care, defined by:

- Negligence. Persistent lack, on the part of caregivers, in covering basic emotional needs.
- Repetitive changes of primary caregiver.
- Education in unusual contexts.

Related to international adoption processes, it is worth noting how some studies show that around 80% of children who are mistreated or with negligent caregivers develop severe symptoms related to a dysfunctional attachment style or ART (Bakermans-Kranenburg et al., 2003; Hornor, 2008; Minnis et al., 2009). In addition, between 10% and 20% of internationally adopted children present significant behavioral and attachment problems, a good part of them presenting this disorder and its persistence being common beyond the age of 11 (Pignotti, 2011; Stinehart et al, 2012).

5 DEVELOPMENTAL TRAUMATIC DISORDER (TTD)

As previously mentioned, adopted children suffer from abandonment trauma and may show traumatic symptoms typical of PTSD or Complex PTSD and, at the same time, develop symptoms related to ART (Baita, 2012; Cook et al., 2005). In the majority of cases, there is no diagnostic category that makes it possible to accurately collect the picture presented by these children (Baita, 2012). In addition, the discriminant validity in the diagnosis of ART must be taken with caution (Pignotti, 2011). For these reasons, authors such as Dr. Bessel van der Kolk, propose the psychopathological conceptualization of Developmental Traumatic Disorder, since this includes more precisely the range of symptoms developed by people who have experienced chronic traumatic events in childhood (Van der Kolk, 2005; Van der Kolk and Courtois, 2005).

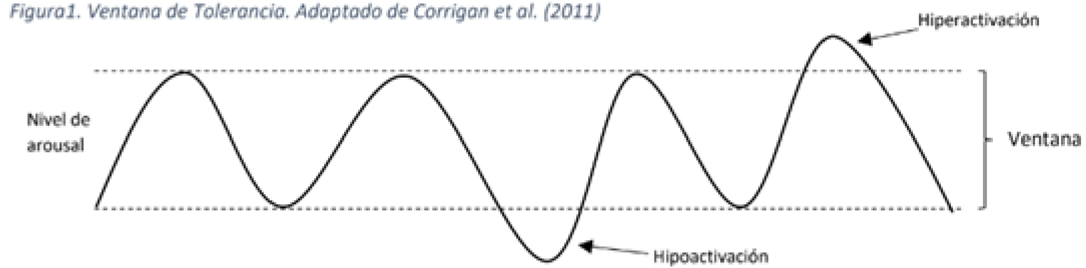
Due to its symptoms and etiology, TTD has been defined by some authors as the childhood version of C-PTSD (Sar, 2011). The proposal to include TTD in the official diagnostic classifications has been transferred by Van der Kolk et al. to the DSM-5 Field Trial for the inclusion of the new diagnosis that addresses the complexity of the symptomatic reality of children exposed to chronic trauma (Teicher, 2009; Van der Kolk et al., 2009).

According to the authors, Traumatic Developmental Disorder is due to the exposure of the child or adolescent to multiple or prolonged adverse events over at least one year. This includes directly experiencing or witnessing repeated and severe episodes of interpersonal violence, significant disruptions in basic care as a result of repeated changes or separations from the primary caregiver, or exposure to severe and persistent emotional abuse.

These exposures lead to symptoms of affective and physiological dysregulation, attentional and behavioral dysregulation, and dysregulation of the Self (oneself) and relational, including here the difficulties to relate effectively in a healthy way. In addition, a Spectrum of Post-traumatic Symptoms typical of PTSD is found in at least two of the aforementioned dysregulations. The duration of the symptoms must be at least 6 months and they must generate disabling functional difficulties or clinically significant disturbance.

This affective dysregulation can be understood from Siegel's Window of Tolerance theory (1999), according to which these children have seen the thresholds of their Nervous System narrowed due to traumatic affective experiences. In this way, we observe greater ease for hyperactivation (Sympathetic System) and hypoactivation (Parasympathetic System), making them more sensitive to social situations, in which the level of arousal can lead them to hyperactivation with anxiety (even showing disruptive behaviors).) or hypoactivation with paralysis.

Figura1. Ventana de Tolerancia. Adaptado de Corrigan et al. (2011)



6 TRAUMA TREATMENT: EMDR THERAPY

From the point of view of development, the best option is the prevention of traumatic situations in children. However, the current social reality causes early abandonment to continue, as well as negligent actions on the part of the parents. In addition, other traumatic experiences can trigger developmental trauma in infants.

Therefore, access to therapeutic spaces should be considered for those children who have already experienced trauma.

Among the therapies with the greatest scientific evidence for the treatment of traumatic symptoms is EMDR (Eye Movement Desensitization and Reprocessing) (de Roos et al., 2011), especially for the treatment of chronic PTSD in children and adolescents (NICE, 2005, 2018). Furthermore, although Cognitive Behavioral Therapy has more empirical evidence in children than EMDR (Field & Cottrell, 2011), the latter has a series of advantages, especially for working with children and adolescents. Thus, it does not require confrontation with the client's beliefs or the explicit narration of the traumatic event, in addition to not requiring homework (World Health Organization, 2013). Specifically, EMDR can be used to elaborate, in an adapted way, the narrative of the adoption story and thus help to process the adoptive experience (Adler-Tapia & Settle, 2012).

EMDR is a trauma-oriented therapy initially developed to treat PTSD (Saphiro, 2001). It is part of the Adaptive Theory of Information Processing to explain that much of the maladaptive symptomatology (thoughts, behaviors, and feelings) is due to the maladaptive encoding of information or incomplete processing of adverse life experiences. These experiences have been coded in isolation from the rest of the person's memories, interfering with the person's functioning and leading to said symptoms. EMDR helps to assimilate this isolated traumatic unconscious content (Lee & Cuijpers, 2013).

The treatment consists of the maintenance of attention by the patient in different components of the traumatic memory (thoughts, bodily sensations, or emotions) while it is stimulated bilaterally. This stimulation is normally done with rhythmic left-right eye movements following the therapist's hand, although there are other forms of bilateral stimulation, such as auditory or tapping on the shoulders, hands, or legs. Thus, through bilateral brain stimulation, different vital experiences are reprocessed, achieving greater regulation in brain activation, with a positive impact on behavioral, emotional, and cognitive regulation (Saphiro, 2001).

EMDR has sufficient empirical evidence to support it. Thus, there are more than 25 Randomized Clinical Trials (RCTs) in which their efficacy in reducing traumatic, anxious, and depressive symptoms are tested. Efficacy in the child and adolescent population is studied in 8 of them (Ahmad et al., 2007; Chemtob et al., 2002; de Roos et al., 2011; Diehle et al., 2015; Jaberghaderi et al., 2004; Kemp et al. al., 2010; Scheck et al., 1998; Soberman et al., 2002). In addition, there is evidence of its usefulness for the treatment of people with impaired executive functions and altered attentional processes after trauma (Camacho-Conde, 2020; Estrada, et al., 2015).

On the other hand, Rodenburg et al. (2009), carried out a meta-analysis in which they verified the efficacy of EDMR in the traumatic treatment of children. Specifically, they found a medium effect size ($d=.56$, $p < .001$) after the treatment and compared the EMDR treatment with a cognitive behavioral treatment and with a control group without treatment, seeing greater efficacy with the EDMR treatment concerning the two other groups.

EMDR has also been shown to be effective for the intensive treatment of C-PTSD (Bongaerts et al., 2017).

In evaluating its effectiveness, most studies have placed their emphasis on measuring traumatic, anxious, and depressive symptoms (Leenarts et al., 2013), so other conditions suffered by children have been left aside. with Developmental Traumatic Disorder, as its impact at the cognitive level. Despite this, we can consider its adequacy for the treatment of said disorder due to its similarity with PTSD and C-PTSD and the efficacy of EMDR for affective regulation (González et al., 2017) and behavior problems (Soberman et al., 2002). Furthermore, Wesselmann et al. (2012), describe a single case study in which they present the efficacy of an integrative model of EMDR and family therapy in improving a child's attachment style and symptoms related to a history of attachment trauma.

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