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EXPERIENCE OF TRAUMA AND PERCEPTION OF ATTACHMENT. COMPARING GROUPS OF ADOLESCENTS HOSPITALISED IN A PSYCHIATRIC WARD AND GROUPS OF NON TREATED YOUTHS

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Summary. Aim: To get a better insight into the problem of interaction between the experience of trauma in the relationship with the parents and the perception of attachment by adolescent patients of a psychiatric hospital. Comparison of two groups of adolescents — hospitalised in a clinic, and untreated

Method: Seventy individuals were examined. The clinical group consisted of thirty inpatients of psychiatric hospital for children and adolescents. The control group consisted of forty secondary school students. The method was based on the use of questionnaires to survey the perception of relationships (PBI) and trauma (CTQ).

Results: The study showed a difference in the traumatic experiences between the examined adolescent patients of a psychiatric hospital and the control group. The study identified a stronger emotional neglect in the clinical group. The study identified a slight difference in the perception of attachment. The study indicated a connection between the trauma and the perception of attachment.

Conclusions: Reporting the trauma, significance of the traumatic experience and perception of the parental protection constitute relevant risk factors for psychiatric hospitalisation in adolescence.

Introduction

Psychotherapists working with families are often faced with descriptions of situations characterised by intensely pathological elements, where many events occur which have a deeply traumatic impact on the children. The violence experienced causes them to feel that their sense of integrity is threatened and leads to extremely traumatic consequences with respect to their self-evaluation. The child, using the available manners of coping in such situations, fights for the preservation of what it deems as the most precious value — his or her bond with the parents. The child does so even in the cases when the unique attachment available to him or her is frustrating, humiliating and causing harm.

Trauma

Trauma is a term derived from Greek, meaning a puncture of the skin, a damage to the body shell, in the medical language the word means a damage to a tissue [1]. Freud [2], using the metaphor of trauma, emphasised that the mind under the influence of events may suffer damage. By the same, he pointed out that the mind has a protective layer which in the case of an interference stronger than its capacity to defend itself, is damaged. The interest in the phenomenon of trauma

emerged in the early nineteenth century, when the French neurologist Jean-Martin Charcot explained the hysterical symptoms as a consequence of traumatic experiences, both physical and emotional [1]. In 1980, introduced the concept describing the consequences of traumatic experiences, termed as the post-traumatic stress disorder (PTSD) [3], was for the first time incorporated in the American classification DSM-III.

Psychopathological symptoms were often found in victims of trauma [4]. According to research by Bryer [5] women who experienced physical or sexual violence, obtain higher scores in tests that measure somatisation, depression, general anxiety, severity of the phobia, hypersensitivity to social contacts, paranoia and "psychoticism" (understood as dissociation symptoms). Lipschitz' study [6] indicates that 61% of patients in psychiatric clinics had experienced physical and emotional neglect. According to Goodman [7], among adult psychiatric patients: 61% were neglected emotionally; 37% were sexually exploited; 44% experienced physical violence; 52% were emotionally abused; 61% were neglected physically. As a result of their studies, Stein et al. [8], found that in the female patients diagnosed with anxiety disorders the coefficient of sexual violence experienced in childhood was 45.1%, while in the group of untreated women it was 15.4%. In the case of panic disorder 60% of the female patients were victims of sexual violence in childhood, compared with 31% in the group of women diagnosed with the other anxiety disorders. The theory of Horowitz [9] has had a significant influence on the explanation of PTSD — according to that theory, the impact of a traumatic event accommodates a large quantity of external and internal (constituting the physiological response) information, not consistent with the existing cognitive system of the individual. The incapacity to process this information leaves them out of the consciousness, where they remain unprocessed (not adapted to the psychological abilities). Thanks to the defence mechanisms such as denial, isolation and splitting, the raw "traumatic" information in the beginning have no destructive impact. After some time, however, they pass onto the level of the consciousness and are processed. This phenomenon has been termed as intrusion (inrush). The intrusive phase contains many cognitive and emotional symptoms of PTSD, principally the painful reproduction and hyperreactivity. These experiences entail a process of denial, creating a defensive posture to adapt. Thus, the traumatised individual oscillates between intrusive reliving and experiencing a generalised withdrawal (emotional dullness), until the moment when the traumatic experiences are integrated [10]. De Masi [11], on the basis of the work of Ledoux [12], suggests that the overwhelming anxiety typical for the panic disorder is trapped in the circuit of the amygdaloid nucleus / limbic system and is not processed in the cerebral cortex. Therefore the imaginary threats — often rooted in the old traumas — are not distinguished from the real ones. Thus, the trauma is reflected in the central nervous system, and thus in the emotions and the body [13]. However, the contents of the

autobiographical memory may be separated into the fact itself and the emotions accompanying it. The facts are recalled easier than the accompanying and associated emotions. The emotions memory can disconnect itself from the events memory. Thus, the memory of the traumatic events is an important issue, playing a major role in the study of the consequences of psychical trauma, trauma and attachment.

Research reveals that the experience of trauma in childhood is associated with [according to: 14]: higher risk of using psychoactive substances [15], use of alcohol during adolescence [16], violent behaviour [17], difficulty with concentration [18], depression [19], fear [20] and an increased risk of suicide during pre-adolescence [21].

Attachment

John Bowlby's attachment theory is, beside the theory of relations with the object, the most important concept describing the development of bonds. In his three books, published in the years 1969-1980, Bowlby has described the need for close relationships as fundamental to the possibility of survival. The author treated the experience of relations as a "matrix" of the future relationships and stressed its importance in shaping the future contacts with the environment. He believed that the experience of attachment or deficit thereof affects the development of the self-image, self-esteem, as well as the cognitive development [22-24]. The description of the disorder in the bond between the immediate guardian and the child entering the world became the foundation of the new paradigm [25, 26]. A description of the development and principal theses of the theory of attachment by Bowlby would exceed the framework of this paper, therefore the authors chose to mention but a selection of issues, important in the light of the subject research.

Trauma and attachment

The attachment theory is largely a theory of trauma [27]. The literature of the subject strongly represents the view that there is a relation between the security of attachment and the trauma. Traumatised children and adults are more likely to present insecure style of attachment [28, 29], and the attachment style presented by an infant will very likely be presented also by an adult. Van Ijzendoorn [30] in his meta-analysis of 18 reports estimated the above probability at 75%. A longitudinal study of the attachment style in adolescents, at the age of fourteen, and subsequently at twenty-five [31], revealed that the adolescents hospitalised in psychiatric clinics at the age of fourteen, the attachment style tested after eleven years could be determined with a high probability as anxiety-based. However, the impact of these facts on adolescents and on the intermediate stage between childhood and adulthood has not been examined in a satisfactory manner. Certain data are provided by the studies by Shapiro and Levendosky [32], as they show the mediating role of the attachment style in the coping strategies used by sexually abused adolescents. A safe attachment was

negatively correlated with the use of preventive coping strategies. Thus, the attachment constituted a mediating vehicle between the trauma of sexual abuse and the level of distress of the examined individuals. Hocking with his team [33] pointed to the mediating role of the anxiety pattern of attachment, between the experience of trauma in childhood and again in adulthood. Wiltgen with his team [34] emphasised the mediating role of an avoidance pattern of attachment, between the trauma experienced after 16 years of age and the clinical symptoms of anxiety in adult psychiatric inpatients.

Mentalisation

Peter Fonagy is a contemporary pursuer of the research on the bond in the context of its impact on psychopathology. He puts a particular emphasis, in the development and expansion of the classical theory, on the development processes and the factors interfering therewith. This eminent researcher focuses on the emotional bond of the child with the child's guardian, which in his opinion is the cornerstone in the development of human mental functioning. Fonagy analyses the consequences of the acquisition of psychological skills in the course of the development process and has examined the effects of interference in that area in the context of relationships. He affirms [35] that the acquisition of cognitive and emotional skills by children is achieved thanks to a stable, secure bond and is not possible without it.

Today the mentalisation is the most important concept in the attachment theory [36]. According to Fonagy' [37] mentalisation is a process occurring as a result of the guardians adjusting to the child's emotional state. The child reflects himself in the mind of the guardian protector and internalises this representation. The mentalisation describes the understanding of psychical (mental) states of oneself and of the others. It is an ability to perceive the motivations of one’s own and of the others' behaviours as a result of subjective mental states. It becomes also a psychological understanding of oneself and of the others, consistent with the reality, instead of just reacting or experiencing. The mentalisation process occurs on the basis of the existence of a trust-based bond, thanks to actions based on the guardian’s ability to observe the child's inner world and on the guardian’s mental and physical availability.

Aim of the study

The aim of the study was to determine the differences between the group of young people hospitalised in a psychiatric ward and the control group of young people, in terms of untreated trauma experience, perception, affection and relationships. The results of the research presented in this paper are a fragment of the doctoral thesis by Bartosz Treger, MD PhD: "The experience of trauma and relationships in childhood and self-image and defence mechanisms in adolescents-psychiatric inpatients" — created under the direction of Prof. Dr hab. Barbara Józefik, PhD, UJ [38,

39]. The study received the approval of the Bioethics Committee (Opinion No. KBET/42/B/2009). The survey was not sponsored.

Material

The clinical group consisted of patients-adolescents: from the fifteenth to the nineteenth year of age who were first admitted to the Inpatient Department of the Psychiatric Clinic for Children and Adolescents SU in Krakow, where they were diagnosed psychiatrically according to ICD-10, and their treatment commenced. The patients in the active process of psychosis were excluded from the study group, as well as those with the IQ below 80 points (examination using WISC-R, WAIS-R tests). The clinical group consisted of 30 persons — 15 girls and 15 boys. Their average age was 16 years and 4 months, the youngest participant was 15 years and 4 months old and the oldest — 17 years and 6 months. The criterion of inclusion for the study was a first-time psychiatric hospitalisation. The study group was heterogeneous in terms of diagnoses: emotional and behavioural disorders — 9; anorexia nervosa — 6; adjustment disorders — 5; anxiety-depressive disorders — 3; anxiety disorders — 7.

The control group consisted of children not included in psychiatric treatment, consisted of 40 persons — 20 girls and 20 boys. The average age in this group was 16 years and 9 months, the youngest member was 15 years and 9 months old and the oldest — 17 years and 8 months. The groups did not differ statistically in terms of age, gender, type of school, place of residence, family structure, parents' education background and their occupation.

Method

In the present study we used the following tools:

1. Questionnaire of the trauma experienced in childhood (Childhood Trauma Questionnaire CTQ) (DP Berstein, L. Fink, L. Handelsman, J. Foote, M. Lovejoy, K. Wenzel, E. Sapareto, J. Ruggerio, 1998), in the Polish translation by J. Bomba, K. Szwajca and B. Treger.

The childhood trauma questionnaire was used for the study (CTQ). It is an inventory of self-reports providing a screening description of the history of abuse and neglect, which is suitable for the examination of adolescents (over 12 years) and adults. CTQ contains questions concerning the five types of abuse: emotional abuse, physical (corporal) abuse, sexual abuse, emotional neglect, physical neglect. The questionnaire also includes a 3-items scale of minimisation / denial, a tool intended to detect falsely negative reports of abuse. The first study was conducted using a 70-item CTQ [40]. The researchers revealed a good reliability and accuracy, including the test-retest reliability after 2 and 6 months [41]. A shortened version of the CTQ was developed, containing 28 items; its usefulness in clinical and other trials has been tested in three different trials [42]: 378 adult substance abusers, 396 adolescents in a psychiatric hospital, and 899 randomly selected women from as health-

oriented organisation. The analysis showed that the items of the abridged version of the CTQ had essentially the same meaning in the clinical and non-clinical groups, thus enhancing the utility of the 28-of item version CTQ as a screening tool in different populations [42]. In the Polish realities, only one study [43] was based on that questionnaire [43], on a group of adults.

2. Questionnaire assessing the relationships with the parents (Parental Bonding Instrument PBI) (G. Parker, H. Turpin, LB Brown, 1983).

The questionnaire assessing the relationship with the parents (PBI), developed by Parker, Turpin and Brown in 1983, translated into Polish by Dr. Agnieszka Popiel, was used in the study of the bond perception. In 1990, William and Parker confirmed, in their study involving a group of students, a satisfactory stability of the results over time [44]. In his research concerning the tool Parker proved its satisfactory accuracy and the independence of the test results from the variations of the mood [45]. PBI has been designed to study the parent — child relationship, and is intended for the persons aged 15+. The questionnaire consists of 25 statements that describe the behaviour of the mothers and fathers, assessed on a four-point scale by Likert. Of the 25 statements 12 refers to the care, and 13 to the control. The care and control dimensions are bipolar, meaning that the examined aspects are care-rejection and control-autonomy. The optimal relationships are defined as a combination of high care and low control. High scores on the care scale reflect emotionality, warmth in the relationship with the child, while low results suggest a rejection, coldness and indifference. High scores on the control scale suggest excessive interference with the affairs of the child, excess of control, active encouragement to psychological dependence, while low scores are an indication of the promotion of independence and autonomy. The theoretical basis of the tool was the concept of Winnicott, making reference to the attachment theory by Bowlby. The Parental Bonding Instrument (PBI) questionnaire is a tool assessing the perception of control and overprotective attitude on the part of the guardians. The verification of the reliability of the Polish version of the PBI questionnaire was made on the basis of the evaluation of the coefficient alpha of internal consistency, by Cronbach. The results (alpha>0.70) reveal a satisfactory level of reliability of the whole questionnaire and of its individual scales.

Results

1. Assessment of the differences between the two groups as to the trauma experience (CTQ)

The analysis was performed using the Mann-Whitney test (non-parametric equivalent of the t-Student test for unrelated variables, its application results from the non-compliance of the basic assumption of the t-test concerning the normality of the distribution of the examined variable in the two groups). The statistically relevant outcome on the level of relevance $\alpha = 0{,}05$.

The results obtained point to significantly higher scores in the clinical group with respect to the scales: emotional abuse (median 9,5 vs. 7,0), physical abuse (median 6,0 vs. 5,0), lying (median 5,0 vs. 3,0). The results on the scale of emotional neglect were higher in the control group (median 22,0 vs. 16,0). The results on the scales of sexual abuse and physical neglect showed no differentiation between the groups.

2. Evaluation of the differences between the groups in terms of the perception of attachment (PBI)

An analysis was performed using the t-Student test for the independent variables for the scale O-K (father's control). For the remaining examined scales, its non-parametric equivalent was used, i.e. the Mann-Whitney test. At the relevance level $\alpha = 0,05$ no major differences were revealed between the two groups. At the relevance level $\alpha = 0,1$ the M-O scale (mother's care) differentiated the groups. A higher level of the willingness to care was reported by the persons from the control group.

3. Analysis of the correlation between the traumatic experience and the perception of the attachment, in the examined groups

Table 1. **Specific scales pertaining to the childhood trauma questionnaire (CTQ) in the clinical group**

		Emotional abuse	Physical abuse	Sexual abuse	Emotional neglect	Physical neglect	Lying
	Important	30	30	30	30	30	30
	No data	0	0	0	0	0	0
Mean		10,53	7,27	5,23	16,87	11,97	4,83
Standard error of the mean		0,849	0,638	0,233	0,997	0,316	0,401
Median		**9,50**	**6,00**	**5,00**	**16,00**	**12,50**	**5,00**
Dominant		5	5	5	15	13	5
Standard deviation		4,652	3,493	1,278	5,463	1,732	2,198
Minimum		5	5	5	6	8	1
Maximum		21	20	12	25	15	9

Table 2. **Specific scores pertaining to the childhood trauma questionnaire (CTQ) in the control group**

		Emotional abuse	Physical abuse	Sexual abuse	Emotional neglect	Physical neglect	Lying
	Valid	41	41	41	41	41	41
	No data	1	1	1	1	1	1
Mean		7,66	5,49	5,27	20,44	12,68	3,41
Standard error of the mean		0,394	0,192	0,171	0,636	0,222	0,294
Median		**7,00**	**5,00**	**5,00**	**22,00**	**13,00**	**3,00**
Dominant		5	5	5	24	13	3
Standard deviation		2,526	1,227	1,096	4,075	1,422	1,884
Minimum		5	4	5	12	10	1
Maximum		14	10	10	25	17	9

Table 3. **Analysis of the correlation between the perception of the attachment and the trauma in the control group.**

	PBI Mother-Control	PBI Mother-Care	PBI Father-Control	PBI Father-Care
Emotional abuse	R = 0,198 p = 0,215	**R = -0,401** **p = 0,009**	R = 0,146 p = 0,363	**R = -0,448** **p = 0,003**
Physical abuse	R = 0,146 p = 0,363	R = -0,049 p = 0,760	**R = 0,353** **p = 0,024**	R = -0,057 p = 0,723
Sexual abuse	R = 0,005 p = 0,967	R = 0,214 p = 0,180	R = 0,157 p = 0,326	R = 0,010 p = 0,951
Emotional neglect	R = -0,199 p = 0,211	**R = 0,594** **p = 0,000**	R = -0,130 p = 0,416	**R = 0,668** **p = 0,000**
Physical neglect	**R = -0,363** **p = 0,020**	**R = 0,354** **p = 0,023**	R = 0,012 p = 0,943	**R = 0,390** **p = 0,012**
Lying	R = -0,097 p = 0,548	R = -0,060 p = 0,709	R = 0,032 p = 0,841	**R = -0,323** **p = 0,040**

Depending on whether or not the assumption of normality of the distribution was fulfilled, for the verification of the hypotheses, the researchers used the line correlation coefficient by Pearson or its non-parametric equivalent, i.e. the coefficient of rank correlation by Spearman.

1. The scale of emotional abuse correlates negatively with the scales of care — with respect to the mother and to the father.
2. The scale of physical abuse correlates positively with the scales of the father's control.
3. The scale of emotional neglect correlates positively with the scales of the father's and mother's care.
4. The scale of physical neglect correlates positively with the scales of the father's and mother's care and negatively with the scales of the mother's control.

Table 4. **Analysis the correlation between the perception of the attachment and the trauma in the clinical group**

	PBI Mother-Control	PBI Mother-Care	PBI Father-Control	PBI Father-Care
Emotional abuse	R = 0,248 p = 0,187	**R = -0,661** **p = 0,000**	R = 0,365 p = 0,073	**R = -0,456** **p = 0,022**
Physical abuse	R = 0,216 p = 0,251	R = -0,162 p = 0,392	**R = 0,522** **p = 0,007**	R = -0,216 p = 0,301
Sexual abuse	R = -0,226 p = 0,230	R = -0,291 p = 0,118	R = -0,269 p = 0,193	R = -0,298 p = 0,149
Emotional neglect	R = -0,137 p = 0,471	**R = 0,851** **p = 0,000**	R = -0,290 p = 0,160	**R = 0,581** **p = 0,002**
Physical neglect	R = -0,095 p = 0,617	R = 0,303 p = 0,104	R = -0,181 p = 0,387	R = 0,151 p = 0,470
Lying	R = 0,217 p = 0,248	R = -0,005 p = 0,979	R = 0,060 p = 0,777	R = -0,176 p = 0,401

1. The scale of the emotional abuse correlates negatively with the scales of care of the mother and father.
2. The scale of the physical abuse correlates positively with the scales of control exercised by the father.
3. The scale of the emotional neglect correlates positively with the scales of care both of the father and the mother.

Discussion of the results

The clinical group, consisting of patients in adolescent age, who stayed as inpatients in a psychiatric ward, experienced a larger number of traumatic events in the area of emotional abuse and physical abuse. These results are in line with the findings presented in the literature of the subject, as quoted earlier herein [6-8]. A more marked emotional neglect is reported by adolescents from the group with no history of psychiatric treatment, which might be an indication that young people with no experience of psychiatric treatment is more sensitive to manifestations of the emotional neglect. This is consistent with the Fonagy's findings on mentalisation, indicating that the person experiencing an adequate level of care can generate an ability to perceive the subtle emotional components of relations [49]. Moreover, it seems possible that the process of growing up and, in particular, the process of co-individuation, might play an important role in this case. The emotional detachment of the adolescents from their parents causes the latter to respond, by a reaction consisting in reducing the strength of the bond, the "attraction", which the youth can read as emotional neglect.

The perception of the attachment differentiated the clinical and the control group only slightly, the difference related to the maternal care, with a higher level of protectiveness being reported by individuals from the control group. This dependence, however, revealed itself at $\alpha = 0.1$. Perhaps the results were significantly affected by the variables mentioned in studies comparing the tool used for own work — the PBI with an interview diagnosing the attachment style in adults, i.e. the AAI (Adult Attachment Interview). The conclusions from the study performed, consisting in correlating these two tools, were that an idealisation of the relationship with the mother or an intense anger with her felt at the moment when the examination was performed, adversely affected the reliability of the result of the PBI test [50]. During the hospitalisation the patients undergo serious mental crises, accompanied also by relational crises expressed as anger with the guardians who consent to their child’s inpatient treatment. It is likely that the persons from the clinical group, during their first hospitalisation had difficulty with adequate perception of the relationship with their guardians. Furthermore, 6 patients from the clinical group had been hospitalised due to an eating disorder of the anorexia nervosa type. The clinical experience indicates that adolescent patients from that group, especially at the beginning of treatment, often idealise the intra-family relationships. This

fact might therefore be associated with the lack of clearly relevant differences between the examined groups, in terms of the attachment perception.

Prudence is also to be recommended while interpreting the results obtained in the study of the dependence between trauma and the attachment perception, even if they seem important for the understanding of the mutual dependencies. Even if the result indicating a lower perception of the mother's readiness to provide care in the clinical group was relevant only at the level of tendencies, the study of associations between the trauma and the attachment shows clearly a relevant correlation between the perception of the caring attitude of both the parents and the experience of emotional abuse. Such dependence with a negative vector, was revealed in both the examined groups. Interestingly, the value of the correlation coefficient describing the strength of the relationship was higher in the clinical group (R = -0.661 vs. R = -0.401). This might be an indicator of the growing strength of the mutual influence of emotional trauma on the way of experiencing the maternal protectiveness, in line with the intensification of experiencing this type of trauma.

Body abuse, also higher in the hospitalised group, correlates with the perception of control exercised by the father. Prudently interpreted this result might indicate that the fathers are more frequent perpetrators of physical violence.

The trauma resulting from emotional neglect is associated with the perception of maternal and paternal care level in both the examined groups. A more acute emotional neglect is reported by the adolescents who had less frequently experienced emotional and physical abuse. In the control group there is a noticeably weaker dependency — than in the clinical group — between the perceived maternal protectiveness and the emotional neglect (R = 0.594 vs. R = 0.851). The result obtained can be interpreted with caution as meaning that the less traumatised individuals (control group) more boldly address their needs as a child and their wish for closeness to the mother, thus becoming more sensitive to manifestations of negligence from the mother's side, with respect to both the emotional and the physical dimension.

It seems, therefore, that the experience of trauma resulting from emotional and physical abuse can intensify the association between that experience and the manner of experiencing the protectiveness of the mother. The above observation seems to be consistent with the clinical experience of work with adolescent patients experiencing violence, where the victim's narrative often becomes dominant.

Conclusions

According to this study, the traumas of emotional and physical abuse and the related intensification of the meaning of the dependence of such experience and the perception of the protective behaviours of the mother constitute an important element associated with the risk of

psychiatric hospitalisation during adolescence. Although the perception of the mothers' attitudes with respect to care differentiated the examined groups only at the trend level, the results cautiously interpreted suggest its indirect yet important role in the behaviour and functioning of the adolescents, especially of the group who experienced the trauma of abuse. The above conclusion seems consistent with the findings obtained by Lancaster et al., who in their research proved that that the scale of the mothers' readiness to provide care in the PBI test can serve as an index of neglect in childhood [51].

It should be emphasised that the conclusions from the study need to be formulated with a great caution, due to the nature and size of the examined group, and to the time context in which the study was performed, i.e. the first two days of hospitalisation. This variable might be relevant — which was not included in this study — for the emotional and cognitive functioning of the examined individuals, and by the same, for the final outcome. The clinical experience suggests that the patients admitted to the ward often are in a situation of ongoing conflict with their parents, focusing on symptoms or problems associated with the separation [52]. This can affect their perception of parents. Additionally, the test tools based on the "pencil and paper" method have their methodological limitations. The most important weaknesses according to David Silverman [follow 53] include the lack of a deeper contact with the examined individual, the ambiguity in the interpretation of the results and basing the statistical correlations on arbitrary variables.

The results obtained also lead to the conclusion that reporting emotional abuse can be "easier" than its verbal description. Which means that filling a questionnaire pertaining to traumatic events is easier than providing information about the trauma in a clinical interview. As a result, the CTQ as a tool can be used as a support of the diagnosis both psychiatric and psychotherapeutic. It should be emphasised that this study is the first one performed in Poland using the CTQ test with respect to adolescents, and the second in general [43]. The study shows that the test in question has diagnostic values and it is advisable to further develop its field of application.

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