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Childhood Traumas: An Outline and Overview

Childhood psychic trauma appears to be a crucial etiological factor in the development of a number of serious disorders both in childhood and in adulthood. Like childhood rheumatic fever, psychic trauma sets a number of different problems into motion, any of which may lead to a definable mental condition. The author suggests four characteristics related to childhood trauma that appear to last for long periods of life, no matter what diagnosis the patient eventually receives. These are visualized or otherwise repeatedly perceived memories of the traumatic event, repetitive behaviors, trauma-specific fears, and changed attitudes about people, life, and the future. She divides childhood trauma into two basic types and defines the findings that can be used to characterize each of these types. Type I trauma includes full, detailed memories, "omens," and misperceptions. Type H trauma includes denial and numbing, self-hypnosis and dissociation, and rage. Crossover conditions often occur after sudden, shocking deaths or accidents that leave children handicapped. In these instances, characteristics of both type I and type II childhood traumas exist side by side. There may be considerable sadness. Each finding of childhood trauma discussed by the author is illustrated with one or two case examples.

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Mental conditions brought on by horrible external events in childhood present a wide range of findings. If one looks only at the clinical manifestations of trauma in a given day in the life of the traumatized child, one could diagnose conduct disorder, borderline personality, major affective disorder, attention deficit hyperactivity, phobic disorder, dissociative disorder, obsessive-compulsive disorder, panic disorder, adjustment disorder, and even such conditions, as yet unofficial in the nomenclature, as precursors of multiple personality or acute dissociative disorder, and not be wrong. If one projects this multiplicity of technically correct diagnoses onto a traumatized child's adulthood, one finds even more diagnostic leeway.

We must organize our thinking about childhood trauma, however, or we run the risk of never seeing the condition at all. Like the young photographer in Cortázar's short story and Antonioni's film, *Blow Up,* we may enlarge the diagnostic fine points of trauma into such prominence that we altogether lose the central point—that external forces created the internal changes in the first place. We must not let ourselves forget childhood trauma just because the problem is so vast.

Studies of adults in mental hospitals (1), adults suffering from multiple personalities (2), adults who are borderline (3), and adolescents who go on to commit murder (4) show that these adults and adolescents very often were abused or shocked in their own childhoods. Studies of adult rape victims demonstrate that they often were raped or incestuously abused as children and that they are quite prone to being raped again and again—in their adult lives (5). Those who harm children have often been harmed themselves as children. And some of those who indulge in self-mutilation or who make repeated suicide attempts give vivid past

histories of long-standing childhood horrors (7).

One could say that childhood trauma is so ubiquitous to the psychiatric disorders of adolescence and adulthood that we should forget it, that it cancels itself out. We know, however, that not every child is directly shocked or personally subjected to terror from the outside. Most children come from relatively kind, nonabusive families. Most youngsters are never enrolled in a pedophilic day-care center or happen upon a satanic cult. The chances of experiencing a frightening flood, hurricane, or earthquake are not that great. The chances of witnessing a murder or of being kidnapped are not overwhelmingly high. Numbers of children should be able to get through their childhoods without any direct exposure to a traumatic event or series of terrible events. And they apparently do so (8, 9).

Even if we were to broaden the diagnosis of childhood trauma, as I will propose in this paper, to allow in any child mentally harmed enough by a single external event or a long-standing series of such events to qualify for a trauma-related diagnosis, we could not possibly cover everything that we see in adults as a result of these early traumas—the borderline patients, the patients with multiple personality disorder, and the chronic victims or victimizers, for instance. We will still need our adult diagnostic schemes and our adult treatment plans. But perhaps, if we looked in a more organized fashion at childhood psychic trauma and at what it does, we would recognize it as the important etiologic determinant that it actually is. We could begin to see how childhood trauma works. And we could study it better.

Like childhood rheumatic fever, which causes a number of conditions in adulthood ranging from mitral stenosis to subacute bacterial endocarditis to massive heart failure, childhood psychic trauma leads to a number of mental changes that eventually account for some adult character problems, certain kinds of psychotic thinking, considerable violence, much dissociation, extremes of passivity, self-mutilative episodes, and a variety of anxiety disturbances. Even though heart failure and subacute bacterial endocarditis in adulthood look very different from one another and demand specific treatments, their original cause—the childhood rheumatic fever—gives an organizing pattern to the physician's entire approach. Every good internist knows how to obtain and assess a history of rheumatic fever, even though. it was the pediatrician who originally diagnosed and treated the sick child.

In this paper, I will define childhood trauma and point to four features that characterize almost all of the conditions resulting from extreme fright in childhood. These four features are seen in children suffering the results of events that were single, sudden, and unexpected, the classical Freudian traumas (10, 11), and in children responding to long-standing and anticipated blows, those resulting in the various child abuse syndromes (12, 13) or survivor syndromes (14–16). These four features appear to last for years in the course of the condition. They are often seen in adults who were traumatized as children, even though the adults now carry other diagnoses. Only one or two of these four features may be evident in an individual traumatized as a child, but from the history it is often evident that the other features played an important part in the person's life.

I will divide all of the trauma-stress conditions of childhood into two rough categories and call them type I and type II childhood traumas. I will propose that children suffering from type I traumas, the results of one sudden blow, differ in certain ways from children suffering from type II traumas, the results of long-standing or repeated ordeals. I will conclude with a note on the crossover conditions, childhood traumas that appear to settle between the two major types that I propose.

This paper is largely theoretical, although each point will be illustrated with a clinical example. It is based, in part, upon three studies: the Chowchilla kidnapping study (8, 17, 18), a retrospective study of 20 preschoolers suffering from a wide range of traumas that were documented by third parties (19), and a study of normal latency-aged children's and adolescents' responses to the Challenger space shuttle explosion (9). The paper is primarily based, however, upon my clinical notes taken from more than 150 individual children who came for evaluation or treatment after a variety of externally generated horrors. The paper is an attempt to organize and to provide a scheme of thinking about childhood psychic trauma. It is not meant in any way as a last-minute addition to the DSM-IV process or as a proposal for a new and revisionary DSM-V. Instead, it is an outline and overview of a group of phenomena that may go their various ways into the adult diagnostic groups but that should still hold together in our thinking because of their association with the earliest traumas.

I will define childhood trauma as the mental result of one sudden, external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations. As the reader will note, I have broadened the concept of trauma to include not only those conditions marked by intense surprise but also those marked by prolonged and sickening

anticipation. All childhood traumas, according to my definition, originate from the outside. None is generated solely within the child's own mind. Childhood trauma may be accompanied by as yet unknown biological changes that are stimulated by the external events. The trauma begins with events outside the child. Once the events take place, a number of internal changes occur in the child. These changes last. As in the case of rheumatic fever, the changes stay active for years—often to the detriment of the young victim.

FOUR CHARACTERISTICS COMMON TO MOST CASES OF CHILDHOOD TRAUMA

There are several well-known characteristics that distinguish the traumas of childhood. Thought suppression, sleep problems, exaggerated startle responses, developmental regressions, fears of the mundane, deliberate avoidances, panic, irritability, and hypervigilance are prominent among these.

I consider four characteristics, however, particularly important in traumatized children no matter when in the course of the illness one observes the child and no matter what age the child is at the time. They are: 1) strongly visualized or otherwise repeatedly perceived memories, 2) repetitive behaviors, 3) trauma-specific fears, and 4) changed attitudes about people, aspects of life, and the future.

One note on traumatic dreams, the classic Freudian sign of trauma that I have not included in my list of four: the repetitive dream is a hallmark of trauma, but it is not always seen in childhood trauma, especially in children under age 5. Dreaming appears to be something that develops into what we recognize as dreaming by about age 3 or 4 (20). Before that, infants physically demonstrate that they are dreaming by making mouthing movements or little sounds in their sleep. Toddlers may scream from sleep without awakening, but this kind of dreaming is often too primitive and inexpressive to establish that traumatic dreams are actually taking place (21). In a study of 20 children with documented traumas that occurred before the age of 5, only four of them verbalized the contents of their dreams (19). The repeated dream apparently is very difficult to find in most traumas before the age of 5. Furthermore, these dreams often take deeply disguised forms as time progresses after the traumatic event. In those children old enough to dream and to remember their dreams, traumatic dreaming may occur at intervals several years apart or in such deeply disguised forms that the process becomes extremely difficult to distinguish from other forms of dreaming.

VISUALIZED OR OTHERWISE REPEATEDLY PERCEIVED MEMORIES

The ability to re-see or, occasionally but less frequently, to re-feel a terrible event or a series of events is an important common characteristic of almost all externally generated disorders of childhood (22). Re-seeing is so important that it sometimes occurs even when the original experience was not at all visual (22). Tactile, positional, or smell memories may also follow from long-standing terrors or single shocks. But the tendency to revisualize appears to be the strongest of all of these re-perceptions in childhood trauma. Visualizations are most strongly stimulated by reminders of the traumatic event, but they occasionally come up entirely unbidden.

The vivid and unwelcome nature of returning traumatic visualizations marks them as special to these externally generated conditions. Children tend to see their traumas and old ordeals at leisure—during times when they are bored with classes, at night before falling asleep, and when they are at rest listening to the radio or watching television. As opposed to those traumatized as adults, traumatized children rarely find themselves abruptly interrupted by sudden, dysphoric visualizations.

Even those who were infants or toddlers at the time of their ordeals and thus were unable to lay down, store, or retrieve full verbal memories of their traumas tend to play out, to draw, or to re-see highly visualized elements from their old experiences (19). In cases in which the facts of a sexual abuse are not known, for instance, children may indicate their internalized visions of the abuse by sketching what they see in their mind or acting it out almost like a movie picture. Such children may use their visual and positional senses, senses that may outlast the verbal memory itself, to draw pictures of themselves "at the most scary moments of [their] life." Of course, other posttraumatic features should be present, too, if the child actually was a trauma victim.

> Three and a half years after experiencing a series of traumatic events, a 5-year-old child was discovered (through pornographic photographs confiscated by U.S. Customs agents) to have been sexually misused in a day-care home between the ages of 15 and 18 months. The girl's parents did not dare speak to her about what they had learned from the investigators. They, in retrospect, realized that she had been sketching hundreds of nude adults beginning from the time

when she had first begun to draw.

While playing in my office, this child told me that a baby she had just drawn was "all naked" and "a bad girl." Unknowingly, she had just depicted herself. Despite the fact that the little girl's only verbal memory of the events was "I think there was grave danger at a lady—MaryBeth's—house," her volumes of drawings represented strongly visualized elements that she had retained and had needed to recreate from these very early, nonverbal experiences.

A 40-year-old mental health professional began working at a facility for male juvenile delinquents. On his long rides home he began seeing himself as a toddler—attacked in a shack by a group of older children. The man drove to the town where he had lived until he was 4 years old, and he found the shack that he had "pictured." The shack stood catercornered to his old house.

REPETITIVE BEHAVIORS

Play and behavioral reenactments are frequent manifestations of both the single blow and the long-standing terrors of childhood. Psychophysiologic repetitions are less frequently observed in ordinary practice, but they gain particular importance in certain cultures (23). Posttraumatic play, defined by the players as "fun," is a grim, long-lasting, and particularly contagious form of childhood repetitive behavior (24). Although reenactments lack the element of "fun," they also repeat aspects of the terrible events. Reenactments can occur as single behaviors, repeated behaviors, or bodily responses. Repetitive behaviors may even be seen in children who were exposed to traumatic events before the age of 12 months (19). In other words, children who have no verbal memory whatsoever of their traumas may be seen to feel physical sensations or play or act in a manner that evokes what they originally experienced at the time of the event. The 5-year-old girl described in the previous case vignette, for instance, experienced "funny feelings" in her "tummy" every time she saw a finger pointed at her. The pornographic pictures confiscated by the customs authorities showed an erect penis jabbing the very spot on the 15–18-month-old child's belly that she had indicated when, at age 5, she spoke of the "funny feelings."

The childhood survivors of single shocks and of long-standing terrors are usually entirely unaware that their behaviors and physical responses repeat something of the original set of thoughts or emergency responses. Thus, the presence or absence of behavioral reenactments may at times be better determined from interviews with third parties.

Behavioral reenactments may recur so frequently as to become distinct personality traits. These may eventually gather into the personality disorders of adulthood, or they may recur so physiologically as to represent what seems to be physical disease. Long after most repeated nightmares have disappeared into deeply disguised form, reenactments continue to characterize the behaviors of traumatically stressed children. Recent psychiatric investigation into the lives and works of important artists—Edgar Allen Poe, Edith Wharton, René Magritte, Alfred Hitchcock, and Ingmar Bergman (25), Stephen King (26), and Virginia Woolf (27)—show that these artists reenacted childhood traumas behaviorally throughout their lifetimes and also played out their traumas in artistic works spanning their entire careers. If one could live a thousand years, one might completely work through a childhood trauma by playing out the terrifying scenario until it no longer terrified. The lifetime allotted to the ordinary person, however, does not appear to be enough.

A 6-year-old girl walked into a circus tent and was suddenly attacked by a runaway lion. The animal tore open her scalp and bit into her face. The girl had to undergo several surgical procedures to repair what happened within a few seconds' time. She was left with an uneven hairline and a large bald spot. After the extraordinary experience, the little girl preferred "Beauty Parlor" to all other games of pretend. She combed her younger sister's hair repeatedly, often bringing the younger child to tears over the roughness of the combing. The little girl's dolls developed bald spots and uneven hairlines without anyone ever observing exactly how these anomalies came into being. The child, previously outgoing and friendly, stuck close to home and rarely ventured out into her neighborhood. At age 6, her main hopes for the future were to grow up and become a runway model or a "beauty parlor lady."

TRAUMA-SPECIFIC FEARS

Some of the specific fears related to the shocks and long-standing extreme external stresses of childhood can be avoided by moving out of town or by changing houses or neighborhoods. Fears can be conditioned away by repeatedly facing the feared object, Most extremely stressed or psychically traumatized children continue to harbor one

or two trauma-related fears, however, well into adulthood. Fears of specific things that are related to experiences precipitated by traumatic events are fairly easy to spot, once one knows what the trauma might have been. This type of literal, specific fear is pathognomonic of the childhood traumas. Whereas neurotically or developmentally phobic children may fear *all* dogs, the dog-bitten youngster will fear the German shepherds, the Dobermans, or whatever species actually created the traumatic state. Whereas neurotically anxious children fear growing up or getting married, traumatized youngsters fear (and re-create) oral sex, anal intercourse, or whatever particular sexual abuse they originally experienced.

Traumatized children tend also to fear mundane items—the dark, strangers, looming objects, being alone, being outside, food, animals, and vehicles, for instance. In fact, fears of the dark and of being alone are strongly connected with sudden shocks in the early years (9). But these mundane fears may also be connected with a number of other emotional disorders and developmental stages of childhood. The panic and extreme avoidances observed following terrifying events, in connection with this mundane group of fears, do make them important to childhood trauma. But the specific, literal kinds of fear noted in the preceding paragraph almost "label" the traumatic condition. When one sees this literal kind of fear lasting throughout the years despite the natural tendencies toward spontaneous desensitization, childhood trauma is the most likely cause.

A girl was sexually misused by her father from age 5 to age 15, at which time she ran away from home, never to return. As a married adult of 38, she feared sex with her husband unless she initiated the act herself. She responded to the female-on-top or side-to-side positions, positions that had not originally been taken by her father. Any sexual positioning that was evocative of the incestuous set of sexual postures stimulated fear, pain, and revulsion.

CHANGED ATTITUDES ABOUT PEOPLE, LIFE, AND THE FUTURE

The sense of a severely limited future, along with changed attitudes about people and life, appears to be important in the trauma and extreme stress disorders originating in childhood. The limitation of future perspective is particularly striking in traumatized children because ordinary youngsters exhibit almost limitless ideas about the future. Truisms, such as "I live one day at a time" or "I can't guess what will happen in my lifetime," come from the rethinkings that occur in the years after traumatic events. Ideas such as "You can't trust the police" or "You can't count on anything or anyone to protect you" also follow from single and long-standing, repeated traumas. Sexually traumatized girls may shrink away from men or accost them with overfriendly advances. Part of this behavior is reenactment, but part reflects attitudinal changes. Limitations in scope and future perspective in childhood trauma victims seem to reflect the ongoing belief that more traumas are bound to follow. Traumatized children recognize profound vulnerability in all human beings, especially themselves. This shattering of what Lifton and Olson call "the shield of invincibility" (28) and what Erikson terms "basic trust" and "autonomy" (29) appears to characterize almost all event-engendered disorders of childhood. The feeling of futurelessness of the traumatized child is quite different from that of the depressed youngster. For the traumatized, the future is a landscape filled with crags, pits, and monsters. For the depressed, the future is a bleak, featureless landscape stretched out to Infinity.

A 17-year-old boy, searching for a freeway shoulder on which to stop his disabled car, was hit from the rear by a speeder. The boy's automobile exploded. He flew out completely unscathed but watched helplessly as his best friend burned to death in the passenger seat.

For months after the event the boy could not work and spent most of his days moping. He was plagued with bad dreams and fears of further disaster. He began psychotherapy; and when I said to him at the end of an early session, "See you next week," he asked, "How do you know it will be next week? Who knows? I may die on my way out of your office. I may be killed out there on the sidewalk. I don't count on seeing you next week. I live day to day—day to day."

A 15-year-old girl came for psychiatric treatment because, since she was attacked at age 8, she had failed to volunteer or speak up in class. Since her acceptance in an academic high school, she could achieve no more than Bs because she was too quiet.

The girl had experienced significant changes in her attitudes about life and people while she was lying in a hospital room for 3 months, following repairs to her vagina, anus, and peritoneum. A man had grabbed her from a Chinatown sidewalk on her way

home from school. He had taken her into an abandoned garage and attacked her vagina with a pair of chopsticks. The girl had decided after her ordeal that she was "chosen" by the deranged man because she had "showed too much." Never again, she had vowed to herself, would she ever "show." People could not be trusted, she believed. Life must be endured, not savored.

FEATURES CHARACTERISTIC OF THE SINGLE-BLOW TRAUMAS, TYPE I DISORDERS

The type I traumatic conditions of childhood follow from unanticipated single events. These are classical childhood traumas by Anna Freud's definition (30). These are also the most typical posttraumatic stress disorders that one finds in childhood, usually meeting the criteria of repetition, avoidance, and hyperalertness that represent the major divisions in our diagnostic manual, DSM-III-R. Those children who suffer the results of single blows appear to exhibit certain symptoms and signs that differentiate their conditions from those resulting from the more complicated events. The findings special to single, shocking, intense terrors are 1) full, detailed, etched-in memories, 2) "omens" (retrospective reworkings, cognitive reappraisals, reasons, and turning points), and 3) misperceptions and mistimings. Type I traumas do not appear to breed the massive denials, psychic numbings, self-anesthesias, or personality problems that characterize the type II disorders of childhood.

FULL, DETAILED MEMORIES

With the exception of youngsters below the approximate age of 28 to 36 months, almost every previously untraumatized child who is fully conscious at the time that he or she experiences or witnesses one terrible event demonstrates the ability to retrieve detailed and full memories afterward (19). Verbal recollections of single shocks in an otherwise trauma-free childhood are delivered in an amazingly clear and detailed fashion. Children sometimes sound like robots as they strive to tell every detail as efficiently as possible. As a matter of fact, children are sometimes able to remember more from a single event than are the adults who observed the same event (24). A few details from a traumatic event of childhood may be factually wrong because the child initially misperceived or mistimed the sequence of what happened. But children with type I disorders seem to remember the event and to give impressively clear, detailed accounts of their experiences.

This remarkable retrieval of full, precise, verbal memories of almost all single-blow traumas makes one conclude that these memories stay alive in a very special way, no matter how much conscious suppression the traumatized child is attempting. Memories of prolonged or variably repeated childhood abuses, on the other hand, appear to be retained in spots, rather than as clear, complete wholes (19). Amnesias, as a matter of fact, are often reported in children who seem to be heading for the multiple personality disorders of adulthood (31). Children who have been repeatedly physically or sexually abused may waver in their accusations of abusers and waver in the completeness and the detail of their memories. But children who have been traumatized a single time do not often forget. As Malle says at the conclusion of his autobiographical film, *Au Revoir les Enfants* (1987), a tale of a single, terrible event from his boyhood in occupied France, "Over forty years have passed, but I will remember every second of that January morning until the day I die."

The first time that he visited the psychiatrist, a 5-year-old boy minutely described his stepfather's murder of his baby brother. The incident had occurred 2 weeks earlier. The boy knew just where under the television table in a motel room he had been hiding. He reported exactly where he had been sitting and lying before taking cover. He described the types of blows that fell upon his younger sibling and meticulously repeated the attacker's phrases and threats. He said that he had been trying to forget all of this but could not. The boy's teacher had been reprimanding him for repeatedly hiding under the desks and tables at school, but neither teacher nor student recognized the significance of this "bad behavior."

OMENS

During and after single-blow shocks, children tend frequently to ask themselves "Why?" and "Why me?" In this way they attempt to gain retrospective mastery over the randomness, the lack of control, and the "less-than-humaneness" of the trauma that they endured. When children traumatized by a single event belatedly develop a reason why everything happened, a purpose to the entire affair, or a way that the disaster could have been averted, considerable mental energy goes into these reworkings of the past. I have termed these belated

reshiftings, reasons, and warnings "omens" (17), while Pynoos et al. call them "cognitive reappraisals" (11). I believe that we are describing the same phenomenon. This kind of rethinking and reworking occurs much more often after one sudden external shock than it does after a prolonged series of terrible experiences. Children who have found omens or reasons to explain why they suffer often feel intensely guilty. Although victims of type II childhood trauma also experience profound guilt, the sense of guilt does not often consciously align itself to the "Why me?" question. The repetitions and long-standing nature of the type II stressors make the inquiry "How could I have avoided it?" far less pressing than the question "How will I avoid it the next time?"

The omen or cognitive reappraisal is a belated way in which the singly traumatized child tries to deal retroactively with what had been entirely unexpected—a sudden, surprising psychological blow. Because repeated horrors encourage a sense of anticipation and expectation, different means of coping come to be employed. These means of coping eventually create the defining characteristics of the type II disorders, characteristics that are unmatched in the type I disorders.

An 8-year-old boy's mother bought him a fancy skateboard, admonishing him to ride only on the sidewalk. The first Saturday morning the boy rode his skateboard on the sidewalk, he was run over by a car backing out of a neighbor's driveway. The boy commented a year later, "I can't help thinking many, many times about what Mom said about riding skateboards on sidewalks."

A 16-year-old girl received a slice of pizza from her best friend as a birthday present. Biting into the pizza, she was poisoned by a corrosive toxin. The girl suffered from internal injuries for more than 6 weeks. Even though the real source of the poison was found by health officials at the pizza parlor, the injured girl thought again and again about the nature of her relationship with the friend who had purchased the pizza. In minutest detail she tried to figure out at what point her friend had decided to kill her.

MISPERCEPTIONS

Misidentifications, visual hallucinations, and peculiar time distortions often occur to children who have experienced single, intense, unexpected shocks (22, 32). In contrast to this, the long-standing, extreme external stresses that affect children are often engineered by perpetrators known to them—caretakers, teachers, or family members, for instance. Because of a child's familiarity with such perpetrators, the chances of early misperceptions become slim. Two important exceptions to this general rule are when a type II victim thinks that he or she "sees" a once-familiar abuser years after losing track of the person and when a known, long-standing perpetrator was never perceived correctly by the child because of a disguise that he or she was wearing (as in Satanism and cults).

Many of the type I childhood traumas include visual misperceptions and hallucinations. These perceptual distortions may seem to indicate organic mental conditions or psychoses, but a few bizarre sightings do not "make" a brain disorder or a schizophrenic episode. Visual hallucinations and illusions are observed in children shortly after traumatic events and, at times, long after sudden, unanticipated shocks. Massive releases of neurotransmitters in the brain at the time of the terror may account for these problems with perception. But the types of substances and mechanisms are, as yet, unknown.

A 7-year-old girl rode in a station wagon alongside her sister and two cousins on a family outing to the mountains. A loose boulder from an adjacent hillside smashed into the roof of the girl's car, killing one cousin and the girl's older sister, while sparing the girl and her other young cousin. For the ensuing year, the surviving girl "saw" her sister at her bedside almost every night. The dead sister visited the living child dressed in pink, green, and orange outfits. She appeared fully fleshed, as she was in life. The vision said nothing. The young survivor felt upset by a sense of menace emanating from her sister's "ghost," yet, at the same time, she felt oddly comforted by the sight.

FEATURES CHARACTERISTIC OF VARIABLE, MULTIPLE, OR LONG-STANDING TRAUMAS, TYPE II DISORDERS

Type II disorders follow from long-standing or repeated exposure to extreme external events. The first such event, of course, creates surprise. But the subsequent unfolding of horrors creates a sense of anticipation. Massive attempts to protect the psyche and to preserve the self are put into gear. The defenses and coping operations used in the type II disorders of childhood—massive denial, repression, dissociation, self-anesthesia, self-hypnosis, identifi-

cation with the aggressor, and aggression turned against the self—often lead to profound character changes in the youngster. Even though a repeatedly abused youngster may not settle into a recognizable form of adult character disorder until the late teens or early twenties, extreme personality problems may emerge even before the age of 5.

The emotions stirred up by type II traumas are 1) an absence of feeling, 2) a sense of rage, or 3) unremitting sadness. These emotions exist side by side with the fear that is ubiquitous to the childhood traumas. Type II disorders, under the scrutiny of able mental health professionals, may come to be diagnosed in childhood as conduct disorders, attention deficit disorders, depression, or dissociative disorders. Recognition of the expanded group of traumas that I am suggesting here may help to define a common etiology and range of findings for many of these childhood conditions. Of course, if a child originally was traumatized, one would expect to find vestiges of the repeated visualizations, repeated behaviors and physiologic sensations, specific fears, and revised ideas about people, life, and the future that appear to characterize the childhood traumas.

DENIAL AND PSYCHIC NUMBING

Denial and psychic numbing have long been considered classic findings of the posttraumatic stress disorders. Diagnostic problems often arise, however, because massive denial and emotional shutdown are so often evanescent or absent in children who have gone through single shocks (17). Although conscious suppression of thoughts will take place in any kind of trauma, and although brief, limited denial and numbing may last from moments to hours after a shocking event, massive denial and psychic numbing are primarily associated with the long-standing horrors of childhood, what I would call the type II traumas. Children who experience this type of stress may employ such extreme numbing and denial that they look extremely withdrawn or inhuman. When very young, they may assume the guise of Spitz's "hospitalism" babies (33) or of "hail fellow well met" superficiality (34), both of which are signs of failure of attachment and of personality organization.

Children who experience type II traumas do not complain of going "numb." The sense of going dead is one that depends upon years of subjectively knowing what it was to feel alive. On the other hand, children who have been repeatedly brutalized or terrorized do exhibit massive denial to the eyes of the trained observer. Such children avoid talking about themselves. They often go for years without saying a thing about their ordeals. They valiantly try to look normal at school, in the neighborhood, and on the playground. They may tell their stories once or twice and entirely deny them later. (This is quite different from some children who have experienced type I traumas, who may tell their stories even at kindergarten Show and Tell.)

Children who experience type II traumas often forget. They may forget whole segments of childhood from birth to age 9, for instance. Where one sees the difference between these "forgetful" children and ordinary youngsters is in the multiply traumatized child's relative indifference to pain, lack of empathy, failure to define or to acknowledge feelings, and absolute avoidance of psychological intimacy. Repeatedly brutalized, benumbed children employ massive denial—and when their denial-related behaviors cluster together, the resultant childhood personality disorder (one that cuts across adult narcissistic, antisocial, borderline, and avoidant categories) is massive.

Profound psychic numbing in children occurs as an accommodation to the most extreme, long-standing, or repeated traumatic situations. Childhood physical and sexual abuse represent two of these extremes. What still makes the underlying idea of "trauma" the correct etiology and pathogenesis here is the fact that the specific fears, the repeated play, the behavioral and physiologic reenactments, the tendencies toward visualizations, and the revised ideas about life, people, and the future seem to persist in so many of these children for years after the last abuse stops.

> Suzanna was 6 years old when her teenaged brother began sexually molesting her. (It turned out that he, in turn, had been sexually molested by a junior high school teacher before he began abusing Suzanna.) Suzanna once tried to tell her mother, "Nobody's supposed to touch you in your—" (she pointed at her genitals). But after that she said nothing further to her parents, teachers, or friends until the school nurse discovered what was happening 2 1/2 years after it began.
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> On psychiatric examination when she was age 9, Suzanna spent much of the first hour pushing her index finger back and forth through a small hole she had made with the rest of her fingers. She repeatedly rubbed the loose couch pillows over one another. She said of her experiences with her brother, "He put his penis where I pooped. It hurt. I told him it hurt, but he said nuttin' back. I didn't like that at all. It didn't really frighten me.

Not really. I just made up my mind to think about other things."

When Suzanna was asked how she was able to do this mind trick, "to think about other things," she replied, "I say 'I don't know' over and over to myself. When I say my prayers I keep saying the last word of the prayer. Sometimes I do it a hundred times. I say 'I don't know' a lot of times in my mind each day.... Sometimes now I find myself not feeling things. I don't feel sad or mad when I should be. I'm not afraid when I should be. I act silly and crazy a lot. The people at my school think I'm funny because of it."

SELF-HYPNOSIS AND DISSOCIATION

Spontaneous self-hypnosis, depersonalization, and dissociation are important outcomes of repeated, long-standing terrors (the type II traumas). Children who have been the victims of extended periods of terror come to learn that the stressful events will be repeated. Some of these children, the ones, perhaps, who have an innate ease of hypnotizability, spontaneously fall upon the technique of self-hypnosis. This mechanism enables a child mentally to escape. Suzanna, the child described in the previous paragraph, used the repetition of a single word, the last word of her prayers, to accomplish this escape from pain and worry. She also lulled herself into mini-trances by saying "I don't know" in her mind. The children at school recognized her affect to be unusual. But nobody but the child herself could recognize the self-hypnosis.

Traumatized children who use a great deal of self-hypnosis may, in fact, go on to develop adult multiple personality disorders (35). This is probably a rare condition. Spontaneous dissociation, however, accounts of a number of more commonly observed findings in abused children—bodily anesthesias, feelings of invisibility, and amnesias for certain periods of childhood life.

Multiple personality disorder, a syndrome in search of its own place in our diagnostic manuals, belongs here, at least in terms of etiology—the repeated, extreme, long-standing traumas of childhood. In children, periods of time that cannot be accounted for, problem behaviors, visual and auditory hallucinations, and headaches appear to indicate that the child is suffering from multiple personality precursors (36). Most self-hypnotizing children who are type II trauma victims fall short of the multiple personality or precursors diagnoses, however. They develop, instead, anesthesias to bodily pain, sexual anesthesias, and extreme emotional distancings. Children who come to expect the repetition of terrors remove themselves in any way that they can. These emotional removals are not possible for the ordinary type I trauma victim.

Frederick was 7 years old when he was sent to live with his aunt because his mother found out, through a tape recording set up to catch her husband at infidelity, that Frederick's stepfather had been throwing him against walls while she worked the evening shift. Frederick did not tell anyone his year-long story, despite two visits to the emergency room and one neighbor-instigated protective service investigation.

While in his aunt's custody, Frederick glanced down at the playground pavement one day and saw blood. After several seconds of searching for a wounded companion, Frederick realized that it was he who was bleeding. The boy realized he could feel no pain.

In a psychotherapy session I asked Frederick how he could make this sort of thing happen. "It jus' happens now," he said. "I used to pretend I was at a picnic with my head on Mommy's lap. The first time my stepdaddy hit me, it hurt a lot. But then I found out that I could make myself go on Mommy's lap [in imagination], and Winston couldn't hurt me that way. I kept goin' on Mommy's lap—I didn't have to cry or scream or anything. I could be someplace else and not get hurt. I don't know how many times Winston punched me out. I wasn't always payin' attention. Like I told you, first I'd be at a picnic on Mom's lap. Later I didn't have to think of no picnic—just her lap. Now if somethin' makes me bleed, I don't think of no lap at all. I jus' don't feel no pain."

Jamie was repeatedly abused by his alcoholic father. He had also repeatedly observed his father beat his mother. At age 8, he witnessed his mother shoot his father to death. When he was 9, the child was psychologically evaluated. At that time he told me, "I started some planets. I made my planets up as a game. But it's real now. It's no game anymore." Jamie described a safe planet he had invented long ago, his own planet. He also had invented a number of very unsafe planets where people "got killed." He said that he had come to achieve invisibility by repeatedly visiting his own safe planet and avoiding the unsafe ones. "Starting when I was 6," he said, "I began to

feel invisible. When my Mom pointed a gun—at my Dad...I was thinking like 'I didn't see it,' like 'This didn't happen.' I blinked to see if I was dreaming....I remember at first pretending I wasn't there—that I didn't see it—that I was on my own planet. I had gone there a lot before. When Mom and Dad would fight, I would try not to hear, not to see. I'd try to go to sleep. Normally I couldn't. I'd try to get out of the room where they were. I'd try to visit my planet. But now my mind, yes, it just goes blank. Mostly it happens at home. A few minutes at a time."

Jamie repeatedly dreamed by night about his father's death. And he visualized the killing by day. But from the moment that his dad was shot, Jamie wondered if he himself could turn invisible. "I know I can," he said. "I do it here on earth. I do it all the time on my planet. You're just going to have to believe me. My friends believe it.... When my father was being shot I felt invisible. But if I turned invisible in front of everybody, they'd take away my powers."

RAGE

Rage, including anger turned against the self, is a striking finding in those posttraumatic disorders that are brought on by repeated or long-standing abuses, the type II disorders. One observes rage and its negative, extreme passivity, in those type II disorders originating in places where trust originally resided. Dorothy Otnow Lewis and her group reported that among adolescent delinquents who go on to commit murder, chronic physical abuse is a key finding within a cluster of several other key findings (36). The rage of the repeatedly abused child cannot safely be underestimated.

Reenactments of anger may come so frequently in the type II trauma disorders that habitual patterns of aggressiveness are established. The rage may become so fearsome to the child as to create extremes of passivity. Wild fluctuations of both active anger and extreme passivity may so dominate the clinical picture that the young person is eventually given a diagnosis of borderline personality. Defenses against rage such as passive into active and identification with the aggressor also put their own peculiar stamps on the type II child. Type II children have been known to attack their own bodies. Self-mutilations or physically damaging suicide attempts occur. The festering anger of the repeatedly abused child is probably as damaging a part of the condition as is the chronic numbing. Both of these, in fact, the numbing and rage, probably figure later in the antisocial, borderline, narcissistic, and multiple personality diagnoses that are so often part of the picture of the type II traumatized child grown up.

A 5-year-old boy whose new stepmother had been tying him with ropes and leaving him locked up in closets behaved well at kindergarten. At home, however, he took scissors to his stepmother's best lingerie. He sprinkled India ink twice into the family wash. He consistently managed not to eat the food his stepmother prepared for him. The boy's stepmother said he was asking for the punishments she gave him. And so the abuses escalated.

A 45-year-old woman had been a teenager in summer camp when the atomic bomb destroyed her home in Hiroshima. (Her immediate family was spared; all were out of town on Aug. 6, 1945.) As an adult, the woman could not get along well with her American-born husband, alternately accusing him of laziness, ineptitude at work, and infidelity. From the time her daughter turned 13, the woman began believing the girl to be promiscuous, a liar, a drug addict, and a thief. The woman could not get along with her co-workers at the international law office where she worked. She was able, she said, to relate only to customers from Japan. They reminded her "of the people [she] used to know at home when [she] was a girl." I invited the woman to come to my office to talk about her experiences with the bomb. She made two appointments for this purpose but failed to appear for either. Obviously, too much time had elapsed to prove any cause-and-effect hypothesis here. It is interesting, however, that the woman's anger and suspiciousness rested only with American and American-influenced people. Native Japanese persons, the victims, not the perpetrators of the atomic bomb, were entirely spared her wrath.

CROSSOVER TYPE I–TYPE II TRAUMATIC CONDITIONS OF CHILDHOOD

When a single psychological shock takes a child's parent's life, leaves a child homeless, handicapped, or disfigured, or causes a child to undergo prolonged hospitalization and pain, the ongoing stresses tend to push the changes in the child toward those characteristic of the type II childhood

traumas. In these cases one often finds features of both the type I and the type II conditions. Those children with permanent handicaps, long-standing pain, or loss of significant objects are often forced into making significant character changes or using numbing tricks to minimize their pain. They may still retain, however, the characteristics typical of responses to single events—clear memory, perceptual distortions, and omens.

PERPETUAL MOURNING AND DEPRESSION

Psychic shock interferes with childhood bereavement and vice versa (37). The combined psychological effects of shock and grief continue to drag on throughout childhood. As time goes by, and the childhood mourning does not proceed through its ordinary stages (38), the young trauma victim is reinjured—from the inside this time—through prolonged exposure to sadness and loss. The psychological condition of mixed mourning and trauma in youth may take the guise of major affective disorder and may have to be treated as such, at least at first. There is a high rate of depression in refugee children from brutal regimes (15, 16). An explanation for this finding may be the unresolved trauma that potentiates and extends the unresolved grief, the grief that furthers the trauma, or both.

A 4-year-old boy watched his older sister's evisceration in a freak accident in a children's swimming pool. Before the disaster she had asked him to play, but he had refused. The little girl then sat down on an exposed drain pipe. The boy spent a couple of years after the accident using wooden blocks to build his own perfect pool. He blamed himself for not agreeing to play with his sister, an act, he felt, that caused his sister's injury. The boy retained a clear memory of all of the events. He showed symptoms typical of type I trauma.

Following his sister's death in transplantation surgery 2 years after the accident, the boy began to retreat from his friends, avoid participating in class, and stay silent much of the time. His teachers complained about his extreme passivity and said he was losing ground in subjects in which he had already proved himself. He lost some weight and stopped sleeping through the night. He lost his playfulness and began losing his friends. His 2 years of mourning had introduced type II characteristics into a previously pure type I disorder.

CHILDHOOD DISFIGUREMENT, DISABILITY, AND PAIN

Children who are physically injured in psychically traumatic accidents tend perpetually to mourn old selves, personas that were previously intact and perfect. Even when perpetual grief is not the problem, posttraumatic physical handicaps frequently demand considerable personality reorganization in order that the child can live with a new, limited self. In children, character rearrangements may become massive. To deal with the pain and procedures accompanying traumatic accidents, children may employ self-hypnosis. They may experience self-revulsion, unremitting guilt and shame, impotent rage at their peers who shun and tease them, and sadness. Suicide attempts are not infrequent in this group. Robert Stoller suggested in a recent paper that some extremes of adult sadomasochistic behavior may originate in painful illnesses, injuries, and procedures during childhood. Rather than self-hypnotizing, these children may divert themselves from the pain by self-stimulating—and thus perpetually associate their pain with sexuality (39). Childhood syndromes of injury and shock do not consistently qualify, under DSM-III-R criteria, as posttraumatic stress disorders (40). But these mixed syndromes of depression, numbing, rage, and fright often carry many of the four characteristics that I associate with childhood traumas. Adjustment to a sudden surprise, coupled with a prolonged ordeal, often lies at the origin of the problem.

A kindergartner climbed onto a large department store display table, causing it to fall over onto her face as her grandmother paid the clerk for a purchase. The child's facial bones were smashed, and although they were beautifully reconstructed, she looked quite different than she had before the accident. Old friends did not recognize her, and other kindergartners told the child that she must be pretending to be Belinda—she could not actually be Belinda.

The little girl, previously outgoing, mischievous, and vivacious, took on a quiet, remote, and perfectly well-behaved mode of behavior. Two years after the accident she said, "I was a devil before, but I was punished for it. Now I'm good." Despite the fact that she experienced bad dreams, liked to play alone under chairs, and tended to mutilate her dolls' faces, Belinda's character change dominated all other posttraumatic findings.

SUMMARY

There appears to be a group of problems brought on in childhood by the experience of extreme fright generated by outside events. Some of these childhood problems are created by one external shock, and others are created by a multiplicity of blows. Untreated, all but the mildest of the childhood traumas last for years. The child's responses, in fact, may create a number of different kinds of problems in adult life. There are four characteristics, however, that seem to affect almost everyone subjected to extreme terrors in childhood. These findings seem to last and can be retrieved in histories. They include repeated visualizations or other returning perceptions, repeated behaviors and bodily responses, trauma-specific fears, and revised ideas about people, life, and the future. These four findings appear to remain clustered together in childhood trauma victims even when other diagnoses seem more appropriate. Like rheumatic fever, childhood trauma creates changes that may eventually lead to a number of different diagnoses. But also like rheumatic fever, childhood trauma must always be kept in mind as a possible underlying mechanism when these various conditions appear.

If one takes all of the disorders of childhood brought on by extreme external events and puts them into the general category of trauma, they can be roughly subdivided into two groupings: type I, which is brought on by one sudden shock, and type II, which is precipitated by a series of external blows. Crossover conditions are quite common and develop when one blow creates a long-standing series of childhood adversities.

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