Review article

Two Case Presentations with Unexpected Outcomes after Childhood Trauma

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Abstract

Bowlby developed the theory of attachment, describing it as a lasting emotional bond between human beings, manifested by seeking proximity to caregivers, especially in times of distress. Children adjust their behavior to prevent separation from their primary attachment figure – someone who provides support, protection and care. Attachment theory provides a favorable framework for understanding our two cases and their developmental paths.

We report two cases of female individuals, both of whom had a family history of psychiatric disease and experienced early parental separation with the grandparents playing significant roles in their upbringing. The two cases had radically different outcomes: one was diagnosed with schizophrenia and the other with generalized anxiety-depressive disorder. We attempt to analyze the reasons for the disparate outcomes of these two cases through the framework of numerous published studies that highlight protective and risk factors for psychiatric disease, studies that highlight the impact of traumatic events in childhood on a child's biological, psychological and social development, as well as through the lens of psychodynamic and attachment theories.

Throughout the analysis, the importance of early intervention is made clear: both through various treatment modalities and preventive measures, as well as by providing successful mental health programs directed towards the destigmatization of children with mental health problems.

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Introduction

This paper was written with several important objectives in mind. The first is to underscore the importance of understanding developmental psychiatry, i.e. the significance of grasping at least one theoretical construct (e.g. attachment theory) within the multidimensionality of development, and to highlight the use of etiopathogenesis as a foundation for approaching the emergence of psychopathology in children after childhood trauma. The second objective is to emphasize the importance of providing a concrete diagnosis in child psychiatry, primarily as a means for adequate selection of treatment, but also as an important tool in the planning of public health interventions such as preventative programs. The third is to highlight the benefits of robust support systems and early professional intervention in cases of childhood trauma.

In his 1964 book, D. W. Winnicott writes that the foundations of an adult's health are laid throughout childhood, and the foundations of human health are laid down by mothers in the first weeks and months of an infant's life. At that time, maternal love and complete dedication are absolutely necessary for the child. This is considered one of the greatest efforts for the mother. The mother is the child's first environment. The child is always seen in relation to the mother (1). This ties in with the concept of basic trust, according to Erik Erikson, which is considered the first stage in human life when the mother cares for the child. Based on that relationship the child develops trust, security and the foundation for future relationships. Otherwise, unfavorable effects may arise in later development, including feelings of alienation (2).

Winnicott wrote about breastfeeding as a secure relationship that enriches the child's emotional life from the beginning, and research by John Bowlby and Harry Harlow shifted the focus of attention from the method of feeding the child to the quality of care, nurturing and the relationship between the primary attachment figure and the newborn/infant (1).

From an evolutionary perspective, the newborn's ability to form attachment is an issue of survival. H. Harlow's experiment on monkeys demonstrated that there is no direct link between feeding and attachment; rather, early attachments result from the comfort and care provided by the caregiver (3). It was also shown that monkeys experienced separation from their mothers as traumatic, and the impoverished emotional life was transmitted transgenerationally. Harlow's discovery is consistent with John Bowlby's attachment theory. Attachment is also recognized as a risk factor (4).

J. Bowlby describes attachment as a lasting emotional bond between human beings, which manifests as seeking closeness to a caregiver, especially in uncomfortable situations. (5) Children adjust their behavior to prevent separation from the primary attachment figure – someone who provides support, protection and care (2).

Mary Ainsworth also researched attachment theory. She discusses three main styles: secure attachment, ambivalent-insecure attachment and avoidant-insecure attachment (6). Mary Main and Judith Solomon added a fourth attachment style called disorganized-insecure attachment (7). Differences in attachment styles that a child develops in interaction with the primary caregiver are a result of differences in the quality of the relationship between the primary caregiver and the child. Research shows that failure to develop secure attachment in early childhood can have a negative impact on behavior in later childhood and throughout life (8).

Attachment theory is also used to explain loneliness and romantic love (9), as well as to explain the processes of mourning and grief (10). In response to the threat of separation, children experience clinging, crying and anger. If the separation persists, withdrawal, apathy and despair occur, which are underlined by neurobiological disturbances (5, 11).

The thesis that separation from the primary caregiver is perceived as stress was also articulated by Spitz. Observing children who

grew up in foster care, he described their condition as anaclitic depression resulting from reduced social interactions. Literature on stress and trauma suggests that stress increases the need for a secure base. Any event that disrupts attachment in the child-caregiver relationship can be perceived as a threat to the loss of the primary sense of security and support, leading to significant trauma (12).

Begovac defines trauma as: "(...) an event (acute and/or series of events) that, due to its intensity, its danger to the child or someone else, its unusual nature and its suddenness or quality of surprise, disrupts the child's usual coping mechanisms and defensive mechanisms, temporarily leaving the child completely helpless" (13).

Case presentation

The following examples illustrate the complex clinical presentations of two female individuals with traumatic experiences during childhood.

The first patient was born as an only child in a nuclear family. As a child, she lived with her parents, maternal grandmother and maternal grandfather. She had a positive psychiatric family history. Her maternal grandmother suffered from depressive disorder and personality changes, while her grandfather suffered from epilepsy. Notably, the patient was not breastfed and was born with developmental hip dysplasia, for which she wore an orthosis and did not attend kindergarten. Throughout her childhood, she was described as insecure and withdrawn, seeking support and guidance. She consistently experienced criticism and verbal aggression from her grandmother. At the age of 9, her parents moved to another city due to a family conflict, and she remained living with her grandmother. They cited her vulnerability as the reason for her staying, wanting to shield her from the additional stress of adapting to a new environment until she matured. Following the separation from her parents, neurotic manifestations emerged – night terrors and enuresis, for which psychological help was sought for the first time. She lived with her grandmother and grandfather until the age of 11. Symptoms subsided until adolescence when, while on vacation at the seaside with her parents, she experienced a panic attack, followed by various obsessive thoughts, bizarre thoughts of being endangered which she had trouble suppressing, a need to check reality, and later delusional ideas and perceptual disturbances towards which she now lacked insight and critical judgment. Since the age of 16, she has been receiving regular outpatient psychiatric treatment. At 18, she was hospitalized for the first time and diagnosed with schizophrenia. Since then, she has been hospitalized several times. She developed a positive transference relationship with her psychiatrist. Multiple combinations of psychiatric medications have been tried with most being abandoned either due to side effects or inadequate treatment response. She regularly adheres to the recommended psychopharmacotherapy. She regularly attends the outpatient clinic as well as any follow-up appointments. She completed high school but has never worked in her field of study, and she is in a long-term relationship, but still relies on the care of her parents, with whom she lives.

The second patient was born as the first of three children in a nuclear family. Her father worked abroad. She had a positive psychiatric family history. Her mother briefly attended supportive psychological counseling during her childhood due to various fears, while her paternal grandmother and paternal aunt suffered from depressive disorder. Notable in the patient's early development is that she was not breastfed and did not attend kindergarten. At the age of one, she gained a younger sister, and at the age of six, a second sister. Throughout her childhood, she was described as withdrawn, calm and disinclined to take initiative. When the patient was 11, her youngest sister fell seriously ill and the mother spent most of her time in the hospital. Occasionally, the mother would visit the family. The grandmother took on the role of caregiver and cared for the older daughters. She was described as a warm, constant figure who provided support. While the mother was dedicated to caring for the youngest child, the patient began complaining of headaches.

Hospitalization of the patient to evaluate the headache was interrupted at the mother's request due to her inability to simultaneously care for all her daughters and her need to be with the youngest. Then, the mother and the patient experienced a car accident, after which the patient began having panic attacks. Two years later, she first visited a child psychiatrist for evaluation of anxious-depressive symptoms. She has been in regular psychotherapeutic outpatient follow-up since then. At one point during adolescence, she was briefly hospitalized. Throughout childhood, she was treated under the „other childhood emotional disorders" diagnosis, while in adulthood she was understood as having generalized anxiety-depressive disorder. She occasionally receives antidepressant therapy. She regularly attends college, is employed and lives alone.

Discussion

In her book Normality and Pathology in Childhood, Anna Freud states: "It is one thing to reconstruct a patient's past and trace symptoms back to their sources in early childhood, and quite another to detect pathogenic factors before they do harm; to establish the degree of normal progress of the young child; to forecast development; to intervene in manipulating the child; to study the child's parents; or, indeed, to work on the prevention of neuroses, psychoses and antisocial phenomena. For the first task, the child psychotherapist will be prepared by all recognized institutions that prepare personnel for psychoanalytic therapy, but for this second task, no such institution exists. Questions such as prognosis and prevention inevitably lead us to the study of the normal..." (14)

The importance of understanding a child's developmental trajectory and its variations in the process of emergent psychopathology is discussed in the scientific literature. The interaction of the child as an active participant in its development as well as its interaction with multidimensional factors are observed. One of the major divisions is between individual and environmental factors, as well as between risk and protective factors. The literature is focused on resilience, i.e. the child's ability to withstand adverse factors (13).

The two cases we described have similarities: both children were separated from their parents at an early age and left in the care of their grandmother. Both have mental illnesses in their family history and later developed psychological distress. However, one developed a lifelong severe mental illness with partially impaired work ability, while the other developed a mental disorder, attends college and is employed. The reasons for this are likely multifactoral and related to the complex interplay of all individual and environmental factors. Throughout this discussion, we will address some of them.

Genetic susceptibility is a recognized risk factor and is likely to have played a role in the development of psychopathology in both our cases. Family, twin and adoption studies attest to the association of genetics in numerous psychiatric disorders, including obsessive-compulsive disorder, panic disorder, major depressive disorder, bipolar disorder, schizophrenia and Alzheimer's disease (11). Genetic loci associated with schizophrenia have been identified (15). While DNA sequencing of individuals with a family history of psychiatric disease is not yet widespread, recent advances have reduced the price of whole genome sequencing to as low as $600 (16). Hopefully, with widespread adoption, at-risk children could be targeted for early therapeutic intervention.

Several meta-analyses have thus shown the positive impact of breastfeeding on later child health and development (17, 18, 19). An American meta-analysis from 2018 identified several factors for early cessation of breastfeeding: smoking, cesarean delivery, lack of dyadic attachment, and lower education and socioeconomic status of the mother (20). We can but speculate as to why our patients were not breastfed, however, the lower education and socioeconomic standing of the parents of both our patients could have played a role.

In both our cases, the primary trauma was separation of the child from its parents. During one period of their development, these children

were left in the care of their grandmother – in the first case, the parents moved to another city, while in the second, there was a physically absent father and a mother who was physically and mentally absent due to caring for another child. A higher incidence of depression has been proven in children who experienced parental absence between the ages of three and fifteen (21). Children left behind due to their parents' economic migration are at a higher risk of abuse, unintentional injuries and psycho-social problems (22).

This case illustrates how separation from the primary caregiver affected sleep and the occurrence of enuresis, as described by Begovac in his book: "Psychoanalysts view secondary enuresis as a conflict at a 'higher level' when regression occurs (the regressive position), as well as the emergence of feelings often associated with rivalry, jealousy and feelings of whether the child is loved enough" (13).

It is important to note the different relationship of the grandmother (as the de facto foster parent) to the child in these two cases. The first child presented was exposed to verbal abuse and was later described as socially isolated from peers until starting school, insecure, with reduced encouragement. She was less supported in achieving autonomy. The second child was described as calm and withdrawn, raised with a sister with whom she could socialize. The grandmother could somewhat substitute for the secure base of the mother. Both patients developed insecure attachment in childhood: the first developed disorganized, while the second developed avoidant-insecure attachment.

In the case of the first patient, who developed schizophrenia, there was a dissolution of her ego when there was conflict between the internal objects of the grandmother and the parents. Thus, the patient resorted to paranoid projection and perceived threats from everyone around her, while identifying most of all with her aggressor (the grandmother). She employed the most primitive defense mechanisms, such as psychotic denial and psychotic projection, as well as immature defenses like projection and reaction formation.

The second patient did not reshape reality but rather escaped from it, indicating neurosis. This patient developed generalized anxiety and depressive disorder in adulthood. Her ego attempted to neutralize anxiety through defense mechanisms such as repression, reaction formation and denial. Later in life, she also employed more mature defense mechanisms such as sublimation, suppression and humor.

Therefore, the treatment approaches for these two patients were different. The first patient underwent supportive psychotherapy along with polypharmacy (antipsychotics, mood stabilizers, anxiolytics and antidepressants). Family psychoeducation was also implemented. This is in line with a 2021 meta-analysis that found that family interventions, family psychoeducation, cognitive behavioral therapy, patient psychoeducation, integrated interventions and relapse prevention programs were superior to standard care alone (usually maintenance treatment with antipsychotics) in preventing relapses in schizophrenic patients at 12 months (23).

The second patient received psychodynamic psychotherapy with occasional pharmacological treatment using only antidepressants.

A meta-analysis showed that children who are exposed to abuse within the family or community have an increased risk of developing various psychological and behavioral difficulties. However, some demonstrate resilience or adaptive functioning, which includes protective factors such as self-regulation, family support, support from the school system and friends (24). As the first patient was subjected to constant verbal abuse by the grandmother and lacked a robust support system, we consider it highly likely that this contributed to the eventual development of the disease.

Also important is the support system that a child has access to after a traumatic event has occurred (12). Children placed with kinship caregivers, compared to those who are not, have better outcomes in terms of behavior,

psychological functioning and feelings of stability (25). One study also suggests that social support is directly related to fewer trauma-related symptoms, especially in adolescents who have not experienced sexual abuse (26). Positive impacts of psychological therapies, particularly cognitive-behavioral therapy, in treating PTSD in children lasting longer than a month have been demonstrated. Identifying risk and protective factors in children who have experienced traumatic events in childhood is important for creating preventive programs and facilitating early interventions by professionals (27).

In childhood and adolescence, there is a delicacy in the approach to the diagnosis of mental disorders. The physician makes the diagnosis, although communication between the physician and the parents about the child's diagnosis is paramount. Sometimes more time is required to make a diagnosis; sometimes a transient mental disorder is at play; sometimes a specific type of therapy is needed to support a diagnosis that may not be definitive. However, defining the diagnosis in child psychiatry is important for scientific research on mental disorders, for therapy and treatment, for the protection of mental health of children and adolescents. Diagnosis involves recognizing the mental disorder with its etiology, course and treatment. Other professionals besides child psychiatrists participate in multidisciplinary diagnostics: pediatricians, primary care physicians, school doctors, psychologists, speech therapists, educational rehabilitators, social workers, etc. Providing a diagnosis to a child enables appropriate multimodal therapy. This treatment approach includes pharmacotherapy, psychotherapeutic and supportive measures for the patient and their family, as well as social therapy. Treatment is sometimes multidisciplinary and involves other professionals (13).

Although the evidence base with regard to trauma therapy in children is not yet strong (mainly due to the unsatisfactory quality of many treatment studies) and treatment guidelines are inconsistent, the evidence clearly suggests that psychotherapy is the first treatment of choice. Medication may be used as a second line if psychotherapy is not available or if the child has a comorbid condition (28).

Conclusion

In childhood and adolescence, there is a delicacy in the approach to the diagnosis of mental disorders that primarily aims for adequate treatment. Various modalities of diagnosis and treatment are used in this process, with psychosocial methods (including psychotherapy) being the cornerstones.

It is known that parents play a crucial role in the treatment and rehabilitation of the child, but in their absence, primary caregivers become pivotal, while professionals and society are there to support them.

The importance of developing and rigorously testing preventative programs cannot be overstated. We suggest a widespread implementation of preventive measures based on interventions aimed at developing secure attachment in children with insecure attachment styles and risk factors such as childhood trauma, heredity and lower socioeconomic status, with an emphasis on early involvement of child psychiatric specialists in patients that show symptoms of psychosis. Special attention should be directed towards the destigmatization of children with mental health problems, providing them with support to realize their potential in life. By investing in the mental health of children, we invest in the future.

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Dva prikaza slučaja s neočekivanim ishodima nakon traume u djetinjstvu

Sažetak

Bowlby je razvio teoriju privrženosti, opisujući je kao trajnu emocionalnu povezanost među ljudima, koja se manifestira traženjem blizine skrbnika, osobito u trenucima stresa. Djeca prilagođavaju svoje ponašanje kako bi spriječila odvajanje od primarne figure privrženosti – osobe koja pruža podršku, zaštitu i njegu. Teorija privrženosti pruža povoljan okvir za razumijevanje naša dva slučaja i njihovih razvojnih putova.

Izvještavamo o dva slučaja žena, obje s obiteljskom poviješću psihijatrijskih bolesti i koje su doživjele rano odvajanje od roditelja, pri čemu su djed i baka igrali značajne uloge u njihovom odrastanju. Ova dva slučaja imala su radikalno različite ishode: jednoj je dijagnosticirana shizofrenija, a drugoj generalizirani anksiozno-depresivni poremećaj. Pokušavamo analizirati razloge za različite ishode ovih dvaju slučajeva kroz okvir brojnih objavljenih studija koje ističu zaštitne i rizične čimbenike za psihijatrijske bolesti, studije koje naglašavaju utjecaj traumatskih događaja u djetinjstvu na biološki, psihološki i socijalni razvoj djeteta, kao i kroz leću psihodinamičkih i teorija privrženosti.

Kroz analizu postaje jasno koliko je važna rana intervencija: kako kroz različite modalitete liječenja i preventivne mjere, tako i kroz osiguravanje uspješnih programa mentalnog zdravlja usmjerenih prema destigmatizaciji djece s problemima mentalnog zdravlja