
Consequences of complex trauma experienced in childhood on mental and physical health -A descriptive study of subjects who visit the psychological assistance center "University of Blida 2"-

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Abstract:

The developmental perspective in understanding prolonged and repeated traumas during childhood is an important perspective in understanding the personal traumas that occurred during childhood on the child's development, especially building his identity and adaptive abilities. This perspective confirms that these effects are greater because these traumas usually occur in The heart of the child's meaningful interpersonal relationships, such as parents or other caregivers.

It should be remembered that PTSD was first coined to recognize the clinical condition of an adult who, at the time of trauma, most likely had significantly higher personal resources than those of a child, particularly with regard to emotion regulation, cognitive skills, and coping. The response to chronic and repetitive psychological trauma is not summed up in a set of conditioned responses to the traumatic event (post-traumatic stress disorder), but rather is translated into a non-adaptive path of development at the neurological, psychological, social and cognitive levels.

Through this research paper, we tried to shed light on the consequences and effects of the complex traumas experienced by a group of subjects who came to the Psychological Assistance Center - University of Blida 2 - for examination, and who numbered 45 individuals, ranging in age from (8 to 42 years). And those who lived through cumulative, i.e. long and repetitive traumatic experiences (physical assault, sexual assault, neglect, or emotional abuse), where these repercussions appeared starting from post-traumatic stress disorder as a clinical form of the classic forms of the development of psychological trauma to 8 other forms of these consequences (1 Dissociation, 2 Relational problems and attachment problems, 3 Injury to identity and self-concept, 4 Somatization and physiological and biological problems, 5 Cognitive problems related to learning, 6 Problems in regulating emotions and alexithymia, 7 Cognitive distortions, especially with regard to understanding the world, 8 Behavioral problems)

Keywords: Complex Trauma, Childhood Development, Psychological Consequences.

1- The problem:

In their work, both Terr and Herman highlighted the importance of a developmental perspective to better understand the effects of prolonged and repeated trauma during childhood. Herrmann describes, in particular, how personal traumas experienced during childhood affect the child's development, particularly the building of his identity and his abilities to relate, and asserts that these influences are even greater because these traumas are usually at the center of the child's meaningful personal relationships, such as parents or caregivers. This developmental perspective on trauma has been at the core of many studies and writings over the past 20 years. In the 1990s and 2000s, many

researchers and clinicians realized that trauma, as conceived in the Diagnostic and Statistical Manual of Mental Disorders, only partially describes children's experience. At the time, documentation of psychological processes came mainly from studies of adult samples, many of whom had been subjected to sporadic trauma. These studies, which are highly relevant to understanding the effects of trauma and the neurobiology of stress, are not very informative of the effects of traumatic stress on developmental processes. These studies also provide very little information about the effects of traumatic stress when the source of the stress is a parent or other caregiver who is necessary for normal development, including the acquisition of skills to manage stress..

It should be remembered that PTSD was first formulated to recognize the clinical status of adults who, at the time of trauma, most likely had much higher personal resources than those of the child, particularly in terms of regulating emotions, cognitive skills and adapting strategies. Also, the traumas experienced by these adults rarely involve people who are responsible for their care or who are responsible for providing them with the necessary support for them to function properly. Conversely, personal trauma that occurred during childhood reveals a child whose adaptive abilities are much lower than those of an adult.

The response to chronic and recurrent trauma is therefore not summed up in a set of conditioned responses to the traumatic event, as seen in post-traumatic stress disorder, but rather translates into an adaptive path of development at the neurological, psychological, social and cognitive levels. Ford et Courtois (2013) argue that repeated activation of the stress response facilitates the development of a life-oriented brain ("survival brain") at the expense of a brain oriented to discovery and learning ("learning brain"). While the learning brain promotes openness, exploration, and discovery of the environment, the survival brain is geared toward vigilance, anticipation, prevention, and protection from potential threats. Although the survival brain is very adequate in certain circumstances, very few situations (including social situations) require such a response on a daily basis. Therefore, children and adolescents who grow in survival mode have more difficulty adjusting to daily activities and maintaining rich and healthy relationships with others. This type of life-sustaining brain stains all their experiences, often recognizing the potential dangers in them, and fear is the most prominent emotion at the heart of these experiences and mobilizes all available resources.

Herrmann proposes adding a new diagnosis to the Diagnostic and Statistical Manual of Mental Disorders, Complex Post-Traumatic Stress Disorder (PTSD-C), which she considers more suitable for repetitive and prolonged trauma. With this proposal, and the addition of the term complex, Herrmann wants to highlight the complexity, variety, multiplicity and heterogeneity of symptoms found in trauma victims. The diagnosis formulated revolves around the following seven criteria: 1) exposure to a prolonged traumatic event, 2) changes in the regulation of emotions are observed, 3) awareness, 4) in self-perception, 5) in aggressor perception, 6) in relationship with others, and 7) in beliefs.

Although it is widely recognized that abuse is painful, the majority of abused children do not develop PTSD. However, many abused children appear to face significant difficulties, as evidenced by the variety of mental disorders diagnosed in abused children and adolescents. These disorders include provocative defiant disorder, depression, attention deficit hyperactivity disorder, phobia disorders, reactive attachment disorder, and separation anxiety disorder (D'Andrea et al., 2012; van

der Kolk, 2009). In addition, many children who have been abused during their lifetime (and sometimes simultaneously) accumulate two, three, four or more distinct diagnoses, which clearly raises many questions about the importance of PTSD to describe the difficulties faced by traumatized children .

This multiplicity of diagnoses may reflect the absence of a true developmental perspective on trauma in the Diagnostic and Statistical Manual of Mental Disorders. For van der Kolk (2005), the fact that the child receives many diagnoses complicates the work of evaluation and intervention with this child, leading to the selection of a disjointed intervention strategy and eliminating the hypothesis that the child's difficulties are caused by developmental trauma. This lack of a developmental perspective of trauma led a group of doctors, researchers and physicians to formulate a new diagnosis, developmental trauma disorder (DTD) (van der Kolk, 2005; van der Kolk et al., 2009), presented as more appropriate to take into account the difficulties faced by traumatized children and adolescents. This proposal is very conceptually close to DESNOS. However, it is suitable for children and adolescents and was formulated in the first decade of the twenty-first century in anticipation of its inclusion in the Diagnostic and Statistical Manual of Mental Disorders-5, and then in preparation. The document definition document is based on five main criteria:

1. Exposure during childhood or adolescence to multiple or long-term trauma.
2. Difficulties in physiological and emotional regulation.
3. Difficulties in regulating attention and behaviors.
4. Difficulties in organizing social relations.
5. Identity problems and traumatic symptoms such as those seen in PTSD.

There are some differences in the way authors define complex trauma (but, in general, there seems to be a certain consensus, either the term complex trauma refers to the dual reality of 1) prolonged exposure to particularly pervasive trauma situations (such as domestic violence), and 2) the multiplicity of negative effects of this exposure as well as its lasting impact on performance. In addition to these elements, there are two traits inherent in complex trauma that explain, at least in part, the cause of The impact of the complex trauma is sharply and permanently. On the one hand, we note the personal (and relational in general) nature of traumatic events or situations specific to complex traumas; on the other hand, the fact that these traumas occur during major periods of development.

Complex trauma has the advantage of recognizing a variety of situations as potentially painful (especially for a child), as well as multiple forms of adaptation (or maladjustment) to trauma. It is part of the perspective of developmental psychopathology, recognizing that the nature of trauma depends on a range of factors and that the developmental outcomes that result from trauma are a function of the interactions or coefficients between the characteristics of trauma, those of trauma. Although this phenomenon is increasingly empirically studied and discussed at the clinical level, identifying the repercussions of complex trauma poses many challenges. First, experiential support typically deals with one or more forms of personal trauma experienced by children (e.g., physical abuse, sexual abuse, neglect, or emotional abuse), without explicitly referring to the concept of complex trauma. Second, the associated ramifications are difficult to identify because they span a wide range of impacts covering multiple areas of youth growth. In addition, the clinical picture varies from person to person, affecting experimental documentation in a single study. In addition, the repercussions of complex trauma intersect and interact with each other, affecting the

overall functioning of the individual. However, the constellation of serious and lasting consequences, documented after the personal trauma suffered in childhood, goes beyond post-traumatic stress disorder and that may manifest itself in psychological, social, biological, and cognitive difficulties.

Based on all of the above, this paper attempts to explore the consequences and effects of complex trauma experienced in childhood on the psychological and physical levels of 45 examinees who frequent for psychological examination to the Center for Psychological Assistance - University of Blida 2 That is why we wonder what are the consequences of complex trauma on the psychological and physical levels of the examinees who frequent the Psychological Assistance Center for psychological examination?

2- Research objectives :

This aims of this study are : - Detection of the consequences of complex trauma for the subjects who frequent the psychological assistance center on the psychological and physical levels.

- Disclosure of the type of traumatic events they were exposed to in childhood, which were the cause of the complex trauma they experienced during this period.

3- Research Methodology:

Approach: Since this research paper aimed to explore the consequences of complex trauma on the psychological and physical health of the subjects who frequent the psychological assistance center, the appropriate approach is the descriptive one.

- Research sample: The research sample consists of 45 cases that used to come to the Psychological Assistance Center for psychological examination, of both sexes (25 females and 20 males) between the ages of (8 to 42 years), and the following is the distribution of the sample by gender and Age:

Table 1 Distribution of the sample by gender :

Sex	Frequency	Ratio
Female	25	55,55%
Male	20	44,44%

We note from Table (1) that the distribution of the sample was heterogeneous in terms of gender, as the percentage of females reached 55.55%, while males reached 44.44%.

Table 2 represents the distribution of the sample according to age groups

Age	Frequency	Percentage
8-12	2	4,44%
13-18	3	6,66%

19-25	13	28,88%
26-35	17	37,77%
36-45	10	22,22%

4- The results of the study:

Since this research is of an exploratory nature, its objectives revolved, as we have seen previously, on detecting the consequences of complex trauma among the examiners who frequent the psychological and physical assistance center and revealing the type of traumatic events they were exposed to in childhood, which were the cause of the complex traumas they experienced during this period. Between them and the effects of complex psychological trauma on the psychological and physical level in this sample:

Table (3) Distribution of Sample Members by Reason for Psychiatric Examination

Reason for checking	Frequency	Ratio
Depression	31	68,88%
PTSD	9	20%
Panic disorder with/without phobia of large areas	35	77,77%
Obsessive-compulsive disorder	10	22,22%
Dissociation disorder	5	11,11%
Psychoanaorexia	2	4,44%
Social phobia	6	13,33%
Phobia of large spaces	5	11,11%
Learning difficulties	2	4,44%
Behavioral	5	11,11%

problems		
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We note through Table 3 that depression was one of the most reasons for requesting examination among the sample members by 68.88, followed by TPA disorder by 77.77% and PTSD by 20%, followed by anxiety disorders in fourth place by 22.22% for obsessive-compulsive disorder, 13.33% for social phobia and 11.11% for phobia of large places, while disintegration disorder and behavioral problems were 11.11%, but these results related to the reasons for the examination did not reveal the truth of the consequences left by complex trauma. The sample members suffer from it since childhood.

- In order to explore the second objective of this research, which is to reveal the type of traumatic events that the research sample was exposed to in childhood, which were the cause of the complex traumas they experienced during this period, the frequencies and ratios were used as follows in the table:

Table (4) Distribution of Sample Members by Types of Recurrent and Protracted Shock Events

Types of traumatic events	Frequency	Ratio
Treatment by family members or the community	45	100%
Sexual harassment	23	51,11%
Rape	22	48,88%
Domestic violence	40	88,88%
Terrorist violence	2	2,44%

We note through Table 4 that all respondents experienced long and repeated traumatic events during childhood, and among the most frequent among the sample members, we find ill-treatment within the family (or outside the family) by 100%, which ranged between verbal and physical violence, followed directly by domestic violence, especially between parents by 88.88%, then sexual harassment, which was repeated for a long time and inside the family home by 51.11%, followed by the event of repeated rape always inside the family home by 48%. Finally, terrorist violence, which was less frequent among respondents by 4.44%

Through our reading of the results of this table, we noticed that the common characteristic between these traumatic events is their occurrence within the boundaries of the family home and by adult individuals of importance to the sample members, in addition to their recurrence for a relatively long period compared to known large traumatic events that are limited in time.

-To find out the consequences of complex trauma experienced in childhood on the psychological and physical levels, frequencies and ratios were used as shown in the following table:

Consequences of complex trauma	Frequency	Ratio
Dissociation disorder	35	77,77%
PTSD	20	44,44%
Relationship and other attachment problems	45	100%
Identity and self-image disorders	45	100%
Physical diseases (somatization)	45	100%
Cognitive and learning difficulties	45	100%
Difficulties in managing emotions and alexithymia	45	100%
Behavioral problems	45	100%
Difficulties in rationalization	45	100%

Through the frequencies and percentages shown in the table above, it was found that the consequences of complex trauma experienced in childhood were distributed in order from the highest to the lowest percentage..as we recorded a ratio of 100/100 in the presence of consequences represented in relational and other problems of attachment..as well as disorders in identity and image The self... physical illnesses and learning difficulties, in addition to difficulties in managing emotions, behavioral problems, and mental difficulties... along with other consequences represented in dissociation disorders with a percentage of 77/. And in the last PTSD, where the percentage was 44.44.

5- Discussion of the research results:

Given the complex consequences of trauma in our research sample, which we observed to include and go beyond post-traumatic stress disorder, there are also other consequences that affected almost every level including psychological, cognitive, emotional, behavioral and even physical.

Through the results, we found that all the sample members were suffering from difficulties and problems at the level of relational and attachment, in identity and self-image, in cognitive and learning abilities, in the management of emotions, in rationalization, in addition to behavioral problems and psychosomatic diseases.

As for the difficulties experienced by the subjects at the relational level and attachment, empirical evidence suggests that the ability to develop a secure attachment pattern is often compromised in children who have grown up in a chaotic environment or who have been abused, usually at the hands of those who are predominantly at the hands of those who are predominantly. Important for them. One of the most important hypotheses most accepted in explaining the narrow relationship between complex trauma and irregular attachment is that the parents of traumatized children - especially victims of ill-treatment in the heart of the family - represent at the same time a source of fear and comfort for their children, according to the theory of attachment when children are in a state of distress and pressure turn towards their parents as a source of comfort, and this allows them to find a state of bio-emotional balance (i.e. the balance of security) But at the same time, in the context of family ill-treatment, distress is provoked by parental behaviors (hostile behaviors, withdrawal) and thus the child finds himself in an ambiguous situation, since the person responsible for ensuring his emotional security (the source of comfort) is also the source of his distress (the source of fear), and thus the usual strategies that bring the child closer to his parents for safety, become ineffective and non-functional. Complex traumas therefore tend to intensify the need for reassurance and protection, while distorting victims' basic trust in others, making them more sensitive to signals or possibilities of rejection, abandonment or loss. (Godbout et al. 2006).

In addition to the lack of resources to deal with their distress. In general, the data confirm that an unstable or unpredictable relationship with the image of attachment, teaches the child that others are unreliable and that they are not honest. However, paradoxically when the image of attachment is a source of abuse or neglect, the child usually understands a negative model of himself as bad and unworthy of love and care. In this regard, different studies have been carried out to evaluate the internal representation of abused children. Overall, the results revealed that abused children had more negative representations of self, others, and relationships with others than children who were not abused and showed signs of insecure attachment. (Venet et al. 2007).

This is what appeared through the difficulties experienced by the sample members at the level of self-image and identity, where early experiences are crucial experiences for the development of identity, so children who grow up in the context of trauma can be psychologically employed in a style (life preservation) so that they develop extreme caution in order to protect themselves from the outside world perceived as threatened and dangerous at the expense of the growth of their inner world (Briere, 2002). For this they will have fewer opportunities to get to know themselves and explore their inner world in the heart of a safe ocean. Victims can also develop introduced symptoms (e.g., distress, fear, anxiety), which makes contact difficult with the inner experience and encourages avoidant behaviors.

As for his body, we found that most of the sample members have psychosomatic diseases that appeared through: irritable bowel syndrome, gland disease, diabetes, arterial hypertension, cardiovascular diseases. When a child is exposed to complex traumas, a series of biological reactions occur spontaneously in response to the fear triggered by events. Although this reaction is necessary for survival – for example by helping to escape or fighting the situation – it will leave

marks throughout the child's development. In particular, complex trauma is associated with a change in the pressure response system, more specifically in the hypothalamus-pituitary-adrenal (HPS) axis that manages the production of corticosteroids, including cortisone. (Pratchett et Yehuda, 2014) Current studies on the subject have revealed to demonstrate two distinct pathways of infection in children who have experienced significant trauma: abnormally high or abnormally low cortisol levels compared to children in the general population. These two situations are not the extreme, because children can no longer access the stress response system in harmony with the situations they have experienced, which are either under-reactive or overreactive. Children with complex trauma are therefore often described as having rapid, intense and disproportionate reactions to stress or, conversely, appearing unaffected, detached and unaware of the danger.

Similarly, the consequences of trauma affect many brain structures, notably the cortical midline, amygdala, islet lobe, posterior parietal cortex, and temporal lobe. Studies thus show that prolonged exposure to trauma generates deficiencies in the functions associated with these structures, which are manifested, for example, by deficiencies related to the ability to self-awareness, emotional regulation and social learning. (Marinova et Maercker, 2015)

- The results of the study also revealed that most of the sample members suffer from difficulties in the learning process, especially in the category of children and adolescents, but in adults appeared in the form of difficulties in cognitive performance and cognitive employment In this regard, Egeland and Sroufe (1981) noted that since preschool, child victims are less motivated and more frustrated during problem-solving tasks, and show less flexibility and problem-solving skills Since then, a series of studies have indicated Experimentally suggests that victims of complex psychological trauma have fewer abilities at the level of cognitive contexts, such as attention and memory. (Bücker et al. 2012)

For example, victims of physical or sexual abuse have more difficulty reporting specific autobiographical memories than those who have not experienced them. (Valentino et al., 2012) They also show fewer abilities, or even deficits, in terms of executive functions such as working memory, inhibitory control, cognitive flexibility, planning and problem solving. These difficulties affect many areas of the victims' lives. In particular, in school, children who have experienced complex psychological trauma are at risk of difficulties in their academic learning that may lead them to repeat a year or even abandon their studies.

In light of these findings, it is therefore not surprising that traumatized children and adolescents face many difficulties on a daily basis, whether at home, at school, or in any other context. Among other things, the cognitive problems of these young people can explain, at least in part, the difficulties they have in their relationships with their peers, especially because they have more difficulty anticipating the consequences of their actions, taking into account others, because they act impulsively or because they are less willing to find effective and positive solutions when they are in conflict. These problems can also explain the difficulties that many face in effectively planning the tasks they have to perform, in respecting deadlines or even the frequent delays in some young people.

- We also found in the sample members problems with emotional regulation and alexthamia Children who grow up in positive and supportive relational contexts gradually learn to understand, decipher, and talk about their emotional world. Thus, the child will learn very early on how to distinguish

between initial emotions – such as joy, anger, sadness, fear and disgust – and gradually socially acceptable strategies for expressing and modifying their emotional states. As it grows, its cognitive repertoire will improve to capture nuances and the complexity of emotions, while improving its management methods. However, a child who grows up in the context of complex trauma will be exposed to multiple risks that interfere with this learning. First, trauma is associated with the experience of alexithymia and intense negative emotions (fear, shame, anxiety, etc.), which go beyond the emotional regulation skills of vulnerable children, and this can lead to permanent mood imbalances such as depression and anxiety disorders. Second, emotional regulation is not learned in a vacuum. Enriching human experiences is essential to creating learning opportunities. In this sense, the absence of adults who support skill development – as in cases of emotional neglect – limits a child's learning opportunities at key points in their development. In addition, cases of psychological, physical and sexual abuse in which abusive adults use, manipulate and blame the child generate great confusion, confusion and distortion of the child's reality, which may interfere with the acquisition of emotional skills. Third, trauma generates very intense feelings (e.g., shame, dread, hopelessness), which the child has not yet developed the cognitive resources to deal with. Thus, this emotional intensity may lead to suppression of emotions, if not complete denial, which constitutes an effective strategy in the short term, but generates significant deficits in the long term. In the same vein, the child must also deal with complex and sometimes contradictory feelings. For example, a child may feel fear and distress when witnessing domestic violence, but they also feel affection for that parent who, at other times, does not act violently, making it more difficult to understand feelings. Fourth, the child is also exposed to multiple traumas to ineffective and problematic emotional regulation patterns, such as seeing a parent angry and acting aggressively, the child will be deprived of important social learning that will help him adopt social behaviors to manage his emotions. Thus, a child who grows up in a traumatic context is at risk of presenting a significant deficit in emotional regulation, more specifically, alexithymia, that is, difficulty identifying, distinguishing and expressing his or her feelings or those of others. This condition is secondary because it is caused by environmental factors (including traumatic events), unlike primary alexithymia whose causes are mainly genetic .

- The results also revealed difficulties in understanding the world among the respondents as the cumulative shocks they experienced left existential effects affecting the perception of the world and hope and confidence in the future. A child with complex trauma may perceive the world as a dangerous, unpredictable place where positive planning or action is futile, and is associated with feelings of helplessness (for example, an inability to stop the abuse). Thus losing hope and functioning in survival mode, where the child lives from one moment to the next, without stopping to think, plan or even dream about the future (NCTSN, 2017). A child also tends to avoid trusting life or others, so they tend to deprive themselves of external support when faced with difficult life events. In every moment. As a result, these victims tend to retreat from enjoying happy or quiet moments with expected childish naivety. It is possible to observe a negative reaction against positive situations, as if the child has taken a vigilant position so as not to be surprised by a negative event. This is a lack of confidence in life itself, seen as having betrayed them. These children prefer to remain neutral than indulge in happiness perceived as ephemeral, and therefore painful.

The results also showed the presence of disturbed behaviors: because exposure to complex trauma increases the risk of internal symptoms (such as fear, depression) and external symptoms (such as

anger, aggression, resistance). Young victims often exhibit aggressive behaviors (such as impulsiveness, angry reactions, or premeditated/destructive aggressive/destructive actions). Although these post-traumatic reactions testify to the suffering of the victims, they have significant repercussions in terms of social, educational and economic costs (Foster and Jones, 2005; Zakireh, Ronis and Knight, 2008). These behaviors are usually intended to reduce distress or internal stress, regain some control over one's existence, or stem from non-adaptive hypersensitivity, poor information processing, impaired impulse control, as well as inadequate internal models after repeated experiences of violence or abuse. This combination of unrestricted reactions, behaviors that reduce internal tension (e.g., self-harm, compulsive sex), and aggressive, antisocial, and delinquent behaviours (e.g., violence and criminality) pose significant challenges to youth management, rehabilitation, and treatment. In fact, combining emotional, behavioral, and cognitive repercussions with aggressive attitudes and behaviors is potentially dangerous and volatile, especially in adolescence.

- The results also showed difficulties in rationalization. Empirical evidence supports conceptual links between childhood trauma and rationalization difficulties (Ensink et al., 2017). In fact, children who are victims of complex traumas tend to remain blind to the meaning of their own behaviors and those of others, and thus use pre-rational thinking methods. These include psychological equivalence, false distortion, and purposeful thinking (Allen, Fonagy, & Bateman, 2008). Psychological equivalence refers to the confusion between internal and external reality, leading to the assumption that his internal states reflect reality and that this reality reflects his internal states (for example, the child concludes that he himself is bad because his father abuses him) On the other hand, pseudo-rationalization is an evaluation of situations that may seem confused with rationality, but in which thoughts and emotions are separate. Finally, in the teleological thinking pattern, the child compensates for his difficulties in rationalization, judging internal experiences as valid only when they are accompanied by physical and concrete proof (Terradas et al., 2016).

We also noticed through the results that most of the sample members have disintegration disorder, although some of them did not report symptoms of disintegration as a reason for examination. Dissociation is a self-integration disorder of one or several manifestations of psychological employment such as memory, awareness, cognition and motor control (Spiegel et al., 2011) It is a mechanism for managing negative emotions perceived to be intense (Oathes et Ray, 2008) and even if they are taught in a small way, the manifestations of disintegration in the child appear similar to those recorded in adults, and as an antidote to traumatic retirement, the child can disintegrate or mentally disconnect from the experience.

Disintegration is due to several elements such as the feeling that he is coming out of his body, as if in a dream or in a state that does not change all reality (dissipation of reality) or as if the experience is happening to another person (dissipation of personality) and the disintegration is due to an injury in terms of memories (memory loss or memory changes) or the meaning of lived experiences, and this leads to gaps in time and even in personal history. In extreme cases or in a pathological way, a child can cut or lose contact with many manifestations of the self: several distinct states of consciousness or multiple personalities (Briere, Weathers et Runtz, 2005). Psychological trauma increases the risk of developing disintegration in child victims, and the chronic victim can increase the likelihood of disintegration being used as a defensive strategy against emotions resulting from

trauma. Adapt to tacitly traumatic or traumatic events, so they tend to disintegrate in a permanent and continuous way in order to disconnect from very harsh feelings or experiences (Hulette, Freyd et Fisher 2011). In contrast, this mechanism can be generalized for some stressful situations or traumatic memories. That the manifestations of disintegration are so different that it cannot be difficult to encompass them all. Assessment scales are often filled in by parents and combined with statements highlighting that the child is a dreamer, showing difficulties concentrating, paying attention or learning from his experiences, poor awareness of the meaning of time, sleepwalking, having imaginary companions, or adopting regressive behaviors compared to his or her development. All of these manifestations can have negative effects on learning, behaviors within the department and social interactions (Putnam, 1997; Putnam, Helmers et Trickett, 1993). However, it should be borne in mind that in a child, imaginative games and creating imaginary friends can be part of normal development (Putnam, 1995). Disintegration is also a risk factor for repeated experience of the role of the victim, so some researchers suggest that the victim be able to show difficulties in taking note of danger signals in her surroundings, or that Tun is in contact with her inner world (sensations and emotions) in children victims of chronic trauma, the intensive use of disintegration can facilitate a split in the soul, allowing the separation of contradictory concepts or images, in order not to be affected by the positive perception of attachment images by negative behaviors

Finally, we found that some of the sample members suffer from post-traumatic stress disorder. For most researchers, responses to trauma are limited to the criteria for post-traumatic stress disorder, the latter as defined by the DSM-5 covers 4 types of symptoms: re-experiencing the traumatic event, avoiding stimuli related to the event, negative thoughts and moods, and finally extreme caution with neurostimulation (American Psychiatric Association [APA, 2013]).

For example, re-living can be in the form of repetitive games, nightmares related to the traumatic event, and a child who does not show symptoms in each set of effects in order to establish a diagnosis must exhibit at least an intrusive symptom, an avoidant symptom or negative thoughts and two symptoms of extreme caution/neurostimulation (APA, 2013). The child is therefore likely to show fewer symptoms in PTSD than an adult (at the level of 3 groups of symptoms instead of 4) in order to establish a diagnosis

All empirical studies (Breslau et al., 1999) support the presence of PTSD in trauma victims, for example, in a study of more than 2,000 people from the same region, which showed that previous exposure to multiple traumatic events was associated with a high risk of PTSD in response to current trauma and that previous multiple traumas had more severe consequences than isolated trauma.

PTSD therefore tends to have significant functional deficits, more chronic symptomatic, very early onset and very high comorbidities with mood and anxiety disorders (Karam et al., 2014). Post-traumatic stress disorder can also result from complex trauma, and on the other hand, traumatic situations that he is exposed to at a young age, especially in the case of frequent and chronic violence in the family context, can lead to developmental injury that exceeds post-traumatic stress disorder, which appears in the form of different symptoms or symptoms that cover up post-traumatic pressure disorder, so the symptoms of post-traumatic pressure disorder do not reach to surround each group. Disorders that appear in individual victims. (van der Kolk et al., 2009). That is why several researchers have introduced the concept of complex trauma. Type II trauma, non-

special maximum stress disorder (DESNOS) or developmental shock disorder all of these terms include the classic post-traumatic stress response, but include deficits in other fields of employment.

Conclusion:

The developmental perspective in understanding long and repeated traumas during childhood is an important perspective in understanding the personal traumas that occurred during childhood on the child's development, especially building his identity and adaptive abilities, as this perspective confirms that these effects are greater because these traumas are usually at the heart of the child's meaningful personal relationships, such as parents or other caregivers.

It should be remembered that PTSD was first formulated to recognize the clinical condition of adults who, at the time of trauma, most likely had much higher personal resources than those of the child, particularly in terms of emotional regulation, cognitive skills and adaptation. The response to chronic and recurrent trauma is not summed up in a set of conditioned responses to the traumatic event (post-traumatic stress disorder), but is translated into an adaptive course of development at the neurological, psychological, social and cognitive levels.

Through this research paper, we tried to shed light on the consequences and effects of complex trauma experienced by a group of examinees who were visiting the psychological assistance center - University of Blida 2 - for examination, who numbered 45 individuals between the ages of (8 to 42 years) and who lived cumulative traumatic experiences, i.e. long and repeated (physical abuse, sexual assault, neglect or emotional abuse), where these repercussions appeared starting from post-traumatic stress disorder. Post-traumatic trauma as a clinical form of classical trauma development into 8 other forms of these consequences (1 dissociation, 2 relational problems and attachment problems, 3 identity injury and self-concept, 4 physiological and biological problems, 5 cognitive and learning-related problems, 6 problems with impulse regulation and alexithymia, 7 cognitive distortions especially in relation to understanding the world, 8 behavioral problems).

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