Commentary
Volume 10:11, 2021

Journal of Trauma & Treatment

ISSN: 2167-1222 Open Access

Short Note on Childhood Trauma

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Description

Childhood trauma has far-fetching complication for both the individuals and society. Childhood trauma is defined as exposure to real or threatened death, significant injury, or sexual violence for the purposes of this critical evaluation, according to the Diagnostic and Statistical Manual of Mental Disorders. This can include direct trauma exposure, witnessing trauma, or learning about a close friend or relative's trauma. Motor vehicle accidents, bullying, terrorism, war exposure, child maltreatment (physical, sexual, and emotional abuse; neglect), and exposure to family and communal violence are all prevalent types of childhood traumas that cause distress, PTSD, and posttraumatic stress symptoms in children (PTSS). Childhood traumas, especially interpersonal, deliberate, and chronic traumas, are linked to higher rates of PTSD, PTSS, depression and anxiety, antisocial tendencies, and a higher likelihood of alcohol and substance use disorders. Trauma can occur as a result of a variety of experiences. A child's life or physiological integrity is jeopardised when they are exposed to childhood trauma. Children can be traumatised by physical or sexual abuse, for example. One-time incidents such as a vehicle accident, natural disaster (such as a storm), or medical stress can all have a psychological impact on kids.

Traumatic stress in children

Children with child traumatic stress disorder have been exposed to one or more traumas during their childhood and have developed reactions that last and impair their daily lives after the events have passed. Intense and ongoing emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, attention and academic difficulties, nightmares, difficulty sleeping and eating, and physical symptoms such as aches and pains are all examples of traumatic reactions. Older children may abuse drugs or alcohol, participate in dangerous behaviour, or engage in sexual conduct that is unhealthy. The long-term effect of early trauma events and increased CRF is that the LHPA axis is reset, resulting in decreased ACTH and cortisol secretions during baseline and non-stressful situations. Cortisol levels are typically lower in adult studies of childhood trauma victims. One of the most consistent outcomes in a meta-analysis was that the longer the time since the trauma, the lower morning cortisol, and daily cortical ACTH, and post dexamethasone cortisol levels were. The latter explanation may best explain the primary disparities in the findings in juvenile PTSD studies, where greater baseline cortisol levels were found in most pediatric investigations, whereas adult PTSD studies focus on previous trauma While adults who were maltreated as children had lower 24 hour cortisol levels, people who were maltreated as children had higher cortisol levels. This attenuation theory is supported by results from the sole longitudinal psychobiological study reported to date, in which non-stress cortisol levels in sexually abused and non-abused girls were measured at six time points from childhood to young adulthood. Non-stress cortisol activity was initially significantly higher in sexually abused girls (post abuse disclosure) compared to non-abused girls in this study; however, cortisol activity was significantly reduced beginning in adolescence and significantly lower during young adult follow-up compared to non-abused females. We discussed how childhood trauma has a negative impact on physiologic stress systems, as well as cognitive and brain development. Childhood trauma is costly to both the individuals and society. Childhood trauma does not always result in resilience. In a longitudinal study of people who had been abused or neglected as children, just 22% of those who had been abused or neglected by the time they reached young adulthood had attained resiliency based on a comprehensive assessment of healthy adult functioning. Females who were not maltreated as children and who grew up in poverty were more likely to display resilience. While there are certain crucial evidence-based treatments for child victims, it is in our best interests to develop a national infrastructure for primary child trauma prevention as a less expensive choice for future victims and society. Understanding the neurobiological repercussions of child trauma can aid in the treatment of child and adult victims, who are more treatment resistant and may have a distinct endo-phenotype than people with medical (including mental health) illnesses who have no such histories. However, more research is needed to understand the neurobiological effects of chronic stress on a child's developing brain and body so that we can treat the negative medical and mental health consequences of early life stress in situations where prevention and effective early intervention are not possible (e.g., warfare, natural disasters, child maltreatment). Understanding the neurobiological and genetic influences of child trauma on development will lead to more innovative and successful treatment options (e.g., personalized medicine).

How to cite this article: Cao, Jinyao. "Short Note on Childhood Trauma." J *Trauma Treat* 10 (2021): 490.

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Received: December 01, 2021; **Accepted**: December 15, 2021; **Published**: December 22, 2021