# Childhood trauma: psychiatry's greatest public health challenge?

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More than a century after Freud, Breuer, and Charcot introduced the concept of so-called traumatic hysteria, psychiatry is rediscovering the central role of trauma in mental disorders. A study reported in *The Lancet Public Health*[1] by Roger Webb and colleagues adds important evidence on the lasting impacts of traumatic experience in childhood.

Webb and colleagues[1] used Danish national register data to identify people admitted to hospital for self-harm, violence, or accident before age 15 years, and examined their rates of self-harm or violent offending up to 35 years of age. As the authors acknowledge, childhood hospital admission for trauma is a complex exposure variable, signifying immediate or direct traumatic experience as well as being a possible marker of broader personal or family vulnerability. That there is an association with later self-harm or violence is perhaps not surprising, but the strength of the associations is striking (women, self-harm: incidence ratio ratio 1·94 [95% CI 1·85–2·02]; violent criminality: 2·16 [1·97–2·36]; men, self-harm: 1·61 [1·53–1·69]; violent criminality: 1·58 [1·53–1·63]). One in four males admitted to hospital for interpersonal violence in childhood were convicted of a violent offence in adulthood. One in four girls admitted to hospital due to self-harm or violence had later hospital admissions for self-harm. Childhood hospital admissions due to self-harm or interpersonal violence were more strongly associated with later harms than admissions with accidental injury. There was a clear dose effect: multiple childhood hospital admissions or exposure to more than one type of trauma were associated with greater likelihood of later self-harm or violence.

The study highlights three key issues regarding the relationship between childhood trauma and later mental illness. First, the breadth and complexity of the mechanisms involved. Psychiatry has traditionally focused on specific trauma-related syndromes such as post-traumatic stress disorder (PTSD) or disorders in the so-called neurotic spectrum. As the study by Webb and colleagues[1] underlines, childhood trauma might have broad effects on self-regulation, mood, and behaviour, expressed through internalising (self-harm) or externalising (violent offending) behaviours. Such evidence has led to calls for borderline personality disorder to be reconceptualised as a complex PTSD. Trauma is associated with reduced response to treatment in mood disorders, including bipolar disorder.[2] Exposure to childhood trauma is implicated as a risk factor for later psychotic experiences, from subclinical psychotic symptoms through to enduring psychotic disorders such as schizophrenia. Recent meta-analytical evidence showed that childhood adversity is associated with a 1·5-fold to 3-fold increased likelihood of psychotic experiences.[3,4] These effects seem to be mediated not only through psychological mechanisms, but also through inflammatory and corticosteroid-related stress pathways with links to brain development and structure.[5,6]

Second, there are major implications for clinical care. If trauma is a common risk factor affecting onset and course in a broad range of disorders, then primary care and specialist clinicians treating mental disorders need training in the assessment of past trauma. This requires a safe clinical environment where there is trust that information provided will be responded to sensitively and appropriately. The study by Webb and colleagues[1] used a prospective measure of trauma un-affected by recall bias. However, clinical assessment usually involves retrospective recall, which is intrinsically more complex. An elegant recent study[7] compared prospective evidence with retrospective recall of childhood trauma. The study found significant under-call and over-recall, influenced by personality dimensions such as agreeableness and neuroticism. Where trauma is identified, evidence on effective interventions is scarce. Evidence-based guidelines exist for treatment of specific trauma-related conditions such as PTSD. Currently, there is little evidence to guide clinicians in addressing trauma in conditions such as serious mood disorders or psychosis. The trauma-informed care movement[8] advocates an approach that goes beyond diagnosis and treatment of specific post-traumatic syndromes to one which broadly recognises trauma, provides safe treatment environments, and mobilises individual strengths. Developing and evaluating specific interventions is a key research priority.[9]

Third, there are implications for prevention. Tragically, childhood exposure to trauma is highly prevalent. Globally, one in eight adults reports childhood sexual abuse and nearly one in four reports childhood physical abuse.[10] UNICEF estimates that currently more than 28 million children are uprooted by conflict, creating a further legacy of childhood trauma whose effects are likely to be felt for decades.

In conclusion, childhood injury and abuse are major and potentially modifiable contributors to the global burden of disease. Recent evidence underlines their effect beyond specific post-traumatic syndromes. Childhood trauma disrupts crucial physiological, psychological, and social developmental processes. It increases the risk of the full range of mental disorders, from personality, mood, and substance use disorders to psychosis. It should be seen as a major challenge requiring not only a systematic public health framework, but also a wider societal response to the prevalence and sequelae of childhood trauma. The questions now must be how best to respond to the central role of trauma in mental illness by developing effective approaches to reduce exposure, to reduce negative outcomes in the young people exposed, and to ensure effective detection and treatment for the millions of people affected.[11]

*Grant Sara, Julia Lappin*
Psychiatry, Sydney Medical School – Northern, Royal North Shore Hospital, St Leonards, NSW, Australia (GS); InforMH, Mental Health and Drug and Alcohol Office, NSW Health, North Ryde, NSW 1670, Australia (GS); National Drug and Alcohol Centre, UNSW Australia, Randwick, NSW, Australia (JL); and Department of Psychiatry, UNSW Australia, Black Dog Institute, Randwick, NSW, Australia (JL)
grant.sara@health.nsw.gov.au

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