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Research Paper

The impact of childhood trauma on children's wellbeing and adult behavior

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ABSTRACT

Background: This article looks at the impact of childhood trauma on children's wellbeing and adult behavior from the perspective of 9 clinical professionals in Ireland. It exhibits how physical, sexual and emotional abuse disrupts one's life through analyzing coping strategies and behaviors adopted by childhood trauma victims following adversity exposure.
Objectives: To examine if coping mechanisms such as denial, self- isolation, drug and alcohol abuse are associated with childhood trauma survivors. Correspondingly, this research investigates if symptoms related to depression and anxiety, sleep disturbance and low self-esteem are consequences of childhood trauma. The final objective explores possible correlations between resilience capacity and social class background. Upon this selection, the authors acknowledge that consequences and post-trauma symptoms can vary depending on numerous factors, including the type of abuse endured by victims.
Methods: Participants were recruited through convenience selection and snowball sampling. Individuals worked in social care, counselling, psychotherapy, psychology and support work. Seven females and two males participated in recorded semi-structured interviews. Six interviews were carried out via phone call and three were conducted face-to-face. Participants shared experiences about their client-based interactions. Participants were assigned a pseudonym to protect their identity.
Results: Within this study, childhood trauma survivors present alcohol and drug dependency issues, deny the negative impact their adversities have on their wellbeing (especially if it was inflicted by their parents), and construct a false self-image to cope rather than self-isolate. Early onset of trauma may contrive a low self-esteem and depression and anxiety can surface due to feelings of inadequacy. Sleep disturbance did not appear as a consequence of childhood trauma in this study. Social class was not an influential factor in mediating the type of traumatic experiences faced by individuals from different backgrounds. Financial circumstances did however, present as significant in impacting support-service availability. Interventions, treatment plans and social support emerged as crucial in enhancing resilience levels, reversing the onset of problematic behavior and psychiatric conditions.
Conclusion: Childhood trauma victims exhibit low self-esteem, and experience depression and anxiety. Some deny their trauma history, while others create a false self-image and engage in alcohol and drug misuse in attempts to prevent their traumatic experiences from impacting their life. Early interventions may reduce trauma symptoms alongside sufficient and customized treatment strategies.
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1. Background

Trauma is any event that does not correspond with everyday situations and can give rise to feelings of severe stress and unhappiness (Wicks-Nelson & Israel, 1997). Emotional struggles as a result of interpersonal trauma could steer emotional vulnerability as feelings of violation and betrayal reside within the sufferer (Lilly & London, 2015). Such feelings can disrupt an individual's emotional response system and lead to internal regulation difficulties at a later stage (Barlow, Goldsmith-Turow, & Gerhart, 2017).

If trauma has been inflicted on a child by their parent(s), their core belief system recognizes that a secure attachment style has not been formed and is deficient in protection, prompting emotional hesitation. A sense of safety and support is paramount in the early years to encourage a child to explore their environment confidently and

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Abbreviations

Cognitive Behavioral Therapy	CBT
Alcohol Use Disorders	AUD
Post-Traumatic Stress Disorder	PTSD

independently, despite any possibility of failure (van Rosmalen, van de Horst, & van der Veer, 2016).

In the case where a child becomes familiar with traumatic events, the onset of behavioral issues increases (Galletly, Van Hoof, & McFarlane, 2011; Connell, Pittenger, & Lang, 2018) because the victim's neurological structure changes in accordance with the adversities experienced or witnessed. Therefore, resulting in the risk of psychopathology development (Dye, 2018).

This research examines trauma in terms of physical, sexual and emotional abuse and uses this to understand future consequences and management strategies following personal hardship. This study researches the link between three consequences of childhood trauma that have appeared in previous literature: 1. Depression and anxiety. 2. Sleep disturbance. 3 Low self-esteem. Alongside three coping mechanisms: 1. Denial. 2. Alcohol and drug abuse. 3. self-isolation. The reason for this selection was to identify if similarities and differences existed between previous research and this study.

1.1. Consequences of childhood trauma

1.1.1. Depression and anxiety

Childhood trauma has been linked to the development of anxiety and depression in later life (Hovens et al., 2010) and a history of abuse may be more identifiable by adulthood as emotional and behavioral patterns have evolved by this period. As of this, various disorders are likely to arise among childhood abuse victims (Lindert et al., 2014).

More specifically, the connection between depression, anxiety and childhood trauma could be related to the individual's neurological response system. Repeated childhood exposure to severe stressors causes excessive transmission of stress hormones in the body, as a way of responding to the event(s) that are happening around them (Heim et al., 2008). Regular exposure to toxic conditions in childhood can distort the biological makeup of the body's Hypothalamic-Pituitary-Adrenal (HPA) axis. This neurological system sends signals to the brain to alert the body of dangerous circumstances. When the HPA axis is over activated the secretion of stress hormones creates a surplus and the body remains alert in preparation to react to perceived harmful situations through the fight-flight-freeze system (Butler et al., 2017; Maack et al., 2015). If a state of readiness through this system occurs frequently, it permits over activation throughout childhood and later promotes the risk of depressive and anxiety disorders due to heightened cortisol levels following traumatic episodes (Klassens, 2010; Chrousos, 2009).

1.1.2. Sleep disturbance

Overcoming trauma can take its toll on a survivor's mindset and consequentially, rumination over distressing experiences is likely. Sleep issues can lead to poor physical and mental health and exacerbate post-trauma symptoms (Belleville, Guay, & Marchand, 2011).

Sleep disturbance is arguably a troubling factor for childhood trauma victims as this routine is associated with comfort and safety and once it has been interfered with during childhood, these associated feelings have been removed from the child's night-time regime (Noll, Trickett, Susman, & Putnam, 2006). Children who have experienced physical and sexual abuse in the bedroom may struggle to fall asleep and maintain a full night of sleep because they have been personally violated in a typically secure setting (Swanson, Hamilton, & Muzik, 2014; Greenfield, Lee, Friedman, & Springer, 2011). Mirroring this, research indicates that children who have experienced trauma, display signs of sleep disturbance almost instantly and report having nightmares as their most dominant post-trauma symptom (Wamser-Nanney & Chesher, 2018).

This being the case, nightmares and sleep disturbance following trauma can represent subconscious feelings of conflict held by the individual. Therefore, responding to and accepting the incident(s) may help minimize the influence it has on one's life. Particularly, Cognitive Behavioral Therapy (CBT) could guide the sufferer in overcoming negative emotions towards past adversities. Some CBT approaches can help an individual to re-imagine their nightmare but create their desired ending. This allows the individual to feel empowered and in control which may diminish previous emotions and reduce the number of nightmares they are having about their past (Casement & Swanson, 2012).

1.1.3. Low self-esteem

If a child's primary caregiver is the purveyor of their trauma, the child could battle with self-esteem problems by adulthood as a result of inadequate relationship and attachment formation (Yumbul, Cavusoglu & Geyimci, 2010). Precisely, abuse can produce feelings of fear and vulnerability within the victims and can drive self-esteem issues following instability in current or previous relationships (Silvern et al., 1995). For children, abusive trauma destructs self-worth and self-identity because unhealthy relationships in the early years depict uncertainty and poor self-belief (Teague, 2013). This implies that traumatic experiences from interpersonal relationships contribute to a child's general self-knowledge. From this, they may adopt relationship patterns derived from childhood if the appropriate measures are not utilized to surpass the negative effect of their adversities (Crowley, 2019).

1.1.4. Coping with trauma

Coping is the behavior and thoughts a person uses to deal with challenging circumstances (Folkman & Moskowitz, 2004). Coping styles can be regarded as active or passive. Active coping methods are implemented when the survivor takes direct action to heal from their experiences, whereas passive coping means minimal or no effective action is taken to overcome adversities, as they are deemed inevitable to the survivor (Olff, Langeland, & Gersons, 2005).

1.1.5. Denial

Denial can be regarded as a defence mechanism rather than a coping strategy because the victim refuses to reflect on an experience in order to protect their wellbeing. On the contrary, coping mechanisms persuade the survivor to engage in a specific activity to combat the influence of the adversities, because they are aware of how it makes them feel. In some cases, traumatic ordeals can provoke feelings of shame which can discourage survivors from seeking support (Tapia, 2014). They can also take responsibility for the abuse, making it harder to mentally revisit the incidents (re-traumatization) (Frazier, 2000).

In spite of this, trained professionals could motivate survivors to tackle their trauma symptoms by maximizing their client's self-capabilities (Knight, 2015). Professionals should focus on reminding the survivors that they are capable of defeating difficulties through their own will power. This informs the client that they can self-manage negative circumstances without fearing or denying them (Levit, 2018), which helps them to progress through life and respond to future challenges in a healthy manner.

1.1.6. Alcohol and drug abuse

Alcohol can also be used to distract oneself from thoughts of previous childhood adversities. Emotional abuse has been linked to alcohol-related issues, including binge-drinking and Alcohol Use

Disorders (AUD). The literature signals that young people who have suffered trauma reportedly felt compelled to consume alcohol and those who were sexually abused tackled AUD earlier in life, in comparison to non-victims (Shin, Lee, Jeon, & Wills, 2015). A study carried out by Schafter et al. (2009) examined the needs of alcohol dependent clients with a history of sexual abuse. On average, males who encountered childhood sexual abuse were reported to consume up to 170g more alcohol than non-abused males and another study demonstrated that traumatized men consumed significantly more alcohol than traumatized women (O'Hare & Sherrer, 2011). Correspondingly, males who present with substance abuse problems are more likely to have experienced physical, sexual and emotional abuse or neglect, contrary to males who do not engage in such behavior (Ekinci & Kandemir, 2015).

It has been suggested that women with a history of childhood abuse may become substance-dependent to emotionally sedate themselves (Grabbe, Ball, & Hall, 2016), while severe cases are predominantly linked to emotional neglect and sexual abuse (Lotzin, Haupt, von Schonfels, Wingenfeld, & Schafer, 2016). Research conducted by Hammersley et al. (2016), reported 25 of 55 study participants (38 male, 17 female), who were recovering from drug dependency, revealed they had been consistently neglected or abused in childhood, which they believe contributed to their reliance on drugs in adulthood.

1.1.7. Self-isolation

Since trauma can deteriorate a person's wellbeing, survivors may seek to isolate themselves in response to the severity and complexity of their emotions and thoughts following a distressing event (Brand, Schielke, & Brams, 2017). Self-isolation can feel like a protective barrier from past adversities, allowing for some survivors to find comfort in it. Nevertheless, failing or unwilling to address a traumatic experience can hinder one's chances of tackling future negative experiences, compared to those who accept and confront their negative encounters (Shallcross, Troy, Boland, & Mauss, 2010).

Trouble regulating negative emotions could increase the risk of Post-Traumatic Stress Disorder (PTSD) symptoms as unpleasant outcomes may be more probable for those who have not developed skills to maintain emotional balance within afflicting situations (O'Bryan, McLeish, Kraemer, & Fleming, 2015).

1.2. The role of social-class background in resilience building

Conflict-related trauma has not been largely associated with any socio-economic background, but PTSD is however, correlated to those facing underprivileged circumstances (Jarl, Cantor-Graae, Chak, Sunbaunat, & Larsson, 2015). In terms of children and youth, those who are neglected or mistreated are more at risk of experiencing traumatic situations, including community violence (Rosen, Handley, Cicchetti, & Rogosch, 2018).

If a child witnesses their social disadvantage through substance abuse in the home, the incarceration of their parent(s), or mental health problems in their surroundings, they may experience trauma due to the insufficient fulfilment of their developmental needs (Keane, Magee, & Kelly, 2016). Thereby, increasing the risk of additional unfortunate events disrupting their mental wellbeing (Wiese, 2010). In the United States it is also believed that individuals from disadvantaged communities have higher chances of experiencing emotionally disruptive issues linked to housing problems and physical violence (Brown, 2008).

Campbell-Sills, Forde, andStein (2009) claim that social support and resources distributed by advanced education, alongside financial stability are protective barriers against stressful circumstances and improves trauma-resilience. Beyond this, it is argued that social support is the most effective tool for resilience building, as intervention and treatment plans assist individuals in their healing process (Steele & Kuban, 2014; Murray et al., 2015).

Children who have built resilience against trauma reportedly portray positive social skills, less emotional problems and a satisfactory reading ability. Not only are resilient children excelling in all these aspects compared to non-resilient children, but they are equally capable as children who have not been mistreated (Jaffee et al., 2017). Consequently, if a child learns to build trust, self-worth and feel emotionally grounded, their resilience levels improve (Nader, 2011). Thus, we argue that social support may be more effective in resilience building than factors affiliated with social class background. It is also hypothesised that social support acts as a mediating factor over level of trauma endured.

2. Methods

2.1. Ethics

Ethics approval was granted by the Human Research Ethics Committee at University College Dublin. The application outlined the purpose of the research and how data would be collected and managed by the primary researcher (first author), before approval was authorized. The research was under surveillance by the second author and monitored for the duration of the study. All methods were carried out in accordance with appropriate regulations and guidelines.

2.2. Study design

This study employs a qualitative design using recorded semi-structured interviews to ensure that understanding and consideration is established between the participant(s) and the primary researcher. The semi-structured interview questions were developed by the primary researcher and were not inspired by other interview frameworks. The personal narratives shared by professionals in this study, provide insight into client experiences following traumatic scenarios. Excessive dependence on quantitative approaches for sensitive issues has been reported as methodologically deficient (Woodhall-Melnik, 2018). Merely, impacting the potential to comprehend the importance of personal childhood trauma experiences. As a result, the choice to exclude a quantitative and mixed methods approach was based on the desire to inspect the subjective details of traumatic circumstances through compassionate and transparent reporting of participant narratives.

The fostering of a qualitative method generated space for logical subjective reasoning in alignment with the conditions of a distinct social matter (Lingard, Albert, & Levinson, 2008). Hereby, the implementation of this approach enabled the use of thematic analysis to complement the inclusion of semi-structured interview questions. This in turn endorsed the research findings and helped elucidate the severity of childhood mistreatment and its negative impact on a person's life.

2.3. Participants

The study recruited participants through convenience sampling and snowball sampling. Initially, connecting with some personal contacts (gatekeepers) in the field, meant that a snowballing method could later be applied to invite participants to be reached through word of mouth. The inclusion criteria consisted of participants having previous or ongoing professional work experience with those who endured childhood trauma, holding a professional qualification to work with vulnerable populations and being able to provide informed consent. Seven participants were contacted through word of mouth and the final two participants were contacted purposely through an online local forum. Convenience sampling was necessary due to the limited time frame of the research and the need to select

appropriate participants before the deadline. The nine participants were invited to partake in the study by a written consent form and an information leaflet via email.

Once consent was obtained, all participants were emailed a copy of the ten semi-structured interview questions that was designed to guide the interview process. The primary researcher made the decision to circulate the interview questions prior to the interviews as the goal was to encourage interviewees to provide a sufficient amount of data without feeling anxious during the conversation (DeJonckheere & Vaughn, 2019). Hence, sharing the questions with the participants promised understanding and comfortability before and during the interviews as it gave them an opportunity to address any questions they had with the researcher prior to interviews commencing. Thus, building rapport and trust with the researcher.

The cohort consisted of seven females and two males. This sample includes a number of qualified professionals in the field of psychology, psychotherapy, social/support care, and counselling. Participants work in different regions across Ireland. Including Dublin, Louth, Mayo and Sligo. This created a varied sample of working professionals in Ireland for the study.

2.4. Data collection and interview procedures

All interviews commenced once consent forms were obtained, any queries concerning the study were answered when approval was granted by the Human Research Ethics Committee at University College Dublin. All participants' real names were replaced with pseudonyms to protect their identity throughout the study, and they were given permission to withdraw any information provided up until the write-up period.

Any details accidently shared during the interview by participants were removed upon request immediately and not included in their transcript. Six semi-structured interviews were carried out over the phone and three were carried out face-to-face. The interview process lasted from early March to early May 2019. Questions were listed in ascending order from 1-10 and follow-up questions were added to enhance the conversational flow of the interviews. Once the interviews terminated, participants were thanked for their participation and checked on at a later date to detect how they were feeling post-interview.

2.5. Data analysis

Following data collection, thematic analysis was conducted to highlight the recurring patterns identified during the analysis of the interview transcripts. The use of thematic analysis assisted the first author to identify recurring patterns concerning the participants' experiences, outlooks and assumptions as this methodological design portrays their internal belief system and how their experiences are shaped (Clarke & Braun, 2017). The primary researcher coded all transcripts to distinguish both similarities and differences between the data and shared it with the second author for review. Once codes were reviewed twice, they were assigned to themes chosen by the primary researcher (Table 2). Although all participants were asked the same 10 pre-selected questions, each interview fostered additional improvised questions to facilitate the flow of the conversation. As a result, each transcript was closely revised for codes separately and lastly compared to develop appropriate themes.

3. Results

Themes were selected based on repeating patterns present in all or most transcripts that were produced after each interview (Table 2). The following section shows that in support of previous research, childhood trauma victims can present self-esteem issues, dismiss the personal impact mediated by their childhood trauma and engage in poor coping techniques such as alcohol and drug misuse. Moreover, the creation of a false-self to prevent adversities from further affecting life-quality was notable.

3.1. The consequences of childhood trauma on an adult's life and on a child's wellbeing

3.1.1. A low self-esteem can manifest in childhood trauma victims

Depression and anxiety are linked to low self-esteem. Tom was asked about his opinion on the self-esteem of a trauma survivor and discussed that he has interacted with clients who: "*present as being very high self-esteem"* but he would view a survivor's self-esteem as: "*nearly always poor"*. He explained that traumatized people can learn to build a stable character to mask their vulnerability, suggesting feelings of depression and worthlessness are held by victims. He considers that they are: *"almost like a very good actor."* However, he is convinced that this approach does not possess long-term sustainability because: *"when you chip at that character, the whole lot just...falls under."*

Furthermore, David established that sufferers of childhood trauma have: *"no self-esteem"* and create a false self-image to cope. Tara confirmed these claims when she noted that they rely on a false self-image, especially if their primary caregiver had failed to meet their developmental needs:

> *"The way they cope with it is that they create maybe a false self for themselves because...when we're kids, we-we want our parents to love us and take care of us. So, if they don't do that we try and become the kind of child we think they'll love."*

Christine supported this by indicating that childhood trauma victims prove they have a low self-esteem when they seek: "*validation and approval"* as this is their: *"calming strategy."* Mary explained that the reason for this (commonly in children) is because: *"they're craving something that they just can't get from their parents."* For her, a low self-esteem in children is easy to recognize but children themselves are: *"not processing their traumas"*, which brings them to: *"think everything's quite normal."*

Similarly, Ava and Anne reported that trauma victims do not always acknowledge the severity of their traumatic history or their personal attitudes because it makes them depressed. Both participants have proposed that their low self-esteem can encourage them to excuse their circumstances or deny that their past has scarred them:

> *"Oh my God, I didn't know it was that bad or some of them will tell us that: "oh I knew, I knew that my mom had experienced it." (Ava)*

> *"It's simply too painful to look at." (Anne)*

All participants reported drug/substance abuse as a common coping mechanism amongst childhood trauma victims. David summed up that the reason for this is because: "*drugs block the pain, block the consciousness."*

3.1.2. Childhood trauma victims can create a false self rather than self-isolate

David hinted that the false self is born because the trauma sufferer was: *"annihilated as a human being"* and has: *"lost trust in all humanity."*

To highlight the extent of this, Ava discussed that domestic abuse survivors can experience anxiety and suicidal ideations. She shared the brutality endured by a young woman in her 20s, who was tied down and raped for days by her partner. She revealed that her client confessed:

"I can't see myself living a normal life. I can't see myself being okay. He has destroyed me."(sic)

From Ava's experience working as a refugee support worker, she disclosed her experience of children at the refugee centre displayed a tendency to exhibit problematic behavior linked to trauma infliction. She noted that some appear anxious and: *"are just glued to their mothers; they won't let her go!"* and stressed that: *they are fearful of being left alone (sic)."*

Christine proposed that accumulative or developmental trauma: "*really wreaks havoc at an individual."* This permits the growth of depression and anxiety disorders as when sufferers build self-confidence there is a chance that confidence: "*is always quite fragile."* To support this, Anne reported that her male childhood trauma victims: *"like to be seen as kind of cocky"*, but in her view it is an act of grandiosity to hide their true self.

All participants made clear that the construction of a false-self is derived from self-hatred or shame and upset. Samantha pointed out that her clients would not: *"see themselves as liking themselves very much."* and in Tara's view self-hatred and a false self-image is linked to the emotional baggage survivors carry from childhood: *"into adulthood."* For David, self-blame, hatred and shame following trauma is: *"the sickest mind frame you can have; that it's your fault that this happened to you."* This theme hints that the false-self can be decomposed through self-compassion and understanding.

3.1.3. Denial or lack of insight into childhood trauma can be connected to intergenerational trauma

Intergenerational trauma appeared as a theme in all interviews when the nature of childhood abuse was discussed. Participants deemed trauma inflicted by parents as severely harmful to a survivors' wellbeing. It was enforced that intergenerational trauma teaches family members behaviors and routines that do not embody positive outcomes:

"I think when it's repeated and when it's been given by the primary caregiver, it's a lot worse." (Samantha)

"A lot of the heroin addicted clients' parents, their parents would be alcoholics and they would be quite aggressive alcoholics." (Anne)

To add, participants outlined that it is vital that intergenerational habits are broken to prevent trauma-related issues from continuing. Ava affirmed that domestic abuse should not be tolerated, and victims (especially mothers) should do their best to seek help as they may be accidently: *"modelling abuse for their children"* and this is a way of: *"telling their children that it's okay, it's normal to be abused."*

Samantha also remarked that some of her clients (who are parents) see no wrong in physical abuse, even if their child is humiliated as they reckon it is: *"acceptable to use as an adult."* She then argued the fact that they: *"see it as maybe normal parenting skills"* could be the root of this belief.

The data makes evident that abuse inflicted by parents leaves both children and adults alike emotionally wounded. These wounds were described as perpetuating over time and in some cases, victims were seen to endure strong, loyal attachments to their parents, albeit the perpetrators of their abuse:

"I mean they're still mad and angry and whatever, but they still have a loyalty to their parents." (Mary)

"Even if their parents are long dead, they're constantly repeating the same messages that they heard in childhood." (Tara)

"Generally, they still believe or, they'll still hold the truths that they were told in childhood." (Christine)

Rosie verified that it is good for her clients to carry out: *"therapeutic work on themselves"*, because it helps themselves and their family members to terminate negative past teachings and live a happier life:

"It is actually a good thing for you to be open with them and say to people: this happened to me and it's affected who I am as an adult, but I'm doing work on it now and I'm trying to work on it."

In summary, participants have declared that intergenerational trauma progresses when trauma is unresolved. Once survivors of childhood maltreatment recognize the previous wrongdoings, they can break traditional cycles and recover from them through support.

3.1.4. Social support is needed to conquer the damage of childhood trauma

Social support emerged as a theme in the data to insinuate its need to assist individuals in overcoming the long-term impact of adversities. The results showed that trauma can happen to anyone irrespective of their social class background. However, differences were detected in the quality and availability of support services across different social class backgrounds:

"I do believe trauma can happen to everybody. It's equal opportunity." (Samantha)

"I think there's a difference in the way people receive the support. As opposed to the trauma, trauma is trauma." (Tom)

This theme unveiled that financial struggles could prevent some trauma sufferers from seeking and obtaining necessary support from mental health services in Ireland. David declared that money controls when one can avail of support. He said: *"If you have money, you get a service"* but for those who are financially restricted, he argued that: *"there's no help whatsoever."* David continued to emphasize the importance of support services and admitted that lack of aid puts survivors at risk of more suffering and stated:

"So, I face the-the individual thing that destroyed my life...destroyed me as a human being and I'm told the service, it exists, but I ring them and you'll get an assessment within a short period of time and your first appointment for counselling, in my experience would be a year later."

Tara also commented on these conditions, stating that in her fee-paying workplace, she does not often manage clients from impoverished backgrounds: *"not because they don't experience trauma"* but rather because: *"they're not in a position to pay for counselling."* To which she added they are required to go to their doctor and be placed on a waiting list.

On the other hand, participants reported that not only does money determine support-service availability for those facing issues of socio-economic adversity, but fears of social stigmatisation may prevent victims from accessing services. In saying that, those who are 'well-off' are considered to be more concerned about receiving judgment from their own 'community,' whereas disadvantaged cohorts worry about external judgement:

"If you're disadvantaged, like people you know, and I hate to say it can look down on you." (Mary)

Ava reported that, from her knowledge people from wealthier communities worry that if they come forward in accessing services, they put their social status and lifestyle at stake. As a result, Ava believes they: *"don't want to talk about it."*

On that topic, Tom, Samantha and David exercised the vitality of customized treatment plans for clients. Tom clarified that tailored

Table 1
Socio-demographic characteristics of participants.

Name (pseudonym)	Gender	Occupation	Location
Anne	Female	Psychologist	Dublin
Mary	Female	Youth support worker	Sligo
Rosie	Female	Psychotherapist	Sligo
Tara	Female	Psychotherapist	Sligo
Samantha	Female	Social care worker	Mayo
Christine	Female	Social care worker	Dublin
Ava	Female	Refugee support worker	Louth
Tom	Male	Social care worker	Dublin
David	Male	Addiction Counsellor	Dublin

treatment is essential depending on the emotional impact the trauma caused. For example, Samantha said that some clients' trauma has their brains: *"stuck on it"* and they keep revisiting their history. This differs for other individuals, as David recalled that one of his clients reported feeling worse after counselling due to their mental revisitation episode(s) (re-traumatization).

4. Discussion & Conclusion

This study aspired to investigate whether denial, self-isolation and drug and alcohol abuse were coping mechanisms adopted by childhood trauma victims. Another objective was to clarify if low self-esteem, depression and anxiety and sleep disturbance were consequences of childhood trauma. The data suggested that some sufferers deny their adversities and refuse to acknowledge their experiences in fear of its negative impact on their wellbeing. Research from Tapia (2014) and Frazier (2000) support these claims by highlighting that reflecting on trauma can produce feelings of shame within the individual, making it harder for them to seek professional assistance and accept their history. Furthermore, the results indicated that instead of self-isolating, childhood trauma victims may choose to construct a false self-image in order to hide the impact their adversities have on their wellbeing. Although, this finding differs to those expressed by Shallcross, Troy, Boland, and Mauss (2010), who state that trauma victims may self-isolate to emotionally shield themselves from their past, it can be argued that the motive to embrace an insincere character is also a way for one to protect themselves from their previous mistreatment. With that said, the findings illustrated that victims who were neglected by their parents can create a false self because they have a low self-esteem and feel that others will approve of them if they alter their personality. This reinforces conclusion drawn by Yumbul, Cavusoglu, and Geyimci, (2010) who declare that poor parent-child relationships can produce internal conflict within the child by adulthood.

The research implied that drug and alcohol misuse can be coping mechanisms of childhood trauma victims as it was reported that all participants mentioned that clients use alcohol and drugs to cope (however, not all statements could be included in this article). Nonetheless, it was summed up that this strategy is oftentimes used to block out emotional wounds caused by trauma exposure. In light of these statements, findings from Shin, Lee, Jeon, and Wills (2015) found similar results; showing that youths who endured trauma felt impelled to engage in alcohol abuse. Similarly, research by Hammersley et al., (2016) outlined that individuals who were wrongly treated in childhood faced drug dependency issues and argued that their abusive history contributed to their drug addiction in adulthood.

Our research also proposed that symptoms connected to depression and anxiety can surface in childhood trauma victims. Participants emphasized that some clients struggle to overcome their trauma by adulthood. Some sufferers are convinced that they cannot live normally or believe that they are worthless if they were constantly told so in childhood. This study along with research by Teague (2013) underpins that this can negatively contribute to interpersonal relationships and general self-concept. In addition, research by Klassens (2010) and Chrousos (2009) established that if an individual grapples with their past and cannot move past it, stress hormones become overactivated in the body causing depression and anxiety related disorders. Unfortunately, this research did not announce sleep disturbance as a central consequence of childhood trauma and therefore could not support previous literature. Lastly, the findings shared that social support, financial aid and professional guidance could minimize the effects of childhood trauma on one's wellbeing. Thus, supporting data offered by Steele & Kuban (2014) and Murray et al. (2015) who proclaim that such resources could build resilience against trauma and stressful situations.

4.1. Limitations and future directions for additional research

The recruitment of professionals from various wellbeing backgrounds based in four counties across Ireland was a strength in the study as it offered unique perspectives on childhood trauma and surrounding issues. The study is limited in size due to the time constraints and resources available. Despite this, it does reflect a relatively expansive geographical spread within the Irish context of perspectives from professionals from a broad range within the fields of mental health and wellbeing, as well as social support services.

Due to geographical location only 3 out of 9 semi-structured interviews were carried out face-to-face and the remaining 6 were conducted via phone call. This proved to be a slight challenge as the scarcity of social cues meant that conversations were prone to verbal interruptions and network connections difficulties.

Maintaining a gender-balance among participants was also challenging as only 2 male participants agreed to contribute to the study. When attempting to address this, one professional speculated that it could be because the field of care and wellbeing is predominately female orientated. Further investigation into this could ameliorate this disparity.

Regardless of the study's constraints, in depth professional narrations were submitted by participants about the lives of those who have endured childhood trauma from an abusive standpoint. These expressions from the Irish mental health, well-being and social care practice sectors have acknowledged the impact of childhood trauma on children's wellbeing. Clear correlations were outlined by these professionals between adult behavior and the existence of a survivor's vulnerability. Moreover, this study has provided a valuable contribution by highlighting the pitfalls in service provisions for those lacking in the financial resources to access private care. This reiterates the need for further research around the disparities between private and public health and well-being sectors in Ireland and the impact this may have on trauma victims.

It is recommended that future research proceeds with face-to-face semi-structured interviews to bypass any interruptions and audio complications. The data generated large volumes of information about traumatic abuse and therefore could not assiduously cover all consequences of childhood trauma, including PTSD and sleeping problems. However, following on from the research trajectory, other academics are encouraged to inspect these elements in a comprehensive manner at another stage.

Another recommendation for future studies is to narrowly investigate the correlation between professional perspective on trauma and gender- a finding that could not be secured due to the gender-imbalance present in this study. This is advised as it is possible that gender variations may exist in perceptions of client experience(s), thus, influencing the professional support available.

It is lastly suggested that additional research explores potential links between financial status and access to resources, as this research declared that support and interventions may reduce the

Table 2
Common themes and codes found in interviews.

Low self-esteem	False self-image	Intergenerational trauma	Social support
Shame	Sex addiction	Craving love	Financial issues
Depression/Anxiety	Relationship instability	Lack of parental teachings	Fear of social stigma
Fear/Anger	False confidence	Recollection	Emotional support
People-pleasing	Denial	Relationship with the primary caregiver	Relationship building
Drug and alcohol use	Self-hatred	Self-doubt in adulthood	Resilience building
Lack of insight	Excessive engagement in activities	Re-traumatization	Lack of trust

severity of trauma symptoms. Moreover, the time constraints within the study, did not facilitate an in-depth social analysis. Future research of this kind could further unveil the possible nuances which may exist for victims, not only across social class, but across gender, ethnicity and (dis)ability (Table 1).

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Ethics approval and participants' consent

Informed consent was obtained from all individuals who participated in the study prior to the data collection and data analysis stages.

Ethics approval was granted by the Human Research Ethics Committee at University College Dublin. The research application outlined the purpose of the research and how data would be collected and managed by the researcher before approval was permitted. The study was thoroughly guided by the second author, Aoife Crummy for the duration of the study. All methods were carried out in accordance with appropriate regulations and guidelines

Data for reference

Interview questions can be accessed via Zenodo: 10.5281/zenodo.4639706.

Declaration of Competing Interest

All authors declare that they have no competing interests.

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