

Differential Associations Between Childhood Trauma Subtypes and Anxiety Symptoms in Young Adults

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Abstract. Childhood trauma act as a potential predictor for anxiety, while many studies regard early predicament as a binary factor instead of a multifaceted progression. This study operated a cross-sectional, correlational design on university-aged sample, aiming to examine the correlations between five childhood trauma subtypes accordingly to CTQ-SF (sexual abuse, physical abuse, emotional abuse, physical neglect, emotional neglect) and three anxiety disorders (Generalized Anxiety Disorder – GAD-7, Social Anxiety – SIAS, Panic Disorder – PDSS-SR) via online assessments. Measures included the CTQ-SF (28 items; five subscales), GAD-7 (0–21), SIAS (20 items), and PDSS-SR (0–28). Anxiety scales were strongly intercorrelated (PDSS-SR-GAD: $r=.65$; GAD-SIAS: $r=.36$; PDSS-SR-SIAS: $r = .21$), while CTQ subscales showed robust covariation (e.g., emotional abuse-physical abuse: $r = .68$; physical neglect-emotional neglect: $r = .62$). Notably, the current study proposed gender as a moderating factor, as gender-specific adversity were reported to render certain anxiety disorders. Consequently, a weak relationship between trauma categories (and CTQ aggregation) and anxiety subtypes was established. The results accentuated the essentiality to conceptualize trauma as a multidimensional determinant, including possible reporting bias and underlying mechanisms that transform subtype-specific experiences into discrepant anxiety types. For future directions, research could employ longitudinal and constant-dose models and discover applicable mediators onto intervening programs. Such extension holds implication on tailorizing trauma-sensitive measuring instruments and protective strategies for young population at early stage.

Keywords: childhood trauma, trauma subtypes, gender differences, young adults

1. Introduction

Experiencing childhood trauma is a well-established risk factor for adverse psychological and physiological health outcomes, often conceptualized within the broader framework of early life stress (ELS) [1]. Specifically, certain types of stressors are associated with the onset of anxiety disorders [2]. Exposure to these stressors, particularly at an early age, may impede the development of psychopathology into adulthood and result in the recurrence of psychiatric symptoms throughout one's lifetime. This association has also been demonstrated in clinical samples, whereby traumatic events in early life served as dormant triggers for subsequent neurobiological alterations [3]. Such

alterations - such as decreased hippocampal subregion volumes and disrupted cortisol levels in response to stress, oftentimes in adverse environments and elevated risk for mental illness throughout life – have been identified in prior research [4]. These neurobiological changes that result from childhood neglect or abuse further increase one's risk for developing future psychopathology and anxiety symptoms later in life [5].

There are numerous theoretical accounts present in the literature that seek to elucidate the relationship between childhood trauma and the emergence of anxiety disorders across a person's lifespan. From a neurobiological perspective, it is suggested that early life stress augments the stress response system of an individual, particularly the hypothalamic-pituitary-adrenal (HPA) axis, leading to abnormal cortisol levels due to hyper- or hypo-activity of the HPA axis, consequently increasing vulnerability to anxiety disorders [6]. Developmental models posit that specific traumatic events at certain points in development are predictive of future psychopathological outcomes by disrupting patterns of attachment security and emotion regulation [7]. The persistence of post-traumatic stress leads to formation of dysfunctional cognitive schemas about self and world which results in a vicious cycle involving avoidance and distorted interpretations of social cues or bodily cues [8]. Taken together, these theories posit that exposure to trauma can produce anxiety via multiple mechanisms and suggest that different types of traumas are associated with specific mechanisms.

Despite the established associations between early traumatic events and subsequent psychopathology in other studies also oversimplify this relationship as a binary factor - people either have experienced it or not - without accounting for other factors such as severity levels or type of trauma experienced. In other words, an established dose-response relationship associated with trauma may be overlooked: as severity or frequency of maltreatment increases or accumulates over time there is corresponding increase in the risks for developing anxiety disorders [9]. Nevertheless, similar findings on related factors are lacking from other studies; several studies argued that stressful events in adulthood were predictive of severity of anxiety symptoms whereas another argued that age at first exposure did not moderate later effects. Also, gender could potentially moderate such relationship such that females became more likely than males to develop anxiety disorders and specific subtypes of traumas were reported by women respectively [10]. On contrast, males have shown more externalizing behavior following exposure [11]. Therefore, such complication demanded research on investigating trauma's severity level and subtypes, as well further classification on possible gender discrepancies in anxiety outcomes.

Existing research accentuated different trauma subtypes possess not only pervasiveness, but their pathological outcomes. For example, previous study empirically concluded a relationship between emotional neglect and abuse and generalized anxiety symptoms [12]. This is further supported by prior findings of a relationship between these two trauma types and more severe social anxiety and poorer quality of life [13], potentially due to lack of approval and support in childhood resulting in reduced interpersonal confidence and fear of judgment [14]. At the same time, physical abuse has been witnessed to be associated with panic disorder through increased physiological arousal and conditioned fear responses [15], whereas sexual and physical abuse had stronger association with PTSD and panic attacks [16]. Collectively, the above findings suggest that trauma specific vulnerabilities are related to specific anxiety disordered phenotypes further supporting the relationship between early adverse environments are related to pathological outcomes.

However, empirical findings are not always consistent on severity of trauma and anxiety. Some studies have reported a clear dose-response relationship in clinical populations studies [17], where research conducted on community populations often do not report any or weaker relationships when

controlling for confounding variables like socio-economic status [18]. Other factors such as use of different assessment instruments (retrospective self-reports vs. prospective reports), different scales for assessing social anxiety and culture can be accounted for. Furthermore, studies adopted a cross-sectional design restrict causal relationship by grouping trauma as an aggregated score, which inevitably conceal crucial patterns within subtypes. These challenges emphasize the need for more detailed research that consider trauma type, severity, and gender, as well the use of well-validated measures to capture specific anxiety domains.

Informed by previous limitations, the present study aims to investigate whether severity levels of childhood trauma subtypes are associated with specific anxiety outcomes in young adults. Although previous studies often treated trauma as a single construct or examined one type of abuse, accumulating evidence suggests that particular trauma risks may confer unique risks for distinct anxiety outcomes. Based on prior literature, it is hypothesized that: (1) higher severity of emotional neglect is associated with greater social anxiety; (2) increased level of physical and sexual abuse is correlated to panic disorder; (3) gender would act as a moderating factor in these associations, with women displayed stronger trauma-anxiety relationships overall.

2. Method

2.1. Participants

Participants consisted of 95 young adults after excluding 15 individuals who either failed the attention check or provided blank responses. Participants' age ranged from 18 to 30, primarily Chinese university students. Participants were mainly recruited through convenience sampling by distributing an online survey link via social media platforms such as WeChat Moments and group chats. Inclusion criteria include being within the target age range and currently enrolled in a university program in China. Participants were informed that the study investigates early life experiences and current emotional well-being. Prior to participation, informed consent will be obtained electronically, and all responses will be anonymous and confidential.

The average age of participants was 20.60 years ($SD = 4.61$). In terms of gender, 63.16% identified as female, 33.68% as male, and 3.16% preferred not to disclose their gender. Regarding educational background, 61.05% of participants reported currently being enrolled in undergraduate programs, 32.63% had completed high school, and 7.37% were pursuing or had obtained a master's degree.

2.2. Design

The study utilized a cross-sectional, correlational design using self-report measures to examine the associations between childhood trauma subtypes and anxiety symptom subtypes in young adults. All variables will be assessed through a one-time online survey administered via a secure web-based platform. Trauma exposure is measured using five subscales of the Childhood Trauma Questionnaire - Short Form (CTQ-SF), which serve as the independent variables. The dependent variables will be generalized anxiety, social anxiety, and panic symptoms, measured by the Generalized Anxiety Disorder 7-item scale, Social Interaction Anxiety Scale, and Panic Disorder Symptom Severity - Self Report, respectively. This non-experimental design allows for the analysis of natural variation in trauma history and anxiety outcomes without manipulation or intervention.

2.3. Materials

The study utilized four different measuring scales as for assessing the intensity of anxiety and trauma. Firstly, early trauma experiences were instrumented by the Childhood Trauma Questionnaire – Short Form (CTQ-SF). The scale comprises 28 self-report items across five trauma subtypes: sexual abuse, physical neglect, emotional neglect, physical abuse, and emotional abuse. There is a 5-point Likert scale for each item, whose scores range from 1 (never true) to 5 (very often true). The ultimate subtype's scores would be tallied by adding up relevant items – higher the score, more severe the trauma exposure. For example, “I got hit so hard that I had to see a doctor” is the ninth question of the scale [19].

To examine the severity of the Generalized Anxiety, the Generalized Anxiety Disorder Scale (GAD-7) is taken up. The instrument contains 7 items, each with a 4-point Likert scale ranging from 0 (not at all) to 3 (nearly every day) and a total score of 21. All symptoms addressed were temporally restrained over the past two weeks, given the context “Over the last two weeks, how often have you been bothered by the following problems?” Similarly, higher scores representing more severe anxiety outcomes [20].

Social anxiety symptoms severity was measured by a 20-item Social Interaction Anxiety Scale (SIAS). This scale measures the affective components of distress and fear of social circumstances. Answers were made on a 5-point Likert scale where responses ranged from 0 = “not at all” to 4 = “extremely”. For example, “I become tense if I have to talk about myself or my feelings” is the third item. The higher the total score, the greater the severity of social anxiety [21].

Panic disorder was measured using the Panic Disorder Severity Scale - Self-Report (PDSS-SR). It's a 7-item scale addressing panic attacks and limited symptom attacks, given explicit operationalization of the two terms. Participants have to select one out of the five options, with each item ranging from 0 (no symptoms) to 4 (extreme). A composite score is calculated by taking the average of the seven items, with its raw score ranging from 0 to 28. “How many panic and limited symptom attacks did you have during the week?” is the first question of this questionnaire [22].

2.4. Procedure

After providing informed consent, participants completed an online survey consisting of demographic items, the CTQ-SF, and anxiety measures (GAD-7, SIAS, PDSS-SR). The order of questionnaires will be randomized to reduce order effects. Participation will take approximately 10-15 minutes. Towards the end of the study, a debriefing page will be displayed.

3. Test results and discussion

A series of one-way ANOVAs were conducted to examine the effects of different levels of childhood trauma (none, low, medium, high) on anxiety scores, including generalized anxiety disorder, social anxiety disorder, and panic disorder, with gender-stratified analysis. For each trauma subtype, participants were grouped by reported severity levels, and mean anxiety scores were compared across these groups. Significance was assessed at $\alpha = .05$.

The ANOVA revealed a statistically significant effect of physical neglect on social anxiety, $F(10, 49) = 2.296$, $p = .027$, and $F(7, 24) = 2.749$, $p = .030$, indicating that participants who reported higher levels of physical neglect also reported greater levels of social anxiety.

Similarly, physical abuse significantly predicted differences in social anxiety, $F(9, 85) = 2.478$, $p = .015$. A one-way ANOVA also showed that the sexual abuse severity significantly influenced panic

disorder symptoms, $F(5, 53) = 2.579$, $p = .029$. Additionally, emotional neglect severity was associated with significantly different levels of panic disorder, $F(18, 41) = 1.943$, $p = .039$.

These findings indicate that the severity of certain trauma subtypes is associated with elevated anxiety symptoms in adulthood. All other ANOVA tests examining the relationship between childhood trauma and anxiety severity did not yield significant results ($p > .05$).

Additionally, the bivariate correlation matrix (see Table 1) offered an overview of correlations between childhood trauma subtypes and anxiety outcomes. Notably, emotional and physical neglect, along with emotional abuse, were positively associated with all three anxiety types, while minimizing/denial scores were negatively correlated, consistent with prior research linking childhood adversity and internalizing symptoms.

Table 1. Correlations between anxiety subtypes and childhood trauma subtypes

Variable	1	2	3	4	5	6	7	8	9	10
1. PSDD-SR	-									
2. GAD	0.65***	-								
3. SIAS	0.21*	0.36***	-							
4. PA	0.04	0	0.09	-						
5. EA	0.15	0.06	0.07	0.68***	-					
6. SA	0.06	0.03	0.01	0.32**	0.4***	-				
7. PN	0.04	-0.06	0.04	0.47***	0.32**	0.24*	-			
8. EN	0.12	-0.02	0.19	0.52***	0.44***	0.23*	0.62***	-		
9. M/D	-0.14	-0.04	-0.21*	-0.43***	-0.31**	-0.16	-0.5***	-0.84***	-	
10. CTQ total	0.11	0	0.11	0.81***	0.78***	0.47***	0.73***	0.81***	-0.6***	-
Mean	3.51	5.59	25.65	6.73	10.4	5.67	8.19	12.25	9.86	51.46
SD	3.59	4.81	12.67	2.83	2.68	1.42	2.82	4.95	3.21	10.53

Note. * $p < .05$; ** $p < .01$; *** $p < .001$

PSDD-SR=Panic Disorder Severity Scale - Self Report, GAD=Generalized Anxiety Disorder Scale, SIAS=Social Interaction Anxiety Scale, PA=Physical Abuse, EA=Emotional Abuse, SA=Sexual Abuse, PN=Physical Neglect, EN=Emotional Neglect, M/D=Minimizing/Denial, CTQ=Childhood Trauma Questionnaire

The present study investigated how various subtypes and severities of childhood trauma are associated with different forms of anxiety in young adults. Using a one-way ANOVA approach, statistically-significant associations were found between amplified physical neglect and higher level of social anxiety scores, consistently across participants in both gender. Correlational researches further substantiate this finding, demonstrating a strong positive correlation between trauma subtypes, with remarkably robust correlation between emotional abuse, physical neglect and the total traumatic score. Such findings offer cogent evidence that specific categories of early-life trauma are not only predictive of certain adulthood anxiety symptoms, but display differential effects accordingly to trauma subtype and anxiety domain.

The significant main effects identified through the ANOVA lend support to the theoretical proposition that early-life adversity can exert lasting influences on both emotional and cognitive development. For example, the observed association between physical neglect and heightened social anxiety may indicate disruptions in social learning, attachment formation, and trust development during critical periods of growth [4]. This aligns with previous research demonstrating that children

exposed to neglect frequently display patterns of social withdrawal and increased vigilance in peer-related situations [23].

Notably, in female participants, sexual abuse and emotional neglect were uniquely linked to elevated panic disorder symptoms. These findings correspond with prior evidence suggesting that panic disorder may be particularly susceptible to early traumatic experiences characterized by fear, betrayal, or unpredictability [24]. One plausible mechanism involves heightened neurobiological sensitivity, wherein repeated exposure to stress during childhood contributes to dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, ultimately amplifying physiological reactivity to later anxiety-provoking contexts [3].

Women more often rely on emotion-focused coping, whereas men tend to use problem-focused strategies such as active planning (e.g., during the COVID-19 pandemic). Crucially, emotion-focused coping that involves avoidance or rumination is associated with higher anxiety symptoms, particularly among women [25]. This gendered divergence in coping offers a plausible explanation for why trauma-anxiety associations emerged more strongly among female participants in the present sample.

The correlation matrix revealed moderate-to-strong associations among CTQ subscales and various anxiety measures, with particularly robust links between emotional abuse, physical neglect, and all assessed anxiety dimensions. Interestingly, minimizing/denial scores exhibited a strong negative correlation with other trauma indices, implying that self-report biases may have reduced the apparent strength of certain effects. Despite this, the overarching pattern underscores the cumulative influence of adverse childhood experiences on increased psychological vulnerability later in life.

The outcomes of this study carry meaningful implications for clinical practice and public health. One of the most notable insights concerns the heterogeneous influence of different trauma subtypes. Rather than treating childhood adversity as a single, uniform predictor of psychological risk, these findings highlight that forms of maltreatment exert distinct effects on anxiety-related symptoms. This perspective supports a growing consensus in developmental psychopathology that early adversity should be conceptualized as a multidimensional construct with unique mechanisms and outcomes [4].

From a clinical perspective, these results advocate for the adoption of trauma-focused mental health screening practices. Incorporating assessments capable of distinguishing among different maltreatment histories would allow clinicians and counselors to detect early indicators of anxiety vulnerability, especially among young adults with experiences of neglect or abuse. Such recommendations are consistent with broader calls to integrate trauma-informed approaches within both academic and therapeutic contexts [26].

Furthermore, the observation of these effects within a non-clinical university population underscores that the psychological consequences of childhood adversity can surface even among individuals functioning within normative developmental contexts. This suggests a need for preventive measures, such as psychoeducational workshops, early-access counseling, and structured social support initiatives, designed to mitigate long-term risk in ostensibly resilient populations.

Finally, by clarifying how specific patterns of maltreatment map onto distinct anxiety outcomes, these findings contribute to refining public health strategies aimed at minimizing the enduring psychological burden of early-life adversity. Such insights can inform targeted interventions, policy development, and resource allocation for populations most at risk.

While the foregoing implications highlight clinically meaningful patterns, two qualifications temper the strength and scope of our inferences. Firstly, we converted CTQ subscale scores into four severity bands (none/low/moderate/high) to enable group-wise ANOVA. This discretization likely

compressed within-group variability and oversimplified a dimensional construct, especially within the “high” category where intensity and chronicity may vary widely. Given evidence that trauma-psychopathology links can be nonlinear and dose dependent, binning may introduce misclassification and attenuate true effects [4]. Relatedly, reliance on self-report raises the possibility of response biases, which could downwardly bias associations.

Secondly, the non-clinical, university cohort is suited to detecting early or subclinical patterns but does not mirror the symptom severity, trauma complexity, or comorbidity typical of treatment-seeking populations. This range restriction may help explain modest effect sizes and limited significance across certain trauma-anxiety pairings. Moreover, students may possess protective resources that buffer anxiety expression following adversity, further constraining generalizability.

Future research on this topic should focus more on longitudinal designs that would enable researchers to follow participants across time. Such designs help in determining whether early-life trauma predicts onset of anxiety disorder, and whether pre-existing vulnerability impact how traumatic events are internalized [27]. Repeated assessments at critical developmental time points can also provide new insights into the development of symptoms from adolescence to young adulthood. Another exciting avenue would be investigating mechanism underlying how trauma influences on anxiety. Previous research have suggested a few potential mediators such as avoidant coping strategies and emotion dysregulation that may account for unique associations between subtypes of trauma exposure and anxiety profile [28]. When studying these processes, longitudinal design would be most appropriate employing path analysis since it accounts for stability and overlap variance in symptoms over time. Combining multiple indicators methods (self-report, behavioral tasks, HPA reactivity) and examining gender-specificity could point to when/for whom these mechanisms operate, which could ultimately guide targeted mechanism-focused interventions.

4. Conclusion

Taken together, the pattern of findings suggests that childhood adversity is multidimensional and tightly interwoven across subtypes, whereas its correlations with anxiety symptoms were modest in this non-clinical, university sample. The strong covariation among CTQ domains and the negative links with Minimization/Denial highlight the need to account for measurement bias when interpreting trauma–psychopathology associations. Given that the design was cross-sectional and relied on self-report instruments administered online, causal inferences cannot be drawn and effect estimates may be conservative. Future work should move beyond categorical severity bands to continuous, dose-response models, incorporate strategies to mitigate underreporting (e.g., validity checks, multi-informant data), and apply longitudinal and mechanistic approaches to clarify when, how, and for whom early adversity confers risk for specific anxiety phenotypes.

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