

## Assessing the Long-term effects of Childhood Trauma: Depression, Anxiety, and Long-Term Illness

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### Abstract

*the study assesses the long-term effects of childhood depression, post-traumatic stress disorder (PTSD), borderline personality disorder (BPD), and anxiety disorder. Data was collected from 400 psychiatric patients in the United Arab Emirates using structured questionnaires. Statistical analysis of the data was conducted using SPSS and AMOS. The findings reveal that childhood trauma, including physical, emotional, and sexual abuse as well as physical and emotional neglect tends to be a significant predictor of depression, anxiety disorder, PTSD, and BPD. Childhood trauma significantly increases the risk of BPD, PTSD, depression, and anxiety disorder. The study contributes to the literature and practice on childhood abuse. It will assist psychiatrists, parents, and other caregivers with understanding how emotional, sexual, or physical abuse or neglect can harm the psychological condition of the child by causing depression, PDST, anxiety disorder, or BPD.*

**Key words:** *childhood trauma, depression, borderline personality disorder, anxiety, post-traumatic stress disorder*

### 1 INTRODUCTION

Childhood trauma is a frequent misfortune that happens to children, which can lead toward various negative outcomes. It refers to a phenomenon that happens to people below the age of 18 and involves any type of abuse such as physical, emotional, or sexual (Etain et al., 2010; Majer, Nater, Lin, Capuron, & Reeves, 2010; Schwandt, Heilig, Hommer, George, & Ramchandani, 2013). Although the literature on childhood trauma provides insights regarding different types of child abuse, some dimensions/sub-types have been neglected. Physical and emotional neglect can result in various psychological, emotional, biological, and other negative outcomes for the individual (Aust, Härtwig, Heuser, & Bajbouj, 2013; Stoltenborgh, Bakermans-Kranenburg, & Van Ijzendoorn, 2013). Different types of child abuse or neglect can have negative long-term outcomes that can harm the safety, health, prosperity, and morale of the individual (Aust et al., 2013). Childhood trauma is increasingly becoming a significant social issue, which tends to affect the individual in certain ways. The literature highlights four key ways that childhood trauma affects a child: behavioral, emotional, social, and cognitive. Emotional refers to the mental health deterioration while the behavioral is associated with high-risk lifestyle, substance abuse, obesity, and suicide (Kendall-Tackett, 2002). Cognitive refers to attitudes and beliefs such as a low opinion of self and lower perception of health. Social includes difficulties maintaining interpersonal relationships and sexual problems (Fleming, Mullen, Sibthorpe, & Bammer, 1999; Kendall-Tackett, 2002). Many studies examine the long-term effects of childhood trauma in cognitive, behavioral, and social ways while the number of studies regarding the emotional long-term effects are scarce. The current study aims to assess the long-term emotional psychological effects of childhood trauma.

The loss of a parent, mistreatment by a loved one, betrayal by a trusted one, neglect by caregivers, violence, and any other trauma or abuse tend to affect the individual mostly in their childhood and adolescence (Bernstein et al., 2003; Butchart, Harvey, Mian, & Furniss, 2006). The increasing interest in emotional and psychological neglect has attracted many researchers to examine the impact of such neglect on the personality and psychological condition of individuals during their childhood; however, the literature that examines the effects of physical abuse and emotional neglect during childhood that lead to certain psychological changes in the individual is limited. The current study bridges this gap by examining the long-term effects of abuses as well as neglects based on five key dimensions (physical abuse, emotional abuse, sexual abuse, physical neglect, and

emotional neglect) of childhood trauma. Accordingly, the current study will be a significant contribution to the literature on childhood trauma and its long-term effects.

The long-term effects of childhood trauma may be explained by drawing on betrayal theory. Betrayal theory predicts the level of trust violated by a negative event caused by a trusted individual (Freyd, 1996). Betrayal theory explains the way negative events caused by trusted individuals are processed and remembered by a child over the long term (Sivers, Schooler, Freyd, & Ramachandran, 2002). Negative events caused by trusted individuals include rape by a caregiver (Freyd, 2003). Parents or parental caregivers cause 80% of maltreatment and traumas (Gilbert et al., 2009). The research examines the long-term effects of childhood trauma through the lens of betrayal theory. The consequences of childhood trauma including depressive symptoms, changes in brain functionality, serious mental and cognitive issues, substance abuse, relationship problems, violence and anger, and poor physical health are highlighted in the literature (Aust et al., 2013; Etain et al., 2010; Majer et al., 2010; Schwandt et al., 2013). However, the literature does not provide sufficient explanation and evidence for the long-term effects of childhood trauma such as depression, anxiety, BPD, and PTSD. Although some studies link childhood trauma with various psychological disorders, none link childhood trauma to PTSD, depression, BPD, and anxiety. The current study focuses on bridging this gap by linking childhood trauma with various psychological disorders including depression, anxiety, PTSD, and BPD.

The remainder of the paper consists of four sections. Section 2 is a review of past studies related to childhood trauma and its long-term effects. Section 3 covers the methodological approach and instruments used to perform the study. Section 4 discusses the findings. The last two sections discuss the findings, conclusions, and implications of the study.

## **2 LITERATURE REVIEW**

### **2.1 Major childhood traumas**

Childhood trauma is one of the most frequently occurring adversity to children and young adults. Childhood trauma may be defined as any experience that occurred to someone below the age of 18 including physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997). Early life stress and childhood maltreatment are synonymous with childhood trauma (Carr, Martins, Stingel, Lemgruber, & Juruena, 2013; Norman et al., 2012). They include any type of emotional or physical maltreatment, all forms of neglect, exploitation of children, sexual abuse that result in actual or potential injury or harm to a child's health, life, safety, development, and dignity (Norman et al., 2012). Childhood and adolescence are time periods which are greatly affected by the loss of a parent, divorce of parents, mistreatment by a loved one, abandonment, lack of proper health care, lack of food and shelter, absence of support and encouragement, molestation, and family violence (Bernstein et al., 2003; Butchart, Harvey, Mian, & Furniss, 2006). Acts involving physical, sexual, and emotional child abuse have been more prominent in the literature and considered the only definition of childhood trauma (Delima & Vimpani, 2011). However, the growing interest in emotional and psychological neglect has been omitted in the definition of childhood trauma (De Bellis, Hooper, Spratt, & Woolley, 2009; Delima & Vimpani, 2011).

### **2.2 Subtypes of childhood trauma**

The main subtypes of early life trauma include physical abuse, sexual abuse, emotional abuse, emotional neglect, and physical neglect. Physical abuse includes any form of assault, life threatening harm by someone older, disciplinary actions by caregivers resulting in severe pain, scars, burns, loss of mobility, beating, pinching, kicking, and so on. Sexual abuse includes any type of sexual activity that exposes the individual to sexual acts, exploitation, exposure to pornography, and so on. The emotional abuse includes verbal abuse affecting the dignity and morale of a child, hurtful or demeaning comments, bullying, and hearing violent acts happening to an attachment figure. Emotional neglect refers to failure of a guardian to provide emotional and psychological support including affection, encouragement, love, and so on. Intentionally ignoring the child and

not interacting with him/her also comes under this category. Physical neglect refers to failure of a guardian to provide necessities to the child such as food, shelter, clean clothes, and basic health care (Bernstein et al., 2003; Butchart et al., 2006; Chrousos & Gold, 1992; Delima & Vimpani, 2011). This type of maltreatment seriously hinders brain development and functionality, especially when the trauma is repeated and is considered life-threatening (Chrousos & Gold, 1992). The greater the severity, duration, and frequency of trauma the worse will be the outcomes (Briere & Jordan, 2009).

### **2.3 Betrayal trauma theory**

The level of trust associated with the caregiver or attachment intensity with the perpetrator significantly affects traumatic events (Freyd, 1996). This type of relational trauma is defined by the betrayal trauma theory (Freyd, 1996, 2003). The theory predicts the level of trust violated by a negative event caused by a trusted individual such as a parent or trusted caregiver. It also explains how the event will be remembered and processed (Sivers, Schooler, Freyd, & Ramachandran, 2002). A particular experience can be simultaneously life threatening and a betrayal. In fact most childhood traumas fall in this category, such as rape by a caregiver (Freyd, 2003). According to a study done by Gilbert et al. (2009), the parents or parental figures cause 80% of maltreatment and traumas. About 4-16% of children every year are physically abused and 10% psychologically abused or neglected. Traumatic events are common in childhood and adolescence (Gamache Martin, Van Ryzin, & Dishion, 2016). Some studies claim that 50-90% of trauma survivors experienced not just an isolated traumatic event, but multiple traumas simultaneously (Finkelhor, Turner, Shattuck, & Hamby, 2013; Gamache Martin et al., 2016).

### **2.4 Childhood trauma and long-term effects**

Childhood complex traumas and betrayal traumas are far more common than other subtypes. For example, a child experiencing sexual abuse can also witness physical abuse as well as emotional abuse, thus, making it a complex trauma. These types of traumas are more likely to produce long-term health and mental effects (Reichard, 2019). They have the potential to affect multiple functions over time. Over 45% of youth studied who had a traumatic history were diagnosed with mental health disorder (Southerland, Casanueva, & Ringeisen, 2009). In the USA, half of the early onset of mental disorders and a third of the adult mental disorders are preceded by family dysfunctions, childhood neglect, and abuse (De Bellis & Zisk, 2014).

Childhood trauma is also associated with the absence of the ability to trust or place too much trust in a perpetrator (Freyd, 1994). A violation of trust is the basis of betrayal trauma theory. Women tend to experience more betrayal traumas and men experience more non-betrayal traumas (Freyd, 2003). Traumas involving high level of betrayal are associated with severe symptoms of mental and health disorders including depression, PTSD, anxiety, and hallucinations (Freyd, 1996; Gamache Martin et al., 2016; Goldsmith, Chesney, Heath, & Barlow, 2013). Most victims of betrayal trauma tend to develop a certain blindness to the caregiver in order to maintain a sense of attachment necessary for survival (Freyd, 1996). Some responses of betrayal trauma include dissociation and amnesia (Freyd, 1994; Kaehler & Freyd, 2009). Such responses can be in lieu of the child's desire to sustain some level of attachment to the abusive guardian for self-nurture and survival. Childhood trauma also foretells specific learned behaviors that a child develops such as flinching, manipulating the perpetrator, or engaging in activities that can limit the intensity of the abuse (Freyd, 1994). Childhood traumas have an element of terror that can set off long-lasting impacts on the child's brain and could alter functionality permanently (Becker-Blease & Freyd, 2005).

Early maltreatment affects the life of children in various ways and leads to long-term effects throughout adult life (Briere & Jordan, 2009; Carr et al., 2013; Delima & Vimpani, 2011; Norman et al., 2012; Springer, Sheridan, Kuo, & Carnes, 2003). Consequences of childhood trauma include depressive symptoms, changes in brain functionality, serious mental and cognitive issues, substance abuse, relationship problems, violence and anger, and poor physical health (Delima & Vimpani, 2011). Children disposed to domestic violence and other forms of abuse experience changes in brain physiology, which in turn affect behavior and normal functionality

(Dube et al., 2005). Certain long-term outcomes of childhood abuse can be subdivided into internal and external symptoms (Carr et al., 2013). External symptoms include violence, aggression, prostitution, sexual problems, delinquency, and hyper activism while internal symptoms include anxiety, physiological arousal, depression, dissociation, fear, and avoidance (Carr et al., 2013).

Childhood traumas that are interpersonal (i.e., involve an act of betrayal), frequent, and intentional involve a high rate of PTSD, post-traumatic stress symptoms (PTSS), anxiety, depression, antisocial behaviors, eating disorders, and substance and alcohol abuse (De Bellis et al., 2009; Dube et al., 2005; Kendler et al., 2000; Widom, 1999). Moreover, such individuals are more likely to engage in risky behaviors, have irritable bowel movement, chronic pain, more use of health services (Arnold, Rogers, & Cook, 1990; Drossman et al., 1990; Houdenhove et al., 2001; Norman et al., 2012). Furthermore, decreased academic scores, lower IQ, and reduced attendance (Jaffee & Maikovich-Fong, 2011; Kinard, 1999) were also found to be among the long-term effects of childhood trauma. Most studies focus on isolated psychological outcomes in relation to traumas and betrayal traumas (Becker-Blease & Freyd, 2005; Carr et al., 2013; De Bellis et al., 2009; Freyd, 1994; Fung, Chan, Ross, & Choi, 2020; Gómez, Kaehler, & Freyd, 2014; Kaehler & Freyd, 2009; Mandelli, Petrelli, & Serretti, 2015). Certain kinds of traumas illicit certain outcomes. Psychological traumas coupled with emotional abuse are prone to damage neurological pathways, sensory development, and mental and physical health (Garbarino & Garbarino, 1980; Mandelli et al., 2015). Moreover, these traumas are predecessors to personality disorders, schizophrenia, anxiety disorders (including PTSD, mood disorders especially depression), eating disorders, and disruptive behaviors (Bradley, Heim, & Westen, 2005; Carr et al., 2013; Heins et al., 2011; Norman et al., 2012). Molnar, Berkman, and Buka (2001) found that sexually abused children were more likely to commit suicide as adults and the risk was 4-11 times higher in men and 4-6 times higher in women. Likewise, sexual abuse in childhood results in long-term illnesses such as borderline personality disorder (BPD), anxiety disorder including obsessive compulsive disorder (OCD), PTSD, acrophobia and panic disorders, mood disorders including major depressive disorder MDD (a bipolar disorder), eating disorders, and disruptive behaviors (Bradley et al., 2005; Carr et al., 2013; Grover et al., 2007; Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992). A study by Paris (1997) conducted on 275 participants, half with BPD and half without BPD revealed that BPD patients (70% females and 45% males) reported sexual abuse in childhood, but the control group also reported such abuse. This lead to the conclusion that childhood abuse acts as a factor in other personality disorders as well. Moreover, just childhood trauma cannot account for the complete etiology of personality disorders (Paris, 1997). High betrayal trauma is significantly associated with BPD as well as medium betrayal trauma (Kaehler & Freyd, 2009). In another study, it was deduced that for men having BPD, all levels of betrayal trauma were significant, but for women only high and medium level of betrayal traumas were significant (Kaehler & Freyd, 2012). Therefore, not only the level of betrayal matters in personality disorders but also the gender. The existing literature does not provide sufficient explanation and evidence of the long-term effects of childhood trauma including BPP and PTSD. The current study fills this gap by hypothesizing:

**H1:** Childhood trauma significantly derives the borderline personality disorder in the individual.

**H2:** Childhood trauma significantly derives the post-traumatic stress disorder in the individual.

Emotional abuse in childhood is associated with BPD, narcissistic personality disorder, schizophrenia, anxiety disorders such as social phobia and PTSD, major depressive disorder (MDD), and substance abuse disorders (Carr et al., 2013; Grover et al., 2007; Heins et al., 2011). The trauma type do not encompass physical neglect and emotional neglect; however, some studies found an association between neglect and psychiatric disorders (Carr et al., 2013). In a study conducted by Mandelli et al. (2015), neglect was found to be the most significant factor in developing depression or early symptoms of depression particularly in women. Although, many psychiatric disorders are associated with childhood abuse, betrayal trauma, depression, anxiety disorder, and personality disorder are the most common ones. Childhood abuse is positively associated with adult depression and anxiety disorders (Springer et al., 2003). In a study conducted by MacMillan et al. (2001), it was concluded



that adult depression is more common in both men and women that experienced childhood trauma. Early onset of depression and recurrent depression is consistent and common in adults that experienced abuse from parents, siblings, or other caregivers (Kessler & Magee, 1994). In a study conducted by Gamache Martin et al. (2016), five distinct profiles of betrayal trauma in conjunction with trauma subtypes emerged. These profiles linked high betrayal trauma, physical abuse and sexual abuse with major depression, hallucinations and PTSD. The study concluded that traumas caused by trusted individuals or family members are more psychologically damaging than other types of traumas (Gamache Martin et al., 2016). Betrayal trauma is also the cause of hallucinations and dissociations. Hallucinations can be tactile, auditory, or visual (Gómez et al., 2014). Fung et al. (2020) found that betrayal trauma positively influences adult depression and dissociation. Moreover, dissociation was significantly associated with betrayal childhood trauma.

**H3:** Childhood trauma significantly derives the long-term depression in the individual.

**H4:** Childhood trauma significantly derives the long-term anxiety in the individual.

### 3 METHODOLOGY

#### 3.1 Population and Sampling

The study examines the effects of childhood trauma (physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect) in the form of depression, anxiety, PTSD, and BPD among individuals in context of United Arab Emirates (UAE). The population of the study consists of patients experiencing depression, anxiety, PTSD, and BPD. Purposive sampling was employed to select 400 adolescent psychiatric patients experiencing depression, anxiety, PDST, or BPD and examine the linkage between childhood trauma and its long-term effects.

#### 3.2 Data Collection

The data was collected using structured self-reported questionnaires from patients and scoring scales by past researchers. The questionnaire was structured using an already developed inventory of variables. To collect the data, key psychiatric centers in the UAE were contacted that deal with childhood abuse and neglect. The data consists of self-reported information given by the patients. The structured questionnaires were distributed among 400 adolescent psychiatric patients to report about their childhood trauma, depression, anxiety, PTSD, and BPD using a closed-ended scale.

#### 3.3 Measurements

The study consists of five key childhood trauma variables (physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect) as the independent variables while depression, anxiety, PTSD, and BPD are the dependent variables. The childhood trauma variables were measured through self-reported questionnaires using the scale developed and validated by Bernstein et al. (2003). The BPD was measured by adopting the scale and scoring criteria used by Watson, Chilton, Fairchild, and Whewell (2006). The PTSD was measured using the inventory by Runtz and Roche (1999), while the depression was measured by adopting the method of Schulz et al. (2014). The anxiety disorder was measured and assessed through the method of Yehuda, Halligan, and Bierer (2001). All the variables were measured on closed-ended scales so that the objective data can be gathered to assess the relationships among the variables.

#### 3.4 Data Analysis

The study examines the relationship between childhood trauma and depressive disorder, anxiety disorder, PTSD, and BPD using statistical analysis. The data collected using closed-ended responses from patients was analyzed using SPSS and AMOS to perform confirmatory factor analysis (CFA) and hypothesis testing. The CFA determines the fitness of the model using five key indicators: CMIN/df, GFI, CFI, IFI, and RMSEA. The

hypotheses are tested based on significance (p-value) to decide whether the childhood trauma significantly results in depression, PTSD, BPD, and anxiety.

#### 4 RESULTS

Out of the 400 questionnaires distributed to patients, 360 self-reported questionnaires were returned while only 341 questionnaires were in proper form to be used in the analysis. The demographic profile shows 187 male and 154 female patients participated in the study.

##### 4.1 Descriptive Analysis

To identify the outliers and check for the normality of the data, a descriptive analysis was performed (see results in table 1).

**Table 1: Descriptive Statistics**

	N	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Std. Error
Childhood trauma	341	2.3387	1.16648	-.381	.132
Depression	341	3.2698	1.12346	-.260	.132
Anxiety	341	2.3812	1.28915	-.449	.132
PTSD	341	3.3226	1.25462	-.443	.132
BPD	341	3.4240	1.25402	-.466	.132

The results in Table 1 indicate that there is no outlier in the data because the mean value of each variable falls within the acceptable range (i.e., within the rating scale). Similarly, the value of skewness in the data is normal because the value of each construct is within the threshold range of skewness value, which is from -1 to +1. Accordingly, the researcher can move forward with the analysis because the data is normal.

##### 4.2 Reliability Test

Cronbach alpha ( $\alpha$ ) is computed for each variable to assess the reliability of the data (see Table 2).

**Table 2: Psychometric Properties**

Latent Variables	Cronbach alpha
Childhood trauma	0.917
Depression	0.974
Anxiety	0.923
PTSD	0.921
BPD	0.929

Table 2 shows the reliability of each construct which is checked by running the Cronbach alpha test. Cronbach alpha presents the internal consistency of each item for each construct. The Cronbach alpha value for all constructs is more than .70, which proves the reliability of the data.

##### 4.3 Convergent and Discriminant validity

The internal consistency of the data and discriminant validity were checked using AVE, MSV, and correlations among variables given in Table 3.

**Table 3: Convergent and Discriminant validity**

	CR	AVE	MSV	Childhood trauma	Depression	Anxiety	PTSD	BPD
Childhood trauma	0.925	0.878	0.248	0.908				
Depression	0.918	0.738	0.265	0.466	0.859			
Anxiety	0.973	0.836	0.265	0.335	0.515	0.914		
PTSD	0.927	0.822	0.231	0.481	0.464	0.395	0.906	
BPD	0.920	0.890	0.303	0.498	0.458	0.427	0.374	0.893

The value of composite reliability and average variance confirm the convergent validity of the data, whereas the correlations show the discriminate validity of the data. Composite reliability for each construct is more than .70, AVE of all variables is > 0.5, and value of MSV against each variables is less than its AVE which proves the convergent validity of the data. Correlations show that every construct has the highest correlation with itself rather than with others, which proves the discriminant validity of the data.

#### 4.4 Confirmatory Factor Analysis

The CFA was performed to check the fitness of the current model which contains childhood trauma, depression, anxiety, PTSD, and BPD as key variables (see Table 4).

**Table 4: CFA**

Indicators	CMIN/DF	GFI	IFI	CFI	RMSEA
Threshold range	<3	>.80	>.90	>.90	<.08
Observed values	2.668	.81	.932	.932	.070

The results in Table 4 show that all indicators are giving values within the threshold range. The value of CMIN/DF is 2.668, which is less than 3; GFI is .81, which is greater than .80; IFI and CFI are .932, which are greater than .90, and RMSEA is .07, which is less than .08. This means that the model of the study has a good fit.

#### 4.5 Hypotheses Testing

In order to test the hypotheses, the path coefficients and significance against them have been computed (see Table 5).

**Table 5: Structural Model Results**

Hypothesized Path	B	S.E	P value	Conclusion
CT → BPD	.264	.056	.000	Accepted
CT → PTSD	.143	.044	.000	Accepted
CT → Depression	.110	.050	.027	Accepted
CT → Anxiety	.169	.047	.000	Accepted

It is evident from the results in Table 8 that childhood trauma (CT) has significant positive effect on BPD, PDST, depression, and anxiety because the p-value against all these positive effects is <0.05. This means that an increase in childhood trauma increases the risk of BPD in the individual by 26.4%. Similarly, an increase in childhood trauma increases the risk of PTSD in the individual by 14.3%. An increase in childhood trauma increases the risk of depression in the individual by 11% and an increase in childhood trauma increases the risk of anxiety disorder in the individual by 16.9%.

## 5 DISCUSSION OF FINDINGS

The study examines the long-term effects of childhood trauma in the form of depression, PDST, BPD, and anxiety disorder. In response to the first hypothesis, the study finds that childhood trauma has a significant potential to cause BPD in the individual because the increase in childhood trauma increases the risk of BPD in the individual by 26.4%. These results are in line with previous studies including Bradley et al. (2005), Carr et al. (2013), Grover et al. (2007), Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen (1992), Paris (1997), Kaehler & Freyd (2009), and Kaehler & Freyd (2012) that emphasized and identified BPD as an outcome of childhood trauma. They suggest that children facing betrayal trauma are likely to suffer from BPD. Therefore, the first hypothesis is accepted based on the current evidence and support from past studies.

The second hypothesis is accepted because the increase in childhood trauma increases the risk of PTSD in the individual by 14.3%. The findings are supported by many other studies (e.g. De Bellis et al., 2009; Dube et al., 2005; Kendler et al., 2000; Widom, 1999). Moreover, Bradley, Heim, & Westen (2005), Carr et al. (2013), Heins et al. (2011), Norman et al. (2012), and Molnar, Berkman, and Buka (2001) also claimed that children facing child abuse or neglect are likely to suffer from PTSD in the long run. Hence, the second hypothesis is accepted and suggests that childhood trauma including physical, sexual, and emotional abuses and neglect can result in PTSD.

The third hypothesis regarding the long-term effect of childhood trauma in the form of depressive disorder is accepted because the study shows that an increase in childhood trauma increases the risk of depression by 11%. Similarly, the fourth hypothesis is accepted because an increase in childhood trauma causes an increase in the likelihood of anxiety disorder in the individual by 16.9%. These results are consistent with other studies (e.g. Carr et al., 2013 and Mandelli et al., 2015) that found neglect as the most significant factor in developing depression or early symptoms of depression particularly in women. Similarly, these results are in line with Springer et al. (2003) who found that childhood trauma is a significant determinant of anxiety and depressive disorders. MacMillan et al. (2001) also concluded that adult depression is more common in both men and women who have experienced childhood trauma. These findings are consistent with Fung et al. (2020) who reveal that the betrayal trauma experienced as a child influences adult depression. Hence, all current findings are in line with the results from previous studies. Based on the findings, individuals experiencing childhood trauma are likely to have anxiety disorder, depression, PTSD, and BPD in their adult life.

## 6 CONCLUSIONS

The study investigates and assesses the long-term effects of childhood trauma in the form of depression, PDST, BPD, and anxiety disorder. The data was collected from 400 psychiatric patients in the UAE using structured questionnaires and statistical analysis was conducted to reveal that childhood trauma including physical, emotional, and sexual abuse as well as physical and emotional neglect tends to act as the predictor of depression, anxiety disorder, PTSD, and BPD in individuals. Further, an increase in childhood trauma significantly increases the risk of BPD, the likelihood of PTSD, the risk of depression, and the risk of anxiety disorder in individuals. The study makes an important contribution to the literature and practice as it bridges a gap by taking childhood abuses as well as neglects into consideration i.e. physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect. Accordingly, the current study makes a significant contribution to the literature on childhood trauma and its long-term effects.

Practically, the study will assist psychiatrist, parents, and other caregivers with understanding how emotional, sexual, or physical abuse or neglect can harm the psychological condition of the child and the role of such abuse or neglect in causing depression, PDST, anxiety disorder, or BPD. The study entails some limitations that should be covered in future studies. For instance, the study does not examine the depression associated with particular divisions of depressive symptoms and major depressive disorder (MDD) which many studies associate with childhood trauma. Future researchers are directed to conduct in-depth examinations of these sub-



types of depression. Similarly, future researchers ought to focus on other personality disorders such as obsessive-compulsive disorder (OCD) and BPD that result from childhood trauma.

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