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THE IMPACT OF CHILDHOOD TRAUMA AND SELF-ESTEEM ON THE DEVELOPMENT OF ANXIETY DISORDERS

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Abstract

Background: *Childhood trauma is associated with the development of anxiety disorders, but it is yet to be determined how childhood trauma is linked to anxiety in adulthood (adult onset anxiety). One possible reason for this route has been speculated to relate to the development of low self-esteem in later years. However, most of the research on this topic has looked only at western populations with limited research looking at non-western populations.*

Objective: *To investigate the relationship between childhood trauma and Self-esteem and anxiety symptoms among young adults of Pakistan. The major focus will be on the potential mediation of the relationship between childhood trauma and anxiety by self-esteem.*

Methods: *This study aimed at understanding how Childhood Trauma (CT), Self Esteem (SE), and Generalized Anxiety (GA) all relate to each other in young adults (between ages of 18-35) through a total sample size of 132 participants (56.8% male). Participants filled out the Childhood Trauma Questionnaire (CTQ), Rosenberg Self Esteem Scale (RSES) and Generalized Anxiety Disorder (GAD-7) questionnaires, and a Pearson correlation coefficient was used to check the relationships between CT, SE & GA, a linear regression analysis in SPSS v23 was performed.*

Results: *Significant negative correlation was found between early life trauma and self-esteem ($r=-0.241$; $p = 0.005$) and moderate positive correlation was found between early life trauma and anxiety ($r=0.400$; $p < .01$). However, there was a very large negative correlation between self-esteem and anxiety ($r=-0.537$; $p < 0.001$) and this finding corroborates the negative correlation between CT & SE mentioonned above. Based on regression analysis, it was found that self-esteem had a significant predictive relationship towards anxiety ($\beta = -0.543$; $p < 0.001$), while the effect of CT on anxiety was not independent when added with self-esteem in the regression model previously discussed.*

Conclusion: *The results of the present study indicate that the symptoms of anxiety might be more directly associated with the development of self-esteem than with childhood trauma. So that we can conclude that self-esteem can be the process through which childhood trauma affects an adult's mental health. What may be helpful for adults who have experienced childhood trauma is to use the effects of childhood trauma (self-esteem) to assist in the better development of self-esteem.*

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Introduction

Traumatic experiences during childhood is a serious global health problem; worldwide, around 60% of all adults say they have experienced trauma at some point in their early years (Kessler et al., 2010) which occurs regularly within childhood depending on where you live. Experiencing trauma while at any of these crucial stages of development interrupts or alters the way that our developing nervous systems, emotion systems and social systems are wired and can cause a person to become vulnerable to the development of One or more mental illnesses throughout their life (Teicher & Samson, 2016). One very common effect is anxiety disorders, with an estimated 18% of adult patients with a history of trauma having some type of anxiety disorder as their result (McLaughlin et al., 2012).

There has been a lot of research that has shown an association between childhood maltreatment and adult anxiety disorders (Norman et al., 2012; Kuzminskaite et al., 2022). Children who are emotionally sexually abused or neglected and suffer mental or psychological abuse tend to have the highest risk for developing anxiety disorders as adults (Gibb et al., 2007; Simon et al., 2009). We do not completely understand how this happens; therefore. we cannot develop successful interventions that would target these populations effectively; they will only exist in hypothesis form based on the existing literature.

The impact of childhood trauma does not stop once the abusive situation has finished; it is present throughout a child's development, creating a domino effect of problems that worsen as the child grows older (Teicher et al., 2016; McLaughlin et al. 2012). These problems appear in three different areas of life: psychological (negative self-concept; shame), behavioural (avoidance; substance use), and neurobiological (stress response; impaired emotion regulation) (Kim & Cicchetti, 2006; Downey & Crummy, 2022; Teicher et al. 2016). All these areas work together to produce a cycle where trauma damages the brain's stress-regulating systems, which can lead to difficulty with behaviours and coping, in turn reinforcing an individual's negative self-beliefs and further damaging their stress-regulating systems (Ross et al., 2021; McLaughlin et al., 2014). As a result of this cycle becoming habitual, be it through repetition or reinforcement, an individual will struggle more with relationships, academic performance, and mental health as they transition into adulthood (Teicher & Samson; 2016; Sowislo & Orth 2013). In order to design effective interventions based upon this pathway from trauma to neurobiological change to psychological symptom to dysfunctional adult, it is incumbent upon clinicians working in the field of trauma recovery to comprehend this directional path (Rutter; 2012; Bonanno, 2004).

Self-esteem, which is an evaluative element of One's self-concept, is also potentially a mediating mechanism according to theory. Childhood trauma (especially trauma by parents) can disrupt positive self-schema formation, creating internalized feelings of worthlessness, shame, and inadequacy; these negative self-perceptions may increase their susceptibility to anxiety through heightened threat sensitivity and reduced coping resources. (Kim & Cicchetti, 2006; Orth et al., 2008; Sowislo & Orth, 2013).

This field of study has had its theory confirmed by many theorists, but almost all previous research has been conducted in developed Western countries and/or institutions. We believe that there are many cultural and other factors (i.e., family dynamics, social stigma associated with mental health, and expectations of traditional gender roles) that influence the way childhood trauma affects self-esteem and anxiety among people not from Western nations. In addition, as there are few mental health support systems in Pakistan and its people's culture is collectivist, we believe that this culture is a significant and under-researched population (Hofmann et al., 2010) in the study of childhood trauma on self-esteem and anxiety. Children who experience trauma during their early years may have brain development (amygdala, hippocampus, and prefrontal cortex) affected by the trauma, causing them to be hyper-vigilant and emotionally dysregulated. Where avoidance and maladaptive coping become their primary ways of coping, this creates negative self-beliefs and low

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self-esteem, leading to adult anxiety disorders (Teicher, 2016; McLaughlin, 2014; Kim & Cicchetti, 2006).

The objective of this study is to test a couple of theories: Firstly, that there is a strong link between childhood trauma and anxiety in young adults, and secondly, the possibility of using self-esteem as a component that connects childhood trauma to anxiety. In our hypothesis, we suggest that childhood trauma correlates negatively with self-esteem, while its relationship to anxiety is positive. Furthermore, we believe that self-esteem can also contribute to predicting future anxiety and childhood anxiety as a result of childhood trauma.

1.1. Rationale of Study

Despite the growing body of research examining the separate influences of childhood trauma, self-esteem, and anxiety disorders, there remains a need for integrated investigations that elucidate the complex interrelationships among these variables. Although extensive studies of children's trauma, self-esteem and anxiety have been conducted on each of these individually, there are few studies that have studied them in together in non-western populations. By examining how childhood trauma shapes self-esteem and contributes to the development of anxiety disorders, this study seeks to advance our understanding of the underlying mechanisms and pathways involved in the etiology of anxiety disorders. Additionally, identifying factors that promote resilience in the face of childhood trauma can inform targeted interventions aimed at mitigating the adverse psychological effects of early-life adversity.

Furthermore, the findings of this study hold implications for clinical practice and public health interventions. By identifying individuals at heightened risk for anxiety disorders based on their history of childhood trauma and self-esteem levels, clinicians can implement early intervention strategies to prevent the onset or exacerbation of anxiety symptoms. Moreover, promoting positive self-esteem and coping skills among individuals with a history of childhood trauma may serve as protective factors against the development of anxiety disorders, thereby enhancing overall mental health outcomes. This research seeks to contribute to the existing literature by providing a comprehensive examination of the roles of childhood trauma and self-esteem in the development of anxiety disorders. By elucidating the underlying mechanisms and identifying potential intervention targets, this study aims to inform the development of more effective prevention and treatment strategies for anxiety disorders, ultimately improving mental health outcomes for individuals affected by early-life adversity.

1.2. Significance of the study

The significance of this study lies in its potential to contribute valuable insights into the complex interplay between childhood trauma, self-esteem, and the development of anxiety disorders. Understanding these relationships can inform preventive strategies, therapeutic interventions, and support systems aimed at mitigating the long-term effects of childhood trauma and promoting mental well-being. Additionally, this research may shed light on the mechanisms underlying anxiety disorders, paving the way for more targeted and effective treatments. Overall, this study has the potential to make a meaningful impact on both clinical practice and public health efforts to address mental health challenges.

1.3. Operational Definitions

Childhood Trauma

A traumatic event experienced before the age of 18 that threatens injury, death, or the physical integrity of self or loved ones that causes fear, terror, or helplessness during the occurrence (American Psychological Association, 2008).

Self-Esteem

An individual's overall sense of worthiness as a person (Schmitt & Allik, 2005).

Anxiety

The body's natural response to stress, a state of fear, apprehension, or anticipation about perceived future events or threats (Craske & Stein, 2016).

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1.4. Objectives

1. To examine the relationship between childhood trauma and self-esteem among individuals with anxiety disorders.
2. To explore the impact of childhood trauma and self-esteem among young adults diagnosed with anxiety disorders.
3. To identify factors associated with resilience in individuals with a history of childhood trauma and their impact on anxiety outcomes.
4. To inform the development of targeted interventions aimed at improving self-esteem and reducing anxiety symptoms among individuals with a history of childhood trauma.

1.5. Research Questions

1. What is the relationship between childhood trauma and self-esteem among individuals with anxiety disorders?
2. How do childhood trauma and self-esteem impact anxiety disorders in young adults?
3. What factors associated with resilience influence anxiety outcomes in individuals with a history of childhood trauma?
4. How can targeted interventions focused on self-esteem and coping skills reduce anxiety symptoms in individuals with childhood trauma?

1.6. Hypotheses

Hypothesis 1

H_0 (Null): There is no significant relationship between childhood trauma and self-esteem among individuals with anxiety disorders.

H_1 (Alternative): There is a significant relationship between childhood trauma and self-esteem among individuals with anxiety disorders.

Hypothesis 2

H_0: Childhood trauma and self-esteem do not significantly impact anxiety disorders in young adults.

H_1: Childhood trauma and self-esteem significantly impact anxiety disorders in young adults.

Hypothesis 3

H_0: Resilience-related factors do not significantly influence anxiety outcomes in individuals with a history of childhood trauma.

H_1: Resilience-related factors significantly influence anxiety outcomes in individuals with a history of childhood trauma.

Hypothesis 4

H_0: Interventions targeting self-esteem and coping skills do not significantly reduce anxiety symptoms in individuals with childhood trauma.

H_1: Interventions targeting self-esteem and coping skills significantly reduce anxiety symptoms in individuals with childhood trauma.

2. Literature Review

2.1. Introduction

This chapter summarizes the theoretical and empirical research investigating the relationships between childhood trauma, self-esteem and anxiety disorders. It draws from the attachment and CBT literatures to formulate the rationale for studying self-esteem as a process through which early adverse events become associated with anxiety in adulthood. A growing body of literature has established an association between childhood abuse and an array of negative outcomes. However, many studies on abuse have been based on clinical samples or identified cases of abuse. These samples may include the most severe cases of abuse and thus may not be representative of the general population. Thus, general population samples may further our understanding of the negative outcomes of abuse. Several epidemiological studies have documented the association between abuse and negative health and psychiatric outcomes (Cromer & Sachs-Ericsson, 2006; Sachs-Ericsson, Blazer, Plant, & Arnow, 2005; Sachs-Ericsson, Kendall-Tackett, & Hernandez, 2007). However, it is important to note that most population studies showing an association between childhood abuse and psychiatric disorders have been, for the most part, based on cross-sectional samples, in which conclusions regarding temporal order cannot be made. Few longitudinal studies have examined the relationship between child abuse and mental health. Those that have been conducted have also primarily focused on young adults and have been predominantly based on samples selected from documented cases of abuse. These studies most likely comprise the more severe cases of abuse;

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thus, these studies' findings may overestimate the association between abuse and mental health outcomes and may not generalize to the population as a whole. Furthermore, it is not clear if results from such studies apply to older adults.

2.2. Theoretical Background

This study is grounded in two theoretical frameworks: Attachment Theory (Bowlby, 1969) and Cognitive-Behavioral Theory (Beck, 1985).

Attachment Theory (Bowlby, 1969)

Attachment Theory, developed by John Bowlby, suggests that early experiences with caregivers significantly influence emotional and psychological well-being. Children who experience secure attachments tend to develop a positive self-image and better coping mechanisms. On the contrary, insecure attachments resulting from childhood trauma may contribute to heightened anxiety later in life. Bowlby's early theories were influenced by ethology, attachment behaviour being seen as a 'safety regulating system' to protect against predators. In this formulation, attachment is seen as protective, since children need protection from disease, injury, and, at times, human predation, and thus their separation distress is viewed as adaptive. Attachment is seen as a feature of a relationship and not a characteristic of the infant alone; it develops as a function of a caregiver's general sensitivity to an infant's signals. Thus, Bowlby suggested, the child learns about the caregiver's emotional and physical availability and responds accordingly. Bringing together elements from cognitive psychology and object relations theory, Bowlby proposed that children internalize their experience with attachment figures to form internal working models of the relationships between themselves and others (McLeod, S, 2009).

Cognitive-Behavioral Theory (Beck, 1985)

The cognitive-behavioral model highlights the importance of the negative cognitive schema in the development and maintenance of symptoms of anxiety. A person experiencing low self-esteem will have dysfunctional beliefs regarding their inadequacy and their worth, which will cause a bias in their processing of information and cause them to react to threats and to amplify their anxiety (Mruk, 2006; Orth et al., 2008). This theory allows us to understand how an individual who has experienced trauma during childhood could develop low self-esteem and, subsequently, develop anxiety. Self-Esteem directly addresses the impact of self-worth on mental health. Low self-esteem is considered a significant factor in the development and maintenance of anxiety disorders. Childhood trauma, such as abuse or neglect, can profoundly affect. One's self-perception and contribute to a negative self-image, increasing vulnerability to anxiety. Thus, personality characteristics such as attachment security can contribute to subjective well-being. In this sense, restorative factors can increase an individual's well-being after a trauma or multiple traumas occur.

2.3. Childhood Trauma

Childhood abuse (physical, emotional & sexual) and neglect (physical and emotional) before turning eighteen years old are part of childhood trauma. Considerable data indicate that these types of childhood trauma are not uncommon. In research conducted through meta-analysis of studies across the globe exploring childhood trauma, 22-36% of adults report having experienced physical abuse during their childhood; 15-20% indicate they experienced sexual abuse; and 30-40% report they have experienced emotional abuse. Psychological abuse, which includes emotional abuse and neglect (the most prevalent type), represents approximately seventy-six percent of all individuals who have been exposed to childhood trauma (Daemen et al., 2021).

Gathier, with the coauthors, demonstrated that Childhood Trauma (CT) can be defined as abuse or neglect experienced before age 18, and this important risk factor in the pathogenesis of affective disorders, including depression and anxiety, in adulthood. (Gathier, Tuijl, & jong, 2024). CT may comprise several types, including emotional, physical, and sexual abuse, and

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emotional and physical neglect. Such negative experiences often happen at the crucial stages of development, which may impair the process of attachment and lead to the development of negative self-perception. Consequently, people exposed to CT are at risk of developing reduced self-esteem, both at conscious (explicit) and unconscious (implicit) levels, which has been associated with more serious and frequent mental health symptoms in adulthood. CT can be estimated with validated instruments that include the Childhood Trauma Interview (CTI) and the Childhood Trauma Questionnaire (CTQ), which evaluate the nature and extent of the trauma experienced. As an illustration, the CTI has items regarding frequency and kind of trauma preceding age 16, and thus, a researcher can calculate a cumulative trauma score. Research on CT and its psychological consequences is essential in establishing specific prevention and intervention measures meant to ensure enhanced mental health outcomes in the long term.

Child abuse is a major life stressor that has important consequences for several indices of mental health in adults (Sachs-Ericsson, Verona, Joiner, & Preacher, 2006). However, the majority of studies examining the negative consequences of abuse have focused on adolescents and young adults. While there have been studies of general population samples, few population studies have focused predominantly on older adults. In the current study, we examined the influence of childhood abuse on the occurrence of internalizing disorders (e.g., anxiety and depressive disorders) in a population of adults aged 50 years and older (mean age = 67 years; SD = 10.3). It is to establish whether childhood abuse has far-reaching effects in increasing rates of internalizing disorders, even for adults over the age of 50 years. Second, we wished to determine the mechanisms (i.e., low self-esteem) by which early abuse may influence the psychiatric functioning in older adults.

Childhood Trauma in the Pakistani Context

Cultural considerations increase the risk of experiencing trauma in Pakistan. Many family structures are collectivist (family-oriented), which can contribute to the occurrence of violence within the family, and concerns about "honor" may discourage people from reporting. A survey of the households of children in Pakistan indicates that 40% of children are physically disciplined (punished), and very few children are documented as experiencing emotional abuse because harsh disciplinarian practices are widely accepted as normal. Cultural beliefs about mental illness create stigma around seeking help for any type of mental health issue, which may contribute to the duration of the trauma experienced. Women are disproportionately at risk of trauma as a result of gender violence and discrimination, and are less likely to be able to cope with their experience. These contextual factors can further reinforce the trauma low self-esteem anxiety pathway by reinforcing internalized culturally negative beliefs about women's value that can co-exist with trauma related negative beliefs.

2.4. Consequences of Childhood Trauma

The effects of childhood trauma are far-reaching and complex. Some of the effects are that the hypothalamic-pituitary-adrenal (HPA) axis is dysregulated, causing chronic stress and high levels of cortisol that make individuals vulnerable to developing mood disorders (Downey & Crummy, 2022). Sleep disturbances such as nightmares and insomnia are common and have a further negative impact on mental and physical wellbeing. Self-esteem is especially impacted; children who are abused by their caregivers have negative self-concepts and experience difficulty with self-worth (Kim & Cicchetti, 2006). The trauma impact isn't limited to emotional areas; it's reflected in destructive coping strategies like denial, using drugs or alcohol, and self-isolation (Downey & Crummy, 2022). Childhood victims of sexual abuse suffer cognitive, affective, and behavioral problems such as anxiety, interpersonal dysfunction, sense of isolation, inappropriate sexual behavior, vulnerability to future sexual abuse, suicidal behavior, depression, and self-destructive behavior (Beitchman et al., 1991, 1992; Cahill et al., 1991).

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2.5. Factors Influencing the Impact of Childhood Trauma

There are multiple factors that determine the severity of the impact of trauma. The frequency and length of the abuse is important, as children who have been subjected to prolonged maltreatment are at a greater risk of enduring psychological impacts like depression, anxiety and post-traumatic stress disorder (Sanghvi et al., 2023). The effects of protective factors (emotional support, secure relationships, social networks) are substantial and act as substantial moderators of outcomes. Kids who lack these supports are at risk for low self-esteem, emotion regulation issues, and poor relationship skills. Self-acceptance is especially impacted, as trauma victims have difficulties with self-esteem and self-love, which puts them in danger for additional psychological difficulties (Sanghvi et al., 2023). Emotional neglect, disruption in psychological development and lack of self-acceptance is the major factor that helps shape the manifestation of childhood trauma in adulthood.

2.6. The Psychological Correlates of Early Childhood Trauma

Individuals with SAD appear to differ from healthy controls in their exposure to early childhood trauma. One important question is whether these early adverse experiences are correlated with One or more aspects of negative psychological functioning in SAD. In non-clinical samples, studies demonstrate associations between a history of childhood trauma and several negative adult experiences, including elevated levels of depression, anxiety, substance use, suicidal behaviors, and emotional-behavioral problems (Silverman, Reinherz, & Giaconia, 1996). More recent studies have evaluated whether distinct forms of childhood trauma are related to specific psychological problems in adulthood. In a sample of young women, physical abuse was related to heightened aggression towards others, and sexual abuse was related to maladaptive sexual behavior (e.g., getting into trouble because of sexual behavior, controlling others through the use of sex) (Briere & Runtz, 1990). By contrast, emotional abuse was related to low self-esteem. In a separate study, women who reported a history of emotional neglect reported greater problems in multiple domains (adult attachment styles, anxiety, depression, somatization, paranoia) than those reporting a history of physical abuse (Gauthier, Stollak, Messe, & Aronoff, 1996). Briere and Runtz (1998) found that maternal physical abuse was associated with interpersonal sensitivity and dissociation, whereas paternal emotional abuse was associated with anxiety, depression, interpersonal sensitivity, and dissociation. Gibb and colleagues found that childhood emotional abuse was more strongly related to diagnoses of depression or social anxiety disorder than either physical or sexual abuse (Gibb, Chelminiski, & Zimmerman, 2007).

Despite mounting evidence for the associations between different forms of abuse and various adverse adult clinical symptoms, very few studies have extended this line of inquiry to SAD. Simon and colleagues (2009) recently examined the relationship between various types of childhood trauma and the severity of social anxiety, global severity of symptoms, disability, resilience, and quality of life in a sample of adults with SAD. A history of childhood emotional abuse or neglect was associated with greater severity of SAD and global symptoms; emotional neglect was also associated with lesser resilience. Childhood sexual abuse was associated with greater disability, whereas childhood physical abuse and neglect were not associated with any of these psychological outcomes.

Histories of childhood trauma are associated with a host of other psychiatric diagnoses in adolescence and adulthood. This chapter addresses the developmental impact of childhood trauma and argues that the explanatory adequacy of most animal models is constrained by the fact that it is impossible to model some of the uniquely human relational factors that are known to predict the development of posttraumatic stress disorder (PTSD): abandonment, betrayal, helplessness, and submission. He discusses the proposal for a diagnostic construct of "complex PTSD," which aims to capture the varied consequences of exposure in early life to

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multiple, repeated, and prolonged interpersonal violence (e.g., sexual or physical abuse, war, community violence). Such a pervasive developmental insult may result in deformations of personality and profound difficulties in negotiating stable relationships with others over the lifespan.

These findings indicate some specificity in the relationship between childhood trauma subtypes and general functional impairment in SAD. However, whether subtypes of childhood trauma might be differentially associated with specific clinical symptoms that have been implicated in the non-clinical literature (e.g., depression, anxiety, self-esteem) remains unknown. Given the evidence that SAD individuals with a history of childhood trauma have poorer treatment outcomes (Alden, Taylor, Laposa, & Mellings, 2006), such knowledge would be useful in developing treatment interventions for this group who do not maximally benefit from current treatments.

A recent study reported that patients with a first episode of psychosis and a history of physical and/or sexual abuse were more likely to present another psychiatric disorder, have worse premorbid function levels, have made a suicide attempt, and attempt suicide during treatment (Conus et al., 2009). In other studies, the prevalence of childhood abuse was 49% in bipolar patients (Garno et al., 2005). In patients with childhood trauma, bipolar disorder has been associated with earlier age onset, worse clinical evolution, more suicide attempts, and higher prevalence of a faster cycling pattern (Leverich et al., 2002). As in patients with schizophrenia, a high frequency of positive symptoms, especially auditory hallucinations, has been found in patients with bipolar disorder and a history of childhood abuse (Hammersley et al., 2003).

2.7. History and Prevalence of Childhood Trauma

By reaching adulthood, most individuals have had previous exposure to childhood trauma. Childhood trauma has continued to be a significant social issue worldwide for countless years and was formally recognized as a major problem during the 1990s (Jones et al., 2020). Those who have faced trauma during childhood often find it exceptionally difficult to overcome their past without appropriate interventions since the traumatic event occurred during such a pivotal point in psychological and physical development. Childhood experiences are the groundwork for how individuals develop and mature throughout the rest of their lives (Novais et al., 2021). Findings suggest that lasting repercussions are increased after experiencing One form of childhood trauma, since individuals are more likely to experience increased oppression through 18 other experiences with childhood trauma. It has been discovered that psychological maltreatment is the most prevalent form of childhood trauma worldwide, with 76.6% of individuals exposed to trauma during childhood having at least One experience with this (Daemen et al., 2021). Those who have experienced psychological maltreatment have been exposed to emotional abuse or neglect.

An individual's response to the stress of childhood trauma differs depending on the individual, but some reactions are seen more commonly among traumatized children (Curran et al., 2021). Some of these reactions are new fears, sleep disruption, separation anxiety, reduced concentration, anger, irritability, and a decrease in activity participation. Childhood trauma is significant due to the developmental period during which it occurs. Children who have experienced trauma are at a period in their lives when they mostly rely on others to support them and their growth, increasing their sense of helplessness (Jonson-Reid & Wideman, 2017).

2.8. Childhood Abuse, Trauma and Social Anxiety

Childhood abuse has a strong connection with the occurrence of social anxiety disorder (SAD) (Nordh et al., 2021). These are the risk factors that abused children (emotionally, physically and sexually) are more likely to have negative self-beliefs, fear of being judged and have trouble trusting others. Such psychological factors could equate to an over exaggerated fear of social situations as found in SAD. When the child is

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abused, it disrupts the sense of safety and value, causing the child to develop self-esteem issues, including shame, guilt, and inadequacy. They might become hypersensitive to disapproval or rejection from others and go out of their way to avoid situations that produce anguish (Nordh et al., 2021). This avoidance only further fuels anxiety over time. Childhood abuse has been reported as a significant predictor of SAD and its severity (Beesdo-Baum & Knappe, 2012). Negative learning experiences when dealing with adult negative treatment can develop negative cognitive patterns that make the world appear threatening, which helps contribute to the onset and/or maintenance of SAD (Kocovski & Endler, 2000). Reviews of environmental risk factors for SAD find that traumatic events such as sexual and physical abuse during childhood are consistently associated with anxiety disorders (Brook & Schmidt, 2008). In retrospective interview studies, a higher prevalence of childhood sexual abuse has been found in children with higher rates of SAD compared to healthy control children (Bandelow et al., 2004), and a higher childhood emotional, sexual and physical abuse severity is associated with an increased risk of developing SAD (Kuo et al., 2011).

As far as anxiety following trauma is concerned, Kuzminskaite and her colleagues (2022) found that childhood trauma, especially emotional maltreatment, relates to anxiety symptoms that slowly worsen with time. They are more likely to experience high levels of social anxiety, panic symptoms and avoidance of phobic situations as well as more severe and chronic levels of anxiety. This long-lasting tendency provides evidence that childhood trauma can make people vulnerable to upcoming stressors and disrupt stress-related systems, increasing vulnerability to anxiety (Kuzminskaite et al., 2022). Childhood trauma is a strong predictor for mental health problems, with 18.3% of adults who were exposed to childhood trauma having anxiety disorders (Vaughan et al., 2021). Females are more likely to exhibit greater rates of anxiety than males, possibly due to the effect of childhood trauma. The link between child abuse and anxiety disorders is complicated and complex. The gender gap in anxiety following childhood trauma is that females appear more susceptible to the impact of trauma than males, with higher rates of anxiety following trauma than in males (Vaughan et al., 2021). Anxiety was positively correlated with different traumas, and highest in those exposed to physical abuse (Pham et al., 2021). Higher scores for anxiety symptoms are also linked to sexual abuse. The results indicate that there are some specific associations between each type of childhood abuse and functional impairment in anxiety disorders.

2.9. Self-Esteem

Self-esteem is a crucial component of mental health and it is defined as a person's assessment of themselves in terms of their value, worth and abilities. This broad term includes self-acceptance, self-respect and self-confidence, and therefore notions of self in different areas of functioning. A life-long process, shaped by achievement, significant relationships and environment. Children and adolescents are in critical periods of self-esteem development which can have a profound influence on their mental health outcomes later in life. During these early years, low self-esteem can make people vulnerable to experiencing high levels of anxiety disorders and other mental health issues.

Pohl, with the coauthors, demonstrated that self-esteem is a significant determinant of psychological outcome in people who have immediately encountered childhood trauma (Pohl, Steuwe, Mainz, Driessen, & Beblo, 2020). Experiencing childhood trauma, including abuse, neglect, or emotional invalidation, can highly interfere with the formation of a stable and positive self-concept. This is especially so in the case of borderline personality disorder (BPD) patients who tend to report multiple and severe early-life adversities. These experiences lead to the formation of dysfunctional self-perceptions and interfere with the skills of healthy emotional regulation, which are the key problems in BPD. Patients with BPD generally have considerably low global self-esteem that is closely correlated with the degree of symptomatology. Poor self-

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esteem has been linked to increased emotional reactivity, impulsivity, and unstable relationships, and these are typical characteristics of BPD. Notably, self-esteem helps individuals to psychologically cope with stress and trauma through resilience and positive coping mechanisms. Higher self-esteem also tends to make individuals more resilient to the psychological consequences of the trauma, as they exhibit diminished posttraumatic stress and emotional dysregulation. Self-esteem, although it reflects early relational experiences in the context of childhood trauma, is also a key protective measure. Improving self-esteem can thus form an important goal in the therapeutic intervention of trauma-related psychopathology, such as with BPD.

Self-esteem, a fundamental aspect of psychological well-being, refers to an individual's evaluation of their value, worth, and competence. This multifaceted concept encompasses feelings of self-acceptance, self-respect, and self-confidence, shaping One's perceptions of Oneself across various domains of life. It is a developmental process influenced by interactions with the environment, significant relationships, and personal achievements throughout One's lifespan. Particularly during childhood and adolescence, individuals undergo crucial stages of self-esteem formation, which can significantly impact their mental health outcomes in later life. Low self-esteem during these formative years may predispose individuals to experience severe anxiety disorders and other mental health challenges. The effects of low self-esteem are diverse and pervasive, affecting academic, professional, and social aspects of an individual's life. In academic and professional settings, individuals with low self-esteem may encounter obstacles such as abuse, criticism, and difficulties in relationships due to feelings of inadequacy and fear of judgment. They may also withdraw from activities and social interactions, leading to isolation and further exacerbating their self-esteem issues. Furthermore, low self-esteem is associated with various health problems, including substance abuse, attention deficit disorder, social phobia, eating disorders, anxiety, and depression.

Research indicates a strong correlation between low self-esteem and mental health disorders, highlighting the importance of addressing self-esteem issues in early intervention and prevention efforts. Studies have shown that individuals with severe anxiety disorders often exhibit lower self-esteem compared to those without such disorders. Similarly, depression and anxiety are closely linked to low self-esteem, indicating a complex interplay between mental health conditions and self-esteem levels. Various factors contribute to low self-esteem, including early life experiences, social comparisons, achievements, feedback, and cultural influences. These factors shape individuals' perceptions of themselves and their abilities, influencing their overall self-esteem. Low self-esteem can have profound consequences, including psychological distress, poor coping skills, interpersonal problems, and increased susceptibility to anxiety disorders. Understanding the relationship between self-esteem and anxiety disorders is essential for developing effective treatment strategies that address underlying psychological factors and promote resilience. Interventions aimed at improving self-esteem and building coping mechanisms can help individuals better manage anxiety symptoms and improve their overall mental health outcomes. By addressing both self-esteem issues and anxiety disorders, comprehensive treatment approaches can facilitate long-term recovery and well-being.

Self-esteem is a potential mediator in the relationship between childhood trauma and CPTSD. Studies have shown that childhood adversity can lead to changes in personal self-worth and may negatively affect the development of self-concepts (Kim & Cicchetti, Citation2006). For example, childhood interpersonal trauma (especially interpersonal violence and sexual abuse) can directly promote the formation of negative self-concepts (Hyland et al., Citation2017), so individuals who have suffered childhood trauma are more likely to be self-deprecating and self-loathing, thus developing lower emotional self-esteem (Gilbert,

Citation2015; Weindl & Lueger-Schuster, Citation2018). Therefore, childhood trauma may affect an individual's mental health by impairing their self-esteem. Moreover, some studies have shown that self-esteem can partially mediate the relationship between specific childhood traumatic experiences (such as sexual abuse) and PTSD (Murphy et al., Citation2014; Turner et al., Citation2010). The predictive role of self-esteem on PTSD has also been generally confirmed: low self-esteem is regarded as a risk factor for PTSD, and high self-esteem can reduce the risk of PTSD (Adams & Boscarino, Citation2006; Frazier et al., Citation2011). Moreover, there are some associations between low self-esteem and DSO symptoms (especially NSC symptoms) in CPTSD, since low self-esteem and NSC are both closely related to negative self-evaluation and the destruction of self-worth (Mann et al., Citation2004).

Although self-esteem and self-concept seem to have many overlaps in definition, they are not synonymous. Self-esteem is usually limited to the evaluative aspects of the self, while self-concept could be used for all self-descriptions, which do not necessarily involve judgments of worth (Watkins & Dhawan, Citation1989). Considering that self-esteem is associated with both PTSD and DSO symptoms of CPTSD and can also be affected by childhood trauma, we assumed that self-esteem itself may mediate the association between childhood trauma and CPTSD. The current study aimed to explore the impact of childhood trauma on CPTSD and focused on the role of self-esteem in their relationship.

2.10. Low Self-Esteem as a Predictor of Anxiety

Self-esteem is a potential mediator in the relationship between childhood trauma and anxiety. From the perspective of child development, personal self-worth can be altered by childhood adversity and self-concepts can be negatively impacted (Kim & Cicchetti, 2006). Childhood interpersonal trauma, especially interpersonal violence and sexual abuse, can directly promote the formation of negative self-concepts (Hyland et al., 2017). Individuals who have suffered childhood trauma are more likely to be self-deprecating and self-loathing, thus developing lower self-esteem (Gilbert, 2015; Weindl & Lueger-Schuster, 2018). Thus, trauma in childhood can impact mental health by its effects on self-esteem. In addition, certain childhood traumatic experiences (e.g. sexual abuse) have been found to indirectly relate to anxiety disorders through self-esteem (Murphy et al., 2014; Turner et al., 2010). This relationship between self-esteem and anxiety has been generally verified: Low self-esteem is seen as a risk factor for anxiety and high self-esteem is seen as a protective factor (Adams & Boscarino, 2006; Frazier et al., 2011). But does self-esteem indeed contribute to psychological health, or, to put it differently, does low self-esteem compromise a person's psychological adjustment? Previous research suggests that self-esteem is linked to indicators of psychological adjustment such as happiness (H. Cheng & Furnham, 2004; Diener & Diener, 1995), high positive affect and low negative affect (Orth, Robins, & Widaman, 2011), and the absence, or a low number, of psychological symptoms such as depression (Orth, Robins, Trzesniewski, Maes, & Schmitt, 2009; J. E. Roberts & Monroe, 1992) and bulimia (Vohs et al., 2001). However, concerning many of these variables, the precise nature of their relation with self-esteem has not ultimately been established (Baumeister, Campbell, Krueger, & Vohs, 2003).

The concept of self-esteem has elicited a large body of theoretical accounts and empirical research (see, e.g., Baumeister, 1998; Kernis, 2006; Swann & Bosson, 2010). Historically, the first influential definition of self-esteem dates back to James (1890), who considered self-esteem to be the ratio of success and pretensions in important life domains. While James focused to a stronger degree on the individual processes that form self-esteem, later symbolic interactionism approaches stressed the social influences on self-esteem (Cooley, 1902; Goffman, 1959; Mead, 1934). For instance, in his conception of the looking-glass self, Cooley (1902) hypothesized that self-views are based upon information

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gathered from explicit or implicit feedback from others. More recent definitions of self-esteem emphasize the fact that self-esteem should be distinguished from other compOnents of the self-concept (such as self-knowledge and self-efficacy), insofar as self-esteem represents the affective, or evaluative, compOnent of the self-concept; it signifies how people feel about themselves (Leary & Baumeister, 2000).

This affective self-evaluation is subjective at its core and is not based on specific behaviors (Robins, Hendin, & Trzesniewski, 2001). According to Rosenberg (1989), high self-esteem “expresses the feeling that One is ‘good enough. ’ The individual simply feels that he is a person of worth. He does not necessarily consider himself superior to others” (p. 31). Although Baumeister and his colleagues share the view of self-esteem as self-appraisal with an affective compOnent, they expand the definition of self-esteem to include feelings of superiority, arrogance, and pride (e.g., Baumeister, 1998; Baumeister, Smart, & Boden, 1996). In the literature, it is debated whether self-esteem is best conceptualized as a global evaluation of the self (i.e., global self-esteem) or as an evaluation in specific self-relevant domains such as intellectual abilities, physical appearance, and social competence (Swann & Bosson, 2010). One finding that sheds light on this debate is that both global and domain-specific self-evaluations show predictive ability for important outcomes, as long as these outcomes exhibit the same degree of specificity as the self-evaluation that is used as a predictor (Swann, Chang-Schneider, & McClarty, 2007).

More precisely, global self-esteem seems to have predictive ability for outcomes measured at a global level (Trzesniewski et al., 2006), whereas domain-specific self-esteem seems to have predictive ability for outcomes measured at a specific level (Marsh, Trautwein, Lüdtke, Koller, & Baumert, 2006). Numerous studies have highlighted the detrimental effects of childhood trauma on mental health outcomes, with a particular emphasis on anxiety disorders. Childhood trauma, including experiences such as physical, emotional, or sexual abuse, neglect, and household dysfunction, has been consistently linked to increased risk for developing anxiety disorders later in life (McLaughlin et al., 2012; Teicher et al., 2016).

Adverse childhood experiences disrupt normative developmental processes, leading to alterations in brain structure and function, as well as dysregulation of stress response systems (Teicher et al., 2003; McLaughlin et al., 2014). These neurobiological changes may predispose individuals to heightened anxiety reactivity and difficulties in emotion regulation, contributing to the onset and maintenance of anxiety disorders. Furthermore, self-esteem emerges as a crucial mediating factor in the relationship between childhood trauma and anxiety disorders. Low self-esteem is often observed among individuals with a history of childhood trauma, as they may internalize negative beliefs about themselves and their worth as a result of their adverse experiences (Leary & Baumeister, 2000). Moreover, low self-esteem has been identified as a vulnerability factor for the development and maintenance of anxiety disorders (Orth et al., 2008). Individuals with low self-esteem may exhibit heightened sensitivity to social evaluation, increased fear of negative evaluation, and greater susceptibility to stress, all of which contribute to the manifestation of anxiety symptoms (Mruk, 2006).

However, the relationship between childhood trauma, self-esteem, and anxiety disorders is complex and multifaceted. While some individuals may develop anxiety disorders following exposure to childhood trauma, others may exhibit resilience despite adverse experiences (Bonanno, 2004). Factors such as genetic predispositions, social support, coping strategies, and cognitive appraisals may moderate the impact of childhood trauma on self-esteem and subsequent anxiety outcomes (Rutter, 2012). Therefore, a comprehensive understanding of the interplay between childhood trauma, self-esteem, and anxiety disorders necessitates consideration of various individual and contextual factors. With regard to the relation between self-esteem and psychological adjustment, there are three reasons for focusing on global self-esteem rather than domain-specific self-esteem. First, most of

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the theories linking self-esteem to psychological adjustment address global self-esteem but not domain-specific self-esteem (Blatt, D'Afflitti, & Quinlan, 1976). Second and relatedly, most studies in this field have used measures of global self-esteem (Orth, Robins, & Roberts, 2008; Zeigler-Hill, 2010). Third, according to the specificity-matching principle, it seems reasonable to examine global self-esteem in this context because indicators of psychological adjustment, such as depression and anxiety, are relatively global constructs that combine several cognitive, affective, and somatic symptoms (Swann et al., 2007).

Anxiety inhibits the development of successful and healthy ER strategies because anxious individuals often rely on avoidant strategies (e.g., suppression), whilst exhibiting difficulties in successfully utilizing reappraisal in negative situations (Carthy, Horesh, Apter, & Gross, 2010). When anxious individuals have been explicitly instructed to use suppression, the physical symptoms of anxiety, such as heart rate, and psycho logical symptoms, such as distress, are significantly increased (Campbell-Sills et al., 2006). Furthermore, fMRI measures have suggested that, when individuals with increased trait anxiety effectively use reappraisal, it takes significantly more cognitive effort than low-anxious individuals (Campbell-Sills et al., 2011). Trait anxiety refers to an individual's baseline level of anxiety, which relates to the individual's personality trait, often this is a response to various situations; whereas state anxiety refers to an individual's current anxiety level, a transient and temporary emotional reaction to adverse events (Marteau & Bekker, 1992).

Similar to self-esteem, self-compassion is associated with a positive attitude toward One's self exerting a beneficial influence on mental health. Self-compassion involves encountering One's empathetically with benevolent respect and an accepting attitude toward One's and One's feelings, especially when confronted with One's weaknesses and inadequacies (Neff, 2003a). Research has shown that less self-compassionate people often experience difficulties in emotional regulation (Finlay-Jones et al., 2015), and they report having a higher level of negative affect than other people (López et al., 2018). Both of these are central symptoms of BPD (Glenn & Klonsky, 2009; Zeigler-Hill & Abraham, 2006). On the other hand, a high degree of self-compassion is associated with positive affect, psychological well-being, resilience, and the use of functional coping strategies to deal with negative life events (Neff & McGehee, 2010).

Furthermore, self-compassion is associated with a lower sense of shame (Johnson & O'Brien, 2013), while a high degree of shame is often an internal threat after trauma, which also frequently occurs in conjunction with BPD symptomatology (Rüsch et al., 2007). Self-compassion has also been shown to predict recovery among people diagnosed with BPD (Donald et al., 2018), and the first clinical treatments of trauma-related disorders that involved fostering patients' self-compassion have shown promising results (Boykin et al., 2018). Self-compassion can, therefore, be considered an important resource after a person has been exposed to trauma. Although there are many similarities between self-compassion and self-esteem, and empirical studies have found high correlations between these two variables, they do not represent the same construct (Leary et al., 2007; Neff & Vonk, 2009). The central difference between self-compassion and self-esteem is that self-esteem entails a self-evaluative compOnent, whereas the focus of self-compassion is on an accepting and appreciative emotional attitude toward One's (Neff & Vonk, 2009).

Whereas several studies indicate reduced self-esteem in patients with BPD, to the best of our knowledge, self-compassion has been only sparsely investigated in patients with BPD. Based on the evidence presented above, we hypothesized that patients with BPD would report both lower self-esteem and lower self-compassion compared to healthy controls. This study further addressed whether both self-compassion and self-esteem protect patients with BPD against the negative consequences of childhood traumatic experiences. Specifically, we hypothesized that the association between

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childhood traumatic experiences and the current severity of BPD symptoms would be weaker among patients with higher levels of self-compassion or self-esteem. Self-esteem is widely conceived as a relatively stable trait, consisting of positive self-evaluations or attitudes towards the self (Rosenberg, 1965). Childhood abuse may negatively influence a child's self-evaluations by providing the child with negative feedback, harsh criticism, and insults, or continued exposure to physical harm from caregivers– all common experiences among children who have been abused (Teicher, Samson, Polcari, & McGreenery, 2006; Trickett & McBride-Chang, 1995).

Attitudes about the self can be broadly classified into those that are explicit and under conscious control, and those that are implicit, automatic, and not under conscious control (Greenwald & Banaji, 1995). Explicit self-evaluations, which can be measured through self-report, may be altered by conscious, reflective processes and are subjective by nature (Evans, 2008). These types of explicit self-construals are what is assessed in the common approaches used for measuring self-esteem. In contrast, implicit self-evaluations are not readily accessible to conscious self-reflection and introspection and are typically measured through Implicit Association Tests (IATs) or name–letter tasks (Greenwald & Banaji, 1995; Nuttin, 1985). These types of implicit tests have been used to examine implicit self-esteem in both children and adults (Creemers, Scholte, Engels, Prinstein, & Wiers, 2012; Cvencek, Greenwald, & Meltzoff, 2016) and allow self-evaluations to be measured behaviorally without relying on verbal responses, checklists, or other forms of reflective self-report.

2.11. From Childhood Maltreatment to Adult Anxiety

There are several pathways to the transition from childhood maltreatment to adult anxiety disorders. Fenichel (1961) pointed out that traumatic stimuli can be deleterious to all, whereas other stimuli that are not deleterious to most can be traumatic to predisposed individuals. It is the psychological and emotional impact of the traumatic experience on an individual that makes a difference in determining the pathogenic power of the event (Roy Byrne et al., 1986). Cruz and colleagues (2022) showed us that abuse and neglect are two of the most detrimental adverse childhood experiences because they can have enduring effects on developmental trajectories. These experiences have a damaging impact on brain and emotional development, particularly at the critical times when children are developing beliefs and expectations about safety, trust and attachment. The interpersonal traumas experienced by caregivers (whether physical abuse, emotional abuse, or neglect) lead to lifelong problems in emotional and behavioral regulation and functional relationships (Cruz et al., 2022). The strong association between anxiety disorders and child abuse is emphasized among psychiatric conditions that have been linked to child abuse. There is an increasing number of epidemiological studies that confirm the link between child abuse and the development of anxiety disorders (Mancini et al., 1995; Stein et al., 1996). As a compOnent of emotional abuse, a threat from parents during childhood (abandonment and hurting) causes uncertainty regarding the others' availability, and then regarding One's security and competence in situations, causing anxiety symptoms and Panic disorder.

It is clear that the importance of physical abuse is great, particularly the emotional abuse and neglect, and has significant implications for disruption in child development that can impact in adult life. The way in which abuse occurs directly mirrors the repetitive cycle of the parent-child relationship that becomes a constant traumatic experience with highly negative and pathognomonic effects on the child's psychological development (Bonevski, 2008). When children are victims of abuse, they develop internal defense models with which the world is perceived as a dangerous place. Over time, trauma has a tendency to cause long-term physical and mental ailments which ultimately contribute to increased perceived threat and a lack of security. This is the place where grown up sufferers of children abuse question their self-

esteem and self-worth in reacting to real or considered dangers. Such distortions in self-esteem are a steady generator for emotional turbulence and risk of anxiety disorders. Increasing attention is also being given to the importance of dissociation as a mental mechanism in a range of psychiatric disturbances (van der Kolk & Fisler, 1995). Traumatic experiences can create dissociation which, in turn, can lead to long term challenges. If faced with an outside stressor, individuals (particularly children) respond by turning a blind eye or by withdrawing (dissociating). While adaptive at the moment, for many people traumatized they are still using dissociation as a coping mechanism when dealing with trauma-related memories and other stressors in their lives. It has been demonstrated that childhood abuse is linked to difficulties through dissociation (Chu & Dill, 1990).

2.12. Neurobiological Effects of Childhood Trauma

Childhood trauma has a substantial influence on how the brain develops and works, both structurally and chemically (Teicher et al., 2016; McLaughlin et al., 2014). The amygdala is frequently overstimulated, resulting in constant facial expressions of distress because of heightened anxiety levels (Teicher et al., 2016; Ross et al., 2021). Additionally, the hipp campus becomes smaller than normal due to stress from repeated exposure to stressors; therefore, it is hard for children with childhood trauma to know whether or not they are safe (Teicher & Samson, 2016; Downey & Crummy, 2022). With children who have suffered childhood trauma, their prefrontal cortex does not work properly; consequently, children are unable to control their emotions, which leads to problems coping effectively with life (McLaughlin et al., 2014; Teicher et al., 2016). There are also problems with the HPA axis, or hypothalamic-pituitary-adrenocortical axis, that creates an abnormal response to stress (Downey & Crummy, 2022; Ross et al., 2021). Lastly, childhood trauma depletes levels of serotonin, dopamine, and norepinephrine, creating a neurotransmitter environment conducive to feelings of anxiety (Ross et al., 2021). However, neuroplasticity allows for healing and recovery from these types of trauma through trauma-focused therapy and self-esteem-building activities/interventions (Teicher et al., 2016; Kim & Cicchetti, 2006; Pohl et al., 2020).

2.13. Contrary and Scientific Perspective

The relationship between trauma and anxiety is not the same for everyone, nor is it determined by factors beyond an individual's control (Bonanno, 2004; Rutter, 2012). Protective factors such as secure attachments, genetic makeup, social support, and coping strategies allow around 40-60% of survivors of trauma to exhibit resilience (Bonanno, 2004; Rutter, 2012). Genetics account for approximately 30-40% of variance in anxiety to be caused by genetic predisposition and gene-environment interaction affecting the risk of experiencing trauma (Caspi et al., 2002; Kessler, et al., 2010). Low self-esteem may cause or predispose a person to experience trauma rather than be a result of experiencing trauma; therefore, there may be a bidirectional relationship between the two variables (Sowislo & Orth, 2013; Orth et al., 2008). Cultural factors can moderate what happens after someone(s) experiences a traumatic event; for example, those who are a part of collectivistically-oriented cultures may have an advantage with support during times of crisis or trauma (Hofmann et al., 2010). Retrospective assessments, such as the Child Trauma Questionnaire (CTQ), are vulnerable to recall bias (Reuben et al., 2016). Additionally, other variables can explain the relationship between the two constructs, such as family instability and impoverished living conditions (Kessler, et al., 2010; Caspi et al., 2002).

2.14. How Childhood Trauma Control Works

There are many ways in which trauma continues to affect individuals via various interconnected mechanisms (Teicher et al., 2016) and (Beck, 1985) and (Kim & Cicchetti, 2006). Trauma creates negative cognitive schemas that filter experience and reinforce negative interpretation

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via a cycle of confirmation for both self and others (Beck, 1985) and (Mruk, 2006). People engage in hypervigilance through avoidance and maintaining a sense of safety, which leads to a lack of disconfirming information to support their beliefs about threats to themselves and low self-worth (Sanghvi et al., 2023) and (Kim & Cicchetti, 2006). In terms of emotions, people engage in dysregulation and avoidance behaviours, such as substance misuse and dissociation, which prevents them from processing traumatic memories (Ross et al., 2021) and (Downey & Crummy, 2022). In interpersonal relationships, patterns of maladaptive relationships based upon early attachments produce a cycle of self-fulfilling prophecies and create beliefs about rejection (Bowlby, 1969) and (Cast & Burke, 2002). From a neurobiological perspective, the consequences of stress are demonstrated by the brain being "trained" to respond with the perception that the world is a dangerous place (Teicher et al., 2016) and (McLaughlin et al., 2014).

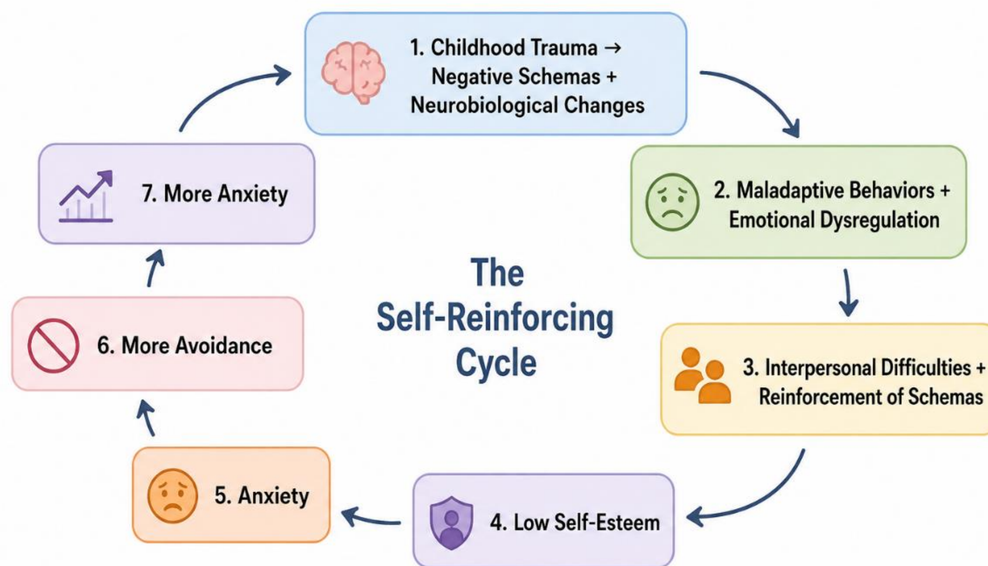

Figure 1: The Self-Reinforcing Cycle of Childhood Trauma Effects (Rutter, 2012; Bonanno, 2004; Kim & Cicchetti, 2006).

3. Methodology

This chapter defines the methodological framework used in carrying out the study; it includes the research design, selection of participants, instruments, and procedures. The methodology was adopted to explore the relationship hypothesized to exist between childhood trauma, self-esteem, and anxiety disorders among young adults in a systematic way.

3.1. Participants

The 132 young adults in this study met the following criteria: (1) 17-34 years old; (2) speak both Urdu and English; and (3) agree to sign an informed consent form. To find participants, the researchers used convenience sampling methods from five universities in Pakistan (Multan, Lahore, Islamabad). The data for the research study were collected using online questionnaires that were sent to all students at each of the five universities by email and through social media (WhatsApp and Facebook). The confidentiality was assured to them so that they would participate with full honesty. There was no discrimination between male and female participants. These were selected based on willingness to volunteer. Anonymity and confidentiality were guaranteed, and the participants were assured that the responses

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would be used only. The method presented free and frank answers, which is very important when researching sensitive matters like childhood trauma, self-esteem, and anxiety disorders.

3.2. Research Design

The cross-sectional research design is used in this study to collect the data from the respondents at a single time point. This design was chosen because it is effective in determining relationships among variables within a specified population. It enables researchers to examine the relations among childhood trauma, self-esteem, and anxiety disorders without long-term follow-up. Cross-sectional studies are of value in providing ideas and hypotheses about psychological variables correlations though they do not prove causality. This design was suitable considering that the study was exploring mental health outcomes among the non-clinical young adult population. To perform a priori power analysis (G*Power) required an n=119 sample to detect the medium effect size (f^2=0.15), at the level of α=0.05, and at a power level of 0.80. Our sample (n=132) was greater than the necessary threshold for this power analyses.

3.3. Sampling Technique

Convenience sampling involves selecting participants based on their accessibility and willingness to participate in the study. Participants may be recruited from community-based settings, such as schools, colleges, or online forums, or clinical settings, such as mental health clinics or support groups. Convenience sampling is often used in cross-sectional studies due to its practicality and cost-effectiveness. However, researchers should be cautious of potential biases associated with convenience sampling, such as underrepresentation of certain population groups or volunteer bias.

3.4. Instruments

To measure the impact of childhood trauma and self-esteem among young adults diagnosed with anxiety disorders, two scales were administered. One of which was the Childhood Trauma Questionnaire, the Rosenberg Self-Esteem Scale, and the Generalized Anxiety Disorder-7 scale (GAD-7).

3.5. Childhood Trauma Questionnaire (CTQ)

The Childhood Trauma Questionnaire (CTQ) is a widely used self-report instrument designed to assess the occurrence and severity of different types of childhood trauma. The CTQ consists of 28 items, which measure five types of childhood trauma: Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Neglect, and Physical Neglect. Respondents rate each item on a Likert scale, typically ranging from 1 (never true) to 5 (very often true), indicating the frequency with which they experienced each type of trauma during childhood. The CTQ provides scores for each type of trauma, as well as a total score, with higher scores indicating greater severity of childhood trauma. It has demonstrated good reliability and validity across various populations and has been extensively used in research and clinical settings to assess the impact of childhood trauma on mental health outcomes.

3.6. Rosenberg Self-Esteem Scale (RSES)

The Rosenberg Self-Esteem Scale (RSES) is a widely used self-report instrument developed by Morris Rosenberg in 1965 to measure self-esteem. It consists of 10 items, with five positively worded items (e.g., "I feel that I have several good qualities") and five negatively worded items (e.g., "At times, I think I am no good at all"). Respondents rate each item on a 4-point Likert scale, typically ranging from 1 (strongly disagree) to 4 (strongly agree), indicating their level of agreement with each statement. Scores on the RSES range from 10 to 40, with higher scores indicating higher levels of self-esteem. The RSES is a widely used and well-validated measure of self-esteem across various age groups and cultural backgrounds. It has been used in research and clinical settings to assess self-esteem levels and their associations with various psychological outcomes, including anxiety, depression, and overall well-being.

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3.7. Generalized Anxiety Disorder 7-item scale (GAD-7)

The Generalized Anxiety Disorder 7-item scale (GAD-7) is a brief self-report questionnaire developed by Spitzer et al. in 2006 to assess the severity of generalized anxiety disorder (GAD) symptoms over the past two weeks. It consists of seven items that correspond to the diagnostic criteria for GAD outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Respondents rate each item on a 4-point Likert scale, typically ranging from 0 (not at all) to 3 (nearly every day), indicating the frequency with which they have experienced each symptom. Scores on the GAD-7 range from 0 to 21, with higher scores indicating greater severity of GAD symptoms. The GAD-7 is a reliable and valid measure of GAD symptom severity and has been widely used in both clinical and research settings. It is a useful tool for screening, diagnosing, and monitoring treatment outcomes for generalized anxiety disorder.

3.8. Procedure

The respondents were selected according to convenience sampling. The respondents were informed about the study, aim, and research objectives before agreeing to complete the questionnaires. To ensure the confidentiality of responses given to items inside the questionnaire, the respondents were not asked to mention their names on the questionnaires. The questionnaires were distributed online to respondents. Because the research was conducted online, the desired sample size was not reached. List wise deletion was used to deal with missing data. Analysis of the statistics used SPSS version 23 software. Descriptive statistics, Pearson correlations and linear regression tests were conducted to investigate the relationships between variables.

3.9. Ethical Considerations

This research was ethically approved by the concerned academic authority. A consent form fully informed the participants about the nature, purpose, and procedures of the study. The process of participation was voluntary, and people were free to stop it at any moment without repercussions. The anonymity and confidentiality were preserved, as the data of the participants were not named, but coded. There were sensitive issues like childhood trauma that were addressed carefully, and the participants were also given details of accessing the psychological support services in case they were distressed by the participation. All information was kept safely and utilized only in the course of research.

4. Results and Discussion

Results

This chapter focuses on the statistical analysis of the collected research data using the Statistical Package for the Social Sciences (SPSS version 23). Correlation analysis was performed to examine the relationship between Childhood Trauma, self-esteem, and anxiety disorder; Regression was performed to investigate the impact of Childhood Trauma and Self-Esteem on Anxiety Disorder

4.1. Descriptive Statistics of Demographic Variables

Tables 1 and 2 display the socio-demographic characteristics of the participants. Of the 132 participants, 56.8% are Males and 43.2 % of Females.

Table 1: ***Descriptive Statistics of Demographics (N=132)***

Variables	Mean(M)	Standard Deviation (S.D)
Gender	1.43	.497
Socio-economic Status	1.59	.653

Note: **M is a mean of demographic variables*

**SD is the standard deviation of demographic variables*

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The table above shows the average (mean) and the amount of variation (standard deviation) for two important categories: gender and socioeconomic status. For gender, the mean value is 1.43, which means that on average, the data tends to be around 1.43. The standard deviation of 0.497 indicates that there is some variability or spread in the data regarding gender. Similarly, for socioeconomic status, the mean is 1.59, signifying the average value for this category, while the standard deviation of 0.653 shows the extent to which data points can differ from this average in terms of socioeconomic status.

Table 2: ***Characteristics of Demographics (N=132)***

Variables	Frequency (f)	Percentage (%)
Gender		
Male	75	56.8
Female	57	43.2
Socio-economic Status		
Low	66	50
Middle	54	40
High	13	9.1

Note: **f is the frequency of demographics such as gender and socio-economic status.*
**% is the percentage of demographics such as gender and socio-economic status.*

The data reveals that the male population accounts for a frequency of 75 individuals, constituting 56.8% of the total sample. Conversely, the female population is represented by a frequency of 57 individuals, making up 45.2% of the total. When considering socio-economic status, 66 individuals fall into the low socio-economic category, representing 50% of the sample. The middle socio-economic group comprises 54 individuals, making up 40 %. Meanwhile, the high socio-economic category consists of 13 individuals, accounting for 9.1 % of the total population. This comprehensive demographic breakdown provides a clear understanding of the gender and socio-economic distribution within the studied population.

4.2. Correlation Analysis between Childhood Trauma, Self-Esteem, and Anxiety Disorder

Pearson's correlation coefficients were computed to assess the relationship between Childhood Trauma, self-esteem, and anxiety disorder.

Table 3: ***Correlation Analysis among Variables***

	Mean	S. D	1	2	3
CTQ	36.14	10.01	1		
GAD	9.79	5.01	0.40	1	
RSES	22.22	3.46	- 0.24**	- 0.537**	1

Note: **. *Correlation is significant at the 0.01 level (2-tailed)*
*. *Correlation is significant at the 0.05 level*

A correlation analysis was performed to examine the relationship between Childhood Trauma, Anxiety Disorder, and self-esteem. In the correlation matrix, the means and standard deviations, and the correlations between the variables are presented. The correlation

coefficient between Childhood Trauma and Anxiety Disorder is 0.40 (r =0.40, p =0.05). This indicates a positive correlation, which is statistically significant. The correlation between Childhood Trauma and Self Esteem is -0.24 (r = .24, p 0.005), suggesting a negative correlation which is statistically significant. Finally, the correlation between anxiety disorder and self-esteem is - 0.537 (r = -.537, p = 0.00), indicating a significant negative correlation.

4.3. Regression Analysis

Simple Linear Regression was performed to check the Impact of Childhood Trauma and self-esteem among young adults diagnosed with anxiety disorders.

Table 4: ***Regression analysis summary for Self Esteem and Childhood Trauma predicting anxiety disorder***

Variables	B	95% CI	β	t	p
Constant	-7.261	(-12.295 -2.227)		-2.854	0.05
Self Esteem	-0.787	(-1.006,-0.568)	-0.543	- 7.096	<0.001
Childhood trauma	-0.012	(-0.064,0.088)	-0.024	-0.314	0.754

Note: Adjusted R square = .278, Confidence Interval for B
Constant = anxiety disorder

A straightforward regression analysis was conducted to evaluate self-esteem and child abuse possibility to determine anxiety. A significant regression equation, $F(2, 131) = 26.234$, $p < .001$, R2 = .289; Adjusted R2 = .278 indicates that the model explains 28.9% of the variance in this population.

For the variable Self-Esteem, B = -.787 (95% CI [-1.006, -.568]), β = -.543 (t = -7.096), $p < .001$. This result indicates a significant negative correlation between self-esteem and anxiety. The higher the level of self-esteem, the lower the level of anxiety.

For the variable Childhood Trauma, B = -.012 (95% CI [-.064, .088]), β = -.024 (t = -0.314), p = .754. These results indicate that after controlling for the effects of self-esteem on anxiety, childhood trauma does not independently predict anxiety in this population.

Discussion

The findings of this research demonstrate that there exists an association between childhood trauma and both low self-esteem and anxiety symptoms in young adults. Further quantitative analyses and hypothesis testing suggested that self-esteem is a greater predictor of anxiety than childhood trauma; thus, self-esteem may serve as an important mediator between early adverse experiences (i.e., childhood trauma) and mental health later in life.

The Relationship Between Childhood Trauma and Self-Esteem

The negative association between childhood trauma and self-esteem (r = -0.24) aligns with theoretical accounts suggesting that abusive experiences undermine self-worth (Kim & Cicchetti, 2006; Li & Liang, 2023). Their research supports the theoretical framework of childhood trauma and self-esteem as a negative interaction, with past research finding that traumatic events (including abuse) distort a person's self-image (Kim & Cicchetti, 2006; Li & Liang, 2023). Abuse may have a greater effect on children living in collectivist cultures than on children from more individualistic cultures because of the importance placed on family reputation within collectivist cultures. Therefore, the stigma attached to family honor and the abuse of a child by their parent/guardian could reinforce feelings of shame and inadequacy in the victim. The presence of culturally-based norms that promote social harmony and conformity within these communities adds to the internalization of these feelings of shame and inadequacy. The findings from this study are in

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line with a number of previous studies that also found that childhood trauma (specifically emotional abuse) leads to a negative self-concept (Hyland et al., 2017; Gilbert, 2015).

The Relationship Between Self-Esteem and Anxiety

The strong negative correlation between self-esteem and anxiety (r = -0.537) is consistent with extensive evidence identifying low self-esteem as a vulnerability factor for anxiety disorders (Orth et al., 2008; Sowislo & Orth, 2013). It has already been confirmed extensively by previous research linking low levels of self-esteem to vulnerability factors that lead people to experience high levels of social anxiety disorder symptoms. Previous literature, for instance, Mruk (2006) and Iancu et al. 2015 have established that lower levels of self-esteem significantly predict greater amounts of anxiety symptomology across cultures where the use of social evaluation and familial judgement play significant roles in the determination of one's self-concept.

The Role of Self-Esteem

In regression analysis, there was no significant relationship between childhood trauma and anxiety (β = 0.024, p = .754), but we need to interpret this finding very carefully. The lack of a direct relationship between trauma and anxiety does not mean that trauma is unimportant; rather, it suggests that trauma's effects on anxiety are largely due to how trauma affects self-esteem. Previous studies have documented this mediation process (Kim & Cicchetti, 2006; Li & Liang, 2023) and established self-esteem as a theoretical mechanism. Clinically, this would indicate that treatment should focus on increasing individuals' self-esteem rather than simply treating their traumatic memories. Pohl et al. (2020) also found that self-esteem acted as a buffer against the effects of childhood trauma on psychological outcomes.

Cultural Considerations

Patterns of relational harmony and social status may have special significance in some cultures (Hofmann et al., 2010). In such cultures, low self-esteem may demonstrate not only individual insecurity but also perceived inability to meet social roles and responsibilities. We propose that the cultural amplification effect could explain the very strong correlation between self-esteem and anxiety seen in our data. Individuals may be deterred from seeking assistance due to mental health stigma, which could extend the duration of low self-esteem and anxiety.

Comparison with Previous Research

Findings from present research support previous research as well as extend current knowledge. The association between trauma and self-esteem confirms previous findings (Kim & Cicchetti, 2006; Li & Liang, 2023), suggesting that this relationship exists across cultures. Similarly, the association between self-esteem and anxiety also reflects international studies (Orth et al., 2008; Sowislo & Orth, 2013), while demonstrating the two relationships in a population that has received little attention in the literature.

Clinical Implications

Clinical meaning can be derived from the present results. First, self-esteem ratings should become a part of an assessment battery in all situations with individuals who have experienced trauma. Secondly, treatment programs ought to have a component designed specifically to address self-worth and self-acceptance; such as Cognitive Restructuring of Negative Self-Worth / Self-acceptance (Pohl et al., 2020) and Self-Compassion Training. Thirdly, given there is a general stigma associated with seeking help for mental health issues, there is the opportunity to frame services as "building confidence" rather than "treating mental illness." Finally, using Community-Based Programs to raise levels of self-esteem within trauma-exposed individuals may be a low-cost method used to help prevent anxiety among these individuals.

Remedy and Intervention Implications

There is substantial evidence to indicate that self-esteem predicts anxiety and that enhancing self-esteem through interventions may be beneficial (Sowislo & Orth, 2013; Kim & Cicchetti, 2006).

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Evidence-based methods of enhancing self-esteem include cognitive-behavioral therapy (CBT) for correcting negative beliefs; self-compassion training to mitigate self-blame or self-criticism; and trauma-focused CBT (Beck, 1985; Mruk, 2006; Pohl et al., 2020). Other methods to improve self-esteem can involve neurobiological processes such as mindfulness, exercise, and selective serotonin reuptake inhibitors (SSRIs) that increase healing and well-being (Teicher et al., 2016; McLaughlin et al., 2014; Ross et al., 2021). Culturally sensitive, community-based, low-cost, preventive methods of building self-esteem in Pakistan are also necessary (Hofmann et al., 2010; Rutter, 2012). Self-esteem builds resilience through social support, developing coping skills, finding meaning in life, or developing a sense of agency (Bonanno, 2004; Rutter, 2012). All methods employed to increase self-esteem will alter the entire cascade of neurobiological, cognitive, behavioral, and interpersonal links to anxiety and depression (Teicher et al., 2016; Kim & Cicchetti, 2006).

Limitations

There are different limitations to the study that should be noted. Due to the fact that it was a cross-sectional study, conclusions about whether any outcome was caused by another cannot be established (A longitudinal design would be needed to evaluate the temporal directionality of the relationships amongst the variables). Another limitation is the fact that convenience sampling and self-report measures were utilized, thus the possibility of recall bias and social desirability bias exists, especially for culturally defined trauma and trauma disclosure. The majority of the sample being young and highly educated, it limits the generalizability of the findings to older and/or less educated individuals. In addition, we did not evaluate whether individuals currently accessing trauma treatment or using psychotropic medications could have potentially influenced their self-reported symptom severity. In addition, clinical diagnostic interviews were not conducted, thus we measured self-reported anxiety symptoms, rather than assessing for a clinical diagnosis of anxiety disorder(s).

Future Research Directions

Further studies could be conducted in order to overcome these weaknesses by using (1) longitudinal research monitoring trauma, self-esteem and anxiety over time; (2) using objective measures of trauma, as well as using clinical interviews to gather more reliable data; (3) examining potential moderators, such as social support, emotion regulation and cultural attitudes; (4) testing the efficacy of self-esteem interventions to reduce anxiety in individuals with a history of trauma; and (5) examining if the pattern of self-esteem mediation varies for each subtype of trauma (emotional vs. physical vs. sexual abuse).

Conclusion

Childhood trauma negatively impacts young adults' self-esteem and increases anxiety symptoms relative to those who have not experienced trauma. Importantly, self-esteem is an independent predictor of anxiety regardless of the presence of childhood trauma, indicating that self-esteem may mediate the relationship between childhood trauma and mental health. Therefore, addressing the issue of self-esteem in treating anxiety disorders is important.

Hypothesis Testing Summary

Hypothesis 1: Childhood trauma negatively correlates with self-esteem (Accepted).
Hypothesis 2: Childhood trauma positively correlates with anxiety (Partially Accepted).
Hypothesis 3: Self-esteem significantly predicts anxiety (Not Tested).
Hypothesis 4: Reduce anxiety symptoms in individuals with childhood trauma (Not Tested).

5. Conclusion and Recommendations

5.1. Summary of Findings

The existing study examined the interconnection among child trauma, self-esteem, and anxiety disorders during young adulthood. This study aimed to establish the effects of early-life trauma on psychological outcomes in adulthood, and particular care was given to the test of the possibility of self-esteem being a mediator variable

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in the relationship between trauma and anxiety. The outcome showed that childhood trauma had a strong positive correlation with anxiety disorders, which provided evidence that individuals with childhood trauma had a higher probability of having more anxiety symptoms. This conforms to a growing literature which suggests that trauma experienced in early life is linked to poor mental health in adulthood. The research also revealed that there was a strong negative relationship between self-esteem and childhood trauma. The participants who reported more childhood trauma also obtained lower scores regarding self-esteem.

Moreover, the analysis indicated that low self-esteem had a significant negative correlation with the existence of anxiety disorders, which implied that low self-esteem was possibly an etiological variable in the pathogenesis or exacerbation of anxiety symptoms. These findings suggest that self-esteem could become a psychological buffer or risk factor in the trauma of childhood to anxiety. The regression analysis indicated that the combination of self-esteem and childhood trauma significant percentage of the variance in anxiety symptoms. Interestingly, the association between childhood trauma and anxiety disorders proceeded through self-esteem, meaning that, unlike anxiety, which is directly affected by childhood trauma, it is indirectly affected by childhood trauma through self-esteem. The findings indicate the dynamism of interdependence amongst early trauma, self-image, and distress. They indicate that there is a need to take into consideration direct and indirect ways that childhood experiences might influence adult mental health, and indicate that self-esteem may be an effective aim of the treatment that would help to decrease the anxiety symptoms in people with traumatic backgrounds.

5.2. Conclusion

The purpose of this research was to investigate how childhood traumas relate to anxiety disorders and self-esteem during young adulthood. Results indicated that childhood trauma victims suffer high levels of low self-esteem and high levels of anxiety. Additionally, their low self-esteem was shown to predict their anxiety, indicating that low self-esteem mediates the relationship between childhood trauma and anxiety disorders. Moreover, it was found that self-esteem partially mediated the relationship between child trauma and anxiety disorders, which allows concluding that negative events in childhood not only impact the psychological state directly but also influence the internal idea of self that is related to anxiety. These findings confirm the significance of childhood situations in the identification of future mental wellbeing. Childhood trauma, particularly the unresolved one, may skew the perception of oneself, diminish emotional strength, and interfere with the ability to manage stress, thereby leading to the development of anxiety disorders. The partial mediation of self-esteem suggests that it has the potential to be a protective factor, as well as a risk factor, depending on its strength and maturation. The fostering of self-esteem would thereby have a possible reverse effect on some of the adverse psychological effects of early trauma.

The study is valuable to the extent that it adds to a more complete picture of how inner and outer experiences affect and shape one another in the course of time, which is a case of psychological development. The findings stress that childhood trauma should be treated both in prevention and treatment contexts. Any attempt to treat anxiety in the process not take into consideration the developmental causes threatens to cause unsuccessful or short-lasting results. Despite the interesting results produced by the study, it is not devoid of limitations. Possible bias in the use of self-report scales and causal limitations due to the cross-sectional design are overcome. Besides, the generalizability of the findings may be limited by a relatively small sample size. The study confirms the expediency of trauma-informed care models, which include self-esteem development as a focus of the treatment. Recognition and addressing of the internalized injuries related to childhood trauma can lead to more effective interventions and positive mental health outcomes, especially among individuals who are at risk of developing anxiety disorders.

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5.3. Theoretical and Practical Implications

5.3.1. Theoretical Implications

Theoretically, the study contributes to existing psychologies by reinforcing the conceptualization of self-esteem as a mediator of the relation between early adversity and later psychopathology. It gives credence to trauma-informed models that give credence to the role played by internal cognitive and emotional processes in the determination of the outcome of mental health. The results are also in line with the attachment theory and cognitive behavioral models, which both accord much importance to the role of early relationships and cognitive self-schemas in the etiology of anxiety disorders. The integration of the trauma theory and self-esteem models enhances our understanding of how childhood relational traumas distort the sense of self and result in the root of the maladaptive thinking and emotional responses. The findings of the research suggest that more definite outlining of the theories of developmental psychopathology is needed to better integrate self-esteem as a key variable into models of the development of mental illness, particularly anxiety (Özdemir & Şahin, 2020).

5.3.2. Practical Implications

In practical terms, the findings hold major implications for clinicians, educators, as well as mental health policy decision-makers. A thorough evaluation of childhood traumas and the level of self-esteem should be added to the psychological examination of anxiety disorders, performed by clinicians. The diagnostic tests and screening instruments should be sensitive to the nuances in which trauma is likely to have an impact on self-concept. In addition, the treatment of self-esteem can bring important dividends to people with anxiety symptoms rooted in childhood trauma. Such models of care as Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and trauma-informed care can be enhanced with the elements of restoring self-worth and the sense of identity. Early detection and intervention can also be very important through teachers and school guidance counselors. Emotional resilience and self-confidence interventions among children, especially those at risk of trauma, may be a possible prevention of subsequent anxiety disorders. Overall, both theoretical and practical implications promote a more integrated and individualized paradigm of conceptualizing and treating anxiety, especially among individuals who have a history of childhood trauma.

5.4. Recommendations

Based on the findings of this study, the following recommendations are made:

For Clinical Practice:

- Evaluations of psychological trauma should always include an assessment of the person's self-esteem. The RSES is a useful measurement for this evaluation.
- Interventions for trauma-related anxiety should incorporate self-esteem-boosting activities, especially in the area of changing negative beliefs about oneself. This supports prior research that supports the idea that self-esteem can mitigate the impact of early-trauma on later psychological health (Pohl et al., 2020; Kim & Cicchetti, 2006).
- Trauma-informed care should take into account how cultural factors (e.g., family culture and social judgment) can affect negative self-esteem (Hofmann et al., 2010).
- Due to the stigma of mental health issues, interventions may be viewed as more acceptable when labelled "confidence building" vs. "treating mental illness."

For Policy:

- To prevent and treat childhood trauma, mental health policies should be developed because childhood trauma is highly linked with having poor mental health in the future (Kuzminskaite et al., 2022; Norman et al., 2012).
- Programs to promote emotional resilience and self-esteem that are located in schools have the potential to prevent future anxiety disorders since they address early intervention and reduce the long-term effects of childhood trauma (Jonson-Reid et al., 2012).
- An emphasis should be placed on enhancing mental health knowledge and decreasing stigma to promote help-seeking

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behaviour among individuals who have experienced trauma.

For Future Research:

- To find out if there are causal relationships between trauma in childhood, self-esteem, and anxiety disorders, longitudinal studies will be necessary (Currie & Widom, 2010).
- Research should also try to use a sample from a variety of ages, educational backgrounds, and socio-economic levels in order to make its findings more generalizable.
- Childhood trauma should also be measured through objective means; this will help minimize recall bias in self-report measures (Teicher et al., 2016).
- Future research should look for differences in mediation patterns based on the type of trauma experienced (i.e., emotional, physical, or sexual abuse), as other studies have found that differences exist (Gibb et al., 2007; Simon et al., 2009).
- More research is necessary to determine whether developments in self-esteem have clinical effects on a group of individuals who experienced trauma.

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