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Original Research

Association Between Childhood Trauma and Severity of Depression Among Adult Psychiatric Patients: A Cross-Sectional Observational Study.

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Abstract

Background: Childhood trauma is a clinically relevant early-life exposure that contributes to vulnerability for depressive disorders and affects symptom burden in adulthood. Psychiatric patients with depressive symptoms frequently report adverse childhood experiences, but trauma-related gradients in depression severity require structured clinical evaluation. **Objectives:** To assess the distribution of childhood trauma among adult psychiatric patients with depressive symptoms and to determine its association with depression severity. **Methods:** This cross-sectional observational study was conducted at Sri Shankaracharya Institute of Medical Sciences, Bhilai, Chhattisgarh, India, from October 2023 to September 2024. A total of 100 adult psychiatric patients with depressive symptoms were enrolled. Childhood trauma was assessed using the Childhood Trauma Questionnaire, and depression severity was evaluated using the Patient Health Questionnaire-9. Descriptive statistics, chi-square test, analysis of variance, Spearman correlation, and ordinal logistic regression were used for analysis. **Results:** The mean age of the study population was 38.7 ± 12.1 years, and females constituted 54.0%. Any childhood trauma was reported by 74.0% of patients. Emotional neglect was the most frequent trauma domain, followed by emotional abuse and physical neglect. The mean PHQ-9 score was 16.8 ± 5.4 . Severe depression increased from 3.8% in patients with no/minimal trauma to 61.9% in those with severe trauma. Childhood trauma severity was significantly associated with depression severity, and total childhood trauma score showed a positive correlation with PHQ-9 score. **Conclusion:** Childhood trauma showed a significant dose-response association with depression severity among adult psychiatric patients. Routine trauma assessment can strengthen clinical formulation and support individualized psychiatric care.

Keywords: Childhood trauma; depression severity; adult psychiatric patients; emotional neglect; PHQ-9; Childhood Trauma Questionnaire; cross-sectional study.

Introduction

precipitate depressive episodes, early-life adversity has a distinct role in shaping vulnerability across the lifespan. Childhood trauma includes emotional, physical and sexual abuse, as well as emotional and physical neglect. These exposures occur during sensitive periods of neurodevelopment and influence emotional regulation, threat perception, attachment security and stress-response systems. The Adverse Childhood Experiences study demonstrated a graded relationship between early adversity and several adult health outcomes, including mental health morbidity [1]. Subsequent epidemiological work also showed that adverse childhood experiences are associated with increased risk of depressive disorders in adulthood [2].

Large population-based and clinical studies have strengthened the evidence that childhood adversities are not isolated historical events, but cumulative risk markers with long-term psychiatric implications. The World Mental Health Surveys reported associations between childhood adversities and a broad range of adult mental disorders across countries [3]. Depression is particularly relevant in this context because its course is affected not only by current symptom intensity, but also by early trauma load, recurrence, chronicity, comorbidity, suicidality and response to treatment. Meta-analytic evidence indicates that childhood maltreatment predicts a more unfavorable course of depressive illness and poorer treatment outcomes [8].

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Different trauma domains do not contribute equally to depression. Emotional abuse and emotional neglect have repeatedly shown strong links with adult depressive symptoms, while physical and sexual abuse also carry substantial psychiatric burden [9,10]. Retrospective assessment of childhood trauma is commonly performed using the Childhood Trauma Questionnaire, a validated self-report instrument that captures multiple maltreatment domains [4,5]. For depression severity, the Patient Health Questionnaire-9 is widely used because it is brief, clinically interpretable and suitable for measuring symptom severity in both medical and psychiatric settings [6,7].

In adult psychiatric practice, patients often present with depressive symptoms without systematic documentation of developmental trauma. In such situations, the clinical formulation remains incomplete, and the opportunity to identify trauma-informed care needs is reduced. Indian hospital-based data on childhood trauma burden and depression severity among adult psychiatric patients are still limited. Therefore, this study was conducted to assess childhood trauma among adult psychiatric patients with depressive symptoms and to examine the association between childhood trauma severity and depression severity. The primary objective was to determine whether increasing childhood trauma burden was associated with higher depression severity. The secondary objectives were to describe trauma domains and evaluate correlations between trauma scores and PHQ-9 scores.

Materials and Methods

Study design and setting: This was a cross-sectional observational study conducted in the Department of Psychiatry at Sri Shankaracharya Institute of Medical Sciences, Bhilai, Chhattisgarh, India. The institution provides outpatient and inpatient psychiatric services for adults with mood, anxiety, psychotic, substance-related and stress-related disorders. The study was carried out over a 12-month period from October 2023 to September 2024. The cross-sectional design was selected to assess childhood trauma exposure and current depression severity at a single clinical contact.

Study population and eligibility criteria: The study included adult psychiatric patients aged 18 years and above who presented with depressive symptoms and were able to provide valid responses to the study questionnaires. Patients were enrolled consecutively until the required sample size of 100 was achieved. Patients with acute severe agitation, severe cognitive impairment, active intoxication, poor capacity to understand the questionnaire, or refusal to provide informed consent were excluded. Repeat enrolment of the same patient was not permitted.

Study tools and data collection: A structured proforma was used to record age, sex, residence, marital status and relevant clinical details. Childhood trauma was assessed using the Childhood Trauma Questionnaire, which evaluates emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect [4,5]. Depression severity was assessed using the Patient Health Questionnaire-9, a nine-item measure that grades depressive symptoms over the preceding two weeks and provides a total score ranging from 0 to 27 [6,7]. Depression was categorized as mild, moderate, moderately severe and severe according to standard PHQ-9 severity bands.

Operational definitions: Childhood trauma was categorized as no/minimal, mild, moderate and severe according to the total trauma burden and domain-level responses. Any childhood trauma was defined as the presence of clinically meaningful exposure in at least one trauma domain. Depression severity was analyzed both as categorical severity groups and as continuous PHQ-9 score. The trauma domains were analyzed individually to examine their relationship with depressive symptom burden.

Statistical analysis: Data were entered into a spreadsheet and analyzed using standard statistical methods. Categorical variables were summarized as frequency and percentage, while continuous variables were expressed as mean and standard deviation. The chi-square test was used to assess the association between childhood trauma severity and depression severity. Analysis of variance was used to compare mean PHQ-9 scores across trauma categories. Spearman correlation was applied to evaluate the relationship between trauma domain scores and depression severity score. Ordinal logistic regression was performed to assess the adjusted association between trauma severity and higher depression severity after controlling for age, sex, residence and marital status. A p-value below 0.05 was considered statistically significant.

Ethical considerations: The study protocol was reviewed and approved by the Institutional Ethics Committee of Sri Shankaracharya Institute of Medical Sciences, Bhilai, Chhattisgarh, India. Written informed consent was obtained from all participants before enrolment. Patient confidentiality was maintained throughout the study, and data were used only for research analysis.

Results

A total of 100 adult psychiatric patients with depressive symptoms were included in the study. The mean age of the study population was 38.7 ± 12.1 years. Most patients were in the 31-40 years age group, followed by 18-30 years. Females constituted 54.0% of the study population. Urban residence was noted in 58.0% of patients, and 58.0% were married. The socio-demographic characteristics are shown in Table 1.

Table 1. Socio-demographic characteristics of the study population

Variable	Frequency / Mean	Percentage
Total patients	100	100.0
Mean age, years	38.7 ± 12.1	—
18-30 years	28	28.0
31-40 years	31	31.0
41-50 years	24	24.0
>50 years	17	17.0
Male	46	46.0
Female	54	54.0
Urban residence	58	58.0
Rural residence	42	42.0
Married	58	58.0
Unmarried	32	32.0
Separated/widowed	10	10.0

Childhood trauma was present in 74.0% of the study participants, while 26.0% had no or minimal trauma exposure. Mild childhood trauma was observed in 24.0%, moderate trauma in 29.0%, and severe trauma in 21.0% of patients. Emotional neglect was the most frequently reported trauma domain, followed by emotional abuse, physical neglect, physical abuse and sexual abuse. The distribution of childhood trauma is presented in Table 2.

Table 2. Distribution and domains of childhood trauma

Childhood trauma variable	Frequency	Percentage
No/minimal childhood trauma	26	26.0
Any childhood trauma	74	74.0
Mild trauma	24	24.0
Moderate trauma	29	29.0
Severe trauma	21	21.0
Emotional neglect	56	56.0
Emotional abuse	48	48.0
Physical neglect	42	42.0
Physical abuse	31	31.0
Sexual abuse	18	18.0

The mean depression score was 16.8 ± 5.4 . Moderate depression was the most common category, observed in 32.0% of patients, followed by moderately severe depression in 28.0% and severe depression in 24.0%. A clear increase in depression severity was observed with increasing childhood trauma severity. Severe depression was present in only 3.8% of patients with no/minimal trauma, compared with 61.9% of patients with severe childhood trauma. This association was statistically significant ($\chi^2 = 38.03$, $p < 0.001$), as shown in Table 3.

Table 3. Association between childhood trauma severity and depression severity

Childhood trauma severity	Mild depression	Moderate depression	Moderately severe depression	Severe depression	Total
No/minimal trauma	9 (34.6%)	11 (42.3%)	5 (19.2%)	1 (3.8%)	26
Mild trauma	5 (20.8%)	11 (45.8%)	6 (25.0%)	2 (8.3%)	24
Moderate trauma	2 (6.9%)	8 (27.6%)	11 (37.9%)	8 (27.6%)	29
Severe trauma	0 (0.0%)	2 (9.5%)	6 (28.6%)	13 (61.9%)	21
Total	16 (16.0%)	32 (32.0%)	28 (28.0%)	24 (24.0%)	100
Statistical test		$\chi^2 = 38.03$		$p < 0.001$	

Mean depression scores increased progressively across trauma categories. Patients with no/minimal trauma had a mean PHQ-9 score of 12.6 ± 4.0 , while those with severe trauma had a mean score of 21.3 ± 4.3 . Total childhood trauma score showed a significant positive correlation with depression severity score (Spearman's $\rho = 0.58$, $p < 0.001$). Among individual trauma domains, emotional abuse showed the strongest correlation with depression severity. On multivariable ordinal logistic regression, moderate and severe childhood trauma remained independently associated with higher depression severity after adjustment for age, sex, residence and marital status. The correlation and regression findings are shown in Table 4.

Table 4. Mean depression score, correlation and adjusted association with depression severity

Variable	Result	p-value
Mean PHQ-9 score in no/minimal trauma	12.6 ± 4.0	—
Mean PHQ-9 score in mild trauma	15.2 ± 4.7	—
Mean PHQ-9 score in moderate trauma	18.1 ± 4.9	—
Mean PHQ-9 score in severe trauma	21.3 ± 4.3	—
ANOVA for PHQ-9 score across trauma categories	$F = 16.28$	<0.001
Correlation between total childhood trauma score and PHQ-9 score	Spearman's $\rho = 0.58$	<0.001
Correlation of emotional abuse with PHQ-9 score	Spearman's $\rho = 0.54$	<0.001
Correlation of emotional neglect with PHQ-9 score	Spearman's $\rho = 0.49$	<0.001
Correlation of physical abuse with PHQ-9 score	Spearman's $\rho = 0.41$	<0.001
Correlation of physical neglect with PHQ-9 score	Spearman's $\rho = 0.36$	0.002
Correlation of sexual abuse with PHQ-9 score	Spearman's $\rho = 0.33$	0.004
Mild childhood trauma and higher depression severity	AOR = 1.64; 95% CI: 0.62-4.38	0.321
Moderate childhood trauma and higher depression severity	AOR = 3.28; 95% CI: 1.24-8.68	0.017
Severe childhood trauma and higher depression severity	AOR = 6.72; 95% CI: 2.31-19.56	<0.001

Overall, the study demonstrated a significant dose-response association between childhood trauma and depression severity among adult psychiatric patients. Higher childhood trauma burden was associated with greater depressive symptom severity, higher mean PHQ-9 scores, and increased odds of moderately severe to severe depression.

Discussion

The present cross-sectional observational study found a high burden of childhood trauma among adult psychiatric patients with depressive symptoms. Nearly three-fourths of the study population reported some form of childhood trauma, and emotional neglect was the most frequently reported domain. This pattern is clinically meaningful because neglect and emotional abuse are often less visible than physical injury but carry substantial psychological impact. The findings are consistent with earlier evidence showing that childhood maltreatment contributes to adult depressive morbidity and shapes the clinical profile of depression [2,8,9].

A clear dose-response pattern was observed between trauma severity and depression severity. Severe depression was uncommon among patients with no/minimal trauma but was present in more than half of those with severe childhood trauma. Mean PHQ-9 scores also increased steadily across trauma categories. These observations support the concept that childhood trauma contributes not only to the presence of depressive symptoms, but also to their intensity. Meta-analytic evidence has shown that childhood maltreatment is associated with more severe, recurrent and treatment-resistant depression [8,9]. Similar findings were reported by Medeiros et al., where childhood maltreatment was linked with earlier onset, greater severity, suicidality and poorer clinical presentation among adults with major depression [14].

Among the trauma domains, emotional abuse showed the strongest correlation with PHQ-9 score, followed by emotional neglect. This finding agrees with previous literature highlighting the importance of emotional forms of maltreatment in adult depression [9,10]. Emotional abuse can shape negative self-schema, shame, interpersonal sensitivity and persistent threat appraisal, while emotional neglect can impair attachment security and emotional regulation. These mechanisms provide a plausible psychological pathway between early trauma and later depressive symptom burden. Hovens et al. also demonstrated that childhood trauma has stronger relevance than general childhood life events in adult depressive and anxiety disorders [12].

After adjustment for age, sex, residence and marital status, moderate and severe childhood trauma remained independently associated with higher depression severity. This strengthens the interpretation that trauma burden has an independent relationship with depressive symptom severity in psychiatric patients. The results also emphasize the practical value of including childhood trauma assessment in routine psychiatric evaluation. Instruments such as the CTQ and PHQ-9 are brief, structured and suitable for clinical research settings [4-7]. Identifying trauma exposure can help clinicians plan trauma-informed psychoeducation, psychotherapy referral, safety assessment and longitudinal follow-up. Because this was a single-centre cross-sectional study, the findings should be interpreted as an association rather than a causal pathway. Nevertheless, the observed gradient between trauma severity and depression severity supports the relevance of developmental history in adult psychiatric assessment.

Limitations

This study was limited by its cross-sectional design, which does not establish temporality or causality. Childhood trauma was assessed using retrospective self-report, creating scope for recall bias and under-reporting. The sample was drawn from a single tertiary psychiatric setting, limiting external validity. Comorbid psychiatric diagnoses and treatment history were not analyzed in detail.

Conclusion

This study found a significant association between childhood trauma and depression severity among adult psychiatric patients. Any childhood trauma was reported by nearly three-fourths of patients, with emotional neglect and emotional abuse being the most frequent domains. Depression severity increased progressively with trauma burden, and severe childhood trauma showed the strongest adjusted association with higher depression severity. Emotional abuse had the strongest domain-level correlation with PHQ-9 score. These findings support the integration of structured childhood trauma screening into psychiatric assessment. Early identification of trauma exposure can improve clinical formulation, guide trauma-informed interventions, and support individualized management for adults presenting with depressive symptoms in psychiatric care settings.

Ethical approval

The study was approved by the Institutional Ethics Committee of Shankaracharya Institute of Medical Sciences, Bhilai, Chhattisgarh, India. Approval number: to be added by the authors.

Informed consent

Written informed consent was obtained from all participants before enrolment.

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