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Wounds That Speak: Exploring Childhood Trauma and Self-Injury in Patients with Generalized Anxiety Disorder

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INTRODUCTION

Anxiety disorders affect up to 20% of adults annually, with Generalized anxiety disorder being among the most prevalent. The defining characteristics of generalized anxiety disorder are persistent feelings of stress and dread, along with exaggerated, irrational and perpetual worry over routine matters. This excessive worry often spans concerns about the future, family, health, or finances, and is difficult to manage, frequently accompanied by vague physical and psychological symptoms.[1,2] The weighted prevalence rates observed was 5.8% for GAD in accordance with the Indian research.[3,4]

GAD often occurs with other disorders like social phobia[5], obsessive-compulsive disorder[6], post-traumatic stress disorder[7] and panic disorder[8]. Key contributors are chronic stress and comorbid medical and psychiatric conditions, family history of GAD (≈25% risk in first-degree relatives), childhood abuse which may impair emotional regulation, while use of substances can both result from and aggravate anxiety. [9,3]

It is increasingly recognized that childhood adversity poses a serious risk of developing vulnerability for the emergence of anxiety disorders. It includes numerous negative experience that can result in long-lasting physical and mental damage. Childhood trauma can impair emotional development and increase susceptibility to anxiety in later life, regardless of whether it results from interpersonal violence, familial neglect, or environmental stresses.[10]

Childhood trauma as characterized by the World Health Organization (WHO) includes a range of abuse and neglect, whether physical, emotional, or sexual, along with exploitation or negligent care. A child's well-being, self-worth, growth, or survival may be harmed by these acts, which take place in relationships built on authority, trust, or responsibility.[11]

According to the National Crime Records Bureau (NCRB) of India, incidents of child sexual abuse occur with alarming frequency, approximately one case every 15 minutes with prevalence rates of abuse varying considerably from 4% to 66% in females and 4% to 57% in males.[12-15]

The different types of childhood trauma include emotional neglect, physical abuse or maltreatment, sexual abuse and others. Neglect was significantly linked to an elevated likelihood of acquiring symptoms of Generalized Anxiety Disorder (GAD), according to a study examining the relationship between parent-to-child maltreatment and GAD diagnosis.[16]

Lindert et al. in 2013, through a systematic review and meta-analysis, explored the association between childhood abuse and adult mental health. Their findings indicate that individuals exposed to physical or sexual abuse in early life are more likely to experience heightened levels of depression, anxiety, and emotional distress later in adulthood. These outcomes emphasize the need for early prevention efforts and sustained mental health support for survivors of childhood abuse.[17]

Grummitt et al. in 2024 reported in a large-scale Australian study that childhood maltreatment accounts for approximately 41% of attempted suicides, 35% of cases of self-harm, and 21% of depression diagnoses in the general population.[18]

A considerable body of research highlights a significant link between early-life maltreatment and engagement in self-injurious behaviors other than suicide.[15] Intentional infliction of bodily harm on oneself lacking the purpose of ending life is termed non-suicidal self-injury (NSSI). According to ICD-11 (MB23.E), Non-Suicidal Self-Injury (NSSI) refers to the purposeful infliction of superficial injury to one's body, often involving actions such as scratching, burning, or striking oneself, with the recognition that the damage will be limited and not intended to cause death.[19] This behavior typically serves as a way to stabilize emotions by alleviating or avoiding intense negative feelings.[20] Indian studies have shown considerable variability in reported prevalence rates, with estimates ranging between 18.5% and 39.2%.[21,22] Individuals with a positive history of NSSI are consistently found to have experienced a greater number of adverse or traumatic childhood events compared to those without such behaviors.[23]

Several studies have explored the relationship between anxiety disorders and non-suicidal self-injury (NSSI). Shi et al. (2025), through a comprehensive meta-analysis, reported that

individuals with anxiety disorders, including GAD were significantly more likely (OR = 3.60) to engage in NSSI compared to those without such diagnoses.[24] Extensive reviews of existing literature have consistently demonstrated a strong link between childhood trauma and NSSI. Martínez et al. (2024), in an aggregated analysis of 46 studies encompassing more than 1.5 million adolescents, reported that emotional abuse (OR = 2.91) and sexual abuse (OR = 2.72) were among the most significant predictors. [25]
The convergence of childhood trauma, NSSI, and GAD has been highlighted in integrated studies. Guo et al. (2023), in a baseline survey of the Chinese Adolescent Health Growth Cohort, demonstrated that adverse childhood experiences (ACEs) are significantly associated with increased risks of both NSSI and suicidal behaviors, with a clear dose-response relationship indicating that the number and severity of ACEs proportionally increased the risk.[26]
Similarly, Xie et al. (2023) examined adolescents with depressive disorders and found that childhood trauma had both direct and indirect effects on NSSI, with negative life events and maladaptive coping styles serving as mediators.[27]
While the above findings highlight how childhood trauma contributes independently to both GAD and NSSI, recent studies have started to look more closely at where these two conditions overlap. Emerging evidence suggests that GAD, especially when linked to early adversity, might heighten vulnerability to NSSI, potentially through emotional dysregulation rooted in those childhood experiences. Despite these insights, research exploring these interconnected factors among Indian patients with GAD remains sparse.

AIM

To study the relationship between childhood trauma and non-suicidal self-injury in patients with Generalized anxiety disorder.

OBJECTIVES

1. To assess severity and type of childhood trauma in patients with Generalized Anxiety Disorder.
2. To assess the functions of non-suicidal self-injury in patients with Generalized Anxiety Disorder.
3. To study the relationship between childhood trauma severity and Non-Suicidal Self Injury in patients with Generalized anxiety Disorder.
4. To examine differences in childhood trauma severity among patients with Generalized Anxiety Disorder based on the presence or absence of Non-Suicidal Self-Injury (NSSI).

METHOD

Design: The study followed a cross-sectional research design as the participants of the study were assessed at a single point of time. The study took place at the Department of Psychiatry, Teerthanker Mahaveer Medical College & Research Centre (TMMC & RC), Moradabad.

Sample: The study includes 84 patients diagnosed with Generalized Anxiety Disorder.

Inclusion criteria:

1. All the outpatients/Inpatients/Referrals with Generalized Anxiety Disorder presenting in psychiatry department of Teerthanker Mahaveer Medical College & Research Centre fulfilling the ICD 11 criteria [28]
2. Patients of both sexes of age group 18 – 65 yrs.
3. Patients who have given informed written consent for the study.

Exclusion criteria:

1. All patients diagnosed with any other psychiatric comorbidity along with Generalized Anxiety Disorder.
2. Patients diagnosed with any other major medical / surgical illness.

Tools

The study used three tools for assessing different variables. Hamilton Anxiety Rating Scale (HAM-A)[29-31] was used for assessing the severity of anxiety levels, Childhood Trauma Questionnaire – Short Form (CTQ-SF) [32,33] was used to assess the severity and type of trauma experienced by the patients with GAD, and lastly Ottawa Self-Injury Inventory (OSI) [34] was used to assess self-injurious behavior.

Hamilton Anxiety Rating Scale [29-31]

The Hamilton Anxiety Rating Scale (HAM-A) gauges the severity of anxiety symptoms in both therapeutic and research settings. It consists of 14 items, each assessing a distinct aspect of anxiety. Clinicians rate the items from 0 (not present) to 4 (extremely severe), resulting in a total score ranging from 0 to 56. Generally, a score below 17 reflects mild anxiety. Scores between 18 and 24 indicate mild to moderate symptoms, while those in the 25 to 30 range point to moderate to severe anxiety. Scores above 30 are typically associated with severe levels of anxiety. The areas assessed include emotional and physical experiences, disruptions in sleep patterns, diminished cognitive functions like memory and concentration, sensory disturbances like hot or cold sensations, and cardiovascular signs such as palpitations or chest tightness. Additionally, it evaluates gastrointestinal discomfort, genitourinary issues, and autonomic signs like dizziness or dry mouth. The clinician also notes the patient's behavior during the interview, observing signs such as visible restlessness or tension in facial expressions. This comprehensive approach ensures that both

subjective complaints and objective signs are taken into account when determining the severity of anxiety.

Childhood Trauma Questionnaire – Short Form (CTQ-SF) [32,33]

The Childhood Trauma Questionnaire–Short Form (CTQ-SF) is a self-administered instrument developed to retrospectively assess negative childhood experiences, particularly those involving abuse and neglect. It contains 28 items, each rated on a 5-point Likert scale from 1 ("Never True") to 5 ("Very Often True"), based on the respondent's perception of events during their upbringing. The questionnaire is structured into five clinical subscales: Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Neglect, and Physical Neglect, with each domain represented by five specific items. In addition to these, three items are included to evaluate potential response bias, such as minimization or denial of traumatic experiences. Subscale scores range from 5 to 25, where higher scores reflect increased severity or frequency of the reported childhood trauma. Overall, the CTQ-SF offers a concise yet comprehensive way to identify and quantify childhood trauma across key domains, supporting both clinical assessment and research investigations.

	Severity		
Subscale	**None/Low**	**Moderate**	**Severe**
Emotional Abuse	5–12	13–15	16–25
Physical Abuse	5–9	10–12	13–25
Sexual Abuse	5-7	8–12	13–25
Emotional Neglect	5–9	10–14	15–25
Physical Neglect	5–7	8–12	13–25

Table 1. Cutoffs for interpretation for Childhood Trauma Questionnaire–Short Form (CTQ-SF)

Ottawa Self-Injury Inventory (OSI) [34]

The Ottawa Self-Injury Inventory (OSI) explores various dimensions of non-suicidal self-injury (NSSI). Rather than focusing solely on frequency, the OSI aims to understand the full spectrum of the behavior, including the underlying motives and emotional processes associated with it. Comprising roughly 27 to 31 items depending on the version used, the questionnaire is organized into four major domains i.e. *Frequency and Methods* of NSSI, *Functions* of NSSI, *Addictive Features*, and *Emotion Regulation and Triggers*. While the OSI does not typically produce a single total score, its items are often analyzed dimensionally to understand the severity, function, and addictive potential of NSSI.

Procedure

A hospital based Observational Cross-sectional study was conducted in the Psychiatry department in a TMMC & RC, Moradabad after getting necessary institutional approval from the College Research Committee (CRC) and Institutional Ethical Committee (IEC). The study was performed on the patients of generalized anxiety disorder fulfilling the ICD-11 criteria [1] and informed written consent were taken. The socio-demographic data were collected in the prescribed format. Followed by demographics, severity of symptoms of generalized anxiety disorder were measured by Hamilton Anxiety Rating scale. [29-31] The same patient was further assessed by Childhood Trauma Questionnaire – SF [32,33] for childhood trauma and evaluated for the frequency of recent Non suicidal self–injury thoughts and behaviors and the functions of NSSI by Ottawa Self-injury Inventory.[34] Lastly, the appropriate statistical analysis was applied.

Data analysis

Data was entered in Excel and analyzed using SPSS version 26. Categorical variables were summarized as frequencies and percentages, with group comparisons done using the Chi-square test. Continuous data were expressed as mean ± SD and compared using the t-test. A p-value < 0.05 was considered statistically significant.

RESULTS

Demographic details

Among the 84 participants, the largest proportion (29.8%) belonged to the 18–29 age group, followed by 26.2% in the 30–39 age group. Individuals aged 40–49 made up 21.4% of the sample, while those aged 50–59 and 60+ comprised 13.1% and 9.5% respectively. Out of the total sample, 28 (66.7%) were males and 28 (33.0%) were females. Most participants were married (75%), while 17.9% were unmarried and 7.1% were divorced or widowed. The majority of participants identified as Hindu (73.8%), followed by Muslims (20.2%), and a small proportion identified with other religions (6%). Educationally, 29.8% had completed secondary education, 28.6% were graduates or postgraduates, 23.8% had primary education, and 17.9% were illiterate. A higher proportion of participants were unemployed (57.1%) compared to those who were employed (42.9%). Most participants (59.5%) were from the middle socioeconomic group, followed by 26.2% from the lower and 14.3% from the upper class. The

average duration of illness among the study sample was approximately 13.2 months (±4.6), reflecting chronicity and the persistence of mental health symptoms over time. The average HAM-A score was 22.8 (±5.4), indicating that the overall sample fell within the mild-to-moderate range of anxiety severity.

Table 2. Types of Trauma

Type of Trauma	None	Low	Moderate	Severe	Total (n)	Mean ± SD (CTQ-SF Score)
Sexual Abuse	28	22	20	14	84	11.67 ± 4.81
Emotional Abuse	16	24	28	16	84	13.14 ± 4.59
Physical Abuse	20	30	22	12	84	12.44 ± 4.61
Emotional Neglect	10	28	30	16	84	13.40 ± 4.26
Physical Neglect	14	32	24	14	84	12.82 ± 4.35

The above result table shows that among the different types of trauma assessed, emotional neglect (13.40 ± 4.26) had the highest average score, followed closely by emotional abuse (13.14 ± 4.59). Physical neglect (12.82 ± 4.35) and physical abuse (12.44 ± 4.61) also appeared frequently, reflecting a pattern of unmet basic needs and exposure to harm during formative years. Emotional neglect was marked as moderate by 30 participants and as severe by 16, while physical neglect followed a similar pattern, with 24 reporting it as moderate and 14 as severe. Emotional abuse was also prominent, with 28 people rating their experience as moderate and 16 as severe. In contrast, 28 individuals reported no sexual abuse at all, but 14 shared that they had experienced it at a severe level. Physical abuse was most often described as low by 30 participants and moderate by 22, indicating it may have been more widespread but often less intense.

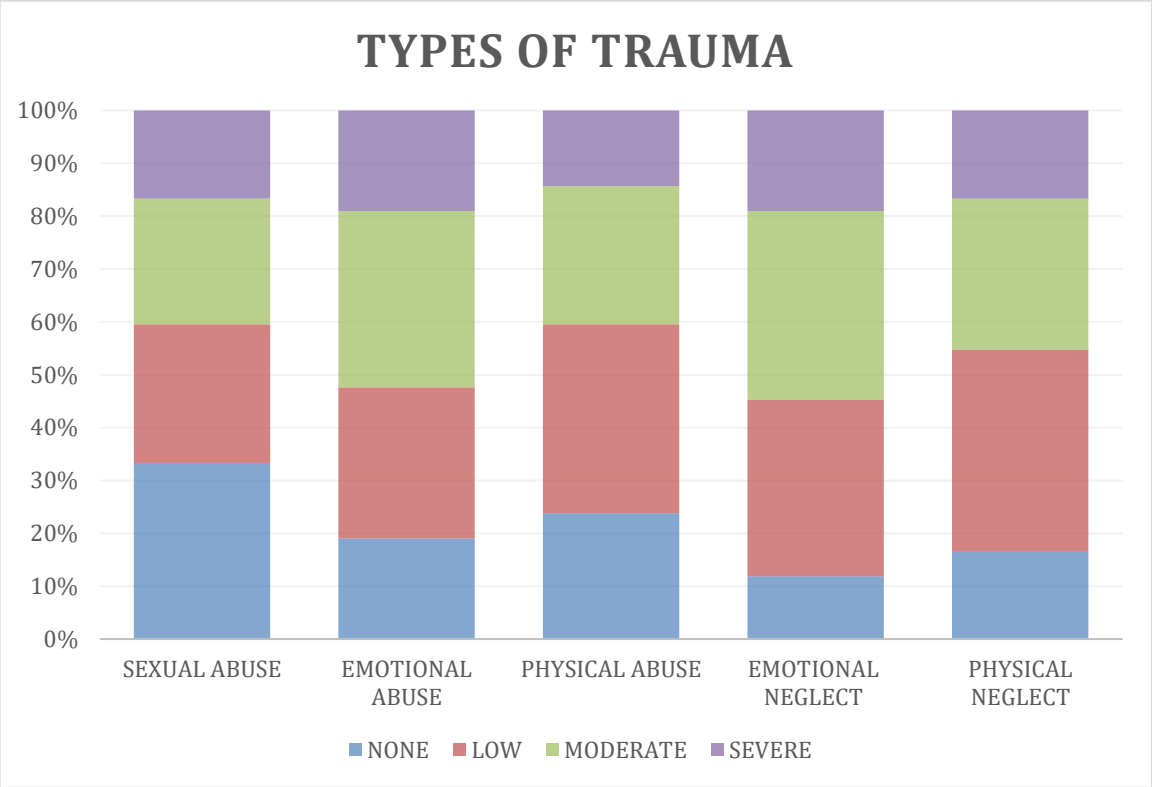

Figure 1. Distribution of trauma severity across CTQ-SF domains in GAD patients (*N* = 84), with domain-wise mean scores ± SD overlaid as black error bars.

Figure 2. categorizes overall trauma severity using CTQ-SF composite scoring, 12 (33.3%) participants fell in the moderate trauma range, followed by 30 (35.7%) participants in the low trauma range. Severe trauma levels were reported by 14 (16.7%) participants, and the rest 12 (14.3%) showed no significant trauma history.

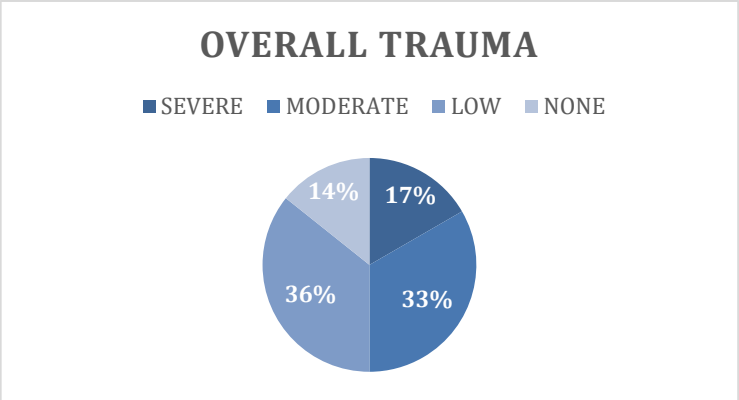

Figure 2. Distribution of overall trauma severity levels among patients with generalized anxiety disorder (GAD). Most participants reported low (35.7%) or moderate (33.3%) trauma, while 16.7% reported severe trauma and 14.3% reported no trauma.

Table 3. Functions scores on Ottawa Self-Injury Inventory

Domain	Raw Mean ± SD	Number of items (Q= 25)	Mean per Item (Mean/Q')
Internal Emotional Regulation	5.6 ± 1.4	8	0.7
Social Influence	4.2 ± 1.8	9	0.47
External Emotional Regulation	1.6 ± 0.8	3	0.53
Sensation Seeking	2.0 ± 0.9	4	0.5
Other	1.1 ± 0.6	1	—
Primary Function	**Internal Emotional Regulation (n=28, 33.3%)**		

Based on the Ottawa Self-Injury Inventory function scores, the most frequently endorsed primary function for NSSI was internal emotional regulation, reported by 33.3% of participants. This domain also yielded the highest raw mean score (5.6 ± 1.4). Social influence and external emotional regulation followed, with raw mean scores of 4.2 ± 1.8 and 1.6 ± 0.8 respectively. Sensation seeking had a mean of 2.0 ± 0.9, and the "other" category yielded a mean of 1.1 ± 0.6. These results suggest that for most individuals with GAD engaging in NSSI, the behavior primarily served to regulate overwhelming internal emotional states, rather than being driven by external demands or thrill-seeking motives.

A statistically significant association was found between trauma severity and the presence of NSSI ($p = 0.004$) [Figure 3.]. Among individuals reporting NSSI, 20 (38.5%) had experienced moderate trauma and 12 (23.1%) had experienced severe trauma. In contrast, those with no or low trauma severity were more likely to report no history of NSSI. These findings support the hypothesis that higher trauma exposure is strongly associated with increased risk of self-injurious behavior.

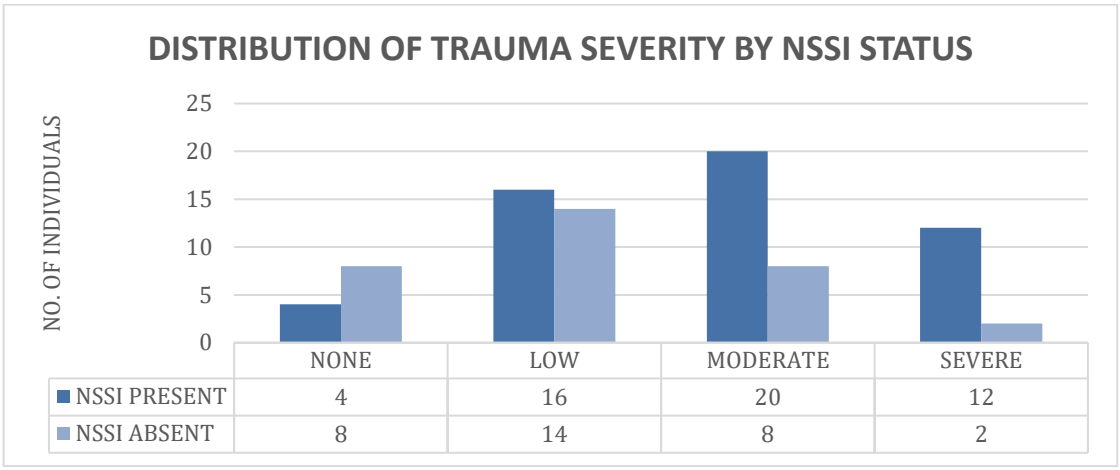

Figure 3. Distribution of trauma severity in GAD patients with (n = 52) and without NSSI (n = 32). A greater proportion of participants with NSSI fell in the moderate and severe trauma categories, compared to those without NSSI.

Table 4. Total Childhood Trauma Questionnaire - SF Score by NSSI status

NSSI	Mean CTQ Score ± SD	t-value	p-value
With NSSI	58.6 ± 13.2	3.78	<0.001**
Without NSSI	47.9 ± 11.4		

GAD patients with Non-Suicidal Self-Injury (NSSI) had a significantly higher mean total CTQ score (58.6 ± 13.2) compared to those without NSSI (47.9 ± 11.4), with a t-value of 3.78 and a p-value < 0.001, which is statistically significant.

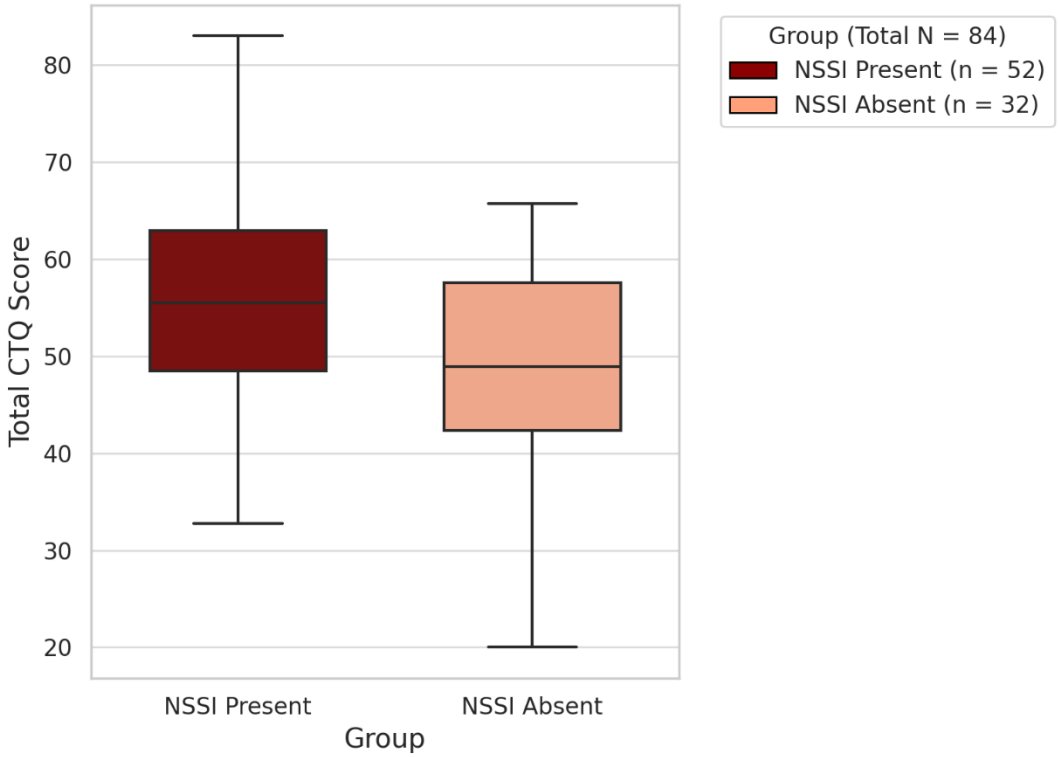

Figure 4. Box plot showing total Childhood Trauma Questionnaire (CTQ) scores in patients with Generalized Anxiety Disorder (GAD), comparing those with Non-Suicidal Self-Injury (NSSI; n = 52) and without (n = 32). Boxes represent interquartile range; horizontal lines denote medians; whiskers indicate 1.5× IQR. CTQ scores were constrained to the observed range (20–90). Mean scores were significantly higher in the NSSI group (t = 3.78, p < 0.001).

DISCUSSION

The aim of the present research was to study the association of childhood trauma and non-suicidal self-injury in patients with generalized anxiety disorder (GAD). With respect to this aim, several objectives were made and data was collected through various tools like HAM-A, CTQ-SF, and OSI using a cross-sectional research design. In the present study, the largest proportion of participants (29.8%) belonged to the 18–29 age group, followed by 26.2% in the 30–39 age group. In Indian context, Bhatia et al. observed that young adults with histories of childhood adversity were more likely to exhibit anxiety symptoms and engage in NSSI, reinforcing the notion that this age group faces increased psychological risk.[35] The current study found that females accounted for a greater proportion of participants (66.7%) compared to males (33.3%). This gender-based discrepancy aligns with findings from a meta-analysis by Bresin and Schoenleber, which reported that females exhibit higher tendencies for non-suicidal self-injury, potentially linked to increased vulnerability to internalizing disorders like anxiety and depression.[37] Further, Brown et al. noted that women with adverse childhood experiences are at a heightened risk of developing generalized anxiety disorder and may adopt NSSI as a means of emotional regulation.[37] In the Indian context, Singh et al. similarly observed that female adolescents exposed to early trauma displayed elevated anxiety symptoms and a greater likelihood of engaging in self-injurious behaviors.[38] Among the participants, 75% were married, while 17.9% were unmarried and 7.1% were either divorced or widowed. This pattern indicates a potential association between marital status and the clinical presentation of GAD and NSSI. Sharma et al. identified that married women with adverse childhood experiences were particularly vulnerable to anxiety disorders and NSSI, emphasizing the influential role of spousal dynamics in shaping mental health trajectories.[39] In our study, most participants followed Hinduism (71.4%), with smaller portions identifying as Muslim (23.8%) or other faiths (4.8%). Verma et al. made a similar observation in the Indian context, individuals who turned to faith as a source of comfort and meaning were more emotionally balanced and showed fewer signs of self-injury.[40] Participants in the study came from diverse educational backgrounds. In this study, 57.1% of participants were not employed, while 42.9% reported having a job. Lack of employment appeared to be linked with emotional challenges such as anxiety and self-harming behavior. Socioeconomic context also plays a significant role in shaping exposure to chronic stress and determining the accessibility of psychological support systems. As noted by Wang et al. (2024), populations residing in rural regions or belonging to economically disadvantaged strata often encounter systemic barriers to mental health care.[41] In this sample, HAM-A scores reflected a broad spectrum of anxiety severity, spanning from mild to pronounced levels, with an average score of 22.8. Comparable patterns were noted by Zhang et al. (2022), who found a wide range of anxiety intensities among trauma-exposed adolescents.[42]

With respect to the first objective of the study, a substantial 85.7% of the individuals disclosed experiences of childhood adversity, with emotional and physical neglect being the most frequently reported forms. Sexual abuse was not reported by 28 individuals, while 22 reported low, 20 moderate, and 14 severe levels. Emotional abuse was rated as moderate by 28 and severe by 16 participants. Physical abuse appeared at low levels in 30 and moderate in 22. Emotional neglect was present at moderate intensity in 30 and severe in 16 cases. Physical neglect was rated low by 32 and moderate by 24 participants. The data indicate that emotional and physical neglect emerged as the most common trauma types, particularly at moderate-to-severe intensities. Childhood trauma can impair emotional development and increase susceptibility to anxiety in later life, regardless of whether it results from interpersonal violence, familial neglect, or environmental stresses.[10] With respect to severity, low trauma levels were identified in 35.7% of the sample, moderate in 33.3%, and severe in 16.7%, while only 14.3% reported no trauma. This distribution highlights that a considerable majority (85.7%) had encountered at least some degree of childhood adversity. Various types of childhood neglect can disrupt a child's development in significant ways. Studies in neurodevelopment indicate that such neglect may interfere with the normal formation and functioning of brain regions that govern stress reactivity and emotional balance. These neurological alterations can increase vulnerability to symptoms often seen in anxiety conditions such as ongoing tension, inability to stay calm, over-alertness, and persistent unease. As the child matures, these disturbances may evolve into full-fledged anxiety disorders.[43]

For the second objective of the study which aimed to assess the functions of NSSI it was found that among those who engaged in NSSI, one-third (33.3%) identified internal emotional regulation as the main reason behind their behavior. Among the measured domains, internal regulation had the highest average score (5.6 ± 1.4), followed by social influence (4.2 ± 1.8), sensation seeking (2.0 ± 0.9), and external regulation (1.6 ± 0.8). This pattern indicates that for many, NSSI served primarily as a mechanism to manage intense internal emotional states. This mirrors insights from Hou et al. (2023).

Furthermore, 59.5% of participants displayed a moderate level of motivation to address these behaviors.[44]

A study by Yan et al. 2023 found that the dominant functional subtype varied across diagnoses: "Sensation Seeking" (39.7%) was common in those with depression, "Anti-suicide" subtype (37.9%) in bipolar disorder, and "Social Influence" (33.3%) in individuals with eating disorders. These patterns suggest a meaningful interaction between underlying psychiatric conditions and the reasons people engage in self-injury, emphasizing the need for more tailored clinical interventions that account for this heterogeneity of patients' functional subtypes of NSSI.[45]

The next objective was to see the relationship between childhood trauma and non-suicidal self injury. The results indicated a statistically meaningful relationship ($p = 0.004$) was identified between trauma severity and the presence of NSSI. Among individuals engaging in NSSI, 38.5% reported moderate trauma and 23.1% reported severe trauma. In contrast, those with no or low trauma were more likely to report no history of NSSI. These findings lend support to the view that increased trauma exposure elevates the likelihood of self-injury. Supporting this, Wang et al. (2024) observed that elevated levels of emotional neglect and abuse are tied to greater risk for self-injury.[41] In a German community study, Brown et al. (2018) found that emotional mistreatment unlike other trauma types was directly linked to NSSI.[36] Similar patterns were seen in a large Chinese cohort of over 95,000 adolescents, where Wang et al. (2024) noted that exposure to multiple ACEs corresponded with a stepwise increase in NSSI risk.[41] Zhang et al. (2023) further clarified this pathway.[46] Lindholm et al. (2022), working with Swedish adolescents, also highlighted that emotional dysregulation and trauma-related symptoms act as full mediators.[47]

Lastly, while aiming to see the difference in childhood trauma severity among GAD patients in terms of those who engage in NSSI and those who do not, it was found that individuals with GAD who also engaged in NSSI had a markedly higher mean CTQ score (58.6 ± 13.2) compared to those without NSSI (47.9 ± 11.4). This difference, supported by a t-value of 3.78 and $p < 0.001$, underscores a strong connection between the extent of childhood trauma and self-injurious behavior in adulthood. Therefore, GAD patients who reported NSSI had significantly greater exposure to childhood adversity. Liu et al. (2017), in a systematic review, found similar associations.[48] Brown et al. (2018), similarly found that emotional trauma predicted self-harming behavior.[37] Zhang et al. (2023) further demonstrated that emotional unawareness and rumination serve as key intermediaries.[46]

Altogether, the findings underscore the importance of recognizing trauma histories and self-injury patterns early in the course of treatment. Embedding trauma-sensitive approaches into care for GAD may help reduce emotional distress and lower the risk of ongoing self-injurious behavior, thereby improving long-term psychological outcomes for this vulnerable group. However, the study is not without its limitations. The study follows a cross-sectional research design, whereas longitudinal studies are needed to better understand temporal patterns and developmental trajectories. Another limitation is the reliance on self-administered tools such as the CTQ-SF and OSI which has the potential to introduce the possibility of recall bias, underreporting, or social desirability effects, particularly in sensitive areas like trauma and self-injury. Future researchers can collect a wider sample across different psychiatric centers and geographical locations to enhance the generalizability of the findings. Lastly, the quantitative nature of the study, while helpful in identifying associations, does not capture the nuanced personal experiences behind trauma and NSSI, which could be explored through in-depth interviews or mixed-method approaches.

CONCLUSION

This investigation set out to examine the relation between childhood trauma and non-suicidal self-injury (NSSI) as they occur in individuals diagnosed with Generalized Anxiety Disorder (GAD). The data revealed that a striking 85.7% of participants had encountered some form of early-life trauma, with emotional and physical neglect being the most frequently reported types. The patterns of NSSI showed that internal emotional regulation was the most commonly cited reason for self-harming behavior. This suggests that for many patients, NSSI functions as a strategy to manage distressing emotional states that feel otherwise unmanageable. The study found a meaningful statistical relationship ($p = 0.004$) between higher trauma severity and the presence of self-injury. Individuals who had experienced moderate to severe trauma were more likely to engage in NSSI, indicating a strong interplay between these variables.

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