Activators and inhibitors of the progression of psychopathological symptoms associated with psychological abuse

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Abstract

Objective The aim of this paper was to identify psychological factors that intensify (activators) or attenuate (inhibitors) the progression of subclinical psychopathological symptoms in young adults exposed to psychological abuse during childhood and adolescence.

Method The study included 416 respondents (mean age, 18.73 ± 0.81 years) with a history of psychological abuse by parents or guardians during childhood and adolescence. Empirical data were collected using standardized self-report measures. Correlation analysis and undirected network analysis were performed.

Results Exposure to psychological abuse was correlated with the severity of subclinical psychopathological symptoms. The "core" of the subclinical condition among survivors of psychological abuse comprised obsessive-compulsive symptoms, interpersonal sensitivity, anxiety, and depression. Network analysis identified two functional groups: inhibitors (autobiographical memory specificity, flexibility and modeling, availability of social support, and trait detachment) and activators (early maladaptive schemas, hostility, obsessive-compulsive symptoms, and psychotic symptoms).

Conclusions The findings indicate the transdiagnostic nature of subclinical distress in young adults with a history of psychological abuse and provide a basis for developing a system of early clinical psychological interventions. Intervention targets and possible strategies are proposed, including strengthening inhibitors and modifying activators.

Keywords: psychological abuse; consequences; mental disorders; subclinical stage; progression; exacerbation; early adulthood.

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Introduction

Child and adolescent maltreatment remains a major socio-legal and medical-psychological problem. According to the World Health Organization (WHO), up to 400 million minors are regularly exposed to various forms of maltreatment by parents and guardians [1]. Psychological abuse accounts for up to 35% of all maltreatment cases, making it the most prevalent form of child and adolescent maltreatment [2]. In this study, psychological abuse is defined as a persistent, long-term pattern of adult behavior centered on disregarding the psychological needs and agency of a child who is inherently unable to resist the adult; this pattern is manifested through active and passive, verbal and nonverbal acts.

Contemporary clinical psychological research increasingly focuses on the long-term consequences of adverse childhood experiences. Psychological abuse is a transdiagnostic risk factor for the onset and progression of schizophrenia and schizotypal disorder [3], depressive disorders [4], anxiety disorders [5], and personality disorders [6]. Most studies in this field have used a cross-sectional design, which allows researchers to identify the presence and/or severity of psychopathological symptoms within a particular spectrum but does not explain the mechanisms through which psychological abuse leads to deterioration in psychological functioning or highlight the factors that may interrupt this association.

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Mental disorders are known to pass through several stages in their development, ranging from an asymptomatic state to a clinically manifest syndrome and a chronic form [7]. The subclinical stage is characterized by psychopathological symptoms that do not meet the diagnostic threshold under DSM-5 or ICD-11 criteria, yet significantly impair subjective well-being and everyday functioning. Subclinical psychopathological symptoms are highly prevalent, affecting 57% of the general population [8]. They are considerably more common among individuals aged 18–30 years and occur more frequently in this age group than clinically manifest mental disorders [9, 10]. Childhood psychological abuse is considered one of the most robust predictors of subclinical psychopathological symptoms in early adulthood [11, 12].

Mediators of the association between psychological abuse experienced during childhood and adolescence and the onset of mental disorders of varying severity, including subthreshold presentations, have been relatively well studied. The formation of early maladaptive schemas is among the most extensively examined mechanisms mediating the effects of psychological trauma [13]. Emotion dysregulation is another consistently identified mechanism. Important cognitive mediators include hopelessness, self-criticism, and impaired mentalizing [13].

Beyond mediators, considerable scientific interest concerns psychological factors that may intensify or attenuate existing subclinical symptoms of mental disorders in individuals exposed to psychological abuse during childhood and adolescence. Cognitive flexibility and self-compassion have been considered potential inhibitors of psychopathology progression [14, 15]. However, evidence regarding their role specifically in the context of psychological abuse remains fragmented. The practical value of such research lies in identifying targets for early clinical psychological interventions aimed at preventing the progression and broader manifestation of mental disorders.

Unlike previous studies, which have predominantly focused on mediating mechanisms, the present empirical study examines psychological factors that create specific conditions for the progression or reduction of subclinical psychopathological symptoms associated with a history of psychological abuse.

The aim of this study was to identify and analyze activators and inhibitors of the progression of psychopathological symptoms associated with psychological abuse experienced during childhood and adolescence.

In this study, activators are defined as psychological factors that contribute to an increase in existing subclinical psychopathological symptoms among survivors of psychological abuse. Inhibitors, in turn, are psychological factors with the potential to reduce the severity of subclinical psychopathological symptoms.

The study hypothesis was that certain psychological factors can either intensify or attenuate subclinical psychopathological symptoms in young adults who experienced psychological abuse during childhood and adolescence.

Method

The present study was approved by the Local Ethics Committee of Ryazan State Medical University of the Ministry of Health of the Russian Federation (Protocol No. 7 dated January 11, 2023).

The study included 416 young adults (318 women and 98 men; students enrolled in secondary and higher education institutions). The respondents' mean age was 18.73 ± 0.81 years.

Inclusion criteria were a history of psychological abuse experienced and terminated during childhood and adolescence and the absence of current traumatic exposure of any origin.

Exclusion criteria were a history of traumatic experiences of another origin, including other forms of maltreatment; diagnosed mental disorders; and somatic diseases that may affect mental and behavioral functioning.

Empirical data were collected using the following psychodiagnostic measures:

1. An author-developed self-report measure for the retrospective assessment of psychological abuse experienced during childhood and adolescence. The measure recorded contextual variables (the number of different psychologically abusive acts directed at the respondent and the subjective intensity of negative emotions caused by psychological abuse) as well as age-related and chronological indicators (mean duration in years and mean ages at onset and cessation). The self-report measure listed 48 psychologically abusive acts; respondents rated their emotional reaction on a scale from 0 (no negative emotions) to 10 (extremely intense negative emotions).

2. The Life Events Questionnaire (LEQ), adapted by N. V. Tarabrina et al. (2007), was used to screen respondents' histories for traumatic experiences of an origin other than psychological abuse.

3. The Personality Inventory for DSM-5—Brief Form (PID-5-BF), adapted by G. V. Kustov et al. (2022), was used to identify pathological personality traits associated with personality disorders.

4. The Young Schema Questionnaire (YSQ-S3R), adapted by P. M. Kasyanik and E. V. Romanova (2013), was used to assess the development of early maladaptive schemas in the respondents.

5. The Symptom Checklist-90-Revised (SCL-90-R), adapted by N. V. Tarabrina et al. (2007), was used to assess the severity of psychopathological symptoms.

6. The Style of Behavioral Self-Regulation questionnaire (SSPM), developed by V. I. Morosanova (1998), was used to measure variables of behavioral self-regulation.

7. The Autobiographical Memory Test (AMT), developed by J.M. G. Williams and D. Broadbent (1986), was used to assess the specificity of autobiographical memories.

8. The Multidimensional Scale of Perceived Social Support (MSPSS), adapted by N. A. Sirota and V. M. Yaltonsky (1994), was used to examine respondents' perceptions of the social support available to them.

Mathematical and statistical analyses were conducted in JASP and included descriptive analysis, correlation analysis, and undirected network analysis.

Results

Retrospective analysis of the respondents' traumatic experiences showed that the mean age at onset of psychological abuse was 10.87 ± 3.33 years and the mean age at cessation was 14.18 ± 2.69 years. Psychological abuse lasted for an average of 4.27 ± 2.98 years. Respondents reported that the pattern of psychological abuse by parents or guardians included an average of 10 different psychologically abusive acts. The most frequently reported acts were yelling and profanity, excessive control, devaluation and ignoring, excessive demands, criticism, inducing guilt, and fostering feelings of worthlessness. According to the respondents, these actions by significant adults were accompanied by pronounced psychological suffering involving fear and helplessness (mean intensity, 5.65 ± 2.45).

Descriptive analysis was then performed on the results obtained in the study sample using the SCL-90-R (Table 1). Among young adults exposed to psychological abuse during childhood and adolescence, mean psychopathological symptom scores exceeded the normative values established during adaptation of the measure (Somatization, 0.55; Obsessive-compulsive symptoms, 0.78; Phobic anxiety, 0.32; Interpersonal sensitivity, 0.95; Depression, 0.72; Psychoticism, 0.44) [16]. The scores more closely corresponded to the range characteristic of clinical groups with adjustment disorders and posttraumatic stress disorder (Somatization, 1.08; Obsessive-compulsive symptoms, 1.15; Phobic anxiety, 0.76; Interpersonal sensitivity, 1.25; Depression, 1.15; Psychoticism, 0.72) [16]. Because the respondents had not previously been diagnosed with mental disorders, the identified psychopathological symptoms were interpreted as subclinical spectrum manifestations. The "core" of the subclinical condition among young adults exposed to psychological abuse comprised obsessive-compulsive symptoms, interpersonal sensitivity, anxiety, and depression (Table 1).

Correlation analysis was conducted to examine associations between the variables of psychological abuse and the severity of psychopathological symptoms in the study sample (Table 2).

Correlation analysis revealed moderate positive associations between the contextual variables of psychological abuse (the number of psychologically abusive acts and emotional response) and all SCL-90-R scales at a high level of statistical significance. These findings suggest a dose-dependent traumatic effect: the more diverse the psychologically abusive acts and the more intense the negative emotional response, the greater the severity of psychopathological symptoms in adulthood. The greatest vulnerability was observed for depression, phobic anxiety, and psychotic symptoms. Mean duration of psychological abuse was also significantly correlated with all scales assessing psychopathological symptoms. Thus, chronic psychological traumatization during childhood and adolescence may contribute to the formation of persistent patterns of psychopathology. Age-related variables of psychological abuse were

Variable	M ± SD	Variable	M ± SD
Somatization	0.91 ± 0.67	Hostility	0.86 ± 0.74
Obsessive-compulsive symptoms	1.23 ± 0.73	Phobic anxiety	0.56 ± 0.60
Interpersonal sensitivity	1.17 ± 0.83	Paranoid ideation	0.98 ± 0.76
Depression	1.16 ± 0.76	Psychoticism	0.54 ± 0.53
Anxiety	1.02 ± 0.84	Global Severity Index	0.97 ± 0.60

Table 1. **Severity of psychopathological symptoms assessed using the SCL-90-R (N = 416)**

either virtually unrelated to psychopathological symptom severity in the study sample or showed weak negative correlations.

Undirected network analysis was used to identify psychological factors that may intensify or attenuate distress associated with subclinical psychopathological symptoms. Variables with high expected influence (EI) values were selected (Table 3). Unlike conventional strength centrality, which sums the absolute values of edge weights, expected influence retains the signs of associations, allowing activating (intensifying) and suppressing (inhibiting) nodes to be identified within the set of variables.

	Number of different psychologically abusive acts	Emotional intensity	Mean age at onset	Mean age at cessation	Mean duration
Somatization	0.320 p < 0.001	0.265 p < 0.001	−0.087 p = 0.076	0.083 p = 0.091	0.196 p < 0.001
Obsessive-compulsive symptoms	0.315 p < 0.001	0.294 p < 0.001	−0.094 p = 0.056	0.175 p < 0.001	0.263 p < 0.001
Interpersonal sensitivity	0.320 p < 0.001	0.376 p < 0.001	−0.144 p = 0.003	0.169 p < 0.001	0.301 p < 0.001
Depression	0.375 p < 0.001	0.397 p < 0.001	−0.136 p = 0.005	0.198 p < 0.001	0.342 p < 0.001
Anxiety	0.397 p < 0.001	0.373 p < 0.001	−0.120 p = 0.015	0.123 p = 0.012	0.264 p < 0.001
Hostility	0.320 p < 0.001	0.283 p < 0.001	−0.081 p = 0.098	0.130 p = 0.008	0.193 p < 0.001
Phobic anxiety	0.395 p < 0.001	0.373 p < 0.001	−0.186 p < 0.001	0.147 p = 0.003	0.314 p < 0.001
Paranoid ideation	0.295 p < 0.001	0.329 p < 0.001	−0.087 p = 0.076	0.180 p < 0.001	0.251 p < 0.001
Psychoticism	0.367 p < 0.001	0.382 p < 0.001	−0.153 p = 0.002	0.117 p = 0.017	0.266 p < 0.001

Table 2. Correlations between variables of psychological abuse and psychopathological symptom scores (N = 416, Pearson's r)

Variable	Expected influence	Functional role
Autobiographical memory specificity (AMT)	−2.260	Progression inhibitors
Modeling (SSPM)	−2.176	
Flexibility (SSPM)	−1.518	
Perceived social support—Friends (MSPSS)	−1.432	
Detachment (PID-5-BF)	−1.297	
Perceived social support—Significant Other (MSPSS)	−0.821	
Obsessive-compulsive symptoms (SCL-90-R)	0.916	Progression activators
Early maladaptive schema: Negativity/Pessimism (YSQ-S3R)	0.983	
Early maladaptive schema: Punitiveness (YSQ-S3R)	0.938	
Hostility (SCL-90-R)	0.860	
Psychoticism (SCL-90-R)	0.750	
Early maladaptive schema: Approval-Seeking (YSQ-S3R)	0.733	

Table 3. Selection of variables based on expected influence (N = 416, undirected network analysis)

Two functional groups of variables associated with the dynamics of subclinical psychopathological symptom progression in young adults with a history of psychological abuse were identified (Figure 2). Progression inhibitors included cognitive resources (autobiographical memory specificity as well as modeling and flexibility as self-regulation strategies), social support from friends and a significant other, and detachment as a stable personality trait. Progression activators included early maladaptive schemas (pessimism, punitiveness, and approval-seeking) and other psychopathological symptoms (hostility, obsessive-compulsive symptoms, and psychotic symptoms).

Discussion

This study sought to identify and analyze psychological factors that may intensify or attenuate subclinical psychopathological symptoms in respondents with a history of psychological abuse.

Young adults with a history of psychological abuse during childhood and adolescence exhibited pronounced subclinical distress despite having no previously diagnosed mental disorders. The polymorphic profile of psychopathological symptoms identified in the study sample is particularly noteworthy: the "core" of the subclinical condition included obsessive-compulsive and anxiety-depressive symptoms as well as interpersonal sensitivity. This finding indicates the transdiagnostic nature of the subclinical stage of mental disorders associated with psychological abuse and is consistent with previous research [17, 18].

The positive correlations between the contextual characteristics of psychological abuse experienced during childhood and adolescence and the severity of psychopathological symptoms support the dose-response model (Figure 1).

Previous studies have demonstrated a dose-response effect for physical and sexual abuse [19]. Our findings indicate that, alongside objective aspects of traumatic exposure, the subjective intensity of psychological suffering is also important. No consistent correlations were found between age-related variables and psychopathological symptoms. Duration, rather than the age at onset or cessation of psychological abuse, may play the key role, which is consistent with theoretical accounts [20].

Network analysis allowed us to move beyond identifying correlations and construct a model of the dynamic interaction among variables (Figure 2).

The key inhibitor was autobiographical memory specificity. This finding is consistent with studies by J.M.G. Williams et al., which showed that reduced specificity of autobiographical memories

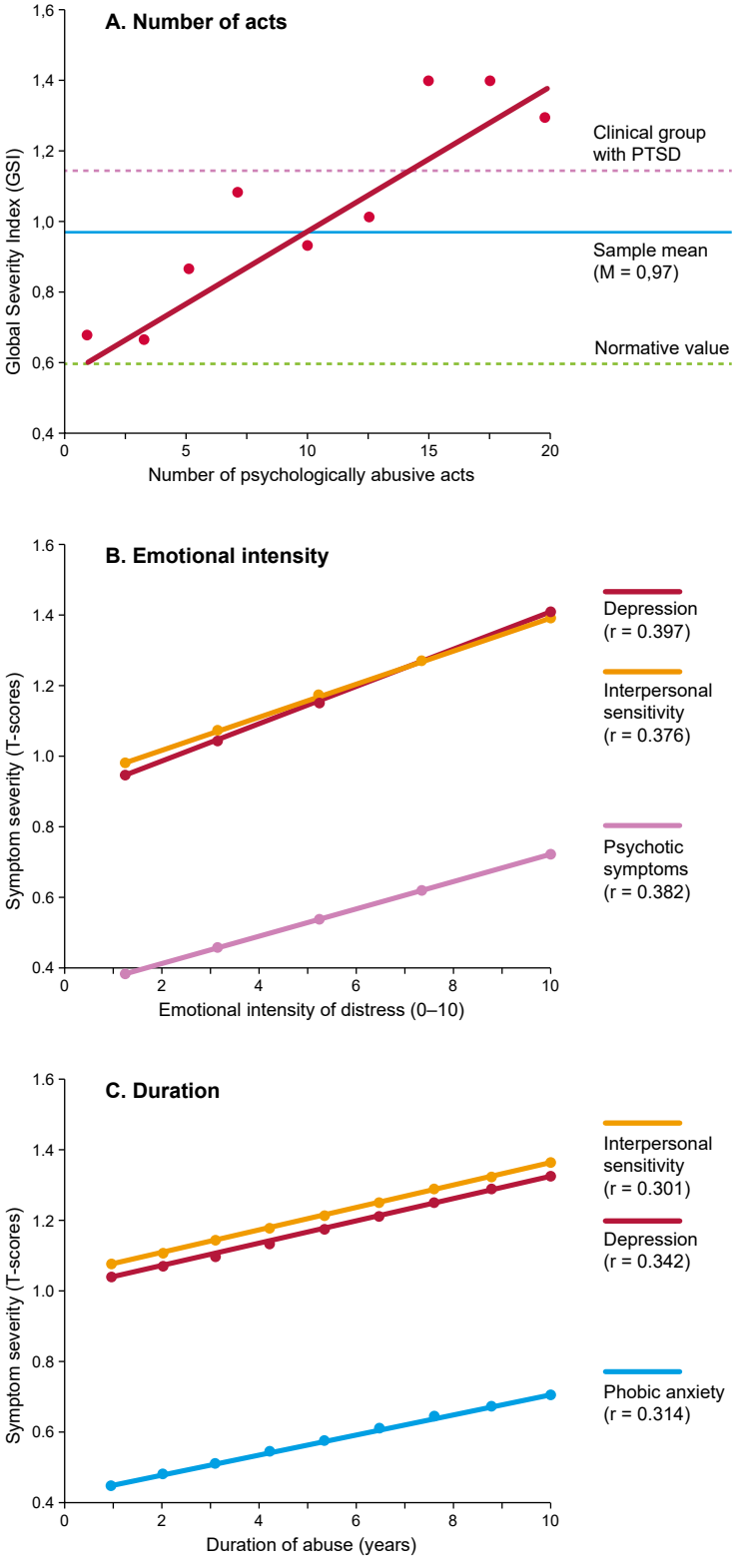


Figure 1. Dose-dependent traumatic impact of psychological abuse

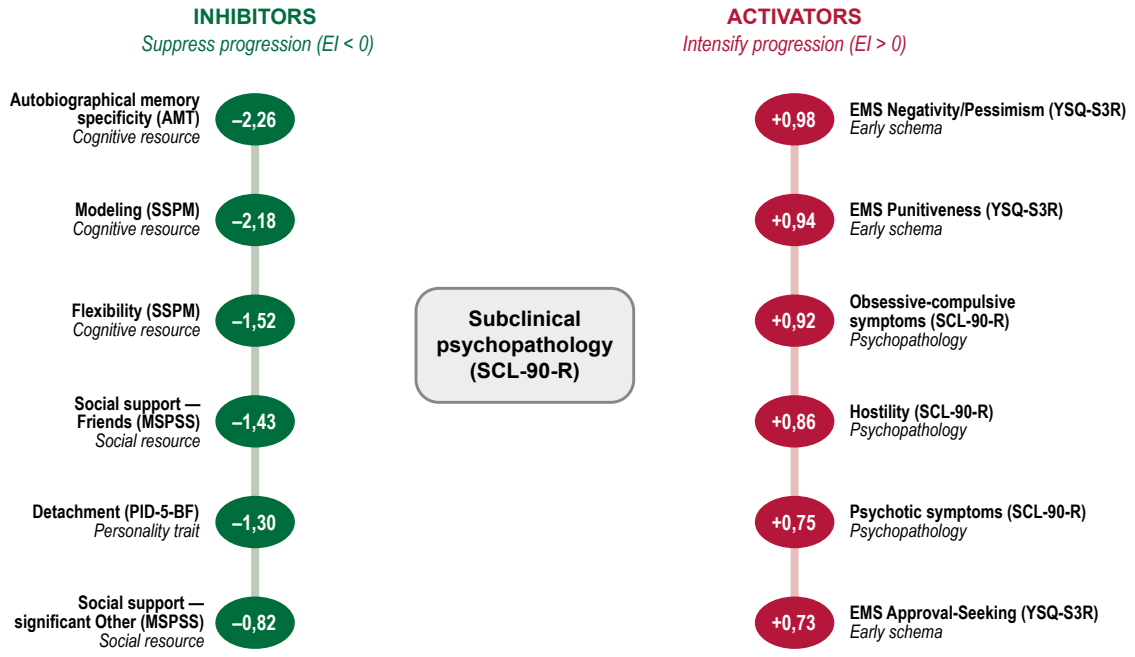


Figure 2. Structure of activators and inhibitors of subclinical psychopathology progression

in survivors of childhood maltreatment contributes to rumination and depressive symptoms [21–23]. Thus, preserving a high degree of autobiographical memory specificity may serve a protective function.

Preserved capacities to model possible courses of action and flexibly modify behavior in response to circumstances enable effective adaptation to various social situations and help prevent escalation of distress associated with subclinical symptoms. L. Yang et al. reported comparable findings: cognitive flexibility mediated the adverse effect of childhood psychological traumatization on the severity of anxiety-depressive symptoms [24].

The availability of social support is an important protective factor against the onset and progression of mental disorders, as confirmed by numerous studies [25]. Notably, perceived social support from friends and a significant other, but not from family, emerged as inhibitors. This may reflect the characteristics of the sample: young adults exposed to psychological abuse perpetrated by parents or guardians.

The most controversial finding was the classification of the PID-5-BF Detachment domain as an inhibitor, although this personality pattern is generally regarded as a risk factor in the scientific and clinical literature. This result may have arisen from the network analysis procedure itself, in which the Detachment variable statistically suppressed other nodes, or it may represent an artifact of the study sample: despite tendencies toward intimacy avoidance and anhedonia, the respondents remained sufficiently adapted to the demands of their social environment. Further research is needed to test the hypothesis that detachment may initially have functioned as a protective mechanism in survivors of psychological abuse but subsequently became consolidated as a dysfunctional personality trait that nevertheless facilitates coping with the consequences of psychological traumatization.

The activators of subclinical psychopathological symptom progression in young adults with a history of psychological abuse included early maladaptive schemas and indicators of impaired mental functioning.

Activation of the early maladaptive schemas of Negativity/Pessimism, Punitiveness, and Approval-Seeking may intensify psychopathological symptoms, particularly those forming the “core” of the subclinical condition among survivors of psychological abuse during childhood and adolescence. This finding is directly consistent with J. Young’s theory that early dysfunctional schemas formed in the context of maltreatment become a kind of “driving force” behind deterioration in mental health [26, 27].

The presence of hostility, obsessive-compulsive symptoms, and psychotic symptoms among the progression activators suggests a self-reinforcing cascade in which symptoms generate and intensify one another. This finding is consistent with the

network theory of psychopathology [28]. Thus, psychopathological symptoms arising from psychological abuse do not merely accumulate; rather, they become systemically organized through network interactions.

The findings have practical value and may be used to develop dynamic interventions aimed at strengthening and stabilizing inhibitors (autobiographical memory, behavioral self-regulation, and perceived social support) and "deactivating" activators (early maladaptive schemas and psychopathological symptoms).

We propose an approximate algorithm and a set of techniques for providing clinical psychological and psychotherapeutic care to young adults exposed to psychological abuse during childhood and adolescence. The following measures may be used to screen for subclinical distress: the SCL-90-R, the SCL-K-9, and the Depression Anxiety Stress Scales-21 (DASS-21). Because the perpetrators of psychological abuse were parents or guardians, family psychotherapy should be avoided during the early stages of care. At the same time, the inclusion of interpersonal sensitivity in the "core" of the subclinical condition warrants caution when introducing survivors to group-based psychological interventions and psychotherapy at the initial stage. Friends, significant others, and helping professionals may serve as sources of psychological resilience and support. Table 4 summarizes the clinical psychological intervention targets and recommended interventions.

Inhibitors	Intervention target	Recommended clinical psychological interventions
Autobiographical memory specificity (AMT)	Restoring the ability to retrieve specific, detailed autobiographical memories	Cognitive training (exercises in generating specific memories from cue words). Expressive writing practices (journaling, therapeutic writing)
Modeling (SSPM)	Developing the ability to mentally construct and test hypotheses about the future	Cognitive behavioral techniques. Metacognitive therapy
Flexibility (SSPM)	Restoring the ability to switch adaptively between behavioral strategies depending on context	Acceptance and Commitment Therapy. Dialectical behavior therapy techniques
Perceived social support—Friends (MSPSS)	Restoring the ability to perceive and use peer support	Social skills training. Group psychotherapy
Perceived social support—Significant Other (MSPSS)	Developing a secure attachment with one significant adult (partner, mentor, or therapist)	Attachment-oriented psychotherapeutic practices. Mentoring
Detachment (PID-5-BF)	Developing effective interpersonal skills in safe contexts	Interpersonal effectiveness skills from dialectical behavior therapy. Group psychotherapy
Activators	**Intervention target**	**Recommended clinical psychological interventions**
Early maladaptive schema: Negativity/Pessimism (YSQ-S3R)	Modifying persistent beliefs that negative outcomes are inevitable and change is impossible	Schema therapy techniques. Cognitive restructuring
Early maladaptive schema: Punitiveness (YSQ-S3R)	Reducing self-criticism and self-punitive tendencies	Schema therapy techniques. Compassion-focused therapy techniques
Early maladaptive schema: Approval-Seeking (YSQ-S3R)	Modifying the maladaptive need for external validation of self-worth	Schema therapy techniques. Group psychotherapy
Obsessive-compulsive symptoms (SCL-90-R)	Reducing patterns of cognitive and behavioral control	Cognitive behavioral therapy techniques for OCD. Metacognitive therapy
Hostility (SCL-90-R)	Modifying patterns of hypervigilance and aggressive defense	Dialectical behavior therapy techniques. Anger management training
Psychoticism (SCL-90-R)	Reducing perceptual anomalies and ideational disorganization	Cognitive therapy (modification of cognitive distortions). Reality-testing skills training

Table 4. Targets and techniques for early clinical psychological interventions

Conclusion

The study demonstrates that psychological abuse experienced during childhood and adolescence is associated with persistent subclinical distress in young adults, with severity comparable to that observed in clinical samples. The principal theoretical contribution is the use of a network approach to identify activators and inhibitors of subclinical psychopathological symptoms, thereby enabling a transition to a dynamic model of the factors that determine the trajectory of the subclinical condition.

The identified dose-response pattern — duration, diversity, and emotional intensity of psychological abuse — confirms the complex nature of psychological traumatization resulting from psychologically abusive treatment and indicates that subjective experiences, alongside objective aspects, should be considered when assessing the risk of psychopathology.

The subclinical condition associated with a history of psychological abuse was dominated by interpersonal sensitivity, obsessive-compulsive symptoms, and anxiety-depressive symptoms. Network analysis identified two functional groups of psychological variables with the potential to intensify or attenuate existing subclinical psychopathological symptoms among survivors of psychological abuse. This result is consistent with the network theory of mental disorders and indicates that clinical psychological interventions should target not isolated symptoms but the pathological connections among them.

Future research should include longitudinal studies to assess the stability of the identified configuration of activators and inhibitors, as well as empirical studies incorporating experimental manipulations designed to deliberately strengthen inhibitors and "deactivate" activators.

The study has several limitations. First, a well-known methodological risk is associated with the use of self-report measures and the retrospective nature of respondents' reports of psychological abuse. Second, the cross-sectional design and network analysis establish an associative structure; additional studies are planned to determine the directionality and causal nature of the associations. Third, women predominated in the study sample. Although this reflects the typical gender distribution in psychological research, it limits the generalizability of the identified patterns to the male population.

Conflict of interest statement

The authors declare no conflicts of interest. The study received no financial support.

References

1. Global status report on preventing violence against children: executive summary. Geneva: World Health Organization; 2020. Accessed: 30 July 2026. Available at: https://www.who.int/publications/i/item/9789240006379
2. Hashim M, Alimoradi Z, Pakpour A, et al. Association of childhood emotional maltreatment with adolescents' psychopathology: a systematic review and meta-analysis. Trauma Violence Abuse. 2024;25(4):2986–3004. https://doi.org/10.1177/15248380241233538
3. Storvestre GB, Jensen A, Bjerke E, et al. Childhood trauma in persons with schizophrenia and a history of interpersonal violence. Front Psychiatry. 2020;11:383. https://doi.org/10.3389/fpsyt.2020.00383
4. Humphreys KL, LeMoult J, Wear JG, Piersiak HA, Lee A, Gotlib IH. Child maltreatment and depression: a meta-analysis of studies using the Childhood Trauma Questionnaire. Child Abuse Negl. 2020;102:104361. https://doi.org/10.1016/j.chiabu.2020.104361
5. Xiao Z, Murat Baldwin M, Wong SC, Obsuth I, Meinck F, Murray AL. The impact of childhood psychological maltreatment on mental health outcomes in adulthood: a systematic review and meta-analysis. Trauma Violence Abuse. 2023;24(5):3049–3064. https://doi.org/10.1177/15248380221122816
6. Wang W, Cui Y, Hu Q, et al. Childhood maltreatment and personality disorders in adolescents and adults with psychotic or non-psychotic disorders. Front Psychiatry. 2024;15:1336118. https://doi.org/10.3389/fpsyt.2024.1336118
7. Clarke SL, Soons N, Videler AC, et al. The progress in the field of clinical staging for mental disorders within the last decade: an updated systematic review. Front Psychiatry. 2025;15:1473051. https://doi.org/10.3389/fpsyt.2024.1473051
8. Johnson JCS, Byrne GJ, Pelecanos AM. The prevalence of subthreshold psychiatric symptoms and associations with alcohol and substance use disorders: from a nationally representative survey of 36,309 adults. BMC Psychiatry. 2022;22(1):270. https://doi.org/10.1186/s12888-022-03834-1
9. Balázs J, Miklósi M, Keresztény A, et al. Adolescent subthreshold-depression and anxiety: psychopathology, functional impairment and increased suicide risk. J Child Psychol Psychiatry. 2013;54(6):670–677. https://doi.org/10.1111/jcpp.12016
10. Copeland W, Shanahan L, Costello EJ, Angold A. Cumulative prevalence of psychiatric disorders by young adulthood: a prospective cohort analysis from the Great Smoky Mountains Study. J Am Acad Child Adolesc Psychiatry. 2011;50(3):252–261. https://doi.org/10.1016/j.jaac.2010.12.014
11. Samplin E, Ikuta T, Malhotra AK, Szeszko PR, Derosse P. Sex differences in resilience to childhood maltreatment: effects of trauma history on hippocampal volume, general cognition and subclinical psychosis in healthy adults. J Psychiatr Res. 2013;47(9):1174–1179. https://doi.org/10.1016/j.jpsychires.2013.05.008
12. Tang W, Deng Z, Sun Z, et al. Childhood trauma and recent stressors in predicting subclinical psychotic symptoms among Chinese university students in southwest China: a machine learning analysis within a gender-specific framework. BMJ Ment Health. 2025;28(1):e301761. https://doi.org/10.1136/bmjment-2025-301761
13. Li ET, Luyten P, Midgley N. Psychological mediators of the association between childhood emotional abuse and depression: a systematic review. Front Psychiatry. 2020;11:559213. https://doi.org/10.3389/fpsyt.2020.559213
14. Tao J, He K, Xu J. The mediating effect of self-compassion on the relationship between childhood maltreatment and depression. J Affect Disord. 2021;291:288–293. https://doi.org/10.1016/j.jad.2021.05.019

15. Wang N, Chu J, Chen G, Pan X, Wang Z, Wang W. Effect of childhood trauma on emotional distress: a chain-mediated effects of alexithymia and psychological flexibility. Brain Behav. 2025;15(9):e70825. https://doi.org/10.1002/brb3.70825
16. Тарабрина НВ, editor. Практическое руководство по психологии посттравматического стресса. Часть 1: Теория и методы. Москва: Когито-Центр; 2007.
17. Urbán R, Kun B, Farkas J, et al. Bifactor structural model of symptom checklists: SCL-90-R and Brief Symptom Inventory (BSI) in a non-clinical community sample. Psychiatry Res. 2014;216(1):146–154. https://doi.org/10.1016/j.psychres.2014.01.027
18. Heleniak C, Jenness JL, Stoep AV, McCauley E, McLaughlin KA. Childhood maltreatment exposure and disruptions in emotion regulation: a transdiagnostic pathway to adolescent internalizing and externalizing psychopathology. Cognit Ther Res. 2016;40(3):394–415. https://doi.org/10.1007/s10608-015-9735-z
19. Steine IM, Winje D, Krystal JH, et al. Cumulative childhood maltreatment and its dose-response relation with adult symptomatology: findings in a sample of adult survivors of sexual abuse. Child Abuse Negl. 2017;65:99–111. https://doi.org/10.1016/j.chiabu.2017.01.008
20. Ross SL, Sharma-Patel K, Brown EJ, Huntt JS, Chaplin WF. Complex trauma and trauma-focused cognitive-behavioral therapy: how do trauma chronicity and PTSD presentation affect treatment outcome? Child Abuse Negl. 2021;111:104734. https://doi.org/10.1016/j.chiabu.2020.104734
21. Williams JM, Scott J. Autobiographical memory in depression. Psychol Med. 1988;18(3):689–695. https://doi.org/10.1017/s0033291700008370
22. MacLeod AK, Williams JM. Overgeneralization: an important but non-homogeneous construct. Br J Clin Psychol. 1990;29(4):443–444. https://doi.org/10.1111/j.2044-8260.1990.tb00911.x
23. Moore SA, Zoellner LA. Overgeneral autobiographical memory and traumatic events: an evaluative review. Psychol Bull. 2007;133(3):419–437. https://doi.org/10.1037/0033-2909.133.3.419
24. Yang L, Tao Y, Wang N, Zhang Y, Liu Y. Child psychological maltreatment, depression, psychological inflexibility and difficulty in identifying feelings, a moderated mediation model. Sci Rep. 2025;15(1):8478. https://doi.org/10.1038/s41598-025-92873-1
25. Sperry DM, Widom CS. Child abuse and neglect, social support, and psychopathology in adulthood: a prospective investigation. Child Abuse Negl. 2013;37(6):415–425. https://doi.org/10.1016/j.chiabu.2013.02.006
26. Basso LA, Fortes AB, Maia CPE, Steinhorst E, Wainer R. The effects of parental rearing styles and early maladaptive schemas in the development of personality: a systematic review. Trends Psychiatry Psychother. 2019;41(3):301–313. https://doi.org/10.1590/2237-6089-2017-0118
27. Costa IFD, Tomaz MP, Pessoa GDN, Miranda HS, Galdino MK. Early maladaptive schemas and harm avoidance as mediating factors between early life stress and psychiatric symptoms in adults. Braz J Psychiatry. 2020;42(5):489–495. https://doi.org/10.1590/1516-4446-2019-0593
28. Borsboom D, Cramer AO. Network analysis: an integrative approach to the structure of psychopathology. Annu Rev Clin Psychol. 2013;9:91–121. https://doi.org/10.1146/annurev-clinpsy-050212-185608