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Gender Differences in the Mediation Between Childhood Abuse/ Neglect and Trauma

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Abstract

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by

Marc Samuel Cutler

MS, Walden University, 2018

BS, University of Phoenix, 2016

AA, Manchester Community College, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Childhood abuse/neglect is a consistent concern in the United States and is related to future physical and mental health concerns. Studies have shown that childhood abuse/neglect can result in negative trauma appraisal, difficulties in emotion regulation, and lower levels of self-compassion. However, less is known about how gender impacts the relationship between negative trauma appraisal, difficulties in emotion regulation, and self-compassion with trauma symptoms in those with a history of childhood abuse/neglect. The purpose of this quantitative cross-sectional correlational study was to measure the impact of gender on the mediating variables (negative trauma appraisal, difficulties in emotion regulation, and self-compassion) and the outcome variable of trauma symptoms with a predictor variable of childhood abuse/neglect. Fairbairnian object-relations theory provided the framework for the study. Data were collected from 176 participants who completed an online survey. Data analyses included conditional process analyses with PROCESS-Macro Model 15. The results indicated that gender did not impact the relationships between the mediating variables and trauma symptoms. Although the null hypotheses could not be rejected, noteworthy findings are presented and discussed. The similarities for males and females in this model may have implications for future interventions. Research into trauma symptoms lead to positive social change by assisting in the improvement of interventions, education, and mitigation of future childhood abuse/neglect.

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Dedication

I dedicate this work to all of those who have supported me throughout the years. To my wife, who is deserving of an honorary doctorate for dealing with my stress and was a constant support. To my daughters, Aurora and Cassiopeia, who inspire me to be a better, more compassionate person. To my father, who constantly pushed me to learn. To my mother, who is a great inspiration, support system, and sound board. I would also like to dedicate this work to all of my previous professors, advisors, and supervisors for pushing me and remaining with me throughout the entire process. Finally, I would like to dedicate this work to my previous, current, and future clients who challenge me to see childhood abuse/neglect from many perspectives.

Acknowledgments

I would like to acknowledge Drs. Bigatti, Tanguma, Burkholder, and Hicks for supporting me through the process and making the process relatively speedy. I aspire to become a researcher, mentor, and professor to the caliber that you all exhibit.

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Chapter 1: Introduction to the Study

Childhood abuse/neglect remains a consistent crisis in the United States. According to the Centers for Disease Control and Prevention (CDC, 2014), in 2008, there were more than 3 million reports of childhood abuse/neglect in the United States with an estimated cost of $124 billion. The American Society for the Positive Care of Children (American SPCC; 2020) reported that in 2018 7.8 million children in the United States were victims of abuse or neglect. Although these numbers are significant, they do not capture the full magnitude of the problem due to insufficient reporting on childhood abuse/neglect (Fluke et al., 2019).

Substantial concerns exist with regards to childhood abuse/neglect among younger populations. In 2018, 1,170 children in the United States died due to childhood abuse/neglect, with 70.6% of the children being 3 years or younger (American SPCC, 2020). Among these deaths, 72.8% were caused by neglect, and 46.1% were caused by physical abuse with or without other forms of childhood abuse/neglect (American SPCC, 2020). Furthermore, among these deaths, 91.7% of the perpetrators were caregivers (American SPCC, 2020). Even when childhood abuse/neglect does not lead to premature death, surviving may produce lifelong physical and mental health concerns (DePierro et al., 2019; Felitti et al., 1998), including symptoms of trauma.

The fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013) defines *trauma symptoms* as a profound set of broad mental health concerns related to a history of potentially traumatic events. Trauma symptoms include increased thought intrusion; hypervigilance; excessive anxiety

and fear; negative thoughts of the self, others, and the world; increased irritability; negative mood and mood regulation; and impaired social understanding (American Psychiatric Association, 2013; DePierro et al., 2019; van der Kolk, 2015).

Childhood abuse/neglect leads to trauma symptoms by shaping cognitive and affective reactions to self, others, and the world (Fairbairn, 1952; van der Kolk, 2015). These cognitive and affective variables include negative trauma appraisal, difficulties in emotion regulation, and self-compassion (Barlow et al., 2017). Negative trauma appraisal is the victims' perceived role in the abuse/neglect (i.e., "I deserved to be hit since I am out of control;" DePrince et al., 2010). Difficulties in emotion regulation include the decreased ability to de-escalate the self in situations of high stress (Gratz et al., 2015). Self-compassion is the ability to provide self-understanding in times of perceived inadequacies (Neff, 2003a). I used negative trauma appraisal, difficulties in emotion regulation, and self-compassion as mediating variables between childhood abuse/neglect and trauma symptoms.

Trauma symptoms are exhibited differently between males and females. The National Center of PTSD (2019) reported in 2018 that 15% to 43% of girls and 14% to 43% of boys were victims of childhood abuse/neglect. Among these numbers, 3% to 15% of girls and 1% to 6% of boys exhibited trauma symptoms (National Center of PTSD, 2019). Among trauma symptoms, males exhibit higher externalizing behaviors than females, whereas females exhibit higher internalizing behaviors than males do (Faus et al., 2019; Muller et al., 2019). Broad differences based on gender have been found in the literature; however, less is known about how negative trauma appraisal, difficulties in

emotion regulation, and self-compassion might differ by gender because of abuse/neglect. In the current study, gender was assessed as a moderator between negative trauma appraisal, difficulties in emotion regulation, and self-compassion. I examined whether gender moderates the relationship between abuse/neglect and negative trauma appraisal, difficulties in emotion regulation, and self-compassion among individuals experiencing trauma symptoms.

In Chapter 1, I introduce the study and explain how the study may promote positive social change. The chapter also contains the study background, problem statement, and purpose of the study. I define terms for clarity and alignment. In addition, I provide brief descriptions of the theoretical framework and analysis plan. Finally, I describe the assumptions, limitations, and significance of the study.

Social Change

The Walden University mission statement (2020) requires that students must conduct research with implications for positive social change. The current study may promote positive social change due to the study's nature and results. According to van der Kolk (2015), childhood abuse/neglect continues to be a national problem and may manifest as trauma symptoms. Significant gender differences exist in trauma symptoms, and more research is required to understand this phenomenon (Barlow et al., 2017). Delineating gender differences of negative trauma appraisal, difficulties in emotion regulation, and self-compassion buffering the relationship between childhood abuse/neglect and trauma symptoms may positively influence social change. This study

may increase knowledge of diagnosing and treating trauma symptoms with an eye toward the influence of gender.

Background

The connection between childhood abuse/neglect and trauma symptoms has been well explored throughout the literature. However, this relationship had not been globally identified until recently. According to Libbrecht and Quackelbeen (1995), severe childhood abuse/neglect was not outlawed until 1875. One year prior, Mary Ellen, a foster child in New York, was the victim of chronic physical abuse and neglect; however, the foster parents could be charged only with animal cruelty (Public Health Foundation of Georgia, 2020). The laws were changed; however, these laws were enforced in only the harshest of incidences (Public Health Foundation of Georgia, 2020).

In earlier periods, childhood abuse/neglect was considered inconsequential. In ancient Rome, the family patriarch determined whether the child lived, died, or was sent to slavery (Public Health Foundation of Georgia, 2020). The Judeo-Christian Bible included stories of drowning babies in Egypt and Abraham's attempted murder of his son (Gallagher, 1997). In ancient Greece, older males would legally perform pederasty (Cavanaugh, 2017). From a modern perspective, these would be heinous crimes; however, this was part of ancient history of human adult and child interactions.

Multiple researchers explored the connections between childhood abuse/neglect and trauma symptoms in the latter 20th century and identified some unique features compared with other potentially traumatic event reactions. First, van der Kolk (2015) found childhood abuse/neglect promoted confounding ideas of the perpetrator. Due to the

perpetrator typically being familial, the victim dichotomously perceives the perpetrator as good and bad (Fairbairn, 1952; van der Kolk, 2015). The victim may blame themselves (e.g., “I should not be so naughty,” or “I should have said ‘no,’”) to preserve the good of the perpetrator and internalize themselves as unconditionally bad (Bedi et al., 2013). Research has identified the link between thoughts of being unconditionally bad and high levels of negative trauma appraisal (Su & Chen, 2018), low levels of self-compassion (Boyraz et al., 2019), and the development of trauma symptoms (Barlow et al., 2017).

Second, childhood abuse/neglect alters cognitive and affect development. A child’s brain continues to develop into early adulthood and processes potentially traumatic events differently compared to adults (Hodgdon et al., 2018). Children do not have fully developed amygdalae, hippocampi, and frontal cortices resulting in maladaptive affective and cognitive development (Opendak & Sullivan, 2016). Research has found maladaptive affect and cognitive development also affect difficulties in emotion regulation (Charak et al., 2018) and self-compassion (Neff, 2003b).

Next, childhood abuse/neglect is typically chronic and complex. According to DePierro et al. (2019), childhood abuse/neglect tends to be repeated, and a combination of different forms (i.e., physical abuse with emotional abuse and neglect) leads to maladaptive affect and cognitive development. Due to the typically chronic nature of childhood abuse/neglect, the child accommodates to consistent threats, thereby altering negative trauma appraisal, difficulties in emotion regulation, and self-compassion (Barlow et al., 2017; Cloitre et al., 2009).

Finally, researchers have identified negative trauma appraisal, difficulties in emotion regulation, and self-compassion as variables that predict the development of trauma symptoms (Barlow et al., 2017). What remains unclear is whether these variables affect both genders equally. I found a gap in the literature regarding whether gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion buffer the relationship between childhood abuse/neglect and trauma symptoms. I conducted my research to increase knowledge of gender differences in introspective thoughts of negative trauma appraisal, difficulties in emotion regulation, and self-compassion to inform and assist gender specifications in trauma therapy.

Problem Statement

Childhood abuse/neglect is a national concern in the United States (Choi et al., 2018; Cromer & Villodas, 2018; Spinazzola et al., 2018). It has been well documented that childhood abuse/neglect affects present and future mood regulation, educational attainment, cognitive functioning, physical and mental health, and self-confidence (Afifi et al., 2017; Augusti et al., 2018; Nuttman-Shwartz, 2017). Childhood abuse/neglect profoundly invokes painful memories that potentially put the trauma survivor at risk for present and future mental and physical health concerns (Felitti et al., 1998).

Furthermore, childhood abuse/neglect significantly alters cognitive, affective, and physiological development (Hodgdon et al., 2018; Li et al., 2017; Malarbi et al., 2017). However, not all victims of childhood abuse/neglect develop trauma symptoms; other variables may buffer the relationship (Barlow et al., 2017). Barlow et al. (2017) identified negative trauma appraisal, difficulties in emotion regulation, and self-compassion buffer

and predict the relationship between childhood abuse/neglect and trauma symptoms. The literature was unclear whether negative trauma appraisal, difficulties in emotion regulation, and self-compassion present differently by gender in the relationship between childhood abuse/neglect and trauma symptoms.

Purpose of the Study

The purpose of the study was to assess gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion buffering the relationship between childhood abuse/neglect and trauma symptoms. I defined the predictor variable (childhood abuse/neglect) as any intentional physical, sexual, emotional maltreatment and pervasive emotional unresponsiveness of a caregiver with a child who is 17 years and younger (see Augusti et al., 2018; Norman et al., 2012). Childhood abuse/neglect was assessed with the Child Abuse and Trauma Scale (CAT; see Sanders & Becker-Lausen, 1995). I defined the first mediating variable (negative trauma appraisal) as the subjective interpretation of childhood abuse/neglect by the individual as affecting the self, environment, and the interaction between both, and this variable was assessed using the Trauma Appraisal Questionnaire (TAQ; see DePrince et al., 2010). The second mediating variable (difficulties in emotion regulation) was defined as the measurable ability to actively control affective expression without external support (see Gratz et al., 2015). Difficulties in emotion regulation were measured with the Difficulties in Emotion Regulation Scale (DERS; see Gratz & Roemer, 2004). The third mediating variable (self-compassion) was defined as the act of understanding the self in response to perceived inadequacies (see Neff, 2003a) and was measured using the Self Compassion

Scale (SCS; see Neff, 2003b). The outcome variable (trauma symptoms) was defined as post-traumatic stress disorder (PTSD) symptoms as detailed in the *DSM-5* (see American Psychiatric Association, 2013) with or without Criterion A (see Friedman, 2013). Trauma symptoms were measured with the Impact of Event Scale-Revised (IES-R; see Weiss & Marmar, 1997). The moderating variable (gender) was defined as the participant's currently preferred gender (male or female), and this variable was measured using a demographic questionnaire. The purpose of assessing gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion mediating the relationship between childhood abuse/neglect and trauma symptoms for an adult population was to delineate gender differences in interpreting childhood abuse/neglect (see Bernhard et al., 2018; Cromer et al., 2019) and to continue building on trauma therapy knowledge (see Barlow et al., 2017).

Research Questions and Hypotheses

RQ1: Does gender impact the strength between negative trauma appraisal and trauma symptoms with a history of childhood abuse/neglect?

H_o1: There is no statistical significance in gender as a moderator of the mediation of negative trauma appraisal and trauma symptoms with a history of childhood abuse/neglect.

H_a1: There is statistical significance in gender as a moderator of the mediation of negative trauma appraisal and trauma symptoms with a history of childhood abuse/neglect.

RQ2: Does gender impact the strength between difficulties in emotion regulation and trauma symptoms with a history of childhood abuse/neglect?

H_o2: There is no statistical significance in gender as a moderator of the mediation of difficulties in emotion regulation and trauma symptoms with a history of childhood abuse/neglect.

H_a2: There is statistical significance in gender as a moderator of the mediation of difficulties in emotion regulation and trauma symptoms with a history of childhood abuse/neglect.

RQ3: Does gender impact the strength between self-compassion and trauma symptoms with a history of childhood abuse/neglect?

H_o3: There is no statistical significance in gender as a moderator of the mediation of self-compassion and trauma symptoms with a history of childhood abuse/neglect.

H_a3: There is statistical significance in gender as a moderator of the mediation of self-compassion and trauma symptoms with a history of childhood abuse/neglect.

Theoretical Framework

The theory of object-relations as first articulated by Klein (1932) and expanded by Fairbairn (1952) was used to understand the mediating effects of negative trauma appraisal, difficulties in emotion regulation, and self-compassion buffering the relationship between childhood abuse/neglect and trauma symptoms. Object-relations theory suggests that infant relational development forms through the unconscious interpretation of caregiver actions (Fairbairn, 1952; Stern, 1994). The infant internalizes the caregiver (object) and relational patterns from the object as positive (good object) or

negative (bad object) interactions (Fairbairn, 1952). Object-relations theory suggests that infants consider their interactions with the caregiver as ways to identify the self, object, and developing relational pattern (Fairbairn, 1952; Stern, 1994). Object-relations theory explains the developmental roots for mood regulation, self-identity, perceived security, and the collection of basic needs (Fairbairn, 1952).

According to Fairbairn (1952), the neglected infant splits their ego in response to needs not being met and to preserve the caregiver/infant relationship. A portion of the ego parallels the negative attributes of the caregiver(s) whereas the other portion continues to seek physiological, cognitive, and emotional needs not met by the caregiver(s) (Fairbairn, 1952; Mitchell & Black, 1995). Mitchell and Black (1995) suggested that children in traumatic or neglectful relationships with the caregiver(s) remain attached and continue to seek attention from the caregiver(s). The maladaptive relationship may parallel the child and adolescent's future relations with a desire to be with abusive and neglectful others (Bedi et al., 2013; Conway et al., 2014; Fairbairn, 1952).

Nature of the Study

This was a cross-sectional quantitative correlational study using a conditional processing analysis with SPSS 25.0 and PROCESS Macro. The predictor variable of childhood abuse/neglect was mediated by negative trauma appraisal, difficulties in emotion regulation, and self-compassion toward the outcome variable of trauma symptoms. The trajectory toward trauma symptoms was to be moderated by gender. To complete a statistical analysis using mediation and moderation requires a conditional

process analysis (Hayes, 2018). I used Model 15 of PROCESS Macro in conjunction with SPSS 25.0 to identify the mediation of negative trauma appraisal, difficulties in emotion regulation, and self-compassion, and the moderation of gender. Data were collected through convenience sampling, using SurveyMonkey, accessed through multiple online media platforms. Data were scored and operationalized, and the PROCESS Macro Model 15 was used to determine the mediating and moderating variables' strength on the mediating and outcome variables.

Definitions

Childhood abuse/neglect: Any intentional physical, sexual, and emotional maltreatment and pervasive emotional unresponsiveness of a caregiver with a child 17 years and younger (Augusti et al., 2018; Norman et al., 2012).

Difficulties in emotion regulation: The quantifiable intra-personal control of emotional state during emotional arousal periods (Gratz et al., 2015).

Gender: The preferred gender identity of the participant while completing the survey. The provided gender does not have to match the biological gender.

Negative trauma appraisal: The subjective perspective of the individual's locus of control and cognitive and affective reactivity toward life stressors and traumas (Kira et al., 2019).

Potentially traumatic event: Global concepts of negative stressors that may be perceived as trauma to differentiate between childhood abuse/neglect and other forms of trauma (i.e., natural disasters or living in war zones) within the literature (De'Andrea et al., 2012).

Self-compassion: The ability to provide introspective empathy in situations of perceived adverse events (Neff, 2003a).

Trauma symptoms: Symptoms that parallel the diagnostic criteria of PTSD per the *DSM-5* (American Psychiatric Association, 2013); however, symptoms may or may not meet the antecedent criteria for the formation of PTSD as highlighted in Criterion A.

Assumptions

Teitcher et al. (2015) identified online surveying as having multiple positives and negatives regarding participation. First, online surveys offer anonymity that allows for more accurate or fraudulent responses (Teitcher et al., 2015). Next, there have been incidents of participants attempting to skew the data through multiple entries (Teitcher et al., 2015). I assumed that all participants in the current study would answer the survey questions accurately without purposely manipulating the data. Furthermore, participants completed the questionnaires no more than one time. The data were visually analyzed to detect potential outliers or inconsistencies. Finally, I assumed the instruments measured the variables correctly and were reliable and valid when used for remembering previous events.

Scope and Delimitations

The research sample I used was limited to individuals that are living within the United States, at least 18 years old, speak English, and reported at least one past childhood abuse/neglect. The participants were recruited through Facebook.

Limitations

Regardless of the strength of a study, there are bound to be limitations. The first limitation was the data were collected over the internet on a volunteer basis. The participant required internet access and a willingness to complete surveys. Individuals who complete questionnaires may be more apt to complete questionnaires in general and may not fully represent the general population (Teitcher et al., 2015). According to Teitcher et al. (2015), online survey participation tends to exhibit extremes more than ambivalent or indifferent results. Second, the study was a retrospective analysis of childhood abuse/neglect in adults. The participants were required to remember previous incidents that could have been vivid, partially, or profoundly confabulated with no means to verify the data. Third, the study did not include randomized participation in a true experimental design. Therefore, causation could not be determined from the results. Regardless of the limitations, the study contributed additional information to the current trauma literature.

Significance

Due to the ongoing national concerns of childhood abuse/neglect relating to mental and physical health concerns (DePierro et al., 2019; Felitti et al., 1998), more research was warranted. Assessing whether there are gender differences in how negative trauma appraisal, difficulties in emotion regulation, and self-compassion buffer the relationship between childhood abuse/neglect and trauma symptoms is significant. The literature suggested there are multiple gender differences in trauma symptomatology (DePierro et al., 2019). Understanding gender differences in the variables of negative

trauma appraisal, difficulties in emotion regulation, and self-compassion may identify gendered strengths and deficits. Identifying strengths and deficits may alter psychotherapy techniques toward more effective treatments. Also, understanding how gender might differ among negative trauma appraisal, emotion regulation, and self-compassion may address a gap in the literature.

Summary

I measured gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion buffering the relationship between childhood abuse/neglect and trauma symptoms. Due to mental and physical health concerns correlating with a history of childhood abuse/neglect (DePierro et al., 2019; Felitti et al., 1998; Ford, 2015; Spinazzola et al., 2019; van der Kolk, 2015), continued research was warranted. The current study had a cross-sectional quantitative design using Preacher-Hayes PROCESS Macro Model 15 conditional process analysis to identify statistical significance.

Chapter 2, the literature review, expands on the information provided in the introduction. An extensive literature review was conducted that included the theoretical framework (Fairbairnian object-relations theory); the predictor variable of childhood abuse/neglect; the mediating variables of negative trauma appraisal, difficulties in emotion regulation, and self-compassion; the outcome variable of trauma symptoms; and using gender as a moderator. The literature review was conducted to identify scientific trends, identify the literature gap and purpose of the study, and justify the variables.

Chapter 2: Literature Review

I conducted a comprehensive literature review on childhood abuse/neglect, trauma symptoms, negative trauma appraisal, difficulties in emotion regulation, self-compassion, and the theoretical framework. The literature review emphasized Fairbairnian object-relations theory by offering historical relevance, an explanation of constructs, and how the theory fit the study. Childhood abuse/neglect was delineated as emotional abuse, physical abuse, sexual abuse, and emotional neglect. The mediating variables of negative trauma appraisal, difficulties in emotion regulation, and self-compassion were exhaustively reviewed to identify current literature trends. Finally, the outcome variable of trauma symptoms was discussed in current literature trends around biological, psychological, and differential diagnosis perspectives. The literature review includes the research trajectory, current trends, and the research design.

Childhood abuse/neglect is a national concern (DePierro et al., 2019; Elghossain et al., 2019; Spinazzola et al., 2018) and continues to produce multiple physical and mental health concerns (Augusti et al., 2018; Felitti et al., 1998; Nuttman-Shwartz, 2017). However, perpetration of childhood abuse/neglect does not guarantee the development of physical and mental health concerns (Felitti et al., 1998). Researchers have studied different mediating variables to better predict childhood abuse/neglect toward trauma symptoms (Fossati et al., 2016; Lazarus & Folkman, 1987; Neff, 2003a; Powers et al., 2015; Sherrer et al., 2015). Barlow et al. (2017) identified statistically significant relationships between childhood abuse/neglect and trauma symptoms mediated by negative trauma appraisal, difficulties in emotion regulation, and self-compassion;

however, it was not clear whether the mediating variables were impacted by genders equally. The purpose of the current cross-sectional correlational study was to examine gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion mediating the relationship between childhood abuse/neglect and trauma symptoms in a convenience sampled adult population.

Literature Search Method

I conducted the literature search through several means. Primary sources were retrieved using the Walden Library databases and Google Scholar. Keywords such as *object-relations*, *trauma*, *abuse*, *neglect*, *development*, *self-compassion*, *prevalence*, *negative trauma appraisal*, and *emotion regulation* were used in the following databases and search engines: PsycINFO, PsycARTICLES, SAGE, Google Scholar, and Thoreau. The searches were specified as peer reviewed and between the years of 2015 and 2020. Seminal work, systemic reviews, meta-analyses, and secondary sources were not restricted by year; however, they were specified as peer reviewed. Much of the seminal work was retrieved through the introduction of current literature citations. Principal authors were identified in the literature, emailed with questions, and sent additional resources. All articles were organized into individual sections in Zotero and were named for the variable, theory, or method. All secondary sources were obtained as physical books.

Theoretical Framework: Object-Relations Theory

Fairbairnian object-relations theory was used as the theoretical framework. The term *object*, in psychology, was first described in psychoanalytic theory by Freud

(Mitchell & Black, 1995). Freud (1923, as cited in Mitchell & Black, 1995) defined an object as a person or inanimate object that meets the infant's basic needs to temper sexual and aggressive drives. Klein (1932, as cited in Mitchell & Black, 1995) sought to expand on Freudian psychoanalytic work with children. Through observations, Klein (1932) postulated that infants exhibit the Oedipal phase and incestuous desires much younger than 5 or 6 years, which was perceived by traditional psychoanalytic thought. Klein (1932) rejected Freud's postulations and suggested that infants innately pursue attachments with objects to meet physiological and interpersonal needs. Freud and Klein (1923, 1932, as cited in Mitchell & Black, 1995) agreed that sexual and aggressive drives were satisfied through connections with an object.

Fairbairn Object-Relations

The contemporary object-relations theory postulates that mental health concerns do not solely originate with the child. Bowlby (1969, as cited in Mitchell & Black, 1995) suggested that mothers may exhibit maladaptive relational patterns, too. Fairbairn (1952) suggested that the basic drives were not aggression and pleasure but seeking relational patterns with objects. The infant initially seeks relational patterns with the caregiver to meet the basic needs of sustenance and comfort (Fairbairn, 1952). Over time, the infant will develop more complex relational patterns to function within the family (Fairbairn, 1952).

The infant constructs relational patterns with the caregiver based on previous interactions. Object-relations theory postulates three distinct interactions (Conway et al., 2014; Fairbairn, 1952; Kernberg, 2015; Stadter, 2016). First, the infant subjectively

interprets the object as dichotomously good or bad; second, the infant assumes the perception of the object upon the self as good or bad; and finally, the infant interprets the relationship between the self and the object as good or bad (Fairbairn, 1952; Kernberg, 2015; Klein, 1932). The three perspectives are integrated into the relational style and may determine concepts of the self, others, and the world (Fairbairn, 1952; Stadter, 2015).

Fairbairn (1952) suggested that the infant and caregiver's prototypical well-developed relationship is ideal and fictitious. To preserve the infant/object relationship, the infant's ego splits into the internal and external egos (Mitchell & Black, 1995). The internal ego holds the desires not met by the object and the external ego helps develop a harmonious infant/object relationship when needs are not met (Fairbairn, 1952). The child does not blame the caregiver for not meeting needs. The infant assumes they are too demanding of the caregiver and internalizes blame (Fairbairn, 1952). The infant perceives the self as unconditionally bad instead of the adult being conditionally bad to preserve the infant/caregiver relationship (Fairbairn, 1952).

As the individual ages, relational patterns become more diverse due to increased interactions. Fairbairn (1952) and Kernberg (1998) postulated that individuals seek current relational patterns that parallel the relational patterns they had with the caregiver(s). If the individual grew up with neglectful and abusive caregivers, the child might seek similar relationships. Kernberg (1998) suggested that infant/object relationships establish the prototype and set the requisites for future relationships. Thus, an individual who grew up with abuse and neglect may continue to seek abuse and neglect from others (Bedi et al., 2013; Fairbairn, 1952; Kernberg, 1998).

Furthermore, a tenet of object-relations theory is that personality development is based on the infant's relational pattern with the object (Fairbairn, 1952). If the child assumes unconditionally bad feelings, the child may exhibit introverted, anxious, or aggressive tendencies (Fairbairn, 1952). Moreover, feeling unconditionally bad decreases self-compassion (Reffi et al., 2019) and increases difficulties in emotion regulation (van Dijke et al., 2018) and negative trauma appraisal (Barlow et al., 2017).

Object-Relations Theory Related to Childhood Abuse/Neglect

Object-relations theory profoundly explains the formation of trauma symptoms affected by childhood abuse/neglect (Bedi et al., 2013; Conway et al., 2014; Fairbairn, 1952). Early psychoanalytic theory (see Fairbairn, 1952) suggests that victims of sexual abuse feel shame due to the gratification of incestuous desires toward the opposite gender parent. Fairbairn (1952) argued against incestuous desires and indicated feelings of shame are associated with cognitive dissonance toward the caregiver's actions, amendments to the object-relational pattern, and internalizing a fantasy of the ideal relational pattern.

Caregivers commit childhood abuse/neglect, yet children continue to seek attention from that caregiver. Fairbairn (1952) postulated that childhood abuse/neglect is observed in two distinct fashions. First, the child will internalize the abuse personified as the bad object (Fairbairn, 1952). This may be noted when the child is reminded of the bad object and exhibits anxiety and fear (Kernberg, 2015). Second, the child seeks good out of the bad object by transferring blame to the self. It is easier for the child to view themselves as unconditionally bad than to see the object as conditionally bad (Fairbairn,

1952). A conditionally bad caregiver would purposefully harm the child (Fairbairn, 1952). The child cannot cognitively assume the parent is purposefully harming and therefore blames themself. Furthermore, it is better to follow an object offering partial needs than receiving no needs (Fairbairn, 1952). Children who live in chronic childhood abuse/neglect remain with the object to seek partial needs instead of receiving no needs.

Fairbairnian object-relations theory postulates the child will self-blame with internalized thoughts of being unconditionally bad (Mitchell & Black, 1995). The child perceives the abuse as deserving due to feelings of being too demanding or out of control (Fairbairn, 1952). As the child understands the self as unconditionally bad, adverse events are perceived as deserving (Kernberg, 2015) and minimize the ability for self-compassion (Neff, 2003a). Because self-compassion is the perception of supporting the self (Neff, 2003a), perceiving the self as unconditionally bad may directly negate or minimize self-compassion (Dahm et al., 2015). The mediating effect of self-compassion between childhood abuse/neglect and trauma symptoms may be examined and explained through object-relations as the theoretical framework.

Moreover, the child perceives themselves as unconditionally bad, deserving of punishment, and self-blaming (Fairbairn, 1952; Stadter, 2016). Because negative trauma appraisal is the cognitive perceptions, processing, self-blame, and memory of childhood abuse/neglect (Kernberg, 2015), this may perpetuate trauma symptoms (McIlveen et al., 2019). Negative trauma appraisal may be examined and explained through object-relations as the theoretical framework.

Finally, Fairbairnian object-relations theory perceives the infant's personality development through internal and external objects (Fairbairn, 1952; Mitchell & Black, 1995; Stadter, 2016). Difficulties in emotion regulation have a relationship with self-compassion, affect, and personality, which determines the reactive style toward negative situations (Schindler & Querengasser, 2019). Object-relations theory suggests that difficulties in emotional regulation are biologically and developmentally produced by innate temperaments and the relational patterns with objects, respectively (Kernberg, 2015). If the relational pattern with the objects suggests difficulties in emotion regulation, the child may develop a similar difficulty in emotion regulation (McAdams, 2015). Difficulties in emotion regulation may be examined and explained through object-relations as the theoretical framework. Due to the overarching theoretical perspectives of Fairbairnian object-relations theory in describing trauma, the theory assisted me in explaining the mediation of self-compassion, negative trauma appraisal, and difficulties in emotional regulation on the relationship between childhood abuse/neglect and trauma symptoms.

Object-Relations Theory in Current Literature

Object-relations theory is old compared to other theories; however, it remains a prominent theory in psychodynamics to examine and explain the trajectory of childhood abuse/neglect toward trauma symptoms (Bedi et al., 2013; Conway et al., 2014; Kernberg, 2015; Meyers, 2016). Bedi et al. (2013) utilized object-relations as a theoretical framework in research using the Thematic Apperception Test with 60 participants identifying with childhood abuse/neglect. Using the Social, Cognitive, and

Object Relations Scale for scoring the Thematic Apperception Test, Bedi et al. suggested that hyperarousal symptoms associated with childhood abuse/neglect may be the internalization of the bad object and seeking similarities among others. Moreover, the bad object's internalization was suggested to project external objects' perception as unconditionally bad, suggesting the world to be profoundly bad (Bedi et al., 2013). This perception reduced confidence, self-compassion, and coping strategies while increasing negative trauma appraisals and negative world views (Bedi et al., 2013).

Conway et al. (2014) researched nonsuicidal self-injurious behaviors in individuals reporting childhood abuse/neglect with object-relations as the theoretical framework. The research identified nonsuicidal self-injurious behaviors correlated with internalized bad objects' beliefs and the self as unconditionally bad. Nonsuicidal self-injurious behaviors were perceived as a deserving punishment or maladaptive emotion regulation that overwhelmed the individual. The individual used nonsuicidal self-injurious behaviors as an external force to distract intense emotions.

Phenomenological and grounded theory research conducted by Meyers (2016) structured object-relations as the theoretical framework to understand the effects of sibling abuse on adults' perception of relational patterns. Meyers identified that most participants perceived little family support and an introverted approach toward adult relational patterns with others. Furthermore, Meyers found these individuals to enter abusive relationships confirming negative thoughts of the self, others, and the world.

Research has used object-relations theory to examine and explain the formation of trauma symptoms caused by childhood abuse/neglect (Bedi et al., 2013; Conway et al.,

2014; Kernberg, 2015; Meyers, 2016; Newirth, 2016; Perrella, & Caviglia, 2017; Stadter, 2016; Taipale, 2017; Tamaddonfard, & Monirpoor, 2016; Waska, 2015; Zornig, & Levy, 2011). Furthermore, the mediating variables of negative trauma appraisal, difficulties in emotion regulation, and self-compassion can be examined and explained with object-relations theory. Finally, Fairbairnian object-relations theory development was based on observations and evidence of children who have survived childhood abuse/neglect from a biological, psychological, and social perspective (Fairbairn, 1952; Kernberg, 1998; Kernberg 2015; Stadter, 2016). Thus, the research used Fairbairnian object-relations theory as the theoretical framework.

Childhood Abuse

According to the U.S. Department of Health and Human Services (2019), childhood abuse is federally defined as, "Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm" (para. 2). This definition represents the minimum requirements that must be added to and defined differently between states (U.S. Department of Health and Human Services, 2019). The description can be interpreted to include both abuse and neglect under the same sequelae toward trauma symptoms and directly blaming the caregiver(s) as the perpetrator (i.e., parent, relative, family friend, or babysitter). Sexual abuse, physical abuse, emotional abuse, and emotional neglect will be the focus of this literature review.

Childhood Sexual Abuse

As defined by Rape, Abuse, & Incest National Network (2020), childhood sexual abuse is any act of sexual gratification perpetrated upon another under 18, including fondling, exhibition, penetration, exposure to pornographic content, and sex trafficking. Initial concepts of childhood sexual abuse may have exhibited the dismissal of symptoms. According to van der Kolk (2015), initial childhood sexual abuse trajectories toward trauma symptoms were determined (without known research) as almost no relationship. This misnomer may be due to early psychoanalytic assumptions of incestuous sexual abuse produced shame in the victim due to unconscious incestuous desires to be intimate with the opposite-sex caregiver (Fairbairn, 1952). This misnomer was considered perplexing, and current models identify sexual abuse as a significant predictor of trauma symptoms (Carlson & Oshri, 2018; Felitti et al., 1998; Hebert et al., 2020; Kloppen et al., 2016; Yuce et al., 2015). However, it is unclear if individual variations of sexual abuse; mediating or confounding variables; revictimization; or dose-response predict the trajectory and severity of trauma symptoms. Thus, the literature on sexual abuse has significant overlap toward similar or inconclusive results.

Assink et al. (2019) conducted a meta-analysis to measure risk factors toward childhood sexual abuse victimization. Using 72 prior studies, Assink et al. identified low effects of minimal parental affection; having a blended or single-parent family; parental substance use; familial relational or domestic violence; chronic mental or physical health concern of the parent or child; low sense of parental competence; child delinquent behavior; low family SES; and internet use. Moderate effects toward childhood sexual

abuse included victimization of another family member; prior other forms of abuse; parental overprotection; low parental attachment; child shyness (Assink et al., 2019), and the victim under the age of 15 (Yuce et al., 2015). Similar information on risk factors was reported in a meta-analysis, with 44 studies focused on forensic settings disclosing childhood sexual abuse conducted by Azzopardi et al. (2019). The similarities may be due to similar methods and studies used by both meta-analyses. A significant piece of information that was not disclosed in Assink et al., due to the scope not including forensic settings, is when victims of childhood sexual abuse are formally questioned, 64.1% disclosed (Azzopardi et al., 2019).

Similar information varies on disclosure rates based on victim's perceptions and gender. Lahtinen et al (2018) used a sample of 11,364 self-reports of childhood sexual abuse from sixth and ninth-grade students in Finland. Lahtinen et al. identified the most likely barrier to disclosure is the victim's perception of the abuse 'not being a big deal.' Other findings suggested that a lack of disclosure may be due to shame and blame (Lahtinen et al., 2018). Lahtinen et al. reported that 71% of males and 26% of females perceived sexual abuse as flattering, desired by the victim, and positive. Risk factors of victims perceiving positive experiences of sexual abuse are if it was isolated abuse or if incremental perpetrator coercion upon the victim was present (Castro et al., 2019; Lahtinen et al., 2018).

However, Lahtinen et al. (2018) suggested that around 80% of childhood sexual abuse victims report the incident to peers but less likely to report to parents, other adults, or authorities. Disclosure rates were 48% close friends, 20% to mothers, 12% fathers, and

12% to authorities (Lahtinen et al., 2018). In comparison, Gerwitz-Mayden and Finkelhor (2020) disclosure rates were 31% parents, 33.7% another adult, and 19.1% authorities. One postulation around low disclosure rates is the perceived severity of childhood sexual abuse (Wekerle et al., 2017). However, Lahtinen et al. and Wekerle et al. (2017) suggested that less severe sexual abuse perpetration may systematically become more severe. Another mediating variable preventing disclosure may be childhood emotional abuse correlated with disclosures to mothers and not fathers (Lahtinen et al., 2018). Moreover, parental perpetration of childhood emotional abuse is perceived as low parental support and preventing parental disclosures and lower levels of resiliency factors for the victim (Gerwitz-Meydan & Finkelhor, 2020; Lahtinen et al., 2018). The victim may perceive low protective factors as a sign of parental disbelief and perpetuate fear of self-disclosure (Lahtinen et al., 2018).

The research identified females are a higher risk for childhood sexual abuse (Castro et al., 2019; Clayton et al., 2018; Gerwitz-Meydan, & Finkelhor, 2020; Gray, & Rarick, 2018; Hebert et al., 2020; Kloppen et al., 2016; Lahtinen et al., 2018; McTavish et al., 2019; Pereda et al., 2016). However, the research identified a misrepresentation of males due to the failures of disclosing childhood sexual abuse if the victim perceived the abuse as negative (Castro et al., 2019; Gray, & Rarick, 2018; Lahtinen et al., 2018). Castro et al. (2019) found that male victims might be more likely to report childhood sexual abuse if the perpetrator was female and less likely to exhibit negative symptoms. If the perpetrator was male, cultural variables of questioning sexuality might diminish potential disclosure (Castro et al., 2019). The discrepancy between disclosure for males

might be due to cultural norms illustrating the male victim as “lucky” if the perpetrator was female and questions of homosexuality if the perpetrator was male (Castro et al., 2019).

Contrasting sharply, a systemic review of Arab nations conducted by Elghossain et al. (2019) reported higher male childhood sexual abuse rates than females. The difference may be around cultural norms. Elghossain et al. reported that males in Arabic countries have more freedom and less supervision, providing more sexual victimization opportunities than females. However, female reporting of childhood sexual abuse may be smaller than the actual number due to the female’s cultural expectations to be celibate before marriage (Elghossain et al., 2019). Reports of female childhood sexual abuse may be minimized due to cultural expectations and not shared with the female victim’s future husband (Elghossain et al., 2019).

Another variable beyond the scope of this study involves peer childhood sexual abuse. Gerwitz-Meydan and Finkelhor (2020) analyzed 506 self-reported childhood sexual abuse cases and identified 76.7% of males and 70.1% of females reporting perpetration by an individual under 18. A longitudinal study conducted by Carlson and Oshri (2018) suggested similar information on peer childhood sexual abuse, especially for older adolescent victims, as more common than incestuous or another adult perpetration. This would further diminish disclosure rates due to limited understanding of the acts perceived as childhood sexual abuse.

Another concern within the literature are incidences of sexual revictimization. Walker et al. (2019) conducted a meta-analysis of 80 studies identifying 47.9% of

childhood sexual abuse cases revictimized by a different perpetrator. One caveat suggested by Walker et al. is that 53% of the studies analyzed were college convenience sampling. Kocturk and Bilge (2018) studied revictimization with three groups from Ankara, Turkey (no abuse, one sexual abuse incident, and revictimized). The study identified lower social support levels of individuals with at least one childhood sexual abuse and less for the revictimized group. This suggested that increased social support may decrease isolation and avoid riskier situations.

Another variable that may increase the probability of revictimization may be hypersexualized behaviors. Castro et al. (2019) suggested many victims of childhood sexual abuse either exhibit hypervigilance against sexuality or hypersexuality. A study by Wekerle et al. (2017) provided more evidence using 297 adolescents from child-welfare services living in Ontario, Canada. The research identified that 43.1% of the sample were victims of childhood sexual abuse, with 38.1% of the childhood sexual abuse victims exhibiting hypersexualized behaviors (Wekerle et al., 2017). Other variables may distinguish the opposing extreme reactions after childhood sexual abuse.

Yuce et al. (2015) researched 590 participants reporting childhood sexual abuse from Turkey on the prevalence of mental health concerns. In the sample, 75.2% exhibited a mental health concern that correlated with childhood sexual abuse. Carlson and Oshri (2018) conducted a four-wave longitudinal study (2-6 months after sexual abuse report, followed by 18, 36, and 72 months) with 444 children between 7 and 15 years-old reporting sexual abuse in the United States to identify trajectories and to mediate variables of depressive symptoms. The results indicated the closer the perpetrator was to

the victim (i.e., family member), the more intense and increasing of depressive symptoms over time (Carlson & Oshri, 2018).

Childhood sexual abuse does not solely promote later mental health concerns (Carlson & Oshri, 2018). Carlson and Oshri (2018) posited shame, betrayal, and other types of childhood abuse/neglect may exacerbate mental health concerns. Shame was associated with the act of allowing the sexual abuse to happen (i.e., too weak to prevent the abuse, freezing response, inability to call for help, and sexual arousal; Carlson & Oshri, 2018). If the victim knows the perpetrator as familial, Gray and Rarick (2018) suggested perceived betrayal may occur. The perpetrator was a trusted individual that defied the respect and autonomy of the victim. Finally, other types of abuse increase the likelihood and exacerbation of mental health concerns due to difficulties in emotion regulation (Hebert et al., 2020; Tlapek et al., 2017; Yoon et al., 2018) and dissociation (Hebert et al., 2020).

Childhood Physical Abuse

According to the National Society for the Prevention of Cruelty to Children (2020), childhood physical abuse is the purposeful act of bodily harm to an individual under the age of 18 perpetrated by an individual above the age of 18. Childhood physical abuse is one of the most studied and recognized forms of abuse. History suggested that childhood physical abuse was initially banned in Nordic countries (Thulin et al., 2019) and criminalized in most countries within the United Nations (Meinck et al., 2015; Elghossain et al.,2019). There are still high prevalence rates across the globe and continuing concerns based on differing definitions. According to Meinck et al. (2015),

some countries allow corporal punishment while other countries identify corporal punishment as childhood physical abuse. Varying definitions confound current literature in seeking accurate prevalence rates and continuing services.

Although many nations consider childhood physical abuse illegal, this continues to be a global concern. Meinck et al. (2015) conducted a meta-analysis on prevalence and risk factors of childhood physical abuse using 23 studies focused on African countries within the United Nations. According to the results, childhood physical abuse prevalence is between 7.6% in South Africa and 45% in Egypt (Meinck et al., 2015). The large discrepancy may be due to Egyptian laws allowing corporal punishment and stricter hierarchal family structures (Meinck et al., 2015). Furthermore, research conducted by Elghossain et al. (2019) conducted a systemic review of 76 studies conducted in 22 Arab Nation countries. The results indicated a prevalence of childhood physical abuse relatively stable between genders (Elghossain et al., 2019). However, exhibiting lower educational attainment levels, increased risky sexualized behavior, substance use, mental and physical health concerns in males more than females (Elghossain et al., 2019). Females show higher levels of internalized behaviors (i.e., anxiety or depression) than males (Elghossain et al., 2019). The discrepancy between gender symptomatology may correlate with cultural gender expectations and supervision differences (Elghossain et al., 2019).

As many nations consider corporal punishment acceptable, to a degree, spanking is not identified as childhood physical abuse by United States social services (Afifi et al., 2017); yet spanking may have detrimental effects on children. A meta-analysis conducted

by Gershoff and Grogan-Kaylor (2016), utilizing 76 studies, identified spanking to correlate with increased internalizing and externalizing (i.e., disruptive behaviors) mental health concerns, lower levels of self-compassion, increased aggression, lower cognitive abilities, and lower moral judgment. The information was replicated by Afifi et al. (2017). Moreover, both Afifi et al. and Gershoff and Grogan-Kaylor reported spanking highly correlated with physical and other forms of childhood abuse. However, Gershoff and Grogan-Kaylor postulated more research into this correlation due to being unsure if increased spanking contributed to negative behaviors or increased negative behaviors contributed to more frequent spanking.

From a gender-specific perspective, childhood physical abuse may be perceived differently. First, according to multiple articles (Annerback et al., 2018; Cui et al., 2018; Elghoussain et al., 2019; Faus et al., 2019; Kolbusky, 2017; Stevens et al., 2015; Yoon et al., 2018a), female victims of childhood physical abuse exhibited higher levels of internalized behaviors, while male victims exhibited higher levels of externalized behaviors. Second, males are more likely to be victims of childhood physical abuse than females (Stevens et al., 2015; Tyler, & Schmitz, 2018). Third, female victims of childhood physical abuse correlated with later substance use more than males identified in a cross-sectional study (see Kobulsky, 2017) and a five-wave longitudinal study (see Kobulsky et al., 2016). Finally, males are more likely to exhibit hypersexualized behavior with a history of childhood physical abuse than females (Yoon et al., 2018a). Hypersexuality in males was suggested to be compensatory masculinity due to victims' perceptions as emasculating (Yoon et al., 2018a). Thus, female victims of childhood

physical abuse are more likely to exhibit internalizing mental health concerns such as anxiety and depression; while males may exhibit externalizing behaviors as well as hypersexualized and aggressive behaviors (Cui et al., 2018; Kobulsky et al., 2016; Kolbusky, 2017; Yoon et al., 2018b).

Furthermore, childhood physical abuse perpetrated by the mother or father may exhibit different victim reactions. Annerback et al. (2018) researched perceived familial relationship, physical and emotional abuse, and symptomatology with maternal, paternal, and both perpetration of physical violence with 664 Swedish children (ages 13, 15, and 17). The results indicated that childhood physical abuse perpetrated by the mother, and both parents were more detrimental than perpetrated by the father (Annerback et al., 2018). Annerback et al. postulated parental differences might be explained by maternal object-relational development as a more robust and earlier relationship compared to paternal relationships. Similar results were indicated by Faus et al. (2019), who collected data from 699 students across 20 schools within the Rio de Janeiro region of Brazil. Specifically, Faus et al. sought to understand the relationship between childhood physical abuse and community violence with the probability of victim aggression. Like Annerback et al., Faus et al. identified maternal physical abuse as more detrimental than paternal physical abuse. This difference may be due to the cultural expectations of the father administering punishment.

Similarly, Cui et al. (2018) researched 296 children from China living with both parents around symptom trajectories associated with childhood physical abuse. Cui et al. reported maternal and paternal physical abuse perpetration to parallel research conducted

by Annerback et al. (2018) and Faus et al. (2019). However, Cui et al. reported that parents tend to exhibit similar parenting styles; thus, most of the childhood physical abuse was perpetrated by both parents. The research identified increased aggression and anxiety in children receiving maternal and both parent childhood physical abuse with minimal correlation to paternal childhood physical abuse (Cui et al., 2018).

Further, Faus et al. (2019) identified participants' perceptions of parental warmth as a resiliency factor for childhood physical abuse and victim aggression. The occurrence may be due to cultural acceptance of childhood physical abuse perceived as corporal punishment. Nevertheless, Faus et al. identified community violence negated parental warmth as resiliency against victim aggression; meaning, childhood physical abuse and community violence correlated with victim aggression whether parental warmth was present. These findings highlight the importance of trajectories and outcomes from abuse to be multifaceted from biological, psychological, and social lenses.

From an intergenerational perspective, a meta-analysis with 84 studies conducted between 1975 and 2017 identified parents with a history of childhood physical abuse were almost three times more likely to be perpetrators of childhood physical abuse than parents with no history of childhood physical abuse (Assink et al., 2018). Not all parents that received childhood physical abuse will abuse their children; however, there is a moderate effect size paralleling other research around the relationship between physical abuse and future aggressive behaviors (Faus et al., 2019; Meinck et al., 2015). Assink et al. (2018) suggested that other variables contribute to childhood physical abuse perpetration, requiring further research.

Regardless of an intergenerational perspective, childhood physical abuse has a relationship with mental and physical health concerns. Ellenbogen et al. (2015) identified childhood physical abuse associated with later aggression when mediated by shame, blame, or guilt with a one-year two-wave longitudinal study with 163 participants. The results indicated much of the variance toward aggression was mediated by childhood emotional abuse (Ellenbogen et al., 2015), which reached similar conclusions as other researchers (Brown et al., 2019; Kang et al., 2018; Moraes et al., 2018). However, Ellenbogen et al. identified relatively severe childhood physical abuse cases to correlate with shame when controlled for childhood emotional abuse. This assumed that the victim's object-relations perspective perceives the self as unconditionally bad (Fairbairn, 1952). Finally, childhood physical abuse histories exhibit more of a dose-response to anger equivalent to internalizing aggression than relatively chronic externalizing aggression (Ellenbogen et al., 2015).

Castellvi et al. (2017) conducted a meta-analysis of 26 longitudinal studies identifying suicidal ideation as a symptom associated with a history of childhood physical abuse. Like other research, Castellvi et al. identified childhood emotional abuse as a mediating variable between childhood physical abuse and suicidal ideation. A systemic review and meta-analysis from Gardner et al. (2019), with 96 studies correlating the severity of mental and physical health concerns associated with childhood physical abuse. Gardner et al. postulated the difference between the presence of childhood physical abuse and trajectories might be due to the perception of childhood physical abuse as deserving or corporal punishment.

Not all physical harm is perceived as abuse in lieu of consequences for negative behaviors. Perceived severe childhood physical abuse may be identifiable by the victim as childhood physical abuse (Ellenbogen et al., 2015); however, parental warmth may alter the perception of childhood physical abuse (Faus et al., 2019). A meta-analysis conducted by McCarthy et al. (2016) with 27 studies suggested the presence of parental warmth as a mediating variable against the development of physical and mental health concerns, while childhood emotional abuse is a mediating variable exacerbating physical and mental health concerns.

From a more direct approach, Renner et al. (2020) conducted prevalence rates of anxiety, depression, and aggression among a sample of 1,019 youths ages 10 to 17 identifying childhood physical abuse with and without childhood emotional abuse. 3.2% anxiety, 3.3% depression, and 11% aggression among individuals reporting only childhood physical abuse; while 10.7% anxiety, 25.1% depression, and 37.8% aggression among individuals reporting childhood physical and emotional abuse, was identified (Renner et al., 2020). Silva and Calheiros (2020) found similar findings with 203 children, corresponding caregiver(s), and social workers under social service investigation. The results identified childhood emotional abuse as a mediating variable between other forms of abuse and the trajectory of physical and mental health concerns (Silva & Calheiros, 2020). Thus, the parental response's perceptions of childhood physical abuse as abuse may be determined as a continuum between emotional warmth and childhood emotional abuse.

Childhood Emotional Abuse

According to Prevent Child Abuse America (2020), childhood emotional abuse is an act perpetrated by the caregiver as rejecting, isolating, terrorizing, ignoring, corrupting, verbally assaulting, or extreme pressuring of the child. Research has identified childhood emotional abuse as a more significant predictor of physical and mental health concerns compared to other forms of childhood abuse (sexual, physical) and neglect, and less likely to be reported and legally pursued (Brown et al., 2019; Curry, 2017; Jaschek et al., 2016; Kang et al., 2018; Kwok et al., 2019; Moraes et al., 2018; Naughton et al., 2017; Nothling et al., 2019; Yu et al., 2019). The discrepancy indicated the challenge of determining childhood emotional abuse as a distinct form that operates separately and concurrently with other childhood abuse and neglect.

First, a systemic review conducted by Naughton et al. (2017) used 32 prior studies to consolidate findings for childhood neglect and emotional abuse for adolescents. According to the systemic review, childhood emotional abuse correlated with future substance use, trauma symptoms, depression, and anxiety (Naughton et al., 2017). From a gender perspective, childhood emotional abuse correlated with an increased probability of sexual victimization and perpetration in males (Naughton et al., 2017). In contrast, childhood neglect correlated with more mental health concerns in females than males (Naughton et al., 2017). For both genders, suicidal ideation is correlated with childhood emotional abuse but not childhood neglect (Naughton et al., 2017).

Additionally, Naughton et al. (2017) identified increased probability of depression if childhood emotional abuse and neglect occurred before 15 years old; potentially

indicating resiliency and emotion regulation formation in middle adolescence. In comparison, Tlapek et al. (2017) researched 237 females within social services participating in trauma-focused cognitive therapy identified similar conclusions. The study indicated that resiliency significantly moderated the relationship between childhood emotional abuse and depressive symptoms (Tlapek et al., 2017). Both articles stated the severity of childhood emotional abuse and the protective factors of resiliency.

From a cross-cultural perspective, childhood emotional abuse exhibits a potential worsening of mental and physical health concerns across multiple domains. Nothling et al. (2019) researched 215 South African adolescents who reported a minimum of one potentially traumatic event and demographics that may exacerbate or predict trauma symptoms. According to the research, childhood emotional abuse was the only variable that increased trauma symptom severity (Nothling et al., 2019). Moreover, Seff and Stark (2019) collected data from 9,338 participants across three countries (2,916 from Haiti, 2,683 from Kenya, and 3,739 from Tanzania) to correlate childhood emotional, sexual, and physical abuse and neglect with externalizing and internalizing behaviors in children and adolescents. The results indicated childhood emotional abuse as the highest predictor of suicidal ideation, as well as cognitive and mental health deficits, while childhood sexual and physical abuse with externalizing behaviors (Seff & Stark, 2019). Both articles indicated severe potential consequences of childhood abuse/neglect; however, it highlighted the exacerbation of trauma symptoms associated with childhood emotional abuse.

From a substance use perspective, Banducci et al. (2018) researched gender differences and identified a correlation of childhood emotional abuse with cannabis or alcohol use among a sample of 206 ninth graders. Banducci et al. identified that females indicated increased use of cannabis and alcohol with higher self-reports of childhood emotional abuse. The research stated the positive attribution of cannabis and alcohol as maladaptive emotion regulation more for females than males (Banducci et al., 2018).

Similarly, Prangnell et al. (2019) researched childhood emotional abuse, chronic pain, and identification of injected substance use among 1,459 participants from Western Canada. From a demographic perspective, 40.5% of the sample identified with past emotional abuse, and 52.1% identified with chronic pain (Prangnell et al. 2019). While running multiple regression models, Prangnell et al. found that childhood emotional abuse is a predictor for increased chronic pain reports. This may be due to the overarching influences of childhood abuse and neglect upon long-term physical and mental health (DePierro et al., 2019; Felitti et al., 1998; Prangnell et al., 2019). Finally, Prangnell et al. identified caregiver's mental health concerns, substance use, unemployment, and giving birth before 22-years of age as variables increasing the probability of childhood emotional abuse perpetration.

Childhood emotional abuse may be contributed to life circumstances of the parent. Brown et al. (2019) conducted an extensive research project using 5,870 participants placed in four cohort (birth-23 months, 2-5, 6-10, & 11-18 years-old) suspected of childhood abuse/neglect. The research identified parent separation and divorce as a significant variable in the presence of childhood emotional abuse (Brown et

al., 2019). Moreover, Brown et al. identified sexual abuse producing significant mental and physical health concerns; however, it was also concurrent with a high prevalence of childhood emotional abuse and physical neglect. This research continued to indicate the importance of childhood emotional abuse as a concurrent form of abuse and exacerbating trauma symptoms.

Similarly, Curry (2017) conducted longitudinal four-wave research with 20,745 participants expanding a decade on adult perceptions of housing insecurity based on a history of childhood abuse/neglect. When controlled for demographics, the study indicated childhood emotional abuse as a higher predictor of housing insecurity than other forms of childhood abuse/neglect (Curry, 2017). Subsequently, Curry postulated childhood emotional abuse significantly disrupted relational development and attachment for the child. Furthermore, Curry suggested childhood emotional abuse as more chronic due to less likely detectable by others and reported to social services; thus, perpetrated longer without mitigation. The information does not suggest that the chronic and temporal aspects of childhood emotional abuse are causal; however, it may be another variable to be considered when addressing childhood physical abuse, sexual abuse, and neglect.

Childhood emotional abuse may have some foundations in caregiver/infant relational patterns and may not be perceived by the caregiver(s) as emotional abuse. The discrepancy produces a challenge in recognizing and mitigating childhood emotional abuse. According to Simmel et al. (2016), intergenerational childhood emotional abuse is consistently the most probable. Intergenerational childhood abuse implies that the

caregiver(s) might exhibit similar parenting styles to their caregiver(s) parenting style. This is further evident with the research identifying a relationship between parenting styles with childhood emotional abuse conducted by Kang et al. (2018), Moraes et al. (2018), Viduoliene (2019), and Yu et al. (2019).

Kang et al. (2018) identified childhood emotional abuse as a significant predictor toward non-suicidal self-injurious behaviors, while Kwok et al. (2019) identified that childhood emotional abuse correlated with increased suicidal ideation. Kang et al. and Kwok et al. used samples of 3,555 and 909 adolescents from the greater Hong Kong region, respectively. The research identified significant perceptual differences in childhood emotional abuse among genders due to cultural gender expectations (Kang et al., 2018; Kwok et al., 2019). Kang et al. identified distress intolerance as an indirect variable between childhood emotional abuse and non-suicidal self-injurious behaviors for females, but not statistically significant for males. Kwok et al. identified gratitude as a mediating variable between childhood emotional abuse and suicidal ideation for both genders. When the researchers controlled other forms of identified childhood abuse and neglect, childhood emotional abuse detected the most significant negative impact (Kang et al., 2018; Kwok et al., 2019). Although childhood emotional abuse is typically concurrent with other forms of childhood abuse/neglect, much of the research identified childhood emotional abuse as the most significant predictor of mental health concerns.

Furthermore, Moraes et al. (2018) identified parenting styles significantly correlate to mental health concerns when moderated by childhood emotional abuse among 487 adolescents from the Rio de Janeiro region of Brazil. The research identified

less violent behavior from adolescents if adolescents reported childhood physical abuse and parental warmth compared with adolescents who reported physical violence and minimal parental warmth (Moraes et al., 2018). Although childhood physical abuse may produce significant mental and physical health concerns (Afifi et al., 2017; DePierro et al., 2019; Felitti et al., 1998), Moraes et al. identified increased externalized and internalized mental health concerns with the inclusion of childhood emotional abuse.

Viduoliene (2019) provided more evidence of parenting styles and childhood emotional abuse increasing mental health concerns. The research utilized 1,265 Lithuanian mothers with a child between 22 and 65 months old (Viduoliene, 2019). The results indicated that childhood emotional abuse and negative child/caregiver attachment produced mental health concerns in children more often than authoritarian parenting and childhood physical abuse (Viduoliene, 2019). This suggested that other forms of childhood abuse/neglect are detrimental to the child's mental and physical health; however, exacerbated by childhood emotional abuse.

Finally, from a parenting style perspective, Yu et al. (2019) researched 120 adolescents from Kuala Lumpur, Malaysia. The study identified varying parenting styles related to childhood emotional abuse probabilities (Yu et al., 2019). The results found an authoritarian parenting style from mother and father predicted the highest childhood emotional abuse rates, permissive parenting style promoted moderate rates, and the authoritative parenting style indicated a moderate negative correlation (Yu et al., 2019). Moreover, Yu et al. reported across all forms of parenting styles that the mother's parenting style was more predictive of childhood emotional abuse than the father's

parenting style within Malaysia (Yu et al., 2019). Insofar, this suggested parenting style indicated a strong predictor, as well as an exacerbation or mitigating variable upon childhood emotional abuse.

Childhood Neglect

Compared to different variations of childhood abuse, neglect may be more detrimental and challenging to detect. According to the Child Welfare Information Gateway (2019), childhood neglect does not meet a child's basic medical, physical, educational, and emotional needs. Physical, medical, and educational neglect will be beyond this research scope, which will focus on childhood emotional neglect. Focusing solely on childhood emotional neglect is due to correlating with trauma symptoms, while other forms of neglect are less clear toward trauma symptoms in the literature (Connell-Carrick, 2003; Cozza et al., 2019). Thus, the literature review will capture the current literature around childhood emotional neglect.

Compared to forms of childhood abuse, childhood neglect may exhibit similar symptom trajectories and mediations comparable to childhood emotional abuse (Gypen et al., 2017; Muller et al., 2019; Schalinski et al., 2019; Vanderminden et al., 2019). This similarity may explain a correlation between childhood emotional abuse and emotional neglect occurring at varying durations for the same child (Vanderminden et al., 2019) and other forms of childhood abuse/neglect (Muller et al., 2019). Although childhood abuse and neglect are different, there is a high probability of coexistence and appearing throughout the lifespan with similar physical and mental health concerns.

From a developmental lens, childhood emotional neglect relates to maladaptive neurological development. Talmon et al. (2019), using a sample of 394 women from Israel, conducted a two-wave longitudinal study peri- and postnatal around the effects of childhood emotional neglect upon motherly perceptions. According to the research, mothers who reported past childhood emotional neglect were more likely to exhibit negative attitudes toward the self as a mother (Talmon et al., 2019). First, perinatal self-perceptions were significantly impaired due to the ego's maladaptive formations and splitting into the self and motherly roles (Talmon et al., 2019). Splitting the ego into roles may indicate object-relations theory on intergenerational attachment development to support the relational desires of the ego while providing adaptive relational patterns for the new child (Mitchell & Black, 1995). Furthermore, childhood emotional neglect significantly decreased perceptions of maternal self-efficacy and negative judgments from others (Talmon et al., 2019). This suggested that a mother with childhood emotional neglect may perceive the self as an 'unfit mother' and may seek to confirm the information and potentially perpetuate childhood emotional neglect upon the new child (Talmon et al., 2019).

Childhood emotional neglect may influence maladaptive neurological formation and propagation. According to Muller et al. (2019), a history of childhood emotional neglect correlated with reduced oxytocin levels in lower peripheral plasma and cerebrospinal fluid samples. Using 121 participants, the research sought to understand the mediating relationships of oxytocin levels and attachment upon childhood emotional neglect and fear of social situations (Muller et al., 2019). Regarding attachment, Muller et

al. identified a significant reduction of attachment styles with lower levels of oxytocin. The relationship may be evident as nasal doses of supplemental oxytocin indicated increased attachments to others in magnetic resonance imaging studies (Jobst et al., 2016; Riem et al., 2017). However, Muller et al. (2019) suggested that many forms of childhood abuse/neglect may produce maladaptive attachment styles. The research indicated the statistical significance of reduced oxytocin levels when childhood emotional neglect was the independent variable (Muller et al., 2019). Regardless, the study indicated a severe deficit in social situations correlated with childhood emotional abuse when mediated by oxytocin levels and attachment styles (Muller et al., 2019).

Moreover, childhood emotional neglect may alter the proportion of cortisol in individuals. Schalinski et al. (2018) studied hair cortisol concentration samples with 183 individuals diagnosed with a mental health concern. The study was designed to understand cortisol level variances based on self-reported ages of childhood emotional neglect and reported age 3 to be the most prevalent age for hair cortisol concentrations (Schalinski et al., 2018). The authors identified significant limitations of self-reporting childhood emotional neglect; however, determined 3-years-old may be a critical age for neuroendocrine development, specifically, upon the hypothalamus-pituitary-adrenal axis (Schalinski et al., 2018). Furthermore, Yeung et al. (2016) conducted salivary cortisol morning concentrations and surveys of 179 individuals diagnosed with fibromyalgia. The research suggested cortisol levels decreased in individuals that reported past childhood emotional and physical neglect and resulted in increased symptoms of pain, depression, and anxiety (Yeung et al., 2016). Past reports of childhood emotional neglect increased

physical and mental health concerns, pain perceptions, hypochondriasis, and bodily inflammation response (Schreier et al., 2020).

Childhood neglect may inhibit cognitive development. Research conducted by Bengwasan (2018) used a modified Stanford-Binet Intelligence Test to identify cognitive abilities of Filipino individuals reporting childhood neglect (n = 100), physical abuse (n = 100), and sexual abuse (n = 100). According to the results, all individuals were well below average among all subtests and overall IQ, with individuals reporting childhood neglect as the lowest and averaging around mild intellectual disability scoring (Bengwasan, 2018). This identified significant cognitive deficits across all forms of childhood abuse and neglect on average and reported similar findings to Malarbi et al. (2016).

Childhood emotional neglect also indicated deficits in social and emotional interpretations. Doretto and Scivoletto (2018) conducted a systemic review with 14 functional MRI (fMRI) studies identifying significant alterations of attentional systems associated with facial recognition. Specifically, amygdalae reactivity was higher in individuals with no neglect when perceiving a negative facial expression (Doretto, & Scivoletto, 2018). In comparison, Benedan et al. (2018) identified significant compliance of leading questions in children reporting neglect compared to children reporting no childhood neglect. However, partially contrasting with Bengwasan (2018), the research identified children reporting neglect to perform adequately on intelligence tasks but lower scores in language (Benedan et al., 2018).

Moreover, Fries and Pollack (2017) researched severely neglected children and identified an inability to utilize implicit information toward goal-directed behaviors. The study suggested that childhood emotional neglect may impede the development of an adaptive dopaminergic reward system reducing goal-directed behaviors (Fries, & Pollack, 2017). Finally, Luke and Banerjee (2013) conducted a meta-analysis with 51 studies identifying significant social and language deficits in children reporting emotional neglect compared to children reporting no neglect.

Severe social and language deficits and early emotional neglect may be related to later physical and mental health concerns. Gochez-Kerr and Helton (2017) sought to understand if an increase in victimization probability occurred in emerging adults (age 18-21) that reported childhood emotional neglect. The research, utilizing 311 participants in welfare systems, indicated a report of childhood emotional neglect was three times more likely to be assaulted and 24 times more likely to be robbed (Gochez-Kerr & Helton, 2017). The research identified that there might be other variables such as educational attainment, location, and childhood abuse that may increase the probability of assault and robbery and requiring further research (Gochez-Kerr & Helton, 2017).

As childhood emotional neglect is the absence of caregiver warmth, there may be identifiable risk factors. Connell-Carrick (2003) conducted a systemic review of risk factors toward childhood emotional neglect perpetration with 24 studies identifying the young age of the child and caregiver(s), single parent, poverty, unemployment, substance use, mental and physical health concern, and history of parent victimization. Cozza et al. (2019) identified similar findings with U.S. Army childhood neglect case studies, while

Gypen et al. (2017) corroborated related risk factors among children in foster care when living with biological caregiver(s). The literature suggested identical risk factors and remaining relatively consistent across genders and ethnicities (Choi & Thomas, 2015; Connell-Carrick, 2003; Cozza et al., 2019; Kieling et al., 2011). However, as percentages between SES are stable, the United States has a higher number of families in lower SES than Higher SES; thus, the number of children experiencing childhood neglect in lower SES is more significant (Kieling et al., 2011).

In summary, childhood abuse/neglect may correlate with later onset physical and mental health concerns. Not all children surviving childhood abuse/neglect develop physical and mental health concerns (Bollens & Fox, 2019; DePierro et al., 2019; Felitti et al., 1998; van Dijke et al., 2018). Thus, the literature suggested such mediating variables as negative trauma appraisal, emotion regulation, and self-compassion, altering the probability of trauma symptoms (Barlow et al., 2017). The next section will discuss the current literature of the mediating variables and impacts upon the relationship between childhood abuse/neglect and trauma symptoms.

Negative Trauma Appraisal

Research provided by Lazarus and Folkman (1987) established the basis of stress and coping theory to understand potentially traumatic events' cognitive processing. According to Folkman et al. (1986), cognition goes through three phases of appraisal when perceiving potentially traumatic events. The primary appraisal assesses the general situation and perceives it as threatening or not; next, the secondary appraisal assesses if the individual can cope with the situation to improve outcomes; and finally, the tertiary

appraisal retrospectively determines if the coping of the situation was beneficial (Folkman et al., 1986; Lazarus & Folkman, 1987). From a potentially traumatic event perspective, the individual will assess the overall threat, determine if there is control, and examine the outcomes.

Trauma appraisal has been extensively used within trauma research from a cognitive perspective and identified as a variable with an indirect relationship with trauma symptoms (Gusler & Jackson, 2015), as well as posttraumatic growth (Kira et al., 2019). Furthermore, trauma appraisal indirectly correlated with emotion regulation (Barlow et al., 2018) and self-compassion (Neff, 2003a) toward trauma symptom trajectories. Negative trauma appraisals within the literature revealed multiple theories and models to understand further mediations between predictor and outcome variables in numerous research articles (Gusler & Jackson, 2015; Kinai et al., 2016; Kira et al., 2019; Kucharska, 2017; McIlveen et al., 2019; O'Hare et al., 2015).

Research conducted by O'Hare et al. (2014), O'Hare et al. (2015), and Sherrer et al. (2015), using similar data sets, identified the mediation of negative trauma appraisals between childhood abuse and neglect with severe mental illness. The data sets consisted of 371, 466, and 291 participants diagnosed with either schizophrenia spectrum disorder or major depressive disorder from four outpatient facilities in the Northeastern United States, respectively (O'Hare et al., 2014; O'Hare et al., 2015; Sherrer et al., 2015). O'Hare et al. (2014) utilized negative trauma appraisals as a mediation between the bereavement of a loved one in participants diagnosed with severe mental illness and acute trauma symptoms. The research concluded that individuals with a pre-existing severe

mental illness increase the probability of trauma symptoms (O'Hare et al., 2014). The authors postulated the correlation might be due to pre-existing negative trauma appraisals and distorted thought processing attributed to severe mental illness (O'Hare et al., 2014). Furthermore, O'Hare et al. (2014) posited that negative perceptions of the self, others, and the world in individuals with severe mental illness might exacerbate symptomatology and positively influence negative trauma appraisals.

Using a more comprehensive sample from the same population, O'Hare et al. (2015) found childhood abuse/neglect correlated with self-injurious behaviors controlling for mental health concerns, substance use, and negative trauma appraisals. The research identified no direct correlation between childhood abuse/neglect and self-injurious behaviors (O'Hare et al., 2015). Indirect relationships of negative trauma appraisal and severe mental illness were more predictive of self-injurious behaviors (O'Hare et al., 2015). O'Hare et al. postulated the results to indicate a portion of individuals surviving childhood abuse/neglect may exhibit resilience while also considering self-injurious behaviors as symptoms and comorbidities with severe mental illness.

Finally, Sherrer et al. (2015) researched negative trauma appraisals of the self, others, and the world. They identified the negative trauma appraisal subconstruct of self-blame to correlate with trauma symptoms when controlling for severe mental illness, substance use, gender, and quantity of identified lifetime traumas (Sherrer et al., 2015). Like O'Hare et al. (2014), the conclusion identified significant negative trauma appraisal levels among individuals diagnosed with severe mental illnesses (Sherrer et al., 2015). An assumption of low self-compassion correlated with severe mental illness seems to be

a universal theme toward negative trauma appraisal across the research (O'Hare et al., 2014; O'Hare et al., 2015; Sherrer et al., 2015).

There are some concerns in the research by O'Hare et al. (2014), O'Hare et al. (2015), and Sherrer et al. (2015). The samples remained relatively equal when considering gender and mental illness; however, they consisted of 71.9% (O'Hare et al., 2015), 72.8% (O'Hare et al., 2014), and 70.8% (Sherrer et al., 2015) Caucasian participants. The numbers are like the overall United States population proportion of 76.5%; however, this percentage includes Latinx that identifies as White Hispanic (United States Census Bureau, 2020). The population percentage of White Non-Hispanic is around 60.4% of the total population (United States Census Bureau, 2020). O'Hare et al. (2015) suggested that results are generalizable in the Northeastern United States. However, the researchers used a disproportionate ethnic sample that may prevent generalizability.

Gusler and Jackson (2017) utilized negative trauma appraisal in a poly-victimization trauma framework to measure trauma symptoms in foster children. Recruiting 272 children, Gusler and Jackson identified that poly-victimization mediated by negative trauma appraisal indicated a higher probability of trauma symptoms. Similar results were suggested by Kanai et al. (2016) with 415 non-clinical Japanese citizens. However, Kanai et al. incorporated negative trauma appraisal, adult life events, and innate temperaments as mediators between childhood abuse/neglect and trauma symptoms. Moreover, childhood neglect mediated by irritability, anxiety, and cyclothymia exhibited a higher probability of trauma symptoms (Kanai et al., 2016).

In comparison to Kania et al. (2016), Ono et al. (2017) utilized 413 Japanese citizens from the general population to understand the indirect relationship of childhood abuse/neglect and later onset depressive symptoms mediated by neuroticism. Although similar in population, the neuroticism, extroversion, openness five factors theory results remained relatively constant with minimal changes between participants with or without childhood abuse/neglect (Kanai et al., 2016; Ono et al., 2017).

From a war trauma lens, Kira et al. (2019) researched 502 Syrian refugees to identify if the independent variables of cumulative trauma and identity salience would produce an outcome variable of trauma symptoms mediated by difficulties in emotion regulation and negative tertiary trauma appraisal. The research defined identity salience as the degree of self- and cultural-identification and postulated as strongly correlated with posttraumatic growth (Kira et al., 2019). The defined mediating variables had a negative indirect relationship associated with identity salience; thus, identity salience exhibited a profound correlation with emotion regulation and negative tertiary trauma appraisal as an indirect relationship toward trauma symptoms (Kira et al., 2019).

Additionally, researchers were interested in identifying gender differences associated with negative trauma appraisal. Some studies suggested that males are more likely to be victims of childhood abuse/neglect; however, more females exhibit trauma symptoms than males (Goodman et al., 2020; Kucharska, 2017). Kucharska (2017) researched 190 males and 277 females from universities located at two urban centers in Poland to identify gender differences of negative trauma appraisal for various forms of trauma. The research identified no significant differences based on gender; however, it

identified many limitations that may have confounded the results (Kurcharska, 2017). Due to the sample coming from a general population at universities, the number of individuals identifying with various traumas reduced power (Kucharska, 2017). Moreover, insignificant participants identified sexual abuse; thus, Kucharska (2017) combined identified sexual abuse participants with identified betrayal trauma participants. Information obtained from Kucharska may not be accurate or reliable toward the negative trauma appraisal differences by gender.

McIlveen et al. (2019) focused on the negative trauma appraisal subconstruct of alienation. According to McIlveen et al., alienation is defined as the range of disconnect and memory of a potentially traumatic event. The research used alienation appraisal as a mediator between potentially traumatic events and trauma symptoms while controlling variables of alexithymia, loneliness, and social support with a sample of undergraduate psychology students (n = 100) and a sample of trauma-exposed adults (n = 93) in Northern Ireland. The sample may have been gender-biased due to the undergraduate sample containing 83% females and the trauma-exposed adult sample containing 32% female. Results with each group did identify that alienation appraisal had a strong indirect relationship between the independent and dependent variables (McIlveen et al., 2019).

Nicolson and Ponnamperuma (2019) conducted research into trauma symptoms based on Hypothalamus-Pituitary-Adrenal axis activation occurring with repeated trauma and the 2004 Sri Lanka tsunami. The results were inconclusive due to the minimal number of the 84 participants meeting DSM-IV TR diagnostic criteria of PTSD (Nicolson & Ponnamperuma, 2019). Nicolson & Ponnamperuma posited the results of low trauma

symptoms might be due to theoretically, more trauma symptoms occur from war (Halevi et al., 2016; Kira et al., 2019) and sexual abuse (Ford & Delker, 2018; Spinazzola et al., 2018). This assumption of natural disaster as a potentially traumatic event indicating a lower probability of trauma symptoms seems to match similar research (Geng et al., 2018; Lee et al., 2017). Geng et al. (2018), Nicolson and Ponnamperuma, and Lee et al. (2017) identified parental reactions to the natural disaster as a mediation between potentially traumatic events and trauma symptoms.

Finally, Su and Chen (2018) researched 592 Taiwanese from the general population to further understand if pre-existing trauma symptoms predicted acute trauma symptoms mediated by negative trauma appraisal and trauma-related rumination. The predictor variable indicated a strong indirect correlation toward acute trauma symptoms mediated with negative trauma appraisal and trauma-related rumination (Su & Chen, 2018).

The literature around negative trauma appraisal indicated the variable as a significant mediator between childhood abuse/neglect and trauma symptoms and affecting internal thoughts of the self, others, and the world (Folkman et al., 1986; Gusler & Jackson, 2017; Kania et al., 2016; Kira et al., 2019; McIlveen et al., 2019; O'Hare et al., 2014; O'Hare et al., 2015; Ono et al., 2017; Sherrer et al., 2015). Therefore, the present study incorporated negative trauma appraisal as a pathway from childhood abuse/neglect toward trauma symptoms.

Difficulties in Emotion Regulation

The current literature demonstrates extensively the role of difficulties in emotion regulation affecting the formation of trauma symptoms. Dunn et al. (2018) identified difficulties in emotion regulation as temporal abilities to de-escalate emotional distress of the sympathetic nervous system, identify the distress, and enact socially appropriate mechanisms to activate the parasympathetic nervous system. Hughes et al. (2020) posited difficulties in emotion regulation, through the extended process model, is cognitively represented into three stages; first, the concerning emotion is identified; next, a previously adapted regulatory skill is selected; finally, the regulatory skill is implemented. With trauma symptoms strongly correlating with the activation of the sympathetic nervous system (Ford, 2015; Malarbi et al., 2017; van der Kolk, 2015), difficulties in emotional regulation are evident as a mediator between childhood abuse/neglect and trauma symptoms (Friedman, 2013; Jenness et al., 2016; Michopoulos et al., 2015; Nickerson et al., 2015; Powers et al., 2015; Powers et al., 2020).

Chaplo et al. (2015) investigated gender differences in sexual abuse and self-injurious behaviors compared with the indirect influences of difficulties in emotion regulation and dissociation. The research used 525 youths in Western United States detention centers; 74.5% were male (Chaplo et al., 2015). From a preliminary correlation, Chaplo et al. identified that sexual abuse was the most predictive of trauma symptoms when compared to other forms of childhood abuse/neglect. This is consistent with van der Kolk's (2015) postulation. However, it contrasts with research that identified emotional abuse as the most predictive of trauma symptoms (Brown et al., 2019; Moraes et al.,

2018; Naughton et al., 2017). Furthermore, out of the sample, around 50% of females and 10% of males reported past sexual abuse or unwanted sexual interaction (Chaplo et al., 2015). The research did not find statistically significant differences in trauma symptoms based on gender; however, female survivors of sexual abuse reported more self-injurious behaviors (Chaplo et al., 2015). Through a mediation model, Chaplo et al. identified profound indirect mediations of dissociation and emotion regulation upon the relationship between childhood abuse and trauma symptoms.

From a different perspective, Charak et al. (2018) researched the delineation of sexual abuse for 335 female emerging adults (age 18-25), determining differences based on subconstructs of emotion regulation. The subconstructs controlling impulsive behaviors, access to emotion regulation strategies, and emotional clarity were significantly decreased among participants identifying sexual abuse compared to the participants that did not identify sexual abuse. From the results, Charak et al. posited that difficulties in emotion regulation scores remained relatively stable regardless of the developmental period of sexual abuse as measured during childhood, adolescence, and adulthood.

Dunn et al. (2018), Jenness et al. (2016), and Powers et al. (2020) suggested a distinct developmental period for difficulties in emotion regulation. Dunn et al. researched difficulties in emotion regulation development with 1,944 participants from the Southern United States identifying as Black and low SES. In comparison, Jenness et al. researched the prevalence of difficulties in emotion regulation among 78 adolescents and families who witnessed the 2013 Boston marathon massacre. Powers et al. (2020)

explored difficulties in emotion regulation development through an intergenerational lens utilizing 105 Black mother/child dyads. Dunn et al. and Powers et al. identified young children as having immature emotion regulation and relying on the caregiver(s) for cues. Thus, from an object-relational perspective, the child relies on the relational patterns to determine difficulties in emotional response and regulation (Bedi et al., 2013; Conway et al., 2014).

According to Dunn et al. (2018), Jenness et al. (2016), and Powers et al. (2020), the critical period for emotion regulation development is in middle childhood. This period is marked by traditional school entrance and distancing from a caregiver for more extended periods. Dunn et al. suggested that risk factors toward decreased emotion regulation include first trauma during middle childhood, interpersonal, and chronic. Jenness et al. identified similar findings identified as pre-trauma symptoms developing around middle childhood as a predictor of difficulties in emotion regulation and increased probability of trauma symptoms after an intense trauma disaster. Finally, Powers et al. identified that the development of difficulties in emotion regulation was more dependent on the caregiver's emotion regulation than if the caregiver and child had prior histories of traumatic events. Insofar, the development of emotion regulation is suggested to occur during middle childhood (Dunn et al., 2018; Jenness et al., 2016; Lee et al., 2017; Powers et al., 2020) and dependent on the relational patterns between the child and object (Conway et al., 2014; Fairbairn, 1952; Powers et al., 2020).

Further research on difficulties in emotion regulation identified childhood abuse/neglect and potentially traumatic events correlating with addiction/substance use.

Utilizing 920 Turkish University students from Ankara, Evren et al. (2019) identified a relationship between childhood abuse/neglect and current adult internet addiction that was mediated by difficulties in emotion regulation. Tull et al. (2016), using 42 participants currently seeking treatment for cocaine use disorder, identified difficulties in emotion regulation, explicitly controlling impulsive behaviors, as a mediating variable between the relationship of trauma symptoms and cocaine use disorder. Finally, Tull et al. (2018) utilized 133 inpatients identifying with substance use disorder (substances were not delineated) to measure the mediation of difficulties in emotion regulation upon the relationship of child abuse and current substance use cravings. Insofar, Evren et al. (2019), Tull et al. (2016), and Tull et al. (2018) identified a statistically significant indirect relationship of difficulties in emotion regulation upon the relationship of childhood abuse/neglect and later substance use.

While Evren et al. (2019) and Tull et al. (2016) relied on surveys, Tull et al. (2018) used surveys, trauma scripts, and cortisol measurements. The research identified that difficulties in emotion regulation was a significant mediator between child abuse and addiction/substance use due to addiction/substance abuse as emotion regulation. Tull et al. (2018) postulated the self-medication model of using substances to decrease trauma symptoms is warranted when pertaining to substance use among individuals with trauma symptoms. Similarly, Evren et al. posited internet use increased among individuals with child abuse to distract and momentary dissociate as a method to enhance emotion regulation. Contrasting, Tull et al. (2016) identified minimal statistical significance to a direct relationship between substance use and trauma symptoms. They identified that

substance use is not a dogmatic approach toward adaptive emotion regulation (Tull et al., 2016). The results indicated some difficulties in emotion regulation was applicable toward certain adverse events; however, maybe a dose-method resulting in higher stress levels mitigated by substances as an emotion regulation skill (Tull et al., 2016).

Difficulties in emotion regulation research conducted in the United States used samples of mixed ethnicities (Chaplo et al., 2015; Charak et al., 2018; Jenness et al., 2016; Sundermann & DePrince, 2015; Tull et al., 2016; Tull et al., 2018; Woodward et al., 2018) and Black participants (Dunn et al., 2018; Michopoulos et al., 2015; Powers et al., 2015; Powers et al., 2020). In contrast, Paulus et al. (2019) identified difficulties in emotion regulation mediating the relationship between potentially traumatic events and alcohol consumption among a Latinx sample. The research used 238 participants, mostly identified as female (88.7%), that survived severe accidents, natural disasters, or sexual assault (Paulus et al., 2019). Paulus et al. identified a statistically significant mediation of difficulties in emotion regulation pertaining to the relationship between potentially traumatic events and alcohol use disorder. The research indicated increased alcohol use and hazardous drinking related to a negative correlation with difficulties in emotion regulation (Paulus et al., 2019).

Rodriguez and Read (2020) observed the mediation of difficulties in emotion regulation upon the relationship between childhood abuse and alcohol use disorder among college students. The researchers recruited 305 participants who were evaluated for PTSD and placed in groups of individuals that identified no trauma (n = 127), identified trauma with minimal trauma symptoms (n = 106), and identified trauma and

trauma symptoms (n = 72; Rodriguez & Read, 2020). Specifically, the research identified the quantity and frequency of alcohol use among college students related to trauma and difficulties in emotion regulation (Rodriguez & Read, 2020). Participants who identified with no trauma scored relatively low for emotion regulation and had similar drinking patterns to the participants with trauma symptoms (Rodriguez & Read, 2020).

Michopoulos et al. (2015) researched a predictor variable of child abuse, an outcome variable of emotional eating, and a mediating variable of difficulties in emotion regulation utilizing 1,110 participants from urban Georgia identifying as Black and low SES (Michopoulos et al., 2015). The results indicated a strong indirect relationship between child abuse and emotional eating when mediated by difficulties in emotion regulation (Michopoulos et al., 2015). The research suggested the strong correlation may be due to first, the craving for calorie-dense foods may increase as a means for difficulties in emotion regulation, and second, the low cost and availability of calorie-dense foods (Michopoulos et al., 2015). As the excessive consumption of calorie-dense foods is strongly correlated to physical and mental health concerns (Felitti et al., 1998), excessive eating in response to difficulties in emotion regulation is detrimental to overall health (Michopoulos et al., 2015).

From a different perspective, Isvoranu et al. (2017) utilized difficulties in emotion regulation as a mediation between the predictor variable of childhood abuse and an outcome variable of psychosis. Using longitudinal data from the Genetic Risk and Outcome of Psychosis Project, the research utilized 1120 participants from inpatient facilities in the Netherlands and Belgium (Isvoranu et al., 2017). The results indicated

that symptomatology had an indirect relationship with difficulties in emotion regulation (Isvoranu et al., 2017). Thus, the increase in daily stress exacerbated psychotic symptoms. Isvoranu et al. clarified the existence of psychosis as not solely based on childhood abuse and attributed multidimensional biological, psychological, and social variances. However, one deviation to consider is the pathway of childhood abuse trajectory toward psychosis mediated by low emotion regulation (Isvoranu et al., 2017).

Powers et al. (2015) researched 67 females with 94% identifying as Black to determine the mediating relationship of difficulties in emotional regulation upon a predictor variable of child abuse and the outcome variable of trauma symptoms. The research conducted by Powers et al. identified that childhood abuse was a significant predictor of lower scores in emotional regulation. Lower scores are perceived due to childhood trauma during a sensitive emotion regulation development (Dunn et al., 2018; Jenness et al., 2016; Powers et al., 2020), altering cognitive patterns of attention and perceptions of threats (Powers et al., 2015). When the participants were administered a selective attention task, the participants with childhood abuse exhibited an inability to disengage with perceived angry faces (Powers et al., 2015). This profoundly suggested that childhood abuse significantly alters patterns associated with difficulties in emotion regulation and eventual personality development (Hughes et al., 2020).

Conducting similar research with a diverse ethnic population of 115 females living around the United States Rocky Mountain region, Sundermann and DePrince (2015) identified difficulties in emotion regulation as a significant mediator between childhood abuse and trauma symptoms. However, the research identified a dose-response

to child abuse as a predictor for negative emotion regulation (Sundermann & DePrince, 2015). Furthermore, among the sample, 5 ½ years-old was the median age for first potentially traumatic events with an average of three perpetrators and 2-3 different variations of potentially traumatic events across the lifespan (Sundermann, & DePrince, 2015).

Finally, Woodward et al. (2018) researched the mediation of difficulties in emotion regulation upon the relationship between childhood abuse and anxious, depressive, and trauma disorders among 50 adolescents at an inpatient hospital facility. Specifically, the research explored anxiety sensitivity across all diagnoses, and identified difficulties in emotion regulation had a significant bidirectional relationship (Woodward et al., 2018). Moreover, difficulties in emotion regulation were significant toward thoughts of losing cognitive control, exacerbating rumination, and current symptoms associated with diagnoses (Woodward et al., 2018). This does not express a causal relationship of mental health concern resulting from child abuse; however, it does suggest the effects of difficulties in emotion regulation upon the current severity of mental health concerns symptomatology.

Nickerson et al. (2015) used difficulties in emotion regulation as a mediator between potentially traumatic events and trauma symptoms and post-migration living difficulties among war refugees. 134 Syrian refugees completed surveys and identified mediations of difficulties in emotion regulation were statistically significant between potentially traumatic events and trauma symptoms; however, trauma symptoms, pertaining to war refugees, were associated with current living difficulties (Nickerson et

al., 2015). The research suggested variables of missing family, shelter, resources, and inculturation influence the varying degrees of trauma symptoms for war refugees (Nickerson et al., 2015). Nickerson et al. warned not to imply living difficulties as mediation for other forms of potentially traumatic events; however, inquiring about exploring this variable as individuals identifying with low SES may exhibit similar living difficulties.

The research identified an overarching use of difficulties in emotion regulation as a significant mediator between childhood abuse and trauma symptoms and objectively interacts with negative trauma appraisal and self-compassion (Chaplo et al., 2015; Charak et al., 2018; Dunn et al., 2018; Evren et al., 2019; Fossati et al., 2016; Gratz et al., 2015; Hughes et al., 2020; Isvaronu et al., 2017; Jenness et al., 2016; Michopoulos et al., 2015; Nickerson et al., 2015; Paulus et al., 2019; Powers et al., 2015; Powers et al., 2020; Rodriguez & Read, 2020; Schindler & Querengasser, 2019; Sunderman & DePrince, 2015; Tull et al., 2016; Tull et al., 2018; Woodward et al., 2018). Thus, the research design incorporated difficulties in emotion regulation as one of the mediating variables.

Self-Compassion

Self-compassion is a construct developed in part through Buddhist tradition. Neff (2003a) proposed self-compassion as an alternative construct of self-esteem. According to Neff, growing research identified self-esteem as fixed and subject to self-criticism. An alternative construct to seek the positive of the self was warranted. Due to individuals' potential to be self-critical beyond others' perspectives, self-compassion considers

improving self-acceptance (Neff, 2003a). Within self-compassion, Neff identified three subconstructs:

1. self-kindness: the ability to understand the self and to provide compassion as opposed to criticism,
2. common humanity: understanding that experiences are not unique to the individual, and others may have similar obstacles,
3. mindfulness: the ability to understand the negative disposition is opposed to the individual's personality characteristics.

Neff (2003a) postulated that the three subconstructs exist as isolated traits and work interchangeably to provide self-compassion levels. In one of the subconstructs falters, the others may decline, influencing an increase of self-criticism for thoughts and actions. This directly influences the potential of rumination of childhood abuse and neglect and perpetuates trauma symptoms (Dahm et al., 2015; Long & Neff, 2018; Neff, 2003a) and maladaptive emotion regulation (Neff, 2003a; McAdams, 2015).

Self-compassion was first explored as a construct by Neff (2003a) and now has been operationalized as the Self-Compassion Scale (see Neff, 2003b). Self-compassion continuously has been identified as a mediator of the relationship between childhood abuse/neglect and trauma symptoms and directly affects the thought of self (Basharpoor et al., 2020; Bistricky et al., 2017; Bluth et al., 2017; Boykin et al., 2018; Boyraz et al., 2019; Hou et al., 2020; Joseph, & Bance, 2019; Long, & Neff, 2018; Reffi et al., 2019).

Boykin et al. (2018) conducted self-compassion and fear of self-compassion research with 288 college women screened for moderate to severe childhood abuse and

neglect. The findings suggested that most women in the study exhibited fear toward self-compassion and difficulties in emotion regulation (Boykin et al., 2018). The results of Boykin et al. drew similarities with Saint Arnault and Sinko (2019) regarding childhood abuse/neglect, promoting a trajectory toward trauma symptoms when mediated by self-compassion. Similarly, much of the research identified self-compassion correlates with early object-relational patterns such as attachment, interpersonal relationships, emotion regulation, and identity of the self (Basharpoor et al., 2020; Bistricky et al., 2017; Boykin et al., 2018; Boyraz et al., 2019; Hou et al., 2020; Naismith et al., 2019; Neff, 2003; Reffi et al., 2019; Saint Arnault & Sinko, 2019).

Research conducted by Dahm et al. (2015) using 115 Iraq/Afghanistan war veterans suggested that self-compassion had a strong correlation with trauma symptoms. This is perceived due to self-compassion being a predictive variable toward intrapersonal emotional intelligence (Dahm et al., 2015). Trauma symptoms were less likely to occur if the veteran exhibited mindfulness, self-compassion, and difficulties in emotion regulation (Dahm et al., 2015). Research with 158 Indian children who survived sexual abuse identified a negative correlation between self-compassion and past negative trauma appraisal (Joseph & Bance, 2019). A study conducted by Joseph and Bance (2019) suggested similar trajectories toward trauma symptoms mediated by self-compassion.

Moreover, Dahm et al. (2015) and Joseph and Bance (2019) reached consistent conclusions with other researchers. Bashapoor et al. (2020) examined self-compassion among 190 Iranian participants that identified surviving childhood abuse and neglect. Findings suggested that self-compassion negatively correlated with childhood abuse and

neglect (Bashapoor et al., 2020). Furthermore, Bistricky et al. (2017) added to the literature by identifying multiple interpersonal familial childhood abuse and neglect was more negatively correlated with self-compassion compared to individuals surviving nonfamilial childhood abuse and neglect. Childhood abuse/neglect being perpetrated numerous times by a familial individual, the probability of trauma symptoms increases (Choi et al., 2019; DePierro, 2019; Ford, 2015; van Dijke, 2015), negatively influence self-compassion (Bistricky et al., 2017; Neff, 2003), and difficulties in emotion regulation (Saint Arnault, & Sinko, 2019).

There are some concerns about ethnic and gender diversity and sample size within the current research in self-compassion. Research from Bistricky et al. (2017), with 132 adults surviving potentially traumatic events, contained a sample of 86.4% female and 87.1% as Caucasian. Other research conducted by Boykin et al. (2018) was specific to a female population and had a relatively diverse community; however, similarly to Boyraz et al. (2019) and Hou et al. (2020) used convenience sampling of college students. Naismith et al. (2019) used 53 participants, 83% of females from an outpatient facility with an undisclosed personality disorder. Although the research was considered preliminary, little generalizability may be applied toward the population regarding the causal relationship of childhood abuse/neglect and self-compassion. Potentially due to the profound proportion of convenience sampling, such researchers as Basharpoor et al. (2020), Hou et al., and Joseph and Bance (2019) have been conducting self-compassion with Iranian, Chinese, and Indian cultures, respectively. In a special issue, Bluth and Neff (2018) called upon research to examine multicultural variances to further self-compassion

research. Regardless of the approaches, the Self-Compassion Scale (see Neff, 2003b) has been used across studies to identify self-compassion levels and recognized as a mediator of the relationship between childhood abuse/neglect and trauma symptoms (Neff, 2003a).

Trauma Symptoms

Trauma symptoms are associated with physical and mental health concerns (DePierro et al., 2019; Felitti et al., 1998). Potentially traumatic events such as corporal punishment (Afifi et al., 2017), witnessing verbal and physical violence (Ha et al., 2019), neglect (Augusti et al., 2018), covert and overt racism (Carter et al., 2019), sexual, emotional, and physical abuse (DePierro et al., 2019), surviving a natural disaster (Lee et al., 2017), and living in war-torn regions (Nuttman-Shwartz, 2017) profoundly invoke painful memories that potentially put the trauma survivor at risk for present and future mental and physical health concerns (Felitti et al., 1998). Many of the previously mentioned potentially traumatic events are beyond this study's scope, which will focus on childhood abuse/neglect. Individually, the research will suggest variations in physiological and psychological symptoms of trauma resulting from childhood abuse/neglect. Furthermore, information regarding differential diagnoses, *DSM-5* PTSD criteria not capturing the extent of potentially traumatic events, and diagnostic incongruence amongst the professional communities will be discussed. Trauma symptoms literature is expansive with new information toward genetic deterioration (Li et al., 2017) and expansions of antecedents and symptomatology (DePierro et al., 2019).

Physiological Symptoms of Trauma

Childhood abuse/neglect has been implicated in maladaptive physiological, cognitive, and affective development. A meta-analysis conducted by Li et al. (2017) suggested that exposure to childhood abuse/neglect may accelerate telomere erosion in adults. Due to the telomere's genetically protective factors, erosion implies an increased probability of cancers and other physiological defects (Li et al., 2017). Deighton et al. (2018) conducted another meta-analysis using 40 selected studies on biomarker degeneration and potentially traumatic events, providing further evidence of telomere erosions. The research suggested that telomere erosion may correlate to early-onset heart disease, cancers, and diabetes (Deighton et al., 2018; Li et al., 2017). Thus, a past of childhood abuse/neglect and trauma symptoms may produce chronic illnesses and early-onset death.

Rinne-Albers et al. (2013) conducted a meta-analysis to understand the correlation between neurodevelopment and childhood abuse/neglect. Rinne-Albers et al. identified a lack of neuroimaging research on trauma and contributed to the difficulties of accessing this accessible for research. Rinne-Albers et al. was able to find three studies and identified that childhood abuse/neglect indicated less brain mass and lowered corpus callosum connectivity compared to control groups; however, further research is required.

Furthermore, Deighton et al. (2018) suggested that the correlation between childhood abuse/neglect and later onset physical health concerns may be expressed through epigenetics. Human biomarkers' expression and deterioration have been identified and require further research (Deighton et al., 2018; Li et al., 2017). One such

postulation, Norman et al. (2012), suggested a genetic variance of a shorter allele serotonin transporter and hypothalamus-adrenal-pituitary axis genes may disrupt adaptive stress regulation and potentially produce anxious and depressive symptoms. Although gene expression may suggest a higher balance on biological variables, the gene expression variations may require environmental variables for maladaptive activation (Deighton et al., 2018; Li et al., 2017; Norman et al., 2012).

Finally, there are relationships between childhood abuse/neglect and the risk of brain injuries and psychotic mental health concerns (Hodgdon et al., 2018; Peh et al., 2019). According to Hodgdon et al. (2018), infants and young children that reported physical abuse indicated the commonality of brain swelling. A dose method showed increased brain damage and swelling, with many infants suffering from multiple and chronic physical abuse (Hogberg et al., 2018). This indicated potential variables that decreased cognitive functionality and IQ in child abuse victims with and without later-onset mental health concerns (Hodgdon et al., 2018; Hogberg et al., 2018; Malarbi et al., 2017). Furthermore, surviving childhood abuse/neglect indicated an increased risk for later onset psychotic mental health concerns (Peh et al., 2019). Although psychotic mental health concerns such as bipolar depression and schizophrenia are considered genetically predisposed, Peh et al. (2019) postulated that these genes' expression might require severe potentially traumatic events to initiate phenotypic expression.

Differential Diagnoses for Trauma

Psychological symptoms of trauma vary widely and may alter based on theoretical orientation development of mental health concerns. According to the *DSM-5*

(American Psychiatric Association, 2013), PTSD symptoms include hypervigilance, hyperarousal, avoidance, intrusive thoughts, somatic symptoms, and disrupted sleep focused on the potentially traumatic event(s). Although the *DSM-5* diagnostic criteria for PTSD requires direct or vicarious interactions with an event that either threatens survival or control (see American Psychiatric Association, 2013), the literature has called for differential antecedents and diagnoses (DePierro et al., 2019; Ford, 2015; Spinazzola et al., 2018; van der Kolk, 2015).

Modern research into trauma symptoms identified many physical and mental health concerns that may be similar and different from PTSD. This may be important due to the growing research around trauma therapy differing from other forms of treatment. More information about antecedents of mental health concerns identified past trauma or life stressors as relatively common occurrences toward mental health concerns beyond criterion A of PTSD (DePierro et al., 2019; Friedman, 2013). Friedman (2013) wrote supplemental literature beyond the PTSD diagnosis. As part of the *DSM-5* PTSD taskforce, Friedman posited a PTSD diagnosis's limitations distinctly ignoring other mental and physical health concerns as troubling. Due to the expansive symptomatology relating to potentially traumatic events and childhood abuse/neglect, Friedman and others (DePierro et al., 2019; Ford, 2015, Spinazzola et al., 2018; van der Kolk, 2015) urged and expansion of *DSM* trauma-related disorders. Friedman anticipated concerns around the diagnostic criteria in prevention to receive adequate therapy based on antecedents more than presenting symptoms. Limitations in the PTSD diagnosis impedes upon thresholds that may otherwise benefit from trauma treatment.

Van der Kolk (1988) suggested differential trauma diagnoses for the *DSM*. The idea was to provide spectra and differentiation toward differing mental health concerns and varying forms of potentially traumatic events. For example, Choi et al. (2018), Cloitre et al. (2009), DePierro et al. (2019), Ford (2015), Grasso et al. (2016), Spinazzola et al. (2018), and van der Kolk (2015) suggested the addition of a *developmental trauma disorder* (DTD) to the *DSM*. Although DTD is not part of the current *DSM*, there is extensive research on constructs and prevalence. The differences between PTSD and DTD may be based on differential antecedents and later onset symptomatology. Van der Kolk postulated DTD as a developmental process of pervasive, complex, and chronic childhood abuse/neglect instead of a singular potentially traumatic event. Although childhood abuse/neglect can result in a PTSD diagnosis, more common diagnoses are disruptive behaviors (oppositional defiant disorder, attention-deficit/hyperactivity disorder, conduct disorder), depression, and anxiety (DePierro et al., 2019; Felitti et al., 1998; Foltz et al., 2013; van der Kolk, 2015). The importance of differential diagnoses is for adequate treatment and pertains to this study to identify various symptoms beyond the scope of PTSD.

Specifically focused on potentially traumatic events that do not qualify for *DSM-5*, PTSD may include chronic emotional abuse and neglect. According to the research, emotional abuse and neglect indirectly and directly influence the relationship between childhood abuse/neglect and trauma symptoms (Curry, 2017; Moraes et al., 2018; Nothling et al., 2019; Viduoliene, 2019). Moreover, emotional abuse also indicated a high prevalence of other forms of abuse/neglect (Cui et al., 2018; Faus et al., 2019; White

et al., 2016). Thus, the scope of *DSM-5* PTSD may not capture the trauma symptoms correlated with all forms of childhood abuse/neglect.

Like DePierro et al. (2019); Ford (2015), van der Kolk (2015), and Allen (2013) suggested a necessity of understanding trauma from a different perspective. Specifically, Allen suggested that trauma symptoms are a spectrum beyond the specificity of the *DSM-5* diagnosis of PTSD. This is important due to the nature of some forms of childhood abuse/neglect not meeting the requisite criteria of PTSD; however, it may meet symptom criteria for PTSD (Allen, 2013; DePierro et al., 2019; Ford, 2015; van der Kolk, 2015). Furthermore, the distinction of childhood abuse/neglect may manifest in other forms of mental health concerns such as depression (Huh et al., 2017; Jaschek et al., 2016; Michopoulos et al., 2015; Nickerson et al., 2015; Renner et al., 2020; Woodward et al., 2018), anxiety (Crum, & Moreland, 2016; Heleniak et al., 2016; Huh et al., 2017; Sundermann, & DePrince, 2015), and disruptive behaviors (Bunte et al., 2014; Foltz et al., 2013; Lavigne et al., 2015). Although detrimental and may overlapping symptoms of *DSM-5* PTSD, these mental health concerns are beyond the scope of this study; however, they remain essential as comorbid diagnoses and differential outcomes of childhood abuse/neglect.

Gender as a Moderator

Throughout the childhood abuse/neglect literature, there are identified gender differences. For example, females are at a higher risk of sexual abuse compared to males (Castro et al., 2019; Clayton et al., 2018; Gerwitz-Meydan, & Finkelhor, 2020); however, this is based on disclosure. According to Lahtinen et al. (2018), rates of sexual abuse

among males and females may be similar; however, disclosure rates vary. Lahtinen et al. reported that 71% of males and 26% of females reported sexual abuse as positive and mutual. This identified gender differences in perception of sexual abuse and the relationship of trauma symptoms (van Dijke et al., 2015).

Stevens et al. (2015) and Tyler and Schmitz (2018) suggested that males are at a higher risk for physical abuse compared to females. Annerback et al. (2018) and Cui et al. (2018) suggested that male victims of physical abuse exhibit more externalizing behaviors (hypersexuality and physical aggression) while females exhibit more internalized behaviors (anxiety and depression) and substance use (Kobulsky et al., 2016; Kobulsky, 2017). These variations may predict differences in the mediating variables of negative trauma appraisal, difficulties in emotion regulation, and self-compassion (Barlow et al., 2018) and the outcome variable of trauma symptoms (DePierro et al., 209; van der Kolk, 2015).

The perceptions of childhood abuse/neglect may differ based on gender and predict levels of negative trauma appraisal, difficulties in emotion regulation, and self-compassion and an outcome of trauma symptoms. According to Moraes et al. (2018), gender perceptions of childhood abuse/neglect may depend on types, dose-responses, and beliefs. For example, a male child may perceive physical abuse as a deserved punishment opposed to a female (Moraes et al., 2018). However, the presence of physical abuse and emotional abuse reported similarities gender levels of trauma symptoms (Moraes et al., 2018). Moreover, perceptual differences of childhood abuse/neglect may alter cognitive and affective beliefs of the self, others, and the world. Barlow et al. (2017) suggested

gender would alter negative trauma appraisal, emotion regulation, and self-compassion, and requires more research.

Gender is a prominent variable in determining many differences in social science. Childhood abuse/neglect perpetration varies based on gender and may change negative trauma appraisal, emotion regulation, and self-compassion (Barlow et al., 2017). Less was known about gender strengthening or weakening the relationships between trauma symptoms and negative trauma appraisal, difficulties in emotion regulation, and self-compassion (Barlow et al., 2017). Thus, the study used gender as a moderator to understand if there are gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion with an outcome of trauma symptoms.

Summary

The literature review is a synthesis of current studies meant to inform and develop the present study. Insofar, I have provided a theoretical framework of object-relations theory to guide the theoretical approach. Next, I examined current studies around childhood abuse/neglect, specifically, in subcategories to suggest similarities and differences in potential symptom outcomes and additional variables. Moreover, I captured the data and argument to use negative trauma appraisal, difficulties in emotion regulation, and self-compassion as mediating variables. I reviewed preliminary information around trauma symptoms and physical and mental health concerns. Finally, I identified and justified gender as a moderating variable and the literature gap.

Childhood abuse/neglect continues to be a global concern, there are multiple models to consider for the proposed physical and mental health concerns as outcomes.

However, not all children that have survived childhood abuse/neglect develop trauma symptoms; thus, there is growing evidence into mediating variables to predict the prevalence and severity of trauma symptoms (Augusti et al., 2018; Barlow et al., 2017; DePierro et al., 2019). Barlow et al. (2017) provided a research study with negative trauma appraisal, difficulties in emotion regulation, and self-compassion as significant mediating variables upon the relationship between childhood abuse/neglect and trauma symptoms. Although the study indicated significant power for a generalized population, less is understood about gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion (Barlow et al., 2017). Thus, the purpose of this study was to assess gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion mediating the relationship between childhood abuse/neglect and trauma symptoms. Chapter 3 includes a description of the study's quantitative methodology and preliminary threats to validity and ethical procedures. The purpose of Chapter 3 is to provide a stepped plan of analysis for transparency and replicability.

Chapter 3: Research Method

The purpose of this cross-sectional correlational study was to assess whether gender moderates the relationship between trauma symptoms and negative trauma appraisal, difficulties in emotion regulation, and self-compassion with a history of childhood abuse/neglect among an adult population. The methodology chapter includes the steps and procedures taken to ensure optimal results in gathering participants, using valid and reliable instruments, and statistical analyses for alignment purposes. Furthermore, the methodology chapter addresses potential threats to validity and ethical considerations to ensure minimal or no psychological and emotional impact on participants while completing the study.

Research Design and Rationale

According to Burkholder et al. (2016), the research design is assembled based on the research question and decisive outcomes. The current study's research questions warranted quantitative methodology. Quantitative methods are broad and include a variety of statistical tests to identify relationships. When looking at multiple variables to determine an outcome variable, a researcher may use multiple regression analysis. However, Jeong and Jong (2016) suggested multiple regression analysis is used when the predictor variables are assumed to occur at once.

The current research questions warranted a more advanced statistical analysis. Due to the occurrence of negative trauma appraisal, difficulties in emotion regulation, and self-compassion mediating the relationship between childhood abuse/neglect and trauma symptoms, and gender moderating trauma symptoms, conditional process analysis

was warranted (see Hayes, 2018). Conditional process analysis explains the entirety of the model through a moderated mediation analysis. According to Hayes (2018), the research questions can be answered using separate statistical analyses; however, this may increase the formula's statistical errors. Hayes created the Model 15 within PROCESS Macro to identify variances within a moderated mediation model (conditional process analysis).

Population

The sample size determines the power of the study. Correll et al. (2020) suggested that the purpose of a power analysis is to "make a less-than-wild guess (of how many participants will be required to reach statistical power) in the absence of data" (p. 200). Thus, a priori power analysis was calculated using G*Power software Version 3.1.9.7. Due to the research design warranting hierarchical regression and conditional process analysis, the G*Power manual suggested using a linear multiple regression: Fixed model, r^2 increase under *F*-test families. Alpha was set to default (0.05), which measures a Type I error's potential probability. The overall power, or beta, was determined as 0.80, which is the probability of preventing a Type II error. The number of predictor variables was set to five (childhood abuse/neglect, gender, negative trauma appraisal, emotion regulation, and self-compassion).

The final data point is the effect size to determine the potential detectability of differences between the proposed research and the hypothetical research differences (Correll et al., 2020). However, setting the effect size may vary between testing and among statisticians. Cohen (1992) suggested a multiple regression effect size set to 0.02

= small, 0.15 = medium, and 0.35 = large. Selya et al. (2012) suggested that smaller standard deviation differences may be required to identify statistical significance for specific populations compared to the general population. This means that there may be relatively similar scoring among a specific population requiring the detection of smaller changes (Ma & Zeng, 2014). Cohen and Correll et al. (2020) identified a medium effect size as enough to identify observable statistically significant changes in the general population. A small effect size may yield increased accuracy; however, it may only determine statistical significance that may not identify practical significance (Correll et al., 2020). Ma and Zeng (2014) suggested 0.08 as an adequate effect size for conditional process analysis with the general population. Thus, G*Power suggested a minimum sample size of 167 participants.

Data Collection

Data were collected through online convenience sampling. I used Survey Monkey to manage surveys and data. A link from SurveyMonkey was generated and placed on a Facebook page. The Facebook page was boosted toward a randomized population that fit the criteria of being 18 years and older and having lived through at least one event of childhood abuse/neglect. The online survey contained two consent pages detailing the process, purpose, autonomy, and rights of the survey participants. To continue the survey, the participant had to understand and agree to the terms. Next, the participant received, in order, the TAQ (see DePrince et al., 2010), DERS (see Gratz & Roemer, 2004), SCS (see Neff, 2003b), CAT (see Sanders & Becker-Lausen, 1995), and IES-R (see Weiss & Marmar, 1997). Finally, a demographic form requested yearly income, highest level of

education, ethnicity, age, and gender for conditional process analysis and descriptive statistics. Data collection advanced after permission was obtained from the Walden University Institutional Review Board (IRB) and continued until the number of participants was above 167. The survey was kept on Facebook after reaching the minimal threshold to attempt to collect more male participants.

Instruments

The instruments used in this study were retrieved through the Walden Library databases. The CAT (Sanders & Becker-Lausen, 1995) is in the public domain; therefore, no permission was required. The TAQ (DePrince et al., 2010) provides permission for use; however, I was emailed for scoring recommendations and was provided honorary permission. The DERS (Gratz & Roemer, 2004), SCS (Neff, 2003b), and IES-R (Weiss & Marmar, 1997) provide permission to use with proper citation. All instruments except the IES-R were used by Barlow et al. (2017) and were used in the current study. Barlow et al. used the Impact of Events Scale (IES; Horowitz et al., 1979), a 15-item Likert scale questionnaire. The IES-R contains the same 15 items as the IES and an additional seven items analyzing an additional subscale of hyperarousal (Weiss & Marmar, 1997). The IES-R would increase the understanding of trauma symptoms through an overall score and subscales of intrusion, avoidance, and hyperarousal.

Furthermore, each instrument contains sets of subscales. The subscales were calculated and recorded into SPSS 25.0 and were not used in the current study. Instead, the subscales would be available for future research.

Predictor Variable

The predictor variable was childhood abuse/neglect. The CAT is a self-reported instrument asking the adult participant to retrospectively interpret negative situations that occurred during their childhood and parental interactions (Sanders & Becker-Lausen, 1995). The CAT contains 38 Likert scale questions (0 = *never*, 1 = *rarely*, 2 = *sometimes*, 3 = *very often*, and 4 = *always*) developed for a total score as well as subscale scores for emotional abuse, physical abuse, sexual abuse, and neglect (Sanders & Becker-Lausen, 1995). The CAT subscales are added up to produce a score. The CAT has no threshold for identifying diagnoses and is used to identify previous childhood abuse/neglect and compared to other CAT scores (Sanders & Becker-Lausen, 1995). The CAT contains items such as "Did your parents ridicule you?" and "Were you expected to follow a strict code of behavior in your home?" (Sanders & Becker-Lausen, 1995). There are no thresholds established for determining diagnoses to preserve a continuum of subjective interpretations of frequency toward childhood abuse/neglect (Sanders & Becker-Lausen, 1995).

The overall Cronbach's alpha was high (0.90), and subscales physical abuse (0.63), sexual abuse (0.76), and neglect (0.86) varied (Sanders & Becker-Lausen, 1995). Test-retest reliability was 0.89 for the entire instrument and 0.91 for emotional abuse, 0.71 for physical abuse, 0.85 for sexual abuse, and 0.91 for neglect. A pilot study using split-half reliability indicated $r = 0.87$ (Sanders & Becker-Lausen, 1995). Concurrent validity was measured with the Hospital Anxiety and Depression Scale identifying a

range of 0.30–0.42 for varying scales and 0.36–0.41 for overall scoring (Kent & Waller, 1998).

Mediating Variables

Negative Trauma Appraisal. The TAQ is a self-reported survey containing 54 Likert scale items (1 = *strongly disagree*, 2 = *somewhat disagree*, 3 = *neutral*, 4 = *somewhat agree*, and 5 = *strongly agree*). Sample questions include "I deserved what happened to me" and "It's as if I'm in a horror movie and can't get out" (DePrince et al., 2010). Cronbach's alpha ranged from 0.86 to 0.93, while test-retest reliability for subscales were betrayal = .88, self-blame = .82, fear = .73, alienation = .85, anger = .82, and shame = .87. Validity was determined through a sample of semistructured interviews and identified potential validity as "very promising" (DePrince et al., 2010, p. 294). TAQ subscales scoring is generated by adding the designated items and dividing by the number of items. TAQ overall scoring is generated by adding the subscales. There are no score thresholds because the scores are used as comparisons for within-subjects and other participants (DePrince et al., 2010).

Difficulties in Emotion Regulation. The DERS is a self-reported survey created to identify global difficulties in emotion regulation, as well as subscales to identify nonacceptance of emotional response, difficulty engaging in goal-directed behavior, impulse control difficulties, lack of emotional awareness, limited access to emotional regulation strategies, and lack of emotional clarity (Gratz & Roemer, 2004). The DERS contains 36 Likert scale items (1= *almost never*, 2 = *sometimes*, 3 = *about half the time*, 4 = *most of the time*, and 5 = *almost always*) with samples such as "I am clear about my

feelings" and "When I'm upset, I have difficulty concentrating" (Gratz & Roemer, 2004). Scoring the DERS requires reverse scoring (i.e., 1 = 5, 2 = 4, 3 = 3, 4 = 2, and 1 = 5) for items 1, 2, 6, 7, 8, 10, 17, 20, 22, 24, and 34. After reversal, all the subscales are added. The overall score is calculated by adding all the subscales. The DERS does not have a score threshold and is used to compare to other participants' scores (Gratz & Roemer, 2004). The DERS has strong internal consistency (a = 0.93) and adequate test-retest reliability (r = 0.57–0.89; Gratz & Roemer, 2004). Finally, the scale was validated using the Negative Mood Regulation Scale identifying the overall correlation as -0.69, which indicates strong construct validity (Gratz & Roemer, 2004).

Self-Compassion. The SCS is a self-reported 26 Likert scale questionnaire (1= *almost never* to 5 = *almost always*) containing items intended to identify levels of self-compassion. The scale has items such as "I'm disapproving and judgmental about my own flaws and inadequacies" and "I try to be loving toward myself when I'm feeling emotional pain" (Neff, 2003b). Besides obtaining an overall score, the SCS contains subscales of self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identified (Neff, 2003b). Scoring the SCS requires reverse scoring of the Self-Judgment, Isolation, and Over-Identified subscales (i.e., 1 = 5, 2 = 4, 3 = 3, 4 = 2, and 5 = 1). The reversed scoring items are 2, 4, 6, 9, 13, 14, 17, 18, 20, 22, 24, and 25. Subscale scores are added and divided by the number of items. The overall score is calculated by adding all the items and dividing by the number of items. The SCS does not contain thresholds and is used to compare within subjects and other participants' scores. Cronbach's alpha was 0.92, and the overall test-retest reliability was 0.93 (Neff, 2003b).

The SCS also indicates strong and moderate validity when compared to multiple instruments (Neff, 2003b).

Outcome Variable

The outcome variable was trauma symptoms. The IES-R is a self-reported questionnaire consisting of 22 Likert scale items (0 = *not at all*, 1 = *a little bit*, 2 = *moderately*, 3 = *quite a bit*, 4 = *extremely*) measuring overall probability of meeting diagnostic criteria for a PTSD diagnosis and subscales of intrusion, avoidance, and hyperarousal (Weiss & Marmar, 1997). Sample items include "I was jumpy and easily startled" and "I had trouble falling asleep." Overall scoring of the IES-R requires adding the subscales. An IES-R score of 24–32 is interpretated as clinical concerns with a potential diagnosis of PTSD, 33–38 is interpreted as a high probability of a PTSD diagnosis, and 39 or above is interpreted as high probability of a PTSD diagnosis and suppression of the immune system's functioning (Weiss & Marmar, 1997). Cronbach's alpha for the overall scale was 0.95, and subscale values were avoidance = 0.86, hyperarousal = 0.85, and intrusion = 0.90 (Beck et al., 2008). Construct validity was between 0.71 and 0.86 compared to multiple instruments indicating strong validity (Beck et al., 2008).

Demographics

Demographics were collected for descriptive statistics and the moderating variable (gender). Yearly income, highest level of education, ethnicity, age, and gender were obtained. Yearly income was a fill-in box. Highest level of education options were not completed high school, high school or GED, some college or trade school,

associate's, bachelor's, master's, or doctorate. Ethnicity options were White non-Latinx, Black, Latinx, Asian, Native American/Alaskan, Multiracial, or other. Gender was male or female, and the question specified it as the gender the individual identified while completing the survey. Age was asked to ensure the participants were 18 years or older.

Data Analysis Plan

Descriptive Statistics

The data analysis required multiple steps to identify variances. First, descriptive statistics of gender, age, income, highest level of education, and ethnicity were determined. Gender, ethnicity, and highest level of education were measured as percentages. Age and income were measured by the mean, range, and standard deviations.

PROCESS Macro Model 15

A conditional process analysis model was used to understand the mediation strengths of negative trauma appraisal, difficulties in emotion regulation, and self-compassion upon the relationship between childhood abuse/neglect and trauma symptoms; and gender moderating the strength between negative trauma appraisal, difficulties in emotion regulation, and self-compassion toward trauma symptoms (Barlow et al., 2017; Hayes, 2018). Five thousand bootstrapping was applied to the model to create a more robust sample (Hayes, 2015). Per Hayes (2018), bootstrapping is used to create a more robust sample due to relatively weak mediation power. Bootstrapping takes randomized data sets from the current data, duplicates, and applies to the statistical

analysis (Hayes, 2018). The nonstandardized regression coefficients (B) were used to determine statistical significance.

Conditional Processing Analysis

Hayes (2018) defined conditional processing analysis as the simultaneous application of mediations and moderations within the same statistical analysis. The purpose of using a conditional process analysis as opposed to separate mediation and moderation models is to decrease statistical error and provide statistical interpretation with a singular approach to moderated-mediation. A mediating variable is interpreted as "how" the variable indirectly contributes to the predictor variable toward the outcome variable (Hayes, 2018). A moderating variable is interpreted as "when" applied, instigating directional, or strengthening the relationship between the predictor and outcome variable (Hayes, 2018).

Moderation

Moderating variables have a distinct difference in statistical analyses. According to Hayes (2018), moderation is considered when the variable is predictive to determine the outcome variable's varying strengths. While mediating variables represent partial (indirect) relationships between the predictor and outcome variable, moderating variables are hypothesized to directly influence the outcome variable's strength (Hayes, 2018). For the proposed research, gender is the moderating variable. Gender will determine strength variations across mediating variables' trajectories toward trauma symptoms.

Mediation

The use of mediating variables is to understand how the predictor variable influences the outcome variable by other factors (Hayes, 2018). Mediating variables can be interchangeable as antecedent and consequent variables (Hayes, 2018). In this model, the outcome variable, trauma symptoms, is only a consequent variable, and the predictor variable, childhood abuse/neglect, is only an antecedent variable. The mediating variables are interchangeable due to the explanation of different indirect pathways. The initial predictor variable of childhood abuse/neglect is the antecedent variable toward the consequent variable of trauma symptoms. To explain the overall mediating model, childhood abuse/neglect is the antecedent variable toward the consequent variables of negative trauma appraisal, emotion regulation, and self-compassion. In contrast, negative trauma appraisal, emotion regulation, and self-compassion are antecedent variables toward the consequent variable of trauma symptoms.

The purpose of using a mediation analysis is to identify previous confounding variables and measure the effects and influence between the predictor and outcome variables (Hayes, 2018). The importance of mediation analysis is due to the rarity of causal models with a dependent variable directly correlating with an independent variable. Thus, if a causal effect of childhood abuse/neglect and trauma symptoms were true, every individual with childhood abuse/neglect would result in trauma symptoms (DePierro et al., 2019; Felitti et a., 1998). This is not a valid statement (Barlow et al., 2017); thus, other variables must influence the relationship between childhood abuse/neglect and trauma symptoms. This study utilized negative trauma appraisal,

difficulties in emotion regulation, and self-compassion mediate the relationship between childhood abuse/neglect and trauma symptoms.

Furthermore, the mediation model consists of multiple mediating variables; thus, a specification of the variable trajectories must be established. Per Hayes (2018), multiple mediation variables can be analyzed as parallel, serial, or both. A parallel mediation analysis postulates having no causal effects on other mediating variables and is used to determine differing strengths of theoretical trajectories upon the outcome variable (Hayes, 2018). Serial mediation analysis is used when determining mediating variable interactions as sequential and parallel while anticipating causal effects between mediating variables (Hayes, 2018).

Barlow et al. (2017) analyzed the mediating variables of negative trauma appraisal, difficulties in emotion regulation, and self-compassion upon the relationship of childhood abuse/neglect and trauma symptoms as a parallel/serial mediation circuit. This would assess eight trajectories, including direct, singular, dyadic, and complete serial circuits of the mediating variables (Barlow et al., 2017; Hayes, 2018). When adding a moderator to a parallel/serial mediation model, the moderator would require eight different data points and increase the degrees of freedom and statistical errors (Hayes, 2018). A parallel mediation analysis would assess gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion independently from the other mediating variables (Hayes, 2018). Independently analyzing the mediating variable would delineate gender differences for the three mediating variables, decrease statistical errors, and produce more robust results.

Data Cleaning

Data may not be accurate until several OLS regression assumptions are met. According to Burkholder et al. (2016), OLS regressions should be linear, normally distributed, contain minimal to no collinearity between predictor variables, and meet homoscedasticity. Assuming the research is linear suggests that the predictor variable has a relationship with the outcome variable (Hayes, 2018). Normal distribution means that each variable meets a normal distribution among participants' scores (Hayes, 2018). Multiple collinearities assumes that predictor variables are highly correlated and may interfere (Hayes, 2018). Homoscedasticity assumes that the variables following a general pattern (Hayes, 2018). Data cleaning was done with SPSS 25.0 and completed prior to analyses.

Linearity was determined with an OLS regression model with Childhood abuse/neglect predicting trauma symptoms. Normal distribution was determined by observations of Quartile–Quartile (Q–Q) plots, histograms with distribution lines, skewness, kurtosis, and Kolmogorov-Smirnov (KS) tests. Q–Q plots and histograms are visuals that detect outliers (Hayes, 2018). Skewness indicates how much the distribution is around the mean and median. Acceptable skewness is between -1 and +1(Hayes, 2018). Kurtosis is another visual measure of distribution and any kurtosis between -3 and +3 are acceptable (Hayes, 2018). The KS test is a measure of distribution (Hayes, 2018). The KS test results in hypotheses testing. The Null hypothesis suggests a normal distribution while an alternative hypothesis suggests a skewed distribution. The KS test will provide a *p* value. If the *p* value is greater than alpha (.05), the null hypothesis is accepted.

Multiple collinearities were determined with an OLS regression with all continuous variables and collinearity diagnostics. Collinearity diagnostics must indicate only a single high correlation. If there are more than one high correlation, there may be collinearity (Hayes, 2018). Another measure of multiple collinearities between predictor variables are tolerance and variance inflation factor (VIF). If VIF is above 4.0 and tolerance is below 0.25 there may be multiple collinearity (Hayes, 2018).

Threats to Validity

Social science research may be incapable of controlling all variables, potentially producing threats to validity. Per Burkholder et al. (2016), research is not void of threats to validity. The researcher attempts to identify and mitigate to adequate success and recognizes and cautions the results in lieu of threats to validity (Burkholder et al., 2016). For example, an individual's questionnaire responses are assumed to be trustworthy; however, they may be confounded by current mood, emotional reactivity, or factitious responses. Threats to validity may be unavoidable; however, recognition and adequate mitigation may improve the research's overall validity.

First, internal validity must be ensured to promote the accuracy of the study. Burkholder et al. (2016) described internal validity as to how consistent the independent variables' changes explain the dependent variable's results while considering confounding variables. The study is using a mediation design to assist in mitigating threats to internal validity. According to Hayes (2015), mediation and moderation models are used to identify indirect relations of influencing variables that may further explain alterations in the dependent variable (outcome variable). It is structurally impossible to

control all threats to internal validity; however, it can be measured by introducing mediating or moderating variables. In the proposed study, childhood abuse/neglect correlates to trauma symptoms; however, there should be a strong correlation to minimize confounding variables. The literature has identified a moderate to a small correlation between childhood abuse/neglect and trauma symptoms; thus, the inclusion of other variables must be conceptualized to explain the relationship (Augusti et al., 2018; Barlow et al., 2017; DePierro et al., 2019; Felitti et al., 1997).

Another threat to internal validity is fraudulent answers provided by the participants. Teitcher et al. (2015) identified online surveying as cost effective methods that increase participant anonymity and provide more breadth and numbers of participants; however, it may also promote fraudulent or biased results. Teitcher et al. (2015) suggested being cautious while conducting an online survey by first looking through the data to visually identify relative consistency throughout a participant's responses to the individual instruments; second, providing clear information in the consent form offering the benefits of providing honest answers; and third, looking for potential outliers that suggested randomized answering. Like all scholarly work, it is important to remain skeptical and observe the results for relative similarities to previous literature analytically.

Next, the research must ensure the mitigation of threats to external validity. Torre and Picho (2016) identified external validity as the ability to generalize the study results toward the general population. Threats to external validity may include sampling bias, controlled research settings, and confounding variables (Torre, & Picho, 2016). For the

proposed study, there may be a sampling bias that could threaten external validity. Due to the convenience sampling method of procuring online participation, those willing tend to complete surveys on a relatively frequent basis. Although there may be cultural and ethnic differences across the gathered sample, there may be relatively unavoidable sampling bias. To prevent sampling bias, Torre and Picho suggested remaining active in the selection process, ensuring a relative percentage sample of various ethnicities, and acknowledging the methodology limitations when determining generalizability.

The final threat to validity is construct validity, which Burkholder et al. (2016) defined as the accuracy of the chosen instruments in identifying and reporting the proposed constructs. Construct validity may be determined by selecting instruments for purpose and the overall validity, internal consistency, and test-retest reliability of the individual instrument (Burkholder et al., 2016). The study will use established instruments that have repeatedly identified and inferred statistical significance across the research. All the selected instruments have been established through mixed-method identification and elimination of items, as well as multiple sets of reliability and validity testing. Furthermore, the instruments have been used frequently and consistently within the literature to convey similar inferential conclusions.

Finally, threats to validity are abundant and may be unavoidable when conducting natural research (Teitcher et al., 2015). This may be acceptable if the validity threats are minimized, recognized, discussed, and assumed while writing the study discussion. One of the impending threats to validity is sampling bias, which must be considered a limitation when inferring the study (Torre, & Picho, 2016). Regardless, research may

identify threats to validity as potential constructs to be examined in future research (Burkholder et al., 2016).

Ethical Procedures

Ethical consideration is central to the process and the outcome of this study. According to the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2017), the scholarly-practitioner abides by the balancing aspirations of beneficence and non-maleficence. This brings the importance of the Walden Institutional Review Board (IRB) to ensure proper measures are made to prevent harm toward a vulnerable community. According to the Walden IRB (2020), a vulnerable population consists of an individual who identifies as under 18 years of age, pregnant, incarcerated, physically disabled, emotionally disabled, or above 65. Working with a vulnerable community does not ensure disapproval from the Walden IRB; however, it requires additional considerations and measures to eliminate or minimize harm (Walden University, 2020).

For the study, the research was conducted with individuals 18-years or older, to avoid age-related vulnerable populations. Furthermore, the research required a retrospective understanding of past childhood abuse/neglect and subsequent results of the mediators and outcome variable; thus, an adult population is required. As the subject matter is around childhood abuse/neglect, there may be concerns from individuals identifying with emotional disabilities. The population was warned of the potential for adverse emotional reactions during the consent process. The consent process highlighted the procedures, purpose, and potential adverse emotional reactions during the research

process. The consent pages informed that no penalty will occur due to attrition as the participant has the right to secede from the study at any time.

Moreover, the online survey process ensured anonymity for the participant. The identifying information were age, gender, and ethnicity. A number was assigned to the participant's results for SPSS 25.0 that will coincide with the temporal completion of the surveys (i.e., the first completion will be labeled 001, the next will be 002, and so on). The identifying codes are for statistical analysis purposes and only coincided with age, gender, and ethnicity. No names were used nor required throughout the process, including consent, which required to click 'next' to continue to the study due to signatures and print name writing being identifiable.

Further anonymity was ensured by deactivating Survey Monkey from recording IP addresses. Finally, ethical procedures followed all guidelines reported to the Walden IRB. If an amendment is required, contacting and approval of the Walden IRB was required before any procedural amendments. Failure to procure Walden IRB approval before amending would result in unethical procedures no matter how insignificant or nonmaleficence. Thus, an essential procedure for ensuring ethical consideration is to work with the Walden IRB.

Finally, the research gathered data from an at-risk population and required proper Walden IRB authorization and provided additional resources. The instruments asked past information of childhood abuse/neglect and may produce distress in the participants. As this may produce harm, psychological resources and techniques were provided to ensure the safety of each participant. I provided websites to search local mental health workers,

emergency internet resources, and phone contacts for local emergency psychiatric services. I also provided some relaxation techniques. The Walden IRB approval number is 06-23-21-0725780 and expires on 6/22/2022.

Summary

The purpose of the methodology section is to understand the procedural process. This ensures the research community's approval/disapproval and procedural steps for replicability (Burkholder et al., 2016). Overall, assessing gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion mediating the relationship between childhood abuse/neglect and trauma symptoms warranted a quantitative research design. More specifically, Preacher-Hayes PROCESS Macro model 15 were used to analyze the data. A minimum of 167 participants was determined through G*Power completed the Online survey study to reach statistical power. To ensure the quality of the results required minimization and recognition of threats to validity and holding ethical procedures to the highest priority. Chapter 4 includes a detailed analysis of the results of the collected data. The purpose of providing statistical information is to share the quantitative reasoning for the assumptions, limitations, and research progression as interpreted.

Chapter 4: Results

Childhood abuse/neglect continues to be a global crisis. Victims may exhibit lifelong physical and mental health concerns caused by childhood abuse/neglect (DePierro et al., 2019; van der Kolk, 2015), including internal affective and cognitive thoughts of the self, others, and the world (Barlow et al., 2017; Ford, 2015). The purpose of the current study was to assess gender differences in negative trauma appraisal, difficulties in emotion regulation, and self-compassion buffering the relationship between childhood abuse/neglect and trauma symptoms. Three research questions with corresponding null and alternative hypotheses guided this study:

RQ1: Does gender impact the strength between negative trauma appraisal and trauma symptoms with a history of childhood abuse/neglect?

H_o1: There is no statistical significance in gender as a moderator of the mediation of negative trauma appraisal and trauma symptoms with a history of childhood abuse/neglect.

H_a1: There is statistical significance in gender as a moderator of the mediation of negative trauma appraisal and trauma symptoms with a history of childhood abuse/neglect.

RQ2: Does gender impact the strength between difficulties in emotion regulation and trauma symptoms with a history of childhood abuse/neglect?

H_o2: There is no statistical significance in gender as a moderator of the mediation of difficulties in emotion regulation and trauma symptoms with a history of childhood abuse/neglect.

H_a2: There is statistical significance in gender as a moderator of the mediation of difficulties in emotion regulation and trauma symptoms with a history of childhood abuse/neglect.

RQ3: Does gender impact the strength between self-compassion and trauma symptoms with a history of childhood abuse/neglect?

H_o3: There is no statistical significance in gender as a moderator of the mediation of self-compassion and trauma symptoms with a history of childhood abuse/neglect.

H_a3: There is statistical significance in gender as a moderator of the mediation of self-compassion and trauma symptoms with a history of childhood abuse/neglect.

The remainder of Chapter 4 includes explanation of the data results and provides answers to the research questions. First, I explain data collection. Next, I present the descriptive statistical analyses of the collected data. Furthermore, procedures for cleaning the data and ensuring appropriate analyses are be discussed. Finally, tests of the research questions and acceptance or rejection of hypotheses is presented.

Data Collection and Analysis Process

Data were collected using Facebook. A page containing the link to the survey was designed for Facebook. I purchased one advertisement boost. The boost sent random Facebook users a link to the page and asked if they were willing to participate in a survey. The boost was directed toward individuals who were 18 years or older and living in the United States. The boost was sent to 18,285 individuals. Among these individuals, 1,095 clicked on the link to the survey. Among individuals who clicked on the survey, 235 participated in the survey. Among the 235 participants, 204 completed the survey.

One of the surveys indicated a 0.00 score on the CAT, which indicated no history of childhood abuse/neglect and was disqualified. This left a total of 203 participants. All surveys were collected between July 14, 2021, and August 2, 2021. Data were transferred from Survey Monkey to SPSS 25.0 and kept in a password-protected encryption file.

Multivariate Assumption Testing

Linearity and Distribution

The assumption of linearity was met between childhood abuse/neglect and trauma symptoms. The variables of childhood abuse/neglect, negative trauma appraisal, and difficulties in emotion regulation were within acceptable margins (see Chapter 3 “Data Cleaning” for explanations). The Quartile–Quartile (Q–Q) plots were relatively linear, the histograms exhibited a normal distribution, and the KS tests were within acceptable ranges. The variables of trauma symptoms and self-compassion Q–Q plots indicated some outliers, histograms visually indicated skewness, and the KS test indicated skewed distribution.

The assumption of normal distribution was not met. To create a normal distribution, participants with outlying scores for trauma symptoms were deleted. Scores were deleted one at a time. After each deletion, a new Q–Q plot, histogram, and KS test were run. This was repeated until the null hypothesis of the KS test was accepted. This required deletion of 27 participants, leaving a sample size of 176. No corrections were required for self-compassion normality after deleting the participant scores for trauma symptoms. After I deleted 27 participants, normality testing (Q–Q plots, histograms, and KS tests) for all variables w within acceptable ranges. Moreover, the symmetry of the

distribution was examined with the skewness and kurtosis of each continuous variable. Because all skewness and kurtosis fell within acceptable ranges (see Chapter 3 for further explanation), there was no need to transform variables to approximate normality (as shown in Table 1).

Table 1

Skewness and Kurtosis

Variable	Mean	*SD*	Skewness	Kurtosis
CAN	1.969	.716	.016	-.238
NTA	18.488	4.414	-.180	-.424
ER	99.028	25.711	.159	-.449
SC	2.719	.799	.353	-.069
TS	41.926	17.708	-.002	-.742

Note. CAN = Childhood Abuse/Neglect; NTA = Negative Trauma Appraisal; ER = Emotion Regulation; SC = Self-Compassion; TS = Trauma Symptoms.

Multiple Collinearity and Homoscedasticity

Per the collinearity diagnostics output, the continuous variables of childhood abuse/neglect, negative trauma appraisal, and trauma symptoms indicated low to no multiple collinearities. Self-compassion and difficulties in emotion regulation indicated some multiple collinearities but remained within acceptable ranges. However, the multiple collinearities between self-compassion and difficulties in emotion regulation could have impacted the output.

The highest VIF was 2.478, and the lowest tolerance was 0.404. All VIF and tolerance were in acceptable ranges; therefore, the data indicated little to no multicollinearity. However, to avoid errors created by multiple collinearities, Hayes

(2018) suggested running the conditional process analysis differently for each mediating variable (negative trauma appraisal, difficulties in emotion regulation, and self-compassion) as seen in Figures 2, 3, and 4. Running three conditional process analyses would not change the results due to the previous conditional process analysis consisting of parallel variables. Therefore, the pathways from the predictor, mediating, and outcome variable would not change.

Figure 1

Conditional Process Analysis Chart With Negative Trauma Appraisal as the Mediator

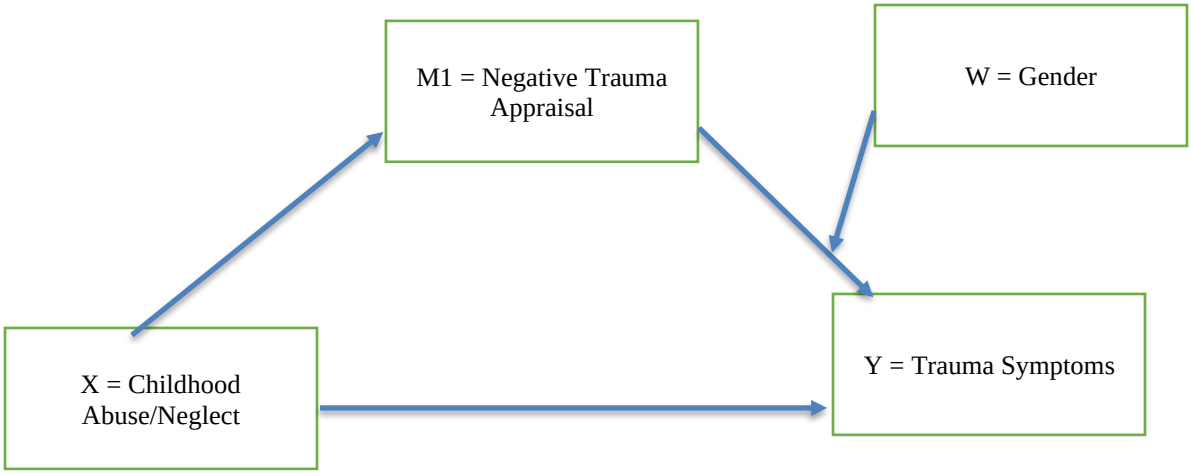


Figure 2

Conditional Process Analysis Chart With Difficulties in Emotion Regulation as the Mediator

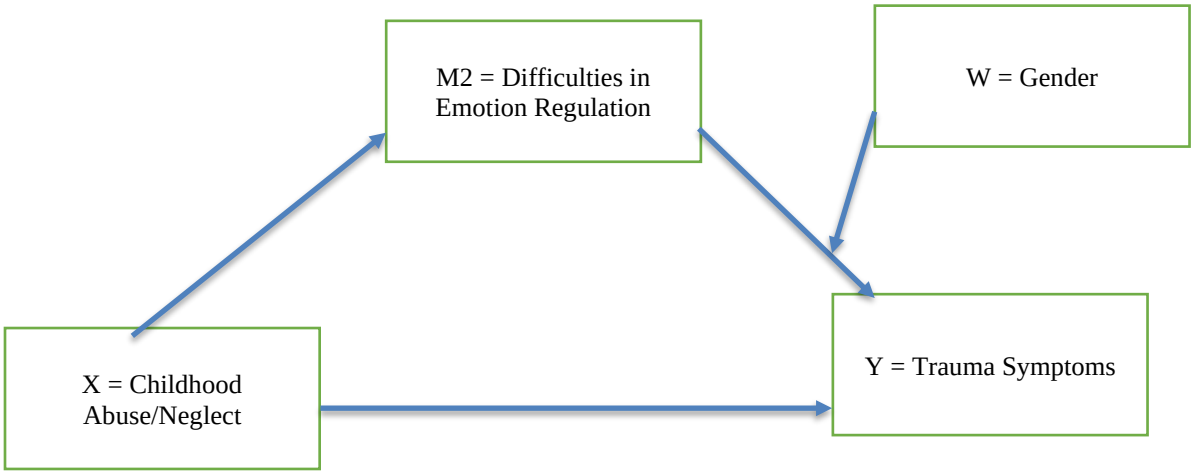
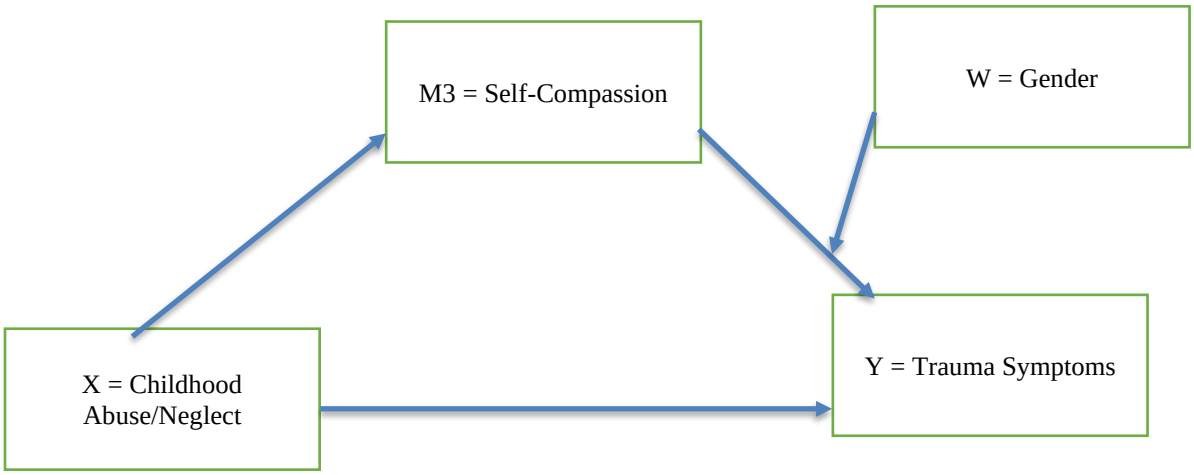


Figure 3

Conditional Process Analysis Chart With Self-Compassion as the Mediator



Descriptive Statistics

Among the participants (N = 176), 125 identified as female (71.0%) and 51 identified as male (29.0%). Other descriptive statistics collected were age, income, ethnicity, and highest level of education. An interesting finding in the demographics was

the high level of master's and doctoral degrees compared to the general population. For more specific information about descriptive statistics, see Table 2.

Table 2

Descriptive Statistics

Demographic characteristic	Mean (*SD*)	Percentage	Range
Age	43.45 (16.17)		19–81
Income (in $)	48.803.64 (45,395.60)		1,200–250,000
Gender			
Male		29.0	
Race/ethnicity			
White		74.4	
Black or African American		5.1	
Hispanic or Latinx		2.3	
Asian or Asian American		7.4	
American Indian or Native Alaskan		2.8	
Multiracial		4.5	
Other		3.4	
Highest Level of Education			
No high school diploma		1.1	
High school diploma or GED		9.7	
Some college		22.2	
Associate's		9.1	
Bachelor's		29.0	
Master's		23.9	
Doctorate		5.1	

Results

Results from the bivariate correlations of the continuous variables are presented in Table 3. The bivariate correlation results indicated childhood abuse/neglect moderately correlated with negative trauma appraisal and trauma symptoms. Childhood

abuse/neglect minimally correlated with difficulties in emotion regulation and self-compassion. However, childhood abuse/neglect, negative trauma appraisal, difficulties in emotion regulation, and self-compassion (for males only) moderately correlated with trauma symptoms. The mediating variables (negative trauma appraisal, difficulties in emotion regulation, and self-compassion were highly correlated. The high correlation between mediating variables was consistent with previous research (see Barlow et al., 2017).

Table 3

Correlation of Continuous Variables

	Gender	CAN	NTA	ER	SC	TS
CAN	Male	1	.554**	.144	-.174	.398**
	Female	1	.475**	.307*	-.051	.492**
NTA	Male		1	.666**	-.422**	.510**
	Female		1	.557**	-.472**	.535**
DER	Male			1	-.617**	.447**
	Female			1	-.727**	.252**
SC	Male				1	-.307*
	Female				1	-.111
TS	Male					1
	Female					1

Note. CAN (childhood abuse/neglect), NTA (negative trauma appraisal), DER (difficulties in emotion regulation), SC (self-compassion), & TS (trauma symptoms).
**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Descriptive Statistics of Variables by Gender

The descriptive statistics of the variables by gender are presented in Table 4. The differences in mean scores for male and female respondents on negative trauma appraisal, difficulties in emotion regulation, self-compassion, and trauma symptoms were not statistically significant. The mean score differences for male and female respondents on childhood abuse/neglect were statistically significant ($p < .01$).

Table 4

Descriptive Statistics of Variables by Gender

Variables	Gender	*M*	*SD*	Min.	Max.
CAN	Male	1.74**	.74	.26	3.45
(Predictor)	Female	2.06**	.69	.42	3.89
NTA	Male	18.64	4.99	6.60	28.66
(Mediator)	Female	18.43	4.18	7.58	27.50
DER	Male	97.69	26.93	50.00	172.00
(Mediator)	Female	99.58	25.29	49.00	156.00
SC	Male	2.79	.71	1.15	4.58
(Mediator)	Female	2.69	.83	1.15	4.85
TS	Male	41.86	16.73	10.00	73.00
(Outcome)	Female	41.95	18.16	10.00	82.00

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

Descriptive Statistics of CAT Subscales by Gender

The mean scores for the predictor variable CAT indicated statistically significant differences between male and female respondents. Table 5 shows the mean scores for the neglect, physical abuse, and sexual abuse subscales from the CAT. The neglect and physical abuse mean scores indicated statistical significance between male and female respondents.

Table 5

Descriptive Statistics of CAT Subscales by Gender

Abuse	Gender	*M*	*SD*	Min	Max
Neglect	Male	1.96**	.81	.21	3.43
	Female	2.34**	.75	.43	4
Physical	Male	1.94*	.81	.17	3.5
	Female	2.27*	.79	.33	4
Sexual	Male	.88	.93	0	3.5
	Female	1.06	1.02	0	4

*. Correlation significant at the 0.05 level (2-tailed).

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

Hypothesis 1

The first hypothesis tested whether gender moderated the mediation of childhood abuse/neglect to trauma symptoms through negative trauma appraisal. The overall conditional process analysis model was statistically significant $R^2 = .34$, $p < .001$. In the conditional process analysis model, childhood abuse/neglect statistically predicted negative trauma appraisal, B = 8.11, $p < .001$, and negative trauma appraisal statistically predicted trauma symptoms, B = 1.69, $p < .001$. The main effect of gender was not statistically significant, B = 15.17 $p = .13$. Gender as a moderator of the mediation of Negative Trauma Appraisal and Trauma Symptoms was not statistically significant, B = -.29, $p = .63$ (see Table 6). Thus, the first null hypothesis could not be rejected.

Table 6

Conditional Process Analysis Output: Negative Trauma Appraisal as Mediator (RQ1)

Variable	*R*	R^2	*F*	*p*
Outcome: Trauma Symptoms	.58	.34	17.45	<.001
	B	*SE*	T	*p*
Childhood abuse/neglect	-8.11	2.17	3.74	<.001
Negative trauma appraisal	1.69	.36	4.75	<.001
Gender	15.17	10.06	1.51	.13
Negative trauma appraisal x gender	-.29	-.48	-.48	.63

Hypothesis #2

The second hypothesis tested whether gender moderated the mediation of childhood abuse/neglect to trauma symptoms through difficulties in emotion regulation. The overall conditional process analysis model indicated statistical significance $R^2 = .28$, $p < .001$. In the conditional process analysis model, childhood abuse/neglect statistically predicted difficulties in emotion regulation, B = 12.28, $p < .001$, and difficulties in emotion regulation predicted trauma symptoms, B = .13, $p = .017$. The main effect of gender was not significant, B = 5.35, $p = .62$. Gender as a moderator of the mediation effect was not statistically significant, B = -.09, $p = .37$. Table 7 has the results of this analysis. Thus, the second null hypothesis could not be rejected.

Table 7

Conditional Process Analysis Output: Emotion Regulation as Mediator (RQ2)

Variable	*R*	R^2	*F*	*p*
Outcome: trauma symptoms	.52	.28	12.92	<.001
	B	*SE*	T	*p*
Childhood abuse/neglect	12.28	2.02	6.09	<.001
Difficulties in emotion regulation	.13	.05	2.42	.02
Gender	5.35	10.80	.50	.62
Difficulties in emotion regulation x gender	.09	.10	.90	.37

Hypothesis #3

The third hypothesis tested whether gender moderated the mediation of childhood abuse/neglect to trauma symptoms through self-compassion. The overall conditional process analysis model indicated statistical significance $R^2 = .28$, $p < .001$. In the conditional process analysis model, childhood abuse/neglect statistically predicted self-compassion, B = 12.87, $p < .001$. Self-compassion did not statistically predict trauma symptoms, B = -1.87, $p = .27$, and the main effect of gender was not statistically significant, B = 23.52, $p = .07$. Gender as a moderator of the mediation effect was not statistically significant, B = -3.90, $p = .28$. Table 8 has the results of this analysis. Thus, the third null hypothesis could not be rejected.

Table 8

Conditional Process Analysis Output: Self-Compassion as Mediator

Variable	*R*	R^2	*F*	*p*
Outcome: trauma symptoms	.49	.24	10.8	<.001
	B	*SE*	T	*p*
Childhood abuse/neglect	12.87	2.05	6.29	<.001
Self-compassion	-1.87	1.69	-1.11	.27
Gender	23.52	13.02	1.81	.07
Self-compassion x gender	-3.9	3.59	-1.09	.28

Summary

This chapter focused on the data collection process, data cleaning, and statistically answering the research questions. There is a relatively clear relationship between childhood abuse/neglect and trauma symptoms. Also, each of the mediating variables related to the other mediating variables. However, gender does not moderate the relationships between the mediators and outcome variable. Therefore, none of the three null hypotheses could be rejected and the answers to the research questions were that gender does not impact the relationships between the mediators and outcome variable. In Chapter 5, I will discuss the implications, limitations, and social changes that may be extrapolated from the statistical analysis.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to assess whether gender impacted internal cognitive and affective reactions to childhood abuse/neglect in the development of trauma symptoms. The internal cognitive and affective reactions to childhood abuse/neglect were identified as negative trauma appraisal, difficulties in emotion regulation, and self-compassion. The application of this study may indicate whether trauma interventions would benefit from gender-specific treatments.

This study addressed a gap in the literature regarding whether gender is a significant variable in trauma research and interventions. The three research questions addressed whether gender impacted the strength of the relationship of the mediating variables with trauma symptoms. Although the null hypotheses could not be rejected and the data showed no role of gender in the mediation model, there may be significant social implications and recommendations toward interventions. This is potentially noteworthy because extant research indicated significant differences in symptomatology between males and females (see Annerback et al., 2018; Cui et al., 2018).

Chapter 5 contains the interpretation of the findings. Initial findings based on the research questions are discussed, followed by a discussion of the more interesting relationships among variables, including (a) the relationship between childhood abuse/neglect and trauma symptoms; (b) that females reported more traumas compared to males, yet each reported similar scores for negative trauma appraisal, difficulties in emotion regulation, self-compassion, and trauma symptoms; (c) that negative trauma appraisal was the only mediating variable between childhood abuse/neglect and trauma

symptoms, for both males and females; (d) that childhood abuse/neglect correlated with difficulties in emotion regulation for females but not males; and (e) that self-compassion did not correlate with childhood abuse/neglect for males and females and correlated with trauma symptoms only for males. I discuss the limitations of this study and recommendation for future studies. Finally, I discuss how the findings of this study may promote positive social change.

Interpretation of Findings

Research Questions

The premise of this study was to identify potential gender differences in the cognitive and affective reactions to the self, others, and the world associated with childhood abuse/neglect and trauma symptoms. This premise was significant for several reasons. First, I explored whether males and females exhibited differences toward certain cognitive and affective reactions. Second, I extended the trauma literature by addressing an identified gap. Finally, the study provided more insight to improve trauma-focused interventions.

The research questions addressed whether gender significantly impacted the relationship between the mediating variables and trauma symptoms. The mediating variables were cognitive and affective reactions (negative trauma appraisal, difficulties in emotion regulation, and self-compassion) to childhood abuse/neglect and related to the formation of trauma symptoms (see Barlow et al., 2017). An initial assumption was that negative trauma appraisal would be higher in females compared to males, self-compassion would be lower for females compared to males, and difficulties in emotion

regulation would be lower for males compared to females. The statistical analyses indicated this was not the case, as means for each variable were similar between males and females, and the overall analyses indicated no effects of gender as a moderator of the relationships between the mediating variables and trauma symptoms.

Previous studies identified gender differences when discussing trauma symptoms (Annerback et al., 2018; Cui et al., 2018). For example, male victims of childhood abuse/neglect may develop more physical aggression compared to females (Annerback et al., 2018), while female victims may be more likely to meet criteria for depression (Cui et al., 2018). It is possible that there are gender differences in the external expression of trauma symptoms; however, in the present study internal cognitive and affective thoughts of the self, others, and the world were found to be similar.

Externalizing behaviors may be related with social norms and expectations of gender differences. Although not lawful, society anticipates males as more physically violent compared to females (Bogren, 2020). There is also a relationship between male-dominant activities (e.g., football, hockey) and increased physical aggression (Bogren, 2020). Therefore, it may be possible that males and females exhibit externalizing behaviors of trauma symptoms differently due to social norms and expectations, while affective and cognitive reactions to childhood abuse/neglect are similar.

It is possible that cognitive and affective reactions to childhood abuse/neglect may be similar between males and females due to similarities in maladaptive cognitive and affective development. This is evident by the maladaptive formation of brain structures for both males and females surviving childhood abuse/neglect compared to

those who do not identify previous childhood abuse/neglect (Hodgdon et al., 2019). Moreover, individuals surviving childhood abuse/neglect process potentially traumatic events differently compared to survivors of later-in-life traumas (Hodgdon et al., 2019). This suggests that childhood abuse/neglect negatively impacts normal brain development (Malarbi et al., 2017). Brain structures after childhood abuse/neglect may be developed to perceive the self, others, and the world as dangerous compared to adaptive brain development (Barlow et al., 2017). Because brain structures determine cognitive and affective reactions to the self, others, and the world, the deficits may not be gender specific.

Additional Noteworthy Findings

Childhood Abuse/Neglect and Trauma Symptoms

It has been well documented that childhood abuse/neglect has a relationship with trauma symptoms (Felitti et al., 2017; Ford, 2015; van der Kolk, 2015). My study corroborated the extant research regarding a direct relationship between childhood abuse/neglect and trauma symptoms. It may be possible that many children surviving childhood abuse/neglect develop maladaptive coping strategies to prevent future childhood abuse/neglect (Wiseman et al., 2021). These maladaptive coping strategies are part of trauma symptoms sequelae and are exhibited as intrusion, avoidance, and hyperarousal (van der Kolk, 2015), the three symptoms identified in my study related to childhood abuse/neglect.

Intrusions are thoughts and images of previous traumas that are repetitive and typically unwanted (Engelhard et al., 2019). These images and memories are usually

activated by a conscious or unconscious stimuli that remind the individual of the trauma. This may be a coping strategy by reminding the individual of previous trauma to warn against new traumas (Wiseman et al., 2021). It may be possible that thought and image intrusions are meant to be preventative; however, they may occur more often when the individual is not in danger (Malarbi et al., 2017).

Avoidance is a significant feature of any negative event and does not necessarily have to be traumatic. However, avoidance from trauma reminders may significantly restrict functionality (Op den Kelder et al., 2019). Avoidance may be influenced by cognitive and affective reactions toward the self, others, and the world (Barlow et al., 2017). It is possible that avoidance of conscious and unconscious reminders of previous traumas may negatively impact the thoughts of the self, others, and the world. This may increase avoidance even if avoidance limits functionality.

Hyperarousal is considered a heightened level of the individual's fear response (Denton et al., 2017). Individuals who do not report a history of childhood abuse/neglect typically have a fear response, too; however, it may be profoundly more sensitive in individuals who report a history of childhood abuse/neglect (Hodgdon et al., 2019). It is possible that maladaptive cognitive and affective reactions to the self, others, and the world may increase the fear of negative events and have the individual ready for any future potentially traumatic events.

Similarities by Gender in Outcomes of Childhood Abuse/Neglect

Males and females reported relatively similar rates of negative trauma appraisal, difficulties in emotion regulation, self-compassion, and trauma symptoms, which are

typical consequences of childhood abuse/neglect (see Barlow et al., 2017). Given the higher rates of abuse for females, it would be expected that they would score higher on these outcomes of abuse as well. This finding may be explained by other differences between males and females.

There may be differences by gender in willingness to report abuse. Differences in reporting are typically seen in clinical and legal settings where females are more likely to disclose childhood abuse/neglect (Lahtinen et al., 2018). According to Marconi et al. (2019), females respond more often and at higher rates compared to males. However, it is not known whether these differences in experience are real or whether disclosures for females are overrepresentations (Marconi et al., 2019). It is possible that females are more open to sharing compared to males. This may be associated with social stigma toward reporting by males (Marconi et al., 2019).

Moreover, disclosure rates of childhood abuse/neglect may be decided by social and psychological perspectives. According to Karugahe and Jones (2021), victimizing females is socially more detrimental for the perpetrator compared to victimizing males. It may be possible that lessons such as “you never hit a girl” may impact the belief that hitting females is wrong; however, hitting a male may be socially acceptable in certain circumstances. Moraes et al. (2018) suggested that society and individuals perceive physical abuse as appropriate punishment toward males but not toward females. It may be possible that any violence toward females is socially considered abuse, while violence toward males is socially considered fighting or corporal punishment (Afifi et al., 2017). Therefore, females may be more likely to perceive and report violence as physical abuse.

From a sexual abuse perspective, males are less likely to perceive sexual abuse as abuse compared to females (Castro et al., 2019) and are less likely to report whether the perpetrator was male (Carlson & Oshri, 2018). If the perpetrator is male, a male victim is more likely to question their sexuality and is less likely to disclose (Carlson & Oshri, 2018). It may be possible that male victims of female sexual abuse are identified as "lucky" for having a sexual encounter at a young age. Also, it may be possible that male victims may be socially perceived as weak for letting sexual abuse occur.

Negative Trauma Appraisal

Negative trauma appraisal is known to have a significant relationship with childhood abuse/neglect and trauma symptoms (Chen, 2020) and therefore was expected to be a mediator in the present study, an expectation that was supported by the data. Negative trauma appraisal occurs when the victims partially or fully blaming themselves for the childhood abuse/neglect. Children who are victims will commonly blame themselves (i.e., "If I was better behaved, I would not need such a severe beating"), and when blaming themselves, they are at a higher risk of developing trauma symptoms. According to stress theory, negative trauma appraisal can be broken down into procedural steps; first, the individual appraises the general threat level; second, the individual evaluates whether they have the proper coping mechanisms to handle the threat; and finally, the individual evaluates the strength of the coping mechanisms (Lazarus & Folman, 1987). This appraisal process is key to understanding the outcomes of abuse/neglect because it helps the child decide how to interpret the event and react to it.

Regardless of gender, children do not have the proper experiences, cognitive development, affective expression, and coping skills to effectively evaluate a trauma and apply coping skills. According to a systemic review by Wiseman et al. (2021), negative trauma appraisal was associated with the development and maintenance of trauma symptoms. The present study exhibited similar findings to Wiseman et al. (2021) by identifying negative trauma appraisal as a significant mediator between childhood abuse/neglect and trauma symptoms and being related to difficulties in emotion regulation and self-compassion. This is consistent with the research conducted by Barlow et al. (2017) and more recent research by Ching et al. (2020) and Himmerich and Orcutt (2021). This suggests the importance of negative trauma appraisal for both genders as a significant feature in maintaining trauma symptoms (see Wiseman et al., 2021). Moreover, coping skills that are developed after the initial childhood abuse/neglect tend to be avoidance and hypervigilance, which are less effective coping skills at mitigating cognitive and affective reactions of later childhood abuse/neglect (Wiseman et al., 2021). It is possible that the maladaptive coping skills developed during the initial childhood abuse/neglect may lead to continued development of maladaptive coping skills and the development and maintenance of trauma symptoms (Wiseman et al., 2021).

Another possible outcome of negative trauma appraisal may be related to bidirectional symptomatology. According to Shigemoto and Robitschek (2021), negative trauma appraisal increased in children and caregivers after childhood abuse/neglect. It is possible that a caregiver cannot provide adaptive coping skills due to requiring their own

coping skills and trauma appraisals to self-soothe and may not be able to apply toward the child.

Males and females may not differ when it comes to blaming themselves. These are internal cognitive and affective variables that may not be gender specific. Beyond the scope of this study is the variable child egocentrism. According to De Meulemeester et al. (2021), egocentrism may explain blaming of the self as a victim of childhood abuse/neglect. Egocentrism is the inability to experience multiple perspectives and more likely to blame the self in negative situations. Regardless of gender, adults may continue to self-blame for past childhood abuse/neglect.

Difficulties in Emotion Regulation

Difficulties in emotion regulation is known to have a significant relationship with childhood abuse/neglect and trauma symptoms (Himmerich & Orcutt, 2021) and therefore was expected to be a mediating variable between the two. This expectation was not supported in the present study. Difficulties in emotion regulation are maladaptive internal cognitive and affective regulators in adverse situations. According to Tinajero et al. (2020), difficulties in emotion regulation are related to hypervigilance, startle responses, and activation of the parasympathetic nervous system. The present study shows no differences in difficulties in emotion regulation scores for males and females.

However, for females and not males, difficulties in emotion regulation were correlated to childhood abuse/neglect. Sanchis-Sanchis et al. (2020), identified similar trends and reported that females are more likely to express positive and negative emotions compared to males. It may be possible that the expression of emotions is more

socially acceptable for females. Vendeville et al. (2019) suggested that females expressing a wider range of emotions reduces difficulties in emotion regulation. In contrast, males that exhibit anger and frustration may be internally feeling fear or sadness. It is possible that the incongruence between externalized anger and internalized fear or sadness may be maladaptive and increase difficulties in emotion regulation.

Self-Compassion

Self-compassion is the ability to provide introspective empathy in durations of perceived adverse events (Neff, 2003a). Self-compassion was expected to mediate the relationship between childhood abuse/neglect and trauma symptoms; this expectation was not supported by the data as self-compassion did not relate to childhood abuse/neglect. This finding contradicted past research (see Barlow et al., 2017). In a recent study (Tao et al., 2021), self-compassion was identified as a mediator between abuse/neglect and depression, a symptom of trauma. However, that study included responses from 4,189 participants and more males than females, which made their sample significantly larger and different than the one in the present study. Unfortunately, Tao et al. did not explore differences by gender in the relationships they studied.

In the present study, self-compassion was related to trauma symptoms only for males. For males, as trauma symptoms increased, self-compassion decreased. It may be possible that the differences are associated with societal norms. Males may be more critical of trauma symptoms because avoidance and hyperarousal may be traits that are considered less “manly” (Cherry & Wilcox, 2021). Males might be more apt to

disapprove of the self for having negative symptoms because mental health concerns are socially considered a feminine trait.

For males and females, self-compassion responses were relatively similar and trending toward the lower level. This may suggest that self-compassion is low regardless of the amount or different types of childhood abuse/neglect. Furthermore, the small correlation between self-compassion and trauma symptoms may suggest other variables besides childhood abuse/neglect impacting self-compassion. These perceived adverse events may be related to childhood abuse/neglect or daily stressors and similar for both genders.

Object-Relations Theory

Through the lens of Fairbairnian object-relations theory, both male and female children cognitively identify the self as unconditionally bad in lieu of the parent being conditionally bad (Fairbairn, 1952). Identifying the self as unconditionally bad directly relates to blaming the self for being victimized. A parent is perceived as negatively responding and correcting of the child's negative behavior (Fairbairn, 1952). Fairbairn did not differentiate between gender due to similar childhood abuse/neglect reactions and this study verified that both males and females have a high likelihood of developing negative trauma appraisal in relation to past childhood abuse/neglect.

Negative trauma appraisal development and maintenance can be explained through object-relations theory. Wiseman et al. (2021) identified that children are less capable of developing coping skills to mitigate the negative effects associated with childhood abuse/neglect. In a relatively healthy child/caregiver relationship, the caregiver

provides the teaching and application of coping skills (Fairbairn, 1952). This could be a hug and calming voice. However, if the caregiver is the perpetrator; a past victim of childhood abuse/neglect; or reactive, the caregiver may not be capable of applying adaptive coping skills to soothe and teach the child (Fairbairn, 1952). Moreover, the caregiver may increase negative trauma appraisals in the child through ridicule, minimization, and repeated perpetration of childhood abuse/neglect (Wiseman et al., 2021).

It is still unclear if the similarities in internal reactions to trauma have always existed or are an artifact of current cultural and social paradigm shifts (Bakker & Walker, 2020). These shifts may indicate gender fluidity and minimization of gender roles as socially more acceptable. From an object-relations perspective, Fairbairn (1952) discussed that external behaviors may be different and more nuanced, but the internal behaviors remain relatively stable between genders. Fairbairn identified different external behaviors as reactivity toward the family unit to create some sort of harmony. The internal behaviors remained relatively dogmatic by suggesting the child as unconditionally bad (Fairbairn, 1952) and may be stable amongst genders.

Limitations

This research had several limitations. First, the study was correlational; thus, no cause-and-effect relationship can be determined. Second, the surveys were gathered over Facebook and the responses were assumed to be accurate. There are no definitive ways to verify response accuracy and it must be assumed that responses were answered based on

the respondents' perception. Moreover, Facebook participants may be a distinct culture that may not be representative of the population.

Third, certain demographics were not collected to ensure the anonymity of the respondents. This included geographics location. It is unknown if the respondents represented the whole United States or regions. Fourth, ethnic and race percentages do not reflect the ethnic and race percentages of the United States. Similarly, percentages of the highest level of education do not reflect the percentages of the highest level of education in the United States. This may prevent generalizability of the findings.

Fifth, there were many more females in the sample (71%) than male. Using gender as a moderator would benefit from having a relatively even split between male and females. Several studies using gender as a moderator had similar gender splits. Shangguan et al. (2021) had a sample containing 75.5% female; Hazrati-Meimaneh et al. (2020) had a sample containing 73.5% female; and Langevin et al. (2015) had a sample containing 79.5% female. According to Hayes (2018), using a conditional process analysis may account for this type of difference and will still produce accurate results.

Recommendations

Therapeutic Interventions

Albeit some forms of therapy may seek to correct externalizing behaviors (i.e., behavioral modification), most therapies seek to alter internalizing behaviors, cognition, and affect to mitigate externalizing behaviors. Externalizing behaviors vary between and within genders (Afiaz et al., 2021). The present study findings suggest that internalizing

behaviors may be similar between gender (Afiaz et al., 2021; Chen, 2020). I recommend that trauma treatment should explore internalized behaviors as similar between gender.

Society may anticipate males as presenting more violent externalizing behaviors and females as presenting more internalizing behaviors. Gender differences in externalizing behaviors may be associated with socially anticipated reactions, while internalizing behaviors are personal and may not be as influenced by socially anticipated reactions (Chen, 2020). Regardless of gender, a victim of childhood abuse/neglect may believe they are to be blamed (negative trauma appraisal), have lower abilities to self-soothe (emotion regulation), and become angry toward the self for not being better (self-compassion). Thus, regardless of gender, I recommend that trauma therapy should detect and include interventions to minimize these three consequences to childhood abuse/neglect.

Another therapeutic intervention may be to dismantle the perception of social norms toward males exhibiting fear and sadness. This may not be exclusive to trauma therapy; however, emotional understanding may improve outcomes for clients with trauma symptoms (Murphy et al., 2019). It is possible that trauma therapy outcomes can improve if the client accepts a full range of emotions no matter the gender. Males may benefit from exhibiting sadness and fear without the worry of peer ridicule (Murphy et al., 2019). Anger has become a more socially accepted emotion for males compared to fear and sadness; however, anger may be the reaction to fear and sadness (Moore et al., 2019). It may be paradoxical that a male is ridiculed for exhibiting fear and sadness and

aggression toward others is more accepting and illegal. Thus, I suggest exploring the full range of emotions as a part of therapeutic treatment.

Future Research

The presented study may provide a basis for more research. Future research might consider gender as a continuous variable, instead of categorical (Bakker & Walker, 2020). Future studies may want to provide more gender options or a gender fluidity measure to determine preferred gender taxonomy. Another future research suggestion would be replication with a larger sample. This would increase sensitivity to detect gender differences. Moreover, the research could be replicated among various cultures to detect if cultural gender roles may impact cognitive and affective reaction to trauma symptoms.

Another variation to the research could be detecting differences by generations. Generations may perceive and report childhood abuse/neglect at different rates, respond differently, and exhibit different trauma symptoms. It is well known that older generations were more likely to use corporal punishment and less likely to perceive it as abuse (Afifi et al., 2017). Furthermore, looking at generational differences may impact retrospective recollections of childhood abuse/neglect and whether time impacts internalized behaviors associated with trauma symptoms. Generational perception differences of childhood abuse/neglect may continue the understanding of trauma and benefit trauma research.

Larger sample sizes in future research may allow for examination of subscales with the current instruments. These subscales can assist in delineating multiple variations

of symptoms, types of abuse or neglect, and specific cognitive and affective reactions with negative trauma appraisal, emotion regulation, and self-compassion. This may provide more information regarding the internalized behaviors of trauma symptoms.

It may be unclear if later life childhood abuse/neglect may differ cognitive and affective disruptions with the inclusion of societal gender norms. I would also suggest looking into social perceptions of trauma symptoms based on gender. This may assist in explaining how externalizing behaviors of trauma symptoms may vary as gender internalizing behaviors remain stable.

Implications for Positive Social Change

Positive social change is a broad term. I define positive social change in accordance with the first two principles of psychology in the EPPCC (American Psychological Association, 2017). The two principles are beneficence and nonmaleficence and describe a careful balance. Similar ideas can be extrapolated toward gender as a social and cultural construct. It is challenging to clearly define masculinity and femininity. These constructs are based on cultural agreements that may or may not be agreed upon by any one individual (Wei et al., 2021).

The study furthers positive social change by suggesting there may be less differences by gender when detecting and treating trauma symptoms. This is important to social change, because literature within the last five years had reported gender differences in internalized behaviors and externalized behaviors (Cui et al., 2018). More recent literature agreed with this study by suggesting internalized behaviors may be similar between genders. Thus, it is important to focus on similar treatment opposed to being

more focused treatment on the externalizing behaviors of males. Granted, safety in therapy is always a concern, the externalizing behaviors may be a symptom from internalizing behaviors and a gender specific socially acceptable reaction.

Conclusion

Childhood abuse/neglect will continue to be a global crisis. It is important to identify that not all individuals that survived childhood abuse/neglect are guaranteed to develop trauma symptoms. If trauma symptoms do occur, there are internalized symptoms that can be detected and treated. This study explored if gender impacts the relationship between mediating variables (negative trauma appraisal, emotion regulation, & self-compassion) and trauma symptoms with a history of childhood abuse/neglect. For the research, I used a sample of 176 respondents. The respondents reported that gender did not indicate significant differences of internalized behaviors. This is promising as the push for gender equality is prevalent within the United States (Bakker & Walker, 2020). Also, regardless of gender differences in externalized behaviors, childhood abuse/neglect may produce similarities for internalized behaviors. Fairbairn (1952) suggested that no matter the gender, an infant is seeking nourishment and comfort. If the infant does not have their needs met, the infant's ego will split into internal and external egos (Fairbairn, 1952). Although the external ego may vary, the internal ego is still considering the self as unconditionally bad, deserving of punishment, and responsible for any childhood abuse/neglect (Fairbairn, 1952). Gender does not change this perception.

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