ACADEMIA International Journal for Social Sciences
Volume 4, Issue 4, 2025 ISSN-L (Online): 3006-6638

Unraveling the Link Between Childhood Trauma And Depressive Symptoms: The Mediating Influence of Attachment Styles

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Received: 06-11-2025 **Revised:** 23-11-2025 **Accepted:** 13-12-2025 **Published:** 24-12-2025

ABSTRACT

This study examines the mediating role of attachment styles (anxious and avoidant) in the between childhood trauma and symptoms of depression. A cross-sectional approach was used. 200 young adults between the age group 19-26 were considered from city Rawalpindi and Islamabad. After consent participants were given demographic information sheet followed by Adverse Childhood Experiences (ACE), the Adult Attachment Scale (AAS), and Hamilton Rating Scale for Depression (HRSD). For statistical analysis (descriptive analysis and inferential statistics such as Pearson correlation and mediation analysis) were conducted

The current study is a Pearson correlation analysis to unfold the relationship between the childhood trauma and depression's symptoms, which shows a clear and significant positive relationship (r=.45, p <. 01). Mediation analysis further shows that Childhood trauma is also positively associated with anxious attachment (B = .17, t = 5.19, p < .001) Anxious attachment also is significantly associated with heightened depressive symptoms (B = .61, t = 4.09, p < .001), In addition, childhood trauma is also associated with avoidant attachment (B = .16, t = 2.43, p = <.001). Avoidant attachment, however, is a very strong predictor of depressive symptoms (B=.72, t=9.73, p<.001). These results do suggest that the Attachment styles (anxious and avoidant) does mediate the relationship between childhood trauma and depressive symptoms.

These findings underscore the importance of encouraging secure attachment in order to mitigate the long-term psychological consequences of childhood trauma.

Keywords: *Childhood trauma, depressive symptoms, attachment styles, young adults, mental health, Pakistan*

INTRODUCTION

The connection between trauma that occurred in childhood, attachment styles, and depressive symptoms. is essential in determining the mental health outcomes among young adults. Young adulthood, the transitional stage that is characterized by, typically, age 18 to age 29, is the period when the children are in their twenties. tremendous transformations in development such as exploration of identity, formation of relationships, and the seeks to be career independent. This age group is commonly related to greater vulnerability. to mental health issues, since the developmental experiences of this period may be long-term. impacts on emotional stability and psychological strength (Arnett, 2000). Childhood trauma that includes

such experiences as emotional or physical abuse. This is because neglect, and household dysfunction, is a well-known major risk factor of the. later development of depressive symptoms (Felitti et al., 1998).

These adverse experiences disrupt normal emotional development, creating vulnerabilities that persist in adulthood. To fully comprehend how childhood trauma contributes to depression, it is essential to consider factors such as attachment styles and resilience, and influence in this relationship. Attachment theory provides a model of how early relationships shape emotional development and mental health (Bowlby, 1982). Attachment styles: The quality of caregiver, guardian and parental attachment styles may be secure or insecure. A cause-and-effect relationship between trustworthy and secure attachment, where the individual is able to believe that others will not hurt them and that they are worthy of being liked, is likely when secure attachment is formed through reliable and timely caregiving. Insecure attachment styles, including anxious and avoidant attachment styles, however, are more likely to develop from neglectful or abusive caregiving contexts (Ainsworth et al., 1978).

Physically intentional and harmful act directed to a child which causes injury, pain, or impairment (Gilbert et al., 2009). Abuse may be inflicted externally as in hitting, punching, or kicking, or even inflicted through burning or causing other forms of physical harm that produce physical injuries, possible chronic health problems, and emotional scars such as fear, aggression, or low self-esteem (Norman et al., 2012).

Emotional abuse involves behaviors that damage a child's self-worth or emotional wellbeing (Baker & Festinger, 2011), including verbal insults, constant criticism, humiliation, rejection, or threats. This could pose serious aftereffects such as anxiety, depression, difficulties in maintaining interpersonal relationships, and poor self-esteem (Spinazzola et al., 2014).

Sexual abuse is any sexual act here the victim is a child who cannot give consent (Finkelhor et al., 2009) such as the acts of molestation, rape, incest, exposure to pornography, and sexual exploitation, and it leads to psychologic sequelae that can be very severe, such as post-traumatic stress disorder (PTSD), shame, guilt, and difficulty with intimacy (Kendall-Tackett et al., 1993).

Emotional and Physical Neglect, referred to as a caregiver's failure to provide for a child's basic needs (i.e., physical care and development, emotional well-being, and educational), consists of a lack of nourishment and sustenance, physical home, shelter, clothing, medical attention, supervision, or emotional support. Neglect may lead to the following: developmental retardation, defective physical health, or an emotional condition of worthlessness or abandonment (Hildyard & Wolfe, 2002). Psychological or emotional neglect arises when a child is denied emotional support, attention, and caring. Long-term neurobiological alteration is known to result due to childhood trauma particularly in brain regions that store the control of stress, emotional processing and decision-making. The hypothalamic-pituitary-adrenal has been identified to be impaired by childhood traumatic experience. The stress hormone dysregulation of stress is caused by (HPA) axis, the stress-regulatory system of the body denotes hormones like cortisol (Teicher et al., 2003). This is a structural and dysregulation that is associated with maladaptive changes in the essential brain areas, including the hippocampus, amygdala, and prefrontal cortex, which is in charge of the memory, emotion control, and executive function (Hart et al., 2012). For example, shrinking in the volume of hippocampal, occasionally observed in individuals with histories of this is because childhood trauma, has been associated with emotional and cognitive impairments, such as depression and PTSD (De Bellis et al., 2002).

Attachment styles describe how people go about establishing emotional connections and how they react to relationships, based on how their early experiences with caregivers were received (Bowlby, 1969). Styles grow depending on the steadiness, sensitivity and responsiveness of the carers towards the signals of the child, which subsequently determine how people attach themselves to relationships in their lives. The

attachment theory by John Bowlby revolves around the significance of secure attachments in the creation of emotional well-being and survival (Bowlby, 1982). Anxious attachment individuals experience inconsistent care, and thus they learn to be fearful of abandonment, overly dependent on others, and more vigilant in relationships. The pattern is associated with emotional instability, low self-esteem, and higher risk of depression or anxiety (Wei et al., 2005).

Avoidant attachment is usually the result of emotionally unavailable or unresponsive parents. Individuals with this style might be suppressing their feelings, avoiding intimacy, and choosing independence as a means of guarding against vulnerability (Bartholomew & Horowitz, 1991). This style is associated with emotional disconnection, helplessness seeking, and higher depression (Shaver & Mikulincer, 2007). Disorganized attachment is when parents are both sources of comfort and fear, usually through traumatic or abusive experiences. This leads to contradictory behavior, discomfort with intimacy, and poor emotional regulation (Main & Solomon, 1990). The style has been linked with an overabundance of mental health problems, such as depression and post-traumatic stress disorder (PTSD) (Lyons-Ruth et al., 2006)

Depressive symptoms are a group of emotional, cognitive, behavioral, and physical signs traditionally associated with depression. They vary in intensity, duration, and influence but collectively interfere with a person's functioning and quality of life (American Psychiatric Association, 2013). Depression is one of the major causes of disability globally, and symptoms range from mild to severe with almost always following significant personal and societal loss (World Health Organization, 2021).

The affective component of depressive symptoms is ongoing sadness, emptiness, or hopelessness (American Psychological Association, 2013). The patients may also have excessive guilt or worthlessness without any obvious cause, which aggravates their emotional state as well.

Depression has a tendency to interfere with cognitive processes due to the occurrence of concentration, decision-making, and memory issues (Austin et al., 2001). Depressive symptomatology is marked by negative thinking in the form of rumination, self-blame, and catastrophizing (Nolen-Hoeksema et al., 2008). The aforementioned thought distortions lead to helplessness and incompetence and reinforce the depressive vicious circle. Behavioral changes are a symptom of depression that may include social withdrawal, reduced activity, and avoidance of self-care activities or personal activities (Joiner et al., 2005). Some of the patients have psychomotor agitation with restlessness and fidgeting, while other have psychomotor retardation with slowness of speech and movement.

Depression frequently comes with the presence of physical complaints, such as fatigue, alteration in appetite or weight, sleep (hypersomnia or insomnia), and unexplained physical pain (Simon et al., 1999). Physical complaints are highly suggestive of emotional and behavioral characteristics of depression, leading to a self-perpetuating cycle.

Depression and depressive symptoms develop in individuals of all ages, cultures, and socioeconomic backgrounds, but there are groups that are more at risk. Depression is brought about by biological causes which include neurochemical imbalance and genetic causes. As an illustration, individuals who have family background of depression or those who test positive in some genetic fails are prone to depression (Sullivan et al., 2000). Mood disorders have also been attributed to imbalance of the neurotransmitter's serotonin and dopamine (Meyer et al., 2006). Other sources of risk to depression are psychological features, like neuroticism, poor self-esteem, and poor coping styles. Individuals that are extremely neurotic or possess low self-esteem tend to be vulnerable to depression due to the fact that these individuals are over-sensitive to stressful issues and are negatively perceptual of themselves (Beck et al., 1979). Depressive symptoms may also increase with the role of maladaptive coping styles, which include ruminations and avoidance, in

impeding the effective processing of emotions and problem solving (Nolen Hoeksema, 2000). Environmental conditions, including chronic stress, child abuse, and social isolation, also play a role in the etiology and maintenance of depression (Felitti et al., 1998). Chronic stress may interfere with the regulation of mood, while child abuse may interfere with emotional development and coping (Hammen, 2005). Social isolation may increase feelings of loneliness and hopelessness, which underlie depressive symptoms (Cohen & Wills, 1985).

Objectives

1. Examine the positive relationship between childhood trauma and depressive symptoms.

2. Investigate the mediating role of attachment styles (anxious, avoidant) between childhood trauma and depressive symptoms.

Hypotheses

1. There will be a positive relationship between Childhood Trauma and Depressive Symptoms among young adults.

2. Attachment styles (Anxious and Avoidant) will mediate the relationship between Childhood Trauma and Depressive Symptoms

RESEARCH METHODOLOGY

Instrument

1. Participants

The research sample size of around 200 young adults (100 males, 100 females). young adults aged 19 to 26 from colleges and universities of twin cities (Rawalpindi and Islamabad) of Pakistan

2. Adult Attachment Scale (AAS)

It measured three attachment styles: secure attachment, anxious attachment, and avoidant styles. It had 18 items scored with help of 5-point Likert scale ranging from 1 to 5. Cronbach's alpha values of .69 for the Close, .75 for the Depend, and .72 for the Anxiety respectively. Test-retest correlations over two months were .68 for the (Close subsclae) .52 (Anxiety subscale), .71 (Depend subscale), thus indicating moderate consistency.

3. Adverse Childhood Experiences

It measures childhood maltreatment: physical abuse, sexual abuse, emotional neglect, emotional abuse and physical neglect. This scale has 10 items and is calculated by summing yes responses. This questionnaire demonstrates excellent reliability, with internal consistency values above .80.

Procedure

Initially, the study is approved by the Institutional Review Board (IRB) of National University of Medical Sciences (06/ IRB& EC/ NUMS/ 116), dated (22 Nov 2024). The data collection was approved by the higher authorities of academic institutes. The recruits were selected using a convenient sampling method

that included young adults aged between 19 and 26 years old and studying in the colleges and universities of twin cities (Rawalpindi and Islamabad). Questionnaire SPSS was used after the Written informed consent participants received questionnaire forms to be statistically analyzed.

Ethical Considerations

This study also attended to the established ethics in studies involving human subjects. In the name of privacy of the participants, some confidentiality procedures were observed. Anonymization was used to maintain anonymity of all the data collected and qualified personnel had access to it exclusively. This minimized the risk of victimization of confidentiality, which came with confidence in the research process and adherence to the best practice in data management. Another transparency mechanism required was to guarantee the research findings to the respondents after the study was done in order to cement their contributions and integrity. Moreover, the interactions were done with utmost respect to ensure the rights, autonomy and personal values of the participants. Ethical considerations were carefully laid down and adhered to in order to protect the rights of the participants. The study was conducted in the best interest of ethical considerations in obtaining desired permissions, the voluntariness, confidentiality, and exposure of the perceived risks. These will encompass not only improving the integrity and reliability of the research, but also gave the participants a peaceful and respectful environment.

Statistical Analysis

Descriptive statistics and other inferential statistical tests like Pearson correlation and mediation were applied to analyze data. All the statistical calculations have been done using Statistical Package for Social Sciences (version names as SPSS- V 29).

Inclusion Criteria

Research participants 19 to 26 years, in their young adulthood. Individuals needed to have at least intermediate education (12 years of schooling) to guarantee adequate literacy for understanding and completing the study's questionnaires. Participants reporting minimum one adverse childhood incidence, such as abuse or neglect, were included, given the study's focus on childhood trauma's effects.

Exclusion Criteria

Individuals with physical disabilities were not included, as such conditions might introduce unrelated factors affecting resilience or depression beyond childhood trauma.Those currently receiving psychiatric treatment or diagnosed with psychiatric /psychological disorders were excluded to prevent overlap between existing mental health conditions and the study's variables.

RESULTS

The sample size was 200 young adults (1:1) males (50.0%) and females (50.0%) because the research plan stated the equal distribution of genders. The age of the participants ranged between 19 and 26 years with most aged between 23-26 (46.5%), secondly aged 21-23 (29.5%), and finally aged 19-21 (24.0%). The sample had a variation in educational attainment with 44.5% having a bachelors degree (BS), 36.0% a masters degree (MS), and 19.5% at the intermediate level.

Table 1: Pearson Correlation values relating to Childhood Trauma and Depression (N = 200)

Sr.no	*Variables*	*1*	*2*
1	*Childhood Trauma*		*.45***
2	*Depressive Symptoms*	*.45***	

Note: **p<.01,

The correlation analysis uncovered a moderately positive link between early age trauma and depression, evidenced by Pearson correlation coefficient as *(r* =.454, *p* < .01). These findings suggest that hypothesis one has been verified.

Table 2: Descriptive Statistics of Subscales (N = 200)

Subscale	*N*	*Min*	*Max*	*M*	*SD*
Physical Abuse	200	5.00	25.00	12.65	5.07
Emotional Abuse	200	6.00	21.00	12.96	3.37
Sexual Abuse	200	5.00	22.00	10.23	4.57
Physical Neglect	200	5.00	17.00	11.95	2.58
Emotional Neglect	200	6.00	25.00	13.28	4.13

The subscales of the ACE reveal differing degrees of childhood trauma among participants. Emotional Neglect recorded the highest average score *(M* = 13.2850, *SD* = 4.13026), followed closely by Emotional Abuse (*M* = 12.9650, *SD* = 3.37948) and Physical Abuse (*M* = 12.6500, *SD* = 5.07506). Physical Neglect (*M* = 11.9550, SD = 2.58775) and Sexual Abuse (*M* = 10.2300, *SD* = 4.57403) had somewhat lower averages. The broad range of scores (e.g., 5–25 for Physical Abuse) indicates diverse levels of trauma exposure, with every participant reporting at least one adverse childhood experience (ACE).

Table 3: Anxious Attachment style Mediation Analysis between early age trauma and depression (N=200)

Paths	*B*	*T*	*P*	*F*	*β*	*R²*
CHT → DS	.47	6.54	<.001	49.58	.40	.50
CHT → ANX	.17	5.19	<.001	26.97	.35	.11
ANX → DS	.61	4.09	<.001	49.58	.30	.50

Effects Pathways summary

Pathways	*B*	*SE*	*t*	*P*	*LLCI*	*ULCI*
Direct Effects	.5713	.0828	7.1	<.001	.4299	.7565
Indirect Effects	.1793	.0884	-	-	.3970	.7454
Total Effects	.7506	.0352	6.4	<.001	.0332	.1050

Note: CHT = Childhood Trauma (X), DS = Depressive Symptoms (Y), ANX = Anxious Attachment (M2)

Childhood trauma also positively predicted anxious attachment (*B* = .17, t = 5.19, *p* < .001), indicating that individuals with more traumatic experiences are more prone to developing anxious attachment tendencies.

Anxious attachment significantly contributes to heightened depressive symptoms (B= .61, t = 4.09, p < .001), suggesting anxious attachment traits are more vulnerable to depression.

The direct effect of early age trauma on depression is significant (t= 7.1, p < 0.001, B = 0.5713,), indicating direct relationship between these variables in this model. The indirect effect through anxiousness is 0.1793 showing significant effect with 95% confidence interval [CI: 0.332 to 0.1050].

Table 4: Avoidant Attachment Mediation Analysis between early age trauma and depression. (N 200)

Paths	*B*	*T*	*P*	*F*	*β*	*R²*
CHT → DS	.47	6.54	<.001	49.58	.40	.50
CHT → AVO	.16	2.43	<.001	5.92	.37	.09
AVO → DS	.72	9.73	<.001	49.58	.45	.50

Effects Pathways summary

Pathways	B	SE	T	P	LLCI	ULCI
Direct Effects	.5354	.0753	6.54	<.001	.3299	5565
Indirect Effects	.1741	.0418	-	-	.2354	.4221
Total Effects	.7095	.0823	8.75	<.001	.02717	.4200

Note: CHT = Childhood Trauma (X), DS = Depressive Symptoms (Y), AVO= Avoidant Attachment (M2)

In this table childhood trauma also positively predicts with avoidant attachment (B = .16, t = 2.43, p = <.001), which shows more traumatic experiences developed avoidant tendencies. Avoidant attachment, however, strongly predicts depressive symptoms (B = .72, t = 9.73, p < .001), revealing that individuals with avoidant attachment patterns also face increased depression levels.

The direct effect of Childhood trauma on Depressive symptoms is significant (B = 0.5354, t= 6.54, p < 0.001), indicating direct relationship between these variables in this model. The indirect effect through avoidance is 0.1741 showing significant effect with 95% confidence interval [CI: 0.2717 to 0.4200]

DISCUSSION

Our first hypothesis "significant relationship between childhood trauma and Depression in young adults" is verified (Table = 3), results suggested positive association between early age childhood trauma and depression *(r = .45, p < .01)* previous research evidence support the findings. Several studies have persistently proposed that early age trauma correlates highly to depressing indications during young adulthood, according to Heim and Binder (2012) stressors in early life like abuse or neglect could create permanent changes to the HPA-axis making someone more prone to depression later in life. A meta-analysis by Infurna and other's (2016) revealed that childhood trauma significantly predicted age at start and magnitude of depression in adulthood having strong predictive value for all forms of emotional abuse and neglect. Norman (2012) suggested that childhood trauma (emotional, physical, and neglect) causes disturbed emotional and psychological development of individual and lead to long-term vulnerabilities like depression. Emotional neglect, described by a absence of emotional care and sensitivity from caregivers,

can cause feelings of worthlessness and low self-esteem being central aspects of depression (Bowlby, 1988). Similarly, emotional abuse, which involves verbal aggression, humiliation, and rejection, can disrupt the growth of a positive self-image that increases vulnerability to depression (Gibb et al., 2001).

The second hypothesis "Attachment styles (anxious, avoidant) will mediate the relationship between childhood trauma and depressive symptoms in young adults" is verified (Table 4&5). Statistical analysis revealed that both anxious attachment and avoidant styles significantly mediated the association between early age trauma and depression. Anxious based attachment style significantly positively predicted depression related symptoms ($p < .001$, $B = .61$). The avoidant attachment style similarly significantly positively predicted depression related symptoms ($p < .001$, $B = .72$) in young adults. Early relational trauma, including emotional unavailability, physical neglect or frightening caregiving, leads to disorganized attachment in infancy, which can later lead to avoidant attachment in adulthood (Lyons-Ruth et. al. (2006).

Avoidant individuals are characterized by emotional detachment and difficulty seeking support. Therefore, avoidant attachment was also found to be having a mediating impact on the relationship between early age trauma and depressive symptoms. Individuals with avoidant attachment tend to subdue their feelings and evade intimacy, leading to feelings of isolation (Shaver & Mikulincer, 2007). Emotional distancing can stop individuals from taking the social support required to manage the impact of trauma, thereby their vulnerability to depression often increases. (Cohen et al., 2017). The results suggest that avoidant attachment could be particularly detrimental with in the framework of childhood trauma, as it limits individuals' ability to form supportive relationships and access resources that could help them cope with adversity.

LIMITATIONS AND RECOMMENDATIONS

Although the study provides valuable insights, it is not without limitations.

1. First, the cross-sectional design limits the ability to establish causal relationships between childhood trauma, attachment styles, resilience, and depressive symptoms. Longitudinal studies that conduct research over longer duration of times would be necessary to track the developmental trajectories of these variables and confirm causality.

2. Second, the dependence on self-report measures may present recall bias, specifically for retrospective reports of childhood trauma. Future research could take advantage from including objective assessments or multi-informant reports methods to reduce this bias.

3. Thirdly, although the study did not explicitly measure disorganized attachment, previous research has shown that this attachment style, often resulting from traumatic or abusive caregiving environments, is associated with extreme mental distress, including depressive symptoms and Post traumatic stress disorder. (Lyons-Ruth et al., 2006). Future research should be aimed at exploring the role of disorganized attachment in mediating the association between early age trauma and depression, specifocally in populations with high levels of trauma exposure.

4. Moreover, the sample limitation was young adults aged 19–26, which limit the generalizability of the study findings to other age groups. So future studies should expand their samples in different dimensions, such as including adolescents and older adults for greater generalizability.

5. Specific cultural context (Pakistan) also adds to the limitation of the findings as the findings may not be generalizable to other cultures with different family structures and societal values, so

Cross-cultural comparative studies could offer valuable insights into the universality and cultural specificity of these relationships. Socioeconomic inequalities, such as poverty and lack of education, are widespread in Pakistan, thereby increasing the possibility that these disparities will further mediate the impact of childhood trauma on any disorder; however, this has not explicitly been addressed in this study. A future examination addressing such limitations will be critical for the planning of culturally viable interventions and policies for aiding childhood trauma survivors in Pakistan.

CONCLUSION

The present study focused on how childhood trauma is related with depression related symptoms and how attachment styles (anxious and avoidant) mediate early age trauma and depression related symptoms. The results suggest that early age trauma was found to be positively related to depression related symptoms, higher trauma leads towareds increased depressive symptoms, demonstrating that early adversative life experiences can have far reaching psychological consequences.

Further, attachment styles (both anxious attachment and avoidant attachment style), mediated the association between early age trauma and depression related symptoms, proposing that insecure attachment styles (anxious and avoidant attachment) may further exacerbate the adverse effects of early age childhood trauma on mental health.

Conflicts of Interest: None

Fundings: None

Disclosure: None

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