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Mediating Role of Self-Compassion and Psychological Resilience in the Relationship between Childhood Trauma and Psychosomatic Symptoms in a Non-Clinical Adult Sample

Klinik Olmayan Yetişkin Örneklemde Çocukluk Çağı Travmaları İle Psikosomatik Semptomlar Arasındaki İlişkide Öz Şefkat ve Psikolojik Sağlamlığın Aracı Rolü

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ABSTRACT

Objective: This study investigates the mediating effects of self-compassion and psychological resilience on the association between childhood trauma and psychosomatic symptoms in a non-clinical adult population.

Method: A convenience sample of 385 adults (250 women, 135 men), aged 18–65 years without clinical diagnoses, participated in the study. Data were collected using the Personal Information Form, Childhood Trauma Questionnaire, Somatization Scale, Self-Compassion Scale, and Brief Resilience Scale.

Results: Childhood trauma significantly predicted higher somatization. When self-compassion was included as a mediator, the model remained significant, with childhood trauma positively associated with somatization and self-compassion negatively associated with somatization. Similarly, when psychological resilience was introduced as a mediator, the model remained significant, with childhood trauma positively predicting somatization and psychological resilience negatively predicting somatization.

Conclusion: Childhood trauma is positively associated with psychosomatic symptoms. Self-compassion and psychological resilience partially mediate this relationship, reducing its intensity. These findings suggest that enhancing self-compassion and psychological resilience may help alleviate the impact of childhood trauma on psychosomatic symptoms.

Keywords: Childhood trauma, psychosomatic symptoms, self-compassion, psychological resilience

ÖZ

Amaç: Bu çalışma, klinik olmayan yetişkin bir popülasyonda çocukluk çağı travması ile psikosomatik semptomlar arasındaki ilişkide öz-şefkat ve psikolojik sağlamlığın aracı rollerini incelemektedir.

Yöntem: Çalışmaya, klinik tanısı olmayan, 18-65 yaş aralığında 385 yetişkin (250 kadın, 135 erkek) katılmıştır ve örneklem uygunluk örneklemesi yöntemiyle seçilmiştir. Veriler, Kişisel Bilgi Formu, Çocukluk Çağı Travma Anketi, Somatizasyon Ölçeği, Öz-Şefkat Ölçeği ve Kısa Psikolojik Sağlamlık Ölçeği kullanılarak toplanmıştır.

Bulgular: Çocukluk çağı travması, somatizasyonu anlamlı bir şekilde öngörmektedir. Çocukluk çağı travması somatizasyonu pozitif yönde öngörürken, öz-şefkat aracı olarak eklendiğinde model istatistiksel olarak anlamlı kalmış, çocukluk çağı travması somatizasyonu pozitif yönde, öz-şefkat ise somatizasyonu negatif yönde öngörmüştür. Benzer şekilde, psikolojik sağlamlık aracı olarak eklendiğinde model anlamlı kalmış, çocukluk çağı travması somatizasyonu pozitif yönde, psikolojik sağlamlık ise somatizasyonu negatif yönde öngörmüştür.

Sonuç: Çocukluk çağı travması, psikosomatik semptomlarla pozitif bir ilişki göstermektedir. Ancak öz-şefkat ve psikolojik sağlamlık aracı olarak eklendiğinde, bu ilişkinin yoğunluğu kısmi arabuluculuk etkisiyle azalmıştır. Bu bulgular, öz-şefkat ve psikolojik sağlamlığın geliştirilmesinin çocukluk çağı travmasının psikosomatik semptomlar üzerindeki etkisini hafifletmeye yardımcı olabileceğini öne sürmektedir.

Anahtar sözcükler: Çocukluk çağı travmaları, psikosomatik semptomlar, öz-şefkat, psikolojik sağlamlık

Introduction

Childhood experiences play a pivotal role in the formation of a healthy personality and represent a critical developmental period in which an individual's psychological, physiological, and social growth is profoundly influenced (Wallon 1968). Any stimuli encountered during this stage have the potential to leave deep and lasting imprints on an individual's life trajectory (Van der Kolk and Fisler 1995, Whitfield 1995). These experiences often encompass parental loss, excessive parental control and overprotection, exposure to war, forced migration, accidents, separation, and witnessing acts of violence. Furthermore, such adverse experiences can significantly

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impair an individual's quality of life and overall life satisfaction, potentially giving rise to a broad range of psychological and somatic outcomes, ranging from psychiatric disorders to physical illnesses (Spertus et al. 2003, Polat 2007, Yüceant 2022).

Lipowski (1987) defines somatization as " a psychosocial difficulty with physical manifestations that recur over time." The term "psychosomatic" originates from the Greek words psyche (soul) and soma (body), signifying the dynamic interplay between psychological and physiological processes. Adverse childhood and adolescent experiences have been associated with the emergence of somatization (Okumura et al. 2020).

Compassion entails recognizing, acknowledging, and understanding another individual's suffering, followed by the intention to alleviate it (Peters 2006). In this context, self-compassion refers to an individual's ability to extend compassion toward themself. The degree of self-compassion and the level of psychological resilience, conceptualized broadly as resilience, play a crucial role in fostering recovery and enhancing overall well-being following traumatic childhood experiences (Cicchetti and Rogosch 2007, Akar 2018, Bellis et al. 2018, Doğan and Yavuz 2020).

Psychological resilience, a key concept in psychology, refers not only to an individual's strengths, resources, and positive traits but also to the flexibility to adapt to adverse circumstances and the ability to regain psychological equilibrium following distressing experiences (Greene 2002). Another definition characterizes resilience as the ability to sustain positive adaptation when confronted with trauma and psychological adversity, especially in the context of stress and challenge (Bahayi 2021).

Two fundamental criteria define psychological resilience. First, an individual must have been exposed to a significant and potentially harmful risk factor. Second, despite encountering substantial adversity capable of disrupting normative developmental processes, the individual must demonstrate successful adaptation (Luthar et al. 2000).

In this regard, it is hypothesized that the use of compassionate language and psychological resilience may play a vital role in mitigating the long-term consequences of childhood neglect and abuse, thereby facilitating effective coping mechanisms in later life (Neff 2003, Allen and Leary 2010, Streb et al. 2013, Pak et al. 2017, Austin et al. 2018, Çetinkaya Büyükbodur 2018, Şeker 2021, Muomah et al. 2021, Ogińska-Bulik and Michalska 2021). Recent empirical findings suggest that individuals who exhibit heightened self-criticism due to a perceived or actual deficiency of compassion tend to display lower levels of psychological resilience (Ünal 2021).

Adults who have experienced childhood neglect and abuse frequently demonstrate impairments in their bio-psycho-social development and overall psychological and emotional stability (Aktay 2020). The repercussions of traumatic experiences can manifest in both the short and long term. A substantial body of research has explored the lasting effects of such experiences on individuals in adulthood. A review of the literature underscores a strong correlation between childhood trauma and somatization, the manifestation of physical symptoms without a medical cause, often rooted in psychological distress. In cases where individuals report chronic pain, headaches, gynecological issues, or digestive disorders without an identifiable medical etiology, these symptoms may originate from unresolved traumatic experiences in early life (Karaer-Karapıçak 2010).

Parental attitudes during childhood significantly shape the development of somatization tendencies. At this developmental stage, children primarily seek love, compassion, and attention from their parents. Beyond affection, individuals also need kindness, mindfulness, and a sense of shared humanity. Under certain conditions, cultivating these attributes may serve as a protective factor against the emergence of somatization stemming from adverse childhood experiences. Deficiencies in self-compassion components are often rooted in inappropriate or inadequate parental attitudes. Research suggests that individuals who were raised in dysfunctional family dynamics tend to exhibit lower levels of self-compassion due to the adverse childhood experiences they endured (Akcan and Taşören 2021, Quinlan et al. 2021, Zhang and Li 2021). Moreover, as self-esteem deteriorates, individuals become increasingly susceptible to both past and future experiences of neglect and abuse. This erosion of self-esteem increases their vulnerability to further victimization, thereby perpetuating a revictimization cycle and psychological distress (Wu et al. 2021).

The primary objective of this study is to examine the relationship between childhood trauma and somatization in individuals without clinical diagnoses, focusing on those who have experienced emotional, sexual, or physical neglect or abuse. Additionally, the study aims to explore the potential mediating role of psychological resilience and self-compassion in this relationship. More specifically, it seeks to determine whether these psychological constructs exert a buffering effect on individuals with a history of trauma. The central research hypothesis posits that self-compassion and psychological resilience serve as mediating variables in the significant and positive relationship between childhood trauma and somatization. A review of the extant literature reveals that no prior

study has simultaneously examined these variables, thereby underscoring the potential theoretical and empirical contributions of this research to the field.

Method

This study employed a relational screening model. The relational model aims to identify the presence and/or strength of the relationship between two or more variables (Karasar 1999).

Sample

The sample size for this study was determined using the G*Power 3.1.9.4 software. A priori power analysis was conducted with a 95% confidence interval, a medium effect size ($f^2 = 0.15$), a power level of 0.80, and an alpha level of 0.05, assuming two predictor variables in a multiple regression model. The analysis was performed using the "Linear Multiple Regression: Fixed model, single regression coefficient" option. The results implied that a minimum sample size of 55 participants was required to achieve the desired statistical power (Noncentrality parameter $\delta = 2.8722813$, critical t-value = 2.0066468, degrees of freedom = 52, Actual Power = 0.8048029).

The final sample consisted of 385 participants, including 250 women and 135 men, aged between 18 and 65. Although 405 individuals initially participated in the study, 20 responses were excluded due to inconsistencies. These inconsistencies were identified in responses to similarly worded items, where contradictory answers suggested random or inattentive responding. As such responses were deemed unreliable, they were excluded from the final analysis.

Eligibility criteria included Turkish citizenship or literacy in Turkish, no diagnosed learning disabilities, no criminal record, and voluntary informed consent. Participants were also required to have no clinical psychiatric diagnosis or history of psychiatric hospitalization. The sample was selected using a convenience sampling method to facilitate accessibility and rapid data collection.

Considering the possibility that some participants may have experienced childhood trauma, an introductory statement was included at the beginning of the form to inform them that certain questions could be distressing or triggering. Participants were given the option to discontinue the survey if they anticipated any discomfort. The sample was limited to individuals without a clinical diagnosis of any psychiatric disorder and with no prior admissions to psychiatric services.

Procedure

This study was approved by the Ethics Committee of Istanbul Aydın University with the decision dated 29.12.2022 and numbered 2022/21. Permissions to use the scales employed in the research were obtained from Şar et al. (2021) for the Childhood Trauma Questionnaire (CTQ-33), Dülgerler (2000) for the Somatization Scale, Akın et al. (2007) for the Self-Compassion Scale, and Doğan (2015) for the Brief Resilience Scale (BRS).

The study was conducted via an online survey created using Google Forms, and the link was distributed through social media platforms. It was assumed that individuals who accessed the form and met the eligibility criteria responded sincerely. The study was not conducted under the auspices of any specific institution or organization. A convenience sampling method was employed, wherein participants were selected based on accessibility and availability. Data were collected through voluntary participation by individuals who accessed the survey via platforms such as LinkedIn, Instagram, and WhatsApp.

The survey consisted of a five-page form, including the Personal Information Form, the Childhood Trauma Questionnaire, the Somatization Scale, the Self-Compassion Scale, and the Brief Resilience Scale. These instruments were prepared in advance on Google Forms and presented to participants. The estimated completion time varied depending on individual reading and response speed, averaging between 25 and 30 minutes. Participants were instructed to answer all items. IP address restrictions were implemented to prevent multiple submissions by the same participant. After receiving ethics committee approval, data were collected through social media platforms including LinkedIn, Instagram, and WhatsApp. Only responses from participants who met the inclusion criteria and completed all items were included in the final analysis.

Measures

In this research, Informed Consent, Personal Information Form, Childhood Trauma Questionnaire, Somatization Scale, Self-Compassion Scale, and The Brief Resilience Scale were administered to the participants.

Personal Information Form

The personal information form was designed to collect demographic data from participants deemed relevant to the study. It gathered information on participants' age, gender, marital status, and income level.

Childhood Trauma Questionnaire (CTQ-33)

The validity and reliability study of the Childhood Trauma Questionnaire, originally developed by David P. Bernstein in 1994, was conducted in Turkey by Şar et al. (2012). The scale includes subdimensions assessing physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect. In a later study, Şar et al. (2021) utilized the CTQ-28, developed by Bernstein in 1995, and expanded it into the CTQ-33 by adding a sixth subdimension: overprotection/control. The current version of the scale comprises 33 items across six subdimensions: emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, and overprotection/control (Bernstein et al. 1994, Şar et al. 2021). Analyses indicated that the Cronbach's alpha reliability coefficient for the scale was 0.87 (Şar et al. 2021).

Somatization Scale

The Somatization Scale is a 33-item instrument developed by compiling items from the Minnesota Multiphasic Personality Inventory (MMPI) related to somatization disorder. Each item has two options: "true" and "false". Participants are expected to mark the option closest to them. Scale scores range from "0 and 33". The validity and reliability of the instrument were examined in a study conducted by Dülgerler (2000) in Turkey. The scale demonstrated an internal consistency coefficient (Cronbach's alpha) of 0.83 and a test-retest reliability coefficient of 0.996. Using the split-half method, the alpha coefficient for the first half was 0.8810 and for the second half, 0.8439. The scale also showed a correlation of 0.80 with the SCL-90-R (Dülgerler 2000).

Self-Compassion Scale

The Self-Compassion Scale was developed by Neff (2003) to assess an individual's level of self-compassion. The scale consists of 26 items and six subdimensions: awareness of shared experiences, over-identification, isolation, mindfulness, self-compassion, and self-judgment. The Self-Compassion Scale has a 5-point Likert-type rating of (1) never (2) rarely (3) often (4) usually and (5) always. The validity and reliability study of the scale in Turkey was conducted by Akın et al. (2007). The overall reliability coefficient in Turkey was found to be 0.94. The coefficients for the subscales were determined as follows: awareness of sharing, 0.87; isolation, 0.89; self-kindness, 0.94; self-judgment, 0.94; mindfulness, 0.92; and over-identification, 0.94 (Akın et al. 2007).

The Brief Resilience Scale (BRS)

The scale developed by Smith et al. (2008) to measure psychological resilience was adapted into Turkish by Doğan (2015). It is a brief, 6-item scale using a 5-point Likert-type format. The scale is designed to assess individual psychological resilience, with higher scores indicating greater levels of resilience. The test-retest reliability coefficient of the original scale ranged from 0.62 to 0.69. In the present study, the reliability coefficient was calculated as 0.77 based on the collected data (Doğan 2015).

Statistical Analysis

The data collected from the participants were analyzed using SPSS 27. Prior to analysis, it was confirmed that all measurement tools met the assumption of normal distribution. This confirmation involved examining the skewness and kurtosis values of the scales, which were expected to fall within the reference range of -3 to +3 (Kalaycı 2009). Based on this evaluation, parametric tests were deemed appropriate for the analysis.

Pearson correlation analysis was used to examine the relationships between the scales, while independent samples t-tests were conducted to compare scale scores across categorical demographic variables. Mediation analysis was performed using Process Macro version 3.5 (Hayes, 2013). Specifically, Model 4 of the Process Macro was employed to assess the mediating effects of psychological resilience and self-compassion in the relationship between childhood trauma and somatization. This model evaluates the effect of an independent variable (X) on a dependent variable (Y) through a mediating variable (M).

Confidence intervals for the indirect effects were calculated using the bootstrapping method, which does not rely on assumptions of normal distribution. This approach is particularly advantageous in mediation analysis due to its robustness in handling various data characteristics (Bradley-Garcia and Clement 2022). To enhance the accuracy and reliability of the results, the number of bootstrap samples was set to 5000— a commonly recommended value for mediation models. Additionally, the significance level for this study was set at $p = .05$.

In social sciences, a p-value below .05 is generally considered indicative of a statistically significant relationship or difference. Lower p-values reduce the risk of Type I errors, thereby increasing confidence in the findings (Hayes 2013).

Results

Among the participants, 64.9% were women and 35.1% were men. In terms of age distribution, 33.2% were between 18–25 years, 5.5% between 26–30, 4.4% between 31–35, 8.6% between 36–40, and 48.3% were aged 41 and above. Regarding marital status, 50.6% were married and 49.4% were single. Educationally, 33.3% were high school graduates, 54.0% held a bachelor's degree, and 12.7% had a master's degree or higher. In terms of income, 31.7% reported earning the minimum wage or less, 20.3% earned slightly above the minimum wage, and 48.0% had a monthly income of ₺10,000 or more. Employment status showed that 62.3% were employed, while 37.7% were unemployed. Finally, 7.3% of the participants reported having a psychological disorder, while 92.7% did not (Table 1).

Table 1. Characteristics of participants (n=385)

Characteristics		**n**	**%**
Gender	Women	250	64.9
	Men	135	35.1
Age	18-25	128	33.2
	26-30	21	5.5
	31-35	17	4.4
	36-40	33	8.6
	41 and older	186	48.3
Marital Status	Married	195	50.6
	Single	190	49.4
Education Level	High School	128	33.3
	Bachelor	208	54.0
	Graduates with a Master's degree and above	49	12.7
Economic Level	Minimum wage and below	122	31.7
	Above minimum wage	78	20.3
	10.000 and above	185	48.0
Working Status	Yes	240	62.3
	No	145	37.7
Psychological Disorder	Yes	28	7.3
	No	357	92.7
	Total	385	100.0

n: Number of participants; %: Percentage

Pearson correlation analysis was conducted to examine the relationships among the measurement tools (Table 2) .In the research, Process 3.5 was applied for the mediation analysis. The results were detailed in Figure 1 and 2.

As shown in Figure 1, childhood trauma significantly predicted somatization. The R2 value was .13, indicating that the predictors explained 13% of the variance in the outcome variable ($F(1,383)=59.89$, $p<.001$). Findings revealed that childhood trauma positively predicted somatization ($\beta=.37$, $t=7.74$, $p<.05$).

The regression model obtained after including the mediator variable self-compassion to the model was statistically significant ($F(2,382)=120.82$, $p<.001$). Among the independent variables, childhood trauma ($\beta=.12$, $t=2.77$, $p<.05$) predicted somatization positively, and self-compassion ($\beta=-.61$, $t=15.16$, $p<.05$) predicted somatization negatively. The R2 value was .38, indicating that the predictors explained 38% of the variance in the outcome variable.

After including the mediator variable in the model, the variance explained by the models increased by 25%. The beta coefficient of childhood trauma decreased from 0.37 to 0.12, however, as it remained statistically significant, this implied a partial mediation. As a result, there was a partial mediating effect of self-compassion in the relationship between childhood trauma and somatization. The total partial mediation effect of these two variables was obtained as $\beta=.25$, $p<.05$.

Table 2. Relationship among the Brief Resilience Scale, Somatization Scale, Childhood Trauma Questionnaire, Self-Compassion Scale

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1-The Brief Resilience Scale	1															
2-Somatization Scale	-.61**	1														
3-Childhood Trauma Questionnaire	-.31**	.37**	1													
4-Emotional Abuse	-.25**	.35**	.81**	1												
5-Physical Abuse	-.23**	.32**	.68**	.63**	1											
6-Physical Neglect	-.05	.05	.60**	.28**	.24**	1										
7-Emotional Neglect	-.28**	.31**	.89**	.65**	.51**	.53**	1									
8-Sexual Abuse	-.24**	.29**	.35**	.25**	.26**	.09	.23**	1								
9-Overprotection/ Control	-.28**	.31**	.74**	.53**	.42**	.21**	.55**	.14**	1							
10-Self-Compassion Scale	.73**	-.61**	-.44**	-.36**	-.31**	-.12*	-.39**	-.30**	-.38**	1						
11-Self-Kindness	.65**	-.50**	-.38**	-.29**	-.24**	-.16**	-.36**	-.30**	-.27**	.86**	1					
12-Self-Judgement	.54**	-.48**	-.38**	-.36**	-.29**	-.04	-.33**	-.25**	-.34**	.83**	.60**	1				
13-Awareness of Sharing	.47**	-.35**	-.29**	-.19**	-.17**	-.20**	-.28**	-.23**	-.17**	.71**	.73**	.40**	1			
14-Isolation	.60**	-.58**	-.40**	-.37**	-.29**	-.07	-.32**	-.21**	-.40**	.81**	.53**	.74**	.35**	1		
15-Consciousness	.62**	-.48**	-.38**	-.26**	-.27**	-.15**	-.35**	-.28**	-.31**	.86**	.84**	.57**	.68**	.56**	1	
16-Over-Identification	.71**	-.59**	-.34**	-.31**	-.27**	.00	-.28**	-.21**	-.36**	.85**	.60**	.76**	.38**	.77**	.63**	1

**p<0.01, *p<0.05; Pearson Correlation Analysis

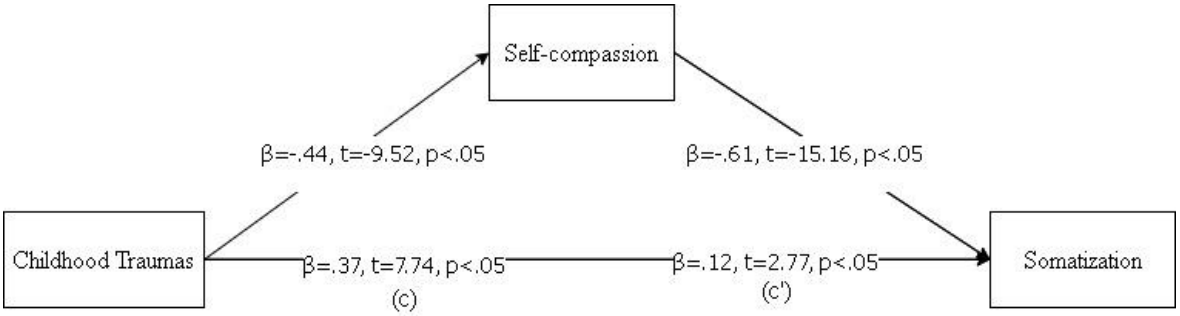

Figure 1. Mediating role of self-compassion in the relationship between childhood trauma and somatization

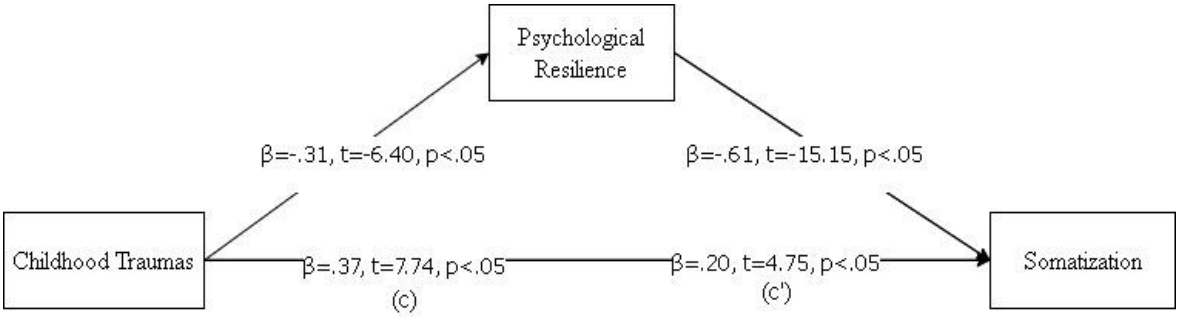

Figure 2. Mediating role of psychological resilience in the relationship between childhood trauma and somatization

As illustrated in Figure 2, childhood trauma was found to significantly predict somatization. The R2 value was .13, indicating that the predictors explained 13% of the variance in the outcome variable ($F(1,383)=59.89$, $p<.001$). Findings revealed that childhood trauma positively predicted somatization ($\beta=.37$, $t=7.74$, $p<.05$).

The regression model incorporating the mediator variable psychological resilience was found to be statistically significant, $F(2, 382) = 132.62$, $p < .001$. Among the independent variables, childhood trauma ($\beta = .20$, $t = 4.75$, $p < .05$) positively predicted somatization, whereas psychological resilience ($\beta = -.61$, $t = 15.15$, $p < .05$) negatively predicted it. The R^2 value was .41, indicating that the predictors accounted for 41% of the variance in the outcome variable.

After the mediator variable was included in the model, the explained variance increased by 28%. The beta coefficient for childhood trauma decreased from 0.37 to 0.20; however, since it remained statistically significant, this indicates a partial mediating effect. Thus, psychological resilience exhibited a partial mediating effect in the relationship between childhood trauma and somatization. The total indirect effect was calculated as $\beta=.17$, $p<.05$.

Discussion

Childhood constitutes a critical period in human development, establishing the foundation for an individual's cognitive, emotional, and social well-being. Adverse experiences during this formative stage can have profound and lasting traumatic effects. Caregivers and other individuals, whether intentionally or unintentionally, may engage in behaviors or adopt attitudes that adversely influence a child's development (Güler et al. 2002). In early childhood (0–6 years), children are particularly vulnerable due to their physical fragility, which increases their susceptibility.

Trauma, which can occur at any stage of life, is defined as exposure to experiences that disrupt healthy development and cause psychological or physiological harm, particularly when experienced in childhood (Karal and Atak 2022). The impact of neglect or abuse, whether inflicted by caregivers, relatives, or strangers, varies depending on factors such as the individual's age, personality, emotional state, level of self-protection, and access to social and personal resources. As a consequence of trauma, individuals may experience a range of difficulties across physical, emotional, cognitive, behavioral, and social domains (Carr et al. 2013). Accordingly, those with a history of childhood neglect and abuse are at an increased risk of developing physical and mental health disorders in adulthood, rendering them more susceptible to heightened levels of distress, depression, and vulnerability (Felitti et al. 1998, Norman et al. 2012).

Research has consistently demonstrated that childhood trauma is associated with severe physical and neurological consequences, including an elevated risk of mortality and disability (e.g., heart disease, cancer, stroke, diabetes), as well as an increased likelihood of developing depression and suicidal tendencies (Danese and McEwen 2012, Hughes et al. 2017, WHO 2020). Common physical complaints reported by affected individuals in adulthood include chronic pain, fatigue, headaches, and other disability-associated symptoms (Bendixen et al. 1994, Koptagel-İlal 1999, Green et al. 2001, Spertus et al. 2003, Sinani 2012). Findings from prior research suggest a significant positive association between childhood trauma and somatization.

Negative experiences inflicted by caregivers, such as neglect and abuse, may hinder an individual's ability to cope with adversity in adulthood, fostering feelings of helplessness and hopelessness (Aydın 2018). These effects may manifest in various aspects of life, with survivors often experiencing persistent shame and self-blame, shaped by manipulative dynamics instilled by their abusers, ultimately obstructing the formation of a healthy self-concept (Lopez-Bornstein 1995).

A study conducted by Cingöz (2022), examining the role of self-compassion in individuals diagnosed with and without somatoform disorders, found that participants diagnosed with somatoform disorders exhibited lower levels of self-compassion compared to their counterparts without the disorder. Furthermore, diminished self-compassion in both groups was associated with a higher prevalence of physical symptoms and a reduced overall quality of life (Dewsaran et al. 2018). These findings suggest that self-compassion may serve as a protective factor in mitigating the physical symptoms resulting from adverse life experiences.

Emotional wounds often require more time to heal than physical injuries (Sokullu-Akıncı 2013). Children exposed to experiences that exceed their mental, physical, and psychological capacities at an early age may internalize feelings of guilt and self-blame due to the manipulative behaviors of their abusers (Collin-Vézina et al. 2015). During this process, negative thoughts and emotions originating from trauma may be processed in maladaptive ways, resulting in distorted self-perception. Consequently, individuals who attribute blame to

themselves accountable for past abuse, engage in harsh self-criticism, and struggle with self-forgiveness tend to exhibit lower levels of self-compassion and psychological resilience. A study found that self-forgiveness, arising from the ability to relinquish self-blame for childhood trauma, was a significant predictor of enchaned psychological resilience (Doğruer 2019).

Children primarily acquire behaviours through observational learning and imitation (Erşan and Er 2022). By witnessing their caregivers' responses to various situations, they develop patterns of response to similar circumstances (Campos et al. 1989, Morris et al. 2007). Accordingly, the language, attitude, and behavior individuals adopt in adulthood often mirror those exhibited by their caregivers. For individuals with a history of neglect or abuse, this may translate into perpetuating self-criticism, harsh self-judgment, and a failure-oriented perspective (Yumuşakkaya 2022). At this juncture, cultivating a compassionate attitude toward oneself becomes paramount. Empirical research has established that self-compassion enhances well-being, happiness, and optimism while simultaneously reducing anxiety, depression, neurotic perfectionism, and rumination (Neff 2009, Yarnell and Neff 2013). Individuals with higher levels of self-compassion demonstrate an increased ability to acknowledge their own shortcomings, circumvent excessive self-criticism, and practice self-forgiveness. Consequently, they exhibit greater psychological resilience, which eneables them to maintain mental well-being in the face of adversity and approach the future with optimism.

Extensive literature suggests that adverse childhood experiences leaves profound emotional scars, negatively impacting an individual's self-concept, self-schema, and self-worth, thereby contributing to maladaptive self-perceptions. Prior studies highlight that early adverse experiences can impair self-compassion (Zhang and Li 2021). Empirical findings further suggest that childhood abuse negatively predicts self-compassion, which, in turn, is a predictor of depression (Akcan and Taşören 2020).

A plausible explanation for the difficulty individuals with a history of childhood trauma encounter in cultivating self-compassion may be rooted in deeply internalized beliefs of worthlessness, unlovability, and helplessness. Such maladaptive self-perceptions often stem from early relational trauma and manifest as a persistently critical and punitive inner dialogue. This harsh self-appraisal can exert a deleterious impact across various domains of functioning, including occupational performance, familial dynamics, and interpersonal relationships. Empirical evidence suggests that higher levels of self-compassion are positively associated with psychological resilience, particularly among university students, by fostering adaptive coping mechanisms in the face of emotionally taxing and distressing life experiences (Yelpaze 2021).

An age-based analysis of the study variables revealed significant associations, with emotional abuse being most frequently reported by participants aged 18–25. Similarly, physical abuse demonstrated a significant correlation with this age cohort. Additionally, sexual abuse demonstrated a significant relationship with individuals aged 18–30, particularly those between 26 and 30, who reported higher scores compared to other age groups. A significant difference was also observed in the somatization variable, with individuals aged 18–25 exhibiting higher somatization scores than older participants.

Findings from the present study underscore a significant association between childhood trauma and somatization. Specifically, individuals aged 18–25 were more frequently exposed to emotional, physical, and sexual abuse. This heightened vulnerability may be attributable to the relative developmental immaturity, partial dependence on caregivers, and limited self-sufficiency characteristic of this age group, which collectively increase susceptibility to neglect and abuse. Nonetheless, this association is likely influenced by additional individual-level factors, including personality traits, coping capacities, and access to psychosocial support systems.

This study is subject to several limitations. First, the sample comprised 385 individuals aged 18 to 65 residing in Turkey, which may constrain the generalizability of the findings to broader, more diverse populations. Although a total of 405 participants initially took part in the study, 20 were excluded due to inconsistencies in the information they provided. Therefore, only the data from 385 participants were considered valid for analysis. In order to obtain a larger sample, individuals who did not have a clinical diagnosis but had a history of trauma were included in the study. The participants had not previously consulted a psychiatrist nor had they been officially diagnosed with childhood trauma. Additionally, the study was not conducted within a specific institution or organization, which may introduce variability in participants' backgrounds. Second, data were collected between September and November 2022, and the economic conditions at the time may have influenced participants' responses. Third, the study relies on self-reported data, which poses the risk of response bias, as some participants may have withheld or misrepresented their experiences and emotions. Finally, the study is constrained by the specific variables measured through The Childhood Trauma Questionnaire (CTQ-33), The

Somatization Scale, The Self-Compassion Scale, and The Brief Resilience Scale, which may not capture the full complexity of the relationship between childhood trauma and somatization.

Conclusion

This study investigates the mediating role of psychological resilience and self-compassion in the relationship between childhood trauma and somatization. The findings indicate that these psychological constructs operate as mediating variables within the observed association. More specifically, the presence of psychological resilience and self-compassion appears to attenuate the adverse effects of childhood trauma on somatization, functioning as protective mechanisms that bolster psychological well-being and reduce distress associated with early traumatic experiences.

The results further demonstrate that self-compassion and psychological resilience partially mediate this relationship. In other words, when psychological resilience and self-compassion are incorporated into the model, they partially mediate the robust positive association between childhood trauma and somatization, thereby contributing to a reduction in the severity of symptom manifestation.

Individuals with a history of traumatic experiences may exhibit diverse responses to these events. Some may express their distress through physical symptoms, illness, pain, and bodily discomfort, particularly when they struggle to resist, verbalize, or articulate their emotions. In such cases, it is posited that the body manifests distress as a response to adverse experiences. Somatization are thus conceptualized as symbolic expressions of psychological, neurological, physiological, or social disturbances arising from negative life experiences, ultimately leading to impairments in bodily functioning (Lipowski 1987). For individuals who have endured trauma, coping and adaptive capacities may be significantly diminished when confronted with subsequent negative life events. This decline is often associated with reduced psychological resilience, as well as impairments in self-esteem, self-efficacy, and self-confidence. Consequently, such individuals may experience heightened stress, anxiety, fear, and depressive symptoms (Lee et al. 2013, Hu et al. 2015, Cutuli et al. 2021). Moreover, these individuals may internalize their distress, encounter difficulties in social expression, exhibit an increased risk of suicidal ideation, engage in compulsive behaviors such as childhood masturbation, and develop various psychiatric disorders (Taner and Gökler 2004).

The study underscores the significant role of psychological resilience and self-compassion in mitigating the adverse effects of childhood trauma and the associated physical manifestations. Based on these findings, it is recommended that mental health professionals implement accessible interventions aimed at enhancing psychological resilience and self-compassion, given their critical role in fostering overall well-being. Additionally, as these competencies are known to be intergenerationally transferable, they may reinforce parent-child relationships and facilitate stronger connections with the external world. Therefore, offering educational counseling to parents of individuals who have experienced childhood neglect and abuse may prove beneficial in fostering their psychological and emotional development. Furthermore, the provision of early psychological support aimed at strengthening self-compassion and resilience may yield more adaptive outcomes in managing both current and future adversities. In the long term, such interventions are expected to make meaningful contributions to preventive mental health care.

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