



Self-Compassion Among Youth with Child Maltreatment Histories and Psychological Distress: A Scoping Review

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Article abstract

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Methods: Eight databases were screened: OVID MEDLINE, OVID PsychInfo, PsycARTICLES, ProQuest Sociological Abstracts, ProQuest ERIC, OVID Embase, CINAHL, and PUBMED. Our search strategy and inclusion/exclusion criteria yielded an initial 4143 studies. With 1365 duplicates removed, 2778 titles and abstracts were screened. 17 studies were included for full-text screening, and seven studies were selected for data extraction and final inclusion.

Results: SC was found to moderate and mediate the relationships between CM and psychological distress. The role of fear of SC was also investigated and found to function as a mediator between CM and PTSD symptom severity. Regarding CM types, emotional abuse was found to significantly predict SC levels in a child welfare population.

Implications: Given the significance of SC and fear of SC in the relationship between CM and psychological distress, implementation of SC into clinical practice should be considered. Recommendations are made to expand research into more diverse populations, such as child welfare and/or Indigenous youth.

Self-Compassion Among Youth with Child Maltreatment Histories and Psychological Distress: A Scoping Review

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Abstract

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Keywords: Self-compassion, child maltreatment, psychological distress, youth.

Introduction

On a global scale, child maltreatment (CM) is a significant health and social problem. The World Health Organization (WHO) defines CM as “all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power” (Consultation on Child Abuse Prevention, World Health Organization. Violence and Injury Prevention Team & Global Forum for Health Research, 1999). Table 1 includes definitions of types of CM. The prevalence of CM varies by type, sex, and location. Based on a review of self-reports in North America, approximately 24.3% of boys and 21.7% of girls report physical abuse; 14.1% and 20.4% report sexual abuse; 28.4% and 23.8% report emotional abuse; and 16.6% and 40.5% report neglect respectively (Moody et al., 2018). It is important to note that these self-reports are likely lower than actual prevalence rates, due to challenges surrounding disclosure (e.g., feelings of shame, fear of not being believed, lack of trust in adults or professionals; Jernbro et al., 2017; Lemaigre et al., 2017). In the 2020 fiscal year, the US and local protective services received approximately 3,925,000 million referrals of CM involving 7,065,000 children, though this data is likely underestimated too (U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, 2022). A combination of prospective case reviews and retrospective self-reports is considered most accurate in determining incidences of CM (Shaffer et al., 2008).

Table 1. Definitions of Child Maltreatment Types (Government of Canada, 2012)

Child Maltreatment Type	Definition
Physical Abuse	“The application of unreasonable force by an adult or youth to any part of a child’s body”
Sexual Abuse	“Involvement of a child, by an adult or youth, in an act of sexual gratification, or exposure of a child to sexual contact, activity, or behaviour”
Emotional Abuse	“Adult behaviour that harms a child psychologically, emotionally, or spiritually”
Neglect	“Failure by a parent or caregiver to provide the physical or psychological necessities of life to a child”
Exposure to Family Violence	“Circumstances that allow a child to be aware of violence occurring between a caregiver and his/her partner or between other family members”

General Negative Outcomes of Child Maltreatment

CM is costly at a system level. In the United States alone, an average of approximately \$210,012 USD is spent per victim of non-fatal CM (Fang et al., 2012). This total includes costs from childhood and adulthood healthcare, special education, child welfare, criminal justice, and productivity losses. Notably, CM is not an isolated event, but long-lasting in its consequences, extensive in its impact across all facets of life, and potentially reoccurring.

CM is associated with a host of negative outcomes that extend into adulthood for the victim. These outcomes include psychological and behavioural problems (e.g., relational challenges, substance abuse; Jonson-Reid et al., 2012; Paradis & Boucher, 2010), physical problems (e.g., disability, brain injury; McKinlay et al., 2014; O’Sullivan & Watts, 2018), sexual problems (e.g., sexually transmitted diseases, unwanted pregnancy; Ajilian Abbasi et al., 2015; Gilbert et al., 2009), and long-term health consequences (e.g., cancer, liver disease; Gilbert et al., 2009; Krug et al., 2002). The effects of CM can also be observed before adulthood. The WHO (2022b) defines youth as ages 15-24 years. This developmental phase includes two major life transitions: adolescence (ages 10-19 years; WHO, 2022a) and emerging adulthood (ages 18-25 years; Arnett, 2000). In the current study, “youth” refers to those aged 15-24 years. Second to infancy, adolescence involves the most biological, psychological, and social role changes during one’s lifetime (Bonnie & Beckes, 2019; Chaku & Hoyt, 2019). Emerging adulthood is the continuation of adolescence, involving identity exploration (e.g., romantic relationships, work), and instability (e.g., residential changes, entering new careers; Arnett, 2000). Youth with histories of maltreatment present significantly more psychological challenges, compared to youth without maltreatment histories (Kisely et al., 2018; Nanni et al., 2012; Scott et al., 2010). These challenges include suicidal ideation, anxiety, depression, emotional distress, and other psychiatric disorders (e.g., post-traumatic stress disorder (PTSD), antisocial personality; Silverman et al., 1996; Wolfe et al., 2001). The type of maltreatment also appears to have significance; for example, histories of sexual and emotional abuse were found to have greater associations with suicidal ideation among adolescents, compared to physical abuse or neglect (Miller et al., 2013). Generally, these consequences are compounded with polyvictimization, where multiple experiences of maltreatment exacerbate negative outcomes

experienced (Finkelhor et al., 2011; Turner et al., 2017). Such findings point to the need for early, and tailored, intervention for youth with CM histories.

Self-Compassion

The potential of self-compassion (SC) has been indicated as relevant for those with a maltreatment history. It is important to note that many different conceptualizations of SC exist, some of which have roots in Buddhist teachings with the religion itself dating back approximately 2,500 years ago (Khoury, 2019; Shonin et al., 2014). However, this scoping review will utilize the definition of SC based on the work of Dr. Kristin Neff, as it was her extensive work in SC that popularized the concept in Western psychology and stands as the most common operationalization of SC, due to the extensive use of Neff's Self-Compassion Scale (Baer, 2010; Barnard & Curry, 2011; Khoury, 2019).

According to Neff (2003a), SC is said to be comprised of three distinct components each having two poles (i.e., positive and negative): self-kindness, common humanity, and mindfulness. Self-kindness refers to being kind and understanding to oneself instead of self-critical (Neff, 2003a). Common humanity consists of viewing personal experiences as part of the larger human experience rather than separate and/or isolated from others, while mindfulness refers to approaching painful thoughts and feelings with balanced awareness instead of over-identification (Neff, 2003a). Therefore, SC encompasses not only acknowledgment and acceptance of one's own suffering, but kindness to forgive oneself (Neff, 2003a). It also includes understanding one's failures and shortcomings in a non-judgmental manner, which better allows the individual to view these as a shared human experience (Neff, 2003a).

Alternatively, Gilbert (2020) defines compassion as being sensitive to self-suffering and suffering in others, as well as a commitment to both alleviate and prevent it from occurring. Gilbert (2014) further defines it as consisting of three elements: compassion felt for others, compassion felt from others to ourselves, and compassion directed to ourselves (i.e., SC). Related to compassion, Gilbert et al. (2011) describes a phenomenon whereby certain individuals, especially those that are highly self-critical, may be fearful of SC and receiving compassion from others. This led to the development of the Fear of Compassion scales, which measured fear of self-compassion (FSC), fear of compassion from others, and fear of compassion for others (Gilbert et al., 2011).

In relation to psychological health, there are two ways that SC may act in a protective manner: (1) SC can interact with risk factors to buffer the adverse effects of the risk factor, and (2) SC can directly counteract the main adverse effects of the risk factor (Strickland et al., 2019). Various studies have demonstrated that SC is inversely related to negative psychological outcomes, such that higher levels of SC served as buffers against outcomes such as anxiety, depression, stress, and PTSD symptomology (Krieger et al., 2013; Macbeth & Gumley, 2012; Neff, 2003b; Scoglio et al., 2017; Winders et al., 2020). Additionally, increased SC was associated with an increase in resilience and emotional regulation, with the latter potentially serving as a mediator between SC and negative mental health outcomes (Inwood & Ferrari, 2018; Scoglio et al., 2017).

The existing literature has also demonstrated that among individuals with a history of CM, SC mediates the severity of psychological distress outcomes such as depression, anxiety, shame, and PTSD symptomology (Barlow et al., 2017; Messman-Moore & Bhuptani, 2020; Ross et al., 2019; Tarber et al., 2016; Wu et al., 2018). From these studies, two relational hypotheses can be suggested: (1) increased SC positively impacts mental well-being by reducing psychological distress severity; and/or (2) increased psychological distress due to CM decreases the level of SC an individual possesses. Most studies investigate the adult population; however, there is a gap in knowledge regarding the relationship between SC and psychological distress in youth survivors of CM. In this paper, psychological distress is broadly defined as subjective general distress that is associated with stress, mental disorders, and emotional problems, as well as having a negative impact on daily activities (Fortin et al., 2006). Emotion dysregulation is also explored as a manifestation of psychological distress, given detected associations between deficits in emotion regulation and measures of mental health (Inwood & Ferrari, 2018; Scoglio et al., 2017).

The aim of this scoping review is to investigate the current state of the empirical literature on the relationships across SC, psychological distress, and CM among youth. This review also aims to investigate how these relationships differ across specific types of maltreatment (e.g., physical abuse, sexual abuse, neglect, emotional harm, and exposure to family violence). Based on the information gathered, recommendations for future research and interventions related to SC for maltreated and distressed youth will be discussed.

Method

This scoping review followed the five stages outlined in the Arksey and O'Malley (2005) framework.

Stage 1 – Identifying the Research Question

Scoping reviews are typically conducted to examine and analyze current research activity on a specific topic (Arksey & O'Malley, 2005; Colquhoun et al., 2014; Levac et al., 2010). The purpose of this review was to analyze literature on the relationship between CM (i.e., physical, emotional, and sexual abuse, and neglect), psychological distress, and SC among youth. The first stage in the review process involves identifying the research question and clearly stating the topic of study, the population, and the outcomes of interest (Arksey & O'Malley, 2005; Colquhoun et al., 2014; Levac et al., 2010). Our topic of study was SC and psychological distress among youths with CM histories. Our target population was youth as defined by the WHO (2022b) – persons between the ages of 15-24 years. Our outcomes of interest were SC, psychological distress, and CM histories. Our two research questions were: (1) What is the relationship between SC and psychological distress in youth with a history of CM? and (2) How does this relationship differ across various types of CM?

Stage 2 – Identifying Relevant Studies

A search for relevant literature was conducted within a total of eight databases: OVID MEDLINE, OVID PsychInfo, PsycARTICLES, ProQuest Sociological Abstracts, ProQuest ERIC, OVID Embase, CINAHL, and PUBMED. A search strategy containing important keywords was developed by several authors (NW, KK, PR, WL, SO) with the assistance of an academic health sciences librarian. The detailed search strategy, customized for each respective database and restricted to title and abstract, can be found in the Appendix. The use of inclusion/exclusion criteria was also implemented for the selection of studies. The inclusion criteria included a focus on SC, psychological distress, and CM; participants aged 15-24 years; English language; and peer-reviewed primary, quantitative research studies. The exclusion criteria included types of communications or studies other than peer-reviewed primary, quantitative research studies (e.g., podcasts, images, personal communications, book chapters, theses/dissertations, reviews, qualitative studies, and case studies). These studies were excluded for the purposes of ensuring only peer-reviewed, rigorous data was collected for review and analysis. Though some theses/dissertations may be considered peer-reviewed, all theses/dissertations were removed to maintain a conservative approach.

Stage 3 – Study Selection

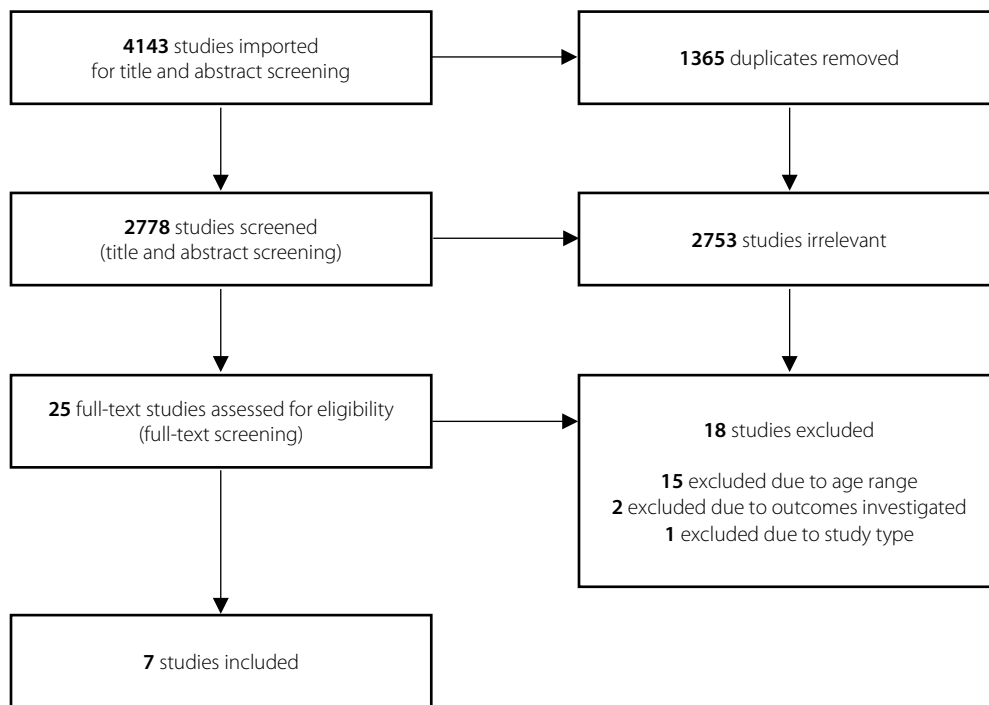
Implementation of our search strategy and inclusion/exclusion criteria to the eight databases yielded an initial total of 4143 studies. Covidence (see <https://www.covidence.org/>) was used to manage study selection and data extraction. 1365 duplicates were removed from the initial screening, and 2778 studies went on to title and abstract screening. From there, 17 studies met our inclusion/exclusion criteria and moved on to full-text review. Out of the 17 studies, seven studies were selected for final inclusion and underwent data extraction. A double-blinded screening process involving five separate reviewers (NW, KK, PR, WL, SO) was implemented throughout all steps of the review process. Any disagreements were resolved by two reviewers (NW, KK) and all reasons for exclusion were recorded. Our process of study selection is outlined in Figure 1.

Stage 4 – Charting the Data

A data extraction form was created through Covidence to determine which variables were relevant to our study aims. The following data items were extracted from each article: study characteristics (title, author(s), year of publication, country of origin, purpose/aim, and methodology), population characteristics (setting/country, participant age, sex and/or gender, sample size), definitions of key terms (i.e., SC, CM, psychological distress), outcome measures, results, and other relevant information, including any relationships between sex and gender and their impact on SC, CM, and/or psychological distress.

Stage 5 – Collating, Summarizing, and Reporting the Results

The final stage involved analyzing the results of the extracted data. Main themes and implications of the findings were determined. The results section outlines individual study characteristics and describes the relationships between history of CM, SC, and psychological distress that were elucidated from included studies.

Figure 1. PRISMA Diagram (study selection process)

Results

Study Characteristics

A total of seven studies were included in our scoping review (Table 2). Three studies originated from the US (Boykin et al., 2018; Miron et al., 2016; Reffi et al., 2019), two from Canada (Tanaka et al., 2011; Vettese et al., 2011), one from China (Hou et al., 2020), and one from Spain (Játiva & Cerezo, 2014). Among the included studies, all of them were peer-reviewed primary articles with six cross-sectional studies (Boykin et al., 2018; Hou et al., 2020; Játiva & Cerezo, 2014; Miron et al., 2016; Reffi et al., 2019) and one cohort study (Tanaka et al., 2011). There were three out of seven included studies that used solely female samples (Boykin et al., 2018; Miron et al., 2016; Reffi et al., 2019). However, two of those three studies used female college students enrolled in psychology courses at a large Midwestern university (Miron et al., 2016; Reffi et al., 2019), while the third used female college students non-selectively (Boykin et al., 2018). Two out of seven included studies had similar male to female participant proportions (Hou et al., 2020; Tanaka et al., 2011), and two of the included studies had a much higher proportion of male than female participants (71.6% to 28.4% and 65.4% to 34.6%, respectively; Játiva & Cerezo, 2014; Vettese et al., 2011). While all included studies enrolled youth participants, three in particular recruited participants over 18 years old (Boykin et al., 2018; Miron et al., 2016; Reffi et al., 2019). The average age of participants across all study samples was 19 years old, and ages ranged from 15 to 24 years old.

All but one of the included studies measured SC per se using the Self-Compassion Scale (Neff, 2003b). On the other hand, two of the studies (Boykin et al., 2018; Miron et al., 2016) measured FSC through the Fears of Compassion Scale, specifically the subscale, Fear of Compassion for Self (FCS-SC; Gilbert et al., 2011). All the included studies measured CM. However, various scales were used in different studies. Five studies (Boykin et al., 2018; Hou et al., 2020; Reffi et al., 2019; Tanaka et al., 2011; Vettese et al., 2011) measured different aspects of CM (emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect) using the Childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994, 2003) or its short forms (CTQ-SF; Bernstein et al., 2003). The remaining two studies (Játiva & Cerezo, 2014; Miron et al., 2016) used the Traumatic Life Events Questionnaire (Kubany, Haynes et al., 2000) and the Juvenile Victimization Questionnaire (Finkelhor et al., 2005), respectively, to assess participants' severity of CM. All seven studies measured psychological distress in various forms. For instance, one study (Miron et al., 2016) used the Posttraumatic Stress Disorder Screening and Diagnostic Scale (Kubany, Leisen et al., 2000) to measure PTSD symptoms and depression symptoms while two studies (Reffi et al., 2019; Vettese et al., 2011) used the modified version of the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) to assess the emotional dysregulation of participants following

traumatic events. Table 2 outlines a detailed comparison of the study characteristics of the included studies, and Table 3 summarizes the findings of each study.

Relationship Between Self-Compassion and Child Maltreatment

CM was significantly negatively associated with SC within all identified studies assessing SC (Hou et al., 2020; Játiva & Cerezo, 2014; Miron et al., 2016; Reffi et al., 2019; Tanaka et al., 2011; Vettese et al., 2011). This relationship was also demonstrated across various forms of CM. Miron et al. (2016) found that exposure to childhood sexual abuse (CSA) or childhood physical abuse (CPA) was associated with significantly lower SC scores compared to no history of CM. In another study that also explored different forms of maltreatment, those who experienced more types of victimization exhibited lower levels of SC than those who experienced fewer types (Játiva & Cerezo, 2014). Similarly, Tanaka et al. (2011) showed CPA, emotional abuse, and emotional neglect were associated with lower levels of adolescent SC. However, only emotional abuse was a significant predictor of low SC when accounting for physical abuse and emotional neglect.

FSC was also examined in two studies (Boykin et al., 2018; Miron et al., 2016). FSC refers to a conditioned fear response to experiencing compassion from others or oneself (Boykin et al., 2018; Gilbert et al., 2011). Gilbert (2014) propose that FSC occurs when a history of maltreatment interrupts the ability of a child to develop emotional regulation skills (i.e., the ability to manage emotional expressions, experiences, and responses; Gross, 1999). This contributes to the development of internal working models, where one is undeserving of love, and compassion is synonymous to weakness. Such internal models are a conditioned fear response towards self-kindness (i.e., FSC; Boykin et al., 2018; Gilbert, 2014). Two studies examined the relationship between FSC and CM, with Boykin et al. (2018) observing that moderate to severe CM was significantly associated with greater FSC compared to those with no or minimal prior history of CM. While Miron et al. (2016) also found that childhood abuse exposure was correlated with higher FSC, researchers further compared differences in FSC among those with experiences of four different groups: CSA only, CPA only, both CSA and CPA, and no history of sexual victimization. Results showed that those who experienced combined CSA and CPA reported significantly greater FSC than those with only a CPA history or no history at all (Miron et al., 2016). These findings extend upon those of Boykin et al. (2018) who did not examine the effects of different types of CM, and instead reported broadly on the effects of CM.

Relationship Between Self-Compassion and Psychological Distress

Throughout the diverse forms of psychological distress present within identified studies, SC was consistently associated with a lower likelihood or severity of psychological distress. Investigated forms of psychological distress included emotional dysregulation (i.e., difficulty with the acceptance, understanding and awareness of emotions, as well as an associated loss of control when upset; Gratz & Roemer, 2004), depression and anxiety symptoms, suicide attempt, addictive behaviour severity, and negative automatic thoughts (i.e., intrusive and repetitive cognition activated by adverse life experiences; Hou et al., 2020). They also included psychological symptom severity as measured by the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), PTSD symptoms (Boykin et al., 2018; Hou et al., 2020; Játiva & Cerezo, 2014; Reffi et al., 2019; Tanaka et al., 2011; Vettese et al., 2011) and psychological maladjustment (Játiva & Cerezo, 2014). Specifically, psychological maladjustment included serious psychiatric disorders in childhood and adulthood, anxiety, social relationship problems, delinquency, depression, behaviour problems, substance abuse, suicide attempts, adult criminality, and PTSD (Játiva & Cerezo, 2014). In studies examining general psychological distress or maladjustment, lower SC was consistently associated with a greater likelihood of psychological distress or maladjustment (Játiva & Cerezo, 2014; Tanaka et al., 2011; Vettese et al., 2011). Similarly, two of the included studies found lower SC was associated with higher depression (Hou et al., 2020; Tanaka et al., 2011). As well, both Reffi et al. (2017) and Vettese et al. (2011) found SC to be negatively associated with emotional dysregulation. Lastly, evidence from individual studies suggested that lower SC was associated with greater alcohol use problems, increased severity of addictive difficulties, internalizing and externalizing problems, negative thoughts, and the increased likelihood of reporting a serious suicide attempt (Hou et al., 2020; Játiva & Cerezo, 2014; Tanaka et al., 2011). The study conducted by Boykin et al. (2018) differed from other studies in that it examined FSC, which was found to be positively associated with greater PTSD symptom severity. While Miron et al. (2016) studied both SC and FSC, the authors did not examine potential distinct relationships between SC and/or FSC and psychological distress.

Table 2. Included Study Characteristics

Author(s) Year of publica- tion	Country where study took place	Research design	Sample size (N=X) Study participants	Age range; average age	Males: Females (Sex)	Men: Women (Gender)	Aims/purpose	Outcomes	Measures
Boykin, D. M., Himmericha, S. J., Pinciottia, C. M., Millera, L. M., Miron, L. R., & Orcutt, H. K. 2018	USA	Cross sectional study	N=288 College students	>18; 19.22	0: 100*	0:0	To examine relation- ships across fear of self- compassion, psychologi- cal inflexibility, child maltreatment, and PTSD symptom severity	- Childhood maltreatment - Emotional abuse - Physical abuse - Sexual abuse - Emotional neglect - Physical neglect - Fear of self-compassion - Psychological inflexibility - PTSD symptom severity	Childhood Trauma Questionnaire; CTQ (emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect) Fear of Compassion Scales-Self-Compas- sion; FCS-SC (fear of self-compassion) Acceptance and Action Questionnaire; AAQ-II (psychological inflexibility) PTSD Checklist for DSM-5; PCL-5 (perceived PTSD symptom severity)
Hou, X.-L., Bian, X.-H., Zuo, Z.-H., Xi, J.-Z., Ma, W.- J., & Owens, L. D. 2020	China	Cross sectional study	N=578 College students	17-24; 20.30	0:0	52.2: 47.8	To examine the relation- ship between general child maltreatment and young adult depression symptoms with negative automatic thoughts and self-compassion serving as mediators of this relationship	- Emotional abuse - Physical abuse - Sexual abuse - Emotional neglect - Physical neglect - Negative automatic thoughts - Self-compassion - Depression symptoms	28-item Childhood Trauma Question- naire-Short Form; CTQ-SF (emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect) Automatic Thought Questionnaire; ATQ (negative automatic thoughts) 26-item Self-Compassion Scale; SCS (self-compassion) Beck Depression Inventory—First Edition; BDI-I (depression symptoms)
Játiva, R., & Cerezo M. A. 2014	Spain	Cross sectional study	N=109 High school stu- dents with poor school performance	15-18; 16.74	71.6: 28.4*	0:0	To analyze the relation- ship between self- reported victimization and psychological maladjustment	- Conventional offenses - Child maltreatment - Peer and Sibling victimization - Sexual victimization - Indirect victimization - Internet victimization - Psychological maladjust- ment - Internalizing behaviour - Externalizing behaviour - Self-compassion	Juvenile Victimization Questionnaire; JVQ (conventional offenses, child maltreat- ment, peer and sibling victimization, sexual victimization, indirect victimization, internet victimization) Youth Self Report; YSR (psychological maladjustment, internalizing behaviour, externalizing behaviour) 26-item Self-Compassion Scale; SCS (self-compassion)

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Author(s) Year of publication	Country where study took place	Research design	Sample size (N=X) Study participants	Age range; average age	Males: Females (Sex)	Men: Women (Gender)	Aims/purpose	Outcomes	Measures
Miron, L. R., Seligowski, A. V., Boykin, D. M., & Orcutt, H. K. 2016	USA	Cross sectional study	N=377 Undergraduate students enrolled in an Introductory Psychology course at a large Midwestern university	>18; 19.12	0: 100*	0:0	To examine the influences of self-compassion and fear of self-compassion on the relationship between childhood abuse histories, and depression and PTSD symptoms	<ul style="list-style-type: none"> - Lifetime trauma history (e.g., childhood physical abuse, childhood sexual abuse) - PTSD symptoms - Depression symptoms - Self-compassion - Fear of self-compassion 	<p>Traumatic Life Events Questionnaire; TLEQ (lifetime trauma history e.g., childhood physical abuse, childhood sexual abuse)</p> <p>Posttraumatic Stress Disorder Screening and Diagnostic Scale; PSDS (PTSD symptoms)</p> <p>Depression, Anxiety, Stress Scale; DASS (depression symptoms)</p> <p>26-item Self-Compassion Scale; SCS (self-compassion)</p> <p>Fear of Compassion Scales-Self-Compassion; FCS-SC (fear of self-compassion)</p>
Reffi, A.N., Boykin, D. M., & Orcutt, H. K. 2019	USA	Cross sectional study	N=245 College students from psychology courses at a large Midwestern university	>18; 19.27	0:0	0:100	To investigate the mitigating role of self-compassion on emotional dysregulation among women with varying child maltreatment experiences	<ul style="list-style-type: none"> - Substance use - Alcohol use - Childhood maltreatment - Self-compassion - Emotional dysregulation 	<p>National Institute of Drug Abuse Quick Screen; NIDA Quick Screen (substance use). Two single items were used to assess alcohol use in the past 30 days. The first item assessed drinking frequency (“During the past 30 days, how often did you usually have any kind of drink containing alcohol?”). This item was included as a predictor of emotional dysregulation. The second item screened for binge drinking patterns (“During the past 30 days, how often did you have 4 or more drinks containing any kind of alcohol within a two-hour period?”; alcohol use)</p> <p>28-item Childhood Trauma Questionnaire-Short Form; CTQ-SF (childhood maltreatment)</p> <p>26-item Self-compassion Scale; SCS (self-compassion)</p> <p>Modified version of the Difficulties in Emotion Regulation Scale; DERS (emotional dysregulation)</p>

Self-Compassion Among Youth with Child Maltreatment Histories and Psychological Distress: A Scoping Review

Author(s) Year of publica- tion	Country where study took place	Research design	Sample size (N=X) Study participants	Age range; average age	Males: Females (Sex)	Men: Women (Gender)	Aims/purpose	Outcomes	Measures
Tanaka, M., Wekerle, C., Schmuck, M.-L., Paglia-Boak, A., & The MAP Research Team 2011	Canada	Cohort study	N=117 Child welfare- involved youth	16-20; 18.1	0: 0	45.3: 54.7	To examine the relation- ships among child mal- treatment, self-compassion, and mental health among child welfare- involved youth	- Physical abuse - Sexual abuse - Emotional abuse - Physical neglect - Emotional neglect - Self-compassion - Depression symptoms - Psychological distress (e.g., depressed mood, anxiety, and problems with social functioning) - Alcohol problems - Substance abuse - Suicide attempt	Childhood Trauma Questionnaire ; CTQ (physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect) 26-item Self-Compassion Scale ; SCS (self-compassion) Center for Epidemiologic Studies Depression Scale ; CES-D; short-form (depression symptoms) The General Health Questionnaire ; GHQ (psychological distress) The Alcohol Use Disorders Identification Test ; AUDIT; 10-item self-report version (al- cohol problems) CRAFFT (substance abuse) Suicide attempt/OSDUHS (suicide at- tempt)
Vettese, L. C., Dyer, C. E., Li, W. L., & Wekerle, C. 2011	Canada	Cross sectional study	N=81 Youth seen at intake to a substance treatment program in a hospital-based, joint youth addictions and mental health treat- ment program	16-24; 19.49	0: 0	65.4: 34.6	To determine the role of self-compassion in pre- dicting emotion dysregulation outcomes beyond child maltreat- ment history, psycho- logical symptom severity, and problem substance use To determine the role of self-compassion in buff- ering the impacts of child maltreatment	- Emotion dysregulation - Child Maltreatment (e.g., physical abuse, physical neglect, emotional abuse, emotional neglect, sexual abuse) - Self-compassion - Psychological symptom severity - Addictive severity - Number of days of sub- stance and alcohol use	Difficulties in Emotion Regulation Scale ; DERS (emotion dysregulation) 28-item Childhood Trauma Question- naire Short Form ; CTQ-SF (childhood mal- treatment e.g., physical abuse, physical ne- glect, emotional abuse, emotional neglect, sexual abuse) 26-item Self-Compassion Scale ; SCS (self-compassion) Brief Symptom Inventory ; BSI (psychologi- cal symptom severity) 6-item Substance Misuse Scale of the Be- haviour and Symptom Identification Scale ; SMS or BASIS (addictive severity) Timeline Follow-back ; TLFB (number of days of substance and alcohol use)

Note. * This study used the terms "sex" and "gender" interchangeably.

Table 3. Study Results

Author(s)	Relationship b/w self-compassion & child maltreatment	Relationship b/w self-compassion & psychological distress	Relationship b/w child maltreatment & psychological distress	Relationship b/w self-compassion & child maltreatment & psychological distress	Gender and sex related findings
Boykin, D. M., Himmericha, S. J., Pinciottia, C. M., Millera, L. M., Miron, L. R., & Orcutt, H. K.	- History of moderate to severe child maltreatment was significantly associated with greater fear of self-compassion compared to minimal to no history of child maltreatment	- Fear of self-compassion was associated with greater PTSD symptom severity	N/A	- Fear of self-compassion functioned as a mediator between child maltreatment and PTSD symptom severity - Moderate to severe child maltreatment was significantly associated with greater psychological inflexibility, PTSD symptom severity, and fear of self-compassion, compared to participants with minimal to no child maltreatment - Fear of self-compassion did not predict PTSD symptom severity when psychological inflexibility was present	N/A
Hou, X.-L., Bian, X.-H., Zuo, Z.-H., Xi, J.-Z., Ma, W.-J., & Owens, L. D.	- Child maltreatment was negatively associated with self-compassion	- Negative automatic thoughts and depression symptoms were negatively associated with self-compassion	- Negative automatic thoughts and depression symptoms were positively associated with child maltreatment - Child maltreatment positively predicted negative automatic thoughts, which positively predicted depression symptoms - Early negative experiences, such as child maltreatment may lead to the development of later depression symptoms (childhood maltreatment was positively correlated with young adult depression symptoms)	- Self-compassion had a significant effect in moderating the relationship between child maltreatment and depression symptoms through negative automatic thoughts (a weaker link was observed in subjects with high self-compassion than those with low self-compassion)	N/A
Játiva, R., & Cerezo M. A.	- Child maltreatment was significantly and negatively associated with self-compassion	- Self-compassion was significantly and negatively associated with psychological maladjustment - Self-compassion was significantly and negatively associated with internalizing and/or externalizing problems	- Conventional offenses, peer and sibling victimization, and child maltreatment all had significant positive relationships with psychological maladjustment, and internalizing and/or externalizing problems	- Self-compassion functioned as a significant mediator between victimization and psychological maladjustment (indirect effect=0.38; $z=2.22$; $p=.02$) with fewer types of victimization experienced being linked to higher levels of self-compassion and lower levels of psychological maladjustment	N/A

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Miron, L. R., Seligowski, A. V., Boykin, D. M., & Orcutt, H. K.	<ul style="list-style-type: none"> - Any type of childhood abuse exposure was significantly correlated with lower self-compassion scores, and significantly higher fear of self-compassion scores, than those without a CSA or CPA history - Participants with a combined CPA/CSA history reported significantly higher fear of self-compassion than those with a history of CPA only and those with no child abuse history 	N/A	<ul style="list-style-type: none"> - Any type of childhood abuse was significantly associated with greater depression symptoms, and PTSD symptoms than non-victims - Participants with a combined CPA/CSA history reported significantly greater depressive symptoms than participants with no abuse history - Participants with a combined history of CPA/CSA had significantly more PTSD symptoms than those reporting no abuse history and those reporting a history of CSA only - There was a significant direct effect of CPA on PTSD symptoms 	<ul style="list-style-type: none"> - CSA history had an indirect effect on depression symptoms and PTSD symptoms through fear of self-compassion, but not self-compassion. - CPA history was directly associated with PTSD symptoms, but not self-compassion or fear of self-compassion - Self-compassion and fear of self-compassion do not exert an indirect effect on post-trauma pathology for survivors of CPA 	<ul style="list-style-type: none"> - Relationship between participant sex and fear of self-compassion was insignificant - Relationship between participant sex and self-compassion was significant, with greater self-compassion scores among men compared to women - Relationship between gender and history of CSA and CPA was significant, with women being more likely to report both than men
Reffi, A. N., Boykin, D. M., & Orcutt, H. K.	<ul style="list-style-type: none"> - Child maltreatment was significantly negatively associated with self-compassion 	<ul style="list-style-type: none"> - Self-compassion was negatively associated with emotional dysregulation 	<ul style="list-style-type: none"> - Child maltreatment significantly predicted emotional dysregulation 	<ul style="list-style-type: none"> - Self-compassion predicted emotion dysregulation at a greater degree than other predictors - Self-compassion functioned as a significant mediator between child maltreatment and emotional dysregulation - When self-compassion was added to the model of child maltreatment's effect on emotional dysregulation, the magnitude of this effect was still significant but reduced 	N/A
Tanaka, M., Wekerle, C., Schmuck, M.-L., Paglia-Boak, A., & The MAP Research Team	<ul style="list-style-type: none"> - Higher degrees of childhood physical abuse, emotional abuse, and emotional neglect were significantly associated with lower self-compassion - Controlling for age and gender, emotional abuse was significantly associated with reduced self-compassion, even when taking into account emotional neglect and physical abuse 	<ul style="list-style-type: none"> - Low self-compassion scores were associated with greater anxiety/depression, psychological distress, alcohol use problems, and serious suicide attempts 	N/A	<ul style="list-style-type: none"> - Child welfare-involved youth were grouped using maltreatment-related impairment risk scores based on 5 different outcomes (i.e., anxiety/depression, psychological distress, alcohol use problem, substance use problems, suicide attempt) - A greater number of positive outcomes (i.e., endorsing maltreatment-related impairments) was associated with lower self-compassion, suggesting that self-compassion, if present, may lessen the severity of maltreatment-related outcomes 	N/A

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Vettese, L. C., Dyer, C. E., Li, W. L., & Wekerle, C.	<ul style="list-style-type: none"> - Greater child maltreatment was associated with lower levels of self-compassion - Child maltreatment history significantly predicted self-compassion 	<ul style="list-style-type: none"> - Greater self-compassion was associated with less emotion dysregulation, and less severe addictive problems and psychopathology 	<ul style="list-style-type: none"> - Greater child maltreatment experiences were associated with greater emotion dysregulation - Greater child maltreatment was associated with higher levels of psychopathology, and greater severity of substance use - Child maltreatment history significantly predicted emotion dysregulation 	<ul style="list-style-type: none"> - Self-compassion significantly predicted emotion dysregulation, beyond child maltreatment history, current psychological distress and addiction severity - Controlling for self-compassion, child maltreatment history had a non-significant impact on emotion dysregulation - Self-compassion significantly mediated the relationship between history of childhood maltreatment and emotion regulation difficulties 	<ul style="list-style-type: none"> - Higher levels of childhood maltreatment were experienced by females compared to males - Total self-compassion score and emotion dysregulation did not have any gender differences - Gender was not controlled for in any analyses because there was no significant differences on the main outcome variable of emotion dysregulation
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Relationship Between Child Maltreatment and Psychological Distress

Numerous studies investigated the relationship between CM and various forms of psychological distress, including depression, automatic negative thoughts, substance abuse, emotion regulation, and PTSD (Hou et al., 2020; Játiva & Cerezo, 2014; Miron et al., 2016; Reffi et al., 2019; Vettese et al., 2011). Within these examinations, a positive relationship between CM and psychological distress was consistently observed. CM was significantly associated with psychological maladjustment (Játiva & Cerezo, 2014), greater psychopathology, a higher severity of substance use (Vettese et al., 2011), internalizing and/or externalizing problems (Játiva & Cerezo, 2014), and emotional dysregulation (Reffi et al., 2019; Vettese et al., 2011).

Within two identified studies investigating depression, CM was significantly associated with depressive symptoms (Hou et al., 2020; Miron et al., 2016). Specifically, Miron et al. (2016) reported that the experience of CSA, CPA, or combined CPA/CSA was significantly associated with increased depressive symptoms and PTSD, compared to those without a history of abuse. Similarly, although Hou et al. (2020) did not consider specific subtypes of maltreatment, CM was found to be significantly and positively associated with both depression and negative automatic thoughts. Furthermore, a mediation analysis found that childhood maltreatment predicted negative automatic thoughts, which in turn predicted depression symptoms. These findings indicate that negative automatic thoughts may mediate the link between childhood maltreatment and symptoms of depression in young adults.

Sex and Gender Related Findings

The role of sex and gender was a topic of inquiry within the studies conducted by Miron et al. (2016) and Vettese et al. (2011) respectively. According to the Canadian Institutes of Health Research, gender can be defined as “the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people” while sex can be defined as “a set of biological attributes in humans and animals” (Canadian Institutes of Health Research, 2020). However, it is important to note that the terms, sex and gender, are sometimes used interchangeably in literature, and therefore may not be accurate to their definitions. For the purposes of this study, males and females refer to sex, and men and women refer to gender. If an included study used sex and gender interchangeably, and binary options, it was assumed to be sex. Both studies found greater levels of childhood maltreatment among females and women compared to males and men, with Miron et al. (2016) specifically considering CSA and CPA. An area of contention was the relationship between gender, sex and SC. While Miron et al. (2016) found no significant relationship between sex and FSC, SC scores among males were significantly higher than among females. In contrast, Vettese et al. (2011) found no significant gender difference in SC scores and emotional regulation between men and women. This discrepancy in results could have been attributed to Miron et al.’s (2016) larger sample size ($N=377$) as opposed to Vettese et al. (2011; $N=81$), thereby allowing for the study to be better powered for detecting sex differences in relation to SC.

Relationship Between Self-Compassion, Child Maltreatment, and Psychological Distress

Across various forms of psychological distress and CM, several studies pointed to the moderating and mediating roles of SC (Boykin et al., 2018; Hou et al., 2020; Játiva & Cerezo, 2014; Miron et al., 2016; Vettese et al., 2011). In the following sections, findings related to moderating roles will be discussed first, followed by mediating roles of SC.

Moderating and Mediating Roles of Self-Compassion

Suggesting moderation effects, Hou et al. (2020) found that the indirect relationship between CM and depressive symptoms through negative self-thoughts was weakened among participants with higher SC. Additionally, researchers found that SC significantly mediated the relationship between CM and emotional dysregulation. In the study by Vettese et al. (2011), the effect of a history of CM on emotion regulation difficulties was reduced to a non-significant level when SC was controlled for, suggesting mediation through SC. These findings align with those from a replicative study – when a model investigating the effect of CM on emotional dysregulation had SC added to it, the association between the two was still significant but reduced (Reffi et al., 2019). In the study by Játiva & Cerezo (2014), the protective mediating role of SC was similarly demonstrated in the relationship between CM and general psychological maladjustment, which encompassed mental health challenges, criminality, and behavioural problems. Individuals who experienced more types of victimization had less SC and greater levels of psychological maladjustment (Játiva & Cerezo, 2014). As well, in the study by Tanaka et al. (2011), “maltreatment-related impairments” (p. 889),

including problems with alcohol use, psychological distress, and report of a serious suicide attempt were associated with lower SC, alluding to the protective role of SC.

Moderating and Mediating Roles of Fear of Self-Compassion

FSC was another factor examined for its association with PTSD symptoms and depression within two identified studies. While related to self-compassion, FSC stands as its own distinct concept (e.g., individuals with low FSC do not necessarily possess high levels of SC). However, FSC can also potentially hinder one's process to increasing SC; to avoid incurring any potential pain, fear may serve as a defense mechanism against utilizing SC (Joeng & Turner, 2015).

The moderating role of FSC was not identified in any of the studies. With respect to PTSD symptoms, evidence from both studies suggested that the indirect effect of CM on PTSD symptoms occurred through the mediation of FSC (Boykin et al., 2018; Miron et al., 2016). Boykin et al. (2018) found that severe to moderate CM was significantly related to psychological inflexibility, elevated PTSD symptom severity, and FSC when compared to those with minimal or no experiences of CM. Further mediation analysis demonstrated an indirect impact of CM on PTSD symptom severity through FSC (Boykin et al., 2018). However, FSC failed to predict PTSD symptom severity in the presence of psychological inflexibility. Researchers tested psychological inflexibility as a moderator of this indirect effect, but the impact of CM upon PTSD severity at varying levels of psychological inflexibility remained non-significant, thus indicating that psychological inflexibility was not a moderator (Boykin et al., 2018).

While investigating the mediating role of FSC, Miron et al. (2016) found that CSA had an indirect impact on PTSD and depression symptoms through FSC. In contrast to previously mentioned findings, SC did not have an indirect effect in this relationship, potentially implicating a unique role for FSC beyond low levels of SC. Another result that contrasts those of other studies was that neither FSC nor SC exerted an indirect effect on PTSD symptoms within survivors of CPA. Furthermore, the indirect effect of CPA through SC on depression and PTSD was non-significant (Miron et al., 2016).

In sum, findings from the present review suggest that SC has both a moderating and mediating role within the relationship between CM and various forms of psychological distress. With regards to its role in different types of CM and psychological distress, limited data alludes to a greater impact of FSC as a mediator in youth who have experienced CSA as opposed to CPA (Miron et al., 2016). In a sample of child welfare-involved youth, higher childhood emotional abuse, physical abuse, and emotional neglect was significantly associated with lower self-compassion, with emotional abuse being the most significant predictor out of the three, when compared to other maltreatment types (Tanaka et al., 2011).

Discussion and Implications

With a primary aim to investigate the relationships among CM, SC, and psychological distress in youth, and a secondary aim to identify if these relationships differ based on types of CM experienced, our scoping review yielded a total of seven studies.

The Role of Self-Compassion

Overall, our results found that SC played a moderating and mediating role in the relationship between CM and psychological distress. In one group of college students, it was observed that SC had a significant impact as a moderator between CM and depressive symptoms through negative self-thought (i.e., higher levels of SC weakened this relationship; Hou et al., 2020). Furthermore, among another sample of college students and youth enrolled in a substance treatment program, SC mediated the relationship between CM and emotional dysregulation (Reffi et al., 2019; Vettese et al., 2011). In both groups, the effect of CM on emotional dysregulation was reduced when SC was controlled for or added to the relationship, suggesting the possibility of mediation. Similar results were seen in high school students with regards to the mediating role of SC present in the relationship between CM and psychological maladjustment (Játiva & Cerezo, 2014). Lastly, in child-welfare involved youth, maltreatment-related impairments (i.e., anxiety/depression, alcohol use problems, psychological distress, and serious suicide attempts) were also associated with lower SC scores, which allowed authors to conclude that the presence of SC may lessen the severity of these impairments (Tanaka et al., 2011).

The mediating role of SC in the CM and psychological distress pathway is consistent with current literature focused on adult populations (Barlow et al., 2017; Messman-Moore & Bhuptani, 2020; Miron et al., 2014; Ross et al., 2019;

Tarber et al., 2016; Wu et al., 2018). For example, Barlow et al. (2017) analyzed data from college students including: childhood abuse, PTSD symptoms, trauma appraisals (i.e., the way in which a traumatic event is understood, such as self-blame or shame), emotion regulation difficulties, and SC. Researchers found that childhood abuse was both a direct and indirect cause of emotion regulation difficulties through trauma appraisals and low SC (Barlow et al., 2017). Likewise, Ross et al. (2019) found that in adults and college students, SC and shame significantly and indirectly (in this order) mediated the pathway from emotional abuse to depression. Authors propose that emotional abuse hinders the creation of a kind relationship with oneself, which may lead to difficulties in or barriers to utilizing SC (Ross et al., 2019). Thus, differences in SC levels within the participants accounted for variance in shame, while shame served as a partial predictor for maltreatment-associated depression (Ross et al., 2019). Although these studies echo the findings that SC is a mediator for child maltreatment-related psychological distress, it is evident that many other factors, such as shame or self-blame, may be involved that prove to be additional or even stronger mediators in this relationship.

The Role of Fear of Self-Compassion

FSC was also investigated in this review. Among a group of college students, it was observed that FSC mediated the relationship between CM and PTSD symptom severity, such that the presence of FSC correlated with greater PTSD symptoms (Boykin et al., 2018). Within a sample of undergraduate students, it was also found that FSC, but not SC, had an indirect effect on depression and PTSD symptoms caused by CSA (Miron et al., 2016). Neither FSC nor SC had any effect on post-trauma pathology and PTSD symptoms caused by CPA (Miron et al., 2016). The differing roles of FSC between CSA and CPA may be related to the type of abuse. CSA has been associated with feelings of self-blame and shame (e.g., feeling responsible for the abuse), which have in turn been linked with PTSD symptomology (Feiring & Cleland, 2007). Current literature also notes that greater severity and persistence of CSA are correlated with self-blame and shame, thereby contributing to variance in the attributions of self-blame and shame by CSA victims (Valle & Silovsky, 2002). Given that FSC indirectly impacts CSA-related depression and PTSD, we hypothesize that the presence of self-blame and shame can impact levels of FSC, which in turn impacts the development of depression and PTSD symptoms. As Miron et al. (2016) simply measure the presence of CSA, future research should encompass additional CSA factors (e.g., severity, frequency), as well as attributions (e.g., self-blame, shame) in order to fully elucidate the relationship between CSA and FSC and ultimately, psychological distress.

It was also noted that in the presence of psychological inflexibility, FSC failed to predict PTSD symptoms in college students (Boykin et al., 2018). Psychological inflexibility can be defined as a combination of cognitive fusion (i.e., the replacement of reality with one's own thoughts) and experiential avoidance (i.e., being averse to negative thoughts, feelings, and memories; Schramm et al., 2020). Although the presence of psychological inflexibility was expected to increase the negative impact of FSC on PTSD symptoms, no moderating role was found (Boykin et al., 2018). Instead, authors found that in a multiple mediation analysis, both psychological inflexibility and FSC were mediators of the relationship between CM and PTSD. However, psychological inflexibility was a stronger mediator of the two and thus reduced the impact of FSC to negligible (Boykin et al., 2018). Psychological inflexibility can be hypothesized to have a greater mediation impact than FSC, as the avoidance and suppression of thoughts and emotions related to a traumatic event (e.g., CM) can increase the risk of developing PTSD (Kachadourian et al., 2021; Schramm et al., 2020). Prior research has also demonstrated that lowering psychological inflexibility may be vital in reducing PTSD symptom severity (Kachadourian et al., 2021; Schramm et al., 2020). In contrast, Miron et al. (2015) investigated the relationships between FSC, psychological inflexibility, and PTSD symptoms in a sample of undergraduate students, and revealed that psychological inflexibility significantly moderated the relationship between FSC and PTSD symptoms. Findings may differ due to differences in samples (e.g., 64.9% female versus 100% female; traumatic event experience versus childhood maltreatment). Specific types of CM may also be more likely to foster psychological inflexibility (e.g., more traumatic and frequent experiences may result in greater suppression and avoidance of thoughts). Further research is needed to elucidate the role of psychological inflexibility in the relationship between CM, FSC, and PTSD symptoms.

The Relationship Between Self-Compassion and Fear of Self-Compassion

While studies analyzed within this review did not explore the relationships between SC and FSC, both SC and FSC were shown to play mediating and moderating roles within the relationships between CM and psychological distress. Furthermore, a commonality between multiple studies was that the presence of other factors such as shame and self-blame might significantly impact these relationships and remain to be explored further.

Current literature points to potential relationships between SC and FSC within the CM and psychological distress pathway. Naismith et al. (2018) investigated the relationships among SC, FSC, and childhood abuse and neglect among other factors, in individuals diagnosed with personality disorder. The authors found that SC was uniquely predicted by low early warmth/neglect, while FSC was predicted by the presence of multiple adverse childhood experiences. Although it is uncertain if there exists a relationship between SC and FSC, both low SC and FSC were associated with self-criticism (Naismith et al., 2018). Based on our current findings, we propose that SC and FSC may be related via the self-kindness aspect of SC. As self-criticism is known to be the negative pole of self-kindness and also contributes to the development of FSC, it is reasonable to conclude that self-criticism, including relevant factors such as self-blame and shame, could reduce levels of SC and increase levels of FSC. Future research should further explore the impact of these factors, and relevance to the relationship between SC and FSC.

Impact of Child Maltreatment Subtypes

Overall, our results garnered limited data on these relations across specific CM subtypes, with only two studies addressing specific types. Of note is Tanaka et al.'s (2011) finding that out of all subtypes of CM, emotional abuse alone was a significant predictor of SC. Prior research has also shown that when compared with physical and sexual abuse, emotional abuse was the strongest predictor of later emotional dysregulation (Burns et al., 2009). Emotional dysregulation has also been found to mediate the relationship between PTSD symptom severity and SC (Scoglio et al., 2017). Assuming emotion regulation serves as a mediator between SC and negative mental health outcomes, the role of emotional maltreatment may be of greater significance than any other form of maltreatment in this pathway. Despite its significance, little attention has been given to emotional abuse clinically, compared to other CM types such as physical and sexual abuse (Wekerle & Smith, 2019). Further research is necessary to elucidate the specific impact of different subtypes of CM as they pertain to SC and psychological distress.

Roles of Sex and Gender

From previous literature, some evidence has pointed towards sex and gender playing a role in individual levels of SC (Bluth & Blanton, 2015; Bluth, Campo et al., 2016; Yarnell et al., 2015; Yarnell et al., 2018). However, while sex and gender have only demonstrated minor differences in SC levels across these studies, these differences could greatly impact the effectiveness of interventions or the analysis of other dimensions (i.e., if sample size was comprised of a majority of a certain sex or gender, small differences may result in a cumulative effect, ultimately causing data to be skewed).

From the studies in the present review, Miron et al. (2016) and Vettese et al. (2011) observed that females and women, respectively, experienced greater levels of CM than males and men. However, their results differed regarding sex and gender differences in SC: males had higher SC scores than females in Miron et al. (2016), whereas Vettese et al. (2011) failed to find any significant gender differences. Some research shows that the sex difference may emerge in later adolescence. Specifically, Bluth and Blanton (2015) found that in a sample of adolescent students aged 11-18 years, older girls (aged 14-18 years) possessed lower SC than both older boys and younger male and female adolescents (aged 11-14 years). Similar to Miron et al. (2016), and Bluth and Blanton's (2015) older adolescent subsample, Yarnell et al.'s (2015) meta-analysis revealed that men on average, possessed slightly higher levels of SC than women, which the authors found to be consistent with prior research that established women as more likely to be self-critical and engage in negative self-talk (Leadbeater et al., 1999; Pritchard & DeVore, 2013).

As observed in our results, the roles of sex and gender are also important for understanding the levels of CM experienced. For example, Cappelleri et al. (1993) carried out an extensive analysis of nationally representative studies in the United States and concluded that females experienced a higher rate of CSA than males, with no sex differences in the experience of CPA. Additionally, Titus et al. (2003) found that victimization experiences differed by gender in adolescents entering substance abuse treatment. Compared to boys, girls were more likely to have experienced any type of victimization and be survivors of victimization experiences (Titus, 2003). However, it is important to note that males have often been underrepresented in CM and abuse studies (Behl et al., 2003). Males also experience more difficulties in disclosure of CSA such as fear of stigmatization as homosexual, given most perpetrators are often other males (Alaggia, 2010; Easton et al., 2013), and the need to adhere to culturally informed masculine roles (Easton, 2013). Given the limited data gathered from the included studies, more male and men-inclusive studies that recognize the barriers faced in representation and disclosure should be conducted to determine the role of sex and gender in SC and psychological distress pathways in youths with CM histories. Though not examining CM, the importance of male and men-inclusive studies is further underscored by Kehayes et al. (2018)'s study investigating the differing impact of

alcohol-related sexual victimization on male and female undergraduate students. Results showed that the relationship between sexual victimization by an intoxicated perpetrator and increased anxiety was stronger in males than females, with the authors calling for greater attention to be paid to the experiences of sexually victimized males (Kehayes et al., 2018). The frequent conflation of terms, sex and gender, also call for more studies that determine the roles of sex versus gender in this relationship.

Future Directions

Given the significance of SC and FSC in moderating and mediating levels of psychological distress for CM victims, it may be worthwhile to consider the applicability of SC in clinical practice. Current existing interventions for victims of CM include trauma-focused cognitive behavioral therapy (TF-CBT; Cohen et al., 2012). TF-CBT is particularly known for its implementation of “trauma narration”, where victims recount the story of their traumatic histories. It may be worthwhile to involve SC practices and strategies prior to or following this stage, to help alleviate any stresses associated with recalling one’s traumatic experiences (Cohen et al., 2012). Moreover, Drs. Kristin Neff and Christopher Germer developed the Mindful Self-Compassion program, which has shown significant gains in SC, mindfulness, and well-being in a randomized control trial of community adults (Neff & Germer, 2013). The program involves an 8-week workshop on training individuals to cultivate skills of SC. Tailored versions of the program exist, including one for teens, which has likewise demonstrated greater SC and life satisfaction, as well as significantly lower depression among participants in the intervention compared to the control (Bluth, Gaylord et al., 2016). Studying the effectiveness of these existing programs among survivors of CM may be valuable. There are also a number of compassion-based interventions including Compassion-Focused Therapy (CFT), Mindful Self-Compassion (MSC), Compassion Cultivation Training, Cognitively Based Compassion Training, Cultivating Emotional Balance, and Compassion and Loving-Kindness Meditations (Kirby, 2017). While these interventions utilize compassion, each are unique in their specific aims and programming content (Kirby, 2017). Of note is CFT, which aims to help individuals who experience shame and self-criticism (i.e., a population relevant to CM), by engaging in affiliative, caring, and altruistic behaviour toward themselves and others (Gilbert, 2014). Its approach incorporates the concept of self-compassion (i.e., being compassionate towards oneself) as a core element and has been shown to reduce outcomes such as depression, anxiety, and psychological distress (Kirby, Tellegen et al., 2017).

Other interventions include emergent mental health technologies (mHealth). The JoyPop™ app (see <https://youthresilience.net/joypop-app>), for example, is an evidence-based, trauma-informed resilience app for youth, including features based on SC and positive psychology. In a sample of undergraduate students who used the app for 30 days, those with greater adverse childhood experiences (ACEs) displayed a more rapid increase in emotion regulation with daily use of the app, compared to those with fewer or no ACEs (MacIsaac et al., 2021). Such SC interventions may therefore be even more relevant to youth with CM histories.

Moreover, the current review predominantly included studies in school samples, with only one investigating child welfare-involved youth and another investigating youth with substance use problems. It may be valuable to further conduct research in more diverse populations, such as those in the child welfare system and those of Indigenous backgrounds, who may be at greater risk of experiencing CM and psychological distress (Collin-Vézina et al., 2011; Hop Wo et al., 2020). One study found that among American Indigenous-identifying adults, SC was associated with lower suicide risk (Dolezal et al., 2021), alluding to the potential benefits of SC among Indigenous youth as well. Child welfare-involved youth, in particular, may benefit from services that promote SC. Having access to such services may help facilitate the transition for youth aging out of care (i.e., at age 18), as they lose access to the resources and support previously provided by the government.

Strengths and Limitations

There are several strengths to this scoping review. This is the first review of our knowledge to investigate the current state of the literature on SC, CM, and psychological distress among youth. Existing reviews on similar topics include meta-analyses on self-compassion and psychological distress among adolescents (Marsh et al., 2018), and the differential effects of self-compassion components on well-being and psychological distress (Chio et al., 2021). Our focus on CM is particularly unique.

Limitations of this review include the cross-sectional nature of studies. The lack of longitudinal data prevents the ability to ascertain cause-and-effect relationships across the three factors of SC, CM, and psychological distress. Understanding the longitudinal steps in these pathways can better support the development of future interventions

(e.g., we can target predictors and risks early on to prevent outcomes, such as psychological distress and low self-compassion). This review also did not implement quality assessment, in an effort to be as comprehensive as possible in being the first review of its topic, therefore limiting the rigor of studies included. Additionally, most samples included solely or mostly female participants. In the included studies, significant differences were found between male and female participants, and men and women participants, respectively (Miron et al., 2016; Vettese et al., 2011). Miron et al. (2016) found significantly higher SC scores in males than females, while Vettese et al. (2011) failed to find any gender-related differences. Future research should further elucidate if gender and/or sex plays a role in the relationships between self-compassion, CM, and psychological distress. Furthermore, although sex and/or gender was investigated in all the included studies, the terms, "sex" and "gender," were used interchangeably for a few select studies (Boykin et al., 2018; Játiva & Cerezo, 2014; Miron et al., 2016). The report of gender, therefore, may not be accurate to its correct definition (i.e., "the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people"; CIHR, 2020). We recommend that future studies include gender in their analysis, with recognition of the expansive gender identities and greater psychological distress potentially faced by the marginalized population of gender-diverse individuals (Cyrus, 2017; Frohard-Dourlent et al., 2020). While age restrictions ensured a systematic approach to the selection of literature, it may have excluded relevant studies with ages close to the inclusion criteria, but younger and/or older (Pohl et al., 2020; Boyraz et al., 2019; Joss et al., 2019).

Conclusion

Overall, the seven studies included in this scoping review point to a moderating and mediating role of SC in the relationship between CM and psychological distress among youth. FSC was also investigated and suggested an indirect effect of CM on increased psychological distress, particularly PTSD symptoms and depression through FSC. With regards to relations of SC to specific types of CM, emotional abuse was found to be associated with significantly lower SC compared to other subtypes. Though the included studies are limited in determining longitudinal relationships, it is clear that SC is significant in the relationship between CM and psychological distress. It is reasonable to presume that other factors, such as severity of maltreatment or feelings of shame, may affect this relationship too. The low number of studies detected leaves room for continued research, deeper understanding, and potential clinical implementation of SC interventions for youth with maltreatment histories and psychological distress.

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Conflict of interest

The authors have no conflict of interest to disclose.

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Appendix: Search Strategy

OID MEDLINE

Exp Child Abuse/ OR Exp Child Abuse, Sexual/ OR Exp Physical Abuse/ OR Exp Domestic violence/

1. (child* adj2 (maltreat* OR trauma* OR abus* OR batter* OR exploit*)) .ti, ab
2. (sex* adj2 (abus* OR victim* OR exploit* OR harass*)) .ti, ab
3. (prostitut*) .ti, ab
4. (molest*) .ti, ab
5. (incest*) .ti, ab
6. (rape*) .ti, ab
7. (traffick*) .ti, ab
8. (CSA) .ti, ab
9. (CSE) .ti, ab
10. (phys* adj2 (abus* OR harm*)) .ti, ab
11. (neglect*) .ti, ab
12. (emotion* adj2 (harm* OR abus* OR maltreat*)) .ti, ab
13. (psych* adj2 (harm* OR abus* OR maltreat*)) .ti, ab
14. (famil* adj2 (violen*)) .ti, ab
15. (domestic* adj2 (violen* OR batter*)) .ti, ab
16. (intimate partner violence) .ti, ab
17. (abus* adj2 (spous* OR wife OR husband)) .ti, ab
18. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18
19. Exp empathy/ OR Exp mindfulness/
20. (self-compassion*) .ti, ab
21. (self compassion*) .ti, ab
22. (self-kindness) .ti, ab
23. (self kindness) .ti, ab
24. (common humanity) .ti, ab
25. (mindfulness) .ti, ab
26. 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26
27. 19 AND 27

OID PsycInfo

1. Exp Child Neglect/ OR Exp Child Abuse/ OR Exp Sexual Abuse/ OR Exp Sexual Harassment/ OR Exp Rape/ OR Exp Domestic Violence/ OR Exp Intimate Partner Violence/ OR Exp Physical Abuse
2. (child* adj2 (maltreat* OR trauma* OR abus* OR batter* OR exploit*)) .ti, ab
3. (sex* adj2 (abus* OR victim* OR exploit* OR harass*)) .ti, ab
4. (prostitut*) .ti, ab
5. (molest*) .ti, ab
6. (incest*) .ti, ab
7. (rape*) .ti, ab
8. (traffick*) .ti, ab
9. (CSA) .ti, ab
10. (CSE) .ti, ab
11. (phys* adj2 (abus* OR harm*)) .ti, ab
12. (neglect*) .ti, ab
13. (emotion* adj2 (harm* OR abus* OR maltreat*)) .ti, ab
14. (psych* adj2 (harm* OR abus* OR maltreat*)) .ti, ab
15. (famil* adj2 (violen*)) .ti, ab
16. (domestic* adj2 (violen* OR batter*)) .ti, ab
17. (intimate partner violence) .ti, ab
18. (abus* adj2 (spous* OR wife OR husband)) .ti, ab
19. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18
20. Exp self-compassion/ OR Exp mindfulness/ OR Exp self-evaluation/ OR Exp Empathy/
21. (self-compassion*) .ti, ab
22. (self compassion*) .ti, ab
23. (self-kindness) .ti, ab
24. (self kindness) .ti, ab
25. (common humanity) .ti, ab
26. (mindfulness) .ti, ab
27. 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26
28. 19 AND 27

PsycARTICLES

1. MAINSUBJECT.EXACT.EXPLODE("Child Abuse") OR
 MAINSUBJECT.EXACT.EXPLODE("Sexual Abuse") OR
 MAINSUBJECT.EXACT.EXPLODE("Incest") OR
 MAINSUBJECT.EXACT.EXPLODE("Sexual Harassment") OR
 MAINSUBJECT.EXACT.EXPLODE("Child Neglect") OR
 MAINSUBJECT.EXACT.EXPLODE("Emotional Abuse")
2. ab(child* NEAR/2(maltreat* OR trauma* OR abus* OR batter* OR exploit*)) OR ti(child* NEAR/2(maltreat* OR trauma* OR abus* OR batter* OR exploit*))
3. ab(sex* NEAR/2 (abus* OR victim* OR exploit* OR harass*)) OR ti(sex* NEAR/2(abus* OR victim* OR exploit* OR harass*))
4. ab(prostitut*) OR ti(prostitut*)
5. ab (molest*) OR ti(molest*)
6. ab(incest*) OR ti(incest*)
7. ab(rape*) OR ti(rape*)
8. ab(traffick*) OR ti(traffick*)
9. ab(CSA) OR ti(CSA)
10. ab(CSE) OR ti(CSE)
11. ab(phys* NEAR/2 (abus* OR harm*)) OR ti(phys* NEAR/2(abus* OR harm*))
12. ab(neglect*) OR ti(neglect*)
13. ab(emotion* NEAR/2(harm* OR abus* OR maltreat*)) OR ti(emotion* NEAR/2(harm* OR abus* OR maltreat*))
14. ab(psych* NEAR/2(harm* OR abus* OR maltreat*)) OR ti(psych* NEAR/2(harm* OR abus* OR maltreat*))
15. ab(famil* NEAR/2(violen*)) OR ti(famil* NEAR/2(violen*))
16. ab(domestic* NEAR/2(violen* OR batter*)) OR ti(domestic* NEAR/2(violen* OR batter*))
17. ab(intimate partner violence) OR ti(intimate partner violence)
18. ab(abus* NEAR/2(spous* OR wife OR husband)) OR ti(abus* NEAR/2(spous* OR wife OR husband))
19. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18
20. MAINSUBJECT.EXACT.EXPLODE(Self-Compassion) OR MAINSUBJECT.EXACT.EXPLODE(Self-Concept) OR
 MAINSUBJECT.EXACT.EXPLODE(Empathy)
21. ab(self compassion*) OR ti(self compassion*)
22. ab(self kindness) OR ti(self kindness)
23. ab(common humanity) OR ti(common humanity)
24. ab(mindfulness) OR ti(mindfulness)
25. 20 OR 21 OR 22 OR 23
26. 19 AND 24

ProQuest Sociological Abstracts

1. MAINSUBJECT.EXACT.EXPLODE("Child Abuse") OR
MAINSUBJECT.EXACT.EXPLODE("Child Sexual Abuse") OR MAINSUBJECT.EXACT.EXPLODE("Sexual Abuse") OR
MAINSUBJECT.EXACT.EXPLODE("Incest") OR
MAINSUBJECT.EXACT.EXPLODE("Sexual Harassment") OR
MAINSUBJECT.EXACT.EXPLODE("Prostitution") OR
MAINSUBJECT.EXACT.EXPLODE("Child Neglect") OR
MAINSUBJECT.EXACT.EXPLODE("Emotional Abuse") OR
MAINSUBJECT.EXACT.EXPLODE("Family Violence") OR
MAINSUBJECT.EXACT.EXPLODE("Spouse Abuse")
2. ab(child* NEAR/2(maltreat* OR trauma* OR abus* OR batter* OR exploit*)) OR ti(child* NEAR/2(maltreat* OR trauma* OR abus* OR batter* OR exploit*)) OR
3. ab(sex* NEAR/2(abus* OR victim* OR exploit* OR harass*)) OR ti(sex* NEAR/2(abus* OR victim* OR exploit* OR harass*)) OR
4. ab(prostitut*) OR ti(prostitut*) OR
5. ab(molest*) OR ti(molest*) OR
6. ab(incest*) OR ti(incest*) OR
7. ab(rape*) OR ti(rape*) OR
8. ab(traffick*) OR ti(traffick*) OR
9. ab(CSA) OR ti(CSA) OR
10. ab(CSE) OR ti(CSE) OR
11. ab(phys* NEAR/2(abus* OR harm*)) OR ti(phys* NEAR/2(abus* OR harm*)) OR
12. ab(neglect*) OR ti(neglect*)
13. ab(emotion* NEAR/2(harm* OR abus* OR maltreat*)) OR ti(emotion* NEAR/2(harm* OR abus* OR maltreat*)) OR
14. ab(psych* NEAR/2(harm* OR abus* OR maltreat*)) OR ti(psych* NEAR/2(harm* OR abus* OR maltreat*)) OR
15. ab(famil* NEAR/2(violen*)) OR ti(famil* NEAR/2(violen*)) OR
16. ab(domestic* NEAR/2(violen* OR batter*)) OR ti(domestic* NEAR/2(violen* OR batter*)) OR
17. ab(intimate partner violence) OR ti(intimate partner violence) OR
18. ab(abus* NEAR/2(spous* OR wife OR husband)) OR ti(abus* NEAR/2(spous* OR wife OR husband))
19. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18
20. ab(self compassion*) OR ti(self compassion*) OR
21. ab(self kindness) OR ti(self kindness) OR
22. ab(common humanity) OR ti(common humanity) OR
23. ab(mindfulness) OR ti(mindfulness)
24. 20 OR 21 OR 22 OR 23
25. 19 AND 24

ProQuest ERIC

1. MAINSUBJECT.EXACT.EXPLODE("Family Problems") OR MAINSUBJECT.EXACT.EXPLODE("Child Abuse") OR MAINSUBJECT.EXACT.EXPLODE("Family Violence") OR MAINSUBJECT.EXACT.EXPLODE("Sexual Abuse") OR MAINSUBJECT.EXACT.EXPLODE("Sexual Harassment") OR MAINSUBJECT.EXACT.EXPLODE("Violence") OR MAINSUBJECT.EXACT.EXPLODE("Child Neglect")
2. ab(child* adj2 (maltreat* OR trauma* OR abus* OR batter* OR exploit*)) OR ti(child* adj2 (maltreat* OR trauma* OR abus* OR batter* OR exploit*))
3. ab(sex* adj2 (abus* OR victim* OR exploit* OR harass*)) OR ti(sex* adj2 (abus* OR victim* OR exploit* OR harass*))
4. ab(prostitut*) OR ti(prostitut*)
5. ab (molest*) OR ti(molest*)
6. ab(incest*) OR ti(incest*)
7. ab(rape*) OR ti(rape*)
8. ab(traffick*) OR ti(traffick*)
9. ab(CSA) OR ti(CSA)
10. ab(CSE) OR ti(CSE)
11. ab(phys* adj2 (abus*" OR harm*)) OR ti(phys* adj2 (abus*" OR harm*))
12. ab(neglect*) OR ti(neglect*)
13. ab(emotion* adj2 (harm* OR abus* OR maltreat*)) OR ti(emotion* adj2 (harm* OR abus* OR maltreat*))
14. ab(psych* adj2 (harm* OR abus* OR maltreat*)) OR ti(psych* adj2 (harm* OR abus* OR maltreat*))
15. ab(famil* adj2 (violen*)) OR ti(famil* adj2 (violen*))
16. ab(domestic* adj2 (violen* OR batter*)) OR ti(domestic* adj2 (violen* OR batter*))
17. ab(intimate partner violence) OR ti(intimate partner violence)
18. ab(abus* adj2 (spous* OR wife OR husband)) OR ti(abus* adj2 (spous* OR wife OR husband))
19. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18
20. ab(self-compassion*) OR ti(self-compassion*)
21. ab(self compassion*) OR ti(self compassion*)
22. ab(self-kindness) OR ti(self-kindness)
23. ab(self kindness) OR ti(self kindness)
24. ab(common humanity) OR ti(common humanity)
25. ab(mindfulness) OR ti(mindfulness)
26. 20 OR 21 OR 22 OR 23 OR 24 OR 25
27. 19 AND 26

OID Embase

1. Exp child abuse/ OR Exp sexual abuse/ OR Exp child sexual abuse/ OR Exp physical abuse/ or Exp family violence/ OR Exp partner violence/ OR Exp domestic violence/ OR Exp child neglect/
2. (child* adj2 (maltreat* OR trauma* OR abus* OR batter* OR exploit*)) .ti, ab
3. (sex* adj2 (abus* OR victim* OR exploit* OR harass*)) .ti, ab
4. (prostitut*) .ti, ab
5. (molest*) .ti, ab
6. (incest*) .ti, ab
7. (rape*) .ti, ab
8. (traffick*) .ti, ab
9. (CSA) .ti, ab
10. (CSE) .ti, ab
11. (phys* adj2 (abus* OR harm*)) .ti, ab
12. (neglect*) .ti, ab
13. (emotion* adj2 (harm* OR abus* OR maltreat*)) .ti, ab
14. (psych* adj2 (harm* OR abus* OR maltreat*)) .ti, ab
15. (famil* adj2 (violen*)) .ti, ab
16. (domestic* adj2 (violen* OR batter*)) .ti, ab
17. (intimate partner violence) .ti, ab
18. (abus* adj2 (spous* OR wife OR husband)) .ti, ab
19. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18
20. Exp empathy/ OR Exp mindfulness/
21. (self-compassion*) .ti, ab
22. (self compassion*) .ti, ab
23. (self-kindness) .ti, ab
24. (self kindness) .ti, ab
25. (common humanity) .ti, ab
26. (mindfulness) .ti, ab
27. 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26
28. 19 AND 27

CINAHL

1. (MM "Child Abuse, Sexual") OR (MM "Child Abuse") OR (MM "Sexual Abuse") OR (MM "Intimate Partner Violence") OR (MM "Domestic Violence") OR (MM "Assault and Battery")
2. TI (child* N2 (maltreat* OR trauma* OR abus* OR batter* OR exploit*)) OR AB (child* N2 (maltreat* OR trauma* OR abus* OR batter* OR exploit*))
3. TI (sex* N2 (abus* OR victim* OR exploit* OR harass*)) OR AB (sex* N2 (abus* OR victim* OR exploit* OR harass*))
4. TI ("prostitut*") OR AB ("prostitut*")
5. TI ("molest*") OR AB ("molest*")
6. TI ("incest") OR AB ("incest")
7. TI ("rape*") OR AB ("rape*")
8. TI ("traffick*") OR AB ("traffick*")
9. TI ("CSA") OR AB ("CSA")
10. TI ("CSE") OR AB ("CSE")
11. TI (phys* N2 (abus* OR "phys* harm*)) OR AB (phys* N2 (abus* OR "phys* harm*))
12. TI ("neglect*") OR AB ("neglect*")
13. TI (emotion* N2 (harm* OR abus* OR maltreat*)) OR AB (emotion* N2 (harm* OR abus* OR maltreat*))
14. TI (psych* N2 (harm* OR abus* OR maltreat*)) OR AB (psych* N2 (harm* OR abus* OR maltreat*))
15. TI (famil* N2 (violen*)) OR AB (famil* N2 (violen*))
16. TI (domestic* N2 (violen* OR batter*)) OR AB (domestic* N2 (violen* OR batter*))
17. TI ("intimate partner violence") OR AB ("intimate partner violence")
18. TI (abus* N2 (spous* OR wife OR husband)) OR AB (abus* N2 (spous* OR wife OR husband))
19. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18
20. (MM "Compassion") OR (MM "Mindfulness") OR (MM "Self Concept") OR (MM "Self-Talk")
21. TI ("self-compassion*") OR AB ("self-compassion*") OR TI ("self compassion*") OR AB ("self compassion*")
22. TI ("self-kindness*") OR AB ("self-kindness*") OR TI ("self kindness*") OR AB ("self kindness*")
23. TI ("common humanity") OR AB ("common humanity")
24. TI ("mindfulness") OR AB ("mindfulness")
25. 20 OR 21 OR 22 OR 23
26. 19 AND 25

PUBMED

1. ("child abuse"[MeSH Terms]) OR "child abuse, sexual"[MeSH Terms]) OR ("domestic violence"[MeSH Terms]) OR ("spouse abuse"[MeSH Terms]) OR ("rape"[MeSH Terms]) OR ("physical abuse"[MeSH Terms])
2. ("child* maltreat*" [tiab])
3. ("child* trauma*" [tiab])
4. ("child* abus*" [tiab])
5. ("sex* abus*" [tiab])
6. ("sex* victim*" [tiab])
7. ("sex* exploit*" [tiab])
8. ("sex* harass*" [tiab])
9. ("prostitut*" [tiab])
10. ("molest*" [tiab])
11. ("incest" [tiab])
12. ("rape*" [tiab])
13. ("traffick*" [tiab])
14. ("CSA" [tiab])
15. ("CSE" [tiab])
16. ("physical abuse" [tiab])
17. ("physical harm" [tiab])
18. ("child batter*" [tiab])
19. ("neglect*" [tiab])
20. ("emotional harm" [tiab])
21. ("emotional abuse*" [tiab])
22. ("emotional maltreatment*" [tiab])
23. ("psychological harm" [tiab])
24. ("psychological abuse" [tiab])
25. ("psychological maltreatment*" [tiab])
26. ("family violence" [tiab])
27. ("domestic* violence" [tiab])
28. ("domestic* batter*" [tiab])
29. ("intimate partner violence" [tiab])
30. ("spousal abuse" [tiab])
31. ("wife abus*" [tiab])
32. ("husband abus*" [tiab])
33. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32
34. ("empathy"[MeSH Terms]) OR "mindfulness"[MeSH Terms])

35. ("self-compassion*" [tiab]) OR ("self compassion*" [tiab])
36. ("self-kindness*" [tiab]) OR ("self kindness*" [tiab])
37. ("common humanity" [tiab])
38. ("mindfulness" [tiab])
39. 34 OR 35 OR 36 OR 37 OR 38
40. 33 AND 39