ORIGINAL ARTICLE
https://doi.org/10.30773/pi.2025.0377
eISSN 1976-3026
OPEN ACCESS

The Mediating Role of Rumination in the Relationship Between Childhood Trauma and the Severity of Major Depressive Disorder

Esra Yalım[1] ✉, Cansu Ünsal Mavi[2], and Kamil Nahit Özmenler[3]

[1]Department of Psychiatry, Çankırı State Hospital, Çankırı, Türkiye
[2]Department of Psychiatry, Kartal Dr Lütfi Kırdar City Hospital, Istanbul, Türkiye
[3]Department of Psychiatry, Health Sciences University Gülhane Training and Research Hospital, Ankara, Türkiye

Objective It is widely accepted that childhood traumas increase the risk of major depressive disorder (MDD) in adulthood and contribute to the chronicity of the disorder. Various mediating factors are believed to exist in the relationship between childhood trauma and depression. The aim of this study is to investigate the mediating effect of rumination in the relationship between childhood traumatic experiences and MDD in a clinical sample.

Methods The sample of this cross-sectional study comprised 94 patients aged 18–65 diagnosed with MDD at the Gülhane Training and Research Hospital Psychiatry Clinic, along with 91 healthy participants. After collecting sociodemographic data, participants completed the Beck Depression Inventory, Childhood Trauma Questionnaire-33, and Rumination Scale. Data were analyzed using appropriate statistical methods.

Results The analyses indicated that rumination may serve a mediating role in the relationship between childhood trauma and depressive symptoms. Specifically, rumination was predicted by childhood trauma (standardized coefficient=0.44, p<0.001) and served as a predictor of depression (standardized coefficient=0.56, p<0.001). The basic model indicated a significant direct effect between childhood trauma and depression severity (p=0.01, b=0.50), while the mediating model demonstrated both a direct effect (p=0.011, b=0.24) and an indirect effect through rumination (p=0.003, b=0.25).

Conclusion The findings of this study suggest that childhood traumatic experiences may be associated with depression severity, and rumination appears to play a mediating role in this relationship. This highlights the need to address cognitive features and traumatic experiences in developing effective prevention and intervention strategies for depression. **Psychiatry Investig 2026;23(2):242-248**

Keywords Childhood trauma; Depression; Mediation; Rumination.

INTRODUCTION

The World Health Organization defines child maltreatment as "the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence, and commercial or other exploitation, which results 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."[1] Childhood trauma, a global phenomenon, has been extensively linked to adverse psychiatric outcomes in adulthood.[2] Individuals exposed to childhood abuse or neglect are at heightened risk of developing a range of psychiatric disorders, including major depressive disorder (MDD), posttraumatic stress disorder, bipolar disorder, dissociation, and substance use disorders, as well as engaging in high-risk behaviors.[3-7] Notably, childhood maltreatment has been identified as a significant risk factor for lifelong depression, contributing to the severity and chronicity of MDD.[8] Patients with MDD who have experienced childhood trauma exhibit a higher frequency of depressive episodes and an increased incidence of suicidal behavior.[9,10] Evidence indicates that among patients with recurrent depression, those with a history of childhood trauma demonstrate an earlier onset of MDD, with physical neglect and emotional abuse serving as significant predictors of the first depressive episode.[11] Furthermore, individuals with MDD and a history of childhood trauma exhibit more severe symptomatology, poorer clinical outcomes, and increased resistance to

Received: October 28, 2025 **Revised:** November 16, 2025
Accepted: November 26, 2025

✉ **Correspondence:** Esra Yalım, MD
Department of Psychiatry, Çankırı State Hospital, Kırkevler, Kastamonu St. No:236, Çankırı Merkez/Çankırı 18100, Türkiye
Tel: +90-5068451315, **E-mail:** yalim.esra06@gmail.com

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (https://creativecommons.org/licenses/by-nc/4.0) which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

 Copyright © 2026 Korean Neuropsychiatric Association

treatment compared to those without such histories.[12]

Rumination is characterized by a persistent focus on negative moods, along with their potential causes and consequences, particularly feelings of sadness and depression.[13] It is well-established that ruminative thinking centered on depressive symptoms can exacerbate both the duration and intensity of these symptoms, contributing to a more persistent depressive state.[14] Research suggests that individuals with a history of adverse childhood experiences may be predisposed to ruminative thinking.[15] Exposure to childhood traumatic events may lead to repetitive negative thought patterns as a maladaptive strategy to regulate emotional distress. Such individuals often engage in rumination as a means of attempting to comprehend and exert control over the distressing aspects of their experiences.[16]

Existing literature identifies the mediating role of factors such as rumination, emotion regulation, and alexithymia in the association between childhood trauma and MDD.[17-19] It has been demonstrated that childhood trauma exacerbates persistent anxiety and rumination, thereby influencing depressive symptomatology.[19] However, despite these findings, there is a notable lack of studies investigating the mediating effect of rumination on the relationship between childhood trauma and MDD in clinical populations.

Given these considerations, the present study aims to examine the mediating role of rumination in the relationship between childhood trauma and depression severity. Understanding these mechanisms may provide insights into the cognitive processes through which early adverse experiences contribute to depressive symptoms and inform the development of targeted prevention and intervention strategies.

METHODS

Participants

The sample for this cross-sectional study comprises 94 patients diagnosed with MDD, who sought treatment at the Gülhane Training and Research Hospital Department of Psychiatry between June 1, 2022 and November 30, 2022. Of these patients, 62 were experiencing their first episode of MDD. This group is matched with 91 healthy controls exhibiting similar sociodemographic characteristics. The inclusion criteria for the study included: a diagnosis of MDD according to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria, age between 18 and 65 years, and the willingness to participate, as evidenced by signing an informed consent form. Exclusion criteria included the presence of any comorbid psychiatric disorders or neurological conditions that could impact cognitive function, as well as the use of any psychotropic medications within the last 6 months.

Data collection tools

Sociodemographic data form

This form was created by the researchers to identify the sociodemographic and clinical characteristics of the participants in accordance with the study's objectives. The form inquires about participants' age, duration of education, marital status, employment status, history of psychiatric disorders, and history of suicide.

Beck Depression Inventory

Developed by Beck et al.,[20] the Beck Depression Inventory (BDI) is designed to objectively measure levels of depression. It consists of a total of 21 items related to how the individual has felt over the past week. The responses are scored on a four-option Likert scale ranging from 0 to 3. The total score can range from 0 to 63, with higher scores indicating greater severity of depressive symptoms. The Turkish validity and reliability study was conducted by Hisli[21] (1989), reporting a Cronbach's alpha coefficient of 0.80. In this study, Cronbach's alpha for the scale was 0.93.

Childhood Trauma Questionnaire-33

The original form, known as the Childhood Trauma Questionnaire (CTQ)-28, was developed by Bernstein et al.[22] The Cronbach's alpha values for the factors ranged from 0.79 to 0.94. An expanded version of the questionnaire, including an additional factor for excessive protection and control, resulted in a 33-item revision, which was adapted into Turkish by Şar et al.[23] The questionnaire is self-reported and utilizes a five-point Likert scale ranging from "(1) Never" to "(5) Very Often." The total score for the 33-item version ranges from 25 to 150. Scores for the subscales of emotional abuse, physical abuse, physical neglect, emotional neglect, sexual abuse, and excessive overprotection-control (OP-OC) are derived from the sum of relevant items. The Cronbach's alpha coefficient for this new version was found to be 0.87, and the Guttmann split-half reliability was reported as 0.69. In this study, Cronbach's alpha for the scale was 0.93.

Ruminative Thought Style Questionnaire

It was developed by Brinker and Dozois[24] to assess general ruminative tendencies. The original version reported a Cronbach's alpha coefficient of 0.92. The Turkish validity and reliability study conducted by Karatepe et al.[25] involved a 20-item self-report measure utilizing a seven-point Likert scale, where each item is rated from "(1) Not at all" to "(7) Very well." The Cronbach's alpha coefficient for the Turkish version was determined to be 0.90. Scores can range from a minimum of 20 to a maximum of 140, with higher scores indicating an increase

in ruminative thought patterns. In this study, Cronbach's alpha for the scale was 0.96.

Procedure

Ethical approval for this study was obtained from the Scientific Research Ethics Committee of Gülhane Training and Research Hospital (21.04.2022/2022-169). The study included patients diagnosed with MDD according to DSM-5 criteria, who presented to the psychiatry outpatient clinic, along with similar volunteer healthy participants. During the examination, a sociodemographic data form was first completed. Subsequently, the BDI was administered to assess the severity of depression, while the CTQ-33 was used to evaluate traumatic experiences, and the Ruminative Thought Style Questionnaire (RTSQ) was employed to measure levels of rumination. The objectives of the study were clearly explained to all participants, and written informed consent was obtained prior to their participation. The research was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki.

Statistical analysis

Based on data from the existing literature, a power analysis was conducted using the G*Power software version 3.1.9.7 (Heinrich-Heine-University Düsseldorf). Assuming an α error of 0.05, a power level of 0.80, and an effect size of f^2=0.15, the minimum required sample size was calculated as 77 participants per group, yielding a total of 154 participants. All statistical analyses of the data obtained from the study were conducted using the Statistical Package for the Social Sciences (SPSS) version 22.0 (IBM Corp.), AMOS-24 (IBM Corp.), and jamovi V2.5 software (https://www.jamovi.org/). The normality of the data distribution was assessed using the Kolmogorov-Smirnov test. For those meeting parametric assumptions, the Student's t-test was applied, while the Mann-Whitney U test was used when these assumptions were not met. The chi-square test was utilized for comparing categorical variables between the two groups. Pearson correlation analysis was employed to examine the relationship between two numerical variables, provided that the assumptions for parametric tests were satisfied. Logistic regression analysis was performed to predict the presence of the disorder. In this study, which investigated the mediating effect of rumination on the relationship between childhood trauma and depression severity, the model was tested through mediation based on theoretical knowledge and basic statistical analyses. A significance level of $p<0.05$ was accepted for all statistical analyses.

RESULTS

The average age of the participants included in the study was 32.51±9.13 years, with 63.2% (n=117) being female. There was no statistically significant difference found in terms of sex (χ^2=0.028, p=0.866) and age (t=0.946, p=0.345). However, statistically significant differences were observed in duration of education (U=1,831, p<0.001), employment status (χ^2=40.735, p<0.001), and marital status (χ^2=12.805, p=0.002). A comparison of other sociodemographic variables between the two groups is presented in Table 1.

The analysis of the correlations among the participants' scores on the BDI, RTSQ, and CTQ-33 is presented in Table 2. A positive and significant correlation was found between the total score of the CTQ-33 and both the total score of the BDI and the total score of the RTSQ. Additionally, a positive and statistically significant correlation was established between the total score of the BDI and the total score of the RTSQ (r=0.671, p<0.001).

The binary logistic regression analysis conducted on parameters (age, sex, RTSQ, CTQ-33) that may affect the development of depression yielded statistically significant results ($\chi^2(9)$=102.613, p<0.001). The model explained 56% of the

Table 1. Comparison of participants' sociodemographic data according to study groups

Variables	Patients (N=94)	Controls (N=91)	Statistics
Age (yr)	31.89±10.50	33.16±7.45	t=0.946, df=183, p=0.345
Sex			χ^2=0.028, df=1, p=0.866
Female	60 (63.8)	57 (62.6)	
Male	34 (36.2)	34 (37.4)	
Marital status			χ^2=12.805, df=2, p=0.002
Single	49 (52.1)	37 (40.7)	
Married	37 (39.4)	54 (59.3)	
Divorced	8 (8.5)	0	
Duration of training (yr)	13.73±.93	17.17±3.02	U=1,831, p<0.001
Number of employees	45 (47.9)	83 (91.2)	χ^2=40.735, df=1, p<0.001
Past history of psychiatric diagnosis	32 (34.0)	0	χ^2=37.458, df=1, p<0.001
Psychiatric hospitalization	3 (3.2)	0	χ^2=2.952, df=1, p=0.086

t: Student's t-test, χ^2: Pearson chi-square test, U: Mann-Withney U test. Values are presented as mean±standard deviation or N (%).

Table 2. Correlation analysis between the scale scores

	1	2	3	4	5	6	7	8
1	-							
2	0.547***	-						
3	0.333***	0.446***	-					
4	0.532***	0.346***	0.648***	-				
5	0.432***	0.579***	0.166*	0.244***	-			
6	0.598***	0.417***	0.247***	0.466***	0.230**	-		
7	0.348***	0.293***	0.417***	0.526***	0.277***	0.318***	-	
8	0.349***	0.251***	0.270***	0.323***	0.323***	0.372***	0.671***	-

1: Emotional Abuse, 2: Physical Abuse, 3: Physical Neglect, 4: Emotional Neglect, 5: Sexual Abuse, 6: Over Protection-Control, 7: Beck Depression Inventory, 8: Ruminative Thinking Style Questionnaire. *p<0.05; **p<0.1; ***p<0.001.

Table 3. Logistic regression analysis of depression predictors

Variables	B	Z value	p	Odds ratio	95% confidence interval
Age	-0.033	-1.260	0.208	0.968	0.920–1.018
Sex	0.207	0.471	0.638	1.230	0.520–2.912
Male-Female					
RTSQ	0.050	5.642	<0.001	1.051	1.033–1.070
EA	-0.044	-0.532	0.595	0.957	0.815–1.124
PA	0.330	2.073	0.038	1.391	1.018–1.901
PN	0.256	2.841	0.004	1.292	1.083–1.541
EN	0.115	1.953	0.050	1.121	1.001–1.257
SA	-0.150	-1.462	0.144	0.861	0.704–1.052
OPC	-0.057	-0.951	0.342	0.945	0.841–1.062

RTSQ, Ruminative Thinking Style Questionnaire; EA, Emotional Abuse; PA, Physical Abuse; PN, Physical Neglect; EN, Emotional Neglect; SA, Sexual Abuse; OPC, Over Protection-Control.

variance in depression status as indicated by the Nagelkerke R^2 coefficient and correctly categorized 79% of the participants overall. The model's sensitivity was 78%, and specificity was 79%. Among the independent variables, the RTSQ (p<0.001), Physical Abuse (p=0.038), Physical Neglect (p=0.004), and Emotional Neglect (p=0.050) were found to be significant predictors. The data from the logistic regression analysis demonstrating the predictive power of these variables regarding the presence of depression are presented in Table 3.

The mediation model demonstrated the strength of the direct relationship between childhood trauma and depression, as well as the strength of the indirect relationship mediated by rumination. The model exhibited adequate fit indices (chi-square to degrees of freedom ratio=3.273, comparative fit index=0.944, root mean square error of approximation=0.079). Similar to the baseline model, all related variables included in the mediation model had medium to high loadings. Rumination was predicted by childhood trauma (standardized coefficient=0.44, p<0.001) and was a predictor of depression (standardized coefficient=0.56, p<0.001). The mediation model highlighted the significance of the indirect pathway indicating the mediating relationship of rumination between childhood trauma and depression in terms of predictive and outcome variables.

The baseline model indicated a significant direct effect between the CTQ-33 and the BDI (p=0.01, b=0.50), while the mediation model demonstrated both direct (p=0.011; b=0.24; 95% confidence interval, CI [0.12–0.36]) and indirect effects (p=0.003, b=0.25, 95% CI [0.19–0.32]) between the CTQ-33 and the BDI through the RTSQ. The total effect in the model was 0.48, with a direct effect of 0.24 and an indirect effect of 0.25. The mediation model is shown in Figure 1. The Sobel test conducted to evaluate the significance of the mediation effect yielded a relatively high value (4.07), indicating that the mediating role of rumination was statistically significant.

DISCUSSION

The present study aimed to examine the potential mediating role of rumination in the relationship between childhood trauma and depression severity among patients with MDD. The findings suggest that childhood trauma may be associat-

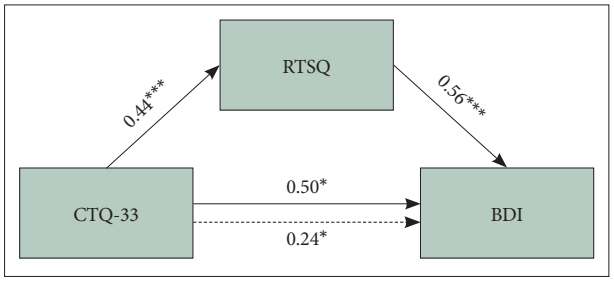


Figure 1. Mediation model of the relationship between Childhood Trauma Questionnaire (CTQ)-33 and Beck Depression Inventory (BDI) via Ruminative Thought Style Questionnaire (RTSQ). Numbers in one-way arrows indicate standardized coefficients. *p< 0.05; ***p<0.001.

ed with higher depression severity, potentially through increased levels of rumination. Specifically, rumination, physical abuse, physical neglect, and emotional neglect were found to be significantly associated with depression severity. These results highlight the possible contribution of ruminative cognitive processes in the link between early adverse experiences and depressive symptoms, underscoring the importance of addressing rumination in clinical interventions.

Mandelli et al.[26] reported that childhood neglect is the strongest predictor of depressive symptoms. Their meta-analysis also found strong associations between emotional, sexual, and physical abuse, as well as domestic violence, and increased risk of depression. In clinically diagnosed populations, neglect had a greater impact on depression risk than sexual or physical abuse, whereas in community-based samples, emotional abuse demonstrated the greatest effect. Humphreys et al.[27] conducted a meta-analysis demonstrating that all forms of childhood trauma are significantly correlated with elevated depression scores and an increased risk of meeting diagnostic criteria for MDD. Notably, emotional abuse and emotional neglect were identified as the childhood traumatic experiences most strongly associated with depression. The study also reported that the effect size of the relationship between emotional abuse and depressive symptoms was greater in child and adolescent samples compared to adult populations, suggesting a potential attenuation of this relationship with increasing age. Spinhoven et al.[28] identified emotional neglect as a significant predictor of depressive and anxiety disorders. Similarly, a Turkish validation of the CTQ-33 found that emotional neglect predicted depression, whereas the excessive control subdimension did not. The study also highlighted the correlation between excessive control, emotional neglect, and emotional abuse.[23] A gender-specific analysis by Lee et al.[8] revealed that physical abuse significantly contributed to depressive symptoms in males, whereas emotional abuse had a pronounced effect in females. Moreover, emotional neglect was found to predict depressive symptoms across both genders. This study identified physical abuse, emotional neglect, and physical neglect as significant predictors of depression, while emotional abuse was not a significant predictor. Mandelli et al.[26] highlighted the challenge of clearly distinguishing emotional abuse from emotional neglect, with Çelik and Hocaoğlu[29] noting that emotional abuse and neglect frequently co-occur, present in approximately 90% of physical abuse and neglect cases. The difficulty in detecting emotional abuse, the use of a clinical rather than community sample, and the potential weakening of the association between emotional abuse and MDD over time may explain the lack of a significant predictive relationship between emotional abuse and MDD in this study. Additionally, it is important to consider that adults may normalize childhood emotional abuse within their cultural context, attributing it to personality traits or familial parenting practices, which could affect the interpretation of these findings. Hovens et al.[12] reported that sexual abuse was not consistently associated with depression as a significant predictor. Despite the known prevalence and long-term consequences of sexual abuse, it is often underreported due to factors such as feelings of shame, fear of disbelief, the desire to protect the perpetrator, and threats.[30] Similar to the study by Hovens et al.,[12] sexual abuse did not emerge as a significant predictor of depression severity, which may partly reflect participants' reluctance to disclose such experiences for the reasons mentioned above. OP-OC is a maladaptive parenting behavior characterized by excessive involvement of caregivers in their children's activities.[31] Overprotective and controlling parenting has been shown to have negative effects on children's mental health, including increased anxiety and depression.[32] Parental overcontrol has been found to be positively correlated with rumination and depression levels.[33] Consistent with previous literature, our study found significant positive correlations between OP-OC levels and both depression and rumination. These findings support the reported detrimental effects of OP-OC parenting behaviors on individuals' psychological functioning and suggest that overprotective and controlling parenting may increase the risk of rumination and depressive symptoms.

The existing literature demonstrates that individuals exhibiting higher levels of ruminative responses to depressive states are more likely to experience exacerbation of depressive symptoms over time, even when accounting for baseline symptomatology.[34] In a longitudinal study, Spasojević and Alloy[35] further substantiated this association by identifying rumination as a significant predictor of MDD. Their findings aligned with prior research, indicating that ruminative thinking functions as a risk factor for the onset and persistence of MDD. Additionally, it has been posited that the predisposition toward rumination is more prevalent among adults who encountered adverse childhood experiences, such as traumatic life events

or parental overcontrol.[15] Mansueto et al.[16] suggested that individuals exposed to childhood trauma may be inclined to engage in repetitive negative thinking, such as rumination, which could serve as an ineffective coping strategy for dealing with negative emotions and psychological distress. It has been proposed that this process might reflect an attempt to make sense of and exert some perceived control over distressing life circumstances. Within the framework of the metacognitive model of MDD, metacognitive beliefs arising from depressive emotions and thoughts are believed to initiate a self-perpetuating cycle of ruminative thinking.[36] A sustained focus on depressive symptoms is thus associated with the increased duration and intensity of these symptoms, contributing to the chronicity of the disorder.[14] Collectively, these findings suggest that rumination constitutes a key factor in both the etiology and maintenance of MDD psychopathology. In accordance with prior literature, the present study identified significant positive correlations between rumination and depressive symptom severity, as well as between rumination and experiences of childhood trauma across all subscales.

However, the current study has several limitations that should be taken into account. Its cross-sectional design, coupled with reliance on self-report measures, raises concerns about recall bias, given that certain information was based on participants' retrospective recollection. Additionally, the relatively small sample size and limited number of male participants limit the generalizability of the findings across genders and to broader populations. The inherent subjectivity of the items assessing emotional abuse and neglect within the CTQ-33 represents an additional limitation. Specifically, these items rely on participants' personal interpretations of their experiences, which may vary considerably based on individual perception, memory accuracy, and cultural or social factors. Furthermore, responses may be influenced by social desirability bias, emotional avoidance, or difficulties in recognizing subtle forms of emotional maltreatment. Similarly, sexual abuse may be underreported due to stigma, feelings of shame, or fear of disclosure, potentially leading to an underestimation of its prevalence and impact in the study sample. Another limitation lies in the study's inability to differentiate between individuals exposed to isolated traumatic events and those subjected to multiple forms of trauma. The study also does not address critical variables, such as the proximity of the perpetrator to the victim, the age of exposure, and the duration of neglect or abuse, all of which could significantly impact the findings. Additionally, the study was conducted in a single-center setting, which may further limit the generalizability of the results. These methodological constraints necessitate careful interpretation of the results and underscore the need for further longitudinal research to elucidate these associations comprehensively.

Research on the mechanisms linking childhood trauma to adult psychiatric outcomes remains limited. Considering the extended latency between childhood trauma and the onset of MDD in adulthood, it is likely that multiple mediating factors contribute to this relationship.[37] Similar to previous studies, our results indicated that rumination may be an important mediating factor in the pathway between childhood trauma and depression severity in adulthood.[19,38] A major strength of this study is the exclusion of participants using psychotropic medications, as these agents have been shown to influence rumination levels.[39] This methodological rigor enhances the internal validity of our findings and supports the robustness of the observed associations.

In conclusion, the findings of this study suggest that childhood trauma is associated with depression severity and that rumination may exacerbate the direct impact of such traumatic experiences. These results underscore the importance of developing targeted therapeutic interventions for individuals with a history of childhood trauma, with particular attention to addressing rumination as a mediating factor in the progression of psychopathological conditions. It is crucial to incorporate adaptive cognitive strategies in clinical settings to mitigate the effects of rumination on mental health outcomes. Further longitudinal research is warranted to elucidate the complex interplay between childhood trauma, rumination, and the emergence of diverse psychopathologies.

Availability of Data and Material

The datasets generated or analyzed during the study are available from the corresponding author on reasonable request.

Conflicts of Interest

The authors have no potential conflicts of interest to disclose.

Author Contributions

Conceptualization: Kamil Nahit Özmenler, Esra Yalım. Data curation: Esra Yalım. Formal analysis: Esra Yalım, Cansu Ünsal Mavi. Investigation: Esra Yalım, Cansu Ünsal Mavi. Methodology: Kamil Nahit Özmenler, Esra Yalım. Project administration: Kamil Nahit Özmenler, Esra Yalım. Resources: all authors. Software: Cansu Ünsal Mavi, Esra Yalım. Supervision: Kamil Nahit Özmenler. Validation: all authors. Visualization: Esra Yalım, Cansu Ünsal Mavi. Writing—original draft: all authors. Writing—review & editing: all authors.

ORCID iDs

Esra Yalım	https://orcid.org/0000-0002-4605-1319
Cansu Ünsal Mavi	https://orcid.org/0000-0002-9891-4278
Kamil Nahit Özmenler	https://orcid.org/0000-0001-7404-6405

Funding Statement

None

Acknowledgments

The authors would like to express their sincere gratitude to all participants for their valuable contributions to this study.

REFERENCES

1. World Health Organization. Child maltreatment [Internet]. Available at: https://www.who.int/news-room/fact-sheets/detail/child-maltreatment. Accessed October 18, 2025.
2. Horwitz AV, Widom CS, McLaughlin J, White HR. The impact of childhood abuse and neglect on adult mental health: a prospective study. J Health Soc Behav 2001;42:184-201.
3. Widom CS, DuMont K, Czaja SJ. A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. Arch Gen Psychiatry 2007;64:49-56.
4. Chu JA, Dill DL. Dissociative symptoms in relation to childhood physical and sexual abuse. Am J Psychiatry 1990;147:887-892.
5. McCutcheon VV, Sartor CE, Pommer NE, Bucholz KK, Nelson EC, Madden PA, et al. Age at trauma exposure and PTSD risk in young adult women. J Trauma Stress 2010;23:811-814.
6. Erten E, Uney AFK, Fıstıkcı N. [Bipolar disorder and childhood trauma]. Psikiyatride Güncel Yaklaşımlar 2015;7:157-165. Turkish
7. Norman RE, Byambaa M, De R, Butchart A, Scott J, Vos T. The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. PLoS Med 2012;9:e1001349.
8. Lee SW, Bae GY, Rim HD, Lee SJ, Chang SM, Kim BS, et al. Mediating effect of resilience on the association between emotional neglect and depressive symptoms. Psychiatry Investig 2018;15:62-69.
9. Örsel S, Karadağ H, Kahiloğullari AK, Aktaş EA. [The frequency of childhood trauma and relationship with psychopathology in psychiatric patients]. Anadolu Psikiyatri Derg 2011;12:130-136. Turkish
10. Bernet CZ, Stein MB. Relationship of childhood maltreatment to the onset and course of major depression in adulthood. Depress Anxiety 1999;9:169-174.
11. Moskvina V, Farmer A, Swainson V, O'Leary J, Gunasinghe C, Owen M, et al. Interrelationship of childhood trauma, neuroticism, and depressive phenotype. Depress Anxiety 2007;24:163-168.
12. Hovens JG, Giltay EJ, Wiersma JE, Spinhoven P, Penninx BW, Zitman FG. Impact of childhood life events and trauma on the course of depressive and anxiety disorders. Acta Psychiatr Scand 2012;126:198-207.
13. Raes F, Hermans D. On the mediating role of subtypes of rumination in the relationship between childhood emotional abuse and depressed mood: brooding versus reflection. Depress Anxiety 2008;25:1067-1070.
14. Nolen-Hoeksema S. Responses to depression and their effects on the duration of depressive episodes. J Abnorm Psychol 1991;100:569-582.
15. Spasojević J, Alloy LB. Who becomes a depressive ruminator? Developmental antecedents of ruminative response style. J Cogn Psychother 2002;16:405-419.
16. Mansueto G, Cavallo C, Palmieri S, Ruggiero GM, Sassaroli S, Caselli G. Adverse childhood experiences and repetitive negative thinking in adulthood: a systematic review. Clin Psychol Psychother 2021;28:557-568.
17. Hopfinger L, Berking M, Bockting CL, Ebert DD. Emotion regulation mediates the effect of childhood trauma on depression. J Affect Disord 2016;198:189-197.
18. Şenkal İ, Işikli S. [Childhood traumas and attachment style-associated depression symptoms: the mediator role of alexithymia]. Türk Psikiyatri Dergisi 2015;26:261-267. Turkish
19. Deguchi A, Masuya J, Naruse M, Morishita C, Higashiyama M, Tanabe H, et al. Rumination mediates the effects of childhood maltreatment and trait anxiety on depression in non-clinical adult volunteers. Neuropsychiatr Dis Treat 2021;17:3439-3445.
20. Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J. An inventory for measuring depression. Arch Gen Psychiatry 1961;4:561-571.
21. Hisli N. [A reliability and validity study of Beck Depression Inventory in a university student sample]. Psikoloji Dergisi 1989;7:3-13. Turkish
22. Bernstein D, Fink L, Handelsman L, Foote J, Lovejoy M, Wenzel K, et al. Initial reliability and validity of a new retrospective measure of child abuse and neglect. Am J Psychiatry 1994;151:1132-1136.
23. Şar V, Necef I, Mutluer T, Fatih P, Türk-Kurtça T. A revised and expanded version of the Turkish childhood trauma questionnaire (CTQ-33): overprotection-overcontrol as additional factor. J Trauma Dissociation 2021;22:35-51.
24. Brinker JK, Dozois DJ. Ruminative thought style and depressed mood. J Clin Psychol 2009;65:1-19.
25. Karatepe HT, Yavuz FK, Turkcan A. Validity and reliability of the Turkish version of the ruminative thought style questionnaire. Bull Clin Psychopharmacol 2013;23:231-241.
26. Mandelli L, Petrelli C, Serretti A. The role of specific early trauma in adult depression: a meta-analysis of published literature. Childhood trauma and adult depression. Eur Psychiatry 2015;30:665-680.
27. Humphreys KL, LeMoult J, Wear JG, Piersiak HA, Lee A, Gotlib IH. Child maltreatment and depression: a meta-analysis of studies using the childhood trauma questionnaire. Child Abuse Negl 2020;102:104361.
28. Spinhoven P, Elzinga BM, Hovens JG, Roelofs K, Zitman FG, van Oppen P, et al. The specificity of childhood adversities and negative life events across the life span to anxiety and depressive disorders. J Affect Disord 2010;126:103-112.
29. Çelik FGH, Hocaoğlu Ç. [Childhood traumas: a review]. Sakarya Tıp Dergisi 2018;8:695-711. Turkish
30. Özdemir DF. [Cinsel istismar ve çocuk ruh sağlığı]. Katkı Pediatri Dergisi 2010;32:569-582. Turkish
31. Wood JJ, McLeod BD, Sigman M, Hwang WC, Chu BC. Parenting and childhood anxiety: theory, empirical findings, and future directions. J Child Psychol Psychiatry 2003;44:134-151.
32. Vigdal JS, Brønnick KK. A systematic review of "helicopter parenting" and its relationship with anxiety and depression. Front Psychol 2022;13:872981.
33. Farina B, Benvenuti SM, Ardito RB, Genova F, Dell'Acqua C, Presti AL, et al. Depressive symptoms in individuals experiencing maternal overcontrol: the specific mediating role of brooding rumination. Pers Individ Differ 2025;236:112995.
34. Nolen-Hoeksema S. The role of rumination in depressive disorders and mixed anxiety/depressive symptoms. J Abnorm Psychol 2000;109:504-511.
35. Spasojević J, Alloy LB. Rumination as a common mechanism relating depressive risk factors to depression. Emotion 2001;1:25-37.
36. Yilmaz AE, Şenormanci G, Şenormanci Ö. Investigation of the metacognitive model of depression in a Turkish sample of major depressive. Turk Psikiyatri Derg 2022;33:82-89.
37. Uchida Y, Takahashi T, Katayama S, Masuya J, Ichiki M, Tanabe H, et al. Influence of trait anxiety, child maltreatment, and adulthood life events on depressive symptoms. Neuropsychiatr Dis Treat 2018;14:3279-3287.
38. Kim JS, Jin MJ, Jung W, Hahn SW, Lee SH. Rumination as a mediator between childhood trauma and adulthood depression/anxiety in non-clinical participants. Front Psychol 2017;8:1597.
39. Bieling PJ, Hawley LL, Bloch RT, Corcoran KM, Levitan RD, Young LT, et al. Treatment-specific changes in decentering following mindfulness-based cognitive therapy versus antidepressant medication or placebo for prevention of depressive relapse. J Consult Clin Psychol 2012;80:365-372.