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**EXAMINING THE EFFECT OF EMOTIONAL
DYSREGULATION AND DISCLOSURE CONCERNS ON
THE RISK OF REVICTIMIZATION IN INDIVIDUALS
WITH CHILDHOOD TRAUMATIC LIFE EXPERIENCE**

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ANKARA, 2024

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DISCLOSURE CONCERNS ON THE RISK OF REVICTIMIZATION IN
INDIVIDUALS WITH CHILDHOOD TRAUMATIC LIFE EXPERIENCE

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ABSTRACT

EXAMINING THE EFFECT OF EMOTIONAL DYSREGULATION AND DISCLOSURE CONCERNS ON THE RISK OF REVICTIMIZATION IN INDIVIDUALS WITH CHILDHOOD TRAUMATIC LIFE EXPERIENCE

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Trauma is defined as human-caused or naturally occurring life events and situations that exceed the coping capacity of an individual and affect the individual emotionally, behaviorally, and physically. Exposure to traumatic life experiences, especially in childhood, leaves more abrasive and long-term effects on the individual and It is seen that it sustained its influence in later life periods. The aim of this study was to examine the role of disclosure concerns and cognitive emotion regulation strategies in the relationship between childhood traumatic life experiences and relational revictimization in adulthood. The study was conducted cross-sectionally with 244 young adult participants. The data obtained using self-report forms were analyzed using simple moderator analysis. According to the findings of the study, it was found that self-disclosure concerns had a positive moderating effect, and positive cognitive emotion regulation strategies had a negative moderating effect on the relationship between childhood maltreatment and revictimization. As disclosure concerns enhance, the risk of individuals experiencing revictimization in the future increases. As positive cognitive emotion regulation skills increase, the risk of revictimization reduces. Therefore, after the first trauma experience, clinical practices aimed at increasing the use of positive cognitive emotion regulation strategies and reducing concerns about self-disclosure may be effective in preventing revictimization in adulthood.

Keywords: Childhood Trauma, Cognitive Emotion Regulation, Self-Disclosure, Disclosure Concern, Relational Revictimization



ÖZET

ÇOCUKLUK ÇAĞI TRAVMATİK YAŞAM DENEYİMİNE SAHİP BİREYLERDE DUYGU DÜZENLEME GÜÇLÜKLERİ VE AÇILMAYA YÖNELİK ENDİŞELERİN YENİDEN MAĞDUR OLMA RİSKİ ÜZERİNDEKİ ETKİSİNİN İNCELENMESİ

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Travma, bireyi ve toplumu duygusal, davranışsal ve fiziksel olarak etkileyen insan kaynaklı veya doğal olarak ortaya çıkan, kişinin baş etme kapasitesi aşan yaşam olayları ve durumlardır. Travmatik yaşam deneyimlerine özellikle çocukluk döneminde maruz kalınması, birey üzerindeki daha örseleyici ve uzun vadeli etkiler bırakmaktadır ve sonraki yaşam dönemlerinde de etkisini göstermektedir. Bu çalışmanın amacı çocukluk çağı travmatik yaşam deneyimleri ve yetişkinlik dönemi ilişkisel yeniden mağduriyet ilişkisinde kendini açmaya yönelik endişeler ve bilişsel duygu düzenleme stratejilerinin rolünü incelemektir. Çalışma 244 genç yetişkin katılımcı ile kesitsel olarak gerçekleştirilmiştir. Öz bildirim formları kullanılarak elde edilen veriler, basit düzenleyici analiz kullanılarak analiz edilmiştir. Çalışmanın bulgularına göre, çocuklukta kötü muamele ve yeniden mağduriyet ilişkisinde kendini açmaya yönelik endişelerin pozitif yönde düzenleyici bir etkisi olduğunu ve olumlu bilişsel duygu düzenleme stratejilerinin negatif yönlü düzenleyici bir etkiye sahip olduğu bulunmuştur. Kendini açmaya yönelik endişeler arttıkça bireylerin gelecekte yeniden mağduriyet yaşama riskleri artmaktadır. Olumlu bilişsel duygu düzenleme becerilerinin kullanımında artış görüldükçe kişilerin yeniden mağduriyet yaşama riskleri azalmaktadır. Dolayısıyla ilk travma deneyimi sonrası, bireylerin olumlu bilişsel duygu düzenleme stratejileri kullanımının artırılması ve kendini açmaya yönelik endişelerinin azaltılmasına yönelik klinik uygulamaların, kişinin yaşamın

ilerleyen dönemlerinde yeniden mağduriyet yaşamasının önlenmesinde etkili olabileceği düşünülmektedir.

Anahtar Kelimeler: Çocukluk Çağı Travmatik Yaşam deneyimleri, Bilişsel Duygu Düzenleme, Kendini Açma, Kendini Açmaya Yönelik Endişeler, İlişkisel Yeniden Mağduriyet

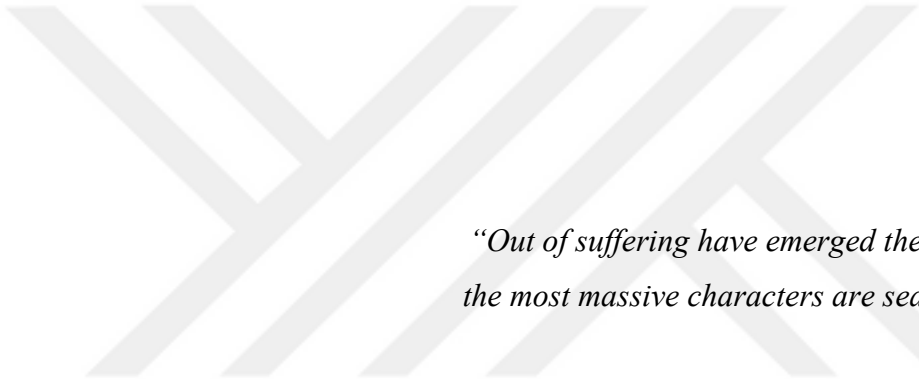


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*“Out of suffering have emerged the strongest souls;
the most massive characters are seared with scars.”*

Khalil Gibran

For all the great characters,
who endeavour to make beauty out of their wounds...

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LIST OF ABBREVIATIONS

CSA	Childhood Sexual Abuse
CEA	Childhood Emotional Abuse
CPA	Childhood Physical Abuse
CPN	Childhood Physical Neglect
CEN	Childhood Physical Neglect
OP/OC	Over-protection/ Over-control
PTSD	Post-Traumatic Stress Disorder
CM	Child Maltreatment
REV	Revictimization

CHAPTER 1

INTRODUCTION

According to the World Health Organization (WHO), *a traumatic event* is defined as short- or long-term exposure to an event or situation that occurs suddenly and unexpectedly, is difficult to control, and causes physical and/or mental stress (WHO, 1992). Traumatic events significantly impact individuals of all age groups (Tedeschi & Calhoun, 2004). They are defined as not only stressful experiences but also feelings of shock, extreme fear, and helplessness. The primary determinant that sets traumatic events apart from other negatively experienced circumstances is the insufficiency of an individual's coping mechanisms and the decline of their ability to adjust to their daily life (Mulder et al., 1998).

Experiences that cause trauma in individuals are examined under three main headings: intentional human-made events, natural disasters, and accidents (Terr, 1991). In addition, traumatic experiences are also divided into two categories: Type-1, which covers short-term traumatic experiences with a single experience, and Type-2, which covers long-term, repetitive traumatic experiences (Green et al., 2000). The type, severity, form, and duration of a traumatic event, the individual's sensitivity to trauma, psychological resilience, existing coping skills, and many other factors may play a role in the emergence and/or exacerbation of various psychological pathologies in individuals (Briere et al., 2008).

1.1. Childhood Trauma

When trauma occurs during "critical" periods of development, such as early childhood or adolescence, it is referred to as *childhood trauma*. Although this concept is generally used for cases of neglect and abuse, many events such as natural disasters, serious illnesses, accidents including situations that threaten the lives of themselves and/or their loved ones, divorce, migration, and war can also constitute traumatic experiences for children (Aker, 2012; Edwards et al., 2003; Erden & Gürdil, 2009). At the same time, overprotective/controlling attitudes of parents are involved in childhood traumas (Şar et al., 2021). Even in cases where the experience is not perceived as abuse or neglect by the child and the adult does not intentionally engage in traumatic behaviors or inaction, the event may fall within the scope of child abuse and neglect

(Colman & Widom, 2004). When examining the adversities encountered during childhood, it is seen that traumatic experiences caused by humans can lead to more traumatic consequences than naturally occurring traumas, and it is much more challenging to normalize again and return to the previous life routine (Sederer, 2012).

Child neglect and abuse, which is under the heading of childhood traumas, is defined as experiences that cause the child to suffer mental, physical, sexual, and social damage and endanger the health and safety of the child as a result of actions and/or inactions that pose a risk to the child's development, which are socially inappropriate and damaging by family members or primary caregivers (Helvacı Çelik & Hocaoglu, 2018). According to the WHO (2006), childhood abuse is "actions exhibited intentionally or unintentionally by an adult, society or state that negatively affect the child's health, psychosocial development, and physical development processes." Child neglect, on the other hand, is "the failure of the person responsible for meeting the needs of the child to fulfill or pay attention to all the basic needs of the child for the child's development" (WHO, 2006). These needs may include the child's emotional development, health, housing, nutrition and education, and safe living conditions (Gibb et al., 2007). An essential factor that distinguishes child abuse and neglect is that abuse is an active event, while neglect is a passive event in the opposite direction (Trickett & McBride-Chang, 1995). In addition, different dimensions of neglect and abuse are interrelated and often co-occur (Cecil et al., 2017). Experiencing one type of neglect or abuse increases the likelihood of experiencing other types of neglect and abuse (Arata et al., 2007; Higgins & McCabe, 2003). Children are often exposed to several types of neglect and abuse (Dong et al., 2004; Turner et al., 2010).

A significant number of children exposed to traumatic events develop maladaptive emotional and behavioral reactions, and their development and adaptation mechanisms are disrupted (Gökler Danışman & Okay, 2017). Prior research suggests that children are more susceptible to trauma and show symptoms of post-traumatic stress disorder (PTSD) at a higher rate as they do not have sufficient experience and problem-solving skills. Anxiety disorders, mood disorders, memory, and attention problems, eating disorders, sleep disorders, somatization disorders, attachment-related problems, and regression are observed in children after trauma experience (Aker, 2012; Cohen et al., 2004; Erden & Gürdil, 2009; Gökler Danışman & Okay, 2017; Karal & Atak, 2022; Malinosky-Rummell & Hansen, 1993; Yiğit, 2018). In addition,

childhood traumatic life experiences have also been found to be associated with high levels of shame, guilt, anger, helplessness, and feelings of worthlessness (Erden & Gürdil, 2009; Gökler Danışman & Okay, 2017; Malinosky-Rummell & Hansen, 1993). Studies also showed that childhood traumatic life experiences have a negative impact not only on psychological well-being but also on healthy behaviors and health outcomes. For instance, children with childhood traumatic experiences are more prone to risk factors such as obesity, smoking, physical inactivity, the incidence of heart, lung, and liver diseases, and diabetes disorders (Sofuoğlu et al., 2014). Furthermore, early traumatic life events may increase the likelihood of engaging in criminal behavior, substance abuse, and antisocial behaviors (Gökler Danışman & Berberoğlu, 2016; Gökler Danışman & Okay, 2017; Holshausen et al., 2016; Hildyard & Wolfe, 2002).

The WHO categorizes child abuse and neglect into four categories: physical abuse, sexual abuse, emotional abuse, and neglect (WHO, 2006). According to the WHO report for the period 2015-2020, approximately three out of four children between the ages of 2 and 4 are repeatedly abused physically or psychologically by their parents or caregivers (WHO, 2015). One in five women and one in thirteen men report having been sexually abused between the ages of 0-17. One-hundred-twenty million girls and young women under 20 have experienced some form of sexual abuse. Approximately 23% of adults worldwide have experienced physical abuse, 36% emotional abuse, and 16% physical neglect as children (WHO, 2020). In studies conducted in Turkey, the age group most frequently exposed to child abuse is 0-3 years (Helvacı Çelik & Hocaoglu, 2018). When looking at the general population, the rate of emotional abuse is 70.4%, the rate of physical abuse is 58.1%, and the rate of neglect is 42.4%. The rate of exposure to more than one childhood trauma is 78.6%. Neglect is more common in girls, and physical abuse is more common in boys. As the child's age increases, the number of childhood traumas increases (Sofuoğlu et al., 2014).

1.1.1. Physical Abuse

Physical abuse, which was first defined as "Battered Child Syndrome" by Kempe et al. in 1985, is generally defined as an injury to the child caused by a non-accidental factor (Wekerle et al., 2007). It is the most common type of abuse and easier to identify than other types of abuse. It is the injury or physical damage to the health

of an individual under eighteen by a parent or other person responsible for the care of the individual. This damage to the child occurs to force submission, punishment, or expression of anger in a way that leaves a mark on any part of the child's body (Schilling & Christian, 2014).

Physical abuse also includes accidents or non-accidental injuries that occur due to insufficient supervision by the family. Accidents may be expected in children, but abuse may occur in cases of damage that are not appropriate for the child's age group and are unlikely to occur on their own (Black et al., 2001). The most common form of physical abuse is beating. The most common type of hospital admission is bruising, where the carer cannot explain how it happened. Burns, poisoning, asphyxia, drowning, and cutting traumas are seen more rarely (Black et al., 2001).

Physical abuse is frequently associated with interpersonal, behavioral, cognitive, and emotional problems, substance abuse, and psychological disorders (Gökler Danışman & Okay, 2017; Pitzer & Fingerman, 2010; Schilling & Christian, 2014; Sugaya et al., 2012). Deficits in social functioning are observed in children who have been physically abused. These children may have difficulty establishing close relationships and have low emotional interaction, conflict, high levels of anger, and abusive attitudes (Pitzer & Fingerman, 2010). In addition, high rates of neurological disorders, academic failure, and deficits in cognitive abilities have been reported in these children (Gökler Danışman & Okay, 2017; Sugaya et al., 2012). The most common problems associated with physical abuse are aggressive and delinquent behaviors. Issues such as substance use disorder, personality disorders, and risky sexual behaviors are observed in children who have been physically abused. It is stated that individuals who have been physically abused engage in self-destructive behaviors to control these problems (Gökler Danışman & Okay, 2017). Studies have shown that physical abuse has a strong relationship with suicide attempts (Borges et al., 2010; Herman, 1992). Some psychiatric disorders, such as anxiety disorders, attention deficit, and hyperactivity disorder, are also common in individuals exposed to physical abuse (Mulder et al., 1998). Posttraumatic stress disorder is also common in cases of physical abuse (Taner & Gökler, 2004). In addition, children who have witnessed violence in the family or who have been exposed to violence themselves are likely to have adopted this situation as a problem-solving method. These children are also more likely to be abused by their spouses in adulthood (Taner & Gökler, 2004).

1.1.2. Sexual Abuse

Sexual abuse is defined as sexual contact between an adult individual and a sexually immature (physiologically/psychologically maturity) child, using force, deception, and threats to achieve sexual satisfaction of the adult with a child under the age of consent (Finkelhor & Korbin, 1988). Sexual abuse can also be perpetrated by another child if there is a clear power and control superiority or age difference (Beitchman et al., 1992). Sexual abuse can occur without contact, such as sexually explicit conversations, exposure to pornographic elements or the sexual lives of adults, voyeurism, and exhibitionism. It can also take place in the form of body contact or touching, contact with genital areas, oral sex, friction through genitals, using the child for pornography purposes, and sexual penetration (Fleming et al., 1999; Haugaard, 2000; Urazel et al., 2017).

It is insufficient to define sexual abuse only as a sexual act directed towards the child and occurring between two individuals. Allowing the relationship, encouraging such a relationship, condoning the relationship, or obtaining a benefit from this relationship is also within the scope of sexual abuse (Akşit et al., 2020; Haugaard, 2000).

Studies show that sexual abuse is mainly perpetrated by people known to the child and family members. It is reported that sexual abuse usually lasts for many years but is often hidden. It is thought that only 15% of cases report sexual abuse. Studies on the prevalence of sexual abuse vary (6-62% for women, 3-39% for men). The actual prevalence is thought to be 12-17% for women and 5-8% for men (Taner & Gökler, 2004). Sexual abuse has been found to be more common in children between the ages of 3 and 5. It is reported that 15% of boys and 25% of girls are exposed to sexual abuse before puberty (İbiloğlu et al., 2018). A prolonged and frequent history of abuse, sexual intercourse with force and penetration, and sexual abuse by the child's parents or stepfamily members causes psychological symptoms to be experienced more severely and intensely (Fergusson et al., 1996).

Some effects concerning exposure to sexual abuse in childhood are as the following: Posttraumatic stress disorder, intense fear, intense shame, insomnia, phobias, night terrors, dissociative disorders, low self-esteem, self-harming behaviors, imitating sexual intercourse, masturbating with an object, anal and vaginal itching,

head and stomach pains, suicide, substance abuse, running away from home, risky sexual behaviors, personality disorders and behavioral problems (Beitchman et al., 1992; Dhaliwal et al., 1996; Fergusson et al., 1996; Gökler Danişman & Okay, 2017; Guiney et al., 2024; Topbaş, 2004; Tyler, 2002). In addition, sexual identity problems, sexual dysfunctions, and behavioral disorders such as engaging in risky sexual activities, inappropriate sexual behaviors, and seductive behaviors toward adults may also be observed (Gökler Danişman & Okay, 2017; Guiney et al., 2024; Topbaş, 2004).

Childhood sexual abuse also increases the risk of revictimization in adulthood. In a study, it was revealed that women who were sexually abused in childhood were twice as likely to be sexually abused in adulthood compared to women who were not. In addition, being abused in multiple areas in childhood increases the risk of revictimization in adulthood (Messman-Moore & Brown, 2004). At the same time, it was found that 60-95% of sexually abusive individuals were exposed to childhood sexual abuse (Topbaş, 2004).

1.1.3. Emotional Abuse

Emotional abuse was defined in the International Meeting on Emotional Abuse held in 1983 as psychological abuse against children and young people, behaviors that are determined to be psychologically damaging according to social and scientific standards, behaviors that are done or neglected even though they should be done (Hayashi, 2022). Emotional abuse can also be defined as the exposure of the child to all kinds of damaging stimuli that prevent the child from developing in a positive way and emotional maltreatment by people who are primarily in the child's close environment and have authority over the child (Glaser, 2002; Stoltenborgh et al., 2012). The concepts of emotional abuse and emotional neglect focus on the relationship between the child and the parent rather than a prominent event experienced by the child (Hibbard et al., 2012). Treating the child or adolescent in a way that offends their feelings, constantly blaming, threatening, belittling, criticizing, depriving the child of social relations, and making expectations from the child that are not appropriate for their developmental level are frequently encountered types of emotional abuse (WHO, 2006).

Emotional abuse is the most common type of abuse. It differs from other types of abuse in that it is difficult to identify due to the lack of concrete physical findings,

as in sexual or physical abuse (Edwards et al., 2003). It is frequently observed in conjunction with other manifestations of mistreatment. Emotional abuse can manifest alone, but it can also coexist with sexual and physical violence, often stemming from both forms of abuse (Edwards et al., 2003; Horner, 2012). It has been reported that neglect is the most frequently reported childhood trauma, followed by emotional, physical, and sexual abuse. Although emotional abuse is widespread, it is one of the types of abuse with the highest rate of concealment (Wright et al., 2009).

Examining the impact of childhood exposure to emotional abuse on children, low self-esteem can be a higher predictor of internalized symptoms such as anxiety disorders, mood disorders, suicidal attempts, posttraumatic stress disorder, and attachment disorders (Chamberland et al., 2011; De Araújo, & Lara, 2016; Gama et al., 2021; Gibb et al., 2007; Gökler Danışman & Okay, 2017). Emotional abuse could also result in externalizing symptoms. Moreover, externalizing symptoms are associated with behavioral disorders, interpersonal difficulties, violent relationships, substance abuse, and criminality (Chamberland et al., 2011; Gökler Danışman & Berberoğlu, 2016). At the same time, emotional abuse has been found to be associated with effective and continuous psychological problems such as anger, shame, feelings of worthlessness, humiliation, and emotional inhibition (Gökler Danışman & Okay, 2017; Norman et al., 2012; Wright et al., 2009).

1.1.4. Physical Neglect

Physical neglect is defined as the deprivation of basic needs such as nutrition, clothing, shelter, and health, which are necessary for the child to survive by parents or caregivers (Bilir et al., 1991). Physical neglect is also defined as the lack and/or delay in the child's health care, not dressing the child in seasonally appropriate and clean clothes, not feeding the child adequately, living in an inadequate physical environment, not taking precautions against accidents that may occur inside or outside the house, leaving the child alone at home at developmentally inappropriate ages and situations, kicking the child out of the house, not providing security, not protecting the child against possible dangers (Acehan et al., 2013; Hildyard & Wolfe, 2002; Kaplan et al., 1999; Schilling & Christian, 2014). It is observed that physical neglect, like physical abuse, can be easily identified. Although physical neglect is reported more frequently

than physical abuse, and it is more likely to be ignored when the diagnosis does not result in severe injury or death compared to other types of abuse (Kara et al., 2004).

Children exposed to physical neglect can have severe and long-term negative consequences on their social, behavioral, cognitive, and emotional development (Edwards et al., 2003; Hildyard & Wolfe, 2002; Norman et al., 2012; Schilling & Christian, 2014). These children may have pale skin, poorly groomed hair and body, and may give the impression of being malnourished (Colman & Widom, 2004). In contrast to children who are physically abused, neglected children have more intense academic and cognitive problems, high rates of social withdrawal, a narrow social environment, and severe internalizing problems (Edwards et al., 2003; Norman et al., 2012). It has also been reported that they have difficulty establishing close relationships, have less positive emotional expressions, and exhibit more externalizing behaviors (Dengizek, 2015; Norman et al., 2012).

1.1.5. Emotional Neglect

Emotional neglect is defined as not meeting the psychological and emotional needs of the child, not showing enough love and attention, not supporting the development process, not responding to the need for emotional and psychological recognition, and acting indifferently by parents or those who take care of the child (Acehan et al., 2013; Egeland, 2009). Emotional unresponsiveness, associated with the lack of communication between parent and child, means absence and neglect. Emotional neglect, like emotional abuse, focuses on the relationship between the child and the caregiver rather than a particular event experienced by the child (Hibbard et al., 2012). Neglecting the child's education is also considered within the scope of emotional neglect (Hibbard et al., 2012). Emotional neglect is less known and less studied than other forms of neglect and abuse due to the difficulties in defining it (Reddy et al., 2006).

Emotional neglect has been shown to cause severe damage to a child's development, and this damage extends into adulthood. Children who are constantly rejected, shamed, humiliated, ignored, and left unattended experience the same pain as physical humiliation (Glaser, 2002). Emotional neglect and abuse in childhood have been found to be associated with a wide range of cognitive, emotional, and behavioral problems in later developmental periods, especially in adolescence and adulthood

(Glaser, 2002). It has been observed that individuals who were neglected in childhood are more prone to develop many psychological disorders, such as mood disorders, anxiety disorders, difficulties in establishing and maintaining relationships, and attachment problems in adulthood (Li et al., 2020; Slep et al., 2011; Şahin-Demirkaya, 2014; Young et al., 2011).

1.1.6. Overprotection – Overcontrol

Overprotection-overcontrol is explained as parents' excessive worrying and eagerness, tolerant, and protective attitudes toward their children (Pettit et al., 2001). This dimension was added to the scale named "The Turkish Childhood Trauma Questionnaire (CTQ-33)" by Vedat Şar and colleagues in 2021 because it is a frequently encountered situation in the Turkish family structure and is thought to have a traumatic effect on children (Şar et al., 2021).

It has been reported that overprotection-control behaviors are associated with anxiety disorders and mood disorders that individuals face later in life (Affrunti & Woodruff-Borden, 2015; Pettit et al., 2001; Zhang et al., 2023). Analyses are associated with depression in women and anxiety disorder in men who were exposed to overprotection and overcontrolled behaviors in childhood (Zhang et al., 2023). During adolescence, overprotective parenting, especially by the mother, may cause adolescents to have more externalization problems, seek more autonomy, and experience more relatedness and frustration in their relationship with their parents (Van Petegem et al., 2020). Overprotection and control behaviors have been found to be associated with internalizing behaviors in subsequent generations due to intergenerational transmission. The study found that there was a correlation between overprotection in mothers of the first generation and anxiety in mothers of the second generation. As a result, the second-generation mothers exhibited more overprotective behaviors. The study revealed a correlation between the excessively protective and controlling behaviors exhibited by second-generation moms and the development of internalization issues in the third-generation and reported a significant correlation between the initial overprotective behaviors exhibited by first-generation moms and the internalizing difficulties observed in the third-generation (Wu et al., 2020).

1.2. Revictimization

Revictimization is defined as the increased risk of re-traumatization at some point in the lives of individuals who had traumatic life experiences in childhood (Farrell et al., 1995). It is stated that various conceptualizations such as "revictimization, multiple victimization, repeat victimization, multivictimization, repetitive victimization, and recidivist victimization" are used in the literature (Widom et al., 2008). The concept of revictimization is considered another traumatic life experience encountered during the period when the impact of the first traumatic experience on the individual has continued. Determining whether victimization will be repeated after the initial interpersonal traumatic experience depends on several factors, including the reactions and coping mechanisms of the affected individual, the risk-benefit evaluation of the perpetrator, and the level of social and public support provided to the traumatized individual (Sparks, 1981). The effect of the period in which the victim was exposed to crime is also a significant determinant in the occurrence of revictimization. The child's physical and psychological well-being declines when they experience traumatic events in childhood and are unable to be protected during their initial victimization. This is due to their inability to recover from the trauma and return to their previous state despite their own efforts and external support. This is because the child is less likely to seek help, express himself/herself clearly, or fight against the offender at the time of the crime. In this direction, the trauma experienced will affect the overall life of the individual, and the individual may become vulnerable to revictimization (Widom et al., 2008). It has been reported that women are three times more likely to experience revictimization than men (Dietrich, 2007).

Childhood traumatic experiences are believed to increase the risk of future revictimization by permanently sensitizing the hypothalamic-pituitary-adrenal system. This makes individuals more vulnerable and more likely to exhibit unhealthy coping behaviors, as well as immature defense mechanisms and damaged self-perception (Davis et al., 2019; Finzi-Dottan & Karu, 2006; Pratchett & Yehuda, 2011). At the same time, childhood abuse and neglect experiences create an expectation of interpersonal violence and rejection (Cloitre et al., 2002; Goodman et al., 2019) and cause individuals to experience learned helplessness due to lower self-efficacy and self-esteem (Aakvaag et al., 2017; Charak et al., 2020; Messman-Moore & Long, 1996; Messman-Moore & Long, 2003). In addition, alcohol abuse has been found to

increase the tendency to mood disorders, anxiety disorders, externalizing behaviors, and risky behaviors, thereby increasing the risk of revictimization (Anda et al., 2006; Benjet et al., 2010). Studies have shown that not only sexual abuse but also other types of interpersonal childhood traumatic life experiences are associated with revictimization (Widom et al., 2008). In addition, it has been found that exposure to more than one traumatic life experience during childhood (Finkelhor et al., 2007; Whitfield et al., 2003; Widom et al., 2008), the primary caregiver was the person who caused the traumatic experience (Edwards et al., 2012; Widom et al., 2008), and exposure to neglect experiences and sexual abuse experiences increase the risk of revictimization compared to other traumatic experiences (Arata, 2002; Roodman & Clum, 2001; Widom et al., 2008). The concept of revictimization, which is also defined as lifelong multiple trauma experiences, is seen in the forms of physical Abuse, Psychological Abuse, and sexual abuse in adulthood. However, it is impossible to distinguish between types of Abuse (Messman-Moore & Long, 2003).

1.2.1. Emotional Abuse

Emotional abuse is a highly perilous and commonly encountered form of violence in everyday life. It entails individuals using words and actions that instill fear in others and undermine their self-assurance and self-worth. It is challenging to identify as it lacks tangible evidence and access to professional assistance, making it difficult to recognize the harm it inflicts (Carney & Barner, 2012; Yoshihama et al., 2009). Emotional abuse has been found to be associated with high levels of withdrawal in social life, high levels of shame, low self-confidence and self-esteem, mood disorders, substance abuse, eating disorders, high levels of loneliness, anxiety disorders, and posttraumatic stress disorder (Cañete-Lairla & Gil-Lacruz, 2017; Cirici Amell et al., 2023; Coker et al., 2002; Duron et al., 2021; Ge et al., 2017; Kimber et al., 2017; Thaggard & Montayre, 2019). Emotional abuse is divided into various types, such as isolation/control, verbal abuse, shaming, emotional rejection, and high expectations (Dokkedahl et al., 2019; Straus et al., 1996; Yavaş Celik & Elmaoğlu, 2022).

1.2.1.1. Isolation and Control

The systematic severing of ties with all people and institutions from which a person can receive material and moral support is defined as *isolation and control*

(Duron et al., 2021). It is commonly perceived as behavioral patterns that aim to diminish the individual's self-esteem, shame them, and discourage them from asserting themselves. It can occur in different forms within the relationship. Isolation and control behaviors in a relationship can include actions such as attempting to control the social environment of the individual, monitoring and controlling their use of communication tools like social media, mobile phones, and computers, displaying jealous behaviors, being suspicious of their words and demanding evidence, excessively involving oneself in their daily affairs and making decisions for them, restricting their freedom to go to desired places or leave the house, and using the pretext of protection to exert control over their life (Dokkedahl et al, 2019; Foshee et al., 1996; Straus et al., 1996; Yavaş Celik & Elmaoğlu, 2022).

1.2.1.2. Verbal Abuse

Verbal abuse refers to verbal attacks to exert authority or influence over another individual (Cañete-Lairla & Gil-Lacruz, 2017). Verbal abuse is generally seen as behavior patterns that are intended to humiliate and gain control over the individual and embarrass the individual. It can occur in different forms within the relationship. For instance, the person involved in the relationship consistently engages in conflicts, frequently interrupts during conversations, displays indifference towards the emotions and thoughts of the other person, deems their feelings and ideas as absurd, subjects them to ridicule and humiliation, uses derogatory nicknames, and resorts to swearing and insulting them. Verbal abuse includes the use of caustic or disparaging language towards an individual, targeting their values, beliefs, family, ethnicity, and character features. It also includes statements conveying that nobody will love or desire them (Cañete-Lairla & Gil-Lacruz, 2017; Gentry & Bailey, 2014; Yavaş Celik & Elmaoğlu, 2022).

1.2.1.3. Shaming

Shaming is defined as exposing an individual's weaknesses, mistakes, and failures or revealing them in the presence of other individuals. It is generally seen as behavior patterns that are intended to humiliate, embarrass, dishonor, and damage the reputation of the individual (Camp, 2022). It can occur in various forms in interpersonal relationships. For example, embarrassing the individual in front of others, sharing personal information and secrets with others, forcing the individual to

act contrary to his/her values and beliefs, making sarcastic and condescending comments about his/her behaviors, feelings, and ideas in public, revealing the flaws of the individual with whom he/she is in a relationship in the presence of other individuals, warning and/or threatening the individual with whom he/she is in a relationship in the presence of other individuals, forcing the individual to do humiliating things are considered as shaming (Camp, 2022; Thaggard & Montayre, 2019; Yavaş Celik & Elmaoğlu, 2022).

1.2.1.4. Emotional Rejection

Emotional rejection is defined as ignoring the other individual in the relationship and not making an effort in the relationship (Yavaş Celik & Elmaoğlu, 2022). Emotional rejection refers to the situation where one person in a relationship fails to respond to the other person's attempts to communicate, acts coldly, ignores them, reduces or completely stops spending time together, neglects their needs, and fails to allocate time for them without any apparent reason (Yavaş Celik & Elmaoğlu, 2022; Zayas et al., 2009).

1.2.1.5. High Expectations

High expectations are defined as unrealistically high expectations for the relationship itself or the person in the relationship (Sullivan & Schwebel, 1995). They are also defined as demanding much more than the person in the relationship can do or give. High expectations encompass behaviors such as demanding that the person in a relationship achieve results that surpass their abilities and skills, expecting them to act beyond their current potential and disregarding their physical and/or mental exhaustion (Yavaş Celik & Elmaoğlu, 2022).

1.2.2. Physical Abuse

Physical abuse is the most easily recognized type of violence, involving the use of physical force to inflict pain, injury, or intentional physical suffering on an individual (Eryalçın et al., 2020). Physical violence encompasses a range of actions such as slapping, beating, kicking, pinching, biting, pushing, dragging, stabbing, punching, striking with a fist or any other object capable of causing harm, burning, suffocating, threatening, or employing a firearm, knife, or any other weapon. It is important to note that physical violence can result in fatalities (Graham-Kevan &

Archer, 2003). Physical abuse has been found to be associated with high levels of shame, anger, and fear, low self-esteem, mood disorders, substance abuse, eating disorders, anxiety disorders, and posttraumatic stress disorder (Campbell & Lewandowski, 1997; Cregan & Kelloway, 2021; Graham-Kevan & Archer, 2003; Haj-Yahia, 1999; Liebschutz et al., 2002; Lindert et al., 2014; Schaaf & McCanne, 1998; Schmidt et al., 1997; Treuer et al., 2005). Physical abuse was analyzed in three sub-dimensions: intimidation, threat/symbolic violence, and physical violence.

1.2.2.1. Intimidation

Intimidation is issuing threats by an individual or a group of individuals to others to cause harm. It is the prevalent form of physical abuse, typically employed as a strategy to exert dominance over the individual (Ward & Muldoon, 2007). It can occur in various forms in interpersonal relationships. Intimidation refers to actions such as damaging valued items, threatening or damaging relationships with others, interfering with various aspects of life (such as work, family, or education), blackmailing, persistently and fearfully following someone, refusing to accept rejection, and intimidating someone by threatening to deprive them of material or moral resources (Dichter et al, 2018; Ward & Muldoon, 2007; Yavaş Celik & Elmaoğlu, 2022).

1.2.2.2. Physical Threat

Physical threat refers to intimidating individuals by indicating they will experience bodily harm (Cregan & Kelloway, 2021). It is generally seen as behavior patterns intended to frighten the individual, gain control, and reduce their autonomy. It can occur in different forms within the relationship. As an illustration, instances of aggressive behavior in a relationship may include physically striking or kicking walls, doors, or objects, forcefully throwing or smashing items, pointing a finger in a threatening manner, advancing towards the partner, glaring at the partner with hostility, displaying a clenched fist, making threats to harm loved ones or possessions, expressing intentions to commit suicide, issuing death threats, or brandishing weapons such as sticks, knives, or firearms (Eryalçın et al., 2020).

1.2.2.3. Physical Violence

Physical violence is any intentional act that causes injury, trauma, bodily harm, or other physical pain to another person through bodily contact. It is generally seen as

behavior patterns intended to intimidate the individual, gain control, and reduce autonomy (Shepard & Campbell, 1992). Physical violence can occur in different forms within relationships. For instance, restraining the individual firmly and impeding their mobility, exerting force, jolting, gripping, yanking their hair, contorting their limbs and/or wrists, striking them on the head and/or body, gnawing, smacking, striking them with other items, hurling other objects, and delivering kicks. Physical violence encompasses acts such as punching, stomping, strangling using hands or various things like scarves or belts, scorching with fire, inflicting wounds with cutting and piercing weapons, causing harm with firearms, and isolating the individual in a room or enclosed area (Eryalçın et al., 2020; Shepard & Campbell, 1992).

1.2.3. Sexual Abuse

Sexual abuse is all sexual behavior or sexual acts that are forced upon a person without their consent. These acts can include physical contact, including penetrative assault (anal, oral, or vaginal sex), or non-penetrative acts, such as masturbation, kissing, rubbing, and touching outside of clothing (Arata, 2002). It may also encompass activities that do not involve physical contact, such as coercing unprotected sex, pressuring a partner into engaging in unwanted or degrading behaviors, causing harm during sexual intercourse, viewing or participating in the creation of sexual images, observing sexual activities, and promoting sexually inappropriate behavior (Bagwell-Gray et al., 2015; Liebschutz et al., 2002). Sexual abuse has been associated with high levels of shame, emotion regulation difficulties, low self-esteem, maladaptive personality traits, mood disorders, alcohol and substance abuse, eating disorders, anxiety disorders, and posttraumatic stress disorder (Arata, 2002; Campbell et al., 2008; DeCou et al., 2017; Dugal et al., 2021; Liebschutz et al., 2002; Salim et al., 2024). Sexual abuse is examined under three headings: sexual coercion, sexual harassment, and sexual assault.

1.2.3.1. Sexual Coercion

Sexual coercion is defined as the abuse of pressure, manipulation, and using authority or status to engage in sexual intercourse without the consent of an individual (Arata, 2002). However, it is an implicit type of violence and the most common type of sexual Abuse (Shackelford & Goetz, 2004). Sexual coercion can occur in different forms within relationships. For example, sending sexually explicit items to other

individuals, giving gifts to have sexual intercourse, threatening and/or implying that they will deprive them of material and/or moral opportunities, threatening and/or implying that they will have sexual intercourse with someone else, insisting and/or pressuring for sexual intercourse even though the other individual is involuntary, blackmailing is considered as sexual coercion (Arata, 2002; Güvenç et al., 2022; Shackelford & Goetz, 2004).

1.2.3.2. Sexual Harassment

Sexual harassment is defined as all sexually offensive behaviors, whether verbal, visual, body language, mail, or electronic means of communication (Arata, 2002; Bagwell-Gray et al., 2015). Sexual harassment can occur in different ways in relationships. For example, it can be manifested in various ways, such as the person in the relationship making remarks to the other person, making sexually explicit conversations and/or jokes without consent, kissing without consent, watching pornographic content in the presence of the person in the relationship without consent, sending pictures or videos with pornographic content without consent, taking photos/videos of the person in the relationship in underwear, naked or during sexual intercourse without consent, talking in a way that degrades the female/male body and sexuality (Bagwell-Gray et al., 2015; Loxton et al., 2013).

1.2.3.3. Sexual Assault

Sexual assault is when a person touches another person sexually without their consent or forces or physically coerces another person to engage in a sexual act against their will (Marshall, 1992). Sexual assault can occur in different forms in relationships. For example, touching any part of the body of the person in a relationship for sexual purposes, forcing unwanted sexual positions, forcing oral, anal, or vaginal intercourse with an organ and/or object, hugging, kissing, caressing, rubbing, masturbating, forcing sexual acts by giving alcohol or drugs, forcing the person in the relationship to have sexual intercourse with another person other than himself/herself, forcing unprotected sexual intercourse, non-consensual cruel and painful sexual intercourse and using sexuality as a reward or punishment method are considered sexual assault (Bagwell-Gray et al., 2015; Marshall, 1992).

1.3. Theories of Revictimization

1.3.1. Schema Approach

Schemas are defined as how people perceive and make sense of themselves, others, and the world around them (Young, 1990). What an individual thinks about a problem he/she faces, how he/she feels himself/herself, and how he/she evaluates the situation he/she is in vary according to the schemas he/she has. Congenital characteristics, situations such as not meeting needs appropriately in childhood, and traumatic life events constitute schemas (Young, 1999). *Early maladaptive schemas* are patterns that repeat themselves throughout life and harm the person. The reason for this is that schemas are familiar and habitual. The stronger the schema, the more often it is triggered and causes problems later in life (Young, 1990).

In total, 18 early maladaptive schemas were defined under five schema domains. These schema domains are Disconnection and Rejection, Impaired Autonomy and Performance, Impaired Limits, Other Directedness, Over-vigilance, and Inhibition. The sub-dimensions are Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, Social isolation/Alienation, Dependency/Incompetence, Vulnerability to Harm and Illness, Enmeshment/Undeveloped Self, Failure, Entitlement/Grandiosity, Insufficient Self Control/Self-Discipline, Subjugation, Self-Sacrifice, Approval Seeking/Recognition Seeking, Negativity/Pessimism, Emotional Inhibition, Unrelenting Standards/Hyper-Criticalness and Punitiveness (Young et al., 2003). Early maladaptive schemas are structures activated by events, situations, and relationships, as well as mediating the individual's perception of the world and guiding his/her responses to the world. Later in life, early maladaptive schemas are activated due to stressful life events, and the individual reacts to the events in a manner consistent with the schema (Young, 1999).

Early maladaptive schemas are assumed to be the basis of many chronic Axis-I disorders (Young et al., 2003). Especially anxiety disorders, substance abuse, eating disorders, somatization, depression, and personality disorders are common cognitive structures that pave the way for the emergence of these disorders (Kellogg & Young, 2006; Schmidt et al., 1995; Young, 1990; Young et al., 2003). Studies show that individuals with early maladaptive schemas are at risk of revictimization due to

changes in how they make sense of the world and relationships (Atmaca & Gençöz, 2016; Cloitre et al., 2002; Munroe, 2014).

1.3.2. Object Relations Theory

The most classic explanation of revictimization is Freud's psychodynamic concept known as the "*repetition compulsion*" (Freud, 1920). Accordingly, people who are unable to adapt to a traumatic experience may be unwittingly driven to relive it in order to gain a sense of mastery over the original trauma (Irwin, 1999). Object relations theory, a theory based on disorders in interpersonal relationships rooted in childhood abuse, offers a more satisfying psychodynamic theory for understanding the etiology of revictimization (Horowitz, 1998). A basic tenet of object relations theory is that individuals' representations of self and others (object) develop in their relationships with their parents and that existing object representations continue to influence interpersonal expectations, behaviors, and emotions throughout life (Carey, 1997). Object relations theory suggests that the experience of abuse by an essential object in a child's life will lead to an internalized sense of worthlessness or low self-esteem. The child may be inclined to recreate abusive relationships in the future because they are familiar to him/her. The child's identification with the perpetrator may make him/her violent and aggressive (Horowitz, 1998).

Children's most significant objects are their parents. Children develop some of their most critical inner purposes through the object relationship or patterns between themselves and their parents, as these early patterns are reinforced and reconstructed thousands of times during childhood (Calabrese et al., 2005). Therefore, these internal meanings and patterns between themselves and others are re-staged with many other objects (people) throughout a person's life. In other words, when the child becomes an adult, these early patterns become the template for adult relationships (Calabrese et al., 2005).

1.3.3. Echologic Model

Another model for revictimization is the Ecological Model (Grauerholz, 2000). In this model, it is emphasized that revictimization is determined multidimensionally by many variables such as the history of the individual exposed to trauma, social relations and resources of the individual exposed to trauma, society, and cultural factors (Grauerholz, 2000). The model has four levels: *ontogenic development*,

microsystem, exosystem, and macrosystem. Ontogenic development is defined as the history that the individual contributes to his/her future relationships. The most crucial ontogenic factor for revictimization is previous abuse or neglect experience. Another ontogenic factor is early family experiences. Dysfunctional families, broken families, patriarchal structures, and unsupportive parents are among the variables of family experiences. The microsystem includes the conditions that existed when the abuse occurred, such as family or other close relationships. The exosystem includes formal and informal social structures. This system includes the lack of alternatives due to a lack of resources, low family support, and social isolation. Finally, the macrosystem refers to the cultural values and belief systems that influence the other three systems and foster revictimization (Grauerholz, 2000).

1.3.4. Traumagenic Dynamics Model

According to traumagenic dynamics model, sexual trauma can lead to various psychological problems by differentiating children's emotional and cognitive orientation towards the world. It has also been reported that victims of abuse develop a negative self-image as a result of internalized stigmatization (Browne & Finkelhor, 1986; Van der Merwe, 2009). It has also been reported that survivors of abuse develop a negative self-image as a result of internalized stigma. In various ways, due to the fear of being stigmatized by society, individuals may experience excessive shame, guilt, low self-esteem, and low self-acceptance. For this reason, early childhood sexual abuse can be hidden for an extended period and lead to social isolation (Browne & Finkelhor, 1986; Finkelhor, 1987). Based on this, it is thought that individuals may experience disclosure concerns after child maltreatment, which may make individuals with childhood trauma more vulnerable to revictimization. Also, differentiated emotional and cognitive orientation towards the world may negatively affect emotion regulation skills and may lead to revictimization (Finkelhor, 1987).

1.3.5. The Importance of Identity in the Relationship between Childhood Traumas and Revictimization

Identity is a dynamic organization of the individual's drives, abilities, beliefs, and history (Erikson, 1968). In Erikson's theory of psychosocial development, conflicts must be resolved at each stage. According to Erikson, identity is the main characteristic acquired in adolescence, and identity confusion against the sense of

identity constitutes the central conflict. According to Erikson, the sense of identity is the feeling of feeling at home in one's body, knowing where one is going, and the feeling that the people who are important to him/her accept him/her (Erikson, 1968). According to Erikson, identity development is neither a process that begins nor ends with adolescence; it develops and changes throughout life. During adolescence, individuals face societal expectations due to cognitive, physical, and psychological changes.

On the one hand, childhood identities and efforts to maintain the existing balance, and on the other hand, social expectations necessitate change in adolescents. In this situation, adolescents must redefine their identity and gain a place in society. Thus, an identity crisis emerges. The successful resolution of the individual's identity crisis results in an identity concept based on a capital comprised of all the experiences in successive stages of previous development (Erikson, 1980).

Due to the difficulties in operationalizing Erikson's views on identity, Marcia proposed the concept of identity statuses to make the concept of ego identity measurable and observable and defined identity statuses according to the presence or absence of the dimensions of commitment and exploration (Marcia, 2002). Identity Diffusion is defined as a status in which individuals explore randomly in identity domains but do not make any commitment. Moratorium is defined as a status in which individuals explore options and experiment but do not make any permanent commitment. Identity achievement is used to describe the process in which individuals form attachments and acquire identity achievement by actively going through the process of exploration and experimenting with various roles. Finally, foreclosure describes the process in which individuals form their identity according to the expectations of their parents or other important people in their lives and make a commitment without any research (Marcia, 2002).

Healthy identity formation is significantly affected by exposure to childhood traumas. In a study, it was found that individuals questioned their identities after childhood life experiences (Kraye et al., 2015). At the same time, high feelings of shame experienced after childhood trauma were also found to be associated with identity development. It has been observed that the feeling of shame may be effective in the individual's inability to complete identity development and experience identity

ambivalence (Berman et al., 2020; Erikson, 1968). Shame has been defined as negative feelings and thoughts arising from thinking that the person is terrible (Kaufman, 1974) and generally constitutes an obstacle to self-disclosure towards trauma (Berman, 2016). Also, the risk of revictimization may increase as individuals move into adulthood without an integrated identity.

1.5. Cognitive Emotion Regulation

Emotion is a psychophysiological structure that starts with a stimulus and ends with a reaction. It also provides the regulation of events in the outside world by enabling the emergence of cognitive, behavioral, and physiological responses and behaviors at the point of adaptation. An individual who undergoes diverse emotional states in various circumstances should display these feelings in a manner that is suitable for the external world. This is crucial for maintaining a healthy and uninterrupted daily routine. Regulating emotions becomes operational (Işıklı & Keser, 2020). All internal and external processes responsible for regulating, evaluating, and adjusting emotional reactions in order for individuals to achieve their goals are defined as emotion regulation (Kallay et al., 2009). The cognitive evaluation of an individual determines whether or not they will experience an emotion and which specific emotion they will experience. Hence, the initial method of regulating emotions is through cognitive processes (Ataman Temizel & Dağ, 2014).

The realization of cognitive processes can be conscious or unconscious. However, cognitive emotion regulation only addresses conscious cognitive processes such as recognizing emotions, thinking, feeling, learning, understanding, storing and retrieving information, decision-making, language, problem-solving, and evaluation. Cognitive processes elicit alterations in individuals' behavioral and physiological reactions. By applying these changes, the individual can effectively generate an emotional response appropriate to current and future circumstances and manage and direct this emotional response through cognitive processes (Ochsner & Gross, 2005). Managing emotional responses involves the use of cognitive emotion regulation strategies in the process of coping with a stressful situation. In this way, individuals can regulate their emotions with cognitive emotion regulation, which could make it easier to cope with intense emotions that arise in the face of stressful events that threaten well-being (Garnefski et al., 2004). It is seen that cognitive emotion regulation

consists of nine different strategies, which are classified as adaptive and maladaptive coping strategies. While self-blame, other-blame, rumination, and catastrophizing are considered maladaptive coping strategies, in the literature, acceptance, refocus on planning, putting into perspective, and positive reappraisal are considered adaptive coping strategies (Garnefski & Kraaij, 2007). However, there are also studies emphasizing that instead of categorizing cognitive emotion regulation strategies as adaptive or maladaptive, processes such as the extent to which strategy is used and the flexibility of the person to use the appropriate strategy for the situation may be more determinant in terms of emotion regulation (Işıklı & Keser, 2020).

Acceptance refers to the extent to which the individual adopts the process of acceptance or renunciation of situations and emotions. This strategy means that the individual accepts that he/she cannot cope if the conditions are inappropriate while processing the emotion. For this reason, it has been found to have a negative relationship with anxiety disorders (Carver et al., 1989). It has also been found to have a positive relationship with psychological resilience (Campbell-Sills et al., 2006; Garnefski et al., 2002).

Refocus on planning refers to identifying good and functional alternatives that can be utilized while coping with experiences and emotions. The person evaluates the best coping method available to him/her in the face of adversity (Folkman & Lazarus, 1980). A positive relationship was found between this strategy and self-esteem (Garnefski et al., 2001).

Positive reappraisal refers to the tendency to make a positive attribution to what happened within the framework of personal development and to reveal the gains of the event for the individual. This is a scenario where the person assesses the negative experiences as a chance for growth and personal development. A positive correlation was discovered between positive reappraisal and optimism and self-confidence (Garnefski et al., 2001).

Putting into perspective is when a person compares a negative event with other life events and thinks that the situation is actually not that bad. The person experiences a perceptual alleviation and tries to reduce the value of the event (Garnefski et al., 2001). This strategy has been found to have a positive relationship with psychological well-being and a negative relationship with anxiety disorders (Carver et al., 1989).

Positive refocusing is based on focusing on relatively happy and pleasant thoughts with positive connotations instead of thinking about adverse life events. Contemplating positive experiences and deliberately avoiding dwelling on terrible life events is believed to have detrimental effects in the future (Garnefski et al., 2001).

Self-blame refers to the tendency to blame oneself for adverse events and to have a tendency to think in a self-blaming manner. It is thought to be closely linked to depression (Anderson et al., 1994). It has also been shown to be a strategy that prevents recovery from symptoms of post-traumatic stress disorder (Ullman & Najdowski, 2009).

Rumination is the intense and repetitive thoughts and feelings about the adverse event that the individual constantly experiences (Garnefski et al., 2002). The individual's mind is constantly preoccupied with thinking about negative events and consequences, which makes the person dysfunctional and triggers depression and anxiety disorders (Nolen-Hoeksema et al., 1994).

Catastrophizing is the characterization of the adverse event experienced by the person as the worst possible situation compared to his/her environment and dwelling too much on the damaging aspect of this event. It is thought to be closely linked to depression, stress susceptibility, and adjustment problems (Garnefski et al., 2002).

Other blame is when the individual attributes negative experiences to others or the environment and blames others or the environment. It has been found that the frequent use of this strategy is related to behavioral problems (Garnefski et al., 2002), and its frequent use is associated with decreased emotional well-being in individuals (Tennen & Affleck, 1990).

As a result of the studies, it was found that there was a significant difference in the use of cognitive emotion regulation strategies between participants with and without psychopathology. Self-blame and catastrophising strategies were found to be used more by participants with psychopathology, whereas positive reappraisal strategy was found to be used more by participants without psychopathology (Garnefski et al., 2002). At the same time, it is seen that women use the strategy of "other blame" at a higher level than men, and men use the strategy of "catastrophizing" at a higher level than women (Demirci & Güneri, 2020). It was also found that young individuals used fewer strategies than older individuals, and the strategies they used were mostly

maladaptive cognitive emotion regulation strategies (Garnefski & Kraaij, 2007). While certain emotion regulation strategies employed by individuals experiencing stressful life events facilitate adaptation to the environment, others can hinder adaptation (Gross, 2015). At the same time, difficulties in emotion regulation are thought to be related to childhood traumas (Burns et al., 2010). In a study conducted with participants with childhood traumatic life experiences, maladaptive cognitive emotion regulation strategies were found to be associated with the intensity of post-traumatic depression (Huh et al., 2017). In another study conducted with adolescents, it was observed that people who were emotionally abused by their caregivers had a cognitively pessimistic view of events, people who were emotionally abused by their peers made negative evaluations in stressful situations and used rumination as a non-adaptive strategy (Padilla Parades & Calvete, 2014). In another study conducted with participants who had experienced traumatic events, it was observed that negative emotions caused somatic symptoms, and these somatic symptoms were associated with more frequent use of maladaptive cognitive emotion regulation mechanisms such as self-blame, rumination, and catastrophizing (Garnefski et al., 2017).

1.6. Trauma Related Self-Disclosure

1.6.1. Self-Disclosure

As a biopsychosocial entity, human beings can only exist in relationships throughout their lives. The establishment of interpersonal relationships depends on the use of communication skills. *Self-disclosure*, one of these communication skills, is the transfer of personal information about oneself to another person or others (Collins & Miller, 1994; Steuber, 2016). The concept of self-disclosure was first used in the literature in 1971 by Sydney M. Jourard in his book *The Transparent Self*. According to Jourard, self-disclosure is the process of introducing oneself to others by revealing personal information about oneself (Chen, 2014).

Self-disclosure is a complex phenomenon that differs according to age, gender, the person to whom it is disclosed, the subjects of disclosure, reciprocity in disclosure, the way of disclosure, and the culture in which it is found (Ağlamaz, 2006; Vogel & Wester, 2003). The level of self-disclosure of individuals can be the primary determinant of their communication with their families, friends, individuals in the work environment, or other people in their environment and can be shaped according

to the approaches of the parties to each other (Brummelman et al., 2024; Wang, 2004). Studies have shown that the attitudes and reactions of individuals to whom traumatic life experiences are disclosed for the first time also affect the trauma perception of the traumatized individual. It has been found that an accusatory attitude of the first person to whom the traumatic life experience is disclosed leads to more negative cognitions related to the trauma and an increase in the stress experienced by the trauma. This is thought to be related to the perception of the first response as more beneficial than other responses (Bonnan-White et al., 2018).

While self-disclosure helps the individual to realize himself/herself and gain a healthy personality, it also enables him/her to be in a healthier communication process with other individuals, to develop deep and close relationships, and to adjust himself/herself according to the environment or situation (Erdost, 2004). It has been found that people with high levels of self-disclosure establish effective interpersonal relationships and have higher levels of perceived social support (Batool & Zubair, 2018). In addition, high levels of self-disclosure are associated with many positive outcomes, such as high life satisfaction, positive emotional personality traits, better physical health, and psychological resilience, while low levels of self-disclosure are associated with negative emotional personality traits, low life satisfaction, and severe depressive symptoms (Kahn & Hessling, 2001; Larson & Chastain, 1990; Pennebaker et al., 1988). At the same time, according to Hunt (1998), self-disclosure is of great importance for individuals to process their traumatic life experiences, make sense of their emotional experiences, and reduce stress levels (Purves & Erwin, 2004). With this function, it is thought to reduce the level of post-traumatic stress, support coping and contribute to post-traumatic growth (Fontana & Rosenheck, 1994; Greenberg & Stone, 1992; Kimbley et al., 2023; Öksüz, 2012; Pennebaker & Graybeal, 2001; Petrie et al., 1995; Pietruch & Jobson, 2011; Stein et al., 2017; Ullman et al., 2007).

1.6.2. Disclosure Concern

Disclosure Concern is defined as the anxiety and reluctance an individual develops toward self-disclosure due to concerns of stigmatization and discrimination (Laschober et al., 2019; Mitzel et al., 2019). It is reported to form the basis of internalized stigma (Hernansaiz-Garrido & Alonso-Tapia, 2017). According to the literature, disclosure concerns have been found to be associated with many problems,

such as depression, anxiety, social isolation, somatization, and lack of social support. It has also been reported to negatively affect people's tendency to receive support for their physiological and psychological health (Chan et al., 2019; Evangelini & Wroe, 2017; Harrison, 2003; Mitzel et al., 2019; Yiğit et al., 2021). Research on stigmatization has shown that people seeking help are often aware of other people's adverse reactions and judgments in their social environment (Brown et al., 2010). Due to the concern of being stigmatized by society, people may hide their childhood traumatic life experiences, and this may cause the person to experience social isolation. As a result, shame, guilt, and a sense of being different from others can lead to low self-esteem (Aberle, 2001; Browne & Finkelhor, 1986; Koçtürk, 2016). The thought that the person will be ashamed of his/her social environment and family or the fear of stigmatization due to seeking help may cause reluctance to seek psychological help (Brown et al., 2010; Wrigley et al., 2005).

1.7. Related Studies in The Literature

Traumatic events are human-caused or naturally occurring life events and situations that affect individuals and society emotionally, behaviorally, and physically. Traumatic events that complicate normal living conditions threaten an individual's physical integrity and beliefs about the world, others, and loved ones (Copeland et al., 2007). It is known that repeated exposure to trauma has a cumulative effect on an individual's physical and psychological health (Nilsson et al., 2015; Ogle et al., 2014). Having trauma victimization in earlier periods of life increases the risk of being exposed to trauma later in life (Aakvaag et al., 2017; Acierno et al., 1999; Fereidooni et al., 2024; Irwin, 1999; Katz et al., 2010; Kessler & Bieschke, 1999; Messman-Moore et al., 2010; Pilkington et al., 2021; Roodman & Clum., 2001; Scoglio et al., 2021; Simmel et al., 2012; Walker & Wamser-Nanney, 2023; Walsh et al., 2011; Widom et al., 2008; Young et al., 2017; Zamir et al., 2018). When the relevant literature is examined, it is seen that the concept of revictimization is mainly studied with sexual revictimization, and the mechanisms underlying the relationship between childhood traumatic life experiences and revictimization have not been fully clarified. According to a systematic review of 71 studies, posttraumatic stress disorder, dissociative disorders, maladaptive emotion regulation, and risky sexual behaviors were shown as symptoms that increase the risk of revictimization (Fereidooni et al., 2024). In addition, self-blame, avoidance, and rumination have been reported to be

cognitive emotion regulation strategies that increase the risk of revictimization. It is also thought that maladaptive emotion regulation skills may contribute to the risk of revictimization because they affect processes such as alcohol and substance use, risk perception, and assertiveness (Fereidooni et al., 2024). Other studies support these findings. In a study involving 633 participants with childhood sexual abuse experience, it was found that maladaptive cognitive emotion regulation strategies were found to mediate the relationship between childhood sexual abuse and sexual revictimization in intimate partner relationships (Krause-Utz et al., 2021). In another study conducted with 425 participants with childhood traumatic life experiences, it was found that individuals with low emotion regulation skills had a higher risk of revictimization in intimate relationships (Zamir & Lavee, 2016). In another study with 241 participants examining the relationship between childhood cumulative trauma experiences and revictimization experience in intimate partner relationships, maladaptive personality traits, negative urgency, and emotional dysregulation were found to mediate the relationship between childhood trauma and revictimization (Dugal et al., 2021). In another study conducted with 710 participants in which the COVID-19 pandemic was considered a traumatic life experience, it was found that emotion regulation difficulties after childhood traumatic experiences increased pandemic-related stress and traumatization (Siegel & Lahav, 2022). In a study with 752 young adult female participants, difficulties in emotion regulation were found to mediate the relationship between childhood sexual and physical abuse and revictimization (Messman-Moore et al., 2010). As a similar result, in another study conducted by Dietrich in 2007 with 207 participants and addressing different variables, it was found that difficulties in emotion regulation after childhood traumatic life experiences predicted revictimization (Dietrich, 2007).

Few studies have examined the effect of self-disclosure on the relationship between childhood traumatic life experiences and revictimization, and they contain contradictory findings. A systematic review of 71 articles reported that individuals who experienced revictimization received less social support and that the adverse initial reaction to the self-disclosure experience was associated with revictimization (Fereidooni et al., 2024). Other studies also support this finding. In the study published by Brenner and Ben-Amitay in 2015, the relationship between childhood sexual abuse and sexual revictimization in adulthood was examined with 60 participants. In the

study, no relationship was found between emotional neglect, physical neglect, and revictimization, but a relationship was found between sexual abuse, emotional abuse, physical abuse, and revictimization. At the same time, the revictimization rate of participants who received negative reactions after self-disclosure regarding trauma was found to be higher than those who received positive responses after self-disclosure or those who had no self-disclosure experience (Brenner & Ben-Amitay, 2015). In another study conducted by Kogan with 111 adolescents, it was found that self-disclosure experiences immediately after childhood sexual abuse experience reduced the impact of trauma on adolescents and reduced the risk of possible sexual revictimization (Kogan, 2005). In another study, it was found that self-disclosure did not contribute directly to the relationship between childhood traumatic life experiences and revictimization but rather contributed indirectly through its relationship with avoidance and intrusive thoughts (Arata, 1998). Also, in a study conducted in 2021 with 275 young adult participants, it was found that self-disclosure did not have a moderating effect on the relationship between childhood traumatic life experiences and revictimization (Desir & Karatekin, 2021).

1.8. Present Study and Hypotheses

Repeated exposure to trauma is known to have a cumulative effect on an individual's physical and psychological health (Nilsson et al., 2015; Ogle et al., 2014). Having trauma victimization in earlier periods of life increases the risk of being exposed to trauma later in life (Scoglio et al., 2021; Walker & Wamser-Nanney, 2023). However, the relationship between childhood traumatic life experiences and revictimization has not been fully explained. The fact that studies have focused on sexual abuse in terms of both childhood trauma and revictimization, other types of abuse are not addressed, and revictimization studies are mainly addressed within the scope of intimate partner violence narrows our perspective in understanding this relationship. Understanding the processes that lead to revictimization is of great importance in terms of preventing individuals from experiencing new exposures and reducing the cumulative negative effects of polyvictimization on individuals. The aim of this study is to understand the impact of cognitive emotion regulation and posttraumatic disclosure concerns on the relationship between childhood traumatic life experiences and revictimization risk. Within the scope of the study, all childhood abuse and neglect experiences and sexual, physical, and emotional revictimization are

addressed. At the same time, not only the intimate partner relationship but also other relationships in the individual's life are examined in terms of revictimization. In this way, it tries to look at both the types of abuse and the perpetrator's place in the individual's life from a broader perspective. It is also the first study in the trauma literature to address disclosure concern, which is defined as the concern of individuals to share their traumatic experiences with other individuals due to potential stigmatization. Disclosure Concerns are a topic that has been studied with populations such as HIV (+) individuals and LGBT+QIA individuals but has not been addressed in the trauma literature (Fekete et al., 2016; Harrison, 2003; Yigit et al., 2021). Another critical point of the study is the two scale studies it adds to the trauma literature. The preliminary studies of The Trauma Related Self-Disclosure Scale and The Relational Traumatic Experiences Scale will be completed within the scope of the study.

Proposed hypotheses of the study are as follows:

1. Trauma related disclosure concern moderates the relationship between childhood trauma and revictimization. High disclosure concern increases the risk of revictimization in individuals with childhood trauma.
2. Cognitive emotion regulation strategies moderate the relationship between childhood trauma and revictimization. The use of maladaptive cognitive emotion regulation strategies increases the risk of revictimization, and the use of adaptive cognitive emotion regulation strategies decreases the risk of revictimization in individuals with childhood trauma.

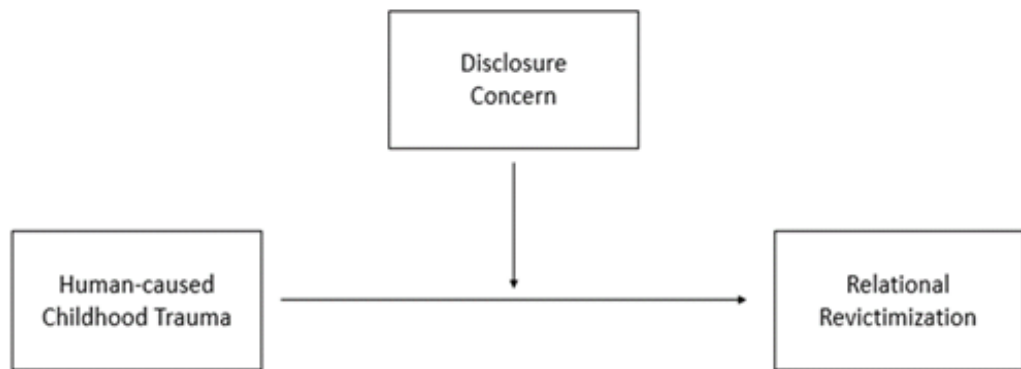


Figure 1. Visual Representation of The First Hypothesis

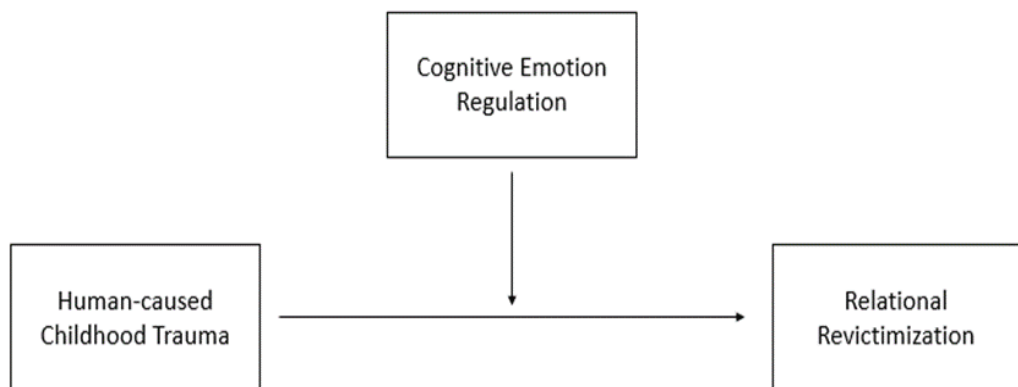


Figure 2. Visual Representation of The Second Hypothesis

CHAPTER 2

METHOD

2.1. Participants

In the study, data were collected from 244 young adult participants with childhood traumatic life experiences.

Inclusion criteria were determined as a) having been exposed before the age of 18, having been exposed to one or more of the childhood traumatic experiences classified as physical abuse, physical neglect, emotional abuse, emotional neglect, sexual abuse and overprotection-control b) being between the ages of 18-25, c) being able to read and write, d) being able to use the Internet, and e) being a volunteer. The exclusion criteria were a) not having been exposed to physical abuse, physical neglect, emotional abuse, emotional neglect, sexual abuse and overprotection-control behaviors before the age of 18, b) being younger than 18 or older than 25, e) being illiterate, and e) not being able to use the internet or computer.

The mean age of the participants was 18.8 years ($SD = 1.86$). While 37 of the participants reported a single type of traumatic life experience, 195 of them reported more than one type of childhood traumatic life experience. Among the participants, 133 (54.5%) reported physical abuse, 32 (13.1%) reported physical neglect, 163 (66.8%) reported emotional abuse, 163 (66.8%) reported emotional neglect, 53 (21.7%) reported sexual abuse and 129 (52.8%) reported overprotection-control behaviors. Other information about the sample is presented in Table 1.

Table 1. *Characteristics of the Sample (N = 244)*

Variables	Frequency	Percentage
Gender		
Female	189	77.4
Male	54	22.1
Unspecified	1	00.4
Level of education		
Primary school	0	0.00
Middle School	1	00.4
High School	130	53.2
Associate degree	22	9.01

Undergraduate	78	31.9
Graduate	13	5.32
Type of childhood traumatic experience		
Physical abuse	133	54.5
Physical neglect	32	13.1
Emotional abuse	163	66.8
Emotional neglect	163	66.8
Sexual abuse	53	21.7
Overprotection-control	129	52.8
Professional psychological support		
Received	81	33.1
Not received	163	66.8
Use of medication		
User	54	22.1
Not user	190	77.8
Health check		
person undergoing health control	14	05.7
person not undergoing health control	230	94.2
Judicial process		
Initiated	6	2.45
Not initiated	238	97.5

2.2. Instruments

2.2.1. Sociodemographic Information Form

The Sociodemographic Information Form developed by the researcher was used to determine the sociodemographic information of the participants in the study. The Form consists of questions about gender, age, educational status, type of childhood traumatic life experience, age at which the trauma was experienced, degree of closeness to the perpetrator, people who are aware of the traumatic experience, status of receiving professional psychological support due to the traumatic experience, health control due to the traumatic experience, drug use due to the traumatic experience, and judicial process status (Appendix D).

2.2.2. The Turkish Version of The Childhood Trauma Questionnaire (CTQ-33)

CTQ-33, which is the expanded version of CTQ-28 by Şar, Necef, Mutluer, Fatih, and Türk-Kurtça, consists of 33 items that are self-reported retrospectively and were intended to evaluate abuse and neglect suffered as a child or adolescent. This scale is a 5-point Likert-type data collection tool comprising 33 items and six sub-dimensions. Each sub-dimension of the final version has three denial items and five statements. The sub-dimensions of the scale are emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, and overprotection/control. Research indicated that the Cronbach's Alpha reliability coefficient of the scale was 0.87 (Şar et al., 2021).

Table 2. Reliability Coefficients of CTQ-28 (Şar et al., 2012) and the Revised Form of CTQ-33 (Şar et al., 2021)

Sub-Scales	Cronbach's alpha (CTQ-28)	Cronbach's alpha (CTQ-33)
PA	.90	.81
EA	.90	.88
SA	.73	.90
EN	.85	.89
PN	.77	.77
OP/OC	-	.84

2.2.3. The Cognitive Emotion Regulation Questionnaire

The Cognitive Emotion Regulation Questionnaire, developed by Garnefski, Kraaij and Spinhoven in 2002 and adapted into Turkish by Ataman in 2011, is a versatile tool that measures the cognitive emotion regulation strategies used by individuals after stressful life events. The scale, which includes 9 subscales (Self-Blame, Acceptance, Rumination, Positive Refocusing, Refocusing on Planning, Positive Reappraisal, Diminishing the Value of the Event, Catastrophizing and Blaming Others) and a total of 36 items, can be applied to a wide range of contexts. The five-point Likert-type scale allows for a score range of 4 to 20 for each subscale, with the overall evaluation based on the scores from the subscales. A higher score from

a subscale indicates a more frequent use of the strategy identified by that subscale. Research has shown that the scale's Cronbach's Alpha reliability coefficient is a robust 0.85 (Ataman, 2011).

Table 3. *Reliability Coefficients of The Cognitive Emotion Regulation Questionnaire Subscales (Ataman, 2011)*

Sub-scales	Cronbach's alpha
Self-Blame	.68
Acceptance	.65
Rumination	.70
Positive Refocusing	.80
Refocusing on Planning	.80
Positive Reappraisal	.79
Diminishing the Value of the Event	.78
Catastrophizing	.81
Blaming Others	.83

2.2.4. Trauma Related Self-Disclosure Scale

The scope of this study was originally developed by the researcher in order to measure the concerns about self-disclosure, which constitutes an obstacle to individuals' self-disclosure related to trauma after trauma experience. In order to create the item pool, English and Turkish literature on disclosure anxiety was reviewed in detail. After the literature review, new scale items were created based on the trauma literature. In this process, other scales examining the subject in different literature were also utilized to create an item pool. Two self-report scales developed in English that measure disclosure concern about health status in HIV (+) individuals and meet the inclusion criteria were found (see Table 4). The scale items were translated into Turkish using the translation-back translation method. After translation, necessary arrangements were made by the trauma literature, and the items deemed appropriate were added to the item pool. The scale, which was obtained as a result of the review of the relevant literature and whose content validity was approved by two different clinical psychologists with doctoral degrees, is a 5-point Likert type (1. *Strongly Disagree* 2. *Disagree* 3. *Neither Agree nor Disagree* 4. *Agree* 5. *Strongly Agree*).

Strongly Agree) and consists of 33 items (see Appendix F). The psychometric properties of the scale will be presented in the first stage of the analysis part of the study.

Table 4. *Scales Used for The Trauma Related Self-Disclosure Scale Item Pool*

Author	Scale Name
Berger et al., 2001	Psychometric Assessment of the HIV Stigma Scale
Vogel et al., 2009	Perceptions of Stigmatization by Others for Seeking Help scale

2.2.5. Relational Traumatic Experiences Scale

Within the scope of this study, a questionnaire was developed by the researcher to measure the exposure of individuals to sexual, physical, and emotional victimization in various relationships such as family, romantic partner, colleague, and social environment in adulthood. In order to create the item pool, English and Turkish literature on relational traumatic experiences was reviewed to create the item pool. As a result of the comprehensive literature review, three subscales were identified: "Emotional Abuse," "Sexual Abuse," and "Physical Abuse." Subsequently, the subscales were categorized and defined under 11 subheadings as "Shaming," "Verbal Abuse," "Isolation and Control," "Emotional Rejection," "High Expectations," "Sexual Assault," "Sexual Coercion," "Sexual Harassment," "Physical Threat," "Physical Violence," "Intimidation." After an extensive literature review, behaviors related to the headings were determined. Scale items were formed as the definition of the subheadings and the listing of behavioral manifestations in daily life. Subsequently, two questions were asked about the type of relationship between the abuser and the traumatized individual and the frequency of abuse. Each scale item consists of 3 questions measuring the individual's exposure to the identified abuse, relationship with the abuser, and frequency of abuse (see Appendix H). Other scales related to the subject were also utilized during the scale development process. At this point, three self-report scales developed in English and three in Turkish met the inclusion criteria (see Table 5). The English scales were translated into Turkish using the translation-back translation method. The scale, obtained from the review of the relevant literature and whose content validity was approved by two different clinical psychologists with

doctoral degrees, consists of 3 sub-dimensions and 11 items in a 5-point Likert type (1. *I have never been exposed to any of these behaviors in any of my relationships.* 2. *I have rarely been exposed to one of these behaviors in my relationships.* 3. *I have been exposed to one of these behaviors in some of my relationships.* 4. *I have been exposed to one of these behaviors in most of my relationships.* 5. *I have been exposed to one of these behaviors in all my relationships*). The psychometric properties of the scale will be given in the first stage of the analysis part of the study.

Table 5. Scales Used for The Relational Traumatic Experiences Item Pool

Author	Scale Name
Straus et al., 1996	Revised Conflict Tactics Scales (CTS-2)
Marshall, 1992	Severity of Violence Against Women Scale
Hudson, 1997	Partner Abuse Scale
Yavaş Celik & Elmaoğlu, 2022	Emotional Abuse Questionnaire
Karakurt et al., 2009	The Turkish Version of Emotional Abuse Questionnaire
Güvenç et al., 2022	Yakın Partner İlişkilerinde Kadının Maruz Kaldığı Cinsel Şiddet Ölçeği

2.3. Procedure

In this study, 244 participants consisting of young adults between the ages of 18-25 who were invited to participate in the study through social media announcements and in-class announcements of faculty members were reached using the standard announcement text (Appendix A). Participation in the study was completely voluntary, and the participants who voluntarily participated in the study were given the Informed Consent Form (Appendix B), Demographic Information Form (Appendix D), Childhood Trauma Questionnaire CTQ-33 (Appendix E), Trauma Related Self-Disclosure Scale (Appendix F), Cognitive Emotion Regulation Scale (Appendix G), and Relational Traumatic Experiences Scale (Appendix H) questionnaires using Qualtrics online data collection program. All participants were given an informed consent form containing information about the study on a page on the link they clicked on before starting the study. After reading the information and filling out the consent

form, the participants were asked the question "Do you have childhood traumatic life experience?" on the page that opened (Appendix C). In order not to collect data from individuals without childhood traumatic life experience and to prevent reciprocity, data were not collected from participants who answered "No" to this question. These participants were arranged in such a way that their participation in the continuation of the questionnaire study was prevented by the program. The participants who answered "yes" continued to fill in the Demographic Information Form, Childhood Traumas Questionnaire CTQ-33, Trauma Related Self-Disclosure Scale, Cognitive Emotion Regulation Scale and Relational Traumatic Experiences Scale, respectively. Participation in the study was voluntary and participants were informed in the consent form that they could withdraw from the study at any time. The data of the participants who left the study were not used, and the data obtained from the participants who volunteered and completed the study were kept on an encrypted computer and were not and will not be shared with third parties in any way in accordance with the principle of confidentiality. At the end of the study, the participants were informed about the study and necessary information was given for communication. The collected data were analyzed using the "Statistical Package for the Social Sciences (SPSS)" program.

CHAPTER 3

RESULTS

3.1. Exploratory Factor Analysis of The Trauma Related Self-Disclosure Scale

Exploratory factor analysis (EFA) was conducted to determine the factor structure of The Trauma Related Self-Disclosure Scale. The data of 11 participants who were outliers were removed from the dataset based on multivariate outlier analysis (i.e., Mahalanobis d values). Subsequently, the assumptions of linearity, multicollinearity ($>.90$), and expected correlation ($<.30$) between items were checked by correlation analysis. It was determined that the assumptions required for suitability for exploratory factor analysis were met. Principal component analysis (PCA) and Direct Oblimin rotation were used. The Kaiser-Meyer-Olkin (KMO) index was 0.95, which indicated that sampling adequacy is excellent for the factor analysis (Kaiser, 1970). Also, Barlett's test for sphericity was significant, $X^2(528) = 6683.8$, $p < .001$, indicating that the data is suitable for factor analysis. According to EFA results, it was seen that there were 3 factors with Eigen values greater than 1. The eigenvalue of the first factor was 16.527, the eigenvalue of the second factor was 2.431, and the eigenvalue of the third factor was 1.165, with 50%, 7%, and 3% of explained variances, respectively, corresponding to 60% of total variance explained. In order to verify the 3-factor structure of the scale, parallel analysis was conducted by using syntax. As a result of the analysis, the eigenvalues obtained from the existing data were compared with the average eigenvalues of the randomly generated data in the parallel analysis. It is seen that the eigenvalue of the first factor and the eigenvalue of the second factor were higher than the average of the eigenvalues obtained from the randomly generated data. On the other hand, when the third factor was analyzed, it was found that the eigenvalue obtained from the existing data was smaller than the eigenvalue obtained from the randomly generated data. Since this result indicated that the third factor might be coincidental, it was decided that the scale had a two-factor structure in line with the findings obtained from EFA and parallel analysis (see Table 6.).

Table 6. *Parallel Analysis Results for The Trauma Related Self-Disclosure Scale*

Factors	Eigenvalues derived	Eigenvalues obtained from
	from data	parallel analysis
Factor 1	16,85	1,78
Factor 2	2,79	1,67
Factor 3	1,58	1,59

Then, EFA was conducted again to determine the factor loadings of the scale items in the two-factor structure. The eigenvalue of the first factor was 16.473 and the eigenvalue of the second factor was 2.389. Factor 1, Stigmatization Concern, consists of 16 items including individuals' concerns about being stigmatised after disclosing their trauma experience and explains 49.9% of the total variance. Factor 2, Disclosure Concern, consists of 14 items that include individuals' concerns about disclosing their trauma experience and explains 7.2% of the total variance. The total variance explained is 57%. Item 20 and item 25 were removed from the scale due to their factor loadings below 0.32 (Yong & Pearce, 2013). In addition, it was decided to remove item 21 because it was cross-loaded on the two factors, the difference between the factor loadings was less than 1 and the communalities value was below 0.50. The factor loadings of the scale items are presented below. In order to determine the reliability of the scale, Cronbach's Alpha was calculated for the whole scale and the items in the subscales. Cronbach's Alpha values were calculated as .96 for the whole scale, .96 for the Stigmatisation Concern subscale, and .94 for the Disclosure Concern subscale in the reliability analyses performed according to the 30-item, 2-subdimensional structure of the scale.

Table 7. *Factor Structure of The Trauma Related Self-Disclosure Scale based on EFA Results*

Item Number and Content	Factor	
	1	2
11.Benim etrafımdayken rahatsız olurlar.	.933	
16.Benden kaçınırlar.	.899	
6.Beni daha az severler.	.874	

3.Bana olumsuz tepki verirler.	.850	
15.Daha az saygı görürüm.	.842	
7.Benim hakkımda olumsuz şeyler söylerler.	.837	
8.Yakın çevrem benden utanır.	.799	
2.Benim hakkımda kötü şeyler düşünürler.	.796	
4.Deli olduğumu düşünürler.	.793	
10.Benim hatam olduğunu düşünürler.	.756	
12.Bana farklı davranırlar.	.750	
9.Beni daha az çekici olarak görürler.	.737	
1.Benimle ilgili daha az olumlu düşünürler.	.696	
13.İşleri kendi başıma halledemeyeceğimi düşünürler.	.684	
5.Beni zayıf olarak görürler.	.657	
14.Normalden daha az yetkinmişim gibi davranırlar.	.642	
21.Kendimi diğer insanlardan ayrı hissediyorum.	.348	.326
26.Travma deneyimimi kime söylediğime çok dikkat ederim.		.836
27.Gizli tutmak için çok çalışıyorum.		.785
28.Yakınımdaki insanlara gizli tutmalarını söyledim.		.753
30.Birine söylemek risklidir.		.752
19.Bunu bir sır olarak saklamam gerektiğini hissediyorum.		.741
18.Birinin benim iznim olmadan başkalarına anlatmasından korkuyorum.		.719
29.Hayatımın pek çok alanında kimse travma deneyimim olduğunu bilmiyor.		.713
32.Arkadaşlıklardan kaçınmak, söylemek konusunda endişelenmekten daha kolaydır.		.510
17.Başkalarına karşı açık olabileceğimi hissetmiyorum.		.503
33.İnsanların bana karşı ayrımcılık yapmasından endişe ediyorum.	.383	.500
31.İnsanların öğrendiklerinde beni yargılayabileceklerinden endişe ediyorum.	.398	.499

22.Başkalarının beni önemseydiğine dair güvenceye normalden daha fazla ihtiyaç duyuyorum.		.469
23.Normalden daha sık yalnızlık hissediyorum.		.460
24.Başkalarıyla olan ilişkilerimde eşit olmadığım hissine kapılıyorum.	.334	.454

3.2. Exploratory Factor Analysis and Confirmatory Factor Analysis Relational Traumatic Experiences Scale

3.2.1. Exploratory factor analysis (EFA) of The Relational Traumatic Experiences Scale

Exploratory factor analysis (EFA) was conducted to determine the factor structure of Relational Traumatic Experiences Scale. The data of 5 participants who were multivariate outliers were removed from the data set by converting Mahalanobis values to p values. Subsequently, the assumptions of linearity, multicollinearity ($>.90$) and expected correlation ($<.30$) were checked by correlation analysis. It was determined that the assumptions required for suitability for exploratory factor analysis were met. Principal component analysis (PCA) and Direct Oblimin rotation were used. As a result of EFA, Kaiser-Meyer-Olkin (KMO) value was 0.824 and Bartlett's test for sphericity results were $X^2 = 890.209$ $df = 55$ ($p < .001$). According to EFA results, it was seen that there were 3 factors with Initial Eigenvalues greater than 1. The Initial eigenvalue of the first factor was 4.248, the eigenvalue of the second factor was 1.520, and the eigenvalue of the third factor was 1.137. The emotional abuse factor (factor 1) explained 34.3% of the total variance, the sexual abuse factor (factor 2) explained 8.9% and the physical abuse factor (factor 3) explained 6.2%. The total variance explained was 49.6%. In order to determine the reliability of the scale, Cronbach's Alpha was calculated over the whole scale and the items in the subscales. In the reliability analyses performed according to the 11-item, 3-subdimensional structure of the scale, Cronbach's Alpha values were calculated as .83 for the whole scale, .79 for emotional abuse subscale, .79 for physical abuse subscale and .66 for sexual abuse subscale.

Table 8. *Factor Structure of the Relational Traumatic Experiences Scale based on EFA Results*

Item Content	Factor		
	1	2	3
Verbal Abuse Item	.802		
Isolation and Control Item	.710		
Emotional Rejection Item	.556		
High Expectations Item	.552		
Shaming Item	.536		
Sexual Assault Item		.701	
Sexual Coercion Item		.664	
Sexual Harrassment Item		.542	
Physical Threat Item			.845
Physical Violence Item			.797
Intimidation Item			.452

3.2.2. Confirmatory Factor Analysis (CFA) of The Relational Traumatic Experiences Scale

Confirmatory Factor Analysis (CFA) was conducted to determine whether the three-factor structure of the Relational Traumatic Experiences Scale would be confirmed. In CFA, many different goodness-of-fit indices are used to determine whether the model fits or not. In this study, the fit of the model was evaluated with the Chi-Square/Degrees of Freedom (CMIN/DF), Comparative Fit Index (CFI), Goodness of Fit Index (GFI), Adjusted Goodness of Fit Index (AGFI), Normal Fit Index (NFI), Root mean square error of approximation (RMSEA) ratios. It is stated that Chi-Square/Degrees of Freedom (CMIN/DF) value less than 3 indicates a good fit and a value less than 5 is an acceptable fit value (Marsh & Hocevar, 1988). For Comparative Fit Index (CFI) (Hu & Bentler, 1999), Adjusted Goodness of Fit Index (AGFI) (Shevlin & Miles, 1998) and Normal Fit Index (NFI) (Bentler & Bonett, 1980), values greater than 0.95 indicate good fit and values between 0.90-0.94 indicate acceptable fit. Root mean square error of approximation (RMSEA) between 0.06-0.08 is stated as acceptable fit (Hair et al., 1998; Hu & Bentler, 1999; Kline, 1994). As a result of the

CFA of the Relational Traumatic Experiences Scale, goodness of fit indices were found as $X^2/df = 2,452$, NFI = .88, CFI = .93, GFI = .93, AGFI = .89, RMSEA = .078. Based on the modification indices, error variances of the items in the emotional abuse factor were correlated. Covariance was yielded between e3 and e4, and between e4 and e5 errors. In this way, better fit were obtained. As a result of the final CFA of the Relational Traumatic Experiences Scale, goodness of fit indices were found as $X^2/df = 2,325$, NFI = .90, CFI = .93, GFI = .93, AGFI = .89, RMSEA = .075. These values show that the model fit indices are within acceptable limits except for the AGFI value. It could be concluded that the three-factor structure of the Relational Traumatic Experiences Scale is supported. Standardized values, inter-item and inter-error covariances is shown in Figure 3.

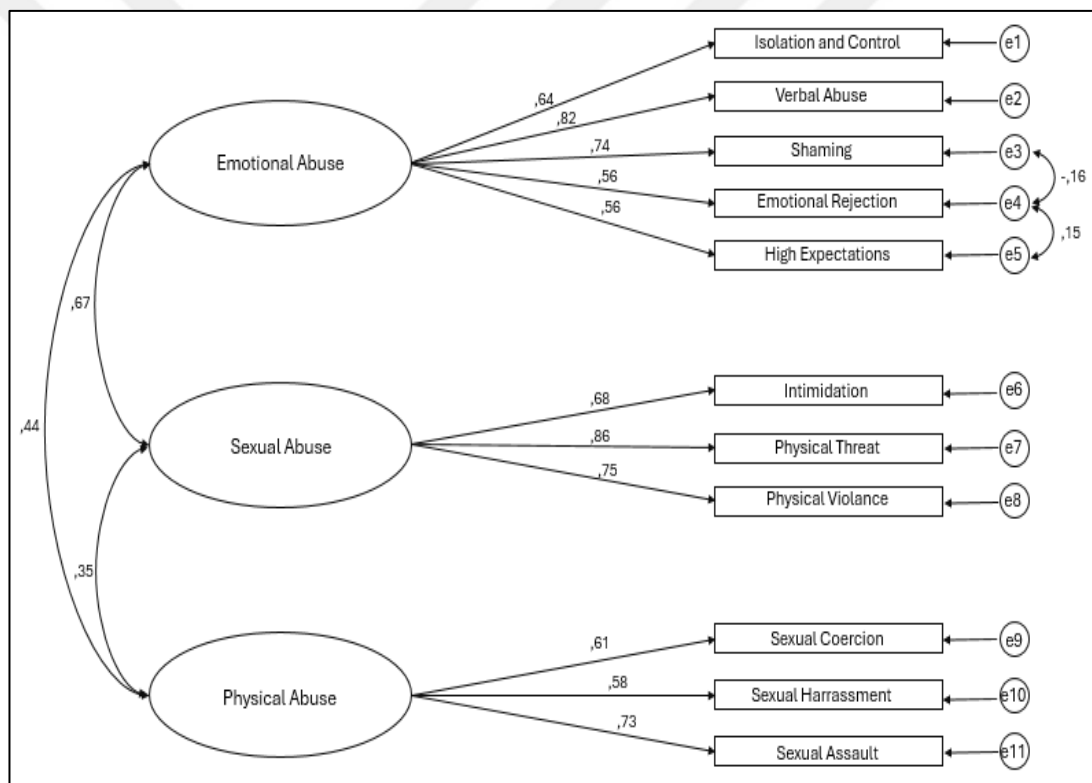


Figure 3. Results of The Confirmatory Factor Analysis of The Factor Structure of The Relational Traumatic Experiences Scale

3.2.3. Descriptive Statistics of Relational Traumatic Experiences

When revictimization in adulthood is examined in terms of emotional abuse sub-dimensions; 46.7 percent of the participants were subjected to isolation in romantic relationships. 39.8 percent of the participants were subjected to isolation in family relationships. 24.6 percent of the participants were subjected to isolation in friendship

relationships. 4.5 percent of the participants have been subjected to isolation in their work relationships. 27 percent of the participants have never been subjected to isolation. 37.3 percent of the participants have been subjected to verbal harrassment in romantic relationships. 38.9 percent of the participants have been subjected to verbal harrassment in family relationships. 32.3 percent of the participants have been subjected to verbal harrassment in friendship relationships. 8.2 percent of the participants have been subjected to verbal harrassment in their work relationships. 27 percent of the participants have never been subjected to verbal harrassment. 24.2 percent of the participants have been subjected to shaming in romantic relationships. 34.4 percent of the participants have been subjected to shaming in family relationships. 24.2 percent of the participants have experienced shaming in friendship relationships. 7.4 percent of the participants have experienced shaming in their work relationships. 41.8 percent of the participants have never experienced shaming. 47.9 percent of the participants have experienced emotional rejection in romantic relationships. 18.9 percent of the participants experienced emotional rejection in family relationships. 34.8 percent of the participants experienced emotional rejection in friendship relationships. 4.5 percent of the participants experienced emotional rejection in their work relationships. 30.3 percent of the participants have never experienced emotional rejection. 21.3 percent of the participants were exposed to high expectations in their romantic relationships. 48.8 percent of the participants were exposed to high expectations in their family relationships. 13.1 percent of the participants were exposed to high expectations in friendship relationships. 12.3 percent of the participants were exposed to high expectations in their work relationships. 33.6 percent of the participants have never been exposed to high expectations.

When revictimization in adulthood is examined in terms of physical abuse sub-dimensions; 17.6 percent of the participants were subjected to intimidation-distress in romantic relationships. 20.5 percent of the participants were subjected to intimidation-distress in family relationships. 9 percent of the participants were subjected to intimidation and harrassment in friendship relationships. 4.1 percent of the participants were subjected to intimidation and harrassment in their work relationships. 59.8 percent of the participants have never been subjected to intimidation. 17.2 percent of the participants have been subjected to physical threats in romantic relationships. 25 percent of the participants have been subjected to physical threat in family

relationships. 7.4 percent of the participants have experienced physical threat in friendship relationships. 0.8 percent of the participants have experienced physical threat in their work relationships. 57.4 percent of the participants have never experienced physical threat. 11.4 percent of the participants have been subjected to physical violence in romantic relationships. 22.5 percent of the participants have been subjected to physical violence in family relationships. 6.6 percent of the participants have experienced physical violence in friendship relationships. 0.8 percent of the participants have experienced physical violence in their work relationships. 63.1 percent of the participants have never been subjected to physical violence.

When revictimization in adulthood is examined in terms of sexual abuse sub-dimensions; 18 percent of the participants were subjected to sexual coercion in romantic relationships. 2.9 percent of the participants were subjected to sexual coercion in family relationships. 4.5 percent of the participants were subjected to sexual coercion in friendship relationships. 0.4 percent of the participants have experienced sexual coercion in their work relationships. 77 percent of the participants have never experienced sexual coercion. 11 percent of the participants have been subjected to sexual harrasment in romantic relationships. 0.8 percent of the participants have been subjected to sexual harrasment in family relationships. 7.4 percent of the participants have experienced sexual harrasment in friendship relationships. 1.2 percent of the participants have experienced sexual harrasment in their work relationships. 77.5 percent of the participants have never been subjected to sexual harrasment. 11.9 percent of the participants have been subjected to sexual harrasment in romantic relationships. 1.2 percent of the participants have experienced sexual harrasment in family relationships. 4.1 percent of the participants have experienced sexual assault in friendship relationships. 0.4 percent of the participants have experienced sexual assault in their work relationships. 82 percent of the participants have never been subjected to sexual assault. A graphical representation of the frequency of exposure to relational revictimization in adulthood is given in Figure 4.

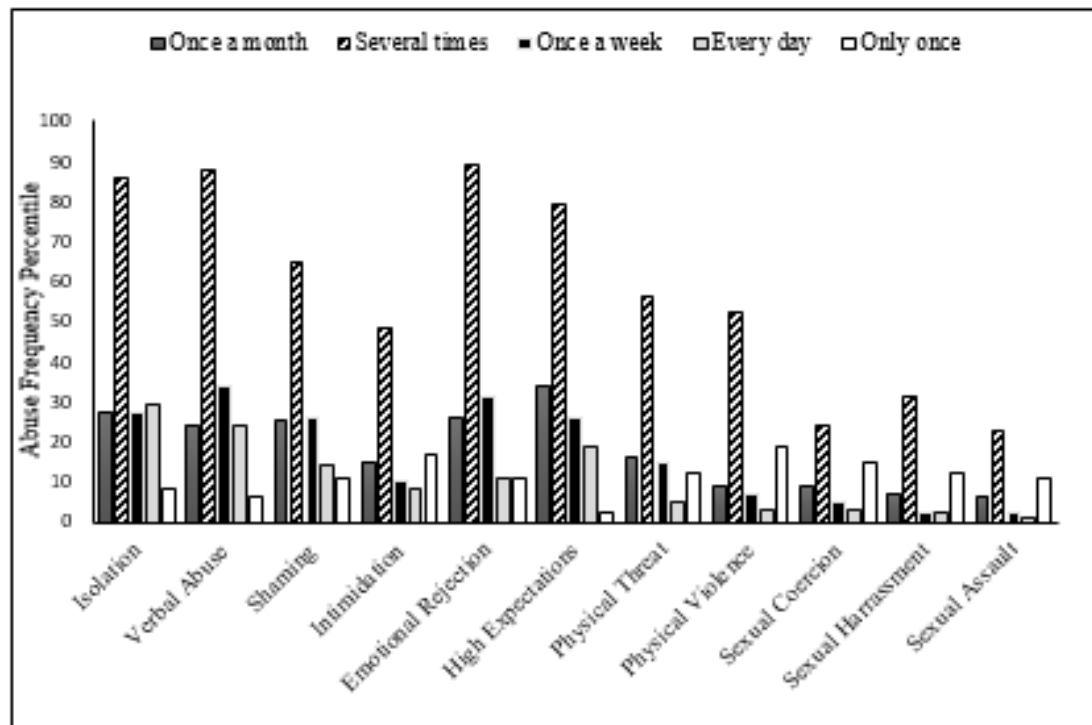


Figure 4. Percentiles of Relational Revictimization in Adulthood

3.3. Main Analysis

Before the main analysis, the data set was prepared for analysis. The data of 12 participants who were outliers were removed from the dataset based on multivariate outlier analysis (i.e., Mahalanobis to p values). There were no missing data in the dataset. Subsequently, the data were analysed in terms of the assumptions required for regression analysis. Skewness and Kurtosis values were examined for normality assumption. Skewness and Kurtosis values between -2 and +2 values provide the normality assumption (George & Mallery, 2010). Skewness and Kurtosis values of all scale total scores and subscale total scores to be used for the analysis provide the normality assumption. All assumptions required for the analysis were met. Before the analysis, descriptive analysis was made for the variables to be used. Subsequently, Pearson Correlation analysis was conducted to examine the relationship between the variables. Finally, simple moderator analysis (Model 1) was conducted to examine the effect of disclosure concern and cognitive emotion regulation strategies on the relationship between childhood traumatic life experience and revictimization.

3.3.1. Descriptive Statistics of the Variables in the Study

Descriptive statistics of the measurement tools which is used in the study are presented in Table 9.

Table 9. *Descriptive Statistic of The Measurement Tools*

Variables	Mean	SD	Minimum	Maximum
Childhood Trauma Questionnaire	68.71	14.8	42	110
Total Score				
Relational Traumatic Experiences Scale Subsections				
Emotional Abuse Total Score	10.89	3.75	5	21
Sexual Abuse Total Score	3.77	1.35	3	12
Physical Abuse Total Score	4.702	2.08	3	14
The Cognitive Emotion Regulation Questionnaire Subsections				
Refocus on Planning Total Score	12.37	3.65	5	20
Other-Blame Total Score	10.75	3.78	4	20
Putting Into Perspective Total Score	11.27	3.60	4	20
Catastrophizing Total Score	9.02	3.47	4	20
Positive Refocusing Total Score	9.40	3.70	4	20
Self-Blame Total Score	9.02	3.27	4	19
Acceptance Total Score	11.87	3.58	4	20
Rumination Total Score	12.65	3.62	4	20
Positive Reappraisal Total Score	11.20	3.78	4	20
Trauma Related Self-Disclosure Scale Subsections				
Stigmatization Concern Total Score	39.00	15.5	16	80
Disclosure Concern Total Score	50.82	14.1	17	81

3.3.2. Pearson Correlations

Correlation analyses of the variables which is used for the analysis were performed. In the analysis, total score of Childhood Trauma Questionnaire for childhood

traumatic life experiences, subscales of Relational Traumatic Experiences Scale for revictimization (Emotional abuse, sexual abuse, physical abuse), subscales of Trauma Related Self-Disclosure Scale for disclosure concern (Stigmatization concern, disclosure concern) and the subscales of the Cognitive Emotion Regulation Questionnaire (Putting Into Perspective, Catastrophizing, Positive Refocusing, Self-Blame, Acceptance, Rumination, Positive Reappraisal, Refocus on Planning, Other-Blame) were used for cognitive emotion regulation skills. According to the results of the analyses, there was a significant positive correlation between relational emotional abuse, sexual abuse and physical abuse and childhood trauma ($r = .46, p < .01$; $r = .23, p < .01$; $r = .47, p < .01$, respectively). A strong positive correlation was found between stigmatisation concern and disclosure concern and childhood trauma ($r = .54, p < .01$; $r = .51, p < .01$, respectively). In addition, childhood traumatic life experience was significantly negatively correlated with putting into perspective, positive refocusing, positive reappraisal, refocus on planning ($r = -.254, p < .01$; $r = -.224, p < .01$; $r = -.412, p < .01$; $r = -.199, p < .01$, respectively) were significantly positively correlated with catastrophizing, self-blame, acceptance, rumination, and other-blame subscales ($r = .328, p < .01$; $r = .155, p < .05$; $r = .144, p < .05$; $r = .157, p < .05$; $r = .146, p < .05$, respectively). Correlation coefficients are given in Table 10.

Table 10. *Pearson Correlation Coefficients Between Research Variables*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1.CTQ Total Score	1	.48**	.23**	.47**	.54**	.51**	-.19**	.14*	-.25**	.32**	-.22**	.15*	.14*	.15*	-.41**
2. Emotional Abuse	.48**	1	.33**	.52**	.36**	.43**	-.07	.16*	-.08	.18**	-.05	.06	.11	.15*	-.22**
3. Sexual Abuse	.23**	.33**	1	.25**	.17**	.18**	-.06	.10	-.10	.21**	-.11	-.04	.14*	.10	-.12
4. Physical Abuse	.47**	.52**	.25**	1	.31**	.31**	-.08	.18**	-.15*	.22**	-.18**	.07	.05	.10	-.24**
5. Stigmatization Concern	.54**	.36**	.17**	.31**	1	.71**	-.05	.15*	-.04	.37**	-.05	.20**	.29**	.26**	-.23**
6. Disclosure Concern	.51**	.43**	.18**	.31**	.71**	1	-.06	.30**	.00	.35**	.03	.16*	.39**	.24**	-.25**
7. Refocus on Planning	-.19**	-.07	-.06	-.08	-.05	-.06	1	.09	.32**	-.10	.31**	-.00	.21**	.25**	.61**
8. Other-Blame	.14*	.16*	.10	.18**	.15*	.30**	.09	1	.14*	.28**	-.04	-.15*	.24**	.18**	-.03
9. Putting Into Perspective	-.25**	-.08	-.10	-.15*	-.04	.00	.32**	.14*	1	-.11	.39**	-.03	.22**	.01	.58**
10. Catastrophizing	.32**	.18**	.21**	.22**	.37**	.35**	-.10	.28**	-.11	1	-.13*	.35**	.13*	.37**	-.18**
11. Positive Refocusing	-.22**	-.05	-.11	-.18**	-.05	.03	.31**	-.04	.39**	-.13*	1	-.03	.12	-.16*	.41**
12. Self-Blame	.15*	.06	-.04	.07	.20**	.16*	-0.00	-.15*	-.03	.35**	-.03	1	.22**	.40**	-.03
13. Acceptance	.14*	.11	.14*	.05	.29**	.39**	.216**	.24**	.22**	.13*	.12	.22**	1	.37**	.12
14. Rumination	.15*	.15*	.10	.10	.26**	.24**	.257**	.18**	.01	.37**	-.16*	.40**	.37**	1	.05
15. Positive Reappraisal	-.41**	-.22**	-.12	-.24**	-.23**	-.25**	.619**	-.03	.58**	-.18**	.41**	-.03	.12	.05	1

Note. * $p < .05$, ** $p < .01$.

3.4. Moderator Analyses

In this study, it was hypothesised that having concerns about self-disclosure after childhood traumatic life experience would increase the revictimization experienced by the individual in adulthood. At the same time, it was hypothesised that the cognitive emotion regulation strategies used by individuals after childhood traumatic life experience would have a moderator effect on the revictimization experienced by the individual in adulthood. For this purpose, the study examined the moderating effect of disclosure concern and cognitive emotion regulation strategies on the relationship between childhood trauma and relational revictimization in adulthood.

3.4.1. The Moderator Role of Self Disclosure In The Relationship Between Childhood Trauma and Revictimization

When the moderating effect of disclosure concern on the relationship between childhood trauma and relational revictimization in adulthood was examined; childhood maltreatment and revictimization were significantly associated ($B = .16$, $SE = .02$, $p = 0.00$). Disclosure concern and revictimization were also significantly associated ($B = .04$, $SE = .014$, $p = 0.05$). However, although the main effects of variables were significant, the interaction was found to be not significant ($B = .0014$, $SE = .0008$, BCa 95% CI $[-.0002$ to $.0030]$, $p = 0.09$).

Therefore, the analysis continued with the sub-dimensions. When the moderating effect of stigmatization concern sub-dimension was examined, childhood maltreatment and revictimization were significantly related ($B = .17$, $SE = .02$, $p = 0.00$). However, stigmatization concern and revictimization were not related ($B = .04$, $SE = .024$, $p = 0.07$). Likewise, the interaction was not significant ($B = .0023$, $SE = .0014$, BCa 95% CI $[-.0004$ to $.0051]$, $p = 0.09$).

When the moderating effect of the disclosure concern sub-dimension was examined, a significant relationship was found between childhood maltreatment and revictimization ($B = .15$, $SE = .02$, $p = 0.00$). Disclosure concern and revictimization were also significantly related ($B = .09$, $SE = .025$, $p = 0.00$). More importantly, the interaction was found to be significant ($B = .0031$, $SE = .0016$, BCa 95% CI $[.0000$ to $.0062]$, $p = 0.04$). Simple slope analyses showed that the association between childhood trauma and relational revictimization was stronger at high levels of disclosure concern [$B = .20$, $SE = .029$, BCa 95% CI $[.1429$ to $.2608]$, $p = 0.00$] compared to low levels of disclosure concern [$B = .11$, $SE = 0.36$, BCa 95% CI $[.0404$

to .1855], $p = 0.02$). Graphical representation of the moderating effect is shown in Figure 5.

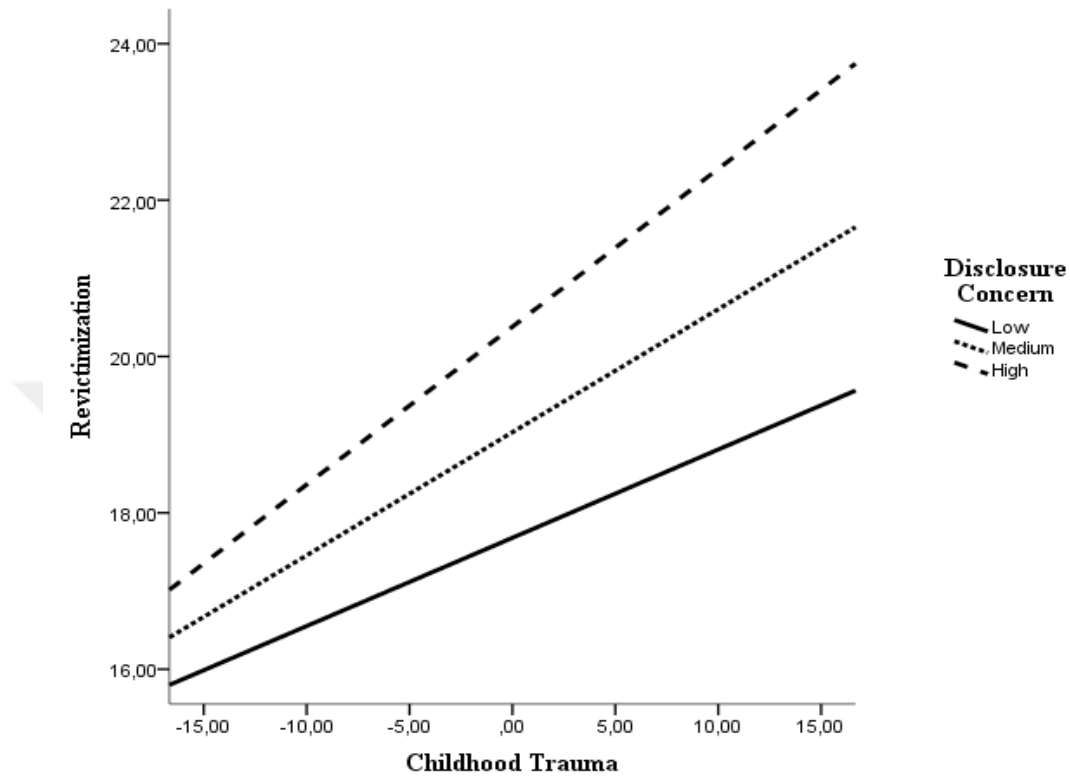


Figure 5. The Moderator Role of Disclosure Concern in the Relationship Between Childhood Trauma and Relational Revictimization in Adulthood

3.4.2. The Moderator Role of Cognitive Emotion Regulation In The Relationship Between Childhood Trauma and Revictimization

Since cognitive emotion regulation strategies were divided into adaptive and non-adaptive, the analyses were continued with sub-dimensions.

When the moderating effect of *Refocus on Planning* sub-dimension of cognitive emotion regulation strategies was examined, a significant relationship was found between childhood maltreatment and revictimization ($B = .21$, $SE = .02$, $p = 0.00$). Refocus on Planning and revictimization were not found to be related ($B = .02$, $SE = .088$, $p = 0.80$). However, the interaction was found to be significant ($B = -.0113$, $SE = .0054$, $BCa\ 95\% \text{ CI } [-.0220 \text{ to } -.0006]$, $p = 0.03$). Simple slope analyses showed that the association between childhood trauma and relational revictimization was stronger for use of the low refocus on planning strategy [$B = .25$, $SE = .030$, $BCa\ 95\% \text{ CI } [.1952$

to .3132], $p = 0.00$) compared to use of the high refocus on planning strategy [$B = .17$, $SE = 0.29$, BCa 95% CI [.1141 to .2292], $p = 0.00$). Graphical representation of the moderating effect is shown in Figure 6.

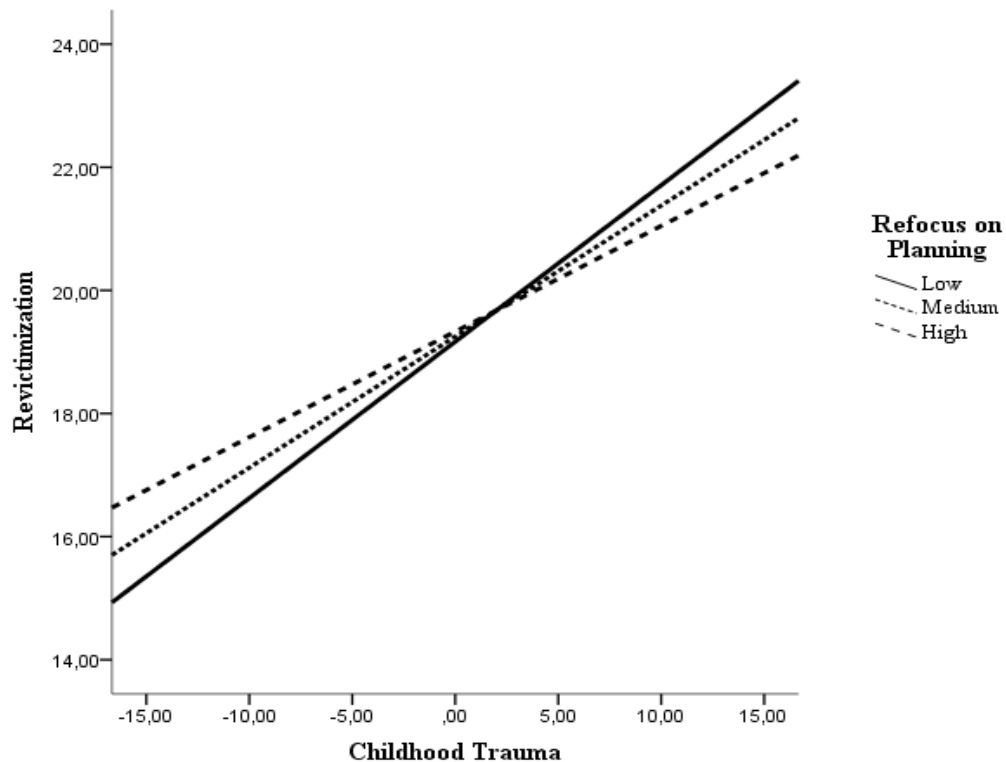


Figure 6. The Moderator Role of Refocus On Planning Strategy in the Relationship Between Childhood Traumatic Life Experiences and Relational Revictimization in Adulthood

When the moderating effect of the *Other Blame* sub-dimension was examined, a significant relationship was found between childhood maltreatment and revictimization ($B = .20$, $SE = .02$, $p = 0.00$). Other Blame and revictimization were significantly related ($B = .18$, $SE = .085$, $p = 0.02$). However, the interaction was not significant ($B = -.0002$, $SE = .0060$, BCa 95% CI [-.0121 to .0116], $p = 0.96$).

When the moderating effect of *Putting into Perspective* sub-dimension was examined, a significant relationship was found between childhood maltreatment and revictimization ($B = .20$, $SE = .02$, $p = 0.00$). Putting into perspective and revictimization were not found to be related ($B = -.002$, $SE = .092$, $p = 0.97$). The interaction was also not significant ($B = -.0030$, $SE = .0062$, BCa 95% CI [-.0152 to .0092], $p = 0.63$).

When the moderating effect of *Catastrophizing* sub-dimension was examined, a significant relationship was found between childhood maltreatment and revictimization ($B = .19$, $SE = .02$, $p = 0.00$). Catastrophizing sub-dimension and revictimization were not related ($B = .12$, $SE = .10$, $p = 0.23$). Likewise, the interaction was not significant ($B = .0053$, $SE = .0055$, BCa 95% CI $[-.0056$ to $.0161]$, $p = 0.34$).

When the moderating effect of *Positive Refocusing* sub-dimension was examined, a significant relationship was found between childhood maltreatment and revictimization ($B = .20$, $SE = .02$, $p = 0.00$). Positive Refocusing sub-dimension and revictimization were not associated ($B = -.02$, $SE = .088$, $p = 0.75$). However, the interaction was found to be significant ($B = -.0127$, $SE = .0060$, BCa 95% CI $[-.0244$ to $-.0009]$, $p = 0.03$). Simple slope analyses showed that the association between childhood trauma and relational revictimization was stronger for use of the low positive refocusing strategy [$B = .25$, $SE = .029$, BCa 95% CI $[.1937$ to $.3108]$, $p = 0.00$] compared to use of the high positive refocusing strategy [$B = .15$, $SE = 0.32$, BCa 95% CI $[.0940$ to $.2227]$, $p = 0.00$]. Graphical representation of the moderating effect is shown in Figure 7.

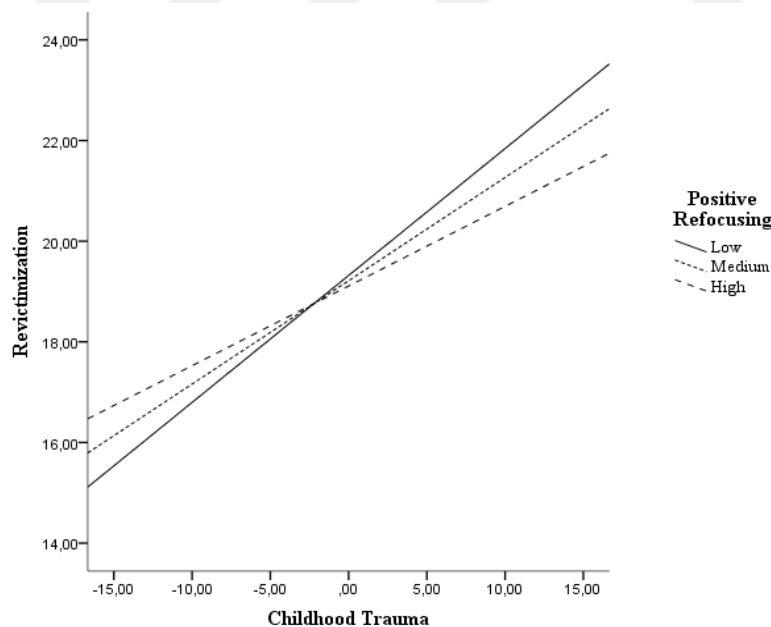


Figure 7. The Moderator Role of Positive Refocusing Strategy in the Relationship Between Childhood Traumatic Life Experiences and Relational Revictimization in Adulthood

When the moderating effect of the *Self-Blame* sub-dimension was examined, a significant relationship was found between childhood maltreatment and revictimization ($B = .21$, $SE = .02$, $p = 0.00$). Self-Blame sub-dimension and revictimization were not related ($B = -.04$, $SE = .10$, $p = 0.66$). Likewise, the interaction was not significant ($B = -.0018$, $SE = .0063$, BCa 95% CI $[-.0141$ to $.0106]$, $p = 0.77$).

When the moderating effect of the *Acceptance* sub-dimension was examined, a significant relationship was found between childhood maltreatment and revictimization ($B = .21$, $SE = .02$, $p = 0.00$). Acceptance sub-dimension and revictimization were not related ($B = .08$, $SE = .09$, $p = 0.33$). Likewise, the interaction was not significant ($B = -.0067$, $SE = .0064$, BCa 95% CI $[-.0192$ to $.0058]$, $p = 0.29$).

When the moderating effect of the *Rumination* sub-dimension was examined, a significant relationship was found between childhood maltreatment and revictimization ($B = .20$, $SE = .02$, $p = 0.00$). Rumination sub-dimension and revictimization were not related ($B = .12$, $SE = .08$, $p = 0.17$). Likewise, the interaction was not significant ($B = -.0014$, $SE = .0062$, BCa 95% CI $[-.0135$ to $.0108]$, $p = 0.82$).

When the moderating effect of *Positive Reappraisal* subdimension was examined, a significant relationship was found between childhood maltreatment and revictimization ($B = .19$, $SE = .02$, $p = 0.00$). Positive Reappraisal sub-dimension and revictimization were not related ($B = -.12$, $SE = .094$, $p = 0.20$). However, the interaction was found to be significant ($B = -.0121$, $SE = .0057$, BCa 95% CI $[-.0234$ to $-.0009]$, $p = 0.03$). Simple slope analyses showed that the association between childhood trauma and relational revictimization was stronger for use of the low positive reappraisal strategy [$B = .24$, $SE = .039$, BCa 95% CI $[.1827$ to $.2991]$, $p = 0.00$] compared to use of the high positive reappraisal strategy [$B = .14$, $SE = 0.03$, BCa 95% CI $[.0813$ to $.2173]$, $p = 0.00$]. Graphical representation of the moderating effect is shown in Figure 8.

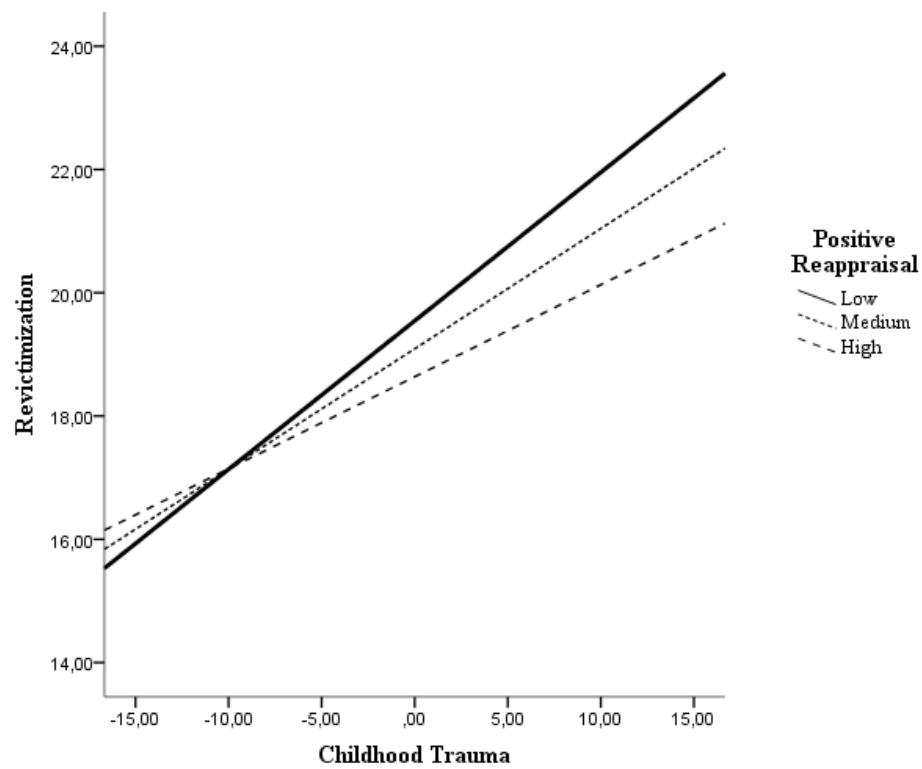


Figure 8. The Moderator Role of Positive Reappraisal Strategy in the Relationship Between Childhood Traumatic Life Experiences and Relational Revictimization in Adulthood

CHAPTER 4

DISCUSSION

Traumatic life experiences deeply affect individuals' lives, and their long-term cognitive, emotional, and neurological effects are more permanent, especially when they occur early in life (Dye, 2018). When the growing trauma literature is examined, there is a strong relationship between human-caused childhood traumatic life experiences and revictimization in adulthood (Pilkington et al., 2021; Roodman & Clum., 2001; Scoglio et al., 2021; Simmel et al., 2012; Walker & Wamser-Nanney, 2023). In this study, using self-report data obtained from an anonymous cross-sectional online survey of young adult participants aged 18-25 who experienced childhood abuse and neglect, the moderating effects of disclosure concern and cognitive emotion regulation skills on the relationship between childhood abuse and neglect experiences and physical, emotional, and sexual revictimization in adult relationships were examined using simple moderator analysis (N = 244).

In this section, the moderating effect of disclosure anxiety on the relationship between childhood traumatic life experiences and revictimization will be examined first. Next, the moderating effects of adaptive and maladaptive cognitive emotion regulation strategies on the relationship between childhood traumatic life experiences and revictimization will be examined. Then, the clinical implications and limitations of the study will be discussed, and finally, suggestions for future studies will be given.

4.1. Discussion of Findings Regarding The Moderator Role of Disclosure Concern In The Relationship Between Childhood Trauma and Revictimization

In this study, it was investigated whether all dimensions of child maltreatment, including childhood sexual abuse, childhood emotional abuse, childhood physical abuse, childhood physical neglect, childhood emotional neglect, and over-protection/over-control predicted all dimensions of revictimization experienced in adulthood, including sexual revictimization, emotional revictimization and physical revictimization through the moderating role of disclosure concern. In this regard, analyses were conducted to investigate the relationships between childhood traumatic life experience, trauma related self-disclosure and its sub-dimensions, and relational revictimization.

The current study confirmed previous findings of a strong positive relationship between childhood abuse and neglect experiences and physical, emotional, and revictimization in adult relationships (Aldao et al., 2010; Arata, 1998; Brenner & Ben-Amitay, 2015; Chen & Cheung, 2021; Fereidooni et al., 2024; Fortier et al., 2009; Krause-Utz et al., 2021; Roodman & Clum., 2001; Scoglio et al., 2021; Walker & Wamser-Nanney, 2023; Young et al., 2017; Zamir et al., 2018). It has been found that childhood traumatic life experiences, which are human-caused, positively predict revictimization. The findings contribute to the existing literature on revictimization. At the same time, the findings show that trauma-related self-disclosure is associated with revictimization. However, when all sub-dimensions of trauma-related self-disclosure are included in the relationship between child maltreatment and revictimization, the interaction is not significant, and there is essentially no moderating effect. When the literature is examined, it is found that trauma-related self-disclosure has no direct effect on the relationship between child maltreatment and revictimization (Arata, 1998; Desir & Karatekin, 2021). Although it does not have a direct effect, it is thought to contribute indirectly due to its effects on other variables (Arata, 1998). Low levels of self-disclosure are associated with anxiety disorders, mood disorders, and PTSD (Bolton et al., 2003; Hoyt et al., 2010; Kahn & Garrison, 2009; Kahn & Hessling, 2001). It may contribute to revictimization indirectly through its impact on psychopathologies.

Although the findings are consistent with the existing literature, when the effects of the sub-dimensions were examined separately, no direct effect of the stigmatization concern sub-dimension was found. When the relevant literature is examined, it is seen that the concept of disclosure concern is intensively studied with HIV (+) individuals (Yiğit et al., 2021). It was found that approximately 80% of individuals living with HIV (+) experienced internalized stigma, and approximately half of them were exposed to verbal violence. The predominant negative attitude toward AIDS in society causes negative emotions such as guilt, anxiety, fear, and insecurity to emerge in patients; it increases individuals' concerns about stigmatization, and this situation reveals disclosure concerns (Kaya et al., 2020). According to the Traumagenic Dynamics Model, sexual traumas are similarly associated with shame and stigmatization (Browne & Finkelhor, 1986). In this respect, sexual traumas differ from other types of trauma. Stigmatization concerns may not have been significant because

all childhood neglect and abuse experiences were addressed in the study. It should also be taken into consideration that trauma may not cause stigmatization in the eyes of society and individuals, especially with the recent increase in awareness of traumatic life experiences.

On the other hand, it is seen that the Disclosure Concern dimension has a positive moderating effect on the CM-REV relationship. The findings confirm the first hypothesis of the current study. Indeed, the level of self-disclosure after a traumatic life experience was found to have a moderating effect on the risk of revictimization in adulthood. As disclosure concern increases, the rate of experiencing relational revictimization later in life increases. Early maladaptive schemas, shaped by childhood traumatic life experiences and cause the individual to produce negative ideas about himself/herself, prevent the individual from objectively reviewing his/her life experiences (Welburn et al., 2002; Yiğit, 2018; Young, 1999). It causes the individual to see the negative parts of the events that he/she experiences in the future by his/her schemas and to ignore the parts that do not fit with his/her schemas (Young & Klosko, 1993). It is thought that the disconnection and rejection schema area that emerges in individuals after childhood traumatic life experiences may be related to disclosure concerns. It is thought that mistrust/abuse schema, which is defined as the expectation that the individual will be intentionally harmed or abused by others, may lead the individual to exhibit self-restrictive behaviors such as suppressing or ignoring the traumatic experiences instead of expressing them (Young et al., 2003). In addition, emotional deprivation schema, defined as the belief that emotional needs will not be met by others, may cause the individual to develop a presupposition that his/her search for emotional support will not be met by others (Young et al., 2003). At the same time, high disclosure concerns may be associated with guilt, shame, anger, and feeling different from others (Prizeman et al., 2024). Defectiveness/shame schema, which is defined as the belief that one's self is defective, worthless, unwanted, and unattractive, and social isolation/alienation schema, which is defined as the feeling of being different from other people and/or not being part of any group or community, are also thought to increase the tendency to hide oneself (Young et al., 2003). This may prevent individuals from opening up after the first traumatic experience and accessing the necessary social support and professional help, which may affect revictimization and lead to social isolation and loneliness in individuals.

There is also evidence that the negative reaction of the person to whom the person disclosed the traumatic experience is influential on the traumatized individual's attitude and perception towards trauma related self-disclosure (Brenner & Ben-Amitay, 2015; Fereidooni et al., 2024). Depending on the negative reaction of the person to whom the traumatic life experience was first disclosed, the person's feelings of helplessness, shame, and guilt may increase. That may exacerbate an individual's disclosure concern, which may increase the risk of revictimization in the future. For this reason, the reactions and attitudes of the first person to whom the individual discloses the traumatic experience are of great importance. Trauma has a complex structure that is difficult to understand. When listening to the trauma history, it should be kept in mind that each child and trauma story is unique. Therefore, the child's temperament, developmental stage, life history, and trauma characteristics should be taken into consideration.

Respectful, empathetic, consistent, and boundary-defined communication should be established. In addition, non-verbal expressions and symbolizations such as art, play, and movement should be used, as verbal expressions are much more limited in children. The child's situation, pace, and needs should be respected. In no way should they be forced to do or explain things. In addition, since children are much more dependent on their families, the family should be included in the process of taking the trauma history of children, psychologically supported, and working together. It is essential for the family to closely monitor the child's behavior, to notice changes in behavior quickly, and to provide safe and supportive environments where the child can express himself/herself without forcing the child. It is also important that the individual who will listen to the trauma story is able to listen to the child effectively, spend time with the child, and play games with the child. Children express their inner world through games that allow creativity. Therefore, it is crucial to play games together in order to understand traumatic situations in children and to help them process them. In these games, children should be allowed to take the lead, and there should be no coercion.

In some cases, children ask direct or indirect questions to adults about issues they have difficulty with. In such cases, explanations should be given age-appropriately, children should be made to feel that their feelings are understood, and they should not be avoided in any way. The most critical issue for children to cope

with their traumas is that the individuals listening to the story should be reassuring and empathetic. Supporting trauma survivors, encouraging them to express their feelings and help-seeking behaviors, and understanding what they need is crucial to reducing the impact of the traumatic experience on them and helping them cope with the process.

4.2. Discussion of Findings Regarding The Moderator Role of Cognitive Emotion Regulation Strategies In The Relationship Between Childhood Trauma and Revictimization

The current study investigated whether all dimensions of child maltreatment, including childhood sexual abuse, childhood emotional abuse, childhood physical abuse, childhood physical neglect, childhood emotional neglect, and overprotection/overcontrol, predict all dimensions of relational revictimization in adulthood, including sexual revictimization, emotional revictimization, and physical revictimization through the moderating role of adaptive and maladaptive cognitive emotion regulation strategies. In this context, analyses were conducted to examine the relationships between childhood traumatic life experiences, cognitive emotion regulation strategies, and relational revictimization.

The results of the second analysis, which was conducted to look at the moderating effect of cognitive emotion regulation strategies, confirmed that human-induced childhood neglect and abuse experiences predict revictimization (Aakvaag et al., 2017; Anda et al., 2006; Fereidooni et al., 2024; Katz et al, 2010; Messman-Moore et al., 2010 Widom et al., 2008; Thomas et al., 2020). As a result of the analysis, no maladaptive cognitive emotion regulation strategy had a moderating effect on the CM-REV relationship. According to the findings, the second hypothesis of the study is not confirmed in terms of maladaptive cognitive emotion regulation skills. Even though there was no direct impact as a moderator, indirectly, through its impact on psychopathologies, it could make an individual vulnerable to revictimization. Maladaptive emotion regulation mechanisms can be considered a trans-diagnostic risk factor in many psychological disorders, including mood disorders, anxiety disorders, substance use disorders, personality disorders, and eating-related disorders (Fereidooni et al., 2024; Huh et al., 2017; Naragon-Gainey et al., 2017). In a study examining the mediating effect of maladaptive cognitive emotion regulation strategies

in the relationship between childhood sexual abuse and adult partner violence, it was found that maladaptive cognitive emotion regulation strategies have a mediating effect (Krause-Utz et al., 2021). It is seen that maladaptive cognitive emotion regulation skills emerge as a result of childhood traumatic life experiences, and revictimization is realized through maladaptive cognitive emotion regulation skills rather than affecting the strength of the relationship. Also, in a meta-analysis study including 114 studies examining the relationship between emotion regulation mechanisms and symptoms of patients with anxiety, depression, eating disorders, and substance use disorders, it was found that the maladaptive emotion regulation strategies significantly increased the susceptibility to psychopathology in the face of negative events (Aldao et al., 2010). It is believed that it may indirectly make individuals susceptible to revictimization due to its contribution to psychopathologies.

On the other hand, the findings confirm this study's second hypothesis regarding adaptive cognitive emotion regulation skills. Positive refocusing, positive reappraisal, and refocus on planning, which are adaptive cognitive emotion regulation skills, were found to have negative moderating effects on the CM-REV relationship. Individuals who frequently use positive reappraisal strategies after childhood traumatic life experiences have a reduced risk of revictimization later in life. Similarly, individuals who frequently use the refocus on planning strategy after childhood traumatic life experiences have a reduced risk of revictimization later in life. Finally, frequent use of the positive refocusing strategy reduces the risk of revictimization later in life. The results found are in line with the literature. Individuals who used adaptive emotion regulation mechanisms were evaluated as less prone to psychopathology (Aldao et al., 2010). At the same time, adaptive cognitive emotion regulation skills such as positive refocusing and refocus on planning have been found to be associated with people's emotional intelligence and thus contribute to traumatic growth after traumatic life experiences (Thomas et al., 2020). Frequent use of adaptive strategies in cognitive emotion regulation was associated with better coping with stressors in the face of adversity and higher psychological well-being (Chen & Cheung, 2021; Zhang et al., 2020; Zhang et al., 2021). As a result, it may be concluded that increasing the use of adaptive cognitive emotion regulation skills has a protective effect regarding revictimization.

4.3. Clinical Outcomes

In the current study, psychological mechanisms that lead to revictimization in adult relationships, especially based on childhood traumatic life experiences, were investigated. In this direction, the findings obtained from the current study indicate that interventions that include the moderator mechanisms of disclosure concern and positive cognitive emotion regulation strategies are essential in preventing exposure to relational revictimization in adulthood.

Within the scope of the current thesis, preliminary studies of the Turkish forms of the Trauma Self-Disclosure Scale and the Relational Traumatic Experiences Scale were conducted. Thus, relational traumatization in adulthood can be an important factor in future studies evaluating relational revictimization and posttraumatic self-disclosure processes. At the same time, it is thought that the current thesis, being the first study in the trauma literature in which the concept of disclosure concern is used, will make a significant contribution to the literature by increasing the comprehensibility of the idea by addressing relational traumatic life experiences in adulthood in all aspects in terms of both relationship diversity and trauma and paving the way for the development of appropriate trauma-based interventions.

Therefore, based on the findings of this study, increasing the use of positive cognitive emotion regulation strategies such as refocusing on planning, positive refocusing, and positive reappraisal, and focusing on reducing disclosure concern may be effective in preventing revictimization after the first trauma experience. At this point, therapists should focus not only on reducing the use of negative cognitive emotion regulation skills but also on increasing the use of positive cognitive emotion regulation strategies. In addition, the study is vital in that it emphasizes the importance of effective listening and therapeutic relationships in reducing disclosure concerns while listening to the traumatic life experience. Based on the results of the study, every individual who works with children and is likely to listen to trauma narratives should know how to listen and approach trauma.

The findings obtained from this thesis study are thought to guide psychotherapy approaches that can intervene in the pathways leading to revictimization arising from childhood traumas in adult relationships and thus help reduce recurrent interpersonal traumas in adult relationships. In other words, understanding how revictimization

experiences can occur in adult relationships will be very useful for practitioners working in clinical psychology to break this vicious cycle in relationships.

4.4. Limitations and Suggestions For Future Research

Finally, although it is the first study to address the concept of disclosure concern in the trauma literature and there are scale studies that are believed to make important contributions to the trauma literature, the current study has some limitations. The first of these limitations is that it is a retrospective study. The history of childhood traumatic life experience was obtained retrospectively through self-report. This may have introduced selection bias, reporting bias and recall bias and may have negatively affected the results. This may reduce the reliability of the data set due to processes such as participants may have difficulty in accurately remembering or reporting certain information or remembering the situation better/worse than it is. It is also a process that limits the understanding of the stability or variability of variables and their long-term effects, as they are collected at a single point in time in a cross-sectional study. At the same time, it may be difficult to determine the temporal sequence of events or to determine whether a particular variable directly affects another. This situation prevents establishing a causal relationship. In addition, the distribution of the participants is not homogenous. The predominance of female participants in the data set also reduces the representativeness and negatively affects the generalisability of the results. It is recommended that the subject should be studied longitudinally so that future studies can control confounding variables such as selection bias, reporting bias and recall bias and evaluate the long-term effects of trauma experience more objectively. It is also recommended that the study should be conducted with larger and more homogeneously distributed samples. In addition, the data obtained within the scope of the study were obtained from young adults aged 18-25. It is thought that studying with larger age groups will contribute positively to the generalisability of the findings.

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APPENDICES

Appendix A. Standard Announcement

Merhaba,

Ben Ayşenur Elif Sertel. TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı'nda öğrenciyim. Tez danışmanlarım Doç. Dr. Ilgın Gökler Danışman ve Doç. Dr. İbrahim Yiğit ile birlikte bilişsel duygu düzenleme ve açığa çıkmaya yönelik endişelerin, çocukluk çağı travmatik yaşam deneyimi olan bireylerin yeniden mağdur olma riskleri üzerindeki etkisini incelediğimiz bir çalışma yürütüyoruz. Araştırma kapsamında katılımcı olarak genç yetişkinlerden veri toplamayı hedefliyoruz. Araştırmaya katılmak için genç yetişkin katılımcılardan beklediğimiz koşullar aşağıda belirtildiği şekildedir:

- 18-25 yaş arasında olmak
- Çocukluk çağında travmatik bir yaşam deneyimi yaşamış olmak

Araştırmaya gönüllü olarak katıldığınız takdirde sizden birtakım anket sorularını cevaplamanız beklenecektir. Sizin anket sorularını tamamlamanız yaklaşık 25-35 dk. sürecektir. Çalışmaya katılım tamamen gönüllülük esasına bağlı olup, istediğiniz an çalışmadan ayrılmakta özgürsünüz.

Araştırmaya katılmak için koşulları sağladığınızı düşündüğünüz yakınlarınıza da çalışmamızın duyuru metnini ileterek bize daha fazla destek olabilirsiniz. Şimdiden teşekkür ederiz.

Araştırma ile ilgili detaylı bilgi ve anket soruları aşağıda verilen bağlantı adresinde yer almaktadır. Herhangi bir soru ve yorum için ise bana e-posta aracılığıyla ulaşabilirsiniz.

Psk. Ayşenur Elif Sertel; e-posta:

Appendix B. The Informed Consent Form

Sayın Katılımcı,

TED Üniversitesi, Sosyal Bilimler Enstitüsü Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Ana Bilim Dalında, Doç. Dr. Ilgın Gökler Danışman ve Doç. Dr. İbrahim Yiğit danışmanlığında, Psk. Ayşenur Elif Sertel tarafından yapılmakta olan yüksek lisans tezi kapsamında duygu düzenleme güçlüğü ve açığa çıkmaya yönelik endişelerin, çocukluk çağı travmatik yaşam deneyimi olan yetişkin bireylerin yaşamlarının ilerleyen dönemleri üzerindeki etkisini incelediğimiz bir çalışma yürütülecektir. Eğer 18-25 yaş arasındaysanız ve çocukluk döneminizde travmatik bir yaşam deneyimi yaşadysanız sizi de bu çalışmaya katılmaya davet ediyoruz.

Bu araştırmaya katılımınızı onayladığınız takdirde, sizden yaklaşık 25-35 dk. sürecek bir anket doldurmanız istenecektir. Çalışma süresince ve sonrasında vermiş olduğunuz bilgileriniz hiç kimseyle izniniz dışında paylaşılmayacaktır. Kimlik bilgileriniz alınmayacak olup bu çalışma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda kullanılacaktır. Toplanan veriler, bilgisayarda şifreli bir dosyada tutulacaktır. Bu anket uygulaması için TED Üniversitesi Etik Kurulu'ndan onay alınmıştır.

Bu çalışmaya katılım tamamen gönüllük esasına dayalıdır. Çalışma çocukluk çağı travmalarını hatırlatıcı nitelikte olup, bazı katılımcılara psikolojik olarak rahatsızlık hissi verebilecek niteliktedir. Eğer herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, uygulamayı nedenini açıklamaksızın yarıda bırakıp araştırmadan çıkmakta serbestsiniz. Çalışmayı yarıda bıraktığınız takdirde verileriniz kullanılmayacak olup silinecektir. Rahatsız hissettiğiniz durumlarda psikolojik destek alabilmeniz için araştırmaya ya da adresleri üzerinden ulaşmanız halinde çalışmacı tarafından gerekli yönlendirme yapılacaktır. Bu çalışmaya katıldığınız için şimdiden teşekkür ederim. Çalışma hakkında daha fazla bilgi almak ve yanıtlanmasını istediğiniz sorularınız için araştırmayı yürüten Ayşenur Elif Sertel ile veya adreslerinden iletişim kurabilirsiniz.

Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na () telefon numarasından veya eposta adresinden ulaşabilirsiniz.

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Bu çalışma kapsamında gereken anket uygulamalarında yer alacağımı biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayınlarda kullanılmasını kabul ediyorum.

Ad Soyad:

Katılımcının İmzası:

Tarih

Teşekkürler,

Ayşenur Elif Sertel

Ziya Gökalp Cad. No:48 Kolej/ Çankaya ANKARA, Ted Üniversitesi

Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağını inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na () telefon numarasından veya eposta adresinden ulaşabilirsiniz.



Appendix C. Selective Trauma Question

18 yaşıınızdan önce; Aile bireyleriniz ya da çevrenizde bulunan diğer bireyler tarafından aşağıda ifade edilen davranışlardan herhangi birine maruz kaldınız mı?

Aşırı koruma- kontrol davranışları (Örn; arkadaşlarınız ile görüşmelerinizin kısıtlanması, telefonunuzun karıştırılması vb.)

Duygusal ihmal davranışları (Örn; sorunlarınızı paylaşamamak, fikirlerinizin önemsenmemesi vb.)

Fiziksel istismar davranışları (Örn; kemer, terlik gibi çeşitli unsurlar ile vurulması, tekme atılması, tokat atılması vb.)

Duygusal istismar davranışları (Örn; aşağılanmak, utandırılmak, hakarete maruz kalmak vb.)

Cinsel istismar davranışları (Örn; cinsel davranışlarda bulunmaya zorlanmak, cinsel içerikli sözlere maruz kalmak vb.)

Fiziksel ihmal davranışları (Örn; yeterli kıyafet bulamamak, yeterli yiyecek bulamamak vb.)

- ☐ Evet
- ☐ Hayır

Appendix D. Demographic Information Form

Yaşınız:

- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25

Cinsiyetiniz:

Eğitim Durumunuz:

- ☐ İlkokul
- ☐ Ortaokul
- ☐ Lise
- ☐ Ön Lisans
- ☐ Lisans
- ☐ Lisansüstü

Çocukluğunuzu düşündüğünüzde; 18 yaşınızdan önce; Aile bireyleriniz ya da çevrenizde bulunan diğer bireyler tarafından Cinsel istismar davranışlarına (Örn; cinsel davranışlarda bulunmaya zorlanmak, cinsel içerikli sözlere maruz kalmak vb.) maruz kaldınız mı?

- ☐ Evet
- ☐ Hayır

Evet ise; bu yaşantıyı ilk deneyimlediğiniz yaşıınız:

Bu yaşantıya sebebiyet veren kişinin yakınlık derecesi (Örn: Ebeveyn, Akıaba, aile dostu, arkadaş vb.):

Bu deneyimden haberdar olan kişi ya da kişiler var mıdır?

- ☐ Evet
- ☐ Hayır

Bu deneyimden haberdar olan kişi ya da kişiler kimlerdir?

18 yaşınızdan önce; Aile bireyleriniz ya da çevrenizde bulunan diğer bireyler tarafından Fiziksel istismar davranışlarına (Örn; kemer, terlik gibi çeşitli unsurlar ile vurulması, tekme atılması, tokat atılması vb.) maruz kaldınız mı?

- ☐ Evet
- ☐ Hayır

Evet ise; bu yaşantıyı ilk deneyimlediğiniz yaşıınız:

Bu yařantıya sebebiyet veren kiřinin yakınlık derecesi (Örn: Ebeveyn, Akraba, aile dostu, arkadaş vb.):

Bu deneyimden haberdar olan kiři ya da kiřiler var mıdır?

- ☐ Evet
- ☐ Hayır

Bu deneyimden haberdar olan kiři ya da kiřiler kimlerdir?

18 yařınızdıan önce; Aile bireyleriniz ya da çevrenizde bulunan diğeri bireyler tarafından Duygusal istismar davranıřlarına (Örn; ařağılanmak, utandırılmak, hakarete maruz kalmak vb.) maruz kaldınız mı?

- ☐ Evet
- ☐ Hayır

Evet ise; bu yařantıyı ilk deneyimlediğiniz yařınız:

Bu yařantıya sebebiyet veren kiřinin yakınlık derecesi (Örn: Ebeveyn, Akraba, aile dostu, arkadaş vb.):

Bu deneyimden haberdar olan kiři ya da kiřiler var mıdır?

- ☐ Evet
- ☐ Hayır

Bu deneyimden haberdar olan kiři ya da kiřiler kimlerdir?

18 yařınızdıan önce; Aile bireyleriniz ya da çevrenizde bulunan diğeri bireyler tarafından Fiziksel ihmal davranıřlarına (Örn; yeterli kıyafet bulamamak, yeterli yiyecek bulamamak vb.) maruz kaldınız mı?

- ☐ Evet
- ☐ Hayır

Evet ise; bu yařantıyı ilk deneyimlediğiniz yařınız:

Bu yařantıya sebebiyet veren kiřinin yakınlık derecesi (Örn: Ebeveyn, Akraba, aile dostu, arkadaş vb.):

Bu deneyimden haberdar olan kiři ya da kiřiler var mıdır?

- ☐ Evet
- ☐ Hayır

Bu deneyimden haberdar olan kiři ya da kiřiler kimlerdir?

18 yařınızdıan önce; Aile bireyleriniz ya da çevrenizde bulunan diğeri bireyler tarafından Duygusal ihmal davranıřlarına (Örn; sorunlarınızı paylařamamak, fikirlerinizin önemsenmemesi vb.) maruz kaldınız mı?

- ☐ Evet
- ☐ Hayır

Evet ise; bu yařantıyı ilk deneyimlediğiniz yařınız:

Bu yařantıya sebebiyet veren kiřinin yakınlık derecesi (Örn: Ebeveyn, Akraba, aile dostu, arkadař vb.):

Bu deneyimden haberdar olan kiři ya da kiřiler var mıdır?

- ☐ Evet
- ☐ Hayır

Bu deneyimden haberdar olan kiři ya da kiřiler kimlerdir?

18 yařınızdıan önce; Aile bireyleriniz ya da çevrenizde bulunan diğeri bireyler tarafından Ařırı koruma- kontrol davranıřlarına (Örn; arkadařlarınız ile görüşmelerinizin kısıtlanması, telefonunuzun karıřtırılması vb.)maruz kaldınız mı?

- ☐ Evet
- ☐ Hayır

Evet ise; bu yařantıyı ilk deneyimlediğiniz yařınız:

Bu yařantıya sebebiyet veren kiřinin yakınlık derecesi (Örn: Ebeveyn, Akraba, aile dostu, arkadař vb.):

Bu deneyimden haberdar olan kiři ya da kiřiler var mıdır?

- ☐ Evet
- ☐ Hayır

Bu deneyimden haberdar olan kiři ya da kiřiler kimlerdir:

Bu deneyim/ deneyimler sonrası psikolojik destek aldınız mı?

- ☐ Evet
- ☐ Hayır

Bu deneyim/deneyimler sonrası psikiyatrik ilaç kullandınız mı?

- ☐ Evet
- ☐ Hayır

Bu deneyim/ deneyimler ile iliřkili bir fiziksel sağıık kontrolünden geçtiniz mi?

- ☐ Evet
- ☐ Hayır

Bu deneyim/deneyimler ile ilgili adli bir süreç yařadınız mı?

- ☐ Evet
- ☐ Hayır

Appendix E. Childhood Trauma Questionnaire (CTQ-33)

Bu sorular *çocukluğunuzda ve ilk gençliğinizde (18 yaşından önce)* başınıza gelmiş olabilecek bazı olaylar hakkındadır. Her bir soru için sizin durumunuza uyan rakamı daire içerisine alarak işaretleyiniz. Sorulardan bazıları özel yaşamınızla ilgilidir; lütfen elinizden geldiğince gerçeğe uygun yanıt veriniz. Yanıtlarınız gizli tutulacaktır.

1. Hiçbir Zaman 2. Nadiren 3. Kimi zaman 4. Sık olarak 5. Çok sık

Çocukluğumda ya da ilk gençliğimde...

1. Yeterli yemeğim olurdu.
2. Gündelik bakım ve güvenliğim sağlanıyordu.
3. Anne ya da babam kendilerine layık olmadığımı ifade ederlerdi.
4. Fiziksel ihtiyaçlarım tam olarak karşılanırdı.
5. Ailemde sorunlarımı paylaşabileceğim biri vardı.
6. Üst baş açısından bakımsızdım.
7. Sevildiğimi hissediyordum.
8. Anne ya da babam kendimden utanmama neden olurdu.
9. Ailemden birisi bana öyle kötü vurmuştu ki doktora ya da hastaneye gitmem gerekmişti.
10. Ailemde değiştirmek istediğim şeyler vardı.
11. Ailemdekiler bana o kadar şiddetle vuruyorlardı ki vücudumda morartı ya da sıyrıklar oluyordu.
12. Kayış, sopa, kordon ya da başka sert bir cisimle vurularak cezalandırılıyordum.
13. Anne ya da babam fikirlerimi önemserdi.
14. Ailemdekiler bana kırıncı ya da saldırganca sözler söylerlerdi.
15. Fiziksel bakımdan hırpalanmış olduğuma inanıyorum.
16. Çocukluğum mükemmeldi.
17. Bana o kadar kötü vuruluyor ya da dövülüyordum ki öğretmen, komşu ya da bir doktorun bunu fark ettiği oluyordu.
18. Ailemde birisi benden nefret ederdi.
19. Ailemdekiler kendilerini birbirlerine yakın hissederlerdi.
20. Biri bana cinsel amaçla dokunmaya ya da kendisine dokundurtmaya çalıştı.
21. Kendisi ile cinsel ilişki kurmadığım takdirde bana zarar vermekle tehdit eden biri vardı.
22. Benim ailem dünyanın en iyisiydi.
23. Birisi beni cinsel şeyler yapmaya ya da cinsel şeylere bakmaya zorladı.
24. Birisi bana cinsel tacizde bulundu.
25. Ailemdekiler bana karşı suçlayıcıydı.
26. İhtiyacım olduğunda beni doktora götürecek birisi vardı.
27. Cinsel istismara uğradığım kanısındayım.
28. Ailem benim için bir güç ve destek kaynağı idi.
29. Ailemdekiler yaşıtımla ve arkadaşlarımla görüşmemi kısıtlardı.
30. Ailemdekiler her şeyime karışırdı.
31. Anne ve babam bir işi kendi başıma yapmama fırsat verirdiler.
32. Ailemdekiler rahat vermeyecek derecede peşimdeydiler.

33. Anne ya da babam beni kontrol etmek için kişisel eşyalarımı benden habersiz karıştırırdı.



Appendix F. Trauma Related Self-Disclosure Scale

Bu sorular *çocukluğunuzda ve ilk gençliğinizde (18 yaşından önce)* başınıza gelmiş olan bazı olaylar hakkındadır. Her bir soru için sizin durumunuza uyan seçeneği işaretleyiniz. Sorulardan bazıları özel yaşamınızla ilgilidir; bu sebeple içtenlikle yanıt vermeniz bizim için çok önemlidir. Yanıtlarınız gizli tutulacaktır.

1. Hiç Katılmıyorum 2. Katılmıyorum 3. Ne Katılıyorum Ne Katılmıyorum 4. Katılıyorum 5. Tamamen Katılıyorum

İnsanlar travma deneyimim olduğunu öğrenirse;

1. Benimle ilgili daha az olumlu düşünürler.
2. Benim hakkında kötü şeyler düşünürler.
3. Bana olumsuz tepki verirler.
4. Deli olduğumu düşünürler.
5. Beni zayıf olarak görürler.
6. Beni daha az severler.
7. Benim hakkımda olumsuz şeyler söylerler.
8. Yakın çevrem benden utanır.
9. Beni daha az çekici olarak görürler.
10. Benim hatam olduğunu düşünürler.
11. Benim etrafımdayken rahatsız olurlar.
12. Bana farklı davranırlar.
13. İşleri kendi başıma halledemeyeceğimi düşünürler.
14. Normalden daha az yetkinmişim gibi davranırlar.
15. Daha az saygı görürüm.
16. Benden kaçınırlar.
17. Başkalarına karşı açık olabileceğimi hissetmiyorum.
18. Birinin benim iznim olmadan başkalarına anlatmasından korkuyorum.
19. Bunu bir sır olarak saklamam gerektiğini hissediyorum.
20. Bu durumun başıma gelmesinde en azından kısmen suçlu olduğumu hissediyorum.
21. Kendimi diğer insanlardan ayrı hissediyorum.
22. Başkalarının beni önemseyeceğine dair güvenceye normalden daha fazla ihtiyaç duyuyorum.
23. Normalden daha sık yalnızlık hissediyorum.
24. Başkalarıyla olan ilişkilerimde eşit olmadığımı hissine kapılıyorum.
25. Bu deneyimimi hiçbir zaman gizleme ihtiyacı hissetmiyorum.
26. Travma deneyimimi kime söylediğime çok dikkat ederim.
27. Gizli tutmak için çok çalışıyorum.
28. Yakınımdaki insanlara gizli tutmalarını söyledim.
29. Hayatımın pek çok alanında kimse travma deneyimim olduğunu bilmiyor.
30. Birine söylemek risklidir.
31. İnsanların öğrendiklerinde beni yargılayabileceklerinden endişe ediyorum.
32. Arkadaşlıklardan kaçınmak, söylemek konusunda endişelenmekten daha kolaydır.

33. İnsanların bana karşı ayrımcılık yapmasından endişe ediyorum.



Appendix G. Cognitive Emotion Regulation Scale

Olaylarla nasıl başa çıkarsınız? Herkesin başından istenmeyen veya tatsız birçok olay geçmiştir veya geçmektedir ve herkes bu duruma kendi yöntemleriyle karşılık vermektedir. İSTENMEYEN VEYA TATSIZ DURUMLARLA KARŞILAŞTIĞINIZDA genellikle ne şekilde düşündüğünüzü, aşağıda yer alan sorular aracılığıyla belirtmeniz istenmektedir.

1) Hiçbir zaman 2) Bazen 3) Düzenli olarak 4) Sık sık 5) Her zaman

1. Bunun suçlusu benim diye düşünürüm.
2. Artık bu olayın olup bittiğini kabul etmek zorunda olduğumu düşünürüm.
3. Bu yaşadığım ile ilgili ne hissettiğimi düşünürüm.
4. Yaşadıklarımın daha hoş olan şeyleri düşünürüm.
5. Yapabileceğim en iyi şeyi düşünürüm.
6. Bu olaydan bir şey öğrenebileceğimi düşünürüm.
7. Her şey çok daha kötü olabilirdi diye düşünürüm.
8. Yaşadığım olayın başkalarının başına gelenlerden daha kötü olduğunu düşünürüm.
9. Bu olayda başkalarının suçu olduğunu düşünürüm.
10. Bu olayın tek sorumlusunun ben olduğumu düşünürüm.
11. Durumu kabullenmek zorunda olduğumu düşünürüm.
12. Zihnim yaşadığım olay hakkında ne düşündüğüm hissettiğimle sürekli meşgul olur.
13. Olayla hiç ilgisi olmayan hoş şeyler düşünürüm.
14. Bu durumla en iyi nasıl başa çıkabileceğimi düşünürüm.
15. Başımdan geçenlerin bir sonucu olarak daha güçlü bir insan haline gelebileceğimi düşünürüm.
16. Diğer insanların çok daha kötü tecrübeler geçirdiklerini düşünürüm.
17. Başıma gelen olayın ne kadar korkunç olduğunu düşünüp dururum.
18. Başımdan geçen olaydan başkalarının sorumlu olduğunu düşünürüm.
19. Bu olayda yaptığım hataları düşünürüm.
20. Bu olayla ilgili hiçbir şeyi değiştiremeyeceğimi düşünürüm.
21. Bu olayla ilgili neden böyle hissettiğimi anlamak isterim.
22. Başımdan geçen olay yerine hoş bir şeyler düşünürüm.
23. Bu durumu nasıl değiştireceğimi düşünürüm.
24. Bu durumun olumlu yanlarının da olduğunu düşünürüm.
25. Diğer şeylerle karşılaştırıldığında bunun o kadar da kötü olmadığını düşünürüm.
26. Yaşadığım bu şeyin bir insanın başına gelebilecek en kötü şey olduğunu düşünürüm.
27. Bu olayda diğerlerinin yaptığı hataları düşünürüm.
28. Esas sebebin kendimle ilgili olduğunu düşünürüm.
29. Bununla yaşamayı öğrenmem gerektiğini düşünürüm.
30. Bu durumun bende uyandırdığı duygularla boğuşurum.
31. Hoş olayları düşünürüm.
32. Yapabileceğim en iyi şeyle ilgili bir plan düşünürüm.

33. Bu durumun olumlu yanlarını ararım.
34. Kendime hayatta daha kötü şeylerin de olduğunu söylerim.
35. Sürekli bu durumun ne kadar korkunç olduğunu düşünürüm.
36. Esas sebebin başkalarıyla ilgili olduğunu düşünürüm.



Appendix H. Relational Traumatic Experiences Scale

Bu sorular yetişkinlik döneminde **(18 yaşından sonra)** başınıza gelmiş olabilecek bazı olaylar hakkındadır. Her bir soru için sizin durumunuza uyan seçeneği işaretleyiniz. Sorular özel yaşamınızla ilgilidir; bu sebeple içtenlikle yanıt vermeniz bizim için çok önemlidir. Yanıtlarınız gizli tutulacaktır.

Yetişkinlik Dönemi Aile, İş, Arkadaşlık ve Romantik Partner İlişkilerinizi Düşündüğünüzde;

Kişinin maddi ve manevi olarak destek alabileceği bütün kişiler ve kurumlarla bağlarının sistematik bir şekilde koparılması olan tecrit ve kontrol etme ilişkileriniz içerisinde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Arkadaş seçimlerinizi onaylamaması
- Kimlerle vakit geçireceğinizi kontrol etmeye çalışması
- Nerede olduğunuzu söylediğiniz halde inanmaması ve kanıt istemesi
- İsteddiğiniz yerlere gitmenize engel olması ve/ veya evden çıkmanıza engel olması
- Onu ihmal ettiğinizden şikâyet etmesi
- Sizi sürekli göz önünde tutmaya çalışması
- Söylediğiniz şeylere şüphe ile yaklaşması ve size inanmaması
- Kusurlarınızı bulmak için ipuçları araması
- Kıskanç davranması
- Onu aldattığınızdan şüphelenmesi ve başkaları ile flört ettiğinize dair suçlaması,
- Onun dediklerini yapmanız için sizi tehdit etmesi,
- Sosyal medya, cep telefonu, bilgisayar gibi iletişim araçlarınızı karıştırması ve kontrol etmesi,
- Sizin adınıza günlük işlerinizde dahi kararı onun vermesi,
- Koruma/sevme bahaneleri kullanarak hayatınızı kontrol etmeye çalışması gibi şekillerde ortaya çıkabilir.

18 yaşından itibaren diğer bireylerle (örn. aile bireyleri, eş, romantik partner, arkadaş, iş arkadaşı vb.) olan ilişkilerinizde yukarıda ifade edilen davranışlardan herhangi birine ne sıklıkla maruz kaldınız?

- ☐ Hiçbir ilişkimde bu davranışlardan birine maruz kalmadım.
- ☐ Ender(nadir) ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Bazı ilişkilerimde bu davranışlardan birine maruz kaldım.
- ☐ Çoğu ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Tüm ilişkilerimde bu davranışlardan birine maruz kaldım.

18 yaşından itibaren bu davranışlardan birine maruz kaldıysanız hangi ilişkilerinizde bu davranışlara maruz kaldınız? Birden fazla seçenek işaretleyebilirsiniz.

- ☐ Aile ilişkileri
- ☐ İş yaşamındaki ilişkiler
- ☐ Arkadaşlık ilişkileri

- ☐ Romantik ilişkiler
- ☐ Diğer ise, açıklayınız:

Bu davranışlara ne sıklıkla maruz kaldınız?

- ☐ Yalnızca bir kez
- ☐ Birkaç defa
- ☐ Ayda bir kez
- ☐ Haftada bir kez
- ☐ Her gün

Sözel taciz, kişinin sizin üzerinizde iktidar/güç kazanmak veya sizi kontrol altına almak amacıyla sözlü saldırıda bulunmasıdır. Sözel taciz ilişkileriniz içerisinde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Sizinle çatışma halinde olması
- Sizinle konuşurken sözünüzü kesmesi
- Kendinizi aşağılanmış/küçümsemiş hissettirmesi
- Size hoşlanmadığınız lakaplar takması
- Size küfür ve/veya hakaret etmesi
- Sizin değer, inanç, aile, etnik köken ve karakter özelliklerinize yönelik iğneleyici sözler ve/veya hakaret içeren kelimeler kullanması
- Sizin duygularınız ya da fikirlerinizi önemsememesi
- Yaptığınız işleri, duygularınızı ve fikirlerinizi gülünç bulması ve alay etmesi
- Kendisi dışında kimsenin sizi sevmeyeceği ya da istemeyeceği gibi ifadeler kullanması
- Sizinle ilgili kusur bulması gibi biçimlerde ortaya çıkabilir.

18 yaşından itibaren diğer bireylerle (örn. aile bireyleri, eş, romantik partner, arkadaş, iş arkadaşı vb.) olan ilişkilerinizde yukarıda ifade edilen davranışlardan herhangi birine ne sıklıkla maruz kaldınız?

- ☐ Hiçbir ilişkimde bu davranışlardan birine maruz kalmadım.
- ☐ Ender(nadir) ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Bazı ilişkilerimde bu davranışlardan birine maruz kaldım.
- ☐ Çoğu ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Tüm ilişkilerimde bu davranışlardan birine maruz kaldım.

18 yaşından itibaren bu davranışlardan birine maruz kaldıysanız hangi ilişkilerinizde bu davranışlara maruz kaldınız? Birden fazla seçenek işaretleyebilirsiniz.

- ☐ Aile ilişkileri
- ☐ İş yaşamındaki ilişkiler
- ☐ Arkadaşlık ilişkileri
- ☐ Romantik ilişkiler
- ☐ Diğer ise, açıklayınız:

Bu davranışlara ne sıklıkla maruz kaldınız?

- ☐ Yalnızca bir kez
- ☐ Birkaç defa

- ☐ Ayda bir kez
- ☐ Haftada bir kez
- ☐ Her gün

Zayıf yönleriniz, hatalarınız ve başarısızlıklarınızı size kötü hissettirmek amacıyla yüzünüze vurmak ya da başka bireylerin yanında bunları açığa çıkarmak olarak tanımlanabilen Utandırma ilişkileriniz içerisinde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Sizi küçük düşürücü şeyler yapmaya zorlaması
- Sizi başkalarının önünde utandırması
- Sizinle ilgili kişisel bilgileri ve sırları başkalarına söylemesi
- Sizi değerlerinize ve inançlarınıza aykırı davranmaya zorlaması
- Kendinizi yaparken kötü hissedeceğiniz şeyler yapmaya ikna etmesi
- Başka kişilerin yanında davranışlarınız, duygularınız ve fikirleriniz ile ilgili alaycı ve küçümseyici yorumlarda bulunması
- Başka bireylerin yanında sizin kusurlarınızı açık etmesi
- Başka kişilerin yanında sizi uyarması ve/veya sizi tehdit etmesi gibi biçimlerde ortaya çıkabilir.

18 yaşından itibaren diğer bireylerle (örn. aile bireyleri, eş, romantik partner, arkadaş, iş arkadaşı vb.) olan ilişkilerinizde yukarıda ifade edilen davranışlardan herhangi birine ne sıklıkla maruz kaldınız?

- ☐ Hiçbir ilişkimde bu davranışlardan birine maruz kalmadım.
- ☐ Ender(nadir) ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Bazı ilişkilerimde bu davranışlardan birine maruz kaldım.
- ☐ Çoğu ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Tüm ilişkilerimde bu davranışlardan birine maruz kaldım.

18 yaşından itibaren bu davranışlardan birine maruz kaldıysanız hangi ilişkilerinizde bu davranışlara maruz kaldınız? Birden fazla seçenek işaretleyebilirsiniz.

- ☐ Aile ilişkileri
- ☐ İş yaşamındaki ilişkiler
- ☐ Arkadaşlık ilişkileri
- ☐ Romantik ilişkiler
- ☐ Diğer ise, açıklayınız:

Bu davranışlara ne sıklıkla maruz kaldınız?

- ☐ Yalnızca bir kez
- ☐ Birkaç defa
- ☐ Ayda bir kez
- ☐ Haftada bir kez
- ☐ Her gün

Karşınızdaki kişinin sizi yok sayması, ilişki içinde çaba göstermemesi olarak tanımlanabilen Duygusal Reddetme ilişkileriniz içerisinde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Aramalarınıza ve mesajlarınıza bir neden olmaksızın cevap vermemesi
- Size soğuk davranması
- Sizi görmezden gelmesi
- Sizinle sohbet etmeyi ve vakit geçirmeyi kesmesi
- Size vakit ayırmaması
- Bahaneler bulması
- İhtiyaçlarınızı göz ardı etmesi gibi biçimlerde ortaya çıkabilir.

18 yaşından itibaren diğer bireylerle (örn. aile bireyleri, eş, romantik partner, arkadaş, iş arkadaşı vb.) olan ilişkilerinizde yukarıda ifade edilen davranışlardan herhangi birine ne sıklıkla maruz kaldınız?

- ☐ Hiçbir ilişkimde bu davranışlardan birine maruz kalmadım.
- ☐ Ender(nadir) ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Bazı ilişkilerimde bu davranışlardan birine maruz kaldım.
- ☐ Çoğu ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Tüm ilişkilerimde bu davranışlardan birine maruz kaldım.

18 yaşından itibaren bu davranışlardan birine maruz kaldıysanız hangi ilişkilerinizde bu davranışlara maruz kaldınız? Birden fazla seçenek işaretleyebilirsiniz.

- ☐ Aile yaşamındaki ilişkiler
- ☐ İş yaşamındaki ilişkiler
- ☐ Arkadaşlık ilişkileri
- ☐ Romantik ilişkiler
- ☐ Diğer ise, açıklayınız:

Bu davranışlara ne sıklıkla maruz kaldınız?

- ☐ Yalnızca bir kez
- ☐ Birkaç defa
- ☐ Ayda bir kez
- ☐ Haftada bir kez
- ☐ Her gün

Karşınızdaki kişinin ilişkiye ya da partnerine yönelik sizin yapabileceğinizden ya da verebileceğinizden çok daha fazlasını talep etmesi olarak tanımlanabilen Yüksek beklentiler ilişkileriniz içerisinde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Çalışmalarınızda yeteneklerinizden daha fazla sonuçlar almanızı beklemesi
- Var olan potansiyelinizin ötesinde davranmanızı beklemesi
- Beklentilerini karşılamayacağını ve/veya yetersiz olduğunuzu hissettiren davranışlar ve/veya söylemlerde bulunması
- Fiziksel ve/veya zihinsel yorgunluğunuzu görmezden gelmesi gibi biçimlerde ortaya çıkabilir.

18 yaşından itibaren diğer bireylerle (örn. aile bireyleri, eş, romantik partner, arkadaş, iş arkadaşı vb.) olan ilişkilerinizde yukarıda ifade edilen davranışlardan herhangi birine ne sıklıkla maruz kaldınız?

- ☐ Hiçbir ilişkimde bu davranışlardan birine maruz kalmadım.
- ☐ Ender(nadir) ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Bazı ilişkilerimde bu davranışlardan birine maruz kaldım.
- ☐ Çoğu ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Tüm ilişkilerimde bu davranışlardan birine maruz kaldım.

18 yaşından itibaren bu davranışlardan birine maruz kaldıysanız hangi ilişkilerinizde bu davranışlara maruz kaldınız? Birden fazla seçenek işaretleyebilirsiniz.

- ☐ Aile yaşamındaki ilişkiler
- ☐ İş yaşamındaki ilişkiler
- ☐ Arkadaşlık ilişkileri
- ☐ Romantik ilişkiler
- ☐ Diğer ise, açıklayınız:

Bu davranışlara ne sıklıkla maruz kaldınız?

- ☐ Yalnızca bir kez
- ☐ Birkaç defa
- ☐ Ayda bir kez
- ☐ Haftada bir kez
- ☐ Her gün

Etrafınızdaki kişi ya da kişilerin, sizin veya yakınlarınızdan birinin zarara uğrayacağı şeklinde tehdit etmesi olarak tanımlanan Korkutma/sindirme ilişkileriniz içerisinde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Sizi değer verdiğiniz şeylere zarar vermesi
- Sizi değer verdiğiniz bir insana zarar vermekle tehdit etmesi
- Diğer bireyler ile olan ilişkilerinize zarar vermesi ve/veya bu ilişkileri tehdit etmesi
- İş yaşamı, aile yaşamı ya da eğitim yaşamı gibi yaşamınızın çeşitli alanlarına zarar vermesi ve/veya bu alanları tehdit etmesi
- Evinizdeki eşyalara zarar vermesi
- Eviniz etrafındaki duvar, yol, kaldırım, bank gibi mülkiyetlere zarar vermesi
- Arabanıza zarar vermesi
- Size şantaj yapması
- Fiziksel veya sanal olarak takip etmesi
- Hayır cevabını kabul etmemesi
- Özel hayatınıza ve alanınıza saldırması
- Israrlı ve korku yaratacak biçimde sizi takip etmesi
- Size sağladığı maddi ve/veya manevi kaynaklardan sizi mahrum edeceğine dair korkutması gibi biçimlerde ortaya çıkabilir.

18 yaşından itibaren diğer bireylerle (örn. aile bireyleri, eş, romantik partner, arkadaş, iş arkadaşı vb.) olan ilişkilerinizde yukarıda ifade edilen davranışlardan herhangi birine ne sıklıkla maruz kaldınız?

- ☐ Hiçbir ilişkimde bu davranışlardan birine maruz kalmadım.
- ☐ Ender(nadir) ilişkimde bu davranışlardan birine maruz kaldım.

- ☐ Bazı ilişkilerimde bu davranışlardan birine maruz kaldım.
- ☐ Çoğu ilişkimde bu davranışlardan birine maruz kaldım.
- ☐ Tüm ilişkilerimde bu davranışlardan birine maruz kaldım.

18 yaşından itibaren bu davranışlardan birine maruz kaldıysanız hangi ilişkilerinizde bu davranışlara maruz kaldınız? Birden fazla seçenek işaretleyebilirsiniz.

- ☐ Aile yaşamındaki ilişkiler
- ☐ İş yaşamındaki ilişkiler
- ☐ Arkadaşlık ilişkileri
- ☐ Romantik ilişkiler
- ☐ Diğer ise, açıklayınız:

Bu davranışlara ne sıklıkla maruz kaldınız?

- ☐ Yalnızca bir kez
- ☐ Birkaç defa
- ☐ Ayda bir kez
- ☐ Haftada bir kez
- ☐ Her gün

Bedensel olarak bir zarara uğrayacağınıza dair korkutulmanız olarak tanımlanabilen Fiziksel Tehdit ilişki içinde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Duvara, kapıya ya da eşyalara vurması ve/veya onları tekmelemesi
- Bir eşyayı fırlatması, parçalaması ve/veya kırması
- Siz içindeyken arabayı tehlikeli şekilde kullanması
- Size parmak sallaması
- Size tehdit eder biçimde bakması
- Size yumruğunu göstermesi
- Sizin değer verdiğiniz şeylere zarar vermesi
- Değer verdiğiniz bir insana zarar vermekle tehdit etmesi
- İntihar etmekle tehdit etmesi
- Sizi öldürmekle tehdit etmesi
- Sopa, bıçak, kesici delici diğer aletler, ateşli silah gibi unsurlarla tehdit etmesi
- Üzerinize yürümesi gibi biçimlerde ortaya çıkabilir.

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18 yaşından itibaren bu davranışlardan birine maruz kaldıysanız hangi ilişkilerinizde bu davranışlara maruz kaldınız? Birden fazla seçenek işaretleyebilirsiniz.

- ☐ Aile yaşamındaki ilişkiler
- ☐ İş yaşamındaki ilişkiler
- ☐ Arkadaşlık ilişkileri
- ☐ Romantik ilişkiler
- ☐ Diğer ise, açıklayınız:

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- ☐ Yalnızca bir kez
- ☐ Birkaç defa
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- ☐ Haftada bir kez
- ☐ Her gün

Fiziksel şiddet, bedensel temas yoluyla başka bir kişide yaralanma, travma, bedensel zarar veya diğer fiziksel acılara neden olan herhangi bir kasıtlı eylemdir. Fiziksel Şiddet ilişkilerinizde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Sizi sıkıca tutarak hareket etmenizi engellemesi
- Sizi itip kakması, sarsması, çimdiklemesi
- Saçınızı çekmesi
- Kolunuzu ve/veya bileklerinizi bükmesi
- Başınıza ve/veya bedeninize vurması, ısırması, tokat atması
- Başka cisimlerle size vurması
- Başka cisimleri size fırlatması
- Tekmelemesi
- Yumruklaması
- Ayakları ile ezmesi
- Elleri veya eşarp kemer gibi çeşitli eşyalar ile boğazınızı sıkması
- Sizi yakması
- Kesici, delici (bıçak, tornavida vb.) aletler ile sizi yaralaması
- Ateşli silahlar ile sizi yaralaması
- Sizi bir oda ya da kapalı bir alana kilitlemesi/hapsetmesi gibi çeşitli davranışlar ile görülebilir.

18 yaşından itibaren diğer bireylerle (örn. aile bireyleri, eş, romantik partner, arkadaş, iş arkadaşı vb.) olan ilişkilerinizde yukarıda ifade edilen davranışlardan herhangi birine ne sıklıkla maruz kaldınız?

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Cinsel Baskı, bir kişinin rızası olmadan cinsel ilişkiye girmek için baskı, manipülasyon, yetki veya statünün kötüye kullanılmasıdır. Cinsel Baskı, ilişkilerinizde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Cinselliği çağrıştıracak eşyalar göndermesi
- Cinsel ilişki yaşamak amacıyla hediyeler alması
- Cinsel davranışlarda bulunmazsanız sizi maddi ve/veya manevi olarak sunduğu olanaklardan mahrum edeceğine yönelik tehdit etmesi ve/veya bunu ima etmesi
- Onunla cinsel ilişki yaşamazsanız kendisinin başka bir kişi ile cinsel ilişki yaşayacağı ile tehdit etmesi ve/veya bunu ima etmesi
- Onunla cinsel ilişki yaşamazsanız ilişkinizin biteceği şeklinde tehdit etmesi ve/veya bunu ima etmesi
- İstemediğinizi bildiği halde cinsel ilişki için ısrar etmesi veya baskı kurması
- Cinsel davranışlarda bulunmazsanız aile ilişkileriniz, eğitim, iş ve sosyal yaşamınızda size şantaj yapacağı şeklinde tehdit etmesi ve/veya bunu ima etmesi
- Onunla cinsel ilişki yaşamamanız amacıyla başka kişilerin onunla cinsel ilişki yaşamaya ilgi duyduklarını ima etmesi ve/veya bunu söylemesi gibi çeşitli biçimlerde ortaya çıkabilir.

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Sözle, gözle, vücut diliyle, posta veya elektronik haberleşme araçlarıyla gerçekleştirilen, cinsel olarak rahatsız edici davranışların tamamı Cinsel Tacizdir. Cinsel Taciz ilişkilerinizde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Size laf atması
- İstemediğiniz halde cinsel içerikli konuşmalar ve/veya şakalar yapması
- İstemediğiniz halde öpücük atması
- İstemediğiniz halde yanınızda pornografik içerikler izlemesi
- İstemediğiniz halde pornografik içerikli resim ya da video göndermesi ve/veya izletmesi
- Sizin onayınız olmadan sizin iç çamaşır, çıplak veya cinsel ilişki esnasında fotoğrafınızı/videonuzu çekmesi
- Kadın/erkek bedenini ve cinselliğini aşağılayacak şekilde konuşması gibi çeşitli biçimlerde ortaya çıkabilir.

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Cinsel Saldırı, bir kişinin başka bir kişiye rızası olmadan cinsel olarak dokunması veya bir kişiyi iradesi dışında cinsel bir eylemde bulunmaya zorlaması veya fiziksel olarak zorlamasıdır. Cinsel Saldırı, ilişkilerinizde farklı biçimlerde ortaya çıkabilir. Örneğin, ilişki içinde olduğunuz kişinin:

- Vücudunuzun herhangi bir yerine cinsel amaçla temas etmesi
- Sizi istemediğiniz cinsel pozisyonlara zorlaması
- Sizi cinsel organına dokunmaya zorlaması
- Bir organı ve/veya nesne ile sizi oral, anal ya da vajinal ilişkiye girmeye zorlaması
- İstemediğiniz halde sarılma, öpme, okşama, ovma, sürtünme, mastürbasyon yapma gibi eylemlerde bulunması
- Size alkol veya uyuşturucu vererek cinsel eylemlere zorlaması
- Sizi başka bir kişiyle cinsel ilişkiye girmeye zorlaması
- Kendisi başka bir kişi ile cinsel ilişkiye girerken sizi izlemeye zorlaması
- Rızanız olmadığı halde hoyratça ve acıtarak cinsel ilişkiye girmesi
- Cinselliği bir ödül ya da ceza yöntemi olarak kullanması gibi farklı biçimlerde ortaya çıkabilir.

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