T.C.

BAHCESEHIR UNIVERSITY

GRADUATE SCHOOL

DEPARTMENT OF CLINICAL PSYCHOLOGY

EXAMINATION OF THE RELATIONSHIPS BETWEEN CHILDHOOD TRAUMA, DISSOCIATION, AND RELATIONAL NEEDS

MASTER'S THESIS

BİLGE BİLİR

ISTANBUL 2025

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I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

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ABSTRACT

EXAMINATION OF THE RELATIONSHIPS BETWEEN CHILDHOOD TRAUMA, DISSOCIATION, AND RELATIONAL NEEDS

Bilge, Bilir
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The current study aims to investigate the relationship between childhood trauma and dissociation as well as how relational needs satisfaction affects this relationship. Study conducted with 313 participants (161 females and 152 males), aged between 18 and 65 years. Data was collected, respectively, using an Informed Consent Form, Demographic Information Form, Childhood Trauma Questionnaire, Dissociative Experiences Scale, and Relational Needs Satisfaction Scale. Data analysis was conducted using SPSS 26.0. Correlational design and hierarchical regression analysis were employed. The correlational analyses demonstrated significant relationships between childhood trauma, dissociation, and relational needs satisfaction. Hierarchical regression analysis acknowledged that relational needs satisfaction has a mediating role in the relationship between childhood trauma and dissociation. The findings are explained in the context of current literature by emphasizing the potential theoretical and clinical implications, highlighting the potential role of relational needs satisfaction's buffering role in the childhood trauma and dissociation context. Further research is essential to have a better understanding of the relationships among relational needs satisfaction, childhood trauma, and dissociation in a more comprehensive way.

Keywords: Childhood Trauma, Dissociation, Relational Needs Satisfaction

ÖZET

ÇOCUKLUK ÇAĞI TRAVMALARI, DISSOSİYASYON VE İLİŞKİSEL İHTİYAÇLAR ARASINDAKİ İLİŞKİLERİN İNCELENMESİ

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Bu çalışmanın amacı çocukluk çağı travmaları ile dissosiyasyon arasındaki ilişkiyi ve ilişkisel ihtiyaçların tatmininin bu ilişkiyi nasıl etkilediğini araştırmaktır. Çalışma 18-65 yaşları arasında 313 katılımcıyla (161 kadın ve 152 erkek) gerçekleştirilmiştir. Veriler sırasıyla Bilgilendirilmiş Onam Formu, Demografik Bilgi Formu, Çocukluk Çağı Travmaları Anketi, Dissosiyatif Yaşantılar Ölçeği ve İlişkisel İhtiyaçlar Tatmini Ölçeği kullanılarak elde edilmiştir. Verilerin analizi SPSS 26.0 programı kullanılarak yapılmıştır. Verilerin değerlendirilmesinde korelasyonel analiz ve hiyerarşik regresyon analizi kullanılmıştır. Korelasyonel analizler çocukluk çağı travmaları, dissosiyasyon ve ilişkisel ihtiyaçlar tatmini arasında istatistiksel olarak anlamlı ilişkiler olduğunu göstermiştir. Hiyerarşik regresyon analizi, ilişkisel ihtiyaçlar tatmininin çocukluk çağı travmaları ile dissosiyasyon arasındaki ilişkide aracılık rolü olduğunu istatistiksel olarak anlamlı bir şekilde göstermiştir. Sonuçlar, potansiyel kuramsal ve klinik çıkarımlar göz önünde bulundurarak, güncel literatür bağlamında açıklanmıştır. Ayrıca ilişkisel ihtiyaçlar tatmininin çocukluk çağı travmaları ve dissosiyasyon bağlamında potansiyel koruyucu rolünün altı çizilmiştir. İlişkisel ihtiyaçların doyumu, çocukluk çağı travmaları ve dissosiyasyon arasındaki ilişkileri daha kapsamlı bir şekilde anlayabilmek için gelecek dönemde daha fazla araştırmaya ihtiyaç vardır.

Anahtar Kelimeler: Çocukluk Çağı Travması, Dissosiyasyon, İlişkisel İhtiyaçlar Tatmini

To My Dear Family and Friends

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CTQ-33	Childhood Trauma Questionnaire
DES	Dissociative Experiences Scale
RNNS	Relational Needs Satisfaction Scale

Chapter 1

Introduction

1.1 Theoretical Framework

Trauma is a concept that has been comprehensively addressed and interpreted by many researchers, each of them expressing their own perspectives and methodologies to reveal the complexities of its effects. These academic efforts intend to contribute to a broader and more nuanced understanding of trauma, including its psychological, emotional, and physiological impacts on individuals. According to the American Psychological Association (2013), trauma is explained as the emotional reactions that are caused by experiencing a variety of severe and hurtful events. These events can be accidents, criminal activities, natural disasters, cases of abuse or neglect, witnessing acts of violence, the death of someone close, or exposure to conflict and war. Such experiences can arouse vital emotional disturbances and psychological effects, which create the essence of trauma. Furthermore, "trauma" is explained as more than only an isolated event; it symbolizes a psychobiological injury shaped by the interaction of psychological, biological, social, and environmental factors. This involves hardships in integrating experiences, such as dissociation and emotional regulation issues, as well as conflicting past and present events, socially impaired caregiving, and a lack of social support (Nijenhaus and van der Hart 2011).

Trauma induces deep and crucial suffering, affecting an individual's physical, emotional, and mental health. Psychologically, the severe shock and feeling of helplessness experienced during traumatic situations can cause lasting and serious effects. In all such events, the nervous system and the brain naturally activate survival mechanisms that can over function more advanced cognitive functions. If the danger is dealt with effectively, the individual will evenly regain a state of internal balance. However, if the threat persists or the answer is not enough, the alarm system stays activated, abandoning the brain and body in a consistent state of pain (Van der Kolk et al., 2014). If experiences are not decently processed and understood over time, both the body’s and mind’s defence mechanisms can begin to activate in more different and varied ways. This can lead to fluctuating and distorted responses since these

mechanisms attempt to deal with the unprocessed experiences (Herman, 2015). One of these distorted mechanisms is dissociation, and it is related to traumatic situations in many different ways.

Dissociation generally appears as a significant consequence of experiencing trauma, and there are many important studies that shed light on this connection between trauma and dissociation. Given the predictable and extensive incidence of trauma in individuals' lives and its connection with the prevalence of dissociative responses, it becomes increasingly clear that any theoretical foundation aimed at understanding psychological structures should integrate the concept of dissociation. This is specifically important for a comprehensive analysis of how trauma impacts mental and emotional functioning. As a result, including dissociation into such frameworks is foundational for apprehending the full scope of trauma's impact on psychological well-being (Howell, 2005). Before examining the relationship between trauma and dissociation detailly, it is significant to provide a comprehensive discussion of dissociation. Comprehending the nature and distinctive parts of dissociation provides the foundational context for understanding how it connects with and is influenced by traumatic experiences.

As a clinical condition, dissociation has been described primarily in terms of fragmentation and disintegration of the mind, self, and body. Dissociation's clinical expressions refer to altered perceptions and behaviours, including derealization, depersonalization, and distortion of perceptions of time, space, and body (Van der Kolk et al., 1996). In the case of dissociation, traumatic memories become disconnected from consciousness, causing a significant separation between different parts of the experience. This separation implies that emotions, actions, memories, and physiological responses no longer interact as they normally do. As a result of this, individuals might not experience the emotional effects of some events, physical disturbances might not be felt in the existence of injuries, and memories might become disintegrated. These disintegrated memory parts might not be recalled or integrated into the person's sense of self, resulting in a fragmented experience of reality (Terr, 1991). Additionally, people often respond to trauma in three fundamental ways: by avoiding the situation, by pursuing a solution to the problem, or by completely disengaging themselves from the traumatic event. These reactions generally come from the people's insufficient coping mechanisms and skills for handling the trauma.

The background of these responses emphasizes their capacity to cope and process the trauma is constrained, affecting how they handle the emotional and psychological effects of the traumatic event (Şar and Öztürk, 2008).

Examining the association between dissociation and trauma involves understanding how early traumatic experiences, especially childhood trauma, might cause dissociative symptoms. It is denoted that childhood neglect and abuse cases are crucial in the occurrence of dissociative experiences. In a meta-analysis study conducted by Vonderlin et al. (2018), it was discovered that people who experienced childhood neglect and abuse exhibited higher rates of dissociation compared to people who did not experience childhood neglect and abuse. In the study, which is conducted with 7,352 participants who had experienced childhood neglect or abuse, it was found that early onset of trauma, long-lasting trauma, and exposure to parental abuse were significant predictors of raised dissociation symptoms. A child who is neglected or abused, especially by an attachment figure, creates a closed system on which he or she relies in order to preserve the continually disturbed balance and regulate intense emotions. When the attachment figure cannot create a safe environment or protect the child against threats, disengaging from the frightening, neglectful, or abusive caregiver is a method of self-protection for the child in order to preserve the connection with the caregiver (Howell, 2005). The defence mechanism of freezing due to traumatic experiences becomes a psychological mechanism that disseminates throughout life if the experience is early-onset and constant (McWilliams, 2013).

Traumatic situations might seriously interrupt people's daily relationships and sense of purpose, making them specifically fragile. These experiences might disintegrate their sense of identity and deteriorate their connections with other people, causing a decreased sense of control, autonomy, and self-esteem. Recreating one's sense of self generally depends on composing supportive relationships. In this context, the social support of trauma survivors plays a vital role, as it promotes the rebuilding of trust and safety, which are foundational for recovery after trauma (Herman, 2007). Marshall and Frazier (2019) indicate that traumatic events initiate the attachment system within individuals, seeking them to find support and security. They indicate that the impacts of trauma might differ significantly based on the availability and competence of the support and security ensured to those affected. In other words, individuals receiving essential support and insurance might impact the extent and

trauma's influence on their mental health. In a study conducted by Özdemir and Yazıcı (2018), it was found that people who had experienced trauma often searched emotional and social support to ease their symptoms and cope with their situations. In spite of their efforts to find support, the researchers found that these people generally saw the actual level of social support they received as lower than expected. This denotes a disconnection between the desire for support and the recognized capacity of the support available to them. Many studies emphasize the importance of social support during childhood, especially when coping with trauma and maltreatment. Social support is crucial in alleviating and reducing the lasting effects of childhood abuse. It helps mediate and buffer the adverse effects, contributing stability and positive reinforcement that can neutralize some of the adverse results of early maltreatment (Sperry and Widom, 2013). Based on all this, it can be said that from the moment that people are born until the end of their lives, their biological drive for attachment and the urge to create relationships constantly shape their behaviour. While a child might be able to survive physically without sufficient human interaction, the lack of meaningful emotional interactions makes it extremely compelling for them to act effectively in social situations. Without regular interpersonal interaction and emotional association, children may not establish the suitable behaviours and social skills essential for healthy human development. This urge for relationships broadens into adulthood as well, where creating attachments is vital because it is extendedly believed that relationships help satisfy a range of personal needs (Erskine, 2011).

Richard Erskine and his colleagues defined eight fundamental relational needs in 1996, which were accepted as a core element of integrative psychotherapy (Erskine and Trautmann, 1996). These are the need for security, validation, affirmation, and significance within a relationship; acceptance by a stable, dependable, and protective other person; the confirmation of personal experiences; self-definition; having an impact on the other person; and having the other initiate and express love. While these are not fundamental, encouraging a sense of self within relationships. These needs are essential to worldwide human connections and are not specific to childhood or any specific developmental period; instead, they are constant aspects of relationships throughout people's lives. When relational needs are unsatisfied, the longing for their satisfaction might deepen, causing a profound sense of desolation and continuous loneliness. Long-lasting neglect of these needs might result in frustration, aggression,

or anger (Erskine and Trautmann, 1996). In the specified model, relational needs are defined as needs that can only be satisfied through relationships and are denoted to be universal human needs. It is highlighted that situations where the need for a relationship is not created and there is no contact with the other might accumulate and become a source of trauma in and of itself. In addition, according to the model, if there is no relationship that can be created, trusted, understood, and, for that reason, supported during or after a traumatic experience, the urge for a relationship is either satisfied rarely and unpredictably or not at all. What will cure the people in this situation is a relationship that might build a healing effect. A healing relationship is a relationship where relational needs are admitted and satisfied appropriately (Erskine et al., 2015; Erskine, 2011).

When encountered with trauma, dissociation causes people to disintegrate mentally and emotionally from their experiences, even as they persist in adjusting their physical actions and behaviours to adapt to external expectations. This mechanism allows them to handle their surroundings efficiently while keeping a sense of internal and external balance. Consequently, dissociation works as a sophisticated defence mechanism aimed at preserving overall mental and physical stability. (Erskine, 1993). Every disintegration in a person's sense of self refers to a basic and immediate urge to stabilize and regulate their emotions, examining the need to manage or compensate for past defects in significant relationships (Erskine, 2019). Erskine denotes that dissociation emerges from trauma and a lack of supportive relationships. Psychotherapy might be supported by focusing on relational methods, including exploring experiences, validating emotions, and providing a persistent, safe existence (Erskine, 1993). Preserving contact helps emerge defences and integrate dissociated parts of the personality. This process allows covered and unresolved aspects to integrate into a unified self, allowing individuals to deal with life's challenges with adaptability and spontaneity without depending on dissociation. Contact therefore plays a vital role in resolving fragmented identity and integrating past traumas and satisfied needs (Erskine, 1993).

1.2 Statement of the Problem

Prior research has found that childhood trauma acts as a significant predictor of dissociation. These studies denote a strong correlation between experiences of trauma during early developmental stages and the development of dissociative symptoms. The evidence indicates that the effect of childhood trauma on dissociation is extensive, affecting both the density of dissociative experiences later in life (Howell, 2005; McWilliams, 2013; Vonderlin et al., 2018). Richard Erskine indicates the important role that relational needs play in the case of trauma and dissociation. He emphasized that examining and fulfilling these relational needs is vital for diminishing some of the symptoms related to trauma and dissociation. According to Erskine, when individuals' relational needs are satisfied, it can ensure a noticeable reduction in symptoms, highlighting the significance of incorporating relational dynamics into therapeutic approaches for more effective outcomes (Erskine, 2019). In spite of the significance of the subject, there has yet to be a study that integrates all three components concurrently, and the body of literature examining this issue is still evolving. Current research on the subject remains inadequate, with various gaps and limitations that need to be examined. The current literature does not completely comprise the complexity of the interactions between these structures, emphasizing the need for further examination and a more comprehensive exploration of this extent.

1.3 Purpose of the Study

The primary aim of this study is to assess the association between childhood trauma dissociation and relational needs. In addition to this, the study aims to examine whether the satisfaction of relational needs acts as a mediating variable in this relationship or not. In other words, it will investigate how the extent to which individuals' relational needs are satisfied can impact or modify the effects of childhood trauma on dissociative symptoms. While this study aims to provide an exploration of the relationship between childhood trauma and dissociation by investigating the role of relational needs satisfaction, it seeks to discover how the fulfilment of relational needs can impact or mediate the association between childhood trauma and dissociative symptoms. Dalenberg et al. (2012) suggested that dissociation and trauma association were consistently investigated. Now, it is crucial to further research this relationship and to investigate variables that might mediate it. As it is implicated, by

exploring these dynamics, the study intends to propose new theoretical pathways and refine existing models of how interpersonal relational factors intersect with trauma-related dissociation.

Another key aim of this study is to encourage mental health practitioners and researchers to investigate the pathways, which is the satisfaction of relational needs, as described within the scope of this research, and respect the association between childhood trauma and dissociation. By emphasizing the role of relational needs satisfaction, the study is aimed at improving theoretical understanding and informing practical approaches in the field of mental health. An additional objective of this study is to investigate childhood trauma and dissociation through the structure of integrative psychotherapy. By accepting this perspective, the study explores to provide a nuanced comprehension of these phenomena and to suggest effective insights for mental health practitioners. Additionally, Richard Erskine has developed specific perspectives on trauma and dissociation; however, a detailed and broad examination of these internal issues is vital for examining the gaps in the contemporary literature as well (Erskine, 1993). This comprehensive analysis aims to bridge the existing gaps and provide a more thorough understanding of trauma and dissociation, thereby advancing the field and improving theoretical and practical insights. In this manner, this approach aims to improve their clinical practice by merging relational needs into the assessment and treatment of childhood trauma and dissociation, thus providing a more comprehensive therapeutic model.

Another objective of the study is to examine the role of dissociation within relational contexts. While existing literature has comprehensively addressed trauma and its relational context, there is a distinguished inadequacy in research focusing especially on the intersection of dissociation and relational context. This study pursues to address this gap by analysing how dissociation is affected by and associates with interpersonal relationships. By examining dissociation from this relational perspective, the study aims to suggest a broader understanding that might distinguish dissociation from being viewed particularly as a pathological disorder or situation, thus contributing to a more extensive view of its social and relational aspects. In addition to that, relational needs have protective aspects that might improve people's life satisfaction in different ways. While relational needs are examined, there is no need to distinguish any pathological situation. This concept can be investigated in terms of

social and relational aspects of life. In that way, it can be possible to understand possible and optimal situations and avoid any pathological conditions. Therefore, this study can be an example for understanding protective ways that prevent pathological situations.

1.4 Research Questions and Hypotheses

Question: How is the relationship between childhood traumatic experiences and dissociative experiences?

Hypothesis 1: There is a positive relationship between childhood traumatic experiences and dissociative experiences.

Hypothesis 2: There is a negative relationship between childhood traumatic experiences and the satisfaction of relational needs.

Hypothesis 3: There is a negative relationship between the satisfaction of relational needs and dissociative experiences.

Hypothesis 4: Satisfaction of relational needs has a mediating role in the relationship between childhood traumatic experiences and dissociative experiences.

1.5 Significance of the Study

An investigation of the scientific literature on trauma and its effects shows that there are important intersections with Erskine's relational needs model, specifically respecting aspects such as feelings of safety, the need for support, and social support, which are components that are associated with relational needs (Toksoy, 2021). In spite of these intersections, it has notable deficiencies of research that simultaneously addresses relational needs and trauma issues within the context of the Relational Needs Model. This gap emphasizes the need for further investigation since there are presently limited studies, which are mostly conceptualized by Richard Erskine, that discover the interaction between relational needs and trauma through the perspective of this specific theoretical model. Additionally, there is an important gap in research specifically focusing on the interplay of dissociation and relational needs as well. This study examines this deficiency by exploring how dissociation is affected by and related to relational needs. By discovering dissociation from this relational perspective, the study

objects to enhance a more comprehensive understanding that goes beyond defining dissociation solely as a pathological concept. Instead of this, it refers to underscore the social and relational dimensions of dissociation by integrating the role of Erskine's relational needs, while leading to a more comprehensive view of how dissociative experiences are engaged with relational factors. Taking into consideration these aspects, this study explores to highlight the interaction among relational needs, trauma, and dissociation by investigating each factor both independently and in conjunction with each other. By evaluating these dimensions together and separately, the study signifies to provide a broad understanding of how relational needs, trauma, and dissociation associate, thereby suggesting insights into their separate and overlapping impacts.

One of the other significances of the current study is to address the existing gap by examining how dissociation is affected by and interconnected with interpersonal relationships without any pathological distinction with a non-clinical sample. By assessing dissociation from a relational perspective, the research tries to contribute a broader understanding that goes beyond approaching dissociation solely as a pathological disorder or isolated condition. Rather than that, the study pursues to suggest a more expansive view that examines the social and relational factors contributing to dissociation. By emphasizing that, it seeks to enhance understanding of how dissociation functions within the context of interpersonal dynamics. Moreover, according to the positive clinical psychology perspective, it is crucial to enhance well-being and personal strengths rather than only focusing on pathological symptoms, mental illness, or dysfunction. The presence of protective factors is as important as pathological symptoms. At that point, relational needs can be examined in terms of protective factors, and it can be beneficial to understand protective ways in terms of positive psychology.

In addition to utilizing a non-clinical sample to explore the association between childhood trauma and dissociation, this study serves as pioneering work in investigating these constructs simultaneously within the perspective of Erskine's Relational Needs Model. By merging childhood trauma and dissociation with Erskine's Relational Needs Model, which highlights the critical role of relational needs in psychological functioning and development, this research tries to contribute a new and comprehensive perspective. Besides, this study is utilizing a non-clinical Turkish

sample. It might also be significant within the cultural context and might be pioneering for future studies. This approach not only improves our understanding of how these factors interplay within the context of a relational perspective but also broadens the contemporary literature by emphasizing the significance of relational needs in forming the experiences of childhood trauma and dissociation.

Another crucial significance of this study is to enlighten mental health practitioners and researchers to examine the pathways related to the satisfaction of relational needs, as described within the framework of this research, and to investigate how these pathways are associated with childhood trauma and dissociation. By emphasizing the role of relational needs satisfaction, the study signifies to enhance theoretical perspective and inform practitioners in the subject of mental health. Richard Erskine's contemporary work in integrative psychotherapy, which emphasizes the significance of relational needs, adjusts with this approach so that practitioners can benefit from this study.

1.6 Definitions

Trauma: Trauma refers to the psychological and emotional responses evoked by exposure to highly stressful events such as accidents, criminal activities, natural disasters, abuse, neglect, witnessing violence, the death of a loved one, or conflict situations. After these incidents, people often face an initial phase that is characterized by shock and denial. This initial reaction is a typical psychological defence mechanism that helps individuals temporarily deal with the devastating nature of the traumatic experience since they start to process and integrate the effect of the event into their comprehension of the world.

Childhood Trauma: Childhood trauma refers to a wide range of distressing situations experienced before reaching the age of 18. These traumatic situations might include immense forms of abuse, such as physical, emotional, sexual, or neglectful abuse. In addition to these, childhood trauma might include crucial life events such as the separation or divorce of parents, the death of a close family member or friend, witnessing acts of violence, experiencing accidents, or enduring other exceedingly stressful situations. It also includes exposure to natural disasters, which might have vital and enduring effects on a child's emotional and psychological well-being.

Dissociation: Dissociation is a psychological condition distinct from interruption in people's perception of their environment, their sense of personal identity, their emotional experiences, and their ability to remember past incidents. This condition includes a disruption in the integrated sense of self, causing a disintegrated or disconnected experience of real life. People experiencing dissociation might face evident alterations in their emotional reactions, cognitive functions, and behavioral schemas. These disruptions might weaken the united formation of their identity, resulting in a fragmented or inconsistent experience of self and surroundings. This phenomenon refers to a pathological process that impacts how individuals process and harmonize their experiences, emotions, and memories.

Dissociative Disorders: Pathological forms of dissociation are defined and classified into diverse mental health disorders based on the particular symptoms and patterns displayed. These disorders are marked by significant disruptions in identity, memory, and consciousness, which signify a disturbance in the united integration of these cognitive functions. According to the DSM-5, dissociative disorders are classified into several important types, each with its own characterized symptomatology. These categories refer to dissociative identity disorder, which means the presence of two or more separate personality states; depersonalization or derealization disorder, marked by persistent or frequent feelings of disintegration from one's body or environment; and dissociative amnesia, characterized by a failure to remember important personal information, usually associated with traumatic or stressful events. Each of these disorders refers to a different aspect of how dissociation might affect an individual's perception of self, reality, and memory.

Relational Needs: Relational needs are essential elements of the worldwide human drive for close relationships and secure attachments. Richard Erskine highlights that for a child to thrive, they must be in relationships where the other person is actively present and involved, attuned, and receptive to the child's relational needs in a satisfied way. Richard Erskine conceptualizes eight vital relational needs: Need for security; validation, affirmation, and significance within a relationship; acceptance by a stable, dependable, and protective other person; the confirmation of personal experiences; self-definition; having an impact on the other person; and having the other initiate and express love.

Integrative Psychotherapy: Integrative psychotherapy refers to a therapeutic approach that gives importance to and accepts the fundamental value of each individual. This approach tries to enhance psychotherapy that effectively addresses a person on different levels, such as behavioural, cognitive, and physiological. It aims to address the complicatedness of human functioning in a nuanced and adaptive manner. Moreover, integrative psychotherapy also integrates the spiritual aspects of life, emphasizing the importance of spiritual and existential interests in the therapeutic process. By combining these various aspects, this perspective provides a holistic and comprehensive framework for examining and encouraging the numerous needs of individuals in their history towards well-being and health.

Chapter 2

Literature Review

2.1 Trauma

2.1.1 What is trauma? According to the American Psychological Association (2013), trauma encompasses the emotional reactions triggered by various distressing incidents, such as accidents, crimes, natural disasters, abuse, neglect, witnessing violence, the loss of a loved one, or exposure to war. Following such events, it's common for individuals to initially experience shock and denial. However, people can use the trauma in everyday language more commonly to describe stressful events in their lives. Even though people use the term psychological trauma as a stressful event in everyday language, it may create events and situations that overwhelm the ability to cope and cause fear of death, annihilation, or psychosis (Giller, 1999). According to Jaffe et al. (2005), it can be distinguished between stress and emotional trauma by examining the outcome and observing the lasting impact an upsetting event has on our daily lives, relationships, and overall well-being. There are some ways to differentiate traumatic distress from everyday stress. This involves evaluating the speed at which distress arises, its frequency and intensity, the perceived threat of the triggering factor, and the duration required to regain calmness.

Besides, it is significant that the term "trauma" denotes a wound or injury not solely as an isolated event but as a psychobiological wound shaped by a complex interplay of psychological, biological, social, and environmental factors. Psychobiological factors encompass the constraints on an individual's ability to integrate experiences, as seen through reactions like dissociation, difficulties in regulating emotions, and the ongoing avoidance of traumatic memories. Environmental factors encompass features of both current and past adverse events that have the potential to cause trauma, as well as caregiver dysfunction and absence, along with insufficient social support for processing and integrating adverse experiences (Nijenhaus and van der Hart 2011). Additionally, trauma should be evaluated not only as an event but also as a psychosocial process experienced over time (Şar and Öztürk, 2013). Also, it is important to keep in mind that trauma arises from the unique circumstances an individual faces, resulting from conflicts between stressors and

coping mechanisms, often accompanied by feelings of powerlessness (Van der Kolk et al., 1996). There are some possible ways to contribute to this uniqueness: the seriousness of the incident, the person's background, the deeper significance the event holds for them, their ability to manage it, their principles and convictions, and the responses and assistance they receive from loved ones or professionals (Jaffe et al., 2005). In this context, a traumatic experience arises when there is a significant disparity between the severity of the external threat and the individual's capacity to manage it emotionally and psychologically (Herman, 2011).

As it can be seen from the short review, trauma is a concept that has been tried to be explained by many researchers. Nevertheless, when it comes to the symptoms of trauma, even though there are many different and subjective ones, there is a more common consensus. Symptoms that occur as a result of trauma can be explained more easily than the events that caused the trauma.

2.1.2 Trauma symptoms. Trauma inflicts profound suffering upon individuals, affecting their body, mind, and soul. Psychologically, the overwhelming shock and sense of helplessness during traumatic events have enduring and severe consequences. When faced with such situations, the brain and nervous system automatically respond, triggering survival instincts that can override higher cognitive functions. If the danger is effectively managed, the individual gradually regains internal balance. However, if the threat persists or the response is inadequate, the alarm system remains active, keeping the brain and body in a perpetual state of distress (Van der Kolk et al., 2014). Over time, if the experience isn't processed and understood, the body’s and mind's defence mechanisms may begin to operate in different and exaggerated ways (Herman, 2015). Brain imaging indicates that trauma alters both the structure and operation of the brain, specifically where the frontal cortex, emotional center, and survival instinct meet (Jaffe et al., 2005). Trauma symptoms are linked with instability in the limbic system and changes in both the hypothalamic-pituitary-adrenal axis and the sympatho-adrenal medullary axis. These alterations impact neuroendocrine and immune functions and influence the central nervous system, leading to symptoms resembling neurological conditions and disruptions in sleep patterns (Gupta, 2013). According to the systematic review by Lopez-Martínez et al. (2018), trauma exposure is linked to worse physical health outcomes. As the frequency of exposure to traumatic events

increases (1 incidence to 5 or more), physical health problems also increase (Scott et al., 2013). Beside the exposure to trauma, even a single traumatic event can cause adverse impacts on physical health, such as cardiovascular, immune, gastrointestinal, or neurohormonal problems (D'Andrea et al., 2011). Also, some post-traumatic stress symptoms include disruptions in eating patterns, sleep difficulties, sexual issues, low energy levels, persistent and unexplained pain, and emotional distress (Jaffe et al., 2005).

Beside all of these, dissociation can arise as an important consequence of trauma. Many researchers have important findings about this. Considering the certainty of experiencing trauma and the frequent occurrence of dissociation as a result, it becomes evident that any framework focusing on psychological structure must include dissociation within its scope (Howell, 2005). In this scope, there is a vital common concept: childhood traumas and their leading to dissociation. This has been studied by a lot of researchers, and many important results have been found. When children undergo psychological trauma, if they are not able to handle it, they may be prone to detaching from themselves. They are able to keep their emotional equilibrium thanks to this space. Especially when the trauma is associated with the family's major caregivers, the dissociative defence mechanisms get more deeply embedded (Şar, 2000). In terms of developmental trauma, it can be said that children are prone to initiating maladaptive pathways such as dissociation, and it is argued that they do it in order to protect themselves from fragmentation in both mental and physical aspects (Schimmenti & Caretti, 2016). In the next part, dissociation and childhood traumas' associations will be examined more in detail.

2.1.3 Childhood traumas. There is highly comprehensive literature in terms of childhood traumas. Even though it has a broad scope, there are some significant points in certain clusters that contribute to each other. Childhood traumas encompass a spectrum of experiences endured before turning 18, such as physical, emotional, sexual, or neglectful abuse. They can also include parental divorce, the loss of a loved one, witnessing violence, accidents, or other traumatic events, as well as exposure to natural disasters. Additionally, childhood traumas can involve behaviours directed at a child by an adult, like a parent or caregiver, that violate social norms by being inappropriate or harmful (Herman, 2011). Kalmakis and Chandler (2014) propose that

adverse childhood experiences encompass a range of events during childhood, differing in severity and frequently enduring over time, that occur within a child's familial or social environment. These experiences result in harm or distress, consequently disrupting the child's physical and psychological well-being and developmental trajectory. In addition to that, unexpectedness is an important aspect of childhood trauma. Childhood traumas encompass occurrences that happen suddenly. impacting both the physical and mental well-being of the individual and posing a threat to their life (Pfefferbaum and Allen, 1998). Besides, childhood traumas can be transmitted from generation to generation. It was investigated by examining 97 various studies. In the analysis, it is claimed that in parents who experienced of physical abuse or witnessed violence,

it was noticed that there is a high risk of abusive or neglectful parenting practices. (Greene et al. 2020). In a meta-analysis by Malarbi et al. (2017), it is indicated that children who experienced traumatic situations showed cognitive impairments when it is compared to control groups. Especially, the most emphasized deficits were found in people who experienced and were diagnosed with PTSD, which shows a strong correlation between cognitive functioning and trauma-related psychological conditions.

There are several notable characteristics of childhood trauma. These include efforts to suppress thoughts, difficulties with sleep, heightened startle reactions, regression in development, irrational fears of everyday situations, intentional avoidance behaviors, episodes of panic, increased irritability, and a state of heightened alertness (Terr, 2003). The other notable aspect of childhood trauma is its prevalence. Individuals who reported experiencing one adverse childhood event were significantly more likely to report additional such experiences, with the likelihood ranging from 2 to 18 times higher compared to those who reported no adverse childhood experiences. There is an important indication that demonstrates a powerful connection between childhood trauma and the development of mental health problems in adulthood. A systematic review and meta-analysis of longitudinal cohort studies indicates that people who experience traumatic events during their early years of their childhood are at a greater risk for emerging different mental health disorders in their later life (McKay et al., 2021). Exposure to multiple traumas was prevalent among the population studied in the adverse childhood experience (Dong et al., 2004). Another

characteristic of childhood trauma is that it is observable across all cultures, social classes, ethnicities, and socioeconomic statuses (Bostancı et al., 2007). Furthermore, child abuse or neglect, which are primary elements of childhood trauma, can also hinder or limit the child's growth. Consequently, childhood traumas involve situations where social interactions, health, and safety are jeopardized (Taner and Gökler, 2004).

Even though it is highly comprehensive literature, there are some common points about trauma types. Childhood abuse and neglect, which are sub-dimensions of childhood traumas, can be described as caregivers' acts that can affect the child's development negatively (Fergusson and Lynskey, 1997). However, there is a primary difference between abuse and neglect. While abuse is active, neglect is passive or can be associated with deficiency (Merrick and Guinn, 2018). In addition to that, there is an important difference as well. While abuse includes three subtypes: emotional, physical, and sexual, neglect has two subtypes: emotional and physical (Herman, 2011).

2.1.3.1 Emotional abuse. According to the DSM-5, emotional abuse can be identified as verbal actions by parents or other caregivers that can damage a person's mental health (APA, 2013). In addition to that, emotional abuse can be described as verbal abuse and excessive expectations from children (Trickett et al., 2011). In particular, emotional abuse is as detrimental as physical abuse (Wolford et al., 2019). However, it is actually difficult to detect and define emotional abuse (Feerick and Snow, 2006).

2.1.3.2 Physical abuse. According to the DSM-5, physical abuse is defined as any intentional physical harm done to a child by a parent, caregiver, or other person with parental responsibility. This can take many forms, from minor bruises to severe fractures or even death. It can also involve biting, shaking, throwing, stabbing, choking, hitting, burning, or any combination of these techniques. (APA, 2013). Contrary to emotional and sexual abuse types, bodily signs of physical abuse can be observed; therefore, it is easier to experience physical abuse (McCoy and Keen 2009).

2.1.3.3 Sexual abuse. According to the DSM-5, sexual abuse can be described as any sexual conduct with a child for sexual gratification by a parent, caregiver, or

someone who is responsible for children (APA, 2013). Any sexual relationship between a child or adolescent, their parents, or someone in their family is called incest. This situation can damage the child's sense of trust and lead to a loss of security. The occurrence of sexual abuse, its intensity and forms, and the degree of closeness to the abuser, especially in the early developmental stages, can deepen the outcome of the harm that will be sustained (Ruppert, 2014).

2.1.3.4 Emotional neglect. Emotional neglect is characterized by failing to detect children's emotional needs and showing indifference or detachment (Stevens et al., 2018). It also involves not providing adequate love and warmth, neglecting support for the child's social development, and not teaching social norms (Liu and Merritt, 2018).

2.1.3.5 Physical neglect. Physical neglect can refer to situations such as not being able to meet the physical needs of children properly, allowing criminal situations, abandonment and educational neglect, medical neglect, a lack of supervision leading to sexual abuse, and failure to provide necessary conditions for all of them (Aktay, 2020). Moreover, physical neglect can also be defined as actions by a caregiver that may cause a child to develop behavioural, cognitive, emotional, or mental problems (Güdek, 2016).

2.1.4 Effects of childhood traumas. Childhood trauma can influence individuals in numerous dimensions, affecting their psychological, social, and physical well-being.

2.1.4.1 Physical effects. Before moving on to the psychological effects, it would be beneficial to understand the physical reflections of the psychological states that people are in. Experiencing toxic stress during childhood is linked to disruptions in various biological systems, including the immune, metabolic, and nervous systems (Slopen et al., 2014). Individuals with a background of childhood trauma experience a notably higher prevalence of digestive, musculoskeletal, and respiratory disorders, as well as migraine (Noteboom et al., 2021). In addition to these, specifically, childhood sexual abuse correlated with a heightened likelihood of developing cardiac disease,

while childhood neglect was linked to an elevated risk of diabetes and autoimmune disorders (Goodwin and Stein, 2004). In this context, childhood trauma can lead to illness through two primary pathways: prolonged stress and the adoption of coping mechanisms like overeating, smoking, substance abuse, and engaging in risky sexual behaviors, which obviously can cause major health problems (Felitti, 2009). Experiencing childhood traumas can lead to the development of chronic and/or unpredictable stress, causing alterations in both the developing brain and body (Kalmakis and Chandler, 2014). According to Grogan and Murphy (2011), exposure of children's developing brains to toxic stress can induce changes, and persistent and unresolved stress or trauma keeps the hypothalamic-pituitary-adrenal (HPA) axis activated, leading to heightened pituitary sensitivity and spikes in cortisol levels. In other words, continual activation of the HPA axis leads to alterations in brain structures, synapses, receptors, and neurohormones, resulting in reduced complexity of dendrites. Cortisol diminishes brain weight, disrupts myelination, and decreases the quantity of dendritic spines. Additionally, cortisol delays the maturation of auditory, visual, and somatosensory-evoked potentials and reduces the volume of the hippocampus, a critical area for memory functions. All these mean that trauma can change brain chemistry and eventually affect cognitive processes substantially.

2.1.4.2 Cognitive effects. Exposure to childhood traumas can impact cognitive processes as well as physical health. Exposure to trauma influences the expectations and priorities of children, shaping how they evaluate and digest information and how they structure their cognitive processes (Van der Kolk, 2003). Early childhood trauma can induce neurobiological alterations that affect human growth and result in substantial shifts in brain function. and these modifications in brain architecture play a role in cognitive and physical capabilities (Dye, 2018). Adults who report experiencing childhood trauma are more likely to exhibit negative self-influenced cognitive distortions (Browne and Winkelman, 2007). Besides, there can be some long-lasting effects of childhood trauma, regardless of any diagnosis related to trauma. Terr (2003) proposes four enduring traits linked to childhood trauma that persist regardless of future diagnosis in patients. These include recurrent or vivid memories of the traumatic incident, repetitive actions, fears specific to the trauma, and altered perspectives on individuals, life, and the future.

2.1.4.3 Psychological effects. Besides the physical and cognitive aspects of childhood trauma effects, there can be vital psychological consequences of childhood trauma exposure. According to the systematic review by Nemeroff (2004), there is a noticeable correlation between childhood adversities and the later emergence of significant psychiatric disorders in adulthood, and people who have experienced childhood trauma are more susceptible to being significantly affected by even minor stressors in adulthood, heightening their likelihood of developing mood and anxiety disorders. Children who faced four or more traumatic events were much more likely to meet the criteria for psychiatric disorders than those who experienced fewer or no traumatic events. For instance, the prevalence of major depression was below 10% among children exposed to two or fewer traumatic events, while over 25% of those who encountered four or more events met the diagnostic criteria for major depressive disorder (Copeland et al., 2007). The literature supports this data. According to the meta-analysis by Mandelli et al. (2015), neglect and emotional abuse are closely linked to depression.

2.2 Dissociation

2.2.1 What is dissociation? The Diagnostic and Statistical Manual for Mental Disorders (DSM-5) defines dissociation as a condition marked by disruptions in an individual's perception of their surroundings, their understanding of their own identity, and their emotional experiences, and their ability to recall memories (American Psychiatry Association, 2013). Dissociation encompasses a pathological phenomenon that undermines the cohesive formation of one's identity and is marked by discernible alterations in emotions, cognition, and action (Öztürk and Çalıcı, 2018). Another explanation is that dissociation involves a state where the usual coherence and unity within consciousness, memory, identity, emotions, bodily perceptions, and actions are disrupted, resulting in a sense of disconnection and fragmentation (Şar, 2018). Especially when it typically occurs in response to stressful situations or distressing stimuli, it disrupts or alters the cohesive functioning of processes like thought, memory, emotion, and identity, which normally operate together (Şar, 2007).

In other words, dissociation refers to the state of being mentally separated from oneself (Yu et al., 2010). This separation can be identified as the fragmentation of the traumatic experience and the separation of experiential and spiritual experiences (Howell, 2005). Dissociation, as opposed to association, involves a separation or detachment process (Şar, 2000). Dissociative experiences span a wide range, from minor instances like daydreaming and forgetfulness to more intricate conditions like dissociative identity disorder (Spiegel, 1997). More importantly, Dalenberg et al. (2022) posit that dissociation operates as a regular phenomenon extending beyond clinical contexts and shouldn't be solely confined to manifestations within clinical settings.

2.2.2 Different forms of dissociation. As stated in the previous section, dissociation can have variations. Generally, while dissociation symptoms are typically considered troubling in severe cases, they can also appear in everyday life at more moderate levels. For instance, routine forgetfulness, becoming absorbed in imaginary pursuits, or feeling uncertain about actions are examples of dissociative experiences in daily life (Ross et al., 1990). Even though dissociation initially functions as a protective mechanism at more moderate levels, it can evolve into a pathological form of dissociation (Spiegel et al., 2013). Pathological forms of dissociation are categorized as various mental health disorders depending on the symptoms (Şar, 2018). Pathological dissociation encompasses disturbances in identity, memory, and consciousness, indicating a breakdown in the integrative functions of these cognitive processes (Öztürk, 2009). According to the DSM-V, dissociation is classified into some primary categories: dissociative identity disorder, depersonalization and derealization, and dissociative amnesia (APA, 2013).

2.2.2.1 Depersonalization and derealization. Depersonalization denotes a range of experiences where individuals perceive significant alterations in their mind-body connection. This encompasses feelings of detachment from one's body, alterations in emotional experiences, shifts in perceptions of thoughts and bodily sensations, and the potential presence of a triggering incident. The most prominent features of depersonalization include sensations of feeling unreal or dreamlike and changes in sensory perceptions. (Spiegel & Cardeña, 1991). In depersonalization, individuals

experience a sense of estrangement from themselves, feeling disconnected from their own bodies. This detachment from reality can lead to existential questioning and a sense of losing control. As a result, individuals may encounter challenges such as decreased concentration, difficulty focusing, and struggles with complex cognitive tasks (Simoen, 2004). Besides, derealization causes a sense of detachment from one's surroundings. The familiar environment may appear unfamiliar, akin to an unfamiliar place. Individuals may perceive people around them as disappearing, moving away, or changing in size (Steinberg, 1995). According to the DSM-5, depersonalization involves a sense of detachment from one's thoughts, sensations, and emotions, as if observing oneself from an external perspective. Derealization, on the other hand, is characterized by perceiving people or objects in one's surroundings as unreal. These experiences must be persistent or recurrent, and during these episodes, the individual's capacity to assess reality must remain intact (APA, 2013).

2.2.2.2 Dissociative amnesia. Dissociative amnesia occurs when memories shift from conscious to unconscious realms, making them inaccessible voluntarily but retrievable under specific triggers like environmental cues or therapy (Spiegel & Cardeña, 1991). Dissociative amnesia differs from ordinary forgetting as it involves selective memory loss regarding personal information or emotional events (Steinberg, 1995). In other words, the incapacity to intentionally recollect personal narratives when there is no evident neurological impairment is problematic from the outset since it considers dissociation to be the main or exclusive pathogenetic process (Staniloiu et al., 2014).

2.2.2.3 dissociative identity disorder. According to the DSM-5, dissociative identity disorder can be distinguished by identity disruption characterized by the presence of two or more separate personality states. This disruption can be specified as a lack of continuity in self-awareness, fluctuations in emotions, behavior, consciousness, memory, perception, thinking, and sensory-motor abilities. These alterations may be evident to others or described by the individual themselves. Besides, dissociative identity disorder can be characterized by memory loss in everyday life along with the alterations (APA, 2013).

Besides all of these, Howell (2005) looks at dissociation from another perspective. Experiences such as meditation, positive trance states, or deeply engaging with a movie are also considered forms of dissociation. A key difference between adaptive or positive dissociation and pathological dissociation lies in voluntary control; adaptive dissociation is consciously initiated by the individual, and they can easily return to normal functioning. Another factor is whether dissociation helps integration or hinders it. Individuals highly prone to dissociation due to traumatic experiences may voluntarily enter states of trance or absorption, mentally distancing themselves from reality, such as becoming absorbed in patterns on a wallpaper. While dissociation serves as a coping mechanism for interpersonal violence, persistently avoiding painful experiences through dissociation inhibits their integration. Although dissociation can be adaptive and lifesaving during traumatic events, it can become maladaptive if relied upon for too long, leading individuals to restrict their lives. to avoid reminders of the trauma. As it can be understood from Howell's perspective, dissociation can be highly used as a defence mechanism. It has a significant impact on vital activities (Howell, 2005).

2.2.3 Dissociation is a defence mechanism. When dissociation is employed as a defence mechanism, individuals manage acute emotional stress by altering their typical sense of self-awareness. This can involve feeling detached from their body (depersonalization) or from their surroundings (derealization), or it can lead to amnesia or a fragmented sense of identity, such as in dissociative identity disorder (DID). During this process, stressors are pushed out of consciousness, which obviously helps (Bernstein and Putnam, 1986). Especially in more intense circumstances, such as after a traumatic event, individuals might mentally distance themselves from their emotions by intellectualizing the event, leading to emotional numbness in order to find relief (Bowins 2004). On one side, it can protect people from the intense emotional stress associated with the traumatic event, but on the other side, it also inhibits the integration of these separate traumatic experiences (Spiegel et al., 2011). According to McNally et al. (2000), individuals who experienced childhood sexual abuse and later repressed those memories for an extended period reported experiencing more dissociative symptoms compared to those who always remembered the abuse. In other words, dissociation may have been used as a suppression mechanism to protect the body and

to create coping strategies. McNally et al. (2000) state that individuals who experienced childhood sexual abuse and subsequently repressed the memory over an extended period exhibited higher levels of dissociative symptoms compared to those who always retained the memory of the abuse. So, the child could hide memories of abuse, leading to a divided personality and forgetfulness about traumatic events. They might also distance themselves from the traumatic aspects of reality, which could persist as enduring features of their personalities (Schore, 2009). Moreover, Blizard (1997) suggested that dissociation could serve as a mechanism for children with abusive caregivers to separate their perception of the nurturing figure from their perception of the abusive figure, and it is crucial for survival. As a result, the child might push memories of abuse out of their conscious mind, leading to a divided personality and forgetfulness of events linked to the trauma. They may also detach. from traumatic aspects of reality through experiences like depersonalization and derealization. These symptoms could become long-lasting traits of their personality.

2.2.4 Childhood traumas and dissociation. When the central nervous system is overwhelmed by the weight of events and emotions it cannot handle, children are more prone to dissociation. This leads to a tendency to cope in different ways, shielding themselves from the negative impacts of childhood traumas. Dissociative experiences, initially utilized to manage anxiety, can become habitual, especially when exposed to repeated severe psychological traumas. Children facing psychological traumas beyond their capacity to endure may develop a sense of detachment, viewing the experiences as happening to someone else rather than themselves. This distance helps them maintain their emotional equilibrium. Particularly when traumas involve primary caregivers within the family, the dissociative defence mechanism becomes increasingly ingrained (Şar, 2000). A neglected or abused child, especially by an attachment figure, establishes a system on which he or she relies in order to maintain the constantly disrupted balance and diminish fluctuating emotions. When the attachment figure is not able to provide a safe environment or protect the child against threats, dissociating from a frightening, neglectful, or abusive caregiver is a form of self-protection for the child in order to maintain the bond (Howell, 2005). Similarly, dissociation may be a vital feature that every person can use to have adaptability and functionality, as well as to protect their bonds. However, a person who is anticipated

to grow healthy can acquire a dissociative disorder because of the early-onset recurrent traumatization process (Lynn et al., 2019). Due to early-onset recurrent traumatization, children are prone to initiating maladaptive pathways such as dissociation, and they do it in order to protect themselves from fragmentation in both mental and physical aspects in the case of developmental trauma (Schimenti and Caretti, 2016). Child abuse, experiencing a fearful event, and violent trauma were the best predictors of dissociation (Dalenberg & Palesh, 2004). In a meta-analysis by Vonderlin et al. (2018), it was found that dissociation scores in victims of childhood abuse and neglect were higher; in addition, when different types of neglect and abuse occurred together, dissociation scores were much higher (Vonderlin et al., 2018).

Dissociative disorders are primarily caused by severe childhood events. First of all, the child starts to use the dissociative mechanism in an attempt to overcome the traumatic experience, but this mechanism develops into a diseased procedure over time (Putnam, 1997). Dissociative identity disorder is considered to result from a complex interplay of developmental and cultural influences, especially severe trauma experienced during childhood (Dorahy et al., 2014). Van der Kolk et al. (1996) argue that post-traumatic stress symptoms can be similar to dissociative disorder symptoms in terms of struggles with emotion regulation and memory processing. Foote et al. (2006) found that 71% of people who are diagnosed with dissociative disorder had a history of childhood physical abuse, and 79% had a history of sexual abuse. In another study, it was found that emotional abuse was high in the group diagnosed with depersonalization disorder. Besides, emotional abuse predicted dissociative experiences solely. However, this relationship was stronger when emotional and sexual abuse occurred together (Simeon et al., 2001).

2.3 Relational Needs

It is impossible to thrive without relationships; surroundings should provide people chances to form and engage in them throughout their lives. Everyone, especially children, needs relationships in which the other person is actively present. It is required the conscientious presence of someone who is sensitive and responsive to our needs, provided that those needs are satisfied properly (Clark, 1991). From the moment we're born until we die, our biological drive for attachment, our urge to create

relationships, guides us. While a child can survive physically, the absence of decent human contact makes it impossible for them to operate emotionally within a social context. Without interpersonal contact and emotional attachment, children cannot develop humanly appropriate behaviours or interactions. Even adults create attachments with people because it is believed that relationships can fulfil our various needs. (Erskine, 2011). Besides, as humans, interacting with people enhances to weaken defence mechanisms and integrate and accept the rejected parts of personality. By improving interaction, past disowned, undiscovered, or unsolved experiences are embodied into a unified sense of self (Erskine and Trautmann, 1996).

Relational needs are an essential component of human interaction, and they are needs that can be met through relationships. They emerge with interaction and improve interaction. Relational needs are associated with the expectations and needs of people from each other in every relationship. All people are familiar with relational needs. This experience is a part of relationships in everyday life and endures from the beginning to the end, not at a specific age or period of life. Besides, the need for relationships does not decrease with time; it is fundamental to humanity. Another significant point about relational needs is that they appear in moments when attention is not paid instead of conscious awareness. These feelings are associated with a sense of emptiness, loneliness, and longing. If the need is met, satisfaction is experienced, but if the need is not met, it can create disappointment and anger. If the need continues to be unsatisfied, hope and energy loss appear, and the person's habitual beliefs about life can be reinforced (Erskine, 2011). If there are absences, disruptions, or a lack of cooperation in relationships with others, the exploration movement becomes frustrated. People tend to cope with situations habitually, and these coping strategies lead to interruptions in the internal and external parts of the self, dissolution, and a tendency toward denial in significant aspects of the self (Erskine et al., 2015).

In psychotherapy, it is actually essential to be attuned to clients' relational needs across all stages of life. It is important to understand the significance of allowing individuals to make choices and express themselves fully and authentically, especially during psychotherapy. By being attuned, it can foster a therapeutic relationship that effectively addresses both the unsatisfied relational needs of the past and the current needs of the client (Erskine, 2019).

2.3.1 Erskine's relational needs. In 1972, Richard G. Erskine, while working as a professor at the University of Illinois, started to formulate the foundational ideas of integrative psychotherapy. He further researched and refined this relational and integrative approach to psychotherapy. In 1996, he and his colleagues stated eight relational needs, and these relational needs are one of the central components of integrative psychotherapy (Erskine and Trautmann, 1996). These are the need for security; validation, affirmation, and significance within a relationship; acceptance by a stable, dependable, and protective other person; the confirmation of personal experiences; self-definition; having an impact on the other person; and having the other initiate and express love. However, and importantly, they are not fundamental survival needs such as food or air, but instead they are the crucial elements that improve life's quality and enhance a sense of self within relationships. Relational needs are fundamental aspects of universal connections; in addition, these needs are not specific to childhood or to a specific developmental period; they are continuing aspects of relationships that are consistent throughout our daily lives. Besides, when relational needs are not fulfilled, the desire for fulfilment starts to be more intense and is experienced as a deep feeling of ongoing emptiness and persistent loneliness. Lengthened unfulfillment of these needs can lead to feelings of frustration, aggression, or anger (Erskine and Trautmann, 1996).

2.3.1.1 Need for security. The experience of having our physical and emotional vulnerabilities protected involves accepting that our different needs and emotions are natural. Security is the feeling of being safe (Erskine and Trautmann, 1996). The need for security in a relationship is associated with the person being able to be themselves as they are without the fear of losing the respect and love of the other people. It is risky for people to be open about their thoughts, feelings, and memories and to share them with others. This openness means showing defences and being open to any kind of opinion the other party can show. Therefore, how the other person reacts to this openness, whether they are really trustworthy or not, causes them to be shyer at the beginning when establishing relationships with people (Erskine et al., 2015).

Attuning to the need for security means the therapist should be aware of how important this is and act both emotionally and behaviourally in a way that assures a sense of safety in the relationship (Erskine, 2001). The need for security is even more

crucial in psychotherapy than in social relationships. Clients reveal profoundly personal feelings, thoughts, memories, and desires in therapy, giving up their defences. Therefore, the therapist's role in creating and protecting a secure environment is crucial, including both verbal and non-verbal communication during sessions. Clients must feel certain that their therapist will not abandon them and will continuously support their well-being. They also need to be sure about acceptance and respect, especially when discussing sensitive subjects like shame or inadequacy (Erskine et al., 2015).

2.3.1.2 Validation, affirmation, and significance within a relationship. Being cared for and valued is essential in every relationship. However, significance involves feeling profoundly understood and valued as a relational need (Erskine et al., 2015). The urge to have another person accept and validate the significance of our inner emotional experiences and fantasies is vital. This involves realizing that our emotions play a key role in internal and interpersonal communication. It requires having our relational needs accepted as natural as well. The therapist's emotional responsiveness to the client's inner world is crucial to validating and affirming the client's emotions, providing reassurance, and normalizing their relational needs (Erskine and Trautmann, 1996).

2.3.1.3 Acceptance by a stable, dependable, and protective other person. The need for acceptance involves being valued by someone who is stable, reliable, and protective. When this need is unsatisfied, it may cause continuous difficulties in development and life (Erskine et al., 2015). Besides, acceptance from a consistent, reliable, and protective person reflects a search for protection and counselling, often leading to idealizing that person. In psychotherapy, this idealization can represent a quest for protection from the negative impact of a controlling or humiliating parent ego state on the vulnerable child ego state. It may also be a search for preservation against one's own fluctuating emotions or exaggerated fantasies (Erskine and Trautmann, 1996).

2.3.1.4 Confirmation of personal experiences. The need for experience to be validated often comes up as a desire to be with someone who shares similar life

experiences and understandings. Their shared life experiences contribute to confirmation and validation (Erskine and Trautmann, 1996).

Attunement is accomplished when the therapist values the client's need for validation by carefully sharing relevant personal experiences, including their own vulnerabilities or related feelings and fantasies, in a client-centered way. It also includes being present and engaged with the client (Erskine and Trautmann, 1996). Furthermore, presence is established via the psychotherapist's persistent, attuned responses to both the client's verbal and non-verbal interpretations. It includes the therapist being careful with the client's emotions, being affected by them while staying responsive, and preserving calmness and patience without being anxious, depressed, or angry. Presence reflects the therapist's complete engagement, both internally and externally, with the client (Erskine, 2011).

2.3.1.5 Self-definition. Self-definition as a relational need includes both the urge to understand and communicate people's own individuality and to receive appreciation and acceptance from other people. Self-definition indicates to the way individuals express their identity through sharing their choices, interests, and ideas, seeking to do so without rejection or humiliation (Erskine and Trautmann, 1996). Being able to have a unique self and appreciate oneself is often not a need that can be easily satisfied. The negative responses to efforts for independence by adults during childhood and huge expectations make it difficult for a person to be oneself and express this entirely. Erskine et al., 2015). Therapeutic attunement happens when a therapist consistently encourages a client's expression about their identity interpretations and validates the need for self-definition. This includes the therapist being continuously present, interested, and respectful, even when there are disagreements between them (Erskine and Trautmann, 1996).

2.3.1.6 Having an impact on the other person. Having an impact on the other person means influencing them in a way that creates a desired effect. A person's sense of capability in a relationship comes from their ability to attract the other's interest and attention, what the other person finds important, and create changes in the other person's feelings and behaviours (Erskine and Trautmann, 1996).

Having an impact on the other person is also experienced in the relationship between the client and the therapist in psychotherapy, as they have an impact on each other. If therapists are in consensus with the clients' issues and needs and participate properly in the clients' issues in therapy, they are affected by what the clients bring about, do, and feel. In the same way, clients are affected by the therapists. When this interaction is turned to the clients' benefit by using the therapists' professional competencies, it contributes to the clients' psychological growth and solving their problems (Erskine et al., 2015).

2.3.1.7 Having the other initiate. Having the other initiate is the urge to create interpersonal contact with someone else. It involves contacting someone in a way that acknowledges and validates the other person's significance in the relationship (Erskine and Trautmann, 1996). If only one part of the relationship starts a step in a relationship, the balance in the relationship will be disorganized for that person, the relationship will become incompetent, and its value will be inquired about after a while (Erskine et al., 2015).

This need is satisfied by verbal or nonverbal approaches when the therapist takes the initiative to enhance the relationship when the client needs this initiation in psychotherapy. In this way, the client is supported to make progress in therapy. The therapist taking the initiative when it is necessarily makes the therapist's participation in the process reasonable for the client. In this way, the therapist shows the client that he or she cares enough to actively take responsibility and guide him or her when it is necessary. When this need is not satisfied, the client may feel that he or she is not understood. The therapist taking the initiative in this way may be effective when it is done at the right time and in the right way properly (Erskine et al., 2015).

2.3.1.8 Expressing love. Love is generally expressed through subtle gestures like gratitude, appreciation, affection, or actions done for the other person. In psychotherapy, the need to offer love, from children to parents, siblings, or clients to therapists, is commonly underestimated. When love cannot be expressed, it blocks the ability to show one's real identity within relationships (Erskine and Trautmann, 1996).

It is actually quite normal for clients to feel strong feelings toward their therapist in psychotherapy. However, therapists often consider the interpretation of

these feelings by clients as a transference based on past relationships, manipulation, or a violation of the boundaries of the therapy relationship. However, as the client's contact with himself or herself enhances and increases during the therapy process, the client feels that it can actually be expressed. Therefore, the expression of these genuine feelings directed toward the therapist means that the client integrates with himself or herself and establishes connection with himself or herself within the therapeutic relationship. At this point, if the therapist accepts the client's expressions of love and gratitude as a normal part of an essential relationship and skilfully accepts them, the client's need to express love will be satisfied properly (Erskine et al., 2015).

2.3.2 Childhood trauma and relational needs. Traumatic life events demolish people's daily life systems, connections, and meaning and can make people vulnerable. People's sense of self is fragmented, and their relationships are also destroyed due to traumatic life events. The fragmented sense of self and loss of control bring about a loss of autonomy and self-esteem as well. The self can only be rebuilt in relationships with others. In this sense, the social relationships of people who have been exposed to trauma and the support they accept are very significant. A supportive network of relationships enhances the recreation of trust and protection, which are the fundamental issues after trauma (Herman, 2007). In addition to that, there are several studies that indicate the importance of social support in childhood, specifically in the face of childhood trauma and maltreatment. Social support plays a crucial role in shaping and diminishing the long-lasting effects of childhood maltreatment. It enhances the ability to mediate and buffer the adverse effects, contributing a source of stability and positive reinforcement that can counterbalance some of the negative consequences experienced in childhood (Sperry and Widom, 2013). Furthermore, it is indicated that having constant social support can act as a protective buffer against the cumulative effects of interpersonal traumas experienced throughout both childhood and adulthood. By contributing emotional and practical assistance, social support may decrease the overall impact of traumatic experiences and help individuals manage their consequences more effectively (Schumm, 2006). In another study, it is demonstrated that perceived social support has a statistically significant mediating effect on the effect of childhood trauma in adolescents. All these mean that the existence and recognition of social support play a significant role in affecting how childhood trauma

functions, emphasizing its importance in buffering and moderating these experiences (Uzun et al., 2024). All of these studies show significant parallels with Erskine's approaches. They altogether display how their findings adjust with Erskine's theories and concepts, emphasizing the coherence between their results and his approaches. This alignment highlights the relevance of Erskine's ideas within the immense context of the research.

When people who have experienced trauma formerly also encounter a lack of meaningful connection in their caregiving relationships, clinical examinations propose that the trauma is unlikely to be entirely integrated. The unsatisfied needs for empathy, caregiving, and protection during the traumatic process are not appropriately admitted or validated, which heightens the impact of the trauma. This causes the experience of being disconnected from conscious awareness, and parts of the self may also be isolated in more severe cases. To regulate this, the person uses a complicated bunch of defences to restrict internal awareness and contain the traumatic experience associated with emotions and unsatisfied relational needs. These components remain within the ego as a separate part of consciousness, unattainable and disconnected. Consequently, the unresolved trauma cannot be integrated with subsequent experiences and learning (Erskine, 1993).

After experiencing trauma, people profoundly need someone who is supportive and who can empathize with their intense emotions and unsatisfied needs. This person should be receptive to difficult expressions, enable a clear understanding of the situation, and assure continued safety through their enduring existence and problem-solving (Erskine, 1993). Fulfilled relational needs require the presence of another person who is both aware of and responsive to relational needs (Erskine and Trautmann, 1996).

The relationship between relational needs and traumatic stress symptoms is negatively correlated. Since the intensity of traumatic stress increases, the satisfaction of relational needs decreases, or as the satisfaction of relational needs increases, the intensity of traumatic stress decreases (Toksoy, 2021).

2.3.3 Dissociation and relational needs. Dissociation is a complicated defence mechanism that helps preserve mental and physical harmony. In the presence of trauma, it causes people to mentally and emotionally disengage from the experience

while continuously adapting situations physically and behaving in a way that they satisfy external expectations (Erskine, 1993). Each split in a people's sense of self shows a primitive and urgent effort to balance and regulate themselves, addressing the need to deal with or compensate for past failures in important relationships (Erskine, 2019).

Based on Erskine's clinical experience, it is found that dissociation generally derives not only from traumatic events but also from the absence of a supportive and healing relationship. Respectively, clients who display dissociation can take advantage of a therapy approach that focuses on relational approaches to treatment. It means engaging with clients through thoughtful discovery of their experiences, being attuned to their emotions and developmental stage, and contributing with a safe, reliable presence. This approach contains acknowledgement, validation, normalization, and a persistent therapeutic existence with the therapist (Erskine, 1993). In addition to that, dissociation generally starts when people's surroundings fail to provide fundamental care and emotional support. For instance, in many incest cases, a child can be told that they "enjoyed it" or have their withdrawal and depression neglected by close surroundings. Without the vital aspects of understanding, affirmation, and empathetic interaction from an important figure, children can try to bury their feelings, needs, and memories so intensely that they may generally even forget their need for relationships. This situation causes ego fragmentation and dissociation at the end (Erskine, 1993). In addition to these, O'Reilly-Knapp (2001) suggests that early traumatic and neglectful experiences can cause the child to develop a disintegrated sense of self and see the world as not safe. These integrated parts of the self that are created because of these experiences evolve dissociated mechanisms and are stored as "encapsulated" mental structures, which are fragmented from conscious awareness as dissociative mechanisms.

Being in contact enhances the ability to break down defences and support the integration of dissociated parts of the personality. By encouraging this connection, deeply unaccepted, unconscious, and unresolved parts can become integrated into a unified self. This integration allows individuals to approach each moment with spontaneity and adaptability, examining the challenges of life and interacting with others without depending on dissociation as a defence mechanism (Erskine, 1993). Contact operates as the mechanism through which the process of dissociation can be

dealed. It evolves into a tool to integrate formerly concealed traumatic experiences, unsatisfied needs, and fundamental emotions by reorganizing this connection. This integration supports creating a cohesive and unified sense of self, thereby examining and resolving fragmented aspects of identity (Erskine, 1993).

A therapeutic relationship defined by genuine contact is vital. Traumas that cause dissociation generally emerge from situations in which clients are unable to defend their physical and emotional safety. Instead, they experienced a deficiency of impact, acceptance, and efficacy. Instead of negotiating to satisfy their needs, these clients can expect to be either overwhelmed or compelled to resort to manipulation and control, containing dissociation. Therefore, creating meaningful contact is especially important in the first stages of therapy with clients who are dissociated, since their mental and physical well-being has been compromised (Erskine, 1993).

Chapter 3

Methodology

3.1 Research Design

In the research study, a quantitative correlational design utilizing a cross-sectional model was applied to examine the degree to which relational needs satisfaction, childhood trauma, and dissociation are related to each other. This approach was used to determine how these variables covary and to analyze the nature of their relationships. By examining these connections, the study aimed to acquire a deeper understanding of how satisfaction of relational needs and childhood traumas are associated with dissociation.

3.2 Setting and Participants

Power analysis was performed by using the GPower 3.1.9.4 program before data collection started. According to this analysis, 134 participants needed to be reached. However, data was collected from 346 samples. In order to provide normality, some outlier samples were excluded. 313 samples whose ranged between 18 and 65 years old were analysed at the end of this exclusion process.

Of the participants, 51.4% (n = 161) were female and 48.6% (n = 152) were male. Among participants, 51.8% (n = 162) were married, 41.5% (n = 130) were single, and 6.7% (n = 21) were divorced. In terms of education levels, participants are asked their last level of education that they are graduated from. There were no participants who are only graduated from primary school. 1.3% (n = 4) were graduated from middle school, 18.4% (n = 57) were graduated from high school, 59.4% (n = 185) were graduated from bachelor, 17.3% (n = 54) were graduated from master degree, and 4.2% (n = 13) were graduated from doctoral degree. In terms of age groups, 12.5% (n = 39) were between 18 and 14 years old, 42.5% (n = 133) were between 25 and 35 years old, 22.5% (n = 69) were between 26 and 45, and 23% (n = 72) were between 46 and 65 years old.

Table 1

Frequency and Percentage Distributions of Participants' Demographic Information

Variable	Category	N	%
Gender	Female	161	51.4
	Male	152	48.6
	Non-Binary	0	0
Education Level	Primary School	0	0
	Middle School	4	1.3
	High School	57	18.2
	Bachelor	185	59.1
	Master Degree	54	17.3
	Doctoral Degree	13	4.3
Marital Status	Married	162	51.8
	Single	130	41.5
	Divorced	21	6.7
Age Group	18-24	39	12.5
	25-35	133	42.5
	36-45	69	22
	46-65	72	23

3.3 Procedures

3.3.1 Data collection instruments. Informed Consent Form, Demographic Information Form, Childhood Trauma Questionnaire (CTQ-33), (α =.75), Dissociative Experiences Scale (DES) (α =.91), and Relational Needs Satisfaction Scale (RNSS),

(α =.82). Participants were given scales to complete; each assignment was given in sequence.

3.3.1.1 Demographic form. The Demographic Information Form (detailed in Appendix B) was designed to collect comprehensive details about the participants. This form included questions aimed at collecting information on different aspects, such as the participants' age, gender, educational background, socioeconomic status, and marital status. This data was aimed at providing a detailed understanding of the participants' backgrounds and contexts.

3.3.1.2 Childhood trauma questionnaire. The Childhood Trauma Questionnaire (CTQ) was initially developed by Bernstein and colleagues in 1994 and contains a set of 33 items designed to examine various forms of childhood maltreatment. The scale measures five different types of abuse and neglect: childhood sexual abuse, physical abuse, emotional abuse, emotional neglect, physical neglect, and overprotection/overcontrol. The original study reported Cronbach's alpha values ranging from.79 to.94, showing strong reliability across the different subscales (Bernstein et al., 1994). In 2012, Şar and colleagues conducted a validity and reliability study of the scale in Turkish, adapting it for use with a Turkish-speaking population (Şar et al., 2012). The Turkish version (see Appendix C) of the scale showed internal consistency coefficients for its subscales ranging between.64 and.87. This range indicates different levels of reliability for the different types of maltreatment assessed in the questionnaire. For the overall scale, the Cronbach's alpha coefficient was found to be.75.

3.3.1.3 Dissociative experiences scale. The Dissociation Experiences Scale (DES) is a 28-item self-report scale that has been successfully utilized in screening and rating dissociative symptoms. The DES has three subscales: absorption (questions 2, 14, 15, 16, 17, 18, 20, 22, 23), amnesia (questions 3, 4, 5, 6, 8, 10, 25, 26), and depersonalization-derealization (questions 7, 11, 12, 13, 27, 28) (Bernstein, Putnam 1986). Depersonalization is characterized as a person's disconnection from their own reality, while derealization is characterized as a person's disconnection from the reality of the world surrounding them. In the validity and reliability study, the test-retest

reliability was.84, and Cronbach's alpha values for the items varied between.19 and.75. The Turkish adaptation, validity, and reliability study of the scale was conducted by Yargıç, and colleagues in 1995 (see Appendix D). The Cronbach's alpha value of the scale was calculated as.91. The test-retest correlation coefficient was.77 for the entire scale and varied between.27 and.80 for each of the questions (Yargıç et al., 1995).

3.3.1.4 Relational need satisfaction scale. The Relational Needs Satisfaction Scale (RNSS) was developed by Zvelc et al. (2020) to evaluate the extent to which individuals' relational needs are fulfilled, drawing on Richard Erskine's conceptualization of eight core relational needs. This scale comprises 20 items designed to assess satisfaction across five distinct dimensions: authenticity (e.g., "I hardly have to hide anything in the company of people close to me"), support and protection (e.g., "I know a capable individual who would help me if I found myself in trouble"), having an impact (e.g., "I feel that I have an influence on others"), shared experience (e.g., "I know people who experience some things similarly to me"), and initiative from others (e.g., "Other people often help me even if I do not specifically ask them to"). The scale is designed to provide a comprehensive measure of relational needs satisfaction, with a high overall reliability score of Cronbach's alpha of .90. The reliability coefficients for each subscale are as follows: Authenticity (α =.80), support, and protection (α =.85), having an impact (α =.81), shared experience (α =.73), and initiative from others (α =.83). Zvelc et al. (2020) indicated that relational needs satisfaction has positive and significant correlations with secure attachment styles, self-compassion, and life satisfaction. Participants using the RNSS rate each item on a scale from 1 (completely disagree) to 5 (completely agree) according to their experiences in interpersonal relationships. To measure the scores for each subscale, responses are summed and then averaged. The total relational needs score is calculated by summing the responses to all items and dividing by the total number of items. Higher scores indicate a greater fulfilment of relational needs. The Turkish adaptation of the RNSS was validated by Toksoy et al. (2020) (see Appendix E). This study confirmed that the 20 items and the five subscales of the original RNSS are applicable and valid for use with Turkish participants. The test-retest reliability of the scale was found as 0.82, showing good consistency over time. The reliability for the Turkish version's subscales were as follows: authenticity (.75), support and protection (.80),

shared experience (.75), having an impact (.70), and initiative from others (.71). The internal consistency of the entire scale was.83, with the following subscale internal consistency scores: authenticity (.63), support and protection (.79), shared experience (.73), having an impact (.78), and initiative from others (.51).

3.3.2 Data collection procedures. To collect data for the study, ethics approval was given by Bahçeşehir University's Research Ethics Committee (see Appendix F). The data collection was managed using Google Forms (an online survey platform). The survey link was distributed via media channels such as WhatsApp and Instagram. To increase data collection, participants were encouraged to share the survey with their networks. Participation in the study was anonymous; personal information was not collected to ensure confidentiality and privacy. Participants were informed of their right to withdraw from the study at any time, and their participation was voluntary at all. Firstly, participants completed an informed consent form (see Appendix A), which gives details of the study's objectives, confidentiality affirmation, and their right to withdraw, and validated their voluntary participation. After providing consent, participants continued to complete the Demographic Information Form, Childhood Trauma Questionnaire (CTQ-33), Dissociative Experiences Scale (DES), and Relational Needs Satisfaction Scale (RNSS). The whole process took approximately 15 minutes.

3.3.3 Data analysis procedures. The collected data was analysed using the SPSS 26.0 software. First of all, a reliability analysis was conducted on the scales conducted in the research. In the second stage, the data's adherence to a normal distribution was analysed by examining skewness and kurtosis values. At first, it was found that some of the scales were not distributed normally according to skewness and kurtosis values. Outlier exclusions were applied. CTQ-33 were still not distributed normally. When possibilities were evaluated optimally, it was decided to apply the logarithm for CTQ-33 values. Then all these values reached normality. When the data are appropriate for normal distribution. Parametric analyses were used. Pearson Correlation analysis was applied to evaluate the relationship between the scales (CTQ-33, RNNS, and DES). Besides relational needs satisfaction's subscales are included in correlation analysis to provide better understanding how these subscales are related

with other variables. Lastly, hierarchical regression analyses were applied to understand the relationship between variables. Besides, multicollinearity and autocorrelation were checked. There should not be autocorrelation and multicollinearity while conducting regression analyses. In terms of autocorrelation, the Durbin-Watson test was used to decide whether there is autocorrelation or not (Durbin Watson, 1950). Durbin-Watson scores were between 1.323 and 1.553. Values between 1 and 3 are acceptable and closing 2 shows that risk for autocorrelation is decreasing (Field, 2024). In terms of multicollinearity, Variance Inflation Factor (VIF) values were checked. Values below 5 show that there is no multicollinearity (Tabachnick & Fidell, 2001). VIF values were between 1 and 1.170, which indicates that there is no multicollinearity problem.

3.3.4 Reliability, validity, and normality. Before starting data analysis, reliability, validity and normality were checked. First of all, in terms of reliability, it was found that Childhood Trauma Questionnaire, Relational Needs Satisfaction Scale and the subscales of this, and Dissociative Experiences Scale were sufficiently reliable. Cronbach's Alpha value for Childhood Trauma Questionnaire is α =.71. Cronbach's Alpha value for Relational Needs Satisfaction Scale is α =.92. When subsacles' realiabilities are taken into consideration, Authenticity is α =.71, Support and Protection is α =.869, Having an Impact is α =.827, Shared Experience is α =.801, Initiate From Others is α =.798. Cronbach's Alpha value for Dissociative Experiences Scale is α =.91. In addition to that, according to all validity and reliability analysis scores, all scales are valid and reliable.

In terms of normality, skewness, and kurtosis values are checked. After outlier exclusion and applying logarithm to CTQ-33, all scales were distributed normally.

Table 2

Reliability Analysis and Skewness and Kurtosis Values of Participants' Scale Scores

Scale	α	Skewness	Kurtosis
lgCTQ-33	.71	.908	1.396
RNNS	.92	1.095	.717

Table 2 (cont.d)

Scale	α	Skewness	Kurtosis
Authenticity	.708	-.823	1.012
Support and Protection	.869	-1.441	1.913
Having an Impact	.827	-.761	-.094
Shared Experience	.801	-.594	-.094
Initiate From Others	.798	-.072	-.649
DES	.91	-.537	.134

3.4 Limitations

Even though considerable efforts were made to design a robust study, the current research still encounters a couple of limitations. These restraints might impact the overall interpretations and findings, featuring areas that could benefit from further exploration. In spite of striving for meticulousness in the methodology, certain factors could have affected the results, and accepting these limitations is significant for a thorough understanding of the study's implications.

First of all, the research is designed to examine the relationship between childhood traumatic experiences and dissociative experiences, with the addition moderating role of relational needs satisfaction While the correlational analyses used in this study efficiently capture the overall association between childhood trauma and dissociative experiences, they include the lack of specific subscales. As a result, it does not specify which particular subscales might impact each other. In addition to this, even though the study analyses the direction and strength of the association when relational needs satisfaction is added into the study, it does not predict any causality. This restriction makes it difficult to give exact conclusions about cause and effect, suggesting that the understanding of the data.

Another limitation is that the questionnaires were distributed via online platforms, and there were no restrictions other than age requested from those who filled out the survey. Besides, the study is distributed via university chat groups and social

media with snowball sampling. The online forms were distributed without any consideration of the participants' educational backgrounds. As a result of this, 70.6% of participants have a college or higher degree. This presents a significant limitation for the study since it limits the ability to generalize the results through different educational backgrounds. Without controlling for education background, the results might show biases or cause problems to generalize results to the extended population.

Another important limitation of the current study arises from the using of self-report questionnaires as a research tool. These instruments are inherently problematic because they rely solely on participants' own assessments. Self-report measures, because of their potential for bias, cannot objectively examine the research variables, which weaken the study's validity and reliability and restrict the ability of generalization of the findings. As a consequence, the correlation between scale scores may have been affected by conservative or limited responses, specifically related to childhood traumatic experiences scores.

The empirical studies on Erskine's relational needs model, which is the subject of this research, are in their early stages. This situation resulted in using a more conceptual framework while evaluating the analyses. The lack of adequate research articles on this subject in the literature created limitations in the discussion of the findings.

Chapter 4

Findings

4.1 Descriptive Statistics

According to the descriptive statistics, it can be shown that the minimum and maximum scores of CTQ-33 are between 43 and 102, and their mean score is 55.88 with an 8.33 SD. In terms of RNNS, minimum and maximum scores of RNNS are between 40 and 100, and its mean score is 79.96 with a 10.72 SD. Lastly, when DES scores are examined, it can be seen that its minimum and maximum scores of DES are between 0 and 41 with an 8.78 mean and 8.78 SD.

Table 3

Descriptive Statistics of Participants' Childhood Trauma Questionnaire, Relational Needs Satisfaction, and Dissociative Experiences Scale Scores

Scale	Minimum Score	Maximum Score	M	SD
CTQ-33	43	102	55.88	8.33
RNNS	40	100	79.96	10.72
DES	0	41	8.78	8.78

4.2 Correlational Analyses of the Relationship Between the Scale Scores

Before starting regression analyses, it needed to be checked whether there was a correlation between scale scores or not. Therefore, Pearson Correlation is applied to all scale scores. Correlation coefficients were shown in Table 4. According to the analyses, all these correlations are significant. The first hypothesis that there is a positive relationship between childhood traumatic experiences and dissociative experiences was analysed, and it is founded that there is a positive, significant relationship between CTQ-33 and DES scores ($r = .256$, $p < .00$). Specifically, people

who have more childhood traumatic experiences are more likely to have dissociative experiences. Therefore, the first hypothesis is accepted. The second hypothesis that there is a negative relationship between childhood traumatic experiences and satisfaction of relational needs was analysed, and results indicated that there is a negative significant relationship between CTQ-33 and RNNS scores (r = -.381, p<.00). In other words, people who have more childhood traumatic experiences are more likely to not have satisfaction of relational needs. Thus, the second hypothesis is accepted. The third hypothesis that there is a negative relationship between satisfaction of relational needs and dissociative experiences was analysed, and it is founded that there is a negative significant relationship between RNNS and DES scores (r = -.345, p<.00). Particularly, people who have not satisfaction of relational needs are more likely to have dissociative experiences. Therefore, the third hypothesis is accepted.

Besides the main scale scores, relational needs satisfaction scale's subscale's correlation analyses are applied. Authenticity subscale is significantly negatively correlated with CTQ-33 (r = -.267, p<.00) and significantly negatively correlated with DES (r = -.320, p<.00). Support and Protection subscale is significantly negatively correlated with CTQ-33 (r = -.325, p<.00) and significantly negatively correlated with DES (r = -.130, p<.00). Having an Impact subscale is significantly negatively correlated with CTQ-33 (r = -.242, p<.00) and significantly negatively correlated with DES (r = -.278, p<.00). Shared Experience subscale is significantly negatively correlated with CTQ-33 (r = -.313, p<.00) and significantly negatively correlated with DES (r = -.305, p<.00). Initiate from Others subscale is significantly negatively correlated with CTQ-33 (r = -.337, p<.00) and significantly negatively correlated with DES (r = -.342, p<.00).

Table 4

Correlational Analysis of the Relationship Between the Scale Scores of the Participants

Variables		1	2	3	4	5	6	7	8
1-LgCTQ-33	r	-	-.381*	-.267*	-.325*	-.242*	-.313*	-.337*	.256*

Table 4 (cont. d)

2-RNNS	r	-	.757*	.734*	.795*	.827*	.829*	-.345*
3-Authenticity	r		-	.468*	.516*	.525*	.505*	-.320*
4-Support and Protection	r			-	.408*	.525*	.435*	-.130*
5-Having an Impact	r				-	.619*	.553*	-.278*
6-Shared Experience	r					-	.639*	-.305*
7-Initiate from Other	r						-	-.342*
8-DES	r							-

* Correlation is significant at the 0.01 level

4.3 Hierarchical Regression Analyses for Mediating Effect of Relational Needs Satisfaction

In order to test the fourth hypothesis, hierarchical regression analyses were applied. It is investigated that whether satisfaction of relational needs has a mediating role in the relationship between childhood traumatic experiences and dissociative experiences or not. Childhood traumatic experiences were taken as the independent variable, relational needs satisfaction as the mediator variable, and dissociative experiences as the dependent variable. As it can be seen in Figure 1, it is expected that childhood traumatic experiences predict dissociative experiences first. Then it is expected that children who have traumatic experiences predicted relational needs satisfaction, while the relational needs satisfaction scale predicted dissociative experiences at the same time.

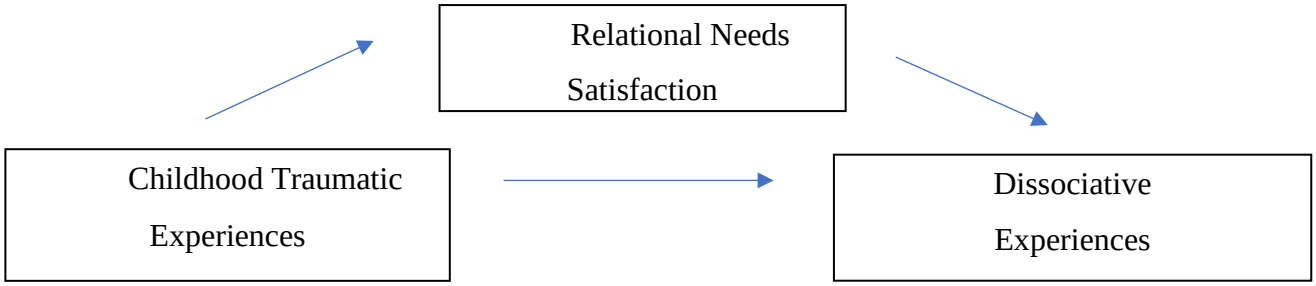

Figure 1. Model for the mediating effect of relational needs satisfaction on the effect childhood traumatic experiences on dissociative experiences.

In the first step of hierarchical regression analyses, the direct effect is examined. It is investigated that childhood traumatic experiences effect on dissociative experiences. First-step regression analysis indicated that CTQ-33 has a significant positive effect on DES, emphasizing that higher scores on the CTQ-33 are related to higher DES scores. However, the low r^2 value suggests that while the relationship is significant, it only means for a small portion of the variance in DES. The model resulted in an R^2 value of .66, indicating that childhood traumatic experiences explained 6.6% of the variance in dissociative experiences. The model's significance was confirmed with $F(1,311) = 21.887$, $p < 0.001$. The regression coefficient was $b = 0.256$, $p < 0.001$.

Table 5

Regression Analysis for Assessing the Effect of CTQ-33 on DES

Variable	B	SE	β	t	p	R	R^2
CTQ-33	37.388	7.992	256	4.678	.00	.256	.066

Dependent Variable: DES

In the second step of hierarchical regression analyses, the mediator effect is investigated. It is investigated that childhood traumatic experiences effect on relational need satisfaction. Second-step regression analysis indicated that CTQ-33 has a

significant negative effect on RNNS, emphasizing that higher scores on the CTQ-33 are related to lower RNNS scores. The model resulted in an R^2 value of .145, indicating that childhood traumatic experiences explained 14.5% of the variance in relational needs satisfaction. The model's significance was confirmed with $F(1,311) = 52.895$, $p < 0.001$. The regression coefficient was $b = -.381$, $p < 0.001$.

Table 6

Regression Analysis for Assessing the Effect of CTQ-33 on RNNS

Variable	B	SE	β	t	p	R	R^2
CTQ-33	-67.859	9.330	-.381	-7.273	.00	.381	.145

Dependent Variable: RNNS

In the last step of regression analyses, the indirect effect is analysed. RNNS is added to the equation as an independent variable together with CTQ-33 to assess whether relational needs satisfaction is a mediator or not. As it can be seen in the results, when the RNNS was added to equation CTQ-33's effect on DES was decreasing. When Table 5 was examined, CTQ-33 B was 37.388 in the first step. However, the effect of CTQ-33 (B = 21.281) was decreasing with the addition of RNNS. It means that relational needs satisfaction has a mediating effect on childhood traumatic experiences and dissociative experiences. In addition to that, $R^2 = 0.137$ indicates that this model explains 13.7% of the total variance on the DES with the CTQ-33 and RNNS together, providing a moderate explanatory power.

As a result of these, the fourth hypothesis is accepted. Satisfaction of relational needs has a mediating role in the relationship between childhood traumatic experiences and dissociative experiences**.** This finding indicates that the effects of childhood trauma on dissociative experiences are not entirely direct. However, it is affected by the degree to which individuals feel their relational needs are satisfied. Specifically, individuals who have experienced childhood trauma might experience different levels of dissociation depending on their relational needs satisfaction. In other words, when relational needs are satisfied, the negative effects of childhood trauma on dissociative

symptoms may be diminished, implying a buffering effect of relational needs satisfaction.

Table 7

Regression Analysis on the Mediating Effect of Relational Needs Satisfaction on Childhood Traumatic Experiences and Dissociative Experiences

Variable	B	SE	β	t	p	R	R^2
CTQ-33	21.281	8.319	.146	2.558	.011	.371	.137
RNNS	-237	.047	-290	-5.078	.000	.371	.137

Dependent Variable: DES

Chapter 5

Discussions and Conclusions

The main aim of this research is to investigate the relationship between childhood traumatic experiences and dissociative experiences while taking into consideration relational needs satisfaction. This study pursues to explore how relational needs satisfaction particularly impact this relationship. Specifically, it investigates whether childhood traumatic experiences might predict dissociative experiences and how relational satisfaction may act as a mediating factor in this relationship. To achieve these objectives, the research adopted a comprehensive set of statistical techniques, including descriptive statistics to analyse the data in the first step, Pearson Correlation analyses to examine relationships between variables, and hierarchical multiple regression analyses to determine the predictive power of childhood traumatic experiences on dissociative experiences while taking into consideration the mediating role of relational needs satisfaction. Each of these steps contributes to an understanding of the data and the relationships among the variables under examination.

In this chapter, the findings from the current study will be demonstrated and analysed in light of the hypotheses, as well as the extensive body of literature related to childhood traumatic experiences, dissociative experiences, and relational needs satisfaction. This discussion will not only conceptualize the results within existing research but also indicate how these findings broaden the understanding of the intricacies involved in childhood traumatic experiences and dissociative experiences. Furthermore, the implications of these analysis results will be discussed in both clinical and theoretical perspectives.

Theoretical implications might include understanding how childhood traumatic experiences affect dissociative experiences and the significance of indicating relational needs satisfaction. Clinical implications include suggestions for therapeutic perspectives that could consider these relational needs when working with individuals who have childhood trauma and experience dissociation. Another implication is that the study is emphasizing developmental perspective and demonstrating how childhood trauma impairs relational skills, while noting that the protective role of relational needs

satisfaction in recovery. In addition to these, the limitations of this current study will be critically explored. These may include constraints related to methodology or the ability of generalization of the findings. Acknowledging these limitations is significant for a balanced interpretation of the findings and their potential implications and applications.

Finally, the chapter will come to an end with recommendations for future research directions. These recommendations will illuminate areas that advantage further investigation, such as longitudinal studies that follow changes in childhood traumatic experiences and dissociative experiences over time, as well as broader explanations of how relational needs satisfaction interact with this dynamic. By identifying these paths for further studies, the research objects to contribute to a more extensive understanding of the factors impacting childhood traumatic experiences and dissociative experiences and the role of relational needs satisfaction in this intricate interaction.

5.1 Discussion of Findings for Research Questions

5.1.1 Discussion of hypothesis I. The first hypothesis of the study offered that there is a positive relationship between childhood traumatic experiences and dissociative experiences. Specifically, it is proposed that participants who reported higher childhood traumatic experiences scores would show higher scores of dissociative experiences scores. The findings supported hypothesis I. Particularly, people who have more childhood traumatic experiences are more likely to have dissociative experiences. These findings align with current literature, which suggests that children who experience psychological traumas that surpass their ability to manage generally develop an intense sense of detachment from their experiences. This detachment shows itself as a dissociative reaction, in which the child perceives the traumatic events as occurring to someone else instead of directly impacting themselves. Correspondingly, they can establish a psychological distance that provide them to manage the devastating emotions associated with their traumatic experiences (Şar, 2000). The meta-analysis by Vonderlin et al. (2018) further supported this concept, finding out increased dissociation scores among victims of childhood maltreatment, specifically when multiple types of abuse happening at the same time.

Such insights emphasize the importance of addressing the psychological consequences of childhood trauma in therapeutic contexts, since the consequence generally extends far beyond current emotional hardships.

The relationship between early childhood trauma and dissociative disorders is specifically noticeable. Since children use dissociation to manage their adverse experiences, this mechanism might progress into a pathological response if trauma sustains. The study of Putnam (1997) indicates that what starts as an adaptive coping mechanism might eventually finalize as dissociative identity disorder, created by a complex interaction of developmental and cultural aspects. Moreover, the data emphasizing that a meaningful percentage of individuals diagnosed with dissociative disorders have a background of physical and sexual abuse underline the crucial urge for early intervention and support the children who have risk factors. In addition to these, the findings of the current study are compatible with the study by van der Kolk et al. (1996), which emphasizes the symptoms of post-traumatic stress might closely similar to those of dissociative disorders, especially in terms of difficulties associated with memory processing and emotional regulation. This interaction suggests that focusing on trauma in a therapeutic context must include a nuanced examination of dissociative mechanisms to improve treatment efficiency. However, as enlightened by Howell (2005), while this mechanism can act as a protective barrier in the beginning, it may start to be habitual, especially in surroundings marked by frequent and severe trauma. The results find out that children who experience psychological traumas beyond their capacity to manage generally establish dissociative strategies to maintain a disrupted emotional balance as a healthy one. These findings are compatible with Schimenti and Caretti (2016), who claim that early-onset frequent traumatization can cause children to initiate maladjusted pathways, such as dissociation, as a means of self-protection.

In general, the study provides for the increasing number of arguments related to childhood trauma and dissociative experiences, emphasizing the importance of early intervention and support. By identifying the negative impacts of trauma and the potential for dissociation as a coping mechanism, it can be informed in terms of prevention and therapeutic approaches objected at promoting resilience and healing in exposed children. Future research should continue to discover the long-term

consequences of childhood trauma and dissociation, as well as the efficiency of different interventions designed to diminish these detrimental effects.

5.1.2 Discussion of hypothesis II. The second hypothesis of the study suggested that there is a negative relationship between childhood traumatic experiences and satisfaction of relational needs. Respectively, it is offered that participants who reported higher childhood traumatic experiences scores would show lower scores of relational needs satisfaction scores or vice versa. The findings supported hypothesis II. Specifically, people who have more childhood traumatic experiences are less likely to be satisfied in terms of relational needs. Besides the main relationship between childhood traumatic experiences and relational needs satisfaction, Relational Needs Satisfaction Scale's subscales are examined in terms of this relationship. All subscales (Authenticity, Support and Protection, Having an Impact, Shared Experience, Initiate from Others) are significantly negatively correlated with childhood traumatic experiences.

The results of this study strengthen the significant correlation between childhood trauma and the satisfaction of relational needs, emphasizing the crucial role that interpersonal relationships play an important role in psychological recovery. Traumatic life incidences generally disorganize individuals' daily lives, connections, and overall sense of meaning, leaving themselves as fragmented and fragile. As Herman (2007) emphasized, such distortions can cause a to have lack of autonomy and self-esteem, highlighted the essentiality of supportive relationships in the development of recreating a coherent sense of self.

Erskine (1993) suggests a profound insight about the impacts of trauma on the individual, assuming that when individuals face traumatic life events, especially in the lack of meaningful connections in caregiving relationships, the trauma is unlikely to be completely incorporated. He claims that the unmet needs for empathy, caregiving, and protection during the traumatic life event are not suitably admitted or validated, which increased the effect of the trauma itself. This approach is supported by Toksoy's study's findings, which show a negative correlation between the intensity of traumatic stress and the satisfaction of relational needs (Toksoy, 2021). Particularly, as the intensity of traumatic stress deepens, individuals generally describe diminished

satisfaction of their relational needs, which further worsens their psychological distress.

The relationship between relational needs and trauma is critical, since Erskine (1993) clarified that individuals depend on complex defence mechanisms to control the emotional breakdowns that can be caused by unsatisfied relational needs and traumatic experiences. He profoundly notes that these components stay within the ego as a disconnected part of consciousness, inaccessible and detached. This disconnection prevents the merging of traumatic experiences with further life events and learning, causing a disintegrated sense of self. The current study's results are compatible with this approach, which shows that higher satisfaction of relational needs is related to lower levels of traumatic stress symptoms.

Moreover, the importance emphasized by Erskine and Trautmann (1996) on the emergence of satisfied relational needs is to include another person who is both aware of and active to those needs, which underlines the significance of relational support in trauma recovery. They amplify satisfied relational needs acquired and present another person who is aware of these relational needs. This responsiveness is not solely a supportive presence but a crucial aspect of healing since it creates an environment where individuals can deal with their trauma more efficiently. The current study's findings validate this idea, showing that individuals who experience more satisfaction of relational needs are better equipped to deal with the impacts of childhood trauma.

The importance of social support, especially during childhood, is later highlighted in research by Sperry and Widom (2013), who emphasize that social support plays a significant role in forming and diminishing the long-lasting effects of childhood maltreatment. They offer that such support increases resilience, ensuring a buffer that can help counterbalance some of the detrimental outcomes of trauma. Correspondingly, Schumm (2006) assumes that recurrent social support acts as a protective buffer, contrary to the accruing effects of interpersonal traumas faced throughout both childhood and adulthood. This is compatible with Erskine's approach that after trauma, individuals have an extreme need for a supportive presence that can resonate with their deep emotions and unsatisfied relational needs. He indicates that this person who is interacted should be open to difficult expressions, provide a

thorough understanding of the situation, and confirm ongoing safety through their enduring presence and problem-solving (Erskine, 1993).

Overall, the alignment of the results with current literature and Erskine's theoretical approach underlines the essentiality of promoting supportive relationships for individuals who are affected by trauma. By prioritizing relational needs in therapeutic interventions, professionals can improve emotional resilience and ease more efficient dealing with traumatic experiences. Further research should endure to discover the elaborate dynamics between relational needs and childhood trauma, especially in describing how different kinds of support can decrease the long-term impact of childhood trauma on psychological health.

Eventually, knowledge acquired from this study can inform the development of interventions objected at encouraging relational bonds, improving general well-being, and advancing improvement in individuals who have a trauma history. The alignments between the current study's findings and Erskine's approaches highlight the comprehensive influence of social relationships in the healing process, indicating that stressing relational needs is outstanding in improving resilience.

5.1.3 Discussion of hypothesis III. The third hypothesis of the study suggested that there is a negative relationship between satisfaction of relational needs and dissociative experiences. Accordingly, it is indicated that participants who reported higher relational needs satisfaction scores would show lower scores of dissociative experiences scores or vice versa. The findings supported hypothesis III. Specifically, people who have more satisfaction in terms of relational needs are less likely to exhibit dissociative symptoms and experience dissociation. Besides the main relationship between relational needs satisfaction and dissociative experiences, Relational Needs Satisfaction Scale's subscales are examined in terms of this relationship. All subscales (Authenticity, Support and Protection, Having an Impact, Shared Experience, Initiate from Others) are significantly negatively correlated with dissociative experiences.

The findings of this study strongly support the third hypothesis that there is an existing significant negative correlation between dissociative experiences and relational needs satisfaction. This relationship enlightens the complicated interaction between trauma and dissociation and the central role that supportive relationships take place in improving psychological resilience and healing. Dissociation is a complex

coping mechanism that arises as a reaction to devastating experiences, permitting people to mentally and emotionally disintegrate while adapting to their surroundings at the same time. Since Erskine (1993) explains in detail, this dissociation serves to protect mental and physical balance. However, it generally results in disintegration of the self.

According to Erskine (2019), every dissociative symptom symbolizes an archaic and immediate attempt to self-regulation and deal with former relational failings. This approach underlines a crucial reality about dissociation. Dissociation emerges not only from direct traumatic life events but also from the lack of caregiving and supportive relationships during early years. The current study is compatible with this concept, disclosing that when people's relational needs are unsatisfied, they are more likely to demonstrate dissociative symptoms. This finding highlights the therapeutic implications of emphasizing relational needs in treatment, especially for people who present with dissociation symptoms.

Erskine's experience offers that a relational perspective to therapy is specifically effective in indicating dissociation. This therapeutic approach includes creating a safe, attuned surrounding where clients can explain and explore their experiences and emotions in a helpful approach. Since he mentions, satisfied relational needs acquire the existence of another one who is both aware of and reactive to relational needs (Erskine & Trautmann, 1996). This approach supports acknowledgment, acceptance, and normalization of people's' experiences, eventually easing a recurrent and reliable therapeutic existence (Erskine, 1993). The therapeutic relationship evolves into a crucial path for clients to reintegrate with the part of themselves that may have been disintegrated because of the former relational traumatic life experiences.

Furthermore, the current study's findings clarify how dissociation generally arises from contexts where individuals have a lack of fundamental emotional support and care. Erskine (1993) profoundly indicates that on conditions of traumatic life experiences such as incest, children may be directed to believe they enjoyed the experience. In addition to this, their emotional disengagement is ignored by their primary caregivers and close environment. These children may cover their feelings and memories intensely, and they start to be disintegrated from their primary needs for relationships because of the lack of vital components of appreciation and empathetic

relationships. This causes ego fragmentation and an escalation in dissociative symptoms since people make an effort to deal with not settled emotions and unsatisfied relational needs.

The importance of essential relationships in therapy cannot be overemphasized. Creating authentic connections eases the collapse of defences and improves the integration of dissociated aspects of the self. As Erskine (1993) indicates, being in contact improves the ability to cope with defence mechanisms and supports the integration of dissociated parts of the personality. By encouraging this relationship, therapists can help clients merge formerly unaccepted and unresolved parts of themselves, allowing them to connect with the challenges of life in a more spontaneous and adaptable approach. This integration is fundamental for building a cohesive self, providing people to leave from dissociation as a primary defence mechanism.

Current study's findings also show that practitioners should be attentive in identifying the indications of dissociative symptoms in clients and realizing the relational context where these symptoms arise. By attentively connecting with clients and acknowledging their experiences, therapists can accommodate an environment for healing.

All in all, the study underlines the crucial role of relational needs satisfaction in diminishing dissociative symptoms. The significant negative correlation clarified in the current study's findings indicates the necessity for therapeutic perspectives that prioritize relational connections and support. By enhancing a safe and nourishing therapeutic environment, practitioners can help people in integrating their disconnected aspects of themselves, providing a cohesive sense of self. Further research should continue to examine the dynamics between relational needs, dissociative experiences, and childhood traumatic experiences, concentrating on how therapeutic interventions can be tailored to improve relational need satisfaction and decrease dissociative symptoms.

5.1.4 Discussion of hypothesis IV. The fourth hypothesis of the study is expected to find a mediating effect of relational needs satisfaction on the relationship between childhood traumatic experiences and dissociative experiences. Correspondingly, it was shown that relational needs satisfaction had a significant mediating effect on the relationship between childhood traumatic experiences and

dissociative experiences. Therefore, the findings supported hypothesis IV, revealing an intricate interplay among these variables. Particularly, people who experience childhood traumatic life experiences are prone to experience lower relational needs satisfaction, which is significantly and negatively correlated with increased dissociative symptoms. This notion highlights the crucial role of relational needs satisfaction as a protective factor against detrimental effects of childhood trauma.

5.1.4.1 Understanding the mediating role of relational needs satisfaction. The findings of the current study offer those relational needs satisfaction act as a significant mediator in the childhood trauma and dissociation relationship. When people experience traumatic life events during their early years, the lack of satisfied relational interactions can heighten feelings of emotional disconnection, distress, and emotional isolation. It is explored that by Van der Kolk (1996) how traumatic life events impact interpersonal relationships, highlighting the effects of trauma can show symptoms on people's sense of self and ability to associate with others. In the framework of the current study, it is apparent that when childhood traumatic experiences can diminish relational need satisfaction, the possibility of developing dissociative symptoms enhances significantly. Moreover, Bowlby (1982) clarified that the bonds created in early years have profound impacts on psychological functioning in terms of emphasizing the healing support. This underlines the significance of secure attachments in the healing progress. The current study's findings are compatible with this approach by showing that relational needs satisfaction not only protect against the immediate impacts of traumatic life events but also act as a reducing factor for long-term dissociative symptoms. When individuals create healthy relationships that satisfy their psychological and emotional needs, they are more likely to process their traumatic life experiences and prevent maladjusted coping mechanisms like dissociation.

5.1.4.2 The complex dynamics of childhood trauma, dissociation, and relational needs satisfaction. The relationship between childhood trauma, relational needs satisfaction, and dissociation is nuanced. Childhood traumatic experiences can interrupt the development of healthy relational satisfaction, causing to hardships in creating supportive relations further in life. Erskine (1993) assumes that the unsatisfied

needs for empathy, support, protection, and caregiving during the traumatic life event are not appropriately validated and accepted, which heightens the impact of the traumatic situation in itself. This approach makes prominent how relational deficits emerge from early traumatic experience might preserve the fact that emotional distress and dissociation symptoms. Furthermore, when individuals come up against traumatic life events without appropriate relational support, they can address to dissociation as a coping mechanism, as Van der Kolk (2005) asserts that dissociation is a natural reaction to intense stress. This indicates that by emphasizing the developmental perspective increasing relational needs satisfaction can perform as a protective factor suggesting people a means to deal with their trauma by more adjusting and alleviating the dependence on dissociation.

5.2 Conclusion

The results of the current study emphasize the complex interplay between childhood traumatic experiences, dissociative symptoms, and relational needs satisfaction. Significantly, the current study supports the idea that satisfied relational needs can serve as a significant protective factor against the detrimental effects of childhood traumatic life experiences in young adulthood and adulthood. People who face higher levels of childhood traumatic life events are more likely to demonstrate lower levels of relational needs satisfaction, which are significantly correlated with heightened dissociative symptoms. This emphasizes that unsatisfied relational needs worsen the psychological breakdowns of traumatic life events, causing individuals to manage dissociative strategies as a coping mechanism.

Relational needs satisfaction arises not just as a protective factor but as a crucial component in the improvement and healing process for people who are affected by trauma. It underlines the significance of relationships in providing emotional resilience. Supporting connections can provide the acceptance, empathy, and sense of safety that people generally have deficits about them following traumatic life experiences. These connections can boost a consistent sense of self, allowing

individuals to merge their traumatic life experiences instead of disintegrating their identities because of dissociation (Erskine, 1993).

The buffering factor of relational needs satisfaction is supported by the current literature that points out how secure attachments can alleviate the further consequences of trauma. When individuals create healthy relationships that fulfil their emotional and psychological needs, they are more likely to deal with their traumatic experiences. This buffering aspect can avoid the progress of maladaptive coping mechanisms like dissociation, which generally act as to preserve emotional stability because of overwhelming distress (Erskine, 1993). In addition to these, the current study's findings claim that interventions objected at improving relational needs satisfaction can crucially enhance therapeutic outcomes for people who have a childhood trauma background. By emphasizing relational need satisfaction in therapeutic structures, practitioners can encourage clients to build and preserve supportive connections, by that establishing a safe space for progress. This perspective not only helps in dealing with trauma but also boosts resilience.

When all these are taken into consideration, the study underlines that relational needs satisfaction is a crucial buffering factor that can importantly protect against the detrimental impacts of childhood trauma. By strengthening relational connections and providing that relational needs are satisfied, people can lessen their dependence on dissociative coping strategies and achieve healthier coping mechanisms.

5.3 Recommendations

5.3.1. Theoretical implications. The results of the current study have various theoretical implications in terms of the intricate relationship among childhood traumatic life experiences, dissociative symptoms, and relational needs satisfaction. First of all, acknowledging a positive correlational association between childhood trauma and dissociative symptoms approves current theoretical approaches that consider dissociation as a coping strategy that evolved in reaction to distressing traumatic life events. This notion augments that dissociative symptoms can be accepted as adaptive reactions that become maladaptive strategies when childhood trauma is recurrent or overwhelming. The study emphasizes the urge for a comprehensive understanding of how these variables interplay by merging childhood

trauma theory and dissociation theory. Secondly, the clarification of relational needs satisfaction as a mediating variable enlightens the significance of social and relational perspectives in psychological consequences. This notion points out the attachment theory, which suggests that secure attachments are essential for resilience and emotional regulation. In addition to these, the current study indicates a developmental perspective by demonstrating how childhood traumatic life experiences can impair the development of healthy relational skills, causing to hardships in further relational connections. This proposes that a developmental perspective which takes into consideration how trauma not only influences people's coping mechanisms but also influences the relational patterns that arise in adulthood. Specifically, the current study offers resilience and healing perspectives in psychology by enlightening the buffering aspect of relational needs satisfaction. This suggestion emphasizes that providing proper relational support can alleviate the detrimental consequences of childhood trauma, bringing a path for recovery.

In conclusion, the current study supports later examination into the mechanisms in terms of which relational needs satisfaction subcategory affects dissociative symptoms. This might provide a new theoretical perspective that analyzes the biopsychosocial aspects causing to dissociation. In short, the theoretical implications of this research point out that the significance of relational aspects in terms of examining the psychological outcomes of childhood traumatic experiences and dissociative experiences. By indicating the mediating role of relational needs satisfaction, the findings imply a more combined approach to childhood trauma and dissociative experience, which accepts the crucial influence of social relationships on psychological outcomes.

5.3.2. Clinical implications. The findings of the current study imply various significant clinical implications for practitioners who are working with people who have encountered childhood traumatic life experiences because of this demonstrating dissociative symptoms. First of all, the validation of the mediating role of relational needs satisfaction points out that therapeutic interventions can combine relational needs satisfaction model and trauma-oriented approaches. Fulfilled relational needs necessitate the presence of another person who is both attentive and responsive to the relational needs of others (Erskine, 1993). This marks that the essentiality of creating

robust therapeutic alliances that promote trust and safety, allowing people to explore their trauma and dissociative experiences in a supportive surrounding where they believe that they are acknowledged and appreciated. Moreover, it is fundamental for practitioners to evaluate and examine clients' relational needs as a crucial aspect of recovery. Accepting how unsatisfied relational needs cause to dissociative symptoms might lead interventions objected at improving social support and interpersonal connections. Therapists can assist in the progress of analyses in terms of relational dynamics. Additionally, since relational needs satisfaction serves as a buffering component against dissociation, practitioners might combine resilience-building strategies by utilizing the buffering aspect of relational needs in therapeutic relationships. Social support serves as a protective factor, so that providing clients with this protective equipment to manage their emotional difficulties more efficiently works and increases the sense of acceptance (Schumm, 2006). Besides, practitioners need to adopt a comprehensive perspective for assessment, considering not only people's trauma background but also their current relational background and social contexts. This extended understanding might notify therapeutic planning and help to clarify the parts in which relational needs may be unfulfilled, creating to more individualistic and efficient treatment plans.

When all these are taken into consideration, the clinical implications of the current study indicate the significance of combining relational aspects into the therapeutic context especially in the case of traumatic life experiences. Practitioners can help clients manage their experiences of childhood trauma and dissociation by directing attention on relational needs and promoting supportive therapeutic context and safe surroundings. This combined perspective not only supports healing but also appreciates the crucial role that social relationships take part in the recovery process. It eventually conduces to more efficient and compassionate care for people who are affected by traumatic life experiences.

5.3.3. Directions for future research. Based on the knowledge that is gained from the current study, future research can discover various key concepts that can later

enhance the understanding of the complicated relationship between childhood traumatic experiences, relational needs satisfaction, and dissociative symptoms.

First of all, conducting longitudinal studies would allow researchers to examine how childhood traumatic experiences and relational needs satisfaction develop over time while determining whether dissociative symptoms exist or not in the case. It can be gained insights about the long-lasting consequences of traumatic experiences and the efficiency of interventions objected at improving relational satisfaction by tracking people across different developmental periods. This perspective would contribute significant data on how changes in relational context can affect dissociative symptoms and general psychological health.

Secondly, further research can concentrate on specific therapeutic interventions, which are created to enhance relational needs satisfaction and examine their effectiveness in alleviating dissociative symptoms. Practitioners can develop targeted treatment plans that focus on the unique and special needs of individuals with trauma backgrounds by assessing different approaches such as relational therapy, trauma-informed care, or society support programs. In addition to these, investigating these relationships within various populations is fundamental for improving the generalizability of the findings. Further studies could take different cultural, socioeconomic, and demographic contexts into consideration to better understand how relational needs and dissociative symptoms exhibit across different groups.

Combining neurobiological measures into future studies could also strengthen the understanding of how childhood traumatic experiences and relational need satisfaction affect brain function and structure. This concept could explain in detail the mechanisms of latent dissociative symptoms and the potential for relational healing by giving a more detailed view of the interplay between psychological and biological factors in the case of trauma. Besides the neurobiological studies, qualitative research methods could be used to understand the experiences of individuals who have encountered childhood traumatic life experiences. Interviews or focus groups could provide knowledge about how individuals notice their relational needs satisfaction and the role of these needs' satisfaction in their coping mechanisms. This qualitative data

could provide an understanding for quantitative findings and suggest a more nuanced perception of the emotional and psychological aspects of relational needs satisfaction.

Finally, future research could explore the specific subcategories of relational needs such as authenticity, support and protection, having an impact, shared experiences, and initiating from that could be efficient to understand which dimension alleviates dissociative symptoms mostly and helps healing. Besides, exploring peer support, familial relationships, and therapeutic alliances could help inform which relational dynamics are most impactful in improving resilience and reducing the effects of childhood traumatic life experiences as well.

By chasing these directions, further research could provide to a more detailed perception about circumstances affecting the complex interplay between childhood trauma, relational needs satisfaction, and dissociation. This extended understanding would appreciate theoretical perspectives and notify practitioners objected at advancing emotional resilience and healing for people who are affected by childhood trauma.

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