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PERSONAL AND VICARIOUS TRAUMATIZATION AND TRAUMA-RELATED SYMPTOMS: EXPLORING THE MODERATING ROLE OF MENTALIZATION

By
Mehtap Özkanca

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Supervisor
Doç. Dr. Oğuzhan Zahmacıoğlu

Jurors
Doç. Dr. Naz Berfu Akbaş
Dr. Volkan Demir

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ABSTRACT

PERSONAL AND VICARIOUS TRAUMATIZATION AND TRAUMA-RELATED SYMPTOMS: EXPLORING THE MODERATING ROLE OF MENTALIZATION

Years of trauma research revealed that consequences of traumatic events are dependent on many factors. Regardless of its severity or age of onset, traumatic events may lead to mental health problems. The most challenging aspect of traumatic experiences is often found to be the difficulty in comprehending these events and integrating them meaningfully within one's life narrative. Thereby, it is hypothesized that one's ability to reflect upon their inner and outer experiences, i.e., one's capacity to mentalize, could mitigate the negative effects of trauma on individuals. Accordingly, this study examined the relationship between personal or vicarious traumatic experiences of adults working with traumatized individuals and their posttraumatic stress symptoms (PTSS). Whether or not mentalization capacity moderated these relationships were investigated. For this purpose, information about experienced personal and vicarious trauma (using the Cumulative Trauma Scale-Short Form), PTSS (using Impact of Event Scale-Revised) and mentalization capacity (using the Mentalization Scale) were collected from 130 participants who were primarily psychologists and social workers. While the results supported the negative relationship between personal trauma and PTSS, no significant relationship was found between vicarious trauma and PTSS. Mentalization did not have a moderating effect, although individuals with more motivation to mentalize were found to be less affected by trauma compared to individuals with less motivation. Lastly, ongoing therapy and supervision were protective factors in this relationship. The meaning of these findings is discussed in the context of Turkey, where traumatic life events are frequently experienced, and regarding the importance of mentalization-based therapeutic interventions.

Keywords: personal traumatization, vicarious traumatization, trauma history, mentalization, posttraumatic stress symptoms.

ÖZET

DOĞRUDAN VE DOLAYLI TRAVMATİZASYON VE TRAVMAYA BAĞLI BELİRTİLER: ZİHİNSELLEŞTİRMENİN DÜZENLEYİCİ ROLÜNÜN ARAŞTIRILMASI

Travma alanında yıllar içinde yapılmış çalışmalar bu kavramın olası tanımlamaları ve sonuçlarının çok fazla değişkene bağlı olduğunu ortaya koymuştur. Travmatik deneyimlerin, hangi şiddette ve yaşam döneminde yaşanmış olduğundan bağımsız olarak, bireylerin ruh sağlığını olumsuz etkileyebildiği bilinmektedir. Travmatik deneyimlerin bireyleri en çok sarsan ve zorlayan tarafının ise bu olayların algılanması ve kişinin hayat hikayesinde manalı bir noktaya oturtulmasının zorluğu olduğu görülmüştür. Bu noktada travmatik deneyimler yaşamış kişilerin içsel ve dışsal deneyimleri üzerine düşünebilme ve fikir yürütebilme becerisinin, başka bir deyişle, zihinselleştirme kapasitesinin, bu deneyimlerin kişinin üzerindeki olumsuz sonuçlarını etkiliyor olabileceği düşünülmektedir. Bundan yola çıkılarak, bu çalışmada travmatize olmuş bireyler ile çalışan meslek gruplarındaki bireylerin kendilerinin yaşamış oldukları veya iş yerinde ikinci dereceden maruz kaldıkları travmatik deneyimlerin bireylerin travma sonrası stres semptomları (TSSS) ile arasındaki ilişki incelenmiş, bu ilişkide bireylerin zihinselleştirme kapasitesinin olası düzenleyici rolü incelenmiştir. Bu amaçla çoğunluğu psikolog veya sosyal hizmet çalışanı olan 130 yetişkin katılımcıdan: bireysel ve iş yerinde maruz kaldıkları travmatik deneyimler (Birikimli Travma Ölçeği kullanılarak), TSSS (Olayların Etkisi Ölçeği kullanılarak) ve mentalizasyon becerileri (Zihinselleştirme Ölçeği kullanılarak) hakkında bilgi toplanmıştır. Sonuçlar bireysel travma ile TSSS arasındaki olumlu ilişkiyi desteklerken, dolaylı travma ile TSSS arasında anlamlı bir ilişki bulunamamıştır. Zihinselleştirme kapasitesinin bu ilişkileri düzenleyici etkisi gözlenmemiş, ancak, zihinselleştirme motivasyonu daha fazla olan bireylerin travmalardan motivasyonu daha az olan bireylerle kıyaslandığında daha az etkilendiği bulunmuştur. Son olarak, travma ile çalışan yetişkinlerin terapi ve süpervizyon alıyor olmasının da bu ilişkide koruyucu etkisi olduğu görülmüştür. Sonuçlar, travmatik yaşantıların oldukça fazla olduğu Türkiye bağlamında ve zihinselleştirme odaklı terapilerin önemi çerçevesinde tartışılmıştır.

Anahtar Kelimeler: doğrudan travmatizasyon, dolaylı travmatizasyon, travma geçmiş, mentalizasyon, travma sonrası stres belirtileri.

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1. INTRODUCTION

Trauma, despite the challenging task of its conceptualizing, is of high research value. Understanding how posttraumatic stress reactions come about and who is prone to vulnerability is valuable (Allen et al., 2012; Rosen & Lilienfeld, 2008). Consistent with the theory of mentalization (Fonagy et al., 2012; Sharp et al., 2012), what matters is the place trauma holds in mind and its integration to the unique and meaningful narrative of the person – that is whether trauma can be mentalized or not. In the case of disruption within the mentalization capacity, "all the inescapable pains of the human condition are experienced with the immediacy of the open wound unprotected by the 'skin' that mentalizing provides" as Allen and colleagues (2012) states (p. 430).

In the current study, the relationship between traumatic exposure in personal and professional life, its effect on the person, related symptoms, and the role of mentalization in said relationship are investigated. In the following sections, the concepts of trauma, vicarious trauma, and mentalization will be elaborated on, accompanied by the review of relevant literature.

1.1. Trauma

Trauma is, traditionally, conceptualized as events that pose severe threat to survival or physical integrity. However, event-based conceptualization of the term may be insufficient since deciding on traumatic events that leave comparable effects on everyone is nearly an impossible task (Allen et al., 2012). Despite this, there are some events that may be rated as traumatic by a majority of people, referring to their potentially catastrophizing nature. To illustrate, natural disasters such as earthquakes, floods or hurricanes, war, terror, captivity, migration, accidents or illness causing severe harm to the person or loved ones, loss of a loved one, physical or emotional abuse or neglect, sexual violence, domestic violence, abandonment, bullying, discrimination based on race or ethnicity and on gender identity or sexual orientation may be categorized as possibly traumatic events. In addition, despite deemed minor than those listed previously, academic failure, moving frequently, loss of a job, or financial issues may also be experienced as traumatic.

The borders of the concept of trauma are not well-defined. There is no direct link between an event and a following effect, people respond in various ways to potentially traumatic events, and sometimes, traditionally defined traumatic events are not even prerequisite for the detrimental aftermath of trauma (Allen et al., 2012; Frans et al., 2005; Rosen & Lilienfield, 2008). Then, trauma can optimally be defined based on its impact, its traces on the person. Trauma can be conceptualized as a threat to psychological integrity, overwhelming the person beyond their capacity (Schimmenti & Caretti, 2016).

The Republic of Turkey is traumatized and traumatizing – considering its history, standing, and population. Events with the potential to leave a traumatic impact that were reported to be prevailing in Turkey may be listed as follows: natural disasters, life-threatening accidents, death of close ones, adverse childhood experiences, domestic violence, sexual violence, war, terror, or displacement (Aker et al., 2007; Karancı et al., 2012). Repeatedly and continuously, we hear about trauma. Prevalence rates of traumatic exposure in Turkish population draws a similar picture. In a study conducted with a large and representative Turkish sample, on the topic of posttraumatic stress, 58.6% of the participants reported experiencing at least one traumatic event (Karancı et al., 2012). Research indicates corresponding rates from other parts of the world – 60.7% for men and 51.2% for women in US (Kessler, 2000), 84.4% for men and 77.1% for women in Sweeden (Frans et al., 2005), and two-thirds of people in a study compiled information from 24 countries (Benjet et al., 2016).

1.1.1. Cumulative Trauma

The concept of trauma can be organized in different ways – namely based on onset or nature. A distinction hinged on onset usually includes childhood and adulthood traumatic experiences. Every child has a unique developmental story, ranging from optimal to traumatic, with varying experiences, especially with parents (Felsen, 2017). Childhood traumatic experiences generally include physical and emotional abuse and neglect, and sexual abuse – where the inflictor can be a parent or someone else (Şar et al., 2020). Exposure to traumatic events as a child, without a doubt, leaves marks on the developing mind, personality and its structures. Although overlooked, traumatic experiences during adulthood can still have significant ramifications considering that the traumatic event would be experienced as alien and unexpected, and it would be harder to dissociate (Felsen, 2017).

There is a line of research on trauma, adopting the distinction between childhood and adulthood onset. In a study conducted with patients with posttraumatic stress disorder (PTSD); dissociation, feelings of guilt and shame, posttraumatic stress symptoms (PTSS), aggression turned to self, and interpersonal sensitivity was found to be correlated with the number of different traumatic events participants had endured; however, only dissociation levels differed in terms of childhood and adult-onset traumatic events, indicating that the negative trauma-related outcomes were associated with the variety in traumatic events, rather than the life stage the event occurred (Hagenaars et al., 2011). In another study, adolescents who reported more traumatic events throughout their lives was found to show higher levels of PTSS and depressive symptoms while controlling for childhood adverse experiences – meaning that the period of exposure was of no importance (Suliman et al., 2009). Similarly, in a study investigating childhood (sexual, physical, and emotional abuse, emotional neglect, and abandonment by mother) and adulthood (sexual, physical and partner abuse, repeated and single exposure) trauma reported a meaningful relationship between the additive effect of these experiences with trauma-related symptoms, such as emotion regulation and interpersonal difficulties, depressive and dissociative symptoms (Cloitre et al., 2009). In a longitudinal study where people were assessed regarding trauma exposure and PTSS at the ages of 26 and 32, those who reported additional exposure between these ages were more likely to develop PTSD compared to those who did not report such exposure (Koenen et al., 2007). Sareen's (2014) findings indicate that multiple traumatic events, regardless of the period they occurred, have an impact on the self, in terms of both repeated exposure to the same event and exposure to qualitatively different evets. In contrast, Schoeld and colleagues (2014) reported that the frequency of exposure in general is a less influential factor than exposure to different types of events, regarding PTSS.

In this respect, a life-long and cumulative perspective for different types of traumas and their effects may be more suitable for a comprehensive consideration, rather than focusing on specific life stages or specific events. In this perspective of multiple traumatic events and their accumulated effect, any event, minor or major can act as a trigger at any point, overwhelming the capacities of the person (Kira et al., 2008). Exploring the aftermath of a single traumatic event occurred in a specific period is naturally valuable, yet a lifelong trauma history is worth investigating as well (Allen et al., 2012; Kessler, 2000; Kira et al., 2008). Cumulative trauma as a concept, according to Kira and colleagues (2008), includes

various events, however major or minor, throughout life that may impact the person, however largely or little, resulting in an accumulated effect.

The focus on types of traumas is another way of categorizing. A life story without any traumatic events or with a single traumatic event, as shown by prevalence rates too, does not reflect reality. Traumatic events can be grouped into two based on the manner they occurred: natural or human-made (Kira et al., 2008). Natural disasters or severe illnesses as a cause of death of loved ones can be considered outside of control, without inflictors. On the other hand, human-made traumatic events may leave a deeper impact on the exposed person since there is another person involved, usually bringing harm, deeply disturbing the belief system and trust in others and the world. These two different types may have differential effects. Another way of grouping traumatic events based on event-related features can be as follows (Eltan & Karancı, 2022): survival trauma (e.g. natural disasters or physical assault), personal identity trauma (e.g. physical or sexual abuse), collective identity-trauma (e.g. discrimination), and family-attachment trauma (e.g. loss of a loved one).

The idea that different types of trauma can have differing levels of impact on the person is largely supported by research. For instance, compared to traffic accidents, sexual violence or loss of a loved one is shown to have a greater impact on the aftermath of trauma (Frans et al., 2005; Owens, 2016; Shakespeare-Finch & Armstrong, 2010) since both physical and psychological integrity is at risk, and involvement of another, either as a close one who is lost or as a perpetrator, is the case (Shakespeare-Finch & Armstrong, 2010).

1.1.2. Risk Factors associated with Traumatic Exposure

Trauma is common; however, some people might be more prone to traumatic exposure than others. Gender, for instance, is associated with differential exposure – men, compared to women, reported higher amounts of traumatic exposure (Frans et al., 2005; Koenen et al., 2007; Perkonigg et al., 2000; Tolin & Foa, 2006). Regardless of gender, previous psychopathology is associated with trauma exposure (Perkonigg et al., 2000), although the direction of association is unclear. Previous trauma is also associated with elevated risk of traumatic exposure (Benjet et al., 2016), especially during childhood (Koenen et al., 2007). Specifically, temperamental difficulties, social withdrawal, hyperactivity, loss of a parent, and caregiver's distress was found to be linked with increased likelihood of exposure (Koenen et al., 2007). Whereas social support (Felsen, 2017) and

being married (Benjet et al., 2016) were proposed to be protective against traumatic exposure.

1.2. Vicarious Trauma

A highly emphasized point in the literature is that trauma is contagious. Experiencing is not the only way for trauma to leave its mark on the individual. Witnessing a traumatic event or being exposed to its explicit details can also have a similar effect. Relatives or acquaintances of the traumatized people may be influenced by the event. Exposure to traumatic events through media or any other channel can also lead to traumatization.

Professionals involved in care for traumatized people are particularly open to this contagious effect. This phenomenon has been termed in various ways – such as compassion fatigue, secondary traumatic stress (STS), burnout, countertransference, or vicarious traumatization (McCann & Pearlman, 1990). STS is explained as “the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995, p. 7). In relation to STS, compassion fatigue is described as a disorder, focusing on the symptomatic response to this stress (Figley, 1995). Burnout can be defined as “a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations" (Pines & Aranson, 1988, p. 9). Countertransference is the conscious or unconscious response of the therapist to the patient's transference (McCann & Pearlman, 1990). Vicarious traumatization is comprised of processes that result in emotional responses and alterations of cognition and behavior, which makes it more encompassing compared to STS and compassion fatigue whose emphasis in on the exposure-related symptoms (Baird & Kracen, 2006; Sabin-Farrel & Turpin, 2003). While any occupation may experience burnout, vicarious traumatization is more specific to people working with traumatized individuals (Molnar et al., 2020; Sabin-Farrel & Turpin, 2003). Countertransference is not specific to trauma-related material and is often specific to the session or the patient (McCann & Pearlman, 1990) while vicarious trauma is implicated in both the professional and personal life of the person (Çalık Var & Çetinkaya Büyükbodur, 2017; McCann & Pearlman, 1990; Sabin-Farrel & Turpin, 2003).

In this study, the term vicarious traumatization will be used since it encompasses the effect of indirect exposure to traumatic material in a broader sense compared to other terms. It will be used to emphasize the impact of indirect exposure during work on the inner world of the person, regardless of the exposure being short- or long-term, being more or less frequent, or including different types of traumatic events.

1.2.1. Vicarious Traumatization in the Workplace

The interest in vicarious traumatization began in the 1980s, and McCann and Pearlman (1990) were the first ones to coin and try describing this term. Vicarious traumatization manifests as professionals' "painful images, thoughts, and feelings associated with exposure to their clients' traumatic memories" and includes "long-term alteration in the therapist's own cognitive schemas, or beliefs, expectations, and assumptions about self and others" (p. 132). Vicarious traumatization is structured within the Constructivist Self-Development Theory (CSDT). The CSDT proposes that people form their own reality and attribute meaning to their experiences via self-constructed schemas, which include ideas, beliefs, expectations and assumptions about themselves and the world around them. According to the CSDT, vicarious traumatization causes these schemas to change for the worse, especially in the areas of trust and safety.

There are certain occupational groups that are exposed to traumatic materials in detail while carrying out their professional requirements. Due to the nature of the occupation, people working in these areas encounter accounts of traumatic experiences, that vary in terms of detail or frequency, in a continuous and cumulative manner (Middleton et al., 2021; Sabin-Farrel & Turpin, 2003). This can be termed as "internarrator transmission", similar to the transmission of intergenerational trauma (Boulanger, 2018, p. 61). In addition to hearing traumatic narratives, witnessing the events or working on its details as a case can also be a part of job demands.

Said occupational groups may include psychotherapists, psychologists, clinicians, psychological counselor, doctors, nurses, social workers in child, elderly or disabled services, emergency workers, ambulance officers, police officers, first responders, firemen, lawyers, prosecutors, or journalists. For this particular study, the term trauma worker will be used after this point, for people working with traumatized individuals and who has the

potential of bearing the outcomes. Witnessing traumatic events or first-person accounts of them in this manner can significantly impact the person's sense of security, causing trauma encountered during work to permeate into other areas of their lives (Ashley-Binge & Cousins, 2020; Boulanger, 2018; Çalık Var & Çetinkaya Büyükbodur, 2017; Middleton et al., 2021; Molnar et al., 2020).

Vicarious traumatization has gained significant research interest considering its impact on trauma workers. One focus of research is the prevalence. Molnar and colleagues (2020), in their systematic review of 39 studies conducted with people working with traumatized children in the US and Europe, documented that 16 to 92% of workers in the field reported vicarious traumatization. The quite wide range was thought to be due to using different measures and reporting different levels of severity in terms of vicarious traumatization – higher percentages were in response to having at least one symptom of work-related stress (Molnar et al., 2020). Moderate levels of vicarious traumatization were reported in 2 to 15% of trauma workers (Bride, 2007; Molnar et al., 2020). In a study conducted with Turkish mental health professionals (psychotherapists, psychological counselors, psychiatrists, social workers, and volunteers), the self-reported rate of vicarious traumatization was stated as 25.4% (Zara & İçöz, 2015).

Another focus of research is the associated outcomes. In their work on mental health professionals' vicarious traumatization, Sabin-Farrel and Turpin (2003) noted associations of it with PTSS, general distress, and burnout. Another review focusing on child welfare and child protective service workers, first responders to children-related crimes, law enforcement, lawyers, and prosecutors identified that disturbances in the sense of trust, maladaptive coping mechanisms, burnout, compassion fatigue, and relationship problems were linked with vicarious traumatization (Molnar et al., 2020). Similarly, criminal lawyers, compared to those who work in other areas, reported higher levels of vicarious traumatization, work-related stress, depression, PTSS, changes in their view of safety regarding self and other, and intimacy, while no differences were found in terms of satisfaction with work and management of work-related stress (Vrklevski & Franklin, 2008). Middleton and colleagues (2021), too, identified several elements of vicarious traumatization in their qualitative study carried out with forensic interviewers. The findings follow: detailed accounts of traumatic events or interviewers' own trauma history can act as triggers, distancing the self from traumatic materials was achieved by dissociation or by

shifting from the emotional to rational, and feelings of inadequacy can be linked with hopelessness, anger and distrust which can impact work performance negatively by leading to lack of motivation or positively by fostering change-oriented thinking and effort.

1.2.2. Risk and Protective Factors associated with Vicarious Traumatization

Not all trauma workers are afflicted by vicarious traumatization. Although the word contagion may imply that the person is immobilized in the face of this indirect traumatic effect (Boulanger, 2018), the idea that everyone working with trauma will experience vicarious traumatization would be flawed. Moreover, there are studies indicating trauma workers' work-related satisfaction, competence, and motivation alongside negative effects (Armes et al., 2020; Molnar et al., 2020). This raises the question of who may be under heightened risk regarding the impact of vicarious traumatization.

Previous trauma history of the worker and higher amount of caseload consistently appear as risk factors in the literature (Armes et al., 2020; Ashley-Binge & Cousins, 2020; Baird & Kracen, 2006; Bloom, 2003; Çalık Var & Çetinkaya Büyükbodur, 2017; Hensel et al., 2015; Lerias & Bryne, 2003; Molnar et al., 2020; Pearlman & Mac Ian, 1995; Sabin-Farrel & Turpin, 2003; Vrklevski & Franklin, 2008; Zara & İçöz, 2015). Frequent exposure to traumatic material (Lerias & Bryne, 2003; Zara & İçöz, 2015), lack of trauma-focused training (Ashley-Binge & Cousins, 2020; Çalık Var & Çetinkaya Büyükbodur, 2017; Hensel et al., 2015), being female (Çalık Var & Çetinkaya Büyükbodur, 2017; Lerias & Bryne, 2003; Molnar et al., 2020), vicarious traumatization due to other channels outside of work (Molnar et al., 2020) and exposure to human-made traumatic events as opposed to natural ones (Zara & İçöz, 2015) are also indicated as risk factors. Being younger and lack of experience (Hensel et al., 2015; Pearlman & Mac Ian, 1995) are found to be associated with susceptibility; however, one study deemed the results inconclusive (Molnar et al., 2020). As mentioned before, the term trauma worker includes various occupational groups who encounter various types of traumatic events. Correspondingly, particular types of trauma may render those working with them more susceptible to experiencing vicarious trauma – including but not limited to sexual abuse (McCann & Pearlman, 1990), child abuse or neglect (Armes at al., 2020), and physical abuse or incest (Kahil & Palabıyıkoğlu, 2018).

A number of variables are discovered as protective against vicarious traumatization. They include workplace support (Ashley-Binge & Cousins, 2020; Hensel et al., 2015; Molnar et al., 2020), social support (Ashley-Binge & Cousins, 2020; Molnar et al., 2020), organizational support (Molnar et al., 2020), self-care practices (Molnar et al., 2020) and supervision (Ashley-Binge & Cousins, 2020; Çalık Var & Çetinkaya Büyükbodur, 2017; Molnar et al., 2020; Sabin-Farrel & Turpin, 2003; Zara & İçöz, 2015) – although Hensel and colleagues (2015) reported no associations regarding supervision.

1.3. Posttraumatic Stress Symptomatology

Posttraumatic stress symptoms (PTSS), or on clinical levels posttraumatic stress disorder (PTSD), are among various presentations of the aftermath of trauma, which are explained above, and perhaps is the most typical (Nietlisbach & Maercker, 2009). Trauma exposure, direct or indirect, is associated with, most typically, intrusion, hyperarousal, and avoidance – that is, PTSS.

1.3.1. Clinical Presentation: Posttraumatic Stress Disorder

PTSD is included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013). The criterion for PTSD includes eight dimensions. The first dimension, Criterion A, is about the event that is thought to be traumatic in nature – such that life is threatened. The exposure to the event in question can be in a direct or indirect – that is witnessing, hearing about it happening to a close one or repeated exposure to explicit details due to requirement. Criterion B includes a symptom cluster that can be referred to as intrusion – intrusive thoughts, nightmares, flashbacks, getting triggered accompanied by stress and physiological reactions. Criterion C is in regard to avoidance from both internal (mental states) and external (triggers) reminders of the event. Alterations in mood and cognitive functioning is referred in Criterion D – such as fragmented memories about the event, negative beliefs about the self, other and world, self- or other-oriented blame, negative emotions like fear, anger, horror, shame, and guilt, anhedonia following the traumatic event, social isolation, and limited range of positive emotions. Hyperarousal is also considered a symptom cluster, as indicated by Criterion E, which includes irritability, self-destructive or

aggressive behavior, hypervigilance, attentional and sleep problems, and exaggerated startle response, especially after the exposure to trauma. Criterion F, G, and H specifies the diagnosis in terms of duration, its effect on functioning and being unrelated to a physiological cause.

It can be said that vicarious trauma-related symptoms, as implied in DSM-5 as well, closely resemble trauma-related ones (Baird & Kracen, 2006; Boulanger, 2018; Çalık Var & Çetinkaya Büyükbodur, 2017; Sabin-Farrel & Tupin, 2003). Vicarious traumatization may be less prominent than personal trauma history in terms of PTSS (Lerias & Bryne, 2003; Rosen & Lilienfeld, 2008), yet it is still considered significant. The relations of personal and vicarious traumatization with the development of PTSS can be considered in terms of exposure through different channels rather than treating them as separate conditions with similar symptoms.

As established previously, one single disorder following one single traumatic exposure is generally not the rule (Allen et al, 2012). Dissociative disorders, psychosis, anxiety disorders, depressive disorders, substance abuse, self-harm and suicide, eating disorders, somatic symptom disorders, and personality disorders can be listed as comorbid conditions with PTSD (Allen et al., 2012; Kessler, 2000; Perkonigg et al., 2000; Şar & Ross, 2006). Herein, one explanation may be that traumatic experiences pose as a risk factor for later psychopathology, while another may be that underlying psychopathology aggregates the impact of such experiences on the person (Kessler, 2000).

Not everyone develops PTSD following traumatic experiences, as prevalence rates for the disorder suggests. In a meta-analysis of 77 studies conducted on the subject, 7.9% of people exposed to trauma manifested PTSD (Brewin et al., 2000). The prevalence of PTSD following natural disasters was reported as 3.8%, in developed countries (Bromet et al., 2017). Similar prevalence rates were reported in Europe as well – 3.6 to 7.6% for men and 7.4% to 11.8% for women (Frans et al., 2005; Koenen et al., 2007). PTSD-related prevalence rates of Turkey were reported as approximately 10% in general (Karancı et al., 2012) and 10 to 25% after a natural disaster, Marmara Earthquake in 1999 (Aker et al., 2007).

PTSS can also be considered in a dimensional manner. Reactions to trauma can range from no impact to extreme distress – a perspective that puts PTSD towards one extreme (Brewin et al., 2000; Rosen & Lilienfeld, 2008). In other words, it is normal to respond to

trauma; however, in the case of PTSD, there is a deviation from said normal (Kahil & Palabıyıkoğlu, 2018; McCann & Pearlson, 1990). It follows that, reactions to trauma, despite being below the constructed threshold for PTSD, can impact the well-being of a person negatively (Sareen, 2014).

1.3.2. Risk and Protective Factors associated with Posttraumatic Stress Symptomatology

The question of why some people are prone to vulnerability and some are not is asked a great deal, forming the literature on risk factors for PTSS and PTSD. Some individual and event-related factors are assessed in terms of their associations with PTSS and, generally, there is a consensus. Previous traumatic experiences, especially during childhood, and previous psychopathology appear as prominent predictors for later PTSD development (Aker et al., 2007; Brewin et al., 2000; Bromet et al., 2017; Koenen et al., 2007; Ozer et al., 2003; Perkonigg et al., 2000; Schoeld et al., 2014). Lower age, socioeconomic statues, and educational attainment is linked with higher PTSS (Bromet et al., 2017; Gül & Karancı, 2017; Perkonigg et al., 2000). Another demographic risk factor is gender, as research suggests. While men report to experience traumatic experiences more, women seem to be more prone to developing PTSD (Gül & Karancı, 2017; Koenen et al., 2007; Perkonigg et al., 2000; Sareen, 2014; Tolin & Foa, 2006). These differences regarding gender may be explained by differential exposure to trauma in men and women, where traumatic experiences women encounter are more likely to be interpersonal (e.g. domestic violence, sexual abuse) in nature (Allen et al., 2012; Tolin & Foa, 2006). Events that include intentional infliction of harm by another or that pose a risk for survival, physical or psychological, are associated with higher PTSS (Bromet et al., 2017; Gül & Karancı, 2017; Perkonigg et al., 2000; Schoeld et al., 2014).

Social support in general, and belonging to a group, place, or person specifically, found to be linked with lower levels of PTSS – appearing as a protective factor (Brewin et al., 2000; Felsen, 2017; Gül & Karancı, 2017; Nietlisbach & Maercker, 2009; Ozer et al., 2003; Sareen, 2014).

1.3.3. Social-Cognitive Perspective for Posttraumatic Symptomatology

Decades of research on the topic of factors associated with severity of PTSS converges on the idea that how the event is perceived overrules most of the event-related or individual characteristics previously listed as risk factors (Aker et al., 2007; Brewin et al., 2000; Bromet et al., 2017; Frans et al., 2005; Kira et al., 2008; Sareen, 2014; Tolin & Foa, 2006). In comparison to pre- or post-trauma factors, peri-trauma factors, that is how everything is processed during the events' occurrence, appeared to be more predictive of PTSS (Allen et al., 2012; Ozer et al., 2003).

The fact that an event is experienced stressful, can be correlated with its potential traumatic impact (Rosen & Lilienfeld, 2008) – and this explains how while some events referred as traditionally traumatic have no effect on occurrence of symptoms (Rosen & Lilienfeld, 2008), some minor life experiences are ascertained to lead to PTSS (Long et al., 2008; Sharp et al., 2012) to a certain extent. When prevalence and complexity of aftermath is considered, in the manner of traumatic event and the following result, it is considerably hard to establish a link between a single event and a single outcome. Traumatized individuals' perspective of themselves and others would be tainted by trauma. Thus, social support and social cognition-related processes (e.g. perception of social cues and interpretation and acting appropriately to these) will be affected (Nietlisbach & Maercker, 2009). Moreover, the process of appraisal for any event is intrinsically connected to how others' experience is perceived (Fonagy et al., 1991; Frankel, 1998). Consequently, interpretation of how the mind works, both for the self and the other – in other words, mentalization – becomes crucial.

1.4. Mentalization

The concept of mentalization, which integrates literature on social cognition, attachment, and psychoanalytic theory, was first proposed by Fonagy (1989). Mentalization "is the imaginative mental activity that enables us to perceive and interpret human behavior in terms of intentional mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons)" (Fonagy et al., 2012, p. 3). In essence, it is keeping self and other in our minds (Fonagy et al., 2012). It refers to "the process by which a brain becomes a mind" (Jurist, 2005, p. 428). It was put forward as related to psychoanalytic concepts, which generally

denote higher-level mental capacities about representations of inner and outer world, like, symbolization (Segal, 1957), secondary mental processes (Freud, 1900), and alpha function (Bion, 1962). It is operationalized as reflective functioning, which is sometimes used interchangeably with mentalization, in order to easily explore and measure it in research (Fonagy et al., 2016).

The four dimensions of mentalization capacity is explained by Fonagy and colleagues (2012), for the purpose of formulating a unified concept about how internal and external stimuli are organized in the mind. In their perspective, mentalization-related processes can be automatic or controlled, internally- or externally focused, self- or other-oriented, and cognitive- or affective-related. Firstly, mentalization can be thought to continuously operate in the background – automatically, or implicitly. The person mentalizes without awareness, in a fast and assumption-based manner. Controlled, or explicit, mentalization refers to the deliberate use of the capacity – in a slower and more reflective manner. Flexibly switching between the two positions with accurate assumptions is desired. Secondly, mentalizing can be based on internal (i.e. thoughts, feelings, wishes) or external (i.e. behaviors) cues. Excessive focus on only one type of cues could be deficient since it may result in inaccurate judgements about self and others. Thirdly, mentalization can be about self or others. Even though these two processes appear to be closely related, excessive focus on one or the other is possible. Moreover, the distinction between self- and other-oriented mentalization enables the acknowledgement that every individual has a mind and mental states of their own. Finally, mentalization covers both cognition and emotion related mental states and identifying, distinguishing, expressing, and processing them.

There are several concepts that share some of these dimensions included within the realm of mentalization – such as theory of mind, psychological mindedness, mindfulness, empathy, and affect consciousness (Choi-Kain & Gunderson, 2008). The theory of mind can be defined as the cognitive capacity involving acknowledgment that others' mind and mental states are distinct from the self's and the accurate identification of said mental states (Choi-Kain & Gunderson, 2008). Theory of mind is other- and cognition-focused while mentalization adds self- and affective-focus to this capacity (Choi-Kain & Gunderson, 2008). Similarly to mindfulness, directing attention consciously to here and now (Brown & Ryan, 2003), mentalization includes observation of the self, in addition to other-related and implicit processing. Psychological mindedness, too, can resemble mentalization capacity

closely. It can be defined as curiosity about one's own and others' feelings, thoughts, and behaviors (Appelbaum, 1973). However, making inferences or subsequent processes are not included in psychological mindedness as they are in mentalization (Choi-Kain & Gunderson, 2008). Empathy, the ability of making inferences about others' emotions and thoughts and experiencing a similar affective state (Decety & Jackson, 2004), incorporates an aspect of sharing which is not present in mentalization and excludes the aspect of self which is present in mentalization (Choi-Kain & Gunderson, 2008). Affect consciousness, or mentalized affectivity, includes identification, processing, and expression of affect in self and others, that is, revaluation of affect is the case in addition to regulation (Choi-Kain & Gunderson, 2008; Jurist, 2005). Both mentalization and affect consciousness include self- and other-dimension, while only mentalization accounts for the related implicit processes (Choi-Kain & Gunderson, 2008). In summary, mentalization encompasses these concepts, bringing together the cognitive and affective, the self and other, the inner and outer, and the explicit and implicit.

1.4.1. Development of Mentalization

Mentalization is considered a capacity, developing and evolving within the social realm, throughout life (Fonagy et al., 2012). Earlier interpersonal experiences are especially critical in terms of the development of mentalization. The baby is dependent on their caregiver for all their needs, from physical to psychological (Fonagy et al., 1991). Internal experiences mean little to the baby, appearing terrifying and remaining as a source of great distress (Fonagy et al., 2012). The responsibility of recognizing the distress, i.e. external, and connecting them with the infant's experience, i.e. internal, falls upon the caregiver (Fonagy et al., 2012).

Early attachment relationships are, therefore, quite crucial for mentalization capacity. Accordingly, the association between attachment patterns and mentalization capacity is well documented (Ensink et al., 2023; Fonagy et al., 2012; Huang et al., 2020). Fonagy and colleagues (2012) maintain that being curious about minds starts in infancy. When the caregiver is able to keep the baby's mind in their mind (i.e. parental reflective functioning), identifying and appropriately reacting to their mental states, the baby's attention is drawn to their own mental states as well. This is achieved by marked contingent mirroring, that is, the caregiver's slightly exaggerated expressions related to the baby's feelings. Through this

mirroring process, if sufficiently provided, representations (thoughts, emotions, beliefs, goals, intentions, or reasons) are formed in the baby's mind, which is connected to better emotion regulation, interpersonal relations, social adaptation, and mentalization capacity later in life.

Considering a developmental psychopathology perspective, traumatic experiences, especially in childhood, impair attachment patterns and mentalization capacity (Allen et al., 2012; Berthelot et al., 2019; Huang et al., 2020; Rüfenacht et al., 2023). When confronted with trauma and accompanying unmetabolized mental states, if the child has no attachment figure to rely on for the metabolization of mental states, or worse, if the attachment figure is involved in the infliction, a paradoxical situation arises where relief is not easily accessible (Fonagy et al., 2012; Rüfenacht et al., 2023). It would be faulty to expect the child to efficiently mentalize about trauma, transform it into a coherent narrative within the self since more likely results would be avoidance of related mental states in a defensive manner or distorted understanding of them (Fonagy et al., 2012; Katzman & Papouchis, 2023; Rüfenacht et al., 2023). The avoidance of mentalizing, both about the self and other, would present as an obstacle during the development of it (Bogdanovic et al., 2023; Katzman & Papouchis, 2023; Rüfenacht et al., 2023; Sharp et al., 2012), which might give rise to to psychological and interpersonal problems later on, assuming the lack of corrective experiences (Fonagy et al., 2012; Rüfenacht et al., 2023).

1.4.2. Mentalization and Trauma

Trauma is conspicuously linked with distorted, disrupted, and impaired mentalization (Fonagy et al., 2012), which in turn has associations with psychopathology (Poznyak et al., 2019; Schwarzer et al., 2021). Fonagy and colleagues (2016) use the terms hypermentalization (the person appears to be able to mentalize, yet the assumptions made are weakly connected to reality) and hypomentalization (the person generally tends to avoid mentalizing altogether) to explain impaired mentalization. Impaired, or in extreme cases absent, mentalization, regardless of trauma history, has connections with autism (Baron-Cohen et al., 1985), depression (Belvederi Murri et al., 2017), eating disorders (Gagliardini et al., 2020), anxiety, obsessive-compulsive, and trauma-related disorders (Sloover et al., 2022), and borderline, antisocial, and narcissistic personality disorders (Luyten et al., 2020b; Gagliardini et al., 2023).

PTSS can also be conceptualized in terms of impairments in mentalization capacity (Ensink et al., 2023; Fonagy et al., 2012; Yang & Huang, 2024). Prementalizing modes, which are considered as different steps during the development of mentalization, is thought to be explanatory mechanisms contributing to PTSS (Allen et al., 2012; Rüfenacht et al., 2023). Firstly, psychic equivalence refers to the idea that mental states are dependent on objective, concrete truths. The experience of the internal is thought to be same as the external – for example, in the aftermath of trauma, triggering stimuli may be experienced as threatening, as if the traumatic event still continues, which creates the state of hyperarousal (Allen et al., 2012; Rüfenacht et al., 2023). Secondly, teleological functioning describes the process of actions taking precedence over mental states (Allen et al., 2012; Rüfenacht et al., 2023). For instance, certain avoidance behaviors are thought to keep trauma-related thoughts away (Allen et al., 2012; Rüfenacht et al., 2023). The concrete behavior takes the place of representations and mental activity, which may also be linked with the illusion of control over trauma, or with reenactments of trauma in other contexts (Allen et al., 2012; Rüfenacht et al., 2023). Thirdly, pretend mode points out the situation where the link between mental states and reality is weakened (Allen et al., 2012; Rüfenacht et al., 2023). Flashbacks, or in extreme cases dissociation, may render the person helpless, without a chance to escape from the pain (Allen et al., 2012; Rüfenacht et al., 2023).

Theoretical perspectives mentioned so far are, in general, supported by research. Yang and Huang (2024), in their meta-analysis of 23 works conducted on the association of traumatic experiences early in life and disrupted mentalization capacity, maintain that, despite the difference of sample characteristics (i.e. age, experienced trauma types, having a psychiatric diagnosis or not) and methodologies, there is a relationship between the two. Specifically, hypomentalization, as opposed to hypermentalization, was found to be associated with childhood trauma. Moreover, as the severity of traumatic experiences increased, the deficits in mentalization, too, increased – suggested also by higher effect sizes in clinical samples compared to nonclinical ones. Higher effect sizes were also observed in studies conducted with children, compared to adolescents and adults, which was explained by the fact that dependency on others decrease with age, enabling the person to buffer more efficiently against the effects of trauma.

Elaborating on the same relationship, Garon-Bissonette and colleagues (2023) grouped pregnant women with child maltreatment histories into three categories based on

their reflective functioning capacities, assessed via interviews: “disavowal-distancing”, “distorted-inconsistent” and “definitive-sophisticated” (p. 373), corresponding to hypomentalizing, hypermentalizing and effective mentalizing respectively. Findings of the study indicated that mentalization capacities of maltreated and nonmaltreated women were comparable and increased likelihood of assignment to distancing or inconsistent categories in the case of maltreatment compared to no maltreatment. Specifically, maltreatment was associated more with inconsistent mentalizing, as opposed to distancing. That is, rather than a general deficiency in mentalization, women with traumatic experiences may engage in inaccurately based mentalization. However, the methodology used in the study may be contributing to inconclusive results. Interview-based evaluation of mentalization focuses on the complexities of the process, instead of considering it as a general capacity.

There is a line of research which explores the associations between mentalization capacity and PTSS – both on clinical and subclinical levels. To illustrate, Huang and colleagues (2020) investigated the mechanisms underlying PTSS and dissociative symptoms of 221 people with a diagnosis of personality disorder and 119 people without one, in addition to past traumatic experiences. In the study, it was established that insecure attachment patterns, anxious and avoidant, and deficiencies in mentalization, hyper and hypomentalization, mediated said relationship.

Likewise, Wagner-Skacel and colleagues (2022) examined childhood abuse and neglect and its relation to PTSS and related conditions such as dissociation, depression, anxiety, and somatization, with 67 patients who had psychiatric diagnoses and treatment histories. It was observed that mentalization capacity fully mediated this relationship. Furthermore, medium to large effects were reported regarding the link between lower mentalization levels and higher symptom severity.

In addition, in a study by Berthelot and colleagues (2019), mentalization, specifically hypomentalization, appeared as mediators in the link from childhood traumatic experiences to depression and PTSS was demonstrated. The study was conducted with 301 pregnant women from the general population, potentially limiting its generalizability.

Similarly, Ensik and colleagues (2023), in their study conducted with 101 pregnant women who had experiences of childhood trauma, suggested that other-oriented mentalization mediated the associations of attachment and PTSS. In this study, in contrast

with previous ones, observer-based measures of mentalization, attachment and PTSS was used, which can be considered as a strength.

Finally, Berthelot and colleagues (2022) studied nonclinical populations with a trauma history in terms of their PTSS, as well as dissociative symptoms and dysfunctional personality characteristics. The conclusion that imbalanced mentalization, especially with regard to traumatic experiences, has links with such symptoms even after controlling for the severity of said experiences and demographic variables was reached.

The aftermath of trauma is not limited to PTSS and there are many studies that investigated other potential outcomes and the possible role of mentalization. In a study focusing on adolescents with psychological or psychiatric treatment histories, childhood emotional neglect was found to be associated with anxiety, depressive and borderline features and hypomentalization was found to be a partial mediator (Martin-Gagnon et al., 2023). Another study suggested mentalization capacity and dissociation to be serial mediators regarding fearful attachment and depressive symptoms, in adults with interpersonal trauma experiences (Bogdanovic et al., 2023). Moreover, childhood traumatic experiences were observed to be related to self-injurious behaviors, with attachment and mentalization having mediator roles (Stagaki et al., 2022). The role of mentalization at the disorder level, too, was investigated, proposing it as a mechanism underlying childhood trauma and borderline (Chiesa & Fonagy, 2014) and psychotic (Weijers et al., 2018) symptoms.

A gap in the literature is that most of the studies focus on traumatic experiences during childhood. It is rational considering the context in which mentalization develops, as described before in detail. An aversion towards mentalizing is understandable in the case of trauma (Fonagy et al., 2023). In adulthood, the detrimental effects of childhood trauma may be diminished by access to a variety of means to deal with them and the chance to form new relationships with friends, teachers, therapists – strengthening mentalization capacity (Berthelot et al., 2019; Fonagy et al., 2023; Garon-Bissonnette et al., 2023). Moreover, it may be easier to mentalize when the event is not actively experienced but it is behind the person (Ensink et al., 2023; Garon-Bissonnette et al., 2023). Considering these two views together, in addition to the possibility of traumatic exposure after childhood, the gap in the

literature becomes apparent – trauma throughout life and its relation to mentalization has not been explored in detail.

1.4.3. Mentalization and Vicarious Trauma

The link between mentalization and indirect exposure to trauma, similarly to the direct one, is implicated as well since they both focus on how the event is processed – that is, mentalized. Trauma, by its definition, holds its place in the mind of the individual like a package – haphazardly put together to avoid, including fragmented pieces of the traumatic experience which occasionally may seep out and intrude upon the mind. In a similar fashion, the professional who was exposed to said package, may become vulnerable to the effect of trauma. Imaginative activity related to accounts of traumatic events may act as the main trigger for it, the reaction is for the intense and unformulated emotions and thoughts (Boulanger, 2018). This process includes both the traumatized individual and the professional, where the transmission between them is most of the time uncontrollable – the person involuntarily, perhaps unconsciously, reflects and the professional is similarly receptive (Boulanger, 2018). It can be said that when traumatic materials encountered in the course of work are not mentalized, they begin to affect the person's psychological states, extending beyond their professional life (Boulanger, 2018; Middleton et al., 2021).

Going back to Fonagy and colleagues' (2012) perspective, mentalization capacity involves a boundary between the minds of one's and others' – the acknowledgement that different mental states are possible for the self and others. Concordantly, the vicarious traumatization of a trauma worker may involve mentalization imbalances, the confusion of experiences, thoughts, and feelings, that is, blurring of boundaries between the minds. By extension, mentalization may be implied as a mechanism underlying vicarious traumatization.

The studies investigating this link are few in number. Keeping in mind that not mentalized is avoided or dwelled on, forensic interviewers' work-related reactions of avoiding discussion of vicarious traumatization (Middleton et al., 2021) or the symptoms they show in their personal lives like dissociation, excessive emotions, and acting out (McCann & Pearlman, 1990; Middleton et al., 2021) align with mentalization framework.

These symptoms can be thought to have associations with a disruption in the mentalization processes, leading to disproportionate responses.

Halevi and Idisis (2018) established the predictor role of self-differentiation on vicarious traumatization, where high self-differentiation pointed to lower vicarious traumatization, in their study conducted with 134 people with social work, psychology, psychotherapy, psychiatry, and clinical criminology backgrounds. In the study, highly self-differentiated workers were perceived to have clear boundaries and emotional control in regard to others' intense reactions within the relationship formed in the line of their work.

Hazen and colleagues (2020) explored the possible contributions of Facilitated Attuned Interaction (FAN) approach to vicarious traumatization and burnout. In this approach, which can be considered as an implementation of mentalization-based practices in work life, self-regulation, empathy, elaboration on materials exposed during work, supervision, and reflection processes were integrated, resulting in a program in which trauma workers, specifically child welfare professional for the purposes of this study, can be trained. Moreover, the findings emphasized the moderator role of the quality of said reflective processes on the link between vicarious trauma and burnout.

1.4.4. Mentalization as a Protective Factor

Mentalization capacity's relation with direct and indirect exposure of trauma is well-established. Following this line of thinking, in the cases of intact mentalization, diminished negative effects of such exposure or in the case of improvements in mentalization, relative relief of related symptoms might be expected. Regardless of the theoretical background or methodologies, therapeutical processes in general touch upon mentalization concept, implicitly or explicitly (Fonagy et al., 2012; Sloover et al., 2022), and mentalization-based interventions target this capacity specifically (Fonagy et al., 2012; Rüfenacht et al., 2023).

Improved, or intact, mentalization, therefore, is associated with well-being (McGowan et al., 2021), positive therapeutic outcomes (Antonsen et al., 2016; Ekabled et al., 2016; Euler et al., 2022), therapeutic alliance (Ekabled et al., 2016), and less use of immature defenses (Hayden et al., 2021). The potential protective role of mentalization capacity is implicated, what is mentalized and thinkable does not necessarily leave a negative impact on the person's inner world (Fonagy et al., 2012).

Likewise, recognizing and reflecting on the entirety of reactions in response to vicarious traumatization may play a critical role on decreasing its impact on psychological well-being (McCann & Pearlman, 1990; Middleton et al., 2021; Sabin-Farrel & Turpin, 2003). In line with this, the importance of mentalization capacity, as well as therapy and supervision process, becomes apparent (McCann & Pearlman, 1990). Considering mentalization theory, when a professional is able to mentalize about vicarious traumatization, that is discerning which reactions correspond to whose emotions, to which participating in therapy or supervision helps, it can be said that vicarious trauma becomes easier to deal with (McCann & Pearlman, 1990).

1.5. Current Study

As trauma exposure, in personal and professional life, is widespread and not every exposure leads to a clinical presentation, it is valuable to investigate the connections among exposure, related symptoms, and mentalization as a possible influential factor. Studies examining the cumulative effect of trauma, both in terms of frequency and lifelong perspective, in relation to mentalization is scarce, especially in trauma workers and in Turkish population. In these respects, the current study is believed to be contributory to the present literature.

As per the literature, the aim was to explore the moderating role of mentalization capacity in the relationship between direct (i.e., personal) and indirect (i.e., vicarious) traumatic exposure and subsequent trauma-related symptoms (i.e., intrusion, avoidance, and hyperarousal).

1.5.1. Hypotheses

Hypotheses of the current study are listed below:

H1: Personal traumatization is expected to be positively correlated with PTSS.

H2: Vicarious traumatization is expected to be positively correlated with PTSS.

H3: Mentalization is expected to be negatively correlated with PTSS.

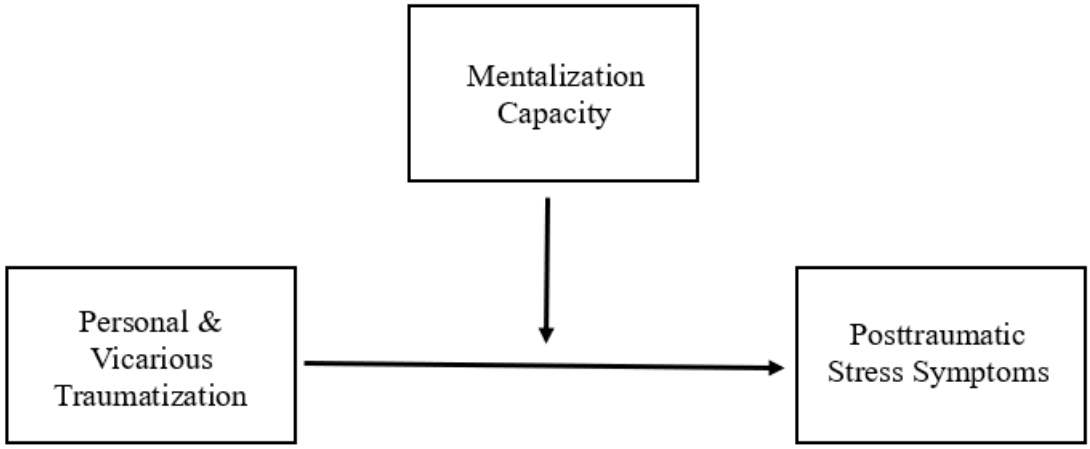
H4: Mentalization is expected to moderate the expected positive correlation between personal traumatization and PTSS, that is, the correlation is expected to be stronger as mentalization decreases (*see* Figure 1).

H5: Mentalization is expected to moderate the expected positive correlation between vicarious traumatization and PTSS, that is, the correlation is expected to be stronger as mentalization decreases (*see* Figure 1).

1.5.2. Conceptual Model

Figure 1

The hypothesized model for the moderator role of mentalization



2. METHOD

2.1. Participants

Initially, 142 people working with traumatized individuals formed the sample. Nine participants were excluded from the final sample due to their reports of no vicarious traumatization, two participants were excluded since they were outliers, and one participant was excluded since they were suspected to not complete the scales truthfully (i.e. giving the same responses for all the items). Finally, a total of 130 participants constituted the sample (109 female and 21 male). To determine the statistical power of the current sample, a G-Power analysis was conducted, with small effect sizes (.05) and alpha value of .05 – revealing the power as .60 (Faul et al., 2007).

The sample mostly involved young adults, with the mean age being 31.75 (*SD* = 6.93). People of various occupational groups participated in the study (*see* Table 1), most of them being psychologists (33%) and working with traumatized individuals daily (28.5%). The average of months spent in the occupation was 81.20 (*SD* = 73.81).

Table 1

Information on participants' occupation

	N	%
Psychologist	43	33
Psychological Counsel	9	7
Doctor	6	5
Nurse	4	3
Lawyer	13	10
Health Worker	6	5
Social Worker	12	9
Sociologist	11	8
Child Development Specialist	3	2
Media-Related	6	4
Other	17	13
Total	130	100

Most participants had undergraduate degrees (51.5%) and described their socioeconomic status (SES) to be ‘middle’ (55.4%). For detailed information on sample characteristics regarding educational attainment, SES, and the frequency of working with trauma, Table 2 can be referred. A small portion of participants were in the process of therapy (n = 33, 25%) and supervision (n = 28, 22%). For those who went to therapy, the average of months they went was 28.79 (SD = 23.08) and for those who were attending supervision, the average of months they attended was 24.61 (SD = 21.41).

Table 2

Information on participants’ educational attainment, SES, and frequency of working with trauma

	N	**%**
Educational Attainment		
High School	3	2.3
BA degree	67	51.5
MA or PhD degree	60	46.2
SES		
Lower	1	0.8
Lower-Middle	26	20
Middle	72	55.4
Upper-Middle	27	20.8
Upper	4	3.1
Frequency of Working with Trauma		
Once a year	10	7.7
A few times a year	18	13.8
Once a month	5	3.8
A few times a month	20	15.4
Once a week	7	5.4
A few times a week	33	25.4
Every day	37	28.5

Note. N = 130.

2.2. Instruments

Participants were asked to complete a survey package consisting of the Mentalization Questionnaire (MentS) for the assessment of their mentalization capacity, the Cumulative Trauma Scale-Short Form (CTS-SF) for the assessment of different types of traumatic events they experienced up to the present, the Impact of Event Scale-Revised (IES-R) for the assessment of symptoms they might experience after traumatic events, in addition to the demographic information form.

2.2.1. The Cumulative Trauma Scale-Short Form

Cumulative Trauma Scale-Short Form (CTS-SF) is a self-report measure designed by Kira and colleagues (2008) in order to assess different types of traumatic events experienced across lifespan. CTS-SF includes 35 events which can be summarized in six factors – collective identity, family, secondary, identity, survival, and attachment trauma. For each event, the occurrence, the frequency of occurrence, the age at time of the first occurrence, and the effect of the occurrence is measured for an extensive evaluation of the trauma history. The frequency of occurrence is assessed with a 5-point Likert scale (0: never, 1: once, 2: twice, 3: three times, 4: many times) and the effect of the event is assessed with a 7-point Likert scale (1: extremely positive, 7: extremely negative). Evaluating perceived positive and negative effects of the event is another, and more preferred, method of scoring. In this method, a 4-point Likert scale is used twice (4: extremely positive, 1: neutral, 4: extremely negative) – resulting in two separate scores, where higher scores indicate higher positive and negative perceived effect. CTS-SF was shown to be a valid measure for clinical and nonclinical populations. Its convergent validity was demonstrated by positive correlations with torture severity and backlash trauma, and its divergent validity was demonstrated by negative correlations with futuristic orientation and sociocultural adjustment. Furthermore, CTS-SF was found to be a reliable measure (Cronbach's alpha = .84).

CTS-SF was adapted into Turkish by Eltan & Karancı (2022). The adaptation has the same number of items with four subscales which were decided by experts on the field (interrater reliability values ranging from 45.7% to 82.9%) since the factor analysis revealed unsatisfactory results. The subscales are survival, personal identity, collective identity, and family-attachment trauma. For the reliability analyses, a composite score (multiplication of

the frequency by the effect of the event) was calculated, both for negative and positive perceptions of the events' effect on the person (namely CTS-SF Negative and CTS-SF Positive). CTS-SF Negative was found to be adequately reliable (Cronbach's alpha = .74); however, CTS-SF Positive was found to have unsatisfactory reliability (Crobhach's alpha = .58). The adaptation was found to be a valid measure, as supported by positive correlations of CTS-SF with trauma symptomatology and post-traumatic growth (concurrent validity), and no significant correlations between CTS-SF and social adaptation or general self-efficacy (divergent validity).

Additionally, whether participants encountered accounts of such events in the course of their work were asked (0: no, 1: yes) in the current study, as a measure of vicarious traumatization.

2.2.2. The Impact of Event Scale-Revised

The Impact of the Event Scale-Revised (IES-R) was developed by Weiss and Marmar (1997) for measuring psychological symptoms of individuals following trauma. The IES-R was designed to have three subscales considering PTSS – intrusion, hyperarousal, and avoidance. However, exploratory factor analysis revealed one factor, which indicates that the IES-R measures stress related to trauma in general rather than trauma related disorders with distinct symptoms (Creamer et al., 2003). The measure consists of 22 items and is scored on a 5-point-Likert scale (0: not at all, 4: extremely). The scale was found to have adequate internal reliability (Cronbach's alpha values: $\alpha = .87$ to .92 for intrusion, $\alpha = .84$ to .85 for avoidance, $\alpha = .79$ to .90 for hyperarousal, and $\alpha = .96$ for total) (Creamer et al., 2003; Weiss & Marmar, 1997).

The IES-R was translated into Turkish by Çorapçıoğlu and colleagues (2006). The translation has the same number of items and the same factor structure. It was found to be a valid and reliable measure in both clinical and nonclinical populations (Cronbach's alpha values ranging between .87 to .94).

2.2.3. The Mentalization Scale

The Mentalization Scale (MentS) is a self-report measure designed by Dimitrijević and colleagues (2018) in order to assess an individual's capacity for mentalization. Self- and other-related mentalization and curiosity about mental states are included in the

conceptualization of this capacity, resulting in three subscales - mentalization related to self (MentS-S), to other (MentS-O) and motivation for mentalization (MentS-M). The MentS has- 28 items in total and the subscales have 8, 10 and 10 items respectively. A 5-point-Likert scale is used for scoring (1: completely incorrect, 5: completely correct), where higher scores suggest more effective mentalization capacity. The MentS was found to be a valid and reliable measure for both clinical and nonclinical populations. as indicated by positive correlations with closely related constructs such as emotional intelligence and empathy and satisfactory internal reliability (Cronbach's alpha values: α = .84 for MentS-Total, α = .76 for MentS-S, and α = .77 for MentS-O and MentS-M).

The MentS was adapted in Turkish by Törenli Kaya and colleagues (2021). The adaptation includes the original three subscales with 1 item from MentS-O and 2 items from MentS-M removed since exploratory factor analysis revealed factor loadings lower than .30 for the said items. The adapted scale had adequate internal reliability (Cronbach's alpha values: α= .84 for MentS-Total, α = .78 for MentS-S, α = .80 for MentS-O, and α = .79 for MentS-M) and adequate test-retest reliability (*r* = .73 for MentS-Total, *r* = .68 for MentS-S, *r* = .70 for MentS-O and *r* = .64 for MentS-M). The adaptation was found to be valid as suggested by positive correlation with emotional intelligence and negative correlation with borderline personality traits.

2.2.4. Demographic Information Form

The Demographic Information Form was designed by the researcher to gather information about some participant characteristics – such as age, gender, educational attainment, perceived SES, occupation, time spent in occupation, frequency of working with traumatized individuals, access to psychotherapy and supervision at the time and duration of said processes. The final two questions were not mandatory and if not answered, participants were assumed to not be receiving psychotherapy or supervision.

2.3. Procedure

Ethics Board of Social Sciences and Humanities of the Yeditepe University's approval was received prior to data collection. In the process of data collection, a Google Forms link was prepared, which included the informed consent (Appendix A), the MentS

(Appendix B), CTS-SF (Appendix C), IES-R (Appendix D), demographic information form (Appendix E) and the debrief (Appendix F). The form was sent out via social media, using a snowballing sampling method. Participants who consented continued with the process of completing the survey package. The process took approximately 15 minutes and participants were debriefed afterwards.

3. RESULTS

In this section, the data analysis process and results will be explained. Firstly, how data was readied for analyses and how scores were obtained for each variable were described. Secondly, sample characteristics were summarized. Thirdly, correlations between the variables of the study were displayed. Lastly, hypothesized moderation models were tested.

3.1. Data Cleaning & Analysis

There were four main variables in the current study: personal traumatization, vicarious traumatization, mentalization capacity, and PTSS. Personal traumatization (PT) was the preferred label for the CTS-SF Negative scores. 28 data points (%0.006) for the perceived effect of the trauma were missing and were completed by participant's means. Later, composite scores were calculated, as advised by the adaptors of the scale, and were used in analyses. Two participants were decided to be outliers (*z* scores being higher than 3) regarding their PT scores, which were removed from the analyses. These composite scores were calculated for four different types of traumatic events indicated by the adaptation of the CTS-SF. Moreover, the age at the time of the event first experienced was left out of the analyses since there was a lot of missing information. Vicarious traumatization (VT) was obtained in a similar fashion to PT, that is, via the multiplication of the frequency of exposure during work (7-point Likert scale; 1: once a year, 7: everyday) by exposure to listed events (min: 1, max: 35), resulting in a composite score similar to PT. However, unlike PT scores, how the person perceived the trauma encountered during work was not included in the scores as a parameter. PTSS was operationalized as IES-R total scores and Mentalization capacity was operationalized as MentS total scores, where higher scores were indicative of higher PTSS and higher mentalization. All of the statistical analyses were conducted via IBM SPSS version 25.

3.2. Sample Characteristics

Prior to moving forwards with the analyses, the normality of the data was checked. Along with skewness and kurtosis values, mean and standard deviation for the main study

variables are displayed in Table 3. Skewness and kurtosis values were mostly in the range between -2 and +2, therefore, a relatively normal distribution of the dataset was assumed (George & Mallery, 2010), except for some of the subscales (CIT and MentS-O) for which nonparametric tests were utilized when necessary.

Table 3

Mean, standard deviation, skewness and kurtosis values of variables PT, VT, IES-R and MentS

Variable	*M*	*SD*	Skewness	Kurtosis
Personal Traumatization (PT)	43.79	31.07	.93	.562
Survival Trauma (ST)	9.31	8.73	1.21	1.09
Personal Identity Trauma (PIT)	16.57	15.95	1.23	1.26
Collective Identity Trauma (CIT)	8.00	11.66	1.87	3.98
Family-Attachment Trauma (FAT)	9.90	8.42	.94	.14
Frequency of exposure	16.44	10.35	.67	-.12
Vicarious Traumatization (VT)	112.70	76.16	.11	-1.32
Impact of the Event Scale (IES-R)	25.95	18.98	.88	.65
Avoidance (IES-R-A)	10.21	7.09	.39	-.63
Hyperarousal (IES-R-H)	6.10	5.87	1.28	1.17
Itrusion (IES-R-I)	9.63	7.87	.89	.31
Mentalization Scale (MentS)	95.86	12.13	-.35	.14
Self-related (MentS-S)	32.26	4.90	-.62	.52
Other-related (MentS-O)	35.53	5.99	-1.60	4.42
Motivation for mentalization (MentS-M)	30.07	5.64	-.67	.11

Note. N = 130.

The links between participants' ages and their PT, VT, MentS and IES-R scores were explored by Pearson product-moment correlation analyses. Age and VT was found to be positively correlated (r = .20, p = .024). The relationships between age and PT (r = -.06, p = .518), IES-R (r = -.07, p = .422), or MentS scores (r = -.10, p = .262) did not reach statistical significance.

To explore the relationship between time spent in occupation and VT scores, a Pearson product-moment correlation analysis was carried out, revealing a small positive correlation between the two (r = .21, p = .016) There were no significant relationships between time spent in occupation and PT (r = -.06, p = .527), IES-R (r = -.08 , p = .358), or MentS scores (r = -.05, p = .556).

To investigate possible gender differences regarding PT, VT, and MentS scores, three independent samples t-tests were conducted. Homogeneity of variances between the groups was assessed by Levene's test, which was nonsignificant (p > .05). In terms of PT, there were no differences between females (n = 109, M = 44.26, SD = 31.54) and males (n = 21, M = 41.37, SD = 29.12), t(128) = .389, p = .698. In terms of VT, there were no significant differences between females (M = 110.43, SD = 77.32) and males (M = 124.48, SD = 70.42), t(128) = -.773, p = .441. In terms of MentS scores, there were no differences between females (M = 98.43, SD = 12.14) and males (M = 94.90, SD = 11.98), t(128) = .12, p = .224. A Mann-Whitney U test was conducted for IES-R scores, where normality could not be assumed, which revealed no significant differences between females (Mdn = 24) and males (Mdn = 22), U = 999.5, z = -.918, p = .359, r = -.08.

To see whether there were differences regarding PT, VT, MentS and IES-R scores of participants who were and those who were not in the process of therapy, a number of t-tests were conducted, after confirming that the data was relatively normally distributed and variances of the groups were comparable (all ps > .05, revealed by Levene's tests). The results are summarized in Table 4.

Table 4

Independent samples t-tests results for comparison between being in therapy process or not

	Those who were in therapy		Those who were not in therapy		*t*	*df*	*p*
	M	*SD*	*M*	*SD*			
PT	48.23	30.80	42.28	31.18	.95	128	.344
VT	106.94	75.19	114.66	76.78	-.50	128	.617
MentS	102.30	10.04	96.35	12.46	2.48	128	.014
IES-R	22.97	18.98	26.96	18.96	-1.04	128	.299

As the results point, those who were in therapy process had higher MentS score. To further explore the relationship between being in therapy and study variables, a Pearson product-moment correlation analysis was used. A moderate positive correlation between duration of therapy and MentS scores was revealed (r = .49, p = .004), as well as a moderate negative correlation between duration of therapy and IES-R scores (r = -.47, p = .006). The duration of therapy was not found to be associated with PT (r = -.32, p = .071) or VT (r = .21, p = .251).

3.3. Correlations among the Variables

The associations between the variables of the study were investigated via Pearson product-moment correlation analyses, where both variables had a relatively normal distribution, and Spearman's rank correlation analyses, where normal distribution could not be assumed for variables (MentS-O and CIT). Results are demonstrated in Table 5, where significant associations are marked.

Table 5

Correlations among study variables and their subscales

	1	2	3	4	5	6	7	8	9	10
PT	-									
VT	.12	-								
IES-R	.19*	-.10	-							
IES-R-A	.24**	-.01	.88***	-						
IES-R-H	.14	-.19*	.90***	.66***	-					
IES-R-I	.14	-.10	.95***	.73***	.84***	-				
MentS	-.01	.17	-.15	-.13	-.16	-.13	-			
MentS-S	.01	.12	-.08	-.11	-.07	-.03	.83***	-		
MentS-O	.06	.12	-.02	-.00	-.05	-.01	.76***	.62***	-	
MentS-M	-.10	.11	-.31***	-.23**	-.31***	-.30***	.56***	.14	.17	-

Note. $N = 130$. * $p < .05$ (2-tailed), ** $p < .01$ (2-tailed), *** $p < .001$ (2-tailed)

In accordance with the results, the first hypothesis, the expectation of a positive correlation between PT and IES-R scores, was supported. The second hypothesis of the study, the expectation of a positive correlation between VT and IES-R scores, was not supported. In contrast, there was a negative association between VT and IES-R Hyperarousal scores. The third hypothesis, the expectation of a negative correlation between MentS and IES-R scores, was supported not in terms of total scores but in terms of Ments-M scores.

3.4. Moderation Analyses

Prior to moving on with moderation analyses, assumptions of multiple linear regression analysis were checked. Absence of outliers and multicollinearity (tolerance values > .10), normal distribution of residuals, linearity and homeoscedasticty was assumed. All of the predictors (PT and VT) and the moderator (MentS), computed as an interaction between predictors (PT*MentS and VT*MentS), were entered into regression analyses after standardization.

The model with PT as a predictor and MentS as a moderator accounted for 6% of the variance in IES-R, $R = .25$, $R^2 = .06$, $F(3, 126) = 2.72$, $p = .047$. The model with VT as a

predictor, MentS as a moderator and IES-R as the outcome was nonsignificant, $R = .18$, $R^2 = .03$, $F(3, 126) = 1.34$, $p = .265$. The results are presented in Table 6 and Table 7.

Table 6

Moderating effect of MentS on the relationship between PT and IES-R

	B	*SE B*	β	*t*	*p*
Constant	24.94	1.63		15.89	< .001
PT	3.67	1.64	.19	2.24	.027
MentS	-1.59	2.71	-.08	-.59	.558
PT*MentS	-.03	.06	-.08	-.56	.576

Note. IES-R as the dependent variable.

Table 7

Moderating effect of MentS on the relationship between VT and IES-R

	B	*SE B*	β	*t*	*p*
Constant	26.09	1.68		15.53	< .001
VT	-1.61	1.70	-.09	-.95	.344
MentS	-2.68	1.70	-.14	-1.58	.117
VT*MentS	-.85	1.61	-.05	-.53	.598

Note. IES-R as the dependent variable.

As indicated by the results, the moderating role of MentS was not supported, which resulted in the rejection of hypotheses four and five. Since Ments-M was found to be correlated with IES-R, rather than MentS, the same moderation models for PT and VT were tested using MentS-M as the moderator, as post-hoc analyses.

The model with PT as a predictor and MentS-M as a moderator accounted for 12% of the variance in IES-R, $R = .35$, $R^2 = .12$, $F(3, 126) = 5.91$, $p = .001$. The model with VT as a predictor and MentS-M as a moderator accounted for 10% of the variance in IES-R, $R =$

.32, R^2= .10, $F(3, 126) = 4.72$, p = .004. The results are presented in Table 8 and Table 9. The moderating effect of MentS-M was not significant; however, MentS-M appeared as the most prominent predictor of IES-R, in comparison to PT and VT.

Table 8

Moderating effect of MentS-M on the relationship between PT and IES-R

	B	*SE B*	β	*t*	*p*
Constant	25.85	1.59		16.28	< .001
PT	2.99	1.60	.16	1.89	.062
MentS-M	-5.63	1.60	-.30	-3.52	.001
PT*MentS-M	-.99	1.78	-.05	-.56	.580

Note. IES-R as the dependent variable.

Table 9

Moderating effect of MentS-M on the relationship between VT and IES-R

	B	*SE B*	β	*t*	*p*
Constant	25.91	1.61		16.13	< .001
VT	-1.34	1.61	-.07	-.83	.407
MentS-M	-5.59	1.62	-.30	-3.51	.001
VT*MentS-M	.39	1.62	.02	.24	.812

Note. IES-R as the dependent variable.

4. DISCUSSION

The potential moderating role of mentalization capacity on the relations of personal trauma history and vicarious traumatization with psychological symptoms emerging in the aftermath of trauma, that is avoidance, intrusion, and hyperarousal, was explored in the current study. In the following segment, the major findings are discussed in detail first. Then, clinical implications and limitations of said findings are contemplated. Lastly, final remarks will be summarized.

4.1. Major Findings of the Study

The correlational analysis revealed an association between personal trauma history and PTSS, meaning that the first hypothesis was supported. The most typically emerging symptoms following traumatic exposure – which are clustered under hyperarousal, intrusion, and avoidance – was found to associated with direct exposure to trauma, as expected. The measurement tool of personal trauma history combined the frequency and the perceived effect of the direct exposure. Most of the previous studies conducted on the topic included both of these dimensions reported similar results (Cloitre et al., 2009; Kira et al., 2008; Koenen et al., 2007; Sareen, 2014; Suliman et al., 2009). Thus, this finding can naturally be considered a replication, being congruous with the literature.

On the other hand, the expectation of an association between indirect exposure to traumatic material and PTSS, the second hypothesis of the study, was not supported, despite the fact that the literature points to such a link (Baird & Kracen, 2006; Boulanger, 2018; Sabin-Farrel & Tupin, 2003; Var & Büyükbodur, 2017). Vicariously experiencing trauma was assumed to have a similar relationship with PTSS as directly experiencing it, as DSM-5 implies (APA, 2013). In the literature, however, vicarious trauma was evaluated via self-reports of trauma-related symptoms, psychological symptoms in general, psychological well-being, in addition to vicarious trauma-specific measures such as self-reports of STS, burnout, or compassion fatigue (Sabin-Farrel & Turpin, 2003). This methodological variety on the topic makes the comparison of studies and examination of the results in a connected manner difficult. Nevertheless, the mentioned relationship was still evident (Molnar et al., 2020), which makes this finding incongruous with previous studies. Furthermore,

hyperarousal-related symptoms were found to be diminishing as vicarious traumatization showed an upward trend. It can be speculated that the more accounts of traumatic events are encountered during work, the more the trauma worker becomes desensitized. The events may become mundane, rather than traumatic, in the work setting.

The expectation of a link between mentalization capacity in general and PTSS, the third hypothesis of the study, was not supported statistically. Still, the findings pointed to a link where increases in mentalization capacity were met with decreases in PTSS. This can be explained by the fact that having the capacity or being ready to mentalize may be more important regarding the emergence of symptoms after the trauma. As suggested in the literature, how trauma is perceived during the occurrence or encounter of the event precedes other risk-associated elements (Allen et al., 2012; Ozer et al., 2003). Alternatively, rather than self- or other-specific mentalizing, a general decrease in thinking on mental activity may be the case (Fonagy et al., 2023).

Personal trauma was revealed as a predictor for PTSS, while vicarious trauma or mentalization capacity in general were not. In this association, there were no statistical support for the moderating influence of mentalization, resulting in the rejection of the fourth and fifth hypotheses of the study. Mentalization capacity as an underlying mechanism for this relationship is apparent (Berthelot et al., 2019; Berthelot et al., 2022; Ensink et al., 2023; Huang et al., 2020; Wagner-Skacel et al., 2022), yet the research considering it a protective factor is scarce. The concept of mentalization brings together the cognitive and affective, the self and other, the inner and outer, and the explicit and implicit, which makes it a challenge to have a comprehensive assessment. There are many tools for the assessment of mentalization capacity involving tasks, interviews or self-reports. These assessment tools are shown to be moderately but not too highly correlated (Rumeo, 2022), which is an indicator of the fact that they measure the same construct while tapping on slightly different aspects of it. Getting a full picture in a research setting, using self-report measures is challenging since only the explicit and externally based aspects can be measured. It may be possible that the implicit or the internally based aspects may have a more prominent relationship with traumatic exposure and its aftermath. Moreover, trauma-specific imbalances in mentalization capacity can be the case, rather than trauma impacting the mentalization capacity in general (Fonagy et al., 2012; Garon-Bissonette et al., 2023).

As part of post-hoc analyses, the possible moderator role of motivation for mentalizing was explored but was not supported either. Motivation for mentalizing emerged as more predictive of PTSS, compared to direct or indirect exposure to trauma, which, again, can be explained by peri-trauma factors' importance regarding PTSS (Allen et al., 2012; Ozer et al., 2003), or a decreased interest in the internal experience and external world – weakening the link (Fonagy et al., 2012; Rüfenacht et al., 2023).

Moreover, the proposed moderation models in the study explained a small portion of variance in PTSS, which can be indicative of the fact that various factors are implied in the pathway from trauma to its aftermath (Allen et al, 2012; Rosen & Lilienfeld, 2008), being incongruent with the idea of 'single exposure-single disorder' (Allen et al, 2012).

There is a number of findings worth mentioning, despite not being among the hypothesized relationships. For instance, being in the process of therapy was found to make a difference regarding mentalization capacity, that is those who had access to therapy had enhanced mentalization capacity. This finding contributes to the idea that therapy process in general enables mental activity and thinking about mental states and, specifically, contributes to the proposed efficacy of mentalization-based approached to therapy (Fonagy et al., 2012). Alternately, since no causal links can be established, those having an easier time mentalizing may be more likely to participate in psychotherapy.

Lastly, although the existing literature reported gender differences in which females being at disadvantage regarding trauma and its aftermath (Çalık Var & Çetinkaya Büyükbodur, 2017; Gül & Karancı, 2017; Koenen et al., 2007; Molnar et al., 2020; Perkonigg et al., 2000; Sareen, 2014; Tolin & Foa, 2006; Vrklevski & Franklin, 2008), and being at advantage regarding mentalization (Rutherford et al., 2012; Törenli Kaya et al., 2021), the results of the current study failed to provide support for the idea, revealing no differences. The participants were mostly female, as trauma workers generally are (Hensel et al., 2015). The discrepancy in the literature and the current findings may be due to the sample size and associated power. An alternative explanation may be that the Republic of Turkey is, unfortunately, rich in traumatic experiences. Thus, the differential impact of trauma in terms of gender may disappear in such an environment.

4.2. Clinical Implications

Mentalization processes are impacted in the case of trauma, which makes it a possible mechanism for various psychiatric conditions (Fonagy et al., 2012). Ineffective mentalizing or the use of prementalizing modes especially leaves the trauma-related or trauma-specific mental states reign over the mind (Fonagy et al., 2012; Rüfenach et al., 2023). Therapy is a natural setting where the unmetabolized can be worked on as the therapist maintain curiosity and capacity to deal with it (Fonagy et al., 2012), mimicking the environment where effective mentalization capacities develop between the caregiver and the child.

Mentalization-Based Treatment (MBT) was first proposed as a novel intervention for borderline personality disorder (BPD; Fonagy & Bateman, 2006); however, its area of use in clinical settings has been subsequently expanded. MBT focuses on enhancement of mentalization capacities in an evidence-based and structured manner where the therapist facilitates mentalization for the patient, building resiliency (Luyten et al., 2020a). Randomized controlled trials conducted for the exploration of MBT's efficacy provided support for its utilization with BPD (Luyten et al., 2020a), which is usually comorbid with PTSD (Smits et al., 2022). PTSD-specific programs targeting PTSS and dissociation are also present (Luyten et al., 2020a; Rüfenacht et al., 2023); however, studies investigating their efficacy is still limited in number (Luyten et al., 2020a). Fostering mentalization in clinical and nonclinical settings, in work for example, and planning interventions are of significance.

4.3. Limitations and Future Directions

Some limitations specific to the current study should be kept in mind during interpretation, where the size of the sample and the associated power being the most constricting on implications and generalizability. The hypotheses of the study were mostly in the expected trend, yet the results failed to reach significance, which may be due to the limited power. Future studies might focus on the same model, since it is theoretically well grounded, aiming for a higher number of participants.

The sample of the current study included various occupational groups, which were implicated by the literature for bearing the impact of vicarious traumatization. Since the current study was exploratory in nature, due to the scarcity of research on mentalization capacity and vicarious traumatization, inclusion of different occupational groups with

differing levels and means of exposure (Hensel et al., 2015; Sabin-Farrel & Turpin, 2003; Zara & İçöz, 2015) was preferred. This may be considered as a factor introducing noise to the data. Vicarious traumatization and its potential link with mentalization capacity is of research value, and focusing on different occupational groups and their unique experiences may be of interest for future studies.

Despite emphasizing the point that how trauma is held in mind takes precedence over the event-specific details, there were no information on how trauma workers were influenced by vicarious traumatization in the calculated scores used in analyses. More frequent exposure may be linked with more negative impact (Lerias & Bryne, 2003; Sabin-Farrel & Turpin, 2003; Zara & İçöz, 2015); however, it would be based on inferences and there are contradictory findings in the literature suggesting no associations between the amount of exposure and vicarious traumatization (Baird & Kracen, 2006). Future studies may consider investigating this information, along with information on in what manner the trauma workers were exposed (i.e. witnessing, hearing about it or reading about the details) as factors associated with their vicarious traumatization.

Mentalization capacity, in the current study was operationalized based on participants' self-evaluations. Different methods of assessment can be subject of future research since they have been shown to tap into different aspects of mentalization, or imbalances regarding it. Interview-based measures evaluate the quality of mentalization (Garon-Bissonnette et al., 2023) while self-report measures tend to generate an idea based on quantity (Rumeo, 2022) – more or less mentalizing. To better investigate the nuances in mentalization capacity in the aftermath of trauma, incorporating implicit mentalization as well, other assessment tools can be utilized, maybe in combination (Rumeo, 2022). The proposed models in this particular study explained a small portion of variance in PTSS, and it can be speculated that these other aspects of mentalization, which was not included, may have some predictive power.

As explained previously, the aftermath of trauma is not universal. The current study focused on PTSS, as the most typical presentation; however, mentalization as a potential mechanism for in the emergence of symptoms following traumatic events might be explored further. Moreover, therapy and supervision processes were revealed as important factors regarding mentalization capacity and PTSS in the current study, which raises the question

of what specific features of these processes are influential – the presence of a relationship, an alliance, social support in general or some other specific characteristics.

Finally, the data was collected in an online setting for the current study, which increases accessibility while decreasing the control over the collection process. Furthermore, the assessment tools used was based on self-reports, which are easy to administer (Rumeo, 2022). However, getting a close to realistic assessment of mentalization capacity might be tricky since it is about how the mind works in general and the possibility of bias is high (Rumeo, 2022), and retrospective assessment of trauma history may be subject to bias as well (Tolin & Foa, 2006), although research suggests it to be minimal (Şar et al., 2022).

4.4. Conclusion

The study explored the links between personal and vicarious traumatization, related symptoms and mentalization capacity within a cross-sectional design. The findings failed to provide support for the moderator role of mentalization; however, motivation for mentalization and personal traumatization appeared as predictors for PTSS. Furthermore, psychotherapy was indicated as important factor regarding PTSS. Even though a meaningful relationship among vicarious traumatization, mentalization and PTSS was absent, the current study was of importance considering it was one of the first attempts of exploring said links in the Turkish population. By building a literature around these topics and furthering our knowledge, evidence-based interventions for trauma workers, which are promoting mentalization and resilience, can easily be planned.

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APPENDIX A: Informed Consent Form (Bilgilendirilmiş Onam Formu)

Bu tez çalışması Yeditepe Üniversitesi Klinik Psikoloji Yüksek Lisans Programı bünyesinde Doç Dr. Oğuzhan Zahmacıoğlu danışmanlığında Mehtap Özkanca tarafından yürütülmektedir. Bu form sizi araştırma koşulları hakkında bilgilendirmek için hazırlanmıştır.

Çalışmanın Amacı Nedir?

Bu çalışmanın amacı, deneyimlenen veya iş gereği dinlenen travmatik yaşantıların psikolojik bazı süreçlerle olan ilişkisini incelemektir.

Bize Nasıl Yardımcı Olmanızı İsteyeceğiz?

Araştırmaya katılmayı kabul ederseniz sizden, geçmiş travmatik yaşantılarınız, iş gereği dinlediğiniz travmatik materyaller, kendiniz ve diğerleriyle olan ilişkiniz hakkında bir dizi soruyu yanıtlamanız beklenmektedir. Bu çalışmaya katılım ortalama 20 dakika sürmektedir.

Katılımınızla ilgili bilmeniz gerekenler:

Bu çalışmaya katılmak tamamen gönüllülük esasına dayalıdır. Herhangi bir yaptırıma veya cezaya maruz kalmadan çalışmaya katılmayı reddedebilir veya istediğiniz noktada çalışmayı bırakabilirsiniz. Çalışma dahilinde kimlik bilgileriniz toplanmayacaktır. Sağladığınız diğer veriler yalnızca araştırma dâhilinde kullanılacaktır. Elde edilecek bilgiler araştırmacılar tarafından toplu halde değerlendirilecek ve bilimsel yayımlarda rapor edilmek için kullanılacaktır.

Olası faydalar ve riskler:

Çalışmaya katılmanız durumunda literatüre bu konu hakkında destek sağlayarak veri eklememize yardımcı olacaksınız. Ankette genel olarak kişisel rahatsızlık verecek sorular bulunmamakla birlikte bazı soruların içerikleri hatırlaması hoş olmayan deneyimler ile ilgilidir. Katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz çalışmaya katılımınızı sonlandırabilir ve araştırmacı ile iletişime geçebilirsiniz.

Bu bilgilendirilmiş onam belgesini okudum ve anladım. Bu araştırmaya katılmayı hür irademle kabul ediyorum.

APPENDIX B: Mentalization Scale (Zihinselleştirme Ölçeği)

Yönerge: Lütfen her bir maddeyi dikkatlice okuyunuz ve size en uygun seçeneği 1 ile 5 arasında işaretleyiniz.

1	2	3	4	5
Tamamen yanlış	Çoğunlukla yanlış	Hem doğru hem yanlış	Çoğunlukla doğru	Tamamen doğru

1. Davranışlarıma yol açan nedenleri anlamayı önemserim.	1	2	3	4	5
2. Başkalarının kişilik özellikleri hakkında karar verirken ne söyleyip ne yaptıklarını dikkatlice gözlerim.	1	2	3	4	5
3. Başkalarının duygularını tanıyabilirim.	1	2	3	4	5
4. Çoğunlukla başkaları ve onların davranışları üzerine düşünürüm.	1	2	3	4	5
5. Genellikle insanları neyin rahatsız ettiğini ayırt edebilirim.	1	2	3	4	5
6. Başkalarının duygularını paylaşabilirim (örn. acısını/sevincini paylaşmak gibi).	1	2	3	4	5
7. Birisi beni sinirlendirdiğinde neden o şekilde tepki verdiğimi anlamaya çalışırım.	1	2	3	4	5
8. Kendimi kötü hissettiğimde üzgün mü, korkmuş mu yoksa kızgın mı olduğumdan emin olamam.	1	2	3	4	5
9. Başkalarının davranışlarını anlamaya çalışarak vaktimi harcamayı sevmem.	1	2	3	4	5
10. Başkalarının düşünce ve duygularını bildiğimde davranışları hakkında doğru tahminlerde bulunabilirim.	1	2	3	4	5
11. Çoğu kez kendime bile neden öyle bir şey yaptığımı izah edemem.	1	2	3	4	5
12. Bazen bir başkasının duygularını o bana henüz bir şey söylemeden anlayabilirim.	1	2	3	4	5
13. Yakın olduğum insanlarla ilişkilerimde ne olup bittiğini anlamayı önemserim.	1	2	3	4	5
14. Kendimle ilgili hoşuma gitmeyecek bir şeyi keşfetmek istemem.	1	2	3	4	5
15. Yakın olduğum insanlarla sık sık duygular hakkında konuşurum.	1	2	3	4	5
16. Üzüldüğümü, incindiğimi ya da korktuğumu kendime itiraf etmeyi güç bulurum.	1	2	3	4	5
17. Sorunlarım hakkında düşünmekten hoşlanmam.	1	2	3	4	5
18. Yakın olduğum insanların belirgin özelliklerini doğru ve ayrıntılı biçimde tarif edebilirim.	1	2	3	4	5
19. Tam olarak nasıl hissettiğim konusunda sıklıkla kafam karışıktır.	1	2	3	4	5
20. Duygularımı ifade etmek konusunda uygun sözcükleri bulmak benim için zordur.	1	2	3	4	5
21. İnsanlar bana kendilerini anladığımı ve akıllıca tavsiyeler verdiğimi söyler.	1	2	3	4	5
22. İnsanların neden belirli şekillerde davrandıkları hep ilgimi çekmiştir.	1	2	3	4	5
23. Ne hissettiğimi kolayca tanımlayabilirim.	1	2	3	4	5
24. İnsanlar kendi duyguları ve ihtiyaçları hakkında konuşurlarken aklım başka şeylere kayar.	1	2	3	4	5
25. Hepimiz hayat şartlarına tabi olduğumuz için başkalarının niyetlerini veya isteklerini düşünmek anlamsızdır.	1	2	3	4	5

APPENDIX C: Cumulative Trauma Scale-Short Form (Birikimli Travma Ölçeği-Kısa Form)

Yönerge: Birçok kişi hayatında farklı olaylar ve durumlar yaşamıştır. Aşağıdaki sorularda size belirli olaylarla ilgili sorular sorulmaktadır. Lütfen her olay için; eğer sizin yaşamınızda olduysa kaç kere olduğunu, sizi olumlu veya olumsuz ne kadar etkilediğini ve iş hayatınızda karşılaşıp karşılaşmadığınızla ilgili soruları yanıtlayınız.

1. **Hayatımda deprem, kasırga veya sel gibi doğal afetlere şahit oldum ya da bizzat yaşadım.**
   Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
   Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
   Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

   İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
   Evet ( ) Hayır ( )
2. **Hayatımda deprem, kasırga veya sel gibi doğal afetlere şahit oldum ya da bizzat yaşadım.**
   Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
   Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
   Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

   İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
   Evet ( ) Hayır ( )
3. **Yaşamımı tehdit eden bir kaza yaşadım (örn. trafik kazası).**
   Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
   Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
   Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

   İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
   Evet ( ) Hayır ( )
4. **Savaşa veya çatışmaya katıldım veya maruz kaldım/teröre maruz kaldım.**
   Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
   Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
   Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

5. **Sevdiklerimin, örneğin ebeveynlerimin veya yakın arkadaşlarımın, ölümcül veya kalıcı hasar bırakan bir olay yaşamasına şahit oldum.**
   Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
   Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
   Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

   İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
   Evet ( ) Hayır ( )

6. **Yaşamımı tehdit eden bir hastalık ya da kalıcı hasar bırakan bir olay yaşadım. (örneğin kanser, felç, ciddi kronik hastalık veya ciddi yaralanma).**
   Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
   Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
   Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

   İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
   Evet ( ) Hayır ( )

7. **Silahlı bir soygun yaşadım (soygun ya da saldırı).**
   Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
   Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
   Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

   İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
   Evet ( ) Hayır ( )

8. **Bir tanıdığın ya da bir yabancının şiddetli bir saldırıya uğramasına şahit oldum (örneğin: silahla vurulma, terör saldırısında yaralanma veya hayatını kaybetme, bıçaklanma, şiddetli dövülme).**
   Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
   Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
   Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

9. Öldürülmek veya ciddi olarak zarara uğratılmakla tehdit edildim.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

10. Bana bakım veren biri, örneğin ebeveynim tarafından fiziksel tacize uğradım, yaralanmama sebep olacak derecede itildim veya dövüldüm.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

11. Bana bakım veren birinin ya da ebeveynimin, bakım veren başka birine ya da diğer ebeveynime vurduğunu, canını acıttığını ya da ölümle tehdit ettiğini duydum veya gördüm.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

12. Benden yaşça büyük biri tarafından cinsel ilişkiye yönlendirildim.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

13. Bir veya birden fazla kişi tarafından tecavüze veya cinsel tacize uğradım veya istenmeyen cinsel ilişkiye maruz kaldım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

14. Hapse girdim ve/veya işkence gördüm.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

15. Ben küçükken annem beni terk etti veya birbirimizden ayrı kaldık.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

16. Ben küçükken babam beni terk etti veya birbirimizden ayrı kaldık.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz

1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

17. Etnik kimliğim, ırkım, kültürüm, dinim veya ulusal kökenimden dolayı başkalarının olumsuz tutumları, kalıp yargıları veya davranışları ile aşağılandım, tehdit edildim veya ayrımcılığa uğradım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

18. Ebeveynlerim boşandı veya ayrıldı.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

19. Irkımın tarihçesinde baskı görme, ayrımcılığa uğrama veya soykırımla tehdit edilme bulunmaktadır.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

20. Görünürde küçük ama tekrarlayan veya hiç kesilmeyen sorunlar veya kronik stres yüzünden sinir krizi geçirdim veya geçirmek üzere gibi hissettim (örneğin kontrolümü kaybedecekmiş gibi).

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz

1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

21. Ebeveynlerimden veya kardeşlerimden en az biri savaşa veya çatışmaya katıldı veya işkence gördü.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

22. Okulda sıklıkla başarısızlıklar yaşadım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

23. Köy, şehir veya ülkemdeki yakın çevremden uzaklaştırıldım ve yer değiştirmeye zorlandım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

24. Daha güçlü kişi veya kişiler tarafından fiziksel saldırıya uğradım, dövüldüm ve yaralandım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

25. Bana bakım veren biri/ebeveyn tarafından cinsel ilişkide bulunmaya yönlendirildim.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

26. Toplumsal cinsiyetimden (kız/kadın veya oğlan/adam) dolayı toplumda; başkalarının olumsuz tutumları, kalıp yargıları veya davranışları sebebiyle ya da kurumlar tarafından (aile üyeleri dışında) aşağılandım, haklarım reddedildi, ayrımcılığa uğradım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

27. İlişkilerimde ciddi reddedilme veya başarısızlık yaşadım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

28. Eş veya evlat kaybı yaşadım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

29. İşime son verildi, işten atıldım veya iş yaşamımda başarısızlığa uğradım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

30. Tekrar evlendim.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

31. Düşük gelirli ve birçok zorluk yaşayan bir ailenin üyesi oldum.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

32. Toplumsal cinsiyetimden: erkek veya kız olmamdan dolayı bazı aile üyelerim (örn. ebeveynler, kardeşler) tarafından aşağılandım, tehdit edildim veya ayrımcılığa uğradım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

33. Başka bir kişiye zarar vermek zorunda kaldım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

34. Şiddet ve yasa dışı olayların sık olduğu bir mahallede yaşadım.

Hiçbir zaman ( ) Bir kez ( ) İki kez ( ) Üç kez ( ) Pek çok kez ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

35. Doğumumun zor bir doğum olduğu söylendi.

Hiç zor değil ( ) Biraz zor ( ) Zor ( ) Çok zor ( ) Aşırı zor (yaşamımı tehdit eden) ( )
Böyle bir olay yaşadıysanız ilk seferinde kaç yaşındaydınız? ___
Böyle bir olay yaşadıysanız bu sizi nasıl etkiledi?

Son derece olumlu	Çok olumlu	Biraz olumlu	Ne olumlu ne olumsuz	Biraz olumsuz	Çok olumsuz	Son derece olumsuz
1	2	3	4	5	6	7

İşiniz gereği böyle bir olayı yaşamış bir başkasının aktarımını dinlediniz mi?
Evet ( ) Hayır ( )

APPENDIX D: Impact of the Events Scale-Revised (Olayların Etkisi Ölçeği)

Yönerge: Aşağıda, stresli yaşam olaylarından sonra insanların yaşayabileceği bazı zorlukların bir listesi sunulmuştur. Her cümleyi dikkatlice okuyunuz. Geçtiğimiz yedi gün içerisinde, yaşadığınız sizi zorlayan travmatik olayları düşünerek, bu zorlukların sizi ne kadar rahatsız ettiğini cümlelerin sağındaki beş kutucuktan yalnızca birini işaretleyerek belirtiniz.

	Hiç	Biraz	Orta düzeyde	Fazla	Çok fazla
1. Benzeyen her şey, olayla ilgili duygularımı aklıma getiriyor ve hatırlatıyor.	0	1	2	3	4
2. Uykumu sürdürmekte, kesintisiz ve derin bir uyku uyumakta zorlanıyorum, uykum bölünüyor.	0	1	2	3	4
3. Olayla ilgisiz ve farklı şeyler dahi bana olayı hatırlatıyor, aklıma getiriyor ve düşündürüyor.	0	1	2	3	4
4. Kendimi huzursuz ve öfkeli hissediyorum.	0	1	2	3	4
5. Olayı düşündüğümde, olayı hatırlatan şeylerle karşılaştığımda keyfimin kaçmasına canımın sıkılmasına izin vermiyorum.	0	1	2	3	4
6. İstemediğim halde olay aklıma geliyor ve onu düşünmek zorunda kalıyorum.	0	1	2	3	4
7. Sanki olayı yaşamamışım, olmamış ve gerçek değilmiş gibi hissediyorum.	0	1	2	3	4
8. Olayı hatırlatan durum, yer ve koşullardan uzak duruyorum, kaçınıyorum.	0	1	2	3	4
9. Olayla ilgili görüntüler fotoğraf gibi, film gibi gözümün önünde canlanıyor.	0	1	2	3	4
10. Ani ses, görüntü ve hareketlerden çabuk irkiliyorum ve abartılı tepkiler veriyorum.	0	1	2	3	4
11. Olayı düşünmemeye çalışıyorum.	0	1	2	3	4
12. Olayla ilgili birçok duyguyu hala taşıdığımı fark ettim fakat bunların üzerinde durmuyorum ve bunları çözmeye çalışmıyorum.	0	1	2	3	4
13. Sanki bütün duygularımı kaybetmiş gibi hissediyorum. Kendimi halsizleşmiş ve donuklaşmış gibi algılıyorum.	0	1	2	3	4

14. Zaman zaman olay sırasındaki duygularımı yeniden hatırlıyorum ve sanki o anı yeniden yaşıyormuş gibi tepkiler gösteriyorum.	0	1	2	3	4
15. Uykuya dalmakta zorluk çekiyorum.	0	1	2	3	4
16. Olayla ilgili yaşadığım duyguları o kadar canlı hatırlıyorum ki, sanki dalga dalga üzerime geliyorlar.	0	1	2	3	4
17. Olayı hafızamdan silmeye ve unutmaya çalışıyorum.	0	1	2	3	4
18. Dikkatimi toplamada ve yoğunlaşmada zorluk çekiyorum.	0	1	2	3	4
19. Olayı hatırlatan şeylerle karşılaştığımda, terleme, kızarma, titreme, çarpıntı, nefes alma güçlüğü, göğüste baskı hissi gibi bedensel belirtiler yaşıyorum.	0	1	2	3	4
20. Olayla ilgili rüyalar görüyorum.	0	1	2	3	4
21. Kendimi tetikte ve diken üstünde hissediyorum, güvenliğimle ilgili endişeler duyuyorum.	0	1	2	3	4
22. Olay hakkında konuşmamaya çalışıyorum.	0	1	2	3	4

APPENDIX E: Demographic Information Form (Demografik Bilgi Formu)

Yaşınız:

Cinsiyetiniz:
- Kadın
- Erkek
- Diğer

Eğitim Seviyeniz (Eğitiminize devam ediyorsanız içinde bulunduğunuz eğitim seviyesini işaretleyiniz):
- İlköğretim
- Ortaöğretim
- Lise
- Lisans
- Lisansüstü

Kendinizi aşağıdaki gelir seviyelerinden hangisinde görüyorsunuz?
- Alt
- Alt-Orta
- Orta
- Orta-Üst
- Üst

Mesleğiniz:

Mesleğinizde toplam çalışma süreniz: … yıl … ay

Eğer yanıtınız evet ise; travma yaşamış bireylerle ne sıklıkla çalışıyorsunuz?
- Yılda bir defa
- Yılda birkaç defa
- Ayda bir defa
- Ayda birkaç defa
- Haftada bir defa
- Haftada birkaç defa
- Her gün

Güncel durumda terapi alıyorsanız, ne zamandır devam ediyorsunuz? … yıl … ay

Güncel durumda süpervizyon alıyorsanız, ne zamandır devam ediyorsunuz? … yıl … ay

APPENDIX F: Debrief (Çalışma Sonu Bilgilendirme)

Geçmiş travmatik yaşantılar ve iş gereği maruz kalınan travmatik materyallerin, sonradan gözlemlenen kaçınma, aşırı uyarılma ve yeniden yaşama gibi bazı psikolojik belirtiler ile arasındaki ilişkide zihinselleştirmenin rolünü inceleyen araştırmamıza katıldığınız için size çok teşekkür ederiz. Araştırmalar, kişinin deneyimlediği ya da dinlediği olumsuz materyallerin travma sonrası gözlemlenen bazı belirtiler ile ilişkili olduğunu; materyalin kendisindense kişinin materyali ne derece zihinselleştirilebildiğinin bu ilişkide bir rolü olabileceğini göstermektedir. Bu çalışmada da, travma sonrası gözlemlenen bazı belirtilerde zihinselleştirmenin olası koruyucu rolünün incelenmesi amaçlanmıştır. Bu çalışmanın, travmatik deneyimlerin kişi üzerindeki etkisi alanındaki literatürün zenginleşmesine yardımcı olacağı ve son zamanlarda yaygınlaşmaya başlayan zihinselleştirme temelli müdahale tekniklerinin geliştirilmesine yardımcı olacağı düşünülmektedir.

Çalışma kapsamında sağladığınız veriler ve çalışma sonuçları bilimsel ve mesleki etik ilkeleri çerçevesinde korunacak, sonuçlar toplu olarak yorumlanıp yalnızca bilimsel yayın amacıyla toplu bilgiler halinde paylaşılacaktır.

Çalışmanın sağlıklı ilerleyebilmesi için çalışmaya katılacağını bildiğiniz diğer kişilerle çalışma ile ilgili detaylı bilgi paylaşımında bulunmamanızı dileriz.

Değerli katılımınız için tekrar çok teşekkür ederiz.

Araştırmanın sonuçlarını öğrenmek ya da daha fazla bilgi almak için aşağıdaki isme başvurabilirsiniz.

Mehtap Özkanca.