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AN EXAMINATION OF THE RELATIONSHIP BETWEEN CHILDHOOD TRAUMA,
RESILIENCE AND SUBJECTIVE WELL-BEING IN ADULTHOOD

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AN EXAMINATION OF THE RELATIONSHIP BETWEEN CHILDHOOD TRAUMA,
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ABSTRACT

This study has been conducted to analyze the relationship among childhood trauma (child abuse & neglect), resilience and subjective well being of young adults. The study sample of this research was 408 young adults consisted of; senior undergraduates enrolled to various universities as well as graduate students from different universities which participated in the education certificate program at Marmara University in the academic year of 2019-2020. The data were obtained via the “*Personal Information Form*” developed by the researcher herself, “*Childhood Trauma Questionnaire*” (Bernstein, Fink, Handelsman, Foote, 1994; Şar, Öztürk, İkikardeş, 2012), “*Psychological Resilience Scale for Adults*” (Friborg, Hjeindal, Rosenvinge, 2003; Besim ve Çetin, 2011) and “*Subjective Well-Being Scale*” (Tuzgöl-Dost, 2004). The statistical analysis of the data collected in the study was tested in the SPSS 21.0 program. Following data collection, versatile extreme values were determined by calculating Mahalanobis distance values, to examine the extreme values. In data analysis process, initially; the “*frequency and percentage values*” of the characteristics of the study group were calculated. The descriptive values, skewness, kurtosis and reliability of three scales used were tested respectively. The data gathered to examine the significant differences of the young adults’ childhood trauma, resilience and subjective well being levels in regard to demographic variables were tested via Independent t-test, one way ANOVA and one way MANOVA when the normal distribution assumption was valid. Cases in which the normal distribution assumption was not met, “*Mann Whitney U*” and “*Kruskal Wallis tests*” as the “*non-parametric tests*” were applied. In order to examine the relationship among variables, correlation analysis (“*Pearson correlation and Spearman Rank coefficient*”) were used. Finally the extent to which childhood trauma and resilience predict subjective well being was calculated via stepwise regression. According to the research findings; the male young adults were found to be significantly more exposed to trauma compared to the female young adults. Childhood trauma

exposure was found not to be differentiated according to smoking and alcohol use status among young adults although “*emotional abuse*”, “*total trauma*” scores were identified significantly differ among participants living in low socio-economical status and suffered from physical illnesses. Additionally, female young adults were found to have high resilience scores due to the social support they received, and being married identified to be significant among young adults high in resilience. Family cohesion and perception of self as sub-dimensions of resilience scores found to be significantly different among young adults who did not have any psychological problems. Finally, in regard to subjective well being, differences according to gender was not statistically significant although the high scores of subjective well being were found to differ among young participants who were married and belong to high socio-economical status and not having any psychological problems. Based on the findings examining the relationship between variables; a moderate and negative significant correlation between subjective well being and childhood trauma’s sub-dimensions, a moderate and positive significant correlation between subjective well being and resilience, and a low but significant correlation between childhood trauma and resilience have been found. Due to the findings revealing to what extent childhood trauma and resilience predict subjective well being; “*perception of self*”, “*perception of future*” as “*sub-dimensions of resilience*” as well as childhood total trauma variables appeared to be the significant predictors of subjective well being. In brief, these three variables explain 52.3% of the total variance in subjective well-being scores.

Key words: Childhood trauma, child maltreatment, child abuse, child neglect, resilience, subjective well being, young adulthood

ÖZET

Bu çalışma, genç yetişkinlerin (istismar ve ihmal kapsamında) çocukluk çağı travmaları, dayanıklılıkları ve öznel iyi oluşları arasındaki ilişkiyi incelemek amacıyla gerçekleştirilmiştir. Araştırmanın çalışma grubu; 2019-2020 akademik yılında farklı üniversitelerin son sınıflarına kayıtlı öğrencileri veya başka üniversitelerden mezun durumunda olan ve Marmara Üniversitesi'nde sertifika eğitimi almakta olan genç yetişkinlerden oluşmaktadır. Araştırma verileri, öğrencilerin kişisel özellikleri ve alışkanlıklarını saptamak hedefiyle; araştırmacı tarafından geliştirilen “*Kişisel Bilgi Formu*”, çocukluk çağı travmalarını belirlemek için Çocukluk Çağı Ruhsal Travma Ölçeği (Bernstein, Fink, Handelsman, Foote, 1994; Şar, Öztürk, İkikardeş, 2012), dayanıklılıklarını belirlemek amacıyla Yetişkinler için Psikolojik Dayanıklılık Ölçeği (Friborg, Hjeindal, Rosenvinge, 2003; Besim ve Çetin, 2011) ve “*öznel iyi oluş*”larını belirlemek amacıyla “*Öznel İyi Oluş Ölçeği*” (Tuzgöl-Dost, 2004) aracılığıyla toplanmıştır. Çalışmada toplanan verilerin istatistiksel çözümlenmeleri SPSS 21.0 programında sınanmıştır. Verilen toplanmasının ardından öncelikle uç değerler Mahalanobis uzaklığı değerleri hesaplanarak belirlenmiştir. Daha sonra verilerin analizine geçilmiş, ilk olarak çalışma grubuna ait özelliklerin frekans ve yüzde değerleri saptanmış, üç ölçeğin her biri için betimsel değerler, çarpıklık, basıklık ve güvenilirlik katsayı değerleri belirlenmiştir. Genç yetişkinlerin çocukluk travmaları, dayanıklılık ve öznel iyi oluşlarının demografik bilgilere göre farklılık gösterip göstermediği, normal dağılım varsayımı karşılandığında “*bağımsız gruplar t-testi*”, “*tek yönlü ANOVA ve tek yönlü MANOVA testleri*” ile, normallik dağılımı karşılanmadığında ise; non-parametrik fark testleri “*Mann Whitney U*” ve “*Kruskal Wallis*” testleri uygulanarak belirlenmiştir. Değişkenler arası ilişkinin belirlenmesinde korelasyon analizleri (Pearson Çarpım Moment ve Spearman Sıra katsayıları), çocukluk çağı travmalarının ve dayanıklılığın öznel iyi oluşu yordama düzeyi belirlemek için ise aşamalı regresyon analizi uygulanmıştır. Araştırma sonucunda; erkek katılımcıların anlamlı bir şekilde daha fazla

çocukluk travmasına maruz kaldıkları, travmaya maruz kalmanın sigara ve alkol kullanımına göre fark yaratmadığı, özellikle duygusal ihmal ve toplam ihmal ve istismarın düşük gelir grubunda daha fazla yaşandığı, duygusal istismar ve ihmale uğrayanların daha fazla fiziksel şikayetlerinin olduğu bulgulanmıştır. Ayrıca, dayanıklılığın kadınlarda erkeklere oranla, sahip oldukları sosyal destekle daha yüksek olduğu, evli olmanın dayanıklılık üzerinde olumlu fark yarattığı, kavramın altboyutlarından aile uyumu ve kendilik algısı puanlarının psikolojik rahatsızlığı olmayanlar lehine farklılık gösterdiği saptanmıştır. Öznel iyi oluşun ise; cinsiyete göre herhangi bir fark yaratmadığı, evli olanların, yüksek gelir grubunda yer alanların, daha yüksek öznel iyi oluşa sahip oldukları ve öznel iyi oluşun psikolojik rahatsızlığı olmayanlarda daha yüksek olarak farklılaştığı saptanmıştır. Araştırmanın değişkenleri arasındaki korelasyon incelendiğinde, öznel iyi oluş ile çocukluk travmasının alt boyutları arasında cinsel ve fiziksel istismar hariç orta düzeyde negatif ilişki, öznel iyi oluş ve dayanıklılık arasında orta düzeyde pozitif ilişki tespit edilmiştir. Çocukluk çağı travmaları ile dayanıklılık arasında düşük düzeyde istatistiksel açıdan anlamlı negatif yönde ilişki belirlenmiştir. Çocukluk çağı travması ve dayanıklılığın öznel iyi oluşu ne derece yordadığına yönelik yapılan aşamalı regresyon analizine göre ise; dayanıklılık alt boyutlarından kendilik algısı ve gelecek algısı ile çocukluk çağı toplam travma değişkeninin, öznel iyi oluş değişkeninin anlamlı yordayıcıları olarak modelde yer aldığı bulgulanmıştır. Yukarıda bahsedilen üç değişkenin öznel iyi oluş puanlarındaki toplam varyansın %52,3'lük kısmını açıkladığı sonucu elde edilmiştir.

Anahtar Kelimeler: Çocukluk çağı travması, çocuğa kötü muamele, çocukluk çağı istismarı, çocukluk çağı ihmali, dayanıklılık, öznel iyi oluş, genç yetişkinlik

*To my amazing parents Nükhet and
Timuçin Altındal; the greatest treasures of my
life...*

*To my precious and loving daughter Serra
Kati; best gift of a lifetime...*

And to all childhood trauma survivors...

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1. INTRODUCTION

1.1. PROBLEM

Positive psychology is a scientific study which emphasizes on the positive aspect of human characteristics, potentials and virtues while nurturing what is best for people's interest. Conversely, this scientific field criticizes the empirical focus of the conventional psychological approach on human *weaknesses, pathology and sufferings*; it seeks ways to reveal human strength and wisdom, and underscores the critical importance to cultivate the 'good' for the sake of the individual as well as the society. The major arguments of the positive psychology involve people's having self contentment and satisfaction about *the past*, keeping the sense of optimism and hope for *the future* and engaging in happiness and flow *at the present time* (Seligman & Csikszentmihalyi, 2000). While well-being as a concept of eliminating the diseases including certain chronic disorders, can not only be defined with its of treating the 'ill-being'. The term encompasses more with positive notions like flourishing, life satisfaction, a life which is worth living, a meaning to pursue through which the person will be upraised (Diener, 2019). The argument of well being in the positive psychology is based on two basic philosophies as hedonic and eudaimonic. While hedonic well-being stress the meaning of pleasant emotions and feeling well, eudaimonic well being insists more on the human functioning in each life domains (Keyes & Annas, 2009; Ryan & Huta, 2009; akt: Adler ve Seligman, 2016). Both movements of thoughts try to reach 'happiness' via the pursuit of the gratification or the meaning (Seligman, Peterson, Park, 2005).

The new movement has appeared in psychology toward the late 20th century and was representing a postmodernist approach which do not necessitates an objective

reality to the science but rather, prefers to rely on a subjective assessment as the source of knowledge (Karairmak & Siviş, 2008). As a clinical orientation, positive psychology is not a novel alternative to replace the traditional tendency in psychology but preferably a *complementary* perspective (Carr, 2016). Consequently this new attitude in therapy concentrated more on optimum human functioning by embracing “build-what’s-strong” instead of “fix-what’s wrong” approach adapted recently (Duckworth, Steen, & Seligman, 2005). Additionally, positive psychology has constructed a new perspective by embedding the description of mental health into its philosophy. The empirical concern of sociologists and scholars regarding the issue, by challenging what is about “a good life” and how “the quality of life” can be measured, led the researches to develop new theories. Afterwards, well being as a new condition has been integrated into the definition of mental health. In the new specification, the expectation to be met has been shifted from describing the mental health via the absence of distress and depression into a need to entail the existence of happiness and life satisfaction criteria. This is how the foundation of ‘subjective well being’ has emerged (Diener, Oishi, Lucas, 2003). In other words, subjective well being, apart from its core representation of ‘pleasure’, is also considered as a vital construct of mental health. In literature, subjective well being refers to the positive aspect of mental (Hefferon ve Boniwell, 2010; akt: Eryılmaz, 2014). Similarly Keyes (2002) argued that a well-being evaluation needs to include a general assessment of how well a person’s full functioning is under consideration. Subjective well being is consisted of people’s own values, emotions and judgements by how it becomes the inevitable indicator of the psychological health. Although the relative meaning attributed to the components of the subjective well being vary due to the culture people get involved in (Diener, Sapyta, Suh, 1998).

The underlying reason for the interest to the concept ‘happiness’ derived from the meaning that people attribute to the term. Respondents in studies mark ‘being happy’ as the ‘extraordinarily important’ item among their priorities in life (Diener & Oishi, 2000). In fact; the ideal response to the investigation challenging “*what is a good life?*”; is about having a confirmation that the person is being contented with his/her life. In this context; subjective well being is the self evaluation of the individuals regarding their lives in both cognitive and affective ways. In order to have high levels of subjective well-being; positive affects need to be frequently experienced compared to the negative affect which need to be present less often and also a perceived life satisfaction in upper levels are required. In this sense, the scientific objective has to be finding out the sources which create people’s happiness (Diener, 1984). Although some scholars assume ‘happiness’ as the affective constituent of subjective well being (Machado, 2019), in general terms, subjective well being in colloquial use, refers to ‘happiness’ (Diener, 2000). The interchangeable use of happiness and subjective well being associate with the rationale that increasing subjective well being will likely to heighten happiness (Ryan & Deci, 2006). The subjective well being as a sub domain of hedonism, is measured by the self report of the individuals. That is how the person becomes the absolute agent to assess his/her own life by personal judgments (Myers & Diener, 1995; akt: Schueller & Seligman, 2010).

Everyone needs to and deserve to be happy. Larsen & Eid (2008) argued happiness as ‘it is not the ultimate but one of the major goals of human beings’. Happiness as an everlasting pursuit to be reached for ages (Bülbül & Giray, 2011), and happiness has tremendous benefits on human health and functioning (Schiffrin, & Nelson, 2008). Lyubomirsky, King and Diener (2005) suggested that happy people

are more prone to achieve desired outcomes in many life domains and this consequence was resulted from the happiness effect itself. Gradually in a community level, subjective well being and life satisfaction gained recognition as a social and economic indicator for all societies' national progress (Cummins, 2016; Diener and Suh, 1997). Diener and Seligman (2002) states that people experiencing high subjective well being are more prone to have substantial social life, strong social and romantic relationships. Beside, happiness enrich people's joy of life, improves productivity in their professional life, improve health and extend longevity (Lyubomirsky, King, Diener, 2005). Subjective well being becomes more of an issue for the specific life stages. Particularly young adulthood is a curical period of life in terms of contibuting to the nation's workforce and to the healthy development and well being of the next generations (U.S Department of Health and Human Services & National Research Council, 2015). One of the pioneer in developmental psychology Havighurst (1972), described the developmental tasks of a young adult as; having an occupation and starting to build a career path and a family, becoming familiar to maintain intimate relationship with a partner, and having children to raise, taking societal responsibilities and expanding the social network. These tasks are affiliated and achievement oriented (Ranta, 2015). Young adulthod as a life period in which people obtains a 'senior' position among adults, contains satisfactory outcomes in terms of sexuality, family and occupation. But as a matter of fact, the costs of this period are assumed to be equal or even exceed the benefits acquired (Levinson, 1986). This stage of life is considered as living the golden era in regards to life satisfaction, also embodies stress, risks, contradictions and disappointments (Aktu, 2016). Most normative transitions emerge in young adulthood. They can be either dysfunctional or promotive in helping the individual to 'grow'. Being able to cope with those

transitions is the important part of achieving developmental task of this period (Perren, Keller, Passardi, Scholz, 2010). Ultimately, the transition from adolescence and emerging into the young adulthood can have influence people's health and well being by altering their future trajectories (Räikkönen, E., Kokko, K., Chen, M., & Pulkkinen, L. 2012; Salmela-Aro, Ek, Taanila, & Chen, 2012). In this respect; the subjective well beings of young adults are important to be examined since developmental tasks of young adults can be quite challenging, stressful and hard to overcome in this life stage. In a research conducted by Topkaya and Meydan (2013) the most common problems among university students have been identified as emotional, economical, academic problems and about the personality disorders. Similarly, the findings of a research applied to the university senior students reveal the significant problems young adults faced with in academic, social and occupational domains (Gizir, 2005). In an empirical study (Lipson, Lattie, Eisenberg, 2019) examining the data on the mental health treatments of 155,000 college students from 196 campuses lasted about 10 years. According to the results the rate of mental treatments received by college students increased from 19% (2007) to 34% (2017) mostly due to depression and suicidality, in addition to the lifetime diagnosis which increased from 22% to 36%. On the other hand, in Turkey based on the life satisfaction survey (2017), research findings suggest that 61, 3% of young adults (ages 18 to 24 years) were reported of being happy (TÜİK, 2018).

Subjective well being has some benefits to human functioning. Happiness has been found to be positively related to high mental and physical health measures. Frequent positive affect is the most apparent symbol that happiness exists, has effects on empowering social relationships, healthy life tendency, to empower immunity as well as to obviate distress, suicidal attempts and certain maladaptive coping

strategies. Beside, one of the components of mental health has been approved as positive affect (Galderisi, Heinz, Kastrup, Beezhold, Sartorius, 2015; Taylor & Brown, 1988). Therefore; happy people are assumed to be healthier compared to ones who express not to be happy. In brief; a person with high subjective well being is expected to be physically and mentally healthy (Lyubomirsky, King, & Diener, 2005). In line with previous studies, the evident benefit of subjective well being in high levels observed in four main life domains; health and longevity, employment and financial status, social connections and social utility (Diener & Biswas- Diener, 2008; Lyubomirsky, King, & Diener, 2005, akt: Diener & Ryan, 2009). Therefore; the repercussions of subjective well being seem to be associated with the developmental tasks a young adult need to achieve. Key markers of this period reflecting the transition include; intense social relationships and occupational issues such as leaving school and home of origin, starting a new career, and getting married and becoming a parent (Shanahan, 2000). The reseaches regarding the subjective well being levels of young adults offer diverse results. For instance; in a meta-analysis, the transition into the parentood had been found to be linked to decrease in life satisfaction but increase in positive affect (Luhman, Hofmann, Eid, Lucas, 2012). Due to the unemployment problem of the young adult, the need to move back to the family home had been found to be linked mostly with negative affect during early adult years (Copp, Giordano, Longmore, & Manning, in press cite in Landsford, 2018)

Subjective well being is vital for an individual not only by its benefits. But it is also an overarching component of the mental health. Well being basically means to 'feel good' and to have a 'healthy functioning' (Keyes, 2002). Keyes describes "*flourishing*" as a state through which people acquire high level of subjective well-being in addition to optimum levels in psychological and social functioning

(Westerhof & Keyes, 2010). Similarly, Diener, Wirtz, Tov, Kim-Prieto, Choi, Oishi, Biswas-Diener (2010) in their newly developed scale, they studied on the renewed well-being measures which are “*psychological flourishing*” in addition to positive and negative feelings.

The subjective well beings of young adults need to be maintained in high or in optimal levels for many reasons. As they are the parents of future generations and most productive segment of the population, they need more recognition for empirical research. More specifically, the college students who study on the faculty of education are important members of society as they are the future agents of education Subjective well being emerge in case when the effects of mental disorders are insignificant, the positive affects are frequently and negative affects infrequently present and life satisfaction reported as high. Although people may still face with some adversities which likely to create disturbance for the mental health during their lifesplan. Trauma is among those critical unfavourable experiences whose impacts are more intense and powerful during childhood. Childhood Maltreatment as one of the childhood trauma is defined by World Health Organization as “*all kinds of physical, emotional, sexual abuse, neglect and exploitation which create real or potential harm to the health, development and dignity of the child before 18 years of age by the caregivers within a relationship of power and trust*” (WHO, 2016). According to the data obtained from American Health and Human Services (2013) each year 700,000 children have been becoming victim of maltreatment (Font & Berger, 2014). In the annual Child Welfare National Symposium have revealed that in United States of America, 683.000 children have been maltreated and 9,2 out of 1000 children were threatened by abuse and neglect (U.S Departmen of Health and Human Services, Children’s Bureau, 2015). According to the results of the report by National Child Abuse and Neglect

Data System (NCANDS) collected among 50 states in U.S.A., over 3,5 million children have been investigated and found out 1,720 children had been reported died due to the abusive and neglectful acts (NCANDS, 2017). In Turkey, according to the data collected by Statistical Organization of Turkey (TÜİK); while the numbers of child abuse victims were 74.064 in 2014, the numbers have been raised to 83.552 in 2016. Between January 2011 and May 2016 among the child monitoring centers in Turkey, 21.068 cases had been reported. 85% of the victims were girls, 15% were boys (Child Abuse Report in Turkey, Asuma & İmdat, 2018).

In maltreatment containing abuse and neglect, the impact of the act is mattered most but not the intention of the caregivers (Helvacı Çelik & Hocioğlu, 2018). Childhood abuse is categorized as “*physical, sexual and emotional*” whereas “*neglect*” is listed as physical and emotional. The behavioral patterns as harmful and inconvenient which adopted by the parents overtime hinder and restrict the development of the child and represent all acts of omission and commission (Taner ve Gökler, 2004).

Being abused or becoming a victim of neglect during childhood, prompted impairments and failures via the epigenetic pathway in the developmental tasks needed to be achieved by the child (Cicchetti ve Handley, 2019). Mental trauma confronted during childhood has an immense influence on the person due to some aspects: timing of trauma is vital when the importance of early development is considered, the relational mechanism in which the discomfort arises and finally the duplicative nature of the event makes the effects of childhood trauma intensified (Şar, 2018). Childhood maltreatment is a pathogenic relationship representing all the possible adverse and negative experiences a child may face with (Cicchetti & Lynch,

1995). In this relational context, family is the main performer. Parents as the one side of the relation, build the milestones of the secure attachment, support the child to pass the developmental stages by becoming available during times of need. During traumatic processes in particular, caregivers undertake the role of the catalyzer (Amaya-Jackson, & Stirling, 2015).

In literature, adverse childhood experiences have recently been addressed with a *life course approach* due to their long term and penetrating effects. The rationale of this perspective relies on the nature of the distress which highly threaten the adjustment capacity of the individual, its ability to trigger the secondary stressors and to restrict the defense capacities of the person (Nurius, Green, Logan-Greene, Borja, 2015). In empirical studies, findings exhibit how the effects of the maltreatment in particular during early developmental stages may endamage the allostatic (load) system in an irreversible way, and cause damages in the emotional section of the brain but also altering the neuroendocrin mechanism (Niehoff, 2007), by shaping the biologic organism, and disrupt some parts of the brain to become oversensitized (Teicher & Samson, 2006). Developmental psychopathology, attribute a great importance on the experiences at the early childhood because of the further impacts those experiences have on the social life and interpersonal relationships in adulthood (Cicchetti ve Toth, 2009; Masten, 2006; Waters ve Cummings, 2000).

One of the destructive effects of childhood maltreatment is ‘the residue’ of the acts. In other words, the abused child may convey the catastrophic results of maltreatment by generations. The “*intergenerational transmission of abuse and neglect*” are burden for all children, families and societies (Cicchetti, 2012). Accordingly, in a research with 1,249 study participants, the possibility to carry the

maltreatment to the next generations through “*social learning modeling*” (Bandura, 1977) have been identified as more risky among people who are abused and neglected on childhood (Kwong, Bartholomew, Henderson, Trinke, 2003). During young adult years, the basic developmental tasks are getting involved in intimate relationship and getting married. In a meta analysis (Li, Zhao, Yu, 2019) a significant association has been identified between maltreatment exposed during early years and violence committed by intimate partner. Similarly, in another research (Fang & Corso, 2007) examining cycle of violence and child maltreatment and partner victimization among young adults, they found out that compared to nonvictims, victims of child maltreatment are more inclined to commit violence (from 1.3% to 17.2% for males).

Childhood maltreatment is a vital issue for an individual since all types of abusive and neglectful acts during early development have persistent effects on adult's health and well being. According to the empirical studies, associations have been found between childhood traumatic experiences and risk factors (Felitti & Anda, 1998) to cause mortality and adult psychopathology (Kessler, McLaughlin, Green, Gruber,... 2010). Based on the research findings, childhood trauma have direct and indirect relations with worsening health and problematic social relationships (Bellis, Lowey, Leckenby, Huges, Harrison, 2013). Moreover; the positive associations between childhood trauma and adult depression (Negele, Kaufhold, Leuzinger-Bohleber, 2015), adult obesity (Fuemmeler, Dedert, Beckham, 2009), substance abuse (Rasmussen, Arefjord, Winje, Dovran, 2018; Douglas, Chan, Gelernter, Arias, Kranzler, 2010), dissociative symptoms and self-destructive behaviors (Zoroğlu, Tüzün, Şar, Öztürk, Erocal-Kara, Alyanak, 2001), self-harming attempts (Aksoy ve Ögel, 1995), post traumatic stress disorder (Taner ve Gökler, 2004), sexual dysfunction disorder (Beithchman, Zucker, Hood, Dacosta, Akman, Cassavia, 1992),

anxiety disorder (Evren ve Ögel, 2003), obsessive-compulsive disorder (Demirci, 2016), antisocial personality disorder (Schilling, Aseltine, Gore, 2007), personality disorders (Rogosch & Cichetti, 2005), negative self-esteem (Güneri-Yönen, 2016) have been determined. Furthermore; the impact of trauma exposed during childhood compared with the trauma experienced in adulthood, was considered to be greater in regard to predicting post-traumatic stress disorder (PTSD) (Neria, Bromet, Sievers, Lavelle, Fochtmann, 2002).

Deviations developed during early childhood due to the trauma exposure may lead the individual to the maladaptive functioning or may detract him/her from normative developmental progress. However, few individuals among all the others who have been exposed to the same adversity may perform well in the face of distress. They can even manifest positive adjustments against adverse circumstances (Cicchetti, 2010; Masten, 2001). This issue impeded the scientific curiosity. Then, the empirical focus of developmental psychopathologists have been shifted from maladjustments and pathology into the factors inducing adaptation and related mechanisms (cited in; Cicchetti, 2013).

Resilience in a broad sense signifies the capacity of the individual to strive against the challenges which threaten that person's stability, viability and development and to recover from adversity (Rutter, 2013). It can also be defined as a successful adaptation performed toward compelling conditions representing a process, a capacity or as an outcome (Masten, Best, & Garmezy, 1990). Cicchetti describes resilience as an attainment of a successful adaptation followed by a severe trauma which likely to undermine the biological and psychological developments (Toth & Cicchetti, 2013).

Resilience as a concept representing a status after trauma, there are some diversifications on defining it. Resilience is being able to have a normal functioning following a trauma and to be able to overcome the negative aspects of distress (Rutter, 1985; Luthar, Cicchetti, Becker 2000). Rutter (2006) describes resilience as an interaction between the severe risky experiences and the psychological outcomes observed as a result of these experiences. According to Southwick (2004), resilience is bending but not being broken after a trauma but even a 'growth' as a learning outcome achieved against challenges. Bonanno (2014) considers resilience as a regained healthy functioning after a short period of disequilibrium (cited in Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014). The term resilience signifies a dynamic process to overcome distress without disrupting adjustment by maintaining the normative physiological and normal functioning. In other words, resilience is an active capacity of adjustment to avoid biological, social and psychological harmful effects of intense stress which might cause to endanger people's physiological and psychological well being. By this description, the absence of psychopathology is not only intended to be mentioned but rather a positive, active and compatible response toward distress (Russo, Murrough, Han, Charney, Nestler, 2012). Therefore; resilience has considered as an agent to enable a moderating process toward trauma or stress (Mancini & Bonanno, 2009).

Resilience has been also examined with its relational dimension of childhood trauma. Child abuse, neglect and family dysfunction are generally observed when prolonged, severe and chronic toxic stress are available and the protective factors are absent in the household (Shonkoff, Boyce, & McEwen, 2009). In literature, despite the negative aspect of childhood maltreatment, the genesis of some positive outcomes by the means of resilience have also been observed. Resilience as symbolizing an

ability to avoid the detrimental residues of trauma, can protect the individual from harm to the developmental progress (Luthar, Cicchetti & Becker, 2000). Few children may encounter with adverse circumstances but still succeed to accomplish their developmental tasks and even go through the process with more benefit called as 'flourishing'. It has been a controversial issue whether this result was gained through a trait the person has already acquired or due to a process or an outcome (Masten & Barnes, 2018). In contrast to the argument that resilience as an innate characteristic, Masten (2018) claims' defend her argument by defining resilience is an ordinary trait everybody possess. She emphasizes on framing the resilience as a natural phenomenon appear along with the developmental phases and as sum of all protective and positive factors. According to Masten, resilience construct only emerge in case of a successfully accomplished developmental process through which convey the person to the future adjustment and well being status (Cutuli, Herbers, 2018). As a similar view, Cicchetti suggested that prior approach attributing resilience to the personal qualifications, has been shifted into a new perspective emphasizing the importance of the factors on the outside of the child (Luthar et al., 2000). Resilience accordingly can be adapted and improved in any developmental phase on the life course (Masten, & Cicchetti, 2016). In this respect, factors leading to resilience can be controlled, modified and this dynamic process can be learned.

Resilience is a process of negotiation, compliance and management of the trauma sources. Meanwhile, the person's qualifications, resources, environmental factors may ease the process in the face of adversity. Protective factors appear against the risk of adopting disruptive behaviors and comprised of all the parameters to influence, alter and modify the existing attitude of the person to cope with the stress (Rutter, 1985). The reason behind the children to cope with the challenges of trauma

and achieve to have positive adult outcomes is the elimination of the risk factors by the powerful impact of protective factors (Murray, 2003). In other words, protective factors undertake a buffering role to moderate the effects of risk factors. They are internal forces and external resources of the individual while coping against risks (Rudzinski, McDonough, Gartner, Strike, 2017). A delicate focus to study on protective factors may enable to increase the resilience of the children and to gain insights regarding the general health and well being of the maltreated children (Afifi & MacMillan, 2011). In order to understand to which extent resilience exists can also be measured by a developmental view. The measurement mentioned is basically consider the normal functioning and the accomplishment of developmental tasks (Masten, 2018). In this sense, resilience needs to be treated with a life course perspective as a complex phenomenon (van der Walt, Suliman, Martin, Lammers, Seedat, 2014). One of the core arguments of developmental psychopathology asserts that the developing child's responses to stress vary according to the protective factors of the ecological surrounding. Therefore, the differentiations on responses cause diversification of developmental outcomes. Having an adaptive or maladaptive functioning depends on a complex biological and psychological structure people have (Cicchetti & Tucker, 1994). Hence, resilience represents a positive adaptation in the face of stress which can vary due to the flow of the developmental process for each individual.

Resilience and subjective well being are considered as engaged constructs in many research. However, the relationship between resilience and well being are not straightforward. In some cases resilience is used as a tool to measure well being (Davydov, 2011; Windle, 2011). Panter-Brick (2014) mentioned resilience in regard to its relationship with subjective well being, as "*not a personal trait*" or capacity but

rather as “*a process*” to benefit from resources with the aim of maintaining well being. In empirical studies, resilience was found to be positively linked with the components of subjective well being. Individuals having high levels of resilience being observed to use frequent positive emotions to ‘bounce back’ in the face of adverse circumstances (Tugade & Fredrickson, 2004).

Some people might have experienced childhood trauma earlier in life although due to the resilience they have built as a protective factor, these individuals may exhibit healthy functioning, positive adjustment in the face of adversity. Additionally, their subjective well beings may be high as well in regard to their resilience as a ‘fundamental adaptation system’ (Masten, 2001) helping to ease the coping mechanism in each development stages against stress and trauma resources. In other words; resilience does not only enable to overcome the challenge, but also relate to subjective well being through affiliating with positive affect and life satisfaction (Carle, & Chassion, 2004; Cohn, Fredrickson, Brown, Mikels, Conway, 2009). Especially resilience and subjective well being become vital during particular life stages. Young adults as the sample of this study, have been through challenging transitions while they have to cope with problems in several life domains. In this critical period resilience appears as a facilitating and protecting component to fulfill the developmental tasks, adjustment of early adulthood (Burt, & Paysnick, 2012) and subjective well being as a important component to maintain mental health of young adults. The relationship among these three variables in the present study is found to be worth examining in regard to young adults. Consequently, the research question of this study is arranged as; “*Is there a significant relationship between the childhood trauma, resilience and subjective well being of young adults?*”. In line with this question, the repercussions of each concept for young adults will be examined

followed by the analysis of the relationship among the concepts mentioned. In this relationship to be assessed, independent variables of this study are childhood trauma and resilience and the dependent variable is subjective well being of young adults. The sub-problems of the study to lead the research question are listed below.

1.2. RESEARCH OBJECTIVE

The aim of this research is to analyze the relationship between childhood trauma, resilience and subjective well being among young adults. In line with this purpose, the childhood trauma, resilience and subjective well being levels of the participants will be examined respectively in regard to certain personal and demographic variables.

Accordingly, the following research questions will be addressed:

1. Do the childhood trauma levels of the young adults differ according to the gender?
2. Do the childhood trauma levels of the young adults differ according to the the marital status?
3. Do the childhood trauma levels of the young adults differ according to the socio-economical status? (SES)
4. Do the childhood trauma levels of the young adults differ according to the the smoking status?
5. Do the childhood trauma levels of the young adults differ according to the the alcohol usage?
6. Do the childhood trauma levels of the young adults differ according to the to the physical illnesses?
7. Do the resilience levels of the young adults differ according to the gender?

8. Do the resilience levels of the young adults differ according to the marital status?
9. Do the resilience levels of the young adults differ according to the socio-economical status (SES)?
10. Do the resilience levels of the young adults differ according to the smoking status?
11. Do the resilience levels of the young adults differ according to the alcohol usage?
12. Do the resilience levels of the young adults differ according to the physical illnesses?
13. Do the subjective well being levels of the young adults differ according to the gender?
14. Do the subjective well being levels of the young adults differ according to the marital status?
15. Do the subjective well being levels of the young adults differ according to the socio- economical status (SES)?
16. Do the subjective well being levels of the young adults differ according to the smoking status?
17. Do the subjective well being levels of the young adults differ according to the alcohol usage?
18. Do the subjective well being levels of the young adults differ according to the physical illnesses?
19. Are there any correlation between the childhood trauma's scores, resilience scores' and subjective well being scores' of the young adults?

20. To what extent do the childhood trauma and resilience of the young adults predict their subjective well beings?

1.3. SIGNIFICANCE OF THE STUDY

The prevalent assumption that the detrimental impacts of childhood trauma are no longer irreversible, brought a new perspective to the existing literature. The new scientific approach adopted the likelihood of a successful recovery from trauma even with some beneficial outcomes such as ‘growth’. Empirical curiosity has been focused on people exposed to toxic stressors or suffered from trauma but still appear to be physically and mentally healthy, to have normal functioning, maintain nurturing relationships with others, experience pleasant emotions, and believe their lives are worth living. Despite the devastating influence of early adverse experiences during childhood, the subjective well being status of the adult individuals have been observed to be relatively high. This phenomenon might be arisen from the resilience these people possess. Resilience refers to the capacity of adjustment and positive outcomes following extreme distress and trauma.

In the new era of psychology, healthy people and communities are not expected to only be released from pathology and diseases. Positive functioning is now assumed to be acceptable when the individual experience a pleasant and satisfied life despite the chronic stress and trauma he/she suffered in the past. The long lasting effects of childhood trauma at later ages becomes more critical especially during young adulthood. As in the most transitional stage of a person’s life course, the individual takes irreversible steps in his/her intimate and social relationships, occupational and financial fields. These decisions will likely to influence in depth, the future course of events in regards to the person’s life satisfaction, emotions, resilience and well being levels.

Consequently, the objective of this study is to contribute to the scientific knowledge by examining the relationship of trauma with subjective well being and resilience for people who had been exposed to childhood trauma in their early developmental years. In addition to the existing literature, this research is significant in consideration of community mental health. Results obtained from this study will reveal the interaction among childhood trauma, resilience and subjective well being. Correspondingly within a positive psychology view, useful insights for the implementations, policies can be developed to enable people of trauma survivors acquiring healthy adaptation skills. Beside, the findings of the current study will provide scientific information for the preventive, protective and enriching programs to be applied by the policy makers, politicians and some occupational groups.

1.4. ASSUMPTIONS

In this study, the study sample has been assumed to have appropriate characteristics to represent the universe. Young adults are assumed to be participated voluntarily in this research and answered the questions in the measurements tools with a sincere attitude.

1.5. LIMITATIONS

This study has some limitations which are listed below:

1. The data of this study is limited by the scales used and by the university senior undergraduates and graduate students in the university students participated in this research.
2. Childhood trauma questionnaire which is a retrospective tool to gather information via self report, measures by which participants might experience recall bias.
3. As a limitation of filling out a trauma scale, participants might be reluctant to express their deep emotions, adverse experiences or interparental conflicts which are hard to confront with.
4. Due to the retrospective nature of subjective well being scale; the time frame of recall may vary from a few seconds to minutes up to years. Therefore; in literature, self reports of assessments regarding the negative, positive affects, life satisfaction need to be repeated preceding days or weeks (Diener, Suh, Lucas, 1999 & Perren, Keller, Passardi, Scholz, 2010)
5. Subjective well being reports have some other limitations. According to Schwarz and Strack (1999) subjective well being values may subject to change due to “the order of items, time-frame of the questions and current mood at the time of measurement”.

1.6. DEFINITIONS

Childhood Trauma:

Childhood trauma is all the experiences including physical, emotional, sexual abuse, neglect, divorce of the parents, lost of a parent, unwanted separation from a

parent, witnessing violence, forced migration, having or witnessing an accident and natural disasters a child is exposed before 18 years of age (Herman, 1992).

Childhood Maltreatment: Any acts of series of “*commission (abuse) and/or omission (child neglect by a parent or a caregiver that result in harm, potential for harm or threat of harm to a child*” (Leeb, Paulozzi, Melanson, Simon, Arias, 2008).

- **Physical abuse:** The sum of all the physical acts consisted of the practices which do not live any visible mark on the child’s body to other practices which live lasting disability, impairments, or even can lead to the death of the child (Barnett, Manly and Cicchetti, 1993 cited in Leeb et al., 2008).
- **Emotional abuse:** Harmful and chronic patterns of behaviors and interactive relations to damage a child’s emotional and mental functioning (Uslu, 2014).
- **Sexual abuse:** “*Any completed or attempted (non-completed) sexual act, sexual contact with, or exploitation (i.e., noncontact sexual interaction) of a child by a caregiver*” (Leeb et al., 2008)
- **Neglect:** The concept is failing to “*meet a child’s physical, emotional, mental necessities*” and therefore to induce the development of the child in a negative way (Beyazova, 2014)
- **Subjective Well-Being (SWB):** An individual’s sum of all the cognitive judgements in regard to his/her life satisfaction and emotional evaluations in regard to his/her negative and positive affects (Diener, 1984).

Resilience: Resilience refers to a phenomenon which represents a capacity of a system adapting to challenging circumstances threatening the “*function, survival or*

development” of the individual in a successful way (Masten, & Barnesi 2018). It represents a healthy functioning against adversity (Masten, 2007) and a positive outcome as a result of the adaptation process to the stress (Masten, 2001).

Young adulthood: Young adulthood may refer to a developmental stage between adolescence and adulthood with a wide range of 18 to 30 age cohort. Most transitions such as building a career, starting a family and becoming parent, occur in this stage which have an powerful impacts on future phases of the life course (Arnett, 2000; Aydın, 2019).



2. THEORETICAL FRAMEWORK

2.1. CHILDHOOD TRAUMA

2.1.1. Stress & Trauma

Psychological distress is one of the most fundamental and universal reasons behind the morbidity, mortality and to the global health-care costs spent around the world. Major depressive disorder (MDD) in particular, was assumed to be ranked as the second major contributor to diseases by the year 2020 (Lopez and Murray, 1998). Although in response to stressors, the stress reactions might be adaptive or maladaptive. Positive outcome occurs when mild and moderate level of stress allows the cognitive as well as emotional learning to generate as a result of exposure (Cozolino, 2010). But depending of the intensity, duration and frequency, the excessive or acute stress most especially faced during the early years of development may have detrimental consequences (cited in Zannas & West, 2013). As a predominant subject in literature; to be exposed to trauma during early developmental years may have permanent consequences (Spotaro, Mullen, Burgess, Wells & Moss, 2004)

Each individual during childhood may experience dissatisfaction or some other unpleasant feelings lacking of gratification as a fact of life. However, they should not be considered as ‘trauma’ under ordinary circumstances. In the case which the effect of the stressor heightens due to the interpenetration of familial and environmental factors, these experiences may transform into adverse consequences; *childhood trauma*. The concept of distinguishing the stress reactions from trauma is *the degree of threat and the degree of helplessness*. One of the most common effects

of childhood traumas can be listed as '*overdeveloped self*' which might lead from mild to severe disassociation from the self. (Şar, 2014).

Trauma is unique to each individual. The damage of trauma affecting the individual will possibly engrave the person across his/her lifespan. The extent to which the 'footprints' of trauma impacts the person depends on the degree, duration of the trauma and the developmental stage of that person passing through (Lieberman, Chu, Horne, Harris 2011). As stated by the American Psychiatric Association; the concept of trauma is defined as "*a perceived experience that threatens injury, death, or physical integrity and causes feelings of fear, terror and helplessness*". Thereby; traumatic events refer to "*abuse, violence, neglect, loss, accidents, disasters, war, and other emotionally harmful experiences*" (APA, 2000). As there are various sort of trauma, this study will specifically examine the childhood maltreatment as covering two distinct terms; parental abuse and parental neglect.

2.1.2. Childhood Maltreatment

In literature, *childhood maltreatment* has been studied under the main topic '*childhood adversities*' (Denholm, Power, Li, 2013). Furthermore, the term '*childhood maltreatment*' is generally used interchangeably with '*child abuse and neglect*' (Nurius, Green, Logan-Greene, Borja, 2015; Hopfinger, Berking, Bockting, Ebert, 2016; Toth & Cicchetti, 2004) however it can also be used as an '*umbrella term*' (WHO, 2016; Yingying, d'Arcy, Shuwai, Xiangfei, 2019; Font & Berger, 2014) constituting both terms; abuse and neglect.

World Health Organization (2006) defines child abuse and neglect as "*All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm*

to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power". But in an inclusive sense, child maltreatment covers the parents' acts of *commission* (spurning, terrorizing) and *omissions* (ignoring need for social interactions) which likely to lead harm to the child (WHO, 1999; Hibbard, Barlow, MacMillan, 2012). All the acts of the caregivers which are resulted in harm or pave the way for a potential "*harm or threat of harm*" to the child are all considered as child maltreatment even in cases where the act is unintentional (Gilbert, Widom, Browne, Fergusson, Webb, Janson, 2009).

Childhood maltreatment is assumed among many scholars as one of the fundamental *environmental pathogens*, creating a risky environment for biological and psychological progress as well as physical health (Cowell, Cicchetti, Rogosch, & Toth, 2015). Maltreated child *deprived of* desirable parental attitudes and positive adaptive behaviors, trap in a cascade of unfavorable developmental process (Cicchetti, 2013). Any forms of maltreatment containing physical, emotional and sexual or engaging in neglectful acts, generally impinge a vital effect on child health and developmental progress (Cicchetti & Toth, 1995).

Maltreatment differentiates from other types of stressors since it has some particular characteristics; "*the chronic nature of the stressor, the age of the victim, the relational context*" in which the trauma appeared. These are worth to consider while understanding the extent and degree of maltreatment's effects. Especially the relational context of the trauma in which the children struggle to survive against his/her own parents whom represents 'harm-producing' and 'harm-reinforcing' roles is critical. This process of chronic trauma caused by maltreatment is an endless conflict and devastating effort to cope with. In order to preserve the balance, the child

engages in some maladaptive cognitive, affective and social- emotional strategies toward the unpredictable and dangerous attitudes of his parents. Dysfunctional patterns of behaviors he develops are generally cognitive hyper vigilance, dissociative experiences and reduced familiarity with internal affective states which then lead to problematic relationships with peer and intimate partners (Scott, Wolfe, Wekerle, 2003).

The statistical analysis can offer a general picture about the gravity of the problem. In 2018, according to the data gathered from fifty states in U.S.A, there are 678,000 children reported suffered from the abuse and neglect in childhood. The figures demonstrate children who are up to one year old as having the highest rate of victimhood. Fatalities among children are considered as the most striking consequence of maltreatment. Only in 2018 in U.S.A, 1,770 children have lost their lives from abuse and neglect. Boys' fatality rates are higher than the girls; as 2.87 compared to 2.19 per 100,000 in the population. The parents of the victims have been reported as the majority (77.5%) of perpetrators. (U.S Department of Health and Human Services, 2018). More than 1.25 million children per year have been committed to abuse and neglect in U.S.A, and this adverse issue cost over \$ 220 million a day to the entire nation (Gelles & Perlman, 2012)

In Turkey, on the other hand, according to the findings of TÜİK (Türkiye İstatistik Kurumu), 158.343 children have been brought to security units in 2016. 16.877 children among those were victimized due to the sexual assaults and 87% were girls.

The figures representing victimized children in Turkey keep escalating and getting worse each year. Between 2014 and 2017, in three years period, numbers of

child victims exposed to abuse had been 5.590 although between 2018 and 2019, the numbers had been raised to 5.254 just within a year (İstanbul Barosu, Çocuk Hakları Merkezi, 2019).

Childhood adversities and dysfunction in family contexts have tremendous effects on child well being alongside on the long lasting adults' health (Chapman, Whitfield, Felitti, Dube, Edwards, Anda, 2004). As the child is more vulnerable to environmental stimuli and adversity, new epidemiologic studies support the argument that especially the exposure to the stress for the children under the age of ten is devastating and significant (Finkelhor, Ormrod, Turner, Hamby, 2012). In contrary, when to review the beneficial influences of early positive and desirable memories, they were found to be significant for future well being of individuals (Masten & Cicchetti, 2016; Waters & Cummings, 2000). A self perceived as positive and favourable relational bonds are critical and they appear as ways to buffer the adaptation when facing with early adversities (Luthar, Crossman, & Small, 2015; Masten, 2013; Wright et al., 2013). In other words, the effect of positive childhood experiences can serve as *a resilient functioning* and can work as an effort to sustain or even restore the positive functioning following the adversity (Masten and Cicchetti, 2016 cited in Narayan, Rivera, Berstein, Harris, Lieberman, 2017).

2.1.3. Parent- Child Relationship

The extensive effects of maltreatment in childhood differentiate due to the meaning attributed by the victim to incident of abuse and/or neglect. In this aspect, the quality and dynamics of the relationship between the victim and the agent (parent) determine the psychological outcome in the child who is the major variable of the incident. Therefore the most disruptive influence of maltreatment appears when the

trauma originates from a person entrusted with the nurturing of the victim, namely; the caregiver in this case (Van der Kolk, & Fisler, 2008).

Children's Act in 1998 states as a definition; "*child as a person below the age of eighteen years*" and as a welfare principle as "*the best interest of the child shall be paramount in any matter concerning a child*". As the act indicates, parents are considered responsible for their child's welfare. Children have psychological needs to be fulfilled apart from basic survival needs. These primary psychological needs are; "*to be safe from danger, to be loved and cared for, to love and care for other, to be respected as a unique and valued individual, and to have a say in one's life*". In which extent the quality and the degree these needs are met, form a basis for the individual's developing potentials, identity, and attitudes. As a consequence, those psychological needs are confirmed as basic human rights but also vital elements to a healthy wellbeing. Eventually, maltreatment occurs when the attempts of the child are distorted, corrupted or foreclosed. "*Child abuse and neglect*", also used in literature as "*child maltreatment*", contains all kinds of "*violence against children*" (The American Professional Society on the Abuse of Children, 2017). Based on the research findings; the first five years of life – as fundamental years for development – is the highest risky period for child maltreatment. 75, 7 % of the children lost their lives resulted from the child abuse and neglect. They are all younger than four years old, but still the highest death rate occur between birth and a year of age (USDHHS, 2009; cited in Lieberman, Chu, Van Horn, Harris, 2011).

In a complementary relationship between children and caregivers, child learns normative rules and expectations of the society through the guidance of their families. Parents punish the child when it resists complying and they reward when children

obey. But in neglectful or abusive families, the balance of fairness is unsteady and problematic (Youniss, 1980). In this case, child shapes a modified sense of fairness in regard to parent-child relationship and develop a representational model in which parent is privileged and exempted from any critics but the child assumes himself as one always to blame (Bowlby, 1980).

Consequently; in order to have a deep understanding of how maltreatment has a severe impact on a child psychological state, it is critical to review the core premise of the attachment theory. This basic foundation is the early secure bond between the child and the caregiver predict the future interpersonal relationship of the individual across the life span (Schneider, Atkinson, Tardif, 2001). The pioneer scholars who developed arguments in regard to the relationship between childhood maltreatment and attachment theory are Ainsworth (1979) and Sroufe (1979, 1983) works. In subsequent theories, the findings suggest that maltreated infants manifest insecure attachments to their caregivers (cited in Aber, & Allen, 1987). Due to the destructive residues followed by abuse and neglect, these children will presumably to develop “*reactive-attachment disorder*” (Greenberg, 1999) which lead to trauma-related attachment problems. Consequently, these children adopt and internalize a “*negative working model*” about themselves, other adults, social connections, and outside world (Becker-Weidman, 2006). The children may experience unresolved conflict by the positive emotions they feel for their abusers or fear for the authority the abusers have over them (Al Odhayani, Watson & Watson, 2013). In contrast, a secure attachment develops a base system by the caregiver to create opportunities for self-regulation of emotions, communication for interpersonal relationship and potential for resilience (Flaherty, & Sadler, 2011). Beside, the continuous social, cognitive and emotional improvements of the neglected or abused children fail to sustain in a healthy way.

Fear is quite common for those children; their attempt to explore outside world is weak and they usually experience anxiety. Since they strive to survive and pave the way to feel secure, their psychological efforts are not to remain for normative developmental needs (Lynch, 2005).

During adolescent stage as an example, neglected child becomes more disadvantageous due to his inability to learn how to regulate the emotions and to receive reinforcements such as acceptance and approval since his parents are ignorant and avoid teaching to guide, to offer what he needs and monitor the child to gain such abilities. (Siyez, 2016).

Childhood maltreatment is a compelling term to use since in order to evaluate the circumstances, two aspects also need to be considered: the developmental stages and sociocultural context in which the attitudes and behaviors become meaningful to the agent. In other words; the dynamics of a particular relationship between a parent and a child can vary in each culture and maturational stage of the child. Interaction given in one culture can be interpreted as normative and acceptable whereas deviant and unacceptable in another. Nevertheless childhood maltreatment is the ‘basic threats to human development’ due to its nature which involve collaborative and destructive attacks of the adult toward the “*child’s development of self and competence*”. (Garbarino, Guttman, Wilson Seeley, 1986).

Accordingly; empirical data demonstrate that neglected children perceive themselves as *worthless* (Polansky, 1981) and abused children accuse themselves as responsible for their parents’ abusive behaviors (Amsterdam, Brill, Bell, & Edwards, 1979; Kempe and Kempe, 1978 cited in Dean, Malik, Richards, Stringer, 1986). A similar scientific outcome was obtained from a research conducted in Turkey

regarding abuse and neglect cases. Due to the finding, the children were displayed *self-blamed tendencies* for the abuse. Some children justify the abusive behaviors' of their parents as believing to think their parents engaged in such behaviors for the sake of their children (UNICEF, 2010).

2.1.4. Types of Maltreatment

There are certain contradictions in entitling adverse childhood experiences in literature. Psychologists or counselors prefer to use the term "*abuse and neglect*", but lawyers conceptualize as "*maltreatment*" whereas health professionals refer to *abuse* or "*battered child syndrome*" (Kempe, Silverman, Droegemueller, & Silver, 1984 cited in Odacı & Çelik, 2017).

As Corcoran and McNulty argued (2018) negative childhood experiences comprising of sexual, physical, emotional abuse are "*traumatic events*" or chronic stressors such as physical and emotional neglect, separation of the parents which are all "*uncontrollable to the child*". Critical characteristics of abuse are being repetitive, being intentional and harming and effecting to the child's physical, cognitive, psychosocial development and health. The basic difference between abuse and neglect is that the abusive behaviors are formed by active behaviors, and neglectful behaviors consist of passive behaviors (Pelendecioglu & Bulut, 2009).

Child abuse and neglect also known as '*psychological maltreatment*' (Glaser, 2002) represents conditions referring to sum of repetitive patterns of extreme incident (s). It generally becomes apparent in six categories which are;

- **Spurning:** It is about parents' verbal and nonverbal acts conveying the messages of feeling rejected, insulted. Caregivers' behaviors also include belittling, degrading, shaming and putting the child in ridiculing situations. In

the mind of that insecure parent, he/she perceives that child as their own reflections as a '*bad copy of its original*'. These sorts of parents are prone to criticize and mostly punish the child and ignore to use reinforcements needed for encouragement. They generally do not hesitate to humiliate the child in public.

- **“Exploiting/ corrupting”**: the caregiver acts lead the child adapting inconvenient behaviours and manners which can be defined as self-destructive, antisocial, criminal, and deviant. In engaging such behaviors, parents become misleading role models for the child whose mental representations about outside world becomes distorted.
- **Terrorizing** embodies caregivers behaviors resulted in living the child threatened and frightened. The violence can be targeted toward the child or to the people or objects that child have affection for; create a terrifying surrounding for the child to witness.
- **Emotional responsiveness**: it occurs when the parents occasionally interact or when absolutely necessary. Child becomes emotionally detached and fails to receive expression of affection, caring, and love he/she needs.
- **Isolating**: When parents unreasonably restrain the child reaching the opportunities to meet they need when interacting with peers and adults inside and outside the home. These opportunities might be hindered by the parents with unnecessary limitations which inhibit the child's psychosocial development with the community.

- **Mental health, medical and educational deprivation:** This form of maltreatment involves parents refusing to allow the child getting the necessary medical and educational treatment (Hart, Binggeli, Brassard, 1997)

2.1.4.1. Neglect

With regards to subdimension of maltreatment, *neglect* encompasses “*failure to provide the child's basic physical needs for adequate food, clothing, shelter, and medical treatment. In addition to inadequate attention to physical needs, forms of this subtype include lack of supervision, moral-legal neglect, and education neglect*”. (Thibodeau, Cicchetti, and Rogosch, 2015)

Neglect leaves the developing mind starving for stimulation. Child lacks of information and interests necessary to explore the self and others. “Neglect slowly and persistently eats away at children’s spirits until they little will to connect with others or explore the world” (Erickson and Egeland, 2002 cited in Howe, 2005).

Physical neglect:

Physical neglect basically contains all forms of a parent’s unwillingness or inability to meet his/her child’s material needs *for reasons other than poverty*. Although the effects of physical neglect are greater than poverty in terms of cognition in particular when compared to the social-emotional development of the child (Brooks-Gunn & Duncan, 1997 cited in Font & Berger).

Child deprived of accessing appropriate nourishing; housing, medical care, education; lacks of a healthy development and nearly renders the child as similar as a poor child. The effects of malnourishment or other failure to some fulfillments and especially in chronic cases the stress and physical deficiencies resulted in

circumstances given, may leave the child unprotected against the environmental hazards (Evans and Kim, 2013).

Economic deprivation the parent experiences may harm the child's health through deprivation. But also child may be impacted by a relational cascade in a way that the parents' hostile behaviors due to the stress they suffer with economic difficulties can be directed to the child. The repercussion of such parental attitudes can be observed on the negative affects and behavioral responses in the child (Conger, Ge, Elder, Lorenz & Simons, 1994).

Emotional Neglect

In neglectful family environment, caregivers avoid taking the responsibility of parenthood and their roles as authority figures. In this sort of surrounding, the child undertakes most of the liabilities for the sake of their own, for their siblings or even for their parents. Concordantly Bowlby (1980) entitled this excessive effort of the child to take the responsibility of his/her parent's as *compulsive caretaking* (Dean, Malik, Richard, Sharon, Stringer, 1986).

In emotional neglect, parents deprive the child of their affection, attention, relational warmth and leave the child unattended during adolescence in particular. Emotional neglect appears in certain forms. Sexual neglect contains acting the child in an inconvenient way upon his/her age and gender expectations. Educational neglect includes remaining unconcerned about the child's educational as well as specific needs, about extended non-attendance of the child to the school and being disregarded to the child's academic failures (Acehan, Bilen, Ay, Gülen, Avcı, İçme, 2013).

Physical or emotional harm caused *by siblings* can also be covered under the parental neglect. Mother or parents or both can engage in ignorant approaches toward their other children (s) who imply violent actions to the child mentioned in a harsh way. As the tortured child is under the responsibility of the parents, they can be considered as neglectful caregivers (Polat, 2017).

In recent literature reviews, emotional neglect during childhood has been accepted as risky element to the development of psychiatric symptoms during adult years. It is also considered as a psychological base to permit the constitution of all other child maltreatment forms. Children having a history of emotional neglect are under risk of experiencing feelings of sadness, guilt, embarrassment and rage since they are not capable to develop the appropriate skills to tolerate, modulate their feelings. This deficiency is due to the dysfunctional role of the family to practice the competencies mentioned (Schimmenti, Maganuco, L. Marca, DiDio, Gelsomino, Gervasi, 2015).

2.1.4.2. Abuse

Emotional Abuse

Emotional abuse refers to all chronic interaction patterns and behaviors by which the child's emotional and mental functioning will presumably get harmed (Beyazıt, 2015). These involve humiliating, teasing behaviors of the parents and rejection of the child, threatening the child, leaving the child unattended, intimidation, exploitation, giving the child an adult role ahead of his developmental time (Polat, 2007). It is considered in the literature as the core issue available in all sorts of maltreatment (Hart, Germain & Brassard 1987)

There is a general tendency to correlate the attachment style and the attitudes of the neglectful parents. A secure attachment develops when a consistent, responsive and sensitive care is present (Ainsworth, 1989). In contrast, abusive caregivers tend to behave as nonresponsive or punitive toward the child. Thus, the history of abuse has been found to be connected with a tendency of an insecure attachment (cited in Baer, Martinez, 2006) and the avoidant or disorganized attachment (Cicchetti, Rogosh, & Toth, 2006).

Accordingly, emotional abuse may lead to a future diminished well being by *maladaptive schemas of thoughts and beliefs* which then cause the person being self-sacrificed, dominant feelings of shame or vulnerability (Messman-Moore & Coates, 2007; Wright, Crawford, & Del Castillo, 2009). Sometimes, the abused child may adapt particular internal models of relationships which are maladaptive but also symbolizing the abuse memory (Shields, & Cicchetti, 2001). These responses are considered as *traumatic reenactment* of the victim in a role playing as victim or perpetrator (van der Kolk, 1989). Moreover, children by imitating his/her parents can repeat and maintain the maladaptive pattern (Bandura and Huston, 1961). For these reasons, emotional abuse is more linked to social-emotional development rather than cognitive development (Maughan & Cicchetti, 2002). Another reason why abused children have maladaptive patterns might be due to the unique way of those children processing the trauma in a different manner than other types of trauma victims. Cicchetti (1989) in his research pointed out how abused children had difficulties in expressing their affects especially negative emotions like hate, disgust and anger. Beside, mothers who are account for the abuse was observed to give rise to the dysfunction in maltreated children. Kropp and Haynes (1987) found that abusive

mothers tend to mislabel the ‘negative’ emotions of their children as ‘positive’ (cited in Pelcovitz, Kaplan, Goldenberg, Mandel, Lehane, Guarrera, 1994).

Psychological abuse also known as emotional abuse (Gervis, & Dunn, 2004), have negative effects also on the subjective well beings of adolescents. There are certain reasons by which the adolescent neglected in the family has a decreased well being; the rejection of the individual (unfulfilled needs and a “*damaged self esteem*” due to the neglectful attitudes of the parent), isolation of the person (constraint of the parents from the child developing effective social relations), corruption of the individual (encouraging the child to adopt and engage in unacceptable behaviors (Hibbard, 2012 cited in Bostan & Duru, 2019).

Psychological abuse (PA) in childhood impinges on the child in a way that damages the newly developing understanding about the self and others which then disrupt *psychological functioning* and *interpersonal behavior*. Children experiencing PA by means of their parents’ rejection and disconnection can adapt maladaptive schemas (Young, Klosko, Weishaar, 2003) through which they absorb rigid interpersonal beliefs. These beliefs generally become dysfunctional and repetitive throughout life (cited in Messman-Moore & Coates, 2007).

Emotional abuse is the “*sustained, repetitive, intensifying and inappropriate*” behaviour that create a harm the developmental course or diminish the developmental potential of mental capabilities and mental progress of the child. Natural mental capabilities include; “*intelligence, memory, recognition, perception, attention, imagination and moral development*”. This type of abuse disrupts the skills of the child to make sense of his/her environment and manage the surrounding in normal circumstances as his age or the development allows him to do (O’Hagan, 1995).

Physical Abuse

Physical abuse can be broadly identified as *non-accident injury* of the child. It is the most extensive abuse type and easiest to recognize (Polat, 2007). It refers all the harmful acts of a mother, father or other caregiver which will deliberately cause wounding or the possibility of physically hurt or injure the child who is under eighteen years of age. The parental damages are applied whether to employ obedience, to discipline the child or for the parents' own sake as a way for anger evacuation, by clapping, pushing, shaking, burning or biting the child which then result in leaving scars in child's body or damage the child (Kaplan, 1996; Kaplan, Pelcovitz, Labruna, 1999; cited in Tıraşçı & Gören, 2007).

It also includes “*hitting, kicking, punching, beating, stabbing, shoving, throwing, pulling, dragging, strangling, smothering, scalding, and poisoning*”. Parents were identified as the perpetrators in 77% of cases according to US figures for verified physical abuse (US Department of Health and Human Services, Administration on Children youth and Families. Child Maltreatment, 2006)

Kulaksızoğlu (2001) describes physical abuse as the ‘corporally disturbance of the child’ by his/her parents or other adults.

The short term consequences of physical abuse are; sleep wetting, thumb sucking whereas long term effects can be listed as tendency toward committing crime and emotional turmoil (Kulaksızoglu, 2004; cited in Pelendecioğlu, Bulut, 2009).

Sexual Abuse

Sexual abuse is briefly the exploitation of a child by an adult to be used as a means for sexual arousal or with the intent of sexual gratification. Sexual abuse is

about forcing to oblige a child or adolescent engaging in sexual activities or deliberately seducing the child or the adolescent. It does not necessarily require an involvement of the perpetrator or presence of high levels of violence and it is not matter whether the child is conscious on the intention of harm (Polat, 2000). The actions are “*physical contact, including assault by penetration or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or preparing a child for possible abusive acts*” (NPSCC, 2017).

In sexual abuse cases the factors which are predicted to influence the child’s response will be depending on the child and family special features, the characteristic of the exposure such as type of sexual act, frequency or entity of the interaction between the child and the abuser (Stokes, Saylor, Swenson, Daugherty, 1995).

Women, victim of sexual abuse in childhood tend to display acts of self harm such as cutting her selves to suppress the pain they suffer. In the most prevalent form of self injury; cutting and scratching the skin, victims engage in those actions more often as the anxiety levels increase. The reason behind this action cannot be defined as a manipulative effort but rather an attempt to decrease the upward anxiety by replacing the emotional pain with the physical pain. Victim of abuse feel the embarrassment followed by self-hatred and unworthiness emotions. Child, who turns into a victim of a sexual abuse, tries to get over the experience, strive to regain its power via self harming activities. The act aims to overcome the feelings of disappointment and anger but also to prevent the process of ‘*depersonalization*’ by

which people can feel disconnected or detached from their own body and thoughts after being traumatized (Aksoy & Ögel, 2003).

Sexual abuse has a particular characteristic among other patterns of abuses in terms of its prevalence: sexual abuse is independent from any sociodemographic features. In other words, in each sociodemographic layer, the probability of sexual abuse to eventuate is equal (Hedin LW, 2000 cited in Taner and Gokler, 2004)

According to the summary report of ‘Research Study on Child Abuse and Domestic Study in Turkey’ (2008) in 61 cities around Turkey, the interviews were gathered among children between 7-18 years of age. The study was conducted in 1328 households interviewing 1886 children. One of the most prevalent findings for the source of the *emotional abuse* is mothers who constantly berate their children at home and teachers who verbalize unpleasant and humiliating critics at school. For *neglect*, most common type is leaving the child unattended and all alone. Compared to other types of abuse, sexual abuse has been the least informed type of case as having 1% of self report rate due to the perceived social drawbacks. (Unicef, 2010).

2.1.5. Effects of Childhood Maltreatment

The impacts of child abuse and neglect followed by a chronic stress can influence even modify the *neurological*, *immunological* and *hormonal* development of children (Berens, Jensen, Nelson, 2017). Future reflections of these effects pave the way to emerge *anti-social* and *health-harming behaviors* and prompt the occurrence of chronic disease and early death (Anda, Felitti, Bremner, Walker, Whitfield, Perry, Dube, Giles, 2006). A body’s biological response system can be modified by an exposure to an instant traumatic event or chronic traumatic experiences. This stress activation is followed by certain behavioral and emotional consequences just as

similar to PTSS (post traumatic stress symptoms). In addition, the stress response system triggers the sensitivity of other interacting systems and disarray homeostatic equilibrium protecting the individual from environmental hazards which then lead to fight or flight (and/or freezing) reactions (Chrousos, & Gold, 1992). Accordingly, dysregulation of biological stress in early development of the child leads to impairment in brain development (DeBellis, 2001). For instance, in empirical literature, the association between *cortisol levels* and trauma response has become prevalent as one of the striking topics of neuropsychology. High cortisol levels are observed among adults having a history of child abuse when these people confront with a traumatic reminder (Bremner, Elzinga, Schmahl, Vermetten, 2003). For example; in a study in which cortisol levels among sexually abused and non-abused girls were compared, the levels of cortisol were detected as significantly higher in abused girls when they disclose about their traumatic experiences. However cortisol levels gradually decreased in adolescence and get lowered during young adulthood as time passes since the trauma exposure (Trickett, Noll, Susman, Shenk, Putman, 2010). Similarly in another meta-analysis about victims of childhood trauma, the findings revealed that the longer the time followed by trauma, the lower the cortisol levels appeared (Yehuda, Kahana, Binder-Brynes, Southwick, Mason, Giller, 1995 cited in DeBellis & Zisk, 2014).

Additionally, abuse and neglect or childhood maltreatment in a broader sense, *generate violence* within indirect ways. In many scientific analyses, maltreatment in early developmental stages is considered accountable for emergence of violent acts in adulthood. For instance; early and chronic sexual abuse history among boys in particular, has devastating outcomes later in life. These victims will likely to get involved in sexual offenses without even remembering their own past of abuse

(Lewis, 2005). This violent perpetuation can be explained with neurobiology. In empirical studies it was found the *hippocampus volume reduction* has been visibly evident *amongst trauma survivors*. As a consequence, all these disruptive trauma effects cause the change in brain structure and function (Güleç, Topaloğlu, Ünsal, Altıntaş, 2012).

A rich academic literature presents the strong correlation between childhood maltreatment and some other risk factors as primary causes of diseases and death in adulthood. The Adverse Childhood Experiences (ACE) Study (1995-97) at Kaiser Permanente is one of these outstanding analyses comparing the interrelation of *the current health status* of the participants with their *childhood experiences*. The outcome of the study had a tremendous impact on new empirical curiosity. Participants having abuse history, was observed to be linked to a wide spectrum of physical and psychological problems ranging from *substance use, smoking, alcoholism as self-soothing coping strategies, severe obesity, skeletal fractures to suicidal attempts, depression and cancers* (Felitti, et al., 1998)

Following the ACE Study, the detrimental consequences of childhood maltreatment on *ill-being* during adulthood have now become a generally accepted argument in literature. Accordingly, people who had experience *four or more types* of childhood abuse are considered as having *two times* as much in risky conditions for smoking, *six times* to have alcohol addiction problems, *over twice* as conceivably to suffer from particular diseases such as cancer, heart diseases (Hughes, Bellis, Hardcastle, Sethi, Butchart, Mikton, Jones, Dunne, 2017). Moreover; rich critical literature has evolved and shown the association between “*self-injurious behavior and childhood histories of physical and sexual abuse*” (Pattison, Kahan, 1983).

Moreover; the consequences of maltreatment during childhood has been carried by generations and through maladaptive schemas. Being suffered from child maltreatment puts the young individual in jeopardy of becoming a perpetrator for following years which then likely initiates a '*cycle of violence*' (Widom, 1989). In this cycle, people who recently witnessed the violence or exposed to it are under risk of becoming a juvenile delinquent, which refers to (*intergenerational*) transmission of antisocial behavior (Widom and Maxfield, 2001). Accordingly, among ample body of research, it is found that the maltreated boys suffered from *neglect* in particular, had condemned for committing *four times more* than juveniles who had no history from childhood neglect (Kazamian, Widom, Farrington, 2011). In traumatic experiences, children exhibit some *trauma-related responses* such as impulsivity, avoidance, hopelessness, disruptive behaviors which then likely to carry over the adult lives through *patterns* or *cognitive schemas*. The repercussions of trauma move forward via repetition of violence whether by becoming the victim of violence or engaging in violent actions as perpetrator (Burgess, Hartman, Clements, 1995).

Childhood maltreatment has also been found to be relevant to *substance use disorder* during adolescence and adulthood. Similarly child maltreatment has one of the fundamental factors to create increased risk for "*tobacco use, alcohol use, illicit drug use and polydrug use*". (Alvarez-Alonso, Jurado-Barba, Martinez-Martin, Espin-Jaime, Balanos-Porrero, 2016). Moreover, girls having a sexual abuse history in childhood are roughly five times higher risk for polysubstance use (consumption of more than one drug at once) compared to non abused adolescent girls.

Numerous studies have demonstrated that abusive parents responsible for maltreatment are also preclude the child to modify accurate strategies for their

emotions and behaviors during stressful times which then result in impulse control deficits in the child (Kim, Cicchetti, Rogosch, & Manly, 2009). Accordingly, abused and children are more prone to display impulse-like behaviors compared to nonmaltreated children. In parallel with this argument, findings reveal the evident link between maltreatment during childhood and aggressive tendencies, antisocial behaviors, social information processing deficit and criminal behaviors (Thibodeau, Cicchetti, Rogosch, 2015).

The scientific findings also demonstrate the relevance between childhood abuse, neglect, low self esteem in adulthood (Onat & Dinç, 2015). The increase in self esteem is connected with receiving positive feedbacks from parents and friends. During early years, one of the major developmental task of the child in regard to the control of the self is expected to control his/her negative affects (Özmert, 2006). As maltreated children experience difficulty in regulating impulsive behaviors, self-esteem can be damaged following abuse and neglect (Cowell, Cicchetti, Rogosch, & Toth, 2015)

Childhood maltreatment contribute emergence of risks of *internalizing* (anxiety, disorder) and *externalizing* behavioural problems (Gilbert, Widom, Browne, Fergusson, Webb, Janson, 2009).

The association between eating psychopathology and childhood maltreatment has also appeared in psychology literature. In retrospective studies, the significant relationship has been detected between sexual abuse during childhood and eating disorders; “*bulimia and anorexia*” in particular (Brewerton, 2007). In another study, “*emotional abuse, physical neglect and sexual abuse*” in particular as childhood

trauma has been determined as remarkable predictor of eating psychopathology (Kong, & Bernstein, 2008)

2.2. SUBJECTIVE WELL-BEING

2.2.1. Positive Psychology and Well-Being,

At the beginning of 20th century, the philosophical movement adopted the *modernist view* and deeply penetrated the behavioral sciences, psychological counseling theories and research methods in psychology. In modernist approach, conventional psychology emphasized on *rational thinking* and brought the *empiricism* forward. The scientific knowledge was reflecting *the truth of the outside world* in this approach. By the end of 20th century; the major characteristics of modern approach had shifted toward the relativity of *postmodern thought*. As the postmodernism became prevalent, the concept of subjectivity and relativity gained recognition in scientific field. The postmodern era appeared in Europe followed by World War I and in United States after the World War II (Karairmak & Siviş, 2018). Social changes in a revolutionary way had also shaped people's psychological needs, expectations and scientific approach toward those.

Psychology after World War II expanded its roots toward focusing more on healing and repairing the damaged human functioning with a disease model. Devastating effects of the war created a massive dissolution among societies; people left hopeless and despondent and '*without jobs, money or status, they were reduced to empty shells*'. Psychology had positioned as a science of 'victimology' treating individuals whose suffering was about their damaged backgrounds, mental disorders or trauma (Seligman, 2000). But despite all the challenges people had faced, few among them were still kept their wisdom and decency. This impression led to find an answer to the query 'how people endure under the circumstances of adversity'. That's

how the necessity for a science of human beings to explore a new principle ‘what is and ‘what *could be*’ emerged. Afterwards many scholars believed that psychology had to serve as more than a curing approach but as a source to nurture what is best. It is not a support mechanism for a wishful thinking for certain but rather a preventive method to lean over strength, capacity, virtues and a better health for people (Csikszentmihalyi, 2000). *Preventive role* of positive psychology is worth mentioning since a good understanding of a human strength can help preventing possible detrimental outcomes of an eventual stress or disease. For instance, As Folkman and Lazarus (1988) argued; an appraisal of a current negative life event will likely to help developing a new constructive coping strategy to mediate possible effects of a prospective challenge. Similarly, for both physical and psychological health “*optimism and a sense of personal control*” are also considered as protecting factors (Gable & Haidt, 2005).

Positive psychology does not exclude negativity, suffering and just embrace happiness but promote *integration of both* aspect of life. It contributes to the science as a new route to comprehend the reasons behind the emergence, timing and appropriate conditions to base the positive emotions, positive characteristics of the personality or institutions can let the person flourish. (Seligman, Steen, Park, Peterson, 2005).

Aristotle argued “*flourishing’ as the ultimate goal of human existence*” (Adler, & Seligman, 2016). Flourishing represents inexistence of negative side of human experience such as anxiety, anger, fear or depression and presence of positive elements such as self-actualization, healthy relationships, and engagement. But well

being is beyond cultivating positive emotions, thriving each domains of life also matter (Adler & Seligman, 2016).

Diener (1984) summarizes the general attitude toward defining *well being* or namely *happiness* in a chronologic way. In the beginning, well being was appraised by the virtue an individual needs to possess via living a dignified life. This criterion was set by others as a desirable state to be expected and was not necessary to happiness. The second wave in regard to well being was more about a move toward questioning the factors which make people *appreciate their lives in a positive way*. This approach was fundamental to value subjective judgment of the individual. Third movement mainly represents current discourse of happiness and connotes meaning on dominance of positive over negative emotions.

Utilitarian approach (Jeremy Bentham, 1948) has initiated the movement of hedonic well being by describing how to reach to a good life. In his formula, the presence of pleasure and absence of pain were basic elements of good life in mental, emotional and physical domains. Early 20th century, subjective well being had been consolidated by empirical studies. Flugel (1925) and some scholars after World War II attempted to recognize people's happiness and life satisfactions using global polls (Diener, Oishi, Lucas, 2012).

Everlasting debate about '*what constitutes a good life?*' query had eventually concluded as 'the good life is happy'. Attempt to understand a person's happiness via his/her self report statements is quite important to be familiar with any society's well being in general. Therefore, the upward subjective well-being levels are central for good lives as well as flourishing societies (Diener, Oishi, Lucas, 2003).

2.2.2. Eudaimonic versus Hedonic Well Being

Two major streams have been guiding well-being domain; as one focuses on happiness (hedonic) and a broad evaluation of affective and life quality *while* other concentrates on human potential (eudaimonic) and a robust to the existential challenges. But both perspectives are concerned with the people's subjective statements of well being (Keyes, Shmotkin, Ryff, 2002). How to achieve living a good life had long been discussed in the literature. Rationale of hedonism is heightening the pleasure and diminishing the pain whereas eudemonia necessitate identifying a person's virtues, fostering them and living accordingly in order to obtain happiness. Seligman introduced another concept to be influenced by Csikszentmihalyi (1990) invention of flow. Flow is a psychological state including highly engaging activities. This new concept differs from hedonic satisfaction by not containing positive sensory and momentary gratification but as a nonemotional and nonconscious activity (Seligman, Steen, Peterson, Park, Seligman, 2005).

Hedonic well being focuses on '*how to feel good*' although eudaemonic wellbeing deals with '*how to function well*' in each domains of life (Keyes, & Anas, 2009). Eudaimonism is an ethical theory entailing to discover '*the daimon*' as a unique entity available within each person and to strive to reach it as a lifetime effort. Daimon represents all the potentials and virtues every individual are assumed to have. Efforts to live in accordance with it and experience the self-realization as a result, is expected to provide convenient conditions for 'eudaimonia'. The term is more about an intrinsic motivation and personal experientialness (Deci & Ryan, 1985) and the emphasis is on spending a lifetime worth living (Waterman, 1993).

These two mainstreaming approach in well being with its roles in psychological domains of cognition, emotion and motivation. While *subjective well being* as the hedonic aspect of well being theory stress on happiness and pleasure, *psychological well being* symbolizes the eudaimonic well being targeting a meaningful life. There are related but separate aspects of positive functioning. Their relatedness depends on PWB as being the significant predictor of SWB when personality is under control (Chen, Jing, Hayes, Lee, 2012).

A special focus on well being is so critical that in contemporary psychology it offers an insight to the optimal psychological experience and function of human being. But in *hedonic well-being* a person's proclaim that he/she is happy *does not necessarily* refer as he/she psychologically well. On the other hand, *eudaimonia* appears *not* to be as an outcome but a process and refers to an awareness and actualization of one's potentials. In this regard, the basic distinctness between the two is the nature of eudaimonic well being representing mostly being the fully functioning. However they also share a common element: both terms contain *hedonic enjoyment* as a satisfaction component (Deci & Ryan, 2006).

Subjective well being has a special role as the fundamental concept in the field prizing subjective assessment of well being. In other words, it represents the special evaluation of the individual's own life with a basis of that individual's self criteria which are found to be the most important judgment (Alexandrova, 2005).

2.2.3. Pioneer Scholars in the Field

Carol D. Ryff is one of the pioneer scholars in the literature of well-being from which positive functioning aspect of well being had been aroused as a center of focus. She developed '*six factor model of psychological well being* as an integrated

theoretical framework combining core ideas of many theories in the field. This united version of particular theories was one thing in common: *new model of health* had been redefined by a description of positive psychological functioning and the positivity as the essential and required element of health and as independently of absence of illness (Van Dierendonck, Diaz, Rodriguez- Carjaval, Blanco, Moreno-Jimenez, 2008). Ryff basic concern was about defining the structure of psychological functioning and her proposition is that happiness could not be considered as a sufficient ingredient to describe well being. Her model was constituted of six dimensions which were admitted as major requisites of human functioning in a positive way: “*self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth*” (Ryff, 1989). While developing her theory, Ryff criticized the data previously postulated about life satisfaction, positive, negative affect as main constituents of well being. According to her, these were serendipitous findings which were far from explaining what *wellness* actually is (Ryff, 1995). Ryff’s psychological well-being theory is mostly associated with *euaimonistic view* since the emphasis on individual potential, self-command, personal growth and pursuit of “*a meaningful life*” comprise a basis of its well being argument (Ryff & Singer, 1996).

Corey Lee Keyes had developed ‘Social Well Being Theory’ (1998) and created a new perspective about the basic component of well being. Initially she supported the argument in regard to the positioning of “*positive psychology as the scientific study of optimal human functioning*”. Secondly, she considered human flourishing as one of the main topics in the field which can only be observed among mentally healthy adults. According to her, these healthy individuals have high levels of emotional well being and self actualization motives. Beside, these people have

another specialty in common: they are sensitive to social actualization as well which involve the notion of supporting the society to develop, change and grow (Keyes, 2002). The theory bases his fundamental claim on defining the optimal functioning and mental health via adults' social well being. Social well being can briefly be described as the assessment of one's status and functioning in the community. Accordingly "*social wellness*" has five distinct dimensions as "*social integration, social acceptance, social contribution, social actualization and social coherence*". In the theory, all those elements are approved as personal assets an individual need to posses in order to respond to social challenges in life. A person sense of belonging to the society, his/her ability to maintain an interactive relationship with the society are considered as one of the major predictor of a healthy functioning a way to well being (Keyes, 1998). Keyes reviewed on the definition of *subjective well being* in regard to mental health or positive functioning in sum. In her theory subjective well being is named under the concept 'emotional well being' whose optimum state is measured through "*the existence of positive affect, absence of negative affect and appreciated life satisfaction*". Thus, she necessitates the presence of positive functioning measurements for well being. Beside, how a person perceives himself his status in the society, possibilities offered to that person for growth in that community and how well the people get harmony with the society are all credentials to be added to the assessment for well being she argues (Keyes, 2002).

Martin E. P.Seligman (2002) *authentic happiness theory* is a affiliation of hedonic and eudaimonic perspectives in well being mindset. In his theory Seligman supports a view to reach the well- being through pathways as pleasure, meaning and engagement. Those sources have effective functions to help people achieve life satisfaction in high levels. Each component has critical importance, distinct

characteristics and unique roles enhancing well being (Schueller & Seligman, 2010). In Seligman's initial theory *Authentic Happiness* (2002), he grounded his opinion on the essential values of positive psychology assuming all individuals as active and rationale agents to reach happiness. In the model, all three elements were regarded to be the absolute agents of the model in order to realize happiness. First element is *pleasure* and refers to contentment, ecstasy, gratification, namely all the feelings that lead to maximizing positive and minimizing negative states. It represents the *hedonic* construct of the model. Second element is *engagement*, flow in other saying. As an opposite side of pleasure, it represents the eudaimonic perspective concentrating on the virtues and strengths all humans need to have reaching "*a good life*". Third element is meaning and entails finding "*what makes a life worth living*". It is about dedicating the self to humanity or a feeling of service exceeding the self (Seligman, 2002). After the launch of his first theory Seligman introduced his second theoretical model: *Well-Being Theory*. Need for a new model was basically due to his evolved argument about happiness and well being. On his first theory, Seligman suggested the life satisfaction as the indicator of happiness and the goal of positive psychology. But then, he diverted his viewpoint into the fact which acknowledges *well-being* as the main focus on positive psychology and flourishing as the well being's hallmark measure. In his new model 'Well-Being Theory', he came up with the new diversification among two concepts: "*well being is 'a construct' whereas happiness is 'a thing'*" which can be measured and more concrete. Based on this argument, *happiness* as a 'real thing' and *life satisfaction* in *Authentic Happiness* theory can be measured through determining positive emotion (pleasure), most engaged life (engagement) and meaning in life. However, well-being is *metaphorically* similar to 'weather' which cannot be measured properly. Assessment of the concept 'well-

being' as a construct would only be possible via measuring the elements constituting the concept. Therefore; the components of "*Well-Being Theory*" are : "*positive emotion, engagement, meaning, accomplishment and positive relationships*". This model is known as PERMA. Consequently, happiness theory emphasizes on people choices to reach happiness and life satisfaction. Happiness does not arise independent of our effort. As a matter of fact, happiness is more than feeling good; it is also having a life surrounded by meaning, good relationships and accomplishment. Finally, the aim of positive psychology is lead up a pathway to human flourishing (Seligman, 2011).

Mihail Csikszentmihalyi is an authority on the subject of happiness in positive psychology. He developed "*the concept of flow*" expressing a state of mind. In the state of flow the person becomes focused and totally absorbed by the challenging task he/she is engaged in. The experience of flow generally signifies a special and pleasant activity which will likely to move the individual in a different mental attitude. Following the flow state, people becomes differentiated and integrated with the experience itself in a diminished consciousness. The theory suggests a unified flow process spreading into a life time practice (Csikszentmihalyi, 1990). The concept of flow had also been entitled by the theoretician as the '*autotelic experience*'. People do those sort of experiences include activities of sport, music any other creative engagements worth doing for their own sakes. In his works (1975, 1996, 1997) he supposed happiness as dependent on the satisfaction level people can get from flow experience. Relationship between flow and happiness is not obvious in general and connected with the subjective experience of that person. In his quote he states '*people are happy not because of what they do, but because of how they do it*'.

In other words, according to the theory, happiness emerges when the person assigns positive meaning to the experience of flow (Csikszentmihalyi, 1999).

Certainly well being indicates the *absence of ill-being* but emphasizes more of a need for *presence of flourishing* which is proceeding from the neutral position to an upward state in terms of life satisfaction, experiencing pleasant emotions or to feel being worthy in a meaningful life. People's comments on well being or happiness may vary. But whatever concepts is used, the content need to include how a person feel '*satisfied*' about her life with a series of judgements rather than a momentary feelings of pleasure. These judgements are domain specific such as work, health or relationships and bring to a sense of happiness people feel and think about (Helliwell & Wand, 2012). In this respect, by subjective well being what is intended to mean is to determine people's perspectives about obtaining a life to thrive and flourish. It is important to have a 'sustainable happiness' involving enjoyment as well as meaning in it which will likely to lead a lasting flourishing (Diener, Biswas-Diener, Lutes, LeViness, Wiking, Kim, Bluettener, 2019) .

2.2.4. Subjective Well-Being by Ed DIENER

The definition of Subjective well-being can be as "*a person's cognitive and affective evaluations of his or her life*" (Diener, Lucas, & Oshi, 2002, p. 63). Subjective well being emerged in literature as an appealing topic due to an empirical focus aroused from a scientific curiosity "*what constitutes a good life?*" As the reference source of the answer is expected from people but not from the experts offered individuals the right to decide how they feel about their own lives. In this regard, Subjective well being (SWB) is also labeled as 'happiness' in colloquial meaning (Diener, 2000). Both terms indicate the *supremacy of positive* feelings and thoughts over negatives in a person's lives (Diener, & Myers, 1995). Subjective well

being is an effort to define to what extent a person likes the life she/he lives. Broadly the term has three aspects to assess: one signifies a global evaluation of negative, other the positive affects containing feelings, emotions, and moods as primarily a *hedonic evaluation*. The third aspect is a consideration of the life satisfaction as a cognitive inference (Diener, 1994).

The constituents of “*subjective well being*” are: “*positive affect, negative affect and life satisfaction*”. First two elements form the affective reactions and third include cognitive judgment of the individual (Diener, 1984). Life satisfaction signifies to a judgmental course in which the person uses his/her own criteria to commentate the content and “*quality of his/her life*”. This appraisal is made by comparison. The person activates the comparison between his/her own standards and given life circumstances as a cognitive effort (Diener, & Pavot, 1993). In 1999, Diener, Suh, Lucas and Smith added a fourth component and named as “*domain satisfaction*”. This is consisted of “*work, family, leisure, health, finances and self*”. In order to be able to define subjective well being, frequent “*positive affect, infrequent negative affect and a global sense of life satisfaction*” need to be present (Diener, Myers, 1995). The third constituent of subjective well being is life satisfaction and added by Andrew and Witney’s in 1976. “*Positive affect*” (PA) reflects the degree to which a person experience enthusiasm, joy and contentment. Being in a high state of PA refers to high energy, gratified engagement although low PA is associated with sadness and languor including “*anger, contempt, disgust, guilt, fear, and nervousness*” (Watson, Clark, Tellegen, 1988). Affective evaluations are mood and emotions. The first component is affective and consisted of positive and negative affects. Positive affect is sum of pleasant emotions as follow: joy, contentment, love whereas negative affect covers unpleasant emotions as sadness, anger, worry, stress. Third component is

global life judgment and refer to life satisfaction, meaning, fulfillment, success. The fourth component of subjective well being is then approved as domain satisfaction (Campbell, Converse, Rodgers, 1967) which expresses a person's judgement of his life in particular domains. These domains are marriage, work, health and leisure which provide insight about how people decide on their overall well being judgments and conclude on global assessment (cited in Diener, Scollon, Lucas 2009).

Diener express three indicators of subjective well being concept. Initially it has a subjective nature and the interpretation of the construct totally depends on the experience of the person. As a matter of fact, even social indicators do not solely influence subjective well being since each individual have unique values and expectations brought from previous experiences (Diener & Suh, 1997). Second, *positive measures* are required to be involved in the term. Absence of negative factors is not merely accepted to be sufficient. Third, the evaluation needs to include a *global assesment* of each life domains (Diener, 1984).

Another issue while to consider subjective well being is *the intensity* and *frequency* of emotions. Pleasant emotions in particular are significant in defining and measuring the concept. Happy people are assumed to experience happiness in an *intense* way. But in contrast, *the frequency* of happy moments was gained more recognition as a better predictor of happiness even they are mild. In other words, feeling positive emotions most of the time and unpleasant emotions few and far between are accepted to be sufficient to describe an individual as 'happy' (Diener, 2000).

Generally speaking, 'happiness' can refer to momentary pleasant moods and emotions as "positive affect" or to general evaluations of life quality as "life

satisfaction”. But subjective well being has been considered as an ‘umbrella term’ to cover all the self- evaluations of people experiences. Well being is subjective and manifestation of it can objectively only be observed through verbal and non-verbal behaviors. However, in current empirical analyses, self reports are used to assess the subjective well being levels of individuals (Diener, Ryan, 2009).

Subjective well being as a people attempt to evaluate their own lives had been accepted as necessary constituent of *positive psychological health* but not sufficient condition of it. The concept can also be reviewed as a ‘value’ since it is about an evaluation based on people’s own values and standards (Diener, Sapyta and Suh, 2009). The measurement of SWB is collected via self-report evaluation of a person’s positive and negative emotional response to events and judgments about his/her life satisfaction in global and domain specific fields in his/her life. SWB is essential but not satisfying characteristics of a society and “*a good life*” (Diener, Oishi and Lucas, 2003).

“*Study of subjective well being*” is also important since ‘*happiness*’ has been ranked as the most important life objective appeared on surveys (Tay, Kuykendall, Diener, 2014). This tendency has certainly aroused by a shifting movement from materialistic to post- materialistic value system. It’s now apart from GDP, income or other economic data, well-being became one of the major social indicator (Cummins, 2016). Subjective well being has a vital role of enriching people in some life domains. In major empirical studies, subjective well being had positive correlation with enhancing job performance, having a strong immune system, using successful coping skills, engaging more social and creative behaviors, having increased marriage satisfaction, performing a better committed citizenship and finally sustaining a good

mental health (Diener and Seligman, 2002, Sheldon and King, 2001). Subjective well being is described as the essential part of positive psychological health (Diener, Sapyta, Suh, 1998). In this respect, the critical importance of subjective well being lies in its functions as a protector against diseases and as a booster to fulfill developmental tasks (Suldo and Schaffer, 2008). In a similar vein, for university students for instance who have been through the psychosocial developmental stages of early adulthood (Erikson, 1964) is substantial to maintain their subjective well beings in high levels (Argyle, 1999 cited in Eryılmaz, 2014). Because some research verify how high subjective well being levels among college students associate with the increase in these students' intellectual curiosity, academic success and university attendance rate (Nickerson, Diener & Schwarz, 2011).

In positive psychology, absence of negative emotions does not specifically signify that a positive state is available. Negative and positive states seem to represent bipolar dimensions although disposal of suffering does not convey to well being. Thus, well-being is a process more than and separate construct apart from depression or anxiety (Seligman, Steen, Peterson, Park, 2005). Beside, positive emotions are so important since they serve to flourish and as hallmark for optimal well-being (Fredrickson, 2001). Positive and negative emotions as affective components of subjective well being are considered as two *independent* factors which need to be measured as *separate* entities (Bradburn & Caplovitz, 1965). They are *not* definitely considered as two opposite poles. The discovery about components of the subjective well being led to a new rationale that *absence of negative states are not necessarily promote positive states*. In other words, eliminating the pain, challenges and adversity will not be sufficient to convey to happiness (cited in Diener, Oishi, Lucas, 2002). They are *inversely correlated* and their impacts in an extended time is preferable than

momentary emotions while assessing the subjective well being. Those emotions have been found to be associated with some particular personality traits. Costa and McCrae (1980) identified “*extraversion*” as influencing “*positive affect*” and “*neuroticism*” similarly to “*negative affect*”. This correlation is explained as a temperamental susceptibility (cited in Diener, 1999). In a four year longitudinal study to analyze the relational interaction between personality and life events, it was found that extraversion creates a pathway to experience more positive life events. In contrast, neuroticism form basis for an incline toward experiencing more negative life events. But still, it is not possible to evaluate life events independent from personality (Pavot & Diener, 1993).

Diener and Seligman (2002) in their unique collaborative research to ascertain the “*very happy people*”, they found out the common characteristics of these people. The very happy people are whom social relationships are rich and satisfying compared to unhappy people. However, social ties are considered essential for happiness but not sufficient at all. Extraversion, low neuroticism, low levels of psychopathology from necessary also critical but not sufficient either. Very happy people experience euphoria less likely and unpleasant emotions at certain times although they have the ability to moderate those emotions in a functional way.

Personality and *culture* are two interrelated factors to impact subjective well being. Both are shaped by social learning, genetics and their interactions. These concurrent features to affect culture and personality form a basis for the argument stating SWB is initially determined by our innate tendencies (Lykken & Tellegen, 1996). In this aspect, theoreticians assess *three* basic individual differences regarding their well being: “*baseline levels of affective and cognitive well-being, emotional*

reactivity, cognitive processing of emotional information". Nevertheless life changing events will likely influence subjective well being of individuals apart from their personality. But the person's response in the face of adverse event will presumably depend on that person's affective baseline level (Diener, Oishi, Lucas, 2003). Personality as the most fundamental element in defining a person's SWB' was commonly held among many scholars (Lucas and Diener, 2009). Similarly, Lyubomirsky, Sheldon and Schkade (2005) suggest that heritability encompass 50% of SWB's measurement other half to the environmental sources (Stones, Worobetz, Brink, 2011).

There is a common belief that subjective well being increases with age (Diener et al.,1999). Although due to a latest global study, across 72 countries, Blanchflower and Oswald (2008) concluded the U shape pathway of subjective well being over the life course (Baiden, Tarshis, Antwi-Boasiako, den Dunnen, 2016).

2.2.5. Predictors and Correlates of SWB

In literature of subjective well being, one of the main issues is to determine predictors of happiness. In three categorizes the factors influencing subjective well being had been framed. The first perspective called as '*bottom up*' argues the contextual factors including the socio-demographic characteristics are fundamentally responsible for effecting subjective well being of individuals. However, external life circumstances (*e.g job, marriage, financial stability, political environment*) even they are account for adverse conditions are found to have weak or short-term impact in SWB. The reason why some life events gradually become relatively impotent for the person experiencing it, can be explained based on the treadmill theory. Brickman and Campbell (1971) based on their theory, suggested that whatever reactions people take a stand to desirable or adverse events, always they return to neutrality. By this theory

relationship between adaptation and happiness gained acceptance and became evident. By treadmill theory, the diversity in attitude toward happiness can be explained via the way each individual are back to their baseline position of happiness (Diener, Lucas, Scollon, 2006). Similarly, homeostatic adaptation concept also helps to reveal the fact about individuals who have innate tendencies “*to bounce back*” to their point of origin after major positive or adverse life events (Cummins, 2010).

In the second perspective ‘*top down*’, personality or positive dispositions gained recognition as major predictors of SWB. The third perspective called as ‘integrative’ and mostly well-accepted are the combination of both approaches and supports the idea that on SWB the impact of multiple variables (e.g. emotional state, past events, expectations of the future) are needed to be considered. Followed by few studies, different constituent of subjective well being had been found to be more correlated with different variables. Hereafter, cognitive dimension of SWB is linked to the contextual variables whereas the affective dimension associated with personality variables (Galinha & Pais-Ribeiro, 2011).

The effect of adverse life events (e.g illness, trauma, divorce, unemployment) on people’s subjective well being levels is significant but not in large impact especially on negative affect component, psychological distress and neurosis. But people having high in “*internal locus of control*” and who are surrounded by “*a strong social support and trustworthy relationships*” in particular are considered more resistant while experiencing with such adversity. However, as the personality trait or a social environment of a person cannot be changed easily, these factors can only be considered as *buffering effects* toward stressful events. It would be rather more effective to cultivate on or even teach ‘effective coping strategies’ to people suffering

adversity with an interventionist point of view. In this aspect, *instrumental coping* has been found to be considered effective in minimizing the dominance of negative affect (Headey and Wearing, 1989).

Many researches have been conducted to determine which variables have an influence over a person's subjective well being. Income, health and physical attractiveness were such examples foreseen to be among them. However, self esteem, a sense of personal control, optimism and extraversion had been identified to be the traits of a 'happy people'. Last but not least, having 'close and intimate relationships' is fundamental for a higher subjective well being (Diener, 1995).

Empirical data manifests how subjective well being is both stable but also changeable across the life span. In these circumstances, affect rather than life satisfaction is more associated with happiness (Fabian, 2016). Although, some predictors of SWB can be identified as common for the majority of people. For instance, in a most recent study (Jebb, Morrison, Tay, Diener, 2020) conducted among 166 countries with more than 1.7 million participants, marriage, employment, prosociality and meaning of life were concluded as the fundamental determinants of subjective well being.

Nonetheless, some experiences have a wide spreading effect on well being throughout the life. In a study of examining the impact of childhood maltreatment on 2000 elderly participants having a childhood physical and sexual abuse history, the long lasting influence of abuse have been appeared as damages on physical and mental health of elder adults (Draper, Pfaff, Pirkis, Snowdon, Lautenschlager, Wilson, 2008). In this regard, the cognitive as well as emotional developments during childhood, family bonds in early stages of development are confirmed as essential

predictors of subjective well being (Khaleque and Rohner, 2002). Thus; *adopting a life course attitude toward subjective well being* leads the way to understand the well being in each developmental stage. Subjective well being is considered as constant over time and constant feature is the importance of family relationships as central influencer of well being (Lansford, 2018).

The *common correlates* of SWB among many nations and cultures, were determined through World Values Survey and the Gallup World Poll across a sample of 123 countries –as expected- some basic needs for food, shelter, safety and socially supportive relationships are correlated to SWB in many demographic groups in regions of the world (Tay & Diener, 2011). Additionally; in a study by Sheldon, Cheng, & Hilpert (2011), the findings revealed that “*culture, self, motive, and trait variables*” have distinct effects upon subjective well being and satisfaction of the psychological needs appear as the mediator of those effects.

2.3. RESILIENCE

2.3.1. A Review and Concept Analysis

Resilience is defined as “*the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress such as family and relationship problems, serious health problems, or workplace and financial stressors*” (APA, 2020).

The special interest in resilience as so in well being lies on the rising move in psychology literature from ‘*deficit*’ model of illness, psychopathology, risks, weaknesses into promoting a healthy development, a quality of life and strengths people possess (Windle, 2011). Resilience overtime became “*one of the most heuristic and integrative concepts in 21st century thinking in the social sciences*”

(Zautra, Hall, Murray, 2010). The term is an active effort to evade the negative psychological, biological and social repercussions of extreme stress which may cost to the person's physical and psychological well being (Russo, Murrough, Han, Charney, Nestler, 2012). Unlike negative side of mental health studies, poor adjustment and threats, resilience literature focuses on promoting and protecting a healthy development even in risky circumstances (Cutuli & Herbers, 2018). But still in literature there is no concurrence on the definition of resilience. Many scholars define resilience with minor additional features from developmental, ecological or neurobiological perspectives.

Masten is one of the pioneer academicians in the field and refers to *resilience* within a developmental perspective. According to her; resilience can comprehensively commented as “*the capacity of a system to adapt successfully to challenges that threaten the function, survival, or future development of the system*” (Masten, & Barnes, 2018). There are some characteristics of resilience. It is about relative attributions of individuals to negative experiences. This qualification assigns an inferential nature to the term. In other words, individual variations matter in the responses to the adversity. These variations depend on personal qualities, the relationships people have and the contexts in which the events are meaningful to that person. These are the indicators of resilience and serve to identify how well the person achieved adapting to the adversity. But essentially, to be able to use the concept ‘resilience’ two essential components need to be available: *a risk or threat to the individual* and *a positive adaptation*. People are not considered resilient unless there is a challenge to derail him/her from the normative development (Masten, 2011, 2018). This challenge might be entitled briefly as ‘an adversity’.

The most significant precursor of resilience is being exposed to an adversity. Three main groups simply help framing the scope of the adversity. These are the *traumatic events* including childhood maltreatment and criminal cases, *the disease processes* and *dialy stressors* (Rudzinski, McDonough, Gartner, Strike, 2017). It is also worth mentioning that *the intensity* and *the duration* of the adversity confronted is critical when it comes to resilience. But still, the impact of the circumstances are - whether they are acute or chronic-create a subjective impact on each individual (Bonanno, Romero, Klein, 2015).

Previously in the resilience work, the term was also defined in a broad sense as ‘doing well despite adversity or risk’ (Luthar & Cicchetti, 2000). But then, resilience science was interested more about the *processes* which presumably affect a person’s function and its development and the phenomenon was addressed as a process oriented dynamic concept (Masten, Best, Garmezy, 1990). Recently, as resilience begin to defined as a “*dynamic process*”, the broad perspective has shifted toward a *relational developmental systems* (Overton, 2013; Zelazo, 2013) embracing the ecological theory. Therefore contemporary approach abandoned the idea about the source of the resilience as an innate notion of ‘hardiness’ or ‘invulnerability’. Instead, resilience is now considered as a “*capacity of a dynamic process*” to be adjusted against the threats (Masten and Cicchetti, 2016). Trait of hardiness (Kobasa, Maddi, & Kahn, 1982) refers admitting that life is valued and even the negative life events worth experiencing to derive lesson from. As these individuals appreciate life with their belief systems they become able to minimize threatening affects of distress with the active coping skills and social support as protective factors (Bonanno, 2004). Resilience as a trait-like approach also associated with the term ‘ego resiliency’ developed by Jeanne and Jack Block (1980) and assumes resilience as a feature

specific to the person. This perspective denotes some personal traits such as resourcefulness and flexible functioning against adversity under the name of resilience. But resilience and ego resiliency are separate terms. While ego resiliency is a personality feature, resilience is a developmental dynamic process. Beside, referring to the term resilience presupposes the existence of an adversity conversely ego resiliency does not (Cicchetti, Luthar, Becker, 2000). As oppose to the view, resilience as a trait, ecological view take a stand that people are social entities.

As a *pattern of positive development*, resilience is not limited to a person's body and mind. Individuals cannot be assessed without their existing social environment. A person's adaptive capacity to strive against adversity also depends on the external system, cluster of processes he/she is surrounded. Resilience has not necessarily been accepted hereupon as a trait. Furthermore; some factors such as personality and cognitive skills appear only to be the contributors of the adaptive system; to resilience. Nevertheless supportive relationships namely the ecological system of the person has a significant role in enriching the resilience (Masten & Barnes, 2018). Egeland (1993) stated the influence of the environment as supporting instrument for increasing the capacity of resilience (cited in Afifi & MacMillan, 2011). In time, some attempts tried to embody the definition of the concept in more details and make the explanation more concrete.

One of the most controversial issues in resilience is about whether the concept can be defined as "*an outcome, a trait or a process*". In cases which resilience is conceptualized as "*an outcome*", this refers to the absence of symptoms or presence of an adaptive functioning after the exposure to the trauma. Cicchetti and Rogosch (2007) prerequisite to describe the *maltreated children as resilient* in order to identify

low levels of psychopathology in addition to high levels of functioning. In their study they found the maltreated but resilient children are high in ego-resilience, ego-control and self esteem. This attribution to the concept actually symbolizes an approach assuming the resiliency as ‘*immunity*’ to adverse life events and resilient children as ‘*invulnerable*’. Resilience as *a trait* is considered as an innate and stable characteristics that some few have and others do not. In this sense, as Ungar criticizes (2008) this view as neglecting the influence of the environmental factors and the cultural context in which resiliency develops as well. *Resilience as a process* indicates a dynamic ability containing to attain and to use particular skills. In this model, people to be resilient are not expected to invulnerable displaying psychopathological symptoms but acquiring an *ability to regain their ‘equilibrium’*. Adaptability is the core construct of this approach to serve easing the recovery and change. Therefore; how to be resilient becomes *as a learned process* through which designated programs for maltreated children can also be effective (Happer, Brown, Sharma-Patel, 2017).

Another controversial debate about resilience stems from its unique specification. Some scholars put particular emphasis on the distinction between recovery and resilience. The term *recovery* allows symptoms of psychopathology appear temporarily within a time period extending over one or two years. In a recovery, individuals exposed to a traumatic event may suffer from depression or posttraumatic stress disorder and get back to the threshold of their *pre-trauma* positions. Also, resilience signifies “*an ability to sustain the equilibrium*” while exhibiting normal functioning across time. They demonstrate few transient disturbances but their healthy physical and psychological functioning keep moving. In other words, resilience is more than absence of psychopathology (Bonanno, 2014). The assessment of resilience as a dynamic process rather than ‘recovery’ symbolizes a

process of transition about functioning instead of a callback to the pre-trauma state (Tomyn, Weinberg, 2016).

Unique distinction between *coping* and *resilience* has also to be taken into account to review the frame of reference. *Coping* helps to examine what a person does in the face of an adversity along with the coping strategies used. On the other hand focus of study in *resilience* is on resources, assets a person acquire as protective factors in order to build up health and normal development after trauma exposure (Baum, 2005). Both concepts are interrelated and their impacts are whether ameliorate or worsen the negative aspects of adverse life events (Skodol, 2010 cited in Chen, 2016).

While resilience has been defined from different perspectives, Walsh evaluates resilience following trauma with a different point of view. According to Walsh (1996) resilience is an inner strength which emerges in turbulent times as a rebound from crisis while struggling against challenges. For many scientists, it refers to ‘*bouncing back*’, as turning back to the pre-crisis condition, to a ‘normal’ life. In other words, it signifies a return to the baseline of the person experiencing the stress or trauma. However, the fact that nothing is static, no one could be expected to remain the same after getting through tough times. Therefore, resilience actually can be described as more than a coping effort or disintegration after the crisis. It is about a transformational state representing ‘*growth*’, a state of ‘*bouncing forward*’ when the person overcome the crisis and explore a new sense of normality (Walsh, 2002). Some scholars do not expect for a positive, outstanding outcome to call it resilience. Rutter (1999) does not confide with the definitions of his colleagues as an acquisition of social competence (Masten et al., 1995) or self-efficacy (Bandura, 1995) or

positive mental health (Ryff and Singer, 1998) while referring to the term *resilience*. According to Rutter; resilience is about a cluster of psychological outcomes. He does not mandate a positive outcome or an extraordinary functioning above normal ranges for resilience.

Resilience has a similar structure among children as well. In literature resilience of children is associated also with stress and coping mechanism. The term refers to the *effective coping* and set of meaningful efforts to sustain *internal as well as external equilibrium* in the face of severe stress or threat. Accordingly these children used to get master in using intellectual skills, cognitive abilities and they are considered as effective problem solvers (Masten & Garmezy, 1990). The ways people react to stressful stimuli (adversity) vary remarkably as well as the residual symptoms they have after the trauma. Especially children, as unique individuals display diverse reactions following a trauma; somehow some of which seem to be unaffected or in contrary exhibit severe behavioral, psychological or physical symptoms. Few among those are observed as “unscathed” (Jaffee, 200) some others who even experience less trauma exposure can acquire more damages. Especially among trauma-exposed children, resiliency is an important phenomenon to reveal the variation in pathology expression (Hornor, 2016).

In resilience literature, it’s worth mentioning that mental disorder is a separate construct from resilience since *the absence of mental disorder* does not necessarily refer to resilience. Positive adjustment and competent functioning are required credentials for resilience. In a similar vein, the presence of mental disorder does not hinder resilience (Cicchetti,& Rogosch 2012). Resilience is not about suppressing the symptoms appeared after trauma as well. It is independent from whether or not the

disorder is present (Keyes, 2002) The findings of a study supported this view: some youth participants suffered from child maltreatment were displayed resilient functioning despite of their adverse reactions (*psychopathological symptoms*) to stress (Happer, Brown, Sharma-Patel, 2017). In other words; people may have symptoms after trauma but still protect their resilience or may not have symptoms but do not also reflect resilience patterns. Individuals to flourish and prevent themselves to languish are the most important argument about resilience following trauma (Ungar, 2013).

2.3.2. Historical View of the Construct

Resilience has first appeared in the empirical literature with the investigations of maladaptive versus adaptive behaviors observed among severe schizophrenia patients. The criterion of the adaptive function was the social competence these patients displayed in their social lives. Meanwhile, researches had also focused on the children's of schizophrenic mothers. The unordinary effort's of those children to thrive against adversity in high risk conditions leaded the way to study resilience and relative nature of responding to stress. The research of Emmy Werner's (1971) focusing on the children in Hawaii who obliged to live in adverse circumstances was a pioneer attempt to discover what is unusual in regard to resilience during hard times. The study was basically aimed to distinguish the protective factors of the children who succeeded to adjust in the face of adversity. Early efforts to disclose resilience was labeling the children as '*resilient children*' and mainly attributing the cause of this special trait to the personal qualities these children have. But during the last two decades, empirical argument is shifted the focus of resilience resources from internal assets into the factors *external* to the child (Cicchetti, Luthar, Becker, 2000).

In the first episode of resilience research, investigators concentrated more on defining and operationalizing the concept. Second wave was about to probe the

processes that children suffered from trauma. The experiences in every development phases of those children exposed to extreme threats became the major topic in resilience. The concern in the third wave was basically about the designed experiments to highlight the resilience processes (Masten, 2011). Fourth wave of resilience research is generated by neurobiological analysis of resilience's interactive relation with brain, genes and hormones.

In this last phase, clinical studies focused on detecting the salient element in understanding the successful adaptations of individuals 'at risky' circumstances due to their family or genetic background. Meanwhile, a shift toward family-centered resilience studies originated from general systems theory (von Bertalanffy, 1968) and centered the integrative framework into the resilience science (Masten, 2018). New approach in child resilience considers family (resilience) as the main component of a system for the adaptive functioning. Both the challenges threatening the family function or protective factors to sustain the vital family environment are the major determinants of recovery or the healthy adaptation (Masten & Cicchetti, 2016).

Some scholars attributed meanings more on *the neurobiological essence of resilience* while defining the concept. According to this perspective; resilience is a neural adaptation following abuse shaped by environmental and biological factors. Abusive parenting as an environmental agent changes the emotional circuitry of the brain and the neuroendocrine system and provokes allostatic overload in the child (Niehoff, 2007). Gradually, the patterns of dysregulated stress responses will go along with adulthood concomitant high allostatic load. This impairment will likely to lead distress and chronic conditions (Danese and McEwen, 2012 cited in Logan-Greene, Green, Nurius, Longhi, 2014).

2.3.3. Resilience & Development

Resilience and developmental psychopathology have overlapping roots due to their common interest in the variations among people. The common field of these two disciplines is people experiences about adaptation and development during their life span (Masten & Cicchetti, 2016). Developmental model assumes that the development course of an individual is complex and composed of genes, internal systems, and interactive relationships. Therefore, this complicated pattern may carry the individual toward or away from psychopathology. People having common life conditions in the beginning may head towards different directions and have diverse outcomes. This is called *multifinality*. In the contrary, individuals from different backgrounds may end up on the same pathways which are called *equifinality*. These terms help to reveal how development and resilience need to analyze with a life course perspective. In this regard developmental psychology and resilience mutually converge (Masten, 2006). Especially the concept of multifinality refers to the fact that a specific adverse event does not necessarily cause the exact outcome for every individual. In regard to this multifinality principal in the development processes, people interact both with vulnerability and protective factors which carry the individuals to diverse developmental outcomes (Cicchetti, 2012).

There is no specific standard to assign for resilience but two criteria are worth mentioning. If a child is qualified as 'resilient' two major judgments are obvious; the child is confronted with an extraordinary adverse occasion and the child is performed *sufficiently well* on critical developmental tasks based on the expectations for his age and culture (Masten, Hubbard, Gest, Tellegen, Garmezy, Ramirez, 1999; Masten 2011).

Initially; resilience was widely accepted as an extraordinary inner skill that special kids luckily acquire. These children often named as '*invulnerable*' or '*invincible*' although according to Masten (2001) resilience is a '*common phenomenon*' for all human beings due to the basic adaptation systems. Resilience is not a "magical" phenomenon but an ordinary process moving along with the development flow. But if given impairments are in these systems before or after the stress, developmental damages will likely occur. In this regard, basic determinants for resilience are specified as *salient developmental tasks*, *competence criteria* and *cultural age expectations* (Masten, 2001).

Developmental tasks are set norms for behaviors and they are specific to the culture in which the person belongs to. These tasks are psychosocial landmarks across lifespan to enable to evaluate whether the development is proceeding in an appropriate way, adaptation and adjustment in the society are sufficiently meet the expectations. Development is a *cumulative* process and along with the societal expectations it prepares the individual for prospective threats with a positive adaptation and well being. In order to gain a competent development, the person needs to fulfill all the requirements of each age salient developmental tasks which consist of behavioral, psychological and social acquisitions (Cutuli & Herbers, 2018).

While defining the resilience, indicators of the concept is another issue to be discussed. Some scholars suggest that *an objective functioning across many domains* require in order making an accurate measurement. Some others only necessitate *the absence of negative behaviors* as measure of resilience (Vered, Jonson-Reid, 2017). A proper evaluation of resilience would be appropriate if the *well adjustment is present in all domains*. For instance, it would be misleading to describe someone resilient if

he/she does not display any depressive symptoms but he/she is substance dependent (McGloin & Widom, 2001).

But development and resilience liaison about children becomes distinct when there are adverse conditions or maltreatment is to be said. In a general sense, resilience or namely positive adaptation is accepted as a capacity to perform with an average functioning involving an accomplishment of stage salient tasks in addition to displaying no trauma symptoms or pathology. But in any case of maltreatment, children suffered from maltreatment are expected *only to exhibit a normal competence across domains* to make inferences about resilience (Walsh, Dawson, Mattingly, 2010). Environment is also an essential ingredient of resilience's foundation since a facilitative and nurturing environment can command the developmental continuum regardless of individual differences. These personal variations may be temperament, genetic predispositions or personality traits of the child. *In adverse circumstances* the existence of a healthy environment is likely to help flourishing a maltreated child. Consequently, nurture overrides nature (Ungar, 2013). Accordingly parenting also gains prominence when there is child maltreatment. Caregivers are essential for their roles to be promoters and protectors of development (Masten, 2014). Supporting social relationships with caregivers are the most salient, protective factor for resilience and have buffering effect against stress (Masten, 2018). For both the risky or ordinary circumstances, the function of the parents is critical for a healthy development and resilience. Therefore any neglectful or abusive act from the caregivers will be detrimental for the early well-being and resilience of the child (Masten & Cicchetti, 2016).

Some setbacks in developmental progress may hinder resilience to occur due to the nature of developmental characteristics. Development is *transactional*. This transaction may be resulted in the *developmental cascade*. They simply refer to a 'snowball effect'. In other words problems which are not fixed in one domain or developmental area may intensify the risk in coming domains or phases. These cascades are essential for resilience interventions in terms of detecting key mechanism for maladaptation (Masten & Cicchetti, 2010). Developmental cascade refers to the transmission of unresolved issues to many domains in micro or macro levels. The spread of the ongoing problems causes for risks in each developmental process and create vulnerabilities for forthcoming competence and adaptation tasks. Cascades may help to demonstrate the massive effects of childhood problems in adolescence and adulthood (Cicchetti & Handley, 2019).

As new perspective evolves in resilience science, the developmental progression became more of an issue in terms of gaining the capacity for positive adaptation. As the person moves through the development progress, he/she confronts with new challenges, opportunities or threats and crisis. Meanwhile, the biological, psychological and social circumstances also change within the context of the individual. Accordingly resilience or positive adaptation is positioned in this continuous movement. This natural flow of human development affects resilience as being not fixed or immutable (Cicchetti, 2012). According to Dr. Southwick resilience has a function which can appear along developmental periods constantly interacting with the environment. He argues that resilience is an *ongoing process* appeared in different domains during life time. For example; a maternal care can be assessed as a *resilience-enhancing function* during early childhood but may hinder the

independency of a young person as a learning outcome during adolescence (Southwick, Bonanno, Masten, Panter-Brick, Yehuda, 2014)

2.3.4. Protective Factors of Resilience

Resilience appears when risk factors encounter with protective factors in an interactive way (Rutter, 2006). Diverse “*risk and protective factors*” for every individual and the interplay of those, define the possibility of a resilient outcome (Mancini and Bonanno, 2009). Risks are critical in perceiving adaptation following a trauma. Masten (1994) describes the risk factors and protective factors *as two opposite poles* and she emphasizes (2001) that to be able to confirm the presence of resilience would be possible if a risk factor exists as well (Karaimak, 2006). Werner (1995) conceptualizes resilience concept in three dimensions: presence of a satisfactory developmental outcome “*despite high risk, a maintained competence under stress and a recovery from trauma*” (Kirmani, Sharma, Anas, Sanam, 2015).

Protective factors can be defined as “*internal strengths and external resources*” which interact with risky circumstances which may result in negative outcomes for the person facing the adversity. Protective factors have influence over the individual to modify or alter his reaction to stress. (Rutter, 1985,1993). There are many risks as protective factors although not a primary but sum of all specifies the likelihood of a resilient outcome (Bonanno, Galea, Bucciarelli, & Vlahov, 2007).

Toxic conditions children are exposed include abuse, neglect, family violence and refer to a “*chronic, severe and prolonged stress*” for the subject. In the absence of “*protective factors*”, these conditions generally become evident (Shonkoff, Boyce, & McEwan, 2009).

Resilient children are assumed not to have unique qualities *but* to retain particular resources symbolizing protective systems in human development. In other words, the presence of a competence in adverse circumstances represents the existence of basic systems which cherish competence for development. These protective walls *namely* protective resources also counterbalance the possible risks to damage the development of the child (Masten & Coatsworth, 1998).

Protective factors impinge on the responses of the children to the adversity. Their impacts are in short or long term by contributing to the stress response in such a way that changes the development and function of the children and appear as predictors of positive outcomes. These are called ‘*promotive*’ (Sameroff, 2000) and ‘*protective*’ factors. These preservative factors can not solely influence the process their impact become powerful when they operate in the appropriate function, context and in the exact time (Masten and Cicchetti, 2016). “*Promotive factors*” (Sameroff, 2000) also known as “*assets*” or “*resources*” and have a general influence on creating positive outcomes. However *protective factors* play a critical role in making a difference when adversity is high. The role of the protective factors is considered as ‘*main*’ while promotive factors are ‘*moderating*’ effects. While some protective factors can be essential against a potential risk during a particular developmental phase, they might no influence for another. Nevertheless some protective factors (a warm, trusty care giving, self-regulation skills, peer relationships) are considered constant in terms of serving to the development process to function properly (Masten, 2001). These factors can be listed in three categories; *individual*, *familial* and *community level*. Individual protective factors are known as assets (competence, self-efficacy) whereas resources including all support systems from community or family are considered as external factors (Windle, 2011).

Protective factors in individual level; are personal traits or resources an individual possess. Family level factors include promoter relationships such as maternal warmth, parental antisocial personality, sibling warm, family coherence, maternal mental health problems. In a study conducted by Herrenkohl, Herrenkohl, & Egolf (1994) on children having history of abuse and neglect, “*the existence of at least one stable caregiver*” found to be a “*protective factor*” in regard to resilience. Environmental protective factors in community level in brief are warm and supportive relationships other than family members or friends. Their availability serves as augmenting element of resilience in high risk status. Institutions offering facilities, child care centers, quality schools or vocational training facilities are example of such factors. The presence of some factors in particular such as crime rate, neighborhood advantage predict better outcomes for adults having childhood maltreatment history (Afifi and MacMillan, 2011; Kanak & Arslan, 2018). In a meta-analysis of nearly 87 articles covering protective factors of resilience, the findings exhibit the association between risk of “*re-traumatization and intergenerational abuse*” with nurturing relationship, emotional support, locus of control, successful coping abilities (Meng, Fleury, Xiang, Li, D’Arcy, 2018)

2.3.5. Resilience & Child Maltreatment

Research on resilience aims to define factors and mechanism that modify the negative sides of maltreatment and abuse to cultivate positive adaptive outcomes (Luthar & Cicchetti, 2000).

During early developmental stages, a child needs to be protected by and receive support from his caregivers. Any harmful treatment impels the child to severe neurobiological, somatic and mental damage which then lead to disability to overcome the further “*psychic stressors*” during the life course (Teicher, & Samson,

2016). In this context, resilience emerges as an outcome or a process to *mediate* the response to trauma (Kocalevent, Zenger, Heinen, Dwinger, Decker, & Brähler, 2015). In a research study to review the relationship between childhood adversity and stress as well as somatic symptoms, a strong association has been found. The resilience particularly gained via social support appeared in the analysis as the *buffering agent* among adversity and stress symptoms (Beutel, Tibubos, Klein, Schmutzer, Reiner, Kocalevent, Brahler, 2017).

Maltreatment during childhood signifies a pathogenic relationship as the most stressful challenge a child has to face with (Cicchetti & Lynch, 1995). A household in which safe and healthy environment has been violated; the child becomes deprived to have proper conditions for his normative development and a good adaptation (Cicchetti & Toth, 1993).

In addition, maltreatment resulted from abuse and neglect, likely originates an epigenesis for the child to block his developmental progress via a cascade of maladaptation in neurobiological, socioemotional and cognitive domains (Cicchetti & Tucker, 1994; Cichetti and Toth, 1995).

Resilience among maltreated children emerges when the child displays a normative competence in multiple domains of functioning. Indicators for each developmental domain are gathered under three titles: behavioral/emotional, social and academic competence. *Behavioral competence* includes internalizing and externalizing problems observed on the child while *social competence* focuses on social skills, social information processing abilities and peer relationship. *Academic competence* is constituted of school performance, measures of achievement and teacher evaluations. Apart from these indicators, self-esteem has recently associated

as an indicator for the development of maltreated children. As some researchers conceptualize it as a moderator, some others argue to be assessed before and after the maltreatment (Walsh, Dawson, Mattingly, 2010).

2.3.6. Neurobiology of Resilience

The fourth wave of resilience is a significant breakthrough in resilience since this scientific focus allows enlightening the neurobiological processes on adaptive systems linked to resilience. In other words, via empirical data received from genetic and neurobiological researches, science aims to promote resilience for individuals experiencing severe adversity. The shift from psychosocial to this biological model is comprised under the genetic and environment (G x E) interaction research field. In this new research era, child maltreatment is considered as one of the most severe “*environmental pathogen*” (Caspi, Hariri, Homes, Uher, & Moffitt, 2010; Karg, Burnmeister, Shedden, & Sen, 2011).

Interactions of genes with the environment, genes are treated as “*protective factors against psychopathology*” for maltreated individuals. In a study of the pioneer scholar Caspi et al. (2012) cited how maltreatment during early stage of lives and antisocial behavior in adolescence and adulthood are moderated by a gene (MAOA). Similarly in another research of Caspi et al. (2013) documented the function of a serotonin transporter (5-HTTP) to be associated with the child maltreatment and depressive symptoms. These studies suggest that genetic variants of some genes may confer a natural protection against maltreatment or may moderate the effects of adversity. In Caspi’s analysis, mental health outcomes and genes variations were not investigated (Masten & Cicchetti, 2016).

One of the prominent studies in G X E interaction research is conducted between maltreated children and other school age children group who did not have such maltreatment history. The objective was to examine any affiliation between child maltreatment and genes variation in regard to adaptive functioning. The following genes: HTTLPR, CRHR2, DRD4-521C/T and OXTR have been empirically tested and found linked to resilient functioning. The findings acknowledge that genotypes are only remarkable if the *context* in the maltreatment is taken into account. Conversely child maltreatment is found to be a main effect for resilience (Cicchetti and Rogosch, 2012).

Neural system and emotion connection also provide some insights for resilience. For instance; left hemisphere of the brain is linked with positive emotions and right with negative ones. In a study (Curtis & Cicchetti, 2007) examining the conceptual models of biology and resilience, positive emotions and competent emotion abilities have been linked with resilience (Cicchetti & Toth, 2015). Cortisol as an important hormone for individuals and generally heightens following trauma exposure (Kotozaki and Kawashima, 2012) and help to facilitate response to stress (Schulkin et al., 1994). In a study conducted among maltreated children, levels of morning cortisol were found relevant with resilient functioning in such a way that these children who had a physical abuse history in addition to increased cortisol levels, were found relevant to the high resilient functioning. The significance of the finding reveals the consequences of chronic trauma exposure and neurobiologic change in maltreated children (Cicchetti & Rogosch, 2007).

Epigenetic is another developing course for resilience. Epigenetic science studies on gene activity and regulation of genes toward environmental changes. DNA

as part of epigenetic is now considered as *not* a static entity (Mill, 2011) and subject to change across life course, even across generations (Cicchetti, Hetzel, Rogosch, Handley, Toth, 2016). The differences in DNA patterns due to disrupted environmental contexts such as *child abuse and neglect* are well accepted in literature. Epigenetic mechanism serves for intervention in resilience due to its reversible nature (Masten & Cicchetti, 2016).

Epigenetic science expounds how individuals strive to adapt into the environment. This definition includes a model of adaptation and resilience. But some external forces such as exposure to trauma could be threatening to the survival and adaptive processes. Genes can be transformed, change its structure *by trauma* and convey risk or vulnerabilities to the individual. Child maltreatment, psychosocial traumas serve as models of how genes modifications may lead to later depression or over internalization symptoms (Caspi, 2003), externalization problems such as drug use, high-risk sexual activity (Sapienza & Masten, 2011).

As part of the epigenetic literature, studies reveal that some damages in brain areas resulted in child abuse and maltreatment lead to hippocampus activation (Heim, Newport, Mletzko, Miller, Nemeroff, 2012). In other words, the research finding of scholars (Teicher, 2006; Russo, Murrough, Han, Charney, and Nestler 2012) supported the neurobiological relevance between child maltreatment and resilience. In those studies the child abuse appeared to be the subject for damaging the same sections of the brain, liable for building resilience such as limbic system (Ashy, Yu, Gutowski, Samkawitz, Malley-Morrison, 2017).

2.4. REVIEWING THE RESEARCH LITERATURE

In a research study conducted by **Bellis, Hughed, Ford, Hardcastle, Sharp, Wood, Homolova, Davies, 2018**; initially the association between the *undesirable consequences of maltreatment* and exposure to household stress, in regard to negative (physical) health status of the child, school absenteeism have been tested. As a second research problem, the extent to which the social resources and social support networks on creating resilience and facilitating the effects of adverse experiences have been analyzed. Due to the findings; a significant link was observed between variables; as number of adverse childhood adversities increase, poor health status of childrens and school absenteeism were getting heightened. The direct effect of resilience through public service and community support were not found but it was considered as partial and indirect variable to influence the child health and school absenteeism.

The main objective of **Tian, Meng, Qiu's (2018)** analysis was to identify the relationship among the cumulative effects of adversities in childhood with mid-late depressive symptoms among 17,425 participants. In this research, childhood adversities were representing the history of abuse and neglect, low socioeconomic status during childhood, parental mental illnesses and perceived loneliness. The salient finding of the current study had contradicted with the existing literature (Spinhoven, Elzinga, Hovens, Roelofs, ZitmanVan, Penninx, 1999) claiming the direct relationship between abuse, neglect and depression in mid late adulthood. However, the indirect effect of childhood maltreatment had been observed through poor health status and low SES during late life. The major association had been identified between the parental health problems of the participants given and the depressive symptoms in mid-late adulthood. The social support (lacking friendship

)had also appeared in the study with its direct and indirect effects as important indicator to predict depression in late adulthood.

Schilling, Aseltine, & Gore (2007) in their research analysis were focused on the impact of “*child abuse and neglect*” on the early adult years in particular. The impacts were examined in regard to the symptoms of depression, drug abuse and antisocial behaviour disorder. The study had prospective design method targeting high school seniors. In order to have a deep understanding about the results and the persistence of its impacts, the scholars had applied the method in twice: beginning with a face to face interview then the survey over the phone after a period of two years. Based on the scientific outcomes, the childhood maltreatment had been found to be significantly correlated with three variables. Remarkable data was the appearance of gender influence only for boys engaging in antisocial behaviour more likely compared to the girl participants. Socio economic disadvantage and racial background had been identified as risks for exposing to abuse and neglect.

The possible impacts of overall childhood adversities on predicting obesity had been tested in the research study of **Davis, Dearing, Usher, Trifiletti, Zaichenko, Ollen, Brinkoetter, Crowell-Doom, Joung, Park, Mantzoros, Crowell (2014)**. *Obesity* was not considered just as a ‘modifiable’ risk factor but rather a direct effect of childhood adversity on obesity was examined by controlling other variables such as gender, race and psychosocial risk and health behaviours. According to the results, childhood adversities which predominantly identified were physical abuse (41%), emotional abuse (23%) and sexual abuse (30%) and parental divorce (42%). Due to the study outcomes; childhood adversity was found to be the one of the most important predictor of obesity apart from the obesity’s effect on psychosocial and

health. Therefore; by this research the devastating influence of childhood adversity accompanied by its severity and chronicity on metabolic functioning in adulthood was well documented.

Choi and Park (2017) in their research study, they analyzed the relationship between the impacts of childhood maltreatment and the pathological personality traits according to Personality Psychopathology Five (PSY-5). This scale was developed by Harkness, McNulty, & Ben-Porath (1195) and it is a dimensional descriptive system of personality and disorders, having the psychometric properties as “*aggressiveness, psychoticism, constraint, negative emotionality/neuroticism, and positive emotionality/ extraversion*” (Vendrig, Derksen, Mey, 2000). The participants were suffered from certain psychiatric disorders including mood, schizophrenia spectrum, and anxiety disorders. In conclusion, childhood maltreatment had appeared as the significant predictor of the “*five trait dimensions*” as mentioned in PSY-5. This result leads to the fact that maltreatment during childhood has an undesirable and impairing effect on the growing of an adaptive system which then contributes to occurrence of some pathological personal traits. Moreover, negative emotionality in addition to lack of positive emotionality was mostly encountered among participants.

In a study by **Greger, Myhre, Lydersen, & Jozeifak (2016)**; the perceived quality of life had been compared between an adolescent population who had childhood maltreatment history, and also considered as high risk for psychiatric symptoms and control groups who have not maltreatment in their past. Childhood maltreatment represented by witnessing of violence, being victim of violence in the community and victim of family violence as well as sexual abuse. Quality of live (QoL) was measured as a subjective variable and was assessed in regard to “*physical*

well being, emotional well being, self-esteem and child relationships to family, friends and schools". According to the results, adolescents who have a maltreated childhood history compared to whom were not, found to have diminished perceived "*quality of life*". Beside, as the type of childhood maltreatment increases, more the quality of life perception got worsen. Low quality of life perceptions were comprised of feeling sick, suffering from pain, fatigue as *physical well being*, whereas *emotional well being* was referring to subjective happiness, loneliness, feeling of insecurity and boredom. Effects of childhood maltreatment were observed as low self esteem and having a limited circle of social resources among adolescents aged 12-23.

Noll-Hussong, Otti, Laeer, Wohlschlaeger, Zimmer, Lahmann, Henningsen, Toelle, Guendel (2010) in their research study aimed to identify the neurobiological effects of sexual abuse on multisomatoform patients. The disease 'multisomatoform disorder' refers to "three or more medically unexplained, currently bothersome physical symptoms which lasted more than two years" (Kroenke, 1997). Patients with and without sexual abuse history on their childhood had been compared in order to comprehend whether the abuse had any impact on pain processing system in the brain. The results revealed a noticeable lower activation of left hippocampus in brain area of sexually abused patients. This outcome had been associated with the neural damage followed by the traumatic experience. Therefore, in parallel with the hypothesis, the neurological change had been observed among multisomatoform patients by means of their sexual abuse history in childhood.

The effects of childhood adversities, psychological distress and resilience were both examined on the existence of depressive symptoms among university students in empirical study of **Kaloeti, Rahmandani, Sakti, Salma, Suparno, Hanafi in 2019.**

The adverse childhood experiences referred to the emotional, physical abuse, maternal abuse in particular, physical neglect, and some other dysfunctions in the household. Results demonstrated the direct relationship between childhood trauma and depression but they did not establish the same direct pathway to resilience. In the current study, the psychological distress had been found to have a direct effect on resilience as well as depression. Beside resilience was identified as ‘mediating’ variable between the psychological distress levels of adolescents and their depressive symptoms. However, resilience was not mediated the trauma during childhood and symptoms of depression. Another salient result was the different aspect of some childhood adversities having a constructive influence by easing the adaptation via promoting resilience.

Iniguez & Stankowski (2016) in their research focused on the association between the childhood adversities and well-being in adulthood. In the study, adversity experiences were indicating physical, emotional, sexual abuse, substance abuse in the household, divorce, incarceration and mental illness in the household. Well-being was referring to physical health outcomes gathered from the electronic medical record (EMR) system. The information was gathered from 800 people in U.S.A. via telephone survey. At least one ACE (adverse childhood experiences) had been experienced by 62% by participants whereas 15% had reported four or more type of ACE in their lives. According to the study findings; a positive relationship between the health problems collected and ACE scores reported by participants’ claims. The emotional abuse was listed as the top prevalent type of childhood adversity followed by substance abuse in the household. The salient results of the study were actually predictable and compatible with the literature, implying the positive correlations between ACE and negative health status including “*increased body mass, and*

diseases including depression, anxiety and asthma” and negative social outcomes (unemployment, lack of emotional support, dissatisfaction with life). The most remarkable result was the inverse and negatively correlated relationship between ACE scores and some physical health outcomes such as hypertension, hypercholesterolemia, heart disease, skin and other cancers.

Logan-Greene, Green, Nurius, Longhi (2014) in their research, they studied the detrimental effects of childhood adversities on adult physical and mental health. Additionally, some other variables such as *demographic, socioeconomic factors* and *resilience* were tested in order to have an understanding about their effects whether as in direct or moderating function. The sample was divided into four age cohorts from 18 to 79. Number of total participants was 19,333. Resilience was measured based on certain resources; “*social/emotional support, life satisfaction, sleep quality*”. ACE measurements were containing all the abuse types and parental mental illnesses, household dysfunction, divorce, and substance abuse. The physical and mental health information was reflecting *perceived* health status of the participants’. According to the results; young cohort (18-35 years old) had been reported exposure to more types of ACE compared to 65 years old and above. Childhood adversities had been found as a major contributor to get sick, having extended illnesses and having more chronic diseases. While the oldest age group having high ACE scores was suffering more on daily chronic health problems, young participants were having more physical rather than mental problems. Sleep as an indicator of resilience in the existing study method appeared as an critical predictor of reduced physical and mental health. Accordingly, sleep disturbance was common in all groups but also found to be the exacerbating factor to heighten the effects of ACE. Life satisfaction as the one of three resources of

resilience was found to be the critical element in creating a buffering effect between the mental health and impacts of adverse childhood experiences.

Yang and Hedeker (2019) examined in their study, to what extent the previously experienced adversity or trauma can have an effect upon the subjective well being in adulthood. In this research addressed with a life course perspective, 5,649 participants with aged 55 and over had been attended to the research, 77% amongst those were experienced at least one trauma during childhood and 72% experienced at least one trauma during adulthood. The results highlighted the impacts of negative childhood experiences as suffering more from depressive symptoms, having decreased perceived health status and less satisfaction with life in adulthood. The impact of the quality of relationship during early childhood as a social support had been observed in affecting well-being in later life. In this aspect; social support during later-life had appeared as a representation of parent-child relationship in creating resilience.

Ashy, Yu, Gutowski, Samkavitz, Malley-Morrison (2017) had searched the connection between childhood maltreatment and adult psychiatric symptoms. The basic argument of the study leaned on the fact that shame, guilt and resilience shared the same psycho-neurological ground with limbic system dysfunction and considered as the ‘intervening variables’ of the study. Accordingly, this common pathway was assumed to reveal the influence of maltreatment during childhood on adult symptomatology. In this integrative neuropsychological model; childhood maltreatment referred to “*parental physical, emotional, sexual abuse and neglect*”. As literature suggested some neurobiological outcomes have an influence on mediating the relationship with childhood maltreatment and later susceptibility to traumatic

exposures and certain psychiatric disorders (Lee & Hoaken, 2007). Similarly in scientific literature limbic system irritability represents an association with maltreatment during early years (Teicher, 2000; 2006). As study results; the maternal psychological and paternal physical maltreatment had been found to be negatively correlated with resilience and maltreatment as *the predictor* of adult psychiatric symptomatology. Shame had been found to be accompanied factor among girls and guilt among boys to this symptomatology. The limbic system dysregulation was identified as a ‘mediating factor’ between the relationships of childhood maltreatment and psychiatric disorders whereas resilience as the protective factor to hamper undesirable outcomes. Finally, the limbic system dysregulation had been found to be negatively related to resilience whereas positively related to shame and guilt.

Brodski and Hutz (2012) examined the recollection of emotional abuse within parental approaches among university students. Another hypothesis of the research was testing the relationship between childhood memories of emotional abuse with current self-worth and subjective well being. Childhood Trauma Questionnaire was used to assess five types of childhood experiences; “*emotional, physical, sexual abuse, as well as physical and emotional neglect*”. The adapted version of “*Rosenberg Self Esteem Scale*” (Rosenberg, 1979) was used to evaluate self-esteem and Diener’s “*Life Satisfaction Scale*” (Diener et al., 1985; Pavot & Diener, 1993) for assessing subjective well being was used as measurement tools. According to the study outcomes, an association was present between the participants who had been *emotionally abused* during childhood and having family whose parental styles were perceived as neglectful and authoritarian. Emotional abuse and self-esteem were found to be negatively correlated. Beside; among participants who claimed having memories in regard to emotional abuse, upper indicators of negative affect and lower

indicators of positive affects; self-esteem and life satisfaction had been specified. The most harmful and detrimental parental attitudes to engender psychopathologic outcomes were found to be as having parents engaging in neglectful and authoritarian styles.

In the study of **Chen's** (2016) the relationship among resilience, copying styles and subjective well-being were reviewed. In the scientific model, *copying styles* were designed as the *mediating variable* between trait-like resilience and subjective well being. Resilience was the moderating factor in predicting SWB through coping styles. In other words, resilience was expected to catalyze the effects of copying strategies on affecting subjective well being. But also, it was aimed to reveal whether the influence of copying styles on SWB was affected by the different levels of resilience. Therefore; as resilience and copying styles were considered as two main constructs of subjective well being in this analysis, were expected to predict SWB. According to the findings, different copying strategies and resilience predicted subjective well being. Moreover; the “*emotion-oriented coping*” style was to be as the agent to mediate the relationship between resilience and negative affect whereas resilience was moderated the relationship between “*task-oriented coping*” and “*life satisfaction*”. Resilience is positively associated with “*task-oriented copying*” strategy although negatively with emotion-oriented coping styles.

Lee, Martin, Tu, Palmer, Jeste (2018) studied on the effects of childhood adversity and resilience on psychologic and physical health, metabolic functions in adulthood. The striking aspect of the study was that the participants were consisted of *schizophrenic patients* and *non-psychiatric comparison group*. Childhood adversities referred to abuse and neglect experienced during childhood. The study proceeded for

five years and socio-demographic characteristics and pathological assessments, mental and physical health measurement had been applied to the participants. Due to the results; by justifying the prior assumption, patients diagnosed with schizophrenia reported childhood background with more of abuse and neglect. But; among the *non-psychiatric* group, childhood trauma was associated more with deteriorating mental and physical health however in schizophrenic group, the childhood trauma was only appeared as affecting the physical but not mental health. For both groups, the severity of the trauma exposed was found to be correlated with worsen physical well-being, higher insulin levels and insulin resistance. However, among certain participants diagnosed as schizophrenic, trauma was not identified as creating a worsen psychopathology or mental health. Apparently, the causes of their mental status were considered apart from the effects of trauma being exposed. Resilience was identified as an important factor in influencing mental and physical health independent from the severity of trauma. Resilience seemed to serve as modifiable protector factor between childhood trauma and mental and physical health. Surprisingly, resilience served more as a moderator to people with schizophrenia having better health outcomes compared to non psychiatric participants reported even severe trauma and but having resilience in low levels.

In the study conducted by **Hong, Tarullo, Mercurio, Liu, Cai, Malley-Morrison (2018)** the detrimental impacts of childhood maltreatment on later perceived stress had been analyzed. The role of resilience (trait- like) as mediator and two “*emotion regulation strategies*” had also been examined. In this study, the resilience was determined as a personality specialty by which people manifest self-reliance, meaningfulness, and modesty (Wagnild & Young, 1993). Childhood maltreatment had been measured in regard to maternal/ paternal emotional and

physical aggression and parental emotional neglect. “*Emotion regulation strategies*” were involving “*suppression*” and “*reappraisal*”. The significant result of the research was the salient relationship between childhood maltreatment, parental in particular and perceived stress. Key findings indicated gender differences in distinction of the causes which result in perceived stress: “*maternal psychological, maternal and paternal emotional neglect*” were positively correlated with “*perceived stress*” in female participants but not in male participants. In regard to mediating roles, both “*emotion regulation strategies*” (“*suppression and reappraisal*”) found to mediate the relationship between the “*maternal/paternal emotional neglect*” and “*perceived stress*” for girls. Resilience appeared to be negatively linked with “*perceived stress*” for both genders although its mediating role between maltreatment and stress was not significant in males.

Fava, Bay-Chang, Nochajski, Bowker, Hayes (2018) in their research in observed the relationship between the childhood maltreatment and a healthy sexual development among youth. The World Health Organization regards sexual health as a human right and part of “*physical, mental, social and emotional well being*” (WHO, 2006, 2010). Accordingly, in the current study the following domains emotional (the essence of the relationship), physical (sexual satisfaction), mental (self-efficacy for self protection) and social (sexual communication) were considered as the major indicators of sexual health. According to the study findings; the risky sexual behaviours during adolescence had been associated with childhood maltreatment.

In the research conducted by **Sheikh, Abelsen & Olsen (2016)** initially the influence of *traumatic experiences, demographic and socio-economic factors* called as ‘structural conditions’ during childhood, on adult social support and some other

behavioural factors were examined. Then, both the impacts of structural factors, social support on mental health and subjective well being were analyzed. The study was a prospective cohort study which lasted from 1974 to 2007/2008 and the existing research was representing the 6th and last section measuring 13,000 (roughly) data of participants born between 1920 and 1977. Social support and behavioural factors (general habits such as smoking, consuming alcohol) were considered as mediators in the study. In conclusion, the childhood trauma experiences (CTE) including psychological, physical abuse, substance abuse distress were associated with decreased mental health, health and well-being. For mental health, childhood traumas were predominantly more important than childhood socio-economic status. However the inverse effect was found to be more critical for health and well being. In other words; the socio-economic status in childhood was considered more important in identifying health and well being. Childhood trauma experiences were associated with lack of social support, addiction of smoking and alcohol. Thus, social support and behavioural elements were linked to lower mental health, health and well being. The remarkable finding of the current study is emphasizing the more powerful impact of *psychological abuse* on creating an unhealthy mental status compared to the effects followed by physical abuse. Moreover, childhood trauma experiences were highly correlated with support received from social environment and behavioural agents in adulthood.

In this research, **Barnum & Perrone-McGovern (2017)** tested their hypothesis suggesting the indicators of secure attachment in high levels, low childhood sexual trauma exposure and high sexual self-esteem will lead to have high subjective well being. Based on the study findings which were conducted among

university students, more the attachment security experienced increased the subjective well-being levels in adulthood was reported.

In the literature the empirical resources focusing on the connection between resilience and subjective well being are quite restricted. In this sense, the current research run by **Tomyn & Winberg (2016)** is important to reveal the aspect of the connection between resilience and subjective well being. The approach of the study in defining resilience is a process of ‘adaptation’ rather than a recover. Thus, resilience reflects a new way of functioning but not as a ‘bouncing-back’ to the pre-trauma state. As a result of the research, the relationship between resilience and SWB were concluded as *a moderate and positive relationship, also as related but partially independent constructs*.

In the scientific analysis of **Beutel, Tibubos, Klein, Schmutzer, Reiner, Kocalevent, Brähler (2017)** the association of resilience and adult adjustment had been examined. While analysing the relationships, the effects of childhood adversities had been discussed with a life course perspective and participants were divided as with and without reported such adversities. The age cohorts of the respondents was quite large from 14 to 92 years. The impact of childhood adversities on creating any psychological and somatic symptoms had been studied. The role of resilience in ensuring a buffering effect was also tested. Consequently; the long term impacts of childhood adversities including all types of abuse and neglect and resilience overcoming depression, anxiety and somatic symptoms are well documented. The adverse experiences during childhood were associated with increased vulnerability signifying helplessness and low self-efficacy. Low level of resilience, lower social support and low income predicted somatic symptoms. Followed by the study

outcomes, it was evident that childhood adversities also accompanied by lower social support during life time which constitutes social component aspect of resilience. People who had childhood adversities also reported to have decreased number of partnership, lowered education level, less income, and increased unemployment rates. Due to the findings, resilience occurred as a buffering variable between childhood adversity and distress as well as somatic symptoms. Respondents who had suffered from chronic childhood adversities and still succeeded to survive, were found to use resilient coping strategy and having less mental issues and problems of health over the lifespan.

Kong & Martire (2018) in her striking study; examined childhood maltreatment's influence on psychological well-being of adults. But the salient aspect of the research was the attempt to identify "*the mediating effect of later-life relationship with an abusive parent*" while investigating the interconnection of parental abuse, neglect and "*psychological well-being*". Adults having a history of childhood maltreatment keep interacting with their abusive caregivers and this relationship may trigger the repercussions from the past abuse history. According to the study findings; maternal childhood neglect and abuse were associated with reduced emotional tie with mother during adulthood which then found to lead to decreased psychological well-being. As a consequence; it was concluded that the burden followed by childhood maltreatment persists with the ongoing relationship with the abusive parent. This cascade of relationship might convey the adult victim having damage sense of psychological well-being.

Kanak & Aslan (2018) in their empirical study among adolescents investigated the relationship between "*perceived emotional abuse and resilience*".

The sources of the perceived emotional abuse of the students were their teachers at school and their parents at home. According to the research findings whose method was purposive sampling, negative correlation between the emotional abuse exposed and the psychological resilience. In other words, the more students think they were emotionally abused, more the level of resilience decrease. The judgmental attitudes including harsh critics, rejection, humiliation of parents and teachers had been found to undermine the development of adolescents. Perceived emotional abuse did not differ in regard to the gender. The academic success and perceived emotional abuse were found to be associated. Students having low academic achievements have high levels of perceived emotional abuse compared to students who have high academic achievement. Finally, the salient outcome of the research was the students having someone to talk and share their problems impacted the levels of emotional abuse the students perceive. The same variable in making a change in level of emotional abuse as ‘problem sharing’ also appeared to heighten the psychological resilience. Students, who had the opportunity to share their problems with others, displayed high resilience compared to students who did not have such advantage.

Eryilmaz and Ercan (2011) studied on the subjective well being in regard to some variables; gender, age cohorts and personality characteristics. The descriptive research was designed in a correlation model. The personality characteristics were assessed due to the ‘Five factors model’ (McCrae & Costa, 1987; Somer, Korkmaz and Tatar 2002). According to the research outcomes; gender was not found to be significant for subjective well being in regard to age cohorts except for the participants 26-45 years old. The subjective well being levels of age cohort 14-17 and 26-45 were relatively higher than 19-25 years of age. The personality traits extraversion, neuroticism, and responsibility were predicted the subjective well being

of age cohort 14-17. For the participants whose age were 26-45, the personality traits neuroticism and sense of responsibility were found to be correlated with subjective well being. Due to the present study, the levels of personality characteristics *predicting the subjective well being* were found to be decreasing as age progress. The subjective well-being of individuals was also being predicted by their personality traits. Finally; in regard to the age cohorts, being between 19-25 years old and being a female participant whose age were between 26-45 found significant.

In the meta-analysis of **Meng, Fleury, Xiang, Li, D'Arcy (2018)** the impact of “*resilience and protective factors*” on preventing the devastating outcomes of childhood maltreatment had been reviewed. In total, 5808 abstracts and 85 articles were analyzed. Due to all the reviews, some findings were summarized as below:

- Resilient groups from children to adult participants were found to be in the low risk group for the emergence of mental health problems. But also they found to display better functioning.
- In almost half of the studies considered resilience followed by childhood maltreatment as the absence of pathology. The correlation between the existence of psychopathology and protective factors was negative. Across all age groups the protective factors were found to create a boundary against developing mental health problems.
- Some protective factors of resilience prevent the victims of childhood maltreatment from re-traumatisation and conveying the negative effects via intergenerational abuse.

- Resilience was found to associated a ‘better life’ which explains diminishing risks for psychopathology, the emergence of traumatisatation, as well as enhancing likelihood of psychological well being and promoting adaptive skills.
- Protective factors in individual, familial and community levels predict resilience which then hinders the undesirable consequences of childhood maltreatment.
- In the literature, the lack of researches about “*emotional abuse and neglect*” compared to “*physical and sexual abuse*” were observed as quite evident

Çakar (2018) in her research article discussed the link between trauma exposure in early developmental years and adult psychological symptoms. The mediating role of resilience and gender were also examined in this relationship. According to the results; the association between childhood trauma experiences and psychological symptoms in adulthood was significantly evident. Negative correlation between childhood traumatic experiences and adult resilience was observed. Beside, resilience was found to function as mediation the effects of trauma on psychological symptoms. In other words; the impacts of the trauma experiences decrease as long as resilience increases.

3. METHOD

This section provides information on description of the research model, characteristics of the working group, tools used, data collection process and analysis.

3.1. RESEARCH MODEL

In this study, the relationship between the subjective well-being of young adults, which is the dependent variable of the study, and the childhood trauma and psychological resilience, which are the independent variables of the study, were examined. In line with its purpose, the research was carried out using the correlational scanning model, which is one of the quantitative research methods. Relational screening model is a research model that is used to consistently determine the existence, amount and / or degree of covariation between at least two or more variables (Creswell, 2017; Karasar, 2018; Tekbıyık, 2014). The model aims to find out to what extent the variables are related to each other rather than determining the cause-effect relationship of the variables, (Karasar, 2013).

3.2. STUDY GROUP

The study group of this research was consisted of young adults who were currently attending university as senior undergraduates and who have graduated from various departments but continued to participate in the educational certificate programme at Marmara University in the academic year of 2019-2020.

The participants were voluntarily joined the research and the study group was selected by using the simple random sampling method. This technique is one of the probability sampling techniques, also known as random sampling, and is also cost-effective (Büyüköztürk, 2017). Simple sampling is generally used in situations where

the researcher's resources such as time and labor are limited (Etikan, Musa, Alkassim, 2015).

The working group of the study consisted of a total of 408 people of whom 317 women (77, 7%), 57 men (14, 0%) and 34 people who did not specify their gender (8, 3%). The average age of the participants is 27 (SD = 6.63). 88 of the participants (21,6%) stated that they were married, 316 (77,5%) of them stated that they were single, and 4 (1,0%) of them did not state their marital status. 158 of the participants (38,7%) perceive their income level as good, 216 as medium (52,9%), and 34 (8,3%) as low. 114 of the participants (27,9%) stated that they smoke, and 294 (72,1%) stated that they did not. 112 of the participants (27,5%) stated that they consume alcohol, 296 (72,5%) of them stated that they do not. 12 (2,9%) of the participants stated that they had a physical illness, 396 (97,1%) of them stated that they did not experience any physical illness. The most frequently reported physical illnesses; scoliosis, neck and lumbar hernia, fibromyalgia, irritable bowel syndrome. Among the participants, 14 people (3,4%) stated that they experienced psychological disorders, while 394 (96,6%) stated that they did not. The most frequently reported psychological disorders were depression, anxiety disorder, panic attack, and obsessive-compulsive disorder.

Information on personality traits and habits of the study group is presented below (See: Tables 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8).

Table 3.1**Frequency and percentage values of young adults by gender variable.**

Gender	<i>f</i>	<i>%</i>	<i>%valid</i>	<i>%cumulative</i>
Female	317	77,7	84,8	84,5
Male	57	14,0	15,2	100
Missing Data	34	8,3		
Total	408	100		

As observed in Table 3.1, 317 (77.7%) of the sample group are female; 57 of them (14.0%) are male and 34 (8.3%) of them did not specify their gender. The sample group consists of a total of 408 university students.

Table 3.2**Frequency and percentage values of young adults by age variable**

	N	Min.	Max.	$\bar{x}$	Sd
Age	405	21	52	27,2	6,63

As presented in Table 3.2, the ages of the students in the sample group vary between 21 and 52 and the average age is 27.2.

Table 3.3**Frequency and percentage values of young adults by marital status variable**

Marital Status	<i>f</i>	<i>%</i>	<i>%valid</i>	<i>%cumulative</i>
Married	88	21,6	21,8	21,8
Single	316	77,5	78,2	100
Missing Data	4	1		
Total	408	100		

As explained in Table 3.3, 88 (21.6%) of the students in the sample group stated that they were married; 316 of them (77.5%) stated that they were single and 4 (1.0%) students did not state their marital status.

Table 3.4

Frequency and percentage values of young adults by to the perceived income level variable

Income Level	<i>f</i>	<i>%</i>	<i>%valid</i>	<i>%cumulative</i>
Good	158	38,7	38,7	38,7
Middle	216	52,9	52,9	91,7
Low	34	8,3	8,3	100
Total	408	100	100	

As presented in Table 3.4, it was observed that 158 (38.7%) of the students in the sample group were in the good income group, 216 (52.9%) were in the middle income group and 34 (8.3%) were in the low income group.

Table 3.5

Frequency and percentage values of young adults according to the smoking status variable

Smoking	<i>f</i>	<i>%</i>	<i>%valid</i>	<i>%cumulative</i>
Yes	114	27,9	27,9	27,9
No	294	72,1	72,1	100
Total	408	100	100	

As presented in Table 3.5, it was observed that 115 (28.2%) of the students in the sample group were smoking, while 293 (71.8%) of them did not smoke.

Table 3.6

Frequency and percentage values of young adults according to the alcohol use status variable

Alcohol	<i>f</i>	<i>%</i>	<i>%valid</i>	<i>%cumulative</i>
Yes	112	27,5	27,5	27,5
No	296	72,5	72,5	100
Total	408	100	100	

As explained in Table 3.6, 112 (27.5%) of the students in the sample group use alcohol while 296 (72.5%) do not use alcohol.

Table 3.7

Frequency and percentage values of young adults according to the physical illness variable

Physical illness	<i>f</i>	<i>%</i>	<i>%valid</i>	<i>%cumulative</i>
Yes	12	2,9	2,9	2,9
No	396	97,1	97,1	100
Total	408	100	100	

As presented in Table 3.7, 12 (2.9%) of the students in the sample group stated that they had physical illness, while 396 (96.8%) of them stated that they did not have any physical illness.

Table 3.8

Frequency and percentage values of young adults according to the psychological problems variable

Psychological disorders	<i>f</i>	<i>%</i>	<i>%valid</i>	<i>%cumulative</i>
Yes	14	3,4	3,4	3,4
No	394	96,6	96,6	100
Total	408	100	100	

As explained in Table 3.8, 14 (3.4%) of the students in the sample group stated that they experienced psychological disorders, while 394 (96.6%) stated that they did not have any psychological disorders.

3.3. DATA COLLECTION TOOLS

“A *Personal Information Form*” was prepared by the researcher to collect information regarding research questions. In addition, “*Childhood Trauma Questionnaire*”, “*Psychological Resilience Scale for Adults*” and “*Subjective Well-*

being Scale” were used to measure the relationship between the participants' childhood trauma, their resilience and subjective well-being.

3.3.1. “*Personal Information Form*”

This form was developed by the researcher to compile demographic informations of the participants. Personal information form consists of personal informations including gender, age, marital status, participants' perceived socio-economical status as well as the informations about their habits such as smoking, alcohol use status, participants' physical illnesses and mental disorders (Appendix-1).

3.3.2. “*Childhood Trauma Questionnaire- CTQ*”

The scale, originally named “*Childhood Trauma Questionnaire*” (CTQ), was developed by Bernstein, Fink, Handelsman, Foote (1994). This assessment tool is a five sub-dimensional scale developed to determine the “*childhood sexual, physical, emotional abuse and emotional and physical neglect*” of persons under the age of 18. Adaptation to Turkish adaptation, validity and reliability studies of the scale were carried out by Şar, Öztürk, and İkikardeş (2012). The scale, which was adapted to Turkish, is a shortened version, originally consisting of 53 items, but later was turned into 28 items by the original authors. “*Childhood Trauma Questionnaire*” is a retrospective self-report scale that measures traumatic experiences, “*physical, emotional, sexual abuse, and physical and emotional neglect*” of individuals before the age of 20. The scale consists of 28 items and has a 5-point likert type, the evaluation is made between 1-5 points (1 = never, 2 = rarely, 3 = sometimes, 4 = frequently, 5 = very often). The scale consists of 5 sub-dimensions. Each subscale of the scale consists of five items; Emotional abuse evaluated with the items 3,8,14,18,25, physical abuse evaluated with the items 9,11,12,15,17, physical neglect evaluated with the items 1,4,6,2,26, emotional neglect evaluated with the items

5,7,13,19,28, and sexual abuse is evaluated with the items 20,21,23,24,27. Each subscale takes a value between 5-25. In addition, total score is obtained from the sum of the subscales in the scale. The total score obtained from the scale takes a value between 25-125. High scores in both subscales and trauma total score indicate high level of trauma exposure. While scoring the scale, firstly, the items numbered 2, 5,7,13,19,26,28 are reversed and scoring is performed. In addition, there are 3 items (items 10, 16, 22) measuring (about minimizing) how individuals approach trauma, namely denial of trauma, and these items do not affect the total score. After the validity studies of the scale were completed, reliability studies were started. In the context of validity study, through the adaptation of the original scale to Turkish, the correlation result values of all items with each other were above 0.30 and most of them were above 0.50, except Item 4 ($r = 0.17$). In the reliability study conducted with 123 participants, the internal consistency value of the scale was found to be 0.93. Cronbach's alpha values for the sub-dimensions were 0.80 for sexual abuse, 0.89 for physical abuse, 0.88 for emotional neglect, and 0.87 for emotional abuse, respectively.

The test reliability coefficient made with the test-retest technique calculated as 0.90 ($p < 0.001$, $N = 48$). Correlation coefficients for the sub-dimensions are respectively: “*emotional abuse*” ($r = 0.90$ $p = 0.001$), “*emotional neglect*” ($r = 0.85$ $p < 0.001$), “*physical abuse*” ($r = 0.90$ $p < 0.001$), “*sexual abuse*” ($r = 0.73$ $p < 0.001$), “*emotional neglect*” ($r = 0.77$ $p < 0.001$) and “*minimization*” ($r = 0.71$ $p < 0.001$). The Cronbach Alpha values calculated for the subscales from these research data vary between 30 and 79 (See: Table 4.1) (Appendix-2).

3.3.3. “*Psychological Resilience Scale for Adults- PRSA*”

The “*Psychological Resilience Scale for Adults*” was developed by Friborg et al. (2003). The Turkish adaptation, validity and reliability study of the scale was carried out by Basım and Çetin (2011). The scale determines the main protective factors in the recovery and maintenance of mental health. It consists of 33 questions and sub-dimensions including “*personal power*”, “*structural style*”, “*social competence*”, “*family adaptation*” and “*social resources*”. The scale was reviewed and with a later study (Friborg et al. 2005) it was considered that the six-dimensional structure of the scale was a better way to describe the resilience model than five-dimensional structure. In the study conducted by Friborg et al. (2005), the “*personal power*” dimension was divided into two as “*self-perception*” and “*future perception*” and a total six-dimensional structure was revealed.

In the scale, both the “*structural style*” (3,9,15,21) and “*perception of future*” (2,8,14,20) are measured with 4 items; and each of “*family cohesion*” (5,11,17,23,26,32), “*perception of self*” (1,7,13,19,28,31,) and “*social competence*” (4,10,16,22, 25,29) are measured with 6 items and “*social resources*” (6,12,18,24,27,30,33) are measured with 7 items. In order to avoid biased evaluations in choosing items in the scale, the format has been chosen very carefully. Namely, in this format, the positive and negative features were on different sides and there were five separate boxes for answers. If “*psychological resilience*” is desired to get higher as the scores get high, the answer boxes need be evaluated as 1,2,3,4,5 from left to right. High scores from the scale mean that the participant’s psychological resilience is high. In the scale; questions which are numbered as 1-3-4-8-11-12-13-14-15-16-23-24-25-27-31-33 will be reverse questions.

Confirmatory factor analysis was performed for the validity study of the scale and it was observed that the six-factor structure has a total variance value of 57%. Internal consistency values for the reliability of the scale was found to be 0.80 for “*perception of self*”, 0.75 for “*perception of future*”, 0.82 for “*social competence*”, 0.86 for “*family cohesion*”, 0.84 for “*social resources*” and 0.76 for “*structured style*” (Friborg et al.2005). It was found that the internal consistency coefficients of the sub-dimensions of the scale varied between 0.66 and 0.81, and test-retest reliability ranged from 0.68 to 0.81. In addition, the total Cronbach Alpha coefficient of the scale was found to be ,86. The Cronbach Alpha values calculated for the subscales from this research data were found between ,55 and ,81 (See: Table: 4.2) (Appendix-3).

3.3.4. “Subjective Well-Being Scale- SWS”

The purpose of the “*Subjective Well-Being Scale*” developed by Meliha Tuzgöl Dost (2005) is to determine the subjective well-being levels by determining the frequency and intensity of positive and negative emotions that individuals experience with their cognitive evaluations about their lives. Subjective Well-Being Scale (SWS) consists of 46 items. The scale includes personal judgments and positive and negative emotion expressions about the life sphere. The sub dimensions of this scale are; “comparing your life with your own past and the life of others, positive and negative emotions, goals, self-confidence, optimism, liked activities, friendship relations, future outlook, family relations, envy of others' lives, coping with life's difficulties, pessimism”. The response system is a five-point likert scale for each statement, such as “(5) Completely Suitable”, “(4) Mostly Suitable”, “(3) Partially Suitable”, “(2) Somewhat Suitable” and “(1) Not Suitable at all”. Scores of each item vary between 5 and 1. 26 items of the scale are positive statements, while 20 of them are negative. Negative statements are the items which are numbered as; 2, 4, 6, 10, 13,

15, 17, 19, 21, 24, 26, 28, 30, 32, 35, 37, 38, 40, 43 and 45. The scores of negative statements were calculated by reverse order. The lowest score that can be obtained from the scale is 46, the highest score is 230. High scores indicate high subjective well-being level. The validity of the SWS has been determined in several ways. First, factor analysis study was conducted. Secondly, the item-total score correlations of the scale were examined. Thirdly, in order to determine the distinctiveness of the scale, the lower and upper 27% score groups were compared with the t test. In the factor analysis study, the KMO coefficient values for the SWS was found to be .861, and the Barlett test was found to be significant. It was observed that the common variance of the factors on each variable ranged from .51 to .75. It was determined that the SWS gives 12 factors with eigenvalues greater than 1. The first factor alone explains 24.52% of the total variance. The total variance explained is 63.83%.

The reliability of SWS was determined in two ways. Initially, the Cronbach Alpha reliability of the scale was calculated by using the data of the same application of 46 items, which were taken validly as a result of the factor analysis. Cronbach Alpha reliability coefficient of SWS was found as .93 according to the results of the application made to a group of 209 people. Secondly, test-retest method was applied. In order to find the stability coefficient of the scale, the tool was applied to a group of 39 people in the research sample twice with two week intervals and the Pearson moments product correlation coefficient was found to be .86. In the light of this research data, the Cronbach Alpha value for the scale was calculated as .94 (See: Table 4.3) (Appendix-4).

3.4. DATA COLLECTION AND ANALYSIS

The data of the research was gathered by the researcher in person during the academic year of 2019-2020. The necessary permissions were obtained from the

Ethics Committee of the Yeditepe University Institute of Educational Sciences (Appendix-5). Before the scale applications, the researcher made the necessary explanations to the participants about the purpose and content of the study and the instructions regarding the scales were read. In the statement; it was notified that participation in the study was voluntary and a reminder was given regarding the principle of confidentiality. Data collection took approximately 25 minutes. The data collection tools used in the study was applied to 476 participants, and the data of 15 participants who filled in incorrect and/or incomplete data were excluded from the evaluation. Versatile extreme values were determined by calculating Mahalanobis (Appendix-6) distance values, during the examination of extreme values. The accepted criterion for versatile extreme values is significant Mahalanobis distance value at $p < .001$ level. Accordingly, data belonging to 20 people were determined as versatile extreme values and were not included in the data set. One-way extreme values were analyzed by converting the raw scores into standard deviation scores and using box plots. The standard Z scores outside the range of +3 and -3 were examined in the box plot and the values not included in the box were evaluated as one-sided extreme values. Accordingly, data belonging to 33 people was removed from the data set because it is one-way extreme value. In addition, histogram graphs of the scales were prepared and findings regarding the normality study are attached (Appendix-6). As a result, the data belonging to 68 people in total were removed from the data set and analysis was carried out with the data of 408 people.

In the analysis of the data, initially, the frequency and percentage distributions of the demographic characteristics of the sample group were revealed, then; the minimum and maximum scores, $\bar{X}$, ss, Sh x, reliability coefficient, skewness and kurtosis values and reliability values were calculated for “*Childhood Trauma*

Questionnaire” score, “*Psychological Resilience Scale for Adults*” score and “*Subjective Well-being Scale*” score (see tables 4.1, 4.2, 4.3).

When the assumption of normal distribution was met in the comparison of means between groups, “*Independent Groups t-Test*”, “*One-Way Analysis of Variance (ANOVA)*” and “*one-way MANOVA*” were applied. In cases where variance-covariance equality is not provided in the MANOVA test, the MANOVA-Pillai's Trace Test was used and when it is provided, Wilks Lambda test was used. When a significant difference was found between groups after “*One-way Analysis of Variance (ANOVA)*”, post-hoc complementary analysis techniques “*Scheffe*” were used to determine between which groups the differences occurred. In cases where the normality assumption was not met in the analyzes made on the basis of sub-scales, “*Mann White U*” and “*Kruskal Wallis test*” analyzes, one of the “*non-parametric difference tests*”, were applied.

Parametric and non-parametric correlation analyzes “*Pearson Product Moment Correlation Coefficient* and *Spearman Rank-Order Correlation Coefficient*” were applied to examine whether there is a statistically significant relationship between variables. “*Stepwise regression analysis*” was applied to determine the predictive level of psychological resilience and subjective well-being of childhood traumas. Statistical analysis of the data was made in the “*SPSS 21.0*” program, the significance was tested at the minimum $p < .05$ level, and the findings were presented in tables for the purposes of the research.

4. FINDINGS

In this part of the study, the findings obtained as a result of the analysis of the data obtained from the “*Personal Information Form*”, “*Childhood Trauma Questionnaire*”, “*Psychological Resilience Scale for Adults*” and “*Subjective Well-being Scale*” are presented. Findings obtained as a result of statistical analysis are presented primarily as descriptive statistical information. Then, these analyzes are presented in tables by considering the order of presentation of the objectives in the study.

Table 4.1

Descriptive Values, Skewness and Kurtosis Values and Reliability Coefficient Values for Childhood Trauma Questionnaire Scores for Young Adults

Dimensions	n	Min	Max.	$\bar{x}$	Se_x	sd	Skewness	Kurtosis	Alpha
Emotional Abuse	408	5,00	14,00	6,55	0,11	2,19	1,47	1,41	,60
Physical Abuse	408	5,00	14,00	5,26	0,05	0,93	5,04	31,61	,63
Physical Neglect	408	5,00	13,00	6,22	0,08	1,66	1,34	1,08	,30
Emotional Neglect	408	5,00	21,00	8,81	0,17	3,44	,810	-,076	,78
Sexual Abuse	408	5,00	20,00	5,45	0,08	1,55	5,50	38,77	,78
Trauma	408	25,00	54,00	32,29	0,32	6,51	,966	,210	,79
Total	408	25,00	54,00	32,29	0,32	6,51	,966	,210	

As stated in Table 4.1; when the Childhood Trauma Questionnaire subscale scores examined, the arithmetic mean of the emotional abuse sub-dimension scores is ($\bar{x}$) = 6.55 and the standard deviation value is (sd) = 2.19; arithmetic mean of physical abuse subscale scores is ($\bar{x}$) = 5.26 and standard deviation is (sd) = .93; arithmetic

mean of physical neglect subscale scores is $(\bar{x}) = 6.22$ and standard deviation is $(sd) = 1.66$; arithmetic mean of emotional neglect subscale scores is $(\bar{x}) = 9.02$ and standard deviation is $(sd) = 3.61$; arithmetic mean of sexual abuse subscale scores is $(\bar{x}) = 8.81$ and standard deviation is $(sd) = 3.44$; Finally, the arithmetic mean of the “*total trauma score*” of the scale was calculated as

$$(\bar{x}) = 32.29 \text{ and its standard deviation } (ss) = 6.51.$$

The reliability coefficient “Cronbach alpha” of the emotional abuse dimension was calculated as .60 in line with the data obtained within the scope of the study. The “*reliability coefficient of the physical abuse*” dimension was calculated as .63. The “*reliability coefficient of the physical neglect*” dimension was calculated as .30. The “*reliability coefficient of the emotional neglect*” dimension was calculated as .78. The “*reliability coefficient of the sexual abuse*” dimension was calculated as .78 and the “*reliability coefficient of the total trauma*” was calculated as .79. When we look at the values of skewness and kurtosis, it was found that apart from the scores of the physical abuse and sexual abuse sub-dimension, other sub-dimension scores obtained from the scale and the skewness and kurtosis values of the total score were between 1.5 and -1.5 and showed a normal distribution.

Table 4.2

Descriptive values, skewness and kurtosis values and reliability coefficient values for Psychological Resilience Scale for Adults scores for young adults

Dimensions	n	Min	Max.	$\bar{x}$	Se_x	sd	Skewness	Kurtosis	Alpha
Structured style						0,8			,55
	408	1,00	5,00	3,62	0,04	3	-,326	-,037	
Perception of						0,9			,74
future	408	1,00	5,00	3,77	0,04	0	-,491	-,297	
Family cohesion						0,8			,81
	408	1,00	5,00	3,73	0,04	8	-,684	,171	
Perception of self						0,7			,74
	408	1,00	5,00	3,77	0,04	6	-,421	,070	
Social						0,7			,72
competence	408	1,00	5,00	3,78	0,04	9	-,552	,263	
Social resources						0,7			,80
	408	1,00	5,00	4,04	0,04	7	-1,03	,738	

As presented in Table 4.2; Considering the scores of the “*Psychological Resilience Scale for Adults*”, arithmetic mean of the structural style sub-scale scores is ($\bar{x}$) = 3.62 and the standard deviation is (sd) = .83; The arithmetic mean of the perception of future sub-dimension scores is ($\bar{x}$) = 3.77 and its standard deviation is (sd) = .90; The arithmetic mean of family cohesion subscale scores is ($\bar{x}$) = 3.73 and standard deviation is (sd) = .88; arithmetic mean of perception of self sub-dimension scores is ($\bar{x}$) = 3.77 and standard deviation is (sd) = .76; arithmetic mean of social competence subscale scores is ($\bar{x}$) = 3.78 and standard deviation is (sd) = .79; The arithmetic mean of the social resources subscale scores was calculated as ($\bar{x}$) = 4.04 and the standard deviation as (sd) = .77.

The reliability coefficient (Cronbach alpha) of the structured style dimension in line with the data obtained within the scope of the research is .55; The reliability coefficient of the perception of future dimension (Cronbach alpha) is .74; Reliability

coefficient of family cohesion dimension (Cronbach alpha) is .81; perception of self dimension reliability coefficient (Cronbach alpha) is .74. “*The reliability coefficient (cronbach alpha)*” of the social competence dimension was calculated as .72 and the “*reliability coefficient (cronbach alpha)*” of the social resources dimension was calculated as .80. When we look at the skewness and kurtosis values, it is observed that the skewness and kurtosis values of the scores obtained from the scale sub-dimensions are between 1.5 and -1.5 and show a normal distribution in this direction.

Table 4.3

Descriptive values, skewness and kurtosis values and reliability coefficient values for Subjective Well-being Scale scores for young adults

Score	n	Min	Max.	$\bar{x}$	Se _x	sd	Skewness	Kurtosis	Alpha
Well-being	408	104,0	230,0	180,09	1,18	23,93	-,424	-,281	,94

As explained in Table 4.3, the arithmetic mean of the Subjective Well-Being Scale is ($\bar{x}$) = 180, 09; standard deviation is (SD) = 23.93 and standard error is (Se_x) = 1.18. The “*reliability coefficient (cronbach alpha)*” of the scale was calculated as .94 in line with the data obtained within the scope of the research. When the skewness (-.424) and kurtosis (-, 281) values are examined, it is observed that the scale scores have a normal distribution.

The difference statistics of young adults “according to their demographic characteristics such as *gender, marital status, income level, smoking, alcohol use and physical illness*” are presented below in tables according to the order of the research questions in the study. Since sexual and physical abuse sub-scales among the sub-scales did not show normal distribution in the analysis of the difference tests for the childhood trauma scale, non-parametric analyzes were performed. Childhood trauma

scale was conducted using both parametric and non-parametric difference tests (when the number of groups is below 30) for the other sub-dimensions and total scores.

4.1. Findings regarding the question; “Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to gender?”

Table 4.4

“Independent groups t-test” and “Mann Whitney-U test” results to determine whether young adults’ Childhood Trauma Questionnaire scores differ according to gender variable

Trauma	Gender	N	$\bar{x}$	Se_x	ss	t test		
						t	sd	p
Emotional Abuse	Female	317	6,49	2,19	0,12	-1,43	372	0,153
	Male	57	6,95	2,38	0,31			
Physical Neglect	Female	317	6,05	1,47	0,08	-3,88	372	0,000
	Male	57	6,91	1,99	0,26			
Emotional Neglect	Female	317	8,55	3,24	0,18	-3,29	372	0,001
	Male	57	10,12	3,85	0,51			
Total Trauma	Female	317	31,76	6,27	0,35			
	Male	57	34,71	6,83	0,90	-3,24	372	0,001
		N	$\bar{x}_{order}$	Σ_{order}				
Sexual Abuse	Female	317	188,62	59603				
	Male	57	181,41	10522	8811,0	-,803		,422

As can be observed in Table 4.4, according to the results of the difference tests conducted to determine whether the Childhood Trauma Scale scores differ significantly according to the gender variable, emotional neglect, physical neglect sub-dimensions and the arithmetic mean of the total trauma score; it can be examined

that there is a statistically significant difference in favor of males ($p < .05$). Emotional abuse and sexual abuse sub-dimension scores did not differ significantly according to the gender variable ($p > .05$).

4.2. Findings regarding the question; "Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to marital status?"

Table 4.5

"Independent groups t test" and "Mann Whitney-U test" to examine whether young adults' Childhood Trauma Questionnaire scores in regards to the marital status variable

Trauma	Marital Status	n	$\bar{x}$	Se _x	ss	t test		
						t	sd	p
Emotional Abuse	married	88	6,46	2,05	0,22	-0,48	402	0,632
	single	316	6,59	2,24	0,13			
Physical Neglect	married	88	6,24	1,62	0,17	0,18	402	0,856
	single	316	6,20	1,66	0,09			
Emotional Neglect	married	88	8,47	3,22	0,34	-1,05	402	0,294
	single	316	8,90	3,49	0,20			
Total Trauma	married	88	31,80	6,19	0,66			
	single	316	32,42	6,60	0,37	-0,79	402	0,430
		n	$\bar{x}_{order}$	$\Sigma order$		U	z	p
Sexual Abuse	married	88	196,87	17521,5				
	single	316	204,09	64288,5		13516,5	-,858	,391

As can be observed in Table 4.5, according to the results of the difference tests conducted to determine whether the scores of the Childhood Trauma Scale differ significantly according to the marital status variable, as it can be observed, the scores obtained from the scale do not show a statistically significant difference according to the groups ($p > .05$).

4.3. Findings regarding the question; “Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to income level?”

Table 4.6

One-way MANOVA results to determine whether young adults’ Childhood Trauma Questionnaire scores (“Total trauma, Emotional abuse, Emotional neglect and Physical neglect sub-dimensions”) differ according to the income level variable.

		Value	F	SD	SD Error	p	η^2
		Hypothesis					
Income	Wilks'						
	Lambda	0,059	3,072	8	806	,002	,030

MANOVA was conducted to determine whether the mean scores of the Childhood Trauma Questionnaire differ significantly according to the income level. The physical abuse and sexual abuse sub-dimensions, which are sub-dimensions of the scale, were not included in the MANOVA analysis since they did not distributed normally. It was found that the assumption of variance and covariance equality was met as a result of the Box's M test, together with the normal distribution assumption from MANOVA assumptions ($F = 1.39$; $p > .05$). Accordingly, MANOVA-Wilks' Lambda test value was used. According to the MANOVA results in Table 4.6, it is observed that the perceived income levels of students creates a statistically significant difference in the scores of the Childhood Trauma Questionnaire (Wilks' Lambda = .059; $F(2,405) = 3.07$; $p < .05$).

The result of descriptive statistics and one-way analysis of variance is given in the table below to examine the difference between the Childhood Trauma Questionnaire total score and other sub-dimension mean scores by income level.

Table 4.7

ANOVA results of young adults regarding the Childhood Trauma Questionnaire scores (“Total trauma, Emotional abuse, Emotional neglect and Physical neglect sub-dimensions”) according to their income levels

Trauma	Groups	n	$\bar{x}$	ss	KT	Sd	KO	F	p	η^2
Emotional Abuse	Good	158	6,22	1,86	27,14	2	13,57	2,93	,054	,014
	Middle	216	6,68	2,30						
	Low	34	6,97	2,42						
Physical Neglect	Good	158	6,26	1,77	0,71	2	0,36	0,12	,885	,001
	Middle	216	6,21	1,67						
	Low	34	6,35	1,54						
Emotional Abuse	Good	158	8,03	3,27	204,9	2	102,47	8,89	,000	,042
	Middle	216	9,16	3,48						
	Low	34	10,35	3,44						
Total Trauma	Good	158	31,13	6,33	443,9	2	221,95	5,30	,005	,025
	Middle	216	32,81	6,58						
	Low	34	34,56	6,43						

When Table 4.7 is examined; There was no statistically significant difference in the scores of the emotional abuse sub-dimension of the Childhood Trauma Questionnaire ($F = 2.93$; $p > .05$) and the physical neglect sub-dimension ($F = 0.12$; $p > .05$). On the other hand, a statistically significant difference was found in the total score ($F = 5.30$; $p < .05$) and emotional neglect sub-dimension ($F = 8.89$; $p < .05$) scores. In order to determine among which groups this significant difference in the scores obtained from the scale, Complementary Post-Hoc Analysis Techniques were used.

In order to decide which post-hoc multiple comparison technique will be used, firstly the Levene's test was used to test the hypothesis of whether the variances of the group distributions were homogeneous or not, and it was observed that the group variances were homogeneous ($p > .05$). For this reason, Scheffe multiple comparison

technique, which is used in cases where the variances are homogeneous, was preferred. Complementary analysis results are given in the table below.

Table 4.8

Complementary analysis results to determine which sub-dimensions of the Childhood Trauma Questionnaire scores of young adults differ according to the income level

Score	(I) income	(J) income	$\bar{X}_i - \bar{X}_j$	Se _x	p
Emotional Neglect	Good	Middle	-1,14	0,36	,006
		Low	-2,33	0,64	,002
	Middle	Good	1,14	0,36	,006
		Low	-1,19	0,63	,166
Total Trauma	Good	Middle	-1,67	0,68	,051
		Low	-3,43	1,22	,021
	Middle	Good	1,67	0,68	,051
		Low	-1,75	1,19	,341

According to the complementary analysis results in Table 4.8, when emotional neglect dimension scores are taken into consideration in groups with high and low income levels; it shows a statistically significant difference in favor of the lower group. When medium and good income groups are considered; it shows a statistically significant difference in favor of the middle group ($p < .05$). The total scores obtained from the scale show a significant difference only between the groups with good income and low income in favor of the low group ($p < .05$). There was no significant difference between the other groups ($p > .05$).

Table 4.9

“Kruskal Wallis-H Test” of the “physical abuse and sexual abuse” sub-dimensions scores of young adults in the Childhood Trauma Questionnaire according to the income level variable

Trauma	Income	N	X_{Order}	X²	sd	p
Physical Abuse	Good	158	201,67	,800	2	,670
	Middle	216	207,14			
	Low	34	200,87			
Sexual Abuse	Good	158	197,94	2,71	2	,257
	Middle	216	207,31			
	Low	34	217,12			

As can be observed in Table 4.9, according to the results of the Kruskal Wallis-H test conducted to determine whether the mean rank of sexual abuse and physical abuse sub-dimension scores differed significantly according to the income level variable, there was no significant difference between the mean rank of the groups ($p > .05$).

4.4. Findings regarding the question; “Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to smoking status?”

Table 4.10

The results of “Independent groups t-test” and “Mann Whitney-U test” of the Childhood Trauma Questionnaire scores of young adults in regards to the smoking status variable

Trauma	Smoking Status	N	$\bar{x}$	Se_x	ss	t test		
						t	sd	p
Emotional Abuse	yes	114	6,45	2,37	0,22	-0,55	406	0,586
	no	294	6,58	2,12	0,12			
Physical Neglect	yes	114	6,29	1,57	0,15	0,50	406	0,615
	no	294	6,19	1,70	0,10			
Emotional Neglect	yes	114	8,77	3,38	0,31	-0,18	406	0,859
	no	294	8,83	3,47	0,20			
Total Trauma	yes	114	32,16	6,46	0,60	-0,26	406	0,793
	no	294	32,34	6,54	0,38			
		n	X_{order}	Σ_{order}		U	z	p
Physical Abuse	yes	114	199,2	22908,5		16238,5	-1,04	,296
	no	294	206,58	60527,5				
Sexual Abuse	yes	114	207,52	23865		22908,5	,296	,591
	no	294	203,31	59571				

As can be observed in Table 4.10, according to the differences test results conducted to determine whether the scores of the Childhood Trauma Questionnaire differ significantly according to the smoking status variable, the scores obtained from the scale do not represent a statistically significant difference according to the groups ($p > .05$).

4.5. Findings regarding the question; “Is there a significant difference between the Childhood Trauma Scale scores of young adults according to alcohol use status?”

Table 4.11

The results of “Independent groups t-test” and “Mann Whitney-U test” of the Childhood Trauma Questionnaire scores of young adults in regards to the alcohol use status

Trauma	Alcohol	n	$\bar{x}$	Se_x	ss	t test		
						t	sd	p
Emotional Abuse	Yes	112	6,50	2,33	0,22	-0,26	406	0,792
	No	296	6,56	2,14	0,12			
Physical Neglect	yes	112	6,27	1,71	0,16	0,35	406	0,725
	No	296	6,20	1,65	0,10			
Emotional Neglect	yes	112	8,63	3,52	0,33	-0,65	406	0,517
	No	296	8,88	3,41	0,20			
Total Trauma	yes	112	32,28	6,91	0,65	-0,03	406	0,977
	No	296	32,30	6,36	0,37			
		n	$\bar{x}_{order}$	Σ_{order}		U	z	p
Physical Abuse	yes	112	202,12	22637		16309,0	-,462	,644
	no	296	205,4	60799				
Sexual Abuse	yes	112	214,23	23993,5		15486,5	-1,70	,089
	no	296	200,82	59442,5				

As it is observed in Table 4.11; due to the findings of differences tests conducted to determine whether the scores of the Childhood Trauma Questionnaire differ significantly according to the alcohol use status variable, the scores obtained from the scale do not represent a statistically significant difference according to the groups ($p > .05$).

4.6. Findings regarding the question; “Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to the presence of a physical illness?”

Table 4.12

“Mann Whitney-U Test” of the Childhood Trauma Questionnaire scores of young adults differ according to the physical illness variable.

Trauma	Physical illness	N	Xorder	Σorder	U	z	p
Emotional Abuse	yes	12	325,12	4226,5	999,5	-4,06	0,000
	no	396	200,53	79209,5			
Physical Abuse	yes	12	214,12	2783,5	2442,5	-0,55	0,583
	no	396	204,18	80652,5			
Physical Neglect	yes	12	226,50	2944,5	2281,5	-,74	0,458
	no	396	203,78	80491,5			
Emotional Neglect	yes	12	290,0	3770	1456,0	-2,68	0,007
	no	396	201,69	79666			
Sexual Abuse	yes	12	192,96	2508,5	2417,5	-,59	0,552
	no	396	204,88	80927,5			
Total Score	yes	12	300,08	3901	1325,0	-2,98	0,003
	no	396	201,35	79535			

As observed in Table 4.12, as a result of the “Mann Whitney-U test” carried out to determine whether the scores of the Childhood Traumatic Scale differ significantly according to the physical illnesses variable; emotional abuse, emotional neglect sub-dimensions and mean rank of the total score differ statistically significantly in favor of those with physical illnesses ($p < .05$). The mean ranks of “sexual abuse, physical neglect and physical abuse” sub-dimensions do not differ significantly according to the groups ($p > .05$).

4.7. Findings regarding the question; “Is there a significant difference between the Psychological Resilience Scale for Adults scores of young adults according to the gender variable?”

Table 4.13

The results of “Independent groups t-test” of “Psychological Resilience for Adults Scale” in regards to gender in young adults.

Psychological Resilience	Gender	N	$\bar{x}$	Se_x	Ss	t test		
						t	Sd	p
Structured style	Female	317	3,64	0,84	0,05	-,082	372	,935
	Male	57	3,65	0,75	0,10			
Perception of future	Female	317	3,79	0,88	0,05	,508	372	,612
	Male	57	3,73	0,97	0,13			
Family cohesion	Female	317	3,77	0,86	0,05	1,80	372	,073
	Male	57	3,55	0,98	0,13			
Perception of self	Female	317	3,76	0,76	0,04	-1,35	372	,179
	Male	57	3,91	0,81	0,11			
Social competence	Female	317	3,78	0,80	0,04	-,196	372	,845
	Male	57	3,80	0,76	0,10			
Social Resources	Female	317	4,10	0,76	0,04	2,34	372	,020
	Male	57	3,85	0,68	0,09			

As can be observed in Table 4.13, according to the findings of the “Independent groups t test”, which was conducted to determine whether the sub-dimension scores of the “Psychological Resilience Scale for Adults” differ significantly according to the gender variable, only social resources dimension scores were statistically appears to differ significantly ($t = .020$; $p < .05$). It was found that other sub-dimension scores did not differ significantly according to the gender variable ($p > .05$).

4.8. Findings regarding the question; “Is there a significant difference between the scores of the Adult Psychological Resilience for Adults Scale of young adults according to marital status?”

Table 4.14

The results of “Independent groups t-test” of “Psychological Resilience for Adults Scale” in regards to the marital status variable.

Psychological Resilience	Marital Status	n	$\bar{x}$	Se_x	ss	t test		
						t	sd	P
Structured style	Married	88	3,72	0,78	0,08	1,37	402	,173
	Single	316	3,59	0,84	0,05			
Perception of future	Married	88	3,92	0,81	0,09	1,86	402	,064
	Single	316	3,72	0,92	0,05			
Family cohesion	Married	88	3,83	0,87	0,09	1,37	402	,170
	Single	316	3,69	0,88	0,05			
Perception of self	Married	88	3,91	0,77	0,08	2,06	402	,040
	Single	316	3,73	0,76	0,04			
Social competence	Married	88	3,95	0,71	0,07	2,40	402	,017
	Single	316	3,73	0,80	0,05			
Social Resources	Married	88	4,10	0,71	0,08			
	Single	316	4,02	0,78	0,04	0,93	402	,351

In Table 4.14, Independent groups t-test is shown to determine whether the sub-dimension scores of the “Psychological Resilience Scale for Adults” significantly differentiate according to the marital status variable. According to the results; it is observed that only self-perception and social competence dimension scores differ significantly in favor of married students ($p < .05$). The results reveal that the mean scores of other sub-dimensions did not differ significantly according to the gender variable ($p > .05$).

4.9. Findings regarding the question; “Is there a significant difference between the scores of the *Psychological Resilience for Adults Scale* of young adults’ according to the income level?”

Table 4.15

“One-way MANOVA” results of the “*Psychological Resilience for Adults Scale*” differ in regards to the income level variable of young adults.

		Value	F	Hipotesis s SD	Error SD	p	η^2
Income	Pillai's						
	Trace	0,035	1,202	12	802	0,277	0,018

MANOVA was conducted to determine whether the mean scores of the “*Psychological Resilience Scale for Adults*” differ significantly according to the income level. As one of the MANOVA assumptions, Box's M test for covariance equality was evaluated and it was determined that the variance and covariance equality was not provided ($F = 1.66$; $p < .05$). In this direction, the preferred Pillai's Trace value was used because it is more resistant to the assumptions not fully met and is more resistant when there are unequal groups. According to the MANOVA results in Table 4.15, it is observed that the perceived income levels of students does not make a statistically significant difference in psychological resilience sub-dimension scores (Pillai's Trace = .035; $F(2,405) = 1.20$; $p > .05$).

4.10. Findings regarding the question: “Is there a significant difference between the scores of the “Psychological Resilience Scale for Adults” of young adults in regards to their smoking status?”

Table 4.16.

“Independent groups t-test” of the “Psychological Resilience Scale for Adults” in regards to the smoking status variable.

Psychological Resilience	Smoking Status	n	$\bar{x}$	Se_x	ss	t test		
						t	sd	p
Structured style	Yes	114	3,53	0,84	0,08	-1,46	406	,144
	No	294	3,66	0,83	0,05			
Perception of future	Yes	114	3,76	0,92	0,09	-0,13	406	,895
	No	294	3,77	0,89	0,05			
Family cohesion	Yes	114	3,74	0,90	0,08	0,23	406	,819
	No	294	3,72	0,87	0,05			
Perception of self	Yes	114	3,77	0,83	0,08	-0,08	406	,940
	No	294	3,77	0,74	0,04			
Social competence	Yes	114	3,86	0,77	0,07	1,31	406	,191
	No	294	3,74	0,79	0,05			
Social Resources	Yes	114	4,01	0,75	0,07	-0,47	406	,637
	No	294	4,05	0,77	0,05			

As can be observed in Table 4.16, the mean scores obtained from the scale according to the results of the Independent groups t-test to determine whether the sub-dimension mean scores of the “Psychological Resilience Scale for Adults” differ significantly according to the smoking status variable revealed that it does not represent a statistically significant difference ($p > .05$).

4.11. Findings regarding the question; “Is there a significant difference between Psychological Resilience for Adults Scale scores of young adults according to the alcohol use status variable?”

Table 4.17

“Independent groups t-test” of the “Psychological Resilience Scale for Adults” in regards to the alcohol use status variable.

Psychological Resilience	Alcohol	N	$\bar{x}$	Se_x	ss	t test		
						t	sd	p
Structured style	Yes	112	3,51	0,89	0,08	-1,73	406	,085
	No	296	3,67	0,81	0,05			
Perception of self	Yes	112	3,81	0,89	0,08	0,52	406	,600
	No	296	3,76	0,90	0,05			
Family cohesion	Yes	112	3,70	0,84	0,08	-0,36	406	,723
	No	296	3,74	0,89	0,05			
Perception of future	Yes	112	3,75	0,81	0,08	-0,39	406	,694
	No	296	3,78	0,75	0,04			
Social competence	Yes	112	3,87	0,75	0,07	1,53	406	,126
	No	296	3,74	0,80	0,05			
Social Resources	Yes	112	4,11	0,68	0,06			
	No	296	4,01	0,80	0,05	1,14	406	,256

As can be observed in Table 4.17; according to the results of the “Independent groups t-test” conducted to determine whether the sub-dimension mean scores of the “Psychological Resilience Scale for Adults” differ significantly with respect to the alcohol use status variable, the mean scores obtained from the scale do not show a statistically significant difference according to the alcohol use status ($p > .05$).

4.12. Findings regarding the question; "Is there a significant difference between the young adults' scores of *Adult Psychological Resilience for Adults Scale* according to the presence of a physical illness"?

Table 4.18

"Mann Whitney-U Test" of the "*Psychological Resilience for Adults Scale*" of young adults in regards to the physical illness variable.

Score	<i>Physical illness</i>	n	X _{order}	Σ _{order}	U	z	p
Structured style	Yes	12	164,42	2137,5	2046,5	-1,251	0,211
	No	396	205,82	81298,5			
Perception of future	Yes	12	223,23	2902	2324,0	-0,585	0,559
	No	396	203,88	80534			
Family cohesion	Yes	12	155,58	2022,5	1931,5	-1,523	0,128
	No	396	206,11	81413,5			
Perception of self	Yes	12	187,92	2443	2352,0	-0,516	0,606
	No	396	205,05	80993			
Social competence	Yes	12	197,46	2567	2476,0	-0,219	0,827
	No	396	204,73	80869			
Social Resources	Yes	12	192,27	2499,5	2476,0	-0,381	0,703
	No	396	204,9	80936,5			

As observed in Table 4.18, as a result of the Mann Whitney-U test performed to determine whether the scores of the "*Psychological Resilience Scale for Adults*" differ significantly according to the physical illness variable, the scores obtained from the scale were statistically it does not differ significantly in terms of ($p > .05$).

4.13. Findings regarding the question; “Is there a significant difference between the “Subjective Well-Being Scale” scores of young adults in regards to gender variable?”

Table 4.19

“Independent groups t test” of the “Subjective Well-being Scale” scores of young adults in regards to the gender variable

Score	Gender	n	$\bar{x}$	Se_x	Ss	t test		
						t	sd	p
Subjective Well-being	Female	317	181,21	23,80	1,34	1,18	372	,238
	Male	57	177,21	23,05	3,03			

As can be observed in Table 4.19; according to the findings of the Independent groups t-test conducted to determine whether the Subjective Well-Being Scale scores differ significantly according to the gender variable, the scale scores do not differ significantly according to the gender variable ($t = 1.18$; $p > .05$). That is, the subjective well-being of male and female participants are similar.

4.14. Findings regarding the question; “Is there a significant difference between young adults' Subjective Well-being Scale scores according to marital status?”

Table 4.20

“Independent groups t test” of the “Subjective Well-Being Scale” scores of young adults in regards to the marital status variable.

Score	Marital Status	n	$\bar{x}$	Se_x	ss	t test		
						T	sd	p
Subjective Well-being	Married	88	185,06	21,50	2,28	2,25	402	,025
	Single	316	178,62	24,41	1,38			

As can be observed in Table 4.20, according to the results of the Independent groups t test, which was conducted to determine whether the scores of the “Subjective Well-Being Scale” differ significantly according to the marital status variable, it is observed that the scale scores differ significantly in favor of married students ($t =$

2.25; $p < .05$). That is, the subjective well-being averages of married individuals are significantly higher than those of single ones.

4.15. Findings regarding the question; “Is there a significant difference between the Subjective Well-being Scale scores of young adults according to income level”

Table 4.21

“One-way analysis of variance (ANOVA)” results of the “Subjective Well-Being Scale” scores of young adults differ according to the income level variable.

Score	Group	n	$\bar{X}$	Ss	Var.K	KT	Sd	KO	F	p
Subjective Well-Being	Good	15	185,99	22,53	Between groups	11828,7	2	5914,33	10,83	,00
	Middle	21	177,75	23,56	In-group	221254,2	405	546,31		
	Low	34	167,76	25,92	Total	233082,8	407			
	Total	40	180,09	23,93						

As can be observed in Table 4.21, as a result of the “One-way Analysis of Variance (ANOVA)” performed to determine whether the Subjective Well-Being Scale scores differ significantly according to the perceived income level variable, the group averages were found to be statistically significant compared to the income level variable. A significant difference has been identified ($F = 10.83$; $p < .05$). “Complementary post-hoc analysis techniques” were used to determine between which groups this significant difference in scores obtained from the scale differed.

In order to decide which “post-hoc multiple comparison technique” to be used following “ANOVA”, initially the hypothesis of whether the variances of the group distributions are homogeneous or not, was tested with the “Levene’s test”. As a result of this test, it was observed that group variances were homogeneous (Levene = .96; $p > .05$). Therefore, Scheffe multiple comparison technique used in cases where variances are homogeneous. Complementary analysis results are given in the table below.

Table 4.22

Complementary analysis results after “One-way Analysis of Variance (ANOVA)” aimed to examine among which sub-dimensions of the Subjective Well-Being Scale scores differ according to the perceived income level variable

Score	(I) income	(J) income	$\bar{X}_i - \bar{X}_j$	Se _x	p
Subjective Well-Being	good	Middle	8,25	2,45	0,004
		Low	18,23	4,42	0,000
	middle	Good	-8,25	2,45	0,004
		Low	9,98	4,31	0,070

According to the complementary analysis results as observed in Table 4.22; The scores obtained from the Subjective Well-Being scale show a statistically significant difference between the group with a high income level and the group with a medium income level in favor of the group with a high income level. There is also a statistically significant difference between the high-income group and the low-income group in favor of the high-income group ($p < .05$). There was no significant difference among other groups ($p > .05$). According to another statement, the subjective well-being level of those who perceive the income group as good is higher than those who perceive the income group as medium and low.

4.16. Findings regarding the question; “Is there a significant difference between the Subjective Well-being Scale scores of young adults according to smoking status?”

Table 4.23

“Independent groups t test” of the Subjective Well-being Scale scores of young adults differ according to the smoking status variable.

Score	Smoking Status	N	$\bar{x}$	Se_x	ss	t test		
						t	Sd	P
Subjective Well-being	Yes	114	179,43	26,13	2,44	-,345	406	,730
	No	294	180,34	23,05	1,35			

As can be observed in Table 4.23; according to the “Independent groups t-test’s” results aimed to examine whether the Subjective Well-being Scale scores differ significantly according to the smoking status variable, the scores obtained from the scale do not show a statistically significant difference according to smoking status ($t = -, 345$; $p > .05$).

4.17. Findings regarding the question; “Is there a significant difference between the Subjective Well-Being Scale scores of young adults according to alcohol use status?”

Table 4.24

“Independent groups t-test” of the “Subjective Well-being Scale” scores of young adults in regards to the alcohol use variable.

Score	Alcohol	n	$\bar{x}$	Se_x	ss	t test		
						t	sd	p
Subjective Well-being	Yes	112	179,11	24,54	2,32	-,509	406	,611
	No	296	180,46	23,73	1,38			

As can be observed in Table 4.24, according to the results of the Independent groups t-test performed to determine whether the scores of the Subjective Well-Being Scale differ significantly according to the alcohol use status variable, the scores

obtained from the scale do not show a statistically significant difference according to alcohol use status ($t = -, 509$; $p > .05$).

4.18. Findings regarding the question; “Is there a significant difference between the Subjective Well-Being Scale scores of young adults according to the presence of a physical illness?”

Table 4.25

“Mann Whitney-U Test” of the “Subjective Well-Being Scale” scores of young adults in regards to the physical illness variable.

Score	Physical	N	Xorder	Σorder	U	z	p
	illness						
Subjective Well	Yes	12	203,27	2642,5	2551,5	-,038	,969
Being	No	396	204,54	80793,5			

As observed in Table 4.25, as a result of the Mann Whitney-U test performed to determine whether the scores of the “Subjective Well-Being Scale” differ significantly according to the physical illness variable, the scores obtained from the scale are statistically significant according to the presence of physical illness variable. ($z = - .038$; $p > .05$).

4.19. Findings regarding the question; “Is there a relationship between childhood trauma levels, psychological resilience levels and subjective well-being levels of young adults?”

Table 4.26

Correlation Analysis (Pearson & Spearman rank) results run to determine the relationship between variables

	Subjective Well Being	Structured Style	Perception of future	Family cohesion	Perception of self	Social competence	Social resources
Emotional							
Abuse	-,334**	-,163**	-,228**	-,408**	-,237**	-,128**	-,300**
Physical Abuse^a	-,166**	-,104*	-,173**	-,210**	-,126*	-0,071	-,210**
Physical Neglect	-,300**	-,139**	-,196**	-,335**	-,150**	-,185**	-,292**
Emotional							
Neglect	-,501**	-,158**	-,265**	-,573**	-,255**	-,199**	-,388**
Sexual Abuse^a	-,166**	-,104*	-,173**	-,210**	-,126*	-0,071	-,210**
Total Trauma	-,488**	-,208**	-,308**	-,559**	-,283**	-,221**	-,411**
Subjective Well Being	1	,362**	,585**	,461**	,631**	,451**	,465**

^aSince the normal distribution assumption is not provided in the relevant subscales; Correlation coefficients of Spearman Rank Analysis result are given. *p<.05; **p<.01

As observed in Table 4.26, “Pearson and Spearman Rank correlation analysis” were conducted to determine the relationship between variables. Between the Subjective Well-Being Scale and “sub-dimensions of Childhood Trauma Questionnaire” “emotional abuse” dimension ($r = -, 33$), “physical abuse” ($r = -, 17$), “physical neglect” ($r = -, 30$), “emotional neglect” ($r = -, 50$), “sexual abuse” ($r = -, 17$) and “total trauma” score ($r = -, 49$) a significant negative correlation has been identified ($p < .05$).

Between “Subjective Well-Being Scale” scores and the sub-dimensions of “Psychological Resilience for Adults Scale” as “structured style” ($r = -, 36$), “perception of future” ($r =, 59$), “family cohesion” ($r =, 46$), “perception of self” ($r =, 63$), “social competence” ($r =, 45$) and “social resources dimension” ($r =, 47$) have a

significant positive relationship ($p < .05$). On the other hand, no significant relationship was found between “social competence” which is “sub-dimensions of Psychological Resilience Scale for Adults” and “physical abuse and sexual abuse which are sub-dimensions” of “Childhood Trauma Questionnaire” ($p > .05$)

Between the total trauma score of the “Childhood Trauma Questionnaire” and “perception of future” ($r = -.31$), “family cohesion” ($r = -.56$) and “social resources” ($r = -.41$) which are the sub-dimensions of the “Psychological Resilience Scale for Adults”, a statistically significant negative correlation ($p < .05$) was found. A negative significant relationship between “family cohesion”, sub-dimension of resilience and “emotional abuse” ($r = -.41$), “physical neglect” ($r = -.34$), “emotional neglect” ($r = -.57$) has been detected ($p < .05$).

4.20. Findings regarding the question; “To what extent do childhood trauma and resilience, subjective well-being predict among young adults?”

Table 4.27

“Stepwise Regression Analysis” to identify the predictive levels of Childhood Trauma Questionnaire scores and Psychological Resilience for Adults Scale scores on Subjective Well-being Scale scores

Model	Variables	B	Se _B	β	T	P	ΔR^2	Binary r	Partial r
1	(Constant)	105,04	4,66		22,52	,000	,398		
	Perception of self	19,88	1,21	0,63	16,40	,000		0,63	0,63
2	(Constant)	156,26	7,00		22,33	,000	,104		
	Perception of self	16,88	1,15	0,54	14,67	,000		0,63	0,59
	Trauma total	-1,23	0,13	-0,34	-9,21	,000		-0,49	-0,42
3	(Constant)	148,18	7,07		20,96	,000	,024		
	Perception of self	12,38	1,51	0,39	8,23	,000		0,63	0,38
	Trauma total	-1,13	0,13	-0,31	-8,57	,000		-0,49	-0,39
	Future perception	5,81	1,29	0,22	4,50	,000		0,59	0,22

$R^2 = .526$ $R = .73$ $F_{(3,404)} = 149,61$ $p < .001$

As observed in Table 4.27, the stepwise regression analysis which was conducted to predict subjective well-being; was completed in three stages. In the first step, the perception of self variable, which is one of the “*Psychological Resilience Scale for Adults*” sub-dimension and which explains the maximum variance with 39.8% in the subjective well-being variable, was involved into the analysis. In the second stage, the trauma total variable was involved into the analysis and increased the explained variance to 50.2% by providing an increase of 10.4%. Finally, in the third stage, the future perception variable, as the Psychological Resilience Scale for Adults sub-dimension was involved and increased the explained variance to 52.6% by providing a 2.4% increase in the variance explained in the "subjective well-being" variable.

Accordingly, stepwise regression analysis was completed within three stages and in the final model, resilience scale sub-dimensions; “*perception of self*” and “*perception of future*”, and childhood “*total trauma*” were included in the model as “*significant predictors of subjective well-being*”. It is observed that these three variables explain 52.3% of the “*total variance in subjective well-being scores*” ($R^2 = .526$, $R = .728$, $F(3, 404) = 149.61$, $p < .001$).

It was determined that structured style, family cohesion, “*social competence*” and “*social resources*” sub-dimensions of the “*Psychological Resilience Scale for Adults*” were *not* found to be significant predictors of subjective well-being scores.

5. CONCLUSION, DISCUSSION AND SUGGESTIONS

In this part of the research, initially the findings will be summarized. Subsequently, the findings obtained in the previous section, will be discussed in the light of the findings in the literature. Finally, recommendations for future researchers and practitioners will be specified.

5.1. CONCLUSION

The aim of this study is to examine the relationship between childhood trauma and resilience and subjective well-being of young adults. In order to achieve this objective, first; childhood trauma, subjective well-being and psychological resilience of young adults were examined according to some personal variables (*gender, marital status, income level, smoking status, alcohol use status, physical illness*). Subsequently, the correlations between the continuous variables of the study were determined. Finally, stepwise regression analysis was used testing to what extent the childhood trauma and resilience of the participants predicted their subjective well-beings.

On the basis of all obtained results; it was concluded that male participants compared to female participants were found to be significantly more exposed to trauma. Exposure to trauma did not make a difference according to marital status, but differed according to their income, especially emotional neglect and total trauma were reported to be experienced more in the low-income group. However, it was found that physical abuse and sexual abuse do not differ according to income group. It has been found that childhood trauma does not make a difference regarding the use of smoking and alcohol status. It was also found that those who were exposed to emotional neglect and emotional abuse had more physical illnesses. However, it was concluded

that there was no difference in terms of physical illness between those who were exposed to physical abuse, neglect and sexual abuse and those who did not.

When the subjective well-beings of young adults are examined, it is observed that subjective well-beings of males and females do not differentiate according to gender, although marital status makes a difference on subjective well-being; it was concluded that married people have higher subjective well-beings compared to single young adults. It was found that the subjective well-being of young adults who perceived their income status as high, differs compared to those who perceived their income level as middle and low, and the subjective well-being of young adults in the high income group was significantly higher. It was concluded that subjective well-being also did not make a difference on smoking status and alcohol using status. Again, it was concluded that subjective well-being did not make a significant difference between those with and without physical illnesses, whereas subjective well-being made a difference in favor of those without psychological illnesses.

When the findings regarding the resilience of the participants are examined; it has been determined that the resilience of females differ from males, and the resilience of female young adults is higher through the support they receive from social resources. It was concluded that marital status makes a difference on resilience and that married young adults have relatively higher resilience. It has been determined that the perceived income level does not make a difference on the resilience of young adults. It was concluded that smoking and alcohol use did not make a difference in the resilience of young adults. It was also found that resilience did not make a significant difference between those with and without physical illnesses.

When the relationship between the variables of the study is examined; a negative and moderate relationship was observed between the Subjective Well-being Scale scores and the “*emotional abuse, physical neglect, emotional neglect*” subdomains scores of “*Childhood Trauma Questionnaire*” and a negative, low level significant relationship was also found with the sexual abuse and physical abuse dimensions. A moderate and strong positive significant correlation was found between the scores of the “*Subjective Well-Being Scale*” and the “*Psychological Resilience for Adults Scale*” subdomains. No significant relationship was detected between the social competence subdomain of the “*Psychological Resilience for Adults Scale*” and the physical abuse and sexual abuse dimensions of the “*Childhood Trauma Questionnaire*”. In addition, a negative, low level but statistically significant relationship was found between psychological resilience dimensions and childhood trauma dimensions.

As a result of the stepwise regression analysis conducted to determine to what extent childhood trauma subdomains and resilience subdomains predict subjective well-being; *total trauma* score as the subdomain of “*Childhood Trauma Questionnaire*” and “*perception of self*” and “*perception of future*” as the subdomains of Psychological Resilience for Adults Scale were included in the model as the significant predictors of the subjective well being. It was found that these three variables explain 52.3% of the subjective well-being scores’ total variance.

5.2. DISCUSSION

In this section, the findings obtained by testing the research questions are discussed respectively as separate discussion items:

5.2.1. Discussion and interpretation of the findings regarding the question; "Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to gender?"

As a result of the study, it was found that there was a differentiation in favor of male students in the "emotional neglect, physical neglect, and total trauma" score sub-dimensions of the "Childhood Trauma Questionnaire" by gender". No difference was found between male and female participants in emotional abuse and sexual abuse sub-dimensions. These findings are similar to many sources in the literature. The World Health Organization in 2013, has conducted research in five different regions of Turkey. 2257 university students participated in this research. 51.2% of these participants were women. This research examines the effects of childhood maltreatment in adulthood. In the study, in line with the data of the present study, the scores of male participants to be exposed to emotional neglect (11.3%) were determined to be higher than the scores of females (6.5%). Similarly, physical neglect scores of males were found to be relatively high compared to female participants. Physical abuse scores of males (26,2%) were found to be higher than females (16,3%). In another research (Odacı & Çelik, 2012) the emotional abuse and neglect scores of male participants have been found to be differentiated, physical abuse scores were relatively higher compared to female participants. In a similar vein, the findings of a comprehensive study conducted in recent years correspond exactly to the present research findings. In the study conducted by Blum, Menmeng, Naranjo-Rivera (2019), the relationship between gender and child maltreatment was examined in 14 low and middle class countries where child maltreatment was experienced. According to the findings obtained; it was concluded that emotional neglect was experienced more frequently (38.4%) than physical neglect (29.2%). Apart from the general understanding in the literature, it has been determined that male are exposed to more abuse and neglect, and accordingly males experience more intense behavioral regulation disorders and aggression problems (Blum et al., 2019). However in Turkey, the figures contradict with the dominant penetration of abuse among males compared to females. In a study conducted by Asuma and Imdat (2018), due to the child monitoring centers in Turkey to which 21.068 cases had been reported, 85% of the victims were identified as girls, 15% were boys.

In our study, the differentiation of “*emotional neglect, physical neglect, and the total trauma*” scores in favor of male young adults can be explained with a cultural approach. In Turkish culture, parents may carry out some deliberate acts of deprivation toward boys with the intention of raising resilient children and stronger male adults for the sake of their survival. This cultural code is unique to collectivist and male-dominated societies and may explain the frequency of childhood neglect in favor of men. In addition, this finding can be accountable with the conventional wisdom that boys are generally more active and mischievous than girls and beating the child which is the most common type of physical abuse is the acceptable way of corporal punishment (Zoroğlu, Tüzün, Şar, Öztürk, Kora, Alyanak, 2001).

5.2.2. Discussion and interpretation of the findings regarding the question; “*Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to marital status?*”

As a result of the analysis, it was found that exposure to childhood trauma did not differ according to marital status. This situation contradicts with the results of the few studies conducted in the literature. In a study (DiLillo & Peugh, 2009) on marital satisfaction and function of couples who were exposed to abuse and neglect during their childhood; study findings suggest that, childhood maltreatment including emotional abuse and neglect in particular for both sexes were found to be the main predictor of marital problems through low trust, increased partner violence. In the same study, it was found that childhood maltreatment has the greatest effect on males. In another study (Nguyen, Karney, Bradbury, 2017) examining the childhood abuse and marital relationships among 414 newly married couples, it was found that people who were abused during childhood years displayed more intense depression and substance addiction symptoms, and especially men experience communication problems more frequently. Moreover, the participants who experienced childhood maltreatment and abuse, despite of being newly married, are found to experience more dissatisfaction with their marriage.

5.2.3. Discussion and interpretation of the findings regarding the question; "Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to income level?"

According to the findings of the study, the total scores of emotional neglect and total trauma sub-dimensions of the Childhood Trauma Questionnaire differs according to the income level. No significant difference was observed in emotional abuse and physical neglect sub-dimensions. In the comparison in which income levels are evaluated as good and low; it has been observed that emotional neglect scores are higher in favor of the group that perceives their income as low. In the comparison in which income levels are evaluated as good and middle level; it has been observed that emotional neglect scores are higher in favor of the group that perceives their income as middle. Again, among young participants those with good and low perceived income level, the trauma total scores obtained was found to be differentiated for the favor of the low income group. In other words, participants with emotional neglect were identified among those in the middle and low income groups. It was found that sexual abuse score, one of the sub-dimensions of the scale, did not differ according to income level. The finding revealing the relationship between income level and history of childhood abuse and neglect is in accordance with the literature. In a study examining the relationship between poverty, economic disadvantage and child maltreatment in Canada (LeFebvre, Fallon, Van Wert, Filipelli, 2017), it was determined that children living in low-income families were twice as likely to be subjected to maltreatment compared to children who were not maltreated. It has also been determined that the most common type of maltreatments applied by families with economic difficulties to their children are all types of neglect, physical neglect in particular. It is thought that the maltreatment is the result of undermining the positive parenting behaviors of a family that has financial deprivation and has difficulties in meeting basic needs and hereby experiences cumulative stress. There are many studies in the literature examining the relationship between child neglect and abuse and low socio-economic status. Pelton (2015) revised his research conducted twenty years back and refound that the relationship between low income and child abuse and neglect continues by reinforcing the severity of the related child maltreatment. In literature, another effect of the relationship of the childhood neglect and abuse with low income status appeared as the maltreatment increases the risk of low socioeconomic well-being in adulthood. In a study conducted

by Zelinski (2009), it was found that people who experienced severe neglect in their childhood were twice as likely to be below the poverty line in adulthood compared to those who did not. In addition, it has been observed how the exposure to abuse and neglect in the low socio-economic income group during childhood increases the risk of repeating maltreatment over generations (Trickett, Aber, Carlson, & Cicchetti, 1991; Paxson & Waldfogel, 2002; cited in Zelinski, 2009). The finding in regards to the repetition of maltreatment seems to be important for the current study since the study group of this research are young adults whose life plans include marriage and becoming parents of their future generations.

5.2.4. Discussion and interpretation of the findings regarding the question; *"Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to their smoking status?"*

As a result of the analysis, it was found that exposure to childhood trauma does not make a difference according to smoking or non-smoking status. Contrary to the findings of this research, in many studies conducted in the field, the smoking habit in adulthood was found to be significantly correlated with being exposed to trauma in childhood. Spratt, Back, Yeatts, Simpson, McRae-Clark, Santa Maria, Price, Hartwell, Brady (2009) found smoking behavior at a rate four times higher in people who had experienced childhood abuse than those who did not have any history of abuse or psychopathology in their childhood. Similarly, Nichols and Harlow (2004) found that in their study among women who experienced physical or sexual abuse in their childhood, the tendency to initiate smoking was 40% higher for victims of abuse than those who did not have such experience. In this study, childhood abuse was determined as the strongest predictor of smoking addiction and triggering effect to start smoking. King, Guilbert, Ward, Arwidson, Noubary (2006) conducted their studies on 12,256 people and found that abuse and neglect in childhood was one of the factors that brought the age of starting smoking under the age of eighteen. In this study, they also found that those without a history of childhood abuse and neglect tend to quit smoking 1.8 times more easily than those who have experienced abuse and started smoking after this experience.

5.2.5. Discussion and interpretation of the findings regarding the question; "Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to alcohol use status?"

According to the findings of the study, it was found that exposure to trauma in childhood does not make a difference on alcohol use status. Contrary to these findings, many studies in the field mention both the effect of trauma in early adulthood and the effect of accelerating the process leading to alcohol addiction from the first period of alcohol use (Oberleitner, Smith, Weinberger, Mazure, McKee, 2015) . Similar findings appeared in the study of Caetano, Field and Nelson (2003). In the study, findings were found about the effects of childhood physical abuse and domestic violence experiences on the development of alcohol-related problems in adulthood. Experiencing or witnessing domestic violence is considered as one of the main predictors in the development of alcohol-related problems in adulthood.

In the current study, the source of the young adults' tendencies toward alcohol to get distanced might be due to the fact that the sample group is included in a cultural structure in which alcohol is generally perceived as a means of addiction, unlike social drinking, and also prohibited by the religious belief that the sample group thought to be involved.

5.2.6. Discussion and interpretation of the findings regarding the question; "Is there a significant difference between the Childhood Trauma Questionnaire scores of young adults according to the presence of a physical illness?"

According to the findings of the research, emotional abuse, emotional neglect and total trauma score, which are sub-dimensions of the Childhood Trauma Questionnaire, differ according to whether young adults have a physical illness. It was determined that "emotional abuse, emotional neglect and total trauma" scores of the young adults differed in favor of those with physical illness. The sexual abuse, physical neglect sub-dimensions of the scale do not differ according to whether young adults have a physical illness. The most common physical illnesses found in the study are scoliosis, neck and herniated disk, fibromyalgia, and irritable bowel syndrome. These diseases are consistent with the literature. In a research conducted on fibromyalgia patients (Weissbecker, Floyd, Dedert, Salmon, Sephton, 2005), it is thought that neuroendocrine impairments observed in participants who were

physically and sexually abused in childhood are due to the increase in cortisol emerged after severe exposure to trauma. Similarly, there are many studies that have determined the pathophysiological relationship of childhood abuse history, sexual abuse in particular with the “*irritable bowel syndrome*” (IBS) which is considered to be the most common gastrointestinal disease in the United States, (Chitkara, Van Tilburg, Blois-Martin, Whitehead, 2008). Studies reveals the relationship between IBS and childhood sexual abuse (Walker et al., 1993; Heitkemper et al., 2001; Bradford et al., 2012) and emotional abuse (Tietjen et al., 2010; cited in Sansone, & Sansone, 2015).

In some studies, the relationship between childhood trauma and a specific physical illness has been sought. For example, Lee, Martin, Tu, Palmer, & Jeste (2018) reported that trauma is associated with poor physical well-being, high insulin values, and insulin resistance. Logan-Greene, Green, Nurius, Longhi (2014) have found significant positive relation between the trauma and physical health problems such as getting sick quickly, prolonged illness, chronic diseases, Negriff, Schneiderman, Trickett (2015) and Anderson (2017) with risky and unhealthy sex life, Davis, Dearing, Usher, Trifiletti, Zaichenko, Ollen, Brinkoetter, Crowell-Dooma, Joung, Parkc, Mantzoros, Crowell (2014) with obesity and eating disorders. Again, Greger, Myhre, Lydersen, and Jozefiak (2016) found that physical well-being and emotional well-being were lower in people who were exposed to childhood trauma than those who did not. In a study conducted by McLaughlin, Misra, Koenen (2017) examining cardiovascular findings, the symptoms of infarction, stroke, coronary heart failure, diabetes and hypertension were found in individuals who were exposed to childhood maltreatment. The long-term effects of abuse and neglect, which are experienced in childhood and considered to be the most destructive environmental pathogen to which the child is exposed, may appear as physical diseases in adulthood. These effects can cause chronic problems in adulthood and negatively affect the general well-being of the person (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, 1998)

5.2.7. Discussion and interpretation of the findings regarding the question; *"Is there a significant difference between the scores of the Psychological Resilience Scale for Adults of young adults by gender?"*

As a result of the study, it was found that there was no significant difference between male and female young adults in the "structured style, perception of future, family cohesion, perception of self and social competence" as "sub-dimensions of the Psychological Resilience Scale for Adults" by gender, while a significant difference was found in favor of women in the social resources sub-dimension. Mother, father, family, spouse, loving partner, friends, teachers, relatives and neighbors who play an active role in the life of the individual constitute the social support resources of the individual. These resources provide mental, emotional and financial support system to the individual and are important roots for mental health (Sheikh, Abelsen & Olsen, 2016; Terzi, 2016). It is known that experiences with friends create an environmental shield consisting of protective factors, especially in cases where relationships with family are severely damaged (Harms, Pooley, Cohen, 2017). As a result of this analysis, it can be thought that the reason why the resilience of female young adults was found to be significantly different compared to men may be due to their support gained from social resources such as friends, relatives and the community as a whole.

5.2.8. Discussion and interpretation of the findings regarding the question; *"Is there a significant difference between the Psychological Resilience for Adults Scale scores of young adults according to marital status?"*

As a result of the research, no significant difference was found in other sub-dimensions of the "Psychological Resilience Scale for Adults" but it was revealed that "perception of self" and "social competence" made a difference in favor of married young adults. The difference obtained in resilience levels of married young adults compared to single young adults is in accordance with the literature. Beside, in literature, as it is appeared on this study, the emphasis on perception of self, is a common variable to study on while examining the relationship between marriage and resilience . At the cognitive level; resilient people acquire a *"strong sense of self"* and their beliefs on their ability to overcome the obstacles are high (Rutter, 1985). At the relational level; resilient people have a superior ability to recognize and express their own emotions and to make sense of others' feelings (Greef & Ritman, 2005). This empathic acquisition can serve to the resilience person in creating social support and

achieving satisfaction in relationships (Skodol, 2010). As a result, social competence possessed is an important predictor of both “*resilience*” (Eschleman, Bowling, & Alarcon, 2010) and “*satisfying romantic relationships*” (Brunstein, Dangelmayer, & Schultheiss, 1996), as mentioned in many studies.

5.2.9. Discussion and interpretation of the findings regarding the question; “*Is there a significant difference between the Psychological Resilience for Adults Scale scores of young adults according to income level?*”

According to the findings of the research; it has been determined that the perceived income levels of young adults do not make any difference in psychological resilience sub-dimensions. Although there is not much research between resilience and income level in the literature, contrary to the findings of this research, there are some approaches and few findings indicating the significant nature of the relationship between socio-economic status (SES) and resilience. The ‘Family Stress Model’ (FSM) is considered as an important theory in explaining the role of the socio-economic level for the social, emotional, cognitive and physical functioning of the child as well as the adult. According to this theory, it is asserted the economic difficulties faced by the family will likely to influence the feelings, behaviors and relationships of the family in a negative way, the parents' attitudes in an adverse way and will likely to reduce the resilience of the youth by damaging their development (Conger & Donnellan, 2007). Again, in a study in which Ağırkan (2017) examined psychological resilience of university students according to their socio-economic levels, it was determined that as the income level increased, psychological resilience levels of individuals also increased.

5.2.10. Discussion and interpretation of the findings regarding the question; “*Is there a significant difference between the scores of the Psychological Resilience for Adults Scale for young adults according to their smoking status?*”

According to the results of the research; the scores obtained from the Psychological Resilience for Adults Scale do not differ according to the smoking status of the young adults. This result does not coincide with the limited literature about the relationship between resilience and smoking. In literature, the low levels of resilience resulted from the negative life events and environmental risk factors experienced in the past are expected to lead the individual to tobacco addiction and to

many other substances (Booker, Gallaher, Unger, Ritt-Olson, & Johnson, 2004; Gordon Rouse, Ingersoll, & Orr, 1998). Similarly, a study investigating resilience and cigarette consumption (Arpawong, Sun, Chen Chang, Gallaher, Pang, Guo, Johnson, Unger, 2010) revealed a significant relationship between early adverse experiences and excessive cigarette consumption. The study revealed the significant relationship between cigarette consumption and family ties, family cohesion, and family supervision as the protective factors of resilience.

5.2.11. Discussion and interpretation of the findings regarding the question; *"Is there a significant difference between the scores of the Psychological Resilience for Adults Scale for young adults according to alcohol use?"*

According to the findings of the study, the scores obtained from the Psychological Resilience for Adults Scale do not differ according to the alcohol use of young adults. Contrary to these findings, there are studies in which the inverse relationship between individuals' resilience levels and their alcohol consumption levels were presented. When alcohol consumption and resilience are examined, studies suggest that the high alcohol consumption levels were argued to be resulted from the absence of protective factors of resilience and a strong support system. Wong (2006) stated that children with low resilience start consuming alcohol early, whereas children with high resilience levels will tend to drink less alcohol (cited in Johson, Dinsmore, & Hof, 2011). In a study conducted on 1,653,721 male participants in Sweden which examined the protective effect of resilience against alcohol addiction, it was found that resilience is an important factor in reducing alcohol use disorder (Long, Lonn, Ji, Lichtenstein, Sundquist, Sundquist, & Kendler, 2017). In a study examining the relationship between trauma, especially among those with a history of childhood abuse, resilience and alcohol consumption, findings revealed - after controlling trauma burden and severity, gender and age-, resilience having an influence on reducing alcohol use problems over the lifetime (Wingo , Ressler, Bradley, 2014).

5.2.12. Discussion and interpretation of the findings regarding the question; "Is there a significant difference between the scores of the Psychological Resilience for Adults Scale of young adults according to the presence of a physical illness?"

According to the findings obtained from the study, it was determined that the scores obtained from the Psychological Resilience for Adults Scale did not make any difference depending on whether young adults have a physical illness or not. There are certain studies in positive psychology literature revealing the relationship between positive physical health and resilience. Participants whose sampling was chosen according to the developmental life cycle, was carried out with the participation of 762 people who were exposed to community trauma. After the mental health treatment, the participants were examined in 1, 3, 6 month time periods and the effects of the practices were analyzed. According to the outcomes of the study, the predictive effect of resilience on physical health and a negative relationship between resilience and health was determined. As a result of increasing resilience, decrease in physical health complaints have been reported, thus the importance of resilience in post-traumatic practices has also been identified (Osofsky, Weems, Graham, Osofsky, Hansel, & King, 2018).

5.2.13. Discussion and interpretation of the findings regarding the question; "Is there a significant difference between the Subjective Well-Being Scale scores of young adults according to gender?"

When the findings of the study were analyzed, it was found that subjective well-being did not differ according to gender. The reason for the diversity of research findings on the relationships between subjective well-being and gender might be due to the fact that the components of the concept are used to be measured separately as "positive affect, negative affect and life satisfaction". Similar to the findings of this study, Batz-Barbarich, Tay, Kuykendall, Cheung (2018) found that gender does not make any significant difference for life satisfaction. In some other studies, the findings signified adult females having higher life satisfaction than males. (Blanchflower & Oswald, 2004; Inglehart, 2002; Tay, NG, Kuykendall, & Diener, 2004). In the research conducted by Pinquart and Sörensen (2001), it was concluded that male participants have higher levels of happiness than females (cited in: Batz & Tay, 2018).

5.2.14. Discussion and interpretation of the findings regarding the question; "Is there a significant difference between the Subjective Well-Being Scale scores of young adults according to marital status?"

According to the research findings, it was determined that subjective well-being differs according to marital status. It was determined that the scores obtained from the subjective well-being scale differed in favor of married people. This situation coincides with the literature. There are study findings available identifying the married couples which have higher subjective well-being compared to single or widowed people (Mikucka 2016; Stutzer and Frey 2006; Waite and Gallagher 2000). In another study on the relationship between marriage and life satisfaction (Botha, & Booysen, 2012), it was determined that married couples have higher life satisfaction than all marital status, especially widows. When the literature is examined, some theorists try to interpret the relationship between marriage and subjective well-being with the cause and effect relationship by emphasizing the positive influence of marriage on people's well beings. On the other hand, some researchers argue that this relationship is formed by a selection process and that happy people can maintain a healthy marriage by the virtue of their correct decisions (Wadsworth, 2016). In a study conducted on married couples in four different countries (Perelli-Harris, Hoherz, Lappegard, & Evans, 2019), it was found that marriage did not create a difference on the degree of the subjective well-being levels instead, living together appeared as a sign of economic and emotional burden.

The sample of the present study consists of young adults and one of the developmental tasks of this period is to build intimate relationships (Koç, Avşaroğlu, & Sezer, 2004). To experience satisfying relationships is assumed to be essential for an individual to have a sense of happiness and confidence (Mavruk-Özbiçer & Aıcı, 2018). Marriage satisfy a person's biological, social and psychological needs (Ozguven, 2009 cited in Gülyüksel-Akdağ, Cihangir-Çankaya, 2015), and provides emotional involvement in high levels through intimate relationships and creates opportunities for the individual to have children, to raise them and enable him/her to pursue their generation with a healthy sexual life experience. In this sense, a strong relationship can be formed between marriage and the well-being of individuals (Gove, Briggs-Style, & Hughes, 1990). Especially in young adulthood, the individual finds a meaning in life through marriage and can reduce their vulnerability to psychological

disorders (Kim & McKenry, 2002; cited: Gülyüksel Akdağ, & Cihangir-Çankaya, 2015). In the present study, the significant differentiation of married couples' subjective well beings compared to single participants may be due to those facts.

5.2.15. Discussion and interpretation of the findings regarding the question; "Is there a significant difference between the Subjective Well-Being Scale scores of young adults according to income level?"

According to the findings of the study, subjective well-being scores of the participants differ according to their income level. The subjective well-being of the young adults who evaluated their income as good was found to be higher than those who evaluated their income as middle and low. Similarly, while high income was found to be related with subjective well-being in many studies (Diener, Biswas-Diener, 2002; Pinquart and Sörensen, 2000; Veenhoven, 1991), income level was not found to be associated with subjective well-being in some studies (Diener, Sandvik, Seidlitz, Diener, 1992). According to Diener's argument; individuals' income levels can only make a difference on people's subjective well-being levels when people's can not able to afford their basic needs through the income they receive (Diener, & Biswas-Diener, 2002).

5.2.16. Discussion and interpretation of the findings regarding the question; "Is there a significant difference between the Subjective Well-Being Scale scores of young adults according to smoking status?"

According to the research findings, the scores obtained from the subjective well-being scale do not show any difference according to the smoking status of young adults. There are studies in the literature in which a significant relationship between smoking and subjective well-being are presented. In the study conducted by Öztürk and Çetinkaya (2015) among university students, the life satisfactions of non smokers were found to be significantly higher than the life satisfaction scores of the smokers. Moreover, this difference appeared between the students who consumed daily more than one packet of cigarettes and the students who never smoked. İlhan (2009) found in his study that subjective well-being was negatively and significantly correlated with smoking frequency. In another study (Atak, 2011), an inverse and moderate relationship was found between smoking and both life satisfaction and subjective well-being. In another study examining the relationship between life satisfaction and quality life indicators, a significant inverse relationship was found between life

satisfaction levels and smoking and alcohol consumption (Strine, Chapman, Balluz, Moriarty, Mokdad, 2007). In another study conducted among university students, the relationship between intense smoking rates and low psychological well-being levels were found (Patterson, Lerman, Kaufmann, Neuner, Audrian-McGivern, 2004).

5.2.17. Discussion and interpretation of the findings regarding the question; *"Is there a significant difference between young adults' Subjective Well-being Scale scores according to alcohol use?"*

According to the research findings, the scores obtained from the subjective well-being scale do not differ according to the alcohol use status of young adults. When the literature is examined, heavy alcohol use has been associated with negative physical and mental health. On the other hand, it is known that moderate alcohol consumption may create some benefits such as low anxiety and depression levels and high psychological well-being (Baum-Baicker, 1985). In a study examining the relationship among subjective well-being, past adverse experiences, and alcohol consumption (Mason & Spoth, 2011), the findings suggested that subjective well-being -when adverse experiences and previous habits about the alcohol consumption were controlled- positively predicted alcohol consumption. On the other hand, some other studies prove the subjective well-being as negatively correlated to the alcohol consumption (Zullig et al., 2001) or having no relationship at all (Bogart et al., 2006; cited in Mason & Spoth, 2011).

5.2.18. Discussion and interpretation of the findings regarding the question; *"Is there a significant difference between the Subjective Well-being scores of young adults according to the presence of a physical illness?"*

No statistically significant differentiation was observed in the subjective well-being scale scores of the young adults according to the physical illness variable. As a concept of positive psychology, high subjective well-being is associated with life satisfaction, absence of negative emotions, presence of optimism and positive emotions due to its semantic nature (Diener & Chan, 2011). In literature how happiness predicts individual health, takes place in two ways; chronic unhappiness has negative effects such as low immunity and high blood pressure. On the other hand, the key to a healthy life of happy people is to take care of their body, increase their resilience and make the right choices (Veenhoven, 2007). According to a study results conducted on 155 adults followed by a three-month experimental practice of

positive psychology , the findings reveal the participants having reported less sick days after the exposure to the practice. Based on the study results as subjective well-being increase, the moments of feeling healthy increases (Kushlev, Heintzelman, Lutes, Wirtz, Kanipoyoor, Leitner, Diener, 2020). In another meta-analysis (Chida, Steptoe, 2008) conducted on positive well-being and mortality rates, the relationship between positive psychological well-being and low mortality rates were determined for both healthy and unhealthy groups.

5.2.19. Discussion and interpretation of the findings regarding the research questions to reveal the relationship among the research variables;

As a result of the correlation analysis aiming to identify the relationship among variables; a moderate level of negative correlation was found between the subjective well-being and “emotional abuse, physical neglect, emotional neglect” as “sub-dimensions of the Childhood Trauma Questionnaire”, and a low level of negative correlation between “physical and sexual abuse”. Medium and low-level negative significant relationships were determined between “the sub-dimensions of the Psychological Resilience for Adults Scale” and the “emotional, physical and sexual abuse and emotional and physical neglect” sub-dimensions of the “Childhood Trauma Questionnaire”. No significant relationship was found only between physical and sexual abuse sub-dimensions of Childhood Trauma Questionnaire and social competence sub-dimension of Psychological Resilience for Adults Scale. A moderately positive significant relationship was found between subjective well-being and sub-dimensions of resilience.

Findings obtained in the current study in regards to the correlation between subjective well-being and childhood trauma sub-dimensions, are similar to those which assess the same relation of variables in the field. There are several academic studies examining the effects of childhood maltreatment on both the subjective well-beings and the components of subjective well beings as “*positive affect, negative affect and life satisfaction*” during adulthood, and the relationship among these variables mentioned (Beck, Reich, Woodward, Olsen, Jones and Patton, 2015; Hughes, Lowey, Quigg, Bellis, 2016; Nagaraj & Vyas, McDonnell, 2018; Oshio, Umeda, & Kawakami, 2012). In addition, some studies examine the relationship between the subjective well being with one type of childhood trauma. For instance, a

significant negative relationship was found between physical and sexual abuse and happiness (Lambert, Fleming, Ameratunga, Robinson, 2014), emotional abuse and subjective well-being (Oshio et al., 2012; Ruiz-Casares, Lacharite, Martin, 2019), intense sexual abuse and subjective well-being (Barnum & Perrone-McGovern, 2017; Sheikh, Abelsen & Olsen, 2016). According to the results of a study conducted by Etter, Gauthier, McDade-Montez, Cloitre, Carlson (2013), an inverse relationship was identified between with their positive affects and their current psychopathological symptoms of individuals who were physically and sexually abused in the early developmental period of childhood. Contrary to these findings, no significant correlation was found in our study between physical and sexual abuse and subjective well-being of young adults. This finding may have resulted from the fact that; among those who have stated of being exposed to the physical and sexual abuse, have been statistically excluded from the obtained data due to the extreme values.

The relationship between trauma and resilience has been discussed in studies examining the indicators of resilience respectively. In this context, the developmental tasks of young adults who are the sample of the present study as well, can be listed as choosing a spouse, starting a family, becoming a parent, getting a job and realizing a career plan, and performing social integration (Aydın, 2015). When these developmental tasks are considered, it is expected young adults to hold a high future perception, a desirable family cohesion and developed social resources. However, the inverse relationship of childhood trauma exposure with future perception, family cohesion, and social competence in the current study demonstrates the fact that those who are exposed to trauma will likely to have low resilience.

The findings in the present study are in accordance with the literature and some other research findings. Trauma experience plays an active role in shaping individuals' thoughts about their future. *Future perception* component in the current analysis as one of the sub-dimensions of the “*Psychological Resilience for Adults Scale*”, reflects the individual's attitude and perspective towards their future (Basım & Çetin, 2011). Ratcliffe, Ruddell, Smith (2014) emphasize that ‘*a sense of foreshortened future*’ which refers to a perceptual tendency of a future with negative expectations, gradually develops in parallel with the loss of trust and belief in people exposed to trauma. Studies have demonstrated the relationship between childhood

trauma and low “*optimism*” (Broekhof, Rius-Ottenheim, Spinhoven, van der Mast, Penninx, Zitman, Giltay, 2015; Kessler, McLaughlin, Green, Gruber, 2010). A significant relationship between trauma and low resilience including low optimism was determined, and it was also found to be associated with low psychological well-being in adulthood (Herrenkohl, Herrenkohl, Klika, Herrenkohl, Russo, Dee, 2012). Moreover, among people who exposed to maltreatment during childhood but being self-reliant and having strong family bonds and close relationships with other family members are likely to become more resilient in adulthood (Rogosch, 1997). In a meta-analysis (Domhardt, Münzer, Fegert, & Goldbeck, 2014) on family support and cohesion as one of the protective factors of resilience (Afifi, & MacMillan, 2011); significant relationships were identified between childhood sexual abuse and perceived family support, early relationship experience with the caregiver, relationship with the father in childhood, and satisfying family bonds. In the meta-analysis mentioned, similar to our research findings; low resilience followed by the exposure to trauma, was thought to arise from the absence of protective factors of resilience. Therefore, in studies conducted, findings ascertaining the diminishment of the trauma effect depending on an increase in resilience signifies the negative relationship between resilience and trauma (Holmes, Yoon, Voith, Kobulsky, Steigerwald, 2015; Jaffee, Caspi, Moffitt, Polo-Tomas, Taylor, 2007).

The last two variables whose correlations in between are examined are resilience and subjective well-being among young adults. When the literature is examined about their developmental tasks, it is very crucial for young adults to establish close relationships and to have social support resources (Aydın, 2015; Gürses & Klavuz, 2011). Social support for a person having a history of childhood abuse, manifests itself in the form of parental support during early childhood and friendship support during adult years. It has a significant influence on the child as well as on the adult’s well-being (Perrewé, Carlson, 2002) and mental health (Runtz and Schallow, 1997). In studies, young adults who were subjected to maltreatment in their childhood had been identified as having experienced difficulty in establishing close relationships due to the trauma (Cicchetti, 1996; Finkelhor, 1995), failed to fulfill their developmental tasks (Pepin, Banyard, 2006). However, social support obtained from the circle of friends are found to affect the development of university students in a positive way and increase their level of happiness (Pepin, & Banyard,

2006). People having healthy relationship with a secure attachment base to both family and friends and in return receive social support, are identified as having higher resilience than those who cannot receive this sort of support (Banyard, & Cantor, 2004). In a study conducted by Kaufman, Yang, Douglas-Palumberi, Houshyar, Krystal, Gelernter (2004), the findings deliver that people who were exposed to trauma during childhood but lack of social support will more likely to experience negative emotions and mental problems two times more than people who have not experience any trauma exposure. In the meanwhile, the quality of social support is not one of the basic predictors of resilience but subjective well being. A finding supporting this view is about people having satisfactory relationships are observed to be happier, experience negative emotions less frequently, and have high life satisfaction (Diener & Seligman, 2002). There are some other studies in the literature representing resilience as to mediate the relationship between positive emotions and life satisfaction since the argument suggests how happy people can get more life satisfaction due to their ability to build and use necessary resources (Cohn, Fredrickson, Brown, Mikels, Conway, 2009).

5.2.20. Discussion and interpretation of the findings regarding the question; "To what extent do childhood trauma and resilience predict subjective well-being in young adults?"

According to the analysis findings, the stepwise regression analysis to predict subjective well-being scores was completed in three phases. In the first phase, the perception of self variable, as sub-dimensions of psychological resilience, explaining the highest variance with 39.8% in the subjective well-being variable, was included in the analysis. In other words, 39.8% change in subjective well-being can be explained by "self-perception". In the second phase, childhood trauma variable was included in the analysis and increased the explained variance to 50.2% by providing an increase of 10.4%. Finally, in the third phase, the perception of future variable, as sub-dimension of psychological resilience, was included in the analysis and increased the explained variance to 52.6% by providing a 2.4% increase in the variance explained in the subjective well-being variable. In brief, perception of self and perception of future are the two important predictors of subjective well-being with their positive and enhancing effects and trauma is the third important predictor with its negative and decreasing effect on subjective well-being.

When the effect of *perception of self* as the sub-dimension of resilience on subjective well-being is examined; perception of self which is an critical indicator of resilience, expresses an awareness of one's own existence and all thoughts about who he/she is (Basım & Çetin, 2011). The individual's thoughts about his/her self, how he/she perceives himself; *self-esteem* begins to develop by the bond he establishes with the caregivers in the early developmental years, by the internalization of the relationships with his parents and the messages received from them. Therefore, self esteem has appeared as the most basic indicator of people's life-long relationships by reflecting a dynamic process (Epstein, 1973; Güneri Yönen, 2016; Sullivan, 1953). The significant relationship of the self esteem with happiness and as its role to be one of the predictors of happiness is encountered in literature (Butt, 2009; Cai, Wu, Brown, 2009; Diener & Diener, 1995; Doğan & Eryılmaz, 2013; Furhnam, Cheng, 2000; Oishi, Diener, Lucas, Suh, 1999). In their research on parental care and self-worth, Hopkins and Klein (1993) determined a positive significant relationship between the maternal bond and the self-perception. In addition to the relationships with the family, the social connections and communications of the individual with his surroundings also support to the development of his self-perception. In this respect, people who are accepted, approved and supported by their social environment feel valued, respected, strong and self-sufficient, will likely to have more resilient, successful and increased well beings (Ryff, 1989). The findings of research demonstrate the positive self-perception as an crucial indicator of resilience, helps the individual to cope with stress in a more effective and succesful way and a lead factor to increase resilience (Miller, Zivnуска, Kacmar, 2019). There are studies in which the positive self-perception has been found to be associated with having positive mental health and experiencing more positive affects including happiness in childhood as well as in adulthood (Gülcan & Nedim Bal, 2014; Du, King, Chi, 2017). On the other hand, based on the evident link between perception of self and well being, some negative relationships and adverse experiences may have negative effects on the development of self-perception (Harvey & Dorahy, Vertue, Duthie, 2012; Yates, Carlson, & Egeland, 2008). Accordingly; the damage on the perception of self which has also been relevant to the low self-esteem, low self capacities and low self-perception (Black, Dubowitz, Harrington, 1994; Brock, Pearlman, Varra, 2006; Çelik and Odacı, 2012; Onat, 2016; Slaninova, & Stainerova, 2015; Zepinic, 2016) may lead to experience negative affect more frequently and to harm the subjective well

being of the individual. Considering all these research findings, it can be said that high self-perception is an a vital indicator of subjective well-being.

When the effects of childhood trauma on subjective well-being in adulthood are examined; traumatic experiences of childhood maltreatment do not only lead to the development of dysfunctional schemas (Kaya-Tezel, Tutarel-Kışlak, Boysan, 2015) and negative self-perception during the life course; but it can affect the life satisfaction of the individual through positive and negative affects as the components of subjective well-being. Considering the fact that individuals reach cognitive judgments in regards to their life satisfaction in the consequence of their affects, life satisfaction can only be achieved by experiencing frequent positive affect and low levels of negative affect (Diener, 1984; Schwarz and Clore, 2007). Childhood trauma has been presented in literature as having long-term and detrimental effects on people's affects. Based on this rationale; early traumatic events have been identified as constituting the risk of experiencing high levels of of negative affect and low levels of positive affect in adulthood (Beck, Reich, Woodward, Olsen, Jones, 2015; Xiang, Yuan, Zhao, 2020). In other words the exposure to childhood trauma has been considered as an important predictor of negative affect as one of the components of subjective well-being. The finding of Etter et al. (2013) supports this view of those who have experienced childhood trauma will likely to experience lowered positive affect in adulthood compared to those who do not have such experiences. The psychopathological symptoms of individuals having a childhood history of physical and sexual abuse in particular, have been found to be inversely significant relationship with positive affect (Barnum & Perrone-McGovern, 2017). The explicit aspect of child maltreatment as all kinds of violence committed by the parent may lead the child to experience more behavioral disorders, having more negative emotions, diminished psychological well being, low levels of happiness and life satisfaction in adulthood (Afifi, Enns, Cox, Graaf, Sareen, 2007; Gilbert et al., 2009; Greenfield, Marks, 2010; Manly, Cicchetti, Barnett, 1994).

Perception of future appeared in the regression analysis as having an effect on subjective well being, is one of the sub-dimensions of "*Psychological Resilience for Adults Scale*". The concept represents the individual's attitudes and perceptions toward future. Having a positive future perception is assumed to have a positive and

constructive effect on resilience process (Basım & Çetin, 2011). In general, in the face of adversity, resilience reflects a strong desire for optimism (Rutter, 2006). Namely; optimism accompanies resilience in challenging times (Carver, Scheier, and Segerstrom, 2010). Optimism plays a fundamental role into adapting to the difficult conditions and accordingly resilient people exhibit high optimism under stress, even the process is difficult and slow to perform (Synder and Lopez, 2002). In a study (Panchal, Mukherjee, Kumar, 2016) examining the relationship between stress, resilience, well-being and optimism among university students supports the findings of the current study; optimism has been found to have a significant and positive relationship with well-being and resilience. In literature, *perception of future* in cases where it is considered as a dimension of resilience, manifests itself as the concept of *optimism* and contributes to the physical and psychosocial well-being of the individual (Ferguson & Goodwin, 2010). Accordingly; the effects of a positive future perception are found to be associated with decreased depressive symptoms (Bongiorno, 2017), and stress (Krypel & Henderson-King, 2010) increased self-confidence (Puskar, Bernardo, Ren, Haley, Tark, Switala, Siemon, 2010), successful adaptation to academic life (Molinero, Zayas, Gonzales, Guil, 2018) and positive relationship with well-being (Kleiman, Chiara, Liu, Jager-Hyman, Choi, Alloy, 2015).

As a result, in the current analysis perception of self and perception of future as the major indicators of resilience, have significant effects in explaining subjective well-being. On the other hand, childhood trauma appears to be as a remarkable variable with its lowering effect on subjective well-being. The findings are in accordance with similar research conducted in the field.

5.3. SUGGESTIONS

Initially recommendations for practitioners will be discussed. In the next section, recommendations for further academic studies will be listed

5.3.1. Recommendations for Practitioners

a) As a result of the study, the most common sub-dimensions of childhood trauma were determined as physical and emotional neglect with a high prevalence among low socio-economical status. In practices to prevent the childhood neglect

around the world, the desirable change has no longer been targetted by focusing solely on parents but rather by handling the issue with the basics of the system theory which suggest to carry out the *transformation of the dysfunctional family structure* as a whole and as a unique entity (Gaudin, 1993). Similarly, in our country, intervention programs aimed at changing the settled and dysfunctional family structures can be implemented on risky families through the public institutions;

- Interventions needs to be determined upon the purposes of reorganizing the tasks of family roles, reshaping dysfunctional perceptions of the family, strengthening *intrafamilial communication*, and support system for the parents to undertake strong leadership roles.
- Most particularly, the practices to be designed with a *cultural conformity*, adjusted with cultural codes, child-rearing patterns and familial dynamics would be resulted in receiving desirable outcomes. The practices given need to be planned having regard to the *collectivist nature* of Turkish society, the widespread existence of community pressure while raising children and adolescents especially in low socio-economic segments.
- Social services to be structured providing practices for the protections of children in regions where families with low socio-economic income are concentrated can be designed.
- Services to offer to the children living in socio economically risky regions would be efficient in building a healthy generation. To provide psychological support tools; such as professional health centers with psychological counsellors where access to art and sport activities available for the children and youth would be helpful to enhance their mental healths and well beings.

b) The most frequently encountered method worldwide to obviate the undesirable effects of “*child abuse and neglect*” as a global problem, is *the public awareness effort*. Preventive activities can be carried out by raising awareness on the whole segments of the society, parents in particular. This strategy needs to be planned accommodating correct parental attitudes about child maltreatment since parents may engage in unhealthy family patterns representing abusive and neglectful acts about which they are unaware of. For this purpose;

- Awareness raising activities such as trainings and seminars can be carried out for all undergraduate students. A comprehensive course related to the child development and child mental health as well as child neglect and abuse can be included into the curriculum by Higher Education Institution (YÖK) to be lectured in all the departments of education faculties where future teachers are trained. Thus, when teachers begin their profession in well equipped on identifying special cases of “*child abuse and neglect*”, will likely to perform desirable educational attitudes in practice.
- Guidance and psychological counseling professionals may prepare some training programs in schools to offer to the families rather than one to one contact in regards to the possible and severe consequences of the childhood maltreatment, the critical role of the family in this issue. In order to maintain a long term relationship with the family, to monitor and control the process technological resources can be useful to benefit.
- In addition to those practices, as a public policy, media tools including billboards in open areas can be used to raise awareness in general public to point out the importance of “*child abuse and neglect*” as a public issue. A

similar social campaign has been implemented by the American Pediatric Association (1994), whose main objective was to gain attention of the families regarding the child physical neglect (Child Welfare Information Gateway, 2011).

c) As another study finding; the opposite relationship between childhood trauma with family cohesion and social resources were significant in the current study. In addition to the family awareness raising activities, the most important intermediaries of social resources which are easy to access and control are support received from both school and teachers. In this regard, the guidance and psychological counseling units can identify children who have experienced maltreatment in schools and can work in coordination with the relevant guidance research centers (RAM). School and RAM liason may serve to provide the families appropriate modeling of parenting attitudes via effective *behavioral techniques*.

d) Studies have revealed the relationship between childhood trauma and low optimism in adulthood (Kessler, McLaughlin, Green, Gruber, 2010). Professionals can invent strategies to work on the special topics of positive psychology such as *happiness, life satisfaction, and optimism* for all age groups in the community. In this respect, it can increase the resilience of children in all the developmental stages. Therefore, children can become more resilient and happy in the face of adversity with preventive efforts.

e) The research finding of the current study identified that the perception of self and future predicted subjective well-being. Positive self perception as a concept to be improved (Doğan & Eryılmaz, 2013) and positive psychology as a source to enhance the subjective well-being by revealing the positive characteristics in the

individual, emphasizing on positive aspect of life and nurturing positive for the future (Seligman & Csikszentmihalyi, 2000), both concepts can be modified and learned for everyone. Accordingly, in the education system especially among primary, secondary schools and college students, individual and group counseling programs aimed to heighten their self perceptions can be designed by guidance and psychological counseling units in the institutions. Particularly university students in Educational Faculties as prospective teachers of community, who received those trainings, will likely to spread the effect of positive psychology principles into the more extensive groups.

5.3.2. Recommendations for New Studies and Researchers in the Field:

a) The study group of the present study consists of young adults voluntarily participated to the study. The study groups of future research can be selected from individuals who are exposed to more intense trauma or at risk of experiencing such trauma. Thus, the relationship between participants' traumatic experiences and their subjective well-being levels can be determined in a more distinct way.

b) Research analysis can be designed to compare individuals having healthy psychological functioning and having no abuse history with individuals who have been exposed to severe traumatic experiences such as women who have been subjected to violence and staying women violence shelters, prisoners or people who have received treatments of alcohol substance use.

c) In future analysis, the relationship of subjective well being as the main variable of this current study with trauma can be examined by an experimental design. In other words; study group can be consisted of trauma victims labeled as experimental group to which a positive psychology intervention program can be

applied. The effectiveness of the program on increasing the participants' subjective well beings can be measured through pre-post tests.

d) During the data collection phase of the current study, the researcher has been exposed to similar type of questions from the participants in regard to fill out the 'Psychological Resilience for Adults' Scale. Participants had difficulty in interpreting *the semantic differential* structure of the scale. Accordingly, a more explanatory passage of instruction to be added to the answer sheet of the scale would help to receive more accurate responses.



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APPENDICES

APPENDIX-1: VERİ TOPLAMA SETİ: GÖNÜLLÜLÜK ve KİŞİSEL BİLGİ FORMU

Sayın katılımcı; bu araştırma “Yetişkinlerin Çocukluk Çağı Travmaları ile Dayanıklılık ve Öznel İyi Oluşları Arasındaki İlişkinin İncelenmesi” başlıklı yüksek lisans tez çalışmam için düzenlemiştir. Çalışmanın amacı; genç yetişkinlerin çocukluk travmaları, dayanıklılık ve öznel iyi oluşları arasındaki ilişkiyi incelemektir. Aşağıdaki değerlendirme ile sizin hayat olaylarına karşı tutumlarınızı ölçen bazı sorulara yanıt aranmaktadır. Bu çalışmaya katılım tamamen gönüllüğe dayanmaktadır. Katılımınız halinde, soruları içtenlikle yanıtlamanız bilimin güvenilirliği açısından önem taşımaktadır. Toplanacak bilgiler sadece bilimsel çalışma için kullanılacak, kişisel olarak hiçbir farklı değerlendirmeye alınmayacaktır. Özel olarak sonuçlar hakkında bilgilenmek isterseniz, aşağıda yazdığım e-mail adresimden bana ulaşabilirsiniz. Katkılarınız için şimdiden çok teşekkür ediyorum.

Y.Ü. EBE PDR Programı

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Yaşınız:.....

Cinsiyet: Kadın () Erkek () Diğer ()

Medeni durumunuz: Evli () Bekar ()

Mesleğiniz:

Kardeş sayısı:

**Size göre sosyo-ekonomik durumunuz: Çok iyi () İyi () Orta ()
Kötü ()**

Sigara kullanma durumu: Evet () Hayır ()

Alkol kullanma durumu : Evet () Hayır ()

Keyif verici madde kullanımı: Evet () Hayır ()

Herhangi bir fiziksel hastalığınız var mı?

Evet () Evetse Hayır ()

Herhangi bir ruhsal probleminiz var mı? Evet ()

Evetse..... Hayır ()

Kendinizi iyi hissetmek veya tedavi amaçlı bir ilaç kullanıyor musunuz?

Evet () Hayır ()

APPENDIX-2: Ç. Ç. T. Ö

Bu sorular çocukluğunuzda ve ilk gençliğinizde (20 yaşından önce) başınıza gelmiş olabilecek bazı olaylar hakkındadır. Her bir soru için sizin durumunuza uyan rakamı daire içersine alarak işaretleyiniz. Sorulardan bazıları özel yaşamınızla ilgilidir; lütfen elinizden geldiğince gerçeğe uygun yanıt veriniz. Yanıtlarınız gizli tutulacaktır.

	Çocukluğumda veya ilk gençliğimde.....	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
1.	Evde yeterli yemek olmadığından aç kalırdım	1	2	3	4	5
2.	Benim bakımımı ve güvenliğimi üstlenen birinin olduğunu biliyordum	1	2	3	4	5
3.	Ailemdelikler bana “salak”, “beceriksiz” ya da “tipsiz” gibi sıfatlarla seslenirlerdi	1	2	3	4	5
4.	Anne ve babam ailelerine bakamayacak kadar sıklıkla sarhoş olur ya da uyuşturucu alırlardı	1	2	3	4	5
5.	Ailemde önemli ve özel biri olduğum duygusunu hissetmeme yardımcı olan biri vardı	1	2	3	4	5
6.	Yırtık, sökük ya da kirli giysiler içersinde dolaşmak zorunda kalırdım	1	2	3	4	5
7.	Sevildiğimi hissediyordum	1	2	3	4	5
8.	Anne ve babamın benim doğmuş olmamı istemediklerini düşünüyordum	1	2	3	4	5
9.	Ailemden birisi bana öyle kötü vurmuştu ki doktora ya da hastaneye gitmem gerekmişti	1	2	3	4	5
10.	Ailemde başka türlü olmasını istediğim bir şey yoktu	1	2	3	4	5
11.	Ailemdelikler bana o kadar şiddetle vuruyorlardı ki vücudumda morartı ya da sıyrıklar oluyordu	1	2	3	4	5
12.	Kayış, sopa, kordon ya da başka sert bir cisimle vurularak cezalandırılıyordum	1	2	3	4	5
13.	Ailemdelikler birbirlerine ilgi gösterirlerdi	1	2	3	4	5

		Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
14.	Ailemdelikiler bana kırıcı ya da saldırganca sözler söylerlerdi	1	2	3	4	5
15.	Vücutça kötüye kullanılmış olduğuma (dövölme, itilip kakılma vb.) inanıyorum	1	2	3	4	5
16.	Çocukluğum mükemmeldi	1	2	3	4	5
17.	Bana o kadar kötü vuruluyor ya da dövölüyordum ki öğretmen, komşu ya da bir doktorun bunu farketdiği oluyordu	1	2	3	4	5
18.	Ailemde birisi benden nefret ederdi	1	2	3	4	5
19.	Ailemdelikiler kendilerini birbirlerine yakın hissedilerdi	1	2	3	4	5
20.	Birisi bana cinsel amaçla dokundu ya da kendisine dokunmamı istedi	1	2	3	4	5
21.	Kendisi ile cinsel temas kurmadığım takdirde beni yaralamakla ya da benim hakkımda yalanlar söylemekle tehdit eden birisi vardı	1	2	3	4	5
22.	Benim ailem dünyanın en iyisiydi	1	2	3	4	5
23.	Birisi beni cinsel şeyler yapmaya ya da cinsel şeylere bakmaya zorladı	1	2	3	4	5
24.	Birisi bana cinsel tacizde bulundu	1	2	3	4	5
25.	Duygusal bakımdan kötüye kullanılmış olduğuma (hakaret, aşağılama vb.) inanıyorum	1	2	3	4	5
26.	İhtiyacım olduğunda beni doktora götürecektir birisi vardı	1	2	3	4	5
27.	Cinsel bakımdan kötüye kullanılmış olduğuma inanıyorum	1	2	3	4	5
28.	Ailem benim için bir güç ve destek kaynağı idi	1	2	3	4	5

APPENDIX- 3: Ö.İ.O.Ö.

Bu envanterde kişiliğinizin ve yaşamınızın çeşitli yönlerine ilişkin ifadeler bulunmaktadır. Bu ifadeleri tek tek okuyarak, ifadenin size ne derece uygun olduğuna karar veriniz. İfade size;						
		Hiç uygun değil	Biraz uygun	Kısmen uygun	Çoğunlukla uygun	Tamamen uygun
1.	Geleceğe yönelik planlar yapmaktan hoşlanırım	1	2	3	4	5
2.	Yaşamımda zevk alarak yaptığım etkinlik sayısı azdır	1	2	3	4	5
3.	Genel olarak kendimi neşeli hissediyorum	1	2	3	4	5
4.	Geriye dönüp baktığımda istediklerimin çoğunu elde edemediğimi görüyorum.	1	2	3	4	5
5.	Kişilik özelliklerimden genel olarak memnunum.	1	2	3	4	5
6.	İstediğim nitelikte ve sayıda arkadaşım olmamasına üzülüyorum.	1	2	3	4	5
7.	Günlük yaşamımdaki sorumluluklarımı başarıyla yerine getiririm.	1	2	3	4	5
8.	Ulaşmak istediğim ideallerim var.	1	2	3	4	5
9.	İlgi ve yeteneklerime uygun etkinliklerin yaşamımdaki yeri istediğim ölçüdedir.	1	2	3	4	5
10.	Küçük sorunları bile büyütürüm.	1	2	3	4	5

		Hiç uygun değil	Biraz uygun	Kısmen uygun	Çoğunlukla uygun	Tamamen uygun
11.	Kendimi genel olarak canlı ve enerjik hissedirim.	1	2	3	4	5
12.	Yakın gelecekte yaşamımda güzel gelişmeler olacağına inanıyorum.	1	2	3	4	5
13.	Kişilerarası ilişkilerde sıklıkla hayal kırıklığı yaşıyorum	1	2	3	4	5
14.	Yaşamıma beni ona bağlayacak anlamlar katmakta zorlanmam.	1	2	3	4	5
15.	Beni eğlendiren faaliyetlere yeterince katılamıyorum.	1	2	3	4	5
16.	Umutlarımın gerçekleşeceğine inanıyorum.	1	2	3	4	5
17.	Mümkün olsa geçmiş hayatımı değiştiririm.	1	2	3	4	5
18.	Ailemle olan ilişkilerimden memnunum.	1	2	3	4	5
19.	Genelde hüzünlü ve düşünceliyim.	1	2	3	4	5
20.	Yaşamımda yapmam gerekenleri düşünmek hoşuma gider.	1	2	3	4	5
21.	Kendimi yalnız hissediyorum.	1	2	3	4	5
22.	Amaçlarıma ulaşmak için çevremdeki olanakları etkili bir şekilde kullanabilirim.	1	2	3	4	5
23.	Genel olarak kendimi huzurlu hissediyorum.	1	2	3	4	5
24.	Başkalarının mutlu görüldüğü kadar mutlu olmayı isterdim.	1	2	3	4	5
25.	Sorunları yaşamın öğretici ve doğal bir parçası olarak görürüm.	1	2	3	4	5
26.	Çevremdeki insanların yaşamlarına imreniyorum.	1	2	3	4	5
27.	Amaçlarıma ulaşmak için yeterince kararlı davranabilirim.	1	2	3	4	5
28.	Yaşamımı genel olarak monoton ve sıkıcı buluyorum.	1	2	3	4	5
29.	Sosyal ilişkilerimdeki girişkenlik yanımdan hoşnutum.	1	2	3	4	5

30.	Kendime hedefler koymakta zorlanıyorum.	1	2	3	4	5
31.	İç dünyamın zaman geçtikçe zenginleştiğini hissediyorum.	1	2	3	4	5
32.	Tanıdığım insanların çoğundan daha fazla sıkıntım var.	1	2	3	4	5
33.	Yaşamın zorluklarıyla başetme gücüne inanıyorum.	1	2	3	4	5
34.	Sevilen ve güvenilen biri olduğumu hissediyorum.	1	2	3	4	5
35.	Geçmişte yaptığım hatalardan dolayı yoğun suçluluk duygusu yaşıyorum.	1	2	3	4	5
36.	Serbest zamanlarımda zevkle vakit geçirecek bir uğraşı bulurum.	1	2	3	4	5
37.	Yaşamım başarısızlıklarla dolu.	1	2	3	4	5
38.	Güçlükler karşısında çabuk pes ederim.	1	2	3	4	5
39.	Çevremde ihtiyaç duyduğumda destek alabileceğim insanlar var.	1	2	3	4	5
40.	Sıklıkla ümitsiz ve çökkün hissediyorum.	1	2	3	4	5
41.	Okumak ve çalışmak benim için zevkli uğraşılardır.	1	2	3	4	5
42.	İsteklerime ve değerlerime uygun bir hayat sürüyorum.	1	2	3	4	5
43.	Ailemle olan ilişkilerimde sorunlar yaşıyorum.	1	2	3	4	5
44.	Yaşama iyimser bir açıyla bakabilme yönümden memnunum.	1	2	3	4	5
45.	Arkadaşlarıma kendimi istediğim gibi ifade edemiyorum.	1	2	3	4	5
46.	Başkalarına yardım edebilme ve onlara destek olma becerimden hoşnutum.	1	2	3	4	5

APPENDIX-4: Y.P.D.Ö.

AŞAĞIDAKİ test maddeleri belirli durum/olgu/olaylar karşısında sizin iki uçlu veya değişik derecede ne yaptığınız/ne hissettiğiniz ile ilgilidir, lütfen size en uygun olanı işaretleyiniz.						
1. Beklenmedik bir olay olduğunda; Her zaman bir çözüm bulurum	1	2	3	4	5	Çoğu kez ne yapacağımı kestiremem
2. Gelecek için yaptığım planların; Başarılması zordur	1	2	3	4	5	Başarılması mümkündür
3. En iyi olduğum durumlar şu durumlardır... Ulaşmak istediğim açık bir hedefim olduğunda	1	2	3	4	5	Tam bir günlük boş bir vaktim olduğunda
4. ...olmaktan hoşlanıyorum Diğer kişilerle birlikte	1	2	3	4	5	Kendi başıma
5. Ailemin, hayatta neyin önemli olduğu konusundaki anlayışı... Benimkinden farklıdır	1	2	3	4	5	Benimkiyle aynıdır
6. Kişisel konuları... Hiç kimseyle tartışmam	1	2	3	4	5	Arkadaşlarımla/Aile üyeleriyle tartışabilirim
7. Kişisel problemlerimi... Çözemem	1	2	3	4	5	Nasıl çözebileceğimi bilirim
8. Gelecekteki hedeflerimi... Nasıl başaracağımı bilirim	1	2	3	4	5	Nasıl başaracağımdan emin değilim
9. Yeni bir işe/projeye başladığımda... İleriye dönük planlama yapmam, derhal işe başlarım	1	2	3	4	5	Ayrıntılı bir plan yapmayı tercih ederim

10. Benim için sosyal ortamlarda rahat/esnek olmak Önemli değildir	1	2	3	4	5	Çok önemlidir
11. Ailemle birlikteyken kendimi.....hissederim Çok mutlu	1	2	3	4	5	Çok mutsuz
12. Beni... Bazı yakın arkadaşlarım/aile üyelerim cesaretlendirebilir	1	2	3	4	5	Hiç kimse cesaretlendiremez
13. Yeteneklerim... Olduğuna çok inanırım	1	2	3	4	5	Konusunda emin değilim
14. Geleceğimin.....olduğunu hissediyorum Ümit verici	1	2	3	4	5	Belirsiz
15. Şu konuda iyiyimdir... Zamanımı planlama	1	2	3	4	5	Zamanımı harcama
16. Yeni arkadaşlık konusu.....bir şeydir Kolayca yapabildiğim	1	2	3	4	5	Yapmakta zorlandığım
17. Ailem şöyle tanımlanabilir... Birbirinden bağımsız	1	2	3	4	5	Birbirine sıkı biçimde kenetlenmiş
18. Arkadaşlarımla arasındaki ilişkiler Zayıftır	1	2	3	4	5	Güçlüdür
19. Yargılarıma ve kararlarıma... Çok fazla güvenmem	1	2	3	4	5	Tamamen güvenirim
20. Geleceğe dönük amaçlarım belirsizdir.	1	2	3	4	5	İyi düşünülmüştür

21. Kurallar ve düzenli alışkanlıklar... Günlük yaşamımda yoktur	1	2	3	4	5	Günlük yaşamımı kolaylaştırır
22. Yeni insanlarla tanışmak... Benim için zordur	1	2	3	4	5	Benim iyi olduğum bir konudur
23. Zor zamanlarda, ailem... Geleceğe pozitif bakar	1	2	3	4	5	Geleceği umutsuz görür
24. Ailemden birisi acil bir durumla karşılaştığında... Bana hemen haber verilir	1	2	3	4	5	Bana söylenmesi bir hayli zaman alır
25. Diğerleriyle beraberken Kolayca gülerim	1	2	3	4	5	Nadiren gülerim
26. Başka kişiler söz konusu olduğunda, ailem şöyle davranır: Birbirlerini desteklemez biçimde	1	2	3	4	5	Birbirlerine bağlı biçimde
27. Destek alırım... Arkadaşılarımdan/aile üyelerinden	1	2	3	4	5	Hiç kimseden
28. Zor zamanlarda...eğilimim vardır Herşeyi umutsuzca gören bir	1	2	3	4	5	Beni başarıya götürebilecek iyi bir şey bulma
29. Karşılıklı konuşma için güzel konuların düşünülmesi, benim için... Zordur	1	2	3	4	5	Kolaydır

30. İhtiyacım olduğunda... Bana yardım edebilecek kimse yoktur	1	2	3	4	5	Her zaman bana yardım edebilen birisi vardır
31. Hayatımdaki kontrol edemediğim olaylar (ile)... Başa çıkmaya çalışırım	1	2	3	4	5	Sürekli bir endişe/kaygı kaynağıdır
32. Ailemde şunu severiz... İşleri bağımsız olarak yapmayı	1	2	3	4	5	İşleri hep beraber yapmayı
33. Yakın arkadaşlarım/aile üyeleri... Yeteneklerimi beğenirler	1	2	3	4	5	Yeteneklerimi beğenmezler

APPENDIX-5: ETİK KURUL ONAYI



T.C. YEDİTEPE ÜNİVERSİTESİ

Sayı : 21568116-302.14.01-E.491

Konu : Özge Katı Etik Kurul Onayı Hk.

29/01/2020

İLGİLİ MAKAMA

Yeditepe Üniversitesi, Eğitim Bilimleri Enstitüsü Rehberlik ve Psikolojik Danışmanlık Yüksek Lisans Programı öğrencilerinden Özge KATI'ya ait "Yetişkinlerin Çocukluk Çağı Travmaları ile Dayanıklılık ve Öznel İyi Oluşları Arasındaki İlişkinin İncelenmesi" başlıklı tez-araştırmasının Beşeri Bilimler etik standartlarına uygunluğuna ilişkin Yeditepe Üniversitesi Beşeri ve Sosyal Araştırmalar Etik Kurul Onayı ekte sunulmuştur.

Bilgilerinize arz ve rica ederim.

İmza
Prof. Dr. Ahmet AYDIN
Rektör V.

Ek: 15.01.2020 Tarihli Etik Kurul Onayı.tif

NOT: BELGENİN ASLI ELEKTRONİK İMZALIDIR.



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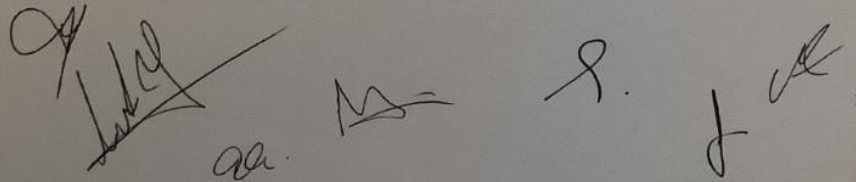
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KURULU KOMİSYONU**

**15.01.2020 TARİHLİ
7/2020 No'lu TOPLANTI KARARLARI**

1) Yeditepe Üniversitesi, Eğitim Bilimleri Enstitüsü "Rehberlik ve Psikolojik Danışmanlık" Yüksek Lisans programı öğrencilerinden Özge KATI'nın "Yetişkinlerin Çocukluk Çağı Travmaları ile Öznel İyi Oluşları Arasındaki İlişkinin İncelenmesi" isimli tez-araştırma önerisinin araştırma başlığında yapılan yazım yanlışı sebebiyle 20.11.2019 tarihi 5/2019 nolu Yeditepe Üniversitesi Beşeri ve Sosyal Araştırmalar Etik Kurulu toplantı kararı iptal edilmiştir.

2) Yeditepe Üniversitesi, Eğitim Bilimleri Enstitüsü "Rehberlik ve Psikolojik Danışmanlık" Yüksek Lisans programı öğrencilerinden Özge KATI'nın "Yetişkinlerin Çocukluk Çağı Travmaları ile Dayanıklılık ve Öznel İyi Oluşları Arasındaki İlişkinin İncelenmesi" isimli tez-araştırma önerisi Beşeri Bilimler etik standartlarına uygunluğu Yeditepe Üniversitesi Beşeri ve Sosyal Araştırmalar Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır.

3) Yeditepe Üniversitesi, Eğitim Bilimleri Enstitüsü "Eğitim Programları ve Öğretim" Doktora Programı öğrencilerinden Atilla ERGİN'nin "Öğretmen Adaylarının Bilişsel Esneklik Düzeyleri, Empati Becerileri ve Karar Verme Stilleri Arasındaki İlişki" isimli tez-araştırma önerisi Beşeri Bilimler etik standartlarına uygunluğu Yeditepe Üniversitesi Beşeri ve Sosyal Araştırmalar Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır.

 1

**YEDİTEPE ÜNİVERSİTESİ BEŞERİ VE SOSYAL BİLİMLER ETİK
KURULU KOMİSYONU**

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Prof. Dr. Suat ANAR

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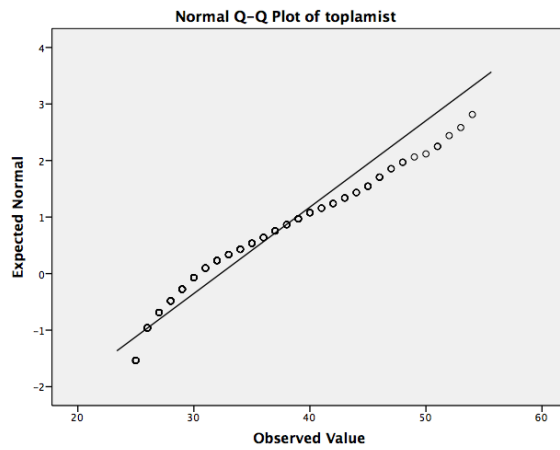
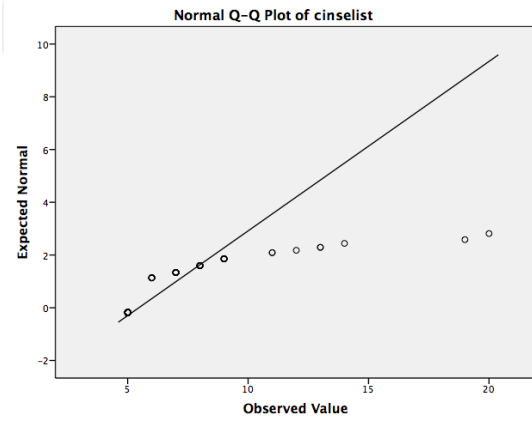
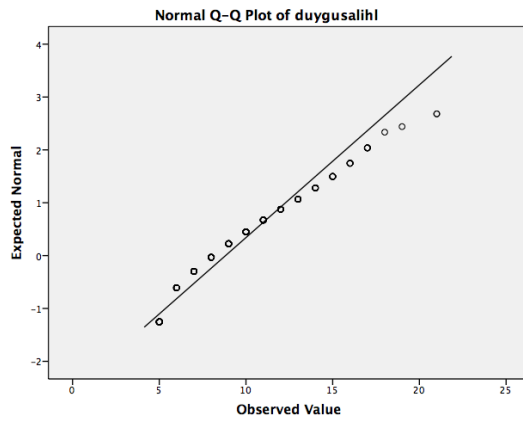
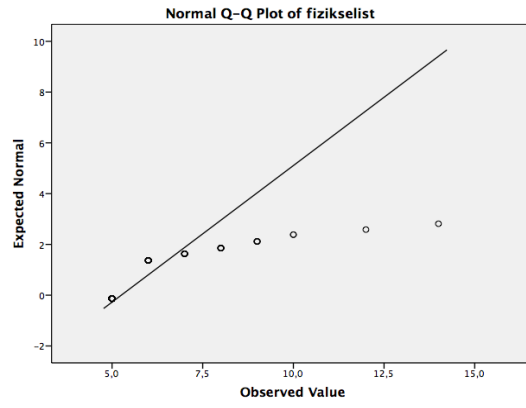
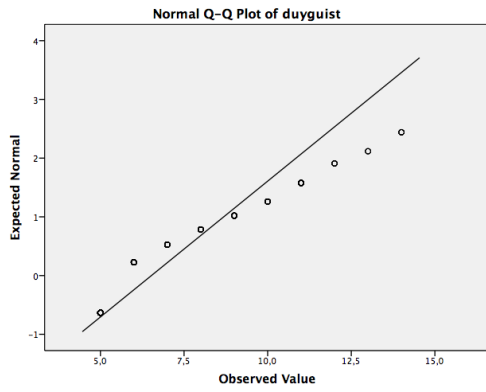
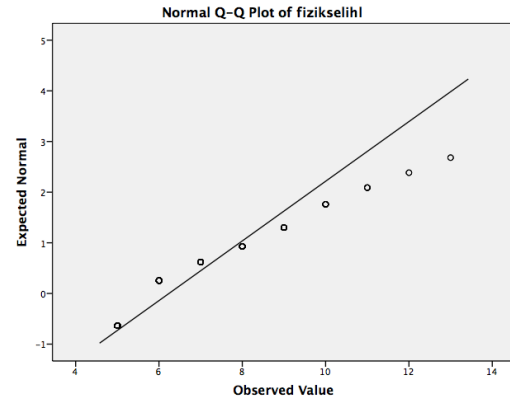
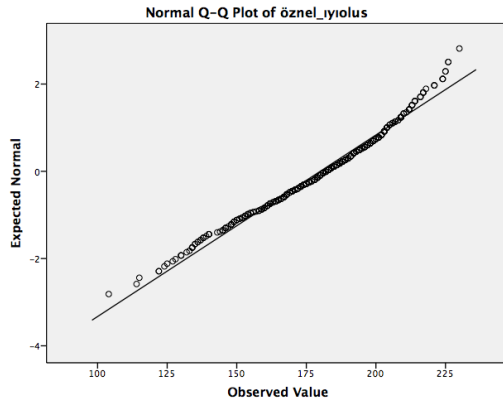
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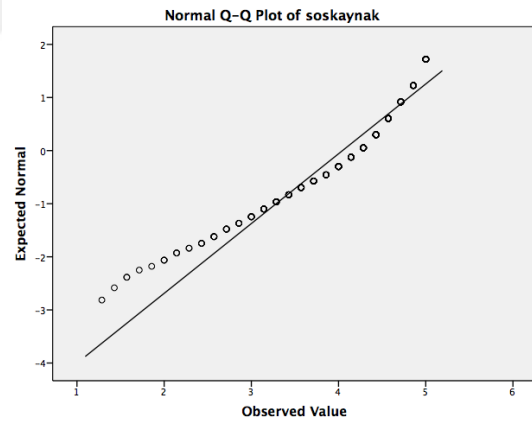
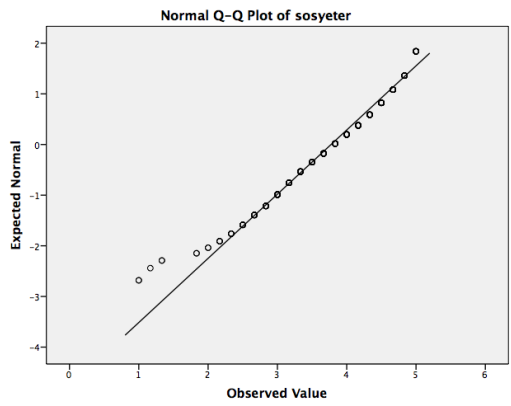
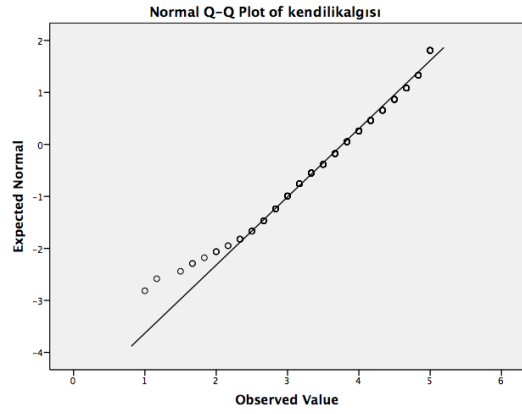
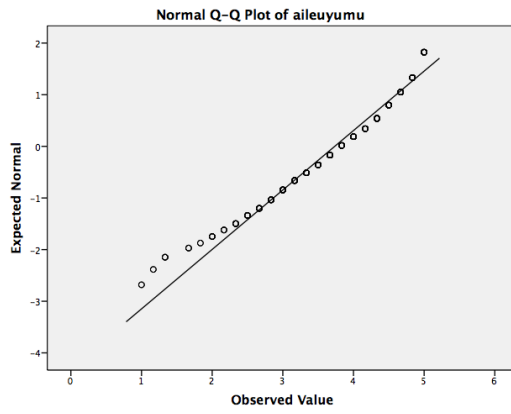
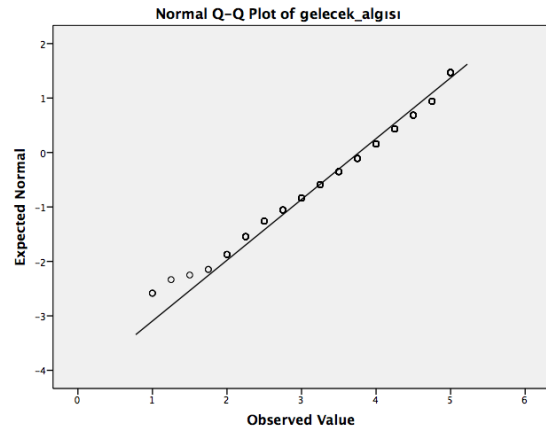
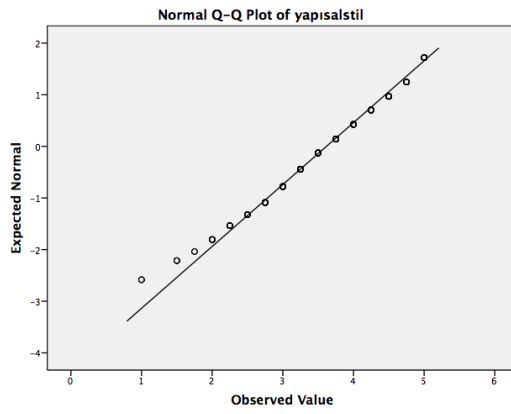
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APPENDIX -6: NORMALLİK ÇALIŞMALARI ve UÇ DEĞER HESAPLAMALARI

Tablo. Mahalonobis uzaklığı değerleri

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44,5121	0,0000	12
44,06544	0,0000	13
40,7274	0,0001	14
39,46568	0,0001	15
36,81515	0,0002	16
34,44996	0,0006	17
33,34557	0,0009	18
33,17895	0,0009	19
31,78444	0,0015	20





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