TRANSGENERATIONAL TRAUMA: AUTONOMY, ANGER AND SOMATIZATION BETWEEN CHILDREN OF TRAUMATIZED AND NON – TRAUMATIZED PARENTS

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

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ABSTRACT

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The current study investigated the transgenerational trauma transmission on second generation by examining autonomy, anger and somatization. The research sample consisted of traumatized parents and their children. The traumatized group was compared with the comparison group who were the children of non- traumatized parents. The participants of the traumatized group had 65 parents and 72 children and control group had 62 parents and 70 children. The ages of the children varied between 18 and 30. The data was collected through a self-report questionnaire. The results revealed that children of traumatized parents are more autonomous and exhibit higher somatization symptoms than children of non-traumatized parents. It was also found that children within the traumatized group showed higher levels of somatization and aggression as the intensity of parental trauma increased.

Keywords: Transgenerational trauma transmission, trauma, somatization, autonomy

ÖZ

Travmanın Kuşaksal Aktarımı: Ebeveyni Travma Yaşamış ve Travma Yaşamamış Çocukların Bağımsızlaşma, Öfke ve Somatizasyon Açısından İncelenmesi

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Bu araştırma travmanın kuşaksal aktarımını, aileden bağımsızlaşma, öfke ve somatizasyon boyutları ile incelemektedir. Araştırmanın örneklemini 1980 askeri darbesini travmatik olarak yaşamış kişiler ve onların çocukları oluşturmaktadır. Travmatik grup ebeveyni sağlıklı olan çocuklardan oluşan kontrol grup ile karşılaştırılmıştır. Travma grubu 65 ebeveyn ve 72 çocuktan ve karşılaştırma grubu 62 ebeveyn ve 70 çocuktan oluşmuştur. Çocukların yaşları 18-30 arasında değişmiştir. Sonuçlar, ebeveyni travma yaşayan çocukların, yaşamayanlara oranla ailelerinden daha bağımsız olduğunu ve daha fazla somatizasyon semptomlarına sahip olduğunu göstermiştir. Buna ek olarak, travmatik grup çocukları ebeveynin travma semptomlarının yoğunluğuna gore incelendiğinde, travmatik etkilerin yüksek olan grubun çocuklarının daha çok somatizasyon gösterdikleri ve öfke seviyelerinin daha yüksek olduğu bulunmuştur. Sonuç olarak travmanın kuşaksal aktarımının gerçekleştiği söylenebilir.

Anahtar Kelimeler: Travma aktarımı, nesiller arası travma, somatizasyon,

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CHAPTER 1

INTRODUCTION

Human history is full of traumatic events both big and small in scale. Some of these events affect a single individual while events spanning groups and societies leave deep psychological scars on a large group of people. Such collective suffering may be a result of natural disasters or wars, and often lead to complex traumas that have varying effects on the individual and the group. More strikingly, these traumas appear to transcend through generations. The effects of the trauma can usually be observed in the children of trauma survivors.

This study focuses on collective trauma survivors who were exposed to brutal systematic torture during the1980 Military Coup in Turkey, and their children. It specifically attempts to investigate the effects of transgenerational trauma by assessing the levels of autonomy, anger expression and somatization in the children of trauma survivors. The study included a total of 144 children, of which 74 of them belong to the trial group and 70 of them belong to the control group. The control group was comprised

of children between the ages of 18 and 30 with no traumatic history within the last 6 months, whose parents were not exposed to any traumatic events during the military coup.

After introducing transgenerational trauma transmission in a broader concept, the initial chapter will present a literature review on the symptoms of collective and complex trauma including the effects of trauma transmission on the children. This will be followed by the definition of the concepts of separation-individuation, anger expression and somatization. Finally, the analysis of transgenerational trauma will be discussed in the context of 1980 military coup.

1.1. Trauma

In a broader meaning the word trauma refers to psychobiological injury and wound (Nijenhuis & Van der Hart, 2011). Traumatic event refers to the experiences which are extraordinarily out of normal ranges of human comprehension with excessive distress. Exposure to traumatic events, containing physical or psychological threats, overwhelms both psychological and biological coping mechanism while threatening bodily integrity of the survivors (Saporta & Van der Kolk, 1992). Van der Kolk and McFarlane (2007) suggests that experiencing strong traumatic events leads to alterations in the people’s psychological, social and biological equilibrium. Some traumatic experiences are the results of either natural disasters such as earthquakes or tsunamis and others take place within the interpersonal context including rape, assault, captivity, wars, internment, violence and torture. Exposure to such overwhelming memories violates basic assumptions of self- worth, security and predictability of future (Janoff - Bulman,

1992). Thus, harsh reality shatters benign assumption about the world and self (Updegraff, Silver &Holman, 2008). Therefore, traumatic events has serious implications on victim's behaviors and every- day functioning in both individual and community levels (Lopez, 2011).

1.1.1. Transgenerational Trauma Transmission

The theory of trans-generational trauma transmission was created after devastating personal losses and its huge impacts on the Jewish community members during the World War II (Bar-on et al., 1998). The term "transgenerational trauma transmission" has been used to suggest that trauma experienced by parents may have negative effects on children's psychology (Sigal, Silver, Rakoff, & Ellin, 1973). In other words, children of trauma survivors are extensively impacted from their parents' traumas caused by unexpected serious harm, death or injury (Levine, 2001). Although children of survivors do not expose direct traumatic stimulus, they show evidence for specific character organizations (Felsen, Irit & Shmuel, 1990). Decades after the trauma, the traces of the traumatic event are apparent both in the lives of survivors and their children. Hoffman (2003) argues that "the second generation of every calamity is the hinge generation in which the meanings of awful events can remain" (p.103).

On the other hand, vicarious and secondary traumatization refers to the impacts of traumatic events on spouses and caretakers emphasizing the indirect influences on the first generation. Therefore, they distinguish from transgenerational trauma primarily referring to the same generation (Kellerman, 2001). Transgenerational trauma indicates

the transmission of traumatic effects from parents to children who were born after the traumatic events experienced by the parents.

Research investigating the effects of parental trauma on the children found evidence of trauma transmission by observing the children's characteristics (Bar-on, 1995; Yehuda, Bell, Bierer, Schmeidler, 2008; Daud, Skoglund & Rydelius, 2005). Patterns emerged including dysfunctions in interpersonal relationships (Wiseman, 2002), increased vulnerability to anxiety and depression symptoms (Fossion et al., 2015), intense burden and guilt feelings (Wiseman, Metzl & Barber, 2006), differences in the way they express anger (Nadler, Kav-venaki & Gleitman, 1985), difficulties in separation-individuation (Katz& Keleman, 1981) and exhibition of somatic symptoms (Eitinger, 1961).

The vast majority of research on intergenerational trauma transmission examines Holocaust survivors, collective trauma victims, and their children (Bar- on, 1995; Yehuda et al., 2008; Danieli,). Other research investigated effects of trauma on second generation by drawing its sample from people who experienced Japanese American Internment camps (Nagata, 1998), African enslavement, Vietnam War (Davidson & Mellor, 2001), genocide in Cambodia (Muong & Sochanvimean, 2013) and second generation refugees (Kalayjian & Weisberg, 2002).

The studies on trans-generational trauma are divided into two categories as clinical and empirical studies. Clinical studies choose the sample among patients receiving psychotherapy, while empirical studies select its samples from nonclinical

community population usually including control groups (Solkoff, 1992). Historically, the initial research attempted to investigate mostly clinical sample from the children of Holocaust survivors. However, studies conducted with clinical samples are highly inclined to pathologize the results due to present sample's profile and overgeneralize the results for the whole second generation (Salkoff, 1992). Therefore, there is a huge gap between the results of clinical and empirical controlled studies for the evidence of psychopathology of children of survivors (Bar-on 1995, Solkoff, 1992). In addition, the review made by Kellerman (2001), revealed that among 35 quasi- experiment studies with control groups, only 12 of them found significant differences for some variables but not in psychopathology. Thus, following research shifted its attention from the psychopathology to the specific patterns and characteristics of second generation including family dynamics and interpersonal relationships (Kellerman, 2000, Bar-on et al., 1998; Krell, 1984). Budick (1985) came up with the term "child of survival complex" not referring to pathology but points to the psychological profile specific for children of survivors.

The mechanisms of transmission gained significant attention. Traumatic experiences are transmitted to the next generations in "direct and specific" ways and "indirect and general" ways (Kellerman, 2001). Direct transmission implies that survivor parents affect children directly and children learn how to think and behave in the same way with the traumatized parent (Kogan, 1995). Moreover, offspring display the same specific syndrome such as PTSD or anxiety (Yehuda et al. 2008). Many of the clinical reports have documented evidence for direct transmission (Weiss & Weiss, 2000). On the other hand, indirect transmission occurs with the general sense of deprivation of the

children through parenting, communication patterns and family environment (Felsen, 1998).

Some qualitative studies examined the pathway of trauma transmission to the children. In this field, psychoanalytic explanations gained attention as an explanation mechanism for indirect transmission. According to psychoanalytic theory, emotions that are repressed and non-processed experienced by the trauma survivors are unconsciously passed on to children (Kellerman, 2001). Kogan (1995) illustrates in her case presentations how parents' traumatic memories are unconsciously lived by their children. Unconscious memories may be evident in the form of family secrets, silence and unfinished tasks of their parents (Danieli, 1998; Wardi, 1992). Danieli explains the reasons for the trauma transmission mainly with three components: trauma itself, conspiracy of silence and the parents' adaptation following the trauma.

1.1.1.1. Communication Style

"Conspiracy of silence" has been found to be a specific pattern of communication among traumatic families. Holocaust survivors faced with invasive societal reactions including denial, indifference, avoidance and repression resulting with a sense of isolation, mistrust and loneliness (Danieli, 1998). Danieli suggests that parents of Holocaust survivors usually remain silent about what they experienced under captivity. They believe that for healthy development of the children it is essential to keep the traumatic experiences secret (Bar-on et al., 1998). This specific pattern is supported by many research studies with different populations (Downes et al, 2012; Kalayjian &

Weisberg, 2002). “Double wall of silence” takes this communication style a step further where neither children asks nor parents tells about the traumas in their histories (Bar-on, 1995). However, parents’ traumas continue to be silently present in the home environment conveying the messages of extreme sufferings (Wiseman et al., 2002). The child fantasizes about the unknown and missing part of their parent’s past. This common way of non-verbal communication among survivor families leads child to feel responsible and guilty for parent’s unexplained grief (Klein- Parker, 1988). The study conducted by Wiseman et al., (2002) suggested that offspring of Holocaust survivors who reported non-verbal communication with their parents have more interpersonal distress than holocaust survivor families with informative verbal communication. On the other hand, parents who share traumatic memories with sensitivity and within a certain limit do not cause any adverse effects in the children (Kupelian, 1991). Therefore, non-verbal communication among trauma survival families may have more destructive impact than verbal and direct conversation. It was proposed that open communication is a signal for better relationship between mother and child by facilitating expression of distressing experiences that child undergoes (Barnes & Olson, 1985). In return, this type of communication works as a protective shield on the child against mental health problems (Daley, 2006).

Previous studies found that gender of the survivor parent and that of children is a strong determinant of parental communication associated with Holocaust and its leading consequences (Karr, 1973). Daughters of mothers utilizing more guilt inducing communication were significantly higher on hypochondriasis, anxiety and paranoia, while for boys this type of communication is correlated with higher education success

(Lichman, 1983). Moreover, indirect communication of either parent results with higher level of depression, paranoia and anxiety in daughters than sons. Karr (1973) documented that daughters respond to parent's traumas by withdrawal, low self-esteem, fear and somatic symptoms.

1.1.1.2. Parenting Style

Past complex traumas negatively impact survivor's parenting skills. For survivors who were children or adolescent at the time of traumatic incident, their traumatic memories and symptoms get triggered when they become parents. Intrusive and dissociative symptoms impede them to function effectively the role of parenting (Field, 2013). Thus, over-protection is one of the frequently observed parenting patterns among the trauma survivors (Steinberg, 1989). Since they perceive the world as a dangerous place many activities seems risky for the survivor parent. Therefore, they overly involve in the children's lives leading to a symbiotic relationship. The boundaries blur and sometimes even disappear between the parent-children dyadic relations (Rowland - Klein & Dunlop, 1997). Inevitable of the enmeshed family relations, separation and individuation processes become highly problematic for those children (Rosenthal & Halik 1990; Mazor & Tal, 1996). In addition, parents over controlling behavior may induce anger feelings in the children. However, any kind of anger expression of the child is not approved and tolerated by the parents. Although children may experience high levels of anger and guilt feelings for their parents' behavior, children of survivor families are less likely to externalize aggression (Wisemen et al., 2006).

Role-reversing parenting implies the relationship in which mother demands her child to meet her own emotional needs, comfort and intimacy. The child focuses on these demands giving up his or her own needs (Chase, 1999). Gampel (1992) defines reverse parenting as "the child becomes his own parent's parent". One of the explanations for the trauma transmission to next generations is the role-reversing parenting pattern among trauma survivors (Field et al., 2013; Macfie et al., 2005). Survival families have an expectation from their children to protect their parents (Shafet, 1994). In situations where parent cannot adapt, the child assumes the responsibility for her parent's emotional well being while damaging her own attachment needs. Increased level of parental trauma is associated with overprotective and role-reversing parental styles, which inevitably results with depression, anxiety and low self-esteem in the children (Jacobvitz & Bush, 1996.). In addition, separation difficulties are frequent outcome in an environment where the child discouraged from autonomy.

A study that interviewed both parents of Holocaust survivors and their children found huge discrepancy in parental expectations and behaviors (Krell et al., 2004). The first encountered paradox is that parents express pride in their children. However children perceive it as an expectation to be perfectionist and no matter how well they perform they usually fail to fulfill parents' expectations. The second paradox is about the parenting practices. Although survivor parents emphasize that they have huge emotional investments on their children as being helpful and tolerant, the children criticize parents for lack of affect and empathy (Krell, et al., 2004)

1.1.1.3. Identification

Finally, projective- identification is a useful construct to define the underlying mechanism of trauma transmission. Survivor parent projects her emotions of anger, disappointment, grief and sadness onto the children (DeGraaf, 1998). Rowland-Klein and Dunlop (1997) explain that Holocaust related emotions and concerns are unconsciously projected onto children by their survivor parents and the child identifies with these thoughts as if he himself is exposed to the traumatic event. Over-identification with survival parent is apparent in the children’s frequent Holocaust related fantasies, dreams, associations and thoughts (Sorscher & Cohen, 1997). The other side of over identification with parental experiences is that child feels the burden of parents’ unfinished tasks (Rowland-Klein & Dunlop, 1997).

1.1.2. Collective Trauma

Kai Ericson (1972) suggested that collective trauma is a result of unpredictable, invasive and destructive occurrences that affect not only individuals but also a group of people including community or a specific group of people. Some examples of collective trauma experiences include Colonialism, World War II and Holocaust concentration camps, Armenian genocide, Khmer Rouge genocide in Cambodia, the destruction of World Trade Center in New York, 2004 tsunami wave in Far East and indigenous people in Australia and Africa. Collective trauma refers to a shared experience of violence that traumatic people identify themselves as victims and dramatically lose their identity (Fassin & Rechtman, 2009). It leads to social transformations with the destruction of

identity, attachment and support within the community (as cited in Abramowitz, 2005, p.2107). Historical trauma, used interchangeably with collective trauma, refers to the complex nature of the event indicating collective suffering of many group members who share common identity resulting with social and psychological distress in multiple layers of individuals, family unit and society (Evans-Campbell, 2008). Evans-Campbell (2008) emphasizes that the effects are accumulated in the next generations. During collective trauma suffering, Ericson (1972) points to mistrust toward social institutions and authorities ensuing isolation of the survivors by just trusting their own personal resource**.** For Lopez (2011), inner feelings of trust and safety that develop during the first years of childhood are overwhelmed and shattered by terrible external reality. Similarly, with the shocking effects of the traumatic event, feelings of fear, hopelessness and apathy spreads within all of the community members (Giesen, 2001). Additionally, collective suffering disrupt traditional cultures, practices and values of traumatized community (Evans-Campbell, 2008). In collective trauma, effects of traumatic memories and related feelings expand to community members who did not suffer directly from the traumatizing stimulus (Giesen, 2001). Evans-Campbell (2008) emphasizes the effects which are accumulated in following generations. Unresolved grief and unprocessed emotions caused by collective traumatic events are transmitted epidemically to the descendants of survivors (Duran, 2006; Riedel, 2014).

People in Turkey experienced a variety of collective traumas. One of the mass traumas Turkish society underwent with huge impact is the 1980 Military coup. Throughout history, Turkey witnessed 3 separate military interventions in 1960, 1971 and 1980. However, 1980 military coup was different in its purpose and intervention

methods. Although the major and visible reasons were discussed as anarchy and economic crisis, additional ideological motives were hidden behind it. As Zeydanlıoglu (2009) argues, after the establishment of Turkish Republic creation of homogenous nations of Turks, "Turkification", became one of the state's purposes. During the Turkification process, non-Turkish people with different ethnic and religious identities such as Kurds were perceived as an obstacle. The increasing terror and economic crisis at that time legitimized the violence of the military takeover (Zeydanlıoglu, 2009). During the coup, Turkish military centralized the power in its hands, and exercised this power to decide who to kill, exile, detain and torture. The military takeover mainly targeted the Kurdish and Alevi population in Turkey.

1.1.2.1. Individual Effects of Torture and Captivity

Systematic torture techniques used during the detention periods were strongly associated with the ideology of creating a homogeneous Turkish population (Zeydanlıoğlu, 2009). "Internal enemies" who were non-Turkish, leftist groups and Alevis, were exposed to horrific systematic torture sessions in prolonged periods of interrogation. The torture techniques used during the military intervention in 1980 were harsher compared to previous military coups. Prisons built in Diyarbakır that housed Kurdish people are well known for their dreadful torture methods. One of the Kurdish torture victims stayed 13 years in Diyarbakır prison, explains that the purpose of the torturer was to kill or make the victim disable (as cited in Paker, 2003, p. 108). Released report of Human Right Foundation in Turkey (1994) showed that from 12 September 1980 until the end of 1984, 650.000 people were detained and 65.000 people were

imprisoned, 208 people murdered as a result of direct or indirect torture mostly during the surveillance and 50 people were executed.

The main rationale of the military was not acquiring information but regaining its power through manipulating and frightening the society with terror (Zeydanlıoğlu, 2009). Paker, who conducted many interviews with the detainees of 12 September coup, suggest that the prison conditions and torture purposes are extremely similar to the concentration camps (Paker, 2003). Therefore, the primary aim of horrific tortures was to convey messages to whole society with the screams coming from the torture victims. People immediately got the warning signals, but they pretended not to witness the screams and denied them due to extreme fear of the state (Dinçer, 2011). Otherwise, accepting screams of violence and feeling empathic with the victims would create unbearable intense emotions such as depression, anger and fear, which would have required taking action against the state (Paker, 1996).

Various horrible torture techniques were used during the prolonged torture sessions. Torture was evident in two forms: Psychological torture and physical torture. Psychological torture is a complex form of interpersonal trauma including humiliation, fright and death threats (Kanninen, Punamäki,& Qouta, 2003). According to the testimonies, the most common methods used were severe and systematic beatings, death threats, intimidation, solitary confinement, pulling of hair, being stripped naked, being blindfolded and hosed, guards' abuse, constant surveillance and intimidation, sleep deprivation, falaga, Palestinian hanging for extensive periods (Zeydanlıoglu, 2009).

Prisons, concentration camps and slave labor camps are the places where victims expose cumulative and repeated trauma occur under captivity over a period of time (Herman, 1992). Besides terrible tortures, it is crucial to take into account the psychological domination of the perpetrator over the prisoner. Under these conditions, the primary aim of the perpetrator is the enslavement and disempowerment of the victim by showing extreme control over the victim's body and in all spheres in his life. Thus, torturer controls what the victim eats, what he wears, when he sleeps and even decides the time for the toilet. In addition, isolation, helplessness and instilling terror over the victim destroy sense of self and autonomy. At this point, hunger strikes are the ultimate attempts to regain his control over his body and life. The prisoner affirms his sense of integrity and self- control while voluntarily depriving from basic needs (Herman, 1992). During the 1980 military intervention, eleven of the prisoners were dead due to hunger strikes (Human Right Association). In order to fully comprehend traumatic experiences the prisoners underwent, one should consider the whole picture in addition to tortures**.**

1.1.2.2. PTSD vs Complex Trauma of Torture Victims

Captivity under such inhumane conditions leads prisoners to experience strong traumatic events which overwhelm ordinary human adaptations with inadequate coping mechanisms while threatening bodily integrity (Saporta &Van der Kolk, 1992). In the face of traumatic events, DSM-III (American Psychiatric Association, 1980) defines Post Traumatic Stress Disorder (PTSD) under three categories: Re-experience, avoidance and hyper arousal. Re-experiencing includes persistent distressing dreams, flashbacks as if the traumatic events were recurring and intense psychological distress

when faced with the events that resemble in some aspects of traumatic memory. Symptoms of avoidance signifies efforts to avoid activities or situations that are associated with the trauma, inability to remember important aspects of the event, diminished interest in activities and detachment from others and sense of hopelessness for future plans. Increased arousal symptoms indicate difficulty falling asleep, irritability or strong anger, concentration difficulty, hypervigilance, exaggerated sudden responses and physiological reactions when encountered with the resembled events.

However, among the trauma specialists there is an argument that DSM criteria do not fully comprise every aspect of traumatic reactions and captures only limited psychological symptoms (Brown& Fromm, 1986; Horowitz et al, 1997). Many suggest that interpersonal traumas violating human rights are so complex that it's hard to reduce its effect into a single diagnosis. Interpersonal trauma takes place within a relational context in which deliberate threat and injury induced to the captor (Schwerdtfeger & Nelson Goff, 2007). Evans - Campbell (2008) emphasized the limitations of PTSD classification by claiming that symptoms only comprise individual effect without any given attention on social and familial levels, does not contain any item about the intergenerational effect of the trauma, and not taking into account the interaction between current and historical trauma.

The reactions given to the traumatic events are largely dependent on the type of trauma. Victims exposed to a single trauma such as motor vehicle accident, natural disaster, pregnancy/birth trauma may result with less psychological damage when compared with complex traumas. Complex traumas occur repeatedly, cumulatively and

increasingly in time. It takes place under captivity where victim is unable to escape and is deliberately traumatized by the captor (Engdahl, Harkness, Eberly, Page, & Bielinski, 1993). For instance, physical and sexual violence in the family, prisons, war, refugees and human trafficking are the situations that victims are exposed to repeated and prolonged traumatic events. The length of traumatic symptoms after a single trauma is expected to be present for shorter time and abate in weeks and months whereas complex traumas cause such a deep injury that symptoms persist for many years after the liberation (Herman, 1997). Thus, in order to capture the whole aspects of complex traumas, Herman (1997) for the first time introduced the concept of “Complex PTSD”. Ford and Courtois (2009) explain this concept with the failure of self regulation and difficulties to regain self-integrity in relationships.

1.1.2.3. Torture Syndrome

In order to explain traumatic stress and long-term physical and psychological impacts of torture during captivity, the term “torture syndrome” was generated from studies that examined political prisoners (Allodi & Cowgill, 1982; Hougen 1988; Abildgaard et al., 1984*)*. Different from DSM definition, torture syndrome clarifies specific patterns for torture survivors and offers a broader spectrum. Torture syndrome is characterized with affective, intellectual, behavioral and psychosomatic dysfunctions (Allodi & Cowgill, 1982). Affective abnormalities include fears, anxiety, phobias, depression and panic. Intellectual difficulties are poor concentration, memory problems and confusion. Moreover, withdrawal, impulsivity, aggressiveness and suicide ideations are behavioral symptoms while frequently observed psychosomatic features are

insomnia, headaches, dizziness, nightmares, sweating, pain, tremor and fainting. The major distinction between DSM symptoms and torture syndrome are altered identity and personality, somatic symptoms, learned helplessness, strong hopelessness feeling, depersonalization and fear of intimacy proposed under the torture syndrome (Somnier et al., 1992).

Additionally, unpredictability is an important dimension for negative impacts on torture survivors. Torture survivors usually lack the knowledge about the time of next torture sessions that results with a chronic state of fear in their cells (Başoğlu & Mineka, 1992). Preference for certainty is crucial for the feeling of safety, which reduces the impact of traumatic stimulus and facilitates a relaxing state in the absence of tortures (Seligman, 1968). As a result of the inescapability and uncontrollability of the situation, these people develop ‘learned helplessness’ which suggests that no matter how hard they attempt, they have no control over the outcome (Maier & Seligman, 1976; Somnier & Genefke, 1986). Additionally, Bettelheim (1943) defines trauma of sociopolitical origin drawing attention to its unpredictable duration with constant threat of death and hopelessness of getting out of it.

The effects of torture and prison conditions have been widely investigated and supported by many researchers. A study comparing tortured refugees and refugees without torture history living in Denmark showed statistically significant differences between the two groups (Thorvaldsen, 1986). Tortured group demonstrated higher rates of sleeping disorders, fatigue, headaches and concentration problems than non-tortured group of refugees. The findings suggest that torture plus exile status has more

aggravating effect on health than being expelled alone (Hougen, 1988). In addition, the study compared tortured prisoners and non-tortured prisoners in Turkey, assessed psychological profiles of prisoner (Paker, Paker, & Yüksel, 1992). The findings revealed that tortured group scored significantly higher on obsession-compulsion, inter-personal sensitivity, anger, depression, anxiety, phobia and paranoid ideation. The study also emphasized high rates of PTSD, % 39 of the tortured prisoners, while none of the prisoners without torture exposure had PTSD (Paker et al, 1992). The results of research investigated sequelae of torture pointed out a wide range of cognitive, emotional and social impairments (Somnier, Vesti, Kastrup, & Genefke, 1992). Anxiety, depression, insomnia with nightmares, social withdrawal, loss of concentration, irritability, sexual disturbances, fatigue, memory dysfunction, aggressiveness and hypersensitivity especially to noise and changed identity are frequently found patterns in tortured survivors (Somnier & Genefke, 1986).

1.1.2.4. Long Term Consequences of Torture

Political prisoners who had been isolated have no chance of connecting with other prisoners and family members, and develop dependent “traumatic bonding” with their captors which is essential for their survival (Bettelheim, 1943; Dutton, Painter, 1981). This obligatory emotional tie with tormentor leads to negative impact on self-esteem and amendments in the victim’s relational world that affects all interpersonal relationships in their lives (Farber, Harlow, &West, 1957). Moreover, attachment to tormentor and lack of any support for long periods of captivity shatters victims’ basic trust which is crucial for all human beings. The sense of abandonment and learned

helplessness during captivity leads the loss of safety and trust in the case of an emergency. With this devastating experience, survivors alternate between the need for intense attachment and terrified withdrawal in their relationships after their release. This is salient in their behaviors; they may be either clinging to a person or may escape suddenly due to strong suspicion (Herman, 1997). As a result they usually suffer from dysfunctional interpersonal relations and higher divorce rates (Gonsalves, 1990).

Chronic trauma victims may feel themselves to be changed irreversibly by having their personality and identity destroyed (Saporta & van der Kolk, 1992). Herman (1997) suggests that prolonged captivity devastates the self. In order to dehumanize their victims, captors use different methods such as taking the victims' name away and replacing it with a number. The effects of long term dehumanization continuously devastate victim's life after the release. The new identity is formed with memories of his enslaved self which includes controlled and violated body image (Herman, 1997). In addition, traumatized people have a tendency to repeat traumatic experiences by re-enacting the trauma in different ways without their awareness (Horowitz, 1986; van der Kolk, 1989). Hoping totally different outcomes, they may frequently expose themselves to similar traumatic situations (Saporta & van der Kolk, 1992).

Even though torture primarily aims to destroy victim's self-esteem, feelings of trust and safety, it often has a side effect of slowing the normal development of the individual due to extended periods of time spent in prison (Genefke, 1994). Social and occupational losses, delays in education, marriage and finding appropriate jobs are frequently observed phenomena contributing to economic and social dysfunction

following their release (Quiroga & Jaranson, 2005). Availability of support through approval and acceptance by a social group is crucial for the recovery phase after release (Başoglu & Mineka, 1992). Otherwise they perceive themselves as socially isolated and living in a socially hostile environment.

Research (Rintamaki, 2009) on adaptation after war captivity, suggested that the prisoner soldiers in the Second World War and Korean war had persistent flashbacks, extreme reactions to reminders of the traumatic experiences and nightmares even after 35-40 years later from their release. Moreover, study indicated high rates of PTSD, ranging from 16% and 88% among ex-POW samples (Rintamaki, 2009). Additionally, it is crucial to emphasize persistent pains as an outcome of physical torture methods (Amanda et al., 2010). Finally, one of the most important long term consequences is the suicidal ideations. Longitudinal study investigated suicidal ideations comparing ex-POWs of 1973 Yom Kippur war and veterans who did not experience captivity (Zerach, Levi- Belz, & Solomon, 2013). The results demonstrated that over the following 17 years, ex-POWs suicidal ideation increases over time compared to non-captive veterans.

1.1.2.5. Collective Effects of Torture

The individual effects of torture on people who are directly exposed to police and military violence have been detailed in previous sections. However, its destructive consequences are not solely limited to the individuals. Torture with such a large number of victim aims to paralyze whole society with devastating effect on political and social life in the country (Genefke, 1994). When a conflict arises between the government and

its own people, as happened during the Military Coup, individuals often have a hard time making sense of their experiences (Paker, 2003). They become suspicious, polarized and full of anger as a result of feeling betrayed by the very entity it deeply trusts for protection and safety. It has been shown that in this sort of conflict, activists develop better coping mechanisms than people who are passively involved. They have a greater understanding of their action's implications, and are better equipped to deal with the consequences (Paker, 2003). 1980 military coup specifically targeted the Kurdish and Alevi population in Turkey with the aim of creating a uniform Turkish society (Zeydanlıoğlu, 2009). Only a small minority of Kurds was actively involved in clashes with the government; the majority of Kurdish people detained and tortured were passive bystanders who had a difficult time with dealing with the post-traumatic events. This leads to deeper and more prolonged effects of trauma in their lives, increasing the likelihood of trauma transmission to their children

Excessive police force and the huge number of people exposed to persecutions caused traumatized community. The parents, wives, children and friends of deaths, detainees and tortured victims were also traumatized from the government's brutal policies. 1980 military coup resulted with approximately 15-20 million traumatized people which correspond to one quarter of the population (Paker, 1996). In order to explain the influences of extreme violence in a broader range, Paker defines 4 affected groups: 1) Victims directly exposed to violence, 2) Relatives/friends of victims, 3) Social groups that victim belongs to, 4) Whole population. Because this section is strongly correlated with the community trauma the third group will be analyzed.

The third group impacted by the ripple effects of systematic torture by the government is the social groups that have close ties to the individuals that directly experience torture. These groups may be political, ethnic or religious. The best examples are leftists, Alevi and Kurdish populations. When the members of these groups witness the suffering of one of their own, they start perceiving the hostility towards their own identity. This leads to deeper sense of belonging to the group, and tightening of bonds between group members (Paker, 2003).

National healing requires truth, justice and apology but first society has to accept what was happened by coming to an end of social denial and silence (Quiroga & Jaranson, 2005). However, Turkish state and society couldn't achieve the confrontation with its bloody history and still continuous to live under the shadow of the coup (Paker, 2007). In addition, Riedel (2014) emphasize that "collective trauma spreads in the face of collective denial" (pg 251) which is exactly defines the attitude of the state and the society following the military coup. The victims are still confronting the pasts trying to have their voices heard and seeking justice through ongoing trials.

1.1.3. Children of Trauma Survivors

Studies inquired the effects of collective traumas on next generations revealed specific patterns and characteristics for the children of trauma survivors. A research conducted with children of aboriginal families living in Canada, found that cumulative effects of collective trauma continuous to negatively influence offspring by making them more vulnerable to greater stressors (Bombay, Mateson & Animsan, 2014).

A study investigated PTSD, depression, anxiety signs, attention deficit problems, maladaptive behaviors, somatization and psychotic symptoms with the 45 children of immigrant Lebanese and Iranian parents who were exposed to torture (Daud, Skoglund & Rydelius, 2005). According to the interview results, torture survivor's children whose ages vary between 6 and 17 had significantly higher scores in PTSD symptoms, somatisation and depressive dimensions than control group (Daud et al., 2005). Moreover, another research conducted by Fossion et al. (2014), demonstrated increased depressive and anxiety symptoms among children of Holocaust survivors. Additionally, lower coping skills in the face of adversities are documented. Authors concluded that the effects of pathological family functioning on depressive and anxiety symptoms are mediated by decreased coping skills (Fossion et al, 2014).

Another research observed the relationship between the psychopathology in children and contribution of maternal and paternal PTSD (Yehuda, Bell, Bierer, Schmeidler, 2008). Results revealed that son or daughters of Holocaust survivors exhibit more anxiety, PTSD, alcohol abuse and mood disorders but not eating or adjustment disorders. More strikingly, it was found that maternal PTSD greatly contributes to PTSD in children, whereas depression is closely associated with the paternal PTSD (Yehuda et al. 2008).

Children of survivors experience interpersonal problems including poor verbal communication skills. Since the events about the trauma are not allowed to be articulated or shared with outsiders due to family secret, the intimate relationship is obstructed (Danieli, 1998). In addition, Mazor & Tal (1996), in their research

investigated the capacity of intimacy with the spouse. The sample was chosen among the children whose parents exposed Holocaust brutalities and immigrated to Israel while the parents in control group were in Israel at the time of Holocaust. Results suggest that out of 10 subscales that measure capacity of intimacy, 7 dimensions showed significant differences between the two groups. These dimensions are attachment to partner, being available, feeling close and helping the spouse, cooperation capacity, trust and loyalty and difficulty to express frustration and anger feelings. More importantly, it was emphasized that the children who were born soon after the war and 15 years after the parental trauma share common specific features of intimacy (Mazor & Tal, 1996). The similar findings were reported by Wiseman et al. (2002). In their study they found that depending on their parents' attitude of hiding past trauma, the children display interpersonal dysfunction and lower affiliation in their relations.

Illiceto et al. (2011) compared the grandchildren of holocaust survivor survivors with children of non traumatized parents. They investigated helplessness, temperament, anger, attitudes, personality and expectations for interpersonal relations. The results indicated that grandchildren of Holocaust survivors perceive others as insecure, unreliable and rejecting. In addition they exhibit higher feelings of aggression and irritation than children of control group.

The sensitivity to their parents' pain is found to be a common theme among second generation (Krell, Suedfeld & Soriano, 2004). Offspring reports that in order to please their victimized parents, children try their best in school achievement, sharing only good news and avoid asking questions about the traumatic memories. In addition,

in the face of parental sadness and depression, being happy is not a positive emotion for this offspring. Thus, sensitivity and concern about the parental sadness instills persistent guilt feelings on the children (Krell et al., 2004). Similarly, the quantitative data results of another study supported that rating parent as vulnerable is positively associated with increased guilt emotions (Wiseman, Metzl & Barber, 2006). According to interview records they usually concerned about inducing worry and pain on their survivors parent. Moreover, emotional burden is an important dimension which is correlated with the guilt feelings observed in the children of survivor victims. A study conducted with second and third generation of Holocaust survivors, demonstrated that emotional burden is positively correlated with parental posttraumatic symptoms (Letzter-Pouw, Ben-ezra & Palgi, 2014). Parental burden refers to the child's identification with parental pain, in return feeling responsible and caring for their parents. Kalajian and Weisberg (2002) studied the cross generational effect of Armenian genocide with eight offspring of survivors. In their interviews majority of the participants stated the burden by carrying the emotional memories of their ancestors that is an obstacle for their freedom. In addition, they reported oppressive burden either to completely cut the bonds with Armenian-American community or overly involve in.

However, literature findings are inconsistent. Several studies did not found any significant association between parental trauma and children psychopathology (Sigal & Weinfeld, 1989; Schwartz et al., 1994). Similarly, Natan (1988) did not found any evidence for higher somatic problems, worse social functioning, psychiatric health problems and low academic success in children of survivor parents, but he pointed to better adjustment capacity for difficult and new circumstances. Therefore, the

conclusion drawn from this finding is that children of survivor families show more resiliencies and are better in coping with stress (Natan, 1988).

Studies investigated the effects of transgenerational trauma with children of survivors found that separation problems are among the most common features (Rowland-Klein & Dunlop, 1997). It was found that children of trauma survivors continue the symbiotic relationship with their parents in later ages and have problematic separation period. In a study with adult children of Holocaust survivors, examined the capacity of separation from the family and capacity for intimate relation with spouse (Mazor & Tal, 1996). The interconnectedness was evaluated under three categories which are psychological, functional and financial. The results revealed that children of Holocaust survivors showed increased level of psychological dependency toward their parents when compared with non -survivor families. However, no evidence was found for the dependency on functional and financial areas. Similarly, Kellerman (2001c) pointed to exaggerated family attachments in these families. Temporary separations among survivor family members are rarely observed. Due to lack of trust to others, overnight trips or vacations without the whole family members are not supported by the parents (Katz & Keleman, 1981). In addition, many offspring reported pressure by the parents for staying at home with the family members instead of support for peer meetings. In these families, detachment is usually experienced with strong feelings of abandonment and trigger parents' feelings associated with previous unbearable traumatic losses (Rowland –Klein & Dunlop). The results of the study conducted by Felsen and Shmuel (1990) indicated that children of Holocaust survivors showed less separateness than children of parents who did not experiences Holocaust. They differentiated from

control group in separation with preference for geographic proximity, frequency of parental meeting and phone calls, and difficulty in separation. Moreover, Freyberg (1980) with the clinical implications demonstrated that due to unfinished individuation, offspring of Holocaust survivors show difficulties in trust, being confident and satisfaction from life.

Studies also support that children of trauma survivors experience more difficulties in expressing anger which is usually apparent in acting outs, anger explosion and highly demanding behaviors in their close relations with spouses or friends (Erel, 1989). Astudy consisting of both qualitative and quantitative data, found that children of survivors had high level of anger (Wiseman, Metzl, & Barber, 2006). Parents' extreme concerns for the safety of the children and overprotective parenting style evoke anger in the children. In the narratives, children reported that although they are aware of the good intention of the parents their controlling behaviors are still made them angry. One of the corner stone study conducted with 19 offspring of Holocaust survivor parents and 19 children whose parents were in Israel at the time of World War II (Nadler, Kav-venaki, & Gleitman, 1985). The results of projective test analyses revealed that compared to control group, children of survivors were more likely to internalize aggression. Control group are more inclined to externalized overt aggression behaviors whereas offspring of traumatized parents feel responsible for the well-being of their parents and consequently internalize anger emotions. Further authors point that so much inhibition of anger may result with the depression, defensiveness and guilt feelings (Nadler et al., 1985). On the other hand, Sigal and Weinfeld (1985) conducted quantitative study in which investigated personality, hostility expression, rigidity, psychosomatic symptoms and

passive or aggressive anger expression comparing Holocaust survivor children and offspring off non survivor parents. The only significant different between the children is the rigidity dimension. According to results of the study, these children did not differ in the way they express anger feelings.

The investigation of somatic symptoms for the children of traumatized parents was scars. Few studies examined and found significant differences in somatization and hypochondriasis for children of survivors. Hoppe (1968) initially pointed to the somatization among children of Holocoust survivor parents. Litchman (1984) found that parental guilt inducing communication was significantly related with hypochondriasis in children along with paranoia and low ego strength. Furthermore, gender differences were found, females having more hypochondriac symptoms than men. As cited previously, Daud et al. (2005) found significant differences in somatization for the children of Holocaust families.

1.2. Separation-Individuation

For the healthy development individual autonomy, independence and self-efficacy are strongly emphasized and encouraged in the perspective of psychoanalytic theories (Ericson, 1968; Mahler, 1972). Separation from the family and individuation during the adolescence period is accounted as a fundamental principle for the classical theories. In the general sense, individuation refers to a process in which adolescent initiates to be autonomous, creating their own boundaries while maintaining the sense of attachment with their parents, friends and partners without sustaining enmeshed relations with them (Lapsley & Edgerton, 2002). Mahler (1974) suggests that mother and child

gradually separate moving out from the symbiotic relationship**.** Separation is a requisite of autonomy in the relational context without total isolation (Lapsey & Stey, 2010). Adolescence is the period in which a separate and distinct self development takes place resulting with the differentiation from parents. People who succeeded the processes of separation- individuation during the adolescence are psychologically healthy, smoothly adjust to college and tolerable to separation feelings (Lindsey, 2014). On the other hand, incomplete separation- individuation stage due to inappropriate environmental conditions that impedes normal development may be an obstacle for the growth of autonomous self which is manifested as intolerance for staying alone, lack of self boundaries and problems with the family (Lapsey & Stey, 2010).

1.2.1. Cultural Differences on Individualism and Collectivism

The self is a social product formed by early parenting practices which are largely shaped by the culture (Kagıtcıbası, 2007). It is crucial to note that so much emphasis and encouragement on separation- individuation process is largely supported in individualistic Western cultures. Western world confirms only separate self as a healthy model. In these cultures the sharp line is drawn between the self and others (Kagıtcıbası, 2007). Whereas in highly collectivistic cultures, Japan and China, where connectedness and dependence valued, symbiotic and enmeshed relationship between parent and children continuous to be present in later ages (Caudill & Frost, 1973). According to Hofstede (1980), individualism is associated with autonomy, emotional independence, privacy rights and pleasure seeking, on the other hand, collectivism values relatedness, collective identity, emotional dependence, group solidarity and sharing.

A study investigated the effects of socio-cultural differences on relatedness and autonomy for major depressive disorder among German and Turkish women. The results showed relatedness predicted better health for Turkish participant of healthy group, whereas for German women autonomy positively associated with better mental health (Balkir, Arens & Barnow, 2012). However, among depressive group autonomy predicts better mental health for both culture.

Not all collectivistic or individualistic cultures adopted exactly same values. A study compared two collectivistic cultures, Japan and Turkey, found differences in the nature of interconnectedness. Results indicated that Japanese interdependency stresses conformity referring to regulate behaviors to satisfy expectations of others, where as Turkish culture emphasized relatedness with enmeshed boundaries in which people perceive the needs of others as their own needs (Güngör, Karasawa, Boiger, Dincer & Mesquita, 2014). In addition, although both cultures are collectivistic the results revealed that they emphasized autonomy for the individual’s well- being.

1.2.2. Autonomous –Related Self

The contradictions to dichotomous conceptualization of the self as either autonomous or related construct lead to new theory assumptions. As opposed to separation- individuation theory, from 1970s the new theories assumed both autonomy and relatedness as two basic needs that can be coexist (Kagitcibasi, 1996; Deci & Ryan, 2000). Therefore, autonomy and connectedness are presented for two different dimensions of the self. For instance, a study compared American and Taiwanese

mothers' childrearing practices found that "independence and interdependence are not in opposition or mutually exclusive" (Wang & Lemonda, 2003). Positioning separateness and connectedness on the same dimension as the two poles of the same continuum is a conceptual problem (Kagitcibasi, 2005).

Self Determination Theory, proposed by Kagitcibasi (2005), is based on the two distinct dimensions named agency and interpersonal distance. Autonomy and heteronomy are the different poles of the agency dimension, while separateness and relatedness constitute the two edges of interpersonal distance. Autonomy is defined as "willful agency" that is self-governed instead of receiving the rules by outsider while heteronomy indicates dependency that person needs for someone else to be governed. It is crucial to emphasize that autonomy does not refers to separateness from others. The dimension of interpersonal distance suggests self-other relationship. In addition, the agency and interpersonal distance dimensions are positioned orthogonally which makes possible the coexistence of each pole, creating four combinations. People may have different degrees on each dimension. For instance, one might have high degrees on both autonomous and separate self at the same time. Studies from different cultures including individualistic societies demonstrated that the optimal and healthiest combination is autonomous-related self whereas heteronomous-separate self indicates pathological cases.

A research study examined Turkish adolescents' well being according to autonomous and related constructs, indicated that adolescents who perceive themselves as relational and autonomous-related have higher life satisfaction and scored positively

in affect scales than autonomous adolescents. The findings reveal the importance of relational needs of Turkish children for the life satisfaction (Ozdemir, 2012). Similarly, another study found positive correlation between autonomy and depression and negative association for autonomy and life satisfaction. Satisfying two basic needs, autonomous-related self contributes both life satisfaction and facilitate coping with depression (Morsunbul, 2013).

Since many of the research studies are conducted with western perspective which strongly accepts separation-individuation construct, the literature review contains findings about the separation- individuation process rather than comparisons about the autonomous-related self.

1.2.3. Parenting Style and Separation

Different caregiver- child interaction, causes variations in the development of the self. The studies suggested that there is significant cross- cultural differences in the parenting practices. Keller et al. (1999) found that bodily contacts are frequently observed in collectivistic African cultures while face to face communication system is more prevalent in western societies. In addition, Choi (1992) in his study compared the Korean and Canadian parent- child interaction. The results suggest that Korean mothers are relationally attuned and often involved in the children's lives causing the development of relational self, however Canadian parents are found to be withdrawn from their children's lives leading to the growth of separate self. The culture of relatedness in collectivistic societies refers to relational model consisting of

connectedness within the familial and cultural environment leading to partially overlapping selves without clear cut boundaries with others (Kagitcibasi, 2007).

Kagitcibasi (2005) analyzed different parenting practices in various cultures to examine the determinants of parenting styles. The link between culture, self and behavior was explored with the developmental perspective to explain underling mechanism behind the autonomous- related self. The concept of autonomous – related self emerged from the theory of family change (Kagitcibasi, 2005). In this model she proposes mainly three family models that are model of interdependence, independence and psychological/ emotional interdependence model.

Family model of interdependence refers to the traditional families whose members emotionally and economically dependent on each other. It is frequently found in patrilineal, agrarian societies in which culture of relatedness is observed in family and societal level. Low socio economic regions of urban societies may function similarly. In the lack of affluence household shares the work, child care and production for the welfare of the family (Kagitcibasi, 2007).Grown up children largely contribute to family economy. Therefore independence and autonomy of the children are not encouraged and perceived as a threat for the family future. Otherwise children would take care of their own interests. As a result, parenting style is shaped accordingly leading to obedience-oriented and authoritarian parenting style. Consequently, the formation of relational self is completed.

On the contrary, family model of independence is prevalent in industrialized, urban, Western cultures. Since affluence and education level is high in these societies children are not expected to contribute family economy. Therefore, children encouraged to be self-sufficient and independent both emotionally and economically. This is enabled with self-reliance orientation by the parents resulting with the separate self formation. Kagitcibasi (1990) in her family change theory suggest that with increasing affluence and decreasing need for economic support of the children there is a global shift from family model of interdependence to the model of independence. However, psychological interdependence continuous to be present especially in collectivistic societies. This pattern brought the third model of family theory.

Finally, the third type is the psychological or emotional interdependence family model in which material autonomy of the child is tolerated. In this model parenting promote both autonomy and relatedness leading to autonomous- related self development. This study shows how culture shape parenting practices which in return leads to specific type of self development.

1.2.4. The Role of Attachment on Separation

The relation between attachment and separation-individuation process was approved by many studies (Van Ijzendoorn & Sagi, 1999; Lopez& Glover, 1993). In a broader concept, Bowlby (1988) defined attachment as the capacity to form bonds with the sensitive and responsive mothering which provides “secure base” for the child while discovering the world. Attachment theory suggests that based on the early relationship

with the caregiver internal working models are formed which contains perceptions about self (I'm lovable) and expectations from relationships with others (Bartholomew & Horowitz, 1991). Once internal working models are created they carried into new relationships throughout the life becoming a part of the personality. People with secure attachment have defined themselves positively and perceive others as trustworthy, reliable and dependable. On the other hand, individuals formed insecure attachment due to unresponsive parenting, may rate their selves unworthy or unlovable and others evaluated as unavailable, rejecting and untrustworthy (Bowlby, 1988). In addition, studies found evidence for the assumption that securely attached individuals feels more comfortable with the autonomy and they do not depend on others for sense of self-worth. In contrast, individuals formed insecure attachment (dismissing, preoccupied and fearful) due to unresponsive and distant parenting, may depend on others or need for avoidance of intimacy which are two opposite sides of the continuum (Ryan & Deci, 2000).

1.3. Anger

1.3.1 Definition of Anger

Anger is one of the universal and common emotions experienced by human beings (Canary, Spitzberg & Semic, 1998). Darwin (1965) evaluates rage having adaptive and survival value which is universal emotion both in humans and animals. People usually feel angry when they face with criticism, rejection, insult and aggression toward them (Lazarus, 1991).

The definition of anger has been a problematic issue. For a long period of time the word anger and aggression was used interchangeably failing to make distinguishes between them (Digiuseppe et al., 2006). The most commonly used definition suggests that "specific uncomfortable subjective experiences and associated cognitions that have variously associated verbal, facial, bodily and autonomic reactions" (Kassinove & Sukhodolski, 1995, p.11). Novaco's (1998) definition of anger includes interpersonal nature of anger suggesting that "a negatively toned emotion subjectively experiences as an aroused state of antagonism towards someone or something perceived to be the source of an aversive event" (p.13). State of antagonism refers to ongoing tension, fight, conflict or struggle. Spielberger (1972) distinguishes the state and trait of anger. State anger is a transient emotion and eventually passes, whereas trait anger implies frequency and intensity of anger emotion. In a broader meaning trait anger involves personality characteristics of anger proneness (Spielberger et al., 1983).

It is important to distinguish the constructs of anger and aggression. As described above, anger is a feeling and attitude, whereas aggression intent to harm and refers to destructive or punitive actions directed toward other people or objects (Spielberg, 1985). Richardson and Baron (1994) emphasize aggression as a behavior that intentionally aims to harm and in contrast to anger it is not an idea, attitude or thought. The link between anger and aggression is proposed by Nasir & Ghani (2014) claiming that when anger cannot be taken under control it leads to aggression.

1.3.2. Direct and Indirect Aggression

Anger is one of the most frequently expressed emotions. Evolutionary, anger is adaptive reaction when encountered with threatening stimulus and necessitates taking actions against danger. The fight or flight response is triggered with the physiological responses under such conditions (Lazarus, 1991).

Because of the accompanying intense physical reactions including flight or defend response, anger is usually difficult to control (Lochman et al., 2009). Responding with angry feelings to other people results interpersonal troubles. However, it is crucial to express anger calmly in an appropriate way rather than inhibiting or restoring to aggression (Guerrero, 1994) The ability to manage anger emotions is closely linked to interpersonal relationship, self-esteem and health (Lochman et al., 2009). Expression of anger may take forms of violence, self-harm, physical and verbal aggression and even homicide.

The most evident form of aggression is physical and verbal attacks. Richardson and Green (2003) in their research investigated how subjects behave when they feel angry. The questionnaire was able to make distinguishes between direct and indirect aggression. Direct aggression, such as yelling or hitting, is oriented straightly to the person aimed to damage. In contrast, behaviors such as spreading rumoring or damaging possessions are the forms of indirect aggression that other people or objects are involved to hurt someone else (Richardson & Green, 2003). Indirect aggression utilizes from the social manipulations without personal involvement to harm the victim (Björkqvist,

Österman & Kaukiainen, 1992). Therefore, relational and social aggression is strongly related with the indirect aggression **of** which social manipulations and disruptive relationships are the mutual elements (Warren, Richardson & McQuillin, 2011). A study results revealed that indirect aggression is more effective in the friendship relations in social network rather than family members (Richard & Green, 2006).

1.3.3. Internalized and Externalized Anger

When anger cannot be expressed against external objects adaptively, it turns inward to the self, leading to depression, psychosomatic problems and even hypertension (Alexander & French, 1948). A study conducted with people suffering from coronary artery disease demonstrated that these are the people who mostly suppress emotions (Denolette et al., 2010). Some researchers argue that people suppress angry feelings to avoid negative social consequences (Beatty & McCroskey, 1997). Inhibition may prevent some social problems but causes adverse effects on people's health. Since not everybody displays angry feelings with aggressive behaviors Spielberger (1985) emphasized the difference of experience of anger and its expression. Anger expression is defined with a dimension varying from strong suppression to exaggerated expression. The term anger-in refers to tendency to suppress feelings of aggression to avoid interpersonal conflict (Spielberger & Reheiser, 2009). Thus, both behavioral and emotional inhibitions are frequent in these people (King, Emmons, & Woodley, 1992). On the contrary, anger-out is the frequent expression of angry feelings which are apparent in verbal and physical aggressive behaviors (Spielberger & Reheiser, 2009). Zeman, Shipman and Suveg (2002) suggest that anger expressed in unacceptable ways is

associated with externalizing problems, in contrast non regulated anger expression such as long lasting crying is strongly linked to internalizing problems (as cited in Raval, Martini, & Raval, 2009).

In addition, culture determines how anger is expressed in the community. In collectivistic cultures such as Far Eastern countries, people prioritize the needs of the groups and community over their own needs (Raval et al., 2009). Given that overt expression of distress may cause discomfort for the society, these cultures value indirect expression of negative emotions (Hofstede, 1980; as cited in Keyes & Ryff, 2003). On the other hand, in individualistic cultures including U.S direct expression of distressing emotions are supported.

1.3.4. Gender Differences in Anger Expression

Men and women show differences in the ways they express and cope with anger. Men usually show higher inclinations for verbal and physical aggression for the solutions of conflict (Bell & Forde, 1999). In many cultures, socialization values for men emphasize aggressiveness, dominance and autonomy, while females are expected to be caring and nurturing (Bem, 1981). As a result of gender specific- socialization in Western cultures, women are expected to suppress their anger and men are encouraged to express it (Lochman et al.). As a result of inhibiting anger behaviors, women report experiencing anger more intensely and for a longer period of time than men (Fischer & Menstead, 2000 ref ara), The study identified gender differences in direct and indirect aggression found higher rates of male for direct physical aggression (Archer, 2004),

whereas studies utilizing laboratory scenario methods suggest that women show more relational aggression compared to men (Hess & Hagen, 2006). Moreover, women report more guilt and concern after expressing feelings of aggression on the negative consequences of their behavior (Eagly & Steffen, 1986).

1.4. Somatization

1.4.1. Definition and Prevalence

Lipowski (1988) defines somatization referring to a tendency of suffering from persistent medically unexplained symptoms resulted from psychological distress (As cited in Gucht & Fischler, 2002).Somatic complains include headaches, stomach pains, backache, allergies, chronic pains, gastrointestinal and cardiovascular problems. Sharp, Bass & Mayou (1995) suggest that almost everybody in his life may suffer from these symptoms for a transient and relatively shorter period of time with no significant effect on daily life (as cited in Suen &Tusaie, 2004). However, three points are crucial to differentiate somatization. Firstly, the medically unexplained physical symptoms should be present persistently decreasing quality of life, secondly, the person is extremely sensitive to bodily sensations and thirdly, somatizers frequently seek medical help instead of dealing with emotional problems (Suen & Tusaie, 2004). Brodsky (1984) also explained somatization as an unconscious way of representing emotional distress through body language (as cited in Koh, Kim, Kim, Park, & Han, 2008). Moreover, Katon et al. (1982) agrees that non organic physical complaints are perceived as one of the coping strategies with psychological distress (as cited in Koh et al., 2008). In addition, alexithymia is a closely related concept with somatization and significantly

prevalent in somatizers, referring difficulty to describe feelings because of the limited ability to separate emotions from bodily sensations (As cited in Komaki, 2013).

Somatization disorder and symptoms especially chronic pain is highly encountered in public health sector. Dionne (1999) found the percentage of somatization prevalence for the whole population in between 58% and 84% (As cited in Sharp & Harvey, 2001). The somatization prevalence study conducted in Germany revealed that among the participants 82% reported at least one somatic symptoms (Hiller, Rief, & Brahler, 2006). Out of 53 symptoms of ICD/ DSM-IV, the mean number of present symptoms per person was 6.6. Back pain and headaches are being the most common somatic symptoms in the population (Hiller et al., 2006; Sharp & Harvey, 2001).

The prevalence rates in Turkey were found between % 43 and 68 % among the patients who referred to hospitals and clinics (Ayhan et al., 1988). A study examined lifetime prevalence of conversion symptoms, a subcategory of somatization, among non clinical sample of 628 women. Results indicated that 48.7 % of the women had conversion symptoms which are extremely high (Sar, Akyüz, Dogan & Öztü, 2009). The most frequently observed symptoms were dizziness (22.9 %) and fainting (22.1%) in Turkish society.

1.4.2. Anger Expression and Somatization

Impeding the expression of emotionally charged feelings is one of the major reasons for somatization (Koh, 2013). Anger is frequently experienced emotion which is

usually suppressed to avoid its aversive consequences. Many research found evidence for the relationship between anger inhibition and somatization (Koh et al., 2008; Liu, Cohen, Schulz & Waldinger, 2011; Okifuji, Turk, & Curran, 1999). Koh et al. (2008) investigated the link between anger management and somatic symptoms in anxiety and somatoform disorders. Results of the study revealed that both disorders were positively correlated with anger inhibition. They further searched the pathway from anger suppression to somatization. The path model analysis showed that non expressed anger feelings are strongly correlated with depression leading to anxiety which has a direct link with somatic symptoms. Thus, anger turned inward has an indirect but significant impact on somatization, whereas overt anger expression has no association with somatization or anxiety disorders (Koh et al., 2008). Other research by Koh et al. (2005) with 47 patients of somatoform disorder supported that anger inhibition is a predictor of somatic symptoms. Similarly, a study conducted by Liu et al. (2011), examined the relationship between anger, attachment and somatization with a sample size of 101. In their research they found that the association between insecure attachment and somatization is mediated by increased level of anger for men and anger suppression for women. In addition, exposing partner violence is strongly associated with higher somatic symptoms by women in this study. Okifuji et al. (1999), specifically examined the correlation between chronic pains and expressed anger. The results suggested that target of anger makes difference. In other words, anger turned inward which targets the self is found to be particularly associated with chronic pain. In contrast, anger directed at health care providers does not contribute to the severity of pain. Thus, it is necessary to consider anger with overall level of anger and where it is directed (Okifuji et al., 1999).

1.4.3. Trauma and Somatization

The association between trauma and somatization has gained significant attention (Taycan, Sar, Celik, & Erdagan-Taycan, 2014; Samelius, Wijma, Wingren, & Wijma, 2009; Kugler et al., 2012). It has been studied with various samples of trauma survivors in different cultures. In Turkey, Taycan et al., (2014) investigated trauma and somatization disorder for women living in eastern Turkey. Due to lack of opportunities in this region, these women represent very low socio economic status. The results indicated high incidence of childhood abuse among women with somatization disorder. Out of 40 somatic patients 36 stated at least one traumatic event either in childhood or adulthood, while solely 23 women had traumatic experience in control group. Furthermore, somatization symptoms were frequently accompanied with depressive, PTSD, borderline personality and dissociative symptoms. The authors concluded that dissociation was strongly associated with somatization. The findings support complex symptoms of cumulative trauma including somatization (Taycan et al., 2014). Similarly, results from another study by Sar, Akyüz, Öztürk, Alioğlu (2013) supported that among less developed regions in Turkey, increased oppressions for women, such as early and arranged marriages has a significant role in cumulative trauma in later life leading to increased rates of somatization and depression. Likewise, a study investigated the impacts of domestic violence, cumulative trauma, on mental health disoders revealed that women being married more than 5 years had higher diagnosis in somatization, emotional and anxiety disorders (Savas & Agrıdag, 2011).

In addition to increased cumulative trauma explanation for the causation of somatization, posttraumatic cognitions were considered as another explanation. The negative cognitions about self, world and future are found to be correlated with persistent PTSD symptoms which is associated with increased somatic symptoms (Koo, Nguyen,Gilmore, Blayney, & Kaysen, 2013).

1.4.4. Cultural Differences on Somatization

Somatization exists in every society however its prevalence rates changes significantly in different cultures. People living in Asian cultures are highly inclined to communicate through somatic symptoms (Suen & Tusaie, 2004; Hsu & Folstein, 1997). To examine cross-cultural variations in somatization, Kleinman (1977) compared Taiwanese and Western patients (As cited in Wang & Kim, 2013). He found that among 25 Taiwanese depressive patients % 88 display somatic symptoms, while only %20 of the western patients had these symptoms. Similar finding was revealed among Vietnamese (Eisenbruch, 1993), Korean (Kirmayer, Doa, & Smit, 1998) and Chinese American (Hsu & Folstein, 1997) populations. In addition, the specific somatic symptoms are observed within the different cultures. For instance, south eastern Asian Cultures value the head therefore, repressed emotions were mostly expressed with headaches, whereas in Latino cultures pain emerges in nervous system including dizziness, weakness and numbness (as cited in Waitzkin & Magana, 1997). Kleinman & Kleinman (1985) argues that somatic symptoms have functional value in maintaining interpersonal ties. For instance, as Lock (1987) suggests Japanese women referring to

health care clinics with bodily complaints receive more interpersonal counseling than mental illnesses (as cited in Keyes & Ryff, 2003).

One of the major reasons for the higher somatization rates in Asian cultures is the stigmatization of psychiatric patients. Due to cultural values the lives of psychiatric patient are negatively impacted in the areas of marriage, job opportunities and family reputation (Suen & Tusaie, 2004). Therefore, referral with the pain and distress is more frequent and socially acceptable. In addition, because of the societal expectations such as obedience, conformity and self control in collectivistic cultures, the negative emotions were mostly suppressed and revealed in somatic symptoms.

Another important factor for higher prevalence of somatization symptoms in different societies is the level of socio-economic status including income and education level. People living in developing countries with low socioeconomic status had increased somatic symptoms (Escobar, Rubio- Stipec, Canino, & Corno, 1989). Living in a deprived environment results with greater psychological distress which is manifested in physical pains (Adler et al., 1994; Davies et al., 2009).

In previous section the associations between trauma and somatization have been discussed. The link between trauma, culture and somatization was examined by Waitzkin and Magana (1997). The relationship between the three was explained with a "black box" metaphor which contains narratives of traumatic events, the presence or absence of trauma during childhood and psychological defense mechanisms the survivor engaged. Theory suggests that cultural context determines how people process the

narratives of trauma and the way they get expressed either verbally or with the somatic symptoms. Depending on vulnerability degree and personal resources, people are affected and react traumatic event in varying degrees of psychological disturbances (Waitzkin & Magana, 1997).

1.5. Research Purpose and Rationale

Majority of existing research and literature on transgenerational trauma has focused primarily on Holocaust survivors and their children. Generalizing the findings from one event would mean to ignore the contextual and cultural differences. Time in history, cultural values of society, specific circumstances under which the events emerge may have an impact on how the trauma is experienced and transferred to future generations.

The studies examined intergenerational transmission of trauma, mostly criticized for selecting its sample among the clinical patients and overlooked the non-clinical population. The absence of the control group against which to compare the results is another limitation that reduces generalization of the findings.

Even though the 1980 military coup in Turkey bears a number of similarities to the Holocaust in its systematic torture of innocent civilians, there are some distinct differences that may factor into trauma transmission. There is currently very limited research focusing on the psychological effects of collective trauma on second generation living in Turkey. Thus, this research is one of the first studies examining the effects of military coup on the children of survivors.

This paper aims to address some of the shortcomings of previous research. It attempts to gather subjects from non-clinical population in its sample of both experimental and control group. Moreover, the measurement selection was made by considering the cultural factors. The autonomous- related scale, originated in Turkey by taking account the cultural values of collectivistic societies, was used.

1.6. Research Question

Main purpose of this study was to assess transgenerational trauma tansmission by questioning whether parent's traumatic experiences transfer to their children.

1.6.1. Main Hypothesis

The main hypothesis suggests that parent's traumatic experiences have a significant effect on their children.

1.6.2. Detailed Hypotheses

1- A) Children of traumatized parents are less likely to become autonomous than children of non- traumatized parents

1-B) Children of traumatized parents are more likely to internalize feelings of aggression than the children of non-traumatized parents

1- C) Children of traumatized parents are more likely to exhibit higher anger level than the children of non- traumatized parents

1- D) Children of trauma survivors exhibit more psychosomatic symptoms than children of parents who have no trauma history.

2- As the intensity of the parental trauma increases, A) children are become less autonomous B) internalize emotion of anger more, C) exhibit higher level of anger D) show higher levels of somatization than children of parents who have experienced less severe trauma.

CHAPTER 2

METHODS

2.1. Participants

2.1.1. Parents

The traumatized parent group participants consisted of 65 parents who were exposed to at least one of the following traumatic experiences during the 1980 military coup: excessive torture sessions consisting of physical and verbal violence and sexual harassment, extended detention period, imprisonment, witnessing of torture, or having a relative or friend condemned to death penalty. 24 out of 65 were parents who share custody of same child or children. All of the parents in the sample have experienced the traumatic event prior to the birth of their children. The exclusion criteria are acute traumatic experience including death of close relative, exposure to violence, life threatening serious illness, accident or surgery, and abortion within the last 6 months. In

addition, the number of divorced parents is intentionally limited to 10 parents. Age of the participants varied from 49 to 69 with a mean of 56.46 (*SD*= 4.15). The mean duration of participants' imprisonment is 43.65 months (*SD*=39.65). 5 of the participants have no history of imprisonment, and the duration of imprisonment for the remaining subjects range up to 11 years.

Unlike traumatized group, the comparison group consists of 62 parents who were not exposed to any traumatic stimulus during the military coup, and none of them has suffered a traumatic experience during the 6 months preceding this study. The ages of the parents are between 35 and 66, with a mean of 51.78. More detailed information about the demographic characteristics of the sample group is presented in Table 2.1. The traumatized and comparison groups were compared according to the demographic variables with Chi-square test. The results showed that there were no differences between the two groups for demographic variables. Table 2.1 and 2.2 demonstrates demographic variables.

2.1.2. Children

All of the children in trauma group were born after the traumatic events experienced by their parents. 8 out of 74 children of trauma survivors were siblings. The children participants were between 18 and 30 years old, and all the children were single at the time of study. The exclusion criteria are acute trauma experience within the last 6 months in both traumatized and comparison groups. Children who had long term separation from either parent due to political reasons or imprisonment of parents were

also excluded from the study. The mean age for children of trauma group is 23.29 (*SD*=3.25), and 22.54 (*SD*= 3.33) for the comparison group. The demographic characteristics of children are presented in Table 2.3.

Table 2.1. Frequencies and Percentages of Sample Characteristics

	Trauma Group		Comparison Group	
Characteristics	Frequencies (N=64)	%	Frequencies (N=62)	%
Gender				
Female	14	21.9	23	37.1
Male	50	78.1	39	62.9
Marital Status				
Married	54	84.4	56	90.3
Divorced	10	15.6	6	9.7
Education				
Primary school	3	4.7	1	1.6
Intermediate school	8	12.5	6	9.7
High school	25	39.1	17	27.4
University	27	42.2	37	59.7
Graduate	1	1.6	1	1.6
Monthly Income (in TL)				
1,000-3,500	25	39.1	36	58.1
4,000-5,000	29	45.3	22	35.5
6,000-7,000	8	12.5	3	4.8
7,000-10,000	2	3.1	1	1.6
Presence of Trauma	64	100	0	0

Table 2.2. Frequencies of Traumatic Experiences of Traumatized Parents

Traumatic experiences	N (64)
Surveillance	59
Imprisonment	59
Physical Abuse	61
Torture during Surveillance	59
Torture during prison period	47
Witnessing torture	58
Death Fear	52
Fear of losing a loved one	52
Getting hurt in a riot	10
Sexual abuse	13
Death penalty of a close relative	21

Table 2.3. Frequencies and Percentages of Children Characteristics

Characteristics	Trauma Group Frequencies (N= 72)	%	Comparison Group Frequencies (N=70)	%
Gender				
Female	36	50.0	40	57.1
Male	36	50.0	30	42.9
Education				
Intermediate school	2	2.8	2	2.9
High school	16	22.2	7	10.0
University	48	66.7	49	70.0
Graduate	6	8.3	12	17.1

2.2. Instruments

2.2.1 Socio Demographic Information Form

Both parents and children were requested to fill in the demographic form (See Appendix B and Appendix C). The form consisted of questions about age, gender, number of siblings, monthly income, level of education, marital status and whether parents share the same household. It was followed with the checklist of traumatic events to examine whether they had traumatic experiences within the last 6 months.

2.2.2. Impact of Event Scale-Revised

The scale originally created by Weiss & Marmar in 1996 to measure the effects of traumatic events consisted of 3 sub-scales that measure the following dimensions of posttraumatic stress symptoms: Avoidance (8 items), hyper arousal (6 items) and intrusion (8 items). The subjects were asked to evaluate intensity of symptoms on a 5 point Likert scale ranging from 1 (not at all) to 5 (extremely). The reliability and validity

studies in Turkish culture are conducted by Çorapçıoğlu, Yargıç, Geyran & Kocabaşoglu (2006). The reported Cronbach alpha for internal consistency is 0.94. The validity of the scale was assessed with the correlation of widely used CAPS scale. Spearman analysis revealed correlations in total scores ($r= 0.705$, $p<.001$), intrusion subscale ($r=.693$, $p<.001$), hyperarousal subscale ($r=.639$, $p<.001$) and avoidance subscale ($r=.491$, $p<.001$). This scale was given only to the parents of traumatized group in order to measure the symptoms experienced within the last month.

2.2.3. Autonomous and Related Self in Family Scales

Autonomous and Related Self in Family Scales was developed by Kagitcibasi and Baydar in 2007 to measure the agency and interpersonal distance within the family context. The scale consists of 18 questions with two sub-scales: Autonomous Self in Family Scale, Related Self in Family Scale. The questions are evaluated on a 5 point Likert scale varying from strongly agree (5) to strongly disagree (1). Reliability coefficient values are .84 for both Autonomous Self and Related Self scales (Kagıtçıbaşı, 2007). High scores on autonomy scale indicate more autonomy and high scores on relatedness scale points to closer interpersonal relationships (See Appendix E).

2.2.4. State - Trait Anger Expression Inventory

State Trait Anger Expression Inventory (STAXI) was developed to measure the experience, control and expression of anger (Spielberger, Jacobs, Russell & Crane, 1983). The scale consists of 34 items which are rated on a 4 point Likert scale: Not at all

(1), Somewhat (2), Moderately (3) and Very much (4). STAI has 4 sub-scales: Trait anger, anger control, anger-in, and anger-out. The last 2 dimensions assess individual's style of anger expression. Scale's adaptation and validation studies are conducted by Ozer (1994). A high score in trait anger indicates high overall anger levels for an individual. A high score in anger control sub-scale point to a high degree of self-monitoring of anger feelings. A high score in anger-in demonstrates inhibition and suppression of anger emotions, and elevated scores on anger-out indicate expression of angry feelings with physical or verbal aggressive behaviors (Spielberger et al., 1983). Results of the Ozer's studies (1994) point to reliability of Cronbach alfa for each subscale: Trait anger: .79, anger-in: .62, anger-out: .78, anger control: .84. Validity was assessed with the correlations of Trait Anxiety (Oner, 1983) and Anger Scale (Ozer, 1975) with validity coefficient .35 and .31, respectively. The factor analysis supported three factors of the scale as found in the original article (see Appendix D).

2.2.5. Somatization Scale

The Somatization scale is a sub-scale of Minessota Multiphasic Personality Inventory (MMPI) (Hathaway & McKinley, 1943). The Turkish validity and reliability tests were conducted by Dulgerler in 2000 (see Appendix F). The somatization scale consists of 33 items and answers are given in "true" or "false" form. Each "True" answer gets 1 point and "False" answer gets 0 point, with a maximum possible score of 33 points. Higher scores indicate existence of higher somatic symptoms. The questions assess somatic symptoms of dizziness, gastrointestinal symptoms, numbness and chronic

pain. The reliability alpha coefficient is .83, split half correlation is .063 and test-retest pearson correlation is r=0.99, p<.05.

2.3. Procedure

The initial contact with the traumatized parents was carried out through "78'liler Vafi" and "Yaşam Ağacı", two institutions established by the coup survivors. The initial participants were asked to refer acquaintances that underwent similar experiences during the military coup. Using the snowball sampling technique, 74 children were reached to fill the questionnaire. The preliminary information about the study was shared with the parent volunteers over the phone, and in-person meetings were scheduled with the attendees who agreed to fully participate. One questionnaire was to be answered by parents, and another one was to be answered by their children. Due to the sensitive nature of the questionnaire, the surveys were administered face to face with parents to address any concerns they may have. Detailed information about the intent of the study was provided to each participant, who was required to sign the consent form. The parents were requested to deliver the second questionnaire to their children. The questionnaires filled by the children were returned by mail.

The parents and children within the comparison group were selected from low-income families to match the socioeconomic levels of the participants within the trauma group. The snowball sampling technique was also utilized in recruiting participants for the comparison group. Following the initial reach over the phone, the questionnaires were sent via e-mail.

CHAPTER 3

RESULTS

3.1 Data Screening

The collected data was analyzed to investigate differences on the dependent variables between the children of traumatized parents and non-traumatized parents. IBM SPSS program was used for the analysis. Prior to analysis, data were screened for univariate and multivariate outliers. One participant was found to be a univariate outlier in Anger-in subscale, and another subject was found to be a multivariate outlier in Autonomous-Related scale. Thus, they were excluded from the analysis. The final analysis was conducted with 72 children and 65 parents in the trauma group, and 63 parents and 70 children in the comparison group.

3.2. MANCOVA Analysis

The total scores for autonomous- related self, anger and somatization variables and the subscales which are anger-in, anger-out, anger control, trait anger, autonomous and relatedness were analyzed separately with multivariate analysis of covariate

(MANCOVA) analysis. Due to the significant gender effect on anger and somatization variables, the present data was examined controlling gender variable in all analysis.

3.2.1 Correlations among Dependent Variables

Prior to conducting MANCOVA, Pearson correlations were performed for all the dependent variables, including subscales, in order to test the MANCOVA assumption of moderate correlation between the dependent variables. The observed correlations are presented in table 3.1, supporting the appropriateness of MANCOVA.

Table 3.1 Pearson Product-Moment Correlation Coefficients Between Dependent Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. Autonomous Self	1.0								
2. Related Self	-.44*	1.0							
3. Total Separation	.50**	.53**	1.0						
4. Somatization	.08	-.10	-.03	1.0					
5. Total Anger	.007	-.25**	-.24**	.21*	1.0				
6. Anger- Trait	-.10	-.20*	-.30**	.30**	.71**	1.0			
7. Anger- In	-.01	-.27**	-.27**	.16	.72**	.26**	1.0		
8. Anger –Out	.01	-.28**	-.26**	.24**	.70**	.67**	.32**	1.0	
9. Anger- Control	.13	.19*	.32**	-.22*	-.02	-.55**	-.02	-.49**	1.0

Note *p<.05 ** p<.01

3.2.2. Results of Analysis for Total Scores between Trauma Group and Comparison Group

Controlling for gender effect, one way MANCOVA was conducted for 2x3 factorial design, to analyze total scores of anger, autonomous-related self and somatization for children of trauma group and non-trauma group. The results suggested that there is a significant difference between the children of traumatized parents group (*M*=10.81) and comparison group (*M*=8.35) in somatization, $F(1, 139)= 6.94$, $p<.05$, $\eta^2=.048$. The results showed that the differences in anger and autonomous-related self are non- significant. The means, standart deviation, *F* and *p* values are presented in Table 3.2. The total scores of anger were further analyzed for three groups: Low trauma, High trauma and No trauma. The parental traumatic symptoms, measured by Impact of Event Scale, divided into two groups according to above and below median score. The results revealed significant differences between children of parents exhibiting less traumatic symptoms (*M*= 69.39, *SD*= 6.17) and children of non traumatic parents (*M*= 73.66, *SD*= 9.33), $F(2, 122)=5.74$, , $p<.05$, $\eta^2=.086$.

3.2.3. Results of Analysis for Subscales of Autonomous- Related and Anger Scales between Trauma Group and Comparison Group

MANCOVA was conducted with gender as covariate, for 2x5 factorial designs, to determine the effects of parental trauma on their children in subscales of trait- anger, anger- control, anger-in, anger- out, separate -self and related- self. Thus subscales constitute dependent variable, while having parental trauma and lack of trauma were taken as independent variable. The results suggested significant mean differences

between the trauma group (*M*=28.18, *SD*= 4.32) and comparison group (*M*=25.60, *SD*= 4.93), in autonomous scale, $F(1,139)=10.63$, $p<.05$, $\eta^2=.071$. Results did not support any significant difference for other subscales. The means, standart deviations, *F* and *p* values were presented precisely in Table 3.2.

Table 3.2. MANCOVA Results of Total Scores and Subscales Between Trauma and Comparison Group

	Trauma (N=72)		No Trauma (N=70)			
	M	*SD*	*M*	*SD*	*F*	*P*
Total Autonomous-Related Self	60.01	4.89	58.48	4.72	3.58	.06
Autonomus Self	28.18	4.32	25.60	4.93	10.62	.001*
Related Self	36.31	5.11	37.27	4.74	1.22	.27
Total Anger	72.43	8.05	73.40	9.04	.78	.38
Anger- In	15.65	3.95	15.57	3.64	.001	.97
Anger-Out	15.12	3.30	14.93	3.46	.04	.85
Anger –Trait	20.50	4.86	20.87	5.25	.22	.64
Anger –Control	21.15	4.38	22.03	4.13	1.87	.17
Somatization	10.72	6.04	8.44	5.27	6.95	.01*

Note * p<.05

3.3.1. Result of Analysis for Total Scores within Trauma Group

The children of trauma group were compared for the traumatic symptoms of their parents. Depending on the scores received from Impact of Event Scale the parents were divided into “low trauma” (n= 31) and “high trauma” (n=33) groups, with the cutoff point of 27. In this analysis the 8 siblings were excluded from the study and MANCOVA was conducted with 64 parent and 64 children.

Controlling for gender effect MANCOVA was conducted to compare children in 2x3 factorial design. Results demonstrated significant differences in total scores of anger, $F(1, 61) = 14.78$, $p<.05$, partial $\eta^2 = .195$ and somatization, $F(1,61)=5.88$, $p<.05$, partial $\eta^2 = .088$. Autonomous- Related Self did not reveal any significant difference according to the intensity of parental trauma. Table 3.3 shows the means, standart deviations, *F* and *p* values.

3.3.2. Results of Analysis for Subscales of Autonomous-Related and Anger within Trauma Group

MANCOVA results revealed significant differences on trait anger, $F(1, 61)=7.02$, $p<.05$, partial $\eta^2 = .10$ and anger-out, $F(1, 61)=7.00$, $p<.05$, partial $\eta^2 = .10$, and anger-in $F(1,61)= 4.86$, $p<.05$, partial $\eta^2 = .074$. Table 3.3 represents mean numbers, standart deviations, *F* and *p* values. However, when further analysis conducted for anger subscales with low trauma, high trauma and no trauma groups, results revealed that there is significant difference only in trait anger subscale, $F(2, 122)= 3.40$, $p<.05$, $\eta^2 = .05$ between the children of three groups (see Table 3.4).

Table 3.3. MANCOVA Results of Total Scores and Subscales among Trauma Group

	Low Trauma (N=31)		High Trauma (N=33)			
	M	*SD*	*M*	*SD*	*F*	*p*
Total Autonomous Related Self	60.70	4.60	60.09	4.66	.57	.45
Total Anger	69.39	6.17	75.18	8.49	14.78	.00*
Somatization	8.90	5.00	12.45	6.08	5.88	.02*
Autonomous Self	28.03	4.23	29.18	4.30	1.04	.31
Related Self	37.26	4.48	35.33	4.98	3.16	.08
Anger- In	14.87	4.00	16.70	3.97	4.86	.03*
Anger-Out	14.16	2.50	16.00	3.79	7.00	.01*
Anger –Trait	18.64	3.37	21.45	5.39	7.02	.01*
Anger –Control	21.71	3.46	21.03	5.14	.31	.58

Table 3.4. MANCOVA Results of Anger in Children of Low, High and Non- Trauma Groups

	Low Trauma (N=31)		High Trauma (N=33)		No Trauma (N=62)			
	M	*SD*	*M*	*SD*	*M*	*SD*	*F*	*P*
Total Anger	69.39	6.17	75.18	8.49	73.66	9.33	5.74	.004*
Anger- Trait	18.65	3.37	21.45	5.397	20.97	5.33	3.40	.036*
Anger- Out	14.16	2.50	16.00	3.80	14.94	3.57	3.04	.051
Anger – In	14.87	4.00	16.70	3.97	15.67	3.82	2.05	.132
Anger- Control	21.70	3.46	21.03	5.14	22.08	4.32	.69	.50

Table 3.5. Summary of Hypotheses

Hypotheses	Support
1- A) Children of traumatized parents are less likely to become autonomous than children of non-traumatized parents	Not Supported
1- B) Children of traumatized parents are more likely to internalize feelings of aggression than children of non-traumatized parents	Not Supported
1- C) Children of trauma survivors exhibit higher level of anger	Not Supported
1- D) Children of trauma survivors exhibit more psychosomatic symptoms than children of parents who have no trauma history	Supported
2- A) As the intensity of the parental trauma increases children are become less autonomous	Not Supported
2- B) As the intensity of the parental trauma increases, children internalize emotion of anger more	Not Supported
2- C) As the intensity of the parental trauma increases, children exhibit higher anger level	Supported
2- D) As the intensity of the parental trauma increases, children show higher levels of somatization	Supported

CHAPTER 4

DISCUSSION

The present study investigated the effects of parental trauma on their children. Autonomous- related self, anger, anger expression and somatization in children was assessed. The results were compared with the children of non-traumatized parents. Findings suggest that children of trauma group are more autonomous, have more diminished anger levels, and exhibit more somatic symptoms than children of non-trauma group. The results of the research will be discussed and compared with the literature findings in the following sections. The last chapter examines implications and limitations of the present study and offers suggestions for further research.

4.1. Children of Trauma Group and Non- Trauma Group

The children of traumatized group were compared in autonomous, anger and somatization with children of parents who haven't experiences traumatic event.

The children of trauma survivors were found to be more autonomous from their families when compared with the children of non traumatized parents. However, as noted in literature review, previous studies investigating separation- individuation in children of Holocaust survivors found that these children showed less autonomy than did members of the control group (Rowland-Klein & Dunlop, 1997; Mazor & Tal, 1996; Kellerman, 2001). Several factors may contribute to differing results observed in the present study.

One reason may be attributed to the differences in how survivors internally processed the emotions associated with trauma to find meaning in their torture. It has been found that highly committed political activists with a strong belief system exhibits relatively low levels of traumatization compared to non-activists (Basoglu et al., 1996) These people have a greater understanding of their action's implications, and are better equipped to deal with the consequences (Paker, 2003). Most of the subjects who agreed to attend this study identified themselves as an activist at the time of the military coup. Comparing them to the Holocaust survivors, it can be argued that they experienced the symptoms of PTSD less severely. Such significant variations in internally processed emotions may lead to different kind of transference to their children as being autonomous.

A second explanation, also tied to majority of participants being political activists, may have to do with the increased levels of autonomy present in parents. Previous studies reveal that parents who reported encouragement for autonomy by their

own families are more likely to support their children's separation (Charles, Frank, Jacabson & Grossman, 2001). Based on the active voluntary involvement in fighting for their rights prevalent across the participating subjects, it can be argued that most parents were relatively autonomous and encouraged autonomy in their children.

Moreover, transmission of resilience is also included in the framework of transgeneration. A long with the trauma transmission the coping strategies and ways of overcoming oppression may be transmitted to children (Duran, Firehammer & Gonzalez, 2008; as cited in Goodman, 2013). This politically active group overcame the persecutions and imprisonment with group rebellions as reported by a participant. If the idea for fighting their rights and revolt has passed on their offspring, then it is not surprising for these children to feel autonomous. Because of all the reasons explained above, the results showed opposite directions of what was hypothesized.

Results indicated that there were no difference in relatedness between the children of traumatized parents and non traumatized parents. Since previous research did not investigate the relatedness in offspring of traumatized parents directly, there is deficient information in the literature at this topic. As stated in previous section, the studies examined separation- individuation found that offspring of traumatic parents showed enmeshed relationship with their parents. However, having difficulties in separation from family does not necessarily mean that children are strongly related with their parents.

For the present study, culture may play an important role for the non significant difference in related- self between the two groups. Turkey is a collectivistic society with strong emotional and material interdependency across generations. Kagitcibasi's model of family change (2007) argues that people living in rural areas have both emotional and material dependency in extended family, whereas individuals in urban areas have characterized with emotional dependency with decreased need of economically due to higher education and income (As cited in Eraslan, Yakalı-Camoglu, Harunzade, Ergun, & Dokur, 2012). A study compared the Japanese and Turkish culture also revealed culture specific elements of collectivism including strong relatedness with enmeshed relations and blurred boundaries (Güngör et al., 2014). Acknowledging Turkish society as highly collectivistic, both groups of the current study were almost equally related to their families. Therefore, as it was expected no differences were observed between the two groups belonging to the same collectivistic culture.

The results showed higher anger levels in the children of non-traumatized parents than children of parents who had relatively lower levels of post traumatic stress symptoms within the experimental group. This result may indicate post-traumatic growth in the children of trauma survivors as the parents' resilience and coping strategies may have transferred to their children (Goodman, 2013). The children of survivors may be positively transformed by listening to the narratives of how their parents coped with their own traumatic experiences. They may have modeled their coping mechanisms after their parents to build up their resilience and subsequently experience lower anger levels when faced with adversities. This is consistent with the findings of the qualitative study conducted with the children of Holocaust survivors

living in Brazil. This study concluded that the presence of an open, loving communication style enabled creation of symbolization mechanisms, which, in turn, favored resilient outcomes among the offspring (Braga et al., 2012).

In the present study, parents indicated openly sharing their traumatic experiences with their children. No participant selected "Never" as an option when asked to identify how frequently they talk about their traumatic experiences. The open communication allowed children to build higher resilience and consequently lower levels of aggression in challenging circumstances.

The results of the present study did not reveal differences in anger expression between the children of comparison and traumatized parents groups. Existing literature suggests that children blame themselves as being a source of parental sadness as a result of fragmented and indirect communication. They are less likely to externalize anger feelings to prevent inducing further pain on their parents (Nadler et al., 1985; Karr, 1973). However, the open communication between parents and children in this study may have allowed better insight into their parents' trauma and prevented feelings of self-blame. Therefore, the need to internalize the feelings of aggression may have been eliminated.

The present study revealed that the children of traumatized parents are more likely to exhibit somatic symptoms compared to children of non-traumatized parents. Although literature is sparse for investigating somatic symptoms on children of survivors, studies including psychosomatic complaints found increased somatic pain and

headaches for offspring of tortured parents (Montgomery, 2004; Lichman, 1983; Daud et al., 2003).

The 1980 military coup in Turkey had long lasting socioeconomic effects on the torture victims. They faced challenges finding jobs and received hostile reactions from the general public during the years following the coup. Given this sociocultural context, the children of survivors may have been reluctant to freely share their personal narrative of the events due to fear of attracting their parents' misfortunes on themselves. The lack of an environment that allows free expression may have prevented the formation of a coherent narrative of their parent's experiences in these individuals. Since the coherence of narrative becomes a crucial mediating variable that links trauma, culture, and somatization (Waitzkin & Magana, 1997), its absence can be the cause of higher levels of somatization observed in the children of coup victims. The non expressed traumatic emotions transferred from the parents may be expressed in the forms of bodily expressions through somatic complaints.

4.2. Children of Trauma Group for High and Low Trauma Symptoms

The children were evaluated on autonomy, anger and somatization for the intensity of traumatic symptoms experienced by the parent.

The present study did not revealed difficulty of separation for the children of highly traumatic parents. However, children of traumatized parents are found more autonomous than children of non traumatized parent. This shows that the major

determinant of autonomy is living with a traumatized parent regardless of the degree of trauma. The degree of trauma does not appear to be a factor in determining the autonomy levels in children. This supports the previously explained theory that having politically active parents play the big role in the child's autonomy with healthy internal processing of trauma.

The results of the study revealed that among the traumatized parent group, children of parents with increased trauma symptoms experienced higher anger levels than children of parents who exhibit less severe traumatic symptoms. This finding is consistent with the study examining the anger feelings in children of Holocaust survivors. It was observed that high trauma symptoms in parents caused children to perceive their parents as more vulnerable and consequently experience higher anger levels (Wiseman et al, 2006).

The link between trauma and aggression levels may be alternatively explained by the link between parental and adolescent aggression. It has been found that increased aggression levels in parents predict higher aggression in their children (Hare, Miga & Alen, 2009). The traumatic events endured by the parents may have evoked higher anger levels that may have transmitted to children.

In addition, the parental burden perceived by the child, a mechanism for trauma transmission to next generations, may explain higher anger levels in children of parents with increased trauma symptoms (Litzeter-Pouw et al., 2014). The traumatized parents may see their children as a source of hope to fulfill their unfinished aspirations and place

additional burden on them. The sample in the experimental group of this study consisted of children who identified themselves as politically active. This may be a sign of the parental burden they carry, which in turn contributes to the higher anger levels they experience.

As previously described high incidence of somatic symptoms as a result of the traumatic experiences are highly prevalent. The present study supported this relation with findings of higher somatic complaints in children of traumatized parents than children of non traumatized parents. Consistently, results also revealed that as the intensity of the parental trauma increased, more severe somatization symptoms were exhibited by the children. This result was strengthened the hypothesis of trauma transmission even further. The higher parental trauma means more secrets for the children to hide in the social relations which consequently expressed in body language through somatization. This finding supports trauma transmission from parent to children as stated in the hypothesis.

Considering both the results of present study and previous literature findings, how trauma internally processed by the parents and the communication style about the traumatic events have significant impact on children. Being politically active and having an open communication with their children may reduce the negative impacts of trauma transmitted on children and even enhance the possibility of post traumatic growth in children.

4.3. Limitations and Further Research

One limitation of this study is that all of the parents within the trauma group were politically active individuals at the time of the military coup. Due to potential differences in the way trauma is processed amongst this group, as previously discussed in detail, it would be better to include torture victims that were passive bystanders. Due to trauma sensitivities, most passive torture victims were reluctant to participate in this study. It may not be appropriate to generalize the results of this study to the children whose parents experienced trauma differently. Also tied to the politically active nature of the parent participants, all parents who participated in this study expressed talking openly about their traumatic experiences with their children. It is possible that children may react to their parent's trauma differently if parents shied away from openly sharing their experiences. The existing literature based on Holocaust survivors point to more limited communication from parents who are passive in their resistance. Including more passive bystanders from the 1980 military coup in the study's sample may yield different results.

This study relies only on quantitative data collected through questionnaires filled by parents and their children. The nature of a questionnaire does not always allow diving deeper into complex trauma experiences. Having a possibility to interview the children would give more qualitative information to better understand the transmission of trauma.

4.4. Clinical Implications

Transgenerational trauma transmission has gained importance after 2nd World War and still has a lot of dimensions to discover. Although Turkey had many traumatic events in its history, research on trauma transmission to second generation had not been previously conducted. From a clinical point of view, understanding the affects of parental trauma on their children would contribute a broader perspective in psychotherapy working with these children and their parents. This study indicated that having open parental communication about traumatic events has a positive influence on both a child's development and parent's processing of their own trauma. Therefore, parents should be encouraged to share their traumatic experiences with their children in an appropriate way within certain limits during psychotherapy.

The somatization effect of trauma is well documented in the existing literature and studies showed that it is prevalent within the Turkish population (Taycan et al., 2014). The present study found evidence for the somatic symptoms in the children of traumatized parents. In the light of this finding, psychologists and medical doctors should carefully examine family history for parental trauma when evaluating children's health. Alternative and more effective treatment methods for children of trauma victims may be developed.

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APPENDIX A

INFORMED CONSENT FOR PARENTS AND CHILDREN

Bu araştırma, Bahçeşehir Üniversitesi Klinik Psikoloji Yüksek Lisans programı çerçevesinde Perla Toledo tarafından yürütülen bir tez çalışmasıdır. Çalışmanın amacı, yaşanılmış travmanın sonraki nesillere aktarımını incelemektir. Bu çalışma anket doldurulmasını gerektiren yaklaşık 10 dakikanızı alacak bir çalışmadır.

Araştırma süresinde elde edilen tüm bilgiler ve kişisel detaylar gizli tutulacaktır ve sadece bu araştırmada kullanılarak toplu olarak değerlendirilecektir. Araştırma boyunca isminiz talep edilmeyecektir. Her katılımcı için bir numara belirlenecek ve toplanan bilgiler bu numara ile kaydedilecektir.

Çalışmaya katılım gönüllülük esasına dayalıdır. Cevaplamak istemediğiniz soruları atlayabilir veya anketi doldurmayı bırakabilirsiniz. Ancak, yarım kalmış ya da çoğu soruların cevapsız bırakıldığı anketlerin verileri kullanılamayacaktır. Mümkün olduğunca boş bırakmadan tamamlamanız faydalı olacaktır. Araştırma ile ilgili sorunuz olduğunda yardım isteyebilirsiniz. Araştırmaya katılımınızla ilgili bir sorun yaşarsanız veya bilgi almak isterseniz toledo.per@gmail.com adresine mail atarak iletişime geçebilirsiniz.

Bu bilgilendirme ve izin formunu okudum. Yürütülen tez çalışmasında kullanmak üzere yapılan bu araştırmaya katılmayı kabul ediyorum.

İsim:

Tarih:

APPENDIX B

SOCIO-DEMOGRAPHIC AND TRAUMA FORM FOR PARENTS

1) Yaşınız:

2) Cinsiyetiniz:

A) Kadın B) Erkek

3) Medeni durumunuz

A)Evli B) Bekar C) Boşanmış D) Dul

4) Evlilik tarihiniz - …………………………………………………

5) Kardeş sayısı? (Kendiniz dahil) …………………..

6) Kaçıncı çocuksunuz?

7) Eğitim durumunuz:

A) Okur yazar B) İlkokul mezunu C) Ortaokul mezunu
D) Lise mezunu E) Üniversite F) Yüksek Lisans

8) Mesleğiniz:

9) Çocuğunuz var mı? Var ise kaç tane yazınız …………

A)Var B) Yok

Kaç yılında doğduklarını yazınız ………………………………,
………..……………………, ……………………….

10) Yaklaşık olarak toplam hane geliriniz aylık ne kadardır?

A)1000-3500TL B) 3600-5000 TL C)6000-7000TL D)8000-10.000
E)10.000 ve üstü

11) Genel sağlık sorunu yaşadınız mı?

A) Evet B) Hayır

12) Psikiyatrik tanı aldınız mı?

A) Evet B) Hayır

13) Daha önce psikiyatrik destek aldınız mı?

A) Evet B) Hayır

14) Son 6 ay içinde aşağıdaki olaylardan birini yaşadıysanız işaretleyin.

a) Yakın aile üyelerinden vefat

b) Ailede şiddette maruz kalma

c) Hastalık, yaralanma, ameliyat ya da kaza nedeniyle hayati tehlike geçirme

d) Düşük veya kürtaj olma

Diğer travmatik bir olay ………………………………………………………..

Aşağıdaki soruları 12 Eylül 1980 darbe sürecini düşünerek cevaplandırınız.

15) Eğitiminiz darbe nedeni ile kesintiye uğradı mı?

A) Evet B) Hayır

16) Politik nedenlerden dolayı görev yeriniz değiştirildi mi veya görevden alındınız mı?

A) Evet B) Hayır

17) Politik nedenlerden dolayı soruşturmaya uğradınız mı?

A) Evet B) Hayır

18) 1980 Darbesi döneminde yaşadığınız travmatik deneyimleri daire içine alarak işaretleyin.

A) Gözaltı

B) Kayıtsız gözaltı

C) Tutuklu kalma

D) Hapiste kalma (süresini belirtin………………………………………)

E) Fiziksel şiddet

F) İşkenceye maruz kalma (Gözaltı süresi boyunca)

G) Hapiste kaldığınız süre boyunca işkenceye maruz kalma

H) İşkenceye tanık olma

I) Yaşamınızın tehlikede olduğunu hissettiğiniz bir olay yaşamak

J) Başkasının yaşamının tehlikede olduğuna şahit olduğunuz bir olay

K) Çatışmada yaralanma

L) Cinsel şiddet

M) Aile veya yakın arkadaşlarınızdan birinin idamı

N) Kayıtsız gözaltı nedeni ile sevdiklerinizden haber alamama

O) Ağır şartlı tahliye

Diğer travmatik olay…………………………………………………………

19) Darbe döneminde yaşadıklarınızı ne sıklıkla aile içinde paylaşırsınız?

A) Hiç konuşmam

B) Nadiren konuşurum

C) Sık sık konuşurum

20) Eşiniz politik nedenlerden dolayı hapiste kaldı mı?

A) Evet B) Hayır

APPENDIX C

SOCIO-DEMOGRAPHIC FORM OF CHILDREN

1) Yaşınız:

2) Cinsiyetiniz:

A)Kadın B) Erkek

3) Medeni durumunuz

A)Bekar B)Evli C) Boşanmış D) Dul

4) Kardeş sayısı? (Kendiniz dahil) …………………

5) Kaçıncı çocuksunuz?

6) Eğitim durumunuz:

A) Okur yazar B) İlkokul mezunu C) Ortaokul mezunu
D) Lise mezunu E) Üniversite F) Yüksek Lisans

7) Mesleğiniz:

8) Çocuğunuz var mı? Var ise kaç tane yazınız ………….

A)Var B) Yok

9) Yaklaşık olarak toplam hane geliriniz aylık ne kadardır?

A)1.000-3.500TL B) 4.000-5.000 TL C)6.000-7.000TL D)8.000-10.000
E)11.000 ve üstü

10) Anne –baba ile büyüme durumunuz

A) Anne ve baba ile birlikte büyüdüm
B) Anne-baba boşanmış, anne ile büyüdüm
C) Anne-baba boşanmış, baba ile büyüdüm
D) Anne vefat etmiş, baba ile büyüdüm
E) Baba vefat etmiş, anne ile büyüdüm
F) Başka bir aile büyüğü ile büyüdüm

11) Ebeveynlerinizden 3 AYDAN fazla ayrı kaldığınız bir dönem oldu mu?

A) Evet annemden, ne kadar süreyle ……………………………………………….

B) Evet babamdan, ne kadar süreyle…………………………………………….

C) Hayır

11-B) EVET ise hangi nedenlerden dolayı ayrı kaldığınızı aşağıdaki seçeneklerden işaretleyin.

A) Yasal sorunlar/politik nedenler ile tutuklu veya hükümlü olması

B) Yatılı okul 1. Ortaokul 2. Lise 3. Üniversite 4.Yüksek Lisans

C) Uzun seyahat

D) Ailede ayrılık

E) İş nedeni ile başka bir şehre/ülkeye gitmek

F) Eğitim için başka bir ülkeye gitme

G) Başka bir aile büyüğünün yanında 3 aydan fazla yaşamak

Başka bir nedenden dolayı…………………………………………….

12) Son 6 AYDIR kiminle yaşıyorsunuz?

A) Anne- baba ile beraber

B) Annemle beraber

C) Babamla beraber

D) Yalnız

E) Eşimle birlikte

F) Kız/ Erkek arkadaşımla

13) Politik görüş, siyasi eylemleriniz veya toplumsal protestolarınızdan dolayı aşağıdakilerden deneyimlediğiniz varsa işaretleyiniz.

A) Gözaltı

B) Tutuklu kalma

C) Fiziksel şiddet

D) İşkenceye maruz kalma

E) İşkenceye tanık olma

F) Hapiste kalma

G) Çatışmada yaralanma

H) Polis şiddetine maruz kalma

I) Cinsel şiddet

J) Ykarıdakilerden hiçbirini yaşamadım

14) Genel sağlık sorunu yaşadınız mı?

A) Evet B) Hayır

15) Psikiyatrik tanı aldınız mı?

A) Evet B) Hayır

16) Daha önce psikiyatrik destek aldınız mı?

A) Evet B) Hayır

17) Aşağıdaki olaylardan birini yaşadıysanız daire içine alarak işaretleyin. İşaretlediğiniz şıkkın yanındaki boşluğa ne kadar zaman önce olduğunu belirtin.

A) Yakın aile bireylerinden birinin ölümü (kardeş yada anababa) …………

B) Ailede şiddette maruz kalma …………………………………….

C) Düşük veya kürtaj olma ……………………………………….

D) Hastalık, ameliyat ya da kaza nedeniyle hayati tehlike geçirme………….

E) Birisinin sizi ölümle tehdit etmesi (örneğin gasp sırasında)……………

F) Ana-baba yada kardeşleriniz tarafından cinsel istismara uğrama …………….

APPENDIX D

SAMPLE ITEMS OF STATE –TRAIT ANXIETY SCALE

YÖNERGE:

Aşağıda kişilerin kendilerine ait duygularını anlatırken kullandıkları bir takım ifadeler verilmiştir. Her ifadeyi okuyun. Sonra **genel** olarak nasıl hissettiğinizi düşünün ve ifadelerin sağ tarafındaki sayılar arasında sizi en iyi tanımlayan seçerek üzerine (x) işareti koyun. Doğru ya da yanlış cevap yoktur. Herhangi bir ifadenin üzerinde fazla zaman sarf etmeksizin, genel olarak nasıl hissettiğinizi gösteren cevabı işaretleyin.

Aşağıdaki ifadeler sizi ne kadar tanımlıyor?

	İFADELER	Hiç (1)	Biraz (2)	Oldukça (3)	Tümüyle (4)
1	Çabuk parlarım.	( )	( )	( )	( )
2	Kızgın mizaçlıyımdır.	( )	( )	( )	( )
3	Öfkesi burnunda birisiyim.	( )	( )	( )	( )
4	Başkalarının hataları, yaptığım işi yavaşlatınca kızarım.	( )	( )	( )	( )
5	Yaptığım iyi bir işten sonra takdir edilmemek canımı sıkar.	( )	( )	( )	( )

YÖNERGE: Herkes zaman zaman kızgınlık veya öfke duyabilir. Ancak, kişilerin öfke duyguları ile ilgili tepkileri farklıdır. Aşağıda, kişilerin öfke ve kızgınlık tepkilerini tanımlarken kullandıkları ifadeleri göreceksiniz. Her ifadeyi okuyun; öfke ve kızgınlık duyduğunuzda genelde ne yapacağınızı düşünerek, o ifadenin yanında sizi en iyi tanımlayan sayının üzerine (X) işareti koyarak belirtin. Doğru yada yanlış cevap yoktur. Herhangi bir ifadenin üzerinde fazla zaman sarf etmeyin.

	İFADELER	Hiç (1)	Biraz (2)	Oldukça (3)	Tümüyle (4)
11	Öfkemi kontrol ederim.	( )	( )	( )	( )
12	Kızgınlığımı gösteririm.	( )	( )	( )	( )
13	Öfkemi içime atarım.	( )	( )	( )	( )
14	Başkalarına karşı sabırlıyımdır.	( )	( )	( )	( )
15	Somurturum ya da surat asarım.	( )	( )	( )	( )

16	İnsanlardan uzak dururum.	( )	( )	( )	( )
17	Başkalarına iğneli sözler söylerim.	( )	( )	( )	( )
18	Soğukkanlılığımı korurum.	( )	( )	( )	( )
19	Kapıları çarpmak gibi şeyler yaparım.	( )	( )	( )	( )
20	İçin için köpürürüm ama göstermem.	( )	( )	( )	( )

APPENDIX E

SAMPLE ITEMS OF AUTONOMOUS-RELATED SELF

Aşağıda, kendiniz hakkında cümleler verilmiştir. Sizden istenen, her bir cümlenin **sizin için** ne derece doğru olduğunu ilgili yeri işaretleyerek belirtmenizdir. Hiçbir maddenin doğru veya yanlış cevabı yoktur. Önemli olan her cümle ile ilgili olarak **kendinizi doğru bir şekilde yansıtmanızdır**. **Her soruda sadece bir seçenek (X) koyarak işaretlenmelidir. Bütün sorular cevaplanmalıdır.**

	Hiç doğru değil (1)	**Doğru değil (2)**	**Kısmen doğru (3)**	**Doğru (4)**	**Tamamen Doğru (5)**
1. Kararlarımı ailemden bağımsız olarak kolayca veremem					
2. Ailem benim ilk önceliğimdir					
3. Kendimi aileme yakın olarak bağlı hissediyorum					
4. Ailemin katılmayacağı kararlar almaktan kaçınırım.					
5. Zor zamanlarda ailemin benimle birlikte olacağını bilmek isterim.					
6. Genellikle ailemin isteklerini kabul etmeye çalışırım.					
7. Aileme çok yakınım.					
8. İnsanlar gelecek planları için ailelerinden onay almalıdırlar					
9. Ailemle geçirdiğim zaman benim için önemli değildir.					
10. Ailemin kabul etmediği biriyle yakın olmam.					

APPENDIX F

SAMPLE ITEMS OF SOMATIZATION SCALE

Her soruyu okuyarak kendi durumunuza göre DOĞRU ya da YANLIŞ olduğuna karar verin ve daire içine alın. Bu soruları sadece kendinizi düşünerek yanıtlayın. Bazı sorular birbirinin aynısı ya da tam tersi gibi gelebilir. Mümkünse bütün soruları cevaplayın.

1. Çoğu zaman boğazım tıkanır gibi olur.	EVET	HAYIR
2. İştahım iyidir.	EVET	HAYIR
3. Başım pek az ağrır.	EVET	HAYIR
4. Ayda bir iki defa ishal olurum.	EVET	HAYIR
5. Midemden oldukça rahatsızım.	EVET	HAYIR
6. Çoğu kez midem ekşir.	EVET	HAYIR
7. Bazen utanınca çok terlerim.	EVET	HAYIR
8. Sağlığım beni pek kaygılandırmaz.	EVET	HAYIR
9. Hemen hemen hiçbir ağrı ve sızım yok.	EVET	HAYIR
10. Bazen başımda sızı hissederim.	EVET	HAYIR
11. Çoğu zaman başımın her tarafı ağrır	EVET	HAYIR
12. Sağlığım bir çok arkadaşımınki kadar iyidir.	EVET	HAYIR
13. Pek seyrek kabız olurum.	EVET	HAYIR
14. Ensemde nadiren ağrı hissederim.	EVET	HAYIR
15. Vücudumda pek az seyirme ve kasılma olur.	EVET	HAYIR
16. Çabucak yorulmam.	EVET	HAYIR
17. Pek az başım döner ya da hiç dönmez.	EVET	HAYIR
18. Tekrarlanan mide bulantısı ve kusmalar bana sıkıntı verir.	EVET	HAYIR
19. Soğuk günlerde bile kolayca terlerim.	EVET	HAYIR
20. Çoğu zamanyorgunluk hissederim.	EVET	HAYIR
21. Hemen hergün mide ağrılarından rahatsız olurum	EVET	HAYIR

CURRICULUM VITAE

EDUCATION

2012 – 2014 — **Bahçeşehir University** Istanbul, Turkey
MS in Clinical Psychology, Psychodynamic approach

2007 – 2012 — **Koç University** Istanbul, Turkey
Bachelor in Science in *Psychology* GPA: 3.07/4.0

2002 – 2007 — **Italian High School**, Istanbul, Turkey

June 2011 – Aug 2011 — **Boston University** Boston, MA
2011 Summer Term
Courses taken: Abnormal Psychology, Language Acquisition

CLINICAL EXPERIENCE

2013- 2014 — **Yedikule Surp Pirgiç Ermeni Hastanesi**

- Conducted individual psychotherapy sessions with patients suffering from relational problems and traumatic life events
- Provided consultation to inpatients going through psychiatric treatment

2010 – 2011 — **Amerikan Hastanesi** Istanbul, Turkey
Pediatric Intern

- Shadowed pedagogue Guzide Soyak within pediatric department of the hospital, focusing on therapy of children ranging from 18 months to adolescence with various disorders
- Attended therapy sessions with patients and observed the doctor's interactions
- Discussed possible therapy options with the doctor after sessions

2011 - 2012 — **Ekip Norma Razon**

- Child observation and discuss psychopathology with therapists
- Book translations that consist of various therapy methods and stories
- Attended 10 week group therapy with hyperactive children

Psi Danışmanlık

- Discussions about the psychopathological problems that are frequently observed during childhood with a therapist (Zeynep Koçak)

Güzel Günler Kliniği (Prof.Dr.Yankı Yazgan - Dr. Berk Ergun)

- Reasons, symptoms and treatment of various disorder that are mostly seen in adults with cognitive behavioral therapy perspective
- It lasts 8 weeks and each session is 7 hours
- It consists of videos from psychiatrist`s real clinical samples and role plays