T.C. DOĞUŞ UNIVERSITY

INSTITUTE OF SOCIAL SCIENCES

DEPARTMENT OF PSYCHOLOGY

THE EFFECTS OF EARLY ADVERSE EXPERIENCES ON RELATIONAL AND EMOTIONAL DIFFICULTIES AS PREDICTORS OF WELL-BEING OF UNIVERSITY STUDENTS

Ph.D. DISSERTATION

GÖKÇEN DUYMAZ SİDAL

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SUPERVISOR:

PROF.DR. FALİH KÖKSAL

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PREFACE

This has been a very long journey for me… There have been so many times that I wanted to leave it aside…If it was not for my supervisor, Prof. Dr. Falih Köksal, that could have happened. I am not sure whether there is a right way to show my gratitude and respect for my supervisor for his endless support, understanding, acceptance and encouragement. Not only he was my mentor in my academic life but also he helped me to be a better person in many ways. And also a better mother…I feel so lucky and priviliged that I had the opportunity to be his student. Thank you sincerely for believing in me…

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Dear Hilal and Şebnem… It has been a pleasure to share this experience with you. Even after going through so many unfortunate incidents, I believe we were able to comfort and motivate each other. Not only as friends but also as colleagues, I believe you are unique in so many ways. Thank you for all…

My dearest, Merve Yılmaz… I had enjoyed so much working with you… And after we fall apart, you were always there. Thank you for all you have done… I can't wait to meet you in the terrace again ;)

Special thanks to Hülya Sözsoy. You made it possible. Or else I would have never had the time to finish this thesis. You have become a part of our family…Thank you for loving and taking care of my son.

You were always with me, my dear parents. I know, sometimes, it had been hard for you to understand why I chose this profession. But, thanks to your support, I am doing what I love most as a career. I believe we have learned so much from each other. You were my strength and comfort when I needed. Thank you for who I am, all you have done for me…

My sweet, lovely sister… I can not imagine what I would have done without you. Despite all the differences we have, you are my best friend. Even when we are far away, you are my biggest support and motivation. I love you…

My husband and my friend, Oytun Sidal, you deserve the biggest thanks for your patience and support… Throughout many years, you were there to listen to my complaints, and put up with my endless hours of studying. And actually, we made it together…

My dear son, Can… I did my best while writing this thesis not to steal from the time we can spend together… All my effort I have taken was to be a "good enough" mother for you… We grew up together again… And I promise you, for a very long time, there will be no "computer working"… I love you so much…

Finally, there are many precious people that I would like to thank who are the reason for this journey… Prof. Dr. Kadir Özer, Doç. Dr. Serap Özer, Doç. Dr. Aslı Akdaş Mitrani, Doç. Dr. Ekin Eremsoy, Dr. Nilüfer Kafesçioğlu, Dr. Aslı Çarkoğlu, Dr. Münire Özlem Çevik, Dr. Müjgan İnözü… You are all with me in my heart and everyday of my professional life, I feel honored and blessed to have the chance to be your student. Thank you for making this possible, thank you for this amazing opportunity.

İstanbul, May 2018 Gökçen Duymaz Sidal

ABSTRACT

The purpose of the present study was to examine the effects of early experience as conceptualized by the early adverse traumatic experiences and perceived parenting styles on relational patterns and emotion regulation difficulties as determinants of well being and psychopathology among Turkish university students. For this purpose, 356 students between the ages of 21 and 45 participated in the study. The assessment battery consisted of Demographic Form, Adverse Childhood Experiences (ACEQ), Short-EMBU (Egna Minnen Betraffande Uppfostran- My Memories of Upbringing), Experiences in Close Relationships-Revised (ECR-R), Separation Individuation Inventory (SII), Depression Anxiety Stress Scale (DASS) and Satisfaction With Life Scale (SWLS). For the data analysis, firstly the associations of ACEQ with other variables were first investigated to reveal the specific effects of early traumatic experiences. The results of regression analyses revealed that ACE significantly predicted the attachment anxiety, separation individuation pathology, emotion regulation difficulties, life satisfaction ve psychopathology. Secondly, in order to examine the association between the study measures path analysis were conducted. The results revealed that maternal overprotection was significantly associated with relational problems and emotion regulation difficulties. Moreover ACE were predictors of emotion regulation difficulties as well. As for well-being, separation individuation pathology and emotion regulation difficulties were associated with depression, anxiety, stress and the satisfaction of life. Finally, the difficulties in adopting emotion regulatory strategies was found to be a mediator between ACE and psychopathology as well as maternal overprotection and psychopathology. The findings of the present study were discussed in the light of the relevant literature with clinical implications and future suggestions.

Keywords: Early adverse experience, parenting styles, attachment, emotion regulation, life satisfaction

ÖZET

Bu çalışmanın amacı, erken dönem olumsuz çocukluk yaşantılarının ve ebeveyn tutumlarının, ilişkisel örüntüler, duygu regülasyonu zorlukları ve yaşam doyumu ve psikopatoloji üzerindeki etkisini incelemektir. Bu amaçla, çalışmaya 21-45 yaşları aralığında 356 öğrenci katılmıştır. Katılımcılara verilen araştırma bataryası, Demografik Bilgi Formu, Olumsuz Çocukluk Yaşantıları Envanteri (OÇYE), Kısaltılmış Algılanan Ebeveyn Tutumları-Çocuk Formu (KAET-ÇF), Yakın İlişkilerde Yaşantılar Envanteri (YIYE-II), Ayrımlaşma Bireyleşme Envanteri (ABE), Depresyon Anksiyete Stres Ölçeği (DASS), Yaşam Doyumu Ölçeği'ni (YDÖ) içermektedir. Çalışma verisinin analizi için öncelikle olumsuz çocukluk yaşantılarının, çalışmanın diğer değişkenleri ile ilişkisine bakılmıştır. Bu bağlamda yapılan regresyon analizinin sonuçlarına göre olumsuz çocukluk yaşantılarının, bağlanma anksiyetesi, ayrımlaşma bireyleşme patolojisi, duygu regülasyonu zorlukları, yaşam doyumu ve psikopatoloji üzerinde anlamlı düzeyde yordayıcı bir etkisi olduğu bulunmuştur. Bunun yanında, çalışmada ele alınan değişkenlerin birbirleri ile olan ilişkisi araştırılmıştır. Bu amaçla yapılan yol analizi sonuçlarına göre, erken dönem deneyimlerin bir uzantısı olarak annenin aşırı korumacı tutumunun, ilişkisel sorunları ve duygu regülasyonu alanında yaşanılan zorlukları yordadığı görülmüştür. Bunun yanında, olumsuz çocukluk yaşantılarının da duygu regülasyonu zorlukları üzerinde yordayıcı etkisi olduğu bulunmuştur. Genel iyilik hali üzerinden, ayrımlaşma bireyleşme patolojisinin ve duygu regülasyonu zorluklarının depresyon, anksiyete, stress ve yaşam doyumunu anlamlı düzeyde yordadığı görülmüştür. Son olarak, duygu düzenleme stratejilerinin, hem olumsuz çocukluk yaşantıları ve psikopatoloji arasında hem de annenin aşırı korumacı tutumu ve psikopatoloji arasında aracı bir etkisi olduğu görülmüştür. Çalışma bulguları, ilgili literatür ışığında tartışılmış, çalışmaya dair kısıtlılıklar ele alınmıştır. Gelecek araştırma ve uygulamalar için önerilere yer verilmiştir.

Anahtar kelimeler: Olumsuz çocukluk yaşantıları, ebeveyn tutumu, bağlanma, duygu regülasyonu, yaşam doyumu

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ABBREVIATIONS

ACE: Adverse childhood experiences

ACEQ: Adverse childhood experiences questionnaire

ANOVA: Analysis of variance

DASS: Depression anxiety stress scale

DERS: Difficulties in emotion regulation strategies

ECR-R: Experiences in close relationships-revised

EMBU: Egna Minnen Betraffande Uppfostoran- Own Memories of Upbringing

HMO: Health Maintenance Organization

MANOVA: Multivariate analysis of variance

MVA: Missing value analysis

SD: Standard deviation

SES: Socioeconomic status

SII: Separation Individuation Inventory

SWLS: Satisfaction with life scale

WHO: World Health Organization

1. INTRODUCTION

"The parent-child connection is the most powerful mental health intervention known to mankind."

Bessel van der Kolk

Early childhood is a time period which is characterized by continous physiological, psychological and social change. The sensitivity of young children to the outside world during this period allows the rapid and healthy development of cognitive and emotional abilities such as language acquisition and emotional regulation. On the other hand, this sensitivity also means a heightened susceptibility to adversity during these early years and may lead to the disruption of healthy development (Lomanowska, Boivin, Hertzman & Fleming, 2017). In early years, these disruptions are usually irreversible as they occur on a biological level which cause changes in the brain structure leading to long term effects (Hertzman & Boyce, 2010). Thus, the climate of social environment and early relational experiences become vital for the vulnerable child.

There is a tremendous amount of research investigating the enduring effects of childhood experiences. Both retrospective and longitudinal studies have revealed that childhood adversity is associated with adult psychopathology, health and academic problems and low socioeconomic status in later life (Kessler, et al, 2010; Garner, Forkey, & Szilagyi, 2015). However, considering the complex nature of human development through the dynamic processes between genetic factors and environmental influences, it is quite difficult to make deterministic assumptions, especially taking the resilient individuals with aversive histories into consideration.

The source of childhood adversity can be quite different, either stemming from the family or the community and the exposure may be chronic or short-term. However, parental adversity is accepted as exceptionally important since the infant is highly dependent on the caregivers in order to develop both behavioral and emotional regulation skills which are the cornerstones of psychological well-being (Bornstein, 1995; Kochanska et al., 1998). Thus, it is essential to investigate the various long term

effects of different types of childhood adversities along with parenting practices and attachment quality of the primary relationships.

In the light of the previous literature, this present study aimed to investigate the potential effects of early experience on relational problems and emotion regulation difficulties as predictors of well-being. For this purpose, early experiences were conceptualized by the adverse experiences exposed in childhood and parenting behaviors as perceived by the children. Furthermore, relational problems were investigated through the perspective of different theories as attachment theory and Mahler's separation-individuation theory, thus were assessed with both attachment dimensions and separation individuation pathology. Finally, depression, anxiety and stress levels as well as the satisfaction of life were measured as the predictors of well being of the sample.

The present study would be the first study investigating the set of aforementioned variables simultaneously. The chapters of the present study proceed as the literature review which covers the theoretical background of the concepts as well as the relevant research outcomes; the method section in which the sample characteristics and assessments that are used are explained; the results section which contain the results of the current study and finally the discussion section in which the results are discussed in the light of the relevant literature and the limitations, suggestions and the clinical implications of the study are given.

2. LITERATURE REVIEW

2.1.Psychological Significance of Early Childhood Experiences on Development

2.1.1. Adverse childhood experiences (ACE)

Over the last few decades, it has been shown that child maltreatment is a global and prevalent problem leading to serious life-long outcomes. Considering its complex nature, it has been recognized as a public health and human rights issue (Reading, et al., 2009). World Health Organization defines child maltreatment as, "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power." (World Health Organization [WHO], 1999). Every year, it has been reported that millions of children are the victims or witnesses of some kind of violence and unfortunately, it has been assumed that many cases of childhood abuse remain unreported (WHO, 2016).

In the psychology literature, child maltreatment has been mostly studied focusing in few specific types of abuses, such as sexual and physical abuse. However, these types of abuse frequently occur in the presence of other psychological abuses, neglect or familial problems (Finkelhor, Baron, Peter & Wyatt, 1986). The failure of addressing these possible co-occurrences may lead to fallacious causal explanations between the type of maltreatment and particular adulthood problems. Thus, it is crucial to understand the long-term consequences of multiple types of child maltreatment that co-occur in one's history in order to develop effective prevention strategies.

Adverse childhood experiences, as a term, is firstly used by Anda and his collagues (2010) in order to emphasize the interrelated adverse experiences in childhood and their possible future impact on various outcomes such as health and psychological well-being. The content of this term is derived in accordance with the findings of one of the widest studies concerning public health, Adverse Childhood Experiences Study (Anda, Butchart, Felitti & Brown, 2010).

2.1.2. Adverse childhood experiences (ACE) study

The Adverse Childhood Experiences (ACE) Study, which is considered as one of the widest epidemiological study on childhood experiences, is conducted with more than 17,000 adult Health Maintenance Organization (HMO) members. The study analyzed the impact of the interrelated traumatic childhood experiences before the age of 18 on later physical health, well-being, disease burden, and death (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss & Marks, 1998). The study was conducted with long years of collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and US Centers for Disease Control and Prevention (CDC) and provided the researchers with a massive detailed data including biopsychosocial information of the participants (Felitti & Anda, 2010). Even though research about health behaviors and diseases have evolved from a biomedical perspective to a biospychosocial perspective and revealed many risk factors concerning the lifestyle and behaviors of individuals for different kinds of illnesses, the underlying mechanisms of these risk factors and behaviors are not yet fully understood and should be further studied (CDC, 2010, U.S. Department of Health and Human Services, 2010, McGinnis JM, Foege, 2010). In support of this view, ACE Study has arisen out of the observations made for a weight loss program. The high drop-out rate of this Weight Loss Program-which exclusively comprised people who are succesfully losing weight made researchers recognize that early experiences of childhood "are not lost, but like a child's footprints in wet cement, are often life long." (Felitti & Anda, 2010, p.77).

In ACE Study, over than 17,000 participants responded to Adverse Childhood Experiences Questionnaire (ACEQ) which was developed by Felitti et al. (1998) particularly for this study. This scale consists of ten questions about adverse experiences that adults were exposed before the age of 18. In particular, the adverse experiences that are covered in the scale are physical, emotional and sexual abuse, emotional and physical neglect, five forms of household dysfunction as witnessing domestic violence, parental loss, drug and alcohol abuse of family members, presence of mental illnesses and criminal behaviors.

The results of the original study revealed that only one third of the participants had never exposed to any kind of adverse experience during childhood. However, if any one category was reported to be present, the likelihood of the presence of at least one

more category was found to be 87%. Moreover, 12,5% of the participants reported to have an ACE score of 4 or more (Dong, Anda, Dube, Giles & Felitti, 2003). Most likely, these are the people health professionals encounter more in both counselling and physical health settings. In terms of gender differences, women were found to be %50 more likely to be exposed five or more types of adverse experiences and this finding was regarded as the social explanation for many undefined illnesses such as fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome and pain disorders which are more likely to be observed among women. It is also important to note that the ACE categories had an equal effect on later functioning; thus similar findings were demonstrated for people with a score of 4 resulting from any of the four categories.

The prevalence rates that have been demonstrated for this original study are as follows; emotional abuse (11%), physical abuse (28%), sexual abuse (28% women, 16% men; 22% overall), physical neglect (10%), emotional neglect (15%), mother treated violently (13%), alcohol or drug use by a household member (27%), imprisonment by a household member (6%), household member was depressed, suicidal, had a mental illness or in psychiatric hospital (17%), not raised by biological parents (%33).

The retrospective analysis of childhood experiences in the ACE Study were found to be related to many physical and psychological health, social and economical problems. Specifically, the total ACE score of individuals, in other words, the number of adverse childhood experiences that one was exposed to were found to be strongly associated with the lifetime risk of depressive disorders (Chapman, Whitfield, Felitti, Dube, Edwards & Anda, 2004), hallucinations (Whitfield, Dube, Felitti, & Anda, 2005), (Chapman, Wheaton, Anda, Croft, Edwards, Liu, Sturgis & Perry, 2011), smoking (Anda, Croft, Felitti, et al., 1999), unintended pregnancy (Dietz, Spitz, Anda, et al., 1999), sexually transmitted diseases like HIV (Hillis, Anda, Felitti, Nordenberg & Marchbanks, 2000), having multiple sexual partners (Dube, Felitti, Dong, Wayne & Anda, 2003), male involvement in teen pregnancy (Anda, Felitti, Chapman, et al. 2001), alcohol abuse (Dube, Anda, Felitti, Edwards & Croft, 2002; Anda, Whitfield, Felitti, Chapman, Edwards, Dube & Williamson, 2002), suicide attempts (Dube, Anda, Felitti, Chapman, Williamson & Giles, 2001), illicit drug use (Dube, Anda, Felitti, Chapman & Giles, 2003) and several physical illnesses leading to death including obesity, diabetes,

schemic heart disease, chronic lung disease, any kind of cancer, skeletal fractures, and liver disease (Felitti, Anda, Nordenberg, et al., 1998). Furthermore, chronic obstructive pulmonary disease (COPD) which is one of the important cause of mortality all around the world had a 2.6 times higher risk of occurrence in people with a ACE score of ≥ 5 (Anda, Brown, Dube, Bremner, Felitti, & Giles, 2008). Moreover, it was demonstrated that there was a graded relationship between ACE and sexual victimization in adulthood (Ports, Ford & Merrick, 2016).

The relation between adverse childhood experiences and medical conditions have been explained in two ways (Felitti, 2009). Firstly, people who are exposed to various of traumatic experiences are more prone to emotional problems with which they try to cope with unhealthy behaviors like smoking, drug or alcohol using, overeating, etc. in order to get an immediate relief. As a result of these compensatory behaviors, the risk of having a chronic illness increases. Secondly, the exposure of chronic stress during childhood in which the nervous, immune and endocrine systems go through profound changes, lead to enduring effects on the person throughout his life (Danese & Even, 2012). Thus, the changes in the biological systems as a result of trauma exposure will inevitably have an impact on cognitive and emotional processing throughout life. The trajectory that was suggested as a result of the insight that ACE study had provided has been demonstrated in Figure 2.1.

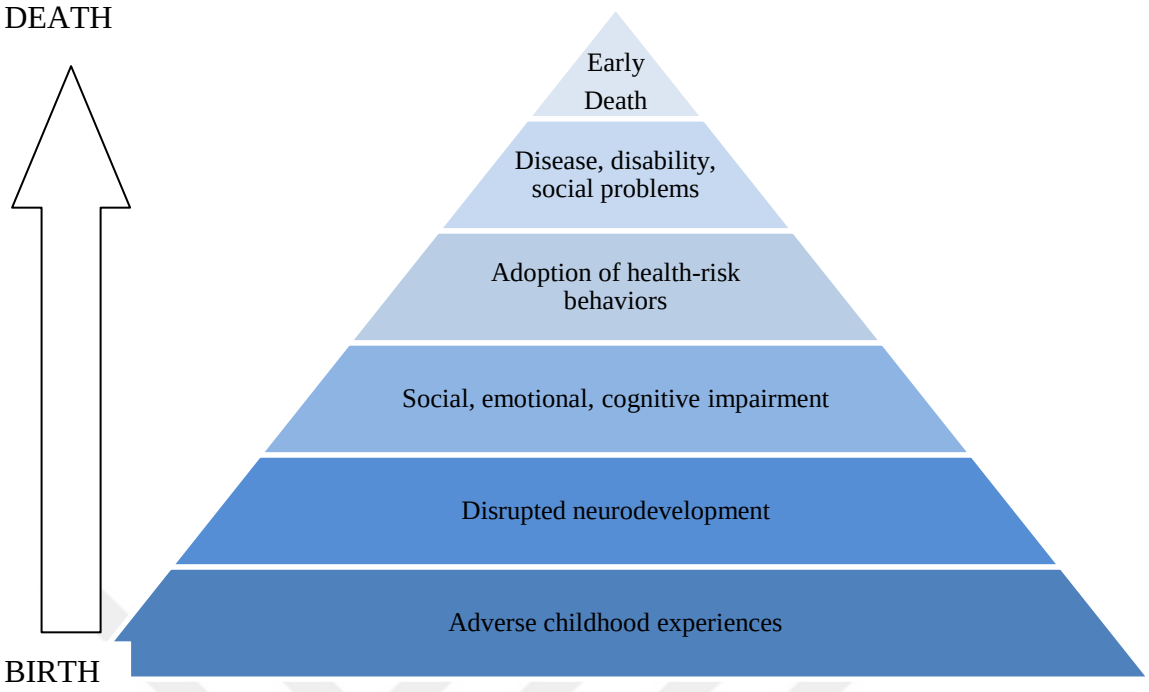

Figure 0.1. Possible trajectory of the influence of Adverse Childhood Experiences throughout the lifespan

Source: Felitti, et al., (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine, 14,4, p.256

2.1.3. ACE study in Turkey

The number of studies on childhood adverse experiences in Turkey are limited and the prevalence rates of specific childhood traumas have revealed inconsistent results, though suggesting an increasing trend throughout the past years (Erol Sahillioğlu, 2017). However, previous research on understanding the magnitude of childhood traumatic experiences in Turkey estimated the prevalence of physical abuse ranging between 13-48%, emotional abuse as 36 to 60% and finally sexual abuse as 10-28% (Zoroğlu, Tüzün, Sar, Tutkun, Savaş, Öztürk, et al, 2003; Eskin, Kaynak-Demir, Demir, 2005; Alikaşifoğlu, Erginoz, Ercan, Albayrak-Kaymak, Uysal & İlter, 2006; Yılmaz Irmak, 2008). Moreover, the prevalence of neglect was estimated as 20% (Ağırtan, Akar, Akbaş, Akdur, Aydın, Aytar et al; 2009). Given the prevalence rates, it has been known that emotional abuse is the most common form of childhood abuse in Turkey (Erol Sahillioğlu, 2017). Furthermore, these rates have been considered to be the tip of the iceberg since it has been estimated that many of the cases go unreported in Turkey. However, it has been known that childhood adverse experiences do not usually

occur in isolation. Taking this intermingled nature of childhood experiences into account, there have been a lack of a more comprehensive approach regarding different types of childhood adversity.

The survey of ACE Study was conducted as a regional study of WHO in Turkey in 2013 with 2,257 participants from different universities in order the identify the prevalence rates of ACE in Turkey as well as the associated health risk factors (Ulukol, Sethi & Kahilogullari, 2014). As for prevalence rates of ACE, half of the participants reported at least one ACE. Moreover, among all ACES, physical abuse had the highest prevalence rate, followed by the exposure to domestic violence, emotional abuse, emotional neglect and sexual abuse. Whereas ACE scores increased by the number of siblings in the family, they were negatively associated with the education level of the parents. The overall prevalence rates of this study was summarized in Table 2.1.

Table 0.1. Prevalence rates of adverse childhood experiences in the regional ACE Study of WHO in Turkey

	Male (%)	Female (%)	Total (%)
Type of abuse			
Physical abuse	26.2	16.3	21.1
Sexual abuse	8.7	7.2	7.9
Emotional abuse	10.7	8.9	9.8
Neglect			
Emotional neglect	11.3	6.5	8.8
Physical neglect	7	4.6	5.7
Household dysfunction			
Exposure to domestic violence	20.9	16.1	18.4
Divorced or separated parents	4.9	5.4	5.2

Depression or suicide attempt	7.1	11.3	9.3
Alcohol use	7.5	5.3	6.4
Drug use	4.8	2.0	3.4
Household incarceration	12.0	8.7	10.3
ACE Score			
0	44.6	55.3	50.3
1	25.2	22.8	23.9
2	14	10.6	12.2
3	7.5	5.7	6.5
4 or more	8.7	5.7	7.1

Source: Ulukol, B., Sethi, D., Kahilogullari, A.K. (2014). Adverse Childhood Experiences Survey among University Students in Turkey. Copenhagen: WHO Regional Office for Europe.

As for health risk factors, the risk of smoking, problematic alcohol use and drug use were found to be significantly associated with increasing ACE scores. Furthermore, the prevalence of emotional problems as defined by crying spells, depression, uncontrolled anger, high stress level, nervousness and trouble refusing requests increased along with the increase in ACE scores (by 6-8 times). The history of adverse experiences also predicted family, school and financial problems. Furthermore, among the cerebrovascular problems, frequent headaches, attacks of dizziness, seizures and convulsions, loss of consciousness, temporarily lost control of hand or food were more likely to be reported as the ACE scores increased. Similarly, participants with a history of ACE, reported more gastrointestinal problems including stomach ulcer, abdominal pains, frequent indigestion, constipation and diarrhea. With the complaints listed in the survey, the overall perception of health were more negative with the increasing number of ACEs (Ulukol, Sethi & Kahilogullari, 2014).

The results of this study revealed different rates of childhood adversity compared to other childhood trauma studies conducted with children in Turkey. Taking the recall bias into consideration as well as the reluctance of disclosing traumatic experiences in early adulthood, the inconsistent results of the variety of studies are reasonable. Moreover, the limited range of age in the aforementioned study obscure the association of ACE and risk of health problems as the chronic diseases are more likely to occur in advanced ages as a result of unhealthy coping behaviors. Most importantly, this study have been conducted with medical professional, thus the questions investigated the presence or absence of sypmtoms instead of a continuous range. However, it has relatively been a more comprehensive study regarding investigating the association between the different types of childhood adversity and health risks.

2.1.4. Parenting styles and primary attachment experience

Family is where the child evolve into a unique human being. A child's first social contacts mostly occur within his family. Transformation of the child which includes the process of becoming a fully independent individual from a dependent baby is inevitably prone to environmental factors. Thus, familial factors are important for explaining the origins of both psychopathology and psychological well-being in adulthood. Attachment experience and parenting styles, which mostly seem interconnected, are considered as the most important determinants in the child's personality development.

For understanding the effects of early experience on adult well-being, both internal and external environment and their interactions should be taken into consideration. Children are born with a capacity for basic biological functions such as circulation and respiration. However, since their nervous system is not fully matured, they need continous assistance of their caregivers for many other functions (van der Kolk, 2003). In other words, the physical development of the brain occurs thoroughout the social interactions of the child. Thus, it would be misleading to discuss childhood trauma without addressing the attachment interactions between children and caregivers. Expectedly, in most cases, parental abuse or neglect cooccur with accidents or more victimization (Claussen & Crittenden, 1991; Edwards, et al., 2001). Moreover, in

considerable amount of cases, the attachment relationships and parenting practices become the source of trauma and stress themselves.

2.1.4.1. Parenting behaviors

Parenting is a set of complex social behaviors which are stemmed from parents'own personal history, genetic make up and personality (Boivin, et al. 2005). Even though parenting is supposed to be a biological mechanism with the boost of hormones and the regulatory function of HPA axis, the disruptions that have occurred in the childhood history of parents may also have detrimental effects on their own relationships with their infants (Lomanowska, Boivin, Hertzman & Fleming, 2017). The intergenerational transmission of parenting has also been demonstrated in other studies and constitutes a risk factor across generations besides genetic background (Belsky, Jaffee, Sligo, Woodward & Silva, 2005; Bailey, Hill, Oesterle, & Hawkins, 2009). Furthermore, the caregiving and attachment patterns are usually activated simultaneously (Doinita & Maria, 2015).

Parenting behaviors creates the emotional climate of the family and this very first relationship between the parent and child, provides the general basis for all the further intimate relationships of that child including peer relationships and parenting (Bartholomew, 1990; Shaver, Collins, & Clark, 1996). Moreover, the perception of the child regarding the parental behaviors is considered to be more important rather than the real behaviors of parents. Specifically, studies have revealed two different dimensions of parenting styles that have been found to be associated with the psychological development of the child. These are parental warmth and parental control (Grolnick & Gurland, 2002).

The first dimension, parental warmth includes all the caring behaviors such as the responsiveness of the family to the child, the expression of positive regard, support and acceptance. Simply put, parental warmth can be described as the love the child experiences from their parents or caregivers. Parental warmth can be also regarded as emotional warmth and has been found to be a protective factor against adult depression (Eisemann, 1997), whereas low levels of perceived parental warmth has been found to be associated with psychological problems in later life (Fauber et al. 1990; Garber, Robinson, & Valentiner, 1997). On the other hand, rejection and criticism are the

reverse side of warmth and can be described as the lack of all aforementioned positive feelings. Rejection and criticism can be quite traumatic for the child and can even be regarded as emotional abuse. These dimensions can appear in several ways: cold and distant behaviors, hostile and aggressive behaviors, neglectful behaviors and the belief of being rejected that the child has even though there is no explicit sign of rejection in terms of negative behaviors (Rohner, 2004; Rohner, 2016). The parental warmth dimension is presented in detail in Figure 2.2.

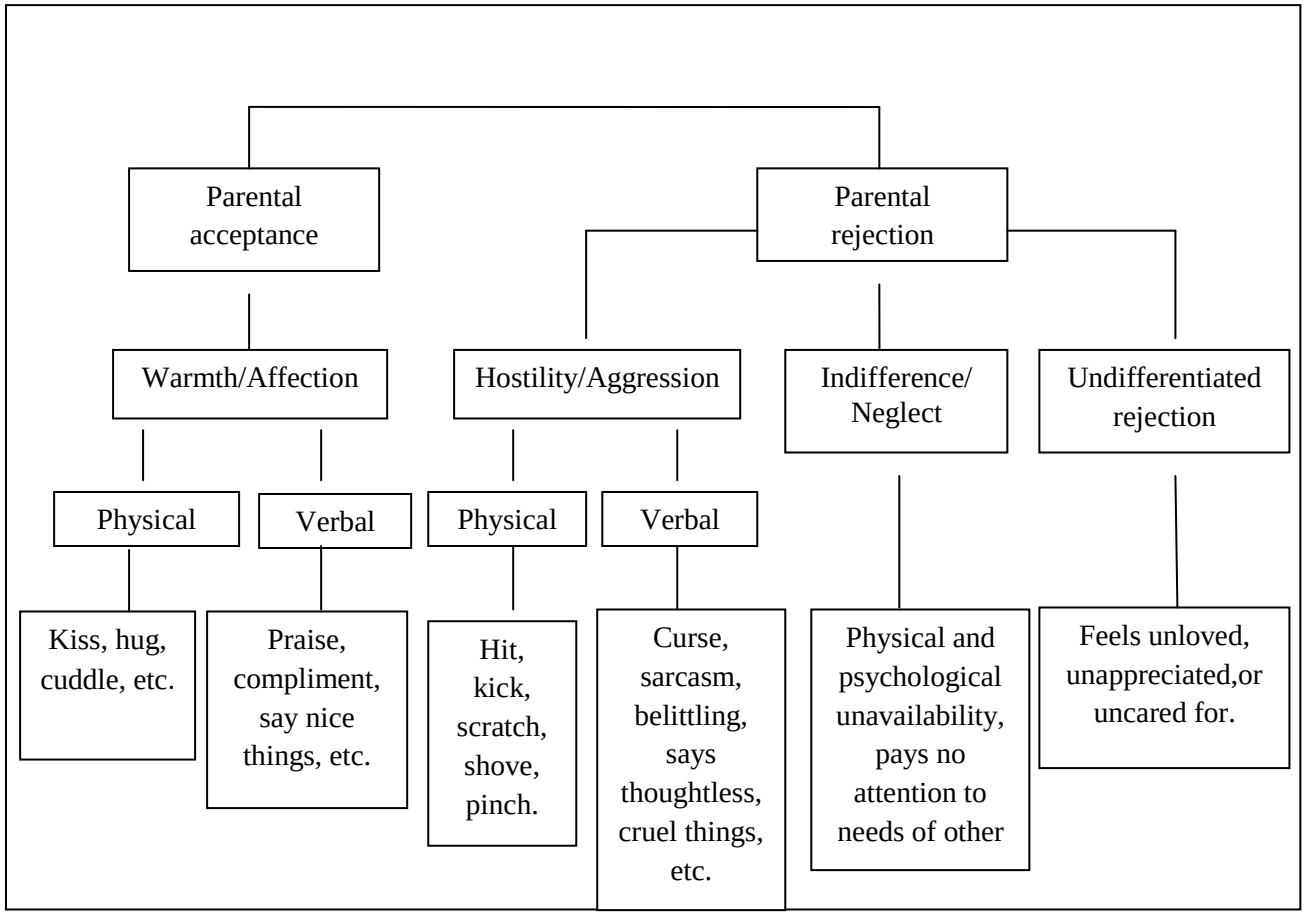

Figure 0.2. The warmth dimension of parenting

Source: "Introduction to Interpersonal Acceptance-Rejection Theory (IPARTheory) and Evidence." by R.P., Rohner, 2016, Online Readings in Psychology and Culture, 6(1). Copyright © 2016 International Association for Cross-Cultural Psychology.

parental rejection tend to have some common psychological characteristics. These are aggression and hostility problems, higher levels of dependence or defensive independence, lower levels of self-esteem and self-adequacy, emotional numbness or instability and a negative view of the world and people (Rohner, 2016). To put it

differently, individuals who feel rejected by their caregivers experience an intense psychological pain which then can lead to overwhelming feelings like aggression and hostility. Thus, they can either have problems in the management of these feelings or they can emotionally become numb in order to protect themselves from further pain. Furthermore, these individuals can become overly dependent in the need of constant reassurance and support as a result of the lack of it during their early social environment. On the contrary, some others may have defensive independence which means the refusal of the need for warmth and likewise positive responses from other people. While these individuals say "I don't need you!", they mostly do not recognize their internal craving for positive interactions. This disposition may then turn into a vicious cycle aggravating the relational problems (Rohner, 2016).

People who have experienced higher levels of parental rejection may develop "rejection sensitivity" which can be described as the hypervigilance to any emotional cues or signs that can imply an emotional undependability (Ibrahim, Rohner, Smith, & Flannery, 2015). This phenomenon occurs following the cognitive processes as selective attention, selective perception, incorrect and biased causal attribution, and impaired information processing. Consistent with this view, studies conducted with PTSD or developmental trauma disorder, as an enduring effect of perceived rejection, have confirmed that these individuals have hypervigilance and anxiety problems as well as self hatred and suicidality (van der Kolk, 2010; Courtois, 2004).

The second dimension, parental control includes both behavioral and psychological control (Barber, Olsen, & Shagle, 1994). Rewards and punishments as a way of shaping and controlling child's behaviors can be regarded as behavioral control whereas psychological control includes parents' emotional reactions and expressions such as disapproval or dissappointment towards the child (Aunola & Nurmi 2004; Barber 1996). High levels of parental control is detrimental to the child and can be identified as overprotection. Parental overprotection and also the lack of encouragement for autonomy can result in low self-esteem and social skills, high levels of internalizing and externalizing problems (Barber and Harmon, 2002; Barber and Olsen, 1997; Garber et al., 1997; Laible and Carlo, 2004). Moreover, especially during late adolescence, high psychological control may impair the identity formation and individuation process in particular (Luyckx et al. 2007; Barber and Harmon, 2002).

Negative parental attitudes are considered as overprotection and rejection and the cross-cultural studies have demonstrated that these behaviors are consistently associated with internalizing problems as anxiety and depression; externalizing problems as conduct disorder and delinquency and even substance abuse (Rapee, 1997; Rohner, 2016). Moreover, there is considerable amount of research demonstrating that parenting styles are related to emotion regulation abilities and psychological well-being of children (Morris et al., 2007; Arrindell, Emmelkamp, Gerlsma, 1990).

2.1.4.2. Primary attachment experience

The theory of attachment, which was originally developed by John Bowlby, emphasizes the effects of early emotional bonding between the infant and caregiver on the personality development and future relationships (Bowlby, 1969, 1973, 1979, 1980). Bowlby drew his theory on a combination of scientific concepts, including psychoanalysis, cognitive and developmental psychology and ethology.

According to Bowlby, the infant is born with an innate and biological capacity to achieve proximity to the caregiver for survival. Bowlby described the concept of the attachment behavioral system that was evolved to operate in the environmental adaptedness in which the genetic selection favored the attachment behaviors since they increase the chances of survival by providing the protection of the caregiver. This is referred as "the biological function of the attachment behavior" (Bowlby, 1988). Bowlby explained the operation of these behavioral systems in an environmental adaptedness as "When we come to consider with what instinctive behavior - or, more properly, with what behavioural systems mediating instinctive behavior - humans may be endowed, a first task to consider is the nature of the environment within they are adapted to operate." (Bowlby, 1969, p.58). This instinctive behavior of the infant is predictable and similar in the species and crucial for the survival and finally it does not necessarily develop with learning. The attachment behaviors of the infant is composed of responses such as smiling, clinging, sucking as well as crying (Bowlby, 1958) to elicit the caregiver's nurturing behavior. Thus, these behaviors can also be called as proximity seeking behaviors. These behaviors are mostly triggered especially in times of distress with the desire to regain the feeling of security. The responsive caregivers are

well aware of the needs of the infants and able to help them to regulate their emotions with nurturing behaviors (Sroufe & Waters, 1977). The soothing behaviors of the caregiver help the infant modulate the physiological arousal and regulate their stress-induced affective states (Hofer, 1994; Schore, 1994). Consistent with this perspective, attachment is also defined as the dyadic emotion regulation (Sroufe, 1996). The synchronicity of these reciprocal interactions is accepted as fundamental for a healthy affective development of the individual (Penman, Meares, & Milgrom-Friedman, 1983).

Although the basic assumptions of attachment theory were introduced by Bowlby, it can actually be considered to be the joint work of Bowlby and Mary Ainsworth (Bretherton, 1992). Ainsworth started to work with Bowlby late in 1950s and contributed to the development of attachment theory, especially with her empirical studies observing early mother-infant relationships (Ainsworth, 1979). Ainsworth developed an experimental procedure called 'The Strange Situation" to investigate the attachment behaviors of the infants, especially the infant's behaviors using the mothers as a secure base for exploration (Ainsworth & Wittig, 1969). The studies conducted with this procedure revealed three different types of attachment styles: "secure", "avoidant" and "anxious-ambivalent". The securely classified children were eager to explore the environment in the presence of the mother, and they wanted to be close to the mother following reunion and then could go on exploration after a while. The avoidant children appeared to ignore that the mother was gone and would refuse to contact or interact and even ignore the mother when she was back. On the other hand, the anxious-ambivalent children showed inconsistent behaviors at the procedure. Even before the mother left, some infants showed signs of anxiety and their anxiety was intensified with the separation. When their mothers were back, they would cry for contact but at the same time, they would not cuddle or "sink in" when they were held. These interaction patterns were found to be related to the maternal sensitivity of the mothers.

In the 1986, Main and Solomon observed infants who exhibit diverse behaviors without an observable goal or intention and cannot be classified into any of the present Ainsworth criteria. The behaviors of these infants include disorganized and disoriented behaviors such as displays of fear or contradictory behaviors or emotions, stereotypic and undirected movements or expressions, confusion or freezing. The observation of

these behaviors led the researchers to classify them as disorganized. The disorganized attachment pattern, in later studies, was found to occur more frequently in the presence of parent psychopathology, child abuse, or very high social risk (Carlson, Cicchetti, Barnett, & Braunwald, 1989; Crittenden, 1988; Lyons-Ruth, Connell, Zoll, & Stahl, 1987).

To sum up, attachment is a behavioral regulatory system as suggested by Bowlby (1969) and includes proximity seeking behaviors as well as coping behaviors with stress which occurs as a result of a separation from or loss of the attachment figure (real or perceived) in the early childhood. The infant's coping behaviors and emotion regulation strategies mostly depend on the quality of the relationship with his caregiver. The literature has already demonstrated the role of emotion regulation in the development and maintenance of different disorders and it is believed to be one of the main mechanisms that interconnect attachment and psychopathology (Chaplin & Cole, 2005). The attachment security predicts effective emotion regulation-that is the secure infant is more able to tolerate and manage negative emotions, where as insecure infants may use maladaptive strategies such as minimization or exaggeration of emotions (Guttmann-Steinmetz & Crowell, 2006).

2.1.5. Separation-individuation process

The period of early childhood is characterized by the development of self in relation to the experiences with significant "others". This developmental period has been attempted to be explained by various psychodynamic theories beside of attachment theories. Among the psychodynamic approaches, object relations theory has emphasized the mental representations of the self and others and how these representations influence the personality development and actual relationships (Greenberg & Mitchell, 1983). Compared to attachment theory which investigates the patterns of attachments as secure and insecure, object relations theory is more concerned with the functioning of the insecure patterns of relationships and psychopathology development (Wright, 1986).

One of the pioneers of object relations theory, Margaret Mahler formulated her theory of Separation-Individuation process with the premise that the infant goes through

an ongoing process from a full symbiotic relationship with the mother to establishing a separate and autonomous self. As Mahler named, "the psychological birth of an infant", is characterized by gaining a sense of separateness and independency from the caregiver (Mahler, Pine & Bergman, 2002). Mahler was the first pediatrician and psychoanalyst who attempted to systematically and longitudinally investigate the infants (Gergely, 2000). She tried to understand the development of the mental representations of self and others within the infant caregiver interactions. The process of individuation, as explained by Mahler enables the individual to engage in mature adult relationships (Mahler et al., 1975). With the observation of normal and disturbed children, Mahler proposed that the ego development occurs through sequential stages. The first stage is referred as the normal autistic stage and sometimes as "awakening" phase and includes the first three or four weeks of the baby's life (Mahler, Pine & Bergman, 1975). During this phase, the infant is in a continuous inward state and dependent on the caregiver for the satisfaction of the physiological states or needs. Even though the infant does not have the cognitive maturity to develop mental representations and the capacity to differentiate between the self and object, this stage constitutes as the foundation for the representations of self and object.

In the second stage which is referred as the "the normal symbiosis phase", lasts until about five months. In this stage, the infant starts to crack out of the "autistic" shell and experience the mother as a need-gratifying object. Different from the biological meaning of symbiosis which includes mutual benefits, this stage describes the absolute dependency of the infant to the mother whereas the mother is not dependent to the infant. Rather, the symbiosis refers to the fusion and dual unity in the mother-infant relationship which means that "I" is not differentiated from "not-I" and there is a delusional common barrier between the infant and the mother and the external world as the infant experiences. The physiological incidents that result in unpleasurable tension such as hunger, vomiting, urinating, defecating, etc are followed by the mother's tension reducing attempts. Thus, the infant learns to differentiate between good/pleasurable and bad/painful qualities of experiences (Mahler & Gosliner, 2017). These are the primary forms of internal mental representations. This stage is also characterized by the splitting as a developmental phenomenon. The infant starts to organize his mental world by splitting the good and bad mental representations of him and the object. The last stage of the separation-individuation starts about five to six

months of age as the baby starts to develop cognitive abilities which enable him to experience the outer world and a sense of identity. “Separation Individuation” process consists of four sub-phases as (a) Differentiation or hatching (b) Practicing (c) Rapprochement (d) Emotional object constancy and individuation.

In the sub-phase of differentiation, the infant’s attention shifts from inward to outward and starts to explore his surroundings, especially the mother. This phase is also the beginning of the self-object distinctions (Mahler, Pine & Bergman, 1979). In practicing stage, with the developing the psychomotor abilities, the infant seeks for active exploration of the environment. The differentiation from the mother increases emotionally with the feeling of omnipotence (Mitchell & Black, 1995). The third sub-phase, rapprochement, is characterized by the ambivalent feelings of autonomy and closeness. As the infant becomes frustrated with his environment and becomes aware of his limited capacities, they need “emotional refueling” and desire the closeness with the mother. The urge for both autonomy and closeness at the same time creates an anxiety which the infant attempts to resolve by splitting- separating mental representations of good from bad-, only this time as a defense mechanism. This crisis is resolved through his interaction with the mother and creating his own individuality by keeping an optimal distance from her (Lamb, 1986; Mahler et al., 1975).

In the final stage of separation individuation, object constancy and individuation, the infant achieves a differentiated and individuated self and internalizes the parents by integrating the split mental representations as a whole. According to Mahler, failure to achieve an individual identity and prolonged use of splitting as a defense mechanism may leave the child prone to separation individuation pathology throughout life (Mahler et al, 1975). Moreover, the adequate nurturance received in each stage results in “good” object representations and the individual achieves object constancy which gives the individual the capacity to tolerate different emotions and regulate them efficiently in times of distress (Zosky, 2008).

Mahler proposed that during these sequential phases, successful individuation requires connection to others without enmeshment or isolation. The disruptions that have been experienced may be manifested in different types of psychopathology in adulthood such as narcissistic and borderline personality, social dysfunction and

depressive symptomatology (Lapsley & Stey, 2010). Moreover, it was also pointed out that the earlier these disruptions occur, the more severe psychopathology an individual would have (Lyons-Ruth, 1991).

The aim of the individuation process is relational autonomy which involves a balance between connectedness and separation and the achievement of this goal is facilitated through secure and supportive relationships (Josselson, 1988). Consistently, the studies pointed out that secure attachment provides a solid base for individuation process facilitating both autonomy and interpersonal relatedness (Levy, Blatt & Shaver, 1998). On the other hand, controlling and overprotecting parenting may disrupt this individuation process creating the feelings of anxiety or guilt (Kins et al., 2012). Despite of the limited number of studies on separation individuation process in adulthood, they showed that separation problems as dependency conflicts were predictors of eating disorders, perception of self-inadequacy and mistrust (Friedlander & Siegel, 1990) whereas emotional independence was associated with better academic adjustment (Hoffman, 1984). However, these studies were conducted within the borders of normal separation individuation and were not sensitive enough to detect the more serious outcomes of the separation individuation process (Rice, Cole & Lapsley, 1990).

Pine (1979) described the pathology of separation individuation process in lower-order and higher-order disturbances considering the failures in organizing the self-other differentiation. The lower-order symptoms are characterized by the failure in differentiation the self from others which may result in merging or enmeshment and the loss of sense of separateness. Thus, individuals with the lack of differentiation may feel panic over this merging or may have acceptance of this dual unity in a pathological manner. Furthermore, these individuals may even act rebellious against the significant others as any similarity between them and their parents would lead to a loss of self. The higher-order symptoms, on the other hand, refers that the self is already differentiated from significant others. However, a fear of loss of the differentiated figure is experienced and these higher-order symptoms are manifested as the inability to tolerate aloneness, desire to gain omnipotent control over others and object constancy deficits (Christenson & Wilson, 1985; Pine, 1979). Furthermore, these individuals have difficulties holding a constant inner representation of self and others and use splitting as

a defense mechanism which then leads to extreme perceptions as well as responses causing problematic relationships as clearly seen in borderline patients.

Christenson & Wilson (1985) developed "Separation Individuation Inventory" for the assessment of separation individuation pathology in terms of use of splitting, having "good/bad" representations of self and others, differentiation problems and relational problems. The findings demonstrated that separation individuation pathology was associated with insecure attachment styles and was negatively correlated with individual and social adjustment to college (Lapsley & Edgerton, 2002) and also psychopathological symptoms such as depression, anxiety, somatic complaints, and obsessive-compulsive behaviors (Lapsley, Aalsma, & Varshney, 2001). Moreover, separation individuation pathology was found to be associated with borderline personality disorder which is characterized by the heightened emotions triggered in close interpersonal relationships (Dolan, Evans, & Norton, 1992).

2.2. The Effects of Early Experiences and Psychopathology

2.2.1. Attachment as a life long process

2.2.1.1.The neurological basis of attachment

Bowlby, while proposing the classic attachment theory, aimed at integrating psychological and biological concepts in explaining the human development. The recent advances in neurobiology, in line with Bowlby's purpose, provided a large amount of interdisciplinary data that supports that the attachment processes can be traced in the structures of the brain (Schore & Schore, 2008). Thus, neurological research provides a deeper understanding of attachment theory and how early relationships have lifelong consequences throughout lives.

Attachment, described as an activated behavioral system, is a vital process for an infant to survive. The amount and the quality of the infant's interaction with the mother and the maternal sensitivity together constitute the attachment dynamics as a "reciprocal interchange" (Bowlby, 1969, p.346). With the control systems perspective, it was proposed that the goal of the infant is not only to maintain the physical proximity, but also have the presence of an emotionally available and responsive attachment figure.

The activation of this control system especially occurs in times of danger and stress and leads to regulatory behaviors of the infants, thus the attachment is referred to as a regulatory mechanism. The neurobiological studies of the control system have identified that the area that is associated with the control of behavior, especially when it is related to affect, is the orbitofrontal cortex which is also called "the senior executive of the emotional brain" (Joseph, 1996). It is involved in the perception of visual, facial and auditory information (Scalaidhe, Wilson & Godman-Rakic, 1997; Romanski et al., 1999), coordinates both positive and negative responses to sensory information (Francis, Diorio, Liu & Meaney, 1999; Blair, Morris, Frith, Perrett & Dolan, 1999) and provides feedback when environmental conditions change (Elliott, Frith & Dolan, 1997). Thus, it has a crucial role in the modulation of the control of goal-directed behavior which is central to the Bowlby's attachment theory (Tremblay & Schultz, 1999). Moreover, the limbic system that are in a critical period of development for the first two years of life in which the infant-mother attachment is established was found to be involved in the emotionally focused learning for the development of attachment behaviors such as imprinting and adaptation to a changing environment (Anders & Zeanah, 1984; Mesulam, 1998).

The orbitofrontal system has direct connections to autonomic nervous system and reticular formation which is responsible for arousal reflex. These connections enable this system to regulate the social and emotional responses and affect that are the key elements of attachment processes (Westin, 1997). Furthermore, the right cortical hemisphere with its reciprocal connections to limbic and subcortical areas is responsible for the process of self-related and emotional information and regulation of psychobiological states (Schore, 1999). The support for the importance of the right hemisphere is acquired from many studies. Firstly, the right hemisphere is dominant in preverbal infants for the first few years of life (Chiron, et al., 1997). Secondly, early social experiences have an impact on the physical maturation process of this region (Schore, 1994) meaning that infant-mother interaction in the first years of the infant promotes "the development and maintenance of synaptic connections during the establishment of functional circuits of the right brain" (Schore & Schore, pp.3, 2008). Furthermore, the right brain is also responsible for the processing of nonverbal affective cues between the infant and the caregiver in the early attachment (Schore, 1994).

The facial expression, body posture and the tone of voice was also highlighted by Bowlby (1969) as the essential features of attachment communication in the early periods of life. In addition, it has been found that this attachment communication occurs between the right hemisphere of the infant and the right hemisphere of the mother (Schore & Schore, 2008). The studies conducted with insecure individuals showed that when the infant was exposed to negative life events such distress and separation, these stressful experiences were also encoded in the right brain (Schore, 2001). Moreover, the studies on memory in infants revealed that the right brain, for the first 2-3 years of life (Kandel, 1999), is the storage for the procedural memory which is referred as "the cerebral representation of one's own past" and constitutes the internal working models as suggested by Bowlby. These internal working models, as mentioned earlier, generates positive or negative expectations and coping responses for affect regulation via the process of the orbitofrontal system as well (Nobre, Coull, Frith & Mesulam, 1999). Bowlby also proposed these internal models as working unconsciously. This assumption was also supported by the study of Bechara, Damasio, Tranel & Damasio, (1997) which has found that nonconscious biases guide behavior before conscious knowledge does with the activation of orbitofrontal cortex.

The early organization of the right brain structures and the functions of orbitofrontal cortex that include the process of affect, stress modulation and self regulation are the critical processes that are suggested to be shaped by attachment experiences (Schore, 2003). Throughout our lives, the right brain that is evolved in preverbal periods plays a key role in implicit processes and is involved in ‘‘maintaining a coherent, continuous and unified sense of self’’ (Devinsky, 2000). A secure person has to "read" the social cues such as eye gaze, bodily gestures, facial expressions appropriately, and then attune with the significant other both physiologically and behaviorally. Attunement as a caregiver is crucial for the emotion regulation and the mother regulates the central and autonomous nervous systems of the infant at the same time (Schore & Score, 2008). Thus, reflective abilities of the infant develop as well as his adaptive stress responses. Excitability and the soothing ability of oneself can be learned in early interaction with the caregiver whose role is to "contain" the intolerable affective states of the infant and transform them into manageable feelings for the infant (Bion, 1962).

2.2.1.2.The stability of attachment: "From cradle to the grave…"

Bowlby, in his attachment theory hypothesized that early infant caregiver interactions enable infants develop cognitive representations referred as internal working models about self, other and the world in general. These working models, later in life, affects the way people process the information in their world- that is which information they attend to and how they interpret and remember the events in their world as well as their own emotional and behavioral responses to these interpretations. In other words, the internal working models work as filters and people interpret their new experiences and relationships through these filters, consistent with their primary representations and expectations. Moreover, these mental processes can be either conscious or unconscious (Bretherton, 1987). Specifically, based on his observations he claimed that the infants with responsive and sensitive caregivers develop a mental representation of the self as acceptable, lovable and worthwhile, whereas unresponsive parenting result in the view of self as unacceptable and worthless (Cassidy, 2000). With these mental representations, infants also develop expectations how they will be responded by significant others in specific situations and if their needs will be fulfilled in the future (Main, Kaplan & Cassidy, 1985). Furthermore, these expectations will lead people feel and behave in the ways that confirm their mental representations resulting in a self-fulfilling prophecy (Ainsworth, 1990). As a result, these working models have a crucial impact on our choices which would confirm our representations, creating a vicious cycle. According to him, these models are resistant to change and continue to shape our relationships throughout our lives (Bowlby, 1973). He claimed that this occurs due to our expectation in relationships "The kinds of experiences a person has, especially during childhood, greatly affect . . . whether he expects later to find a secure personal base, or not" (Bowlby, 1979, p. 104). Thus, it is claimed that attachment between infants and caregivers has enduring effects on adult psychological functioning.

In order to test the hypothesis of the stability of the attachment organization, longitudinal studies are conducted in the following years after the development of the theory.

The largest study of early attachment, the Minnesota Study of Risk and Adaptation from Birth to Adulthood (Sroufe, 2005; Sroufe et al., 2005) which followed children from 12 and 18 months to age of 28, revealed significant associations between

attachment security and some personality characteristics such as emotional health, self-esteem, self-confidence, positive emotionality, ego resiliency, and social competence in interactions with others. Moreover, early infant representations that are formed as a result of early infant-mother processes predicted both early and later self and relationship representations and were found to be associated with later social functioning (Carlson, Sroufe, & Egeland, 2004). In terms of romantic relationships, early attachment security predicted the relationship security with romantic partners in young adulthood (Roisman, Collins, Sroufe, & Egeland, 2005; Grossmann, Grossmann, Winter, & Zimmermann, 2002). Furthermore, the findings have shown that the parents' experiences in their own family of origin had an impact on the relationships with their own children in adult life (Belsky & Pensky, 1988). For instance, in the study of Rutter et al. (1990), it was found that women, who were raised in institutions, had more insensitive and intrusive maternal behaviors than others who were raised by their families. This finding was also supported by the longitudinal study of women from Berkeley Guidance Studies in which the girls, who received ineffective parenting, became more ill-tempered mothers who in return resulted in more problematic behaviors of their toddlers (Caspi & Elder, 1988). Moreover, the retrospective studies revealed that the adults, who described their childhood experiences more positively and balanced, tended to have secure infants who were classified in the Strange Situation Procedure (Main & Goldwyn, 1991). In the light of this literature, it can be claimed that early attachment organization not only impacts the significant relationships in our lives, but also has tremendous effects on the personality organization as well.

Even though Bowlby's work was focused on the nature of primary attachments, he described these relationship patterns as "from cradle to the grave" (Bowlby, 1979, p.129). Thus, based on the Bowlby's original theory, Hazan and Shaver (1987) were the first researchers investigating the attachment behavioral system in adult relationships and they pointed out the commonalities between early attachment relationships and adult romantic relationships. Firstly, adults can also use their partners as a "secure base" in the presence of a threat similar to an infant and the partners exhibit the similar behaviors such as physical contact, "baby talk" and sharing (Hazan & Shaver, 1990). Moreover, the resistant nature of the working models may result the adults experience their romantic relationships in parallel to their previous attachment relationship (Hazan & Shaver, 1987). However, in adulthood, one does not need to exhibit actual attachment

behaviors, but can also activate the mental representations of the partner shaped by the early relationships.

Hazan and Shaver (1987) conceptualized the adult romantic attachment styles as similar to the patterns observed in infant-caregiver relationships. Firstly, the authors adopted the three styles of attachment patterns (secure, avoidant, anxious-ambivalent) that are described in Ainsworth's work (Ainsworth, Blehar, Waters, & Wall, 1978). In the following years, Bartholomew and Horowitz (1991) suggested that a four-category would be more accurate since the avoidant group would show two different forms of behaviors in the experiments. In the avoidant group, some of the individuals were avoidant as a result of fear of being hurt or rejection, whereas the other avoidant group would engage in a defensive independence state. Thus, the categories of fearful and dismissing were added instead of the avoidant category. This four-category assessment of adult attachment styles was then divided into two dimensions as attachment anxiety and attachment avoidance as suggested by Bowlby in his original theory (1969/1982): model of self and model of other. Based on the studies and measures of Bartholomew and Horowitz, Brennan, Clark, and Shaver (1998) developed the Experiences in Close Relationships Scale to measure attachment-related anxiety and avoidance in a continuum and having low scores on both dimensions indicate attachment security. The dimensional attachment conceptualization is demonstrated in Figure 2.3.

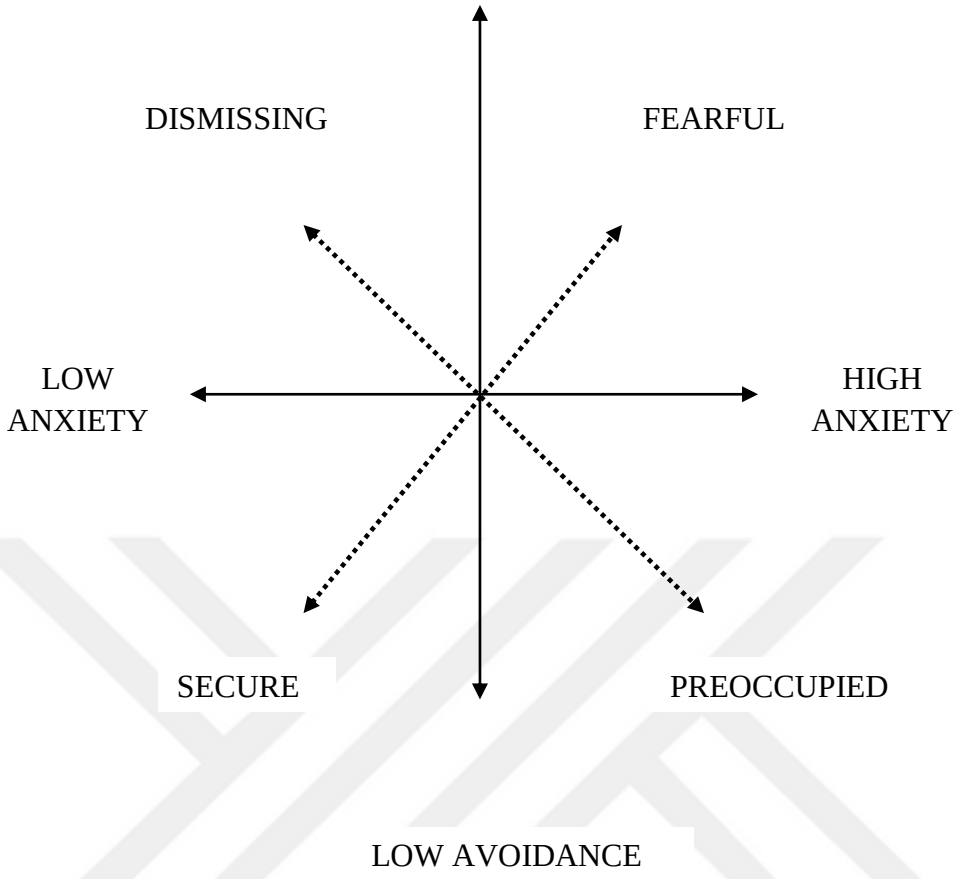

Figure 0.3. Two dimensional model of attachment

Source: http://labs.psychology.illinois.edu/~rcfraley/measures/measures.html

2.2.1.3.Attachment and adult psychopathology

The research on the association of early attachment and adult psychopathology is limited except a few longitudinal studies (Carlson, 1998; Dutra & Lyons-Ruth, 2005; Grossmann, Grossmann, & Waters, 2005; Sroufe et al., 2005). However, there is evidence for the contribution of attachment related issues for the development of major psychological disorders.

Bowlby (1980) proposed that depression in adulthood occurs due to the actual loss of a caregiver, development of an unworthy and unloving self as a result of the absence of a secure relationship with the caregiver. The empirical studies supported this view by showing that people who lost their mothers by death on early or middle childhood were

more likely to be diagnosed with depression later (Harris, Brown, & Bifulco, 1990). On the other hand, loss by separation predicted less severe forms of depression. Moreover, when the loss was followed by other negative conditions such as neglect or indifference, the risk for developing depression would be twice (Harris, Brown, & Bifulco, 1986).

Regarding the anxiety disorders, Bowlby (1973) proposed that anxiety can be explained as the concern of the infant about the availability of the attachment figure. Consistent with this proposition, the studies revealed the links between negative attachment related experiences and anxiety. Specifically, panic disorder patients reported more frequently early stressful life events such as the loss of a parent or inadequate care giving (Brown & Harris, 1993; Bandelow, et al., 2002). The meta-analysis conducted by de Ruiter and van IJzendoorn (1992) also showed that people with agoraphobia reported more separation anxiety in childhood. Lastly, people with generalized anxiety disorder experienced more rejection by their parents and role reversal that controls (Cassidy, 1995).

The studies on dissociative disorders revealed consistent association between disorganized infant attachment and dissociative symptoms (Carlson, 1998; Dutra and Lyons-Ruth, 2005). Moreover, it was suggested that the child with disorganized attachment may have not learned to protect himself from threats because of the caregiver's frightening manner towards him, thus may be more susceptible to later abuse, which in turn increases the diagnosis of dissociative disorders (Liotti, 2004).

According to the attachment perspective, eating disorders were explained as an avoidant strategy of the individual to turn their attention away from their own distress which they have experienced in their primary attachment relationship (Cole-Detke & Kobak, 1996). The studies have shown that people with eating disorders generally report their mothers as being over controlling and perfectionist (Minuchin, Rosman, & Baker, 1980), and their fathers as emotionally rejecting (Cole-Detke & Kobak, 1996). Regarding the attachment states of mind, there have been inconsistent results. Whereas women with eating disorders were most likely to be classified as dismissing, they were more likely to be classified as preoccupied in the presence of a co morbid diagnosis of depression (Cole-Detke & Kobak, 1996; Fonagy, et al., 1996).

In the literature of schizophrenia, the concept of expressed emotion was found to be the salient risk factor in terms of family relationships, rather than infant attachment (Goldstein, 1985). Schizophrenia is more likely to be diagnosed in families with high expressed emotion which is characterized by either over involvement or high levels of criticism. Moreover people with schizophrenia were more likely to be classified as unresolved (Tyrrell, et al., 1999) even though this might be a misinterpretation since it is also a characteristic of their disorder rather the classification.

Borderline personality disorder was proposed to result from the failure to develop the capacity for mentalization in the early relationship with the caregiver (Fonagy & Target, 1997). In terms of attachment related experiences in childhood, borderline patients reported higher levels of abuse and emotional neglect (Herman, Perry & van der Kolk, 1989; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989), separation from caregivers (Zanarini et al., 1989).

In order to explain the development of antisocial disorder, Bowlby suggested that stressful and prolonged separations from caregivers together with frightening threats result in high levels of anger which is then projected to other targets (Bowlby, 1973). The empirical studies revealed that long durations of separation from attachment figures, fathers' antisocial behavior and mothers' neglect were associated with antisocial disorder supporting the view of Bowlby (McCord, 1979). Furthermore, it was found to be linked to unresolved and dismissing states of mind (Allen, Hauser, & Borman-Spurrell, 1996; Levinson & Fonagy, 2004; Rosenstein & Horowitz, 1996).

Finally, research regarding the specific psychopathology revealed only consistent associations between disorganized infant attachment and dissociative disorders (Carlson, 1998; Sroufe et al., 2005) and between resistant infant attachment and anxiety disorders (Warren et al., 1997). The other complex findings that are mentioned above can be explained by several reasons. Firstly, the issue of comorbidity is a major issue resulting in mixed results. Second, it is noteworthy to point out again that, attachment related experiences contribute as risk factors rather than causes. Moreover, each individual with very different characteristics from birth to all developmental stages might move in very different directions which are also pointed out by Bowlby (1973) with the metaphor "branching railway lines." Lastly, we should be in caution about the

impact of life experiences on our personality development, as in the example of the classification of “earned secure”- having a secure and autonomous sense of self despite of the description of difficult early history by Main and Goldwyn (1984).

The contribution of attachment on psychological well-being has been demonstrated on a variety of studies in the literature (Mikulincer & Shaver, 2007; van Ijzendoorn and Bakermans-Kranenburg, 1996). Specifically, it has been empirically established that while secure attachment style was positively associated with positive affect (Torquati & Raffaelli, 2004) and well-being (La Guardia, Ryan, Couchman, & Deci, 2000), the anxiety and avoidant styles were related with negative affect and lower levels of life satisfaction (Ling, Jiang, & Xia, 2008; Van Buren & Cooley, 2002; Wearden, Lamberton, Crook, & Walsh, 2005). Moreover, it has been found that the association between attachment and well-being is mediated by emotional regulation strategies that people adopt (Karreman & Vingerhoets, 2012). Specifically, secure individuals tend to use appraisal as an emotion regulation strategy and had higher resilience, whereas preoccupied attachment was mediated by lower appraisal and resilience in predicting well-being.

2.3.Emotion regulation

2.3.1. Early experience and neurological development of emotional processing

Research on brain development has demonstrated that childhood trauma and early familial interactions have an enormous effect on the cognitive, emotional and physical functioning of the child (Perry, 2000). Generally, developmental neurobiology of trauma has revealed considerable effects on three intertwined pathways. Firstly, certain brain structures mature at different times and that results in different effects of trauma on different ages. Secondly, the exposure to trauma will alter the neuroendocrinologic responses, which means the alteration of hormonal processes. Lastly, as a result of these structural and biological changes, there will be enduring effects on the coordination of cognitive, emotional and physical processes (van der Kolk, 2003). Specifically, the stress that the child was exposed to may lead to changes in both the structure and the chemical activity of the brain (such as reduced volume in hippocampus and corpus collosum (McCrory, De Brito, & Viding, 2010), abnormal cortisol levels (Bruce, Fisher,

Pears, & Levine, 2009).). When a child is born, it is capable of experiencing fear and threat due to the immediate functioning of amygdala right after birth (Nadel, 1992). On the other hand, the maturation of hippocampus continues until the age of 5 and prolonged exposure to trauma or stress affects the development of the hippocampus, cortical and cerebellar structures. These developmental changes especially results in difficulties in sensory processing (Teicher, Anderson, Polcari, 2002). Furthermore, the first interactions of the child in the attachment relations strengthen their neural pathways which in turn the child learn how to get his needs met and how to respond to stress. The security in the attachment relationship is a protective factor in the neural disorganization of the brain (van der Kolk, 2003). In the case of maltreatment, when the child is abused or neglected, the negative interactions causes brain to be hyperalert for danger and thus do not permit for healthy development. The neural pathways that are strengthened under negative circumstances prepare the child for the future negative environment and may result in oversensitivity which is a key factor in the development of psychological disorders (Shonkoff & Phillips, 2000, Perry, 2000). Specifically, child maltreatment may lead to negative cognitions about environment and create a persistent fear response with a disability of situational differentiation. Thus, the expectation of danger results in hyperarousal and the child puts a lot of effort to monitor the probable threatening cues in the surroundings (National Scientific Council on the Developing Child, 2010). Moreover, the structural and chemical changes in the brain may result in dysfunctional emotion regulation and make the child more prone to internalizing symptoms such as anxiety and depression (Healy, 2004) as well as extenalizing problems including aggression and delinquency (Eisenberg, Spinrad & Eggum; Eisenberg et al., 2001; Gilliom et al., 2002). The stress of childhood trauma also decreases the cognitive functioning as can be obversed in academic achievement, diminished attention and lower levels of IQ (Wilson, Hansen & Li, 2011). In terms of physical development, it was demonstrated that the developmental milestones of abused or neglected children are delayed (Scannapieco, 2008). Finally, child maltreatment may cause children to have difficulties in social situations. These children give weaker responses to rewards and they have more difficulties engaging in social situations (Dillon et al., 2009).

Furthermore, the studies showed that they are less likely to understand other's emotions and thoughts (Wimmer & Perner, 1983, Pears & Fisher, 2005). Specifically,

the facial recognition trials with abused and neglected children revealed that, with their altered cognitions, they are found to perceive neutral face expressions as anger and sad respectively. Moreover, abused children had an decreased reaction time to angry faces as a result of their oversensitivity (Pollak, Cicchetti, Hornung & Reed, 2000).

2.3.2. Emotion regulation strategies

Emotion regulation is a fundamental theme in developmental psychopathology and a marker for understanding life-long problems. Even though, the complexity of the phenomenon provokes a disagreement about the definition, Thomson adopted a more comprehensive approach and defined it as "Emotion regulation consists of the extrinsic (temperament) and intrinsic (especially through parenting practices) processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals." (Thompson, 1994, pp. 27–28). Consistent with this definition, it is suggested that emotion regulation enables to adopt adaptive and flexible behavioral strategies, thus is a core element in the socialization process (Thompson, 1994).

The modal model of emotion that was suggested by Gross and Thompson (2007), explains emotions in a sequential manner. Firstly, emotions arise only when the situation is meaningful or psychologically relevant to the person. These situations may be external as well as internal based on our mental representations. Secondly, when the situations are attended, the appraisals for these specific situations are made. These appraisals, in turn, trigger the specific emotional responses. People frequently prefer to enhance, maintain or inhibit their emotional arousal depending on their goals in the specific social context it may concern. Furthermore, emotional responses may then alter the situation as well as the emotional tone as a feedback loop. It is important to note that these emotional responses are flexible depending on the social context. For instance, while it might be acceptable to express anger in our close relationships, it would not be appropriate in the work environment. Thus, the regulation of emotions are not only for personal strategic purposes but it also serves for the cultural expectations in social relationships along with the expression of emotions (Saarni, 1990).

Gross (1998) suggested that there are five different sets of emotion regulation strategies. The first four of these strategies includes situation selection, situation modification, attentional deployment, cognitive change which are also called as antecedent-focused emotion regulation strategies as they are adopted before the emotions are not generated based on the appraisals. Situation selection refers to choosing the situations that will give rise to the desirable emotions. However, there are two difficulties that are faced while implementing this strategy. Firstly, people generally misestimate their emotional responses for the future scenarios as a result of their biased thinking (Gilbert, Pinel, Wilson, Blumberg, & Wheatley, 1998). Secondly, they may choose the short-term comfort over the long term goals. For instance, an agoraphopic would most likely to stay at home in order to avoid the anxiety that he will experience outside, even though in the long term choosing to go out would lessen his anxiety in the long run. On the other hand, situation modification refers to modifying the present situation. The assistance of a supportive person in an anxiety-provoking situation might be an example for this strategy. Attentional deployment includes distraction and concentration. Whereas the former means moving attention away from the emotion evoking stimuli, the latter refers to redirecting attention to our emotions, such as rumination (Nolen-Hoeksema, 1993). Finally, the cognitive change involves the reinterpretation or reappraisal of the emotional stimuli (Gross, 2002). The response-focused emotion regulation, on the other hand includes response modulation which occurs after the emotional responses are generated (Gross & Munoz, 1995) . Response modulation aims to alter or amelioriate the physiological or behavioral consequences of emotions (i.e. drugs, exercise, relaxation, food, alcohol).

As the literature on the dysregulation of emotions suggested that the strategies for emotion regulation only covers one aspect of the construct. Beside of the strategies to modify emotions, the evaluation and awareness of emotions are crucial parts of an adaptive emotion regulation (Thompson & Calkins, 1996). Thus, emotion regulation can not be regarded as simply emotional control. On the contrary, it has been demonstrated that avoidance of undesirable thoughts and emotions may lead to a variety of psychological disturbances (Hayes et al, 1996) and constricted expression of emotions have been found to be related with increased physiological arousal (Gross & Levenson, 1997). Thus, acceptance of emotions as well as the emotional responses without the effort of inhibiting them and behaving according to the desired goals while

experiencing undesirable emotions have been suggested as a more adaptive emotion regulation (Linehan, 1993, Thomas & Calkins, 1996, Gratz & Roemer, 2004).

Gratz and Roemer (2004) developed Difficulties in Emotion Regulation Scale taking the aforementioned conceptualizations of emotion regulation. The assessment covers the aspects of awareness and acceptance of emotions, the ability to control impulsive behaviors and behave towards the desired goals in spite of the negative emotions, the ability to use contextually appropriate regulation strategies. The studies conducted with this measure revealed that emotion dysregulation as a significant predictor of self harm in women and mediated the relationship between PTSD and impulsive behaviors such as antisocial behaviors or risky sexual behaviors (Weiss, Tull, Viana, Anestis & Gratz, 2012). Moreover, it has been shown that patients diagnosed with borderline personality disorder had increased difficulties in engaging in goal directed behavior while experiencing distress (Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2006).

2.3.3. Development of emotion regulation in attachment relationships

Emotional development occurs in the matrix of attachment relationships in the early years and can be defined as a transition "from dyadic regulation from self-regulation of emotion." (Sroufe, 1996, p.151). The complete dependency of the newborn evolves through repeated experiences of distress-relief cycles and shared positive affect between the caregiver and infant (Lamb, 1981). The responsiveness of the caregiver and the synchronicity of this relationship enables the infant develop skills for self regulation.

Emotional development, in general, can be explained throughout some phases. Firstly, the newborn whose behaviors are based on reflexes and drives evolves into an emotional being engaging in purposeful action (Sroufe, 1996). It has been argued that even as early as 3 months, infants start to express some emotional reactions as they develop an awareness of their surroundings. These reactions are believed to be controlled by innate mechanisms and include approaching or withdrawing behaviors from stimuli (Kopp, 1982, Rothbart, Derryberry, & Hershey, 2000). Self-soothing

behaviors such as sucking or manifesting discomfort by crying are among the primitive mechanisms that elicit the parenting behaviors (Kopp, 1982). The period after 3 months, are suggested to imply the beginning of the emotional life (Spitz et al., 1970) as the child starts to exhibit basic voluntary behaviors to modify his emotional arousal such as approaching the mother in the presence of an aversive stimuli (Harman, Rothbart, & Posner,1997).

In the following months, approximately in the second half of the first year, expectation and intention becomes an important aspect of emotional reactions with the improvement of memory (Nelson, 1994). In this phase, mental images can be linked to different affects (Hoffman, 1985). The most obvious example of these reactions are the differential positive gestures toward the caregiver, showing an established pattern of positive affect as a result of repeated interactions (Sroufe, 1996). By the end of the first year, emotion becomes associated with different encounters and context and starts to have a guiding role on behavior and facilitates learning (Bronson & Pankey, 1977). In other words, affect is not only directed to immediate events, but also is linked with past experience and influences future actions. Moreover, the infant acquires the awareness of emotions and is now capable of giving explicit signals to the caregiver in times of distress for the purpose of regulation (Sroufe, 1996). At this time, the infant becomes truly active in his relationships with his caregivers and forms a reciprocal relationship with them. By the end of the second year, the infant starts to use the active and specific strategies of emotion regulation to manage his emotions. Along with the development of motor and language skills, the infant becomes more responsive to the demands of the social context (Rueda, Posner, & Rothbart, 2004).

Emotional development can be described as a movement from physiological states to explicit emotional reactions and it is intertwined with brain maturation, thus cognitive development. Bowlby suggested that these early interactions results in a fundamental cognitive and emotional network and called them “internal working models” through which the individual will experience the world throughout his life (Bowlby, 1973).

The attachment literature suggests that in the very first years of life, emotion regulation takes place in order to accomplish proximity to the attachment figure. Through countless interactions between caregiver-infant relationship, the infant learns

to choose within a variety of emotional responses that will serve him to achieve his goal (Cassidy, 2008). The affective communication between child and caregiver requires the caregiver's sensitivity to the alerting signals of the child, and this sensitive response amelioriates the child's negative emotions which in turn enhances the child's tolerance to the frustrating situations as well as his meta-emotion (Kobak, 1985; Cassidy, 2008). Stern (1985) described this cycle as "affective attunement" as sensitive mother recognizing the infant's affect, accepting and sharing them back with the infant, thus teaching the child that emotions are acceptable and can be shared in social relationships. On the other hand, the insecure child minimizes or heightens emotional expressions as an adaptive strategy. The avoidant child who is consistently rejected, learns to minimize the attention to the relationship and need for the caregiver. This minimizing strategy enables the child to maintain a sufficient proximity to the attachment figure since the attachment behaviors are rejected and the negative emotions of the child are not regulated by the caregiver (Main & Solomon, 1986). On the other hand, the heightening of emotions were exhibited by ambivalent children which experienced inconsistent availability of the caregiver. These children develop an increased dependence to the caregiver as a strategy to draw attention (Main & Solomon, 1986). Furthermore, neglect was also found to be associated with this attachment pattern in children (Youngblade & Belsky, 1989). Even though the strategy of heightening emotions can actually elicit the caregiver's attention, it may also interfere with the developmental tasks such as exploration which is critical for the individuation process (Bowlby, 1973).

Apart from the attachment literature, from a developmental perspective, there are certain reasons why the first years of life is considered as very important. Firstly, consequences of the earlier phases have an impact on the subsequent phases. If the infant gets appropriate care and attention from his caregivers and establishes a secure relationship with them, he would be able to be more resilient in later life especially during the times of distress. Secondly, the child is supposed to acquire social and emotional skills in each developmental stage that enables him to be able to engage in the current environment and gain the necessary personal resources for healthy adaptation (Waters & Sroufe, 1983). For instance, the child who did not develop a sense of security in his early interactions, may avoid social contacts in his school years, which in turn leaves the child with underdeveloped social abilities and without support he may need. Lastly, internal working models which stays at the core of emotional

development, develop throughout the primary relationships in these early years and influences the way others and in general the world is perceived and experienced. Thus, they have a profound effect on our choices and behaviors. Specifically, for example a child who had experienced a psychological abandonment by his parents, would most likely to feel abandoned in his current relationships even when this is not the case.

2.3.4. Emotion regulation in adulthood

The attachment behavioral system as proposed by Bowlby (1969/1982), regulates cognitive, emotional and behavioral functions in order to gain proximity to the attachment figure especially in times of distress. In adulthood, people become fully active in their regulatory functions by adopting different cognitive, emotional and behavioral maneuvers. However, the strategies of different attachment orientations, guide the process of emotion regulation, thus influencing their responses.

In order to understand the activation of the attachment system in adulthood and how the emotions are regulated by different attachment styles, a control systems model was proposed by Mikulincer and Shaver (2007). According to this model, the generation of a particular emotion is triggered by a perceived change in the environment (Shaver et al. 1987; Oatley & Jenkins, 1996), especially when it is personally relevant. The appraisal of this change as favorable leads to positive emotions whereas the appraisal of a possible threat to negative emotions. It is important to note that the appraisal of threat is subjective and may be unconscious and automatic. Moreover, the threat is not exclusively perceived from the external environment but also can be triggered by the inner mechanisms such as thoughts, images, emotions and dreams. Thus, even the thought of a possible threat can activate the attachment system (Mikulincer, Florian, & Hirschberger, 2003). The activation of the attachment system is expressed through action tendencies which include cognitive, emotional, behavioral and physiological responses. However, these responses are context dependent and sometimes regulatory efforts are taken to alter, suppress or postpone the emotional expression in specific circumstances. The activation of the attachment system is demonstrated in Figure 2.4.

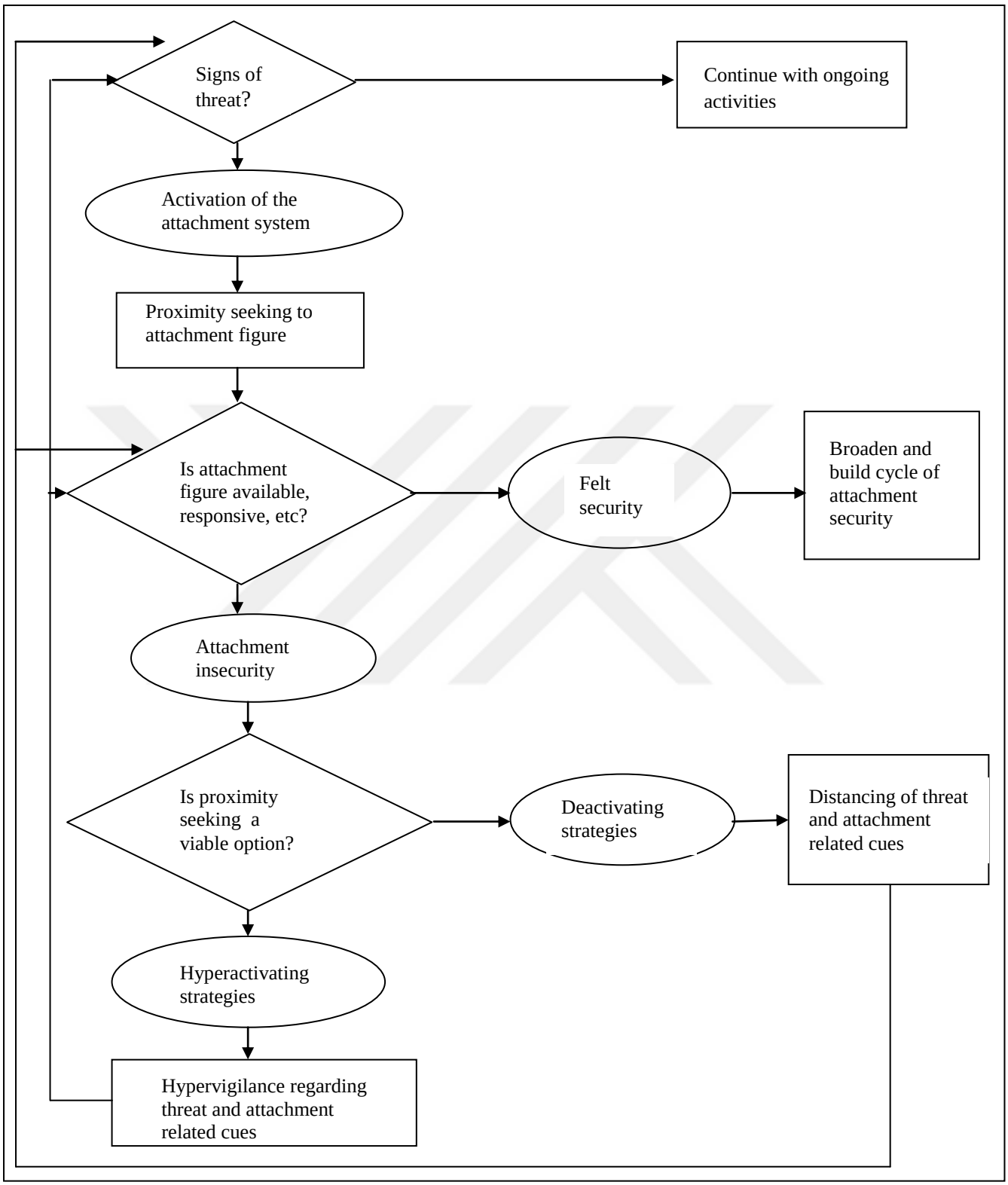

Figure 0.4. The activation of the attachment system

Source: "Attachment in Adulthood" by M. Mikulincer & P. R., Shaver, 2007, NewYork, NY: Guilford Press. Copyright 2017 by the publisher. Reprinted with the permission of Guilford Press.

People with a sense of attachment security, use constructive regulatory efforts such as problem solving, reappraising and seeking support in order to alleviate stress and maintain close relationships. Instead of denying or avoiding the emotions, they can accept the emotion as well as the situation and can make flexible reconstruction of their cognitions or actions. Cassidy (1994) pointed out the importance of this regulation effort as "the experience of security is based not on the denial of negative affect but on the ability to tolerate negative affects temporarily in order to achieve mastery over threatening or frustrating situations" (p. 233). Moreover, early secure attachment relationships facilitates the awareness and understanding of the emotions which is called as self-reflective capacity by Fonagy (1991) and important characteristic of adaptive emotion regulation.

However, when the attachment figure is unavailable or unresponsive, then the secondary strategies were learned through these interactions either as deactivation and hyperactivation. People with avoidant attachment orientations aim to down regulate their emotions by suppressing or inhibiting in order to keep the attachment system deactivated. Instead, these people rely on their selves and attain a defensive independence without the risk of feeling vulnerable and avoid their emotions (Cassidy, 1994). Their biased thinking style and reliance on their personal strength as well as their false self can keep them from using adaptive coping efforts and impair their information processing, especially interfering with the acknowledgement of the new information. Furthermore, they would also avoid their own emotions and any kind of internal stimuli (thoughts, memories, feelings etc.) and external stimuli to maintain the attachment system deactivated along with the suppression of the expression of emotions emotion (Kobak et al., 1993; Mikulincer & Shaver, 2007). Anxiously attached individuals, on the other hand overestimate the likelihood of threat and become more vigilant and use hyper activating strategies to sustain and exaggerate emotions in order to gain the attention and protection of the attachment figure (Kobak et al., 1993). Mikulincer & Shaver, 2007). In adult relationships, this system may be manifested in behaviors such as clinging, being overly dependent and needy. The constructive ways of emotion regulation such as problem solving is perceived as irrelevant to anxious people as they need to maintain the sense of self as helpless and vulnerable. On the contrary, they tend to exaggerate threatening appraisals of the environmental changes and make global personal and uncontrollable attributions to the threat related stimuli (Mikulincer &

Florian, 1998). Furthermore, anxiously attached people had a heightened sensitivity to their negatively charged internal, cognitive, emotional and physiological states (Main & Solomon, 1986; Mikulincer & Shaver, 2007). Finally, hyper activation may lead individuals use self-defeating approach tendencies that result in failure, creating a vicious cycle of distress. Even though, the hyper activation strategies result in increased states of distress, the partial reinforcement achieved by the inconsistent attention of the attachment figure sustains the system (Cassidy & Berlin, 1994).

2.4. The Hypotheses of the Present Study

In the light of the literature that has been summarized above, the aim of this present study is to evaluate the relational and emotional consequences of early experience as predictors of well-being and psychopathology in adulthood. In order to achieve a more comprehensive understanding of early experience, adverse childhood experiences and parenting styles simultaneously were measured as the first set of variables. Secondly, the relational consequences were investigated through attachment insecurity and separation individuation pathology which are both hypothesized to stem from early childhood experiences. Moreover, the emotional consequences were examined by emotion regulation difficulties. Finally, the possible effects of aforementioned variables on psychopathology (i.e. depression, anxiety and stress) and life satisfaction were investigated.

Adverse Childhood Experiences Questionnaire used in this present study assesses 10 different types of traumatic experiences in childhood. Despite, the questionnaire was previously used in one of the Turkish studies; the present study would be the first one investigating the associations between early experiences and lifelong difficulties in an extended scope. Thus, the first part of the results would focus on the isolated effects of ACE on the other variables. Subsequently, the associations between all of the study variables would be investigated.

1. The research hypotheses related to ACE are as the following:

It was hypothesized that:

a. There would be differences between males and females in terms of reported ACE consistent with the existing literature.
b. Higher scores of ACE would be significantly associated with lower income.
c. Higher levels of ACE scores would be associated with more health problems.
d. Higher levels of ACE scores would be associated with attachment insecurity.
e. Higher scores of ACE would predict higher levels of separation individuation problems.
f. Higher scores of ACE would predict higher levels of emotion regulation difficulties.
g. Higher scores of ACE would be associated with higher levels of psychopathology.
h. Higher scores of ACE would be associated with lower levels of life satisfaction.
i. There would be gender specific differences in terms of the effects of different types of ACE.
j. Parenting styles are assumed to be intertwined with adverse childhood experiences as ACEQ investigates the parental adversities as well. Thus, it was hypothesized that both maternal and paternal warmth would be negatively correlated with ACE and maternal and paternal rejection would be positively correlated with ACE. As for parental overprotection, for this specific sample, it was hypothesized that there would be a significant positive correlation with ACE.

To the best knowledge of the author, it would be the first study investigating the set of variables including ACE and perceived parenting styles as predictors of attachment insecurity, separation individuation pathology, emotion regulation difficulties and satisfaction of life and psychopathology. In essence, the primary aim of this study is to understand the associations between these variables. Within the frame of the primary aim, the following hypothesis was specified for analysis:

2. Regarding the perceived parenting styles, it was hypothesized that

a. Maternal and paternal warmth would be negatively correlated with separation individuation problems, emotion regulation difficulties and anxiety and depression.
b. Parental overprotection and rejection would be positively correlated with relational problems, insecure attachment patterns and mental health related problems.
c. The effects of perceived parenting styles would be expected to be significantly different on males and females.

3. It was hypothesized that there would be a significant negative correlation between attachment insecurity and life satisfaction and there would be a significant positive correlation between attachment insecurity and psychopathology as measured as depression, anxiety and stress. Moreover, attachment insecurity would be expected to be positively correlated with separation individuation pathology and emotion regulation difficulties.

4. It was hypothesized that early experiences as measured by ACE and perceived parenting styles would be predictors of psychopathology and well-being. Moreover, the effect of early experiences on psychopathology and well-being would be mediated by attachment insecurity, separation individuation pathology and difficulties in emotion regulation.

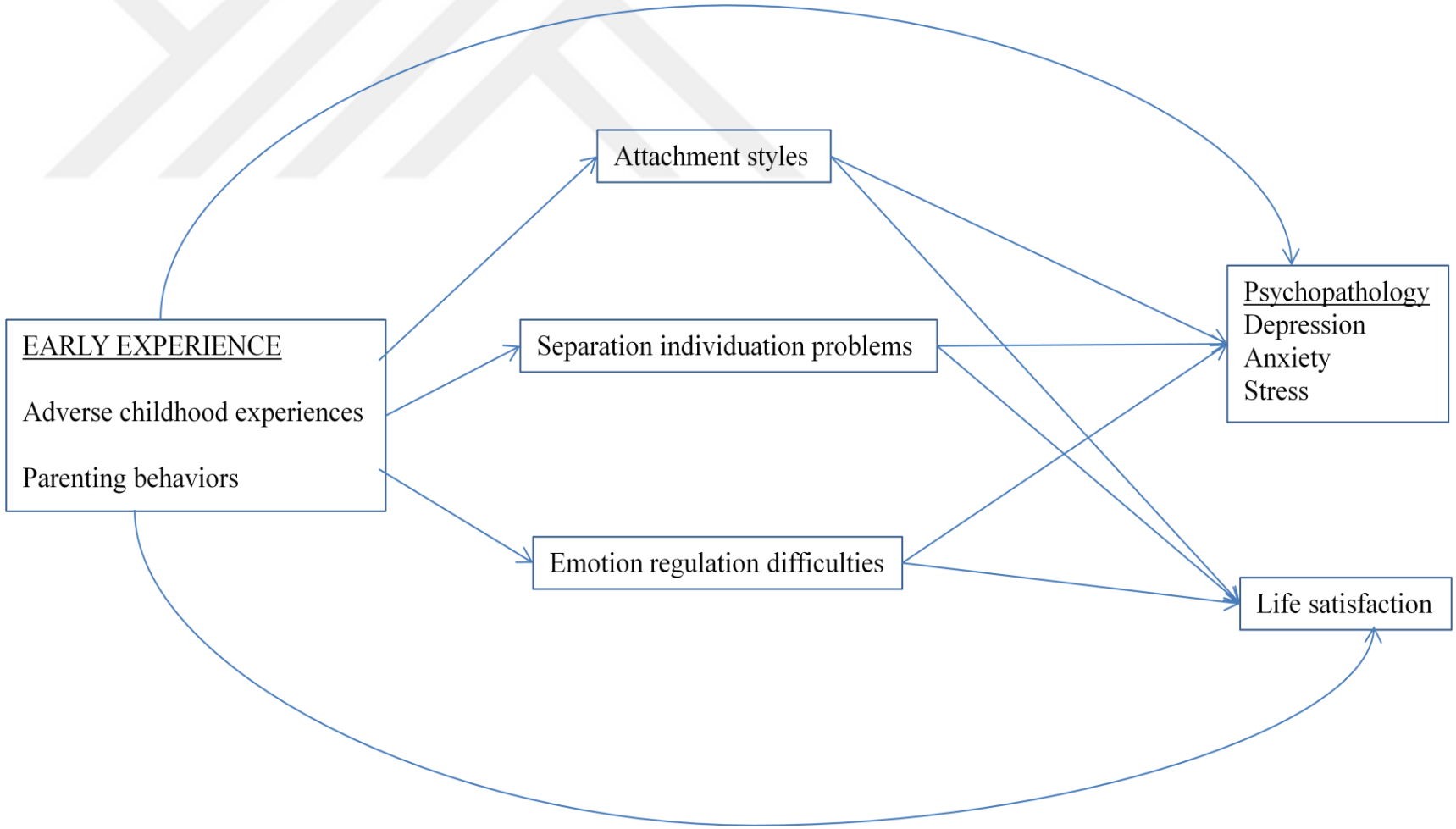

Figure 0.5. The hypothesized model of the present study

3. METHOD

3.1.Participants

This present study has been conducted with 398 students (227 female, 171 male) who are students from different departments of Doğuş University (Psychology, Electronics and Communication Engineering, Industrial Engineering, Computer Engineering, Administration, Mechanical Engineering, Economics and Finance, Architecture, Interior Architecture, Information System Engineering, Visual Communication Design). However, the Missing Value Analysis (MVA) revealed that 34 participants have more than %5 of missing values and they were excluded from the analysis. Moreover, eight subjects were also excluded as a result of the check items. Thus, the subject size of this study was accepted as 356.

In this present study, the age of the students ranged from 18 to 45 with a mean of 21,46 (SD= 3,28). 72.8% of the students have been living with their family and 89.9% of them belong to higher-middle or middle socioeconomic status. 79% of the participants reported that they have experienced at least one romantic relationship. The students who volunteered for the study were given appointments in the lab of the Psychology department. They attended the study on an individual basis voluntarily and were required to fill in the questionnaires. The descriptive statistics of the demographic characteristics are summarized in Tables 3.1, 3.2, 3.3, 3.4. and 3.5.

Table 0.1. Descriptive statistics of demographics of the participants

		Frequency	
Gender	Female	202	56,7
	Male	154	43,3
Socioeconomic status	High	15	4,2
	High middle	154	43,3
	Middle	166	46,6
	Low middle	18	5,1
	Low	3	0,8
Time spent most of the	Village	6	1,7
	District	39	11

lifetime	City	67	18,8
	Metropolis	244	68,5

3.1.1. Student information

The participants were undergraduate students from different departments of Dogus University that are listed below. The mean of the GPA of the participants is 2,49 (SD=0,60) with minimum GPA score of 0,97 and maximum of 4,00.

Table 0.2. Descriptive statistics of school information

Frequency			
Living with	Home with parent	259	72,8
	Home alone	25	7,0
	Home with friend	40	11,2
	With relative	8	2,2
	Dorm	21	5,9
	Other	3	0,8
Class	First year	94	26,4
	Second year	92	25,8
	Third year	112	31,5
	Fourth year	58	16,3
Department	Industrial	156	43,8
	Psychology	104	29,2
	Computer	21	5,9
	Administration	13	3,7
	Electronics and	18	5,1
	Architecture	12	3,4
	Mechanical	15	4,2
	Engineering	3	0,8
	Economics and	6	1,7
	Information System	3	0,8
	Visual	1	0,3
	Interior Architecture	4	1,1

3.1.2. Relationship status

The mean of the number of relationships of the participants is 2,1 (SD=3,02) with minimum 0 and maximum 36 months. Among those who had at least one relationship, the mean of the longest relationship of the participants is 26,46 (SD=29,6) with minimum 0,01 and maximum 336 months and the mean of shortest relationship of the participants is 3,47 (SD=6,36) with minimum 0,01 and maximum 60 months.

Table 0.3. Descriptive statistics of relationship status

		Frequency	
Marital status	Single	222	62,4
	Dating someone	122	34,3
	Engaged	3	0,8
	Living with	2	0,6
	Married	7	2,0
In a Relationship	Yes	283	79,5
	No	73	20,5

Table 0.4. Parental descriptive statistics

Frequency			
Mother Alive	Yes	350	98,3
	No	6	1,7
Father Alive	Yes	338	94,9
	No	18	5,1
Mother Status	Together	318	43,8
	Separate	12	29,2
	Divorced	14	5,9
	Remarried	5	3,7
	Widow	7	5,1
Father Status	Together	317	43,8
	Separate	22	29,2
	Divorced	11	5,9
	Remarried	6	3,7
Mother Education	Illiterate	6	1,7
	Primary school	81	22,8
	Secondary school	73	20,5
	High school	121	34
	College	13	3,7

	University	59	16,6
	Graduate	3	0,8
Father Education	Illiterate	1	0,3
	Primary school	39	11
	Secondary school	57	16
	High school	130	36,5
	College	22	6,2
	University	96	27
	Graduate	11	3,1

Table 0.5. Descriptive statistics of health condition

		Frequency	
Health Problem	Yes	60	16,9
	No	296	83,1

3.2.Instruments

The instruments used for this present study include the Demographic Form which aims to obtain general information about the participant such as age, education, socioeconomic and marital status and family background (see Appendix I), Adverse Childhood Experiences Questionnaire (see Appendix II), Short- EMBU (Egna Minnen Betraffande Uppfostoran- Own Memories of Upbringing) (see Appendix III), Life Satisfaction Scale (see Appendix IV), Separation-Individuation Inventory (see Appendix V), Experiences in Close Relationships Revised (see Appendix VI), Difficulties in Emotion Regulation Strategies (see Appendix VII), and Depression Anxiety Stress Scale (see Appendix VIII).

3.2.1. Adverse Childhood Experiences Questionnaire

Adverse Childhood Experiences Questionnaire was originally designed for The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study in order to investigate

the long-term effects of child abuse and neglect on later life and well-being (Felitti, et al., 1998). The questionnaire investigates childhood experiences in two main categories through 10 questions; exposure to childhood abuse (psychological, physical and sexual) and exposure to household dysfunction which constitutes exposure to substance abuse, mental illness, mistreatment of the caregiver and criminality in the household. All of questions start with the phrase "While you were growing up during your first 18 years of life . . .". The questions are all close ended and requires Yes or No responses. Each positive response is considered as one point and the sum of all questions is calculated as the total score. The range of the total score is between 0 and 10.

For this present study, the questions of ACE Study were translated into Turkish and later back translated by a bilingual psychologist. The questions of ACEQ were listed following the demographic information questions.

The cronbach alpha values for the internal consistency of the questionnaire in this present study was obtained as 0.69.

3.2.2. Short - EMBU (Egna Minnen Betraffande Uppfostoran- Own Memories of Upbringing)

Short- Egna Minnen Betraffande Uppfostoran (EMBU-Own Memories of Upbringing) is a 23-item self-report scale which was designed to assess adult's perceptions of parental rearing behaviors in childhood (Perris, Jacobsson, Lindström, von Knorring, & Perris, 1980). The scale is expected to be filled in separately for mothers' and fathers' behaviors and the responses are rated on a 4 point Likert-type scale (1 = never; 2 = sometimes; 3 = often; 4 = most of the time). The scale is computed as the sum of three different factors as rejection, emotional warmth, and overprotection for each of them. Rejection includes the hostile, abusive and humiliating and disrespectful behaviours of the parents as well as physical punishment. On the contrary, emotional warmth consists of parental behaviors such as showing respect, love, positive attention. Lastly, as the third factor overprotection refers to exaggerated levels of intrusion and rigid rules, expectation for high achivement and compliance. The studies has found that the short version of the scale with these three factors to be valid and reliable (Arrindell et al., 2001).

The Turkish version of EMBU has been firstly adapted by Karancı, et al. (2006) in a cross cultural study and found to be a reliable and valid measurement. The subsequent studies conducted on the scale revealed the same three factors as in the original scale both for mothers and fathers. Moreover, the alpha coefficients for the internal consistency of emotional warmth, overprotection and rejection for mothers were found to be .79, .73 and .71, respectively, whereas for fathers they were found as .75, .72 and .64., respectively.

The cronbach alpha values for the internal consistency of the questionnaire in this present study were found as follows: 0.64 (the total scale for mothers), 0.69 (the total scales for fathers), 0.78 (maternal warmth), 0.75 (paternal warmth), 0.74 (maternal overprotection), 0.75 (paternal overprotection), 0.75 (maternal rejection), 0.73 (paternal rejection).

3.2.3. Experiences in Close Relationships-Revised (ECR-R)

Experiences in Close Relationships-Revised (ECR-R) which has been developed by Fraley, Waller and Brennan (2000), is a measure of adult attachment style. The scale consists of 36 items which measures adult attachment on two dimensions: anxiety and avoidance. The first 18 items in the scale compromise the attachment-related anxiety scale whereas the remaining 18 items compromise the attachment-related avoidance scale. The items are rated according to a 7 point Likert type scale ranging from 1(strongly disagree) to 7 (strongly agree).

The scale was adapted to Turkish by Selçuk, Günaydın, Sümer and Uysal (2005). The Cronbach alpha coefficients for avoidance and anxiety dimension are .90 and .86, respectively. Moreover, positive correlations were found between anxiety and avoidance dimensions and self-esteem and relationship satisfaction.

The cronbach alpha values for the internal consistency of the questionnaire in this present study were found as 0.78 for anxiety and 0.79 for avoidance.

3.2.4. Separation-Individuation Inventory (SII)

Separation-Individuation Inventory, which was developed by Christenson and Wilson (1985), aims to assess psychopathology in terms of separation individuation problems

based on Margaret Mahler's psychodynamic theory of personality development. The scale is a 10 point Likert type scale which consists of 39 items. The separation individuation problems listed through these items are clustered in three main domains: differentiation, splitting and relationship problems. Differentiation refers to the deficiency in forming boundaries between self and others resulting in fusion. Secondly, the subscale of splitting measures the extent the splitting as the psychological defense which can be described as the way of separating the parts of the self and the other into "good" or "bad" is used. Lastly, the third subscale, relationship problems assesses relational difficulties such as inability to tolerate loneliness or trust other people. Subjects are expected to rate how each statement is accurate for themselves (1= does not fit me at all, 10= always fits me). Higher scores indicate difficulties in separation-individuation processes and extreme scores has been found to be related with borderline personality disorder. The coefficient alpha of the total inventory was found to .91 Christenson & Wilson, 1985).

The inventory was firstly adapted to Turkish by Göral (2002) as part of the master thesis which revealed low alpha coefficients. Thus, the psychometric study of the inventory has been repeated and found to be a reliable and valid instrument. Specifically, the factor analysis of the inventory in three factor structure as in the original. Moreover, it was found to have internal consistency with the alpha coefficients of .90, .78, .80, .65 for total inventory, splitting, differentiation and relationship problems, respectively. In terms of validity, it was found to have a moderate concurrent, discriminant and predictive validity (Göral Alkan, 2010).

The cronbach alpha values for the internal consistency of the questionnaire in this present study were found as 0.88 for the total score of SII. Moreover, the cronbach alpha values for the subscales were as follows: 0.71 for splitting, 0.74 for differentiation, and 0.61 for relationship problems.

3.2.5. Difficulties in Emotion Regulation Scale (DERS)

DERS was developed by Gratz and Roemer (2004) in order to measure emotion regulation with four different components which are: "involving the (a) awareness and

understanding of emotions, (b) acceptance of emotions, (c) ability to control impulsive behaviors and behave in accordance with desired goals when experiencing negative emotions, and (d) ability to use situationally appropriate emotion regulation strategies flexibly to modulate emotional responses as desired in order to meet individual goals and situational demands" (p. 42).

The original DERS which was developed by Gratz and Roemer (2004) consists of 6 subscales with 36 items: Awareness, Clarity, Nonacceptance, Strategies, Impulse and Goals. The Turkish version of the scale was adapted by Rugancı (2010) revealing the same factors with high internal consistencies as in the original scale. Moreover, the Cronbach Alpha coefficient for DERS was found to be .93 and test-retest reliability resulted in .83. The total scores of DERS were positively correlated with anxiety, depression, negative self, hostility and somatization. As a result, the Turkish version of DERS was found to have satisfactory psychometric properties.

The cronbach alpha values for the internal consistency of the questionnaire in this present study were found as follows: 0.92 (total score of DERS), 0.81 (Goals), 0.86 (Strategy), 0.79 (Nonacceptance), 0.81 (Impulse), 0.82 (Clarity), 0.63 (Awareness).

3.2.6. Depression Anxiety Stress Scale (DASS)

The DASS (Lovibond & Lovibond, 1995) is a 42- item self report scale which assesses the states of depression, anxiety and stress. Each item on DASS is rated on a 4 point Likert type scale ranging from 0 (never) to 3 (always). The original DASS revealed excellent psychometric qualities. The internal consistency for depression, anxiety and stress subscales were found to be .96, .89 and .93, respectively. Moreover the scale was correlated both with the Beck Depression (r=.74) and Beck Anxiety Inventories (r=.81).

The DASS was adapted to Turkish by Akın and Çetin (2007). The Cronbach Alpha coefficient for the entire scale was. 89 where as for the depression, anxiety and stres subscales were .90, .92 and .92. Similar to the original findings of DASS, the correlations between DASS and BDI and BAI were .87 and .84 respectively.

The cronbach alpha value for the internal consistency of the questionnaire in this present study was found as 0.96 for the total score of DASS. Moreover, the cronbach

alpha values of the subscales were as follows: 0.94 for depression, 0.86 for anxiety and 0.88 for stress.

3.2.7. Satisfaction with Life Scale (SWLS)

Satisfaction with Life Scale which is developed by Diener, Emmons, Larsen and Griffin (1985), is aimed at assessing the individuals' degree of life satisfaction as a component of well-being. It is compromised of five items and rated on a 7 point Likert type scale ranging from "strongly disagree" to "strongly agree". The higher scores in the scale indicates higher life satisfaction.

The Turkish adaptation of SWLS was done by Durak, Gençöz and Şenol-Durak (2008) and the reliability of the scale was reported as .81. Moreover, a negative correlation was found with Beck Depression Inventory (r=-.40).

The cronbach alpha value for the internal consistency of the questionnaire in this present study was 0.86.

3. 3. Procedure

The research battery consisted of 7 different inventories as well as a a brief demographic form and was administered to the students of Dogus University following the approval of Ethics Committee of Dogus University. The study was conducted at the lab of Psychology Department. The participation to the study was voluntary and they the participants were informed that they have the right to quit any time. Prior to the beginning of the research, each participant was assigned an individual identification number in order to maintain confidentiality and anonymity. The participants were initially given a consent form which included a brief description of the study and the statement that participation for this study is fully voluntary. Furthermore, the participants were provided with the contact information of the researcher and they were informed that the data collected in the study would be analyzed collectively and the results of the study would be shared by the department.

The research battery was counterbalanced in 8 different versions in order to eliminate any response bias as a result of sequences. The assessment process took approximately 45 minutes and were carried out by the researcher or the research assistant of the Psychology department who were trained and supervised prior to the study.

4. RESULTS

In order to test the hypothesized model, a series of statistical analysis were conducted following the preliminary analysis which aim to exclude the missing data as well as the

outliers. Firstly, the possible differences of the demographic variables of age, gender and SES were examined for each of the study variables. In order to see the general patterns between the study variables, a correlational analysis were conducted. Since the present study is the first one investigating the variable of ACE, the associations of this variable with other study measures were examined separately. Furthermore, a series of regression analyses were conducted to demonstrate the effects of different types of traumatic experiences. Finally, the general constructs in the hypothesized model were tested via Path Analysis to see the specified effects of the factors of the general constructs.

4.1.Preliminary Analysis

Prior to conducting the main analyses, the variables were checked for the patterns of missing data and outliers using the missing value analysis (MVA). Firstly, 34 participants who had missing values of all variables more than %5 were deleted from the data. Secondly, 8 participants who recklessly filled in the questionnaire were detected by the check items (DAS-16 and ERS-27) and were also excluded from the further analysis. Thus, 356 subjects from a total number of 399 were remained for the data analysis.

Missing values analysis were conducted for both quantitative and categorical variables. For quantitative variables, Little's Missing Completely at Random (MCAR) test is the most common test for missing cases being missing completely at random. If the p value for Little's MCAR test is non-significant, then the missing cases in the data are assumed to be appear random for the analysis. According to Little's MCAR test, the test statistics for quantitative variables were found to be non-significant at the ($p>0.05$) level, indicating that these variables considered missing completely at random. Therefore, Expectation Maximization algorithm suggested by Little (1988) is used to predict the missing values for each quantitative variables. Furthermore, for the categorical cases, multiple imputation method is performed with the linear regression method to predict the missing data in the categorical variables.

4.2.Tests of Normality

Since the statistical procedures that are adopted in this present study are based on the assumption that the data collected from this sample has a normal distribution, tests of normality have been conducted for each of the study variables. Specifically, the Kolmogorov-Smirnov (K-S) test is used to decide if a sample comes from a population with a specific distribution. The Kolmogorov-Smirnov (K-S) test is based on the empirical distribution function (ECDF) As can be seen at Table 4.2, the skewness and kurtosis values with K-S test are computed.

Furthermore, the outliers in the data are explored using box-plots of the variables. According to box-plots there are some outliers detected in some of the variables in the data set. These outliers removed from the data set. If the variables are still shows non-normality then some proper mathematical transformations (such as; logarithmic, exponantial, square root, etc.) are applied to the variables therefore, the normal or near-normal distribution assumption are hold for interested variables. Thus, the further analyses were conducted with the remaining 356 participants.

Table 4.1. Results for the tests of distrubution of normality for the study variables

	Skewness	**Kurtosis**	**K-S test**
Life Satisfaction (SWLS)	-,399	-,598	0,002

Perceived Parenting Styles (EMBU)			
Maternal warmth	-,714	,042	0,000
Paternal warmth	-,600	-,175	0,001
Maternal overprotection	,411	-,153	0,005
Paternal overprotection	,494	-,033	0,000
Maternal rejection	2,354	7,562	0,000
Paternal rejection	2,276	7,151	0,000
Separation-Individuation Inventory			
Splitting*	,125	-,498	0,848
Differentiation*	,485	,328	0,388
Relationship problems*	,496	,791	0,136
Attachment dimensions			
Anxiety*	-,326	-,404	0,101
Avoidance*	,251	-,444	0,307
Depression Anxiety Stress Scale			
Depression	,857	-,138	0,000
Anxiety	1,090	1,271	0,000
Stress*	,308	-,457	0,057
Emotion Regulation Difficulties			
Goals	-,283	-,083	0,007
Strategy	,487	-,593	0,001
Nonacceptance	,678	,172	0,009
Impulse	,610	-,016	0,000
Clarity	,675	,886	0,000
Awareness	-,718	1,153	0,000

Note = * implicates the variables with the normality distribution

4.3.Descriptive Statistics of the Measures of the Study

After the missing data analysis and appropriate corrections on the data, the further analysis are conducted with 356 subjects (202 female, 154 male) who filled in the questionnaires individually. Firstly, the descriptive characteristics of the following measures used in this present study were explored. The measures are as follows: Adverse Childhood Experiences Questionnaire, Short- EMBU (Egna Minnen Betraffande Uppfostoran- Own Memories of Upbringing) with dimensions of Warmth, Rejection and Overprotection both for mothers and fathers, Satisfaction w,th Life Scale, Psychological Well-Being Scale, Separation-Individuation Inventory with the subscales of Splitting, Differentiation and Relationship Problems, Experiences in Close

Relationships Revised with the dimensions of Anxiety and Avoidance, Difficulties in Emotion Regulation Scale with the subscales of Acceptance, Goals, Impulse, Awareness, Strategies and Clarity, and lastly Depression Anxiety Stress Scale (see Table 3.2).

Table 4.2. Descriptive statistics of the measures of the study

Measures	**Mean Male N= 154**	**Mean Female N= 202**	**Mean Total N=356**	**SD**	**Range**
ACEQ	1,6	1,67	1,6	1,79	0-8
S- EMBU					
Mwarmth	20,47	22,06	21,37	4,12	7-28
Moverprotection	19,77	19,37	19,51	4,24	10-33
Mrejection	9,88	9,36	9,58	2,97	7-25
Pwarmth	18,56	20,74	19,8	4,7	7-28
Poverprotection	18,59	18,8	18,7	4,18	9-32
Prejection	9,99	9,24	9,56	3,11	7-28
ECR-Revised					
ECR-Anxiety	3,47	3,53	3,51	,87	1,22-5,72
ECR-Avoidance	3,18	3,49	3,36	,91	1,61-6,06
SII					
Splitting	56,28	54,54	55,3	15,7	20-98
Differentiation	53,27	50,6	51,76	17,7	17-122
Relationship Problems	52,69	53,73	53,28	13,5	19-108
DERS					
Nonacceptance	13,03	12,97	12,99	4,99	6-30
Goals	15,72	16,61	16,23	3,17	6-24
Impulse	14,44	14,32	4,37	4,24	6-29
Awareness	17,56	18,04	17,83	3,27	5-25
Strategies	20,03	20,77	20,45	6,12	10-36
Clarity	13,53	13,89	13,73	2,37	8-22
SWLS	21,12	23,06	22,22	6,49	5-35
DASS					
Depression	12,22	11,29	11,7	9,62	0-39
Anxiety	10,24	10,8	10,56	7,32	0-42
Stress	17,13	18,55	17,93	8,48	0-42

Note: ACEQ=Adverse Childhood Experiences Questionnaire; S-EMBU= Short-EMBU (Egna Minnen Betraffande Uppfostoran- Own Memories of Upbringing); ECR-Revised: Experiences in Close Relationships-Revised; SII= Separation-Individuation Inventory; DERS= Difficulties in Emotion Regulation Scale; SWLS= Satisfaction with Life Scale; PWB= Psychological Well-Being Scale; DASS= Depression Anxiety Stress Scale.

4.4.ACE Prevalence Rates

Table 5.1 presents the percentages of exposure to different kinds of childhood adversity. As can be clearly seen, emotional abuse and emotional neglect are among the highest that have been experienced in this current sample. Furthermore, the percentages of ACEQ scores are classified as in the original ACE study (Dube et al., 2003).

Table 4.3. Prevalence (%) of childhood adversity by category in the present study

Category of adversity	**Males**	**Females**	**Total**
	n= 154	**n = 202**	**n= 356**
Type of abuse			
Emotional	36,4	35,6	36
Physical	35,6	28,2	30,9
Sexual	1,9	6,4	4,5
Neglect			
Emotional	29,2	37,1	33,7
Physical	3,2	4,5	3,9
Household dysfunction			
Parental separation or divorce	9,7	9,4	9,6
Mother exposed to physical	16,2	17,3	16,9

violence			
Substance abuse in household	10,4	3,5	6,5
Mental illness or suicide attempt in family member	12,3	19,3	16,3
Incarceration of household member	5,2	5,4	5,3
ACE Score			
0	40,3	37,1	38,5
1	17,5	17,8	17,7
2	13,0	17,8	15,7
3	12,3	11,4	11,8
4 or more	16,9	15,8	16,3

4.5. The Differences of Demographic Characteristics on the Study Measures

In order to examine the possible differences of demographic variables as gender, age and SES on the measures of the study, univariate and multivariate analyses were conducted. Firstly, the demographic characteristic of age was categorized into different groups considering the number of cases in each group. Secondly, SES was recategorized into two groups as high and low since the number of cases in each previous category was not sufficient enough for further analysis. That was due to the fact that the data was collected from a private university which had rare cases of low income. The categorizations are summarized in Table 3.4.

Table 4.4. The recategorizations of the variables

Demographic variables	N	%
Gender		
Female	202	57
Male	154	43
Age		
18 to 21 (Younger)	217	61
21 to 45 (Older)	139	39
SES		
High	169	47,5
Middle to low	187	52,5

4.5.1. Differences of age, gender and SES on ACE

A three way between subjects ANOVA were conducted in order to examine the possible differences of demographic characteristics of age, gender and SES on adverse childhood experiences.

The results for ANOVA revealed significant main effect only for age [F (1, 348) = 13.33, p <.001]. The main effects for gender and SES as well as the interaction effects were found to be nonsignificant.

Table 4.5. Demographic differences on ACEQ

Source ACEQ scores	Type III Sum of Squares	df	MS	F	p
Gender	2.73	1	2.73	1.26	.26
Age	28.83	1	28.83	13.33	.00
SES	4.19	1	4.19	41.94	.17
Gender X Age	5.24	1	5.24	2.42	.12
Gender X SES	.38	1	.38	.18	.68
Age X SES	.43	1	.43	.20	.66
Gender X Age X SES	2.55	1	2.55	1.18	.28
Error	752.97	348	2.16		

The results indicated that younger participants (M = 1.27, SD = 0.10) reported significantly lower levels of adverse childhood experiences compared to older participants, (M = 1.86, SD = 0.13).

4.5.2. Differences of age, gender and SES on perceived parenting styles

MANOVA was conducted to examine the differences of age, gender and SES on the perceived parenting styles (i.e.warmth, overprotection and rejection) of mothers and fathers respectively as reported by the participants.

Firstly, MANOVA was conducted for maternal parenting behaviors. The results for MANOVA revealed a significant multivariate main effect for both gender, Wilks' λ = .975, *F* (3, 346) = 2.95, p <. 05, ηp2 = .025 and age, Wilks' λ = .967, *F* (3, 346) = 3.95, p <. 01, ηp2 = .033. Moreover, there was a significant interaction effect of gender and SES, Wilks' λ = .978, *F* (3, 346) = 2.64, p = .05, ηp2 = .022. The univariate analyses were further conducted for the significant effects following the Bonferroni correction as (significance levels accepted as .05/3 = .016). The results of the univariate analyses yielded gender main effect was significant for maternal warmth [F (1, 348) = 8.60 p <.005; ηp2 =.024]. Likewise, the main effect of age was only significant for maternal warmth, [F (1, 348) = 11.11, p <.005; ηp2 =.031]. However, the interaction effect between gender and SES did not reveal any significant results in terms of different parenting behaviors. Thus, the results indicated that younger (M= 3.10, SD = 0.4) and female (M= 3.10, SD = 0.4) participants reported higher levels of maternal warmth compared to older (M= 2.90, SD = 0.5) and male participants (M= 2.91, SD = 0.5).

Table 4.6. Demographic differences on perceived maternal parenting styles

Source EMBU-Perceived maternal parenting styles	Wilks' Lambda	Multi. df	Multivariate F	Multi. η2	Uni df	Univariate F	Univariate η2
Gender	.96	3, 346	2.95*	.03	-	-	-
Mwarmth	-	-	-	-	1, 348	8.60**	.02
Moverpro	-	-	-	-	1, 348	.22	.001
Mreject	-	-	-	-	1, 348	.92	.003
Age	.97	3, 346	3.95**	.03	-	-	-
Mwarmth	-	-	-	-	1, 348	11.11**	.03
Moverpro	-	-	-	-	1, 348	.03	.00
Mreject	-	-	-	-	1, 348	3.50	.01
SES	.99	3, 346	1.72	.02	-	-	-
Mwarmth	-	-	-	-	1, 348	.25	.001
Moverpro	-	-	-	-	1, 348	4.49	.13
Mreject	-	-	-	-	1, 348	.02	.00

Gender X Age	.98	3, 346	2.83	.02	-	-	-
Mwarmth	-	-	-	-	1, 348	2.60	.01
Moverpro	-	-	-	-	1, 348	3.27	.01
Mreject	-	-	-	-	1, 348	5.45	.02
Gender X SES	.98	3, 346	2.64*	.02	-	-	-
Mwarmth	-	-	-	-	1, 348	4.97	.01
Moverpro	-	-	-	-	1, 348	2.09	.01
Mreject	-	-	-	-	1, 348	5.09	.01
Age X SES	1.00	3, 346	.31	.003	-	-	-
Mwarmth	-	-	-	-	1, 348	.14	.00
Moverpro	-	-	-	-	1, 348	.76	.002
Mreject	-	-	-	-	1, 348	.46	.001
Gender X Age X SES	.98	3, 346	1.92	.02	-	-	-
Mwarmth	-	-	-	-	1, 348	5.4	.02
Moverpro	-	-	-	-	1, 348	.13	.00
Mreject	-	-	-	-	1, 348	.32	.001

*p < .05, ** p < .01

Secondly, MANOVA was conducted for paternal parenting styles and the results yielded a significant multivariate main effect for only gender, Wilks' $\lambda = .96$, F (3, 346) = 5.31, p <. 01, $\eta p2 = .04$. The univariate analyses were further conducted for the significant effects following the Bonferroni correction as (significance levels accepted as .05/3 = .016). The results of the univariate analyses yielded gender main effect was significant for paternal warmth [F (1, 348) = 15.43 p <.005; $\eta p2 = .04$]. Thus, the results indicate that female participants, (M= 2.93, SD = 0.5) reported higher levels of paternal warmth compared to male participants, (M= 2.65, SD = 0.5).

Table 4.7. Demographic differences on perceived paternal parenting styles

Source EMBU-Perceived paternal parenting styles	Wilks' Lambda	Multi. df	Multivariate F	Multi. η2	Uni df	Univariate F	Univariate η2
Gender	.96	3, 346	5.31**	.04	-	-	-
Fwarmth	-	-	-	-	1, 348	15.43**	.04
Foverpro	-	-	-	-	1, 348	.56	.002
Freject	-	-	-	-	1, 348	3.89	.01
Age	.99	3, 346	1.77	.02	-	-	-
Fwarmth	-	-	-	-	1, 348	3.18	.009
Foverpro	-	-	-	-	1, 348	.73	.002
Freject	-	-	-	-	1, 348	2.54	.007
SES	.99	3, 346	1.22	.01	-	-	-
Fwarmth	-	-	-	-	1, 348	.02	.00
Foverpro	-	-	-	-	1, 348	2.15	.006
Freject	-	-	-	-	1, 348	.15	.00
Gender X Age	.99	3, 346	.48	.004	-	-	-
Fwarmth	-	-	-	-	1, 348	.03	.00
Foverpro	-	-	-	-	1, 348	1.39	.004
Freject	-	-	-	-	1, 348	.13	.00
Gender X SES	.99	3, 346	.68	.006	-	-	-
Fwarmth	-	-	-	-	1, 348	.15	.00
Foverpro	-	-	-	-	1, 348	1.85	.005
Freject	-	-	-	-	1, 348	.23	.001
Age X SES	.99	3, 346	1.53	.01	-	-	-
Fwarmth	-	-	-	-	1, 348	.73	.002
Foverpro	-	-	-	-	1, 348	3.31	.009
Freject	-	-	-	-	1, 348	.23	.001
Gender X Age X SES	.99	3, 346	1.72	.02	-	-	-
Fwarmth	-	-	-	-	1, 348	2.19	.006
Foverpro	-	-	-	-	1, 348	.51	.001

Freject	-	-	-	-	1, 348	.04	.00

*p < .05, ** p < .01

4.5.3. Differences of age, gender and SES on separation individuation pathology

MANOVA was conducted to examine the differences of age, gender and SES on the separation individuation pathology (i.e.splitting, differentiation and relationship problems).

The results for MANOVA revealed a significant multivariate main effect only for age, Wilks' λ = .98, *F* (3, 346) = 2.65, p <. 05, ηp2 = .02. However, there were no significant main effects for the other demographic variables or no interaction effects. The univariate analyses were further conducted for the significant main effect following the Bonferroni correction as (significance levels accepted as .05/3 = .016). The results of the univariate analyses yielded the main effect of age was significant for splitting [F (1, 348) = 7.48, p <.01; ηp2 =.02], differentiation, [F (1, 348) = 6.33, p <.05; ηp2 =.02] and relationship problems, [F (1, 348) = 4.65, p <.05; ηp2 =.01]. Along with the mean scores, the results indicate younger participants reported higher levels of separation individuation pathology as splitting (M= 4.75, SD = 1.25), differentiation, (M= 3.82, SD = 1.26) and relationship problems, (M= 4.19, SD = .99) compared to older participants, (M= 4.39, SD = 1.39, for splitting; (M= 3.50, SD = 1.25), for differentiation and (M= 3.95, SD = 1.11) for relationship problems).

Table 4.8. Demographic differences on separation individuation pathology

Source Separation individuation pathology	Wilks' Lambda	Multi. df	Multivariate F	Multi. η2	Uni df	Univariate F	Univariate η2
Gender	.98	3, 346	2.63	.02	-	-	-
Splitting	-	-	-	-	1, 348	2.12	.006
Differentiation	-	-	-	-	1, 348	2.31	.007
Relationship prob.	-	-	-	-	1, 348	.23	.001

Age	.98	3, 346	2.65*	.02	-	-	-
Splitting	-	-	-	-	1, 348	7.48**	.02
Differentiation	-	-	-	-	1, 348	6.33*	.02
Relationship problems	-	-	-	-	1, 348	4.65*	.01
SES	1.00	3, 346	.155	.001	-	-	-
Splitting	-	-	-	-	1, 348	.21	.001
Differentiation	-	-	-	-	1, 348	.46	.001
Relationship problems	-	-	-	-	1, 348	.14	.00
Gender X Age	.99	3, 346	1.75	.02	-	-	-
Splitting	-	-	-	-	1, 348	2.36	.007
Differentiation	-	-	-	-	1, 348	.002	.00
Relationship problems	-	-	-	-	1, 348	.89	.003
Gender X SES	.98	3, 346	1.98	.02	-	-	-
Splitting	-	-	-	-	1, 348	2.06	.006
Differentiation	-	-	-	-	1, 348	.24	.001
Relationship problems	-	-	-	-	1, 348	4.33	.01
Age X SES	.99	3, 346	1.24	.01	-	-	-
Splitting	-	-	-	-	1, 348	2.99	.01
Differentiation	-	-	-	-	1, 348	1.19	.003
Relationship problems	-	-	-	-	1, 348	2.94	.01
Gender X Age X SES	.99	3, 346	.35	.003	-	-	-
Splitting	-	-	-	-	1, 348	.26	.001
Differentiation	-	-	-	-	1, 348	.03	.00
Relationship problems	-	-	-	-	1, 348	.14	.00

*p < .05, ** p < .01

4.5.4. Differences of age, gender and SES on attachment dimensions

MANOVA was conducted to examine the differences of age, gender and SES on the attachment dimensions (i.e. Anxiety and avoidance).

The results for MANOVA revealed a significant multivariate main effect only for gender, Wilks' λ = .98, *F* (2, 347) = 3.36, p <. 05, ηp2 = .02. However, there were no significant main effects for the other demographic variables or no interaction effects. The univariate analyses were further conducted for the significant main effect following the Bonferroni correction as (significance levels accepted as .05/3 = .016). The results of the univariate analyses yielded the main effect of age was significant for only avoidance, [F (1, 348) = 6.57, p <.05; ηp2 =.02]. Along with the mean scores, the results indicate females (M= 3.43, SD = 0.7) were more likely to have avoidance in their relationships compared to males, (M= 3.18, SD = 0.7).

Table 4.9. Demographic differences on attachment dimensions

Source Attachment dimensions	Wilks' Lambda	Multi. df	Multivariate F	Multi. η2	Uni df	Univariate F	Univariate η2
Gender	.98	2, 347	3.36*	.02	-	-	-
Anxiety	-	-	-	-	1, 348	1.10	.003
Avoidance	-	-	-	-	1, 348	6.57*	.02
Age	.98	2, 347	2.81	.02	-	-	-
Anxiety	-	-	-	-	1, 348	2.63	.007
Avoidance	-	-	-	-	1, 348	4.35	.01
SES	.99	2, 347	1.58	.009	-	-	-
Anxiety	-	-	-	-	1, 348	2.74	.008
Avoidance	-	-	-	-	1, 348	.05	.00
Gender X Age	.98	2, 347	2.75	.02	-	-	-
Anxiety	-	-	-	-	1, 348	4.12	.01
Avoidance	-	-	-	-	1, 348	.39	.001

Gender X SES	.99	2, 347	1.29	.007	-	-	-
Anxiety	-	-	-	-	1, 348	2.18	.006
Avoidance	-	-	-	-	1, 348	.99	.003
Age X SES	1.00	2, 347	.022	.00	-	-	-
Anxiety	-	-	-	-	1, 348	.03	.00
Avoidance	-	-	-	-	1, 348	.02	.00
Gender X Age X SES	.99	2, 347	2.20	.01	-	-	-
Anxiety	-	-	-	-	1, 348	.17	.00
Avoidance	-	-	-	-	1, 348	3.57	.01

*p < .05, ** p < .01

4.5.5. Differences of age, gender and SES on difficulties in emotion regulation

In order to examine the differences of age, gender and SES on difficulties in emotion regulation, MANOVA was conducted with 6 areas of emotion regulation skills (Goals, strategies, impulse, acceptance, awareness, clarity) as the dependent variables.

The results for MANOVA revealed a significant multivariate main effect only for gender, Wilks' $\lambda = .98$, F (2, 347) = 3.36, p <. 05, $\eta p2 = .02$. However, there were no significant main effects for the other demographic variables or no interaction effects. The univariate analyses were further conducted for the significant main effect following the Bonferroni correction as (significance levels accepted as .05/6 = .008). The results of the univariate analyses yielded the main effect of gender was significant for only goals, [F (1, 348) = 1.10, p <.01; $\eta p2 = .003$]. Along with the mean scores, the results indicate females (M= 3.34, SD = 0.5) were more likely to have difficulties in engaging in goal directed behaviors compared to males, (M= 3.12, SD = 0.5).

Table 4.10. Demographic differences on emotion regulation difficulties

Source Difficulties in emotion regulation	Wilks' Lambda	Multi. df	Multivariate F	Multi. η2	Uni df	Univariate F	Univariate η2
Gender	.98	2, 347	3.36*	.02	-	-	-
Goals	-	-	-	-	1, 348	1.10**	.003
Strategies	-	-	-	-			
Nonacceptance	-	-	-	-			
Impulse	-	-	-	-			
Clarity	-	-	-	-			
Awareness	-	-	-	-			
Age	.98	2, 347	2.81	.02	-	-	-
Goals	-	-	-	-	1, 348	2.63	.007
Strategies	-	-	-	-	1, 348	4.35	.01
Nonacceptance	-	-	-	-			
Impulse	-	-	-	-			
Clarity	-	-	-	-			
Awareness	-	-	-	-			
SES	.99	2, 347	1.58	.009	-	-	-
Goals	-	-	-	-	1, 348	2.74	.008
Strategies	-	-	-	-	1, 348	.05	.00
Nonacceptance	-	-	-	-			
Impulse	-	-	-	-			
Clarity	-	-	-	-			
Awareness	-	-	-	-			
Gender X Age	.98	2, 347	2.75	.02	-	-	-
Goals	-	-	-	-	1, 348	4.12	.01
Strategies	-	-	-	-	1, 348	.39	.001
Nonacceptance	-	-	-	-			
Impulse	-	-	-	-			
Clarity	-	-	-	-			
Awareness	-	-	-	-			

Gender X SES	.99	2, 347	1.29	.007	-	-	-
Goals	-	-	-	-	1, 348	2.18	.006
Strategies	-	-	-	-	1, 348	.99	.003
Nonacceptance	-	-	-	-			
Impulse	-	-	-	-			
Clarity	-	-	-	-			
Awareness	-	-	-	-			
Age X SES	1.00	2, 347	.022	.00	-	-	-
Goals	-	-	-	-	1, 348	.03	.00
Strategies	-	-	-	-	1, 348	.02	.00
Nonacceptance	-	-	-	-			
Impulse	-	-	-	-			
Clarity	-	-	-	-			
Awareness	-	-	-	-			
Gender X Age X SES	.99	2, 347	2.20	.01	-	-	-
Goals	-	-	-	-	1, 348	.17	.00
Strategies	-	-	-	-	1, 348	3.57	.01
Nonacceptance	-	-	-	-			
Impulse	-	-	-	-			
Clarity	-	-	-	-			
Awareness	-	-	-	-			

*p < .05, ** p < .01

4.5.6. Differences of age, gender and SES on psychopathology

In order to examine the differences of age, gender and SES on psychopathology, MANOVA was conducted with three subscales of DASS as depression, anxiety and stress.

The results for MANOVA revealed a significant multivariate main effect only for gender, Wilks' λ = .97, *F* (3, 345) = 3.51, p <. 05, ηp2 = .03. However, there were no significant main effects for the other demographic variables or no interaction effects. The univariate analyses were further conducted for the significant main effect following

the Bonferroni correction as (significance levels accepted as .05/3 = .016). However, the results of the univariate analyses yielded no significant effects for the subscales of DASS.

Table 4.11. Demographic differences on psychopathology

Source Depression Anxiety Stress	Wilks' Lambda	Multi. df	Multivariate F	Multi. η2	Uni df	Univariate F	Univariate η2
Gender	.97	3, 345	3.51*	.03	-	-	-
Depression	-	-	-	-	1, 347	.71	.002
Anxiety	-	-	-	-	1, 347	.58	.002
Stress	-	-	-	-	1, 347	1.95	.006
Age	.99	3, 345	1.12	.01	-	-	-
Depression	-	-	-	-	1, 347	1.14	.003
Anxiety	-	-	-	-	1, 347	2.97	.008
Stress	-	-	-	-	1, 347	.65	.002
SES	.98	3, 345	2.00	.02	-	-	-
Depression	-	-	-	-	1, 347	3.05	.01
Anxiety	-	-	-	-	1, 347	4.63	.01
Stress	-	-	-	-	1, 347	.90	.003
Gender X Age	1.00	3, 345	.49	.004	-	-	-
Depression	-	-	-	-	1, 347	.43	.001
Anxiety	-	-	-	-	1, 347	.03	.00
Stress	-	-	-	-	1, 347	.86	.002
Gender X SES	.99	3, 345	1.64	.02	-	-	-
Depression	-	-	-	-	1, 347	3.78	.01
Anxiety	-	-	-	-	1, 347	4.54	.01
Stress	-	-	-	-	1, 347	3.50	.01
Age X SES	.99	3, 345	1.08	.01	-	-	-
Depression	-	-	-	-	1, 347	1.58	.005
Anxiety	-	-	-	-	1, 347	.66	.002
Stress	-	-	-	-	1, 347	.01	.00

Gender X Age X SES	1.00	3, 345	.60	.005	-	-	-
Depression	-	-	-	-	1, 347	1.09	.003
Anxiety	-	-	-	-	1, 347	1.15	.003
Stress	-	-	-	-	1, 347	.24	.001

*p < .05, ** p < .01

4.5.7. Differences of age, gender and SES on life satisfaction

One way ANOVA was conducted in order to examine the differences of age, gender and SES on satisfaction with life.

The results for ANOVA revealed significant main effect for gender, F (1, 348) = 4.39, p <.05]. and SES, [F (1, 348) = 14.05, p <.001]. The main effects for age as well as the interaction effects were found to be nonsignificant.

Table 4.12. Demographic differences on satisfaction with life

Source					
SWLS	Type III Sum of Squares	df	MS	F	p
Gender	6.99	1	6.99	4.39*	.04
Age	.26	1	.26	.16	.69
SES	22.36	1	22.36	14.05**	.00
Gender X Age	1.87	1	1.87	1.18	.28
Gender X SES	.42	1	.42	.27	.61
Age X SES	5.31	1	5.31	3.33	.07
Gender X Age X SES	4.40	1	4.40	2.76	1.0
Error	553.93	348	1.59		

*p < .05, ** p < .01

The results indicated that females, (M= 4.57, SD = 0.1) reported significantly higher levels of life satisfaction compared to males, (M= 4.27, SD = 0.1). Furthermore, participants who have a higher SES, (M= 4.69, SD = 0.1) reported higher levels of life satisfaction than those with lower SES, (M= 4.16, SD = 0.1).

4.6.Correlational analysis of the study variables

Correlational analyses were conducted in order to explore the associations between research variables. The correlational matrix was analyzed in three parts with related variables. The study variables are clustered in the correlational analyses for research purposes as measures of early experience (S-EMBU and ACEQ), measures of relational consequences (ECR-R and SII), measures of emotional consequences (DERS) and finally dependent variables as predictors of well-being; subjective well-being (SWLS) and psychopathology scales (DASS).

4.6.1. Early experience and relational consequences

The intercorrelations between measures of early experience and relational consequences are shown in Table 4.2. According to the results of correlational analysis, ACEQ scores revealed significant negative correlations with the subscales of EMBU, perceived mother warmth (r = -.24, p <.01) and father warmth (r = -.34, p <.01). In other words, subjects who were exposed to more childhood adversity, had lower levels of perceived warmth from their parents. Similarly, ACEQ scores had significant positive correlations with overprotection (for mothers, r = .24, p <.01; for fathers, r = .19, p <.01) and rejection (for mothers, r = .43, p <.01; for fathers, r = .42, p <.01) of both parents. Thus, it can be assumed that subjects who were exposed to more childhood adversity, had more negative experiences as overprotection and rejection in their family environment. However, it is important to note that these parental characteristics may be the source of the childhood adversity themselves.

Furthermore, ACEQ scores were found to be positively correlated with the subscales of SII; splitting (r = .14, p <.01), differentiation (r = .19, p <.01) and relationship problems

(r = .13, p <.05). In other words, people who experienced higher levels of childhood adversity, had higher levels of individuation and relationship problems. Lastly, ACEQ scores were positively correlated with attachment anxiety.

Moreover, overprotection of mothers and fathers revealed significant positive correlations with splitting (for mothers, r = .21, p <.01; for fathers, r = .14, p <.01), differentiation (for mothers, r = .23, p <.01; for fathers, r = .22, p <.01), and relationship problems (for mothers, r = .22, p <.01; for fathers, r = .18, p <.01), as well as attachment anxiety (for mothers, r = .21, p <.01; for fathers, r = .15, p <.01),. In other words, as the levels of parental protection increased, the relational problems increased as well. Lastly, rejection of mothers were found to have significant positive correlations with differentiation (r = .14, p <.01)., relationship problems (r = .11, p <.05). and attachment anxiety (r = .16, p <.01), whereas rejection of fathers had significant positive correlations with splitting (r = .11, p <.05)., differentiation (r = .20, p <.01). and attachment anxiety (r = .16, p <.01).

To sum up, childhood adversity and perceived parental characteristics were found to have low to moderate correlations with some of the relational problems as expected. On the other hand, attachment avoidance was not found to be correlated with any of the early experience factors that are assessed in this present study.

Table 4.13. Intercorrelations between measures of early experience and relational consequences

	ACEQ	M-warmth	F-warmth	M-overpro	F-overpro	M-reject	F-reject	SIIsplit	SIIdiffer	SIIrelprob	Att-anxiety	Att-avoidance
ACEQ	1											
M-warmth	-,24**	1										
F-warmth	-,34**	,65**	1									
M-overpro	,24**	-,04	-,06	1								
F-overpro	,19**	-,04	,00	,69**	1							
M-reject	,43**	-,41**	-,36**	,43**	,24**	1						
F-reject	,42**	-,36**	-,54**	,24**	,32**	,60**	1					
SIIsplit	,14**	-,02	-,13*	,21**	,14**	,08	,11*	1				
SIIdiffer	,19**	-,09	-,16**	,23**	,22**	,14**	,20**	,76**	1			
SIIrelprob	,13*	,08	-,02	,22**	,18**	,11*	,09	,71**	,64**	1		
Att-anxiety	,15**	-,14*	-,11*	,21**	,15**	,14*	,16**	,47**	,51**	,38**	1	
Att-avoidance	-,03	,02	,04	,00	-,01	-,08	-,01	,27**	,23**	,26**	,25**	1

**Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Note: **ACEQ**: Adverse Childhood Experiences Questionnaire; Subscales of S-EMBU (Egna Minnen Betraffande Uppfostran- My Memories of Upbringing), **M-warmth**: Mother emotional warmth; **F-warmth**: Father emotional warmth; **M-overpro**: Mother overprotection, **F-overpro**: Father overprotection, **M-reject**: Mother rejection, **F-reject**: Father rejection; **SII** (Separation-Individuation Inventory), **Split:** Splitting, **Differ:** Differentation, **Relprob**: Relationship problems; **Att-anxiety**: Attachment anxiety; **Att-avoidance**: Attachment avoidance.

4.6.2. Early experience and emotion regulation difficulties

The correlational matrix demonstrating the associations between the study variables of early experience and emotional dimensions as emotional regulation difficulties are shown in Table 4.3. Firstly, it was found that ACEQ scores were positively correlated with the subscales of Goals (r = .14, p <.01), Strategy (r = .23, p <.01) and Impulse (r = .13, p <.01) of DERS. In other words, subjects who experienced higher levels of childhood adversity were having more difficulties in terms of behaving according to the

desired outcomes, to flexibly use emotional regulation strategies and control their impulsive behaviors.

Furthermore, warmth of parents had small positive correlations with the Awareness (for mothers, r = .14, p <.01; for fathers, r = .15, p <.01), which means that subjects who received higher levels of warmth from their parents had higher levels of difficulties to understand their own emotions. This finding was opposite to what was expected, thus this variable was excluded from the main analysis due to low validity. Parental protection was positively correlated with Goals (for mothers, r = .14, p <.01; for fathers, r = .15, p <.01), Strategy (for mothers, r = .27, p <.01; for fathers, r = .19, p <.01), Nonacceptance (for mothers, r = .18, p <.01; for fathers, r = .20, p <.01), Impulse (for mothers, r = .24, p <.01; for fathers, r = .23, p <.01), and Clarity (for mothers, r = .13, p <.05; for fathers, r = .14, p <.05) dimensions of DERS. Moreover, rejection of mother was found to be positively correlated with Strategy (r = .18, p <.01), and Impulse (r = .13, p <.05), whereas rejection of father had positive correlation with Strategy (r = .16, p <.01), Nonacceptance (r = .15, p <.01), Impulse (r = .13, p <.05), and Clarity (r = .13, p <.05). In other words, higher levels of overprotection and rejection of parents was associated with higher levels of emotion regulation difficulties.

Table 4.14. Intercorrelations between measures of early experience and emotional regulation difficulties

	ACEQ	M-warmth	F-warmth	M-overpro	F-overpro	M-reject	F-reject	DERS-goals	DERS-strategy	DERS-accept	DERS-impulse	DERS-clarity	DERS-aware
ACEQ	1												
M-warmth	-,24**	1											
F-warmth	-,34**	,65**	1										
M-overpro	,24**	-,04	-,06	1									
F-overpro	,19**	-,04	,002	,69**	1								
M-reject	,43**	-,41**	-,36**	,43**	,24**	1							
F-reject	,42**	-,36**	-,54**	,24**	,32**	,60**	1						
DERS-goals	,14**	-,057	-,031	,14**	,15**	,01	,07	1					
DERS-strategy	,23**	-,12*	-,14**	,27**	,20**	,18**	,16**	,43**	1				
DERS-accept	,08	-,04	-,1	,18**	,20**	,099	,15**	,27**	,59**	1			
DERS-impulse	,13*	-,13*	-,11*	,24**	,23**	,13*	,13*	,29**	,65**	,49**	1		
DERS-clarity	,06	,08	-,003	,13*	,14*	,04	,13*	,11*	,30**	,27**	,35**	1	
DERS-aware	-,02	,14**	,15**	,03	,02	-,098	-,02	,08	,01	-,04	-,02	,12*	1

**Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Note: **ACEQ**: Adverse Childhood Experiences Questionnaire; Subscales of S-EMBU (Egna Minnen Betraffande Uppfostran- My Memories of Upbringing), **M-warmth**: Mother emotional warmth; **F-warmth**: Father emotional warmth; **M-overpro**: Mother overprotection, **F-overpro**: Father overprotection, **M-reject**: Mother rejection, **F-reject**: Father rejection; **DERS:** Difficulties in Emotion Regulation Scale, subscales: Goals, Strategies, Nonacceptance, Impulse, Clarity, Awareness.

4.6.3. Emotion regulation difficulties and well-being

The correlational matrix of emotion regulation difficulties and well-being (see Table 4.4.) revealed that subjective well being scores were negatively correlated with Goals (r = -.21, p <.01), Strategy (r = -.23, p <.01), Nonacceptance (r = -.14, p <.05), and Impulse (r = -.10, p <.05), subscales of DERS. In other words, as people have more emotion regulation difficulties, their life satisfaction levels decreases.

Furthermore, the subscales of DASS as depression, anxiety and stress were all positively and moderate to highly correlated with all of the factors of DERS except awareness. As the levels of emotion regulation difficulties increased, the levels of psychopathology also increases as assessed by the aforementioned variables in this present study.

Table 4.15. Intercorrelations between emotion regulation difficulties and well-being

	SWLS	PWB	DASS-depression	DASS-anxiety	DASS-stress	DERS-goals	DERS-strategy	DERS-accept	DERS-impulse	DERS-clarity	DERS-aware
SWLS	1										
DASS-Depression	-,40**	-,01	1								
DASS-Anxiety	-,17**	,09	,72**	1							
DASS-Stress	-,26**	,03	,74**	,73**	1						
DERS-goals	-,21**	-,02	,32**	,29**	,33**	1					
DERS-strategy	-,23**	-,02	,66**	,59**	,60**	,43**	1				
DERS-accept	-,14*	-,01	,44**	,43**	,36**	,27**	,59**	1			
DERS-impulse	-,10*	,02	,49**	,52**	,54**	,29**	,65**	,5**	1		
DERS-clarity	-,04	,03	,34**	,38**	,30**	,11*	,30**	,27**	,35**	1	
DERS-aware	,14**	,23**	-,09	-,06	-,04	,08	,01	-,04	-,02	,12*	1

**Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Note: **SWLS:** Satisfaction with Life Scale; **DASS:** Depression Anxiety Stress Scale. **DERS:** Difficulties in Emotion Regulation Scale, subscales: Goals, Strategies, Nonacceptance, Impulse, Clarity, Awareness.

4.6.4. Early experience and well-being

The intercorrelations between early experience and well-being measures are shown in Table 4.5 below. According to the results of correlational analysis, it was found that ACEQ scores are negatively and significantly correlated with life satisfaction (r = -.30, p <.01). Moreover, ACEQ scores had significant positive correlations with depression (r = .24, p <.01), anxiety (r = .27, p <.01) and stress (r = .31, p <.01) subscales of DASS. Thus, it can be stated that as childhood adversity scores increased, the subjective and psychological well-being decreased.

In terms of perceived parental dimensions, warmth of mother had significant positive correlations with life satisfaction (r = .27, p <.01) and significant negative correlations (r = -.17, p <.01) with depression. Similarly, warmth of father was found to be positively correlated with life satisfaction (r = .39, p <.01) and also negatively correlated with depression (r = -.19, p <.01), anxiety (r = -.12, p <.05) and stress (r = -.18, p <.01) scales. In other words, as parental warmth increased, the levels of life satisfaction increased.

The overprotection and rejection dimensions for both of the parents was found to have significant positive correlations with all of the dimensions of DASS scores; depression (for maternal overprotection, r = .24, p <.01, for maternal rejection, r = .21, p <.01, for paternal overprotection, r = .21, p <.01, for paternal rejection, r = .22, p <.01), anxiety (for maternal overprotection, r = .27, p <.01, for maternal rejection, r = .23, p <.01, for paternal overprotection, r = .24, p <.01, for paternal rejection, r = .22, p <.01) and stress (for maternal overprotection, r = .29, p <.01, for maternal rejection, r = .22, p <.01, for paternal overprotection, r = .26, p <.01, for paternal rejection, r = .21, p <.01). Furthermore, these variables were also negatively correlated with life satisfaction except paternal overprotection.

To sum up, the correlational analysis demonstrated low to moderate significant correlations between the measures of early experience and well-being.

Table 4.16. Intercorrelations between measures of early experience and well-being

	ACEQ	M-warmth	F-warmth	M-overpro	F-overpro	M-reject	F-reject	SWLS	PWB	DASS-depression	DASS-anxiety	DASS-stress
ACEQ	1											
M-warmth	-,24**	1										
F-warmth	-,34**	,65**	1									
M-overpro	,24**	-,04	-,06	1								
F-overpro	,19**	-,04	,00	,69**	1							
M-reject	,43**	-,41**	-,36**	,43**	,24**	1						
F-reject	,42**	-,36**	-,54**	,24**	,32**	,60**	1					
SWLS	-,3**	,26**	,39**	-,14**	-,09	-,15**	-,21**	1				
DASS-Depression	,24**	-,17**	-,19**	,24**	,21**	,21**	,22**	-,40**	-,01	1		
DASS-Anxiety	,27**	-,07	-,12*	,27**	,24**	,23**	,22**	-,17**	,09	,72**	1	
DASS-Stress	,31**	-,07	-,18**	,29**	,26**	,22**	,21**	-,26**	,03	,74**	,73**	1

**Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Note: **ACEQ**: Adverse Childhood Experiences Questionnaire; Subscales of S-EMBU (Egna Minnen Betraffande Uppfostran- My Memories of Upbringing), **M-warmth**: Mother emotional warmth; **F-warmth**: Father emotional warmth; **M-overpro**: Mother overprotection, **F-overpro**: Father overprotection, **M-reject**: Mother rejection, **F-reject**: Father rejection; **SWLS:** Satisfaction with Life Scale; **DASS:** Depression Anxiety Stress Scale.

4.7.The Associations Between ACEQ Scores and Other Study Variables

The present study was one of the few studies that used ACEQ for investigating different types of childhood adversities. Thus, the associations of ACEQ with other study variables were investigated separately prior to the analysis of the hypothesized model. Firstly, ACEQ scores were categorized in five different levels as 0= no reported ACE, 2= 2 reported ACE, 3 = 3 reported ACE, 4 = 4 or more reported ACE in order to see the trend of categories by conducting a series of MANOVAs with the study variables.

Secondly, , in order to see the effects of different types of ACEQ, a series of hierarchical regression analyses were conducted with other study variables.

4.7.1. ACEQ and health problems

In order to understand the effect of ACE on health, a chi-square test of independence was calculated comparing the levels of adverse childhood experiences. There was a significant difference in terms of reported ACEs (X^2 (4, N = 356) = 9.782, p=.04). Specifically, it was demonstrated that people who had higher numbers of ACE, were more likely to report that they have a health problem.

Table 4.17. The presence of a health problem among ACE respondents

	ACEQ Scores				
	0	1	2	3	4 or more
Health status					
Yes	12,4% (17)	15,9% (10)	12,5% (7)	21,4% (9)	29,3% (17)
No	87,6% (120)	84,1% (53)	87,5% (49)	78,6% (33)	70,7% (41)

Chi-square= 9,782 p=.04

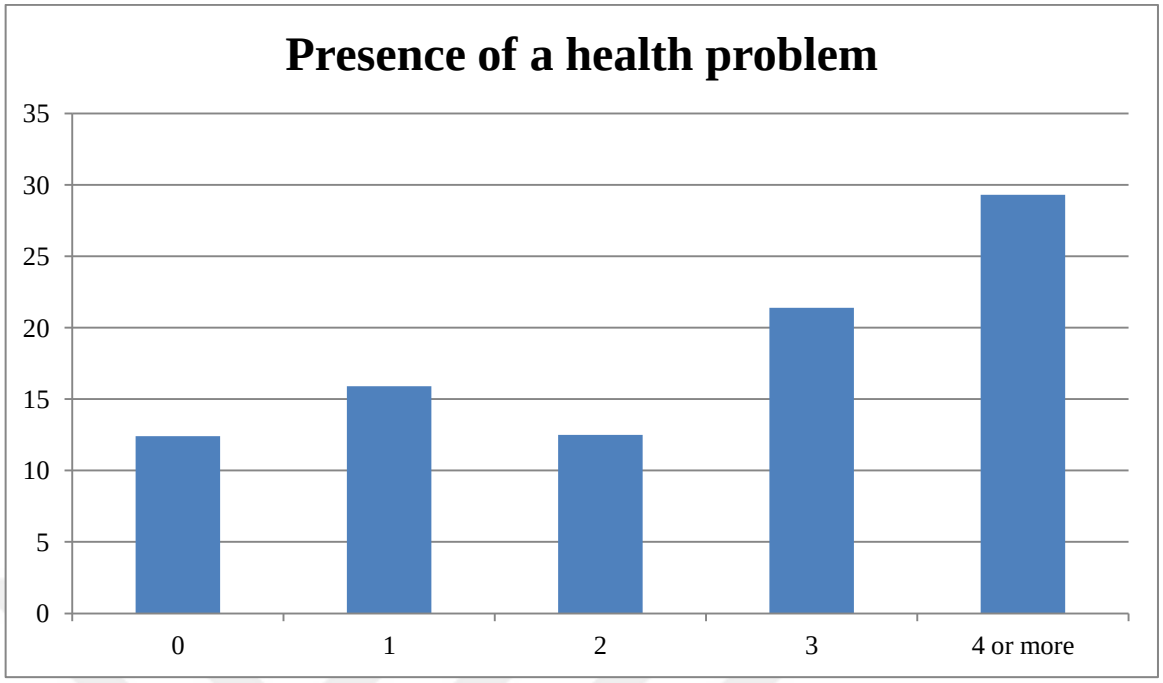

Figure 4.1. The presence of a health problem among ACE respondents

4.7.2. ACEQ and parenting behaviors

MANOVA was conducted to investigate the differences of ACEQ scores for the parenting behaviors, as warmth, overprotection and rejection. The data was examined separately for each gender, in order to see the possible relational patterns.

The results for MANOVA yielded a significant multivariate main effect for ACEQ scores on perceived parenting styles for women, Wilks' $\lambda = .714$, F (24, 671.02) = 2.84, $p <. 001$, $\eta p2 = .08$. The multivariate $\eta 2 = .08$ indicates that approximately 8% of multivariate variance of the dependent variables is associated with the group factor.

Concordantly, MANOVA results revealed a significant main effect for men as well, Wilks' $\lambda = .704$, F (24, 503.57) = 2.84, $p \leq .001$, $\eta p2 = .08$. The multivariate $\eta 2 = .08$ indicates that approximately 8% of multivariate variance of the dependent variables is associated with the group factor.

Table 4.18. The mean and standart deviation scores of perceived parenting styles

	ACEQ Scores									
	0 (n=75)		1 (n=36)		2 (n=36)		3 (n=23)		4 or more (n=32)	
Variables	M	SD	M	SD	M	SD	M	SD	M	SD
For females										
Maternal warmth	3.14	.14	3.08	.17	3.07	.19	3.07	.22	2.93	.3
Maternal overprotection	2.91	.20	2.90	.25	2.91	.25	2.98	.14	3.04	.22
Maternal rejection	2.10	.17	2.20	.21	2.22	.19	2.22	.24	2.41	.34
Paternal warmth	3.08	.18	3.01	.24	2.99	.25	3.02	.24	2.80	.36
Paternal overprotection	2.87	.21	2.88	.24	2.87	.25	2.99	.17	3.00	.26
Paternal rejection	2.07	.17	2.19	.22	2.19	.24	2.17	.25	2.42	.37
For males										
Maternal warmth	3.14	.14	3.08	.17	3.07	.19	3.07	.22	2.93	.3
Maternal overprotection	2.91	.20	2.90	.25	2.91	.25	2.98	.14	3.04	.22
Maternal rejection	2.10	.17	2.20	.21	2.22	.19	2.22	.24	2.41	.34
Paternal warmth	3.08	.18	3.01	.24	2.99	.25	3.02	.24	2.80	.36
Paternal overprotection	2.87	.21	2.88	.24	2.87	.25	2.99	.17	3.00	.26
Paternal rejection	2.07	.17	2.19	.22	2.19	.24	2.17	.25	2.42	.37

Since the overall results were found to be significant, firstly the univariate analyses for female participants was conducted using Bonferroni corrections with an adjusted alpha level of 0.008 (0.05/3=0.008) yielded statistically significant main effects for maternal warmth, F (4, 197) = 6.46, $p < .001$, $\eta p2 = .12$, and maternal rejection, F (4, 197) = 11.02, $p < .001$, $\eta p2 = .18$ as well as paternal warmth F (4, 197) = 7.47, $p < .001$, $\eta p2 = .13$ and paternal rejection F (4, 197) = 11.61, $p < .001$, $\eta p2 = .19$.

Furthermore, the univariate analyses for male participants demonstrated significant main effects for maternal rejection, F (4, 149) = 7.10, $p < .001$, $\eta p2 = .16$, paternal warmth, F (4, 149) = 7.09, $p < .001$, $\eta p2 = .16$ and paternal rejection F (4, 149) = 7.88, $p < .001$, $\eta p2 = .18$.

Table 4.19. Tests of between subjects effects for ACEQ scores on perceived parenting styles

Source ACEQ scores	Type III-SS	df	MS	F	Hp2	p
Females						
Maternal warmth	.986	4	.246	6.46	,12	.000*
Maternal overprotection	.525	4	.131	2.70	,05	.032
Maternal rejection	2.189	4	.547	11.02	,18	.000*
Paternal warmth	1.818	4	.454	7.47	.13	.000*
Paternal overprotection	.613	4	.153	2.98	.06	.020
Paternal rejection	2.668	4	.667	11.61	.19	.000*

Males						
Maternal warmth	.313	4	.078	1.15	.04	.201
Maternal overprotection	.502	4	.125	2.95	.07	.021
Maternal rejection	1.81	4	.453	7,10	.16	.000*
Paternal warmth	1.96	4	.489	7.09	.16	.000*
Paternal overprotection	.208	4	.052	1.14	.03	.341
Paternal rejection	1.947	4	.487	7.88	.18	.000*

*p < .001

For the purpose of understanding the group differences, posthoc comparisons are conducted for the significant factors for both genders.

The female participants who reported 4 or more childhood adverse experiences had significantly lower levels of percieved maternal warmth (M= 2.93, SD= .3) compared to those who had reported one (M= 3.08, SD= 0.17) and two adverse experiences (M= 3.07, SD= 0.19) as well as to those who experienced no childhood adversity (M= 3.14, SD= 0.14). Consistent with this finding, perceived maternal rejection was higher for the female participants who had experienced 4 or more adverse experiences (M= 2.41, SD= .34) than those who reported having less than four childhood experiences. Furthermore, similar results were obtained for perceived paternal parenting styles. The female participants who had reported 4 or more childhood adverse experiences had significantly lower levels of paternal warmth (M= 2.80, SD= .36) and higher levels of paternal rejection (M= 2.42, SD= .37) than those who had less than a score of 4.

The male participants who had an ACEQ score of 4 and more, had perceived higher levels of maternal rejection (M= 2.41, SD= .34) than those who did not report any kind of adverse experience (M= 2.10, SD= .17). In terms of paternal warmth, male

participants who did not report any adverse experience were found to have significantly higher perceived paternal warmth (M= 3.08, SD= .18) compared to those who had scores of 3 and more (ACEQ=3, M= 3.02, SD= .24; ACEQ=4 or more, M= 2.80, SD= .36). Finally, male participants who did not report any adverse experience had significantly decreased levels of perceived paternal rejection (M= 2.07, SD= .17) compared to those who had scores of 2 and more (ACEQ=2, M= 2.19, SD= .22, ACEQ=3, M= 2.19, SD= .24; ACEQ=4 or more, M= 2.42, SD= .37).

4.7.3. ACEQ and attachment dimensions

In order to investigate the possible differences between childhood adversity scores and attachment dimensions, MANOVA was conducted for two attachment dimensions (i.e., attachment anxiety and attachment avoidance) as the dependent variables.

A one-way MANOVA did not reveal a significant main effect for ACEQ scores on different dimensions of attachment, Wilks' Lambda = .96, F (8, 700) = 1.74, p >.05, ηp2 = .019.

Table 4.20. Mean and standart deviation scores of attachment dimensions by ACEQ scores

	ACEQ Scores									
	0 (n=137)		1 (n=63)		2 (n=56)		3 (n=42)		4 or more (n=58)	
Variables	M	SD	M	SD	M	SD	M	SD	M	SD
Attachment anxiety	3.36	.86	3.44	.93	3.69	.79	3.56	.88	3.71	.85
Attachment avoidance	3.35	.88	3.44	.95	3.42	.91	3.37	1.00	3.23	.92

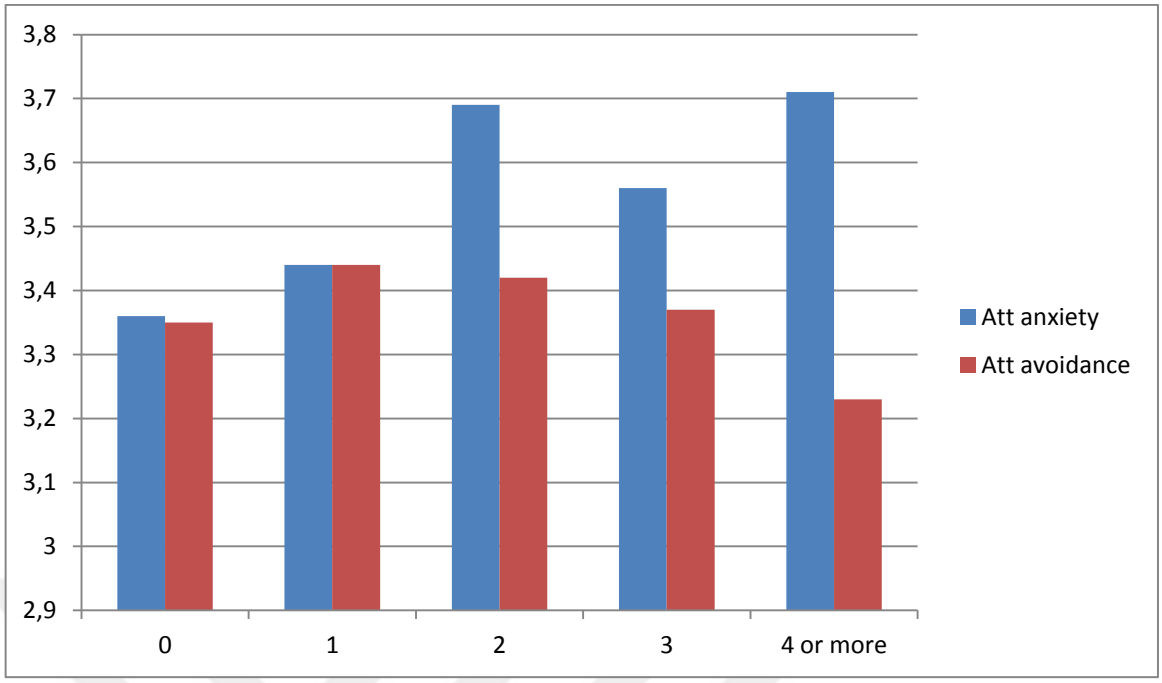

Figure 4.2. The attachment dimension scores among ACE respondents

4.7.4. ACEQ and emotion regulation difficulties

A one-way MANOVA was conducted in order to investigate the possible differences of ACEQ scores on the emotional regulation difficulties (i.e., goals, strategy, nonacceptance, clarity, and awareness) that participants have.

The results for MANOVA revealed a significant multivariate main effect for ACEQ scores, Wilks' $\lambda = .868$, F (24, 1208.26) = 2.08, $p <. 005$, $\eta p2 = .035$. The multivariate $\eta 2 = .035$ indicates that approximately 3.5% of multivariate variance of the dependent variables is associated with the group factor.

Table 4.21. Means and standart deviations of emotion regulation difficulties by ACEQ scores

	ACEQ Scores									
	0 (n=137)		1 (n=63)		2 (n=56)		3 (n=42)		4 or more (n=58)	
Variables	M	SD	M	SD	M	SD	M	SD	M	SD
DERS-Goal	2,73	0,23	2,79	0,20	2,77	0,18	2,75	0,23	2,83	0,18
DERS-strategy	2,89	0,31	2,97	0,30	3,03	0,26	3,00	0,3	3,1	0,28
DERS-nonaccept	2,46	0,41	2,46	0,44	2,54	0,34	2,51	0,34	2,55	0,36
DERS-impulse	2,58	0,28	2,65	0,29	2,65	0,29	2,51	0,34	2,67	0,36
DERS-clarity	2,58	0,18	2,66	0,14	2,63	0,18	2,60	0,13	2,6	0,2
DERS-awareness	2,86	0,19	2,86	0,21	2,92	0,18	2,92	0,18	2,81	0,29

Given the significance of the overall test, the results were investigated separately. The univariate analyses was conducted using Bonferroni corrections with an adjusted alpha level of 0.008. As shown in the table XX, the univariate analyses revealed a statistically significant main effect only for the Strategy subscale of DERS.,$F(4, 351) = 5,67$, $p < .001$, $\eta p2 = .061$.

Table 4.22. Tests of between subjects effects for ACEQ scores on emotion regulation difficulties

Source ACEQ scores	Type III Sum of Squares	df	MS	F	Hp2	p
DERS-goal	,479	4	,120	2,703	,030	,030
DERS-strategy	1,938	4	,485	5,671	,061	,000*
DERSnonaccept	,517	4	,129	,852	,010	,493
DERSimpulse	,404	4	,101	1,168	,013	,324
DERSclarity	,331	4	,083	2,927	,032	,021
DERSawareness	,287	4	,072	1,591	,018	,176

*p < .001

Moreover, post-hoc comparisons yielded that participants who had ACEQ scores of 2 (M= 3,03, SD= 0,26) and who had scores of 4 or more (M= 3,1, SD= 0,28) had more difficulties in terms of using the appropriate emotion regulation strategies compared to participants who reported no childhood adversity (M= 2,89, SD= 0,31).

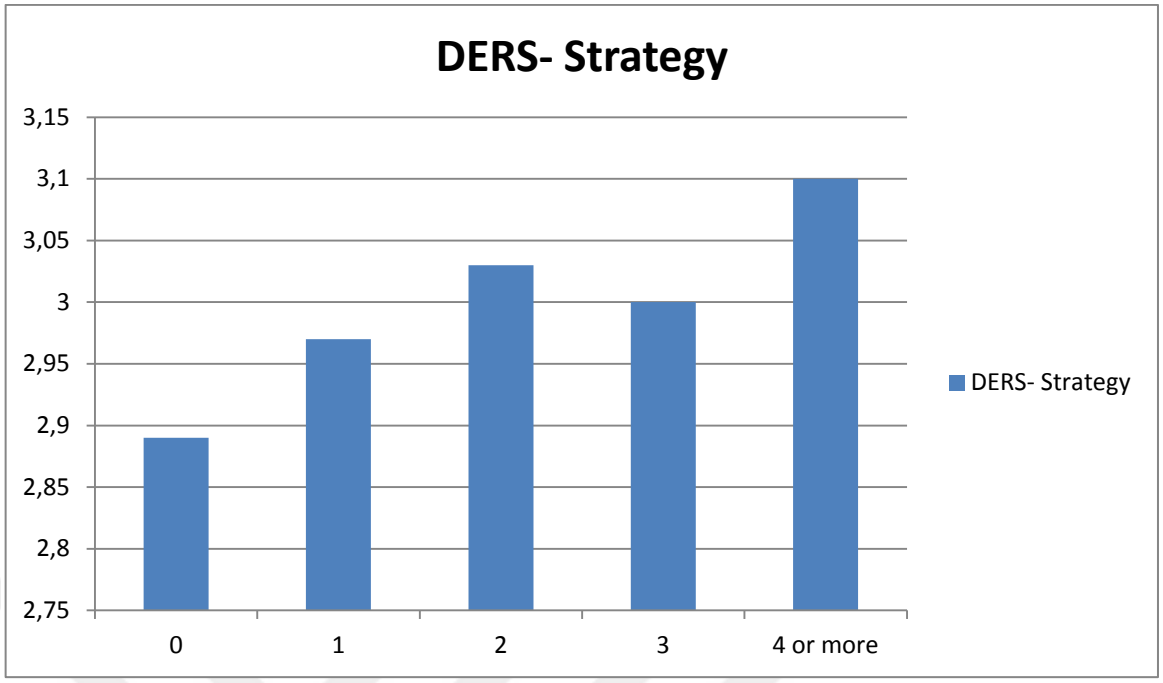

Figure 4.3. Strategies scores among ACE respondents

4.7.5. ACEQ and separation-individuation pathology

A one-way MANOVA was conducted in order to examine the possible differences of ACEQ scores on the separation individuation problems through three dimensions as splitting, differentiation and relationship problems which were assessed by the Separation Individuation Inventory (SII).

The results for MANOVA did not reveal a significant multivariate main effect for ACEQ scores on any of the three dimensions of SII, Wilks' Lambda = .948, F (12, 923,66) = 1.57, p >.05, ηp2 = .018.

Table 4.23. Mean and standart deviation scores of separation individuation pathology

	ACEQ Scores									
	0 (n=137)		1 (n=63)		2 (n=56)		3 (n=42)		4 or more (n=58)	
Variables	M	SD	M	SD	M	SD	M	SD	M	SD
SII										
Splitting	53,42	15.58	53,49	16,7	56,07	15,15	58,14	12,03	58,86	17,48
Differentiation	48,32	16,24	48,98	19,35	55,16	18,31	54,86	16,24	57,35	17,98
Relationship problems	51,81	13,29	52,48	15,38	53,86	11,72	54,02	10,6	56,52	15.47

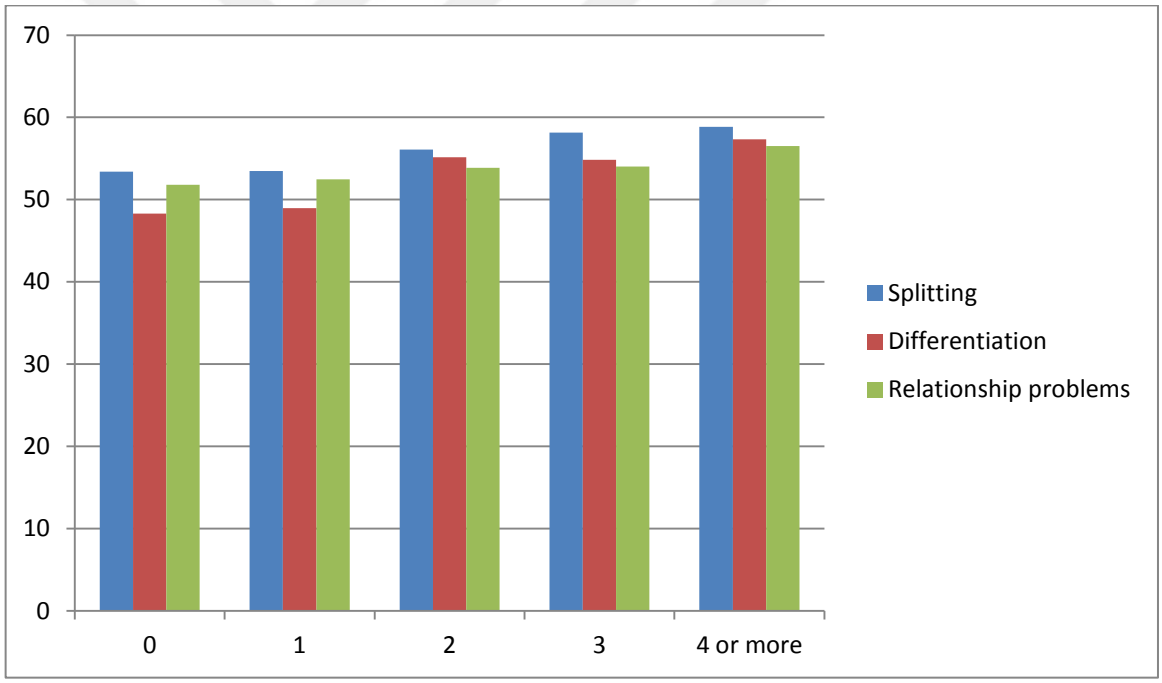

Figure 4.4. Separation individuation pathology scores among ACE respondents

4.7.6. ACEQ and well-being

4.7.6.1.Subjective well-being: Life satisfaction

One-way between subjects ANOVA was conducted in order to investigate the differences among four levels of ACEQ scores and subjective well-being as assessed by the Life Satisfaction Scale. There was a statistically significant difference between groups with different levels of ACEQ scores as determined by one-way ANOVA, [F (4, 351) = 10.889, p = 0.00] as shown in Table 4.24.

Table 4.24. Results of ANOVA for ACEQ scores on subjective well-being

Source	SS	df	MS	F	p
Between groups	4,714	4,000	1,179	10,889**	0,000
Within groups	37,989	351,000	0,108		
Total	42,703	355,000			

*p<0.05

The following multiple pairwise comparisons revealed that participants with an ACEQ score of 4 or more (M= 2.82, SD= 0.46) had significantly lower levels of life satisfaction than the participants who had less than a score of 3 (for those who had a score of 2, M= 3.08, SD= 0.26; for those who had score of 1, M= 3.4, SD= 0.34, for those who did not have reported any kind of childhood adversity, M= 3.15, SD= 0.27). Furthermore, participants who had reported three different childhood adversities (M= 2.98, SD= 0.34) had significantly lower levels of life satisfaction than those who did not report any kind of childhood adversity.

Table 4.25. Mean and standart deviation scores for life satisfaction by ACEQ scores

	ACEQ Scores									
	0 (n=137)		1 (n=63)		2 (n=56)		3 (n=42)		4 or more (n=58)	
	M	SD	M	SD	M	SD	M	SD	M	SD
Life Satisfaction	3,15	0,27	3,04	0,34	3,08	0,26	2,98	0,34	2,832	0,45

Şekil 4.5. Life satisfaction scores among ACE respondents

4.7.6.2.ACEQ and psychopathology

For the purpose of examine the possible differences between participants who had different childhood adversity scores and psychopathology, MANOVA was conducted. Depression Anxiety Stress Scale (DASS) was used to evaluate psychopathology through three symptom clusters as depression, anxiety and stress as the dependent variables.

MANOVA results revealed a statistically significant main effect for ACEQ scores on DASS scores, Wilks' Lambda = .894, F (12, 921.01) = 3.324, $p < .001$, $\eta p2 = .037$. The multivariate $\eta 2 = .037$ indicates that approximately 3.7% of multivariate variance of the dependent variables is associated with the group factor.

Considering the significance of the overall test, the results were examined separately. The univariate analyses with Bonferroni corrections with an adjusted alpha level of 0.016 (0.05/3=0.016) yielded a statistically significant main effect for all of the subscales of DASS as depression $F(4, 350) = 6.51$, $p < .001$, $\eta p2 = .069$, anxiety $F(4, 350) = 7.9$, $p < .001$, $\eta p2 = .083$. and stress $F(4, 350) = 8.41$, $p < .001$, $\eta p2 = .088$.

Table 4.26. Tests of between subjects effects for ACEQ scores on psychopathology

Source

ACEQ scores

	Type III SS	df	MS	F	Hp2	p
Depressionsqrt	55,749	4,000	13,937	6,507	0,069	0.000
Anxietysqrt	39,387	4,000	9,847	7,899	0,083	0.000
Stress	2228,991	4,000	557,248	8,406	0,088	0.000

*$p < .001$

In order to evaluate the group differences among the dependent variables, pairwise comparisons are examined. According to the mean scores as shown in Table XXX, participants who reported ACEQ scores of 4 or more (M= 3,85, SD= 1,35) had significantly higher levels of depression compared to participants with scores of 0 (M= 2,69, SD= 1,5) and 1 (M= 3,05, SD= 1,49). Furthermore, participants who did not report any kind of childhood adversity (M= 2.67, SD= 1.16) had significantly lower

levels of anxiety than participants who reported 2 (M= 3.28, SD= 1.18) and 4 or more adversities (M= 3.58, SD= 1.15). Lastly, participants who reported 4 or more childhood adversities (M= 22.53, SD= 9.08) had significantly elevated levels of stress than those who reported one adverse experience (M= 17.81, SD= 7.92) and those who did not report any experience at all (M= 15.35, SD= 8.3). Moreover, participants who did not report any adverse experience had significantly lower levels of stress than those who had an ACEQ score of 2 (M= 19.12, SD= 7.95) .

Table 4.27. Mean and standard deviation scores of psychopathology by ACEQ scores

	ACEQ Scores									
	0 (n=137)		1 (n=63)		2 (n=56)		3 (n=42)		4 or more (n=58)	
Variables	M	SD	M	SD	M	SD	M	SD	M	SD
DASS										
Depression	9.47	8.77	11.48	10.15	12.56	9.83	11.34	8.44	16.56	10.00
Anxiety	8.44	6.09	10.45	6.88	12.08	8.11	10.64	5.86	14.1	8.93
Stress	15.35	8.3	17.8	7.9	19.12	7.95	18.56	6.67	22.53	9.08

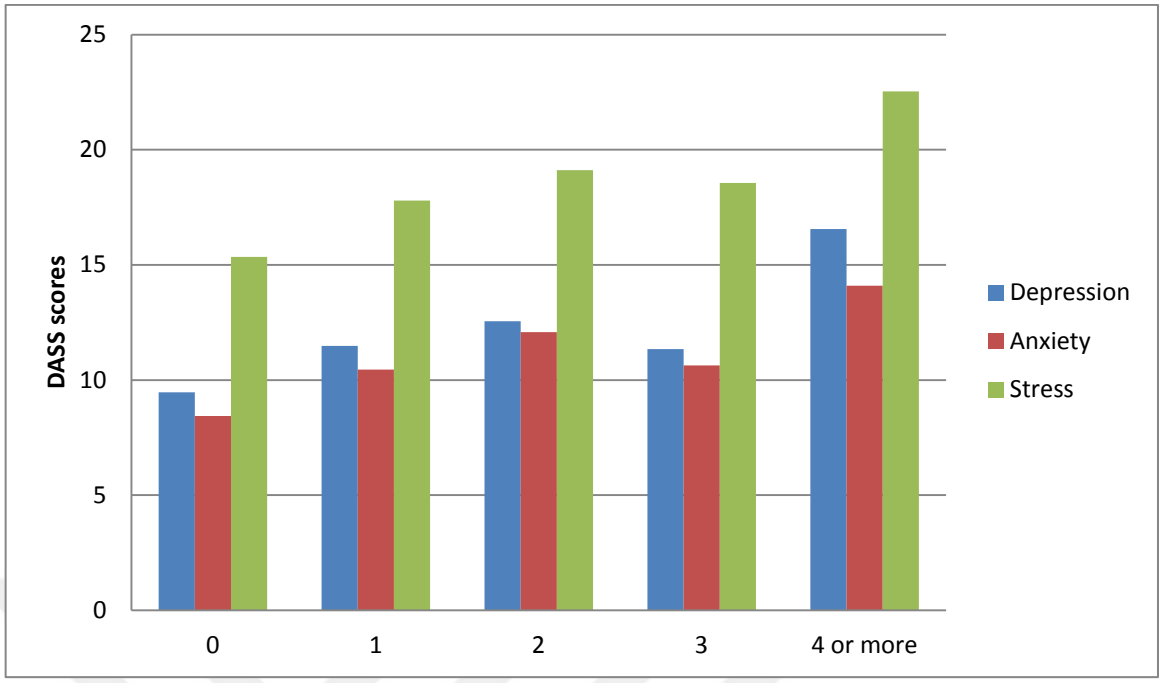

Figure 4.6. Psychopathology scores among ACE respondents

4.8.The Effects of Different Types of Childhood Adverse Experiences

ACEQ consists of 10 questions, each assessing the presence of a different type of childhood adversity. In order to examine the effects of different types of childhood adversities on relational problems, emotion regulation difficulties, subjective well-being as assessed by life satisfaction and psychopathology, hierarchical multiple regression analysis were conducted with each dependent variable.

4.8.1. The effects of different types of chilhood adverse experiences on attachment insecurity

A hierarchical multiple regression analyses was performed to examine the associates of attachment dimensions as anxiety and avoidance within the different types of childhood adversities as assessed by ACEQ both for women and men.

Firstly, a two step hierarchical multiple regression was conducted with attachment anxiety. In the first step which aimed to control the demographic variables, age and SES were entered. Secondly, each of the questions of ACEQ was entered as a different

variable into the equation via stepwise method. The results are reported separately for men and women in Table 4.28 and Table 4.29.

Table 4.28. Summary of hierarchical regression analysis for demographic variables and questions of ACEQ predicting attachment anxiety for men

Variable	β	t	F change	df	R	R2	ΔR 2
Step 1: Control variables							
-							
Step 2: Predictor							
Emotional abuse	.27	3.45**	9.97	1, 152	.25	.06	.06
Substance abuse in the household	-.16	-2.08*	4.34	1, 151	.3	.09	.03

*p < .05, **p < .001

For men, the hierarchical multiple regression analysis yielded no significant results for the demographic variables. In the second step, among the different types of childhood adversities, emotional abuse (β = .27, t [152] = 3.45, p < .001) and substance abuse in the household (β = -.16, t [353] = -2.08, p < .05) revealed significant results for attachment anxiety. Emotional abuse explained a variance of 6%, (F [1, 152] = 9.97, p < .01), whereas household substance abuse explained a variance of an additional 3%, (F [1, 151] = 4.34, p < .01). Thus, these results indicated that among different types of childhood diversities, emotional abuse and substance abuse in the household were the significant predictors of attachment anxiety. Those who reported to have emotional abuse were more likely to have attachment anxiety. Unexpectedly, the finding with the household substance abuse were the opposite of what have been expected. Those who reported to have someone in the household abusing substances, were less likely to have attachment anxiety.

Table 4.29. Summary of hierarchical regression analysis for demographic variables and questions of ACEQ predicting attachment anxiety for women

Variable	β	t	F change	df	R	R2	ΔR 2
Step 1: Control variables							
-							
Step 2: Predictor							
Emotional neglect	.15	2.19*	4.81	1, 200	.15	.02	.02

*p < .05

For women, the hierarchical multiple regression analysis yielded no significant results for the demographic variables. In the second step, among the different types of childhood adversities, emotional neglect (β = .15, t [200] = 2.19, p < .001 was found to be significant predictor for attachment anxiety and it explained 2% variance of the equation, (F [1, 200] = 4.81, p < .05). Thus, these results indicated that among different types of childhood diversities, emotional neglect was the significant predictor of attachment anxiety. Among female participants, those who reported to have emotional neglect was more likely to have attachment anxiety.

Secondly, the hierarchical multiple regression analysis was conducted to identify the effects of different childhood adversities on attachment avoidance. In the first step, the demographic variables were controlled and secondly the adversity types were entered both for men and women. However, none of the indicators were found to have significant associations with attachment avoidance for both of them.

4.8.2. The effects of different types of chilhood adverse experiences on separation individuation pathology

A hierarchical multiple regression analyses was performed to examine the associates of separation individuation pathology both for women and men.

After controlling for the demographic variables, the questions of ACEQ were entered in the second step of the equation via stepwise method.

The hierarchical multiple regression analyses for women revealed no significant associations for separation individuation pathology. For men, the analysis revealed that among the different types of childhood adversities, emotional abuse (β = .25, t [152] = 3.14, p < .005 was found to be associated with separation individuation pathology and it explained 6% variance of the equation, (F [1, 152] = 9.86, p < .005). Thus, these results indicated that among different types of childhood diversities, emotional abuse was a significant predictor of separation individuation pathology for male participants.

Table 4.30. Summary of hierarchical regression analysis for demographic variables and questions of ACEQ predicting separation individuation pathology for men

Variable	β	t	F change	df	R	R2	ΔR2
Step 1: Control variables							
-							
Step 2: Predictor							
Emotional abuse	.25	3.14*	9.86	1, 152	.25	.06	.06

*p < .005

4.8.3. The effects of different types of chilhood adverse experiences on emotion regulation difficulties

A hierarchical multiple regression analyses was performed to examine the associates of difficulties in emotion regulation difficulties both for women and men.

For men, the hierarchical multiple regression analysis revealed that emotional abuse (β = .19, t [152] = 2.41, p < .05 was found to be associated with emotion regulation difficulties and it explained 4% variance of the equation, (F [1, 152] = 5.82, p < .05). These results can be interpreted as, among different types of childhood adversities, male participants who reported to have emotional abuse throughout their childhood were more likely to have emotion regulation difficulties. The results for men are summarized in Table 4.31.

Table 4.31. Summary of hierarchical regression analysis for demographic variables and questions of ACEQ predicting difficulties in emotion regulation strategies for men

Variable	β	t	F change	df	R	R2	ΔR 2
Step 1: Control variables							
-							
Step 2: Predictor							
Emotional abuse	.19	2.41*	5.82	1, 152	.19	.04	.04

*p < .05

For women, on the other hand, revealed the significant predictor for emotion regulation difficulties as emotional neglect, (β = .21, t [200] = 3.04, p < .005) and explained 4% of the variance (F [1, 200] = 9.23, p < .005). That is, among different types of childhood adversities, emotional neglect was found to be the strongest predictor of emotion regulation difficulties for female participants. The results are demonstrated in Table 4.32.

Table 4.32. Summary of hierarchical regression analysis for demographic variables and questions of ACEQ predicting difficulties in emotion regulation strategies for women

Variable	β	t	F change	df	R	R2	ΔR 2
Step 1: Control variables							
-							
Step 2: Predictor							
Emotional neglect	.21	3.04*	9.23	1, 200	.21	.04	.04

*p < .005

4.8.4. The effects of different types of chilhood adverse experiences on satisfaction of life

A two step hierarchical multiple regression analyses was conducted via step wise method to examine the possible predictors of life satisfaction among different types of childhood adversities both for women and men.

For men, the hierarchical multiple regression analysis revealed that among demographic characteristics that have been controlled, only SES (β = -.18, t [152] = -2.28, p < .05), was found to be an indicator for life satisfaction. SES contributed 4% of the variance of the equation (F [1, 152] = 6.79, p < .05). In the second step, analysis for the main predictors, yielded significant results only for emotional neglect (β = -.27, t [151] = -3.45, p < .001), and it explained 7% variance of the equation, (F [1, 151] = 11.92, p ≤ .001). To sum up, these results indicated that, among different types of childhood adversities, the life satisfaction of male participants with lower SES was more likely to be negatively affected by emotional neglect that they have been exposed throughout their childhood. The results for men are reported in Table 4.33.

Table 4.33. Summary of hierarchical regression analysis for demographic variables and questions of ACEQ predicting satisfaction of life for men

Variable	β	t	F change	df	R	R2	ΔR 2
Step 1: Control variables							
SES	-.18	-2.28*	6.79	1, 152	.21	.04	.04
Step 2: Predictor							
Emotional neglect	-.27	-3.45**	11.92	1, 151	.34	.11	.07

*p < .05, **p ≤ .001

For women, in the first step, the hierarchical multiple regression analysis revealed that among demographic characteristics that have been controlled, only SES (β = -.15, t [200] = -2.37, p < .05), was significantly associated with life satisfaction. SES contributed 3% of the variance of the equation. The preeceding procedure, on the other hand, yielded significant results for emotional neglect (β = -.2, t [199] = -2.94, p < .005), physical neglect (β = -.2, t [198] = -2.94, p < .005), and witnessing domestic violence (β = -.16, t [197] = -2.33, p < .05), among different types of childhood adversities. Emotional neglect explained 5% variance of the equation, (F [1, 199] = 17.95, p < .005), whereas physical neglect explained 4% of the variance (F [1, 198] = 9.98, p < .005). Lastly, witnessing domestic violence during childhood explained an additional variance of 2%, (F [1, 197] = 5.43, p < .05). To sum up, these results indicated that, among different types of childhood adversities, the life satisfaction of female participants with lower SES was more likely to be negatively affected by emotional neglect, physical neglect and witnessing domestic violence throughout their childhood. The results for women are summarized in Table 4.34.

Table 4.34. Summary of hierarchical regression analysis for demographic variables and questions of ACEQ predicting satisfaction of life for women

Variable	β	t	F change	df	R	R2	ΔR 2
Step 1: Control variables							
SES	-.15	-2.37*	5.98	1, 200	.17	.03	.03
Step 2: Predictor							
Emotional neglect	-.2	-2.94**	17.95	1, 199	.33	.11	.08
Physical neglect	-.2	-2,94**	9.98	1, 198	.39	.15	.04
Domestic violence	-.16	-2,33*	5.43	1, 197	.42	.18	.02

*p < .05, **p < .005

4.8.5. The effects of different types of chilhood adverse experiences on psychopathology

A two step hierarchical multiple regression analyses was conducted via step wise method to examine the possible predictors of pscyhopathology as assessed by DASS within three aspects; depression, anxiety and stress among different types of childhood adversities both for women and men. For the research purposes, the total scores of DASS were used in order to identify the overall effect.

For men, the hierarchical multiple regression analysis revealed that among demographic characteristics that have been controlled, only SES (β = .14, t [151] = 1.78, p < .05), was found to be an indicator for life satisfaction. SES contributed 4% of the variance of the equation (F [1, 151] = 6.55, p < .05). In the second step, analysis for the main predictors, yielded significant results for emotional neglect (β = .18, t [150] = 2.31, p < .05) and exposure to mental illness or suicide attempt in the household (β = .16, t [149] = 2.01, p < .05). These two significant factors explained the variance of 4%, (F [1, 150] = 6.52, p ≤ .05). and 2%, (F [1, 149] = 4.04, p ≤ .05), respectively. Cumulatively, 11% of the variance has been explained with these factors. To sum up, these results indicated that, among different types of childhood adversities, emotional neglect and mental illness in the household during childhood were the most significant indicators of

psychopathology of male participants, after controlling for demographic variables. The results for men are reported in Table 4.35.

Table 4.35. Summary of hierarchical regression analysis for demographic variables and questions of ACEQ predicting psychopathology for men

Variable	β	t	F change	df	R	R2	ΔR 2
Step 1: Control variables							
SES	.14	1.78*	6.55	1, 151	.20	.04	.04
Step 2: Predictor							
Emotional neglect	.18	2.31*	6.52	1, 150	.29	.08	.08
Mental illness in the household	.16	2.01*	4.04	1,149	.33	.11	.02

*p < .05

For women, after controlling for the demographic variables, the hierarchical multiple regression analysis revealed that, likewise men, emotional neglect (β = .24, t [200] = 3.63, p < .001) and exposure to mental illness or suicide attempt in the household (β = .21, t [199] = 3.17, p < .005) were the significant predictors of psychopathology. These two significant factors explained the variance of 8%, (F [1, 200] = 17.06, p ≤ .001) and 4%, (F [1, 199] = 10.04, p ≤ .005), respectively. Cumulatively, 12% of the variance has been explained with these factors. To sum up, these results indicated that, among different types of childhood adversities, emotional neglect and mental illness in the household during childhood were the most significant indicators of psychopathology of female participants, regardless of their age and SES. The results for women are reported in Table 4.36.

Table 4.36. Summary of hierarchical regression analysis for demographic variables and questions of ACEQ predicting psychopathology for women

Variable	β	t	F change	df	R	R2	ΔR 2
Step 1: Control variables							
-							
Step 2: Predictor							
Emotional neglect	.24	3.63*	17.06	1, 200	.28	.08	.08
Mental illness in the household	.21	3.17**	10.04	1,199	.35	.12	.04

*p < .005, ***p < .001

4.9.The Results for the Hypothesized Model Using Path Analysis

The hypothesized model was tested using Mplus 6.12 with the maximum likelihood estimation for parameters and the bias-corrected bootstrapping method as it is recommended when testing the mediation effects with samples smaller than 400.

In the hypothesized model, it is proposed that early experiences as measured by perceived parenting styles and adverse childhood experiences would be indirectly associated with the well-being during adulthood.

The results of the path analysis revealed that the fit of the model was acceptable, $\chi 2$ (30, N = 161) = 53.17, p = .006, CFI = .93, RMSEA = .07 (90% CI = .04-.10), SRMR = .09. Among the variables of early experience, overprotection of the mother ($p \leq .01$) and paternal warmth ($p \leq .05$) significantly predicted the use of splitting as an indicator of separation individuation pathology. For differentiation, maternal overprotection (p = .06) and adverse childhood experiences (p = .07) were only marginally significant. On the other hand, maternal warmth significantly predicted the relationship problems as the last indicator of SII ($p \leq .01$), whereas maternal overprotection was found to be marginally significant (p = .06).

Regarding the associations between early experience and attachment insecurity, attachment anxiety was only significantly predicted by maternal overprotection ($p = .002$), whereas maternal warmth was found to be marginally significant ($p= .06$). Moreover, as for attachment anxiety, only the maternal rejection was found to be a significant predictor ($p = .03$).

Furthermore, the associations between early experience and emotion regulation difficulties were investigated. Among the variables of early experience, adverse childhood experiences ($p \leq .01$) and maternal rejection ($p \leq .05$) significantly predicted the difficulties in engaging in goal-directed behaviors. Secondly, the difficulties in using the emotion regulation strategies were predicted by adverse childhood experiences, ($p \leq .01$) and maternal warmth, ($p \leq .01$). Moreover, maternal overprotection was significantly associated with impulse control difficulties, ($p \leq .05$). Finally, the lack of emotional clarity was only predicted by paternal rejection, ($p \leq .05$).

In the second part of the path analysis, the associations between relational and emotion regulation variables and well being were investigated. Firstly, depression as measured by DASS was predicted significantly by splitting, ($p \leq .05$) and differentiation, ($p \leq .01$) indicators of separation-individuation pathology as well as goals and clarity subscales of DERS, ($p \leq .01$). Secondly, anxiety was predicted significantly by differentiation, ($p \leq .01$) and relationship problems, ($p \leq .05$) as indicators of separation-individuation pathology and also was significantly associated with strategies, ($p \leq .01$) impulse, ($p \leq .05$) and clarity subscales of DERS, ($p \leq .01$). Finally, stress as measured by DASS was predicted by splitting and strategies, ($p \leq .01$) impulse, ($p \leq .01$) and clarity, ($p \leq .05$) subscales of DERS. Regarding the subjective well being of the participants, differentiation, , ($p \leq .01$) and relationship problems, ($p \leq .05$) as the indicators of separation individuation pathology and the emotion regulation difficulties of engaging in goal directed behavior, ($p \leq .05$) and using emotion regulation strategies, ($p \leq .05$) predicted the life satisfaction.

Based on the findings of the path analysis, further analysis was conducted in order to investigate the possible mediational effects in the model. The mediational analysis revealed that the relationship between maternal overprotection and depression was mediated by difficulties in using emotion regulation strategies (indirect effect size = .12, $p \leq .01$). Similarly, the relationship between adverse childhood experiences and

depression was also mediated by difficulties in using emotion regulation strategies (indirect effect size = .07, $p \leq .05$). Moreover, the relationship between adverse childhood experiences and anxiety as well as maternal overprotection and anxiety were both mediated by difficulties in using emotion regulation strategies (indirect effect size = .04, $p \leq .05$ and indirect effect size = .07, $p \leq .01$, respectively). The relationship between stress and maternal overprotection was mediated by the use of splitting as a defense mechanism (indirect effect size = .05, $p \leq .05$). Finally, the relationship between adverse childhood experiences and stress as well as maternal overprotection and stress were both mediated by difficulties in using emotion regulation strategies (indirect effect size = .05, $p \leq .05$ and indirect effect size = .09, $p \leq .01$, respectively).

To make relatively simple, only significant links between the variables in the study were drawn. The results of the path analyses are summarized in Table 4.37 and the results of the mediation analyses are demonstrated in Figure 4.7 and Figure 4.8.

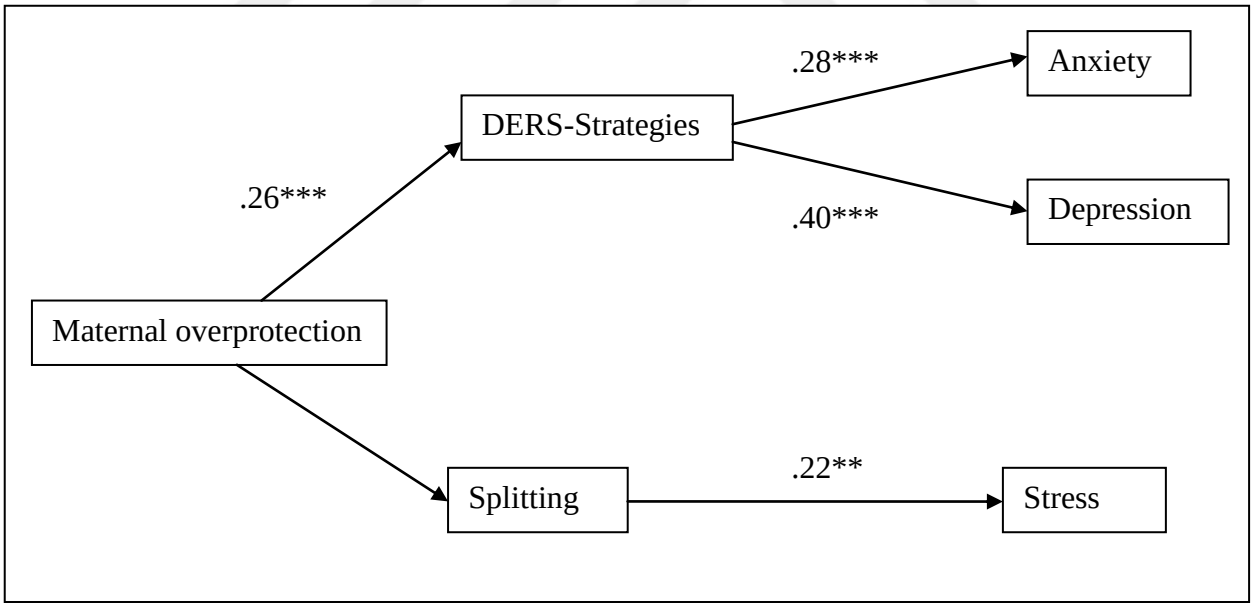

Figure 4.7. Mediation between maternal overprotection and psychopathology

Note. ***p<.001; **p<.01

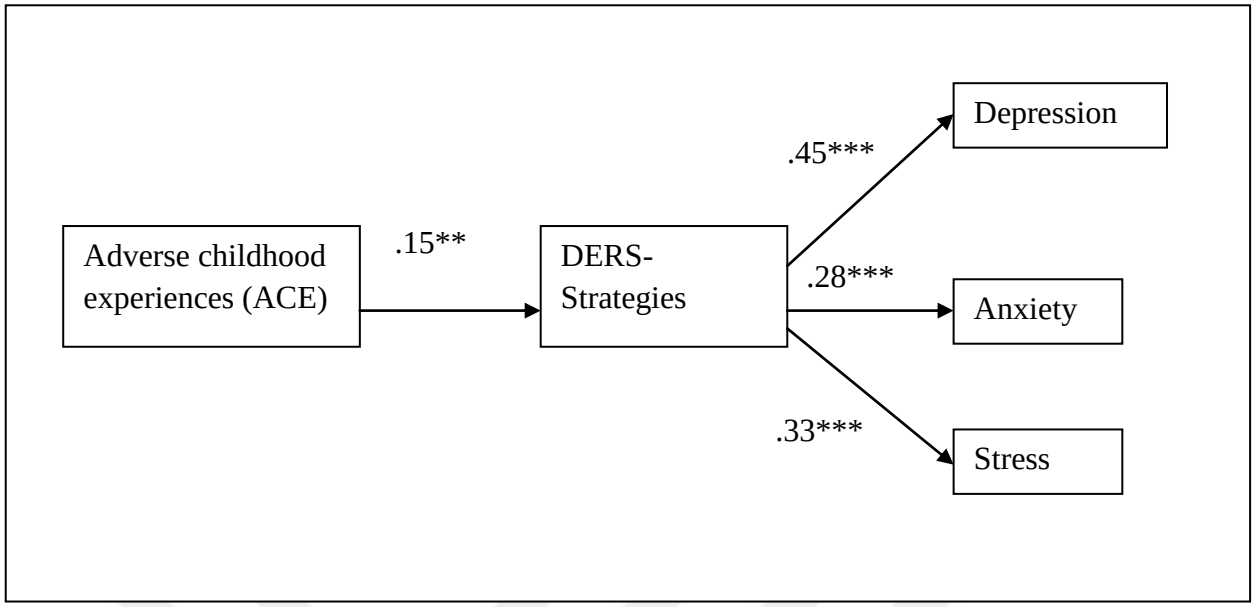

Figure 4.8. Mediation between ACE and psychopathology

Note. ***p<.001

Table 4.37. Path analysis

Dependent variables	Predictor variables	β	p
Splitting	Maternal overprotection	.22	.01
	Paternal overprotection	-.16	.06
Relationship problems	Maternal warmth	.18	.06
	Maternal overprotection	.15	.002
Attachment anxiety	Maternal warmth	-.13	.06
	Maternal overprotection	.24	.002
Attachment avoidance	Maternal rejection	-.17	.03

DERS-Goals	ACE	.15	.01
	Maternal rejection	-.17	.02
DERS-Strategies	ACE	.15	.007
	Maternal overprotection	.26	.001
DERS-Impulse	Maternal overprotection	.18	.03
DERS-Clarity	Paternal rejection	.16	.04
DASS-Depression	Splitting	.16	.03
	Differentiation	.27	.000
	DERS-Strategies	.45	.000
	DERS-Clarity	.15	.001
DASS-Anxiety	Differentiation	.19	.01
	Relationship problems	.14	.03
	DERS-Strategies	.28	.000
	DERS-Impulse	.14	.02
	DERS-Clarity	.18	.000
DASS-Stress	Splitting	.22	.004
	DERS-Strategies	.33	.000
	DERS-Impulse	.20	.000
	DERS-Clarity	.10	.04
SWLS	Differentiation	-.26	.002
	DERS-Goals	-.11	.05
	DERS-Clarity	-.15	.05

5. DISCUSSION

The aim of this present study was to investigate the effects of early experience as conceptualized by the early adverse traumatic experiences and perceived parenting styles on relational patterns and emotion regulation difficulties as determinants of well being and psychopathology among Turkish university students. The study was demonstrated by employing an attachment perspective with its neurological components in order to exemplify the possible long term effects of primary experiences throughout our lives. Firstly, the findings of this present study will be discussed in the light of relevant literature as well as the former hypotheses of the study. Secondly, the theoretical and clinical implications will be examined, finally the limitations, strengths and future directions of the current study.

The present study hypothysized that early experiences of childhood will have enduring effects on the individual' well-being by impairing self-regulation abilities and interpersonal relationships. Placing the social functioning at the core of well-being is based on the psychoanalytic perspectives of the development of self throughout the intersubjective relationship with the caregiver. These primary relationships serve as a prototype of the latter social world and where the individual views himself within this world. Furthermore, the desperate need of this infant for his caregiver and the excruciating tension the child experiences can only be ameliorited in these primary relationships and the ability of the mother to notice and respond appropriately to these stress times helps the infant develop the regulation abilities of his own which is defined as coregulation. Thus, these primary attachments provide the infant with scripts of the relationships containing the self and other maps and regulatory functions which enable him to survive in the world.

This current study aimed at explaining the possible cultural differences in Turkey regarding the parenting practices and traumatic experiences exposed during childhood and their long term effects. Turkey, as a collectivistic culture, has put a lot emphasis on social relationships and the expectations evolved in these relationships. Thus, beside of the hypothetical assumptions regarding the adulthood well being, this study is expected to contribute to the explanation of this societal stance as a developmental trajectory with its own characteristics.

5.1.Differences of Demographic Characteristics as Functions of Measures

The first part of the study investigated the differences of demographic characteristics (gender, age and SES) for each of the study measure. For that purpose, age as younger and older; and SES as high and low were recategorized into two groups beside of gender. It is important to note that the main reason behind this recategorization was the resctricted range of the study sample in terms of age and SES.

Firstly, as for ACE scores, the results showed that younger participants (18-21) had significantly decreased number of adverse childhood experiences compared to older participants (21-45), but there was no difference in terms of gender and SES. However, the existing literature on the original ACE study revealed significant gender differences as higher rates of having 4 and more ACE categories for women (8.5% for women and 3.9% for men), (Felitti et al., 1998). On the contrary, the regional study of Turkey on ACE, found that males reported higher number of ACEs. Specifically, males had significantly higher reports of physical abuse, emotional neglect, physical neglect, and domestic violence (Ulukol, Sethi & Kahilogullari, 2014).

In terms of parenting styles, female participants had higher levels of maternal and paternal warmth. Moreover, younger participants also reported higher levels of maternal warmth. The gender specific difference revealed in the current study is consistent with the relevant literature which demonstrated that parents use more sensitive and autonomy-supportive parenting styles with girls and more controlling behaviors with boys. Thus, while mother-daughter relationship focuses on warmth and closeness, dominance and power becomes more salient in mother-son relationship (Mandara, Murray, Telesford, Varner, Richman, 2012; Tamis-LeMonda, Briggs, McClowry, Snow, 2008; Kochanska, Barry, Stellern, O'Bleness, 2009). This difference may be more salient in Turkish culture in which the gender roles are thought to be more traditional. Moreover, the paternal warmth reported by girls can also be interpreted as the changing role of fathers in Turkey (Boratav, Fisek & Ziya, 2014). Despite of the invisibility of their own fathers, new generation of fathers are more likely to invest their relationships with their children (Boratav, Fisek & Ziya, 2014; Yalçınöz, 2011). It is important to note that in this current study that the overall socioeconomic status of the sample was higher compared to the general population of Turkey. Thus, it could be a

good question to examine if the transition of family roles can be observed in more rural parts of Turkey as well.

For relational problems, as assessed by separation individuation pathology and attachment insecurity, the findings of demographic characteristics revealed that younger participants had more problems in terms of using splitting as a defense mechanism, differentiation of self and others and relationship problems. This finding is consistent with the view of adolescence and young adulthood as the second phase of separation individuation process. This phase comes along with both emotional and life style changes leaving the individual face with new developmental tasks. Transition to college may involve separation from home and the parents, establishing a new social network, and facing with new academic challenges. These transitional problems are most salient in the first years of college, in which the students try to adapt their new life circumstances. This major life transition is referred as "high-risk psychosocial circumstances" and leave the individual vulnerable to psychological problems (Monroe, Imhoff, Wise & Harris, 1983). Furthermore, beside of physical separateness or life style changes that might occur in this transitional phase, ideological separateness might occur as a result of this individuation process. The main task of this period is the achievement of self identity and autonomy and separating from parental identification while still having a sense of belongingness (Blos, 1967; Lapsley, Rice, & Shadid, 1989). This individuation process is viewed as a painful struggle that the individual has to disengage from the parental extension of his ego and parental support and develop his self identity (Blos, 1967).

For attachment insecurity, the present study showed that female participants were more likely to experience avoidance in their close relationships. The relevant literature on attachment insecurity and gender differences did not demonstrate any meaningful and consistent results in romantic relationships, even though there have been some studies that revealed women to be more anxious and men as more avoidant (Collins & Read, 1990; Hazan & Shaver, 1987; Shaver, Papalia, et al., 1996). The heightened engagement of women on the relationships might be explained by the women's different stance as viewing the emotional closeness more important than men. This stance is developed by the cultural gender specific norms and different parenting attitudes to boys and girls (Campenni, 1999; Chick et al., 2002). Thus, emotional

closeness becomes a more important aspect in relationships for women, whereas being powerful and autonomous for men. The contradictive finding of the current study which revealed females as more avoidant can be discussed in the light of the hypothesis of "reproductive suppression" which is explained as a temporary interruption of reproduction as a result of an acute stress. Along with the process of separation and individuation, females in the transition of college life may experience more stress, thus may suppress their reproductive motives and may avoid romantic relationships temporarily (Del Giudice, 2009).

As for emotion regulation difficulties, females were more likely to have difficulties in engaging in goal directed behaviors especially when experiencing negative emotions compared to males. The previous literature on gender differences regarding emotion regulation had pointed out that these differences were shaped by both biological and social factors (Tamres et al., 2002). However, small differences have been demonstrated by some of the studies and they demonstrated the heightened emotional expressivity and emotional awareness of women (Barrett et al., 2000; Mendes et al., 2003), the more frequent use of emotion regulation strategies (Garnefski et al., 2004) and the increased intensity of emotions experiences by women (Gross & John, 1998; Williams & Barry, 2003). The specific finding in this present study might be explained by all of the factors that are mentioned above as well as the adoption of passive and emotion-focused strategies by women (Thoits, 1995; Vingerhoets & Van Heck, 1990). Women, when experienced an intense negative emotion, may have difficulties in engaging in behaviors which would lead them to the desirable goal. On the other hand, the ideal self as powerful and autonomous for males may also teach them to behave in accord to the desired goals and engage in solution-focused behaviors. Consistently, a study in Turkey conducted by Erol Öngen (2010) revealed that women were more likely to use rumination compared to males who preferred positive refocusing, replanning and reappraisal as ways of cognitive emotion regulation.

Finally, demographic characteristics differences are examined on the variables of depression, anxiety and stress and the satisfaction of life. While there were no significant differences for psychological problems, life satisfaction was significantly associated with gender and SES. Even though, the literature on life satisfaction found to be unassociated with gender and age, this study revealed a small difference as females

having higher levels of life satisfaction (Arrindell et al., 1991; George, 1991; Pavot et al., 1991). However, it would be misleading to interpret this finding without understanding the other characteristics of the sample that have been studied in this study. Moreover, high socioeconomic status was also a predictor of life satisfaction parallel to the previous findings of SWLS (Diener, Diener, & Diener, 1995). Life satisfaction is defined as a cognitive judgmental process in which the individual assesses the life circumstances according to his own set of standards (Pavot & Diener, 2009). In young adulthood, these standards are more open to the influence of their social environment. The social comparison between peers becomes inevitable resulting in the assessment of life quality. The sample of this study consists of the students of a private university in which the overall income is high. Thus, apart from the actual income, the relative income compared to their peers may become one of the factors for life satisfaction. Likewise, this finding should be taken into consideration cautiously with the other possible contributing factors.

5.2.Discussion of Findings Related to Adverse Childhood Experiences Questionnaire (ACEQ)

5.2.1. The comparison of prevalence rates of ACE

This present study aimed to examine the relative effects of different types of childhood adversities on psychopathology and well-being. ACEQ, in general, provides the opportunity to investigate multiple adverse experiences at once and the aim was to demonstrate cultural specific factors as well as the common factors cross culturally. Moreover, this current study can be regarded as an attempt to replicate the findings demonstrated in the regional of ACE. Childhood trauma is still considered as a taboo which should not be mentioned about in Turkey because of the possible family and social pressure and these incidents can be kept as family secrets throughout whole life. Thus, it is believed that it is crucial for psychology field to throughly understand the life long consequences of adverse early experiences and develop prevention programs on child bearing attitudes and childhood trauma.

The prevalence rates of adverse childhood experiences were demonstrated in the Table 5.1.

Table 5.1. Comparison of prevalence rates of ACE studies

	Present study	The regional study of WHO in Turkey	The original findings
Category of adversity	**Total n= 356**	**Total n= 2,257**	**Total n= 17,337**
Type of abuse			
Emotional	36	9.8	10,6
Physical	30,9	21.1	28,3
Sexual	4,5	7.9	20,7
Neglect			
Emotional	33,7	8.8	14,8
Physical	3,9	5.7	9,9
Household dysfunction			
Parental separation or divorce	9,6	5.2	23,3
Exposure to domestic violence	16,9	18.4	12,7
Substance abuse	6,5	6.4	26,9
Mental illness or suicide attempt	16,3	9.3	19,4
Household incarceration	5,3	10.3	4,7
ACE Score			
0	38,5	50.3	36,1
1	17,7	23.9	26
2	15,7	12.2	15,9
3	11,8	6.5	9,5
4 or more	16,3	7.1	12,5

Source: Ulukol, B., Sethi, D., Kahilogullari, A.K. (2014). Adverse Childhood Experiences Survey among University Students in Turkey. Copenhagen: WHO Regional Office for Europe; Felitti, V. J. & Anda, R. F., (2010). The Relationship of Adverse Childhood Experiences to Adult Health, Well-being, Social Function, and Healthcare. In R. Lanius & E. Vermetten (Eds.),

The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease. Cambridge University Press.

The prevalence rates of the present study and CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study in terms of total scores are closer compared to the previous study conducted in Turkey. Moreover, there are major differences that current study has prominently higher rates of emotional abuse and emotional neglect and lower rates of sexual abuse, parental separation/divorce and substance abuse. Higher rates of emotional abuse and emotional neglect should be interpreted cautiously as most of the participants were in young adulthood and might have reactive relationships with their parents as a continuum of their developmental process. Moreover, the rates for them were much higher from the rates in the previous Turkish study. This might be a result of the difference in the content of the questionnaire in which the incidents of emotional abuse and emotional neglect were clarified with concrete examples such as "I used to think that my parents wished that I had never been born", "For me, my family members used adjectives that possess negative features like "ugly", "lazy", "dumb", and "clumsy".". Furthermore, reported total scores of ACEs were higher in the current sample compared to the previous Turkish study. This finding can be interpreted as the level of comfort the participants felt during the data collection. In the current study, the data has been collected in the psychology department by the researcher who is a psychologist and the anonymity of the study was explained in person. However, there might also have been the attempt to get help as some of the participants, actually, indicated that they needed help and applied for therapy to the university counselling center. For both of the Turkish findings, reported sexual abuse rates are lower compared to the US study, which is considered to be a reflection of cultural beliefs and expectations. Beside of the recalling bias, the participants would not want to report since sexual abuse is accepted as shameful in traditional countries like Turkey and the victims can blame themselves for the acts. Similarly, the lower rates of parental divorce/separation can be explained by the cultural and religious factors. The lack of financial resources of women as well as the stigmatization of women as "widows" can contibute to the lower divorce rates in Turkey. The divorce rate of Turkey increased from 1,34 to 1.59 per thousand between the years of 2002-2016 and the rates were likely to be higher in cities as İzmir, Muğla and Antalya (Turkish Statistical Institute, 2016). Thus, the results for divorce in the current study is high above the average of

Turkey, reflecting the effects of characteristics of the region and the sample with high socioeconomic status. Finally, the household substance abuse was much lower in Turkey compared to US sample which can be explained by the religious constraints in Turkey. However, it would be more beneficial to identify the type of substance (alcohol, tobacco, illegal drugs, prescribed medications etc.) to clarify the specific rates.

To sum up, there have been major differences of Turkish and US samples mostly due to cultural factors. However, it is important to note that the studies conducted in Turkey has been proceeded with participants who are university students. Thus, this low risk sample can not be a representative of the Turkish population and childhood adversity is more prevalent in populations having low levels of education and income.

5.2.2. ACE as a risk factor

Childhood adversity has been repeatedly found to be linked with various of negative consequences effecting physical and mental health (Felitti,2009; Felitti, et al., 1998). Even though the physical health consequences are out of the scope of this present study, generally it has been found that with an increasing number of childhood adversities, participants tended to report the presence of a health problem in the current study as well. However, the specification of the health problems can not be analyzed or discussed because of the limited number of respondents participated in the study and the resctricted range of ages in which most of the health problems do not emerge until the advanced years.

5.2.2.1.ACE and parenting styles

The association of parenting behaviors and childhood adversity has been investigated for males and females separately as maternal and paternal behaviors can differentially effect each gender. Since ACEQ had several questions on parental adverse behaviors, the associations were apparently expected. However, the aim was to observe the gender specific effects of these associations. Specifically, lower levels of paternal warmth and higher levels of maternal and paternal rejection were found to be associated with increased number of ACEs for both men and women. Additionally, maternal warmth

was found as another significant factor for women. These dimensions of parenting attitudes are emotionally charged and can contain experiences of emotional abuse or neglect. These results are consistent with the reported prevalence rates of ACEs, especially of emotional abuse and neglect. Moreover, parental warmth, itself can be regarded as a protective factor and may involve the prevention of possible childhood traumas. The addition of maternal warmth as a significant factor for women can be explained by the closer relationships of girls to their mothers and the relevant expectations in accordance to this norm as suggested by the literature (Hortaçsu, 1989; Olson, 1982).

5.2.2.2.ACE and relational problems

The association between childhood adversity and relational problems as attachment insecurity and separation individuation pathology, on the other hand, was not found in the present study. However, there as a trend of increasing attachment anxiety as the number of ACEs increase. The relevant literature on the subject demonstrated that early childhood adversities including abuse, parental divorce were linked to the formation of insecure attachment that leads to life-long relational problems (Morton & Browne, 1998; Baer & Martinez, 2006; Riggs & Kaminski, 2010). More specifically, physical abuse in childhood has been found to be linked to attachment avoidance and attachment anxiety (Unger & De Luca, 2014). Moreover, reporting the increasing number of ACEs were related to having a disorganized attachment as assessed by Adult Attachment Interview, especially in clinical sample (Murphy et al., 2014). The studies summarized are conducted with different measurements than ACEQ except the last one and mostly focused on specific types of adversities. It is quite possible that certain types of traumas might be linked to attachment insecurities. Furthermore, it has been reported that 22% of the abused and neglected children remained resilient and do not suffer from the negative consequences of the past (McGloin and Widom, 2001). The resilience factors can involve positive coping mechanisms, activities that promotes self efficacy and belongingness and earned security through meaningful ans supportive relationships during childhood and adulthood. (Csikszentmihalyi, 1990; Masten & Obradovic, 2006; Walsh, Blaustein, Knight, Spinazzola, & van der Kolk, 2007; Main, Goldwyn & Hesse, 2003; Saunders, Jacobvitz, Zaccagnino, Beverung, & Hazen, 2011). Considering the

socioeconomic status of the participants in the present study, it is likely that these individuals were exposed to different environments which enhance these activities and relationships in their past. Moreover, attachment theory emphasizes that the first years of lives are crucial in the formation of internal working models of self, others and the world. Likewise, individuation process is a developmental task of the early childhood. However, ACE questionnaire investigates the traumas that have been occurred through the age of 18. It is quite possible that childhood traumas that occurs in these early years might have the most influential effect on attachment and this could be a primary question for further studies.

5.2.2.3.ACE and emotion regulation difficulties

Childhood adversity has been shown to be associated with biological, cognitive and social impairments in both children and adults and emotion dysregulation is one of the key important factors that accounts for the increased risk for these impairments (Dvir, Ford, Hill, & Frazier, 2014). In terms of emotion dysregulation, adverse experiences in childhood lead to negative effects on emotional reactivity, emotional expression, awareness of emotions and the use of maladaptive emotion regulation strategies such as suppression and rumination which in turn mediates the relationships between adversity and psychopathology (Shields & Cicchetti, 1998; McLaughlin & Hatzenbuehler, 2009; McLaughlin, Hatzenbuehler, Mennin, Nolen-Hoeksema, 2011; D'Andrea, Ford, Stolbach, Spinazzola & van der Kolk, 2012). Moreover, adaptive emotion regulation involves the use of regulation strategies that are context specific and flexible to meet the desired goals (Gratz & Roemer, 2004). However, the structural changes in the brain as a result of childhood adversity may restrain the ability of self-regulation. Consistently, the present study which assessed the possible emotion regulation difficulties revealed that participants were more likely to experience difficulties in terms of using emotion regulation strategies to meet their goals. The items that have been included in this factor includes statements such as "When I'm upset, I believe that I'll end up feeling very depressed", "When I'm upset, I believe that wallowing in it is all I can do". Thus, these statements reflect the manifestations of helplessness they experience. They simply feel that they have been lost in the emotion and do not have the capacity or opportunity to change it. This overwhelming experience can be tracked back to early childhood in

which self-regulation abilities would expected to evolve through the 'containing' functioning of the mother as suggested by Bion (1959, 1962). Thus, the difficulties of emotion regulation would be discussed along with the perceived parenting styles in addition to childhood adversity.

Supporting the relevant literature, the present study demonstrated that childhood adversity was related to lower levels of life satisfaction and higher levels of psychopathology as conceptualized as depression, anxiety and stress (Hughes, Lowey, Quigg & Bellis, 2016). Even though, this first part of the results yielded a direct relationship among these variables, the possible mediators in this relationship provides with a more accurate explanation of the trajectory, thus further be discussed.

5.2.3. The effects of different types of chilhood adverse experiences

Research on childhood adversity suggested that different types of childhood traumas most generally occurs simultaneously and it is almost impossible to isolate the effects of them. For instance, one study found that only less than 5% of the traumatized individuals experienced one type of trauma in isolation among physical abuse and neglect, emotional abuse and neglect and sexual abuse (Ney, Fung & Wickett, 1994). Despite of the overlapping nature of childhood traumas, it has also been suggested that abuse in the context of neglect may reflect a more severe form of adversity. Furthermore, abuse in its nature has the most potential to provoke feelings of fear and stress and impair the emotional processes in the brain (Cicchetti, Rogosch, Gunnar & Toth, 2010). Thus, neglecting the child alone to deal with these overwhelming feelings might lead to emotion dysregulation. Consistently, the studies conducted on adverse childhood experiences revealed high correlations among the adversity types measured in the questionnaire. Moreover, the likelihood of reporting multiple adversities were found to be high (Anda et al., 1999; Felitti et al., 1998).

Despite of the aforementioned overlapping nature of childhood adversity, the present study also aimed to observe the possible adversities that has the most potential impact on the well being in adulthood through relational and emotional outcomes. Specifically, for attachment anxiety, emotional abuse for men, and emotional neglect for women were significant predictors of attachment anxiety. This finding can be interpreted as the

differential self development through cultural practices across genders. As men were raised with the expectations of "being powerful and assertive", women were more likely to be raised as "obedient and emotional" in traditional cultures like in Turkey. Thus, whereas emotional abuse includes an "attack" on the self of the individual, neglect is more about the sense of being "invisible". This finding is also consistent with the different psychopathology that girls and boys exhibit. Boys are more likely to have externalizing symptoms and girls tend to have more internalizing symptoms as a result of insecurity in the family environment (DeKlyen & Greenberg, 2008). Thus, it could be possible that the behaviors of boys are more likely to trigger abusive parenting behaviors and as a vicious cycle may affect the sense of self of boys more prominently than girls. Furthermore, the effects of emotional abuse for men was also found to be a predictor of separation individuation pathology and emotion regulation difficulties, whereas emotional neglect as a predictor of emotion regulation difficulties for women in the present study, supporting this interpretation.

For well-being in adulthood as conceptualized as life satisfaction and depression, anxiety and stress, different types of traumas appeared to have differential effects on each gender. Specifically, for life satisfaction, SES and emotional neglect were found to be related related for both genders. However, women were also shown to be effected by physical neglect and to a lesser extent, domestic violence. This finding could also be a support for the "fragile" sense of women as a result of social learning. Finally, for psycholopathology, there were no gender differences. For both men and women, emotional neglect and exposure to mental illness or suicide attempt in the household were significant predictors of depression, anxiety and stress levels.

These results examined the direct associations between the variables and as mentioned previously, it is impossible to interpret the impact of any type of trauma without the additional effect of another. Thus, further analysis were conducted to decide the complex effects of childhood adversity and the possible associations between them.

5.3.Findings Related to Correlational Analysis of the Study Measures

In the present study, correlational analysis of the study measures as childhood adversity, parental behaviors, separation individuation pathology, attachment insecurity, emotion

regulation difficulties and finally depression, anxiety, stress and life satisfaction has been conducted to investigate the possible associations.

5.3.1. Parental behaviors

Firstly, childhood adversity was found to be associated with lower levels of parental warmth and higher levels of overprotection and rejection. It is important to note that the assessment of childhood adversity contains items of physical, emotional, sexual abuse, emotional and physical neglect and household dysfunctions. Thus, the association found was expected since the parental behaviors can be the source of the adversity. Moreover, regarding trauma, family environment can be ameliorating and be a protective factor facilitating resilience.

5.3.2. Separation individuation pathology and attachment insecurity

Childhood adversity was also found to be associated with separation individuation pathology as specified as the use of splitting as a defense mechanism, problems related to differentiation of self from others and relationship problems. Moreover, childhood adversity was also found to correlated with attachment anxiety but not attachment avoidance. These associations could be interpreted as the effect of trauma in the development of self and development of the relational world through the process of individuation. Along with the biological effects of trauma, hypervigilance and anxiety are the most common markers of trauma and it is quite possible that the anxiety can also be prominent in close relationships. Likewise, overprotection and rejection of parents were associated with separation individuation pathology and attachment anxiety. Parental overprotection, in general can interfere with developmental task at any age and can restrain the child from being an autonomous individual. In earlier ages, overprotection may cause the child feel vulnerable and helpless with the tranmission of anxiety feelings. In adolescence, it may be experienced as a restriction resulting in defensive autonomy. Rejection of parents, on the other hand, may cause the child reject himself, as through self development process, the self contains the extension of parental egos. Moreover, the perception of others as uncaring will inevitably impact the interpersonal relationships. It would be expected that parental rejection would be related with attachment avoidance according to the attachment theory (Ainsworth et al., 1978).

However, in this study, the rejecting attitude of the parents was associated with attachment avoidance. This finding should be investigated further along with the effect of other parental behaviors and the possible overlapping negative influences.

5.3.3. Emotion regulation difficulties

Beside of the associations of early experience and relational problems, childhood adversity was also found to be associated with emotional outcomes as regulation difficulties. Specifically, individuals with a history of ACE had more difficulties in terms of goal oriented behaviors in the presence of negative emotions, using emotion regulation strategies and impulse control. This finding is in line with the trauma literature which has shown that childhood trauma was linked to emotion regulation difficulties as emotional avoidance and nonacceptance (Gratz, Bornovalova, Delany-Brumsey, Nick, and Lejuez, 2007), inhibition of emotional expression (Reddy, Pickett, & Orcutt, 2006). In most studies, the association between childhood trauma and psychopathology is mediated by emotion dysregulation (Rosenthal, Rasmussen Hall, Palm, Batten, and Follette, 2005; Gratz, Tull, Baruch, Bornovalova, & Lejuez, 2008; Burns, Jackson, & Harding, 2010) and this mediation has also been one of the research question of this current study.

Parental overprotection and rejection were also found to be associated with different areas of emotion regulation difficulties except awareness of emotions. The awareness subfactor, actually, revealed associations opposite to what was expected. This finding can be further investigated as it was a reflection of the sample characteristics or structural problem of the items. Moreover, this item has also revealed the lowest correlations with hypothysized variables in the Turkish relability and validity study (Rugancı, 2008). Parental overprotecting and rejecting involves non empathic relationship with the child, thus the child is mostly left alone with the intense emotions they experience without the capacity to regulate them. Whereas the overprotective parents puts their beliefs, rules and standards above to the child's, the child can feel quite invisible with rejecting parents. These behaviors may also be experienced as abuse or neglect in some cases. Emotion regulation difficulties, on the other hand was found to be related with well being as assessed by levels of depression, anxiety and stress as

well as perceived satisfaction of life as in the expected directions for this study and consistent with the existing literature.

5.3.4. Well being

The associations between early experience and well-being were found significant in the expected directions. Specifically, childhood adversity was related to higher levels of depression, anxiety and stress and lower levels of life satisfaction. Moreover, as the parental warmth increased, so as life satisfaction but psychopathopathology levels decreased. Finally, parental overprotection and rejection were found to have significant positive correlations with depression, anxiety and stress whereas maternal overprotection and rejection as well as paternal rejection were negatively associated with life satisfaction. These findings are consistent with the relevant literature that demonstrated the adverse, enduring effects of childhood stressors through relational and emotional problems as well as lack of self-worth (Anda et al., 2006; Danese & McEwen, 2012; Riggs, 2010; Hughes, Lowey, Quiggl & Bellis, 2016).

5.4.From Early Experience to Adulthood Well-being

Early childhood is a developmental period characterized by tremendous changes and vulnerability of the infant to the environment. This vulnerability serves for the efficient learning capacity of the infant in order to survive. However, at the same time, dependency of the infant makes the social environment crucial for his development and adaptation.

The world of the infant has been studied and explained by many different psychological theories. The psychoanalytic theories firstly emphasized the importance of the primary relationships in the development of ego and the attachment theory clearly explained as a biological adaptive mechanism for infants to develop attachment relationships with their caregivers (Klein, 1952; Bowlby, 1969). The recent neurological studies demonstrated the neurological and biological structural changes of the infant as a result of reciprocal relationships with the primary attachment figures (Schore, 1994). However, rather than

finding direct relationships, it is crucial for the psychology field to understand the risk factors that have the potential to effect a life time.

The current study aimed at understanding the effects of adverse childhood experiences and perceived parenting styles on separation individuation pathology, attachment insecurity and emotion regulation difficulties and life satisfaction and psychopathology. These associations were investigated by using path analysis. It was predicted that early experience measures would be mediated by relational and emotional difficulties and effect the well-being during adulthood. The results demonstrated that for separation individuation pathology, splitting was predicted by maternal and paternal overprotection, relationship problems were predicted by maternal warmth and maternal overprotection. Splitting is conceptualized as a developmental task in early childhood in which the child learns to tolerate the painful moments with the mother as splitting the bad representations of her (Mahler, 1975). However, if this stage has not reached a resolution and the child will not be able to fuse the opposite parts of the object, then he will experience difficulties in interpersonal relationships characterized by the failure to integrate the "good" and "bad" qualities of the others. Thus, at one minute the person may talk about a friend as "totally careless and mean", the other moment he can describe as "my dearest friend". This kind of behaviors are mostly observed in people with borderline personalities. In normative development, the splitting evolves into fusion as the infant learn to tolerate disturbing emotions and images and gain the ability of fusion. Thomasgard and Metz (1993) pointed out the importance of the parental attitude in Mahler's separation individuation process as "ever increasing autonomy for the child, requiring parents in a parallel process, to progressively relinquish control in a manner consonant with the child's capacity for independent functioning." (p. 68). Overprotective parents may be anxious themselves and this might sometimes lead to anger as the control of the infant becomes harder as he grows. Thus, the "bad" qualities of the parent might be more than they could be tolerated. Moreover, overprotective parents might have difficulties in the regulation of their own emotions which makes it impossible to regulate their offsprings. In adolescence, the themes of independence and ego are revisited and the adolescent struggles with developing the sense of self, separate from his parents. They can seek for more independence and might be annoyed any kind of control or inhibition by their parents. The results in this present study can be interpreted as the disruptions of ego development through overprotective parents. The

parents are supposed to support the attempts of the child towards being an autonomous individual, while they are still emotionally attached. However, overprotective parents can oversupervise the children and actually impair self esteem. Furthermore, their lack of emotion regulation skills and fusion abilities might impact all the other interpersonal relationships and splitting, in that case, can be used defensively. However, in the period of young adulthood, they could be more reactive to any kind of interference by their parents, thus it could be a preiod in which the parents are perceived more negatively.

In terms of attachment insecurity, attachment anxiety was predicted by low maternal warmth and maternal overprotection and attachment avoidance was predicted by maternal rejection. This finding is consistent with the relevant literature that lower levels of parental control is associated with attachment security (Feeney &Vleet, 2010). Specifically, whereas maternal warmth requires the mother to be responsive and sensitive to the child's needs, maternal overprotection, as aforementioned is mostly related to feelings of anxiety and actions of restrictions. Maternal overprotection, in this sense contains the emotional and physical control over the child. Moreover, when the mother is rejecting, the child learns that attempts to get intimate would be risky for the child, thus the child learns to deactivate his emotions to survive. Furthermore, the associations between early experience and emotion regulation difficulties revealed that difficulties in behaving in accordance with the desired goals was predicted by adverse childhood experiences and maternal rejection; difficulties in using emotion regulation strategies was predicted by adverse childhood experiences and maternal overprotection. Maternal overprotection was also a predictor of impulse control whereas paternal rejection predicted difficulties in clarifying one' own emotions. To sum up, emotion regulation difficulties are mostly effected by the behavioral patterns of the mother and adverse childhood experiences. Especially, maternal overprotection has been found as a strong predictor for emotional dysregulation which is consistent with the previous research on the subject (Feeney & Vleet, 2010).

Finally, adulthood well being measures were partially explained by some of the difficulties in emotion regulation and separation individuation problems. However, attachment security was not a predictor of well being. Furthermore, difficulties in using emotion regulation difficulties mediated the relationship between childhood adversity and psychopathology and also between maternal overprotection and psychopathology.

Similarly, splitting mediated the relationship between maternal overprotection and psychopathology. The findings have supported the hypothesis of the study except attachment insecurity which was predicted to be a significant factor for lower levels of adulthood well being. Contrary to the findings of this study, studies have shown that attachment security is generally associated with higher levels of satisfaction in relationships (Feeney, 1994), and lower levels of psychopathology (Mikulincer & Shaver, 2012). The emphasis on the separation individuation pathology on the findings might be discussed as a age specific factor in this study. The young adulthood is a phase in which individuals begin to form intimate and romantic relationships with others and have put much importance to romantic relationships among all social relationships. On the other hand, the nature of these relationships are mostly unstable and short term. Moreover, some of the participants have never experienced a romantic relationship. Thus, attachment security might be found as a significant factor when these relationships are experienced and become more stable for evaluation of self in those relationships.

Finally, the results of this study can be evaluated in the light of the new developmental concept of "emerging adulthood". This phase of life, with a focus of between ages 18 and 25 is characterized by the uncertainty in the different areas of life including love, work and worldview. It is proposed that most of the identity formation process through explorations takes place in the emerging adulthood with the feelings of ambuigity. Furthermore, these explorations might result in dissappointment or rejection which might result in stress in the individual's life. Thus, the results of this study might reflect the difficulties that this specific age group especially encounters (Arnett, 2000).

5.5.Critical Parenting Behaviors

This study demonstrated the importance of maternal parenting behaviors. Particularly, maternal overprotection was associated with attachment insecurity, emotion regulation difficulties and adulthood well being. Studies on the family relationships in Turkey revealed that parental control and nurturance were high and obedience, conformity, dependency and loyalty are encouraged in these relationships (Fisek, 1991; Kağıtçıbaşı, 1982; Sunar, 2002). Furthermore, mothers are regarded as more affectionate and mostly

this physically (Kağıtçıbaşı, Sunar and Bekman, 1988). On the other hand, generational changes as encouragement of emotional expression and independence have also been noted (Ataca, 2006). Thus, considering the socioeconomic status of the participants in this study, the expectations of the children might be an extension of this trend. Children of the new generations in urban regions might see more independence that the parents are eager to allow. Furthermore, it might also be a reflection of the age which is characterized by the development of self and relationships independently from their parents.

Overprotective parenting has recently received some public attention and labels such as "helicopter parenting" have been referred for these parents. Studies on overprotection showed that overprotection has been linked to psychological problems, lack of independence, self-efficacy and resilience, impaired socio-emotional functioning, increased levels of depression and low levels of life satisfaction (Eager & Little, 2011; Ungar, 2009; Cooklin, Giallo, D'Esposito, Crawford & Nicholson, 2013; Givertz & Segrin, 2012). Beside of the disruptions of their developmental processes as a result of restrictions, the intrusive behaviors of the parents might prevent children take responsibility of their own actions. These results should be taken into consideration cautiously since parental overprotection is not a resemblance of lack of parental warmth as it is in Western cultures (Kağıtçıbaşı & Sunar, 1992). However, the findings of this present study is in line with the Western literature and this might be due to the characteristics of the participants (living mostly in İstanbul, high education level, high income).

In the current study, parental overprotection has also been found to be associated with emotion regulation difficulties. This finding can be discussed as the failure of parents' own regulation abilities. Specifically, parental overprotection might also be due to parental fear (Hancock, Lawrence & Zubrick, 2013). This fear can be realistic as with the belief that the world has become more dangerous, but also as an exaggerated appraisal of threat. In either case, this fear has been attempted to be overcome by control. However, this also brings the possibility that at times of stress and when the control can not be achieved, the emotions of fear and anxiety can be overwhelming for the individual and impair the reciprocal relationships with children. As aforementioned, development of self is a process from dyadic regulation to self regulation. Thus, when

the parent can not regulate her own affect, it would be most likely that she will fail to regulate her child's. Consequently, the child would not be able to learn the approprite regulation strategies and would have difficulties in times of intense feelings.

The maternal warmth, on the other hand, have been found mostly associated with relational problems and these findings support the tremendious literature on attachment theory which claimed that the reciprocal relationships with the primary caregiver serves as a relational map called internal working model including beliefs, expectations and behaviors effecting other relationships. The lack of obvious associations of fathers may also be interpreted as the more distant stance of fathers with children and traditional sharing of family roles as mothers engaging more in child bearing practices and fathers as breadwinners (Sunar, 2002; Ataca, 2006).

5.6. Childhood Adversity and Well-being

The association between childhood adversity and adulthood well being has been found to be mediated by emotion regulation difficulties. The literature on childhood adversity has demonstrated that exposure to traumatic experiences might influence the brain structure and activity (Dvir, Ford, Hill & Frazier, 2014). Consequently, not only they have difficulties in cognitive processes as appraisal of threats but also they have higher reactivity to stress and they can not modulate the affect adequately and more likely to have problems associated with anxiety, hyperarousal and depression (Dvir, Ford, Hill & Frazier, 2014; van der Kolk, 2003). However, a cause and effect relationship can not be concluded based on these findings as there are some protective factors leading to resilience in traumatized children. These protective factors can be summarized as attachment security, parental warmth and lack of physical punishment, appropriate care and attention, monitoring the child to make sure they do not engage in relationships with delinquent friends, and finally self esteem and efficacy of the child (Sousa, Herrenkohl, Moylan, Tajima, Russo & Herrenkohl, 2011; Benda & Corwyn, 2002; Salzinger, Rosario & Feldman, 2007; Guterman, 1997; MacLeod & Nelson, 2000).

Adverse childhood experiences questionnaire that has been used in the present study, has measured the incidence of abuse and neglect without identifying the source. Thus, it is quite possible that the source of the trauma could be related to the parents and this

might have caused the correlations between ACE and parenting behaviors. Moreover, the age of the participant at the time of the specific traumatic experience has not been asked. However, considering the effects of trauma in line with the developmental theories that take the biological and meurological mechanisms into account can provide with more complementary information. Specifically, it could be suggested that the earlier the traumatic experience has been exposed, the more problems that one could assume.

5.7. Clinical Implications

The present study was the first study investigating the relationships between adverse childhood experiences and parenting behaviors and adulthood well being integratively in a Turkish sample and demonstrated the importance of early experience on the well being in adulthood.

Along in line with the previous literature, emotion regulation is a key factor bridging between early experience and adult well being. Thus, clinicians working with psychopathology with adults should be well aware of these abilities of the client and revisit the recollections of the childhood in psychotherapy in order to understand how these difficulties have been formed through the early interactions with the family. Moreover, "reparenting" of the therapist models for the adaptive responses when the client has overwhelming emotions. It is also important to understand the client's cognitions and emotions on the emotions themselves. In other words, clients may have the tendency to think about the emotions as "good" or "bad" and the unsuccessful attempts for suppression may take place leading to more psychopathology in the long run. Thus, with clients with a history of trauma and disrupted primary attachments, psychotherapy should not only focus on resolving situational problems, but on understanding the precipitating factors and the therapeutic relationship itself can be healing. Third wave therapies (eg. Acceptance Commitment Therapy) emphasize the acceptance of the emotions and behaving in accordance to the values and goals and demonstrates promising results in terms of emotion regulation. However, in my opinion, reaching for the past of the client along with techniques of third wave therapies could be more effective and meaningful for the client.

Secondly, clinicians working with children should be cautious about the specific parenting behaviors and provide psychoeducation about the critical parenting behaviors to parents in addition to the therapy sessions with children. Moreover, the therapist can inform the parents about the importance of emotion regulation skills and assist them in regulating the children's emotions through techniques such as "mirroring". It is also crucial to be aware of the generational transmission of relational patterns and understand the roots of parental behaviors and refer the parents to psychotherapy when needed.

Beside of the interventions, prevention programmes that aim to increase awareness for childhood adversity and educate the parents, teachers and health professionals about the risk factors for childhood adversity, the long term consequences of childhood traumas and protective factors to provide resilience in children. These prevention programmes should adopt a multidisciplinary approach with the engagement of schools, medical institutions and legal institutions and should be purely based on the child's rights.

5.8.Limitations and Future Directions

The current study has a number of methodogical limitations. Firstly, the main limitation was the sample size and characteristics. The study was conducted with a total number of 399 participants. However, due to missing items and outliers, the analyses were run with 356 participants. Even though the sample size was enough for the statistical analyses, further studies can be conducted with a larger sample size which would allow to observe the effects of adverse childhood experiences more efficiently. Additionally, the sample included university students from a private university which is characterized by high income, high education level and a restricted range of age. These factors limited the generalization of the findings to the general population. Specifically, high socioeconomic status is associated with lower risk of childhood adversity and more authoritarian parenting (Halfon et al., 2017; Glasgow et al., 1997). Furthermore, the age range of the participants was low and some of the observed difficulties in the measured variables might be due to the developmental tasks of their age. Thus, further studies are suggested to be conducted by employing participants having different characteristics in terms of income, education, and age.

Moreover, research has shown that childhood adversity are most likely to be seen in the clinical population (Kessler et al., 2010). Thus, it would be more informative to examine the trajectory of the relationship between early experience and psychopathology in the clinical population. The inclusion of clinical population in this research subject would also provide the comparable effects as well as the protective factors.

Secondly, the design of the study was retrospective are subject to numerous biases. Recalling bias, the fallibity of memory and the reluctance for disclosure are the common problems in retrospective reports. Specifically, for ACEQ, it is quite possible that some of the traumatic memories were not recalled by the participants, especially those which were exposed in the very early years. Moreover, the participants just simply may not want to disclose the information pertaining trauma. Particularly, it has been pointed out that 80% of sexual abuse incidents are underreported due to feelings of shame and guilt (Kenny & McEachern, 2000).

The possibility of similar response bias are existing for the scale, (Egna Minnen Barndoms Uppfostran; My memories of upbringing) which measures the percieved parenting styles during childhood. Additionally, the participants transitioning into adulthood, may have a negative attitude toward parents with increasing conflicts in the family and the desire of independence. Thus, longitudinal studies are suggested to observe the long term effects of early experience.

Thirdly, ACEQ consists of questions regarding the different types of traumas exposed before the age of 18. However, the incidence time of the particular trauma could also be asked in the further studies as the developmental and neurological studies suggest that traumatic experiences in the early years of life would result in more impairments. Furthermore, the duration and the intensity of traumatic experience and the relation to the person involved in the traumatic act could also be investigated as a more comprehensive understanding of the experience.

Fourthly, trauma has been shown to be clearly linked to somatoform disorders (Rodin et al, 1998). Considering the high rates of emotional abuse and emotional neglect in this current study with the university sample, future studies should also examine the associations between childhood experiences and somatization symptoms.

Despite of the limitations summarized, this dissertation aimed at understanding the dynamic structure of early experience and its inevitable effect on adult functioning. For future research, it would be beneficial to extend the study to the general population and obtain culture specific results for providing effective prevention and intervention strategies for Turkey.

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APPENDIX I

KİŞİSEL BİLGİ FORMU

1. Cinsiyet: Kadın ( ) Erkek ( ) 2. Yaş: …….

3. Okuduğunuz bölüm:……. 4. Sınıf: 1 ( ) 2 ( ) 3 ( ) 4 ( )

5. Not ortalamanız: ……. (4 üzerinden)

6. Hayatınızın çoğunu geçirdiğiniz yer:

a. Köy/kasaba ( )

b.İlçe ( )

c. Şehir ( )

d. Büyükşehir ( )

7. Şu anda İstanbul'da yaşama şartlarınız:

Evde aile ile____Evde tek ____Evde arkadaş ile____Akraba yanı___ Yurt____Diğer____

8. Medeni durum:

Bekar ( ) Biriyle çıkıyorum ( ) Sevgilim ile beraber yaşıyorum ( ) Nişanlı ( ) Evli ( ) Ayrı: ( )

Boşanmış: ( ) Dul: ( ) Ne zamandır? _____

8. Daha önce romantik bir birlikteliğiniz oldu mu?

Evet ( ) Kaç kez? .....

Hayır ( )

9. En uzun süren romantik ilişkinizin süresi: …….

10. En kısa süren romantik ilişkinizin süresi: ……..

11. Sosyo-ekonomik seviyenizi nasıl tanımlarsınız?

Üst sınıf ( ) Üst-Orta Sınıf ( ) Orta Sınıf ( ) Düşük-Orta Sınıf ( ) Düşük Sınıf ( )

12. AİLE:

	Yaşıyor mu?		Medeni durum			
	Evet	Hayır	Beraber	Ayrı	Boşanmış	Yeniden evlendi
Anne						
Baba						

13. Anne babanın eğitim durumu:

	ANNE	BABA
Okur-yazar değil		
İlkokul mezunu		
Ortaokul mezunu		
Lise mezunu		
Yüksekokul mezunu		
Üniversite mezunu		
Yüksek lisans/doktora		

14. Herhangi bir sağlık probleminiz var mı?

Evet ( ) Hayır ( )

Varsa, ne olduğunu belirtiniz: …….

APPENDIX II

Adverse Childhood Experiences Questionnaire

1. Çocukluğunuzda (18 yaşınızı doldurmadan) bir ebeveyn ya da başka bir yetişkin tarafından duygusal istismara maruz kaldınız mı (Hakaret etmek, aşağılamak, alay etmek, küçük görme, tehdit etme)?

   Evet ( ) Hayır ( )

2. Çocukluğunuzda (18 yaşınızı doldurmadan) bir ebeveyn ya da başka bir yetişkin tarafından fiziksel istismara maruz kaldınız mı (Dövmek, vurmak, bir şeyler atmak, yaralamak)?

   Evet ( ) Hayır ( )

3. Çocukluğunuzda (18 yaşınızı doldurmadan) sizden en az 5 yaş büyük bir yetişkin tarafından cinsel istismara maruz kaldınız mı (dokunmak, oral, anal veya vajinal ilişki)?

   Evet ( ) Hayır ( )

4. Çocukluğunuzda (18 yaşınızı doldurmadan) aile içinde sevilmediğinizi, önemli ya da özel olmadığınızı hissettiniz mi veya ailenizin birbirine yakınlık hissetmediğini ya da birbirini desteklemediğini hissettiniz mi?

   Evet ( ) Hayır ( )

5. Çocukluğunuzda (18 yaşınızı doldurmadan) yeterince yiyeceğinizin olmadığını, kirli kıyafetler giymek zorunda kaldığınızı ve sizi koruyacak kimsenin olmadığını hissettiniz mi? Ya da ebeveyninizin çok sarhoş olduğu için size bakamayacağını, ihtiyacınız olduğu zaman sizi doktora götüremeyeceğini düşündünüz mü?

   Evet ( ) Hayır ( )

6. Çocukluğunuzda anne babanız ayrıldı ya da boşandı mı?

   Evet ( ) Hayır ( )

7. Çocukluğunuzda anneniz herhangi bir fiziksel şiddete maruz kaldı mı? (dövmek, çekmek, yumruk veya obje ile vurmak, bir şeyler atmak, tehdit)

   Evet ( ) Hayır ( )

8. Çocukluğunuzda alkol ya da madde bağımlılığı olan biri ile yaşadınız mı?

   Evet ( ) Hayır ( )

9. Çocukluğunuzda ailenizde (evde beraber yaşadığınız birinde) depresyon ya da başka bir psikolojik hastalığı olan, veya intihara kalkışan var mıydı?

   Evet ( ) Hayır ( )

10. Çocukluğunuzda ailenizde (evde beraber yaşadığınız birinde) hapse giren oldu mu?

    Evet ( ) Hayır ( )

APPENDIX III

Short - EMBU (Egna Minnen Betraffande Uppfostoran- Own Memories of Upbringing)

Aşağıda çocukluğunuz ile ilgili bazı ifadeler yer almaktadır. Anketi doldurmadan önce aşağıdaki yönergeyi lütfen dikkatle okuyunuz:

1. Anketi doldururken, anne ve babanızın size karşı olan davranışlarını nasıl algıladığınızı hatırlamaya çalışmanız gerekmektedir. Anne ve babanızın çocukken size karşı davranışlarını tam olarak hatırlamak bazen zor olsa da, her birimizin çocukluğumuzda anne ve babamızın kullandıkları prensiplere ilişkin bazı anılarımız vardır.

2. Her bir soru için anne ve babanızın size karşı davranışlarına uygun seçeneği yuvarlak içine alın. Her soruyu dikkatlice okuyun ve muhtemel cevaplardan hangisinin sizin için uygun cevap olduğuna karar verin. Soruları anne ve babanız için ayrı ayrı cevaplayın.

Örnek:

Annem ve babam bana iyi davranırlardı.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3 (O)	4
Baba	1	2 (O)	3	4

1. Anne ve babam, nedenini söylemeden bana kızarlardı ya da ters davranırlardı.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

2. Anne ve babam beni överlerdi.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

3. Anne ve babamın yaptıklarım konusunda daha az endişeli olmasını isterdim.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

4. Anne ve babam bana hak ettiğimden daha çok fiziksel ceza verirlerdi.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

5. Eve geldiğimde, anne ve babama ne yaptığımın hesabını vermek zorundaydım.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

6. Anne ve babam ergenliğimin uyarıcı, ilginç ve eğitici olması için çalışırlardı.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

7. Anne ve babam, beni başkalarının önünde eleştirirlerdi.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

8. Anne ve babam, bana birşey olur korkusuyla başka çocukların yapmasına izin verilen şeyleri yapmamı yasaklarlardı.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

9. Anne ve babam, herşeyde en iyi olmam için beni teşvik ederlerdi.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

10. Anne ve babam davranışları ile, örneğin üzgün görünerek, onlara kötü davrandığım için kendimi suçlu hissetmeme neden olurlardı.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

11. Anne ve babamın bana birşey olacağına ilişkin endişeleri abartılıydı.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

12. Benim için birşeyler kötü gittiğinde, anne ve babamın beni rahatlatmaya ve yüreklendirmeye çalıştığını hissettim.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

13. Bana ailenin "yüz karası" ya da "günah keçisi" gibi davranılırdı.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

14. Anne ve babam, sözleri ve hareketleriyle beni sevdiklerini gösterirlerdi.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

15. Anne ve babamın, erkek ya da kız kardeşimi(lerimi) beni sevdiklerinden daha çok sevdiklerini hissederdim.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

16. Anne ve babam, kendimden utanmama neden olurlardı.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

17. Anne ve babam, pek fazla umursamadan, istediğim yere gitmeme izin verirlerdi.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

18. Anne ve babamın, yaptığım herşeye karıştıklarını hissederdim.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

19. Anne ve babamla, aramda sıcaklık ve sevecenlik olduğunu hissederdim.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

20. Anne ve babam, yapabileceklerim ve yapamayacaklarımla ilgili kesin sınırlar koyar ve bunlara titizlikle uyarlardı.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

21. Anne ve babam, küçük kabahatlarım için bile beni cezalandırırlardı.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

22. Anne ve babam, nasıl giyinmem ve görünmem gerektiği konusunda karar vermek isterlerdi.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

23. Yaptığım birşeyde başarılı olduğumda, anne ve babamın benimle gurur duyduklarını hissederdim.

	Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, çoğu zaman
Anne	1	2	3	4
Baba	1	2	3	4

APPENDIX IV

Satisfaction of Life Scale (SWLS)

Aşağıda 5 cümle ve her bir cümlenin yanında da cevaplarınızı işaretlemeniz için 1'den 7'ye kadar rakamlar verilmiştir. Her cümlede söylenenin sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümlenin yanındaki rakamlardan yalnız bir tanesini daire içine alarak işaretleyiniz. Bu şekilde 5 cümlenin her birine bir işaret koyarak cevaplarınızı veriniz.

		Kesinlikle katılmıyorum	**Katılmıyorum**	**Kısmen katılmıyorum**	**Kararsızım**	**Kısmen katılıyorum**	**Katılıyorum**	**Kesinlikle katılıyorum**
1	Hayatım bir çok yönden idealimdekine yakın	**1**	**2**	**3**	**4**	**5**	**6**	**7**
2	Hayat şartlarım mükemmel	**1**	**2**	**3**	**4**	**5**	**6**	**7**
3	Hayatımdan memnunum	**1**	**2**	**3**	**4**	**5**	**6**	**7**
4	Hayattan şimdiye kadar istediğim önemli şeyleri elde ettim	**1**	**2**	**3**	**4**	**5**	**6**	**7**
5	Eğer hayata yeniden başlasaydım hemen hemen hiçbir şeyi değiştirmezdim	**1**	**2**	**3**	**4**	**5**	**6**	**7**

APPENDIX V

Separation Individuation Inventory (SII)

Aşağıdaki cümleler genel olarak insanlarla ve kendimizle ilgili düşüncelerimizi yansıtmaktadır Her ifadeyi aşağıda verilen 10 dereceli ölçeği kullanarak değerlendiriniz. Yaptığınız derecelendirmeyi cümlenin yanındaki boş kutuya yazınız. Lütfen hiçbir soruyu boş bırakmayınız.

Hiç katılmıyorum									**Tamamen katılıyorum**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

1. İnsanlar birine gerçekten çok değer verip bağlandığında, sıklıkla kendileri hakkında kötü hissederler.

2. Bir kişi, başka birine duygusal olarak aşırı yakınlaştığında, çoğu zaman kendini kaybolmuş hisseder.

3. İnsanlar birine gerçekten öfkelendiğinde genelde kendilerini değersiz hisseder.

4. İnsanların birine karşı duygusal olarak çok fazla yakınlaşmaya başladıkları zaman, büyük bir olasılıkla incinmeye en açık oldukları zamandır.

5. İnsanlar zarar görmemek için başkaları üzerindeki kontrolü elinde tutmaya ihtiyaç duyar.

6. İnsanları tanıdıkça değişmeye başladıklarını hissederim.

7. Hem iyi hem kötü yanlarımı aynı anda görebilmek benim için kolaydır.

8. Bana öyle geliyor ki insanlar benden ya gerçekten hoşlanıyor ya da nefret ediyorlar.

9. İnsanlar bana karşı çoğu zaman sanki ben yalnızca onların her isteğini yerine getirmek için oradaymışım gibi davranıyor.

10. Kendimden gerçekten hoşlanmak ile kendimi hiç beğenmemek arasında ciddi anlamda gidip geliyorum.

11. Kendi başıma olduğumda bir şeylerin eksik olduğunu hissederim.

12. İçimde bir boşluk hissetmemek için etrafımda başka insanların olmasına ihtiyaç duyarım.

13. Başka biriyle aynı fikirde olduğumda bazen kendime ait bir parçamı kaybetmiş gibi hissederim.

14. Herkes gibi ben de, ne zaman gerçekten saygı duyduğum ve hürmet ettiğim biriyle karşılaşsam kendimi daha kötü görürüm, kendimle ilgili daha kötü hissederim.

15. Kendimi ayrı bir birey olarak görmek benim için kolaydır.

16. Anne babamdan ne kadar farklı olduğumu fark ettiğim zamanlarda çok rahatsızlık duyarım.

17. Önemli bir karar almadan önce neredeyse her zaman anneme danışırım.

18. Diğer insanlarla bağlılık kurup bunun gereklerini yerine getirmek benim için oldukça kolaydır.

19. Duygusal yönden biriyle yakınlaştığımda ara sıra kendime zarar veriyormuşum gibi hissediyorum.

20. Ya birini çok sevdiğimi ya da kimseye katlanamadığımı hissediyorum.

21. Sıklıkla, düşmekle ilgili beni korkutup tedirgin eden rüyalar görürüm.

22. Gözlerimi kapatıp, benim için anlamı olan kişileri zihnimde canlandırmak bana zor geliyor.

23. Birden fazla kere nasıl ya da neden olduğunu anlayamadığım şekilde, uykudan uyanır gibi kendimi biriyle ilişkide buldum.

24. Kabul etmeliyim ki, kendimi yalnız hissettiğimde çoğunlukla sarhoş olmak

isterim.

25. Ne zaman biriyle kavgalı ya da birine çok kızgın olsam kendimi değersiz hissederim.

26. En derin düşüncelerimi söyleyip paylaşacak olsaydım, içimde bir boşluk hissederdim.

27. İnsanların benden hep nefret edermiş gibi olduklarını hissederim.

28. Anne- babama ne kadar çok benzediğimi fark ettiğim zamanlarda kendimi çok rahatsız hissediyorum.

29. Biriyle yakın bir ilişki içinde olduğumda sıklıkla kim olduğum duygusunun kaybolduğunu hissederim.

30. Başkalarını aynı anda hem iyi hem kötü özelliklere sahip insanlar olarak görmek benim için zordur.

31. Bana öyle geliyor ki kendim olabilmenin tek yolu diğerlerinden farklı olmaktır.

32. Duygusal açıdan birine aşırı yakınlaştığımda, benliğimin bir parçasını kaybettiğimi hissediyorum.

33. Ne zaman ailemden uzakta olsam kendimi çok rahatsız hissediyorum.

34. Fiziksel yakınlığı ve şefkati almak, kendi başına, onu bana kimin verdiğinden daha önemliymiş gibi olabiliyor.

35. Bir başka insanı gerçekten iyi tanımak bana zor geliyor.

36. Bir karar vermeden önce annemin onayını almak benim için önemlidir.

37. İtiraf etmeliyim ki, başka birinin kusurlarını gördüğümde kendimi daha iyi hissediyorum.

38. Diğer insanları yakınımda tutabilmek için, içimde onları kontrol etme dürtüsü duyarım.

39. İtiraf etmeliyim ki, birine duygusal olarak yakınlaştığımda, bazen onlara acı çektirme isteği duyarım.

APPENDIX VI

Experiences in Close Relationships Revised (ECR-R)

Aşağıdaki maddeler romantik ilişkilerinizde hissettiğiniz duygularla ilgilidir. Bu araştırmada sizin ilişkinizde yalnızca şu anda değil, genel olarak neler olduğuyla ya da neler yaşadığınızla ilgilenmekteyiz. Maddelerde sözü geçen "birlikte olduğum kişi" ifadesi ile romantik ilişkide bulunduğunuz kişi kastedilmektedir. Eğer halihazırda bir romantik ilişki içerisinde değilseniz, aşağıdaki maddeleri bir ilişki içinde olduğunuzu varsayarak cevaplandırınız. Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 7 aralıklı ölçek üzerinde, ilgili rakam üzerine çarpı (X) koyarak gösteriniz.

1----------2----------3----------4----------5----------6----------7

Hiç katılmıyorum — Kararsızım/ fikrim yok — Tamamen katılıyorum

1. Birlikte olduğum kişinin sevgisini kaybetmekten korkarım.	1	2	3	4	5	6	7
2. Gerçekte ne hissettiğimi birlikte olduğum kişiye göstermemeyi tercih ederim.	1	2	3	4	5	6	7
3. Sıklıkla, birlikte olduğum kişinin artık benimle olmak istemeyeceği korkusuna kapılırım.	1	2	3	4	5	6	7
4. Özel duygu ve düşüncelerimi birlikte olduğum kişiyle paylaşmak konusunda kendimi rahat hissederim.	1	2	3	4	5	6	7
5. Sıklıkla, birlikte olduğum kişinin beni gerçekten sevmediği kaygısına kapılırım.	1	2	3	4	5	6	7
6. Romantik ilişkide olduğum kişilere güvenip inanmak konusunda kendimi rahat bırakmakta zorlanırım.	1	2	3	4	5	6	7
7. Romantik ilişkide olduğum kişilerin beni, benim onları önemsediğim kadar önemsemeyeceklerinden endişe duyarım.	1	2	3	4	5	6	7
8. Romantik ilişkide olduğum kişilere yakın olma konusunda çok rahatımdır.	1	2	3	4	5	6	7
9. Sıklıkla, birlikte olduğum kişinin bana duyduğu hislerin benim ona duyduğum hisler kadar güçlü olmasını isterim.	1	2	3	4	5	6	7
10. Romantik ilişkide olduğum kişilere açılma konusunda kendimi rahat hissetmem.	1	2	3	4	5	6	7
11. İlişkilerimi kafama çok takarım.	1	2	3	4	5	6	7

12.Romantik ilişkide olduğum kişilere fazla yakın olmamayı tercih ederim.	1	2	3	4	5	6	7
13.Benden uzakta olduğunda, birlikte olduğum kişinin başka birine ilgi duyabileceği korkusuna kapılırım.	1	2	3	4	5	6	7
14.Romantik ilişkide olduğum kişi benimle çok yakın olmak istediğinde rahatsızlık duyarım.	1	2	3	4	5	6	7
15.Romantik ilişkide olduğum kişilere duygularımı gösterdiğimde, onların benim için aynı şeyleri hissetmeyeceğinden korkarım.	1	2	3	4	5	6	7
16.Birlikte olduğum kişiyle kolayca yakınlaşabilirim.	1	2	3	4	5	6	7
17.Birlikte olduğum kişinin beni terk edeceğinden pek endişe duymam.	1	2	3	4	5	6	7
18.Birlikte olduğum kişiyle yakınlaşmak bana zor gelmez.	1	2	3	4	5	6	7
19.Romantik ilişkide olduğum kişi kendimden şüphe etmeme neden olur.	1	2	3	4	5	6	7
20.Genellikle, birlikte olduğum kişiyle sorunlarımı ve kaygılarımı tartışırım.	1	2	3	4	5	6	7
21.Terk edilmekten pek korkmam.	1	2	3	4	5	6	7
22.Zor zamanlarımda, romantik ilişkide olduğum kişiden yardım istemek bana iyi gelir.	1	2	3	4	5	6	7
23.Birlikte olduğum kişinin, bana benim istediğim kadar yakınlaşmak istemediğini düşünürüm.	1	2	3	4	5	6	7
24.Birlikte olduğum kişiye hemen hemen her şeyi anlatırım.	1	2	3	4	5	6	7
25.Romantik ilişkide olduğum kişiler bazen bana olan duygularını sebepsiz yere değiştirirler.	1	2	3	4	5	6	7
26.Başımdan geçenleri birlikte olduğum kişiyle konuşurum.	1	2	3	4	5	6	7
27.Çok yakın olma arzum bazen insanları korkutup uzaklaştırır.	1	2	3	4	5	6	7
28.Birlikte olduğum kişiler benimle çok yakınlaştığında gergin hissederim.	1	2	3	4	5	6	7
29.Romantik ilişkide olduğum bir kişi beni yakından tanıdıkça, "gerçek ben"den hoşlanmayacağından korkarım.	1	2	3	4	5	6	7
30.Romantik ilişkide olduğum kişilere güvenip inanma konusunda rahatımdır.	1	2	3	4	5	6	7
31.Birlikte olduğum kişiden ihtiyaç duyduğum şefkat ve desteği görememek beni öfkelendirir.	1	2	3	4	5	6	7
32.Romantik ilişkide olduğum kişiye güvenip inanmak benim için kolaydır.	1	2	3	4	5	6	7
33.Başka insanlara denk olamamaktan endişe duyarım	1	2	3	4	5	6	7

34.Birlikte olduğum kişiye şefkat göstermek benim için kolaydır.	1	2	3	4	5	6	7
35.Birlikte olduğum kişi beni sadece kızgın olduğumda önemser.	1	2	3	4	5	6	7
36.Birlikte olduğum kişi beni ve ihtiyaçlarımı gerçekten anlar.	1	2	3	4	5	6	7

APPENDIX VII

Difficulties in Emotion Regulation Strategies (DERS)

Aşağıdaki cümlelerin size ne sıklıkla uyduğunu altta belirtilen 5 dereceli ölçeğe göre değerlendiriniz. Her bir cümlenin karşısındaki 5 dereceli ölçekten, size uygunluk yüzdesini de dikkate alarak, yalnızca bir tek rakamı yuvarlak içine alarak işaretleyiniz.

Bazen (%11-%35) Çoğu zaman (%66-%90)

1----------2----------3----------4----------5

Hemen hemen hiç zaman (%0-%10) Yaklaşık yarı yarıya (%36-%65) Hemen hemen her (%91-%100)

1. Ne hissettiğim konusunda netimdir.	1	2	3	4	5
2. Ne hissettiğimi dikkate alırım.	1	2	3	4	5
3. Duygularım bana dayanılmaz ve kontrolsüz gelir.	1	2	3	4	5
4. Ne hissettiğim konusunda hiçbir fikrim yoktur.	1	2	3	4	5
5. Duygularıma bir anlam vermekte zorlanırım.	1	2	3	4	5
6. Ne hissettiğime dikkat ederim.	1	2	3	4	5
7. Ne hissettiğimi tam olarak bilirim.	1	2	3	4	5
8. Ne hissettiğimi önemserim.	1	2	3	4	5
9. Ne hissettiğim konusunda karmaşa yaşarım.	1	2	3	4	5
10. Kendimi kötü hissetmeyi kabullenebilirim.	1	2	3	4	5
11. Kendimi kötü hissettiğimde böyle hissettiğim için kendime kızarım.	1	2	3	4	5
12. Kendimi kötü hissettiğim için utanırım.	1	2	3	4	5
13. Kendimi kötü hissettiğimde işlerimi bitirmekte zorlanırım.	1	2	3	4	5
14. Kendimi kötü hissettiğimde kontrolden çıkarım.	1	2	3	4	5
15. Kendimi kötü hissettiğimde uzun süre böyle kalacağıma inanırım.	1	2	3	4	5
16. Kendimi kötü hissetmemin yoğun depresif duyguyla sonuçlanacağına inanırım.	1	2	3	4	5

17. Kendimi kötü hissettiğimde duygularımın yerinde ve önemli olduğuna inanırım.	1	2	3	4	5
18. Kendimi kötü hissederken başka şeylere odaklanmakta zorlanırım.	1	2	3	4	5
19. Kendimi kötü hissederken kontrolden çıktığım duygusu yaşarım.	1	2	3	4	5
	1	2	3	4	5
21. Kendimi kötü hissettiğimde bu duygumdan dolayı kendimden utanırım.	1	2	3	4	5
22. Kendimi kötü hissettiğimde eninde sonunda kendini daha iyi hissetmenin bir yolunu bulacağımı bilirim.	1	2	3	4	5
23. Kendimi kötü hissettiğimde zayıf biri olduğum duygusuna kapılırım.	1	2	3	4	5
24. Kendimi kötü hissettiğimde de davranışlarım kontrolümün altındadır.	1	2	3	4	5
25. Kendimi kötü hissettiğim için suçluluk duyarım.	1	2	3	4	5
26. Kendimi kötü hissettiğimde konsantre olmakta zorlanırım.	1	2	3	4	5
27. Kendimi kötü hissettiğimde davranışlarımı kontrol etmekte zorlanırım.	1	2	3	4	5
28. Kendimi kötü hissettiğimde daha iyi hissetmem için yapabileceğim hiç bir şey olmadığına inanırım.	1	2	3	4	5
29. Kendimi kötü hissettiğimde böyle hissettiğim için kendimden rahatsız olurum.	1	2	3	4	5
30. Kendimi kötü hissettiğimde, kendimle ilgili olarak çok fazla endişelenmeye başlarım.	1	2	3	4	5
31. Kendimi kötü hissettiğimde, kendimi bu duyguya bırakmaktan başka çıkar yol olmadığına inanırım.	1	2	3	4	5
32. Kendimi kötü hissettiğimde davranışlarım üzerindeki kontrolü kaybederim.	1	2	3	4	5
33. Kendimi kötü hissettiğimde başka bir şey düşünmekte zorlanırım.	1	2	3	4	5
34. Kendimi kötü hissettiğimde duygumun gerçekte ne olduğunu anlamak için zaman ayırırım.	1	2	3	4	5
35. Kendimi kötü hissettiğimde, kendimi daha iyi hissetmem zaman alır.	1	2	3	4	5
36. Kendimi kötü hissettiğimde duygularım dayanılmaz olur.	1	2	3	4	5

APPENDIX VIII

Depression Anxiety Stress Scale (DASS)

Lütfen aşağıdaki ifadeleri son 1 haftadaki durumunuzu göz önünde bulundurarak cevaplandırın.

	Son 1 haftadaki durumunuz	Hiçbir zaman	Bazen	Oldukça sık	Her zaman
1	Oldukça önemsiz şeyler için üzüldüğümü farkettim	0	1	2	3
2	Ağzımda kuruluk olduğunu farkettim	0	1	2	3
3	Hiç olumlu duygu yaşayamadığımı farkettim	0	1	2	3
4	Soluk almada zorluk çektim (*örneğin fizik egzersiz yapmadığım halde aşırı hızlı nefes alma, nefessiz kalma gibi)*	0	1	2	3
5	Hiçbir şey yapamaz oldum	0	1	2	3
6	Olaylara aşırı tepki vermeye meyilliyim	0	1	2	3
7	Bir sarsaklık duygusu vardı *(sanki bacaklarım beni taşıyamayacakmış gibi)*	0	1	2	3
8	Kendimi gevşetip salıvermek zor geldi	0	1	2	3
9	Kendimi, beni çok tedirgin ettiği için sona erdiğinde çok rahatladığım durumların içinde buldum	0	1	2	3
10	Hiçbir beklentimin olmadığı hissine kapıldım	0	1	2	3
11	Keyfimin pek kolay kaçırılabildiği hissine kapıldım	0	1	2	3
12	Sinirsel enerjimi çok fazla kullandığımı hissettim	0	1	2	3
13	Kendimi üzgün ve depressif hissettim	0	1	2	3
14	Herhangi bir şekilde *geciktirildiğimde (asansörde, trafik ışıklarında, bekletildiğimde)* sabırsızlandığımı hissettim	0	1	2	3
15	Baygınlık hissine kapıldım	0	1	2	3
16	Neredeyse herşeye karşı olan ilgimi kaybettiğimi hissettim	0	1	2	3

17	Birey olarak değersiz olduğumu hissettim	0	1	2	3
18	Alıngan olduğumu hissettim	0	1	2	3
19	Fizik egzersiz veya aşırı sıcak hava olmasa bile belirgin biçimde terlediğimi gözledim *(örneğin ellerim terliyordu*)	0	1	2	3
20	Geçerli bir neden olmadığı halde korktuğumu hissettim	0	1	2	3
21	Hayatın değersiz olduğunu hissettim	0	1	2	3
22	Gevşeyip rahatlamakta zorluk çektim	0	1	2	3
23	Yutma güçlüğü çektim	0	1	2	3
24	Yaptığım işlerden zevk almadığımı farkettim	0	1	2	3
25	Fizik egzersiz söz konusu olmadığı halde kalbimin hareketlerini hissettim *(kalp atışlarımın hızlandığını veya düzensizleştiğini hissettim)*	0	1	2	3
26	Kendimi perişan ve hüzünlü hissettim	0	1	2	3
27	Kolay sinirlendirilebildiğimi farkettim	0	1	2	3
28	Panik haline yakın olduğumu hissettim	0	1	2	3
29	Bir şey canımı sıktığında kolay sakinleşemediğimi farkettim	0	1	2	3
30	Önemsiz fakat alışkın olmadığım bir işin altından kalkamayacağım korkusuna kapıldım	0	1	2	3
31	Hiçbir şey bende heyecan uyandırmıyordu	0	1	2	3
32	Birşey yaparken ikide bir rahatsız edilmeyi hoş göremediğimi farkettim.	0	1	2	3
33	Sinirlerimin gergin olduğunu hissettim	0	1	2	3
34	Oldukça değersiz olduğumu hissettim	0	1	2	3
35	Beni yaptığım işten alıkoyan şeylere dayanamıyordum	0	1	2	3
36	Dehşete düştüğümü hissettim	0	1	2	3
37	Gelecekte ümit veren birşey göremedim	0	1	2	3
38	Hayatın anlamsız olduğu hissine kapıldım	0	1	2	3

39	Kışkırtılmakta olduğumu hissettim	0	1	2	3
40	Panikleyip kendimi aptal durumuna düşüreceğim durumlar nedeniyle endişelendim.	0	1	2	3
41	Vücudumda *(örneğin ellerimde)* titremeler oldu.	0	1	2	3
42	Bir iş yapmak için gerekli olan ilk adımı atmada zorlandım	0	1	2	3

CURRICULUM VITAE

EDUCATION

2002-2006 Middle East Technical University, Faculty of Arts & Sciences

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2008-2010 Dogus University, Graduate program of Clinical Psychology (MA)

2011-2018 Dogus University, PhD program of Clinical Psychology

PUBLICATIONS

Sidal, G.D., Köksal, F. (2018) The Differential Effects of Attachment Orientations on the Perception of Facial Emotional Expressions. *J Child Dev Disord*. 4:3. doi: 10.4172/2472-1786.100053

PRESENTATIONS

Kafescioglu, N., Carkoglu, A., Oner, S., Duymaz, G., Ozcanli, F., & Suvarioglu, I. C. (2011, June). The couple communication and interaction patterns in the Turkish context. Oral presentation at the International Association of Cross Cultural Psychology Regional Conference, Istanbul, Turkey.

Kafescioglu, N., Duymaz, G., Oner, S., Ozcanli, F., & Suvarioglu, I. C. (2010, October). Learning from research: Therapy with Turkish families. Workshop presented at the European Family Therapy Association Congress, Paris, France.

Duymaz, G. (2009). The impact of religiosity on depression and anger among the mothers of disabled children. Oral presentation at the 39th Annual Congress of European Association of Behavioral and Cognitive Therapies, Dubrovnik, Crotia.

DENİZ PARLAK	Ph.D. DISSERTATION	2018