Adverse Childhood Experiences and Romantic Relationship Satisfaction:

The Role of Dyadic Coping

By

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This is to certify that I have examined this copy of a master's thesis by

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To my parents. For their unconditional love and support.
To my advisor. For her guiding light.
To my significant other and friends. For their patience and faith in me.

Abstract

Adverse childhood experiences (ACEs) are unfavorable events occurring before age 18. ACEs can negatively affect social functioning in adulthood, including relationship satisfaction (Ross et al., 2020). However, studies document that when partners have strong dyadic coping skills (strategies they build together to deal with daily external stressors), they experience high levels of relationship satisfaction (Bodenmann et al., 2019). The current study expanded on that literature and explored the direct and indirect associations of ACEs and relationship satisfaction and the role of dyadic coping as a potential mechanism in that process. The sample included 361 Turkish unmarried emerging adults who were 18 to 30 years old and in a committed relationship for at least six months. Data were collected from December 2021 to May 2022 through Qualtrics. Participants' individual coping strategies and gender were investigated as moderators. Data were analyzed using a Structural Equation Modelling (SEM) paradigm to test the moderated mediation model. Results suggested that there was a negative and a significant relationship between ACEs and relationship satisfaction (β = -.19, p = .01). Besides, dyadic coping was positively associated with relationship satisfaction (β = .49, p < .001) but negatively associated with ACEs (β = -.32, p < .001). Mediation analysis suggested that dyadic coping partially mediated the relationship between ACEs and relationship satisfaction. There were no moderating effects of gender (β = -.05, p = .40) or individual coping style (β = -.01, p = .74) in the final model. These findings illustrate the need for early intervention efforts for individuals with ACEs to mitigate potential risks to their relational well-being.

Keywords: Adverse childhood experiences, dyadic coping, relationship satisfaction, gender, individual coping, stressor

Özet

Çocukluk çağı olumsuz yaşantıları (ÇÇOY), 18 yaşından önce deneyimlenen istismar, şiddet, boşanma gibi olumsuz olaylar olarak tanımlanır. ÇÇOY'nın yetişkinlik döneminde yakın ilişkileri olumsuz etkilediği bilinmektedir (Ross, 2020). Öte yandan, stresle çift olarak başa çıkan çiftlerde ise ilişki doyumunun her iki partner için de yüksek olduğu gösterilmiştir (Bodenmann ve diğerleri, 2019). ÇÇOY ve stresle başa çıkma konusunda zengin bir alanyazın olmasına rağmen (örneğin, Sheffler ve ark., 2019), çiftlerin birlikte stresle nasıl başa çıktıkları hakkında daha az bilgi birikimi mevcuttur. Çalışmamız, beliren yetişkinlik dönemindeki gençlerin ÇÇOY ve yakın ilişkilerine odaklanmakta ve stresle çift olarak başa çıkmanın rolünü incelemektedir. Araştırma örneklemi, en az 6 aydır devam eden romantik ilişkisi olan, 18-30 yaş aralığında 361 gençten oluşmaktadır. Anket, Qualtrics aracılığıyla çevrimiçi olarak katılımcılara sunulmuştur. Verilerin analizi için Yapısal Eşitlik Modellemesi (SEM) kullanılmıştır. Modelde, ÇÇOY bağımsız değişken, stresle çift olarak başa çıkma 'aracı değişken', bireysel başa çıkma stratejileri ve cinsiyet ise 'düzenleyici değişkenler' olarak kullanılmıştır ve romantik ilişki doyumu yordanmıştır. ÇÇOY, hem stresle çift olarak baş etme (β=-.32, p <.001) hem de ilişki doyumu (β =-.19, p <.01) ile doğrudan ve negatif ilişkili bulunmuştur. Stresle çift olarak baş etme ile ilişki doyumu ise pozitif ilişkilidir (β = .49, p <.001). Öte yandan, ÇÇOY ve ilişki doyumu arasındaki dolaylı ilişki istatistiksel olarak anlamlı bulunmuştur (-.16, p = .00). Cinsiyet ve kişisel baş etme yöntemleri ise anlamlı sonuçlar göstermemiştir (p> .05). Çiftlerin beraber stresle başa çıkma stratejileri geliştirmeleri, geçmişte deneyimlenen olumsuz yaşantıların izlerini hafifletmek ve ilişki memnuniyetini desteklemek adına önemli görülmektedir.

Anahtar kelimeler: çocukluk çağı olumsuz yaşantıları, stresle çift olarak baş etme, ilişki doyumu, baş etme stratejileri, beliren yetişkinlik.

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CHAPTER 1

INTRODUCTION

Adverse childhood experiences (ACEs) are potentially traumatic events, including maltreatment, abuse, neglect, and exposure to harmful incidents in the child's household. (Boullier & Blair, 2018). ACEs are disturbingly common in Turkey. In a study conducted by WHO among 2,257 university students in Turkey, 49.7% of the participants were exposed to at least one ACE in their lifetime (Velipaşaoğlu et al., 2017).

ACEs can have adverse and lasting effects on health and well-being in adulthood. Studies have shown links between ACEs and adult depression as well as substance misuse (Ross et al., 2020). Regarding romantic relationships, adults with ACEs struggle with building trusting and fulfilling relationships, have communication and self-regulation issues, and experience relational distress (Wheeler et al., 2019). While there is an accumulation of research on coping with ACEs (e.g., Sheffler et al., 2019), little is known about how partners cope with ongoing stressors together. Therefore, the current study addresses the relationship between ACEs and relationship satisfaction, focusing on dyadic coping in a Turkish sample.

1.1 Definitions of adverse childhood experiences (ACEs)

ACEs are characterized by three main categories: experiences of abuse, neglect, and household challenges. Under the category of abuse, there is emotional, physical, and sexual abuse. Emotional abuse refers to a primary caregiver (PC; e.g., parent, stepparent, foster parent) or an adult living in the same household insults, swears, represses, or acts in a way that would

make the child feel threatened or unsafe (e.g., withdrawing love, name-calling, threatening with violence; Romito & Pope, 2020). Physical abuse occurs when a primary caregiver (PC) or an adult living in the same household pushes, grabs, slaps, throws something or hits the children in a way that injures the child. Lastly, sexual abuse refers to an adult, relative, family friend, or stranger who is at least five years older than the child touches or sexually fondles the child or exploits the child to create sexual images/acts, or exposes the child to sexual images (i.e., showing pornography; Mathews & Collin-Vézina, 2019). Sexual abuse also includes forcing the child to touch the adult sexually or attempting to have sexual intercourse with the child (Boullier & Blair, 2018).

Regarding neglect, there are emotional and physical aspects. Emotional neglect occurs when no member of the child's family shows love and warmth to the child or cares for their needs for connectedness. On the other hand, physical neglect is the failure of family members to take care of the child's biological and medical needs and protect them from physical harm and victimization. For example, a neglected child may not have enough food or clean clothes to wear. Additionally, neglect may occur when parents are under the influence of drugs that impair their ability to fulfill parenting responsibilities (Boullier & Blair, 2018).

Household challenges are childhood incidents and difficulties children experience in their families. One of those challenges can be witnessing intimate partner violence (e.g., the mother being pushed, hit, slapped, kicked, bitten, or threatened with a weapon by the father or a partner) in the household. Other challenges include parental divorce, having family members who misuse substances, having a mental illness (e.g., major depressive disorder), attempting suicide, or having committed a crime (Boullier & Blair, 2018).

Of note, sources of ACEs and perpetrators are not limited to the family; external risks and adverse events also play a role. For example, there can be child labor or prostitution, discrimination, immigration, war, or poverty (Boullier & Blair, 2018). However, because the previously mentioned conceptualization of ACEs is commonly accepted and used more widely in empirical research (Ports et al., 2020), the current study will only focus on abuse, neglect, and household challenges in childhood as ACEs.

1.2 Consequences of ACEs in childhood and beyond

Research has shown that ACEs and associated environmental stress can affect the child's developing brain and immune and endocrine systems (Nelson et al., 2020). For instance, ACEs may alter the stress-signaling regulation pathways and immune system functioning related to the brain's overall functioning and structure (Nelson et al., 2020). ACEs can also be indirectly associated with forming dysfunctional cognitions and ideations about the world and self (Nelson et al., 2020). Therefore, ACEs are related to long-term physical health challenges (e.g., chronic stress, heart challenges, chronic pain, and challenges in sleeping) and unhealthy life choices (e.g., severe obesity, having sexually transmitted disease, etc.). In addition, individuals with ACEs experience mental health problems and issues with academic achievement and work productivity (Boullier & Blair, 2018; Ross et al., 2020). For instance, these individuals are more likely to smoke (Ford et al., 2011; Topitzes et al., 2010), binge drink (Timko, Sutkowi, Pavao, & Kimerling, 2008), and misuse substances (Sharp, Peck, & Hartsfield, 2012). Furthermore, individuals with ACEs are more likely to engage in risky behaviors in adolescence than those without ACEs (Chung et al., 2010; Rothman et al., 2008). Anxiety, depression, suicidality, PTSD, and substance use disorder are also common among adults with ACEs. For example, a

study found that childhood physical and sexual abuse and witnessing domestic violence significantly increased the odds of suicide attempts (Kalmakis & Chandler, 2015).

ACEs are also associated with impairments in close relationships. Studies suggest ACEs may result in poorer social functioning in adulthood (Shaw et al., 2017). This can result in less relationship support and more relationship strain (Umberson et al., 2014), lower relationship quality (Wheeler et al., 2018), and increased risk of intimate partner violence (Whitfield et al., 2003). In addition, when there is cumulative stress experienced during the developmental years, there could be a manifestation of lifelong differential vulnerability to stress. Therefore, adverse childhood experiences could create psychological and physiological vulnerability to stress, leading to edgy or anxious individuals struggling to build close relationships (Miller, 20111). Additionally, individuals exposed to adversities in early childhood may become watchful, mistrustful, and skeptical in adulthood. These tendencies are inevitably linked to difficulties forming close social ties (Umberson et al., 2014).

Adults with a history of ACEs struggle with trusting their partners and practicing empathic communication in romantic relationships (Liverpool Clinical Commission Group, 2021). Research has shown that ACEs, especially parental divorce in childhood, are negatively associated with manifesting attachment behaviors (Zemp et al., 2016) in adulthood. Findings suggest that children may experience fewer psychological problems and exhibit more social competence in families where the parents demonstrate mutual support and joint problem-solving in times of stress. In the opposite scenario, interparental discord harms children's development by undermining their emotional security and their felt safety within the family.

The family-of-origin is seen as the unit in which the individual has their physiological and emotional beginnings. Experiences in the family of origin may lead children to internalize

how their parents support each other in times of stress. This internalization would form schemas of socially acceptable ways of interacting with their partners in times of stress (Donato et al., 2011). Research by Larson and Holman (1994) confirms that the processes and interactions in the family-of-origin predict the quality of a relationship more accurately than a single incident. It may be that children in families with a secure environment and the skills they acquire from witnessing their parents' interactions allow them to choose appropriate partners. Likewise, they get the opportunity to learn from an early age that partners have specific responsibilities and functions to fulfill for each other. Therefore, they can meet the needs of their partners in a relationship and claim responsibility for establishing mutual support. (Botha et al., 2009).

Overall, exposure to ACEs in early childhood can limit an individual's access to healthy social ties and support and shape their relational patterns and romantic relationships. For instance, adults who had adverse experiences in early childhood may face difficulties in balancing romantic relationships and outside stressors. This misbalance may further strengthen the ACE's correlation with relationship dissatisfaction and perceived lack of support (Breitenstein et al., 2017). Studies revealed that as childhood adversities increase, so does the relationship strain and dissatisfaction (Boullier, & Blair, 2018; Wheeler et al., 2021). As such, it is crucial to explore ACEs in the context of romantic relationships. The adverse effects of ACEs can influence not only the individuals' well-being but also their romantic relationships. For instance, ACEs may indirectly impact each partner's physical health through relationship quality (Wheeler, 2017). When one partner has reported ACEs, its adverse outcomes may spill over to the relationship, and their level of chronic stress may reduce the quality of their relationship. Therefore, a dyadic perspective on coping is warranted.

1.3 Dyadic coping and romantic relationship outcomes

Dyadic coping is characterized by supportive interactions, communication patterns, and stress management between couples when they experience external stressors (Bodenmann et al., 2019). Such stressors occur outside of the romantic relationship, such as workplace, with friends or family, in leisure time, or can be prolonged stressors (Falconier & Kuhn, 2019).

After examining multiple conceptualizations of dyadic coping, Falconier (2019) suggested that dyadic coping stems from supportive communication and interaction between partners and includes both dyadic and individual-level processes. Dyadic coping compromises how a distressed partner communicates and discloses their stress (either positive or negative), how the other partner responds to the disclosure (individual-oriented appraisal), and how the couple responds to a shared problem or a stressor. Specifically, dyadic coping includes; stress communication (communication of the experience of stress between partners), individual positive dyadic coping (one partner's positive responses to help the other partner to cope with stress via support, empathic responding, delegated dyadic coping, and active engagement), positive conjoint dyadic coping (what partners do together to cope with shared or dyadic stress; common, collaborative, communal dyadic coping, mutual responsiveness), negative individual dyadic coping (one partner's negative responses to the other partner's stress; e.g., protective buffering, overprotection, hostile/ambivalent responses, and controlling behavior, mocking the other partner's feelings and patronizing them, invalidating their experience, providing insincere, superficial, and ambivalent support; Bodenmann, 2008), and lastly negative conjoint dyadic coping (partners' conjoint negative response to deal with a shared or dyadic stress; common negative dyadic coping, disengaged avoidance; Falconier & Kuhn, 2019).

Bodenmann's (1995) Systemic Transactional Model sets the foundation for conceptualizing dyadic coping and how it is linked to romantic relationship processes. According to Bodenmann (1995), when one partner is experiencing daily stressors, this affects the other partner directly or indirectly in committed relationships. This interdependence represents a dyadic phenomenon such that one partner's stress can spill over to the couple's relationship. Likewise, both partners can get affected by a shared stressor (Randall and Bodenmann, 2009). Stress originating outside the relationship can spill over into the relationship, and the emotions associated with that stress can carry over into the relationship. Such stress can lead to lower tolerance and make effective stress communication between the partners difficult. As a result, it is highly likely to decrease relationship functioning.

Hence, how a couple manages problems and conflicts and deals with negative affect is vital for a couple's relationship satisfaction (Ditzen et al., 2013; Baucom et al., 2015). Higher levels of external stress are related to lower levels of relationship satisfaction (Bodenmann, 1997; Randall and Bodenmann, 2009; Randall and Bodenmann, 2017). Yet, in situations where one partner is faced with a significant stressor (e.g., physical illness) or both members of the couple are challenged by a shared stressor (e.g., unemployment, financial difficulties), enacting dyadic coping strategies may help to manage distress (Bodenmann, 2005). Effective dyadic coping strategies reduce stress for both partners and enhance relationship quality (Falconier & Kuhn, 2019).

A growing body of research lends empirical support to those premises. Longitudinal studies have shown that dyadic coping represents a protective factor for the couple's relationship with better relational outcomes. A systematic review of dyadic coping (Bodenmann and Falconier, 2019) suggested that supportive and mutual coping are associated with reduced

hostility and avoidance in the couple's relationship. Moreover, mutual coping was associated with increased emotional and empathic responsiveness, which, in turn, was linked to overall relationship satisfaction (Bodenmann et al., 2019; Falconier et al., 2015). Finally, dyadic coping has been established as a significant predictor of relationship maintenance (Falconier & Kuhn, 2019).

Additionally, couples who utilize positive dyadic coping strategies to deal with daily stressors or medical or mental health issues build more constructive communication and report higher sexual and relationship satisfaction (Falconier & Kuhn, 2019). Those couples have more commitment to and investment in the relationship and experience more stability. (Falconier & Kuhn, 2019). On the other hand, the absence of dyadic coping is the main predictor of separation and divorce in relationships (Bodenmann, 2008).

1.3 Dyadic coping, distress, and ACEs

Partners can be significant sources of emotional support for coping with ACEs. From a dyadic perspective, one partner's mental well-being affects the other partner's mental well-being. Likewise, how one partner communicates and manages stress influences the other partner's coping strategies. There is growing evidence that dyadic coping may buffer the detrimental effect of internal stress on relationship functioning (e.g., Brock & Lawrence, 2008; Neff & Broady, 2011). For example, stressors external to marriage have been associated with less satisfying spousal interactions (Repetti, 1989), more negative attributions about spouse behavior (Neff & Karney, 2004), and marital disharmony (Karney et al., 2005). Specifically, social support is identified as a stress buffer, reducing the harmful effects of stress on mental health. One of the mechanisms through which spousal support contributes to marital satisfaction is preventing

stress-related exhaustion of the marriage relationship. External stress can spill over into the relationship, causing internal stress, making stress a dyadic versus individualistic phenomenon, and straining the relationship. Dyadic coping decreased the impact of chronic external and internal stress, particularly for women. Women who reported higher dyadic coping skills had higher relationship satisfaction, which was also positively linked to their partner's relationship satisfaction (Merz et al., 2014).

Neff and Broady (2011) also suggested that effective problem-solving behaviors of partners (which are an essential part of dyadic coping) may buffer the spillover of external stress into the relationship. Particularly if couples experience stress early in their relationship, they are exposed to situations in which they must deal with stress; thus, these couples gain experience coping with stress early on in their relationship. Moving on from these points, it is likely that the negative effects of chronic stressors like ACEs will get buffered by dyadic coping within romantic relationships.

1.4 Current study

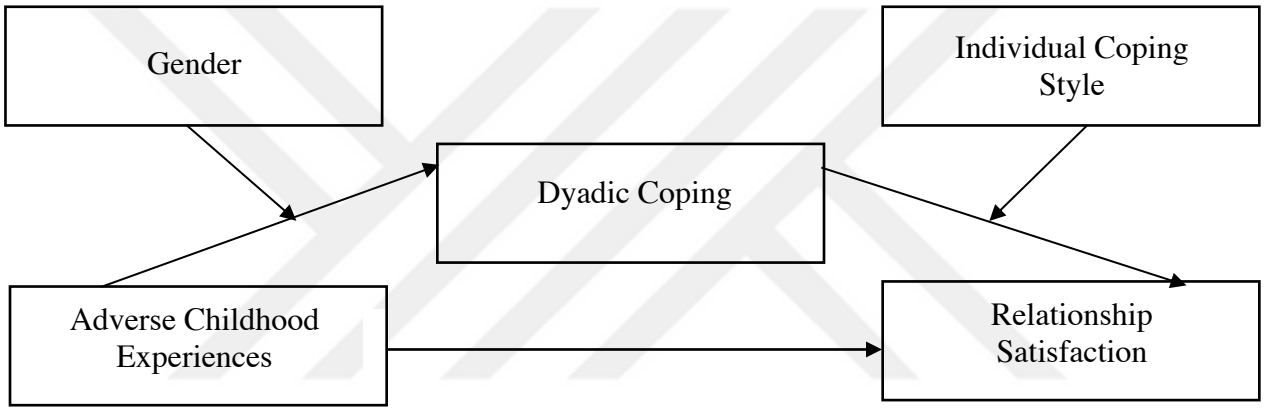
Prior studies have mainly focused on ACEs and their association with mental and physical health outcomes. However, less is known about the role of dyadic coping in alleviating the experiences of ACEs and its association with relationship satisfaction. The current study addresses this gap.

Guided by Bodenmann's (1997) model of dyadic coping, the current study explored the relationship between romantic relationship satisfaction, ACEs, and dyadic coping. Consistent with the reviewed literature, it was hypothesized that H_1) ACEs would be negatively associated with relationship satisfaction; H_2) dyadic coping would be positively associated with relationship

satisfaction; H_3) ACEs would be negatively associated with dyadic coping; and H_4) Dyadic coping would mediate the relationship between ACEs and relationship satisfaction, buffering the negative association between ACEs and relationship satisfaction.

Additionally, we hypothesized that gender would moderate the relationship between dyadic coping and adverse childhood experiences. ACEs' impact on females would form a greater moderating effect on dyadic coping than males (H_6). This hypothesis is based on several studies. For example, Neff and Broady (2011) found that women (but not men) with higher dyadic coping skills experienced better relationship satisfaction. Their dyadic coping skills spilled over to their partners, creating higher relationship satisfaction for both parties. Additionally, women's dyadic coping was found to help enrich broader relationship functioning for both partners (Papp & Witt, 2010), and women experience more complex forms of childhood adversity (Haahr-Pedersen et al., 2020). Likewise, Davies and Cummings (1994) suggested that daughters appear to be more influenced by their parents in negative dyadic coping than sons. Based on prior research on coping (i.e., Herzberg, 2013), we also hypothesized that individuals with adaptive coping strategies would form a stronger dyadic coping within their relationships, resulting in higher relationship satisfaction (H_7). The hypothesized model is shown in Figure 1.

Figure 1. *Hypothesized Model*



CHAPTER 2

METHOD

2.1 Participants and procedure

Data were collected online through Qualtrics from December 2021 to May 2022. Participants were invited through different social media platforms (i.e., Facebook or Instagram) and word of mouth. Participation in the study was voluntary. The study's eligibility criteria were being 18 to 30 years old, unmarried, and in a committed relationship for at least six months. Participants who were eligible signed an online consent form and completed the survey measures (details below under 'measures'). The study took approximately 15 minutes to complete. All procedures were approved by the Institutional Review Board of Koç University (Protocol no: 2021.356.IRB3.158).

Using Fritz and MacKinnon's (2007) guidelines, we estimated that the required sample size was 360 with an alpha of .05 and a power level of .80. Table 1 presents the sample's demographic characteristics. A total of 361 individuals participated in our study. Of the entire sample, 203 participants were (56.23%) women, and 158 (43.77%) were men. The average age of our participants was 24 (SD = 2.9), ranging from 18 to 33 years old. Regarding marital status, 95% were single but in a relationship, and 5% were engaged. Only 2% of the sample reported having children. Regarding education status, 216 (59.83%) participants were university graduates, 79 (21.88%) of them were high school graduates, and the rest of the sample had a graduate degree (n = 66, 18.3%). In addition, 197 (55%) of our participants worked full time, 164 (45%) were not employed, and 1,65% were current students. The monthly income

distribution of our participants ranged from 2,900 TL (minimum wage during the data collection) to 11,000 TL (Table 1).

Table 1. Demographic characteristics of the sample *(N = 361)*

Age (years)	*Mean (SD)*	24	(2.9)
Sex			
Male	*n (%)*	158	(43.8%)
Female	*n (%)*	203	(56.2%)
Monthly income			
2,900 TL and below	*n (%)*	115	(32.9%)
2 901 TL – 4,999 TL	*n (%)*	47	(13.4%)
5,000 TL – 7,000 TL	*n (%)*	64	(18.3.1%)
7,001 TL – 9,000 TL	*n (%)*	41	(11.4%)
9,0001 TL – 11,000 TL	*n (%)*	26	(7.4%)
11,000 TL and above	*n (%)*	58	(16.6%)
Education level			
High School	*n (%)*	79	(21.9%)
University	*n (%)*	216	(59.8%)
Masters	*n (%)*	65	(18.0%)
PhD	*n (%)*	1	(0.3%)
Employment status			
Student	*n (%)*	4	(1.65%)
Employed	*n (%)*	197	(55%)

Not employed	*n (%)*	164	(45%)
Having children			
Yes	*n (%)*	7	(2%)
No	*n (%)*	354	(98%)
Relationship Status			
In a relationship	*n (%)*	345	(95%)
Engaged	*n (%)*	16	(5%)
Relationship Duration	*n (%)*	6+ months	(100%)

2.2 Measures

The survey included a demographics form, followed by measures of ACEs, dyadic coping, relationship satisfaction, and individual coping. Scales used in the current study were originally developed and psychometrically validated in English. We used the validated Turkish translations of all the scales. Higher scores on a given scale indicated a higher assessment of that construct (i.e., a high score in dyadic coping showed more dyadic coping behaviors and strategies).

2.2.1 Independent Variable

2. 2. 2. 1 The Childhood Trauma Questionnaire (CTQ). CTQ is a self-report questionnaire that retrospectively assesses childhood abuse experiences among adolescents and adults. The measure was originally developed by Bernstein (1994) to assess five types of adverse childhood experiences (emotional neglect, emotional abuse, physical neglect, physical abuse, and sexual abuse). The scale has 28 items rated on a 5- point Likert scale (sample item: “I believe that I was emotionally abused.” The CTQ has demonstrated reliability and validity, including

test-retest reliability coefficients ranging from .79 to .86 and internal consistency reliability coefficients ranging from .66 to a median of .92 (Bernstein & Fink, 1998). The Turkish version of the scale was adapted by Tekin and Kırlıoğlu (2020), the Cronbach Alpha of CTQ was .97, and the Cronbach Alpha of the sub-dimensions ranged from .93 to .96 in a community sample of adults. In the current sample, the reliability coefficient was 0.89 of the full scale.

2.2.2 Dependent Variable

2.2.2.2 The Revised Dyadic Adjustment Scale (RDAS). The RDAS is a 14-item self-report questionnaire that assesses overall relationship satisfaction under seven dimensions and three overarching categories. Dimensions include consensus in decision-making, affection, and values; satisfaction in the relationship with respect to stability and conflict regulation; cohesion in activities and discussion. The RDAS has a Cronbach's alpha (reliability) of .90 and has shown good construct validity with the Locke-Wallace Marital Adjustment Test (Fink & Shapiro, 2019). While one item is rated on a 5-point scale, the other 13 are rated on a 6-point scale (Sample item: 'How often do you discuss or have you considered divorce, separation, or terminating your relationship?'). Scores on the RDAS range from 0 to 69, with higher scores indicating greater relationship satisfaction. The Turkish version of the scale was translated by Fışıloğlu & Demir (2000), the Cronbach Alpha was .92, and the split-half reliability coefficient was .86. In our sample, the reliability coefficient was 0.78 of the full scale.

2.2.3 Mediator

2.2.3.1 The Dyadic Doping Inventory (DCI). The scale was developed by Guy Bodenmann (2018) to assess perceived communication and dyadic coping in close relationships when one or both partners are under stress. The DCI measures dyadic coping as a

multidimensional construct and includes 37 items and four subscales: supportive, delegated, negative, and joint (common) dyadic coping (Sample item: “My partner listens to me and gives me the opportunity to communicate what really bothers me.”). Supportive dyadic coping occurs when one partner provides a problem or emotion-focused support that helps the other partner cope. Delegated dyadic coping is when one partner takes over responsibilities to reduce their partner's stress. Negative dyadic coping includes hostile, ambivalent, and superficial actions or words with toxic intentions. Joint (common) dyadic coping occurs when both partners experience stress and symmetrically work together to handle these stressful situations. In addition to perceptions about dyadic coping, the DCI also assesses stress communication and evaluates the quality of self-perceived dyadic coping. A psychometric study of the original scale (Bodenmann et al., 2018) demonstrated adequate construct validity (0.62) and internal reliability (αs ranged from .71 to .92) with French adult samples. Kurt & Akbaş (2019) adapted the DCI to Turkish and found adequate reliability, with the Cronbach alphas ranging from .63 to .87 across different subscales. We used the total score of the DCI in the current study, and its internal consistency was 0.91.

2.2.4 Moderator

2.2.4.1 The Brief Stress Coping Profile (BSCP). We used the BSCP to assess our participants' individual coping strategies. The original version of BSCP consists of 18 items rated on a 4-point scale. It is a self-evaluation scale for evaluating workers' coping profiles. Kageyama, Kobayashi, Kawashima, and Kanamaru developed this scale in 2004. The scale consists of 6 subscales (Sample item: “I try to see positive sides of the matter.”). The subscales are the active solution of the problem, seeking help for the solution, changing mood, changing a

point of view, an emotional expression involving others, avoidance, and suppression. We will be using the overall score of these scales. The Cronbach's alpha coefficients in the original BSCP scale ranged from 0.64 to 0.77 (Kageyama et al., 2004). The Turkish version of the BSCP scale was adapted by Örnek et al. (2017). The Turkish version of the BSCP supported the psychometric properties of the original BSCP. The reliability of the BSCP subscales varied from .66 to .79. In our study, we used the total scale score, and the reliability coefficient was 0.70.

2.2.5 Demographic Variables

2.7.1 Demographic form. Participants completed a series of questions related to their demographic characteristics such as age, gender, SES, duration of the relationship (in months), number of children (if any), education level, occupation status, previous psychiatric diagnosis, and any current psychiatric medication.

2.3 Data Analysis

First, we conducted preliminary data analyses to examine a) the demographic characteristics and mental health status of the sample; and b) the distribution of variables (via frequencies, means, skewness, kurtosis, and standard deviation of the continuous variables) and determine whether they violated the assumption of normality (i.e., skewness and kurtosis scores should be within the range of +1.96 and -1.96). Next, we ran bivariate correlation analyses between study variables (dyadic coping, relationship satisfaction, adverse childhood experiences, and individual coping styles). In addition, we conducted independent samples t-test to investigate gender differences in mentioned variables.

The main analysis utilized a Structural Equation Modelling (SEM) paradigm. We ran a series of structural equation models until the adequate fit was reached at Comparative Fit Index (*CFI*) > .90, Root Mean Squares Error of Approximation (*RMSEA*) < .08, and Standardized Root Mean Square Residual (*SMRM*) < .08 (Hair, Black, Babin & Anderson, 2009). The SEM was preferred since it allows for testing multiple associations between variables while estimating measurement errors (Nunkoo & Ramkissoon, 2012). All variables were observed in the moderated mediation SEM model, following Hayes (2017) guidelines. The exogenous variable was ACEs; endogenous variables were relationship satisfaction and dyadic coping (also a mediator). Moderator variables included gender and individual coping. To examine direct and indirect links between ACEs and relationship satisfaction, we ran a bootstrapping analysis using a 95% confidence interval (CI) and 5000 random samples. We used the full maximum likelihood (FML) estimation to handle missing data in the structural model.

CHAPTER 3:

RESULTS

3.1 Preliminary Analysis

Because the main independent variable was ACEs, we first examined the distribution of psychiatric disorders in the sample to avoid contamination with PTSD and other disorders. Of 361 adults, 15.79% (n = 57) reported having received a psychiatric diagnosis, and 11.63%; (n = 7) reported using a psychiatric medication. The most common diagnoses were anxiety disorder (16.07%; n = 9), depression (12.5%; n = 7), and ADHD (10.71%; n = 6), followed by Insomnia (7.14%; n = 4) and OCD (5.36%; n = 3) in the entire sample. PTSD diagnosis was 1.79% (n = 1). Given the low prevalence of psychiatric diagnosis in the sample, we did not expect an interaction with or contamination of ACEs. Next, we examined whether the distribution of scales confirmed the assumption of normality. As indicated in Table 2, kurtosis and skewness of scales were all in an acceptable range (+1.96 and -1.96). Therefore, it was concluded that the data were distributed normally and could be used for SEM.

Table 2: Descriptives of the scales

Scale	Mean	SD	Range	Kurtosis	Skewness
CTQ	14.11	6.76	7-35	0.34	0.98
RDAS	38.49	6.46	17-50	0.66	-0.80
DCI	105.92	16.19	60-135	-0.61	-0.38
BSCP	54.01	6.22	34-70	0.38	-0.24

Note: CTQ =Childhood Trauma Questionnaire; refers to adverse childhood events; RDAS = Relationship Dyadic Adjustment Scale; refers to relationship satisfaction; DCI = Dyadic Coping Inventory; refers to dyadic coping; BSCP=Brief Stress Coping Profile; refers to individuals coping styles

To understand the prevalence of unique adverse experiences, we analyzed the CTQ scale items and subscales frequencies. Of 361 participants, 54% reported at least one ACE. As shown in Table 3, the most frequent ACE was emotional neglect (5.98%; *n* = 21), followed by physical neglect (5.32%; *n* = 19) and divorce (4.15%; *n* = 15). Abuse experiences ranged from 2.37% (emotional abuse; *n* = 8) to sexual abuse (2.96%; *n* = 10). Most adverse experiences occurred before age 12 in the current sample (Table 3).

Table 3: The descriptive of adverse childhood experiences

Corresponding Subscale	Item number	Event	*n* *f (%)*	Age of occurrence *f (%)*
Physical Neglect (with reverse coded items; *n* = 19, 5.32%)	24*	There was someone to take me to the doctor if I needed it.	324 89.79%	0-11: 57.14 % 12-18: 23.32 % 0-11,12-18: 19.53 %
	2*	I knew there was someone to take care of me and protect me.	328 90.98%	0-11: 56.97 % 12-18: 23.64 % 0-11,12-18: 19.39 %
	4	My parents were too drunk or high to take care of the family.	9 2.62%	0-11: 72.0 % 12-18: 20.0 % 0-11,12-18: 8.0 %
	1	I didn't have enough to eat.	8 2.42%	0-11: 88.88 % 12-18: 5.55 % 0-11,12-18: 5.55 %
	6	I had to wear dirty clothes.	8 2.34%	0-11: 60.0 % 12-18: 40.0 %
Emotional Neglect (all reverse coded; *n* = 21, 5.98%)	17*	People in my family felt close to each other.	344 95.40%	0-11: 55.18 % 0-11,12-18: 23.33 % 12-18: 21.48 %

	12*	People in my family looked out for each other.	345 95.83%	0-11: 55.52% 12-18: 23.13 % 0-11,12-18: 21.35 %
	7*	I felt loved.	334 92.66%	0-11: 55.69 % 12-18: 24.05 % 0-11,12-18: 20.25 %
	5*	Someone in my family helped me feel important or special.	336 93.10%	0-11: 58.25 % 12-18: 22.22 % 0-11,12-18: 19.53 %
	26*	My family was a source of strength and support	336 93.12%	0-11: 56.96 % 12-18: 22.33 % 0-11,12-18: 20.71 %
Physical Abuse (*n* = 9, 2.52%)	14	I believe that I was physically abused.	9 2.64%	0-11: 51.85 % 12-18: 25.92 % 0-11,12-18: 22.22 %
	15	Beaten so badly that a teacher/ neighbor/doctor noticed it.	9 2.62%	0-11: 66.67 % 12-18: 16.67 % 0-11,12-18: 16.67 %
	11	I was punished with a belt/board/cord/other hard objects	9 2.57%	0-11: 57.89 % 0-11,12-18: 26.31 % 12-18: 15.79 %
	9	Got hit so hard that I had to see a doctor or go to the hospital	8 2.45%	0-11: 70.0 % 12-18: 23.33 % 0-11,12-18: 6.67 %
	10	My family hit me so hard that it left me with bruises and marks.	8 2.30%	0-11: 65.52 % 0-11,12-18: 17.24 % 12-18: 17.24 %
Emotional Abuse (*n* = 8, 2.37%)	8	I thought that my parents wished I had never been born.	8 2.39%	0-11: 68.25 % 12-18: 17.46 % 0-11,12-18: 14.28 %
	13	People in my family said hurtful or insulting things to me.	7 1.95%	0-11: 67.68 % 12-18: 19.19 % 0-11,12-18: 13.13 %

	3	People in my family called me "stupid," lazy," or "ugly."	7 1.93%	0-11: 65.55 % 12-18: 22.22 % 0-11,12-18: 12.22 %
	16	I felt that someone in my family hated me.	10 2.79%	0-11: 67.5 % 12-18: 25.0 % 0-11,12-18: 7.5 %
	23	I believe that I was emotionally abused.	10 2.79%	0-11: 50.45 % 12-18: 35.13 % 0-11,12-18: 14.41 %
Sexual Abuse (*n* = 10, 2.96%)	19	Someone tried to touch me in a sexual way/made me touch them.	11 3.23%	0-11: 52.94 % 12-18: 35.29 % 0-11,12-18: 11.76 %
	22	Someone molested me.	11 3.08%	0-11: 52.17 % 12-18: 32.61 % 0-11,12-18: 15.22 %
	25	I believe that I was sexually abused.	10 3.01%	0-11: 54.54 % 12-18: 34.09 % 0-11,12-18: 11.36 %
	21	Someone tried to make me do/watch sexual things.	9 2.77%	0-11: 53.66 % 12-18: 31.71 % 0-11,12-18: 14.63 %
	20	Someone threatened me unless I did something sexual.	9 2.70%	0-11: 52.63 % 12-18: 36.84 % 0-11,12-18: 10.53 %
Divorce (*n* = 14, 4.15%)	18	My parents divorced/separated when I was little.	14 4.15%	0-11: 56.52 % 12-18: 33.33 % 0-11,12-18: 10.14 %

Note: * Percentages on the fourth column refer to the raw data percentages before the reverse codes. Items 2, 5, 7, 12, 17, 24, and 26 are reverse coded prior to the analysis, and higher percentages refer to more adverse life experiences in the main analysis. Items 19 to 22 and 25 = sexual abuse; items 3, 8, 13, 16, and 23 emotional abuse; items 9 to 11 and 14, 15 = physical abuse; items 1, 2, 4, 6, and 24 = physical neglect; items 5, 7, 12, 17, and 26= emotional neglect.

Pearson correlation coefficients were computed to assess the bivariate associations between the scales (Table 4). Correlations ranged from $r = -.36$ to $r = .56$, were low to moderate in magnitude, and were all in the expected direction. Specifically, ACE was negatively correlated with relationship satisfaction ($r = -.36, p < .001$), dyadic coping ($r = -.33, p < .001$), and individual coping ($r = -.30, p < .001$). Dyadic coping, individual coping, and relationship were all positively correlated and statistically significant at $p < .001$ (Table 4).

Table 4. *Pearson correlations between scales*

	1	2	3	4
1. CTQ	1			
2. RDAS	-.36***	1		
3. DCI	-.33***	.56***	1	
4. BSCP	-.30***	.25***	.39***	1

Note: CTQ =Childhood Trauma Questionnaire; refers to adverse childhood events; RDAS = Relationship Dyadic Adjustment Scale; refers to relationship satisfaction; DCI = Dyadic Coping Inventory; refers to dyadic coping; BSCP=Brief Stress Coping Profile; refers to individuals coping styles
*** $p < .001$

An independent samples t-test analysis revealed that women (*Mean* = 39.60, *SD* = 6.05) reported significantly higher relationship satisfaction than men (*Mean* = 37.07, *SD* = 6.71; t (359) = 3.75, $p < 0.001$). In addition, there were gender differences in dyadic coping [t (359) = 2.02, $p = 0.04$], with women reporting higher dyadic coping (Table 5). However, no differences were found in ACEs [t (359) = -1.41, $p = .61$] and individual coping scores [t (359) = 0.39, $p = .68$].

Table 5. *Independent samples t-test for comparing gender*

Scales	Gender	*Mean*	*SD*	*df*	*t*	*p*-value
CTQ	Female	13.67	6.12	359	-1.41	0.61
	Male	14.67	7.48			
DCI	Female	107.43	15.28	359	2.02	0.04
	Male	103.98	17.14			
BSCP	Female	54.12	6.06	359	0.39	0.68
	Male	53.86	6.44			
RDAS	Female	39.60	6.05	359	3.75	< 0.001
	Male	37.07	6.71			

Note: CTQ =Childhood Trauma Questionnaire; refers to adverse childhood events; RDAS = Relationship Dyadic Adjustment Scale; refers to relationship satisfaction; DCI = Dyadic Coping Inventory; refers to dyadic coping; BSCP=Brief Stress Coping Profile; refers to individuals coping styles.

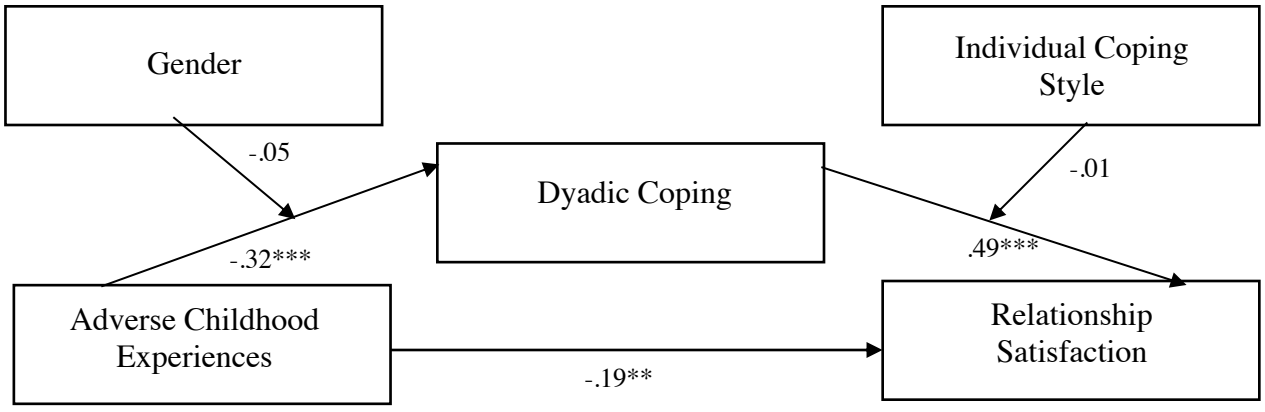
Additionally, an independent samples t-test was computed to compare the means of ACEs by the age of occurrence (experiencing ACE at age 0 to 11 vs. 12 to 18 years old). There were no statistically significant findings between the age of occurrence groups in their ACEs ($p > .05$). Given those preliminary findings, we added gender and individual coping as moderating variables in the model, but the psychiatric diagnosis was not included. In addition, all bivariate correlations were in an acceptable range, indicating no sign of multicollinearity. Therefore, the initial hypothesized model was retained and tested in the main analysis.

3.2 Main Analysis: Moderated Mediation Analysis via Structural Equation Modeling

The full structural model showed that ACEs were negatively associated with relationship satisfaction (β = -.19, $p < .001$) and dyadic coping (β = -.32, $p < .001$). On the other hand, dyadic coping was positively associated with relationship satisfaction (β = .49, $p = .01$). Regarding the indirect effects of ACE and relationship satisfaction, the pathway was significant at $p < .001$. Those findings illustrate that dyadic coping partially mediated the relationship between ACEs and relationship satisfaction. The full model explained 34% of the variance in relationship satisfaction. The fit indices of the moderated mediation model to the data were adequate [X^2 (11) = 30.31, $p < .001$; *CFI* = .93; *RMSEA* = .07; *SMRM* = .07] (Table 6; Figure 2).

All moderating variables were nonsignificant in the model. Specifically, gender (0 = female, 1 = male) did not moderate the relationship between ACEs and dyadic coping (β = -.05, $p = .40$). Similarly, the moderating effect of individual coping style on the relationship between dyadic coping and relationship satisfaction was not significant (β = -.01, p = .74).

Figure 2. *Moderated Mediation SEM Model*



*** p < 0.001
** p < 0.01
Model fit indices: $x^2(11) = 30.31$, $p < .001$; CFI = .93; RMSEA = .07; SMRM = .07

Table 6. *Standardized coefficients for the full model*

Variables	Standardized coefficient	P value
Adverse Childhood Experiences by;		
Dyadic Coping	-.32	$p < .001$
Relationship Satisfaction	-.19	$p < .001$
Dyadic Coping by;		
Relationship Satisfaction	.49	.01
Gender on;		
ACEs to Dyadic Coping	-.05	.40
Individual Coping Style on;		
Dyadic Coping to Relationship Satisfaction	-.01	.74

CHAPTER 4

DISCUSSION

The present study investigated the relationship between ACEs and relationship satisfaction through the lens of dyadic coping in a sample of partnered Turkish emerging adults. In sum, our study has shown ACEs' direct and negative relationship with dyadic coping and relationship satisfaction. Additionally, an increase in dyadic coping was associated with higher relationship satisfaction. Participants' gender and individual coping styles did not have moderating roles in this process.

Overall, our study demonstrated the negative links between early childhood trauma and romantic relationships. Our study was congruent with the WHO findings indicating 49.7% of university students in Turkey were exposed to at least one ACE in their lifetime (Velipaşaoğlu et al., 2017). Likewise, in our study, 54% of our participants reported ACE, which indicates an accurate representation of the population and the alarming commonality of ACEs. It appears that ACEs can limit an individual's access to healthy social ties and support (Umberson et al., 2014). Consequently, individuals with such childhood experiences may struggle in their relationships in adulthood (Peterson et al., 2021). As congruent with the literature (e.g., Ross et al., 2020), our study added evidence of a negative relationship between ACEs and relationship satisfaction. Individuals who have experienced ACEs may struggle with building fulfilling relationships and experience distress in their romantic lives (Wheeler et al., 2019). The more ACEs reported, the less satisfaction our participants felt in their relationships, as chronic stress most likely spilled over to their relationships.

Additionally, the literature suggests that adults with a history of ACEs experience difficulties trusting their partners and practicing empathic communication, which are essential to accomplishing dyadic coping (Liverpool Clinical Commission Group, 2021). Congruently, our hypothesis suggesting the negative link between ACEs and dyadic coping skills was supported in the current study. Experiencing such detrimental social encounters from an early age may have altered the development of a sense of unity, security, and trust in others. When individuals have ACEs, they may be deprived of the opportunity to have the reassurance that they can provide and receive support from others to feel secure while facing stress.

The link between ACEs and romantic relationships points to a developmental process. When children experience ACEs, their basic needs for security and trust are either not met, compromised, or even violated. According to Whishman (2006), intimacy disturbances and experiencing uncertainty about interpersonal closeness become an issue in relationships throughout one's adult life in the form of anger and suspicion. This could result in difficulties in seeking help from others and fully embracing the partner's efforts to help. Likewise, it can alter skills of articulating and communicating needs to others and recognizing others' needs (Nelson & Selisha, 2015). Maintaining positive, reciprocal social connections involves reading social cues, articulating the self, and finding others who will not exploit and abuse. Unfortunately, the ability to create and maintain relationships is affected by past abuse. Adult survivors are often in relationships with general dissatisfaction (Fleming et al., 1999). Such dissatisfaction can be related to the consequences of early experiences of childhood abuse. Adults with ACEs may negatively perceive the self as damaged, unworthy, or unlovable (Kapeleris & Paivio, 2011; Paivio & Pascual-Leone, 2010; Whishman, 2006). In one study, participants disclosed that it was

hard to trust a partner and be themselves because they had once trusted someone close to them who had betrayed them during childhood (Sigurdardottir et al., 2012).

Another note is that adult ACE survivors tend to be either avoidant or intrusive in their relationships. Avoidance may occur via low interdependency, low self-disclosure, and low warmth in the romantic relationship. On the other hand, being intrusive is associated with excessive self-disclosure and demand for extreme closeness. Both approaches are dysfunctional and likely to result in relationship dissatisfaction or resolution (Kendall-Tackett, K., 2002).

Relevantly equivalent to our findings, literature has suggested that having high levels of dyadic coping results in greater relationship satisfaction (Neff & Broady, 2011). In our final model, the most robust relationship was between dyadic coping and relationship satisfaction (compared to other pathways). That is, adaptive communication skills, supportive interaction, and stress management were strongly linked to relationship satisfaction. Dyadic coping, by nature, is a shared process and requires both partners' participation and joint effort (Bodenmann, 2005). However, in the current study, participants reported dyadic coping at the couple subsystem (that is, perceptions of their partner's and own supportive behaviors). Thus, participants may have generalized their personal supportive and responsive behaviors to the romantic relationship. Such generalization could be linked to relationship satisfaction such that by generalization their responsiveness, caring partners may feel more security and trust in the relationship (Collins & Feeney, 2000). Therefore, by the nature of our assessment in the current study, a participant's report of dyadic coping and relationship satisfaction may overlap because it reflects the participants' overall perception of the romantic relationship.

As hypothesized, we found evidence that dyadic coping partially mediated the relationship between ACEs and relationship satisfaction. These findings indicate that dyadic

coping may serve as a buffer in reducing the negative association between ACEs and relationship satisfaction. It appears that dyadic coping may be vital in the relationship, even if a partner has early childhood traumas. Turkish emerging adults', benefit from the buffering and supportive elements of dyadic coping while facing a chronic stressor like ACEs to improve their relationship satisfaction.

Contrary to our hypothesis, there was no moderating association of gender on the relationship between ACEs and dyadic coping. This finding was unexpected because an accumulation of research suggests that ACEs are more common among women while women are also more likely to socialize to develop interpersonal skills for dyadic coping (Felitti et al., 1998; Neff & Broady, 2011). Even though there is empirical evidence that women are more perceptive of dyadic coping in romantic relationships, the negative associations between ACEs and dyadic coping may still be consistent for both men and women. Another factor in this indifference could be related to how ACEs were operationalized in the current study. We assessed various ACEs varying from sexual abuse to parental divorce and used an overall score for each participant. Therefore, the overall scores might have overlooked possible differences between men and women.

Furthermore, we hypothesized that individuals with adaptive coping strategies would form stronger dyadic coping within their relationships and greater relationship satisfaction. This hypothesis was not supported; the individual's coping styles did not make a difference in the positive relationship between dyadic coping and relationship satisfaction. One explanation of this finding relates the dyadic coping being a relational construct that is above and beyond each partner's features (Falconier & Kuhn, 2019). Partners are influenced by each other's commitments, behaviors, communication techniques, emotion regulation techniques, reactions,

and personal histories and assets (Falconier & Kuhn, 2019). Therefore, it is likely that individual coping styles may not contribute to that dyadic construct, as expected.

Our study suggested that dyadic coping alleviates childhood trauma's harmful effects while promoting relationship satisfaction. Accordingly, another explanation for the insignificant moderation of individual coping styles can be that the role of dyadic coping was so vital that it surpassed the potential association between individual coping and relationship satisfaction.

4.1 Limitations and Strengths

One major limitation of the study was convenience sampling. The current sample does not represent the entire Turkish emerging adult population, as our sample consisted of highly educated individuals. Also, our data relies on individuals' self-reports of their behavior and those of their partners. A more valid assessment of dyadic coping would include both partners' reports on their relationship.

Another limitation was that ACEs were asked retrospectively, which creates a susceptibility to bias in memory recollection and retrieval (i.e., false memories, childhood amnesia). A prospective design with a long-term follow-up would control such contamination. Additionally, the study was cross-sectional in its design. Therefore, the direction of our hypotheses can be in reverse. It is equally likely that participants have experienced ACEs and found themselves in unsatisfactory relationships, or they tend to recall adverse life events more often, given their current unhappy states. Similarly, we can't infer whether participants were more open to noticing dyadic coping strategies because they were already satisfied with the relationship. Or they experienced more dyadic coping processes and felt supported, therefore, were more satisfied in the relationship. Additionally, the study sample was not large enough to

test alternative hypotheses or individually examine the role of abuse type. For example, there was not enough power to explore the direct and indirect effects of physical, emotional, sexual abuse and neglect separately for relationship satisfaction. Of note, the current study focuses on youth in committed romantic relationships. Studies with married emerging adults testing the same model could yield different results given that individuals in long-term relationships are more invested in the relationship (Lantagne & Furman, 2017) and are more likely to perform maintenance behaviors (Chonody & Gabb, 2018) but report lower relationship satisfaction (Molero et al., 2016).

Lastly, the current study did not assess participants' past or current experiences of intimate partner violence. Research has shown that individuals with histories of ACEs are at risk of experiencing abuse in romantic relationships (Hartney, 2022). Therefore, it is likely that some participants who report low positive dyadic coping may be in dysfunctional and abusive relationships.

Despite these limitations, the current study has significant contributions to the literature. Our study expands the research on romantic relationships of Turkish emerging adults. It is known that intimacy can be challenging in this age group (Uçar & Demir, 2022). Therefore, shedding light on the importance of dyadic coping for this age group might contribute to understanding related processes such as maintenance behaviors, satisfaction, and commitment. Additionally, our assessment of ACEs relied on the CTQ measure, a comprehensive tool that captures various types of abuse, compared to other measures such as Violence Exposure Scale for Children-Revised (VEX-R) (Liebschutz et al., 2018). In light of our assessments, the current study might raise awareness of the commonality of ACEs and how they are associated with negative consequences (Ross et al., 2020). In our study, 54% of our participants reported

childhood adversity, which was alarmingly common. Also, this was directly and negatively related to their experienced satisfaction from their relationships. These findings could hopefully be beneficial for prevention work.

Our study also allowed an investigation into how related concepts of gender and individual coping play a role in the inspected relationship. Findings suggested that, regardless of gender, ACEs may detrimentally affect individuals' romantic relationships in adulthood. This finding contributes to the literature by showing how indiscriminatingly damaging ACEs can be.

4.2 Implications for Future Research

Future research could investigate the possible cultural elements that contribute to our findings, especially in rural areas of Turkey with samples of evidently conservative and collectivist backgrounds. Studying how emerging adults form a sense of unity and intimacy with a romantic partner, how conservatism creates a strain in nonmarital relationships, and if dyadic coping gets a chance to emerge and buffer such adversities could be future research topics.

Additionally, our study could be replicated with older and married adults because the link between ACEs and relationship processes may differ when partners are more invested in the relationship. Also, a study with a larger sample size can investigate how each subcategory of CTQ is specifically associated with both dyadic coping and relationship style. This way, gender differences can be analyzed within each subcategory which might show different results. Future studies with a longitudinal design would capture how dyadic coping and relationship satisfaction change over time for individuals with ACEs. Furthermore, our study findings may inspire future research to collect dyadic responses from couples for a better understanding of a binary interplay.

Moreover, how dyadic coping comes into play in the face of different stressors and how dyadic coping adjusts and changes through life are questions that can be asked in the future. Also, negative (such as hostile or ambivalent dyadic coping styles) and positive types of dyadic coping, can be compared to see how each type contributes to the current model's dynamics. Negative dyadic coping styles can be investigated or controlled for possible abuse in current relationships of individuals with histories of ACEs. Finally, there is more to be understood about the makings of dyadic coping, its subcategories, and how it can be strengthened within relationships.

4.4 Suggestions for Clinical Practice

Our study has shown the harmful links between ACEs and social functioning in adulthood. These findings illustrate that in therapy, identifying and addressing ACEs are fundamental (Bethell et al., 2017). Addressing underlying trauma with techniques such as trauma-focused cognitive behavioral therapy (Mannarino et al., 2012), emotionally focused couples therapy (EFT; Greenberg, Rice, & Elliott, 1993; Johnson, 2004), or schema therapy (Young, 1990) may annihilate the adverse effects of trauma. EFT can help clients make positive meaning that increases resilience by reflecting on and integrating traumatic experiences (Johnson, 2019). Schema therapy can also be helpful in restructuring early-developed maladaptive schemas related to traumatic experiences (Dobson et al., 2021). In addition, the self and attachment difficulties associated with chronic childhood abuse and other forms of pervasive trauma must be understood and addressed in the context of the therapeutic relationship (Pearlman & Courtois, 2005). Also, parents can be informed about ACEs, and ways of regulating emotions, reactions, and stress can be provided to communities for prevention.

Additionally, dyadic coping is essential for relationship satisfaction (Bodenmann et al., 2019). It can buffer the destructive effects of childhood adversities while improving relationship satisfaction. These findings highlight the importance of corrective experiences and social support in healing and eliminating the negative impacts of past adversities (Blair et al., 2019). It hopes to increase the quality of life by adapting dyadic coping skills, especially within romantic relationships. These findings have several implications for couples' therapy. First, couples might benefit from increased awareness about the association between dyadic coping and relationship satisfaction, as well as the buffering association of dyadic coping in the face of stress (Falconier et al., 2015). Therapy could incorporate conversations about how couples can improve their dyadic coping skills. Accordingly, couple therapy could use psychoeducation and skills training (Bodenmann & Randall, 2012) to increase the dyadic coping skills of partners. Therapists can work towards communication training, emotion regulation, providing emotional and problem-focused support, taking responsibility for the relationship and the other person, showing conjoint effort, and many other elements that make up dyadic doping (Kayser et al., 2007). These therapy efforts can eliminate stress problems while increasing relationship satisfaction for both partners.

4.4 Conclusion

The current study points out the importance of solidarity between partners in romantic relationships of emerging adults with a history of adverse childhood experiences. Therefore, it seems essential for couples to develop strategies to cope with stress together, alleviate the traces of adverse events experienced in the past, and increase relationship satisfaction.

REFERENCES

Acquati, C., & Kayser, K. (2019). Dyadic coping across the lifespan: A comparison between younger and middle-aged couples with breast cancer. *Frontiers in Psychology*, *10*. https://doi.org/10.3389/fpsyg.2019.00404

Berkowitz, S. J. (2012). Childhood trauma and adverse experience and Forensic Child Psychiatry: The Penn center for youth and family trauma response and recovery. *The Journal of Psychiatry & Law*, *40*(1), 5–22. https://doi.org/10.1177/009318531204000102

Bethell, C. D., Carle, A., Hudziak, J., Gombojav, N., Powers, K., Wade, R., & Braveman, P. (2017). Methods to assess adverse childhood experiences of children and families: Toward approaches to promote child well-being in policy and Practice. *Academic Pediatrics*, *17*(7). https://doi.org/10.1016/j.acap.2017.04.161

Blair, A., Marryat, L., & Frank, J. (2019). How community resources mitigate the association between household poverty and the incidence of adverse childhood experiences. *International Journal of Public Health*, *64*(7), 1059–1068. https://doi.org/10.1007/s00038-019-01258-5

Boullier, M., & Blair, M. (2018). Adverse childhood experiences. *Pediatrics and Child Health (United Kingdom)*, *28*(3), 132–137. https://doi.org/10.1016/j.paed.2017.12.008

Bodenmann, G., Falconier, M. K., & Randall, A. K. (2019). *Dyadic Coping: A Collection of Recent Studies*. https://doi.org/10.3389/978-2-88963-031-8

Bodenmann, G. (2008). Dyadic coping and the significance of this concept for prevention and therapy. *Zeitschrift Für Gesundheitspsychologie*, *16*(3), 108–111. https://doi.org/10.1026/0943-8149.16.3.108

Bodenmann, G. (1997). Dyadic coping - a systemic-transactional view of stress and coping among couples: Theory and empirical findings. *European Review of Applied Psychology, 47*, 137–140.

Botha, A., Van den Berg, H. S., & Venter, C. A. V. (2009). The relationship between family-of-origin and marital satisfaction. *Health SA Gesondheid*, *14*(1). https://doi.org/10.4102/hsag.v14i1.441

Brock, R. L., & Lawrence, E. (2008). A longitudinal investigation of stress spillover in marriage: Does spousal support adequacy buffer the effects? *Journal of Family Psychology*, *22*(1), 11–20. https://doi.org/10.1037/0893-3200.22.1.11

Celsi, L., Paleari, F. G., & Fincham, F. D. (2021). Adverse childhood experiences and early maladaptive schemas as predictors of cyber dating abuse: An actor-partner Interdependence Mediation Model Approach. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.623646

Chonody, J. M., & Gabb, J. (2018). Understanding the role of relationship maintenance in enduring couple partnerships in later adulthood. *Marriage & Family Review*, *55*(3), 216–238. https://doi.org/10.1080/01494929.2018.1458010

Clinical Commission Group, L. (2021, February 11). *What are adverse childhood experiences aces?* Liverpool CAMHS. https://www.liverpoolcamhs.com/aces/what-are-adverse-childhood-experiences/

Coulter, S. (2011). Systemic psychotherapy as an intervention for post-traumatic stress responses: An introduction, theoretical rationale, and overview of developments in an emerging field of interest. *Journal of Family Therapy*. https://doi.org/10.1111/j.1467-6427.2011.00570.x

Dobson, K. S., A., D. D. J., Martin, R., & Young, J. (2021). In *Handbook of cognitive-behavioral therapies* (pp. 317–340). essay, The Guilford Press.

Donato, S., Iafrate, R., Bradbury, T., & Scanini, E. (2011). Acquiring dyadic coping: Parents and partners as Models. *Personal Relationships*, *19*(2), 386–400. https://doi.org/10.1111/j.1475-6811.2011.01368.x

Donato, S., Parise, M., Iafrate, R., Bertoni, A., Finkenauer, C., & Bodenmann, G. (2014). Dyadic coping responses and partners' perceptions for couple satisfaction. *Journal of Social and Personal Relationships*, *32*(5), 580–600. https://doi.org/10.1177/0265407514541071

Fagundes, C. P., Glaser, R., & Kiecolt-Glaser, J. K. (2013). Stressful early life experiences and immune dysregulation across the lifespan. *Brain, behavior, and immunity*, *27*(1), 8–12. https://doi.org/10.1016/j.bbi.2012.06.014

Falconier, M. K., & Kuhn, R. (2019). Dyadic Coping in Couples: A Conceptual Integration and a Review of the Empirical Literature. *Frontiers in Psychology*, *10*. https://doi.org/10.3389/fpsyg.2019.00571

Falconier, M. K., Jackson, J. B., Hilpert, P., & Bodenmann, G. (2015). Dyadic coping and relationship satisfaction: A meta-analysis. *Clinical Psychology Review*, *42*, 28–46. https://doi.org/10.1016/j.cpr.2015.07.002

Fritz, M. S., & MacKinnon, D. P. (2007). Required Sample Size to Detect the Mediated Effect. Psychological Science, 18(3), 233–239. https://doi.org/10.1111/j.1467-9280.2007.01882

Fışıloğlu, H., & Demir, A. (2000). Applicability of the Dyadic Adjustment Scale for Measurement of Marital Quality with Turkish Couples. *European Journal of Psychological Assessment*, *16*(3), 214–218. https://doi.org/10.1027//1015-5759.16.3.214

Genç, E., Su, Y., & Turhan, Z. (2021). The mediating role of dyadic coping on the effects of covid-19 and relationship satisfaction among Turkish couples. *The American Journal of Family Therapy*, 1–19. https://doi.org/10.1080/01926187.2021.1984338

Giunta, C. T., & Compas, B. E. (1993). Coping in marital dyads: Patterns and associations with psychological symptoms. *Journal of Marriage and the Family, 55*(4), 1011–1017. https://doi.org/10.2307/352780

Gündüz, A., Yaşar, A., Gündoğmuş, İ., & Konuk, E. (2018). Adverse childhood events Turkish form: Validity and reliability study. *Anatolian Journal of Psychiatry*, 68. https://doi.org/10.5455/apd.294158

Haahr-Pedersen, I., Perera, C., Hyland, P., Vallières, F., Murphy, D., Hansen, M., Spitz, P., Hansen, P., & Cloitre, M. (2020). Females have more complex patterns of childhood adversity: Implications for mental, social, and emotional outcomes in adulthood. *European Journal of Psychotraumatology*, *11*(1), 1708618. https://doi.org/10.1080/20008198.2019.1708618

Hartney, E. (2022). Why Sexually Abused Children Grow Up to Have Abusive Relationships. *Verywell Mind*

Herzberg, P. Y. (2013). Coping in relationships: The interplay between individual and dyadic coping and their effects on relationship satisfaction. *Anxiety, Stress & Coping*, *26*(2), 136–153. https://doi.org/10.1080/10615806.2012.655726

Hilpert, P., Randall, A. K., Sorokowski, P., Atkins, D. C., Sorokowska, A., Ahmadi, K., Alghraibeh, A. M., Aryeetey, R., Bertoni, A., Bettache, K., Błażejewska, M., Bodenmann, G., Borders, J., Bortolini, T. S., Butovskaya, M., Castro, F. N., Cetinkaya, H., Cunha, D., David, O. A., … Yoo, G. (2016). The Associations of Dyadic Coping and Relationship Satisfaction Vary between and within Nations: A 35-Nation Study. *Frontiers in Psychology*, *7*, 1106. https://doi.org/10.3389/fpsyg.2016.01106

Johnson, S. M. (2019). An attachment view of Love: The EFT approach. *The Practice of Emotionally Focused Couple Therapy*, 26–39. https://doi.org/10.4324/9781351168366-3

Jones, C. M., Merrick, M. T., & Houry, D. E. (2020). Identifying and preventing adverse childhood experiences. *JAMA*, *323*(1), 25. https://doi.org/10.1001/jama.2019.18499

Jones, M. S., Pierce, H., & Shafer, K. (2022). Gender differences in early adverse childhood experiences and youth psychological distress. *Journal of Criminal Justice*, 101925. https://doi.org/10.1016/j.jcrimjus.2022.101925

Kageyama, T., Kobayashi, T., Kawashima, M., & Kanamaru, Y. (2004). [Development of the Brief Scales for Coping Profile (BSCP) for workers: basic information about its reliability and validity]. *Sangyo eiseigaku zasshi = Journal of occupational health*, *46*(4), 103–114. https://doi.org/10.1539/sangyoeisei.46.103

Kalmakis, K. A., & Chandler, G. E. (2015). Health consequences of adverse childhood experiences: A systematic review. *Journal of the American Association of Nurse Practitioners*, *27*(8), 457–465. https://doi.org/10.1002/2327-6924.12215

Karatekin, C., & Ahluwalia, R. (2016). Effects of adverse childhood experiences, stress, and social support on the health of college students. *Journal of Interpersonal Violence*, *35*(1-2), 150–172. https://doi.org/10.1177/0886260516681880

Karatekin, C. (2018). Adverse childhood experiences (aces) and help-seeking for health-related interventions in young adults. *The Journal of Psychology*, *153*(1), 6–22. https://doi.org/10.1080/00223980.2018.1476316

Kendall-Tackett, K. (2002). The health effects of childhood abuse: Four pathways by which abuse can influence health. *Child Abuse & Neglect*, *26*(6-7), 715–729. https://doi.org/10.1016/s0145-2134(02)00343-5

Kurt, İ. E., & Akbaş, T. (2019). Stresle Çift Olarak Baş Etme Envanteri'nin Türkçe'ye Uyarlanması. *OPUS Uluslararası Toplum Araştırmaları Dergisi*, 1–1. https://doi.org/10.26466/opus.547217

Kırlıoğlu, M. & Tekin, H. H. (2020). Adaptation of Childhood Trauma Questionnaire (CTQ) To Turkish Culture: Validity and Reliability. Gümüşhane Üniversitesi Sosyal Bilimler Dergisi, 11 (2) , 325-335

Lantagne, A., & Furman, W. (2017). Romantic relationship development: The interplay between age and relationship length. *Developmental Psychology*, *53*(9), 1738–1749. https://doi.org/10.1037/dev0000363

Ledermann, T., Bodenmann, G., Gagliardi, S., Charvoz, L., Verardi, S., Rossier, J., Bertoni, A., & Iafrate, R. (2010). Psychometrics of the Dyadic Coping Inventory in Three Language Groups. *Swiss Journal of Psychology - SWISS J PSYCHOLOGY*, *69*, 201–212. https://doi.org/10.1024/1421-0185/a000024

Levesque, C., Lafontaine, M.-F., Caron, A., Flesch, J. L., & Bjornson, S. (2014). Dyadic empathy, dyadic coping, and relationship satisfaction: A Dyadic model. *Europe's journal of Psychology*, *10*(1), 118–134. https://doi.org/10.5964/ejop.v10i1.697

Liebschutz, J. M., Buchanan-Howland, K., Chen, C. A., Frank, D. A., Richardson, M. A., Heeren, T. C., Cabral, H. J., & Rose-Jacobs, R. (2018). Childhood trauma questionnaire (CTQ) correlations with prospective violence assessment in a longitudinal cohort. *Psychological Assessment*, *30*(6), 841–845. https://doi.org/10.1037/pas0000549

Lyons, K. S., Vellone, E., Lee, C. S., Cocchieri, A., Bidwell, J. T., D'Agostino, F., Hiatt, S. O., Alvaro, R., Vela, R. J., Riegel, B., Molloy, G. J., Perkins-Porras, L., Strike, P. C., Steptoe, A., Frasure-Smith, N., Lespérance, F., Gravel, G., Masson, A., Juneau, M., … Clark, M. S. (2012). Revised Dyadic Adjustment Scale (RDAS). *Journal of Cardiovascular Nursing*, *27*(1), 43–54.

Mannarino, A. P., Cohen, J. A., Deblinger, E., Runyon, M. K., & Steer, R. A. (2012). Trauma-focused cognitive-behavioral therapy for children. *Child Maltreatment*, *17*(3), 231–241. https://doi.org/10.1177/1077559512451787

Mathews, B., & Collin-Vézina, D. (2019). Child Sexual Abuse: Toward a Conceptual Model and Definition. *Trauma, Violence & Abuse*, *20*(2), 131–148. https://doi.org/10.1177/1524838017738726

Melville, A. (2017). Adverse childhood experiences from ages 0–2 and Young Adult Health: Implications for preventive screening and early intervention. *Journal of Child & Adolescent Trauma*, *10*(3), 207–215. https://doi.org/10.1007/s40653-017-0161-0

Merz, Meuwly, N., Randall, & Bodenmann, G. (2014). Engaging in dyadic coping: Buffering the impact of everyday stress on prospective relationship satisfaction. *Family Science*, *5*. https://doi.org/10.1080/19424620.2014.927385

Molero, F., Shaver, P., Fernandez, I., Alonso-Arbiol, I., & Recio, P. (2016). Long-term partners' relationship satisfaction and their perceptions of each other's attachment insecurities. *Personal Relationships*, *23*(1), 159–171. https://doi.org/10.1111/pere.12117

Mosley-Johnson, E., Garacci, E., Wagner, N., Mendez, C., Williams, J. S., & Egede, L. E. (2018). Assessing the relationship between adverse childhood experiences and life satisfaction, psychological well-being, and social well-being: United States Longitudinal cohort 1995–2014. *Quality of Life Research*, *28*(4), 907–914. https://doi.org/10.1007/s11136-018-2054-6

Narayan, A. J., Lieberman, A. F., & Masten, A. S. (2021). Intergenerational transmission and prevention of adverse childhood experiences (aces). *Clinical Psychology Review*, *85*, 101997. https://doi.org/10.1016/j.cpr.2021.101997

Nelson, C. A., Bhutta, Z. A., Burke Harris, N., Danese, A., & Samara, M. (2020). Adversity in childhood is linked to mental and physical health throughout life. *BMJ*, *371*, m3048. https://doi.org/10.1136/bmj.m3048

Ornek, O. K. (2017). Reliability and validity of the Turkish version of the BRIEF scales for the COPING profile in textile workers. *COJ Nursing & Healthcare*, *1*(2). https://doi.org/10.31031/cojnh.2017.01.000508

Papp, L. M., & Witt, N. L. (2010). Romantic partners' individual coping strategies and dyadic coping: Implications for relationship functioning. *Journal of Family Psychology*, *24*(5), 551–559. https://doi.org/10.1037/a0020836

Park, Y.-M., Shekhtman, T., & Kelsoe, J. R. (2020). Effect of the Type and Number of Adverse Childhood Experiences and the Timing of Adverse Experiences on Clinical Outcomes in Individuals with Bipolar Disorder. *Brain Sciences*, *10*(5). https://doi.org/10.3390/brainsci10050254

Pearlman, L. A., & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress*, *18*(5), 449–459. https://doi.org/10.1002/jts.20052

Peeters, N., van Passel, B., & Krans, J. (2021). The effectiveness of schema therapy for patients with anxiety disorders, OCD, or PTSD: A systematic review and Research Agenda. *British Journal of Clinical Psychology*, *61*(3), 579–597. https://doi.org/10.1111/bjc.12324

Peterson, C., O'Neal, C. W., & Futris, T. G. (2021). Military couples' childhood experiences and romantic relationship satisfaction: The role of accepting influence. *Family Process*. https://doi.org/10.1111/famp.12689

Ports, K. A., Ford, D. C., Merrick, M. T., & Guinn, A. S. (2020). Chapter 2 - ACEs: Definitions, measurement, and prevalence☆. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse Childhood Experiences* (pp. 17–34). Academic Press. https://doi.org/https://doi.org/10.1016/B978-0-12-816065-7.00002-1

Romito, K., & Pope, J. (2020). *Child abuse: Emotional abuse by parents*. Child Abuse: Emotional Abuse by Parents | Michigan Medicine. https://www.uofmhealth.org/health-library/tm5075.

Ross, N., Gilbert, R., Torres, S., Dugas, K., Jefferies, P., McDonald, S., Savage, S., & Ungar, M. (2020). Adverse childhood experiences: Assessing the impact on physical and psychosocial health in adulthood and the mitigating role of resilience. *Child Abuse & Neglect*, *103*, 104440. https://doi.org/https://doi.org/10.1016/j.chiabu.2020.104440

Preacher, K. J., Rucker, D. D., & Hayes, A. F. (2007). Addressing moderated mediation hypotheses: Theory, methods, and prescriptions. *Multivariate Behavioral Research*, *42*(1), 185–227. https://doi.org/10.1080/00273170701341316

Scher, C.D., Stein, M.B., Asmundson, G.J.G. *et al.* The Childhood Trauma Questionnaire in a Community Sample: Psychometric Properties and Normative Data. *J Trauma Stress* 14**,** 843–857 (2001). https://doi.org/10.1023/A:1013058625719

Schilling, E. A., Aseltine, R. H., & Gore, S. (2007). Adverse childhood experiences and mental health in Young Adults: A longitudinal survey. *BMC Public Health*, *7*(1). https://doi.org/10.1186/1471-2458-7-30

Schneider, F. D., Loveland Cook, C. A., Salas, J., Scherrer, J., Cleveland, I. N., & Burge, S. K. (2017). Childhood trauma, social networks, and the mental health of adult survivors.

Journal of Interpersonal Violence, *35*(5-6), 1492–1514. https://doi.org/10.1177/0886260517696855

Shaw, M. T., Pawlak, N. O., Frontario, A., Sherman, K., Krupp, L. B., & Charvet, L. E. (2017). Adverse Childhood Experiences Are Linked to Age of Onset and Reading Recognition in Multiple Sclerosis. *Frontiers in Neurology*, *8*, 242. https://doi.org/10.3389/fneur.2017.00242

Sheffler, J. L., Piazza, J. R., Quinn, J. M., Sachs-Ericsson, N. J., & Stanley, I. H. (2019). Adverse childhood experiences and coping strategies: identifying pathways to resiliency in adulthood. *Anxiety, Stress, & Coping*, *32*(5), 594–609. https://doi.org/10.1080/10615806.2019.1638699

Uçar, S., & Demir, İ. (2022). Exploring romantic relationship patterns among Turkish emerging adults: A grounded theory study. *Emerging Adulthood*, 216769682210947. https://doi.org/10.1177/21676968221094751

Umberson, D., Williams, K., Thomas, P. A., Liu, H., & Thomeer, M. B. (2014). Race, gender, and chains of disadvantage. *Journal of Health and Social Behavior*, *55*(1), 20–38. https://doi.org/10.1177/0022146514521426

Velipaşaoğlu, S., Ödek, Ö. B., Parin, S., Topbaş, M., Akşit, S., Koç, F., Köse, K., & Çan, G. (2017, March 18). *Adverse childhood EXPERIENCES survey among university students in turkey (2014)*. World Health Organization. https://www.euro.who.int/en/countries/turkey/publications/adverse-childhood-experiences-survey-among-university-students-in-turkey-2014

Wheeler, N. J., Barden, S. M., & Daire, A. P. (2019). Mediation of childhood adversity and health by relationship quality in diverse couples. *Family Process*, *59*(3), 1243–1260. https://doi.org/10.1111/famp.12467

Wheeler, N. J., Regal, R. A., Griffith, S. A. M., & Barden, S. M. (2020). Dyadic influence of adverse childhood experiences: Counseling implications for mental and relational health. *Journal of Counseling & Development*, *99*(1), 24–36. https://doi.org/10.1002/jcad.12351

Willis, G. M., & Levenson, J. S. (2016). The relationship between childhood adversity and adult psychosocial outcomes in females who have sexually offended: Implications for treatment. *Journal of Sexual Aggression*, *22*(3), 355–367. https://doi.org/10.1080/13552600.2015.1131341

Zemp, M., Bodenmann, G., Backes, S., Sutter-Stickel, D., & Revenson, T. A. (2016). The importance of parents' dyadic coping for children. *Family Relations*, *65*(2), 275–286. https://doi.org/10.1111/fare.12189

APPENDIX A: Participation Criteria

1. 18-30 yaş aralığında mısınız? Evet ( ) Hayır ( )
(Hayır dediğinde anket sonlanır)

2. Medeni durumunuz nedir? Evli ( ) Nişanlı ( ) Bekar ( ) Boşanmış ( )

Dul ( )
(Evli dediğinde anket sonlanır, araştırmaya katılamaz)

3. Şu an devam eden romantik bir ilişkiniz var mı? Evet ( ) Hayır ( )
(Hayır dediğinde anket sonlanır)

4. İlişkiniz ne kadar süredir devam ediyor? Ay olarak belirtiniz: _____ay
(12 aydan az dediğinde anket sonlanır)

APPENDIX B: Demographics Form

1. Yaşınız: _____
2. Cinsiyetiniz: Kadın ( ) Erkek ( )
3. Mezun olduğunuz eğitim derecesi: İlkokul ( ) Ortaokul ( ) Lise( )
   Üniversite ( ) Yüksek L. ( ) Doktora ( )
4. Çalışıyor musunuz? Evet ( ) Hayır ( )
5. Meslek: _____
6. Aylık net geliriniz?: 2900 tl ve altı ( ) 2901 tl- 4999 tl ( ) 5000 tl-7000 tl ( )
   7001tl- 9000 tl ( ) 9000 tl- 11000 tl ( ) 11000 tl ve üzeri ( )
7. Çocuğunuz var mı? Evet ( ) Hayır ( )
8. Evet ise kaç tane? _____
9. Bir ruh sağlığı profesyoneli tarafından (klinik psikolog, psikiyatrist vb) tanısı konmuş herhangi bir psikolojik rahatsızlığınız var mı?
   Evet ( ) (Tanıyı belirtiniz: …….)
   Hayır ( )
10. Şu anda psikiyatrik bir ilaç kullanıyor musunuz? Evet ( ) Hayır ( )

APPENDIX C: Childhood Trauma Questionnaire

Çocukluk Çağı Travma Ölçeği (ÇÇTÖ)

Aşağıda yer alan ifadeler çocukluk ve ergenlik çağınızda meydana gelen bazı deneyimleriniz ile ilgilidir. İfadelere yanıt verirken nasıl hissettiğinizi en iyi açıklayan sayıyı daire içine alın.

"1" rakamı "asla doğru değil" anlamına gelmekte iken "5" rakamı ise "çok doğru" anlamına gelmektedir. Bu soruların bazıları kişisel nitelikte olsa da, lütfen olabildiğince dürüst yanıtlamaya çalışın. Yanıtlarınız gizli tutulacaktır. İfadeleri "Ben büyürken....." cümlesini tamamlayacak şekilde doldurunuz.

"Ben büyürken....."	1	2	3	4	5
1. Yeterince yemek yoktu					
2. Bana bakan ve beni koruyan birinin var olduğunu biliyordum					
3. Ailemdeki insanlar bana "aptal", "tambel" ya da "tipsiz" gibi şeyler derdi.					
4. Ebeveynlerim aileye bakamayacak kadar çok içer ya da sarhoş olurdu.					
5. Ailemde önemli ve özel biri olduğumu hissetmeme yardımcı olan biri vardı.					
6. Kirli kıyafetler giymek zorunda kalırdım.					
7. Sevildiğimi hissediyordum.					
8. Ebeveynlerimin benim hiç doğmamış olmamı istediklerini düşünürdüm.					
9. Ailemden birisi bana öyle kötü vurmuştu ki doktora ya da hastaneye gitmem gerekmişti.					
10. Ailemle ilgili değiştirmek istediğim bir şey yoktu.					

11. Ailemdeki insanlar bana o kadar şiddetle vuruyorlardı ki vücudumda morartı ya da izler kalıyordu.					
12. Kemer, sopa, ip ya da başka sert bir cisimle cezalandırılıyordum**.**					
13. Ailemdeki insanlar birbirlerine ilgi gösterirlerdi.					
14. Ailemdeki insanlar bana kırıcı ya da aşağılayıcı sözler söylerlerdi**.**					
15. Fiziksel olarak istismar edildiğime inanıyorum.					
16. Mükemmel bir çocukluk geçirdim.					
17. Bana o kadar kötü vuruyorlar ya da dövüyorlardı ki öğretmen, komşu ya da bir doktorun bunu farkettiği oluyordu.					
18. Ailemden birisi benden nefret ederdi.					
19. Ailemdekiler kendilerini birbirlerine yakın hissederlerdi.					
20. Birisi bana cinsel amaçla dokunmaya çalıştı ya da kendisine dokundurtmaya çalıştı					
21. Kendisi ile cinsel bir şey yapmadığım takdirde bana zarar vermekle ya da hakkımda yalanlar söylemekle beni tehdit eden birisi vardı.					
22. Dünyanın en iyi ailesine sahiptim.					
23. Birisi beni cinsel şeyler yapmaya ya da cinsel şeyleri izlemeye zorladı.					
24. Birisi beni taciz etti (cinsel olarak benden yararlandı).					
25. Duygusal olarak istismar edildiğime inanıyorum.					
26. İhtiyacım olduğunda beni doktora götürecek birisi vardı**.**					

27. Cinsel olarak istismar edildiğime inanıyorum.					
28. Ailem bir güç¸ ve destek kaynağıydı.					
29. Ben küçükken annem ve babam ayrıldı/boşandı.					

(Her madde için) Bahsi geçen olay hangi yaşlarda gerçekleşti? 0-11 ( ) 12-18 ( )

APPENDIX D: Dyadic Coping Inventory

Çift Olarak Baş Etme Envanteri

Aşağıdaki sorular sizin ve eşinizin stresle nasıl başa çıktığınızı belirlemeye yöneliktir. Kafanızda bazı problemleri somutlaştırarak bunlar üzerinde bir süre odaklanıp cevaplamalarınızı somur durumlara yönelik olarak gerçekleştiriniz. Lütfen aşağıdaki ifadeleri dikkatli bir şekilde okuyarak aklınıza ilk gelen, uygun olduğunu düşündüğünüz cevabı aşağıda verilen derecelemeyi kullanarak uygun olan seçeneği işaretleriniz. Lütfen tüm soruları cevaplayınız.

0= Hiçbir zaman
1=Nadiren
2=Bazen
3= Sık sık
4= Her zaman

	0	1	2	3	4
BU BÖLÜM STRESİNİZİ EŞİNİZLE NE KADAR PAYLAŞTIĞINIZLA İLGİLİDİR.					
1. Eşimin bana olan destek ve yardımından memnun olduğumu ona söylerim.					
2. Yapacak çok işim olduğunda eşimden bazı işleri yapmasını isterim.					
3. Hayatımda bazı şeyler iyi gittiğinde bunları davranışlarımla eşime belli ederim.					
4. Eşime açık olarak ne hissettiğimi ve onun desteğini önemsediğimi söylerim.					
BU BÖLÜM STRESLİ OLDUĞUNUZDA EŞİNİZİN NE YAPTIĞIYLA İLGİLİDİR.					
1. Eşim bana empati ve anlayış gösterir.					
2. Eşim hep benim yanımda olduğunu ifade eder.					
3. Eşim stresli olduğum ve bununla yeterince başa çıkamadığımda beni suçlar.					
4. Eşim stresli durumları farklı bir açıdan görmeme yardımcı olur.					
5. Eşim beni çok iyi dinleyerek gerçekten beni rahatsız eden şey hakkında konuşmamı sağlar.					
6. Eşim benim yaşadığım stresi ciddiye almaz.					
7. Eşim bana isteksiz ve gönülsüz şekilde destek verir.					
8. Benim yapmam gereken işleri yaparak eşim bana yardım etmeye çalışır.					

9. Bir problemle karşılaştığımda eşim durumu daha iyi değerlendirmeme yardımcı olur.					
10. Çok yoğun olduğumda eşim bana yardım eder.					
11. Stresli olduğumda eşim benden uzaklaşmaya çalışır.					
BU BÖLÜM EŞİNİZ STRESLİ OLDUĞUNDA STRESİNİ SİZİNLE NE KADAR PAYLAŞTIĞIYLA İLGİLİDİR.					
1. Eşim ona sağladığım destek ve yardımdan memnun kaldığını bana ifade eder.					
2. Eşim yapacak çok işi olduğunda benden yardım ister.					
3. Eşim hayatında bazı şeyler iyi gitmediğinde bunları davranışlarıyla bana belli eder.					
4. Eşim açık olarak ne hissettiğini ve benim ona olan desteğimi takdir ettiğini söyler.					
BU BÖLÜM EŞİNİZİN STRESİNİ DİLE GETİRDİĞİNDE SİZİN NE YAPTIĞINIZLA İLGİLİDİR.					
1. Eşim ona sağladığım destek ve yardımdan memnun kaldığını bana ifade eder.					
2. Eşim yapacak çok işi olduğunda benden yardım ister.					
3. Eşim hayatında bazı şeyler iyi gittiğinde bunları davranışlarıyla bana belli eder.					
4. Eşim açık olarak ne hissettiğini ve benim ona olan desteğimi takdir ettiğini söyler.					
BU BÖLÜM EŞİNİZ STRESİNİ DİLE GETİRDİĞİNDE SİZİN NE YAPTIĞINIZLA İLGİLİDİR.					
1. Eşime empati ile yaklaşır ve anlayış gösteririm.					
2. Eşime onun yanında olduğumu ifade ederim.					
3. Eşim stresle yeterince başa çıkmadığı için onu suçlarım.					
4. Eşime stresinin o kadar kötü olmadığını söyler ve durumu farklı bir açıdan görmesine yardım ederim.					
5. Eşimi çık iyi dinleyerek gerçekten onu rahatsız eden şey hakkında konuşmasını sağlarım.					
6. Eşimin yaşadığı stresi fazla ciddiye almam.					
7. Eşim stresli olduğunda ondan uzaklaşmaya çalışırım.					
8. Eşimin problemleriyle kendi kendine başa çıkması gerektiğini düşündüğüm için ona isteksiz ve gönülsüz destek veririm.					
9. Eşime yardım etmek için genelde onun yaptığı işleri üstlenirim.					
10. Eşim bir problemle karşılaştığında onun durumu daha iyi değerlendirmesine yardımcı olurum.					
11. Eşimin işi çok olduğunda ona yardım ederim.					
BU BÖLÜM SİZ VE EŞİNİZ BİRLİKTE STRESLİ OLDUĞUNDA NE YAPTIĞINIZLA İLGİLİDİR.					
1. Problemin üstesinden gelmek için birlikte çaba göstererek doğru olan çözümleri bulmaya çalışırız.					

2. Problemle ilgili ciddi bir tartışmaya odaklanarak problem çözümü için kafa yorarız.					
3. Problemi birlikte ele alarak farklı bir bakış açısıyla görmek için birbirimize yardım ederiz.					
4. Birbirimizi rahatlatmak için birlikte müzik dinlemek, masaj yapmak, duş almak gibi farklı etkinlikler yaparız.					
5. Sevgimizi birbirimize yoğun olarak hissettirerek ve sevişerek stresle başa çıkmaya çalışırız.					
BU BÖLÜM BİR ÇİFT OLARAK STRESLE BAŞAÇIKMANINIZI NASIL DEĞERLENDİRDİĞİNİZLE İLGİLİDİR					
1. Eşimin desteğinden ve onunla birlikte kullandığımız stresle başa çıkma yöntemlerimizden memnunum.					
2. Bir çift olarak stresle başa çıkma yöntemlerimizi etkili buluyorum.					

APPENDIX E: Revised Dyadic Adjustment Scales

Yenilenmiş Çift Uyum Ölçeği

Aşağıdaki konularda eşinizle anlaşıp anlaşamadığınızı ilgili kutucuğa (X) işareti koyarak belirtiniz.

		Hiçbir zaman anlaşamayız	**Nadiren anlaşırız**	**Bazen anlaşırız**	**Oldukça sık anlaşırız**	**Çoğu zaman anlaşırız**
1	Dini konular					
2	Muhabbet-sevgi gösterme					
3	Temel kararların alınması					
4	Cinsel yaşam					
5	Geleneksellik					
6	Mesleki kararlar					

Aşağıda eşinizle ve evliliğinizle ilgili bazı ifadeler yer almaktadır. Lütfen aşağıdaki ifadeleri okuyup size ne derece uygun olduğunu ilgili kutucuğa (X) işareti koyarak belirtiniz.

		Hiçbir zaman	**Nadiren**	**Bazen**	**Oldukça sık**	**Çoğu zaman**
7	İlişkinizi bitirmeyi ne sıklıkta tartışırsınız?					
8	Eşinizle ne sıklıkla münakaşa edersiniz?					
9	Evlendiğiniz için pişmanlık duyar mısınız?					
10	Ne sıklıklabirbirinizin sinirlenmesine neden olursunuz?					

11	Siz ve eşiniz ev dışı etkinliklerinizin ne kadarına birlikte katılırsınız?					
12	Ne sıklıkla teşvik edici fikir alışverişinde bulunursunuz?					
13	Ne sıklıkla bir iş üzerinde birlikte çalışırsınız?					
14	Ne sıklıkla bir şeyi sakince tartışırsınız?					

APPENDIX F: Brief Stress Coping Profile

Kısa Baş Etme Yöntemleri Ölçeği

Sıkıntılı veya zor bir sorunla karşılaştığınız durumda, o sorunla baş etmek için genelde ne yaparsınız? Aşağıda belirtilen yöntemleri okuduktan sonra karşılarında verilen sıklıklardan size uygun olanı (x) koyarak işaretleyiniz, lütfen.

Sıkıntılı ve zor bir durumla karşılaştığımda:	Hiç (1)	Nadiren (2)	Bazen (3)	Sık sık (4)
1. Sorunun nedenini inceleyerek çözmeye çalışırım				
2. Yaşadığım sorunun geçmişteki sorunlarla bir ilişkisi olup olmadığına bakarım.				
3. Sakin bir şekilde düşünürüm.				
4. Güvenebileceğim birine danışırım.				
5. Soruna dahil olan insanlarla konuşarak sorunu çözmeye çalışırım.				
6. Sorunu çok yakından bilen birine danışırım.				
7. Hoşlandığım ve eğlendiğim şeyleri yaparak dikkatimi/kafamı dağıtmaya çalışırım.				
8. Beni sakinleştirecek, rahatlatacak şeyleri yapmaya çalışırım.				
9. Kendimi yenilememi ve dinlenmemi sağlayacak aktiviteler yapmaya çalışırım (örneğin seyahat yapmaya ya da dışarı çıkıp hava almak gibi).				

10. İyimser olmaya çalışırım.				
11. Olayın pozitif tarafını görmeye çalışırım.				
12. Yaşadığım sorunun benim için iyi bir deneyim olduğunu düşünmeye çalışırım.				
13. Bu sorunun arkasında/nedenin birisinin olduğunu düşünürüm.				
14. Sorunun yaşandığı/sorunu yaşadığım kişiyi suçlarım.				
15. Sorunla ilişkisi olmayan birine içimi dökerim.				
16. Sorunu görmezden gelirim.				
17. Hiçbir şey yapmadan sorunu zamana bırakırım, bir gün değişecek diye düşünürüm.				
18. Sorunu tahammül etmekten ve dayanmaktan başka hiçbir şey yapmam.				