THE ROLE OF SELF DISGUST IN THE RELATIONSHIP BETWEEN CHILDHOOD TRAUMA AND DISSOCIATION

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PLAGIARISM

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ÖZET

Bu çalışmada, erişkin bireylerde çocukluk çağı travmaları ve dissosiyasyon arasındaki ilişkide öz-tiksinmenin aracı rolünün incelenmesi amaçlanmıştır. Araştırmaya 21-50 yaş arasında 376 katılmıştır. Katılımcılara "Sosyodemografik Bilgi Formu", Çocukluk Çağı Ruhsal Travma Ölçeği 33 Maddelik Formu, Dissosiyasyon Ölçeği ve Öz-Tiksinme Ölçeği kullanılmıştır. Araştırmada, çocukluk çağı travmaları, dissosiyasyon ve öz-tiksinme arasındaki ilişkinin incelenmesi için Pearson Korelasyonu uygulanmıştır. Çocukluk çağı travmalarının dissosiyasyon düzeylerine etkisinde öz-tiksinmenin aracı rolünün incelenmesi için aracı rol analizi yürütülmüştür. Araştırmada elde edilen bulgular doğrultusunda, katılımcıların çocukluk çağı travmalarının dissosiyasyon ve öz-tiksinme ile pozitif yönlü ve anlamlı ilişkisi olduğu saptanmıştır. Aracı rol analizi bulguları doğrultusunda, çocukluk çağı travmalarının dissosiyasyon üzerinde doğrudan etkisi olmadığı ve öz-tiksinmenin olması durumunda etkinin anlamlı olduğu sonucu elde edilmiştir. Öz-tiksinme, çocukluk çağı travmatik öyküsü olan bireylerin dissosiyatif belirtileri olması açısından tetikleyici bir unsur olarak değerlendirilebilir. Elde edilen sonuçların ileri araştırmalarla desteklenebileceği ve klinik pratikte çocukluk çağı travmatik öyküsü olan bireylerde dissosiyasyon riskinin değerlendirilmesinde öz-tiksinmenin değerlendirilmesinin etkili olabileceği düşünülmektedir.

Anahtar kelimeler: Çocukluk çağı travmaları, dissosiyasyon, öz-tiksinme, travma

ABSTRACT

In this study, it was aimed to examine the mediating role of self-disgust in the relationship between childhood traumas and dissociation in adults. 376 participants between the ages of 21-50 participated in the study. “Sociodemographic Information Form”, Childhood Mental Trauma Scale 33-item Form, Dissociation Scale and Self-Disgust Scale were used on the participants. In the study, Pearson Correlation was applied to examine the relationship between childhood traumas, dissociation and self-disgust. Mediator role analysis was conducted to examine the mediating role of self-disgust in the effects of childhood traumas on dissociation levels. Based on the findings obtained in the study, it was found that the childhood traumas of the participants had a positive and significant relationship with dissociation and self-disgust. In line with the mediator role analysis findings, it was concluded that childhood traumas do not have a direct effect on dissociation and the effect is significant in the presence of self-disgust. Self-disgust can be considered as a triggering factor for individuals with a childhood traumatic history to have dissociative symptoms. It is thought that the results obtained can be supported by further research and the evaluation of self-disgust may be effective in the evaluation of the dissociation risk in individuals with a childhood traumatic history in clinical practice.

Key words: Childhood traumas, dissociation, self-disgust, trauma

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CHAPTER 1

INTRODUCTION

The severity of events that may threaten the life of the person or disrupt the integrity of the self during childhood and the inconvenience of family and environmental conditions in which they occur can turn these experiences into a traumatic process (Chu et al. 1999). A traumatic situation is a vital imbalance between objective threat and subjective coping power (Herman, 2011). Repetitive and traumatic experiences that begin at an early age constitute the main reason for dissociation When the relevant literature is examined, it is understood that there is a relationship between the dissociation symptoms of individuals under traumatic stress (Terr, 1979; Yehuda et al., 2001)

Self-disgust, which is considered as the other variable, is the feeling of disgust experienced against one's own behavior, physical appearance or personality (Overton et al., 2008). Recent studies have emphasized the role of self-disgust in the development of various emotional and behavioral problems, especially depression. Self-disgust is accepted as an important concept that has the potential to emphasize not only the individual but also the social aspect of the person (Bahtiyar & Yıldırım, 2019).

Additionally, Powell et al. (2014) found that feelings of self-disgust were brought on by evaluation of the self; however, other studies found that specific factors, such as a disordered (Jones et al., 2008) or traumatized (Jung and Steil, 2012) body part or the body itself, brought on the same feelings (Espeset et al., 2012). Previous research has revealed that psychopathologies like post-traumatic stress disorder, depression, and anxiety disorder all exhibit self-disgust, and that this condition is particularly linked to a feeling of worthlessness (Engelhard et al., 2011; Olatunji, 2010; Power and Fyvie, 2013).

Studies show that those with a history of childhood trauma are more likely to use low self-esteem and more avoidant coping mechanisms (eg, isolation, self-criticism) than those without a history of childhood trauma (Bryant -Davis, 2005; Finkelhor, 2009). In this respect, it is thought that the mediating effect of self-disgust, which was discussed in both social and individual dimensions in previous studies and came to the forefront with the concept of worthlessness, may provide important findings in terms of

examining individual factors that may increase the risk of dissociation after traumatic stress.

In the light of the literature findings mentioned above, the aim of this study is to examine the mediating role of self-disgust in the relationship between childhood trauma and dissociation.

1.1. Definition of Childhood Traumas

Trauma that is particular to the circumstance to which the person is subjected and is brought on by conflicts between stressors and coping mechanisms, along with feelings of powerlessness (Van der Kolk et al, 1996). Critical experiences known as psy-chological traumas permanently alter a person's sense of himself and his surroundings. "Psychic trauma" refers to overwhelming and traumatic experiences that cannot be han-dled by coping mechanisms and defensive systems but instead have unique impacts on a person's mental structure (Ruppert, 2011).

Childhood traumas are one of the situations that might have a traumatic impact on the person. Herman (2011) described childhood traumas as the experiences a person has before the age of 18, including physical, emotional, sexual, and neglectful abuse; parental divorce; and loss of a significant other. witnessing violence, accident or wit-nessing a traumatic event, and natural disasters. Childhood traumas also cover events that occur unexpectedly, affecting the physical and mental integrity of the person and threatening his life (Pfefferbaum and Allen, 1998). According to Yurdakök (2010), child maltreatment includes behaviors that are intentionally or unintentionally done even though by caregivers, parents or other adults. Maltreatment during childhood also include a high level of physical and emotional harm to the child and are divergent with societal norms.

The literature contains a wide range of viewpoints on childhood traumas. For example, Terr (1991) brought out one of the most important justifications for trauma. Psychological traumas, according to him, are the reaction to the stressor rather than the event's original cause, as well as the internal outcome or psychological impact of external occurrences. Additionally, he compiled childhood traumas into two broad headings. The first type has been defined as “the mental result of an unexpected and sudden event (Type I). The second type are categorized as multiple, persistent, long-term traumas (Type II) that blocks previous coping and defense functions and makes

individual helpless (Terr, 1991). Type I traumas include accidents, being exposed to violent acts such as rape, armed attack, short-term natural disasters (earthquake, flood etc.). This type of trauma is related to classic symptoms of PTSD noted in DSM including hyperarousal, avoidance, and reexperiencing symptoms. Yet, instances of type II trauma include ongoing or protracted experiences like being tortured, being a prisoner, experiencing physical or sexual abuse as a child, and being accompanied by fearful waiting. Type II traumas might have symptoms like depersonal-ization, rage, denial, and dissociation (Terr, 1991).

Childhood traumas include acts directed at the child by an adult such as a parent or caregiver, which are considered inappropriate or harmful by social rules (Herman, 2011). Child abuse or neglect which are main components of childhood traumas also prevent or restrict the child's development. As a result of all these, childhood traumas are situations where social interactions, health and safety are endangered (Taner and Gökler, 2004).

As cited in Yaşar and Akduman (2007), Tardieu (1860) first mentioned the physical and sexual abuse of children. Additionally, after the World War II, the mobilization of many national and international organizations aiming to protect children can be considered as the biggest developments for children as preventions for childhood abuse and neglect (Polat, 2001). The first scientific records and definitions about childhood traumas on mental illnesses had been held in the time of the World War II. These types of childhood traumas were also called as historical traumas (Kellermann, 2001). These studies consist of the psychological reactions observed in children who lost their parents or survived the concentration camps after World War II (Mohatt et al, 2014).

Eventually, certain studies were conducted on both physiological and psychological reactions caused by natural disasters as well as abuse in children (Nimkin and Kleinman, 2001).

Childhood traumas can be seen in every culture, social class, ethnic group, and socioeconomic status (Bostancı et al., 2007). Different forms of abuse and neglect are not only seen in families, but also in society, social, and legal institutions. It has been seen as a public health problem that also affects education systems and business organizations (Akduman et al., 2005). World Health Organization (WHO) defines child abuse as “behaviors that are intentionally or unintentionally committed by an adult and

that adversely affect the child's physical development and psychosocial development". What is important in this definition is not the intention of the adult, but the effect of the action on the child (World Health Organization, 2010).

Even though the distinction between neglect and abuse is that neglect is seen as passive and abuse is active actions towards the child, child abuse and neglect can cause severe mental and physical health issues which cause permanent emotional or physical wounds throughout children's lives (Belsky, 1993; Cicchetti and Lynch, 1993). Additionally, the conceptualization of child abuse and neglect can differ in terms of different traditions and beliefs. Therefore, there has been no distinct definition regarding these terms (Putnam-Horstein et al., 2013). Specifically, in families where child abuse and neglect are experienced, parenting attitudes are inconsistent, and parents may have been exposed to abuse in their childhood. Besides, psychiatric disorders such as schizophrenia, depression, alcoholism, and anxiety disorder can be found among family members (Polat, 2007).

1.1.1. Types of childhood traumas

Childhood abuse, which is included in the sub-dimensions of childhood traumas, or neglect are defined as the actions or inactions by caregivers that will hinder the development of the child (Fergusson and Lynskey, 1997). Based on these kinds of behaviors and attitudes, the child's physical, mental, sexual, and social development and functioning are adversely affected, and their health and safety are endangered (Taner and Gökler, 2004). The main difference between child neglect and abuse is that neglect is passive, and abuse is active (Merrick and Guinn, 2018). Exploitation, or abuse includes physical, emotional, and sexual abuse under 3 headings; Neglect is classified under two headings including physical and emotional neglect (Herman, 2011).

Physical Neglect: Physical neglect includes expulsion of children from home, not fulfilling or delaying their health-related needs, not providing a healthy environment, leaving them alone at home, and not meeting their basic needs (nutrition, cleaning, etc.) (Gaudin, 1995; Şar, 1998). Similarly, it is defined as not meeting the child's early basic needs (nutrition, shelter, health, clothing, protection) by the caregiver or other adults (Dubowitz et al., 1993).

Emotional Neglect: Emotional neglect can be defined as not responding their children's emotional needs and acting distant and indifferent towards them (Stevens et

al., 2018). Additionally, it is defined as ignoring emotional needs of the child, not showing enough love and warmth, not providing support for his social development, and not teaching social rules (Liu and Merritt, 2018).

Physical Abuse: Children may experience age-related accidents, but abuse should be considered in accidents that are not suitable for the age of the child and in events that are less likely to happen on their own. Physical abuse is observed as the use of violence by an adult against the child in a way that harms the child's body, with or without a tool, to show his or her physical strength (Dubowitz and Bennett, 2007). It does not have to be only beating but also any non-accidental action that leaves a mark on the child's body (Betchel et al., 2004).

Emotional Abuse: Emotional abuse is one of the types of abuse that is difficult to define. The fact that the border between the ideal parental attitude and the parental attitude below the expectations is not clear makes it difficult to define this abuse (Feerick and Snow, 2006). Emotional abuse can be seen together with other types of abuse, or it can be exposed alone (Korfmacher, 1998). Emotional abuse is as damaging as physical abuse (Wolford et al., 2019). Emotional abuse is also more common than other types of abuse (Liu and Merritt, 2018)

Sexual Abuse: Sexual abuse is the kind of childhood abuse by an older adult for pleasure/gratification. Sexual abuse is the behavior that the child does not understand in terms of the development of the child by the caregiver or the adults who have confidence or power around him (Hu et al., 2018; Vrolijk-Bosschaart et al., 2018). It is expressed as the child's being involved in sexual acts, where there is no question of taking permission due to their age (Butchart et al., 2006). Fear, anxiety, depressed mood, hostility, PTSD, and inappropriate sexual behaviors are found as common the emotional and behavioral outcomes of childhood sexual abuse (Cicchetti et al., 2010).

Overprotection-control: The extreme protection-control dimension, which is included in the sixth dimension of the childhood traumas scale, represents the intrusive and limiting behavior of the individual during his childhood (Şar et al., 2017).

1.1.2. Effects of childhood traumas

Trauma if it occurs during “critical” times of development, such as early childhood or adolescence can be defined as childhood traumas. According to DSM-5, exposure to a serious injury or threat of injury, witnessing the death or injury of another

person, learning about the unexpected death or serious injury of a family member or another relative are the characteristics that define the traumatic nature of the event (APA, 2013).

According to estimates made from epidemiological studies, a quarter of children are exposed to a significant traumatic event before they reach adulthood (Cohen, 2010). When the worldwide prevalence rates of childhood traumatic experiences were examined, Gilbert et al. (2009) stated that physical abuse was 17.6% and sexual abuse was 9.1%. In addition, it has been stated that 15-30% of girls and 5-15% of boys are victims of sexual abuse (Gilbert et al., 2009).

Trauma, depending on the type, severity, lifestyle and many other factors, it may play a role in the emergence and/or exacerbation of various psychiatric disorders on the individual. Children with strong psychological resilience, effective coping skills and protective support systems may not experience any mental pathology even after major traumatic events. However, researchers reported that a significant portion of children exposed to the traumatic event developed maladaptive emotional and behavioral responses, and their development and adaptation were impaired (Cohen et al., 2004; Donnelly et al., 2006; Gilbert et al., 2009; Scheringa, 2008). Disorders as a result of trauma may occur directly related to the traumatic experience, depending on individual, social and biological differences, and may also lead to the development of other mental disorders in the later stages of life. It has been reported that many mental pathologies such as post-traumatic stress disorder, major depressive disorder, conduct disorder, anxiety disorder, psychotic disorder and substance abuse can develop in children after exposure to traumatic events (Donnelly et al., 2006).

PTSD has been noted as one of the widely seen psychopathology as an important result of childhood traumas. PTSD is defined as a mental disorder that can be comorbid with other psychiatric disorders and occurs due to a traumatic history (American Psychiatry Association, 2014). Other psychiatric diagnoses that often accompany PTSD are depression and anxiety disorders, alcohol and substance use disorders, antisocial personality disorders, dissociative disorders, and somatization disorders. It is reported that up to 75% of individuals with PTSD have at least one additional psychiatric disorder based on the results in the study by Wanklyn et al in 2016. The combination of PTSD with major depression is high in most studies (Wanklyn et al., 2016). Additionally, Wanklyn et al (2016) noted that other

psychopathologies include anxiety disorders, alcohol and substance addictions, dissociative disorders, and eating disorders. In children, oppositional defiant disorder and anxiety disorder can be seen with PTSD (Scheringa, 2008).

On the relationship between recurrent depression in adulthood and childhood traumas, Moskvina et al. (2007) reported that there was at least one trauma in 79% of them in a study conducted with 324 people diagnosed with recurrent major depression. In this study, a significant relationship was found between the severity of trauma and the onset of depression.

1.2. Dissociation

The word dissociation is a combination of the Greek words *dis* (negativity) and *sociare* (unity or connection) and means loss of connection or unity. The meaning of the word in the sense that people have an attitude that will distance themselves from that event and they experience disconnection between the mind and the event itself (Diseth, 2005; Putnam, 1997; Dirie, 1998).

Janet found that the concept of dissociation is a concept first found in the work of *Moreau de Tours* in 1845. Its equivalent term *psychological dissolution (desagregation psychologique*), also introduced by Moreau de Tours in 1845, was equally well received.

Dissociation is defined as the psychophysiological detachment of a person's thoughts, feelings with their behaviors (Putnam, 1993). The Diagnostic and Statistical Manual for Mental Disorders (DSM-5) defines dissociation as the distortions of the person's perception related to his/her environment, identity perception, emotions, and memory (American Psychiatry Association, 2014). According to a recent definition by Öztürk and Çalıcı Can(2018), dissociation is a concept that includes a pathological process negatively influencing the integration of identity, in which there can be certain specific and noticeable changes in the feelings, thoughts and behaviors.

Additionally, victims of trauma protect themselves from the problems by making themselves independent from trauma with this defense mechanism (Şar, 2000; Şar and Öztürk, 2008; Topçu, 2009). As a result of this, symptoms defined as dissociative experience occur with the emergence of clinically observable extreme changes in the identity, memory, affect and behavior.

When reviewing related literature, there are many studies that define dissociation as a defense mechanism (Öztürk, 2017; Putnam, 1993; Solomon, 2004; Şar and Öztürk, 2008; Topçu, 2009). Dissociation is defined mainly as a primitive defense mechanism used against traumatic experiences. According to the psychoanalytic approach, the basic defense mechanisms used to cope with trauma are divided into two main categories as suppression and dissociation. According to this approach, when the individual is exposed to trauma, it causes the loss of connections between the traumatic event and these defense mechanisms. Thus, the experienced trauma is isolated from the mind and memory (Solomon, 2004). Many studies on trauma and dissociation mention amnesia at this point where there are breaks between memories.

On the other hand, it has been suggested that the body uses dissociative defense mechanisms such as watching oneself from the outside due to severe traumatic experiences such as war and life-threatening illness. According to Şar and Öztürk (2008), people usually respond to trauma in three main ways: escaping, trying to find a solution, and completely distancing oneself trauma-related event. In the background of the reactions related to the trauma, there is a limited response and coping skills of the individuals to the trauma-related event.

Two functions of dissociation against trauma have been described previously. Firstly, dissociation distances the person from the traumatic effects of the event for the moment. Secondly, it enables postponing the necessary self-regulation process through detachment. Thus, even if one is in a state of helplessness due to traumatic event, the feeling of loss of control is prevented through dissociation (Şar, 2000). According to many views, dissociation, which is initially considered as an effort to overcome trauma, turns into a permanent, maladaptive mechanism (Şar, 2000). Öztürk (2018) defined this situation as a pathological process and gave an example of pathological dissociation when a person reacts as "I am not the one experiencing this" or "This is happening to someone else, not me" during the trauma. Similarly, Öztürk (2017) also asserted that the person may protect themselves from the effects of trauma by causing dissociation to record the perceptions and memories.

1.2.1. Different forms of dissociation

Dissociation is defined as a defense that is formed as the continuity of one's own integrity, depending on these experiences. These defenses are shaped based on experiences that are generally experienced in childhood but include even traumatic

experiences in adolescence and early adulthood. It is seen that dissociations seen in individuals may not always be clinical, and situations such as children's playing imaginary games or having imaginary friends are not associated with dissociation (Butler, 2006; Irwin, 1995; Ross, Joshi, and Currie, 1990; Waller et al., 1996).

In general, although the symptoms of dissociation are viewed as disturbing in extreme conditions, dissociation can manifest itself in daily life and at normal levels. For example, regularly forgetting something, being preoccupied by imaginary activities, not being sure about doing something or not are among the symptoms of dissociation in daily life (Ross et al.,1990). Additionally, whether dissociation could be experienced in daily life, it could lead to stress in extreme levels (Butler, 2006; Waller et al., 1996). When considered in this context, although dissociation is a process that initially serves to protect the person, especially in the face of traumas, it may turn into pathological dissociation (Spiegel et al., 2013). Pathological dissociation is classified as different mental health conditions based on the symptoms (Şar, 2018; Putnam, 1993). In DSM-V, there are 5 main categories of dissociation, dissociative identity disorder, dissociative fugue depersonalization/derealization, dissociative amnesia, and dissociative disorder not otherwise specified, defined as "dissociation in the usually integrated functions of consciousness, memory, identity, or an environmental perception". (APA, 2013).

Inattention, *amnesia*, and *daydreaming* are dissociative experiences encountered in normal life. However, developing amnesia to the traumatic event is another dissociative experience or reaction. Amnesia can develop in perceptions, emotions, and behaviors as well as information. When one of them is remembered, the others can be remembered later. Post-traumatic dissociative reaction shows on-off kind of function. That is, memory fluctuates, causing to experience the similar event as if it happened at that moment, and to forget it as if it never happened at other times (Spiegel, 1997). It is quite common for victims to describe dissociative experiences during traumatic events. These spontaneous experiences serve to protect the person against extreme fear, pain and helplessness. Many rape and incest victims stated that while they were watching themselves from outside their bodies at the time of rape, they felt as if they were raping someone else and felt pity for this incident they experienced (Spiegel, Hunt and Dondershine, 1988).

The main feature of dissociative amnesia is the inability to recall important personal information in a way that cannot be explained by ordinary forgetfulness. Some

memories, feelings and thoughts, or large groups of memories and associated emotions are inaccessible (Spiegel et al., 2011). Dissociative amnesia usually begins and ends abruptly. However, slow onset (usually following a mild clouding of consciousness with or without a headache) and slow remissions (memory fragments appear over time) may also be observed. Often a generalized amnesia is followed by a more limited state of amnesia (Şar et al., 2013). Healing is often spontaneous. Relapses may occur if stressors persist. A fugue may occur during an episode of dissociative amnesia. In these situations, the individual abruptly departs the location they are in, giving the impression that they are traveling or moving while appearing to be relatively disordered (Ar et al., 2014).

There are numerous clinical manifestations of dissociative amnesia. It is especially prevalent in clinical populations with a regional or restricted scope. Nothing that occurred inside a specific time frame, usually in the hours after a terrible event, is recalled (Dell, 2013). In selective amnesia, some of the events that occurred in a certain time are not remembered. Systematic amnesia is similar to this, but certain and interrelated events are not remembered. The generalized type is relatively rare. The person does not remember his life. In permanent amnesia, events from a certain time are not remembered, including those in the present, and are forgotten immediately after the events have occurred (Spiegel et al., 2011).

As a similar form of amnesia, *absorption* is the situation in which a person fully participates and concentrates all his attention on intellectual, perceptual, and memory-based features (Butler et al., 1996). In other words, absorption is the state of being immersed in another task at a level where one cannot notice what is happening around them (Ogawa et al., 1997). An example of absorption at the non-pathological level of dissociation that can be encountered in daily life is the state of losing oneself while watching a movie, reading a book or driving a car (Ray, 1996). Muris and Merckelbach (1997) have associated absorption with experiences such as forgetting conversations with other people in one's daily life, losing one's head in conversations and what is being said, or having the ability to ignore when one feels a pain in the body.

Another form of dissociation which is associated with dissociative amnesia is listed as *dissociative fugue*. Since dissociative fugue is mostly accompanied by dissociative amnesia, it is no longer a separate diagnosis in DSM-5 (American Psychiatry Association, 2013). However, it has been classified in the ICD-10 as a

separate diagnosis. In fugues seen during an episode of dissociative amnesia, the person suddenly leaves the place they are in, while appearing to be relatively organized and traveling or exhibiting disorganized walking, running, or escaping behavior (Öztürk and Uluşahin, 2015; Brandt and Van Gorp, 2016). A person who unexpectedly moves away from his/her current location may stay or travel in his/her new place for hours to years. There is complete amnesia to his previous identity and place of residence (Staniloiu and Markowitsch, 2011). He may have acquired a new identity. In these cases, temporal lobe pathology should be investigated thoroughly (Öztürk and Uluşahin, 2015).

Although it is not one of the syndromes defined in the DSM-5 diagnostic system as dissociative disorders, *dissociative type convulsions* are seen quite frequently. Specifically, the DSM-5 did not qualify it as specific to dissociation, as it included such conversions as a subtype of "Conversion Disorder" under the heading *"somatoform disorders"*. However, the emergence of consciousness and memory as a temporary inability to perform their natural functions due to a mental trauma, especially without an organic cause, supports the idea that this situation should be considered as a dissociative reaction (Öztürk and Uluşahin, 2015; Spiegel et al., 2013). Although dissociative reactions are the result of mental processes, they can also manifest with many bodily symptoms. Dissociative seizures can be characterized as the loss of both cognitive and bodily functions for a while (Gupta, Vujcic and Gupta, 2017; Rifkin et al., 1998).

Dissociative identity disorder (DID) is defined as paradigmatic dissociative psychopathology because of the main symptoms seen in dissociative disorders such as amnesia, fugue, depersonalization, and derealization in patients with DID (Loewenstein et al., 2017). The main symptoms of DID are related to identity and memory. Different personality states that are continuous and can replace each other continue to exist together in the same person and recurrent amnesias accompany the picture.

For DID it was stated by Putnam that an alter personality is a highly differentiated state of consciousness organized around a sense of self (including body image) with an ongoing effect, a limited behavioral repertoire, and a set of situation-dependent memories. Additionally, Kluft defines it as separated self-states, i.e. (alter) personalities, are mental foci of (relatively stable and ongoing) patterns of selective activation of mental content and functions. These contents and functions are sensitive to intrapsychic, interpersonal and environmental stimuli; they have a sense of their own identity and mentality, they have a thought process and the capacity to initiate action. Each is to be

understood not as a part of the mind, but as a different organization of the mind. When alter personalities are considered as different patterns rather than being a part of the whole, it is better understood why their number can be very large. A patient may have multiple minor parts as well as sophisticated alter personalities. Some pieces only carry an emotion or a memory, their emergence occurs in a flashback fashion.

Field studies on DID have not yet provided reliable epidemiological data. The prevalence in the general adult population was found to be 0.4-1.5%, and the incidence is higher in women (Loewenstein et al., 2017; Şar, 2018). On the other hand, the incidence of 14% ICD in a group of patients receiving treatment for synthetic substance addiction is striking (Ross et al., 1992).

In *depersonalization*, the individual perceives himself as if he is watching from the outside. Depersonalization is the state of having repetitive experiences in which the person is detached from his own body and observing and watching the outside world like someone else (APA, 2004). This situation, in which the person observes himself from the outside and feels like he is in a dream, usually starts with feelings and thoughts such as numbness, change of body parts and feeling ants in the body (Öztürk, 2017). During depersonalization, the person knows the reality of his experiences because he does not lose his ability to evaluate reality, but he can sometimes express that he has difficulty in distinguishing these memories from dreams (Öztürk, 2017).

Derealization, on the other hand, is more related to the separation of one's environment or the feeling of not being real. Derealization is the state of feeling unrealistic according to one's perception of one's vision, emotions, cognitive processes and the outside world as unreal (APA, 2013). Derealization, which means the unreal and disjointed experience of the experiences that a person experiences about those around him, is discussed and researched together with the subtype of depersonalization according to many sources. The person expresses that he/she perceives the outside world as if he/she is dreaming. Paramnesias such as deja vu and jamais vu are considered examples of derealization (Brandt and Van Gorp, 2006). It is an important issue that the ability to evaluate reality is not impaired during these experiences. Transient experiences with both conditions are extremely common in the normal and clinical sample. Among dissociative disorders, the most consistent epidemiological study findings have been recorded in this disorder (American Psychiatry Association, 2013). There is a 19-50% prevalence of depersonalization-derealization experiences in

the general population without meeting the diagnostic criteria for a disorder (Loewenstein et al., 2017). This diagnosis, which is called only depersonalization disorder in DSM-IV, has been arranged to cover both conditions in DSM-5. In ICD-10, other neurotic disorders are under the heading of diagnosis. The prevalence of the disorder that meets the diagnostic threshold is 1-3% in the general population and 16% in inpatient psychiatric patients (Hunter et al., 2004).

1.2.2. Childhood Traumas and Dissociation

Mental trauma has different effects on adults and children. Recurrent developmental traumas encountered in childhood have more devastating effects than a single traumatic event in adulthood. The susceptibility to dissociation is high in children, but this predisposition decreases with age (Şar, 2018). Childhood traumatic experiences constitute the main cause of dissociative disorders in adulthood. The dissociative mechanism is initially used by the child as an effort to overcome the traumatic experience. However, this mechanism turns into a pathological process incompatible with time (Putnam, 1997).

Reenactment of childhood traumatic events is quite common in the dissociative experiences in adulthood. Dissociative disorders are generally caused by childhood mental traumas, including suicide attempts, self-harming behaviors, unconsciousness, amnesias, concentration difficulties, affective instability (mood swings), revictimization (revictimization), anger outbursts, amnesias, and identity confusion (Lynn et al., 2019; Öztürk, 2003; Öztürk, 2009a; Van der Kolk and McFarlane, 2012).

Dissociative defenses make it difficult to accurately elaborate the danger. Dissociative disorder cases also frequently show the symptoms of post-traumatic stress disorder (Van der Kolk and McFarlane, 2012). Dissociation is basically a capacity that exists in every individual and serves to adaptation and functionality. However, with the chronic traumatization process that starts at an early age, a dissociative disorder may occur in an individual who is normally expected to have a healthy development. Dissociation initially occurs by the childhood as a process normally associated with an effort to overcome the traumatic experience. However, over time, this mechanism can turn into a non-adaptive and pathological process (Lynn et al., 2019).

The psychological response to trauma can occur in the form of dissociation, which negatively impacts the continuity of the individual's life. Dissociation assumes a

dual role here, which will cause the person to divide perceptions and memories and record them (Coons, 1998). On the one hand, it tries to protect the victims from the heavy burden of the trauma at the time of the event, on the other hand, it also prevents the reintegration of these separated traumatic experiences (Spiegel et al., 2011). While a part of the mind maintains the sense of control and dominance at the time of trauma, other mental processes can cause loss of control on a dissociative ground after the event is over (Spiegel, 1988).

Dissociative disorders, characterized by multiple or recurrent early-onset childhood traumatic experiences and suicide attempts, are a psychiatric diagnosis group that should be examined in multiple axes in terms of clinical psychology, psychiatry, and forensic psychiatry (Coons, 1998). When dissociative disorder cases are examined clinically, it can be thought that this subject is also within the scope of victimology, which is closely related to forensic psychiatry, considering that these cases are chosen as victims by their families or social circles and that they constantly encounter similar traumatic experiences of the dissociated person (Öztürk, 2003).

Traumatic events paralyze the normal coping systems that provide the individual's sense of connection, meaning, and control, and cause the person to experience extreme helplessness and horror. Therefore, repetitive childhood traumatic experiences that begin at an early age led people to dissociative defenses and experiences (Spiegel, 1997; Öztürk, 2003).

Despite the high prevalence rates of dissociative disorders among all psychiatric diseases and the large number of scientific publications related to this diagnosis group, the knowledge and experience of clinicians in their treatment is very limited, both in our country and in other countries (Akyuz et al., 1999; Dorahy et al., 2014; LaFrance et al., 2013). However, in recent years, the interest of both clinical psychologists and psychiatrists in traumatic dissociative disorders in our country has increased (Öztürk, 2003; Öztürk, 2009a; Şar, 2018). Effective results cannot be obtained with medical (drug) treatments and other psychotherapy methods that are not focused on the diagnosis of dissociative disorder (Coons, 1998). For this reason, it is very important to use clinically oriented and trauma-centered psychotherapy methods specific to this diagnosis to ensure complete well-being in the treatment of dissociative disorders (Öztürk, 2003; Öztürk, 2009a).

1.3. Self-Disgust

Disgust, one of the basic emotions, mainly indicates repulsions (Ekman & Cordaro, 2011). These repulsions mainly stemmed from the sense of bad taste that is experienced or vividly imagined. Additionally, disgust is related to anything that trigger certain sensations which occur secondly through the senses of smell, touch, or sight (Darwin, 2009; Ekman & Cordaro, 2011). In general, disgust coordinates the psychological and physiological mechanisms that primarily serve to avoid toxic things, parasites and infections (Tybur et al., 2013). This could be seen in expression of disgust. It is physiologically accompanied by reactions such as nausea and vomiting, and thus infectious substances are avoided or rejected (Rozin & Fallon, 1987).

Many different situations could cause disgust even though disgust evolved from the “distaste” response through preadaptation processes (Rozin et al., 2008). Similarly, La Rosa and Mir (2013) suggested that disgust is broader than unpleasant tastes and food refusal. People can experience disgust for some animals such as rats, spiders, worms, cockroaches, body products (feces, urine, saliva, sweat, etc.), poor hygiene, sexual stimuli, dead bodies, disruption of skin (blood, open wounds, etc.), visible signs of infection (lesion, color change, abnormal body proportions, etc.) and even some aggressive social behaviors, beliefs, institutions, people can experience disgust (Rozin et al., 1999). Additionally, disgust is crucial for individuals in terms of distancing themselves from other things as a matter of safety. Therefore, disgust can provide a censorship function (Rozin et al., 2008). In other words, people create a safe space for themselves by distancing themselves from the things they detest. In addition, the feeling of disgust can determine which situations or objects will be accepted in the society.

Clinical psychology offers empirical foundations for the notion that disgust can be directed in ways that are inconsistent with oneself. This has been described as a distinct emotion called "self-disgust," which encompasses feelings of loathing for one's appearance and behavior, especially when those acts go against the characteristics of the ideal self-concept (Moncrieff-Boyd, 2014).

It is a generally accepted that the understanding and rules of the culture in which the person lives play a very important role in its development and maintenance of self-perception as well as self-disgust. Gilbert (2015) stated that individuals desire to have a self-concept that is accepted and valued in their social environment, and they avoid being in any situation contrary to this. Therefore, it can be considered that self-disgust

may have a functional role in ensuring the continuity of the values held in the socio-cultural context (Powell et al., 2015). To maintain their commitment to these values and norms, individuals conduct a self-evaluation process by evaluating their possible selves in any situation or event.

1.3.1. Self-disgust as an emotional schema

Self-disgust also brings with it several different types of behavior (Eid and Diener, 2001). It has been suggested that self-disgust is a negative personality trait, a feeling similar to shame (Power & Dalgleish, 2008) and a unique sense of self-cognition (Roberts & Goldenberg, 2007). In recent studies, self-disgust is defined as an "Emotional Schema" that has both emotional and cognitive components (Powell et al., 2015). The "emotional schema" includes the fact that person directs disgust towards their own behavior, physical appearance, or psychological characteristics, and operates several cognitive evaluation processes**.** Since emotional schemas develop through experiences and social learning, it has been stated that experiences and previous learning influence cognitive evaluation processes (Powell et al., 2015).

Emotional schemas, as stated by Izard (2007), develop through the interaction of perceptions, emotions, and appraisals. Although it is accepted that the feeling dimension of emotional schemas has an evolutionary origin, it is suggested that especially perceptual and cognitive elements are affected by individual and cultural factors. Additionally, emotional schemas, unlike basic emotions, are long-term and increase in number with developmental processes including psychosocial development and vicarious learning processes (Powell et al., 2015). Emotional schemas are functional and constructive in dealing with the challenges of daily life within the sociocultural context. Besides, emotional schemas have both emotional and cognitive aspects and are activated by individuals' memories, inferences, and non-cognitive processes (e.g., hormones) (Izard, 1992). The combination of people's perceptions and thoughts with the new information they learn contributes to the formation of the emotional schema. On the other hand, it can be considered that over time, the consistency of emotional schemas can become stable features that support personality traits. In addition, the fact that emotional schemas have emotional and cognitive dimensions, being affected by developmental processes, shows that people's experiences and the culture they live in can have important effects on emotional schemas. For instance, as noted by Schultz et al. (2004), a child with an anger schema may cause him to respond to an anger-inducing

situation that other children would not. Over time, this can lead to aggression in the child.

According to the conceptualization of emotional schema, self-disgust is a maladaptive disgust response triggered by certain aspects of the self that are considered important to an individual's self-concept, considered stable, and cannot be easily changed (Izard, 2007). In this respect, it can be understood that the emotional and cognitive qualities included in the emotional schema are also consistent with the development of self-disgust. The emotional schema involves the dynamic interaction of disgust-based emotions with self-related cognitive components. That is, the emotional schema of self-disgust consists of relationships learned from an individual's early ages (criticism and abuse based on disgust) and includes interactions between self-perception, emotion, evaluation, and higher-order cognitions. Therefore, when individuals feel disgusted with themselves, they become preoccupied with other things and the tension may be relieved by self-harm (Powell et al., 2015a).

1.3.2. Self-disgust as a self-conscious emotion

Powell et al. (2015a) defines self-disgust as an experience of disgust as a result of one's negative self-evaluation. That's why self-disgust is considered among self-conscious emotions. Self-conscious emotions involve self-evaluation. This self-evaluation manifests itself in a person's evaluation related to bodily parts and behaviors (Powell et al., 2015b). This evaluation process makes self-disgust similar to self-conscious emotions such as shame, guilt. Self-conscious emotion motivates people to behave socially appropriately and morally in their close relationships and social interactions. For instance, guilt and shame may stem from behaviors that some people see as unethical. Additionally, these emotions can make it easier to realize what is seen as ethical because if it is not followed, a person will feel shame and/or guilt. Additionally, one may associate pride with good deeds and supporting doing similar actions in the future (Baumeister et al., 1994). Each emotion arises on a certain event and triggers a certain subjective experience. As stated in self-disgust, for self-conscious emotions, an individual’s evaluation of his/her characteristics can be negative and embarrassing unlike other people’s judgments towards herself. Additionally, emotional arousal for any specific event may have been shaped by people's previous learning (Powell et al., 2015b).

Being a self-conscious emotion, self-disgust entails a portion of a person's critical and unfavorable assessment of themselves. It varies from universal disgust in that it is aimed at oneself as opposed to another. Self-disgust has been conceptualized with two self-conscious and evaluation based as well as emotional components: self-criticism and self-hatred (Smith et al., 2015, p. 62). Self-criticism can be defined as negative self-labelling thoughts and judgement with negative emotions such as anger and criticism with the self (Kannan and Levitt 2013; Shahar et al, 2015; Whelton and Greenberg 2005). Additionally, self-hatred can be defined as continual feelings of inadequacy, worthlessness, guilt, and low self-esteem. Based on these definitions, self-criticism can be considered as one of the components of self-hatred. Besides, these two emotions can be also evaluated as complementary features of self-disgust.

In terms of self-disgust, the individual evaluates whether the social or moral norms of the society and one's own actions and physical appearance are consistent. This evaluation process enables the person to continue his/her life in harmony with the community that he/she lives ~~in~~ and facilitates consistent interpersonal relationships. However, a person can develop a sense of self-disgust by directing the primary emotion to oneself if he/she faces with inconsistency in his/her interpersonal relationship as well as his/her self-evaluation (Gilbert, 2007). For example, in a relational conflict, the person may think that she is wrong and reflect her self-evaluation through self-disgust.

1.3.3. Self-disgust and psychopathology

Self-disgust, which is associated with decreased psychological well-being, has an important role in the development and maintenance of mental health problems (Clarke, et al., 2019). Recently, the feeling of self-disgust has been studied more with psychopathologies such as mood disorders, PTSD, sexual dysfunction, body dysmorphic disorder, and eating disorders. In addition, the relationship of self-disgust with sleep disorders, emotion regulation strategies, self-harm, avoidance, self-regulation, impulsivity, alcohol use, and borderline personality disorder has previously studied (Lazuras et al., 2019; Akram et al., 2019).

It is thought that an important factor that can support the relationship of self-disgust with psychopathologists is that people have a severely critical attitude towards themselves and therefore self-harm can be observed. For example, Gilbert and colleagues (2004) emphasized that self-criticism, which plays an important role in the development and maintenance of many psychopathologies, is not a one-way process

and defined two different forms/functions as self-reassuring and self-persecution. A person can use the strategy of self-criticism in order to be a better, moral person in society, to have goals and values that he has determined individually, and to avoid making mistakes in this process. In this form, which is called “self-reassure”, the person criticizes oneself for being accepted individually, socially or morally. This form is more associated with feelings of anger, frustration, disappointment, and sadness. In the "self-harm" form of self-criticism, self-disgust is in the background.

Gilbert (2009) stated that people have certain criteria that they idealize themselves individually or socially, and they need to evaluate whether their thoughts, actions and characteristics match with each other. If there is no compatibility between idealization and reality, the person criticizes oneself in order to avoid certain parts of himself (physical appearance or psychological characteristics) or behaviors that he finds disgusting. According to this idea, self-criticism makes it easier for a person to cope with negative feelings through self-disgust and self-hatred. However, it has been stated that this form of self-criticism, called "self-harm", seriously affects the course of psychopathologies (Gilbert et al., 2006).

Studies in which feelings of self-disgust were evaluated in the context of mood difficulties suggested that self-disgust plays a mediating role in the relationship between various life events (illness, etc.) or dispositional factors (dysfunctional attitudes, cognitive distortions, etc.) and subsequent psychopathologies including depression and anxiety (Ypsilanti et al., 2018; Ypsilanti et al., 2019). Behavioral self-disgust is defined as the negative feelings and disgust that the person feels about her own actions, while physical self-disgust refers to the feeling of disgust about the person's external appearance (Jones et al., 2008). When reviewing the differences between behavioral and physical self-disgust in terms of their relationship with emotions, research findings demonstrated that anxiety is more strongly predicted by behavioral self-disgust compared to physical self-disgust (Jones et al., 2008).

Additionally, it has been noted that there are more studies examining self-disgust with depression symptoms (Brake et al., 2017; Overton et al., 2008; Powell et al., 2013; Ypsilanti et al., 2018; Ypsilanti et al., 2019). For example, in a study conducted by Overton et al. (2008), it was concluded that self-disgust is associated with depression and this situation is related to dysfunctional cognitions that lead to depressive symptoms. A longitudinal study by Powell et al. (2013) was conducted in which a non-

clinical sample was examined over a 12-month period of aversion and depressive symptoms. Researchers conceptualized self-disgust as a phenomenon that plays a mediating role in the relationship between dysfunctional attitudes (e.g. perfectionist tendencies) and depression (Powell et al., 2013). Additionally, it was concluded that the depression symptoms of the participants at 6 months and 12 months were significantly predicted by self-disgust.

There are also studies in the literature questioning the role of self-disgust in the difficulties experienced by people related to their body perceptions. (Neziroğlu et al., 2010; von Spreckelsen et al., 2018). In a study by von Spreckelsen and colleagues (2018), it was examined whether negative body image is related to self-disgust, disgust sensitivity and susceptibility. Results indicated the negative body image was found as significantly correlated with self-disgust, disgust sensitivity, and disgust susceptibility. Consistently certain studies also have shown that there is a positive correlation between disgust sensitivity and self-disgust (Moncrieff-Boyd et al., 2014; van Overveld et al., 2006). In the relationship between self-disgust and body image, individuals' level of disgust sensitivity is expected to be stronger, because disgust sensitivity is defined as a feature that suggests that disgust is an unpleasant emotion and should be avoided (van Overveld et al., 2006). Accordingly, in the same study by von Spreckelsen et al. (2018), self-disgust partly accounted for the association between disgust susceptibility and negative body image. Although previous studies have focused disgust sensitivity on pathologies, subsequent studies have found a self-disgust role between this disgust sensitivity and negative body image (Moncriett-Boyd et al., 2014; Neziroğlu et al., 2010 van Overveld et al., 2006; von Spreckelsen et al., 2018).

However, it was observed that self-disgust had a mediating role only in the relationship between disgust susceptibility and negative body image. Indeed, the results showed that depression and anxiety symptoms reported by people who lost their legs as a result of amputation was closely related to their feelings of self-disgust (Mckechnie & John, 2014). In another study based on this finding, it was suggested that the increase in the use of prosthetic legs in individuals is associated with reduced physical self-disgust (Burden, Simpson, Murray, Overton, and Powell, 2018). The results, which support this assumption, show that the physical self-disgust feeling experienced by individuals decreases with the increase in the use of prostheses.

Eating disorders as other forms of/ related to negative body image, are associated with Self-disgust. Therefore, studies related to eating disorders indicate body image dissatisfaction as a main triggering factor for eating psychopathology (Chu et al, 2015; Olatunji et al., 2015). According to Olatunji and colleagues' (2015) research, body image dissatisfaction is viewed as a physical dimension of self-disgust. Self-disgust due to body image disturbances triggers certain maladaptive behaviors and eating disorder symptoms including social withdrawal, and food restriction. For instance, in a recent study, it was stated that suicidal thoughts in people with high levels of physical self-disgust were significantly predicted by eating disorder symptoms Chu et al., 2015). The study findings show that self-disgust may be a condition that causes people with eating disorders symptoms to have a punitive attitude towards themselves. Additionally, self-disgust may differ based on the type of the behavior. For instance, for anorexia nervosa, there may be disgust due to the person's physical appearance, whereas among individuals with binge eating and bulimia nervosa, feeling of guilt or disgust can be experienced after binge eating episodes. The person may turn to dysfunctional eating behaviors to punish oneself and get away from disgusting thoughts. For example, in one study, it was found that physical self-disgust mediated the relationship between bulimia nervosa symptoms and shame (Olatunji et al., 2015).

1.3.4. Self-disgust and childhood traumas

Badour and Adams (2015) suggested that traumatic experiences may cause feelings of self-disgust in people. Similarly, Power and Dalgleish (2016) stated that people who were exposed to neglect and abuse in childhood are likely to develop feelings of disgust towards their bodies and themselves. Jung and Steil (2012), on the other hand, included self-disgust in the model in which they specifically explained the relationship between childhood sexual abuse experience and feeling of being contaminated, and suggested that self-abuse is related to sexual abuse. In another study, it was found that people who were exposed to sexual and physical abuse during their childhood experienced more physical and behavioral feelings of self-disgust compared to people who were not exposed to these traumatic experiences, and it was stated that traumatic experiences in childhood increased the risk of self-disgust (Ille et al., 2014). Petrak et al. (1997) found that self-disgust is one of the psychological distresses experienced by women who have been sexually assaulted, including those who have been sexually abused in childhood.

Studies focusing on the relationship between difficulties developing due to trauma and self-disgust were previously examined. It was noted that the focus of the first studies carried out was the feeling of self-disgust reported by individuals during the traumatic experience. In the studies carried out in the following years, the relationship between self-disgust and PTSD symptoms, which have a continuous quality, was tried to be understood (Brake et al., 2017). Experiences such as sexual or physical abuse can affect the evaluation processes of the person's physical integrity, moral and security notions, and may lead to the formation of self-disgust that are permanent and maladaptive. A comparison was made between individuals with PTSD symptoms due to the impact of abuse in early childhood and a healthy control group in terms of reported feelings of self-disgust (Rüsch et al., 2011). Compared to the control group, it was observed that people who were exposed to sexual abuse during their childhood reported their feelings of self-disgust significantly higher.

There are different views on when self-disgust first develops. Power and Dalgleish (2015) stated that the development of this emotion dates to early childhood. It has been suggested that parental attitudes in this period have an important role in the development of self-disgust. Persistent disgust-based criticism from family members

1.3.5. Self-disgust and dissociation

Self-disgust can be considered as a result for someone’s perception regarding his psychological symptoms. For instance, a person with depressive symptom may think that his symptoms and inactivity as disgusting. At that moment, the person is trying to protect himself from the disturbing stimulus. In self-disgust, the thing that bothers the person is oneself (Chu et al., 2022).

When considering the relationship between dissociation and self-disgust, it is important to examine the emotions that may support the relationship. First, it is possible that the person experiences negative emotions such as shame or anger due to their traumatic experiences and develops dissociative symptoms when they have difficulties in coping with these emotions. Studies have also suggested that dissociation may be a defense against the feeling of shame that occurs after a traumatic experience (Lewis, 1971; Kaufman, 1989). In addition, in a study conducted by Talbot et al. (2004), it was determined that there was a significant relationship between shame-proneness and dissociative symptoms.

Lewis (1971), the researcher who presented the theoretical framework for the relationship between dissociation and shame, used the term *bypassed shame*. According to this approach, the feeling of shame poses a threat to the integrity of the person and must develop defenses to overcome this situation. To cope with this situation, they may use certain strategies including neglect, harming themselves, harming others or withdrawal. On the other hand, Van der Kolk (2014) stated that the feeling of shame arises because of unresolved trauma. In other words, shame is in the background of the trauma and is often not expressed. For this reason, it is the case that the person adopts maladaptive coping skills to cope with the unspoken feeling of shame. According to the results obtained in the previous studies, evidence was obtained regarding the relationship between the feeling of shame felt as a result of the traumatic event and dissociation (Goldsmith et al., 2012; Steele et al., 2016; Van der Kolk, 2014).

Unlike the feeling of shame, which is claimed to have a strong connection with dissociation, the feeling of disgust, which is thought to have an important effect, but limited research has been conducted, is also an important indicator in explaining the relationship between trauma and dissociation. As stated by Vogt (2012), the feeling of disgust is an important symptom for the diagnosis of complex trauma and dissociative disorder. In addition, the feeling of disgust is secretly experienced in traumatized and dissociated individuals and may be reflected by symptoms such as somatic complaints or phobias.

In the study conducted by Chu et al. (2022), they examined the self-evaluation of the person in dissociation. In line with the data of 106 people with mental symptoms who participated in the study, it was concluded that people with dissociative symptoms matched themselves with rejecting and revolting expressions rather than acceptance-related expressions. Therefore, the person experiences detachment in order to escape that undesired condition. Additionally, self-disgust may be a correlate of other constructs such as shame which do explain the development of a psychopathology. For example, sexual abuse may create both feelings of shame and self-disgust. Therefore, these emotions may trigger dissociative symptoms (Powell et al., 2015a).

Powell et al. (2014) highlighted the importance of the nature of self-disgust with their study. They reported severe psychological and behavioral reactions to self-disgust under these circumstances. These reactions were related to the desire to literally cut

away or cleanse the disgusting part of the self, dissociating the "disgusting" self from the rest of one's identity, and withdrawing from other people.

Similar experience was described in the other studies (Espeset et al., 2012; Jones et al., 2008; Jung and Steil, 2012). In these studies, a physical sense of repulsion and nausea, social withdrawal, extreme desire at cleansing; (Jung and Steil, 2012) and a degree of dissociation and cognitive avoidance from the "disgusting" part of the self were reported (Espeset et al., 2012).

1.4. Current Study

This study examines the relationship between self-disgust, childhood traumas and dissociation. In addition, it is seen that the relationship between childhood traumas and dissociation has been found in previous studies. On the other hand, studies examining the mediating role of self-disgust in the relationship between childhood traumas and dissociation are limited. Therefore, this research will be a current study examining the effect of self-disgust on childhood traumas and dissociation.

1.5. Hypotheses

The hypotheses of the study are listed as following:

H1: There is a statistically significant relationship between childhood traumas and self-disgust.

H2: There is a statistically significant relationship between childhood traumas and dissociation.

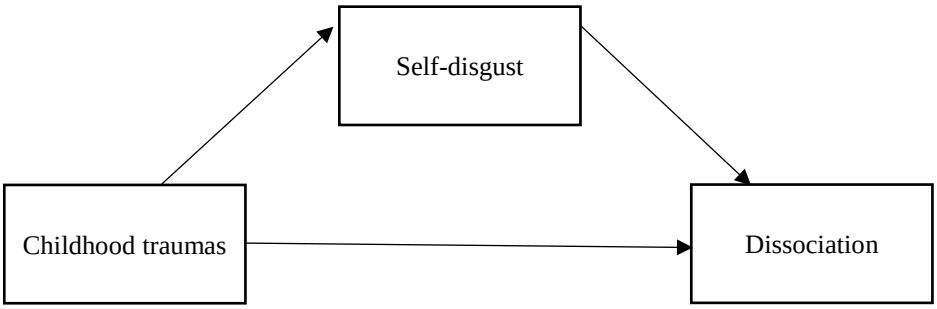
H3: There is a statistically significant relationship between self-disgust and dissociation.

H4: There is a mediating role of self-disgust in the relationship between childhood trauma and dissociation.

Based on the hypothesis listed above, this research model was examined for this study:

Figure 1.

Research model



CHAPTER 2

MATERIALS AND METHODS

2.1. Participants

For the study, questionnaires were provided to participants to find out the relationship of childhood traumas with dissociation and self-disgust. The sample of the study consisted of adults between the ages of 21 and 50. First of all, the number of samples in the study is 417. Due to age range between participants, individuals aged below 21 and above 50 were excluded from the data set. Before data analysis, it was determined that there were 376 valid data. The sample size were 376 individuals for the study. The questionnaires which were provided by the researcher are listed with their background information below:

2.2. Measurement Instruments

2.2.1. Sociodemographic information form

It is a questionnaire developed by the researcher and includes personal variables. In the form, there are multiple choice questions about gender, age, marital status, education level, income level, psychiatric diagnosis, and chronic disease variables.

2.2.2. Childhood trauma questionnaire – revised form (CTQ-33)

Developed in 1994 by Bernstein and colleagues. In the form consisting of 33 items, a total score consisting of five sub-scores on childhood sexual, physical, emotional abuse and emotional and physical neglect and their combination can be obtained (Bernstein et al., 1994). In the original study, Cronbach alpha values were found between .79 and .94. The validity and reliability study of the scale in Turkish was conducted by Şar and colleagues 2012 (Şar et al., 2012). In the present study, it was found that the Cronbach alpha internal consistency coefficients of the sub-dimensions varied between .64 and .87. In this study, Cronbach alpha coefficient for CTQ total score was found as .75

2.2.3. Self-disgust scale

The Self-Disgust Scale is a 12-item self-report scale developed to evaluate the level of disgust that individuals have about their physical appearance and behavioral characteristics (Overton et al., 2008). The psychometric properties of the developed

scale were reviewed by Powell et al. (2015) on a sample of 293 university students. This revised new form is a 7-point Likert-type (0: I do not agree at all, 7: I completely agree) self-report-based measurement tool with 22 items. Seven items were added to rebalance the content of the scale. In the analyzes, these items are excluded, and the other 15 items are used. It consists of two sub-dimensions: Physical Self-Disgust and Behavioral Self-Disgust. There are five items in each of the sub-dimensions. Four items in the scale are reverse coded. The total score that individuals get from the SDS varies between 0 and 105. However, Powell et al. (2015), as a result of their factor analysis, found that two separate five items were collected in two factors: physical self-disgust and behavioral self-disgust, and the remaining five overlapping items were cross loaded on these two factors. Accordingly, he stated that the total score obtained from the scale can be calculated on the items in the two subscales. In this form of scoring, the total score that individuals can get from the scale varies between 0 and 70.

The results of validity and reliability analysis showed that the internal consistency coefficient and construct validity value of the scale were at a satisfactory level. The Cronbach value of the scale was found to be .92 and it was found to be moderately correlated with the Disgust Sensitivity sub-dimension of the Disgust Tendency and Sensitivity Inventory-Revised Form (Van Overveld et al., 2006).

Another study was conducted with 526 university students in order to re-examine the psychometric properties of the scale (Burden et al., 2018). Confirmatory Factor Analysis results showed that both single-factor (CFI = .832, RMSEA = .124, 95% CI [.116, .132]) and two-factor (CFI = .948, RMSEA = .074, 95% CI [.066, .083]) indicated support for the proposed structure. The results obtained from the reliability analysis showed that the Cronbach Alpha coefficient was .92 for the whole scale, .86 for physical self-disgust and .78 for behavioral self-disgust. Turkish adaptation of the scale was conducted by Bahtiyar and Yıldırım in 2019. The psychometric properties of the scale indicated that reliability coefficients 0.78 and 0.71 for two subscales. In this study, Cronbach alpha coefficient for Self-Disgust Scale total score was found as .71

2.2.4. Dissociative Experiences Scale (DES)

Dissociative Experiences Scale is a 28-question self-assessment scale developed by Bernstein and Putnam to evaluate the dissociative experience levels of individuals. Turkish validity and reliability studies of the scale were conducted by Şar, Öztürk and İkikardeş in 2012.

For each item of the scale, individuals score between 0% and 100%, and the result is obtained by calculating the average of the scores. Along with the Dissociative Experiences Scale subscale item numbers, depersonalization / derealization (1, 7, 11, 12, 13, 16, 27, 28), amnesia (3, 4, 5, 6, 8,9, 10, 25, 26) and It consists of three subscales: absorption (2, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24). Scores above 30 from the scale indicate the presence of dissociative disorder. Internal consistency of the scale's reliability (Cronbach alpha = 0.91) and test-retest score (r = 0.78) were found to be high. In this study, Cronbach alpha coefficient for Dissociative Experiences Scale total score was found as .93

2.3. Study Design

The convenience sampling method was be used for the data collection in this study. The data will be collected by using "Google Forms" which is an online questionnaire tool. The link to the forms was shared via various social media.

First, the respondents will be asked to complete an informed consent form. In that form, the respondents will be informed about the aims of the study, that the study participation is voluntary, and they have a right to withdraw at any point without penalty. They will be also provided with the researcher's contact information in case they have any questions about the study. The respondents who completed the informed consent form will go on to complete the demographic information form, Turkish forms of Self Disgust Questionnare, CTQ-33 and DES. After all the forms had been completed, the respondents will be asked if they wanted to save their responses. The entire data collection process will take approximately 10–15 minutes.

CHAPTER 3

FINDINGS

3.1. Descriptive Findings

Table 1.

Descriptive Statistics of the Sample

Sociodemographic Variables	*Groups*	*N*	*%*
Gender	Male	110	29.3
	Female	266	70.7
Marital Status	Single	188	50.0
	Divorced / Widowed	8	2.2
	Married	78	20.7
	In a relationship	102	27.1
Income	Low	45	12.0
	Middle	281	74.7
	High	50	13.3
Living with whom?	Living with family	221	58.8
	Living with friends	15	4.0
	Living with partner/spouse	80	21.3
	Living alone	60	16.0
Employment	Unemployed	105	27.9
	Full time job	218	58.0
	Part-time job	53	14.1
Chronic Disease	Yes	60	16.0
	No	316	84.0
Psychological Support	Yes	157	41.8
	No	219	58.2
Smoking	I Quit	26	6.9

"Table 1 (Continued)"

	Yes	157	41.8

	No	193	51.3
Alcohol Use	Yes	242	64.4
	No	134	35.6
Family psychiatric Illness history	Yes	78	20.7
	No	298	79.3
Family chronic illness	Yes	169	44.9
	No	207	55.1
	Total	**376**	**100.0**

Table 1 shows the frequency distributions of the participants' sociodemographic variables. Among the 376 participants, the rate of women is 70.7% and the rate of men is 29.3%. When the marital status of the participants was examined, singles were 50.0%; married 20.7%; Those who have a relationship are 27.1% and those who are divorced are 2.2%. Those with low-income level are 12.0%; medium levels are 74.7% and high levels are 13.3%. 58.8% of those living with their families; living with friends 4.0%; 21.3% living with their spouse/partner and 16.0% living alone. Unemployed participants are 27.9%; those working in a full-time job are 58.0% and those working in a part-time job are 14.1%. There are 16.0% participants with chronic diseases. There are 41.8% of the participants who stated that they received psychological support. 6.9% of those who quit smoking; smokers 41.8%; the rate of non-smokers is 51.3%. Participants who drink alcohol are 64.4%. There are 20.7% of the participants stating that there is a psychiatric disease in their family. There are 44.9% participants stating that they have a chronic disease in their family.

Table 2.

Descriptive Statistics of the Questionnaires

Variables	*N*	*M*	*SD*	*Skewness*	*SE*	*Kurtosis*	*SE*
Dissociation	376	15.92	12.39	1.27	.12	1.28	.25
Self-Disgust	376	28.56	10.22	1.18	.12	1.00	.25
CTQ	376	42.83	10.76	1.12	.12	.94	.25

Note: CTQ=Childhood Trauma Questionnaire

According to the descriptive findings in Table 2, the mean, standard deviation, skewness and kurtosis values of the scores obtained by the participants from the scales are given. According to the results, it is seen that the skewness and kurtosis values of total scores of dissociation, self-disgust and childhood traumas were found as normally distributed. Mahalanobis distance values were checked for the detection of outlier values and values below the 0.001 level. The total number of participants was 376 people. Based on the findings, no outliers were found prior to data analyses. Mahalanobis Distance and Cook Distance and which are the outlier determination methods, are the outlier data points determined by the combinations of the variables (Tabachnick and Fidell, 2013).

3.2.Correlational Findings

Table 3.

Correlational Findings

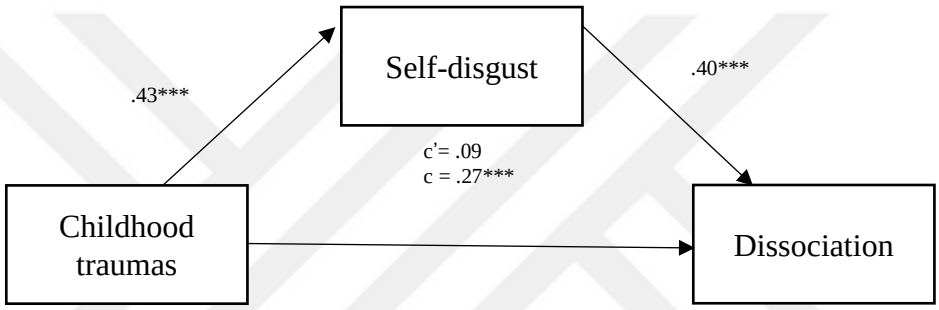
Variables	*M*	*SD*	*1*	*2*	*3*
1. Dissociation	15.92	12.39	1		
2. Self-Disgust	28.56	10.22	.37**	1	
3. CTQ	42.83	10.76	.24**	.46**	1

***p<.01, Note: CTQ=Childhood Trauma Questionnaire*

Based on the findings in Table 3, there was a positive and significant correlation between dissociation and self-disgust (r=.37; p<.01). A significant and positive correlation was also found between dissociation and childhood traumas (r=.24; p<.01). Self-disgust scores were found as significantly and positively correlated with childhood trauma total scores (r=.46; p<.01).

3.3. Mediation Analysis Findings

Figure 2. *Mediation analysis with childhood traumas, dissociation and self-disgust*



When the relationship between childhood traumas and self-disgust is examined (path a), the predictor of childhood trauma (B=0.43, SE=0.04, p<.01) on self-disgust is significant. According to the results, childhood traumas significantly predict individuals' self-disgust levels positively and significantly. When the direct effect of self-disgust on dissociation levels was examined (path b), it was found that self-disgust (B= .40, SE=0.06, p<.01) significantly and positively predicted dissociation scores. The participants' self-disgust scores positively and significantly predicted their dissociation scores. According to the findings obtained in the analyzes conducted with the bootstrap method, the total effect (path c) on childhood traumas dissociation was found to be significant (B= .27, SE=0.05, p<0.01). In addition, the direct effect of childhood traumas on dissociation (path c´) was not statistically significant (B=0.09, SE=0.06; p>0.05). When the mediating role of self-disgust in the relationship between childhood traumas and dissociation is examined (B=0.17, SE=0.03, 95% CI [0.110, 0.256]), the mediating role of self-disgust is statistically significant. The mediation of self-disgust is significant since the confidence intervals do not include 0. Finally, when the

significance of the whole model was examined, it was seen that the whole model was significant and explained 6% of the variance (R^2= 0.06 F (2, 374) =22.27, p<0.001).

CHAPTER 4

DISCUSSION

The aim of the present study was to examine mediating role of self-disgust on the relationship between childhood traumas and dissociation among Turkish adult individuals. Based on this research objective, firstly descriptive analyses were conducted. Then, to examine the relationship between variables, correlational analysis was performed between scales (Childhood Trauma Questionnaire (CTQ-33), Dissociative Experiences Scale, and Self-Disgust Scale). Lastly, mediation analysis was conducted to explore the role of–self-disgust on the relationship between childhood traumas and dissociation.

In this section, results will be discussed in the lights of previous literature. Moreover, limitations of the study will be provided and directions for future research will be presented. Lastly, clinical implications will be listed.

4.1. Findings Related to Correlation Analysis

Based on the findings obtained in the study, it was found that the childhood trauma scores of the participants had a positive and significant relationship with dissociation and self-disgust scores. This shows that participants with high childhood trauma scores also have high dissociation and self-disgust scores. When the relevant literature is examined, it is seen that the research findings are consistent.

When reviewing the literature related to the relationship between childhood traumas and self-disgust, previous studies emphasized the significant relationship between early traumatic experiences and self-disgust. For instance, Badour and Adams (2015) suggested that traumatic experiences may cause feelings of self-disgust in people. Similarly, Power and Dalgleish (2016) stated that people who were exposed to neglect and abuse in childhood are likely to develop feelings of disgust towards their bodies and themselves. Jung and Steil (2012), on the other hand, included self-disgust in the model in which they specifically explained the relationship between childhood sexual abuse experience and feeling of being contaminated, and suggested that self-abuse is related to sexual abuse. In another

study, it was found that people who were exposed to sexual and physical abuse during their childhood experienced more physical and behavioral feelings of self-disgust compared to people who were not exposed to these traumatic experiences, and it was stated that traumatic experiences in childhood increased the risk of self-disgust (Ille et al., 2014). Petrak et al. (1997) found that self-disgust is one of the psychological distresses experienced by women who have been sexually assaulted, including those who have been sexually abused in childhood. This result suggests that the possibility of self-disgust tends to be higher, both physically and psychologically, due to the the effects of traumatic experience including self-blaming thoughts due to trauma or abuse, thinking that they are the problem because such an event has happened to them, and a sense of worthlessness.

Similar with the findings in this study, previous research conducted for examining the relationship between trauma-related symptoms and self-disgust were noted that the focus of the first studies carried out was the feeling of self-disgust reported by individuals during the traumatic experience. In the studies carried out in the following years, the relationships between self-disgust and PTSD symptoms, which have a continuous quality, were tried to be understood (Smith et al., 2015; Dyer et al., 2015; Brake et al., 2017). Experiences such as sexual or physical abuse can affect the evaluation processes of the person's physical integrity, moral and security understanding, and may lead to the formation of self-disgust feelings that are permanent and maladaptive. A comparison was made between individuals with PTSD symptoms due to early childhood abuse and a healthy control group in terms of reported feelings of self-disgust (Rüsch et al., 2011). Compared to the control group, it was observed that people who were exposed to sexual abuse during their childhood reported their feelings significantly higher levels of self-disgust. This result, which was pointed out by the analyzes, was also supported by the study conducted by Brake et al. (2017). They suggested that self-disgust is one of the important factors explaining the relationship between PTSD symptoms and suicide attempts. It has been found that self-disgust is closely related to suicide risk, as it contributes to the formation and maintenance of cognitive distortions (Chu et al., 2013).

Another significant finding in this study was the relationship between dissociation and traumatic experiences. The results of the study provided consistent

results with related literature. It was stated that dissociative defenses make it difficult to accurately elaborate the danger. Consistently, dissociative disorder cases also frequently show the symptoms of post-traumatic stress disorder (Van der Kolk and McFarlane, 2012). Besides, dissociation is basically a capacity that exists in every individual and serves to adaptation and functionality. However, with the chronic traumatization process that starts at an early age, a dissociative disorder may occur in an individual who is normally expected to have a healthy development. Dissociation initially occurs by the childhood as a process normally associated with an effort to overcome the traumatic experience. However, over time, this mechanism can turn into a non-adaptive and pathological process (Lynn et al., 2019).

When reviewing previous literature regarding the connections between dissociation and childhood traumatic experiences, it was noted that dissociative disorders which are characterized by multiple or recurrent early-onset childhood traumatic experiences and suicide attempts, are a psychiatric diagnosis group that should be examined in multiple axes in terms of clinical psychology, psychiatry, and forensic psychiatry (Coons, 1998). When dissociative disorder cases are examined clinically, it can be thought that this subject is also within the scope of victimology, which is closely related to forensic psychiatry, considering that these cases are chosen as victims by their families or social circles and that they constantly encounter similar traumatic experiences of the dissociated person (Öztürk, 2003).

Based on the statements from the previous literature as well as conceptualizations, the relationship between childhood traumas and dissociative experiences has been proven (Van der Kolk et al., 1991). It can be said that the results obtained from this study are consistent with the related studies (Şar, 1998). Dissociative experiences, which are developed as a defense mechanism despite the traumas experienced in childhood, protect the ego integrity of the individual and ensure that such anxiety-inducing memories are removed from the level of consciousness. Thus, instead of dealing with these memories and experiences, the person prevents them.

When considering the underlying factors related to the relationship between dissociation and childhood traumatic experiences, It can be associated with the fact that while a part of the mind maintains the sense of control and dominance at the time of trauma, other mental processes can cause loss of control on a dissociative

ground after the event is over (Spiegel, 1988). Therefore, traumatic events paralyze the normal coping systems that provide the individual's sense of connection, meaning, and control, and cause the person to experience extreme helplessness and horror. Therefore, repetitive childhood traumatic experiences that begin at an early age led people to dissociative defenses and experiences (Spiegel, 1997; Öztürk, 2003). Based on these findings and statements explaining possible mechanisms related to trauma and dissociation, it can be said that the study provided consisted results with previous explanations.

In this study, it was also found out that there was a significant relationship between dissociation and self-disgust. When reviewing the relationship between dissociation and self-disgust in the previous literature, it is important to note that the emotions that may support the relationship. First, it is possible that the person experiences negative emotions such as shame or anger due to their traumatic experiences and develops dissociative symptoms when they have difficulties in coping with these emotions. Studies have also suggested that dissociation may be a defense against the feeling of shame that occurs after a traumatic experience (Lewis, 1971; Kaufman, 1989). In addition, in a study conducted by Talbot et al. (2004), it was determined that there was a significant relationship between shame-proneness and dissociative symptoms.

In terms of explaining the relationship between dissociation and self-disgust, the connections between shame and dissociations should be considered, because shame is considered as one of the self-conscious emotions associated with self-disgust. Lewis (1971), the researcher who presented the theoretical framework for the relationship between dissociation and shame, used the term *bypassed shame*. According to this approach, the feeling of shame poses a threat to the integrity of the person and must develop defenses to overcome this situation. To cope with this situation, they may use certain strategies including neglect, harming themselves, harming others or withdrawal. On the other hand, Van der Kolk (2014) also provided consistent framework regarding the relationship between shame and dissociation. He stated that the feeling of shame arises because of unresolved trauma. In other words, shame is in the background of the trauma and is often not expressed. For this reason, it is the case that the person adopts maladaptive coping skills to cope with the unspoken feeling of shame. According to the results obtained in the previous studies,

evidence was obtained regarding the relationship between the feeling of shame felt as a result of the traumatic event and dissociation (Goldsmith et al., 2012; Steele et al., 2016; Van der Kolk, 2014).

When considering the findings in this study, it is important to emphasize the influences of cultural differences in emotional experiences and expression styles. Emotional experiences are influenced by cultural differences as well. The idea of ideal affect, which refers to the emotional condition that a culture encourages people to strive towards, was first introduced by Tsai, Knutson, and Fung in 2006. For instance, although Eastern cultures frequently value low-arousal good moods like tranquility, Western cultures frequently favor high-arousal positive states like exhilaration. Additionally, evidence for "independent" and "interdependent" perspectives of the self that differ across cultures and affect emotional experiences was provided by Kitayama, Markus, and Kurokawa in 2000. While people in interdependent cultures (usually Eastern) feel more other-focused emotions like empathy, persons in independent cultures (generally Western) tend to be more self-enhancing.

Turkish culture is well renowned for emphasizing close communal relationships, kindness, and emotional openness. Particularly in families and close relationships, there is frequently open, expressive exchange of feelings (Kagitçibasi, 2005). Similar to many collectivist cultures, Turkish people frequently use high-context communication (Hall, 1976). The use of implicit signals and nonverbal cues is prevalent in this approach. Therefore, rather than relying solely on vocal expressions, it may be necessary to pay closer attention to nonverbal signs and context.

Similar to the feeling of shame, which is stated with its connections with dissociation, it can be observed that a significant association between self-disgust and dissociation were studied. For instance, in the study conducted by Chu et al. (2022), it was concluded that people with dissociative symptoms matched themselves with rejecting and revolting expressions rather than acceptance-related expressions. Therefore, the person experiences detachment to escape that undesired condition. Additionally, the feeling of disgust, which is thought to have an important effect, but limited research has been conducted, is also an important indicator in explaining the relationship between trauma and dissociation. As stated by Vogt

(2012), the feeling of disgust is an important symptom for the diagnosis of complex trauma and dissociative disorder. In addition, the feeling of disgust is secretly experienced in traumatized and dissociated individuals and may be reflected by symptoms such as somatic complaints or phobias.

In addition to the relationship of self-disgust with trauma and dissociation, previous studies in which self-disgust was conducted in the context of mood difficulties were conducted. For instance, Stewart et al. (2020) asserted that mood disorders have been studied as major comorbid conditions observed in trauma and dissociation.

In their studies, it is suggested that self-disgust plays a mediating role in the relationship between various life events (illness, etc.) or predispositional factors (dysfunctional attitudes, cognitive distortions, etc.) and subsequent psychopathologies including depression and anxiety (Simpson et al., 2010; Powell et al., 2013; Ypsilanti et al., 2019). There are certain research results indicating that anxiety is more strongly predicted by behavioral self-disgust compared to physical self-disgust (Jones et al., 2008).

Apart from the possible connections of self-disgust with childhood traumas and dissociation, it has been noted that there are more studies examining depressive symptoms in addition to childhood traumas as compared with the studies indicating the relationship between self-disgust and trauma. A longitudinal study was conducted in which the self-disgust and depressive symptoms of a non-clinical sample were examined over a 12-month period. Researchers conceptualized self-disgust as a phenomenon that plays a mediating role in the relationship between dysfunctional attitudes (such as perfectionist tendencies) and depression (Powell et al., 2013). It was concluded that the depressive symptoms of the participants at 6 months and 12 months were significantly predicted by self-disgust. Recently, two studies were conducted examining the influence of self-disgust on the depressive symptoms among people diagnosed with cancer (Azlan et al., 2017). The sample of the first study consisted of people diagnosed with cancer with a high level of disgust sensitivity (Powell et al., 2016). It has been found that both physical and behavioral self-disgust play a mediating role in the relationship between the side effects of cancer-related disgust and depression. However, in the second study conducted by Azlan et al. (2017), it was found that depression in individuals diagnosed with cancer

and in the process of treatment was more strongly predicted by physical self-disgust rather than behavioral self-disgust. Although it is noteworthy that there are conflicting results in terms of types of self-disgust, the common understanding that has developed with the studies carried out to date is that the feeling of self-disgust plays an important role in the etiology of depression. When considering the importance of depressive symptoms in self-disgust, it is important to include possible depressive symptoms which could be observed due to traumatic experiences. Therefore, the relationship between mood difficulties and self-disgust can facilitate further studies related to childhood trauma and self-disgust.

4.2.Findings Related to Mediation of Self-Disgust on the Relationship Between Childhood Traumas and Dissociation

Based on the mediation analysis findings, it was concluded that childhood traumas do not predict dissociation and the prediction was significant in the presence of self-disgust. Self-disgust can be considered as a triggering factor for individuals with a childhood traumatic history to have dissociative symptoms.

When the relevant literature is examined, it is seen that the relationship between self-disgust and childhood traumas has been examined previously. However, , studies examining the mediating role of self-disgust in the relationship between childhood traumas and dissociation are limited. In a study by Simpson and colleagues (2020), the mediating role of self-disgust in the relationship between childhood traumas and psychosis was examined. The aim of the study was to examine the extent to which the levels of self-disgust in people with a history of psychosis and childhood traumatic history affect the relationship. The study aimed to examine whether self-disgust is a transdiagnostic element or not. 78 people who stated that they had a history of psychosis participated in the study. Participants responded to questionnaires on variables of childhood traumas, self-disgust, psychosis, self-esteem, and external shame. Based on the finding in this study, it was found that childhood traumas have a significant and indirect effect on negative and positive symptoms of psychosis through self-disgust. In addition, the indirect effect was found to be significant when self-esteem and shame variables were controlled. In their research, examining the effect of the relationship between childhood traumas and self-disgust on psychosis, it is based on the idea that one's body is contaminated both physically and emotionally by someone else, especially as a result of childhood

abuse. It is stated that this emotion, which is revealed by the traumatic experience, turns into a maladaptive self-disgust in later periods (Badour et al., 2013). It is also stated that this situation may create a risk factor for later dissociation and psychosis experiences. When considered in terms of dissociation, it is thought that dissociation can be considered as a maladaptive defense in which the person is sometimes deliberately involved, rather than the experience of being disconnected from reality as much as psychosis. For instance, in addition to clinical psychotherapy studies, the emphasis on the concept of 'hysterical psychosis' played a role in the initiation of systematic studies in the field of dissociative identity disorder (DID) in Turkey. In research conducted by the Istanbul Medical Faculty group in 1995, it was argued that there was a clear link between hysterical psychosis and DID categories, that DID cases could apply to psychiatry with hysterical psychosis, and that hysterical psychosis constitutes a diagnostic perspective for DID. This view has attracted great interest at the international level, and it has been accepted that this is the first study that clearly indicates this link (Tutkun et al., 1996).

Along with the studies carried out, it is noteworthy that the self-disgust feelings of individuals have an important role in the development of PTSD symptoms. For instance, in the context of childhood trauma, there is a significant overlap between the sensations of self-disgust and contamination. For instance, those who have experienced childhood abuse, especially CSA, frequently describe feeling contaminated on the inside or outside (Badour & Feldner, 2016). When people feel "tainted" or "dirty" as a result of the traumatic experience, it can be said that they are exhibiting self-disgust in the form of this sensation of contamination.

In previous studies, self-disgust modulates the link between adolescent psychological suffering and childhood trauma. Childhood trauma, such as sexual or physical abuse, is frequently associated with long-term feelings of self-disgust and contamination. Survivors may perceive themselves as permanently "dirty" or "tainted" due to the abusive experiences (Badour, Feldner, Babson, Blumenthal, & Dutton, 2013).This shows that those who have gone through childhood trauma may suffer self-disgust, which can lead to a number of psychological problems as they get older. For this reason, it is stated in the literature that interventions to reduce PTSD symptoms should be shaped by including feelings of self-disgust (Jung and Steil, 2012, 2013). It is noteworthy that there are studies in the literature that question the

role of self-disgust in the difficulties experienced by people related to body perceptions. (Stasik-O'Brien and Schmidt, 2018; von Spreckelsen et al., 2018). In a study, it was examined whether negative body image is related to self-disgust, disgust sensitivity and susceptibility (von Spreckelsen et al., 2018). It has been suggested that self-disgust plays a mediating role in existing relationships. The results of the analysis indicated that negative body image was significantly associated with an increase in disgust susceptibility, disgust sensitivity, and self-disgust severity. However, it was observed that self-disgust had a mediating role only in the relationship between the tendency to disgust and negative body image. However, the results obtained showed that the level of depression and anxiety symptoms reported by people who lost their leg as a result of amputation was closely related to their feelings of self-disgust (Mckechnie et al., 2014). In another study based on this finding, it was suggested that the increase in the use of prosthetic legs in individuals was associated with reduced physical self-disgust (Burden et al., 2018). The results obtained in support of this assumption show that the physical self-disgust feeling experienced by individuals decreases with the increase in the use of prostheses. When the studies conducted within the scope of eating disorders in which body image dissatisfaction is seen as an important symptom are examined, it has been observed that the results indicating that the physical dimension of self-disgust triggers and sustains behaviors such as social withdrawal, food restriction, and avoidance of body awareness (Espeset et al., 2012). In a recent study, it was stated that eating disorder symptoms predicted suicidal thoughts in people with high levels of physical self-disgust (Chu et al.,2015). Another study discovered that the link between the symptoms of bulimia nervosa and shame was mediated by physical self-disgust (Olatunji et al., 2015).

4.3.Strengths and Limitations of the Research

This study which is allowing us to understand the complex relationships between various variables has several strengths. First, it is seen that there are previous studies on childhood traumas, but studies examining the variables of self-disgust and dissociation together with childhood traumas are limited. In this respect, it is thought that the research can contribute to the literature.

The strength of this research is that previous studies have seen studies examining the relationship between trauma and dissociation or trauma (e.g. Lynn et

al., 2019; Öztürk, 2003; Öztürk, 2009a; Van der Kolk and McFarlane, 2012) and self-disgust (e.g. Brake et al., 2017; Rüsch et al., 2011), but it has been noticed that research examining the role of self-disgust in the relationship between trauma and dissociation is limited. The aim of this study is to determine the extent to which self-disgust makes a difference between the variables whose bilateral connections were examined before. In this respect, it can be said that the contribution of the research to the literature is a strong aspect.

In addition to its strengths, this study has various limitations. The first of these concerns is studying of "childhood trauma", which is a sensitive concept that, when asked, can trigger participants about their respective experiences. On the other hand, the study was conducted with online surveys and the absence of face-to-face communication with the participants can be male and female participants is not equal in our study, and it can be said that there is an important difference between the groups in terms of the number of people. While this makes it difficult to generalize the results obtained on the relationship between gender and childhood traumas, self-disgust, and dissociation. Additionally, the number of people in employed and unemployed groups is not equal, the difference between these two groups is significant.

However, the reason for the stated limitations is the necessity of collecting data during the COVID 19 pandemic process. On the other hand, the fact that individuals have more access to online applications in this process has brought along the provision of therapeutic support online. In this case, the use of online surveys to reach the participants is due to the limited use of face-to-face surveys and many other services in COVID 19 outbreak.

4.4.Clinical Implications

In the psychotherapy process, the situations and events that trigger the self-harming behavior, the negative automatic thoughts that pass through the person's mind before the behavior, and the evaluation of the emotions created by these thoughts and the physiological symptoms. However, it is stated that questioning dysfunctional automatic thoughts and developing functional, helpful and more realistic thoughts instead of these thoughts will play an important role in the treatment of self-harming behaviors (Simmons and Griffths, 2014).

The experience of self-disgust, the intensity of this emotion, and the evaluation of the change in the intensity of emotion after the behavior, and the emotions that trigger dissociation, in this direction, as self-disgust, which is thought to be important to examine as an transdiagnostic structure in case of dissociation in childhood traumas, plays a role in the continuation of these behaviors. Simpson and colleagues (2020) also focused on the fact that self-disgust is a transdiagnostic element when working with childhood traumas and dissociation. Based on previous findings related to self-disgust, it can be stated that gaining more functional and alternative coping methods which are mainly focused on self-disgust, will contribute to the treatment process. Finally, if there is a childhood abuse history, it is thought that the evaluation and questioning of the basic beliefs and assumptions that may develop depending on these experiences and affect the development of self-disgust in the later stages of the psychotherapy process stands at a critical point in this process.

4.5. Directions for Future Research

The study was conducted with a non-clinical sample group. Since there are the limited number of studies on this subject, further studies with both clinical and non-clinical sample groups are needed to fill the gap in this area. In further research, self-disgust can be compared with groups with and without PTSD symptoms and self-disgust can be compared in clinical and non-clinical groups. For example, in a study by Rüsch et al. (2011), a comparison was made between individuals with PTSD symptoms due to the impact of abuse in early childhood and a healthy control group in terms of reported feelings of self-disgust.

In line with previous studies, it has been suggested that the frequency of self-loathing varies depending on the types of childhood trauma (Badour et al., 2013). In this direction, it is thought that conducting research on which type of childhood trauma is associated with self-disgust may be beneficial in further clinical practice.

Additionally, using a self-report scale that measures only frequency to evaluate childhood abuse and neglect experiences is also one of the limitations of this study. In the literature, it is stated that the possible effects of traumatic experiences can be shaped according to qualities such as how old they start before the age of 18, how long/how old they are exposed, how many times they are exposed during this period, the severity of the traumatic experience, and who/who they are exposed to (Capreto, 2017). For this reason, it is thought that obtaining such detailed

information about the abuse experience in future research will provide more comprehensive and generalizable findings.

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Appendix A: Informed Consent Form

Bu arastirma bilimsel bir amaçla yapilmaktadir ve katilimci bilgilerinin gizliligi esas tutulmaktadir. Sizden kimlik bilgileriniz istenmeyecek olup, verdiğiniz bilgiler gizli tutulacaktır. Sizden elde edilen veriler sadece araştırmacılar tarafından değerlendirilecek olup sadece bilimsel amaçlı yayınlarda kullanılacaktır. Sizden tahminen 15-20 dakika ayirarak bazi sorular cevaplamaniz istenmektedir. Bu tez araştırmasında katılmak tamamen gönüllülük esasina dayanmaktadir. Çalismaya katilmama veya katildiktan sonra herhangi bir anda çalismayi birakma hakkina da sahipsiniz. Eger arastirma ile ilgili daha fazla bilgiye ihtiyac duyarsaniz Arastirma tamamlandiginda sonuçlar hakkinda bilgilendirilmek istiyorsaniz lütfen arastirmaciya bildiriniz. Arastirmada sorulan sorulardan bazilari duygulariniz ve geçmiş yasantilariniz ile ilgilidir. Bu sorular bazi kişilerde olumsuz duygu ve düşünceler uyandırabilir. Böyle bir durumla karsilastiginizdan o sorulari cevaplandirmama ve katiliminizi sonlandirma hakkına sahipsiniz.

Yukarıda yazılanları okudum, verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabulediyorum. Bu çalışmaya tamamen gönüllü olarak katılmayı kabul ediyorum.

__ Evet __Hayır

Appendix B: Sociodemographic Information Form

1 Cinsiyetiniz

1. Kadın
2. Erkek

Yaşınız: _____

Medeni durum:

1. Evli
2. Bekar
3. İlişkisi var
4. Boşanmış / Dul

Maddi gelir algısı

1. Düşük
2. Orta
3. Yüksek

Kiminle yaşıyorsunuz?

1. Eş/partner
2. Aile
3. Arkadaş
4. Yalnız

Çalışma durumu

1. Tam zamanlı çalışıyorum
2. Yarı zamanlı çalışıyorum
3. Çalışmıyorum

Tanı alan kronik bir rahatsızlığınız var mı?

Evet Hayır

Daha önce psikolojik destek aldınız mı?

Evet Hayır

Ailede psikiyatrik rahatsızlık öyküsü

Evet Hayır

Appendix C: Childhood Trauma Questionnaire (Ctq-33)

1)Yeterli yemeğim olurdu.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

2) Gündelik bakım ve güvenliğim sağlanıyordu.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

3) Anne ya da babam kendilerine layık olmadığımı ifade ederlerdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

4) Fiziksel ihtiyaçlarım tam olarak karşılanırdı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

5) Ailemde sorunlarımı paylaşabileceğim biri vardı

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

6) Üst baş açısından bakımsızdım.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

7) Sevildiğimi hissediyordum.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

8) Anne ya da babam kendimden utanmama neden olurdu.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

9) Ailemden birisi bana öyle kötü vurmuştu ki doktora ya da hastaneye gitmem gerekmişti.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

10) Ailemde değiştirmek istediğim şeyler vardı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

11) Ailemdekiler bana o kadar şiddetle vuruyorlardı ki vücudumda morartı ya da sıyrıklar oluyordu.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

12)Kayış, sopa, kordon ya da başka sert bir cisimle vurularak cezalandırılıyordum.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

13) Anne ya da babam fikirlerimi önemserdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

14) Ailemdekiler bana kırıcı ya da saldırganca sözler söylerlerdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

15) Fiziksel bakımdan hırpalanmış olduğuma inanıyorum.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

16) Çocukluğum mükemmeldi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

17) Bana o kadar kötü vuruluyor ya da dövülüyordum ki öğretmen, komşu ya da bir doktorun bunu fark ettiği oluyordu.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

18)Ailemde birisi benden nefret ederdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

19)Ailemdekiler kendilerini birbirlerine yakın hissederlerdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

20) Biri bana cinsel amaçla dokunmaya ya da kendisine dokundurtmaya çalıştı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

21) Kendisi ile cinsel ilişki kurmadığım takdirde bana zarar vermekle tehdit eden biri vardı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

22) Benim ailem dünyanın en iyisiydi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5.Çok Sık

23) Birisi beni cinsel şeyler yapmaya ya da cinsel şeylere bakmaya zorladı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

24) Birisi bana cinsel tacizde bulundu.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

25) Ailemdekiler bana karşı suçlayıcıydı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

26) İhtiyacım olduğunda beni doktora götürecek birisi vardı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

27) Cinsel istismara uğradığım kanısındayım.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

28) Ailem benim için bir güç ve destek kaynağı idi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

29) Ailemdekiler yaşıtlarımla ve arkadaşlarımla görüşmemi kısıtlardı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

30) Ailemdekiler her şeyime karışırdı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

31) Anne ve babam bir işi kendi başıma yapmama fırsat verirlerdi.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

32)Ailemdekiler rahat vermeyecek derecede peşimdeydiler.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

33)Anne ya da babam beni kontrol etmek için kişisel eşyalarımı benden habersiz karıştırırdı.

1.Hiç Bir Zaman 2.Nadiren 3.Kimi Zaman 4.Sık Olarak 5. Çok Sık

Appendix D: Dissociative Experiences Scale

1. Bazı insanlar, yolculuk yaparken yol boyunca ya da yolun bir bölümünde neler olduğunu hatırlamadıklarını birden farkederler. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

2. Bazı insanlar zaman zaman, birisini dinlerken, söylenenlerin bir kısmını ya da tamamını duymamış olduklarını birden farkederler.Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

3. Bazı insanlar kimi zaman, kendilerini nasıl geldiklerini bilmedikleri bir yerde bulurlar.Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

4. Bazı insanlar zaman zaman kendilerini, giydiklerini hatırlamadıkları elbiseler içinde bulurlar.Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

5. Bazı insanlar zaman zaman eşyaları arasında,satın aldıklarını hatırlamadıkları yeni şeyler bulurlar.Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

6. Bazı insanlar, zaman zaman, yanlarına gelerek başka bir isimle hitabeden ya da önceden tanıştıklarında ısrar eden, tanımadıkları kişilerle karşılaşırlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

7. Bazı insanlar, zaman zaman, kendilerinin yanıbaşında duruyor ya da kendilerini birşey yaparken seyrediyor ve sanki kendi kendilerine karşıdan bakıyormuş gibi bir his duyarlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

8. Bazı insanlara, arkadaşlarını ya da aile bireylerini, zaman zaman tanımadıklarının söylendiği olur. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

9. Bazı insanlar, yaşamlarındaki kimi önemli olayları (örneğin nikah ya da mezuniyet töreni) hiç hatırlamadıklarını farkederler. Yaşamınızdaki bazı önemli olayları hiç hatırlamama durumunun sizde ne oranda olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

10. Bazı insanlar zaman zaman, yalan söylemediklerini bildikleri bir konuda, başkaları tarafından, yalan söylemiş olmakla suçlanırlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

11. Bazı insanlar kimi zaman, aynaya baktıklarında kendilerini tanıyamazlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

12. Bazı insanlar kimi zaman, diğer insanların, eşyaların ve çevrelerindeki dünyanın gerçek olmadığı hissini duyarlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

13. Bazı insanlar, kimi zaman vücutlarının kendilerine ait olmadığı hissini duyarlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

14. Bazı insanlar, zaman zaman geçmişteki bir olayı o kadar canlı hatırlarlar ki, sanki o olayı yeniden yaşıyor gibi olurlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

15. Bazı insanlar kimi zaman, olduğunu hatırladıkları şeylerin, gerçekte mi yoksa rüyada mı olduğundan emin olamazlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

16. Bazı insanlar zaman zaman, bildikleri bir yerde oldukları halde orayı yabancı bulur ve tanıyamazlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

17. Bazı insanlar, televizyon ya da fim seyrederken, kimi zaman kendilerini öyküye o kadar kaptırırlar ki çevrelerinde olan bitenin farkına varamazlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

18. Bazı insanlar kimi zaman kendilerini, kafalarında kurdukları bir fantazi ya da hayale o kadar kaptırırlar ki, sanki bunlar gerçekten başlarından geçiyormuş gibi hissederler. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

19. Bazı insanlar, ağrı hissini duymamayı zaman zaman başarabildiklerini farkederler. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

20. Bazı insanlar kimi zaman, boşluğa bakıp hiç bir şey düşünmeden ve zamanın geçtiğini anlamaksızın oturduklarını farkederler.Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

21. Bazı insanlar, yalnız olduklarında, zaman zaman sesli olarak kendi kendilerine konuştuklarını farkederler.Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

22. Bazı insanlar kimi zaman iki ayrı durumda o kadar değişik davrandıklarını görürler ki, kendilerini neredeyse iki farklı insanmış gibi hissettikleri olur. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

23. Bazı insanlar, normalde güçlük çektikleri bir şeyi (örneğin spor türleri, iş, sosyal ortamlar vb.) belirli durumlarda son derece kolay ve akıcı biçimde yapabildiklerini farkederler. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

24. Bazı insanlar, zaman zaman, bir şeyi yaptıklarını mı yoksa yapmayı sadece akılarından geçirmiş mi olduklarını (örneğin bir mektubu postaya attığını mı yoksa sadece atmayı düşündüğünü mü) hatırlayamazlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

25. Bazı insanlar kimi zaman, yaptıklarını hatırlamadıkları şeyleri yapmış olduklarını gösteren kanıtlar bulurlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

26. Bazı insanlar, zaman zaman eşyaları arasında, kendilerinin yapmış olması gereken, fakat yaptıklarını hatırlamadıkları yazılar, çizimler ve notlar bulurlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

27. Bazı insanlar, zaman zaman kafalarının içersinde, belli şeyleri yapmalarını isteyen ya da yaptıkları şeyler üzerine yorumda bulunan sesler duyarlar. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

%0 10 20 30 40 50 60 70 80 90 %100

28. Bazı insanlar, zaman zaman, dünyaya bir sis perdesi arkasından bakıyormuş gibi hissederler, öyle ki insanlar ve eşyalar çok uzakta ve belirsiz görünürler. Bu durumun

sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız. %0 10 20 30 40 50 60 70 80 90 %100

Appendix E: Self-Disgust Scale

1. Kendimi iğrenç bulurum.1 2 3 4 5 6 7

2. Kendimle gurur duyarım.1 2 3 4 5 6 7

3. Davranışlarımdan tiksinirim.1 2 3 4 5 6 7

4. Bazen kendimi yorgun hissederim.1 2 3 4 5 6 7

5. Kendime tahammül edemem.1 2 3 4 5 6 7

6. Başkalarıyla beraber olmaktan keyif alırım.1 2 3 4 5 6 7

7. Birçok nedenden dolayı kendimden tiksinirim. 1 2 3 4 5 6 7

8. Çekici olduğumu düşünürüm.1 2 3 4 5 6 7

9. İnsanlar benden uzak dururlar.1 2 3 4 5 6 7

10. Dışarıda olmaktan keyif alırım.1 2 3 4 5 6 7

11. Davranışlarımla ilgili iyi hissederim.1 2 3 4 5 6 7

12. Görünür olmak istemem.1 2 3 4 5 6 7 13. Sosyal bir insanımdır.1 2 3 4 5 6 7

14. Sıklıkla iğrenç olduğunu düşündüğüm şeyler yaparım. 1 2 3 4 5 6 7

15. Aynada kendime bakmaktan kaçınırım.1 2 3 4 5 6 7

16. Bazen kendimi mutlu hissederim.1 2 3 4 5 6 7

17. İyimser biriyim.1 2 3 4 5 6 7

18. Ben de herkes gibi davranırım.1 2 3 4 5 6 7

19. Kendime bakmak beni rahatsız eder. 1 2 3 4 5 6 7

20. Bazen kendimi üzgün hissederim. 1 2 3 4 5 6 7

21. Görüntümü mide bulandırıcı bulurum. 1 2 3 4 5 6 7

22. Davranışlarım insanlara itici gelir.1 2 3 4 5 6 7

Appendix F: Debriefing Form

Araştırmaya katıldığınız için teşekkür ederiz. Bu araştırmanın amacı, çocukluk çağı travmaları ve dissosiyasyon arasındaki ilişkide öz tiksinmenin rolünün incelenmesidir. Bu araştırmada sırayla si- zlere Demografik Bilgi Formu, Çocukluk Çağı Travmatik Yaşantılar Ölçeği, Dissosiyatif Yaşantılar Ölçeği ve Öz-tiksinme Ölçeği veri toplama araçları verilerek sizlerin yanıtlanması amacıyla listelen- miştir. Sizden, çevrimiçi bağlantıyla ulaştırılan veri ölçüm araçlarına yanıt vermeniz istenmiştir. Vermiş olduğunuz yanıtlar doğrultusunda, bireylerin çocukluk çağı travmaları ve dissosiyasyon belir- tilerinin öz-tiksinme tarafından etkilenme düzeylerinin incelenmesinin, çocukluk çağı travmatik öyküsüne ilişkin bireysel faktörlerin incelenmesi açısından önemli bulgular sağlayabileceği düşünülmektedir. Size de bu araştırmaya katkıda bulunduğunuz için ayrıca teşekkür ederiz.

Teşekkürler