REPUBLIC OF TURKEY

ISTANBUL AREL UNIVERSITY

INSTITUTE OF SOCIAL SCIENCES

The Department of Psychology

Clinical Psychology

THE ASSOCIATION BETWEEN POSTTRAUMATIC STRESS DISORDER AND TRAUMA-RELATED GUILT, SHAME, FEAR, AND SENSE OF CONTROL IN WOMEN WITH SEXUAL TRAUMA

DOCTORAL DISSERTATION

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Supervisor: Prof. Dr. Ebru ŞALCIOĞLU

İstanbul, 2018

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KABUL VE ONAY

YÖK

PLAGIARISM

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

09 March 2018

Tubanur BAYRAM KUZGUN

ÖZET

CİNSEL TRAVMA YAŞANTISI OLAN KADINLARDA TRAVMA SONRASI STRES BOZUKLUĞU İLE TRAVMA SONRASI SUÇLULUK, UTANÇ, KORKU VE ÇARESİZLİK ARASINDAKİ İLİŞKİ

Tubanur Bayram Kuzgun

Doktora Tezi, Psikoloji Anabilim Dalı

Danışman: Prof. Dr. Ebru Şalcıoğlu

Mart 2018 – 102 sayfa

Travma sırasında hissedilen korku / sıkıntı / rahatsızlık ve düşük kontrol algısı çeşitli travma gruplarında travma sonrası stres bozukluğu (TSSB) ile ilişkili bulmuştur. Travma sırasındaki bu duygusal tepkilerin TSSB'ye nasıl bir mekanizma ile etki ettiği net değildir. Bir açıklama travma sonrası kişinin güvenliğine yönelik algıladığı tehditle ilişkili korkunun ve genel olarak hayatında çaresizlik algısının, travma ile ilişkili utanç ve travma ile ilişkili suçluluk düşüncelerinin, travma sırasında hissedilen korku /sıkıntı / rahatsızlık ve kontrol kaybı ile TSSB arasındaki ilişkideki aracılık ettiği olabileceğidir. Nitekim, daha önceki çalışmalarda korku, çaresizlik, utanç ve suçluluk ile ilgili düşüncelerin TSSB ile ilişkili olduğu desteklenmiştir. Bu çalışmada bu aracılık hipotezi cinsel travma deneyimi olan kadınlarda Yapısal Eşitlik Modellemesi kullanılarak sınanmıştır. Facebook reklam aracı ile 601 cinsel travma yaşamış kadın Travma ile İlişkili Suçluluk Ölçeği, Travma ile İlişkili Utanç Ölçeği, Korku ve Kontrol Duygusu Ölçeği ve Travmatik Stres Belirtileri Ölçeği'nde yer alan soruları ve cinsel travma yaşantısı sırasında hissettikleri korku / sıkıntı / rahatsızlık ve kontrol algısını ölçen soruları cevaplamışlardır. Ölçme modeli ve yapısal model kabul edilebilir uyum iyiliği değerleri göstermiştir. Bulgular, TSSB belirtileri ile travma sırasında hissedilen korku / sıkıntı /rahatsızlık ve kontrol duyguları arasındaki ilişkiye travma sonrası korku, çaresizlik ve travma ilişkili utancın aracılık ettiğini, fakat suçluluk düşüncelerinin bu ilişkiye aracılık etmediğini ortaya koymuştur. Bu bulgular, travma sonrası hissedilen korku, çaresizlik ve travma ile ilişkili utancın TSSB'de önemli bir rol oynadığını göstermektedir. Bu bulgular ayrıca cinsel travma sonrasında hissedilen korku, utancın giderilmesinin ve kişinin hayatı

üzerindeki kontrol duygusunun arttırılmasının travmatik stres belirtilerinin iyileşmesinde etkili olacağına işaret etmektedir.

Anahtar kelimeler: cinsel travma, tssb, korku ve çaresizlik, utanç, suçluluk.

ABSTRACT

THE ASSOCIATION BETWEEN POSTTRAUMATIC STRESS DISORDER AND TRAUMA-RELATED GUILT, SHAME, FEAR, AND SENSE OF CONTROL IN WOMEN WITH SEXUAL TRAUMA

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Peri-trauma emotional reactions and sense of control have been shown to be important predictors of post-traumatic stress disorder (PTSD) in various groups of trauma survivors. It is not clear how these reactions exert their impact on PTSD. One hypothesis could be that post-trauma fear due to an ongoing sense to threat to safety and sense of helplessness in life, trauma-related shame and guilt cognitions mediate the association between peri-trauma reactions and PTSD. These post-trauma reactions have been reported to be associated with PTSD. The present study examined these associations using structural equation modeling (SEM) in sexual trauma survivors. Data from 601 women with sexual trauma history were collected using the Facebook advertisement tool. Survivors completed online versions of Trauma-Related Guilt Inventory, Trauma-Related Shame Inventory, Fear and Loss of Control Scale and Traumatic Stress Symptom Checklist and rated their peri-trauma fear / distress / discomfort and sense of control. Both the measurement model and the structural model provided an acceptable fit. The findings provided support to the hypothesis that the relationship between PTSD symptom severity and peri-trauma distress and sense of control is mediated through post-trauma fear and helplessness responses and trauma-related shame but did not support the mediatory role of guilt cognitions. These findings highlight the important role played by post-trauma emotional reactions in traumatic stress and suggest that effective psychological interventions aimed at reducing fear and shame and enhancing sense of control over one's life would be effective in improving traumatic stress symptoms in survivors of sexual trauma.

Keywords: sexual trauma, ptsd, fear and helplessness, shame, guilt.

DEDICATION

To my son, Gujan

Intellect is priceless, education has no limit.

Ancient Circassian Saying

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LIST OF ABBREVIATIONS

PTSD	Post-Traumatic Stress Disorder
TRGI	Trauma-Related Guilt Inventory
TRSI	Trauma-Related Shame Inventory
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-5	The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition / Text Revision
APA	American Psychiatric Association
WHO	World Health Organization
CDCP	The Centers for Disease Control and Prevention
ABS	Australian Bureau of Statistics
NIBRS	The National Incident-Based Reporting System
FSCS	Fear and Sense of Control Scale
TSSC-5	Traumatic Stress Symptom Checklist
CAPS	Clinician's Administered PTSD Scale
SPSS	Statistical Package for the Social Sciences
CFA	Confirmatory Factor Analysis
WLS	Weighted Least Square
SEM	Structural Equation Modeling
GFI	Goodness-of-Fit Index
S-RMR	Standardized Root Mean Square Residual
RMSEA	The Root-Mean-Square Error of Approximation
CFI	Comparative Fit Index
CFBT	Control Focused Behavioral Treatment
IFI	Incremental Fit Index

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CHAPTER 1

INTRODUCTION

1.1. Definition of the Problem

Sexual violence is one of the most debilitating traumatic event which may be experienced by men and women. The National Intimate Partner and Sexual Violence Survey presents that one in five women and one in seventy-one men have been experienced rape in their lifetimes (Black et al., 2011). Survivors of sexual violence have experienced psychological problems, most commonly Posttraumatic Stress Disorder (PTSD). Evidence shows that the likelihood to develop PTSD following a sexual trauma event ranges between 17% and 65% (Campbel, Dworkin & Cabral, 2009).

There is an increasing recognition of emotions such as guilt, shame, and anger other than fear (perceived current threat) in PTSD. Evidence shows that the relevance of self-evaluative emotions such as shame and guilt is central to the development and course of PTSD (Harman & Lee, 2010; Hathaway, Boals, & Banks, 2010; Semb, Strömsten, Sundbom, Fransson, & Henningson, 2011). Trauma-related guilt has been found to contribute to the development of PTSD among rape survivors (e.g., Resick & Schnicke, 1993). Moreover, trauma-related shame has been found to contribute to the maintenance of PTSD symptom severity through ongoing self-criticism which increases sense of current threat (Harman & Lee, 2010). The relation between sexual trauma and shame is that sexual trauma leads to an increase one's sense of being negatively judged (Maercker & Müller, 2004; Peterson & Muehlenhard, 2004) and being surrounded by physical / social threats (Dobbs, Waid, & Shelley, 2009).

In addition to trauma-related guilt and trauma-related shame, post-traumatic fear and helplessness are considered as critical risk factors for PTSD. Unpredictability and uncontrollability of a traumatic event have resulted in post-trauma loss of control, and lack of perceived safety in different type of traumas such as war (Basoglu et al. 2005), torture (Basoglu & Salcioglu, 2011), earthquake (Basoglu & Salcioglu, 2011; Salcioglu, 2004), and domestic violence (Salcioglu et al., 2017). Uncontrollability of a traumatic event is a critical risk factor for PTSD. A survivor's perceived sense of uncontrollability

increases the perceived distress and fear during trauma and increases the risk of PTSD. Foa, Zinbarg & Rothbaum (1992) states that uncontrollable stressors are more likely to lead to the generalized arousal symptom which is a characteristic of PTSD than does controllable stressors.

1.2. The Aim of the Current Study

The aim of the current study is to determine whether trauma-related guilt, trauma-related shame, and post-traumatic fear and helplessness mediate between peri-traumatic fear and distress, peri-traumatic sense of control and subsequent PTSD among women with sexual violence. For this purpose, Trauma-Related Guilt Inventory (TRGI) developed by Kubany et al. (1996) and Trauma-Related Shame Inventory (TRSI) developed by Oktedalen (2014) were translated into Turkish. The mediatory role of post-traumatic fear and helplessness, trauma-related guilt, trauma-related shame between peri-traumatic fear and distress, peri-traumatic sense of control and PTSD was tested.

CHAPTER 2

TRAUMA AND POST-TRAUMATIC STRESS DISORDER

2.1. Definition of Traumatic Event

Trauma is a term the definition of which has been changed over the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) to The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). DSM-III (American Psychological Association: APA, 1980: 247) defines trauma as ‘an experienced event that is outside the range of usual human experience, and that would be markedly distressing to almost anyone' (Criterion A). Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition/Text Revision (DSM-IV-TR; APA, 2000: 463) specifically defines a trauma as ‘direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate’ (Criterion A1). The person's response to the event must involve 'intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior)' (Criterion A2). Briere and Scott (2006: 3) states that DSM-IV-TR provides a list of potentially traumatic events, such as 'combat, sexual and physical assault, robbery, being kidnapped, being taken hostage, terrorist attacks, torture, disasters, severe automobile accidents, and life-threatening illnesses, as well as witnessing death or serious injury by violent assault, accidents, war, or disaster'. However, the definition of trauma (Criterion A) was modified in DSM-5 to restrict its inclusiveness and subjectiveness. According to DSM-5 (APA, 2013: 271) definition of trauma requires ‘actual or threatened death, serious injury, or sexual violence’. Stressful experiences not involving an immediate threat to life or physical injury such as psychosocial stressors (e.g., divorce or job loss) are not considered as trauma (Pai, Suris & North, 2017).

2.1.1. Symptoms and Clinical Features of PTSD

PTSD diagnosis is considered as a direct consequence of traumatic events. PTSD was initially proposed in 1980 in the DSM-III. After the DSM-III, there have been several changes made in the PTSD section. In the DSM-5 which is the last revision of DSM, PTSD is no longer categorized as an anxiety disorder. PTSD is included in a new section called Trauma and Stressor-Related Disorders. Since PTSD patients report distress about negative emotions like fear, anger, sadness, and disgust in daily life (Finucane, et al., 2012) symptoms such as persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame) are also included in DSM-5.

Diagnostic criteria for PTSD in DSM-5 include ‘a history of exposure to a traumatic event that meets specific situations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity. The sixth criterion regards duration of symptoms; the seventh appraises functioning; and, the eighth criterion purifies symptoms as not attributable to a substance or co-occurring medical condition' (APA, 2013: 271). Table 2.1 shows PTSD criteria for DSM-5.

Table 2.1

PTSD criteria for DSM-5

Note:

The following criteria is applied to adults, adolescents, and children older than six years. For children six years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Repeated experiencing or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse).

Note:

Criterion A4 does not involve exposure to electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Note:

In children older than six years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and effect of the dream are related to the traumatic event(s).

Note:

In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note:

In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted," ‘The world is completely dangerous," "My whole nervous system is permanently ruined").

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others.

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

2. Reckless or self-destructive behavior.

3. Hypervigilance.

4. Exaggerated startle response.

5. Problems with concentration.

6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than one month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms:

The individual’s symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization:

Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g.,

Feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. Derealization:

Persistent or recurrent experiences of unreality of surroundings

(e.g. the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note:

To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression:

If the full diagnostic criteria are not met until at least six months after the event (although the onset and expression of some symptoms may be immediate).

2.1.2. Prevalence of PTSD

When numerous countries are considered, 20 – 90% of the general population is exposed traumatic events at least once in their lives (Perrin et al., 2014). PTSD is a common psychological problem that is suggested to affect approximately 3.7% of the general population (Kessler, Sonnega, Bromet, & Hughes, 2005). Stein et al. (2010) reported the World Health Organization (WHO) surveys in which data obtained from 20 countries. The loss of a loved one (30.5%), witnessing violence to others (21.8%), and experiencing interpersonal violence (18.8%) were the most reported traumas.

The traumatic events do not always cause to PTSD. In some cases, time removes the effects of trauma (Keane, Weathers & Foa, 2000: 18). Evidence shows that only approximately 10% of the exposed individuals subsequently developed PTSD. Therefore, the lifetime prevalence rates of PTSD are 1.3% and a 12-month prevalence of PTSD was found 0.7%. Although men were more likely report traumatic events, women consistently reveal a higher lifetime prevalence of PTSD than men (Perkonigg, Kessler, Storz & Wittchen, 2000). According to De Vries & Olff (2009) the prevalence rates of PTSD vary

from country to country. The prevalence of PTSD in Europe was 1.9%, in the Netherlands was 7.4% and almost no PTSD in Switzerland (Hepp et al., 2006). The PTSD prevalence rate in the United States was 6.8% (Kessler et al., 2005). The prevalence rates of PTSD in post-conflict countries was 37.4% (de Jong et al., 2001).

According to Norris (1992), men and women report different types of traumatic events. The death of a relative or someone close, sexual assaults or sexual abuse is more common traumatic experiences among women. Moreover, motor vehicle crash, natural disaster, non-sexual assault, and combat were found to be more common among men survivors. US population with 43.093 respondents' the lifetime prevalence of PTSD was 6.4%. Women with PTSD were more likely than men with PTSD to confirm sexual assault (12.8% vs. 1.0%), physically assaulted by intimate partner (7.3% vs. 0.6%), unexpected death of someone close (25.6% vs. 20.8%), and severe illness or injury to someone close (17.0% vs. 12.8%) than men with PTSD. On the other hand, men with PTSD were more likely than women with PTSD to endorse military combat (16.1% vs. 0.1%), seeing someone seriously injured or dead (8.7% vs. 4.5%), and life-threatening accident (5.0% vs. 2.8%) than women with PTSD (Pietrzak, Goldstein, Southwick & Grant, 2011a). They also described the most commonly reported traumatic events: Serious disease or injury to someone intimate (affecting 48.4% of those who did not have PTSD symptoms and 66.6% of those with PTSD), sudden death of someone close (affecting 42.2% of those without PTSD and 65.9% of those with PTSD) and seeing someone severely injured or killed (affecting 24% of those without PTSD and 43.1% of those with PTSD).

2.1.3. The Course of PTSD

When people exposed to a traumatic event, the effects of this event might decline by the time. However, in some cases, symptoms of PTSD may reveal soon after exposure to a traumatic event or may be delayed for a while. Duration of PTSD symptoms might, therefore, serve as an indicator of the impact of the condition on an individual's life. Until the end of the first month of a traumatic event exposure, some people may reveal acute stress reactions. Some might have experienced the effect like reduced functioning, however, will never fully met the diagnosis of PTSD (Norman, Tate, Anderson, & Brown, 2007). In some cases, acute stress reactions may turn into PTSD, but PTSD diagnosis does not always have to require initial acute stress reactions.

Santiago et al. (2013) reviewed 35 studies to comprehend the course of disorder and recovery for people experiencing PTSD (early onset, later onset, chronicity, remission, and resilience) before the first year after trauma exposure is up. Review of PTSD prevalence across time (1, 3, 6 and 12 months) in different traumatic event categories shows some differences by category. The course of PTSD among those exposed to an intentional trauma which involves the deliberate infliction of harm and non-intentional trauma differs. The prevalence of PTSD in non-intentional trauma is most likely to decrease over time (30.1% at month 1 and 14.0% at month 12). However, the prevalence of PTSD in the intentional traumas seems increasing over time (from 11.8% to 23.3%). Of individuals exposed to intentional traumatic events, 37.1% (range 6.5–87.5%) developed PTSD in the first year after exposure to the traumatic event. More than half, 62.9% (range 12.5%-93.5%) never developed PTSD, 12.9% (range 1.7–43.8%) had PTSD only at Time 1 (1-1.5 months). Similarly, a median of 14.5% had PTSD at both Time 1 (1-1.5 months) and Time 2 (3-12 months) (39.0% of those diagnosed with PTSD) and 1.3% had PTSD onset after Time 1 (1-1.5 months) (3.5% of those diagnosed with PTSD). On the other hand, the course of PTSD occurred that low levels of PTSD symptoms progressed with little increase over time whereas high levels of symptoms represented a significant increase over time (Foa, 1997).

2.1.4. Comorbidity with Depression and Anxiety

PTSD has the comorbidity with depression and anxiety disorders. Evidence shows that the comorbidity rates of PTSD and depression range from 21% to 94% (DeMarinis & Jhansson Sundquist, 2005; Frayn et al., 2005; Ginzburg, 2007; Hashemian et al., 2006; Mollica et al., 1999; Salcioglu, Basoglu & Livanou, 2003; Sundquist, Jhansson), and anxiety (Hashemian et al., 2006; Mayou et al., 2001; Sundquist et al., 2005; Zayfert et al., 2002; as cited in Ginzburg, Ein-Dor, & Solomon, 2010) range from 39% to 97%. Moreover, it has been found triple comorbidity in which 11%-67% of patients have PTSD, anxiety, and depression (Brady and Clary, 2004; Hashemian et al., 2006). Hagenaars, Fisch & van Minnen (2011) reported no significant differences between single versus multiple traumas and childhood and adulthood traumas regarding patients' depressive symptoms and comorbidity.

Rytwinski, Scur, Feeny & Youngstrom (2013) conducted a meta-analysis of 57 studies with 6.670 participants. Consistent with studies mentioned above, they reported

that around half of the participants (52%) with PTSD represent comorbid major depressive disorder. As a consequence of high comorbidity, patients reported significant subjective distress and impairment in contrast to patients with PTSD alone (Ikin, Creamer, Sim, & McKenzie, 2010; Momartin, Silove, Manicavasagar, & Steel, 2004; Nixon, Resick, & Nishith, 2004; Post, Zoellner, Youngstrom, & Feeny, 2011; as cited in Rytwinski et al., 2013). The study with Korean War veterans showed the comorbidity rates of PTSD and depression. Of all veterans, 61.8% veterans were in the 'neither PTSD nor depression' group, 16.8% veterans in the comorbid PTSD and depression group, 15.3% veterans in the PTSD-only group, and 6.2% veterans in the depression- only group. Of all veterans with PTSD, around half (52.3%) experienced the comorbid depression (Ikin, Creamer, Sim, & McKenzie, 2010).

Ginzburg et al. (2010) summarized how comorbidity rates have been tried to explain by different researchers. The first explanation proposes that depression and anxiety might increase the risk for PTSD. O'Toole, Marshall, Schureck & Dobson (1998) suggest that PTSD onset predates depression onset among participants with PTSD and depression. Others argue that depression and anxiety develop secondary to PTSD (Engdahl, Dikel, Eberly & Blank, 1998; Franko, Thompson & Barton, 2005; Kessler et al., 1995). The third explanation states that PTSD and depression symptoms overlap, so the comorbidity between two disorders may be artificial (Franklin and Zimmerman, 2001; Southwick et al., 1991). This explanation is supported by researchers who showed that patients with comorbid PTSD and depression do not differ from those with PTSD alone in terms of PTSD severity (Franklin and Zimmerman, 2001; Solomon and Bleich, 1998), and responsiveness to treatment (Labbate, Sonne, Randal, Anton & Brady, 2004).

2.1.5. Predictors of PTSD

Predictors of PTSD can be classified into pre-trauma individual variables, peri-trauma variables, and post-trauma variables.

2.1.5.1. Pre-trauma Variables

Pre-trauma variables that have been identified as predictors of PTSD include type of trauma, gender, sociodemographic factors, vulnerability, and clinical variables. The epidemiological study of Perrin et al. (2014) documented that the type of trauma event was an important predictor of the subsequent PTSD (Lukaschek, 2013; Brewin, Andrews,

and Valentine, 2000; Ozer, Best, Lipsey, and Weiss, 2003; Breslau, 2009). Evidence shows that being exposed to assaultive violence carries the highest risk for developing PTSD (Frans, Rimmo, Aberg, & Fredrikson, 2005; Hapke, Schumann, Rumpf, John & Meyer, 2006, as cited in Perrin et al., 2014). Although rape poses high risk of PTSD in either sex, sexual harassment carries the highest risk of traumatization for PTSD in women while being exposed to combat and witnessing someone being injured or killed carries highest risk of traumatization in men (Kessler et al., 1995).

Gender is another predictor of PTSD. As it was discussed above, even though traumatic experiences were found to be less likely in women than in men, women show higher tendency to develop PTSD than men do (Perkonigg et al., 2000). Evidence based on epidemiological studies showed that women report a higher prevalence rate of PTSD (Piccinelli & Wilkinson, 2000) and higher comorbidity for depression than men (de Graaf et al., 2002). The reason why women tend to develop PTSD could stem from the higher prevalence of sexual abuse and rape in women. Rather than military samples, in the majority civilian studies showed that women were more tend to develop PTSD than men. Moreover, women's different coping styles, limited socioeconomic resources, and biological sex differences may contribute their vulnerability to developing PTSD (Gavranidou & Rosner, 2003).

History of psychiatric illness is also a frequent predictor of PTSD. Hapke (2006) stated that anxiety disorders, somatoform disorders, and depressive disorders were found to be predictors of PTSD, whereas alcohol dependence or abuse and nicotine dependence were not. When compared to individuals with no psychiatric history, individuals with at least one psychiatric history have been found to be three times at more risk for PTSD. A psychiatric history (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993; Ursano et al., 1999; Vasterling, Brailey, Constans, Borges, & Sutker, 1997) has been found to be a predictor of PTSD in crime, war, and motor vehicle accident survivors and a family psychiatric history (Reich et al., 1996) is another pre-trauma predictor of PTSD in war survivors. Moreover, younger age at trauma and race (minority status), had weaker but significant effect sizes as a predictor of PTSD (Brewin, 2000).

Of the pre-trauma characteristics, lower intelligence (Koenen, Moffet, Poulton, Martin, & Caspi, 2007; McNally & Shin, 1995), was found to be the predictor of PTSD in war survivors. Moreover, Parslow and Jorm (2007) highlighted cognitive predictors.

Pre-trauma performances on immediate and delayed verbal recall (Delis et al., 1988), working memory, visuomotor speed (Smith, 1982), and verbal intelligence (Nelson, 1982; Nelson and Willison, 1991) was negatively related to re-experiencing and arousal symptoms of PTSD.

Moreover, childhood trauma is also essential pre-trauma predictor of PTSD. Evidence shows that participants with childhood trauma experience were found to be inclined to have PTSD in adulthood than participants without childhood trauma experience (Cougle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010). Childhood sexual and physical abuse have been found as a predictor of PTSD. However, childhood sexual and physical abuse seems to contribute to the high comorbidity rate of PTSD with anxiety and depressive disorders (Perrin et al., 2014).

The last but not least, lower socio-economic status (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999; Basoglu et al., 1997; Brent et al., 1995; Cordova et al., 1995; Dunmore, Clark, & Ehlers, 1999; Ursano et al., 1999, Vasterling et al., 1997) has also been found as a predictor of PTSD in crime, torture, suicide of a peer, breast cancer, war, disaster, and motor vehicle accident survivors.

2.1.5.2. Peri-trauma Variables

Of the peri-trauma characteristics, peri-trauma psychological processes and trauma severity have been found to be critical predictors of PTSD. Peri-trauma psychological processes such as negative emotions during trauma and dissociation have been found to be the powerful predictors of PTSD (Ozer et al., 2003). Brewin (2000) reported that the relationships between negative emotions of survivors during trauma and PTSD seem to be higher in samples of interpersonal violence. The impact of trauma severity varies according to military versus civilian trauma survivors. The effect of trauma severity seems significant in the military trauma samples which mainly based on male combat veterans. Trauma severity varies also in the civilian studies (.20 to .26 effect size in crime, disaster, and motor vehicle accidents survivors; .10 to .14 effect size in the survivors of burns and other specific traumas).

2.1.5.2.1. Unpredictability and Uncontrollability of a Traumatic Event

Unpredictability and uncontrollability of a traumatic event are important risk factors for PTSD. Foa et al. (1992) states that uncontrollable stressors are more likely to lead to the generalized arousal symptoms which is a characteristic of PTSD than does controllable stress. In addition, studies of motor vehicle accidents showed that passengers tend to exhibit more post-accident psychopathology than do drivers (Kuch, 1989, as cited in Salcioglu, 2004). A survivor's perceived sense of unpredictability and uncontrollability increases the perceived distress during torture and war trauma and it increases the risk of PTSD (Basoglu et al. 2005, 2007). The total number of torture events reported by survivors was not a predictor of PTSD, whereas perceived distress during torture strongly related to PTSD (Basoglu & Paker, 1995, as cited in Salcioglu, 2004). Moreover, a sense of preparedness in political torture survivors have found to decrease perceived distress during torture and subsequent PTSD (Basoglu et al. 1997).

2.1.5.3. Post-traumatic Variables

Of the post-traumatic characteristics, lack of social support (Astin et al., 1993; Green & Berlin, 1987; Green, et al., 1990; King et al., 1999; Kemp et al., 1995; Perrin et al., 1996; Perry et al., 1992; Weiss et al., 1995; as cited in Brewin et al. 2000) have been found to be critical predictors of PTSD in crime, war, burn survivors and health care workers of disaster. More subsequent life stress (Epstein, Saunders, Kilpatrick & Resnick, 1998) is found as another important predictor of PTSD in healthcare workers who cared for survivors of the air disaster.

In addition, Krause, Kaltman, Goodman & Dutton (2008) discussed that avoidant coping strategies predict a substantial portion of PTSD as time progress in domestic violence sample. Aupperle, Melrose, Stein, & Paulus (2012) stated that hyperarousal and disengagement from trauma-related stimuli lead to avoidance of the reminders of the trauma.

2.1.5.3.1. Post-trauma Fear and Sense of Control

A learning theory formulation of traumatic stress developed by Basoglu & Salcioglu (2011) suggests that an individual appraises the traumatic event as uncontrollable if the perceived control over negative outcomes of stressor events is low,

therefore, s/he experiences distress, fear, or panic. The perceived control could be considered as behavioral, cognitive, and emotional and the uncontrollability caused by loss of control over stressors leads to fear of possible future occurrences of the event and a sense of helplessness which is a good predictor of post-traumatic stress symptoms (Salcioglu et al., 2017).

Of post-trauma characteristics, post-traumatic fear of recurrence of trauma and helplessness are predictors of PTSD. Unpredictability and uncontrollability of a traumatic event have resulted in post-trauma helplessness, and lack of perceived safety in war survivors, including combat veterans (Basoglu, Salcioglu, & Livanou, 2002; Basoglu, Ekblad, Bäärnhielm, Livanou, 2004; Basoglu et al., 2005; Livanou, Basoglu, & Marks, 2002; Salcioglu, Basoglu, & Livanou, 2007), torture (Basoglu & Salcioglu, 2011), earthquake (Basoglu & Salcioglu, 2011; Salcioglu, 2004), and domestic violence survivors exposed to physical, psychological, and sexual violence stressors (Salcioglu et al., 2017).

CHAPTER 3

SEXUAL TRAUMA

3.1. Definition of Sexual Trauma

Sexual trauma / violence has been defined in the World Report on Violence and Health as ‘any sexual act, attempts to obtain a sexual act, or acts to traffic for sexual purposes, directed against a person using coercion, harassment or advances made by any person regardless of their relationship to the survivor, in any setting, including but not limited to home and work’ (Jewkes, Sen & Garcia-Moreno, 2002). The Centers for Disease Control and Prevention defines sexual violence as any sexual act that perpetrated against someone's will (Basile, Smith, Breiding, Black, & Mahendra, 2014).

Sexual violence can include rape, attempted rape, or other forms of sexual assault. WHO (2002) launched the first ‘*World report on violence and health’* and made some definitions related to sexual violence. Rape defined as physically or somehow forced or coerced penetration of the vulva or anus by using a penis, other body parts or an object. The unsuccessful attempt to do so is called attempted rape. Gang rape defined as a rape of a person by two or more perpetrators. Sexual violence does not only include rape or rape attempt but also includes other forms of sexual assault. Sexual assault consists of any act involving a sexual organ, directed to coerced contact between the mouth and penis, vulva or anus. However, the Women's Safety Survey conducted by Australian Bureau of Statistics (ABS) definition of sexual violence does not include unwanted sexual touching. This behavior is preferred to classify as ‘harassment’ (along with obscene phone calls, indecent exposure by a man, and inappropriate comments about body/sex life by a man) (McLennan 1996: 82). Sexual trauma can be further defined by the nature of contact that can overlap (Rind, Tromovitch, & Bauserman, 1998). Table 3.1 represents the categorizations of sexual violence by the nature of contact.

Table 3.1

Categorizations of Sexual Violence by the Nature of Contact

	Contact	Non- contact
Penetration	• Rape (e.g., oral, vaginal, or anal penetration)	x
Non- penetration	• Attempted rape (attempted oral, vaginal, or anal penetration) • Sexual assault (e.g., fondling)	• Sexual harassment (e.g., exhibitionism, voyeurism, or sexually harassing gestures / photos / verbal comments)

There are some examples of sexual violence that may become occurring in different settings or circumstances. According to WHO (2002), the examples include 'rape within marriage or dating relationships, rape by strangers, systematic rape during armed conflict, unwanted sexual advances or sexual harassment, including demanding sex in return for favors, sexual abuse of mentally or physically disabled people, sexual abuse of children, forced marriage or cohabitation, including the marriage of children, denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases, forced abortion, violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity, forced prostitution and trafficking of people for the purpose of sexual exploitation'.

To sum up, unwanted exposed sexual behavior requires one of the three assumptions to be defined as a sexual violence (Edwards, 2003: 9). First, the exposed sexual behavior makes the survivor feel uncomfortable, distressed, frightened or threatened, or which results in harm or injury for that person. Second, the survivor has not freely agreed or given consent, or to which that person is not capable of giving consent. Last, the perpetrator may use physical, emotional, psychological or verbal force or (other) coercive behavior against that person. In terms of consent, Peterson and Muehlenhard (2007a) argued that external consent may not correspond to one's internal wish to engage in a sexual act. They found 6% of individuals who gave external consent reported the intercourse was unwanted.

3.1.1. Prevalence of Sexual Trauma

Sexual violence has been a neglected area of research for some reasons. According to WHO (2002), the notification of sexual violence has been obtained from police, clinical settings, and nongovernmental organizations, and survey studies. The cases reported to police seem very few. Study findings and the work of nongovernmental organizations reveal a more substantial portion of the data even though the disclosed proportion of events have always remained. The extent of the problem in the world and Turkey will be discussed in here. Since the disclosed portion of cases has remained, it has been suggested to be keeping away from global comparisons.

3.1.2. The Extent of the Problem in the World

A nationally representative survey in the United States revealed that 60.4% of women were raped before the age of 18. Of 30.4% women being perpetrated within the context of a dating relationship and 20% being perpetrated by an acquaintance (Basile, Chen, Black & Saltzman, 2007). Evidence showed that 7.2% of women aged 15 years or older reported non-partner sexual violence during their lifetime. Prevalence rates of non-partner sexual violence vary across regions. The rates are ranging from 3.3% in Asia, south, to 21.0% in sub-Saharan Africa, central (Abraham et al., 2014).

According to WHO report of the prevalence rates of partner sexual violence, between 6% and 59% of women have experienced sexual violence from their husband or a boyfriend in their lifetime (Garcia-Moreno, Henrica, Ellsberg, Heise & Watts, 2005). Evidence on population-based studies obtained from 39 countries represented that between 0.3% and 39% of women have experienced intimate or non-intimate partner sexual violence once or more times in their lives. Australian, Danish, Swiss and Swedish arms of the International Violence Against Women Study found that a total of 34%, 28%, 27% and 25% of women, respectively, have been ever raped in their lives (United Nations Entity for Gender Equality and the Empowerment of Women, 2011; Mouzos & Makkai, 2004).

In the United States, about 13% of women reported experiencing sexual coercion in their lifetime, about 2% of women in the 12 months before the survey. Of 27.2% of women reported some form of unwanted sexual contact in their lifetime and the 12-month prevalence was 2.2% of women. More frequently, 33.7% and 3% of women reported non-

contact unwanted sexual experiences in their lifetime and in the 12 months before taking the survey, respectively. The rate of sexual violence in men relatively smaller than in women. Of 6% and 1.5% percent of men reported sexual coercion in their lifetime and last 12 months, respectively. The rate of unwanted sexual contact of men was 11.7% in their lifetime and 2.3% in last 12 months. Of 12.8% of men reported non-contact unwanted sexual experiences in their lifetime, and 2.7% of men experienced these experiences in the 12 months before the survey (Black et al., 2011).

3.1.3. The Extent of the Problem in Turkey

Altınay and Arat (2008) have found that the rate of sexual coercion (asked as 'have you ever been forced to have sex by your husband?) in women by their husbands is 14%. Conversely, 67% of them exposed to physical violence, too. Karal and Aydemir (2012) reported that 44% of divorced/estranged, 22% of widowed, 14% of married, 2% of unmarried women had experienced sexual violence in their lifetime. Moreover, women aged between 45-49 exposed to sexual violence little more than women aged between 25-34, 19%, and 13%, respectively. The prevalence of sexual violence varies regarding welfare level. Women come from the best welfare level have the lowest (10.3%) rate of sexual violence, the middle welfare level has 14.6%, and the low welfare level has 18.9% in Turkey.

In an epidemiological study conducted by Turkish Republic Prime Ministry Directorate General on the Status of Women (2009) examined the occurrence of inter personal violence in 10,798 women. The lifetime prevalence of sexual violence has found 15.3%. In the same study, 9.1% of ever married women reported to have physically forced to have sexual intercourse, 11.4% of women reported to had sex because afraid of what partner might do, and 3.3% of women reported to be forced by something degrading / humiliating, respectively. Moreover, in a study of 220 domestic violence survivors, 61.8% of survivors reported to have forced sexual intercourse / rape by their partners and 5% of survivors reported to be forced by sexual intercourse with others (Salcioglu et al., 2017).

3.2. Mental Health Consequences of Sexual Trauma

People might experience severe, life-threatening events. Among other traumatic events, rape is one of the most psychologically damaging experience. There are

immediate and long-term mental health consequences of sexual trauma. Acute consequences of sexual trauma consist of negative feelings such as shock, denial, fear, confusion, withdrawal, guilt or nervousness. In some cases, sleep and eating disorders may occur. Symptoms seem to peak at the third week of the sexual trauma. Between first and second months after the sexual trauma, symptoms increase and get worse then begin to decline (Campbell, 2001).

Long-term consequences of sexual trauma include PTSD, depression, anxiety disorders, alcohol or illicit substance dependence, suicidal ideation, and suicide attempt (Campbell, Dworkin, & Cabral, 2009). PTSD symptoms have been reported up to the first year of sexual trauma, especially if there is no treatment (Kimerling & Calhoung, 1994). The suicidal ideation is another important mental health consequence of sexual trauma. According to data obtained from women suffering from intimate partner violence, the likelihood of threatening or suicide attempt within three months was 5.3 times higher than women who were only physically abused (McFarlane et al., 2005). Consistent with this, the USA national study showed that both suicidal ideation and suicide attempts occur after the experienced sexual trauma within the same year (Ullman & Brecklin, 2002).

3.2.1. PTSD

Creamer, Burgess, and McFarlane (2001) suggest that across all trauma types including car accidents, physical attacks, robberies or natural disasters, sexual trauma has found to predict the development of PTSD more strongly (as cited in Jina & Thomas, 2013). They found that in Australian sample, rape and sexual harassment were the trauma with the highest risk of PTSD in either sex. Increasing body of evidence (Clum, Calhoun, & Kimerling, 2000; Kilpatrick et al., 1989; Kilpatrick & Resnick, 1993; Kilpatrick et al., 1987; Rothbaum et al., 1992) shows that sexual assault survivors' likelihood to develop PTSD range between 17% and 65% (as cited in Campbell, Dworkin & Cabral, 2009). College studies have found the prevalence of PTSD was 14.8% among women who experienced an attempted or completed rape (Elhai et al., 2012). Moreover, evidence showed that post traumatic symptoms range from 94% at one-week post-trauma to 65% at one-month post-trauma (Rothbaum et al., 1992).

PTSD symptoms are often present within the first two weeks (Rothbaum, 1992) and usually by three months after rape (Foa, 1997). Several factors appear to play a role

in whether rape victims experience PTSD symptoms. These factors include duration of the assault (Ullman & Brecklin, 2002a) greater perceived life threat (Ullman & Filipas, 2001), getting injured during the rape (Acierno et al., 1999), rape tactics such as forcible, incapacitated (in which rape survivor voluntarily uses alcohol or drug), and drug and alcohol-facilitated rape (in which a perpetrator deliberately gives the victim drugs without her permission or tries to get her drunk (Zinzow et al., 2010)), history of trauma (Ullman & Filipas, 2007), and negative or unsupportive reactions after disclosing the rape to others (Jacques-Tiura, 2010; Littleton, 2010).

Additionally, the relationship to the perpetrator have been positively correlated with post-traumatic stress symptoms. Sexual trauma survivors who had more contact with their perpetrator endorsed greater impact of the sexual trauma. Survivors who sexually assaulted in a cohabiting, marital, or acquaintance relationship reported more hyperarousal symptoms than did survivors in a dating or sexually intimate relationship. Additionally, married and cohabiting survivors reported more hyperarousal symptoms than women in the acquaintance group. Survivors who sexually assaulted by a married or cohabiting partner reported more intrusive symptoms than individuals in a dating or sexually intimate relationship. Furthermore, women in a sexually intimate relationship with their perpetrator reported lower intrusive symptoms than did individuals assaulted by an acquaintance. (Culbertson & Dehle, 2001).

3.2.1.1. Course of PTSD in Women Survivors of Sexual Trauma

As discussed above as a predictor, women, in general, are more likely to have a tendency to develop PTSD, and their symptoms are also more resistant to recover than men. Moreover, Kessler et al. (1995, as cited in Jina & Thomas, 2013) found that sexually assaulted women who develop PTSD are significantly more likely to have comorbid psychological problems than those who do not develop PTSD.

3.2.1.2. Predictors of PTSD in Women Survivors of Sexual Trauma

There are several predictors of sexual trauma. Firstly, being married or cohabiting with a partner is an important predictor since, around the world, one of the most common forms sexual trauma is being perpetrated by an intimate partner. Evidence shows that the risk of developing PTSD and depression is the highest in the case that women experienced sexual violence by their intimate partner (Campbell & Soeken, 1999). Secondly, being

young is another predictor of sexual trauma. According to the data received from The National Incident-Based Reporting System (NIBRS) in which three States participated (Alabama, North Dakota, and South Carolina), around 40% of all survivors of sexual violence are aged 18 years or less. About 80% of rape survivors were under the age of 30 and about 40 % of these were under the age of 18. Survivors younger than 12 years old accounted for 15% of those raped, and the rate of rape survivors between the ages 12 and 17 is 29% (Greenfeld, 1997).

According to WHO (2012) multi-country study, the lifetime prevalence of sexual partner violence reported by women, between the ages 15 to 49 ranged from 6% in Japan to 59% in Ethiopia. In addition to this, family members victimized 43% of these young survivors age less than 30% and 11% of survivors age 30 or older. Older survivors' (age of 30 or above) rate of having been raped by a stranger is 36%, whereas young survivors' (age of less than 30) rate of having been raped by a stranger was 3% (Greenfeld, 1997).

In addition, having previously been raped predicts to be raped again. Data received from a national study of violence against women in United States represents that the rate of being raped is 18.3% among women who were raped before the age of 18 years whereas the rate of being raped is 8.7% those who were not raped until the age of 18 years (Tjaden & Thoennes, 2000).

Evidence showed that survivor’s alcohol or drug consumption also predicts being exposed to sexual trauma (Crowell & Burgess, 1996). Poverty is another important predictor of sexual violence. Because of poverty, women tend to have occupations that carry relatively higher risks of sexual violence, including sex work (Omorodion & Olusanya, 1998).

3.2.1.3. Depression

Evidence showed that approximately 13%-51% rape survivors meet diagnostic criteria for depression (Acierno et al., 2002; Becker et al., 1998; Burnam, et al., 1988; Clum et al., 2000; Dickinson et al., 1999; Frank & Anderson, 1987; Golding, 1996; Kilpatrick et al., 1987; Winfield et al., 1990; as cited in Campbell, Dworkin & Cabral, 2009).

3.2.1.4. Other Problems

Sexual trauma survivors may suffer from other important negative mental health consequences such as anxiety, addiction, and suicidal ideation. The rate of post-traumatic fear and anxiety of sexual assault survivors were found between 73% and 82% (Frank & Anderson, 1987; Ullman & Siegel, 1993). Moreover, between 13% to 49% of survivors suffer from alcohol addiction, whereas 28% to 61% report addiction to other illicit substances (Frank & Anderson, 1987; Ullman, 2007; Ullman & Brecklin, 2002a). Survivor's suicidal ideations range between 23% to 44% (Frank & Stewart 1984; Frank et al., 1981; Kilpatrick et al., 1985; Petrak et al., 1997) and 2% to 19% reported attempted suicide (Davidson et al., 1996; Frank et al., 1981; Kilpatrick et al., 1985). The association between suicidal ideation and PTSD remains, even after controlling for sex, age, education, symptoms of post-traumatic stress disorder and the presence of psychiatric disorders.

3.2.1.5. Guilt and Shame Related Cognitions Following Sexual Trauma

There is an increasing recognition of emotions such as guilt, shame, and anger other than fear (perceived current threat) in PTSD. Evidence showed that the relevance of self-evaluative emotions such as shame, guilt as central to the development and course of PTSD (Harman & Lee, 2010; Hathaway et al., 2010; Semb et al., 2011).

3.2.1.5.1. Guilt Related Cognitions Following Sexual Trauma

Guilt defined as 'an unpleasant feeling with an accompanying belief that one should have thought, felt or acted differently' (Kubany et al., 1996). Kubany and Watson (2003) described the cognitive component as the recognition / belief that one's thoughts, feelings, or actions have been violated in terms of personal and / or moral standards of behavior. They described that affective component (i.e., distress) is elicited when outcomes of the traumatic event are appraised as negative. Moreover, the trauma memory is specifically conceptualized with the affective component of guilt as emotional and physical distress

Lee, Scragg, and Turner (2001) suggested that the degree of guilt related to the traumatic event depends on an individual's life principles and their perceived responsibility for damage and they suggested that guilt charged intrusions led to

ruminative activity. There is an increasing body of evidence implies the relationship between guilt and also PTSD and depression as a secondary diagnosis (Dutton, et al., 1994; Foa, Steketee, & Rothbaum, 1989; Frazier & Schauben, 1994; Janoff-Bulman, 1989; Kubany, 1994; Kubany & Manke, 1995; Norris & Kaniasty, 1991; Resick & Schnicke, 1993, as cited in Kubany et al., 1996).

Trauma-related guilt has been worked through different trauma populations such as survivors of childhood sexual abuse (Spaccarelli, 1994): rape survivors (Resick & Schnicke, 1993); battered women (Cascardi & O'Leary, 1992); survivors of serious accidents and burns (Janoff-Bulman & Wortman, 1977); combat veterans (Kubany, 1994); survivors of technological disasters (Miles & Demi, 1992); and surviving family members of survivors of homicide, suicide, accidents, and sudden illness (Gerber & Resick, 1992; Joseph, Hodgkinson, Yule, & Williams 1993; McNiel, Hatcher, & Reubin, 1988).

Kubany et al., (1996) assumed that the development of guilt might change due to beliefs and feelings they had or did not have, and justification of the behaviors. In addition, survivors of domestic violence, childhood sexual abuse, and adult sexual assault (Feiring. Taska. & Chen. 2002; Gibson & Leitenberg. 2001; Kubany et al., 1996) have severe degree of guilt and shame; women have been found to have a tendency to develop these emotions much more (Else-Quest et al., 2012).

Street, Gibson, and Holohan (2005) suggested that the mediator between the relationship between trauma-related guilt and PTSD is the use of avoidant coping strategies such as self-distractions, behavioral disengagements, and denial among individuals with childhood traumatic events (e.g., childhood sexual abuse). As a consequence, guilt cognitions remain emotionally painful and inhibit the integrations of traumatic event successfully with an individual's beliefs (Kubany & Manke; 1995) and functions as intrusive recollections (Pugh, Taylor, & Berry, 2015).

3.2.1.5.2. Shame Related Cognitions Following Sexual Trauma

Shame has been described as 'a profound disappointment in the kind of person one thought one was' (Manion, 2002: 76), regarding others' approval of the person because the person has broken or failed to meet social standards (Miller, 2011). According to Miller (2013: 92), shame is a less intense form of disgust that involves 'violent

rejection' of the self or others, however, both leads to the disregard for and rejection of the self. Other theorists have conceptualized shame in the context of fear and threat, where shame is a 'fear of exposure' (Gilbert, 1997: 113; Dorahy & Clearwater, 2012). Similarly, Corrigan (2014: 174) described shame as 'the emotion that accompanies the failure to have defended the self at the center of its peri-personal space from either physical or social threat and the behavioral component is the urge to withdraw, to hide'. Bryan, Morrow, Etienne, and Ray-Sannerud (2012) defined shame (intrapersonal cognitive / affective state) as an uncontrollable psychological state in which the individual has negative self-evaluations and experiences inferiority, helplessness, and vulnerability.

Shame has been found to contribute to the maintenance of PTSD symptom severity through ongoing self-criticism which increases the sense of current threat (Harman & Lee, 2010). The relation between sexual trauma and shame can be considered as sexual trauma leads to increase one's sense of being negatively judged (Maercker & Müller, 2004; Peterson & Muehlenhard, 2004) and being surrounded by physical / social threats (Dobbs et al., 2009). Evidence in the female survivors of childhood sexual abuse sample has indicated that reduced shame mediated recovery on PTSD symptoms while reduced guilt did not (Ginzburg et al., 2009).

To sum up, guilt is related to the lack of justification of behaviors, while shame is related to look down on the self (Tangney and Dearing, 2002). Pugh et al. (2015) proposed four models to comprehend the relationship between guilt, shame and PTSD. Model 1 suggests that guilt is related to cognitions of self-blame, which depends on responsibility on a traumatic event which associated with PTSD (Foa and Rothbaum, 1999). Therefore, the modification of 'guilt cognitions' is the aim of the cognitive therapy to alleviate PTSD symptoms. The second model suggests the reverse which is PTSD brings about the guilt cognitions (e.g., being maladjusted in society or family, and felt guilty) (Galovski and Lyons, 2004). The third model is dissimilar to the first and second model which has suggested that guilt is a product of trauma. Rather than having a casual process between guilt and PTSD it is suggested that guilt may occur alongside the development of PTSD which does not contribute to the development of PTSD. The fourth model proposes that rather than guilt, shame may have a mediatory role between trauma and PTSD. This model offers that guilt-PTSD relationship explained by shame rather than depressive symptoms. So, the evidence suggested that when controlling the influence of depressive

symptoms guilt was still correlated positively with PTSD. However, when the influence of shame was controlled, guilt showed a negative correlation with PTSD which represented that guilt affected PTSD when fused with shame (Tangney, Stuewig, & Mashek, 2007).

CHAPTER 4

METHOD AND PROCEDURES

4.1. Study Design and Sampling

In the present study, data were collected from women with sexual trauma. By using convenience sampling, individuals from the target population were reached through the Facebook advertising tool which showed an ad about the study to female Facebook users aged between 18 and 55. The participation was voluntary. The inclusion criteria were being woman, age between 18 and 55, sexual trauma history and written informed consent for participation in the study. Sexual trauma was defined as unwanted sexual contact, attempted rape and experience of rape. Participants were required to respond 'yes' to at least one of the three questions below to participate in the study:

1. Have you ever been exposed to unwanted sexual contact? (e.g., intentional touching of genitals or any part of the body such as breasts or buttocks; forced touching of the perpetrator's genitals or any part of the body; exposure to sexually explicit images or videos).
2. Has anyone ever attempted to rape you? (incomplete forced vaginal or anal penetration)
3. Have you ever been raped? (completed forced vaginal or anal penetration)

Figure 4.1 shows the flow of participants through each stage of the study. The Facebook advertising tool showed the study ad to 308,977 women. A total of 5,902 clicked the ad which took the participant to the website hosting the study measures. After reading the study description 28 refused to participate in the study and 914 gave informed consent for participation in the study (4,960 did not respond). After excluding males (n = 5) and respondents who did not report any sexual violence experience (n = 305), data from 604 participants were analyzed.

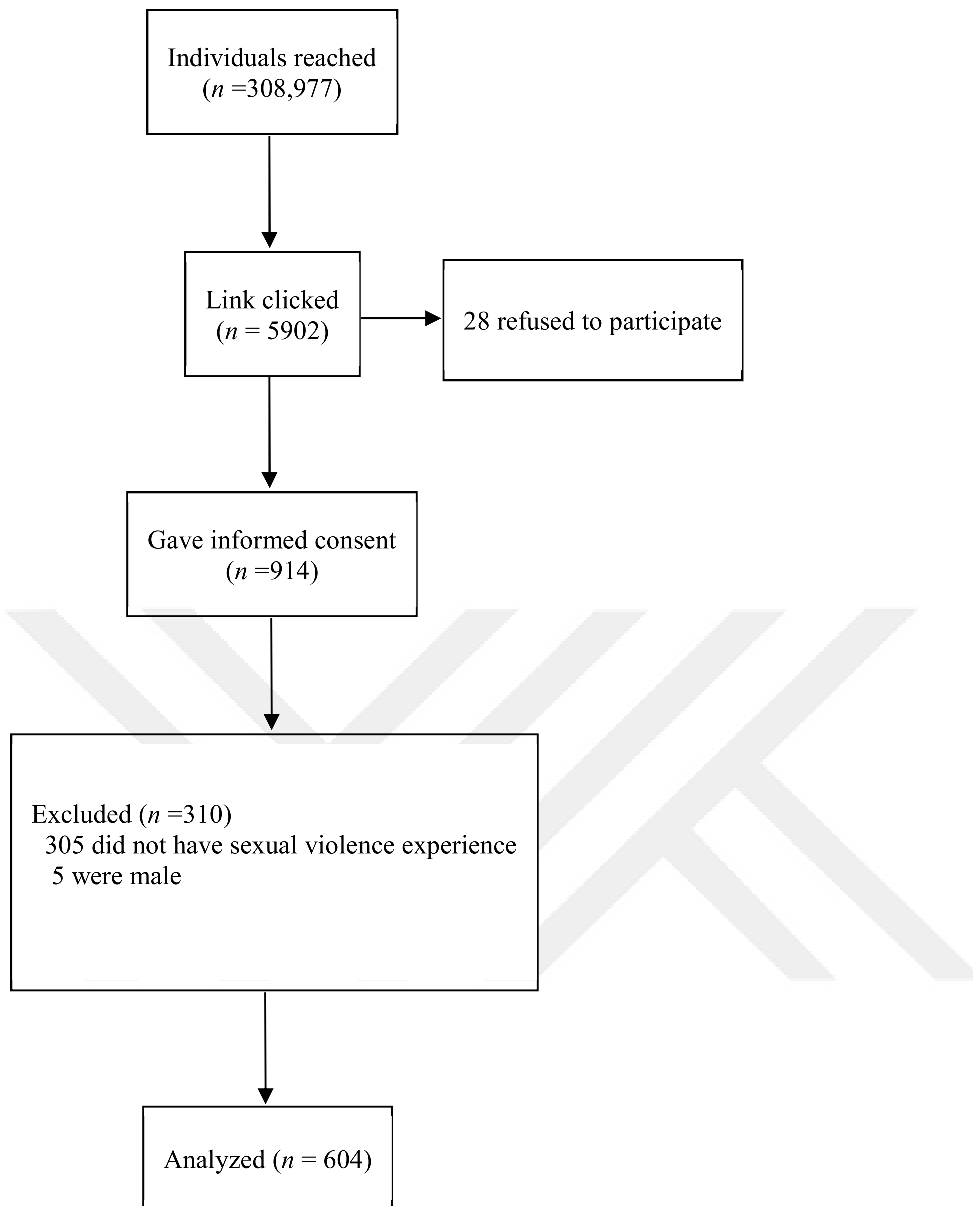

Figure 4.1. Diagram showing the flow of participants through each stage of the study

4.2. Study Measures

Participants completed a demographic information form, a trauma information form and four scales measuring trauma related guilt, shame, post-trauma fear and helplessness responses and PTSD (see Appendix A for study measures).

4.2.1. Demographic Information Form

This form was designed to get the information on gender, age, marital status and occupation, history of mental disorder, treatments and sexual trauma history.

4.2.2. Trauma Information Form

Three questions asked whether the person experienced any unwanted sexual contact, attempted rape and rape. Whenever the respondent had any of these experiences she indicated who the perpetrator was (an unfamiliar person, boyfriend, husband, first degree relative, second degree relative, and an acquaintance) and how many times she was exposed to such sexual violence. Five questions assessed the degree of sense of control before, during and after the traumatic incident and the degree of fear of death and distress during trauma exposure.

4.2.3. Trauma-Related Guilt Inventory

TRGI (Kubany, 1996) is a 32-item self-report questionnaire that was developed to evaluate the cognitive and affective components of guilt related to the traumatic event. Items are measured on five-point Likert-scale (0 = never/not at all true; 4 = always/extremely true). In a sample of 200 trauma survivors TRGI had a good internal consistency ($\alpha = .86$), test-retest reliability, construct validity, and structural validity and showed moderate correlations with PTSD symptoms (Kubany et al., 1996). An exploratory factor analysis extracted three subscales which characterized guilt cognitions ($\alpha = .92$), distress ($\alpha = .82$), and global guilt ($\alpha = .91$).

For this thesis, the English version of the TRGI was translated to Turkish by the researchers who are two clinical psychologists (Ebru Salcioglu and Tubanur Bayram Kuzgun). The translated scale was then back translated to English by an expert translator (Şule Erdoğdu). The back translation was examined by the researchers and no significant inconsistencies were noticed between the original and back-translated scales. The Turkish version of the TRGI was piloted among 20 Arel University students to ensure the clarity of items. In the current study TRGI showed excellent internal consistency with a Cronbach's alpha coefficient of .91. The Cronbach's alpha coefficients of subscale were .91 for global guilt, .92 for distress, .89 for guilt cognitions, .81 for hindsight-bias responsibility, .73 for wrongdoing, .73 for lack of justification.

Since distress and global guilt, the two subscales of TRGI, overlapped with PTSD and TRSI items; only data from guilt cognitions subscale was used the analyses.

4.2.4 Trauma-Related Shame Inventory

TRSI is a 24-item self-report questionnaire that measures internal and external referenced shame related to trauma experience (Oktodalen et al., 2014). The items are rated on a five-point Likert-scale (0 = not true of me; 3 = completely true of me). In a sample of 50 patients in treatment for PTSD a Univariate Generalizability Analysis showed that the scale had four facets [p x o (i:ra) design] including reference (internal and external) and aspect (self-condemnation and affective-behavioral). The generalizability and dependability coefficients of the scale were .874 and .868, respectively.

The English version of the TRSI was translated to Turkish by the researchers and back translated to English by an expert translator. The back translation was examined by the researchers and no significant inconsistencies were noticed between the original and back-translated scales. The Turkish version of the TRSI was piloted among 20 Arel University students to ensure the clarity of items. In the current study TRSI showed excellent internal consistency with a Cronbach's alpha coefficient of .97. The Cronbach's alpha coefficients of subscale were .92 for internal condemnation, .90 for internal affective behavioral, .84 for external condemnation, .90 for external affective behavioral.

4.2.5. Fear and Sense of Control Scale

Fear and Sense of Control Scale (FSCS, Salcioglu et al., 2017) is 10 item self-report inventory that measured the cumulative impact of traumatic stressors on feelings of fear and sense of helplessness at the time of assessment. Items are rated on a five-point Likert scale (0 = not at all true - 4 = very true). In a study of 220 domestic violence survivors the scale showed very good reliability with a Cronbach's α value of .87 (item-total correlations ranging between .47 and .71 and inter-item correlations ranging between .22 and .67). An exploratory factor analysis extracted two factors which represented *fear due to a sense of ongoing threat to safety* and *sense of helplessness in life.* The Cronbach's α value on each subscale based on two extracted factors was .81. In the current study of women with sexual violence history the Cronbach's alpha internal consistency coefficient of the overall scale was .90 and those of subscales were both .85.

4.2.6. Traumatic Stress Symptom Checklist

Traumatic Stress Symptom Checklist (TSSC-5) is a 17-item self-report questionnaire that assess PTSD symptoms as defined in DSM-IV-TR. Survivors indicate their level of distress in association with each PTSD symptom within the last week on a four-point-Likert-scale, ranging from 0 = not at all bothered to 3 = very much bothered. The scale showed high internal consistency in studies involving earthquake (Cronbach's alpha= .92, n=130) and war (Cronbach's alpha= .96) survivors (Basoglu, et al. 2001; Basoglu and Salcioglu, 2011). When the cut-off was set to 25, TSSC-5 showed high sensitivity, specificity and correct classification rate with respect to PTSD diagnosis as established using the Clinician's Administered PTSD Scale (CAPS, Blake et al. 1990) in earthquake and war survivors (.81, .81, 81% and .86, .84 and 84%, respectively).

Following the revision of the diagnostic criteria for PTSD in DSM-5 TSSC-5 has been revised by including 3 symptoms and by rewording of some items for clarity. In a community sample (n = 350) recruited from among people who responded to posts on the social media calling for participation in a study that examined the role of ongoing sense of threat of terrorism on PTSD the new scale (TSSC-5) showed excellent internal consistency (Cronbach's alpha = .94, Benbanaste, in preparation). Similarly, in the current study of survivors of sexual violence the Cronbach's alpha internal consistency coefficient for the scale has been found to be .94.

4.4. Procedure

The study design and instruments were approved by the Ethical Committee of the Istanbul Arel University (see Appendix B). Study measures were uploaded to an online PHP based software programme that was prepared by a computer engineer. After completing the demographic and trauma information forms participants filled in the remaining measures in a random order as determined by the software. At the end of the study, participants received feedback regarding the severity of their PTSD symptoms. Those who scored higher than 25 were informed that they had clinically significant PTSD symptoms that may deserve clinical attention and were given contact information of the researchers. Those who requested help were given free cognitive and behavioral treatment (see Appendix C for feedback texts).

4.5. Statistical Analysis

SPSS (Statistical Package for the Social Sciences - 22.0) and Lisrel 8.80 were used for statistical analyses. Basic analysis was conducted with SPSS. A two-step model (a measurement model and a structural model) was conducted with Lisrel to test hypothesized model.

Associations among variables were examined by Pearson r correlation coefficients for continuous and Spearman rho (rs) correlation coefficients for ordinal (or non-normally distributed data) variables. Prior to test hypothesized model, Confirmatory Factor Analysis (CFA) of TRGI and TRSI was computed to see whether construct validity of the two study measures (translation and back translation were conducted for this study) were eligible to use with their theoretically driven factor structures. Then two-step models were used to test hypothesized model. The first model was to test measurement model and the second step was to test the structural model of the study. Below, CFA and two-step models were briefly explained in the line of theoretical bases.

CFA is a powerful statistical technique is driven by the theoretical relationships among the latent constructs and indicators. In contrast to Exploratory Factor Analysis, CFA explicitly tests a priori hypothesis about the constructs. Brown (2014) suggested that CFA is commonly used for developing and refining study measures, assessing construct validity, identifying method effects, and evaluating factor invariance across time and groups. In the present study, the estimation of parameters based on the Weighted Least Square (WLS) method was used because the analysis involved items that were rated on an ordinal scale. WLS method that requires the asymptotic covariance matrix which represents the estimated sample variances under arbitrary non-normal distributions (Browne, 1984a).

Structural Equation Modeling (SEM) with two-step models was tested. Maximum Likelihood Estimation was used in these analyses. In the first step the measurement model was validated and then in the second step the structural model was tested. Anderson and Gerbing (1988) suggest that prior to test structural model, a measurement model tests the relationship between latent variables and their indicators. The measurement model is eligible to test whether the measured variables accurately reflect the related contracts. The structural model includes relations among the latent variables and tests the strength of the

relations among these variables. Goodness-of-fit indices and chi-square tests are used to assess the adequacy of the measurement and structural models. The goodness-of-fit of the models evaluated with the following: a ratio of chi-square to degrees of freedom ($\chi 2$ / df), goodness-of-fit index (GFI), standardized Root Mean Square Residual (S-RMR), incremental fit index (IFI), the root-mean-square error of approximation (RMSEA), comparative fit index (CFI). A ratio of chi-square to degrees of freedom ($\chi 2$ / df) value lower than 2 indicates a good fit and lower than 5 is acceptable. The GFI, IFI, CFI values higher than .90 indicates a good fit. The RMSEA and S-RMR values lower than .05 indicates a good fit and lower than .08 is acceptable (McDonald & Moon-Ho, 2002; Schermelleh-Engel, Moosbrugger & Müller, 2003).

4.6. The Hypothesized Structural Model

Figure 4.2 shows the hypothesized structural model tested in the study. Six latent variables and eighteen observed variables were included in the structural model. Latent variables were 'CONTROL' (peri-trauma sense of control), 'DISTRESS' (peri-trauma fear and distress), 'SHAME' (trauma-related shame after trauma exposure), 'FHELP' (post-trauma fear due to a sense of current threat to safety and sense of helplessness in life), 'GUILT' (trauma-related guilt cognitions), and 'PTSD' (traumatic stress symptoms as assessed by TSSC-5). Sense of control over the onset of sexual violence (PERCON1), sense of control over physical and / or emotional pain during sexual trauma (PERCON2) and sense of control over terminating sexual trauma (PERCON3) were used as indicators of 'CONTROL'. Peri-trauma fear/distress / discomfort (PERDIS1) and fear of death during sexual trauma (PERDIS2) were used as indicators of 'DISTRESS'. Four indicators measured the 'SHAME' latent variable: INCON (internal condemnation), INAFB (internal affective behavioral), EXTCON (external condemnation), EXTAFB (external affective behavioral). FEAR (post-trauma fear due to a sense of current threat to safety), HELPLES (post-trauma sense of helplessness in life) were the indicators of 'FHELP'. For the latent variable 'GUILT', three indicators were used: BIAS (hindsight bias), WDOING (wrongdoing), and JUSTIF (lack of justification). For the latent variable 'PTSD, four indicators were used: REXP (reexperiencing symptoms), AVID (avoidance symptoms), COG (negative alterations in cognitions), HYP (hyperarousal symptoms).

The following hypotheses were tested:

1. Peri-trauma sense of control has a direct and positive effect on peri-trauma fear and distress responses.
2. The effect of peri-trauma fear and distress responses on PTSD are mediated through post-trauma fear due to a sense of ongoing threat to safety and sense of helplessness in life.
3. The effect of peri-trauma fear and distress responses on PTSD are mediated through post-trauma shame.
4. The effect of peri-trauma fear and distress responses on PTSD are mediated through trauma-related guilt.

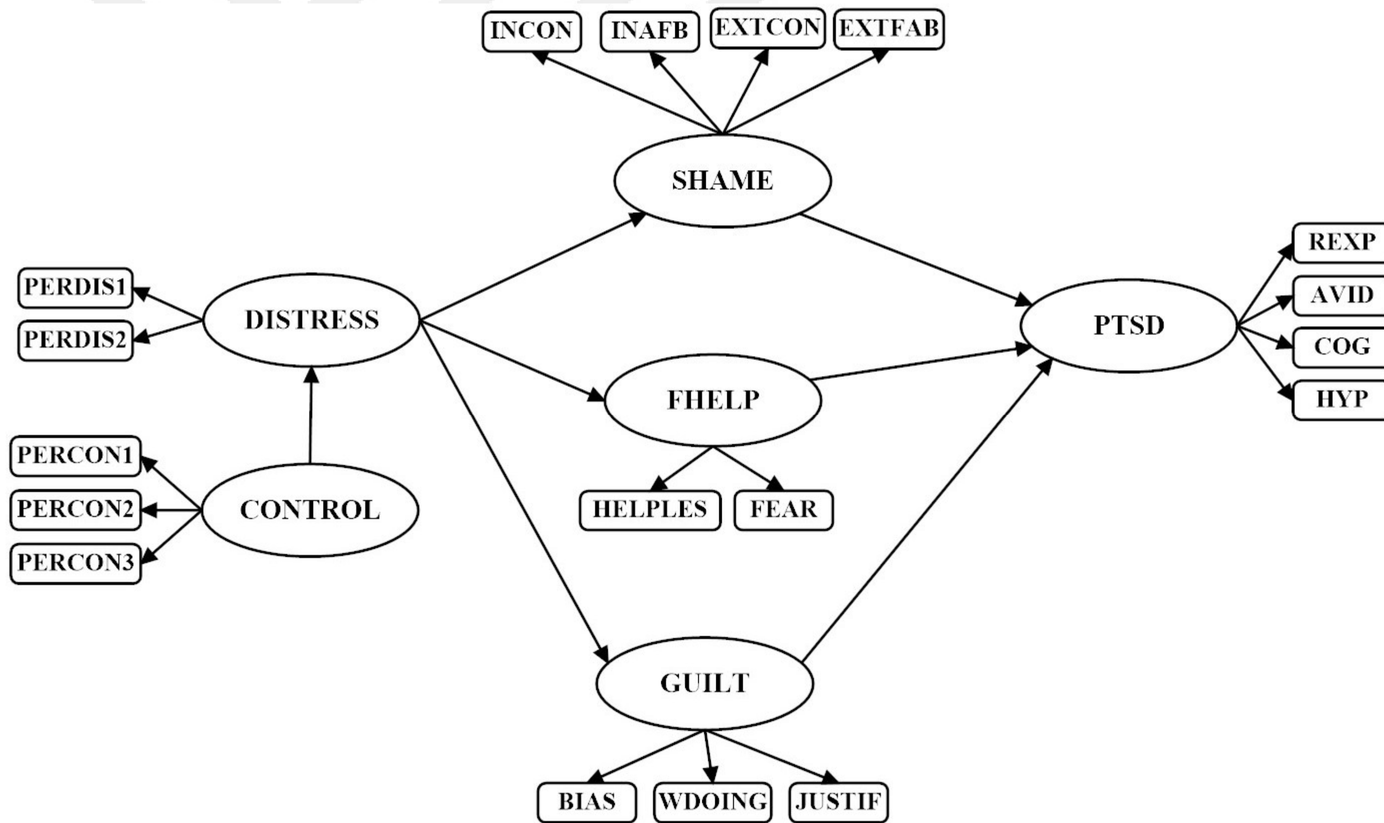

Figure 4.2. Theoretical model of the study

Note. CONTROL = peri-trauma sense of control, PERCON1 = sense of control over the onset sexual violence, PERCON2 = sense of control over physical and / or emotional pain during sexual trauma, PERCON3 = sense of control over terminating sexual trauma**,** DISTRESS = peri-trauma fear and distress, PERDIS1 = peri-trauma fear / distress / discomfort, PERDIS2 = fear of death during sexual trauma, SHAME = trauma related shame, INCON = internal condemnation, INAFB = internal affective behavioral, EXTCON = external condemnation, EXTAFB = external affective behavioral, FHELP = post-trauma fear and helplessness, FEAR = post-trauma fear, HELPLES = spost-trauma helplessness, GUILT = trauma related guilt cognitions, BIAS = hindsight bias, WDOING = wrongdoing, JUSTIF = lack of justification, PTSD = traumatic stress symptom checklist, REXP = reexperiencing symptoms, AVID = avoidance symptoms, COG = negative alteraltions in cognitions, HYP = hyperarousal symptoms.

CHAPTER 5

RESULTS

5.1. Sample Characteristics

5.1.1. Data Screening

Prior to statistical analyses, data were screened for missing values, univariate and multivariate outliers. Data from peri-trauma distress and control ratings, TRGI, TRSI, FSCS, and TSSC-5 were checked for accuracy of data entry, missing values, normality assumptions. There were not any missing values in the because the software did not allow participants to move through the scales if there were any missing responses. Skewness values did not indicate any univariate outliers. Three participants were identified through Mahalanobis distance as multivariate outliers with cut-off score of 22.46 ($df = 6$, $p < .001$) and were excluded from the analyses, leaving the study with 601 participants.

5.1.2. Demographic and Personal History Characteristics

The mean age of the total sample was 32.5 ($SD = 10.0$). Other demographic and personal history characteristics are presented in Table 5.1. The education level of the sample was quite high with 86.2% of the participants having an undergraduate degree or higher. More than half of the sample were single and employed. One-fifth of the participants ($n = 121$) reported having received treatment for a mental health problem before exposure to sexual trauma. Self-reported diagnoses or problems were depressive disorders ($n = 42$), anxiety disorders ($n = 21$), problems related to social environment ($n = 9$), mixed depression and anxiety ($n = 8$), bipolar disorder ($n = 7$), PTSD ($n = 6$), obsessive compulsive disorder ($n = 6$), acute psychotic disorder ($n = 3$), physical violence ($n = 3$), mixed depression, anxiety, and obsessive compulsive disorder ($n = 2$), dissociative disorders ($n = 2$), sexual problems ($n = 2$), attention deficit and hyperactivity disorder ($n = 2$), personality disorder ($n = 2$), somatoform disorders ($n = 2$), and speech problems ($n = 1$), and other problems ($n = 3$). Seventy-one percent ($n = 86$) of these participants received pharmacotherapy as treatment.

Table 5.1

Demographic and personal history characteristics

	n	%
Education level		
Primary school	5	0.8
Secondary school	10	1.7
High school	68	11.3
University	396	65.9
Master	93	15.5
Doctorate	29	4.8
Marital status		
Married	129	21.5
Single	335	55.7
Divorced	104	17.3
Live together	33	5.5
Employment status		
Employed	353	58.7
Unemployed	248	41.3
History of psychiatric disorder		
Yes	121	20.1
No	480	79.9
History of psychiatric medication		
No medication	480	79.9
CBT	7	1.2
Pharmacotherapy	86	14.3
EMDR	1	0.2
Not know	17	2.8
Other	10	1.7

Note. N = 601

5.1.3. Trauma Characteristics

A total of 591 (98.3%) participants reported having experienced unwanted sexual contact, 230 (38.3%) attempted rape and 172 (28.6%) rape. These figures were not mutually exclusive as of all rape survivors 165 (95.9%) also reported unwanted sexual contact and 107 (62.2%) reported attempted rape.

Table 5.2

Frequencies of Unwanted Sexual Contact, Attempted Rape and Rape

	Unwanted sexual contact (n = 591)	Attempted rape (n = 230)	Rape (n= 172)
	n (%)	n (%)	n (%)
1 (single perpetrator / once)	117 (19.7)	120 (52.1)	87 (50.5)
2-5	282 (47.7)	82 (35.6)	56 (32.5)
6-9	59 (9.9)	2 (0.8)	3 (1.7)
10-13	32 (5.4)	2 (0.8)	8 (4.6)
14 through highest	98 (16.5)	23 (10)	17 (9.8)

Note. N = 601

Table 5.2 shows the frequencies of unwanted sexual contact, attempted rape, and rape. Regarding frequencies, participants experienced sexual trauma once, or more commonly, several times in their lives. Around half of the participants have experienced attempted rape (52.1%) and rape (50.5%) once, unwanted sexual contact (47.7%) between two and five times in their lifetimes.

A total of 324 (54%) women experienced one type of sexual violence event perpetrated by a single actor only once. Others experienced multiple events by single or multiple perpetrators one or more times. Table 5.3 reports the breakdown of perpetrators in single incident sexual violence events. In many cases, sexual violence was perpetrated by an acquaintance, an unfamiliar person or a boyfriend. The rates of sexual violence perpetrated by husbands and first-degree relatives were relatively low.

Three in four (74.2%) participants did not sustain any injury during trauma exposure. The level of injury suffered by participants was slight (superficial cuts, soft tissue injuries, etc.) in 130 (21.6%), moderate (moderate tissue injuries, big bruises, scotch, etc.) in 20 (3.3%) and severe (fractures, internal bleeding, contusions, etc.) in 5 (0.8%) cases.

Table 5.3

Experience of One Type of Traumatic Event by One Perpetrator

	Unwanted Sexual Contact (n = 117)	Attempted Rape (n = 120)	Rape (n = 87)
	n (%)	n (%)	n (%)
First-degree relative	5 (4.2)	3 (2.5)	0 (0)
Second-degree relative	9 (7.6)	10 (8.3)	5 (5.7)
Husband	2 (1.7)	2 (1.6)	4 (4.5)
Boyfriend	13 (11.1)	26 (21.6)	31 (35.6)
An acquaintance	34 (29.0)	49 (40.8)	33 (37.9)
Unfamiliar person	54 (46.1)	30 (25)	14 (16.0)

Note. N = 601.

5.1.4. Peri-trauma Emotional Reactions and Sense of Control

Table 5.4 shows the distribution of ratings of peri-trauma fear / distress / discomfort, sense of control at various stages of exposure, and sense of helplessness. Seventy-one percent of study participants reported severe or extremely severe fear / distress / discomfort during exposure to sexual trauma. Forty percent also reported varying levels of fear of losing their lives. About one in every three survivors reported not having any control over the onset, emotional or physical impact and ending of the trauma event. Very few of them (around one in ten), on the other hand, were completely in control. Peri-trauma fear / distress / discomfort ratings showed significant correlations with sense of control over the onset of trauma ($r_s = .08$, $p < .05$), sense of control during trauma ($r_s = .17$, $p < .001$), sense of control over terminating trauma ($r_s = .16$, $p < .001$) and fear of death ($r_s = .37$, $p < .001$).

Table 5.4

Peri-trauma Control and Peri-trauma Distress Characteristics

	n	%
Sense of control over the onset sexual violence		
Completely in control	44	7.3
Markedly	66	11
Moderately	121	20.1
Slightly	159	26.5
No control at all	211	35.1

Sense of control over physical and /or emotional pain during sexual trauma		
Completely in control	48	8.0
Markedly	45	7.5
Moderately	129	21.5
Slightly	155	25.8
No control at all	224	37.3
Sense of control over terminating sexual trauma		
Completely in control	50	8.3
Markedly	65	10.8
Moderately	122	20.3
Slightly	156	26
No control at all	208	34.5
Peri-trauma fear / distress / discomfort		
No fear / distress / discomfort	8	1.3
Slight	63	10.5
Moderate	102	17
Severe	224	37.3
Extremely severe	204	33.9
Fear of death during sexual trauma		
No fear at all	363	60.4
Slight	116	19.3
Moderate	42	7.0
Severe	41	6.8
Extremely severe fear	39	6.5

Note. $N = 601$.

5.2. Frequency and Median of Rating on Outcome Measures

Table 5.5 shows frequency and median rating on TRGI / Guilt cognitions subscale. Table 5.6 shows frequency and median rating on TRSI. Table 5.7 shows frequency and median rating on FSCS. Table 5.8 shows frequency and median rating on TSSC-5.

Table 5.5

Frequency of and Median Ratings on TRGI (Guilt Cognitions Subscale)

	Mdn (IQR)	Not at all true	Slightly true	Somewhat true	Very true	Extremely true
		n (%)	n (%)	n (%)	n (%)	n (%)
Wrongdoing						
3. I had some feelings that I should not have had.	2 (3)	189 (31.4)	81 (13.5)	97 (16.1)	105 (17.5)	129 (21.5)
7. I did something that went against my values.	1 (3)	276 (45.9)	72 (12.0)	84 (14.0)	70 (11.6)	99 (16.5)
11. What I did was inconsistent with my beliefs.	0 (2)	305 (50.7)	67 (11.1)	84 (14.0)	68 (11.3)	77 (12.8)
16. I had some thoughts or beliefs that I should not have had.	2 (3)	177 (29.5)	104 (17.3)	121 (20.1)	104 (17.3)	95 (15.8)
21. I should have had certain feelings that I did not have.	1 (2)	267 (44.4)	102 (17.0)	138 (23.0)	53 (8.8)	41 (6.8)
Hindsight bias / responsibility						
1. I could have prevented what happened.	2 (3)	159 (26.5)	116 (19.3)	170 (28.3)	68 (11.3)	88 (14.6)
5. I was responsible for causing what happened.	0 (1)	335 (55.7)	119 (19.8)	72 (12.0)	35 (5.8)	40 (6.7)
9. I knew better than to do what I did.	1 (3)	189 (31.4)	112 (18.6)	123 (20.5)	91 (15.1)	86 (14.3)
14. I should have known better.	3 (3)	93 (15.5)	79 (13.1)	112 (18.6)	128 (21.3)	189 (31.4)
19. I blame myself for what happened.	1 (2)	236 (39.3)	136 (22.6)	118 (19.6)	58 (9.7)	53 (8.8)
23. I blame myself for something I did, thought, or felt.	1 (2)	205 (34.1)	127 (21.1)	120 (20.0)	83 (13.8)	66 (11.0)
26. I hold myself responsible for what happened.	1 (2)	299 (49.8)	115 (19.1)	92 (15.3)	54 (9.0)	41 (6.8)
Lack of justification						
4. What I did was completely justified.	2 (2)	113 (18.8)	106 (17.6)	176 (9.3)	98 (16.3)	108 (18.0)
8. What I did made sense.	2 (2)	141 (23.5)	106 (17.6)	165 (27.5)	79 (13.1)	110 (18.3)
12. If I knew today—only what I knew when the event(s) occurred—I would do exactly the same thing.	4 (2)	73 (12.1)	42 (7.0)	85 (14.1)	78 (13.0)	323 (53.7)
17. I had good reasons for doing what I did.	2 (2)	99 (16.5)	97 (16.1)	147 (24.5)	113 (18.8)	145 (24.1)

Table 5.6

Frequency of and Median Ratings on TRSI

	Mdn (IQR)	Not true of me n (%)	Somewhat true of me n (%)	Mostly true of me n (%)	Completely true of me n (%)
Internal condemnation					
1. As a result of my traumatic experience, I have lost respect for myself	1 (2)	255 (42.4)	175 (29.1)	104 (17.3)	67 (11.1)
5. As a result of my traumatic experience, I cannot accept myself	1 (2)	284 (47.3)	148 (24.6)	84 (14.0)	85 (14.1)
10. As a result of my traumatic experience, I find myself less desirable	0 (2)	332 (55.2)	116 (19.3)	78 (13.0)	75 (12.5)
13. As a result of my traumatic experience, there are parts of me that I want to get rid of	1 (3)	172 (28.6)	129 (21.5)	134 (22.3)	166 (27.6)
15. Because of my traumatic experience, I feel inferior to others	0 (1)	350 (58.2)	115 (19.1)	54 (9.0)	82 (13.6)
21. As a result of my traumatic experience, I don't like myself	1 (2)	289 (48.1)	136 (22.6)	89 (14.8)	87 (14.5)
Internal affective behavioral					
3. I am ashamed of myself because of what happened to me	1 (1)	298 (49.6)	164 (27.3)	64 (10.6)	75 (12.5)
8. I am ashamed of the way I behaved during my traumatic experience	1 (2)	265 (44.1)	138 (23.0)	99 (16.5)	99 (16.5)
9. I am so ashamed of what happened to me that I sometimes want to escape from myself	1 (2)	288 (47.9)	123 (20.5)	81 (13.5)	109 (18.1)
11. I am ashamed of the way I felt during my traumatic experience	0 (1)	358 (59.6)	111 (18.5)	65 (10.8)	67 (11.1)
20. My traumatic experience has revealed a part of me that I am ashamed of	1 (2)	291 (48.4)	146 (24.3)	83 (13.8)	81 (13.5)
23. Because of what happened to me, I am disgusted with myself	0 (1)	366 (60.9)	106 (17.6)	54 (9.0)	75 (12.5)
External condemnation					
12. If others knew what had happened to me, they would look down on me	0 (2)	304 (50.6)	133 (22.1)	80 (13.3)	84 (14.0)
17. If others knew what happened to me, they would find me unacceptable	0 (1)	326 (54.2)	126 (21.0)	68 (11.3)	81 (13.5)
2. Because of what happened to me, others find me less desirable	0 (1)	430 (71.5)	100 (16.6)	52 (8.7)	19 (3.2)
4. As a result of my traumatic experience, others have seen parts of me that they want nothing to do with	1 (2)	300 (49.9)	131 (21.8)	100 (16.6)	70 (11.6)
6. If others knew what happened to me, they would view me as inferior	1 (2)	262 (43.6)	128 (21.3)	96 (16.0)	115 (19.1)
14. If others knew what happened to me, they would not like me	0 (2)	324 (53.9)	114 (19.0)	82 (13.6)	81 (13.5)
External affective behavioral					
16. If others knew what happened to me, they would be ashamed of me	0 (1)	332 (55.2)	124 (20.6)	65 (10.8)	80 (13.3)
19. If others knew how I behaved during my traumatic experience, they would be ashamed of me	0 (1)	342 (56.9)	111 (18.5)	75 (12.5)	73 (12.1)
24. I am so ashamed of what happened to me that I sometimes want to become invisible to others	0 (1)	409 (68.1)	82 (13.6)	45 (7.5)	65 (10.8)
22. If others knew how I felt during my traumatic experience, they would be ashamed of me	0 (1)	408 (67.9)	88 (14.6)	55 (9.2)	50 (8.3)

	Mdn (IQR)	Not true of me n (%)	Somewhat true of me n (%)	Mostly true of me n (%)	Completely true of me n (%)
18. As a result of my traumatic experience, a part of me has been exposed that others find shameful	0 (1)	343 (57.1)	126 (21.0)	68 (11.3)	64 (10.6)
7. If others knew what happened to me, they would be disgusted with me	0 (1)	358 (59.6)	101 (16.8)	63 (10.5)	79 (13.1)

Table 5.7

Frequency of and Median Ratings on FLCS

	Mdn (IQR)	Not at all true n (%)	Slightly true n (%)	Moderately true n (%)	Fairly True n (%)	Very true n (%)
Fear due to sense of current threat to safety						
2. I fear reliving the same events.	2 (3)	93 (15.5)	136 (22.6)	73 (12.1)	109 (18.1)	190 (31.6)
3.I fear for my life.	1 (2)	284 (47.3)	144 (24.0)	61 (10.1)	66 (11.0)	46 (7.7)
5. I cannot lead my normal life for fear of the same events happening again.	0 (1)	327 (54.4)	129 (21.5)	62 (10.3)	46 (7.7)	37 (6.2)
6. I feel I am in danger.	1 (2)	262 (43.6)	162 (27.0)	72 (12.0)	54 (9.0)	51 (8.5)
7. I feel my loved ones are in danger.	1 (2)	269 (44.8)	131 (21.8)	77 (12.8)	64 (10.6)	60 (10.0)
9. I have developed some fears that I did not have before.	1 (3)	172 (28.6)	171 (28.5)	79 (13.1)	88 (14.6)	91 (15.1)
Sense of helplessness in life						
1. I have no control over my life.	1 (2)	212 (35.3)	169 (28.1)	142 (23.6)	49 (8.2)	29 (4.8)
4. I feel helpless.	1 (2)	212 (35.3)	162 (27.0)	82 (13.6)	68 (11.3)	77 (12.8)
8. I think I cannot change anything in my life.	1 (2)	258 (42.9)	130 (21.6)	84 (14.0)	60 (10.0)	69 (11.5)
10. I have no courage.	1 (2)	295 (49.1)	137 (22.0)	71 (11.8)	44 (7.3)	54 (9.0)

Table 5.8

Frequency of and Median Ratings on TSSC-5

	Mdn (IQR)	Not at all	Slightly	Fairly	Very much
		n (%)	n (%)	n (%)	n (%)
1. Intrusive memories	1 (2)	159 (26.5)	205 (34.1)	149 (24.8)	88 (14.6)
2. Flashbacks	0 (1)	332 (55.2)	164 (27.3)	70 (11.6)	35 (5.8)
3. Nightmares	1 (2)	239 (39.8)	194 (32.3)	113 (18.8)	113 (18.8)
4. Psychological distress upon reminders of trauma	2 (2)	98 (16.3)	175 (29.1)	178 (29.6)	150 (25)
5. Physical distress upon reminders of trauma	1 (2)	230 (38.3)	185 (30.8)	105 (17.5)	81 (13.5)
6. Avoidance of trauma-related thoughts	2 (2)	126 (21)	141 (23.5)	140 (23.3)	194 (32.2)
7. Avoidance of trauma reminders	1 (2)	181 (30.1)	136 (22.6)	135 (22.5)	149 (24.8)
8. Psychogenic amnesia	1 (2)	208 (34.6)	149 (24.8)	118 (19.6)	126 (21.0)
9. Negative cognitions about self, the World and people	2 (2)	113 (18.8)	130 (21.6)	144 (24.0)	214 (35.6)
10. Blaming oneself or other for trauma	2 (2)	147 (24.5)	136 (22.6)	142 (23.6)	176 (29.3)
11. Persistent fear, shame, anger after trauma	1 (2)	231 (38.4)	169 (28.1)	113 (18.8)	88 (14.6)
12. Loss of interest	1 (2)	244 (40.6)	145 (24.1)	109 (18.1)	103 (17.1)
13. Detachment from people	1 (2)	195 (32.4)	151 (25.1)	115 (19.1)	140 (23.3)
14. Numbing of positive emotions	1 (2)	250 (41.6)	154 (25.6)	99 (16.5)	98 (16.3)
15. Irritability or anger outbursts	1 (2)	253 (42.1)	145 (24.1)	88 (14.6)	115 (19.1)
16. Risky or self-destructive behaviors	0 (1)	363 (60.4)	116 (19.3)	61 (10.1)	61 (10.1)
17. Hypervigilance	1 (2)	180 (30)	187 (31.1)	120 (20)	114 (19)
18. Exaggerated startle response	1 (2)	168 (28)	166 (27.6)	133 (22.1)	134 (22.3)
19. Concentration difficulty	1 (2)	226 (37.6)	145 (24.1)	113 (18.8)	117 (19.5)
20. Insomnia	1 (2)	234 (38.9)	166 (27.6)	92 (15.3)	109 (18.1)

There was no cut-off point established for PTSD diagnosis in TSSC-5. However, a cut-off points of 25 was established for the previous version of the scale, which assessed 17 PTSD symptoms as defined by DSM-IV-TR. Based on this cut-off the estimated rate of PTSD was 50% in this sample. The mean TSSC-5 score was 24.7 (SD = 14.9).

5.3 Correlations Among Observed Variables

Table 5.9 shows the correlations among observed variables. Sense of control over the onset sexual violence showed significant correlations with negative alterations in

cognitions ($r_s = .09$, $p < .05$). Sense of control over physical and / or emotional pain during sexual trauma showed significant correlations with re-experiencing symptoms ($r_s = .18$, $p < .001$), negative alterations in cognitions ($r_s = .17$, $p < .001$), and hyperarousal symptoms ($r_s = .16$, $p < .001$). Sense of control over terminating sexual trauma, peri-trauma fear and distress / discomfort, and fear of death during sexual trauma showed significant correlations with all PTSD indicators. Among the correlations between TSSC-5 symptom clusters and other observed variables, the highest correlations were obtained between negative alterations in cognitions and internal condemnation ($r = .74$, $p < .001$), negative alterations in cognitions and internal affective behavioral ($r = .64$, $p < .001$), hyperarousal symptoms and post-trauma fear ($r = .63$, $p < .001$).

Table 5.9

Correlations Among Observed Variables

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. PERCON1	2.7	1.2	--																	
2. PERCON2	2.7	1.2	.65***	--																
3. PERCON3	2.6	1.2	.60***	.77***	--															
4. PERDIS1	2.9	1.0	.08*	.17***	.16**	--														
5. PERDIS2	0.8	1.2	0.01	.09*	.09*	.37***	--													
6. INCON	5.1	4.6	.09*	.19***	.19***	.17***	.12**	--												
7. INAFB	5.3	5.3	.06*	.15***	.17***	.14***	.08*	.85***	--											
8. EXTCON	5.0	5.0	0.01	.13**	.13**	.13**	.15***	.79***	.77***	--										
9. EXTAFB	4.3	5.1	0.02	.12**	.14**	.11**	.08*	.80***	.86***	.88***	--									
10. FEAR	8.1	6.2	0.04	.11**	.09*	.28***	.28***	.58***	.52***	.47***	.46***	--								
11. HELPLES	4.8	4.4	0.05	.10*	.10**	.21***	.17**	.65***	.56***	.51***	.51***	.70***	--							
12. WDOING	7.3	5.0	0.01	0.04	0.07	-0.01	-0.02	.56***	.60***	.54***	.58***	.31***	.39***	--						
13. BIAS	10.3	6.3	-0.05	0.01	0.03	-0.01	-0.03	.52***	.59***	.48***	.52***	.29***	.38***	.66***	--					
14. JUSTIF	8.8	4.1	.25***	.27***	.27***	-0.04	0.03	.25***	.29***	.24***	.25***	0.01	.12**	.24***	.34***	--				
15. REXP	5.6	4.0	0.05	.18***	.17***	.32***	.23***	.63***	.58***	.53***	.51***	.60***	.57***	.39***	.37***	.15***	--			
16. AVID	3.0	2.0	0.02	0.07	.10**	.24***	.19***	.52***	.47***	.43***	.41***	.48***	.41***	.29***	.34***	.17***	.71***	--		
17. COG	9.2	5.9	.09*	.17***	.19***	.25***	.19***	.74***	.64***	.61***	.57***	.61***	.62***	.41***	.41***	.17***	.71***	.64***	--	
18. HYP	6.8	4.9	0.04	.16**	.14***	.23***	.21***	.60***	.52***	.51***	.48***	.63***	.60***	.38***	.33***	.11**	.66***	.55***	.76***	--

Note 1. N = 601, Note 2. $^{*}p<.05$, $^{**}p<.01$, $^{***}p<.001$. *Note 3.* PERCON1 = sense of control over the onset sexual violence, PERCON2 = sense of control over physical and / or emotional pain during sexual trauma, PERCON3 = sense of control over terminating sexual trauma**,** PERDIS1 = peri-trauma fear / distress / discomfort, PERDIS2 = fear of death during sexual trauma, INCON = internal condemnation, INAFB = internal affective behavioral, EXTCON = external condemnation, EXTAFB = external affective behavioral, ,FEAR = post-trauma fear, HELPLES = post-trauma helplessness, BIAS = hindsight bias, WDOING = wrongdoing, JUSTIF = lack of justification, REXP = reexperiencing symptoms, AVID = avoidance symptoms, COG = negative alteraltions in cognitions, HYP = hyperarousal symptoms.

5.4. Confirmatory Factor Analysis of Guilt Cognitions Subscale of TRGI

CFA of TRGI was computed to test whether the scale's original factor structure provided a good fit to our data. The original English version of scale had three factors (global guilt, distress, guilt cognitions) and three sub-factors of guilt cognitions (wrongdoing, hindsight bias, lack of justification). Since guilt cognitions were used in the hypothesized model, CFA for guilt cognitions was computed using the WLS. *Figure 5.1* and *Figure 5.2* shows TRGI factor solution tested with CFA and standardized solution values of the TRGI / guilt cognitions, respectively. The model yielded a reasonable fit to data: $\chi 2$ (101, N =601) =446.74; $p < .001$; GFI= 0.97; S-RMR=0.07; IFI=0.97; RMSEA=.07; CFI=0.97. The modification indices suggested adding correlated errors between item 1 (I could have prevented what happened) and item 5 (I was responsible for causing what happened), between item 8 (What I did make sense) and item 12 (If I knew today—only what I knew when the event(s) occurred—I would do exactly the same thing) and, between item 3 (I had some feelings that I should not have had) and item 16 (I had some thoughts or beliefs that I should not have had). The final CFA model produced an acceptable fit to the data: $\chi 2$ (98, N =601) =368.03; $p < .001$; GFI= 0.98; S-RMR=0.06; IFI=0.97; RMSEA=.06; CFI=0.97.

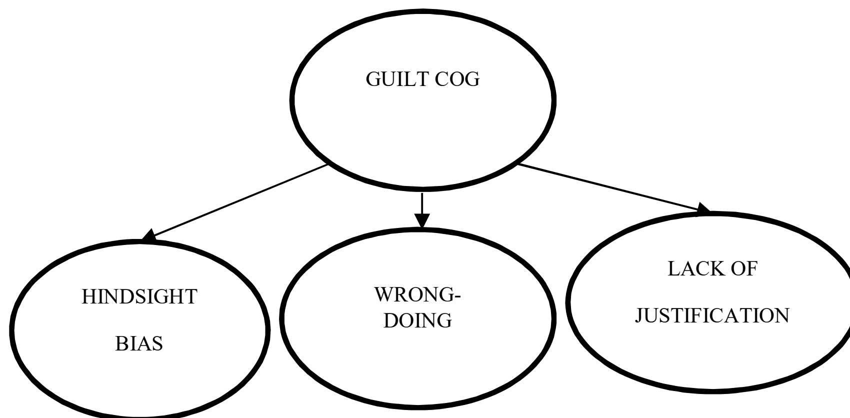

Figure 5.1. TRGI factor solution tested with CFA.

Note 1. N = 601. Note 2. GUILT COG: guilt cognitions, HINDSIGHT BIAS: hindsight bias/ responsibility, WRONGDOING: wrongdoing, LACK OF JUSTIFICATION: lack of justification.

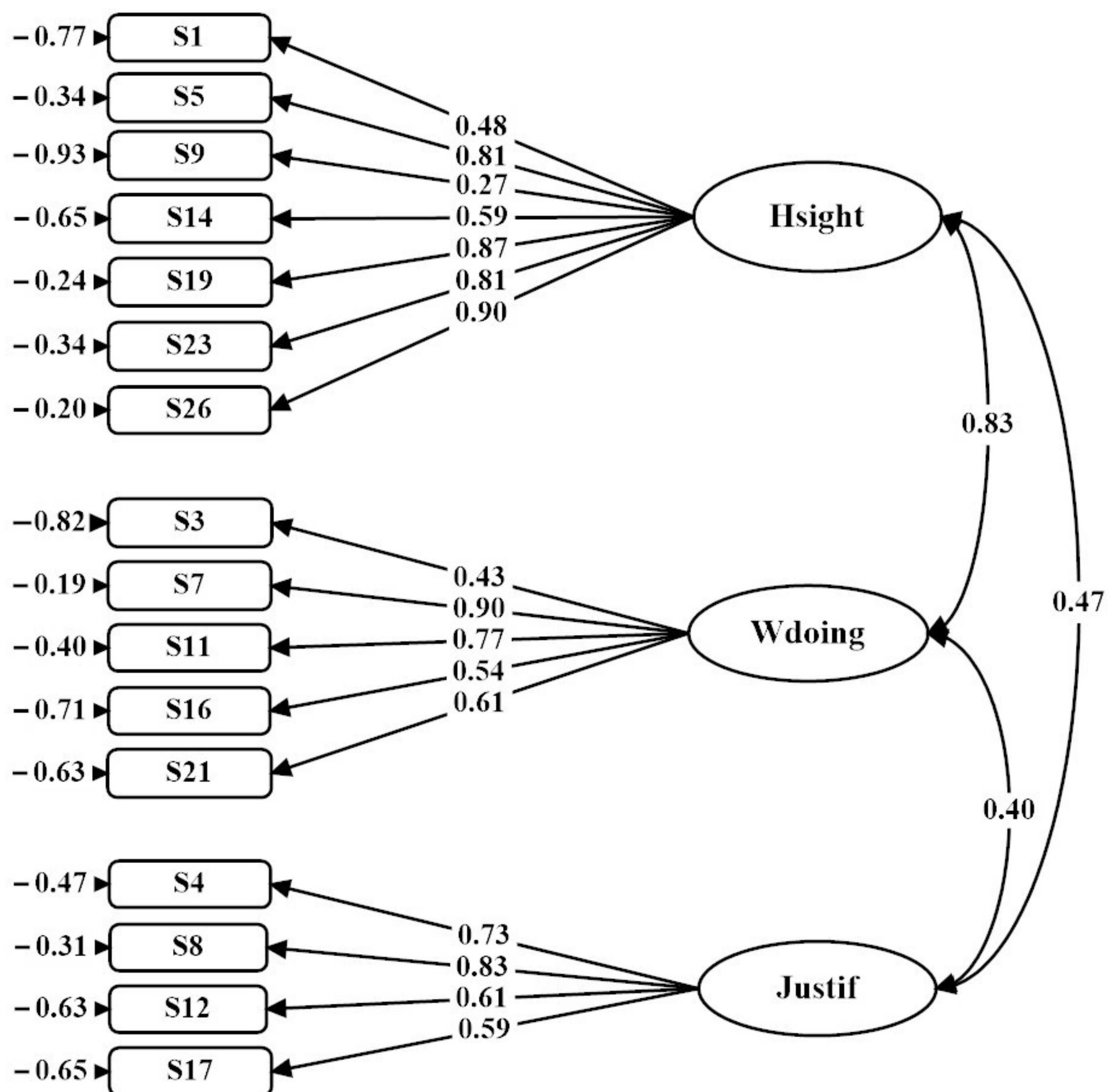

Figure 5.2. Standardized solution values of the TRGI / guilt cognitions scale; CFA.

Note 1. N = 601. Note 2. Hsight: hindsight bias/ responsibility, Wdoing: wrongdoing, Justif: lack of justification.

5.5. Confirmatory Factor Analysis of TRSI

CFA of TRSI was computed to test whether the scale's original factor structure provided a good fit to our data. The original English version of scale had four facets (internal: condemnation and affective/behavioral, external: condemnation and affective/behavioral). Thus, a second-order CFA was computed. The first order includes condemnation and affective behavioral dimensions; the second order includes condemnation: internal condemnation and external condemnation; and affective

behavioral: internal affective behavioral and external affective behavioral. *Figure 5.3*. and *Figure 5.4* shows TRSI factor solution tested with CFA and standardized solution values of the TRSI, respectively. The goodness of fit indices showed that the original factor structure of the model was acceptable to our data. CFA evaluated using the WLS and three indicators of goodness of fit indices showed that the model provided an acceptable fit to the data: $\chi 2$ (247, N =601) =1500.22; $p < .001$; GFI= 0.98; S-RMR=0.05; IFI=0.98; RMSEA=.09; CFI=0.99.

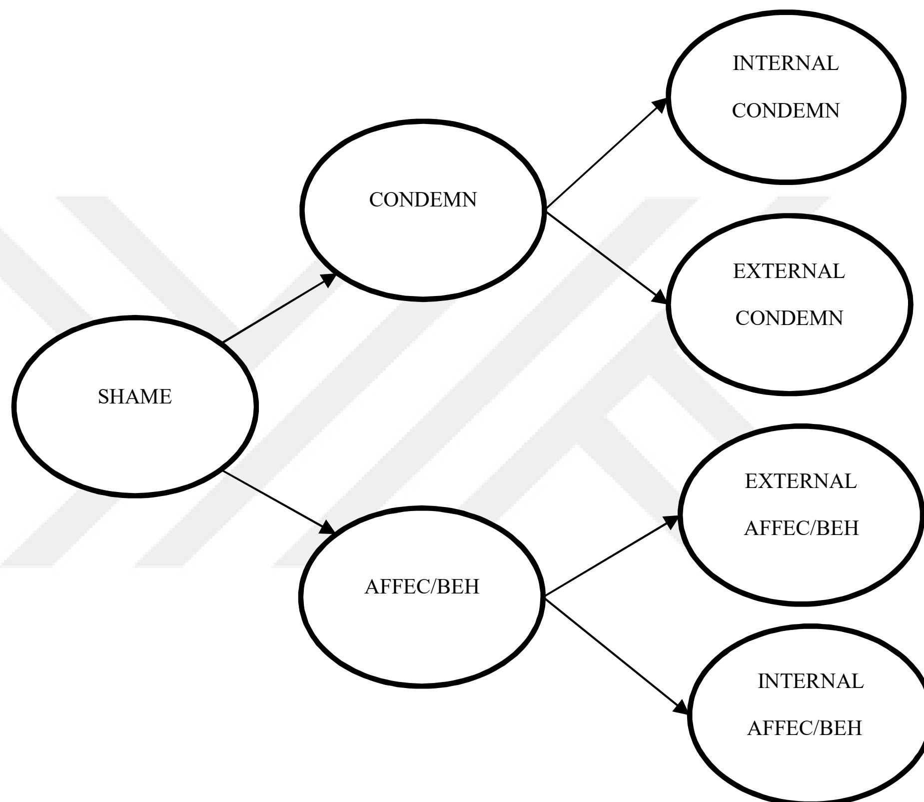

Figure 5.3. TRSI factor solution tested with CFA.

Note 1. N = 601, Note 2. SHAME: trauma-related shame, CONDEMN: condemnation, INTERNAL CONDEMN: internal condemnation, EXTERNAL CONDEMN: external condemnation, AFFEC/BEH: affective/ behavioral, INTERNAL AFFEC/BEHA: internal affective/ behavioral, EXTERNAL AFFEC/BEH: external affective/ behavioral.

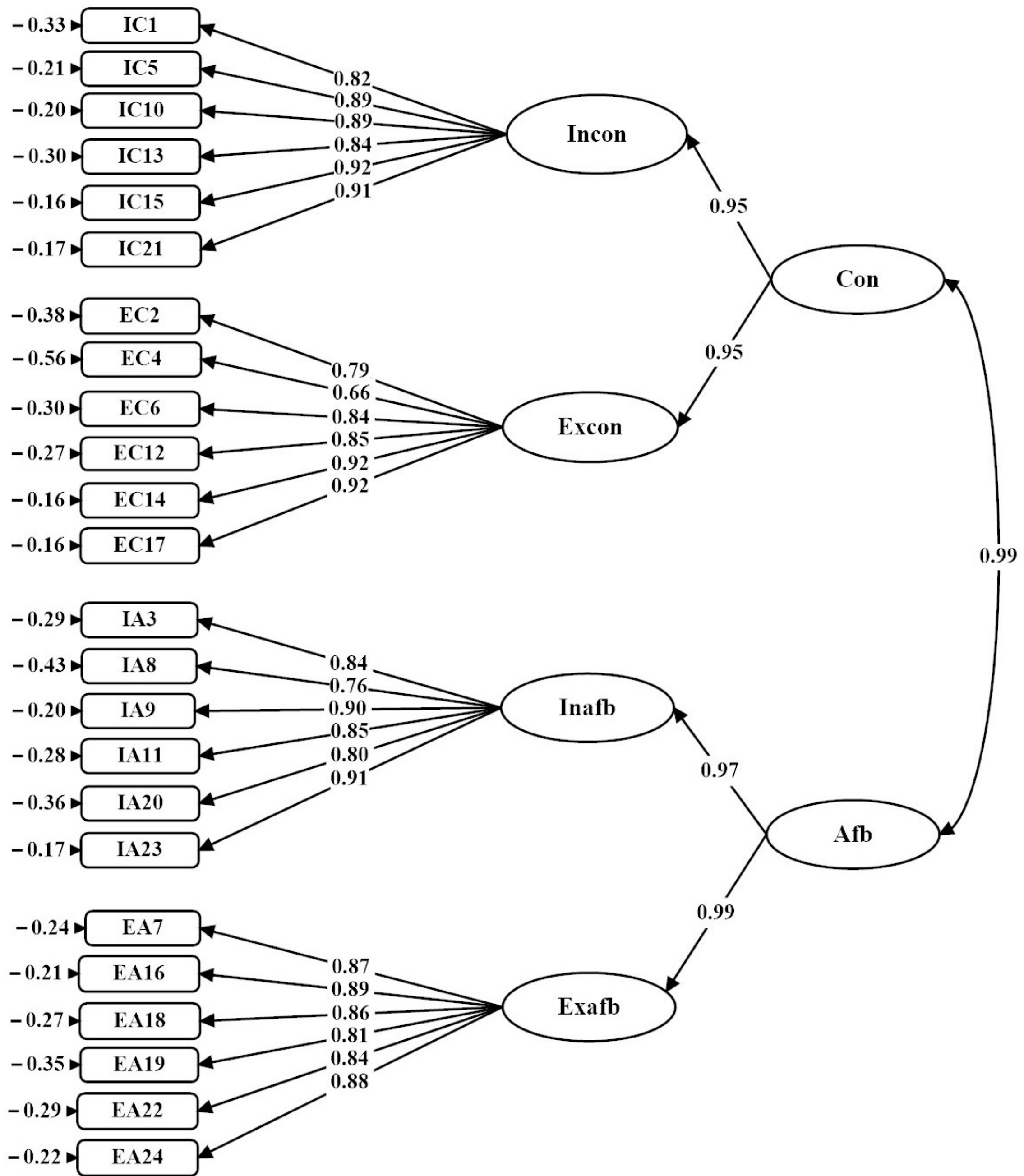

Figure 5.4. Standardized solution values of the TRSI; CFA.

Note 1. N = 601. Note 2. Con: condemnation, Incon: internal condemnation, Excon: external condemnation, Afb: affective/ behavioral, Inafb: internal affective/ behavioral, Exafb: External affective/ behavioral.

5.6. The Measurement Model

The measurement model with eighteen observed variables and six latent variables was tested. The measurement model was evaluated using the maximum likelihood method, which produced a reasonable fit to the data: $\chi 2$ (120, N =601) =748.70; p < .001; GFI= 0.88; S-RMR=0.05; IFI=0.96; RMSEA=.09; CFI=0.96. Modification indices

suggested adding a correlated error between the two factors of the TRSI scale (EXTAFB and EXTCON)[1]. After adding this correlated error to model, goodness of fit indices were better: $\chi 2$ (119, N =601) = 628.97; p < .001; GFI= 0.90; S-RMR=0.05; IFI=0.97; RMSEA=0.08; CFI=0.97. Modification indices suggested adding other correlated errors between AVID and REXP of the TSSC-5 scale [2]. Adding these correlated errors resulted in an increase in the model fit statistics. The χ^2: df ratio was within the suggested range (χ^2/df ratio = 4.69). The final model yielded an acceptable fit: χ^2 (118, N =601) = 554.76, p<.001; GFI= 0.91; S-RMR=0.05; IFI=0.95; RMSEA=.07; CFI=0.97. Thus, the measurement model indicated that the latent variables were estimated successfully from the observed variables. The factor loadings of the final model (with two modification) ranged from .36 to .95 and t-values of the model ranged from 8.43 to 30.20.

Figure 5.5 shows the standardized solution values of the measurement model. The first model showed a reasonable fit to the data. The loadings of the indicator / observed variables of 'CONTROL' ranged from .77 to .95. The loadings of the two indicators of 'DISTRESS' were .66 and .75. The loadings of the indicator variables of 'SHAME' ranged from .84 to .94. The loadings of the 'FHELP' were .98 for FEAR, and .89 for HELPLES. The loadings of the indicator variables of the 'GUILT' ranged from .36 to .82. The loadings of the four indicators of 'PTSD' ranged from .70 to .90. The correlations among latent variables ranged from -.03 to .79. The highest correlations were obtained between FHELP and PTSD (r = .79, t > 1.96). The correlation between GUILT and DISTRESS was also insignificant (r = -.03, t < 1.96).

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[1] Adding correlated errors between the two indicators of shame significantly decreased the chi-square value ($\Delta\chi^2$ (1) = 119.73 p <.05).

[2] Adding correlated errors between the two indicators of TSSC-5 significantly decreased the chi-square value ($\Delta\chi^2$ (1) = 74.21, p <.05)

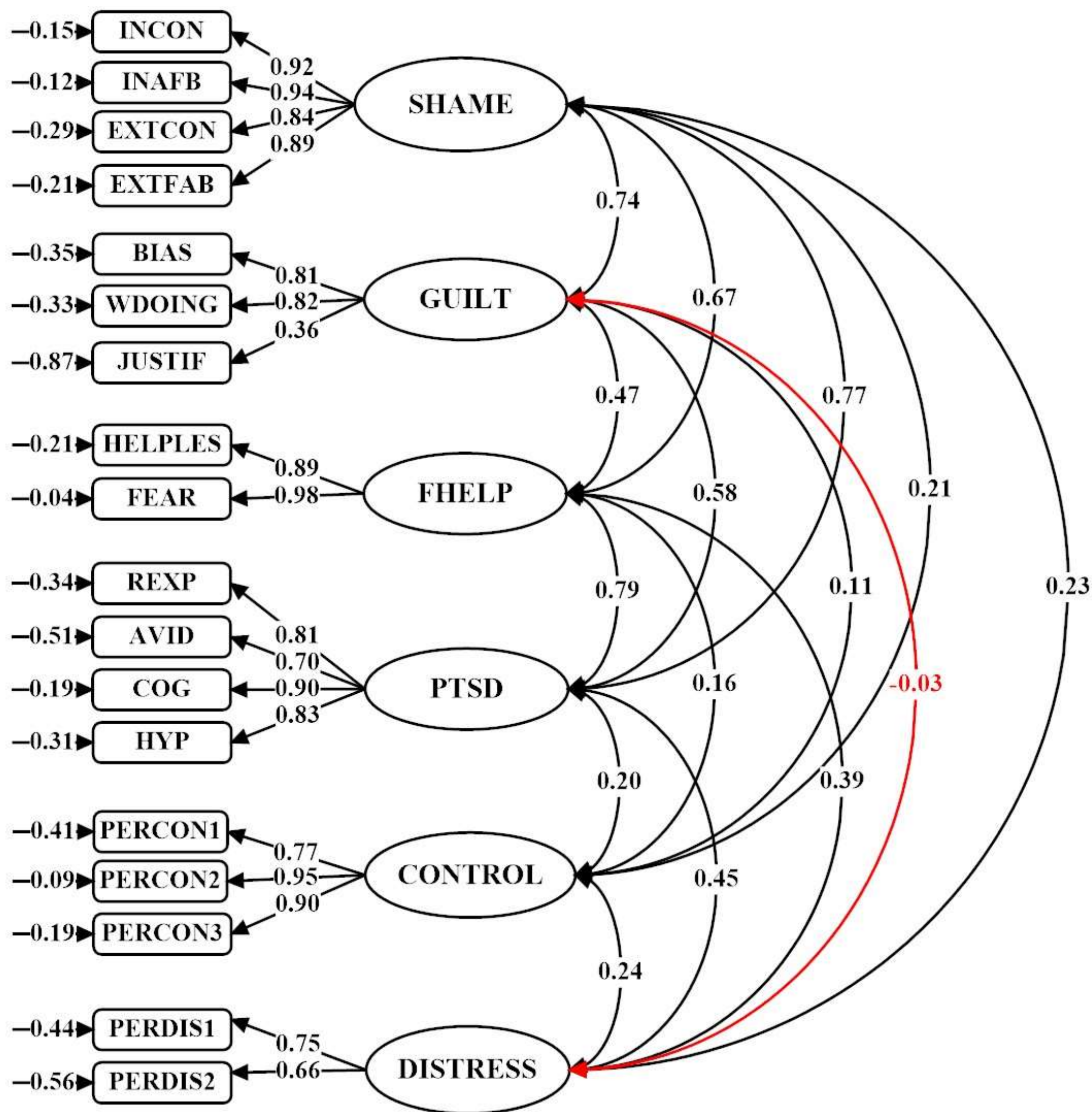

Figure 5.5. Standardized solution values of the measurement model**.**

Note 1. N = 601. Note 2. CONTROL = peri-trauma sense of control, PERCON1 = sense of control over the onset sexual violence, PERCON2 = sense of control over physical and / or emotional pain during sexual trauma, PERCON3 = sense of control over terminating sexual trauma, DISTRESS = peri-trauma fear and distress, PERDIS1 = peri-trauma fear / distress / discomfort, PERDIS2 = fear of death during sexual trauma, SHAME = trauma related shame, INCON = internal condemnation, INAFB = internal affective behavioral, EXTCON = external condemnation, EXTAFB = external affective behavioral, FHELP = post-trauma fear and helplessness, FEAR = post-trauma fear, HELPLES = post-trauma helplessness, GUILT = trauma related guilt cognitions, BIAS = hindsight bias, WDOING = wrongdoing, JUSTIF = lack of justification, PTSD = traumatic stress symptom checklist, REXP = reexperiencing symptoms, AVID = avoidance symptoms, COG = negative alteraltions in cognitions, HYP = hyperarousal symptoms.

5.7. The Structural Model

The analysis was conducted to test whether the relation between PTSD symptom severity and peri-trauma distress and sense of control is mediated through post-trauma shame, fear and helplessness over life, and guilt cognitions. The structural model provided a reasonable fit to data due to the goodness of fit indices. The model produced similar results as those produced by the measurement model, given that it has the same number of parameters. The model provided an acceptable fit: $\chi 2$ (122, N =604) = 567.03, p<.001; GFI= 0.90; S-RMR=0.06; IFI=0.97; RMSEA=.07; CFI=0.97.

Figure 5.6 shows standardized solutions of structural model. The findings supported Hypotheses 1. Peri-trauma sense of control had a direct and positive effect on peri-trauma fear and distress ($\beta = .25$, $t = 4.99$, $p < .05$). Peri-trauma fear and distress had a direct and positive effect on post-trauma fear and sense of helplessness ($\beta = .40$, $t = 7.11$, $p < .05$) and the latter had a direct and positive effect on PTSD ($\beta = .41$, $t = 9.63$, $p < .05$). Similarly, peri-trauma fear and distress responses had a direct and positive effect on post-trauma shame ($\beta = .25$, $t = 4.70$, $p < .05$) and the latter had a direct and positive effect on PTSD ($\beta = .34$, $t = 5.81$, $p < .05$). When both direct and indirect paths were included in the model, the standardized beta coefficient between DISTRESS and PTSD was reduced from 0.45 to 0.22 but it remained significant ($p < .01$). This finding showed that the effect of peri-trauma emotional responses on PTSD were both mediated through post-trauma fear and sense of helplessness and shame, explaining 16.4% and 8.5% of the variance in PTSD symptoms, respectively. These findings supported Hypotheses 2 and 3. On the other hand, even though trauma-related guilt had a direct and positive effect on PTSD ($\beta = .14$, $t = 2.56$, $p < .05$), peri-trauma fear and distress responses did not have a significant effect on trauma-related guilt ($\beta = -0.02$, $t = -0.34$, ns). Thus, Hypothesis 4 was not supported. The LISREL estimates for the indirect effect of DISTRESS on PTSD was significant (estimate for the indirect effect = 0.25, SE = .04, $t = 5.57$).

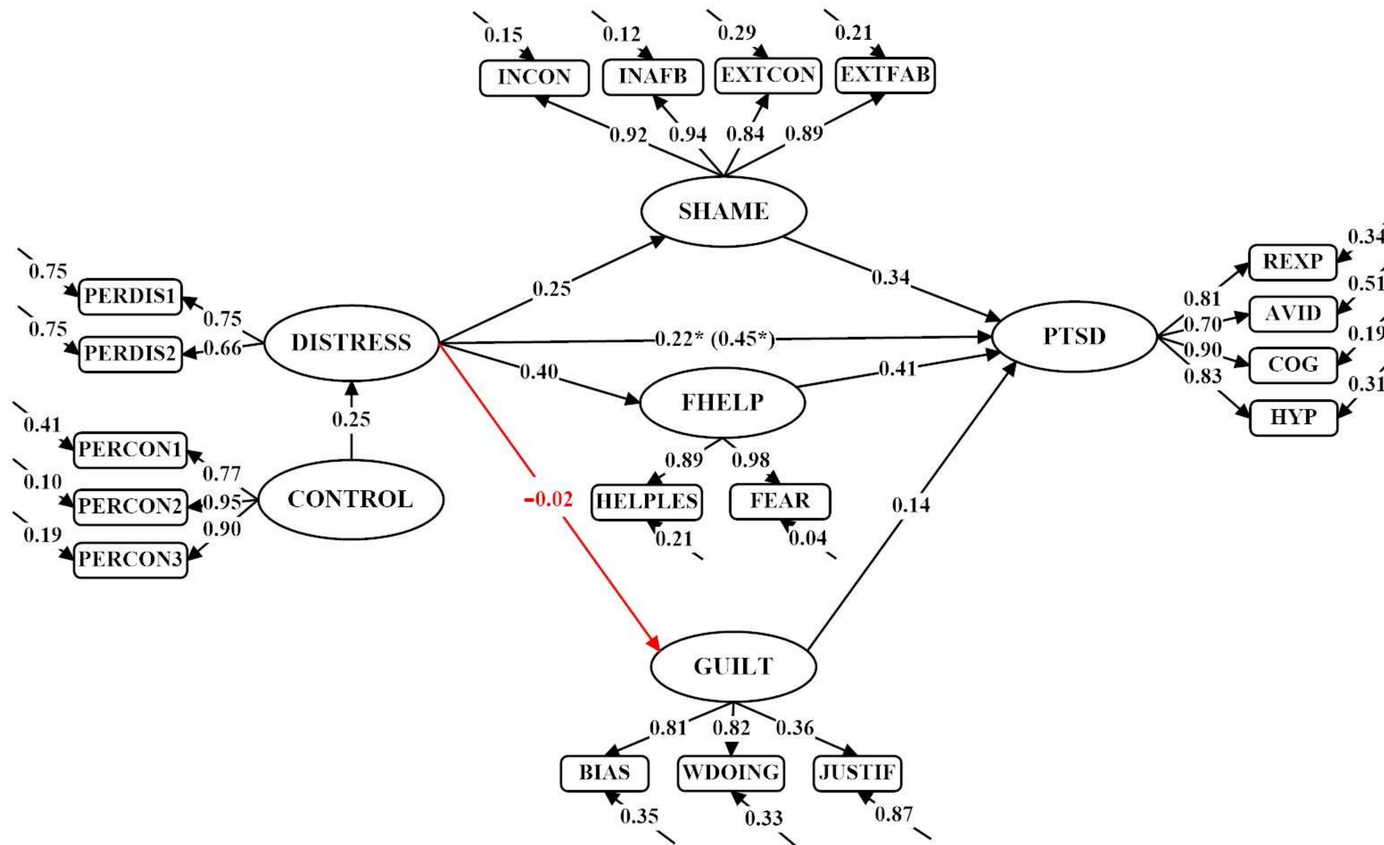

Figure 5.6. Standardized solutions of structural model.

Note 1. N = 601, Note 2. CONTROL = peri-trauma sense of control, PERCON1 = sense of control over the onset sexual violence, PERCON2 = sense of control over physical and / or emotional pain during sexual trauma, PERCON3 = sense of control over terminating sexual trauma**,** DISTRESS = peri-trauma fear and distress, PERDIS1 = peri-trauma fear / distress / discomfort, PERDIS2 = fear of death during sexual trauma, SHAME = trauma related shame, INCON = internal condemnation, INAFB = internal affective behavioral, EXTCON = external condemnation, EXTAFB = external affective behavioral, FHELP = post-trauma fear and helplessness, FEAR = post-trauma fear, HELPLES = post-trauma helplessness, GUILT = trauma related guilt cognitions, BIAS = hindsight bias, WDOING = wrongdoing, JUSTIF = lack of justification, PTSD = traumatic stress symptom checklist, REXP = reexperiencing symptoms, AVID = avoidance symptoms, COG = negative alteraltions in cognitions, HYP = hyperarousal symptoms.

CHAPTER 6

DISCUSSION

6.1. Sample Characteristics

Out of 5902 people who clicked the Facebook advertisement of the study, 904 of them gave informed consent. About two-thirds of the consenters (604 out of 914 = 66%) reported sexual trauma. It is not possible to determine the true response rate in this study. However, it may be assumed that if every person who clicked the study would have given informed consent to participate, then the number of eligible participants would have been 3895 (66% of 5902), yielding a response rate of 15.5%. Thus, it can be concluded that 15.5% the response rate lies somewhere between 15.5% and 66.8%. The sample included women with high levels of education 86.2% of them having an undergraduate degree or higher. Participants were also young, single and employed. The sample may not be truly representative of the population of interest. As the aim of the study was not to report prevalence of psychiatric problems in women exposed to sexual trauma, the select nature of the sample does not invalidate findings regarding the structural model.

6.2. Psychometric Properties of the Study Measures

To examine the associations between PTSD and trauma-related guilt and shame valid and reliable measures of the latter constructs were needed. For this purpose, TRGI and TRSI were translated into Turkish and their psychometric properties were examined in this sample. TRGI and TRSI both showed excellent internal consistency. A three-factor model based on guilt cognitions subscale of TRGI (wrongdoing, hindsight bias, lack of justification) that was tested with CFA provided a reasonable fit to the data thereby supporting the construct validity of the guilt cognitions subscale. These findings were in line with the Polish adaptation study of TRGI (Popiel & Zawadzki, 2015) in a sample of 280 motor vehicle accident survivors and the Spanish adaptation study (Pereda et al., 2011) of the TRGI in a sample of 650 university students, which supported the factorial structure of the guilt cognitions subscale. Similarly, a second-order CFA that was computed for TRSI (the first order included condemnation and affective-behavioral dimensions; the second order included condemnation: internal condemnation and external

condemnation; and affective behavioral: internal affective behavioral and external affective behavioral) showed that the original factor structure of the model was acceptable. These findings suggested that the Turkish versions of TRGI and TRSI were valid measures of trauma-related guilt and shame.

6.3. Trauma Characteristics

Almost all participants (98.3%) reported having experienced unwanted sexual contact, while 38.3% reported an experience of attempted rape and 28.6% reported an experience of rape. Because these figures were not mutually exclusive, the sample was not suitable to compare the three sexual trauma clusters regarding their relative effects on mental health.

Almost half of the survivors reported having experienced unwanted sexual contact (47.7 %) between two and five times in their lifetimes. About half of the survivors reported having experienced attempted rape (52.1 %) and rape (50.5%) by single perpetrator only once in their lifetimes. It seems that the rest of the sample experienced rape and attempted rape by a single perpetrator multiple times, multiple perpetrators one time or multiple perpetrators multiple times. It is interesting to note that 75% and 84% of women experienced attempted rape and rape, respectively, by someone familiar to them.

The current study showed that for 37.9% and 40.1% of the rape survivors was perpetrated by an acquaintance and intimate partner (a boyfriend and a spouse), respectively. The evidence is consistent with other studies showing that the rapists were mostly endorsed as ‘an acquaintance’ or ‘intimate partner’. A nationally representative survey in the United States represents that 20.0% and 30.4% women survivors having experienced their first forced sex by an acquaintance and an intimate partner (boyfriend or spouse), respectively (Basile et al., 2007). Additionally, Tjaden & Thoennes (2000) found that the 21% and 62% of women were perpetrated by acquaintances and intimate partners (current or former spouse, cohabiting partner, boyfriend, or date), respectively (as cited in Basile et al., 2007).

6.4. Peri-trauma Emotional Reactions

In the present study, around one in ten were completely in control during sexual trauma. Survivors who maintained some degree of control over stressors showed a

tendency to report lower levels of distress. These results were consistent with studies showing that perceived distress during trauma is associated with perceived control during trauma in survivors of earthquakes (Salcioglu, 2004), war (Basoglu et al., 2005), torture (Basoglu & Salcioglu, 2011), and domestic violence (Salcioglu et al, 2017). Lack of capability to exercise control over stressors have been found to enhance several deficits in animals such as alternations between sudden outbursts of agitated behaviors, a state of lethargy, passivity, and withdrawal (Mineka & Hendersen, 1985, Mineka & Kihlstrom, 1978; as cited in Foa, Zinbarg, & Rothbaum, 1992). As it was discussed in Chapter 2, a learning theory formulation of traumatic stress developed by Basoglu and Salcioglu (2011) put forth the explanation that a survivor has previously experienced lack of control over negative consequences of stressor events, s/he appraises the traumatic event as uncontrollable and experiences fear, distress, or panic. Sense of control could be considered as behavioral, cognitive, and emotional and the uncontrollability caused by sense of control over stressors leads to fear of possible future occurrences of the event and a sense of helplessness which is a good predictor of post-traumatic stress symptoms (Salcioglu et al., 2017).

Among several peri-trauma characteristics that have been studied, perceived sense of threat (e.g., fear of death) has been found to be a strong predictor of later distress. About three in every four survivors experienced severe or extremely severe fear/distress /discomfort during exposure to sexual trauma. This is consistent with suggestions that survivors' peri-trauma perception of risk of severe violence or death is an equally if not a more powerful indicator of consequent distress than are severity indices such as injury and the assailant's use of an arm. (Bernat et al., 1998, Girelli et al., 1986, as cited in Kaysen et al., 2005). In our sample, 98.8% of rape survivors reported varying levels of fear during trauma. This figure is consistent with a previous study showing that 97.2% of female rape survivors endorsed having felt afraid during or immediately after trauma (Kaysen et al., 2005). Kaysen et al. (2005) found that 89.9% rape survivors believed they might be seriously injured or killed during trauma. Parallel to this finding, our data showed that 51.1% of rape survivors sustained fear of death during trauma exposure (not included in Chapter 5). These findings highlight once again the very frightening nature of rape.

6.5. Correlations Among Study Measures

In the present study, the sense of control during trauma correlated with hyperarousal symptoms ($r = .16, p < .001$). The findings supported to the learning theory formulation of PTSD (detailed in chapter 3). Indeed, Foa et al. (1992) stated that uncontrollable stressors are more likely lead to the generalized arousal symptoms which is a characteristic of PTSD than does controllable stress. In addition to this, the correlation coefficient between hyperarousal symptoms and avoidance which are the two indicators of PTSD was high ($r = .55, p < .0001$). The finding was consistent with the study showed that patients were experiencing more arousal of threatening trauma-related pictures and that they seemed more likely to avoid these pictures (Fleurkens, Rinck, & van Minnen, 2014).

DSM-5 added a new cluster of symptoms called negative alterations in cognitions designed to represent cognitive and mood disturbances seen with PTSD showed low or moderate degree correlation with indicators of guilt cognitions. For instance, the correlation coefficient between wrongdoing (e.g., what I did was inconsistent with my beliefs) and negative alterations in cognitions was .41. However, it showed high degree correlation with indicators of fear and helplessness and shame. For instance, the correlation coefficient between fear (e.g., I fear reliving the same events) and negative alteration in cognitions was .61. The correlation coefficient between internal condemnation (e.g., 'as a result of my traumatic experience, I find myself less desirable') and negative alterations in cognitions was .74. Therefore, cognitive and mood disturbances of PTSD seem associated with fear, helplessness, and shame more than guilt, in sexual trauma population.

Endorsement rates of the items were examined. Highly-rated items belong to the several indicators used in the model: hindsight bias/responsibility, lack of justifications, fear, avoidance, and negative alteration in cognitions. TRGI showed the top three highly-rated items as 'extremely true' and items were 'I should have known better' (31.4%), 'If I knew today—only what I knew when the event(s) occurred—I would do exactly the same thing' (53.7%), 'I had good reasons for doing what I did'. (24.1%). One item: 'I fear reliving the same events' (22.6%) in FSCS showed highly-rated as 'slightly true'. TSSC-5 showed the top three highly-rated items as 'fairly very true'. Items were 'Avoidance of

trauma-related thoughts (32.2%), ‘Negative cognitions about self, the World and people’ (35.6 %), ‘Blaming oneself or other for trauma’ (29.3%).

6.6. The Model Test

6.6.1. Summary of Findings

The mediatory role of post-trauma fear and helplessness, guilt, shame between peri-trauma fear and distress, peri-trauma sense of control and PTSD was tested. Consistent with the hypothesized model peri-trauma distress predicted trauma-related shame, post-trauma fear and helplessness responses, which in turn predicted PTSD symptom severity. However, inconsistently with the hypothesized model, although guilt cognitions predicted PTSD, they were not associated with peri-trauma distress. These findings indicated that shame, post-trauma fear and helplessness mediated the association between peri-trauma emotional reactions and traumatic stress symptoms, but guilt cognitions did not.

6.6.2. The Association between Peri-Trauma Distress and Sense of Control

The findings based on the structural model supported Hypothesis 1. Peri-trauma sense of control had a direct and positive effect on peri-trauma fear and distress responses. Peri-trauma control explained 6% of the variance in peri-trauma distress. The self-rated measure of sense of control in this study may not have sufficiently assess such a complex construct, which may have resulted in such a small amount of variance it explained in peri-trauma distress. Other factors such as neuroticism (Cox, MacPherson, Enns, & Mcwilliams, 2004), preexisting mental health conditions (Atkeson, Calhoun, Resick, & Ellis, 1982), and genetic/ biological factors such as alteration in cortisol response (Yehuda, 2006), MHPG (3-Methoxy-4-Hydroxyphenylglycol), a metabolite of norepinephrine may also play a role in determining the level of peri-trauma distress. To enhance the power the predictors of peri-trauma fear and distress, future researchers should also examine the effects of tonic immobility (Bovin et al., 2008) freezing response (Rizvi et al., 2008) and panic (Fikretoglu et al., 2007) that are previously found to contribute to the peri-trauma fear (as cited in Rosendal et al., 2011).

6.6.3. The Mediator Role of Fear and Helplessness and Shame

In the present study, post-trauma fear and helplessness and shame were found as mediators in the association between peri-trauma control, distress and PTSD symptom severity. Post-trauma fear due to a sense of ongoing threat to safety and helplessness in life explained the largest amount, explaining 16.4% of the variance, in this psychiatric condition. These findings were consistent with the findings from studies that explored the role of fear and helplessness among different trauma populations of earthquake, war, torture, and domestic violence as it was discussed above. Perceived distress or fear associated with traumatic stressors may have brought about a sense of powerlessness or helplessness, decreasing the possibility to take any action to defend oneself (Jones et al., 2001; Walker, 2009, as cited in Salcioglu et al., 2017). This would contribute our understanding of the role of fear and helplessness among sexual violence population.

Hypothesis 3 is supported as the effect of peri-trauma emotional responses on PTSD were mediated through trauma-related shame explaining 8.5% of the variance in PTSD symptoms. As was discussed in Chapter 2, the experience of sexual trauma leads to increase one's sense of being negatively judged (Maercker & Müller, 2004; Peterson & Muehlenhard, 2004) and being surrounded by physical / social threats (Dobbs et al., 2009). Human being tends to hide 'the perceived defect from others' in an effort towards self-protection (La Bash & Papa, 2014) from damage at the hands of those with higher standing in the social hierarchy (Folger, Johnson, & Letwin, 2014). A similar mechanism may play a role in sexual trauma. The importance of shame in PTSD contributed to newer theories and increasing evidence in the recent years which suggest that non-fear emotions, such as shame, may be important features of PTSD (Holmes et al. 2005; Grunert et al. 2007; Resick et al. 2008; Harman and Lee 2010; Semb et al. 2011).

6.6.4. The Non-Mediator Role of Guilt

Correlations among variables showed post-trauma guilt was predicted PTSD, but the association was small. Guilt subscales were not associated with distress and two of control questions. Lack of justification was associated with more sense of control over trauma. In other words, those people who viewed their actions as more justifiable were those who had experienced more loss of control over the traumatic event during exposure.

In the present study, Hypothesis 4 (the effect of peri-trauma emotional responses on PTSD were mediated through trauma-related guilt) was not supported. The path between peri-trauma distress and trauma-related guilt was not significant. However, our results were consistent with previous studies showing strong positive correlations between trauma-related guilt and PTSD in individuals surviving a different type of traumatic events. Trauma-related guilt arises when survivors who negatively evaluate their action or inaction during trauma and their cognitive appraisals includes negative self-evaluation of one's behavior in comparison to valued standards (Kubany & Watson, 2003; Tangney & Dearing, 2002). Evidence showed that approximately half of the sample of sexually abused women, two in three of a Vietnam Veteran survivor reported experiencing moderate or higher levels of guilt due to their behaviors, thoughts, and feelings during their traumatic experiences (Kubany et al., 1996).

6.7. Limitations and Strengths of the Study

There are several limitations of the present study that should be acknowledged. Convenience sampling has resulted in the recruitment of young, single, and employed women survivors of sexual trauma, and findings may not be generalizable to the overall sexual trauma population in Turkey. Also, self-report methodology was used to assess the sexual trauma in women which limits the information obtained from participants. Since the design of the current study was cross-sectional, it should be cautious to conclude unidirectional relationships. Longitudinal studies are required to investigate temporal changes on dimensions such as type of sexual violence, frequency of sexual violence, type of perpetrator, and to examine association of these dimensions with post-traumatic stress symptoms. Moreover, considering preexisting mental health condition was pre-trauma predictor of PTSD, further studies should assess the effect of preexisting mental health condition on hypothesized model.

Despite the limitations, the present study has several strengths. First, the evaluation of various sexual trauma-related dimensions including peri-trauma variables (control and distress) and post-trauma variables (shame, guilt, fear, and helplessness) in the same study is not common in the trauma literature. Therefore, the present study enabled the relative contribution of those variables on post-traumatic stress severity simultaneously. Also, sample size of the study afforded significant statistical power to the study. Moreover, the study employed valid and reliable measures which had good or

excellent psychometric properties. Finally, the study was theory-driven, grounded in literature and had solid scientific background focused on testing hypotheses taken from existing theoretical frameworks.

6.8. Implications for Future Research

The present study contributed to our understanding of the mechanisms of traumatization and maintenance of post-traumatic stress symptoms in sexual violence survivors. As was discussed by Salcioglu et al. (2017) psychological interventions would be effective in this trauma population to the extent that they help overcoming shame, fear, and restoring the sense of control over one's life. Future studies are needed to examine the efficacy and effectiveness of such interventions in survivors of sexual violence. Psychologists need proper training in psychological trauma and effective psychological interventions for trauma survivors.

Considering the fact that peri-trauma fear (Basoglu et al., 2002; Salcioglu et al., 2003; Livanou, et al., 2002) and dissociative reactions (Shalev, Peri, Canetti, & Schreiber, 1996; Ursano et al., 1999) have found as the strongest predictors of PTSD, future researches should take into consideration the effect of subsequent dissociation to the peri-trauma fear (Merrill, Guimond, Thomsen, & Milner, 2003).

6.9. Clinical implications

Our results have important clinical implications for psychological treatment of sexual trauma survivors. The present study showed that in addition to the post-traumatic stress symptoms, subsequent feelings of fear and helplessness, and shame would contribute the mechanisms of PTSD in sexual trauma survivors. Indeed, reformulation of PTSD regarding an alteration in mood, where the traumatized person experiences an increase in negative emotions, such as fear, anger, guilt, and shame (Badour, Resnick, & Kilpatrick, 2015) gained increased attention in the DSM-5. Regarding treatment policies, psychotherapeutic interventions would be effective when it takes the mechanism of the traumatization into consideration (Basoglu, 2007, as cited in Salcioglu et al., 2017). Therefore, the understanding of the mechanisms of fear, helplessness, and shame would contribute to the treatment of PTSD in sexual trauma survivors.

According to official PTSD treatment guidelines such as those by the International Society for Traumatic Stress Studies (Foa, Keane, Friedman, & Cohen, 2009) or the National Institute for Health and Care Excellence, Clinical Guidelines on PTSD (NICE, 2005), a treatment protocol that includes exposure to trauma memories or reminders is recommended as a first line of treatment for PTSD. Although exposure is used mainly to reduce fear and anxiety reactions, it is also used to reduce other emotions such as shame and anger. Therefore, a treatment program that involves exposure would also be effective in decreasing trauma-related shame. Given the role of sense of helplessness in life in PTSD, it would be safe to assume that an intervention designed to overcome fear, reduce helplessness, and restore sense of control over one's life would be effective in improving PTSD symptoms. An exposure-based treatment protocol developed in Turkey, the Control-Focused Behavioral Treatment (CFBT, Basoglu & Salcioglu, 2011), achieved high rates of improvement in traumatic stress and depressive symptoms in survivors of earthquakes (Basoglu et al., 2005; Basoglu & Salcioglu, 2011) , wars (Salcioglu & Basoglu, 2015), torture (Salcioglu & Basoglu, 2011; Salcioglu & Basoglu, 2015) and rape (Salcioglu & Basoglu, 2011) by enhancing sense of control over trauma reminders or cues through blocking cognitive and behavioral avoidance. CFBT is a promising treatment for sexual violence survivors.

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APPENDICES

APPENDIX A: SCALES

APPENDIX A1: Informed Consent Form

BİLGİLENDİRİLMİŞ ONAM FORMU

Bu araştırma İstanbul Arel Üniversitesi, Sosyal Bilimler Enstitüsü, Psikoloji Bölümü Klinik Psikoloji Doktora Tezi kapsamında yürütülmektedir. Öncelikle size bu araştırma ile ilgili bilgi vermek istiyorum.

Kişinin kendi rızası olmadan maruz kaldığı ve/veya katılımına zorlandığı cinsel deneyimlere cinsel şiddet adı verilmektedir. Türkiye'de ve dünyada pek çok kadının deneyimlediği cinsel şiddetin yarattığı travma önemli psikolojik sorunlara yol açabilmektedir. Cinsel şiddetin hangi mekanizma ile psikolojik sorunlara yol açtığının araştırılması etkili psikolojik tedavi yöntemlerinin geliştirilmesi için çok büyük önem taşımaktadır. Araştırmalardan edinilen bilgiler aynı zamanda bu konuda hak mücadelesi yapmak için de işe yaramaktadır.

Bu araştırma, cinsel şiddetin hangi psikolojik mekanizmalarla travma sonrası stres ve depresyon belirtilerini yol açtığını incelemek için yürütülmektedir. Araştırmaya, hayatının herhangi bir döneminde cinsel şiddet görmüş olan kadınları davet ediyoruz. Bu araştırmaya katılmakla hem sizinle benzer olaylar yaşamış ve yaşayacak olan kadınlara yönelik etkili psikolojik tedavi hizmetlerinin geliştirilmesine yönelik bilimsel verilerin ortaya çıkmasına katkıda bulunacak, hem de cinsel şiddetle ilgili hak mücadelemize destek vermiş olacaksınız. Bu araştırma tamamen gizlilik ilkesi ile yürütülmektedir ve hiçbir aşamada size kimliğinizi belli edecek sorular sorulmayacaktır. Ayrıca, vereceğiniz tüm bilgiler kesinlikle gizli tutulacaktır ve üçüncü şahıslarla paylaşılmayacaktır. Bu bilgiler diğer katılımcıların verdiği bilgilerle birlikte istatistik analizlerine tabi tutularak doktora tezinde, bilimsel yazılarda ve kongre bildirilerinde kullanılacaktır.

Araştırmaya katılım tamamen gönüllülük ilkesine bağlıdır. Araştırmaya katılımı kabul eden kadınlardan bir dizi ölçeği tek seferde çevrimiçi olarak doldurmaları istenecektir. Okuma hızına göre değişiklik gösterse de ölçekleri doldurma ortalama 30 dakika sürmektedir. Araştırmada tüm soruları cevaplamak analizler için gerekli olduğundan boş soru bıraktığınızda bir uyarı ile karşılaşacaksınız. Araştırmanın herhangi bir aşamasında herhangi bir neden göstermeden araştırmadan çekilebilirsiniz. Araştırmadan çekilmeniz durumunda o aşamaya kadar verdiğiniz bilgiler veri analizlerinde kullanılmayacaktır.

Yaşadığınız cinsel şiddet olayları hakkında düşünmek ve bununla ilişkili sorulara yanıt vermek size şu anda zor görünebilir. Ancak, uzman bir ekip tarafından titizlikle hazırlanmış bu ölçekleri doldurduğunuzda isteğiniz dahilinde, sorunlarınıza yönelik Arel

Üniversitesi Sosyal Bilimler Enstitüsü Klinik Araştırma ve Uygulama Merkezi'nden ücretsiz psikolojik tedavi hizmeti alabilirsiniz [3*].

☐ Yukarıda belirtilen açıklamaları okudum ve araştırmaya gönüllü olarak katılmayı kabul ediyorum.

☐ Araştırmaya katılmayı reddediyorum. Araştırmaya katılmayı reddediyorsanız lütfen sebebini belirtiniz.

[3] tubanur.bayram@gmail.com adresinden bilgi alabilirsiniz.

APPENDIX A2: Trauma Information Form-1

TRAVMA BİLGİ FORMU-1

Aşağıda cinsel saldırı türleri ile ilgili seçenekler sunulmuştur. Hayatınız boyunca bu cinsel saldırı türlerinden bir ya da birkaçını deneyimlemiş ya da hiçbirini deneyimlememiş olabilirsiniz. Lütfen tüm hayatınızı göz önünde bulundurarak aşağıdaki bilgileri dikkatle doldurunuz.

1- **Bir başkasının cinsel organınıza sizin rızanız olmadan cinsel amaçlı dokunması, bir başkasının bedeninizin herhangi bir yerine sizin rızanız olmadan cinsel amaçlı dokunması, bir başkası tarafından canlı ya da çevrimiçi cinsel içerikli görsellere maruz kalmanız, bir ötekinin cinsel organına sizin rızanız olmadan cinsel amaçlı dokunmak zorunda kalmanız, bir ötekinin bedenine sizin rızanız olmadan cinsel amaçlı dokunmak zorunda kalmanız, cinsel tecavüz ya da tecavüz girişimi içermeyen diğer cinsel travmalardan en az birini yaşadınız mı?**

☐ Evet ☐ Hayır

Evet ise kaç kere yaşadınız?

....

Evet ise en son böyle bir olaya maruz kaldığınız tarih nedir?

(Ay/Yıl) ..../........

Tanımadığım biri

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

Erkek Arkadaşım

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

Eşim

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

Birinci derece akrabam (baba, ağabey vb)

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

İkinci derece akrabam (amca, dayı, dede vb)

☐Evet ☐Hayır (Evet ise kaç kere: ....)

Tanıdığım başka biri

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

2- Cinsel tecavüz girişimi (istenmeyen anal ya da vajinal birleşmeye başarısız girişim) yaşadınız mı?

☐ Evet ☐ Hayır

Evet ise kaç kere yaşadınız?

....

Evet ise en son böyle bir olaya maruz kaldığınız tarih nedir?

(Ay/Yıl) ..../........

Tanımadığım biri

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

Erkek Arkadaşım

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

Eşim

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

Birinci derece akrabam (baba, ağabey vb)

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

İkinci derece akrabam (amca, dayı, dede vb)

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

Tanıdığım başka biri

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

3- Cinsel tecavüz (istenmeyen anal ya da vajinal birleşmeye başarısız girişim) yaşadınız mı?

☐ Evet ☐ Hayır

Evet ise kaç kere yaşadınız?

....

Evet ise en son böyle bir olaya maruz kaldığınız tarih nedir?

(Ay/Yıl) ..../........

Tanımadığım biri

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

Erkek Arkadaşım

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

Eşim

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

Birinci derece akrabam (baba, ağabey vb)

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

İkinci derece akrabam (amca, dayı, dede vb)

☐Evet ☐Hayır (Evet ise kaç kere: ....)

Tanıdığım başka biri

☐ Evet ☐ Hayır (Evet ise kaç kere: ....)

APPENDIX A3: Demographic Information Form

DEMOGRAFİK BİLGİ FORMU

4- Cinsiyetiniz:

☐ Kadın ☐Erkek

5- Doğum yılınız:

____

6- Eğitim düzeyiniz:

☐İlkokul ☐Ortaokul ☐Lise ☐Lisans ☐ Lisansüstü

7- Medeni durumunuz:

☐Bekar ☐Evli ☐Boşanmış/Dul ☐Birlikte yaşıyor

8- Çalışıyor musunuz?

☐ Hayır ☐Evet

9- Yaşadığınız cinsel travmadan önce tedavi gerektiren bir ruhsal sorun yaşadınız mı?

☐ Hayır ☐Evet

Evet ise bu sorunu tanımlayınız.

....

Evet ise aldığınız tedavi türünü belirtiniz:

☐Bilişsel Davranışçı Terapi

☐İlaç tedavisi

☐Psikodinamik Terapi

☐EMDR Terapisi

☐Diğer

APPENDIX A4: Trauma Information Form-2

TRAVMA BİLGİ FORMU-2

10- Cinsel şiddete maruz kaldığınız sırada genel olarak ne kadar korku, sıkıntı ya da rahatsızlık yaşadınız?

☐Hayır, hiç korkmadım / rahatsızlık duymadım.

☐Biraz korktum / rahatsızlık duydum.

☐Orta derecede korktum / rahatsız oldum.

☐Oldukça korktum / rahatsız oldum.

☐İleri derecede korktum / rahatsız oldum.

11- Yaşadığınız cinsel şiddet olayının başlamasını engellemek için bazı şeyler yapabildiniz mi? Cinsel şiddetin başlamasını engellemek için ne kadar kontrol hissettiniz?

☐Tamamen kontrolüm vardı (yapabileceğim her şeyi yaptım).

☐Oldukça kontrolüm vardı (yapabileceğim çoğu şeyi yaptım).

☐Orta derecede kontrolüm vardı (yapabileceğim bazı şeyleri yapabildim).

☐Biraz kontrolüm vardı (az bir şey yapabildim).

☐Hiç kontrolüm yoktu (hiç bir şey yapamadım).

12- Cinsel şiddete maruz kaldığınız sırada daha az fiziksel ya da psikolojik acı (sıkıntı) duymak için bazı şeyler yapabildiniz mi? Cinsel şiddet üzerinde ne kadar kontrol hissettiniz?

☐Tamamen kontrolüm vardı (yapabileceğim her şeyi yaptım).

☐Oldukça kontrolüm vardı (yapabileceğim çoğu şeyi yaptım).

☐Orta derecede kontrolüm vardı (yapabileceğim bazı şeyleri yapabildim).

☐Biraz kontrolüm vardı (az bir şey yapabildim).

☐Hiç kontrolüm yoktu (hiç bir şey yapamadım).

13- Cinsel şiddete maruz kaldığınız sırada cinsel şiddetin sonlanması için bazı şeyler yapabildiniz mi? Cinsel şiddetin sonlanması için ne kadar kontrolünüz vardı?

☐Tamamen kontrolüm vardı (yapabileceğim her şeyi yaptım).

☐Oldukça kontrolüm vardı (yapabileceğim çoğu şeyi yaptım).

☐Orta derecede kontrolüm vardı (yapabileceğim bazı şeyleri yapabildim).

☐Biraz kontrolüm vardı (az bir şey yapabildim).

☐Hiç kontrolüm yoktu (hiç bir şey yapamadım).

14- Cinsel şiddet nedeniyle fiziksel yaralanma yaşadınız mı?

☐ Hayır, yaşamadım.

☐ Hafif yaralanma (sınırlı ve yüzeysel yaralanma, örn. küçük morarmalar, kesik, 1. derece yanık) yaşadım.

☐ Orta derece yaralanma (doku travmaları, büyük morlukla veya kesikler, 2. derece yanık) yaşadım.

☐ Ağır yaralanma (derin doku yaralanmaları, kırık, 3. derece yanık, iç organlarda zarar-kanama) yaşadım.

15- Cinsel şiddete maruz kaldığınız sırada hayatınızı kaybetmekten korktunuz mu?

☐ Hayır, hiç korkmadım.

☐ Biraz korktum.

☐ Orta derecede korktum.

☐ Oldukça korktum.

☐ İleri derecede korktum.

APPENDIX A5: Trauma-Related Guilt Inventory

TRAVMA İLE İLGİLİ SUÇLULUK ÖLÇEĞİ

Travmatik olay yaşayan insanlar (fiziksel ya da cinsel istismar, savaş, sevilen birinin ani ölümü, ciddi kazalar ya da felaketler vb.) bu olaylara farklı tepkiler verirler. Bazı insanlar bu yaşantılar sırasında yaptıkları ile ilgili bir şüphe duymazken, bazı insanlar şüphe duyarlar. İnsanların şüpheleri yaptıkları (ya da yapmadıkları), inandıkları, düşündükleri ya da hissettikleri şeylerin doğruluğuna, uygunluğuna dair olabilir.

Bu ölçeğin amacı sizin bu travmatik yaşantınıza verdiğiniz tepkileri değerlendirmektir.

Lütfen birkaç dakika başınıza gelen olay hakkında düşünün. Aşağıdaki maddeler bu yaşantınız ile ilgili düşünceleri anlatmaktadır. Her bir madde için nasıl hissettiğinizi en iyi açıklayan ifadeyi işaretleyin.

Travmatik olaylara karşı insanlar farklı tepkiler verecekleri için, aşağıda belirtilen cümlelerin doğrusu veya yanlışı yoktur.

1- Olanları önleyebilirdim.

☐ Kesinlikle doğru

☐ Oldukça doğru

☐ Doğru

☐ Biraz doğru

☐ Hiç doğru değil

2- Başıma gelenlerden dolayı hala sıkıntılıyım.

☐ Her zaman doğru

☐ Sıklıkla doğru

☐ Bazen doğru

☐ Nadiren doğru

☐ Hiç doğru değil

3- Hissetmemem gereken duygular hissettim.

☐ Kesinlikle doğru

☐ Oldukça doğru

☐ Doğru

☐ Biraz doğru

☐ Hiç doğru değil

4- Yaptığım şey tamamen makuldü.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

5- Olanlardan ben sorumluyum.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

6- Olanlar bana duygusal acı veriyor.

☐Her zaman doğru
☐Sıklıkla doğru
☐Bazen doğru
☐Nadiren doğru
☐Hiç doğru değil

7- Kendi değerlerime ters olan şeyler yaptım.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

8- Yaptığım anlaşılır bir şeydi.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

9- Yaptığım şeyden daha iyisi ne olabilirdi biliyordum.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru

☐Hiç doğru değil

10- Sonuçtan dolayı üzüntü ya da keder içindeyim.

☐Her zaman doğru
☐Sıklıkla doğru
☐Bazen doğru
☐Nadiren doğru
☐Hiç doğru değil

11- Yaptığım inançlarımla tutarlı değildi.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

12- Olaylar olduğunda bildiklerimi bugün biliyor olsam yine aynı şeyi yapardım.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

13- Olanlardan dolayı yoğun bir suçluluk hissediyorum.

☐Her zaman doğru
☐Sıklıkla doğru
☐Bazen doğru
☐Nadiren doğru
☐Hiç doğru değil

14- Ne yapmam gerektiğini daha iyi bilmem gerekirdi.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

15- Olanları düşündüğüm zaman şiddetli duygusal sıkıntı yaşıyorum.

☐Her zaman doğru

☐Sıklıkla doğru

☐Bazen doğru

☐Nadiren doğru

☐Hiç doğru değil

16- Düşünmemem ya da inanmamam gereken düşüncelerim ya da inançlarım oldu.

☐Kesinlikle doğru

☐Oldukça doğru

☐Doğru

☐Biraz doğru

☐Hiç doğru değil

17- Yaptığım şeyi yapmak şeyi yapmamak için iyi nedenlerim vardı.

☐Kesinlikle doğru

☐Oldukça doğru

☐Doğru

☐Biraz doğru

☐Hiç doğru değil

18- Olanlarla ilgili ne sıklıkta suçluluk hissettiğinizi belirtin.

☐Hiç

☐Nadiren

☐Ara sıra

☐Sıklıkla

☐Her zaman

19- Kendimi olanlardan dolayı suçluyorum.

☐Kesinlikle doğru

☐Oldukça doğru

☐Doğru

☐Biraz doğru

☐Hiç doğru değil

20- Olanlar çok acı ve ızdıraba neden oluyor.

☐Kesinlikle doğru

☐Oldukça doğru

☐Doğru

☐Biraz doğru

☐Hiç doğru değil

21- Hissetmediğim bazı duyguları hissetmeliydim.

☐Kesinlikle doğru

☐Oldukça doğru

☐Doğru

☐Biraz doğru

☐Hiç doğru değil

22- Olaylarla ilgili hissettiğiniz suçluluğun yoğunluğunu ya da şiddetini belirtiniz.

☐Hiç

☐Biraz

☐Orta

☐Fazla

☐Aşırı

23- Kendimi yaptığım, düşündüğüm veya hissettiğim bir şey için suçluyorum.

☐Kesinlikle doğru

☐Oldukça doğru

☐Doğru

☐Biraz doğru

☐Hiç doğru değil

24- Olanlar hatırlatıldığında terleme, kas gerginliği ya da ağız kuruluğu gibi güçlü fiziksel tepkiler yaşıyorum.

☐Her zaman doğru

☐Sıklıkla doğru

☐Bazen doğru

☐Nadiren doğru

☐Hiç doğru değil

25- Genel olarak olanlar hakkında kendinizi ne kadar suçlu hissediyorsunuz?

☐Hiç suçlu değil

☐Biraz suçlu

☐Orta derecede suçlu

☐Çok suçlu

☐Aşırı suçlu

26- Kendimi olanlardan sorumlu tutuyorum.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

27- Yaptığım şey hiçbir şekilde makul değildi.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

28- Doğru ve yanlışla ilgili benimsediğim ilkeleri ihlal ettim.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

29- Yapmamam gereken bir şeyi yaptım.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

30- Yapmadığım bir şeyi yapmam gerekirdi.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru
☐Hiç doğru değil

31- Yaptığım şey affedilebilir değil.

☐Kesinlikle doğru
☐Oldukça doğru
☐Doğru
☐Biraz doğru

☐Hiç doğru değil

32- Yanlış olan hiçbir şey yapmadım.

☐Kesinlikle doğru

☐Oldukça doğru

☐Doğru

☐Biraz doğru

☐Hiç doğru değil

APPENDIX A6: Trauma-Related Shame Inventory

TRAVMA İLE İLGİLİ UTANÇ ÖLÇEĞİ

Travma yaşantısı olan insanlar genellikle farklı tepkiler verirler. Aşağıda insanların zaman zaman akıllarına gelebilecek düşünceleri ya da hisleri tanımlayan maddeler yer almaktadır. Bu ölçeğin amacı sizin bu travmatik yaşantınız sırasında ya da bu travmatik yaşantı ile ilgili sonrasında geliştirdiğiniz düşünce ve duygularınıza ilişkin verdiğiniz tepkileri değerlendirmektir.

Lütfen birinci kısımda işaretlediğiniz ve başınıza en son gelen cinsel travma yaşantısı hakkında birkaç dakika düşünün. Aşağıdaki maddeler bu yaşantınız ile ilgili düşünceleri anlatmaktadır. Lütfen her bir maddeyi dikkatlice okuyunuz ve geçtiğimiz bir hafta boyunca her bir madde ile ilgili size en çok uyan ifadeyi sağdaki kutuların içindeki size en uygun rakamı yuvarlak içine alarak gösteriniz.

Travmatik olaylara karşı insanlar farklı tepkiler verecekleri için, aşağıda belirtilen cümlelerin doğrusu veya yanlışı yoktur.

	Benim için hiç doğru değil	Benim için biraz doğru	Benim için çoğunlukla doğru	Benim için tamamen doğru
1. Travmatik yaşantım yüzünden kendime saygımı kaybettim.	0	1	2	3
2. Başıma gelenler yüzünden insanlar beni daha az beğenilir buluyor.	0	1	2	3
3. Başıma gelenler yüzünden kendimden utanıyorum.	0	1	2	3
4. Travmatik yaşantım sonucu insanlar hiç görmek istemeyecekleri yanlarımı gördüler.	0	1	2	3
5. Travmatik yaşantım yüzünden kendimi kabullenemiyorum.	0	1	2	3
6. Eğer insanlar başıma gelenleri bilselerdi beni aşağı görürlerdi.	0	1	2	3
7. Eğer insanlar başıma gelenleri bilselerdi benden iğrenirlerdi.	0	1	2	3
8. Travmatik yaşantım sırasındaki davranışlarımdan utanıyorum.	0	1	2	3
9. Başıma gelenlerden dolayı o kadar çok utanıyorum ki bazen kendimden kaçmak istiyorum.	0	1	2	3
10. Travmatik yaşantım sonucu kendimi daha az beğenilir buluyorum.	0	1	2	3
11.Travmatik yaşantım sırasında hissettiklerimden dolayı kendimden utanıyorum.	0	1	2	3
12. İnsanlar başıma gelenleri bilselerdi bana tepeden bakarlardı.	0	1	2	3
13. Travmatik yaşantım yüzünden kurtulmak istediğim yanlarım var.	0	1	2	3
14. İnsanlar başıma gelenleri bilselerdi benden hoşlanmazlardı.	0	1	2	3
15. Travmatik yaşantım yüzünden kendimi insanlardan daha aşağı hissediyorum.	0	1	2	3
16. İnsanlar başıma gelenleri bilselerdi benden utanırlardı.	0	1	2	3
17. İnsanlar başıma gelenleri bilselerdi beni kabul edilebilir bulmazlardı.	0	1	2	3
18. Travmatik yaşantımın sonucunda başkalarının utanılır bulduğu bir yanım ortaya çıktı.	0	1	2	3
19. İnsanlar travmatik yaşantım sırasında nasıl davrandığımı bilselerdi benden utanırlardı.	0	1	2	3
20. Travmatik yaşantım utandığım bir yanımı ortaya çıkardı.	0	1	2	3
21. Travmatik yaşantım yüzünden kendimden hoşlanmıyorum.	0	1	2	3
22. İnsanlar travmatik yaşantım sırasında nasıl hissettiğimi bilselerdi benden utanırlardı.	0	1	2	3
23. Başıma gelenler yüzünden kendimden iğreniyorum.	0	1	2	3
24. Başıma gelenler yüzünden o kadar utanıyorum ki insanlara görünmez olmak istiyorum.	0	1	2	3

APPENDIX A7: Fear and Loss of Control Scale

KORKU VE KONTROL DUYGUSU ÖLÇEĞİ

Aşağıda kadınların yaşayabileceği bazı duygular ve düşünceler yer almaktadır. Lütfen her cümleyi dikkatle okuyun ve sizin için ne kadar doğru olduğunu sağdaki kutuların içindeki size en uygun rakamı yuvarlak içine alarak gösteriniz.

	Hiç doğru değil	Biraz doğru	Orta derecede doğru	Oldukça doğru	Çok doğru
1.Yaşamım üzerinde hiç kontrolüm yok.	0	1	2	3	4
2. Aynı olayları yeniden yaşamaktan korkuyorum.	0	1	2	3	4
3. Hayatımdan endişe ediyorum.	0	1	2	3	4
4. Kendimi çaresiz hissediyorum.	0	1	2	3	4
5. Korku yüzünden normal yaşamıma dönemiyorum.	0	1	2	3	4
6. Kendimi tehlikede hissediyorum.	0	1	2	3	4
7. Sevdiğim kişilerin tehlikede olduğunu hissediyorum.	0	1	2	3	4
8. Günlük hayatımdaki sorunlarla başa çıkabilecek gücü kendimde bulamıyorum.	0	1	2	3	4
9. Yaşamımla ilgili hiç bir şeyi değiştiremeyeceğimi düşünüyorum.	0	1	2	3	4
10.Kendime güvenmiyorum.	0	1	2	3	4
11.Daha önce olmayan bazı korkular yaşıyorum.	0	1	2	3	4
12.Hayatımla ilgili kararlar alamıyorum.	0	1	2	3	4
13.Yaşamımda tek başıma ayakta durabileceğimi sanmıyorum.	0	1	2	3	4
14.Hiçbir şeye cesaretim yok.	0	1	2	3	4
15. Sorunlarımın üstesinden gelemeyeceğime inanıyorum.	0	1	2	3	4

APPENDIX A8: Traumatic Stress Symptom Checklist- 5

TRAVMATİK STRES BELİRTİ ÖLÇEĞİ

Aşağıda olumsuz bir olaydan sonra birçok insanın yaşadığı bazı sorunlar sıralanmıştır. Lütfen SON BİR AY İÇİNDE bu sorunların sizi ne kadar rahatsız ettiğini belirtiniz (uygun kolonun altına X koyunuz).

	HİÇ	BİRAZ	OLDUKÇA	ÇOK
1.Yaşadığım olayla ilgili bazı anıları /görüntüleri aklımdan atamıyorum.	0	1	2	3
2. Yaşadığım olay birdenbire gözlerimin önünden bir film şeridi gibi geçiyor ve geri dönüp olayı yeniden yaşıyor gibi hissediyorum ya da davranıyorum.	0	1	2	3
3.Yaşadığım olayla ilgili sıkıntılı rüyalar görüyorum.	0	1	2	3
4. Herhangi bir şey bana yaşadığım olayı hatırlatınca sıkıntı, rahatsızlık duyuyorum.	0	1	2	3
5. Herhangi bir şey bana yaşadığım olayı hatırlatınca çarpıntı, terleme, baş dönmesi, bedenimde gerginlik gibi fiziksel belirtiler yaşıyorum.	0	1	2	3
6. Yaşadığım olayla ilgili anıları, düşünceleri aklımdan atmaya çalışıyorum.	0	1	2	3
7. Bazı durumlardan, eşyalardan, yerlerden, kişilerden yaşadığım olayı hatırlattığı, düşündürdüğü ya da kötü hissettirdiği için kaçıyorum ya da kaçınıyorum.	0	1	2	3
8. Yaşadığım olayın bazı bölümlerini hatırlamakta güçlük çekiyorum.	0	1	2	3
9. Yaşadığım olaydan sonra dünya, insanlar ya da kendimle ilgili aşırı olumsuz düşüncelerim oluştu (örneğin, dünyanın çok tehlikeli bir yer olduğu, insanların kötü ve güvenilmez olduğu, kendimin kötü ve değersiz olduğu gibi düşünceler).	0	1	2	3
10. Yaşadığım olayın sebebi ya da sonuçları ile ilgili kendimi ya da başkalarını suçluyorum.	0	1	2	3
11. Yaşadığım olaydan beri sürekli korku, öfke ya da utanç içindeyim.	0	1	2	3
12. Eskiden zevk aldığım şeylere karşı ilgim azaldı.	0	1	2	3
13. İnsanlardan uzaklaştığımı, onlara karşı yabancılaştığımı hissediyorum.	0	1	2	3
14. Güzel duyguları hissedemez oldum (örneğin, mutluluk, tatmin, sevgi ve bunlar gibi).	0	1	2	3
15. Yaşadığım olaydan sonra en küçük şeylere bile eskisinden daha çabuk öfkeleniyorum ve patlıyorum (örneğin, bağırıyorum, eşyaları kırıp döküyorum, insanlara vuruyorum gibi).	0	1	2	3
16. Riskli ya da kendime zarar veren şekilde davranıyorum (örneğin, tehlikeli bir şekilde araba kullanıyorum, alkol ya da uyuşturucu madde alıyorum, kendimi fiziksel olarak yaralıyorum gibi)	0	1	2	3
17. Kötü bir şey olacakmış gibi sürekli tetikte bekliyorum.	0	1	2	3
18. Ani bir ses ya da hareket olduğunda irkiliyorum.	0	1	2	3
19. Dikkatimi yaptığım işe toplamakta güçlük çekiyorum.	0	1	2	3
20. Uyumakta güçlük çekiyorum.	0	1	2	3

APPENDIX B: Research Ethics Committee Approval

T.C.
İSTANBUL AREL ÜNİVERSİTESİ
REKTÖRLÜK

Sayı : 69396709-300.00.00- 3244-1 28/12/2016
Konu: Etik Kurulu Kararları

Sayın Tubanur BAYRAM KUZGUN

Üniversitemiz Etik Kurulu'nun 23/12/2016 tarih ve 2016/07 sayılı toplantısında alınan karar aşağıda sunulmuştur.

Gereğini bilgilerinize saygılarımla rica ederim.

Prof. Dr. İhsan DERMAN
Rektör

23/12/2016 tarih ve 2016/07 Sayılı Etik Kurulu kararı:

KARAR NO-3: Üniversitemiz Sosyal Bilimler Enstitüsü Psikoloji Doktora Programı öğrencisi **Tubanur BAYRAM KUZGUN**'un "Cinsel Travma Yaşantısı Olan Kadınlarda Travma Sonrası Bilişler, Suçluluk ve Utancın Travma Sonrası Stres Belirtileri Üzerindeki Etkileri" isimli çalışması görüşüldü. Yapılan görüşmeler sonucunda; **Tubanur BAYRAM KUZGUN**'un çalışmasıyla ilgili Üniversitemiz Fen-Edebiyat Fakültesi Psikoloji Bölümü öğretim üyesi Doç. Dr. Ömer Faruk ŞİMŞEK'in de görüşü doğrultusunda söz konusu projenin uygun olduğuna oybirliği ile karar verildi.

DAĞITIM

Gereği İçin	**Bilgi İçin**
- Tubanur BAYRAM KUZGUN	- Sosyal Bilimler Enstitüsü Müdürlüğüne

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APPENDIX C: Feedback Texts

BİLGİLENDİRME 1

Araştırmaya katılımınız için teşekkür ederiz. Yaşadığınız olaylarla ilgili sorular yanıtlamanın ne kadar zor olduğunu biliyoruz ve bu soruları yanıtlayarak bilimsel bir araştırmaya destek verdiğiniz için teşekkür ediyoruz.

Verdiğiniz yanıtlardan elde edilen puanlar yaşadığınız cinsel saldırı olayına bağlı psikolojik destek almanızı gerektiren: "Travma sonrası stres belirtileri" yaşadığınızı gösteriyor.

Bu sorunlar cinsel saldırı yaşamış kadınların önemli bir kısmında görülen sorunlardır. Bu sorunlarla yaşamak bir kader değildir ve bunların psikolojik yöntemlerle tedavisi mümkündür. Eğer sorunlarınız için psikolojik destek almak isterseniz aşağıda iletişim bilgileri verilen İstanbul Arel Üniversitesi, Sosyal Bilimler Enstitüsü, Psikoloji Uygulama ve Araştırma Merkezi ile ya da doğrudan benimle bağlantı kurabilirsiniz:

İstanbul Arel Üniversitesi Sosyal Bilimler Enstitüsü Psikoloji Uygulama ve Araştırma Merkezi.

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BİLGİLENDİRME 2

Araştırmaya katılımınız için teşekkür ederiz. Yaşadığınız olaylarla ilgili sorular yanıtlamanın ne kadar zor olduğunu biliyoruz ve bu soruları yanıtlayarak bilimsel bir araştırmaya destek verdiğiniz için teşekkür ediyoruz.

Verdiğiniz yanıtlardan elde edilen puanlar yaşadığınız cinsel saldırı olayına bağlı psikolojik destek almanızı gerektiren herhangi önemli bir psikolojik belirti yaşamadığınızı gösteriyor.

Fakat yine de psikolojik destek almak isterseniz aşağıda iletişim bilgileri verilen Arel Üniversitesi Klinik Uygulama ve Araştırma Merkezi ile ya da doğrudan benimle bağlantı kurabilirsiniz.

İstanbul Arel Üniversitesi Sosyal Bilimler Enstitüsü Psikoloji Uygulama ve Araştırma Merkezi.

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CURRICULUM VITAE

PERSONAL INFORMATION

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2009 – 2010: Ruhr University, Bochum (Psychology, Erasmus Student)

2005 – 2009: Izmir University of Economics (Psychology / English, Full Scholarship)

FOREIGN LANGUAGES

English, French

WORK EXPERIENCE

2014 – present: Istanbul Arel University, Psychology Department, Lecturer

2013 – 2014: Istanbul Arel University, Psychology Department, Research Assistant

2012 – 2013: Balıklı Greek Hospital, Visiting Fellow

2011 – 2013: Anaeli Rehabilitation Centre, Psychologist

PUBLICATIONS

Kurt P., Eroğlu K., **Kuzgun T.B.**, & Güntekin B. (2017). The modulation of delta responses in the interaction of brightness and emotion. *International Journal of Psychophysiology, 112*, 1-8.

Koydemir S., Şimşek, Ö.F., **Kuzgun T.B.**, & Schütz, A. (in press). Feeling special, feeling happy: authenticity mediates the relationship between sense of uniqueness and happiness. *Current Psychology.*