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TRAUMA, DISSOCIATION AND TIME PERCEPTION

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Abstract

This thesis aims to explore the links between trauma, dissociation and time perception. More specifically, it reports a survey which assessed traumatic and dissociative experiences and different dimensions of time perception. The study was designed as an online survey and included general (i.e. nonclinical), adult participants in Turkey. The results suggest that the new scale tested in this study promises to be an additional tool to the already used constructs which conceptualize time on a chronological line. If validated in subsequent research, the scale might have significant clinical and theoretical contributions. The second major finding is that both the average number of traumatic experiences reported and the number of participants who score high on dissociation are greater than expected for a nonclinical group. Finally, an analysis of dissociation with other variables reveal that time perception, particularly nonlinear experience of time, is the strongest predictor. The implications of these findings for future research and clinical practice are discussed in the final section.

Özet

Bu tez travma, disosiasyon ve zaman algısı arasındaki bağlantıları arařtırmayı amaçlamaktadır. Daha spesifik olarak, travmatik yařantılar, disosiatif deneyimler ve zaman algısının deęişik boyutlarını deęerlendiren bir anketin sonuçlarını aktarmaktadır. Arařtırma internet anketi olarak tasarlanmış ve genel (yani klinik olmayan) yetişkin bir gruba uygulanmıştır. Sonuçlar, bu arařtırmada test edilmiş olan yeni ölçeęin, řimdiye kadar zamanı kronolojik bir çizgi üzerinde ölçen ve sıkça kullanılan dięer ölçeklere ek bir araç olacaęını vaat etmektedir. Bundan sonraki arařtırmalarda geçerlilięi ve güvenilirlięi teyid edilirse, bu ölçeęin önemli teorik ve klinik katkıları olacaęı düşünölmektedir. Arařtırmanın ikinci önemli bulgusu, hem ifade edilen ortalama travma sayısının, hem de disosiasyon ölçeęinde yüksek puan alan kiři sayısının, klinik olmayan bir grup için beklenenden yüksek olmasıdır. Son olarak, disosiasyon dięer deęişkenlerle birlikte incelendięinde, onu en kuvvetli öngören faktör, zaman algısı, özellikle de linear olmayan zaman deneyimi çıkmıştır. Son bölümde, bu bulguların gelecek arařtırmalar ve klinik pratik açısından çıkarımları tartışılmaktadır.

CHAPTER 1

INTRODUCTION

This chapter presents a theoretical framework on key components of this study; namely, trauma, dissociation and time perception. In reviewing the relevant literature, it also aims to provide a historical outlook on the conceptualization and assessment of these issues and thus to locate the potential contributions of this study.

The chapter first summarizes discussions on trauma in terms of psychiatric and psychoanalytic approaches; it then reviews clinical implications. The second section reviews psychiatric and psychoanalytic perspectives on dissociation. The next section addresses the significance of time as framing discussions on trauma and dissociation. The final section presents findings of research on trauma and dissociation in Turkey.

1.1. PSYCHOLOGICAL TRAUMA

1.1.1. Trauma and mental health

According to World Health Organization's (WHO) recent data, global lifetime prevalence of psychological abuse of children is 36%, physical abuse of children is 23% and neglect of children is 16% (World Health Organization, 2014). Their 2015 estimate of victims of homicide is close to half a million people globally (World Health Organization, 2015). Global epidemiology of traumatic experience of any type is pervasive: A meta-analysis of WHO World Mental Health (WMH) surveys reveals that lifetime exposure to any type of trauma is 70.4% across respondents. The average number of trauma among those who reported at least one was 2.9. Almost 70% of those who reported any type of trauma exposure reported more than one trauma (32.1% reported one trauma, 67.9% more than one). The most common types of traumas were unexpected death of a loved one (31.4%), witnessing or discovering death or serious injury (23.7%), muggings (14.5%), life-threatening traffic accidents (14%) and life-threatening illness (11.8%). Exposure to trauma correlated with demographic

factors: Women are more likely to experience intimate partner sexual violence, men more likely to experience physical violence and accidents, exposure to violence and accidents are more likely to occur in early life, violence, natural disasters and accidents are more likely to occur as income level decreases and finally, marital status increase or decrease the risk of exposure to trauma depending upon the context (Kessler, Aguilar-Gaxiola, Alonso, Benjet, Bromet, Cardoso, On behalf of the WHO World Mental Health Survey Collaborators, 2017). With the inevitable multitude of health implications as a result of trauma exposure, numerous studies explore the epidemiology of trauma and trauma related mental health issues such as post traumatic stress disorder (PTSD). For example, a nation wide study in Netherlands reports lifetime prevalence of any type of trauma as 80.7% and lifetime prevalence of PTSD 7.4% (de Vries & Olf, 2009), in Australia exposure to any type of trauma is reported to be 50.7% and prevalence of PTSD is 1.5% (Rosenman, 2002). While the conceptualization and assessment of trauma vary across studies, thus questions regarding comparability must be taken into account, historical, cultural, and political factors that lead to trauma exposure are significant. For example, while violence and witnessing violence is reported to constitute the largest proportion of all types of trauma in South Africa, accidents and unexpected death of a loved one are the largest types of traumas among all reported in Italy, Spain or Japan (Carmassi, Dell'Osso, Manni, Candini, Dagani, Iozzino, Koenen, de Girolamo, 2014; Olaya, Alonso, Atwoli, Kessler, Vilagut, Haro, 2015; Kawakami, Tsuchiya, Umeda, Koenen, Kessler, World Mental Health Survey Japan, 2014). Atwoli, Stein, Koenen & McLaughlin's review of existing studies suggests that trauma exposure is higher in lower-income countries, PTSD rates are similarly high in lower-income countries and in post-conflict contexts; furthermore, exposure to trauma increase the risk for various health problems independent of PTSD (Atwoli, Stein, Koenen & McLaughlin, 2015). In short, socio-political context, demographic factors and trauma exposure are to be examined together in order to assess clinical implications for mental and physical health risks.

The ubiquity of trauma in everyday life leads to discussions on the merit of accepting it as part of human experience and searching for psychological and spiritual means of growth when one faces it (eg. Epstein, 2013). Varying conceptualizations also add to the complexity in the ways in which psychological trauma is approached: Is what renders an experience traumatic its nature, its scale, its frequency and duration or its perceived impact? As Levine (2014) states, confusion in the usage of the term also stems from the fact that trauma is used both for the stimulus and the effect and in reference to different types of events (p. 215). This study will conceptualize trauma as instances that “overwhelm the ordinary human adaptations to life” which “evoke the responses of catastrophe” (Herman, 2015, p. 33). Assessment of epidemiology of trauma is significant for identification of mental health needs of the specific context, exploration of further health risks and to gauge clinical implications.

Trauma is a devastating experience for the individual for its inflicting of insufferable pain on the body, psyche and spirit. On a physiological level, the shock and helplessness experienced when facing an overwhelming attack has serious and long-term consequences. During a traumatic event, the brain and the nervous system respond automatically; once the survival mechanism kicks in, the higher functions of the brain are shut down and the body is pushed to fight, run away, hide or freeze. If the danger is overcome successfully, internal equilibrium is gained gradually. If it is not overcome successfully in the sense that adequate response can't be performed (such as in being held captive, in being assaulted by an intimate and/or more powerful figure, in experiencing an accident, etc.), the alarm system remains online, the brain and the body remains in a state as if the traumatic situation endures (van der Kolk, 2014, pp. 167-168). In time if the experience is not processed and made sense of, the physical and psychological defense systems start to function in an altered and exaggerated way (Herman, 2015, p. 34). As a result, the person might experience a host of symptoms which are typically grouped as: 1. Intrusions (fragments of the traumatic event intruding into present awareness), 2. Hyper-arousal (continual alarmed response to danger as if it is still present), 3. Avoidance or numbing (avoiding trauma related

stimuli), 4. Changes in personal identity (self-perception infused with shame and guilt). (Herman, 2015, p. 34; van der Kolk & McFarlane, 1996, p. 9).

The series of symptoms as described here are most typically diagnosed as Post Traumatic Stress Disorder (PTSD). Although the term itself has appeared in psychiatric terminology relatively more recently, trauma conceptualized as a horrifying, overwhelming event appears to be evident across time and cultures; narratives of post-trauma suffering date back to epics such as Gilgamesh and Histories of Herodotus (Crocq & Crocq, 2000). In modern psychiatry “traumatic neurosis” is referenced first only in 1884 (Crocq & Crocq, 2000, p. 49) Push of wars led to further elaboration of the concept, from references to ‘shell shock’ to ‘war neurosis’ after WWI, and formulation of Post-traumatic Stress Disorder (PTSD) after Vietnam War. Trauma and PTSD entered into the diagnostic canon with the Diagnostic and Statistical Manual of Mental Disorders (DSM)’s third edition in 1980. Jones & Wessely (2007) argue that PTSD’s inclusion in DSM in 1980 marks a paradigm shift in the conceptualization of responses to trauma; until then, the psychiatric approach to post-trauma reactions were viewed as abnormal, explained through hereditary disposition, early negative experiences or underlying psychiatric illness (p. 165). Recognition of PTSD in DSM indicated the shift of the cause of the response to from an inherent weakness residing in the individual to the terrifying event itself (p. 165). By the publication of the 5th edition of DSM in 2013, “Trauma and Stressor-Related Disorders” constitutes a new section, PTSD and acute stress disorder (ASD) are presented with further detail and are no longer classified with anxiety disorders (American Psychological Association, 2013).

Attention to trauma in the psychoanalytic literature presents a slightly different picture and that is discussed in the next section.

1.1.2. Trauma and Psychoanalysis

Psychoanalytic theory provided one of the earliest approaches to the issue through Freud and Breuer, “trauma seemed to inhere in the very concept of

psychoanalysis" (Boulanger, 2007, p. 44). When Freud took up Charcot's treatment of hysteria, trauma was at the center of his quest to understand the psyche. Together with Breuer, his early work identified trauma as a central concern. It was conceptualized to include severe events, which involved "mortal danger" to the individual. The person, after an "incubation period", would experience attacks during which he relives and expresses what has been experienced earlier (Breuer & Freud, 1956, pp. 1-2). Freud's early work pointed to a traumatizing event, most typically sexual abuse, experienced early in life and repressed to the subconscious, having long lasting, damaging effects on the ego.

Freud moved however to discard sexual abuse from his theory and this has led to a fierce debate within and outside the analytic tradition (Masson, 1985). In Freud's life time, trauma due to the destructive consequences of war were present, in fact the aftermath of WWI is said to leave him quite pessimistic about human nature. The often-cited last sentence of *Civilization and Its Discontents*, expresses his pessimism regarding the force of aggression (Freud, 1923). By this point, he had already incorporated a death instinct in his theory, and in *Civilization* he discusses it distinct from and operating on equal footing in force with the pleasure principle. Through his letters with Einstein on the nature of war, he details how the aggressive drive manifests in individual and collective behavior (Einstein, Freud & Gilbert 1933). Although aggression and its destructive aftermath is clearly present in Freud's later writings, they are incorporated in drive theory and thus traumatic event as coming from outside and impacting the psyche is not addressed. Later phases of psychoanalytic approaches, as in object relations theory, have taken external events' impact on the psyche into account, but their focus has been on the *development* of the self, and they view psyche as having a durable structure once fixed.

Both the debates on war neurosis after WWI and II and evolving psychoanalytic discussions on the structure of the self inevitably led the attention to catastrophic experiences that occur as a response to events outside the psyche and experiences that happen not only in early development but that happen also later in life. Thus, core questions regarding the psychic structure began to be

discussed through elaboration of trauma and its effects. These discussions focus on the fact that through trauma, the existing psychic structure receives a blow, its functions are shut down and the parameters of the self are disassembled. For patients who have experienced extreme trauma, conventional tools of analysis such as free association are rendered inept. This requires a revisiting of the theoretical framework; documentation of such experiences through major wars provided sufficient material for this purpose.

One of the earlier systematic accounts of trauma is Abram Kardiner's Study of WW I veterans in the 1920s in New York. Kardiner's study is significant in at least two ways: First, he referenced trauma as a 'physioneurological' phenomenon involving both somatic and psychological components, thus, acknowledging their intertwined nature. Second, his detailed description of the "pathological traumatic syndrome" drew attention to trauma's shattering impact on the ego. Staying stuck in the traumatic event marked most of such symptoms which altered the perception of the person's outside world and his inner self (as cited in van der Kolk, p. 196). Thus, Kardiner not only links the somatic and the psychological, but also highlights a dialectical view of the inner and the outer.

The Holocaust and its aftermath also brought explorations of trauma to the foreground. The extreme experiences documented by survivors reveal that in such contexts a shared understanding of reality and thus communicative channels are obliterated, the inter-relational context vanishes and thus, the survivor is left isolated in her/his inner world (Laub & Auerhahn, 1989). The breaking down of the relational context also means that one loses an outside witness to his/her experiences, to his/her belonging to a place and continuity in time (Gerson, 2009). Massive trauma through imprisonment and torment, in destroying individuals, relationships or institutions, also destroys their orienting function in survivors' lives (Gerson, 2009, p. 1343). This loss equals to the loss of meaning and unless the need for a witness is fulfilled, the survivor is trapped into a dead internal space. Under such dire circumstances, the psyche descends into its most primitive forms and survival mechanisms kick-in to organize psychosomatic functioning (Tarantelli, 2003). Similar post-Holocaust case studies reveal that massive psychic

trauma destroys the relied upon inner space, including object constellations; the only object that is left for identification is the aggressor, which in turn leads the death instinct to take over. (Laub, 2005). Admittedly, most instances of serious trauma are not comparable to the extreme states of deprivation and torment experienced in concentration camps, still, these accounts provide a picture of the devastating effects of trauma on the psychic structure.

Aside from war and conflict, trauma's societal dimensions have also been scrutinized: The risks poverty and deprivation pose on individuals and families have been extensively researched and have been linked to increased probability of trauma exposure. The risks include but are not limited to experiencing crime, family violence, chronic illness, exposure to environmental hazards (Kiser & Black, 2005, p. 727). Such situations, especially if experienced early in life and over time, lead complex traumatic symptoms and shape affect regulation, meaning systems, attachment patterns (as reviewed in Kiser & Black, p. 730). In fact some research suggest a link between early childhood trauma and increased risk for psychosis later in life (Read, van Os, Morrison, & Ross, 2005).

Taking the socio-political context into account in understanding the causes and consequences of trauma, the relational turn in psychoanalysis contributed to a more complex understanding of trauma and its impact to the psychic structure. Scholars such as Herman (2006) brought the socio-political context, i.e. external reality, to attention in understanding trauma related psychopathology as well as its significance in the history of psychoanalytic theory. Furthermore, this approach locates the self into a relational sphere in which biological, psychological and cultural factors mutually influence each other. Relational perspective, in challenging the self as a fixed, durable entity and instead looking into "multiplicity of self states" reformed psychoanalytic theory (Boulanger, 2007). Once self is viewed as mutually shaped by inner and outer psychic reality, the sole focus on inner conflict and repression expanded to external context and trauma and dissociation.

Dissociation during and after trauma is of particular interest in illustrating

the gaps between inner and outer reality during and after trauma. In van der Kolk's words, "Dissociation is the essence of trauma" (van der Kolk, 2014, p. 205). Briefly, dissociation refers to the cognitive and emotional fragmentation of the traumatic event due to its overwhelming nature, as a result, "the emotions, sounds, images, thoughts, and physical sensations related to the trauma take on a life of their own." (van der Kolk, 2014, p. 205).

Boulanger (2007) details dissociation's function during and after trauma: When a child is faced with terror and is unable to integrate the experience, she/he dissociates to manage the overwhelming and confusing stimuli; dissociation protects the body and the psyche from the devastating experience. At the same time, through dissociation the traumatic self is encapsulated and fixed in the experience itself, enabling split off other contingent selves to engage with the world (Boulanger, 2007, 642). In adults, however, not only the capacity to dissociate is diminished (Howell, as cited in Boulanger, 2007, p. 643) but it is also experienced differently. It offers protection during the experience of terror, but as the self is already fully formed, it does not offer encapsulation of the traumatized self. Rather, the person is left in that state of terror (p. 643). Experience of dissociation varies individually and depending upon the context but if experienced as an adult, at a certain critical point in response to trauma, it shatters the self, ripping it off from what was once familiar. It leaves the self experiencing its psychic foundations in a way that does not happen in everyday life. The person "finds himself stripped to his bare and unfamiliar psychic bones" (Boulanger, 2007, p. 646). Thus, while in childhood dissociation shapes the formation of the self, in adulthood, it leads to its collapse (Boulanger, 2002, p. 3).

The state of dissociation during trauma affects recall of memories as well. In children, traumatic memories are stored under layers of dissociative defenses and contingent selves. It is often almost impossible to piece together what has happened when trauma is revisited later on. In adults, the knowledge that the event has happened is fixed, in a way it imprints existence from that point on. Although the memories are unprocessed and un-integrated; they continually invade the psyche in their most fragmented, raw form. The adult knows the event

to have happened, it is not in the past, and it becomes a continual nightmare. This glues the person into the traumatic moment, with no connection to the familiar past self or a possibility of a viable future. Taken-for-granted existence in a linear life path is disrupted (Boulanger, 2002, 2007).

Another horrific consequence is loss of agency. Since the very elements of the self that processes and attaches meaning to moment-to-moment existence are broken, the person is left alone in an overwhelming sensory and affective existence. In this regard, a full understanding of the subjective experience of trauma must recognize the “core biological self” as a foundation (Boulanger, 2007, p. 643). This biological core includes the network of sensory functions that continually monitor the environment, the responses in the body, and integrate them into the regulating mechanisms. The biological core informs the psychological responses, thus, the physiological and the psychological systems are in constant feedback.

All these responses require the therapeutic stance and technique to adapt to the reality of the patient, who might not be able to free associate, symbolize and tolerate pain with respect to the stored fragments of the traumatic experience. Hence, several suggestions have been offered for psychotherapy, such as attention to the somatic (eg. Van der Kolk, 2014) and releasing the traditional, neutral stance of the analyst (eg. Boulanger, 2007; Rosenblum, 2009; Peskin, 2012). Rosenblum (2009), for example, argues that the analytic urge to bring up the repressed might cost the patient’s fragile navigation system, the only way the analyst might offer help might be to be an “authenticating witness, the sanctuary provider, the experience-sharing companion” (p. 1335). Peskin (2012) similarly argues that the most devastating aspect of trauma is shame, humiliation, and the social and personal pressures to hide the experience. Thus, the task of therapy is “the practice of rehumanization—of reengaging discredited personhood” (p. 191). When the analyst works as a therapeutic witness, she helps the patient recover a sense of social reality, and the therapist will be relieved of anxieties of what to bring forth and what not to speak regarding the traumatic experience. The witnessing legitimates and solidifies the relational context .

Although the therapeutic context might assure safety, the patient himself/herself might not recognize this, as any moment of consciousness (that would facilitate recognition of safety) would increase self-reflective capacity and in turn decrease dependence on relied upon measures such as dissociation. This might be too dangerous for the patient and hence does not happen simply through a reassuring therapeutic stance (Bromberg, 2003, p. 563). For this, the dyadic experience of dissociation during therapy must be reckoned. Dissociative experience is reviewed in more detail in the next section.

1.2. DISSOCIATION AND TRAUMA

1.2.1. Dissociative disorders

As evident in the previous section, dissociation has been embedded in the discussion of trauma from earlier works to the contemporary relational approaches. Similar to the course of psychiatric attention to trauma, dissociation also garnered recent interest with a full section in DSM V for dissociative disorders. Dissociative disorders are characterized in DSM by “a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior” and the symptoms as “ a) unbidden intrusions into awareness and behavior, with accompanying losses of continuity in subjective experience (i.e., “positive” dissociative symptoms such as fragmentation of identity, depersonalization, and derealization) and/or b) inability to access information or to control mental functions that normally are readily amenable to access or control (i.e., “negative” dissociative symptoms such as amnesia).” (p. 291). The disorders included are dissociative identity disorder, dissociative amnesia, depersonalization/derealization disorder, other specified disorder, and unspecified disorder (p. 291).

The increased attention to dissociation and the inclusion of an extended section in DSM has been impelled by numerous recent studies which indicate that global epidemiology of dissociative disorders in clinical populations might be quite high, ranging from 13-20.7% in North America to 4.3 – 8% in Netherlands,

Germany and Switzerland (Şar, 2011, p. 2). Dissociation is also reported to have high comorbidity with other psychiatric disorders, confounding their treatment (Sar & Ross, 2006).

Increasingly, dissociation is examined within a socio-political context, viewed as resulting from various types of human rights abuses, such as those committed in the contexts of genocide (Sandole & Auerbach, 2014), interrogation (Putnam, 2014), sexual abuse and incest (Middleton, 2014).

Referenced by Putnam as “the escape when there is no escape” (Putnam, 1992, p. 104), dissociation is intricately linked with trauma. It is the defense that kicks in when there is no means to fight back the threat, when one is held captive, tortured, or a sudden accident takes place, or when a caregiver abuses a child. Dissociation can take place during and after the traumatic event, accordingly its conceptualization can indicate subtypes. Primary dissociation involves the splitting of the traumatic experience into raw, sensory fragments; their disintegrated storage defies formation of a cohesive narrative about the experience, as a result, the somatosensory elements continue to press in the form of nightmares and flashbacks (van der Kolk, McFarlane, Weisaeth, 1996, p. 307). Secondary dissociation refers to the split between the observing and the experiencing ego during the trauma; detachment from the experience reduces the pain and the complete awareness of the full event (van der Kolk, McFarlane, Weisaeth, 1996, p. 307). Tertiary dissociation is conceptualized as the long-term consequences of dissociative experiences, creating distinct identity states. Multiple identity disorder (MID) and Dissociative Identity Disorder could be viewed as examples of tertiary dissociation (van der Kolk, McFarlane, Weisaeth, 1996, p. 308).

Another classification has been made through the type of dissociative symptoms: “Positive” dissociative symptoms refer to flashbacks or intrusion of aspects of identity that are not part of person’s normal functioning; “negative” dissociative symptoms refer to gaps in awareness, memory, sense of self, the ability to control parts of the body (Spiegel, Loewenstein, Lewis-Fernández, Sar, Simeon, Vermetten, ... & Dell, 2011, p. 826).

Although various dimensions of dissociation both as a defense and as a disorder have been offered, the central feature appears to be the “disruption to one or more mental functions” (Sar, 2014, p. 172). Disruptions might manifest in memory, thinking, identity, sensorimotor functioning, and/or behavior (p. 172). Dissociation in this sense is linked to various psychopathologies; it has also been present at the heart of psychoanalysis since its emergence. Next section will review psychoanalytic approaches to dissociation.

1.2.2. Dissociation and Psychoanalysis

Tracing of dissociation’s emergence in psychiatry inevitably leads to Pierre Janet. Although a process as similar to dissociation can be found in the works of a previous French psychiatrist Moreau de Tours, who referred to ‘psychological desegregation’, Janet is one of the first to offer an elaborate theory of dissociation (Van der Hart & Friedman, 1989; Van der Hart & Dorahy, 2009). Janet’s detailed study of cases with hysteria and utilization of hypnosis for treatment led him to develop a multi-dimensional perspective of dissociation that is argued to be still of relevance (van der Kolk & van der Hart, 1989). His theory includes principles on the elements of personality, perception of reality and disturbances to its functioning when trauma occurs, the nature of conscious and unconscious activity (which he referred as automatism), dissociation as a result of trauma and the capacity to use psychic energy (van der Hart & Friedman, 1989, p. 16). Janet argued that under normal circumstances new experiences are integrated into a unitary system of consciousness and are accessed voluntarily. However, if the new experience is frightening and cannot be processed, it is split off from conscious awareness. The raw sensory fragments of the event remain present in the split-off part and press into emotions and behaviors. They are kept apart from conscious awareness and can only be accessed through hypnosis, however their presence form what Janet referred as “subconscious fixed ideas” (van der Kolk & van der Hart, 1989, p. 1532). These ideas present themselves as fragments of the traumatic event and lead the individual to feel depleted over time. Interestingly,

for Janet it was not so much the magnitude of the shocking event that leads to dissociation but rather the “vehement emotion” in response to the event that destroys the psychic system and causes further symptoms (van der Kolk & van der Hart, 1989, p. 1532).

Janet’s continues to inspire works on dissociation, however, for some time psychoanalytic theory didn’t focus on it. Freud & Breuer did acknowledge Janet’s contribution early on (van der Hart & Horst, 1989) however, with the abandonment of the seduction hypothesis, the emphasis moved from outer events to inner drives and from dissociation to repression.

Howell & Itzkowitz (2016) argue that in object relations theorists such as Fairbairn, Winnicott and Guntrip, as well as in the interpersonal theory of Sullivan the influence of outer culture is present. In fact, the concept of ‘not me’ in Sullivan pointing to the impact of overwhelming anxiety on the mind resembles “a container (or place holder) of dissociated self-experience” (p. 28). They also state that it is really through the relational school in psychoanalysis in which mind begins to be observed as being shaped through both inner and outer reality, the devastating consequences of outside events as in trauma are acknowledged and therapy is viewed as a two-person endeavor (pp. 28-29).

Relational approach’s emphasis on the momentary interactions between the therapist and the patient, and the interactions between ‘there and then’ and ‘here and now’, brings a dynamic facilitator for dissociated states to be brought to the fore. Because dissociation is not so much about unearthing what has been repressed but rather about bringing the unowned, split-off, unintegrated aspects of the self, the relationality in therapy is particularly highlighted. Bromberg (2003), for example, suggests that the challenge in therapy with patients who have dissociated self-states is that if traumatic material is retold, it is relived and unless the shame is recognized, the patient feels worse than before (p. 563). Avoidance of shame is not simply avoidance of a particular affect, but avoidance of “exposure of oneself to oneself” (p. 567). Bromberg states that trauma affects “the very experience of selfhood” and thus when it is recalled, affective dysregulation is so great that it is experienced as being at the edge of ‘self-annihilation’ (p. 567).

The subsymbolic component of the dyadic engagements between the therapist and the patient, which might be dissociated by both parties require therapist's attunement (p. 562). It is only through the therapist's recognition of his/her dissociated states during sessions, his/her own reflection on shame as experienced countertransferentially that might bring the patient's dissociated states into awareness (Bormberg, 2016).

Bromberg and other relational analysts' attention to neuroscience research bring the intersections of relational psychoanalytic theory and neuroscience to observation of dissociated states' enactment in the therapeutic context. (Bromberg, 2003, Bucci, 2011). Some recent work that integrates the subsymbolic components into relational therapy advocate new forms of treatment such as of as eye movement desensitization and resensitization (EMDR) and along with relational psychotherapy (Ringel, 2014).

A recent review of phenomenological, neurobiological and physiological components of trauma-related dissociation proposes a four dimensional model that tracks dissociation in 1) time, 2) thought, 3) body, and 4) emotion. Of the time component, the capacity to mentally locate oneself in the past or the future, and the experience of being in the now to be disrupted (Lanius, 2015).

Experiencing of time as a framework for therapy and as the container of therapeutic encounter is critical. Next section will present several approaches to time perception and psychopathology.

1.3. TIME PERCEPTION AND TRAUMA

1.3.1. Time perception and clinical psychology

Perception and experiencing of time with respect to clinical situations has been a significant area of research on conditions such as, attention deficit and hyperactivity disorder (ADHD) (Barkley, Murphy & Bush, 2001; McGee, Brodeur, Symons, Andrade & Fahie, 2004; Meck, 2005), depressive disorders (Wyrick, & Wyrick, 1977, Sévigny, Everett, & Grondin, 2003; Gil, S., & Droit-Volet, 2009; Thönes, S., & Oberfeld, 2015), schizophrenia (eg. Densen, 1977,

Elvevåg, McCormack, Gilbert, Brown, Weinberger & Goldberg, 2003; Penney, Meck, Roberts, Gibbon & Erlenmeyer-Kimling, 2005; Carroll, Boggs, O'Donnell, Shekhar, & Hetrick, 2008), addictive disorders (Petry, Bickel, & Arnett, 1998; Wittmann, Leland, Churan & Paulus, 2007; Chou & Ting, 2003). There has also been considerable attention to trauma and PTSD's disturbance on time perception (Zimbardo, Sword, & Sword, 2012; Simmons, Flagan, Wittmann, Strigo, Matthews, Donovan, & Paulus, 2013; Sword, Sword, Brunskill, & Zimbardo, 2014; Stolarski & Cyniak-Cieciura, 2016). Although a considerable amount of research exists on predictors of PTSD and intrusions are assessed as part of other several subscales, few address time distortion as a variable on its own.

Terr's studies on children who have experienced trauma detail distortions in their time perception after the event (1983, 1984, 1985). She has argued that distortion of time functions to restore the sense of control and autonomy that existed before the traumatic experience.

One of the systematic measurement tools to assess time perception is Zimbardo Time Perspective Inventory (ZPTI). This inventory takes its conceptualization of time from Lewin as "the totality of the individual's views of his psychological future and his psychological past existing at a given time" (Lewin, as cited in Zimbardo & Boyd, 1999, p. 1271). Time perspective is a nonconscious process that orders and assigns meaning to personal and social events, and consequently shapes decisions and behavior in everyday life (Zimbardo & Boyd, 1999, pp. 1271-1272). This inventory measures time perception through three time zones (past, present, and future) and further divides them in line with the quality of their perception (past negative, past positive, present hedonistic, present fatalistic, and future), thus yielding a five-unit time line (Zimbardo & Boyd, 1999). The inventory has been used to explore various behavioral patterns, such as risky driving (Zimbardo, Keough, Kelli, Boyd, 1997) and substance use (Keough, Kelli, Zimbardo, Boyd, 1999). These studies suggest that dominance of any time perspective leads to problematic consequences, especially if one is stuck in a 'negative' zone. The researchers propose a therapy perspective that encourage a balanced and flexible time perspective that would

facilitate adaptation to changing situations (Sword, Sword, Brunskill, & Zimbardo, 2014, p. 3). A recent study on trauma and post-trauma symptoms identify ZTPI subscales as a significant intermediary variable for post-trauma psychological health (Eker, 2016). It finds that one's orientation towards the past could have a significant role in her/his making use of available support and thus has an impact on well-being (p. 55).

ZTPI provides a reliable and valid tool that is easy to administer in a variety of settings; there is a growing literature which discusses implications of time perspective for clinical and nonclinical situations. This inventory details the subcomponents of time perception and points to where a person might reside on the scale given particular situations and if and when a balanced time perspective manifests. However, this conceptualization still envisions time on a continuous line. The next section will detail alternative perspectives.

1.3.2. Kairos and chronos

In contrast to the uni-dimensional, linear conceptualization which pervades much of the clinical research on time disturbances, an alternative, multi-dimensional framework has been present in psychoanalytic scholarship. First introduced by Kelman in his classic 1969 paper, this approach takes its inspiration from ancient Greek formulation of time in terms of *chronos* and *kairos*.

Kelman's paper reviews references to *chronos*, the linear and measurable sense of time, that stretches from past to the future, and *kairos*, the unique, auspicious moment which emerges unexpectedly and must be seized upon in Greek mythology. He argues that *kairos* has its corollary in Christian theology and Eastern belief systems; furthermore, his encounters with members of various cultures suggest that *kairos* appears to be a "universal human potential", it resonates with almost everyone in his audiences across cultural and religious contexts (p. 61). Through his detailed review of clinical situations, he indicates that what might resemble a *kairos* experience, that is, an opportune moment in which change appears possible, is indeed the result of many *mini kairos* moments.

In reviewing various psychotherapeutic encounters which involve a 'kairos experience', he identifies the structure of kairos as: "a right time in the course of events to do certain things that will favor a crucial happening; the necessity to be aware that there is such a right time so that it might be prepared for; and that it is an opportunity which must be immediately recognized and seized upon" (Kelman, 1969, p. 80). Kelman proposes kairos as a form of pattern change, the old patterns, through confrontation, dialogue, conflict and crisis finally create a shift, and a counterform which is more open, flexible, and dynamic emerges (p. 81). Thus, Kelman's perspective proposes a phenomenological understanding of time in therapy which highlights the dynamic, moment-to-moment interactions between the patient and the therapist that shape a new form of being for the patient. The final moment of the shift is the kairotic moment.

Kelman's offering of kairos to understand therapeutic change has had a following since then, ranging from implications for Jungian perspective (Hainline, 1980) to an Ericksonian one (Goldwert, 1981), to group therapy (Roberts, 2003) and exploration of somatization (Fischbein, 2017). Much referenced 'now moment' in therapy has also been described as kairos in that it implies that "a unique moment of opportunity must be seized, because your fate will turn on whether you seize it and how" (Stern, 1998, p. 912).

Joannidis' deliberation of chronos and kairos presents a similar conceptualization of time, yet he reframes their implications for therapy through incorporating the internal and external reality dimension: Chronos identifies time as sequence, that implies before and after, and the objective, shared reality of succession (Joannidis, 2005, p. 164). Kairos, instead, is time as duration, it "is the world of narration, a sphere of episodes that have a beginning, a middle, and an end: the human and living time of intentions and goals" (p. 164). Thus, therapeutic encounter contains the interaction, or complementarity of chronos and kairos, the objective reality of shared time and the subjective inner reality of the patient. Their interaction and complementarity is what brings about change (p. 164). Time in this perspective is the container for the subjective and objective: while the patient brings his/her kairos into therapy, it meets chronos during

moments of interpretation. The kairos of the patient meets chronos in analysis, as a result, a new order, a new kairos emerges.

This study will explore time in connection to trauma and dissociation. It will utilize ZTPI as it has been a reliable method to measure time perspective. It will also aim to tap into subjective experience of time through development of a new scale. The questions in the scale inquire about the inner experience of time, and explore whether it is cyclical, fixed or dynamic, and whether it confirms a belief in the auspicious moment.

1.4. STUDIES OF TRAUMA, DISSOCIATION AND TIME PERCEPTION IN TURKEY

Trauma and dissociation for clinical populations have extensively been researched in Turkey, particularly since the 1990s. Although early accounts of dissociative symptoms point to their prevalence in psychiatric wards (e.g. Öztürk & Volkan, 1971 as cited in Tutkun, Şar, Yargıç, Özpulat, Yanık & Kızıltan, 1998) more systematic explorations can be traced to further specialization on dissociation in terms of teaching and research, utilization of standardized screening instruments (Yargic, Tutkun & Sar, 1995) and/or systematic case studies. While some of the research focus on symptomatology and treatment of dissociative identity disorder (e.g. Sar, Yargic & Tutkun, 1996; Sar & Tutkun, 1997; Şar, Unal, & Öztürk, 2007), others assess dissociative disorders among psychiatric patients (Sar, Tutkun, Alyanak, Bakim & Baral, 2000) and as linked to other psychiatric conditions such as addiction (Karadag, Sar, Tamar-Gurol, Evren, Karagoz & Erkiran, 2005), borderline personality disorder (Sar, Akyuz, Kugu, Ozturk, 2006), conversion disorder (Sar, Akyuz, Kundakci, Kiziltan, & Dogan, 2004) and schizophrenia (Sar, Taycan, Bolat, Özmen, Duran, Öztürk, & Ertem-Vehid, 2010). Dissociative disorders have been linked to past trauma, particularly childhood trauma (e.g. Sar, Kundakci, Kiziltan, Bakim & Bozkurt, 2000; Tamar-Gurol, Sar, Karadag, Evren, & Karagoz, 2008; Şar, Islam & Öztürk, 2009; Şar, Taycan, & Bolat, 2010; Sar, Taycan, Bolat, Özmen, Duran, Öztürk, & Ertem-

Vehid, 2010). Dissociation in nonclinical populations has been assessed as well (Akyüz, Doğan, Şar, Yargıç, & Tutkun, 1999; Şar, Akyüz & Doğan, 2005); in one of these studies life-time diagnosis of a dissociative disorder among women was reported to be as high as 18.3% (Şar, Akyüz & Doğan, 2005, p. 172). Although age and level of income were not linked to diagnosis of dissociation, the difference in terms of level of education between those who were diagnosed and those who were not was statistically significant but not notable (0.3 years higher for those not diagnosed) (p. 172). Sexual abuse, emotional abuse and physical neglect were found to be strong predictors of a dissociative disorder diagnosis (p. 174).

Şar, Middleton & Dorahy's (2013) call to locate dissociative disorders within their socio-political context, and even more specifically, to understand them as a response to oppression is worthy of further exploration. They propose that dissociative disorders could be viewed as a "chronic human rights abuse syndrome of childhood" which involves "oppression of the child by the abusive and potentially colluding nonabusive caretaker, and the multiple ways in which their lived experience is ignored or invalidated by social, political, and medical systems" (p. 124). The ignoring or the invalidation of oppression is exactly what maintains the existing power structure, consequently, exploring dissociation emerges as a significant phenomenon both for its clinical and socio-political implications. In Turkey, although no extensive study which explores dissociative symptoms in response to various forms of socio-political oppression exists yet-to-date, the high prevalence of dissociative symptoms in the general population as well as those seeking psychiatric help can be linked to abuse in childhood and the enduring trauma within the social, political and economic contexts later in life.

As similar to dissociation, psychological trauma has also been considerably researched in Turkey, most typically within clinical populations, but also through fieldwork to observe trauma-stricken populations. Aker, Önen & Karakılıç's (2008) review reveals that although Turkish history embodies numerous types of trauma, published studies of psychological trauma appear only after 2000s. Most

such studies have been conducted to explore the symptoms post 1999 Marmara earthquake (p. 39). Similarly, a 2013 review of psychiatric epidemiology also shows that most typical trauma-screening field work focus on PTSD after natural disasters: Of the 21 studies they reviewed, 18 examine post trauma symptoms after earthquakes and only 3 examine trauma experienced in conflict zones (Binbay et. Al, 2013, p. 7). A scanning of Ulakbim with the keyword trauma generates a similar result: Of the thesis submitted to the Council of Higher Education, trauma experienced due to socio-political strains are only few and date to the last couple of years. There are however studies on specific types of traumatic experiences, although most of them focus on particular demographic groups experiences and/or particular types of traumas.

Of specific types of trauma, sexual abuse history has been screened by only one study in a nonclinical population: The frequency has been identified to be 13.4% among female high students in Istanbul. The study found most perpetrators to be males and about 50% of them to be strangers (Alikasifoglu, Erginoz, Ercan, Albayrak-Kaymak, Uysal, & Ilter, 2006, p. 252). Intimate partner violence (IPV) has been studied more extensively. A relatively recent review of existing research on IPV against women reveals that the prevalence rates range between 13 to 78%. The review points to physical and emotional violence as most common types of reported abuse. Poor socio-economic status, low education levels, marriage at a young age, living with extended family, exposure to violence in childhood all increased the risk of exposure to IPV for women (Guvenc, Akyuz, & Cesario, 2014, p. 340). Studies on the effects of forced migration has been somewhat scant and mostly involve Turkish or Kurdish migrants who are settled outside Turkey. A 2010 study on Kurdish women who are internally displaced in Turkey and those settled in Europe find that majority of them experienced PTSD like symptoms. (Gülşen, Knipscheer, & Kleber, 2010, p. 113).

In summary, screening of the range of past traumatic experiences in the nonclinical population in Turkey has not been conducted. This study will attempt to contribute to the literature in this regard.

1.5. CURRENT STUDY

In having reviewed the relevant literature, this study will aim to contribute to discussions of trauma, dissociation and time experience through four research questions. The first question will explore to what extent a time perception can be captured through chronological as well as non-chronological dimensions. This is significant particularly for understanding the dynamics that mark trauma and dissociation. Second research question is related to trauma: What are the extent and types of traumatic experiences in the general nonclinical adult population in Turkey? As surveys of trauma in nonclinical groups are rare in Turkey, an overall analysis of traumatic experiences in this study's sample will give an idea. Third research question will assess dissociative experiences, trauma and time perspective correlate. As the literature reveals, time perspective is rarely measured in its connections to trauma and dissociation. Final research questions aims to identify predictors of dissociation: To what extent demographic factors, traumatic experiences, and time perception predict dissociative experiences? The design of the study is presented in the next chapter.

CHAPTER 2

METHOD

This chapter details the design of the study and procedures employed for data collection. It first presents participants' selection process and their demographic characteristics. It then discusses the instruments utilized in the study. Final section presents the procedure for data collection.

2.1 Participants

The participants of this study were volunteers who responded to the invitation circulated through email and social media. The only requirement to participate in the study was to be between ages 20 and 60. The survey could be filled out on SurveyMonkey. Of the 292 respondents who attempted, 208 completed the first section of the study including time perception related questions and 164 completed the entire survey.

Of the 164 who completed the full survey, 122 (74.4%) were women and 41 (25%) were men; 1 (0.6%) respondent didn't want to identify gender. The age of the participants ranged from 20 to 58 ($M = 34.40$, $SD = 10.64$), 51.2% of the participants were 30 or younger. Of the participants, 59 (36%) were married, 94 (57.3%) were single, 7 (4.3%) were divorced, 1 was widowed, 3 (1.8%) were categorized as other. When asked if they are currently in a relationship, 97 (59.1%) respondents confirmed that they were in a relationship.

The level of education ranged from high school to PhD: 14 (8.5%) had a high school diploma, 82 (50.0%) had a university diploma, 48 (29.3) had an MA degree, and 20 (12.2%) were PhD's.

With respect to their living arrangement, 77 (47.0%) reported to live with their immediate family, 35 (21.3%) reported to live with their partner, 31 (18.9%) reported to live alone, 18 (11.0%) reported to live with a friend, and 3 (1.8%) reported to live with their extended family.

Finally, in terms of income level, 58 (35.4%) respondents had a monthly average income of 5000YTL or above, 27 (16.5%) between 4000 and 4999, 19 (11.6%) between 3000 and 3999, 18 (11.0%) between 2000 and 2999, 19 (11.6%) between 1000 and 1999, and finally, 23 (14.0%) 999 YTL or below.

2.2 Instruments

2.2.1 Demographic Information Form

Demographic information Form (Appendix A) included questions about the participants' age, gender, education level, professions, birth place, marital status, relationship status, living arrangement and perceived socioeconomic level.

2.2.2 Sequential and Opportune Time Scale (SOTS)

This set of questions (Appendix B) explored the participants' experience of time as sequential / chronological and opportune / meaning-based. The 15 items on the scales were to be rated on a 5-point Likert scale and one item had a categorical response option. The questions were formulated upon a rigorous review of the existing literature on time perception in clinical settings. The researcher and her advisor formulated the items, the scale was finalized after two rounds of editing. As this was the first time the scale was used in a study, reliability analysis was conducted prior to other analyses. Findings of the reliability analysis are presented in the Results section.

2.2.3 Dissociative Experiences Scale (DES)

Dissociative Experiences Scale (DES; Appendix C) is a 28 item self-report measure, designed to screen for dissociative disorders. Originally developed by Bernstein and Putnam (1986), it assesses the type and severity of dissociative symptoms. The scores for each item range from 0 to 100 and examples of the symptoms include finding oneself in a place that one does not know how she/he

got to, finding oneself in clothes that one can not remember putting on, feeling like watching oneself as somebody else, not remembering significant events in one's life. Some of the indicators suggest minor gaps in awareness, such as getting absorbed while watching TV or film, and are reported to be observed in nonclinical populations as well (Carlson & Putnam, 1993). Some others indicate moderate to severe forms of dissociation such as depersonalization, derealization, or autobiographical amnesia. Although there has been some interest in extracting subscales from DES for clinical and nonclinical populations (e.g. Ross, Joshi & Currie, 1991) there does not seem to be a consensus for whether or not the subscales measure the underlying factors.

Scoring of DES is figured through calculating the average score for all items. The scale is not advised to be used as a diagnostic tool by itself, however, scores above 30 are reported to be indicative of dissociability and highly predictive of multiple personality disorder (Carlson, Putnam, Ross, Torem, Coons, Dill, Loewenstein, Braun, 1993).

Reliability and validity of the Turkish version is reported to be as high as the original version (Yargıç, Tutkun & Şar, 1995) and the scale has been utilized in various studies since its adoption (e.g. Akyüz, Doğan, Şar, Yargıç & Tutkun, 1999; Zoroglu, Tuzun, Sar, Tutkun, Savas, Ozturk, Alyanak, & Kora, 2003). The cut-off score of 30 has been confirmed to be useful in Turkish clinical settings as well (Tutkun, Şar, Yargıç, Ozpulat, Yanık, Oztitan, 1998; Yargıç, Tutkun & Şar, 1995). In the present study, the Cronbach's alpha coefficient was 0.947, thus the scale provided a reliable way to assess dissociation.

2.2.4 Traumatic Experiences Checklist (TEC)

Traumatic Experiences Checklist (TEC; Appendix D) is a 33 item self-report measure developed by Nijenhuis, van der Hart and Kruger (2002). It assesses participants' trauma history with respect to emotional neglect, emotional abuse, physical threat to life, extreme pain, sexual harassment and sexual abuse. The scoring can be reported per subscale or as a total score. The total score

represents the overall number of the types of incidents experienced by the respondent and ranges between 0 and 29. This study will use the total score of TEC.

The scale has been translated into Turkish by Şar (2002), it has been reported to be satisfactorily valid and reliable (Semiz, Başoğlu, Ebrinç, Ergün, Noyan & Çetin, 2005) and utilized in other studies since then (Semiz, Basoglu, Ebrinc, Cetin, 2008; Evren, Dalbudak, Evren, Cetin, Durkaya, 2011). The Cronbach's alpha is 0.743 in this sample, and thus confirms its suitability for further analysis.

2.2.5 Zimbardo Time Perception Inventory (ZTPI), Condensed Form

Developed in 1999 (Zimbardo & Bond, 2015) this scale is a self-report measure of one's connection to time (Appendix E). Originally comprised of 56 items which tap into 5 sub-dimensions (past-negative, past-positive, now-hedonistic, now-fatalistic, and future), as it got translated into Turkish, both a full version (Kislali, 2007) and a condensed version have been developed (Guler-Edwards, 2008). This study uses the condensed form, which includes a total of 25 items comprised of 5 items per each subscale. The items for the subscales include statements that indicate negative (Painful past experiences keep being replayed in my mind.) and positive orientation towards one's past (On balance, there is much more good to recall than bad in my past.), hedonistic (It is important to put excitement in my life.) and fatalistic (Fate determines much in my life.) attitude for the present, and statements that indicate future orientedness (When I want to achieve something, I set goals and consider specific means for reaching those goals).

The Cronbach's alphas for subscales in this study are, for past-negative 0.787, for past-positive 0.730, for now-fatalistic 0.707, for now-hedonistic 0.748, and for future 0.750. Upon finding the subscales' reliability sufficient for this sample, they have been employed for further analysis.

2.3 Procedure

Data has been collected through an online survey tool (surveymonkey). The survey first presented an informed consent form to inform the participants about the procedure of the study and ask for voluntarily participation. The form included a brief description of the purpose of the study, information about the participants' right to quit at any point, their right to contact the researcher if they had any questions or concerns about their participation, and finally, the option to confirm voluntary participation. Once the respondent confirmed participation, the survey composed of the instruments in the order that has been listed above was presented. It took about 15 to 20 minutes to complete the questionnaire.

Of the 292 who confirmed the informed consent request, 241 completed the first set of demographic questions, 208 completed all questions until the end of sequential – opportune time scale questions, 179 completed all through the end of the dissociation scale, 167 through the trauma scale and finally, 164 completed all questions including the Zimbardo time perception inventory. Thus, 164 completed the full survey and detailed analysis will include this group. Although there is much discussion in the literature regarding response rates for online surveys, no uniform model for acceptable rates seem to be set, rather factors influencing response rates are reviewed (eg. Fan & Yan, 2009). The response rate in this study (56%) yielded an adequate sample for analysis, particular patterns in drop-outs reveal that the higher number who quit was earlier in the survey (33 after the first scale, 27 and 12 after each subsequent scale) and thus, perhaps rather than the content, the time commitment might have been a factor in contributing to the response rate.

With respect to ethical issues, no identifying information has been collected. One significant question was to what extent the traumatic experiences scale, which includes questions that tap into possibly stressful memories, would potentially cause distress to the participants. Previous research on the experience of participating in studies that address trauma report that in general adverse reactions are not as common as expected (Walker, Newman, Koss & Bernstein,

1997). Nevertheless, as a precautionary measure, participants have been encouraged to quit at any point if they experienced stress, to contact the researcher if they had any questions; in addition, a final comments section was included for questions, concerns or feedback about the study. No particular comment that suggested serious adverse reactions as a result of having participated in the study was made.

CHAPTER 3

RESULTS

This chapter presents the results in four subsections: 1. Time perception, 2. Descriptive statistics of traumatic and dissociative experiences, 3. Correlates of trauma and dissociation and 4. Factors that predict dissociation.

Time scale development will present the results of Principal Component Analysis and internal consistency analyses for Sequential and Opportune Time Scale (SOTS). Second section will present frequency distributions of Dissociative Experiences Scale (DES) and Traumatic Experiences Checklist (TEC). The third section will present correlations between dissociation, trauma, and time perception. The final section will present regression analysis that identifies predictors of dissociation.

3.1. Descriptive Statistics of Time Measures

This section will present the descriptive statistics of time measures. First, descriptive statistics for Sequential and Opportune Time Scale and Zimbardo Time Perspective Inventory will be detailed, after this, correlations between the subscales of these two scales will be presented.

3.1.1. Sequential and Opportune Time

Sequential and Opportune Time Scale (SOTS) is a measure developed for the purposes of this study. It included 15 items measured on a Likert scale and one categorical item with options from which the respondents would select the most appropriate one (See Appendix B). The scale questions aimed to tap into time experienced on a chronological line, time experienced as cyclical, repetitive, in the now or back-to-back, and finally, time experienced as the opportune moment.

In order to assess the scalability of these items, first descriptive statistics and inter-item correlations based on the responses of 208 participants who filled

out the survey until the end of SOTS questions were examined. In order to extract underlying dimensions, a preliminary Principal Component Analysis (PCA) was conducted. This was an exploratory analysis with no specific hypothesis to be tested, thus PCA was preferred.

To assess the factorability of the sample and data, The Kaiser-Meyer-Olkin measure of sampling adequacy was conducted, it was found to be 0.696, indicating that the sample was adequate for analysis. Bartlett's Test of Sphericity was significant ($\chi^2(105) = 634.134, p < .001$), thus correlation matrix was suitable for factor analysis. The inspection of the anti-image correlation matrix and initial communalities further confirmed the aptness of the data.

PCA initially yielded 4 components with eigenvalues greater than 1. The Varimax rotation was preferred in order to maximize factor loadings and simplify the resulting component structures. One of the items' factor loading was low and it was discarded (Item 11). With the remaining 14 items, a three-factor solution produced a statistically and theoretically meaningful matrix. The three components explain 45.5% of the total variance. Table 3.1 presents the items listed under each component and their factor loadings.

Table 3.1. Item-Factor Loadings of SOTS

Component 1: Stuck	Loading
4. Some events in my life seem to be so near, as if no time has passed.	0.734
1 Sometimes I visualize a moment or image from the past as if I am experiencing it now.	0.731
5. I sometimes experience time like a repeating cycle, as time goes by it is as if I go back to the beginning.	0.674
3. I have felt like experiencing two events back-to-back even though time had passed between them.	0.665
2. Sometimes I visualize a moment or event from the future as if I	0.663

am experiencing it now.

13. I have difficulty in letting myself go with the flow. 0.674

Component 2: Kairos

7. For me it is the content and meaning rather than duration that defines time. 0.606

6. I believe that some things happen in their own opportune time, we can not know when beforehand. 0.511

12. I think life offers unexpected opportunities that are independent from time and space. 0.513

8. When I remember events, how I feel is more important than when they happened. 0.488

Component 3: Chronos

10. I realize that I sort my memories chronologically. 0.749

14. I like to organize myself according to each day and hour. This way, I minimize the possibility of something unexpected happening to me. 0.666

15. If I were to tell my life story, I would tell it in the order of my birth to today. 0.606

9. Time is a straight line, it always moves forward. 0.442

The components were consistent with the time perception conceptualizations offered in the literature: The first component tapped into a feeling of being stuck in the past, being fixed to the future, or experiencing of time cyclically, thus the items relayed experiencing of time as if one is stuck or trapped. The second component includes items that emphasize belief in opportune time and was labeled Kairos. The third component included items that express a chronological experience of time and was labeled Chronos. The internal

consistency of each component and the items included are listed in Table 3.2.

Table 3.2. Internal Consistency Coefficients for SOTS

Component	No. of Items	Items	Cronbach's alpha
Stuck	6	1, 2, 3, 4, 5, 13	0.765
Kairos	4	6, 7, 8, 12	0.549
Chronos	4	9, 10, 14, 15	0.507

Internal consistency was examined by Cronbach's alpha. For the first component, the alpha was 0.765 and thus indicated high internal consistency. The other two components had alpha levels marginally below the recommended level. An inspection of inter-item correlations supported that the values were due to the dependency of the alpha value on the number of items. Since this is an exploratory analysis of alternative conceptualization of time, the components were utilized for further analysis.

The mean of the items comprising each component was calculated in order to obtain the component score. Table 3.3 presents the descriptive statistics of the component scores. Of the three, Stuck has a lower mean and Kairos has the highest. The correlations of these components with other variables will be presented in the last two sections.

Table 3.3. Descriptive Statistics for Component Scores

Component	Min.	Max.	Mean	SD
Stuck	1.0	5	2.99	0.88
Kairos	1.25	5	3.81	0.72
Chronos	1.0	5	3.12	0.80

The last question of the scale asked the respondents to indicate what makes them become aware of the passage of time during the day. The option that best suited the respondent's experience was to be selected. Since this question presented a categorical variable, its frequency distribution is analyzed separately. Table 3.4 presents the frequency distribution of this variable, *passage of time*.

Table 3.4. Frequency Distribution of Passage of Time

Values	Frequency	Percent
1. I become aware of time when the time of a preplanned appointment, class, meeting, etc approaches.	39	23.8
2. Call to prayer and namaz times make me aware.	3	1.8
3. Weather outside makes me aware (sunrise, sunset, rain, etc)	18	11.0
4. Repetitive events during the day (eg. Meal times, sleep) make me aware of the passage of time.	35	21.3
5. The remains of the day, moments and events make me aware of time.	13	7.9
6. I become aware when I look at the clock.	52	31.7
7. Other (please indicate)	4	2.4
Total	164	100.0

The category with the highest frequency was 'looking at the clock' (31.7%). Preplanned events was the second most selected option (23.8%) and repetitive events was the third (21.3%). If one can categorize the options in terms of linear/chronological (Items 1, 6) and nonlinear/cyclical experiences of time (Items 2, 3, 4, 5), linear/chronological time implies the dominant experience. When the two highest frequency options are combined, slightly over half of the participants

(55.5%) indicated some form of a chronological marker for how they become aware of the passage of time.

3.1.2. Zimbardo Time Perspective Inventory

The Zimbardo Time Perspective Inventory (ZTPI) includes 5 subscales: Past Negative, Past Positive, Present Hedonistic, Present Fatalistic and Future. Each subscale in the condensed version has 5 questions, bringing the total number of the items in the questionnaire to 25. The scoring for each subscale is obtained through averaging the scores of the items included. Descriptive statistics for ZPTI Subscales are presented in Table 3.5.

Table 3.5. Descriptive Statistics for ZPTI Subscales

Subscale	Min.	Max.	Mean	SD
Past Negative	1	5	3.04	0.91
Past Postive	1	5	3.24	0.81
Present Hedonistic	1	5	2.79	0.76
Present Fatalistic	1.20	4.40	2.42	0.71
Future	1.40	5	3.49	0.77

The descriptives of the subscales indicate that there is no concentration around the minimum or maximum scores for any of the items. The average for Present Fatalistic is slightly lower than the other items, but since the standard deviation is comparable to others and its mean is not notably lower, all items' distribution is identified to be similar.

3.1.3. Correlations between Sequential and Opportune Time Scale and Zimbardo Time Perspective Inventory Subscales

In order to identify whether or not Sequential and Opportune Time Scale (SOTS) components are linked to Zimbardo Time Perspective Inventory (ZTPI), a correlation analysis was conducted. The sample consists of people who filled out the whole set of questionnaires (n=164). They are presented in Table 3.6.

Table 3.6. : Pearson Correlation Coefficients of ZTPI and SOTS Subscales

	Past Negative	Past Positive	Present Hedonistic	Present Fatalistic	Future
Kairos	.038	.220**	.113	.212*	.123
Chronos	.034	.240**	-.084	-.115	.207**
Stuck	.481**	.085	.078	.258**	-.081

As Table 3.6. shows, the subscales of the two time perception measures correlate: While Kairos is positively correlated with Past Positive ($r(164) = .220, p < .01$), and Present Fatalistic ($r(164) = .212, p < .05$), Chronos is positively correlated with Past Positive ($r(164) = .240, p < .01$), and Future ($r(164) = .207, p < .01$). Stuck is positively correlated with Past Negative ($r(164) = .481, p < .01$) and Present Fatalistic ($r(164) = .258, p < .01$). These correlations confirm the theoretical background of the SOTS: Chronos would be expected to link to a projection of time as a linear line that stretches from the past into the future and hence it would make sense to correlate with Past Positive and Future. Stuck would link to some form of disruption in the linear experience of time, its correlation with Past Negative is also meaningful. ZPTI's Present Fatalistic subscale indicates a sense of not having control over time, in that sense, both Stuck and Kairos' positive correlation would be anticipated. Finally, Kairos' correlation with Past Positive points to the distinguishing factor between Kairos

and Stuck. While both indicate a nonlinear experiencing of time, Kairos embodies potential and opportunities (hence correlates with Past Positive) whereas Stuck simply involves disruption in linearity without expectation of significant moments coming up. Thus, each component's correlation with either a positive or negative past in ZPTI subscales further confirm their meaning.

3.2. Descriptive Statistics of Traumatic and Dissociative Experiences

The frequency distribution of items in the Traumatic Experiences Checklist (TEC) and Dissociative Experiences Scale (DES) were examined to assess the overall state of traumatic experiences and dissociation in the sample.

The frequencies and percentages for each type of traumatic experience as measured by TEC are presented in Table 3.7. Since each item was a "yes" or "no" answer question, here, only those who answered positively are reported. The table compiles all traumatic experience questions' frequencies, thus, the total percentage is more than 100%.

Table 3.7. : Frequency Distribution of Traumatic Experiences

Item	Frequency	Percent
1. Having to look after parents and/or brothers and sisters during childhood.	31	18.9
2. Family problems	72	43.9
3. Loss of a family member (brother, sister, parent) during childhood.	13	7.9
4. Loss of a family member (child or partner) during adulthood.	25	15.2
5. Serious bodily injury.	9	5.5
6. Threat to life from illness, an operation, or an accident.	36	22

7. Divorce of parents.	33	20.1
8. One's own divorce.	15	9.1
9. Threat to life from another person.	11	6.7
10. Intense pain.	57	34.8
11. War-time experiences.	2	1.2
12. Second generation war- victim.	5	3
13. Witnessing others undergo trauma.	57	34.8
14. Emotional neglect by parents, brothers or sisters.	51	31.1
15. Emotional neglect by more distant members of family.	36	22
16. Emotional neglect by non-family members.	41	25
17. Emotional abuse by parents, brothers or sisters.	55	33.5
18. Emotional abuse by more distant members of family.	21	12.8
19. Emotional abuse by non-family members.	55	33.5
20. Physical abuse by parents, brothers, or sisters.	40	24.4
21. Physical abuse by more distant members of family.	4	2.4
22. Physical abuse by non-family members.	19	11.6
23. Harsh punishment.	10	6.1
24. Sexual harassment by parents, brothers, or sisters.	4	2.4
25. Sexual harassment by more distant members of family.	4	2.4
26. Sexual harassment by non-family members	24	14.6
27. Sexual abuse by parents, brothers, or sisters.	4	2.4
28. Sexual abuse more distant members of family.	8	4.9
29. Sexual abuse non-family members.	37	22.6

Of all traumatic experience items, item 2 (problems in the family, such as alcoholism, poverty, mental health problems) was confirmed by the highest number of participants, nearly half of the sample checked 'Yes' (43.9%). Items 10 (severe pain due to surgery or injury) and 13 (witnessing another person's traumatic experience) come next in terms of highest frequencies, each were confirmed by 34.8% of the sample. Items 17 (emotional abuse by parents or siblings) and 19 (emotional abuse by those outside the family, such as neighbors, friends or teachers) were also each confirmed by about one third of the participants (33.5%). A considerable percentage of participants reported that they were subject to sexual abuse by those outside the family, such as neighbors, friends or teachers (22.6%)

A total trauma score was assigned through adding each of the traumatic experiences if they were checked "Yes". The descriptive statistics for this variable is presented at Table 3.8.

Table 3.8. Descriptive Statistics for Total Score of Traumatic Experiences Scale (TES)

Variable	Min.	Max.	Mean	SD
Total Trauma Score	0	17	4.76	3.56

The average number of trauma in the sample was close to 5. When the total number of traumas experienced was recoded as 0, 1, or more than 1, an overwhelming majority of the sample fell into the More than 1 (Multiple) trauma category. Table 3.9 presents the frequency distribution of the Quantity of Trauma variable.

Table 3.9. Frequency Distribution of Quantity of Trauma

Value	Frequency	Valid Percent
Multiple Trauma	142	87.1
Single Trauma	15	9.2
No trauma	6	3.7
Total	163	100

The second set of variables that will be presented in this section is Dissociative Experiences Scale (DES) Score and the Dissociation Cut-off Score. The DES includes items that are scored out of a 100 and the Scale score is obtained by averaging all items' scores. Table 3.10. presents the descriptive statistics for DES Score.

Table 3.10. Descriptive Statistics for Dissociative Experiences Scale (DES) Score

Variable	Min.	Max.	Mean	SD
DES Score	0.36	80.36	18.88	14.79

As reviewed in the literature, the average scores above 30 indicate a higher likelihood of inclination towards dissociability. The DES score is recoded into a binary variable that includes those with a score below the 30 cut-off and those who are above it. Table 3.11 presents the frequency distribution for Dissociation Cut-Off Score.

Table 3.11. Frequency Distribution for Dissociation Cut-Off Score

Value	Frequency	Percent
Below 30	133	81.1
Above 30	31	18.9
Total	164	100

Expectedly, the average DES Score in the sample was quite low with 18.88, and over 80% of the participants scored below the cut-off. However, still almost 20% scored above the cut-off score. The correlations between dissociation, traumatic experiences and time perception will be examined in the next section.

3.3. Correlates of Trauma and Dissociation

This section will present the variables that correlate with traumatic experiences and dissociation. While the first section presents correlations between demographic variables, trauma and dissociation, the second section will introduce time perception into analysis. It will present correlations between trauma, dissociation, Zimbardo Time Perspective Inventory Subscales and SOTS subscales.

3.3.1 Traumatic Experiences, Dissociation and Demographic Characteristics

The association of traumatic and dissociative experiences with age, level of education and level of income were inspected by correlation analyses. Since level of education and income were measured at the ordinal level Spearman correlation was preferred.

Table 3.12. Spearman Correlation Coefficients between Demographic Variables, Trauma and Dissociation

	Age	Level of Education	Level of Income	Trauma	Dissociation
Trauma	.071	.010	-.005	1.000	.332**
Dissociation	-.051	-.021	-.089	.332**	1.000

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

The only correlation that is significant in this analysis is between trauma and dissociation scores, the two variables are positively correlated ($r(163) = .332, p < .01$). The demographic variables didn't correlate with trauma and dissociation.

In order to assess whether or not gender was linked to trauma and dissociation Independent-Samples t-tests were conducted. Table 3.13 presents the results for Descriptive Statistics of Trauma and Dissociation by Gender.

Table 3.13: Descriptive Statistics of Trauma and Dissociation by Gender

	Gender	N	Mean	Std. Deviation
Trauma	Female	121	5.04	3.62
	Male	41	3.71	2.98
Dissociation	Female	122	18.17	13.86
	Male	41	20.10	16.55

The differences between female and male participants' average number of traumatic experiences was found to be significant ($t = 4.58, df = 83, p < .05$). Women reported more traumatic experiences ($M = 5.04, SD = 3.62$), as compared to men ($M = 3.71, SD = 2.98$). The difference was not statistically significant for the dissociation scores.

3.3.2. Traumatic Experiences, Dissociation and Time Perception

As described in section 3.1. two separate measures were used to assess time perception of the participants. The Sequential and Opportune Time Scale provided 3 subscale scores: Stuck, Kairos and Chronos. The Zimbardo Time Perspective Inventory provided 5 subscale scores: Past Negative (PN), Past Positive (PP), Present Hedonistic (PH), Present Fatalistic (PF), and Future.

Table 3.14 Pearson Correlation Coefficients between Dissociation, Trauma, ZTPI Subscales, SOTS Subscales

	Disscore	Traumascor
Past Negative	.206**	.146
Past Positive	-.095	-.305**
Present Hedonistic	.115	.072
Present Fatalistic	.330**	.022
Future	-.066	-.148
Kairos	.119	.032
Chronos	-.142	-.140
Stuck	.497**	.227**

Trauma score is negatively correlated with Past Positive ($r(163) = .305, p < .01$) and positively correlated with Stuck ($r(163) = .227, p < .01$). As much of the literature reviewed in the previous chapter indicates, past traumatic experiences disturb one's orientation to the present, create a sense of feeling stuck in the before and after of the trauma. These findings are in line with the reviewed literature.

Dissociation Score is positively correlated with Past Negative ($r(164) = .206, p < .05$), Present Fatalistic ($r(164) = .330, p < .01$), and Stuck ($r(164) = .497, p < .01$). These correlations might again be expected in that previous research suggests a strong link between trauma and dissociation and thus dwelling in a negative past might be likely. Similarly, a fatalistic approach to the present

also might indicate loss of agency and feelings of helplessness. It is interesting that the correlation with Stuck is higher than the other two, thus perhaps, dissociation is not only associated with a negative assessment of the past or feeling helpless in the now, but also associated with a different –nonlinear –experience of time all together.

3.3. Factors that Predict Dissociation

Analyses conducted so far suggest that both Trauma and Dissociation scores are not dismissible in this sample. Furthermore, Trauma scores are positively correlated with Dissociation scores, confirming what has been much suggested in the extant research. Once demographic variables were examined along with trauma and dissociation scores, there did not appear to be any significant relationship. With the time related scales however, again, a perhaps expected and equally interesting pattern emerges; both trauma and dissociation are linked to the experience of time. Trauma is linked to an attachment or fixation to the past and is negatively correlated with Future orientedness. Similarly, Dissociation is linked with a negative past and a fatalistic experience of present. Both Trauma and Dissociation are positively correlated with Stuck suggesting a different experiential dimension for time for those who have had traumatic experiences and also those who score high on the dissociation scale. Based on these preliminary observations, the final analysis here will test a model to identify predictors of dissociation. This analysis provides a comprehensive picture of the relative effects of trauma and different aspects of time perception on dissociation.

A Stepwise Regression Analysis with Dissociation as the dependent variable, and subscales of ZTPI and subscales of SOTS as predictors was conducted. The model summaries are presented in Table 12.

Table 3.15: The Model Summary of Stepwise Regression Analysis for Dissociation

Model	R	R ²	Adjusted R ²	SE of the Estimate	Change Statistics				
					R ² Change	F Change	df1	df2	Sig. F Change
1	.501 ^a	.251	.247	12.82807	.251	54.071	1	161	.000
2	.543 ^b	.295	.286	12.48732	.044	9.906	1	160	.002
3	.565 ^c	.319	.306	12.31396	.024	5.537	1	159	.020

Note. a. Predictors: (Constant), Stuck

b. Predictors: (Constant), Stuck, Present Fatalistic

c. Predictors: (Constant), Stuck, Present Fatalistic, Chronos

In the third model, 30.6% of the variation in Dissociation is explained by Stuck, Present Fatalistic, and Chronos, $F(3,159) = 24.801$, $p < 0.001$. Table 3.16 lists the regression coefficients and standardized beta values for variables included in the final model.

Table 3.16: Coefficients for Stepwise Regression Analysis of Dissociation.

	Unstandardized		Standardized	t	Sig.
	B	SE	Beta		
(Constant)	-5.447	5.901		-9.23	.357
Stuck	7.941	1.176	.459	6.751	.000
Present Fatalistic	4.014	1.410	.195	2.848	.005
Chronos	-2.912	1.238	-.156	-2.353	.020

This model suggests that the strongest predictor for Dissociation is Stuck with a Beta of 0.459, the second is Present Fatalistic with a Beta of 0.195, and third, Chronos, with a Beta of -0.156. Time perception experienced as feeling stuck predicts an increase in dissociation by almost 8 units. Present Fatalistic

perception predicts an increase by 4 units, Chronos predicts a decrease by almost 3 units.

Dissociation's strongest predictor is found to be time perception variables, trauma for example didn't enter into the model. Next Chapter will discuss implications of these findings.

CHAPTER 4

DISCUSSION

This study originally had four research questions: First, it aimed to offer a scale for a nonlinear conceptualization of time perception. Second, it aimed to scan the extent and types of traumatic experiences and dissociation in a general, ie. nonclinical, adult population. Third research question assessed the patterns through which dissociation, trauma and time perception correlate. As the literature reveals, time perspective is rarely measured in its connections to trauma and dissociation and this study aimed to identify how both previous conceptualizations of time perception and the new scale offered here link to dissociation and trauma. Final research question aimed to identify predictors of dissociation. This chapter is organized in accordance with these research questions; the first and second questions will be discussed separately, the third section will present discussion of the third and fourth research questions together. The final two sections will discuss the clinical implications of this research and its limitations and questions for further work.

4.1. Time perception

With respect to the first question, a nonlinear understanding of time had its origins in philosophy and has been much discussed in psychoanalytic literature (eg. Kellman, 1969; Joannidis, 2005) but has not been operationalized for empirical observation. This nonlinear conceptualization offers an additional dimension to the existing paradigm in scholarly discussion and research, that is, time experienced on a chronological dimension, stretching from past into the present and future, with equal units of intervals. As psychoanalytic literature indicates, time within and outside the therapeutic interaction can also be experienced in nonlinear forms, such as two significant moments that might be apart on chronological time can be connected, memories can be weaved together with elements of emotional weight, and a sudden moment of shift occurs and it

sets that one moment in time apart from the others (Joannidis, 2005). The Sequential and Opportune Time Scale was designed for this purpose, that is, to tap into aspects of time perception and experience that are beyond the chronological depiction.

The descriptive statistics and inter-item correlations based on 208 participants' responses revealed the scale to be fit for further analysis. Kaiser-Meyer-Olkin measure of sampling adequacy, Bartlett's Test of Sphericity also supported the scale's suitability for factor analysis. Accordingly, a Principal Component Analysis (PCA) was conducted. Item 11's factor loading was low, thus, it was discarded. The remaining items yielded a three-factor solution which explains 45.5% of the total variance. The components that emerged expressed chronological time, being stuck in time and kairos.

The first component confirms previous assessments of time perception such as Zimbardo Time Perspective Inventory (eg. Zimbardo & Boyd, 2015). It included items that express a chronological experience of time and was labeled Chronos. The second component identified an overall experience of feeling 'stuck' or experiencing time periods in a nonlinear fashion. This construct is similar to ZTPI's Past Negative or Past Positive dimensions in that it highlights fixations in time periods, however, the component also indicates nonlinearity: such as experiencing two separate moments back-to-back, or experiencing time cyclically. Moreover, it relays a sense of not being able to flow with time, be it linear or nonlinear. In short, it conveyed a feeling of being caught in time and was labeled Stuck. The third component of the SOTS was labeled Kairos. However, because the sample size was small and the number of items in the component was few, the reliability coefficient turned out to be weak. Future research can explore this construct and assess further survey items that might be added to the component.

The mean of the items in each component were calculated to obtain the component score. While Stuck had the lowest mean (2.99) Kairos had the highest (3.81). Since no similar measure exists, it is difficult to compare these findings with past research. It could be argued that a belief in opportune moment is quite

prevalent as it had been observed by Kellman (1969) when he first offered the concept for psychoanalysis. Stuck, on the other hand, is rated slightly lower than the others suggesting that a sense of feeling stuck in the flow of time is relatively uncommon for a nonclinical group.

The scale's last question assessed how a person becomes aware of the passage of time. Of the options that were provided, 'looking at the clock' (31.7%) was the most preferred one. The answer with the second highest frequency was 'preplanned events' (23.8%); together these two options comprised slightly over half of all answers. If these two options represented some form of a chronological assessment of time, the rest of the options (such as repetitive events during the day, weather outside, call to prayer) provided cyclical/nonlinear experiences of time. Although the chronological reminder or clock time appears to be slightly more favorable, the other reminders are also quite common. Future studies could look into correlates of this variable.

The second scale that assessed time perception was the Zimbardo Time Perspective Inventory (ZTPI), condensed form, which included 5 subscales: Past Negative, Past Positive, Present Hedonistic, Present Fatalistic and Future. The subscales' reliability coefficients were satisfactory; their descriptive statistics suggested that there was no remarkable skew, as a result ZTPI has been confirmed to be utilizable for this study. Consequently, SOTS components have been tested against ZTPI to further assess their validity.

The correlation analysis of the two scales' components reveals that Chronos is positively correlated with Past Positive and Future, Kairos is positively correlated with Past Positive and Present Fatalistic. Stuck is positively correlated with Past Negative and Present Fatalistic. These correlations confirm the theoretical background of the SOTS: Chronos is linked to a positive experience of the past and is linked to the future. Stuck and Kairos are linked to Present Fatalistic as they both indicate a sense of not having control over the flow of time. While Stuck correlates with a negative past, Kairos correlates with a positive one. Kairos' signaling a belief in auspicious moment would embody a trust in positive potentials (in the form of unepextecd 'lucky breaks'), thus its correlation with Past

Positive would also confirm the component's validity. ZTPI's Present Hedonistic did not correlate with any of the SOTS components; this subscale includes items that suggest prioritizing pleasure in the present and taking risks if necessary, in a sense, experiencing of present time through action but without concern for consequences (Sircova et al, 2014). SOTS subcomponents focus on linearity and nonlinearity and didn't have any item that might relate to hedonism.

In short, the SOTS' validity could be argued to be supported through its components correlations with ZTPI subscales. Further work could develop more items for measuring nonlinearity, particularly Kairos.

4.2. Traumatic Experiences and Dissociation

The second research question aimed to understand the extent and type of traumatic and dissociative experiences in the general, nonclinical adult population in Turkey. Although there is a significant number of research on PTSD after natural disasters or political conflict (eg., Önder, Tural, Aker, Kılıç, & Erdoğan, 2006; Binbay, Direk, Aker, Akvardar, Alptekin, Cimilli & Taycan, 2014) systematic surveys of general population are rare. This is quite significant in order to assess the general mental health needs of the adult population in Turkey.

The findings suggest that there is a considerable number of traumatic experiences reported; the average number of trauma reported by respondents was 4.76. An overwhelming number of participants (86.6%) reported multiple traumas, only 3.7% of the participants reported no trauma and only 9.2% reported a single traumatic item. It must be noted that the trauma score is compiled through each type of items checked in the survey, not the number of traumatic events. In other words, when multiple trauma is referenced, it refers to multiple types of traumatic events (such as emotional abuse, poverty in the family, etc) but not how many times each event had been experienced. Thus, possibly the number of traumatic experiences could be a lot more with the assumption that each type of traumatic event might have been experienced more than once.

As compared to global findings of trauma and PTSD, these numbers still seem to be high, for example, the meta-analysis of World Mental Health Survey reports indicates the average number of trauma to be 2.9. (Kessler, Aguilar-Gaxiola, Alonso, Benjet, Bromet, Cardoso, On behalf of the WHO World Mental Health Survey Collaborators, 2017). The same meta-analysis identifies demographic factors linked to trauma exposure, such as gender and socio-economic status. As the sample in the present study is considerably more educated and earns a higher level of income as compared to the general population in Turkey, the average number of trauma reported here appears to be of concern. Although we don't have comparable statistics for the general population in Turkey, trauma exposure is likely to be even higher.

Another possibility for high levels of trauma exposure is that for post-conflict countries or those with high levels of poverty, overall levels of traumatic incidents are typically high and exposure does not necessarily correlate with socio-economic status; all segments of society are exposed to trauma regardless of their socio-economic status (eg. Atwoli, Stein, Koenen & McLaughlin, 2015). For Turkey, perhaps, the baseline of average number of traumatic incidents experienced is quite high for all and possibly the risks increase with certain demographic factors (such as gender, levels of income, geographic location, etc.). Further research is essential in order to identify the patterns in exposure to traumatic incidents in Turkey.

The most frequently reported traumatic experience was problems in the family, it was reported by 43.9% of the participants. Past research suggests that living in chronologically traumatic environments lead to erosion in family life (Kiser & Black, 2005). Furthermore, traumatic experiences originating from the family, especially in early childhood, lead to psychopathology later in life and could be transmitted to future generations (Kiser & Black, 2005, Öztürk & Şar, 2006). The fact that this type of trauma is reported by almost half of this group, which is considerably more privileged with respect to socioeconomic status as compared to the Turkish population at large, leads one to question the prevalence of this type of trauma in the general population. Similarly, emotional abuse by

parents or siblings and emotional abuse by those outside the family were each reported by one third of the sample. Emotional abuse's pervasiveness adds to the previous finding about family trauma: Enduring experiences of trauma is most typically linked to the family or immediate environment (such as neighbors, teachers, etc).

Slightly over one fifth of the participants reported that they have been subject to sexual abuse by those outside the family, such as neighbors, friends or teachers. This finding indicates even a higher frequency of sexual abuse as compared to a previous study conducted among high school students in Istanbul. In that study, overall experience of sexual abuse was reported by 13.4% of the participants; among those who reported sexual abuse as part of their history, 50% reported the perpetrator to be a stranger (Alikasifoglu, Erginoz, Ercan, Albayrak-Kaymak, Uysal, & Ilter, 2006, p. 252). Operationalization of sexual abuse in each study might slightly differ and one could argue that high school students' might have been more reluctant to report sexual abuse, thus the previous study's finding might have underestimated the frequency. Further studies that will explore sexual abuse outside clinical settings is essential to understand the extent of this type of trauma's occurrence in the Turkish population.

The findings with respect to traumatic experiences have socio-political implications: First, psychological trauma, especially, if researched at a collective level, should be explored within its context. The origins, typology and symptoms all manifest in a particular socio-political context and only through taking them into account theoretical and clinical implications can be gathered. For example, significance of socio-economic status, level of education, gender and other demographic factors might be considerable in assessing the risk for trauma exposure. Although this study didn't trace post-trauma symptoms (such as PTSD) and whether or not therapy support was present after trauma, most likely, the social origins of trauma (such as those that are due to poverty, or oppressive school settings, or domestic violence or sexual abuse) also shape whether or not social support and perhaps therapy help is available. In short, the very setting

trauma takes place also shape post-trauma experience, leading to a continuous cycle of further trauma in one's life and perhaps passing it on to future family generations. Second, psychological trauma cannot be solely a concern at the individual level; it has larger social consequences. Although it is beyond the scope of this study, traumatic experiences reported at such a significant rate might lead to further wider health problems, consequently economic costs and even the quality of political participation and civic life.

As part of the second research question Dissociative Experiences were also assessed, for that purpose Dissociative Experiences Scale (DES) was utilized. The average score in the sample turned to be 18.88 (out of a 100). As it is indicated in the literature, a score of 30 signals tendency for a dissociative disorder and thus used as a cut-off score in similar studies that assess dissociative experiences. In this sample, over 80% of the participants scored below the cut-off and almost 19% scored above the cut-off score. As there is no previous research that assess a dissociation in a nonclinical population in Turkey, it is difficult to locate this finding. In one study which screened adult women in a provincial town in Turkey, life-time diagnosis of a dissociative disorder was reported to be 18.3% (Şar, Akyüz & Doğan, 2005, p. 172) which is quite similar to this finding. Sampling procedure and administration of DES differ in each study, thus to what extent this study's sample can be compared with the previous one is questionable, nevertheless, both findings point to the necessity of identifying the extent of dissociative experiences in nonclinical groups in Turkey. The prevalence might be higher than assumed.

In summary, the findings with respect to trauma and dissociation suggest that there is a considerable number of traumatic experiences reported and a non-negligible percentage of the participants score above the cut-off score of dissociability. The snow-ball method of sampling inevitably yielded a sample that can't be generalized to the larger population. It is comprised of a group that is mostly female, highly educated and has a higher level of income as compared to the general population. Observing the prevalence of traumatic experiences and

dissociability in this group leads one to question their prevalence in the larger population. Şar, Middleton & Dorahy's (2013) argument to explore dissociative disorders as a product of socio-political conditions, perhaps a response to human-rights abuses is of relevance here.

4.3. Trauma, Dissociation, Time Perception

The third and fourth research questions explored how trauma, dissociation and time perception might correlate and the factors that predict dissociation. This study does not claim to identify a dissociative diagnosis, the sole purpose is to explore dissociability as linked to past trauma on the one hand, and linked to experience of time on the other. In this sense, dissociation is found to be correlated with trauma: As expected, the two variables are positively correlated ($r(163) = .332, p < .01$). The demographic variables didn't correlate with either trauma or dissociation in this sample, except for gender: Women reported in average more trauma ($M = 5.04, SD = 3.62$) as compared to men ($M = 3.71, SD = 2.98$). The finding is consistent with past research; in general, women are reported to have higher risks of exposure to trauma in Turkey. (eg., Alikasifoglu, Erginoz, Ercan, Albayrak-Kaymak, Uysal, & Ilter, 2006; Guvenc, Akyuz, & Cesario, 2014). The difference between men and women was not statistically significant for dissociation scores.

Trauma score is negatively correlated with Past Positive ($r(163) = .305, p < .01$) and positively correlated with Stuck ($r(163) = .227, p < .01$). Dissociation Score is positively correlated with Past Negative ($r(164) = .206, p < .05$), Present Fatalistic ($r(164) = .330, p < .01$), and Stuck ($r(164) = .497, p < .01$). Finally, time perception, particularly, Stuck, is found to be the strongest predictor for dissociation. The regression model identified the strongest predictor for Dissociation to be Stuck with a Beta of 0.459, the second is Present Fatalistic with a Beta of 0.195, and third, Chronos, with a Beta of -0.156. These findings can be located in studies on trauma's impact on memory systems and post-trauma

experience of time (eg. Terr, 1983; Terr, 1984; Van der Hart, & Friedman, 1992; Van der Hart & Steele, 1997; van der Kolk, 2014; Zimbardo, Sword & Sword, 2012; Eker, 2016). ZTPI subscales' correlation with both trauma and dissociation confirm past findings, the components of SOTS, particularly Stuck's correlation can be an additional dimension of understanding both. Not only the weighing of the past in a negative or positive manner, but disruption in the linearity of time experience seems to be of interest. Furthermore, the experience of feeling stuck in time as a strong predictor for dissociation is worthy of further exploration. Given this study's limitations in sample composition and size, the new time scale must be interpreted with caution. Whether or not nonlinear forms of time experience precedes or is a byproduct of dissociation could be explored in future studies.

In summary then, time experience and dissociation independent of past trauma appears to be connected and this is worthy of exploration in further research. A recent study on trauma and post-trauma symptoms identify time perception as a significant intermediary variable for post-trauma psychological health (Eker, 2016). While type of trauma and the time passed after the event were not linked to the symptoms, Past Negative and Past Positive subscales in ZTPI did have a mediator role between psychological trauma and mental health (p. 54). This research also found time perception variables significant as predictors of dissociation. Further research on dissociation and time perception might reveal mechanisms that mediate between the two.

4.4. Implications for Research and Clinical Practice

One of the significant contributions of this study has been to offer a new way to operationalize nonlinear experiences of time. Psychoanalytic literature does offer numerous accounts of the significance of time as a container during clinical practice. Normative assumptions regarding linearity in experience of time has been questioned through theoretical work and case studies. However, yet-to-date, no means to assess nonlinear perception of time exists, and thus, this research might offer a modest first effort in that direction. The scale offered here,

if expanded and further confirmed for validity and reliability, might help in understanding links between past traumatic experiences and subjectivity in the present moment. It might also help to understand dissociative experiences in and out of clinical settings. Beyond trauma and dissociation, the scale might also help to assess differences in the experience of time among various groups, such as different age groups (children and teenagers and adults), genders, levels of education and so on. Are there differences for example in the tendency to feel stuck in time with respect to any of these variables? Or differences regarding a belief in the opportune moment? The scale offered here, particularly in its attempt to operationalize kairos might provide a valuable avenue for clinical practice and further research: If one's belief in kairos is robust, it might indicate that he/she also might hold on to the possibility of a break, a positive change. This might render the attempt in clinical practice to create a new narrative worthwhile. The implications of a belief in kairos for psychotherapy and everyday life will reveal the links between emotions, narratives, agency and change.

A second significant contribution of this study was its attempt to screen past trauma and dissociative experiences in a general population. As it has been discussed, although these issues are widely researched in Turkey, most studies focus on clinical populations. Turkish history as well as present is replete with various sources of trauma inducing events; these include but are not limited to conflict, forced migration, economic migration, natural disasters, man-made disasters, poverty. Anecdotal evidence suggests that there are increasing numbers of residents in Turkey who have been directly traumatized or have witnessed others' trauma through the economic and political turmoil of the last couple of years. Thus, a general assessment of trauma and its impact on mental and physical health is in urgent need. This study's findings suggest that a considerable number of people have experienced traumatic events in their past, a significant portion of the group tends toward dissociability. Given the more privileged status of the sample in terms of level of education and income, one wonders about the larger population. This study might have provided a limited means to suggest the

urgency of the need for further work on trauma and dissociation in the general population.

Finally, the study's examining of the role of time perception in exploring dissociation is significant. Empirical work that looks into correlates of dissociation and trauma have not included time dimension so far, this study indicates a significant role for time perception in understanding dissociability. The details of the link between these variables could be examined in future studies.

4.5. Limitations and Suggestions for Further Research

The major limitation of this study has been its sample. The snow-ball method inevitably yielded a somewhat self-selected group who are limited in their representativeness of the general population. The study has been announced through various avenues, all attempts have been made to increase the number and diversity of the participants. However, it is not a random sample after all. A country-wide random sample would assure generalizability; future research if it assures a larger random sample would provide means to assess the reliability of the findings presented here.

As linked to the limitation regarding the sample, the new scale offered here has been tested on an adequate but somewhat small sample. A larger and again a representative sample would provide a more reliable means to test the construct. Furthermore, SOTS could be strengthened through adding more items to each component. Particularly, *kairos* as a subcomponent of SOTS is in need of further items to explore the dimension of opportune time.

The execution of the scales in the study through an online survey had its advantages and disadvantages. On the one hand, the reach of an online survey as well as the anonymity it provides helped this study as well. The participants could have filled possibly sensitive questions in their own space and time. Furthermore, the survey has been circulated in a speedy and efficient manner. On the other hand, drop-out rate could have been reduced through a face-to-face survey. Face-to-face administration could assure respondents to complete the survey, provide

support if there is confusion over some of the questions and most significantly provide further observational details on participants. Most studies that administer DES, for example, employ face-to-face administration method as the clinical data obtained that way is more rich. Similarly, although the trauma scale had questions about the age during which trauma was experienced as well as its subjective impact, a significant number of participants didn't fill out those questions. A face-to-face survey would assure reception of such valuable data.

The trauma check-list used in this study has been helpful in itemizing the types of trauma experienced, however, more items that are specific to the Turkish context as well as others could have been added. These include but are not limited to traffic accidents, earthquakes, political violence, migration. In addition, although TEC is a detailed check-list that explores the context of trauma (such as perpetrators, whether or not therapy help was received, etc), for the sake of brevity, the detailed open-ended questions were excluded in this study. Thus information on perpetrators, duration and frequency of the trauma and post-trauma help have not been gathered. Further research might need to take these into account to better explore trauma's impact on the participants.

CONCLUSION

This study explored connections between traumatic experiences, dissociation and time perception. In identifying the patterns between these experiences, first it offered a new scale to assess time perception. The scale aims to operationalize time in both linear and nonlinear experiential dimensions. The results suggest that the subcomponents of the scale are worthy of further exploration in future studies. If validated in subsequent research, the scale might have significant clinical and theoretical implications.

The second major contribution of this study was to assess traumatic experiences and dissociation symptoms in the general adult population in Turkey. The findings indicate that even in a nonclinical population, which in this study's sample had higher levels of education and income levels as compared to the general population in Turkey, past traumatic experiences are quite pervasive and most often multiple. Similarly, dissociability was reported by a higher than expected percentage for a nonclinical group. Future studies are in order for a more detailed screening of trauma and dissociation in the general adult population.

Final contribution of the study is in its investigation of the links between dissociation, trauma and time perception. Here, time perception, particularly nonlinear experience of time is found to be significantly linked to dissociation. Although the limitations of the study in terms of sample size and the scope of the questionnaire did not allow for a detailed analysis of the intermediary links between these two concepts, the identification of time experience as a strong predictor of dissociation (and perhaps independent of traumatic experiences) is a noteworthy finding and could be followed up in upcoming studies.

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APPENDICES

Appendix A: Informed Consent Form

Sayın Katılımcı,

Bu araştırmanın amacı, Türkiye'deki yetişkinlerin geçmişte yaşadıkları travmatik deneyimlerin günlük hayata etkilerini anlamaktır. Bu araştırma Yrd. Doç. Dr. Alev Çavdar danışmanlığında İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı Yetişkin Alt-Dalı öğrencisi Selcan Kaynak tarafından tez çalışması kapsamında yürütülmektedir.

Araştırmaya 20- 60 yaş arasındaki bireyler katılabilmektedir. Katılım gönüllülük esasına dayanmaktadır. Araştırmada kimliğinizi sorgulayan bir soru bulunmamaktadır. Araştırma sırasında elde edilen bilgiler gizli tutulacak ve anonim olarak değerlendirilecektir. Araştırmaya katılımınızın size herhangi bir zarar vereceği öngörülmemektedir. Soruları yanıtlarken herhangi bir rahatsızlık hissederseniz çalışmaya devam etmeyebilirsiniz. Çalışma yaklaşık 30 dakika sürmektedir. Çalışmanın güvenilirliği açısından, anketi tamamlayan katılımcıların hiçbir soruyu boş bırakmamaları beklenmektedir.

Araştırmaya yönelik herhangi bir sorunuzun olması halinde araştırmanın yürütücüsü Selcan Kaynak (selcan.kaynak@bilgiedu.net) ile iletişime geçebilirsiniz.

Araştırmaya katkıda bulunduğunuz için teşekkürler.

Yukarıdaki açıklamayı okudum, bu çerçevede araştırmaya katılmayı kabul ediyorum.

Evet, kabul ediyorum

Hayır, kabul etmiyorum

Appendix B: Demographic Information Form

1. Yaşınız
2. Doğum yeriniz: _____
3. Cinsiyetiniz
 - a. Kadın
 - b. Erkek
 - c. Diğer
 - d. Belirtmek istemiyorum
4. Eğitim seviyeniz (en son mezun olduğunuz okul)
 - a. İlkokul
 - b. Ortaokul
 - c. Lise
 - d. Üniversite
 - e. Lisansüstü
 - f. Doktora
5. Çalışıyor iseniz mesleğiniz: _____
Öğrenci iseniz, bölümünüz: _____
6. Şu anda ilişkiniz var mı?
 - a. Evet
 - b. Hayır

Evet ise ne kadar zamandır devam ediyor? ____ yıl ____ ay
7. Medeni durumunuz?
 - a. Evli
 - b. Bekar
 - c. Boşanmış
 - d. Dul
 - e. Diğer: _____
8. Kiminle birlikte yaşıyorsunuz?
 - a. Aile
 - b. Akraba
 - c. Arkadaş
 - d. Partner
 - e. Tek başıma

9. Gelir düzeyiniz

- a. 0- 999
- b. 1000- 1999
- c. 2000- 2999
- d. 3000- 3999
- e. 4000- 4999
- f. +5000

Appendix C: Sequential and Opportune Time Scale (SOTS)

Aşağıdaki maddeler günlük hayatınıza dair bazı deneyimleri içeren 16 sorudan oluşmaktadır. Lütfen her soruda, anlatılan durumun size ne derece uyduğunu değerlendiriniz ve uygun olan seçeneği işaretleyiniz.

1 den 15. sorunun sonuna kadar olan kısımda, her bir maddenin deneyimlerinizi ne oranda yansıttığını karşılardaki 5 aralıklı ölçek üzerinde, ilgili rakamı işaretleyerek gösteriniz.

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

Hiç uymuyor

Tamamen uyuyor

	1	2	3	4	5
1. Bazen geçmişten bir an ya da imge, şimdi yaşıyormuşum gibi gözümde canlanır.	1	2	3	4	5
2. Bazen gelecekle ilgili bir an ya da imge, şu anda oluyormuş gibi gözümde canlanır.	1	2	3	4	5
3. Aralarında zaman geçmiş olsa bile iki olayı arka arkaya yaşamış gibi hissettiğim olur.	1	2	3	4	5
4. Hayatımdaki bazı olaylar, sanki üstünden hiç zaman geçmemiş gibi yakın gelir.	1	2	3	4	5
5. Zamanı bazen tekrarlayan bir döngü gibi yaşıyorum, zaman geçtikçe başa dönüyor gibiyim.	1	2	3	4	5
6. Bazı şeylerin kendine göre en uygun zamanda gerçekleşeceğine inanırım, bunu önceden bilemeyiz.	1	2	3	4	5
7. Benim için zamanı süresinden çok içeriği ve anlamı tanımlar.	1	2	3	4	5
8. Olayları hatırladığımda ne zaman olduğundan çok ne hissettiğim önemlidir.	1	2	3	4	5
9. Zaman düz bir çizgidir, hep ileriye doğru akar.	1	2	3	4	5
10. Anılarımı kronolojik olarak dizdiğimi fark ediyorum.	1	2	3	4	5
11. Bazen akıp giden zamanın içinde bir anın belirdiğini ve harekete geçmem gerektiğini hissedirim.	1	2	3	4	5

12. Hayatın insana zamandan ve mekandan bağımsız birden beliren fırsatlar sunduğunu düşünürüm.	1	2	3	4	5
13. Kendimi akışa bırakmakta zorlanırım.	1	2	3	4	5
14. Gün ve saatlere göre kendimi planlamayı severim. Böylece, başıma beklenmedik bir şey gelme ihtimali de azalmış olur.	1	2	3	4	5
15. Hayat hikayemi anlatacak olsam doğduğum tarihten bugüne sırayla anlatırım.	1	2	3	4	5

16. soruda size en uygun gelen cevabı işaretleyiniz.

17. Gün içinde zamanın geçmiş olduğunu nasıl fark ederim?

- Saate bakınca fark ederim
- Günden aklımda kalan anlar, olaylar zamanı fark ettirir
- Gün içinde tekrarlanan aktiviteler (yemek, uyku, vb) zamanın geçtiğini fark ettirir
- Dışarıdaki hava durumu fark ettirir (güneşin doğuşu, batışı, yağmur yağması, vb.)
- Ezan ve namaz vakitleri fark ettirir
- Önceden planlamış olduğum bir randevu, ders, toplantı, vb. saati yaklaşınca fark ederim.
- Diğer _____

Appendix D: Dissociative Experiences Scale (DES)

Bu test günlük hayatınızda başınızdan geçmiş olabilecek yaşantıları konu alan 28 sorudan meydana gelmektedir. Sizde bu yaşantıların ne sıklıkta olduğunu anlamak istiyoruz. Yanıt verirken, alkol ya da ilaç etkisi altında meydana gelen yaşantıları değerlendirmeye katmayınız. Lütfen her soruda, anlatılan durumun sizdekine ne ölçüde uyduğunu 100 üzerinden değerlendiriniz ve uygun olan rakamı daire içine alınız. Örnek: %0 10 20 30 40 50 60 70 80 90 %100

SORULAR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22. Bazı insanlar kimi zaman iki ayrı durumda o kadar değişik davrandıklarını görürler ki, kendilerini neredeyse iki farklı insanmış gibi hissettikleri olur. Bu

durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

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

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

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

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

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

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

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

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

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

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

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

28. Bazı insanlar, zaman zaman, dünyaya bir sis perdesi arkasından bakıyormuş gibi hissederler, öyle ki insanlar ve eşyalar çok uzakta ve belirsiz görünürler. Bu durumun sizde ne sıklıkta olduğunu yüz üzerinden değerlendirerek uygun olan yüzdeyi daire içine alınız.

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

Appendix E: Traumatic Experiences Checklist (TEC)

İnsanların başından geçen ileri derecede üzücü ve sarsıcı yaşantılara TRAVMA adı verilmektedir. Aşağıdaki listede sizin de başınıza gelmiş,olabilecek bazı travma yaşantıları sorulmaktadır. Sorularda üç şey üzerinde durulmaktadır: Olay başınızdan geçmiş midir? Olay sırasında kaç yaşındaydınız? Olay sizi ruhsal bakımdan ne kadar etkilemiştir?

A) Sorulan 29 çeşit olaydan her biri için başınızdan geçip geçmediğini EVET ya da HAYIR cevabını daire içine alarak işaretleyiniz.

B) EVET cevabını verdiğiniz her soruda olay sırasında kaç yaşında olduğunuzu yazınız. Olay bir kereden fazla oldu ise her defasında kaç yaşında olduğunuzu belirtiniz. Eğer olay bir yıldan fazla sürdü ise belirtiniz (örneğin 7 ile 12 yaş arası) biçiminde yazınız.

C) Başınızdan geçen her bir olayın üzerinizdeki ruhsal ETKİSİNİ (uygun düşen rakamı daire içersine alarak) belirtiniz.

1 = hiç etkilemedi 2 = biraz etkiledi 3 = orta derecede etkiledi 4 = çok etkiledi 5 = ileri derecede etkiledi

İşbirliğiniz için teşekkür ederiz.

	Başınıza geldi mi?	Kaç yaşında?	Etkilenme
1. Çocukluğunuzda anababanıza ya da kardeşlerinize bakmak zorunda olmak	Hayır Evet	.....	1 2 3 4 5
2. Ailenizde problemler olması (örneğin ana ya da babanızda alkolizm ya da ruhsal problem olması, fakirlik)	Hayır Evet	.....	1 2 3 4 5
3. SİZ ÇOCUKKEN aile bireylerinden birinin ölümü (kardeş ya da anababa)	Hayır Evet	.....	1 2 3 4 5
4. ERİŞKİNLİĞİNİZDE aile bireylerinden birinin (çocuk ya da eş) ölümü	Hayır Evet	.....	1 2 3 4 5
5. Vücutça ağır yaralanma (örneğin kol ya da bacak kaybı, ağır yanık)	Hayır Evet	.....	1 2 3 4 5

6. Hastalık, ameliyat ya da kaza nedeniyle hayati tehlike geçirme	Hayır Evet	1 2 3 4 5
7. Anababanızın boşanması	Hayır Evet	1 2 3 4 5
8. Kendinizin boşanması	Hayır Evet	1 2 3 4 5
9. Birisinin sizi ölümle tehdit etmesi (örneğin gasp sırasında)	Hayır Evet	1 2 3 4 5
10. Şiddetli ağrı çekme (örneğin yaralanma ya da ameliyat nedeni ile)	Hayır Evet	1 2 3 4 5
11. Savaş koşullarında yaşanan olumsuz olaylar (örneğin esir düşme, yakınların ölümü, mahrumiyet, yaralanma)	Hayır Evet	1 2 3 4 5
12. İkinci kuşak olarak savaşın etkilerine maruz kalma (Anababa ya da yakın akrabalarınızın başına savaş koşullarında kötü olaylar gelmiş olması)	Hayır Evet	1 2 3 4 5
13. Başkasının travmaya uğramasına tanık olma.	Hayır Evet	1 2 3 4 5
14. Anababa ya da kardeşleriniz tarafından duygusal ihmale uğrama (örneğin yalnız bırakılma, yetersiz sevgi görme)	Hayır Evet	1 2 3 4 5
15. Diğer aile bireyleriniz tarafından duygusal ihmale uğrama (örneğin amca, dayı, teyze, hala, yeğen, büyükanne ve büyükbaba)	Hayır Evet	1 2 3 4 5
16. Aileniz dışındaki kişiler tarafından duygusal ihmale uğrama (örneğin komşular, arkadaşlar, üvey anababa öğretmenler).	Hayır Evet	1 2 3 4 5
17. Anababa ya da kardeşleriniz tarafından duygusal tacize uğrama (örneğin küçük düşürülme, alay edilme, aşağılayıcı isim takılması, sözle tehdit edilme, haksız yere ceza verilmesi)	Hayır Evet	1 2 3 4 5
18. Diğer aile bireyleriniz (örneğin amca, dayı, teyze, hala, yeğen, büyükanne ve büyükbaba) taraafından duygusal istismara	Hayır Evet	1 2 3 4 5

uğrama (örneğin küçük düşürülme, alay edilme, aşağılayıcı isim takılması, sözle tehdit edilme, haksız yere ceza verilmesi)

19. Aileniz dışındaki kişiler (örneğin komşular, arkadaşlar, üvey anababa öğretmenler) tarafından duygusal istismara uğrama (örneğin küçük düşürülme, alay edilme, aşağılayıcı isim takılması, sözle tehdit edilme, haksız yere ceza verilmesi)

Hayır Evet 1 2 3 4 5

20. Anababa ya da kardeşleriniz tarafından vücutça istismara uğrama (örneğin, size vurulması, eziyet edilmesi, ya da yaralanmanız)

Hayır Evet 1 2 3 4 5

21. Diğer aile bireyleriniz (örneğin amca, dayı, teyze, hala, yeğen, büyükanne ve büyükbaba) tarafından vücutça istismara uğrama (örneğin, size vurulması, eziyet edilmesi, ya da yaralanmanız)

Hayır Evet 1 2 3 4 5

22. Aileniz dışındaki kişiler (örneğin komşular, arkadaşlar, üvey anababa öğretmenler) tarafından vücutça istismara uğrama (örneğin, size vurulması, eziyet edilmesi, ya da yaralanmanız)

Hayır Evet 1 2 3 4 5

23. Size çok ağır cezalar verilmesi

Hayır Evet 1 2 3 4 5

Cevabınız evet ise bu nasıl bir cezaydı, açıklayınız.

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24. Anababa ya da kardeşleriniz tarafından cinsel tacize uğrama (bedensel temas ya da dokunma OLMAKSIZIN cinsel davranışlarda bulunulması)

Hayır Evet 1 2 3 4 5

25. Diğer aile bireyleriniz (örneğin amca, dayı, teyze, hala, yeğen, büyükanne ve büyükbaba) tarafından cinsel tacize uğrama (bedensel temas ya da dokunma OLMAKSIZIN cinsel davranışlarda bulunulması)

Hayır Evet 1 2 3 4 5

26. Aileniz dışındaki kişiler (örneğin komşular, arkadaşlar, üvey anababa, öğretmenler) tarafından cinsel tacize uğrama (bedensel temas ya da dokunma OLMAKSIZIN cinsel davranışlarda bulunulması) Hayır Evet 1 2 3 4 5

27. Anababa ya da kardeşler tarafından cinsel istismara uğrama (bedensel temas ya da dokunmanın olduğu istenmeyen cinseldavranışlar) Hayır Evet 1 2 3 4 5

28. Diğer aile bireyleriniz (örneğin amca, dayı, teyze, hala, yeğen, büyükanne ve büyükbaba) tarafından cinsel istismara uğrama (bedensel temasya da dokunmanın olduğu istenmeyen cinsel davranışlar) Hayır Evet 1 2 3 4 5

29. Aileniz dışındaki kişiler (örneğin komşular, arkadaşlar, öğretmenler) tarafından cinsel istismara uğrama (bedensel temas ya da dokunmanın olduğu istenmeyen cinsel davranışlar) Hayır Evet 1 2 3 4 5

30. Sizi etkilemiş olan BAŞKA travma (ileri derecede üzücü olay) yaşadınız varsa onları da belirtiniz.

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Appendix F: Zimbardo Time Perception Inventory (ZTPI), Condensed Form

Her maddeyi okuyunuz ve “bu benim için ne kadar geçerli?” sorusunu yanıtlayınız. Ölçek üzerinde uygun kutucuğu işaretleyiniz.

Lütfen hiçbir maddeyi atlamayarak maddelerin tümünü işaretleyiniz. 1)Benim için hiç doğru değil (2)Benim için doğru değil (3)Kararsızım (4)Benim için doğru (5) Benim için çok doğru

1. Kader, hayatımdaki birçok şeyi belirler.	1	2	3	4	5
2. Sık sık, hayatımda neyi farklı yapmalıydım diye düşünürüm.	1	2	3	4	5
3. Geçmişim hakkında düşünmek bana zevk verir.	1	2	3	4	5
4. Bir şeyi başarmak istediğimde hedefler koyar ve bu hedeflere ulaştıracak belli yolları dikkate alırım.	1	2	3	4	5
5. Düşünüp tartınca, geçmişimde kötü şeylere kıyasla, hatırlanacak iyi şeyler daha çok.	1	2	3	4	5
6. Yarının işlerini bitirmek ve gerekli diğer işleri yapmak, bu gecenin eğlencesinden önce gelir.	1	2	3	4	5
7. Herşey olacağına vardığı için, benim ne yaptığının gerçekte bir önemi yok.	1	2	3	4	5
8. “Eski güzel zamanlarda” yaşamın nasıl olduğundan bahseden hikâyelerden hoşlanırım.	1	2	3	4	5
9. Acı veren geçmiş deneyimler zihnimde durmadan canlanır.	1	2	3	4	5
10. Mümkün olduğunca dolu dolu ve günümü gün ederek yaşamaya çalışırım.	1	2	3	4	5
11. Geçmiş zamanın mutlu anıları zihnimde hemen beliriverir.	1	2	3	4	5
12. Anlık dürtülerle karar veririm.	1	2	3	4	5
13. Hayatıma heyecan katmak benim için önemlidir.	1	2	3	4	5

14. Çocukluğumu olumlu duygularla hatırlarım.	1	2	3	4	5
15. Riskler almak hayatımı sıkıcı olmaktan kurtarır.	1	2	3	4	5
16. Gençliğimin tatsız görüntülerini unutmak benim için zordur.	1	2	3	4	5
17. Herşey o kadar çok değişiyor ki, tam anlamıyla geleceğe dair plan yapamazsınız.	1	2	3	4	5
18. Hayatımın rotası etkileyemeyeceğim güçler tarafından kontrol ediliyor.	1	2	3	4	5
19. Gelecek için kaygılanmak anlamsız geliyor; çünkü nasılsa bu konuda yapabileceğim hiçbir şey yok.	1	2	3	4	5
20. Düzenli bir ilerleme ile projelerimi zamanında tamamlarım.	1	2	3	4	5
21. Hayatıma heyecan katmak için riskler alırım.	1	2	3	4	5
22. Yapılması gereken bir iş olduğunu bildiğim zaman, beni işten alıkoyabilecek cezbedici şeylere karşı direnebilirim.	1	2	3	4	5
23. Geçmişte başıma gelen kötü şeyler hakkında düşünürüm.	1	2	3	4	5
24. İlerlememe katkıları olacaksa, ilgi çekici olmayan, zor görevlerde çalışmaya devam ederim.	1	2	3	4	5
25. Yaşamımda kaçırdığım güzel şeyleri düşünürüm.	1	2	3	4	5

**ETİK KURUL DEĞERLENDİRME SONUCU/RESULT OF EVALUATION BY
THE ETHICS COMMITTEE**

(Bu bölüm İstanbul Bilgi Üniversitesi İnsan Araştırmaları Etik Kurul tarafından
doldurulacaktır /This section to be completed by the Committee on Ethics in research
on Humans)

Başvuru Sahibi / Applicant: Mehpere Selcan Kaynak

Proje Başlığı / Project Title: Trauma, Disassociation and Time Perception

Proje No. / Project Number: 2018-20024-23

1.	Herhangi bir değişikliğe gerek yoktur / There is no need for revision	XX
2.	Ret/ Application Rejected Reddin gerekçesi / Reason for Rejection	

Değerlendirme Tarihi / Date of Evaluation: 20 Şubat 2018


Kurul Başkanı / Committee Chair

Doç. Dr. İtir Erhart


Üye / Committee Member

Prof. Dr. Hale Bolak


Üye / Committee Member

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