

THE PREDICTORS OF THE TRAUMATIC EFFECT OF EXTRAMARITAL
INFIDELITY ON MARRIED WOMEN:
COPING STRATEGIES, RESOURCES, AND FORGIVENESS

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ABSTRACT

THE PREDICTORS OF THE TRAUMATIC EFFECT OF EXTRAMARITAL INFIDELITY ON MARRIED WOMEN: COPING STRATEGIES, RESOURCES, AND FORGIVENESS

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The aims of the present study are to examine the traumatic effects of EMI on the offended partners as well as to find out the predictors (coping, resources, and forgiveness) of the severity of PTSD. The participants of the study consisted of 189 married women who had continued their marriage after discovery of partners' EMI. EMI was assessed with one item measure with the six-point continuum starting from "entirely sexual" to "entirely emotional" involvement. The instruments of the study: Post-Traumatic Stress Disorder Symptom Scale-Self Report (PSS-SR), Ways of Coping Inventory (WCI), The Conservation of Resources Evaluation (COR-E), and Forgiveness Inventory (FI: its reliability and validity study was completed for the present study). Although EMI is a traumatic event that was not consist with the DSM-IV, the results of the present study revealed that 34.4% of participants completed the whole DSM-IV criteria for PTSD. More specifically, the rates of participants who met the criteria were: 50.7% A (stressor), 97.9% B (intrusive recollection), 85.2% C (avoidant/numbing), 91.0% D (hyper-arousal), 93.1% E (duration), 85.7% F (functional significance). In addition, the results of the present study showed: Coping; problem-focused group had lower PTSD than emotion-focused coping groups, Resource; a resource loss group had higher PTSD than resource gain group, and Forgiveness; stage I-impact group showed the highest PTSD whereas

the stage III-recovery group showed the lowest PTSD. Furthermore, the final model of regression analyses revealed the predictors of PTSD total symptom severity as emotion-focused coping, resource gain, and stage I-impact, and these variables explained 46 % of the total variance. The results were discussed in accordance with the relevant literature.

Keywords: Extramarital Infidelity, PTSD, Coping, Resource, Forgiveness

ÖZ

EVLİLİK DIŐI İLİŐKİNİN ALDATILAN EŐ ÜSTÜNDEKİ TRAVMATİK ETKİLERİNİN BELİRLEYİCİLERİ: BAŐ ETME STRATEJİLERİ, KAYNAKLAR, VE AFFETME

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Bu çalıŐmanın amacı, evlilik dıŐı iliŐkinin aldatılan eŐ üstündeki travmatik etkilerini araŐtırmak ve TSSB düzeyinin yordayıcılarını (baŐ etme stratejileri, kaynaklar ve affetme) belirlemektir. ÇalıŐmanın katılımcıları, eŐlerinin evlilik dıŐı iliŐkileri ortaya çıktıktan sonra evliliđine devam eden 189 kadından oluŐmaktadır. Bu çalıŐmada evlilik dıŐı iliŐki, “tamamen cinsel” boyuttan “tamamen duygusal” boyuta uzanan altılı dereceye sahip tek soruluk ölçek ile deđerlendirilmiŐtir. Yine bu çalıŐmanın ölçüm araçları: Travma Sonrası Stres Tanı Ölçeđi, Stresle BaŐa Çıkma Yolları Ölçeđi, Kaynakların Korunumu Ölçeđi ve geđerlik-güvenirlik analizleri bu çalıŐma için yapılan Affetme Ölçeđi. Her ne kadar “evlilik dıŐı iliŐki” DSM-IV’ün travmatik olay kriterleri ile uyumlu olmasa da, bu çalıŐmanın sonuçları katılımcıların % 34.4’ünün TSSB kriterlerinin tamamını karŐıladıđını göstermiŐtir. Daha detaylı biçimde katılımcıların tamamladıđı kriterler: 50.7% A (stressör), 97.9% B (zorlayıcı hatırlamalar), 85.2% C (kaçınma/küntlük), 91.0% D (aŐırı uyarılmıŐlık), 93.1% E (devamlılık), 85.7% F (iŐlevsellik etkisi). Buna ek olarak, çalıŐmanın sonuçlarının gösterdiđi bulgular: BaŐ etme stratejisi; problem-odaklı grup, duygu-odaklı gruba göre daha düşük TSSB semptomu sergilemektedir, Kaynaklar; kaynaklarında kayıp yaŐayan grup, artış yaŐayan gruba göre daha yüksek düzeyde TSSB semptomları göstermektedir, ve Affetme; Affetme düzeyi açısından birinci evrede (etki) olan grup, en yüksek düzeyde TSSB gösterirken, üçüncü evrede (iyileŐme) olan grup en düşük oranı

sergilemiştir. Bunun dışında, TSSB'nin yordayıcılarını belirlemek için yapılan regresyon analizleri duygu-odaklı baş etme, problem-odaklı baş etme, kaynak artışı ve birinci evreyi göstermiştir. Bu değişkenler toplam varyansın %46'sını açıklamaktadır. Sonuçlar ilgili literatür doğrultusunda tartışılmıştır.

Anahtar Kelimeler: Evlilik Dışı İlişki, TSSB, Baş Etme Stratejileri,
Kaynaklar, Affetme

To her

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Life is full of negative life events such as death of loved one, personal injury or illness, being fired, INFIDELITY etc. Each individual tries to COPE with them in this or that way. But without the RESOURCES, these events are felt more TRAUMATIC by an injured person. Since I started to the PhD program at Psychology Department of Middle East Technical University, I have been experiencing some of them (e.g., death of loved one, personal injury, loosing job, and divorce). Definitely, I could not be able to cope with these events, and complete this thesis without my resources which were specified below. At the beginning, I ask FORGIVENESS from the one whom I forgot to thank.

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CHAPTER 1

INTRODUCTION

Infidelity is one of the most complex issues for research applications and also among the most common presenting problems in clinical practices. There is no reliable statistics about frequencies of marital infidelity but studies suggest that lifetime prevalence estimates for extramarital infidelity (EMI) in the United States (U.S.) range from 20% to 40% for men and 20% to 25% for women depending on the age and gender of the individual (Whisman & Snyder, 2007; Atkins, Baucom, & Jacobson, 2001; Laumann et al., 1994). The research that used broader definitions of infidelity even found higher rates. According to Whisman, Dixon and Johnson (1997), couple therapists in the U.S. estimate that between 29% and 65% of couples report difficulties related to EMI. Besides an enormous interest of arts (cinema, music, literature etc.) and magazine in EMI, the main reason that infidelity receives attention from researchers is that it is so damaging to relationships (Gordon, Baucom, & Snyder, 2004). Not only couples and individuals but also their offspring have shown the profound effects of EMI (Lusterman, 1998).

In the literature, several attempts have been made to understand the nature of infidelity. Thompson (1984) is among the others to identify the typology of infidelity which is widely accepted by researchers: sexual-only, emotional-only, and combined sexual and emotional. Sexual-only type is any behavior that involves sexual contact, such as intimate touching, kissing, or sexual intercourse.

On the other hand, emotional-only type is any formation of emotional attachment to the other person, and may involve actions like dating, flirting, or falling in love. The last category of the Thompson' typology combines both sexual and emotional involvements. Other than marital context, infidelity can also occur in a cohabitating or dating relationship. Drigotas and Barta (2001) defined infidelity as “*a partner's violation of norms regulating the level of emotional or physical intimacy with people outside the relationship*” (p. 177). Blow and Hartnett (2005a) suggested a broader definition of infidelity:

a sexual and/or emotional act engaged in by one person within a committed relationship, where such an act occurs outside of the primary relationship and constitutes a breach of trust and/or violation of agreed-upon norms (overt and covert) by one or both individuals in that relationship in relation to romantic, emotional or sexual exclusivity (p. 191).

Because of complex interactions among numerous variables, the research on infidelity is extremely complex. In the review article of Blow and Hartnett (2005a), the important variables were summarized as culture, gender, and other issues in the primary relationship (premarital experience, marital satisfaction etc.). Research focused on the cultural effects has stated that infidelity is a common problem in many cultures even though there is a strong norm in society against EMI (Treas & Giesen, 2000; Vanlandingham et al., 1998; Wiederman & Allgeier, 1996). Widmer, Treas and Newcomb (1998) sampled individuals from 24 countries and found that there was strong disapproval of EMI in different cultures, although some communities appeared to be more tolerant (e.g., Russia, Bulgaria, Czech Republic) than others. Gender is identified as another major variable for infidelity research. According to Glass and Wright (1985), men describe their

affair as more sexual than emotional, whereas women describe in opposite way. More recent research argued that women's infidelity is typically tied more closely to relationship dissatisfaction whereas men's infidelity is tied more closely to sexual dissatisfaction (Allen et al., 2008; Atkins, Yi, Baucom, & Christensen, 2005). Furthermore, the sex differences appeared as a factor on infidelity-divorce relationship. Approximately 40% of divorced individuals reported that they had at least one extramarital sex during their marriage (Janus & Janus, 1993). Although infidelity was found one of the most frequently cited causes of divorce (Amato & Rogers, 1997), the statistics reported by the Turkish Statistical Institute (TURKSTAT, Divorce Statistics, 2006) showed that adultery rates were lower than 1% for the whole divorce cases for Turkish population. However, the results of national survey (TURKSTAT, Family Structure Research, 2006) showed that EMI of husbands was seen as a divorce reason by 58% of men and 61% of women whereas EMI of wives was perceived as the exact reason for divorce by 92% of men and 87% of women. In sum, men involved EMI are seen to be more tolerable than women.

A review of the infidelity literature shows that the main part of the infidelity research has focused on the issues in the primary relationships with the aim of identifying specific risk factors for infidelity tendency and predictors of infidelity (Drigotas et al., 1999; Zak et al, 2002). Likewise, Allen et al. (2008) have emphasized premarital precursors of marital infidelity and found significant relationships between negative communication and EMI. In another research, Shackelford, Besser and Goetz (2008) examined the personality as a predictor of EMI and found that people with low on agreeableness and conscientiousness have

been stated as showing higher probability of extramarital involvement. Apart from certain personality characteristics, a number of authors have emphasized marital satisfaction in the primary relationship as a main issue. Research suggests that individuals who report low marital satisfaction have higher tendency for EMI (Polat, 2006; Atkins, Baucom & Jacobson, 2001; Shackelford & Buss, 1997; Shen, 1997; Glass & Wrigth, 1985). However, the connection between marital satisfaction and infidelity may not be so simple (Spanier & Margolis, 1983). For better understanding of infidelity, researchers have also focused on the justification of infidelity. Yeniçeri and Kökdemir (2006) examined the explanations for infidelity and found six components of EMI namely legitimacy, seduction, normalization, sexuality, social background, and sensation seeking.

Literature also suggests that infidelity is harmful not only for individuals but also for relationships (Whisman, Dixon, & Johnson, 1997). After the discovery of marital infidelity, only a small percentage of couples could improve their relationships but most of the partners suffer from emotional problems (Charny & Parnass, 1995). Sweeney and Horwitz (2001) stated that there is a lack of existing research about the relationship between mental health outcomes and infidelity. In the literature, depression is one of the major topics which has been studied in the field of infidelity. In terms of the negative consequences of EMI, betrayed women are more likely to experience a major depressive episode (Cano & O'Leay, 2000). Consistent with this, Glass and Wright (1992) reported that offended partners show intense anger, feeling of shame, depression, intrusive and painful memories, avoidance, emotional numbing, and increased arousal. In the last decade, the infidelity has been studied as an interpersonal trauma and its

emotional effects have been examined (Meldrim, 2006, Schalk, 2006; Whisman & Wager, 2005). Likewise, Gordon and Baucom (1998) agreed that the discovery of EMI imposes trauma that extends far beyond its effects on the offended partner. It is generally accepted that EMI has traumatic effect, and trauma based treatment is offered to injured partners by many clinicians (Baucom, Snyder, & Gordon, 2009, Ortman, 2009; Glass, 2003; Beadle, 2001; Lusteran, 1998; & Spring; 1996). Based on these findings and suggestions, it can be concluded that the traumatic role of infidelity in individuals' mental health need further understanding.

The present study examines post-traumatic effects of extramarital infidelity on the offended partners. Based on the statement that infidelity is an interpersonal trauma (Gordon & Baucom, 1999), this study focuses on the factors affecting the severity of post-traumatic symptoms. These factors are coping strategies used by discoverer, conservation of resources (loss and gain), and forgiveness stages of the injured partners. In addition, some critical demographic variables pointed out by literature are examined. In the following sections, first, background information for the study is outlined. Second, aims and significance of the study are presented. Third and the last, implications of the present study are introduced.

1.1 Background Information

Psychological trauma is one of the basic concepts of the present study in which Herman's (1992) trauma model is followed. As, it is widely accepted, trauma paradigm posits that stressful life events may result in long-term negative outcomes for individuals. Indeed, a number of authors define the term trauma as the reactions to the traumatic events. Herman (1992) who expanded the trauma

paradigm stated that the concept of trauma has changed from an external event to an individual's psychological response to the critical life event. According to her, a particular form of psychological trauma has appeared to public awareness three times over the past decades: (1) hysteria, (2) shell shock, and (3) sexual and domestic violence. Historically, the first one was "hysteria", which was seen as the archetypal psychological disorder of women. The frontier of the study of hysteria was Jean-Martrin Charcot who has focused on neurological damage instead of inner lives experience. It was pointed out that this first attempt to explain the traumatic theory of hysteria was failed by Freud's theoretical explanation. Freud has focused on fantasies instead of common real life experience. The second one was "shell shock" emerged following the First World War after more than eight million men died. Charles Myers was one of the well-known psychologists worked with the cases that had been exposed to violent death and showed nervous disorder called "shell shock". Thus, the American Psychiatric Association included it as part of the official classification of mental disorders in to the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980). The third one was "sexual and domestic violence". As a result of the feminist movement developed in Western Europe and North America in the late nineteenth-century, it has been recognized that the traumatic disorders were not only for men in war but also for women in civilian life (Herman, 1992).

For better understanding of psychological trauma, the characteristics of traumatic events and reactions might be explained. According to Jensen (2003), the main characteristics of traumatic events are the threat directed toward the

victims' (1) life, (2) body part, (3) loved one, and (4) belief system. From this perspective, traumatic events are categorized as an accidentally human-made (plane crash, traffic accident etc.), an intentional human-made (rape, war, torture etc.), and a nature-made (earthquake, hurricane, flood, etc.). Herman (1992) sees the emotional problems following the traumatic events as a normal response to the abnormal circumstances. In addition, it was stated that *“traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life”* (p. 33). According to her, the major parts of the response to the psychological trauma are to feel powerless and to disconnect from others. In the trauma literature, it is also a central idea that traumatic events do not traumatize all the time. Even in the United States, where the majority of the population has been exposed to one or more traumatic event, only a minority of trauma victims (less than 10%) has developed a disorder (Breslau, 2009). Consistent with this, the statement that the severity of traumatization depends on the balance between stressor factors (socio-economic problems, ethnic problem, previous threats etc.) and protective factors (social support, safety feeling, family support etc.) has found more support in the trauma literature.

Trauma diagnoses are categorized based on the time past after traumatic events: (1) All immediate reactions to the traumatic events are called as Acute Stress Disorder (ASD), (2) After more than one month, these reactions are named as Post Traumatic Stress Disorder (PTSD), (3) If the stressor (threat) continues, trauma reactions are explained by the term Continued Stress Disorder (CSD), (4) whereas the prolonged exposure to threat is called as Complex PTSD (incest,

child abuse, sexual abuse, torture etc.). Although it is not common, Traumatic Psychosis is another traumatic reaction (Jensen, 2003). In the present study, PTSD is considered as the major trauma diagnosis and its physical, cognitive, affective, and social responses are summarized.

Herman (1992) categorized all the symptoms of PTSD as follows: Hyperarousal, Intrusion, and Constriction. Hyperarousal symptoms are the main characteristic of PTSD. According to her *“hyperarousal reflects the persistent expectation of danger; intrusion reflects the indelible imprint of the traumatic moment; constriction reflects the numbing response of surrender”* (p. 35). Thus, physiological arousal continues for a person after experiencing traumatic event and certain physical and emotional stimuli continue to trigger to victim’s body (Van Der Kolk, McFarlane & Weisaeth, 1996). The second category of the symptoms of PTSD is intrusion which reflects the persistence of thoughts, feelings, and behaviors specifically related to the traumatic event. Individuals with intrusion symptoms experience the event as if it is continually recurring in the present (Herman, 1992). The intrusion symptoms include intrusive recollections, traumatic nightmares, PTSD flashbacks, trauma-related/stimulus-evoked psychological distress and physiological reactions. The last symptom group of PTSD is constriction symptoms which described as the shutting down the system of self-defense: *“The helpless person escapes from her situation not by action in the world but rather by altering her states of consciousness”* (p. 42). In addition, avoidant and numbing symptoms are the major symptoms of constriction.

Consistent with the Herman's trauma paradigm explained above, in the fourth edition of Diagnostic and Statistical Manual of Mental Disorders-Text Revision (DSM-IV-TR; American Psychiatric Association, 2000), the definition of a traumatic event consists of two components: (1) Exposure to a catastrophic event (the A1 criterion); and (2) Emotional distress due to such exposure (the A2 criterion). Thus, the DSM-IV indicates that *"the person experienced, witnessed or was confronted with an event(s) that involved actual or threatened death or serious injury or a threat to the physical integrity of self and others,"* and which evoked *"intense fear, helplessness, or horror"*. In addition, the PTSD syndromes are defined by three symptom groups in the DSM-IV: (1) re-experiencing the traumatic event (1 out of 5 criterion symptoms is required), (2) avoidance of stimuli that resemble the event and numbing of emotional responsiveness (3 out of 7 criterion symptoms are required), and (3) increased arousal (2 out of 5 symptoms are required).

Besides emotional and physical response to trauma, cognitive reactions which occur after traumatic events have received much attention from the trauma researchers. According to Meldrim (2005), when a person is completely powerless and placed in a situation s/he has no control over on continuous basis, a state of learned helplessness may occur. This experience shatters people's basic beliefs and assumptions and leads traumatized people to produce dysfunctional cognition associated with the traumatic event (Bolton & Hill, 1996; Horowitz, 1986). Foa and Rothbaum (1998) reported that people with PTSD build negative schemas about the self (e.g., "I am worthless"), the world (e.g., "The world is a dangerous") and the other (e.g., "They are untrustable"). Moreover, Resick and

Schnicke (1992) highlighted the significance of dysfunctional cognitions that are believed to be much more important than the threat itself. A number of studies (e.g., Andrews et al., 2000; Herman, 1992) have also emphasized that the traumatic experience may destroy the trust and cause a loss of belief.

In the trauma literature, both epidemiology and effects of traumatic experiences have been explained by various psychological theories. Brewin and Holmes (2003) reviewed psychological theories of PTSD and divided them into three types: (1) social-cognitive theories, (2) conditioning theories, and (3) information-processing theories. On the other hand, two other major theories of stress, namely, Coping Theory (Lazarus & Folkman, 1984) and Conservation of Resource Theory (Hobfoll, 1989) are the focus of the present study.

The stress and coping model was developed by Lazarus and Folkman (1984) based on cognitive-behavioral theory. Lazarus (1991) defined coping as an appraisal process emerging from the discrepancy between personal resource and demands of situation. A central idea is that coping is a cognitive activity incorporating (a) an assessment of impending harm and (b) an assessment of the consequences of any coping action. Thus, coping paradigm posits that individual differences of reactions to the stressful life events are explained by the coping strategies that people use. Lazarus and Folkman (1984) presented two types of cognitive appraisal called primary and secondary. Primary appraisal can be irrelevant, benign-positive, or stressful. Being irrelevant is assessed when an interaction with the environment has no implications for individuals. On the other hand, benign-positive is a reference to an interaction that has no negative or apprehensive attributes, but is likely to result in pleasurable emotions. In addition,

stress appraisal fall into three parts including harm/loss, threat, and challenge. The first part is “harm/loss” in which the individual has experienced loss. The second part of stress appraisal is “threat” in which stressor has anticipated, but not occurred. The last part is “challenge” appraisals focus on the growth. Moreover, secondary appraisal is the evaluation of coping resource (physical, social, psychological, and material assets) and options.

After the appraisal of the stressful event, the next phase of stress response is to choose coping strategies; problem-focused or emotion-focused coping defined by Lazarus and Folkman (1984). Problem-focused coping strategies include changing the actual relationship between the person and the situation. These types of coping strategies include efforts for focusing on the problem itself either by defining the problem situation or working out possible solutions. On the other hand, emotion-focused coping strategies focus on changing emotions without addressing problems directly. Emotion-focused coping strategies include strategies as avoidance, minimization, distancing, selective attention, and positive comparisons. According to Lazarus (1993), the effectiveness of a specific coping response is evaluated within its context. A series of studies has found that using problem-focused coping strategies instead of emotion-focused may help for controlling the negative effects of trauma (Ehler, Mayou & Bryant, 1998). However, Reichman et al. (2000) has emphasized that there are no good or bad coping strategies. Finally, the last step of the coping model is resolution (Lazarus & Folkman, 1987). After attempts to cope with stressful life events, the resolution may be favorable or unfavorable. Based on the model, favorable resolution occurs with positive emotion whereas unfavorable resolution creates distress. However,

Folkman (2001) later reported that unfavorable resolution can also conclude with positive emotion when the affected individual gains meaning from the experience.

In addition to the trauma and coping model, the second psychological theory of stress focused on the present study is the Conservation of Resources (COR) theory developed by Hobfoll (1989). The COR theory is an integrative stress theory that considers both environmental and internal processes. This resource-based theory depicts reaction differences of individuals to the stressful events. According to Hobfoll (2001), COR theory predicts a range of stress outcomes in organizational setting, health context, following traumatic stress, and in the face of everyday stressors. The COR theory defines stress as a state “*in which valued goals are threatened or lost, or where individuals are unable to create the necessary conditions for obtaining or sustaining these goals*” (p. 341). Hobfoll (1989) described three situations in which psychological stress takes place: (1) individuals’ resources are threatened with loss, (2) individuals’ resources are actually lost, or (3) individuals fail to gain sufficient resources. Moreover, Hobfoll (1998) proposed three major principles from COR theory’s central tenet. The first principle is defined as “*resource loss is disproportionately more salient than resource gain*” (p. 62) meaning that loss of resources has greater impact on psychological health than resource gain. Supporting this principle, research has demonstrated that loss of resource is a better predictor than resource gain for PTSD and psychological distress (e.g., Benight et al., 1999; Ironson et al., 1997). The second principle is explained as “*people must invest resource in order to protect against resource loss, recover from losses, and gain resources*” (p. 73). Based on this principle, people who have fewer resources are

expected to be less capable of resource gain and more vulnerable to resource loss. Thus, those people who have fewer resources possess weaker stress resistance than those with rich resources. The last principle is that “*resource gain becomes important in the context of resource loss*” (p. 80). For instance, people who see a person using a wheelchair might check on their own health resources so that they could appreciate their own health conditions (Hobfoll, 1998; Wells, Hobfoll, & Lavin, 1999).

In Hobfoll’s (1998) model, four types of resources are defined: (1) objects resources (home, transportation, and fetish objects), (2) personal resources (skills [occupation, leadership, etc.], and personal traits [self-esteem, optimism, etc.]), (3) condition resources (being healthy, employment, marriage, etc.), and (4) energy resources (money, credit, knowledge, etc.). In order to examine individuals’ resources, Hobfoll and his colleagues developed a scale named the Conservation of Resources Evaluation (COR-E) (Hobfoll, Lilly, & Jackson, 1992). There are two separate forms of COR-E; Loss and Gain forms. Although COR-E has been utilized to examine the COR theory in a variety of samples (e.g., Banou, Hobfoll, & Tochelman, 2009; Walter & Hobfoll, 2009; King et al., 1999; Wells, Hobfoll, & Lavin, 1999; Ironson et al., 1997), there is no study that investigates its role in infidelity.

The present study is also focuses on the three-stage forgiveness model developed by Gordon and Baucom (2003). Briefly, forgiveness is described as the forgoing of vengeful behavior (Heider, 1958). Although forgiveness has been viewed and treated as a predominantly spiritual or religious concept, it has received more attention from psychologists and scientists in the last few decades

(Worthington, 2005). In the area of clinical psychology, forgiveness research has grown rapidly. As a matter of fact, today, the literature of forgiveness includes theoretical explorations, practical considerations, and empirical articles, including process and outcome studies (Wade, Johnson, & Meyer, 2008). Forgiveness is generally accepted as a process. Therefore several models describing the process of forgiveness have been published. The three-stage forgiveness model (Gordon & Baucom, 2003) is directly related to major betrayals (e.g., infidelities, significant deceptions, and violations of trust). According to Gordon and Baucom, the forgiveness paradigm posits that forgiveness appears to help the reconstruction of the assumptions which are violated by traumatic experience. It is generally accepted that there are overlap between the traumatic reactions and the responses after interpersonal trauma. Likewise the typical responses to the traumatic events, Gordon and Baucom described the process of forgiveness with three stages: the impact, search of meaning, and recovery. They explained the process of forgiveness:

The major betrayal that requires a forgiveness process can be seen as an interpersonal trauma that disrupts the person's previous assumptions and expectations of his or her partner and their relationship in general. Therefore, the need to engage in the forgiveness process may result from an individual's attempt to reconstruct or modify these former beliefs about the partner and the relationship, and to regain a sense of interpersonal control, predictability, and safety in the relationship if the person is to effectively move on from the event (p. 181).

In the three-stage forgiveness model, the focus of Stage I (impact) is the effect of the betrayal on injured partners and their relationships. Similar to the other forgiveness stage models, this stage is described as a period of significant

cognitive, emotional, and behavioral disruptions (Gordon & Baucom, 1998). Moreover, these responses indicate that important assumptions of injured partner (e.g., one's partner can be trusted, relationship is safe) have been violated. Because of these shattered assumptions, injured partners are likely to engage in a process of collecting details or to explain the negative event. They also feel out of control, powerless, and no longer able to predict future. Furthermore, in the Stage I, withdrawing is observed on offended partners in order to protect themselves. It is generally accepted that understanding why the negative life event occurred is the central theme for a violated person (Worthington, 1998; McCullough, Worthington, & Rachal, 1997; Horowitz et al., 1991). According to Gordon and Baucom (2003), the Stage II of the forgiveness model focuses on this theme. In this stage, injured partners try to discover why the betrayal occurred in order to make the partner's behavior more understandable and predictable. Thus, understanding may help to increase sense of control over one's own life, sense of safety and security, and to decrease feeling of powerlessness. Finally, in Stage III, the injured partners move beyond the betrayal and start to take control over their life again. In this stage, the injured partners are expected to develop a non-distorted view of their partner and relationship. Also, intense negative feelings toward the partner to understand the event are seen less frequently in the Stage III. Gordon and Baucom (2003) developed a forgiveness inventory (FI) which assesses injured partners' process of forgiveness in terms of the three-stage model of forgiveness.

The forgiveness process may result from individuals' attempts to reconstruct or modify their former beliefs about their partner and the relationship.

Gordon and Baucom (1998) stated that a major betrayal activities requiring forgiveness disrupt the injured partners' basic assumptions about their partner and relationship in general. More recent research (Fincham, Beach, & Davila, 2004) has confirmed that forgiveness may reduce marital conflict and enhance spouses' cognitions. Consistent with these findings, Gordon, Snyder, and Baucom (2005) found a negative correlation between the forgiveness level and trauma symptoms of offended partners in their case study. Sells and Hargrave (1998) agreed that forgiveness involves overcoming anger, revenge, shame, record of wrongs and resentment. According to Fincham et al. (2004), forgiveness also involves decreasing negative motivation toward the betrayer partner.

1.2 Aims of the Study

As mention earlier, extramarital infidelity (EMI) occurs with high frequency and produces penetrating consequences for individuals and couples (Atkins et al., 2005b). Whisman et al. (1997) stated that EMI is the second most damaging problem for the couples and the third most difficult problem to treat for the couple therapist in clinical practice. Indeed, in the last decade, academic journals have released special issues on extramarital infidelity and numbers of books have been written about treatment of infidelity (e.g., Ortman, 2009; Baucom, Snyder, & Gordon, 2009; Piercy, Hertlein, & Wetchler, 2005; Vaughan, 2003; Glass, 2003; Brown, 2001; Subotnic & Harris, 1999; Lusteran, 1998; Spring & Spring, 1996).

EMI has been discussed as an interpersonal trauma in the couples' life by many clinicians (Whisman & Wagers, 2005). Although there is a strong

agreement on the idea that injured partners have symptoms similar to post-traumatic stress disorder, there is only limited research to examine traumatic responses of offended partners. Recently, Meldrim (2005) completed a qualitative study to examine the impact of infidelity on the offended spouse (ten women and seven men) and participants described their spouses EMI as the most or one of the most traumatic and difficult events of their lifetime. Likewise, Schalk (2006), focused on the description and meaning of the experience of coping with EMI, and found that the offended partners described their experiences as traumatic. In another study, Steffens and Rennie (2006) reported that wives of sexual addicts respond to disclosure with significant trauma-related distress. Moreover Snyder et al. (2007) defined trauma as a major negative event or set of events that destroys important assumptions or fundamental beliefs about the world or individuals. These assumptions and beliefs help to create more predictable world and to feel safe. The trauma literature posits that when these assumptions are violated, individuals may lose predictability of future and experience a loss of control (Snyder, Gordon, & Baucom, 2004). Most of offended partners have reported the loss of the positive images of their partner and the assurance of secure, committed relationship (Meldrim, 2005; Glass, 2003). Following EMI, offended partner can no longer trust his or her partner or feel safe within the relationship (Blow & Harnett, 2005b). Likewise, Gordon, Baucom, and Snyder (2005a) stated that infidelity could be disruptive to ability to function well and to interact with each other. Mainly, intrusive thoughts about the event are the main disruption experienced by the injured partner. On the other hand, the change in beliefs about the partner and relationship is a primary cognitive response to the discovery of the

infidelity. According to Ortman (2009), experiencing betrayal of trust makes injured partners more traumatized after the discovery of EMI.

In terms of negative consequences of infidelity, Glass and Wright (1992) remarked that betrayed partners show intense anger, feeling of shame, depression, intrusive and painful memories, avoidance, emotional numbing and increased arousal. Also, Meldrim (2005) reported that betrayed partners experience intrusive thoughts and persistent rumination about the marital infidelity. In addition, Blow and Hartnett (2005b) suggested a list of betrayed partners' reactions; rage, loss of trust, decreased personal and sexual confidence, damaged self-esteem, fear of abandonment, and overwhelming. Consistent with this, research shows that injured partners may experience the symptoms of the Post Traumatic Stress Disorder (PTSD) which is a condition follows exposure to life threatening traumatic events (Gordon, Baucom, & Snyder, 2005a; Meldrim, 2005; Glass, 2003; Lusterman, 1998). According to the DSM-IV (American Psychiatric Association, 2000), criteria for PTSD include; experience of intense fear, helplessness, or horror; re-experiencing of the event; avoidance of reminder of event; emotional numbing; heightened anxiety; irritability and rage. Lusterman (1995) and Ortman (2009) support the idea of overlap between the symptoms of injured partners and PTSD symptoms. Ortman (2005) underlined the primary symptom of the betrayed partners as expressing rage, and other responses are behavioral avoidance, hyper-vigilance, obsessive questioning, and other extremely negative, punitive interchanges. Like Ortman, Lusterman (1995) also used DSM-IV format description for PTSD to explain the symptom of a betrayed partner, as follows:

A: The stressor is the discovery of protracted marital infidelity when the 'victim' believes that a monogamous contract still obtains. B: The traumatic event is persistently reexperienced in the last one of the following ways: (1) Recurrent and intrusive distressing recollections of the event and the many lies the victim begins to realize preceded the moment of discovery;(2) Recurrent distressing dreams;(3) Sudden acting or feeling as if the traumatic event were recurring, with particular emphasis on the lying that preceded discovery. C: obsessive rumination about the affair, its discovery, and the antecedents of the affair, combined with attempts to stop the obsessive ruminations. It is also characterized by an alternating sense of estrangement from the mate, followed by burst of great need for closeness and reassurance. There is generally a sense of foreboding that the marriage will end, often despite assurances to the contrary. D: Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following: (1) Difficulty falling or staying asleep; (2) Irritability or outburst of anger; (3) Difficulty concentrating;(4) Hypervigilance; (5) Exaggerated startle response; (6) Physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (p. 264).

The review of the literature on infidelity has shown that there are too many questions which have not been studied yet. More specifically, there is a need for exploring the emotional process within individuals after discovering of EMI. Although the benefits of using a trauma model to understand the emotional impact of infidelity is obvious, there is no empirical data that address the actual process after EMI (Blow & Harnett, 2005b). In addition to that, the essential part of infidelity research might focus on coping with the consequences of infidelity. In the light of the infidelity literature, the aims of the present study are to examine the traumatic effects of extramarital infidelity on the offended partners as well as to find out the predictors (coping strategies, conservation of resources, and forgiveness stages) of the severity of post-traumatic symptoms. Furthermore, the current study also aims to explore the effects of the critical demographic variables

(types of infidelity, duration of affair, past experience with infidelity etc.) on the level of traumatic reactions.

Regarding presented aims, this current study proposes to answer the following research questions:

1. Do offended partners meet the criteria for the diagnosis of PTSD after discovering EMI?
2. Which demographic variables are important with respect to the severity of traumatic reactions after discovering EMI?
3. Do offended partners who use the problem-focused coping strategies instead of the emotion-focused strategies have less PTSD symptoms?
4. Does resources loss have more impact on the offended partners' symptom level of PTSD compared to resources gain?
5. Could forgiveness decrease the PTSD symptoms of offended partners?
6. What are the main predictors of the severity of PTSD clusters on the offended partners?

1.3 Significance of the Study

It is well known that infidelity is harmful for individual and relationship (Whisman, Dixon, & Johnson, 1997). After the discovery of marital infidelity, only a small percentage of couples improve their relationships and both partners suffer from cognitive and emotional problems (Charny & Parnass, 1995). However, the emotional consequences of EMI have been rarely studied. Blow and Hartnett (2005a) has pointed out the lack of field-specific infidelity research. Although there is an agreement on the statement that infidelity is an interpersonal

trauma and has traumatic effects on offended partners, this statement is supported only by clinical observation, case studies, and a few qualitative researches. At this point, the main significance of the present study is to provide a quantitative data for the trauma concept of infidelity. Thus, the current study may contribute to understand offended partners' traumatic reactions, specifically PTSD symptoms, after discovering partner's EMI.

Psychological trauma has been studied frequently in the field of mental health. There are reliable results and numerous theoretical models which provide the process of PTSD (e.g., Ehlers & Clark, 2000; Brewin, 2001; Foa & Rothbaum, 1998; Janoff-Bulman, 1992; Chemtob et al., 1988; Horowitz, 1986; Keane, Zimering, & Caddell, 1985). However, in the field of infidelity, most of trauma models which try to explain injured partners' reactions are just conceptual. Therefore, another significance of the present study is to explore the process of betrayal trauma, especially regarding the coping strategies and conservation of recourse model. The current study may help to extend the findings of the relationship between coping strategies and PTSD to the field of infidelity. It is generally accepted that emotional coping strategies, comparing with problem focused coping, result in higher rates of PTSD (Gil, 2005; Gavranidou & Rosner, 2003). However, the coping strategies used in response to EMI have still remained questionable. Especially, it is important to know which coping strategies are used by offended partners who continue their marriages after discovering of partner's EMI.

Like the coping model of Lazarus and Folkman (1984), the resources-based COR theory (Hobfoll, 1989) is a widespread model used to understand

reaction differences of individuals to the stressful life events. COR theory has been successfully employed in predicting a range of stress outcomes except marital stress. The current study may also have an important contribution to COR theory. In the aftermath of EMI, it is important to assess what types of resources have been used by offended partners who choose to stay in their marriage. In the trauma and stress literature, it is generally accepted that resource loss predicts worse outcome during the stress process. The present study may examine the main principals of the COR theory with the offended partners and their traumatic reactions. Therefore, the results of the present study may help to ascertain why individuals react differently to EMI and how resource affects the level of symptom severity.

Moreover, forgiveness is relatively unexplored topic for the psychology literature. In the area of clinical applications, forgiveness research has not well established yet. In order to help individuals or couples coping with EMI, forgiveness model might be explored by professionals. At this point, another important aspect of the present study is to provide findings to support the assumption that forgiveness is important to cope with EMI. Parallel to the trauma process, Gordon and Baucom (2003) conceptualized a forgiveness model and developed a reliable and valid scale for measuring the level of forgiveness. Furthermore, the other significant aspect of the present study is to adopt forgiveness measure, namely Forgiveness Inventory (FI; Gordon & Baucom, 2003) into Turkish culture. Considering the limitation of scales which directly assess marital infidelity in the forgiveness literature, this study has a significant role to adapt this measure into Turkish literature.

Although there is no any academic study of prevalence of EMI for Turkish population, the only statistics comes from the 2005 Durex Global Sex Survey (Durex, 2005) completed in 41 countries. The results showed that 58% of participants which was the highest rate in the survey from Turkey answered “yes” to experience of EMI as a response to the question “Sexual experiences you’ve had”. It seems that EMI is also common in Turkish population but the literature of infidelity is just based on a few studies. Yeniçeri and Kökdemir (2006) examined the justifications for infidelity and found six components of extramarital infidelity named legitimacy, seduction, normalization, sexuality, social background, and sensation seeking. The other study conducted by Polat (2006) focused on the relationship between marital satisfaction and infidelity tendencies. Also, she developed an Infidelity Tendency Scale. The participants of these studies were graduate students and non-affair group. Therefore, the present study addresses this gap in Turkish infidelity literature and contributes to the Turkish sample of offended partners who continue their marriage after dissolution of EMI.

1.4 Implications of the Study

Studies posit that the impact of the discovery of EMI is more traumatic than it was previously understood (Gordon & Baucom, 1999; Lusteran, 1998). However, treatment options for couples and individuals who want to recover from infidelity are so limited (Blow & Hartnett, 2005a). On the other hand, there are many well developed treatment models for traumatic disorders. Contributing to increasing our understanding of offended partners’ traumatic reactions, specifically PTSD symptoms, may help to bring out the models of trauma

treatment into the field of infidelity. Thus, one of the main implications of the current study would be expanding the treatment options used by clinicians for the victims of infidelity whereby showing overlap between the impact of EMI and PTSD. More specifically, the present study could provide considerable information about which types of coping strategies, emotional-focused or problem-focused, would be more helpful to deal with the effects of EMI. In terms of generalization of the findings of the current study, clinicians could support their treatment plan as improving specific coping strategies. On the other hand, resources are found to be significantly important for dealing with any traumatic events (Hobfoll, 2001). Knowing that which resource loss is common on betrayed partners after discovering EMI would underline the critical resources. Indeed, the findings may shed light on preventing resource loss and negative consequences of EMI.

In order to help couples coping with EMI, this study may lead to better understanding of the process of forgiveness. One of the main implications of present study is to provide a Turkish version of Forgiveness Inventory (FI) developed by Gordon and Baucom (2003) to the field. According to their model, forgiveness of infidelity involves three stages: the impact, search for meaning, and recovery phases. The main assumption is that each individual who suffers from EMI has different needs in accordance with the forgiveness stages. The FI may help clinicians to assess offended partners' current stages. Indeed, clinicians may benefit from using FI in order to identify the couples' specific needs for dealing with the negative effects of EMI.

Finally, studying the critical demographic variables (types of infidelity, duration of affair, past experience with infidelity etc.) would provide information to determine the characteristics of individuals who are at risk to be traumatized following discovery of EMI. Overall, the present study would be beneficial for the clinicians in order to prevent negative impact of extramarital infidelity on both injured partners and couples before and after EMI occur in the primary relationship.

CHAPTER 2

LITERATURE REVIEW

The chapter two reviews the related literature in five sections in accordance with the presented aims of the study. In the first section, exploring the concept and findings of infidelity are presented. In the second section, psychological trauma which is sought as a lens for the impact of infidelity is presented. Specifically, the literature on PTSD is examined. Related to trauma, the next three sections are focused on coping strategies, conservation of resource and forgiveness.

2.1 Infidelity

The purpose of this section is to better understand infidelity and its devastating effects on the individuals and marriage. For this aim, infidelity is presented as follows; definition and types of infidelity, prevalence, gender difference, issues in the primary relationship, individual factors, the aftermath of infidelity, and healing process. In the literature related to infidelity, there are numbers of term used to describe infidelity such as, affair, cheating, betrayal, and etc. In the present study “extramarital infidelity” (EMI) is preferred. Also, partner who has EMI is called “involved partner” and individual who has an involved partner are called “injured or offended partner”.

2.1.1 Definitions and Types of Infidelity

Infidelity is one of the most complex issues for research applications and also among the most common presenting problems in clinical practices. Besides an enormous interest of arts (cinema, music, literature etc.) and magazine, the main reason that infidelity receives attention from researchers is that it is so damaging to individuals and relationships (Gordon, Baucom, & Snyder, 2004). Moreover, not only couples and individuals but also their offspring have shown the penetrating effects of EMI (Lusterman, 2005).

Although infidelity is a common phenomenon for marriages, it has been poorly understood (Atkins, Baucom, & Jacobson, 2001). After Thompson' (1983) review, Blow and Hartnett (2005a) completed a methodological review of the available research literature on infidelity from 1980 to 2005 and highlighted critical points that limited these studies. According to their review, one of the most significant methodological critiques is the lack of operational definition of infidelity which is changed from one study to another. They found that favored definition of infidelity is limited to heterosexual, extramarital intercourse. Consistent with this, the online Oxford dictionary defines infidelity as "*the action or state of being sexually unfaithful*" (www.askoxford.com). However, this definition excludes from many other extramarital action. Unlike the narrow description, Drigotas and Barta (2001) defined infidelity as "*a partner's violation of norms regulating the level of emotional or physical intimacy with people outside the relationship*" (p. 177). Moreover, Blow and Hartnett (2005a) suggested a broader definition of infidelity:

A sexual and/or emotional act engaged in by one person within a committed relationship, where such an act occurs outside of the primary relationship and constitutes a breach of trust and/or violation of agreed-upon norms (overt and covert) by one or both individuals in that relationship in relation to romantic, emotional or sexual exclusivity (p. 191).

With this broad view, other than marital context, infidelity can also occur in a cohabitating or dating relationship (Meldrim, 2005). Although self-help literature (e.g., Subotnik & Harris, 2003; Lusterman, 2003) offers general types of infidelity such as one-night stands, philandering, serial, flings, romantic love, long-term relationships etc., Thompson (1984) is among the others to identify the typology of infidelity which is widely accepted by researchers: sexual-only, emotional-only, and combined sexual and emotional. Sexual-only type is any behavior that involves sexual contact, such as intimate touching, kissing, or sexual intercourse. On the other hand, emotional-only type is any formation of emotional attachment to the other person, and may involve actions like dating, flirting, or falling in love. The last category of the Thompson' typology combines both sexual and emotional involvements. Glass and Wright (1985) explore this typology of infidelity on a six-point continuum going from sexual to emotional involvement: never involved sexually or emotionally (0), entirely sexual (1), mainly sexual (2), more sexual than emotional (3), more emotional than sexual (4), mainly emotional (5), entirely emotional (6).

In recent years, internet infidelity provides a new challenge to researcher and clinicians seeking to define infidelity. Nelson (2005) completed a survey with experts and showed that most mental health professionals believed that internet infidelity cases are not differed from other cases of marital infidelity. Harrold B. J.

(2001) stated that internet infidelity was found to be similar to the traditional infidelity in cause and effect. However, it is conducted in a space that enhanced perceived intimacy and may have been more intrusive, by virtual presence, in couple's life. Millner (2008) supported this general acceptance with his case study and reported that male marital partner struggle with intimacy and emotional expression as well as his exploration into the world of cybersex and infidelity. Moreover, Grootjohf, Dijkstra, and Barelds (2009) investigated men's and women's (from student and community sample) responses to emotional and sexual infidelity over the internet and found that gender differences in response to the internet infidelity parallels those for offline infidelity. Thus, internet infidelity is not sought as another type of infidelity.

2.1.2 The Prevalence of Infidelity

Due to the lack of operational definition, there is no reliable statistics about frequencies of infidelity. According to Blow and Hartnett (2005b) most of studies which attempt to estimates the rates of infidelity have focused on sexual intercourse with heterosexual couples. Wiederman (1997) reported that 88% of women and 78% of men denied any experience of extramarital sex on the 1994 General Social Survey of 1288 women and 884 men in the U.S. Likewise, Atkins, Baucom, and Jacobson (2001) reported that 13% of participants of national survey in the U.S. accepted to experiencing extramarital sex. Another survey with women completed by Forste and Tanfer (1996) showed that 10% of participant had a secondary sex partner whereas the rate of having a secondary sex partner

were lower for married women (4%) comparing with dating women (18%) and cohabiting women (20%).

Depend on life time or recent experience; the studies of the prevalence of infidelity reveal different results. Laumann et al. (1994) reported that 25% of married men and 15% of married women reported having extramarital sex at least once along their marriage. On the other side, less than 4% of participants reported extramarital sex in the previous year. Treas and Giesen (2000) examined the prevalence of sexual infidelity and found that the lifetime prevalence of infidelity differed by method of assessment, with 15.5% of respondents reporting a lifetime history of sexual infidelity on a self-administered questionnaire vs. only 11.2% when asked in an interview. Consisted with this, Whisman and Snyder (2007) stated that the estimated prevalence of infidelity was much smaller with the face-to-face interview than with the computer based. Although there are some researches that revealed significantly lower prevalence statistics (Choi, Catania, & Dolcini, 1994; Leigh, Temple, & Trocki, 1993; Smith, 1991), the research that used broader definitions of infidelity has found higher rates. According to Whisman and Snyder (2007), lifetime prevalence estimates for EMI in the United States (U.S.) range from 20% to 40% for men and 20% to 25% for women depending on the age and gender of the individual. Moreover, couple therapists in the U.S. estimate that between 29% and 65% of couples report difficulties related to EMI. (Whisman, 1997). DuPree et al. (2007) summarized the statistics about the prevalence of EMI that estimated the range from less than one-fourth of committed relationships. These rates are changed (higher or lower) from one country to other (Pulerwitz, Izazola-Licea, & Gortmaker, 2001; Solstad & Mucic,

1999). Because there is no any academic study of prevalence of EMI for Turkish population, the only statistics comes from the 2005 Durex Global Sex Survey (Durex, 2005) completed in 41 countries. The results showed that 58% of participants which was the highest rate in the survey from Turkey answered “yes” to experience of extramarital infidelity as a response to the question “Sexual experiences you’ve had”. Although there is no reliable statistics for the prevalence of infidelity, it is generally accepted that the actual prevalence of infidelity is higher than its observed (Johnson, 2003).

2.1.3 Gender Differences in Infidelity

Gender is identified as another major variable for infidelity research and has studied most often (Atkins, Baucom, & Jacobson, 2001). It is generally accepted that more men engage in infidelity comparing with women (Allen & Baucom, 2004; Atkins, Baucom, & Jacobson, 2001). In addition, men have a stronger desire (Prins et al., 1993) and more permissive attitudes toward engaging infidelity (Lieberman, 1988; Thompson, 1984). Schmitt (2004) completed a large-scale cross-cultural survey, and found that men desire more sexual partners than women.

Gender is a factor that affects the type of infidelity. Glass and Wright (1985) found that men describe their infidelity as more sexual than emotional, whereas women describe that in opposite way. Blow and Hartnett (2005b) stated that *“for women there generally appears to be a greater emphasis on emotional connection than for men, whereas for men, there generally seems to be a greater emphasis on sexual experience”* (p. 221). Even in the sexual type infidelity

women and men are different, former tend to have less physically intense experience such as to hug or kissing instead of intercourse (Glass & Wright, 1985). Groothof, Dijkstra, and Barelds (2009) stated that more men than women indicate that their mate's sexual infidelity would upset them most, whereas more women than men indicate that their mate's emotional infidelity would upset them most. Furthermore, Miller and Manner (2009) found that sex differences in responses to sexual versus emotional infidelity are substantially greater among individuals high in chronic jealousy than among individuals low in chronic jealousy.

It is also appeared that gender differs depending on the justification of infidelity. More recent research has supported that women's infidelity is typically tied more closely to relationship dissatisfaction whereas men's infidelity is tied more closely to sexual dissatisfaction (Allen et al., 2008; Whisman & Snyder, 2007; Atkins et al., 2005b). Furthermore, the sex differences appeared as a factor of infidelity-divorce relationship. Results showed that female EMI ends up with divorce more frequently than male EMI (Shackelford, Buss, & Bennett, 2002; Sweeney & Horwitz, 2001). The statistics reported by the Turkish Statistical Institute (TURKSTAT, Divorce Statistics, 2006) showed that adultery rates were lower than 1% for the whole divorce cases for Turkish population. However, the results of national survey (TURKSTAT, Family Structure Research, 2006) showed that EMI of husbands was perceived as a divorce reason by 58% of men and 61% of women whereas EMI of wives appeared as the exact reason for divorce by 92% of men and 87% of women. In sum, men involved EMI are seen to be more tolerable than women. Contrarily, some researches have confirmed that

men and women really do not differ in terms of extramarital action (Prins et al., 1993). Wiederman (1997) supported this notion and found that there were no differences in frequency and types of infidelity for gender. Thus, there is no simple relation between gender and infidelity. Moreover, there are large interaction effects among gender, and other important variables such as age, relationship type, and infidelity type (Blow & Hartnett, 2005b).

2.1.4 Issues in the Primary Relationships

A review of the infidelity literature shows that the main part of the infidelity researches has focused on the issues in primary relationship such as primary relationship status, primary relationship satisfaction, sexual satisfaction, length of the primary relationship, and parental status. A central idea to focus on these issues is that identifying specific risk factors and to be able to predict or prevent EMI (Drigotas, Saftrom & Gentilla, 1999; Zak et al, 2002). Like Allen et al. (2008), some researchers have also emphasized premarital precursors of marital infidelity. The first issue is the primary relationship status and results of some studies suggest that marriage discourage individuals from experiencing EMI. Blow and Hartnett (2005b) stated that “*there is a commitment mechanism in marriage that may serve as a protective factor against infidelity for some couples*” (p. 221). Consistently, Forste and Tanfer (1996) reported that married women are less likely to engage in EMI comparing with dating or cohabiting women. Treas and Giesen (2000) also found similar results and supported this notion.

The other issue in the primary relationship is marital satisfaction. Blow and Hartnett (2005b) indicated that individuals engage in infidelity if there were something wrong in their primary relationship. A series of studies has found that marital satisfaction and infidelity tendency are negatively correlated (Atkins et al., 2001; Shackelford & Buss, 1997; Shen, 1997). In the recent study, Polat (2006) developed the Infidelity Tendency Scale and examined the relationship between those variables. The result of her study showed that individuals who report high marital satisfaction also scored low in infidelity tendency and it was true for both sex. Glass and Wrieth (1985) reported that dissatisfaction changed due to types of infidelity. Specifically, wives and husbands who are involved in both sexual and emotional EMI are even more dissatisfied with their marriages than those engaged in either sexual-only or emotional-only EMI. However, Wiggins and Lederer (1984) compared relationship satisfaction of involved partners who engage in infidelity with their coworkers and non-coworkers, and found that former group reported significantly higher marital satisfaction than latter. These findings were explained by Blow and Hartnett (2005b) as: *“people who engage in infidelity with coworkers are not necessarily unhappy in their primary relationships; rather, they are acting on the opportunity available to them”* (p. 222). Glass (2003) also stated that *“good people in good marriages are having affairs”* (p. 1). Thus, the connection between marital satisfaction and infidelity may not be so simple (Spanier & Margolis, 1983).

The other important issue in the primary relationship is sexual satisfaction which may play a part in individuals' tendency toward infidelity. Liu (2000) found that decrease in the frequency of sexual activity in a marriage leads to a

higher incidence of infidelity. He also reported that gender has a mediator role between sexual satisfaction and infidelity in which there is a stronger negative correlation for men. This mean that men' sexual dissatisfaction elicits more extramarital action than women. Consistent with these findings, Campbell (2010) reported that decreased marital satisfaction and decreased sexual satisfaction were both associated with an increased likelihood of infidelity. In sum, the quality of sexual life in marriages is seen as a risk factor for EMI.

Some researchers have underlined that the effect of length of the primary relationship. Although there are inconsistent results, it is generally accepted that longer primary relationships have higher infidelity tendency comparing with shorter relationships (Whishman & Wagers, 2005; Forste & Tanfer, 1996). Liu (2000) used National Health and Social Life Survey data and reported that the rates of EMI reach a peak in the seventh year of marriage and decline steadily thereafter for married women. On the other hand, for married men, the rates of EMI reach a critical point in the eighteenth year of marriage. Contrarily, Treas and Giesen (2000) found no correlation between relational length and infidelity.

The other unclear issue is presence and number of children in the primary relationship. Most of clinicians accept that having children which decreases the relational and sexual satisfaction of couples also increases the tendency of infidelity (Gottman & Notarius, 2000). However, this statement has not been supported by research. Besides having children, researches say very little about specific life stressors and change that might affect the tendency of infidelity such as spousal illness, pregnancy or injury (Blow & Hartnett, 2005b).

2.1.5 Demographics and Infidelity

In the infidelity related literature, some researchers have focused on investigating the demographic variables which may influence the rates of infidelity tendency such as culture, educational levels, income levels and employment status. On the cultural issue, African American and White American were compared and found that African American group showed higher infidelity tendency (Treas & Giesen, 2000; Amato & Rogers, 1997). Contrarily, Choi et al. (1994) reported no significant difference between Whites, Hispanic or African American in order to involve EMI. Because of the lack of international studies which explore the experiences of specific ethnic groups, the relation between race and infidelity is unclear (Blow & Hartnett, 2005b). However, there is a comparative study which came from the other field of science, literature. Recently, Koçak (2007) compared two classic novels which focus on marriage and infidelity from different culture (French author Emile Zola's "Therese Raquin" and Turkish author Mehmet Rauf's "Eylül"). The comparisons in terms of 'marriage', 'betrayal' and 'regret' showed that there were some common points in both novels that have importance in French and Turkish cultures.

The relation of education and income levels with infidelity are other untapped issues in this field. Shen (1997) found that younger and well-educated individuals and males are more likely to have more EMI. Moreover, Forste and Tanfer (1996) found that married women who have higher level of education than their partner are more likely to have EMI. Similarly, Atkins, Baucom, and Jacobson (2001) reported that individuals who have higher level of education also have higher infidelity tendency than those who have lower education. They also

found that the higher income people have, the more likely they are engaged in EMI. In addition, individuals who are financially dependent on their partners have higher risks for engaging in EMI. Not only the level of income but also employment, itself has a significant influence on the rates of EMI. According to Treas and Giesen (2000), the work environment provides opportunity for EMI for both genders. In addition to the work environment, social environment is seen as an important factor which affects the rate of EMI. Vanlandingham et al. (1998) examined some of the key social variables underlying patterns of EMI. The results highlighted the peer influence which is interpreted in light of contemporary theories of social influence and sexual behavior. On the other hand, Zak et al. (2002) reported that person who experience social support for their primary relationship are less likely to engage in infidelity.

2.1.6 Individual Factors in Infidelity

Individual factors such as specific characteristics (e.g. sexual attitudes, past divorce, parental divorce), personality and individual justification of EMI have been often studied in the field of infidelity. A number of authors have emphasized that individuals who have strong interest in sex have higher tendency of EMI (Liu, 2000; Treas & Giesen, 2000). In addition, women who have a liberal sexual attitude would show high rates of EMI (Hansen, 1987). Past divorce (Atkins, Baucom, & Jacobson, 2001) and remarriage (Christopher & Sprecher, 2000) also seem to affect having EMI. In addition, parental divorce was found as a factor that increases the odds of engaging in EMI (Amato & Rogers, 1997). More recently, Platt et al., (2008) examined the impact of parental infidelity on

adult children, and found that adult children who had knowledge of their father's infidelity were more likely to engage in infidelity than adult children without such knowledge. However, parental infidelity was not significant in predicting the future romantic attachment styles of adult (Sotomayor, 2003).

Shackelford, Besser, and Goetz (2008) examined personality as a predictor of infidelity, and used the "five factor model" (urgency, agreeableness, conscientiousness, emotional stability, openness). Their results indicated that individuals with particularly disagreeable spouses (low on Agreeableness) and particularly unreliable spouses (low on Conscientiousness) were more likely to engage in EMI. Schmitt and Buss (2000) also stated that both low agreeableness and low conscientiousness were found to be shared major component of impulsivity and inability to delay of gratification. In the more recent study, Shaye (2010) found that extraversion was positively associated with infidelity, while conscientiousness was negatively associated to infidelity for men. It means that individuals who are extravert have more extramarital infidelity comparing with those who are conscientious. In another study, interaction between men's personality traits and partner-directed violence were examined and found that men's conscientiousness predicts partner-directed violence when perceived risk of partner infidelity was high (Kaighobadi & Shackelford et al., 2009). In another recent research, Campbell (2010) reported that privateness and rule-conscientiousness both were found to be moderators of the relationships between sexual satisfaction, marital satisfaction, and infidelity. Apart from certain personality dimensions, Allen et al. (2008) examined communication skills of couples as premarital precursors of EMI. It was reported that lower positive communication and higher

invalidation were common for couples in which one of the partners engaged in EMI.

In the literature of infidelity, researchers have started to examine relationship between attachment style and infidelity. Bogaert and Sadava's (2002) found that individuals who had higher score on an anxious attachment style were more likely to engage in EMI. In another research, Allen and Baucom (2004) found that women with a preoccupied attachment style and men with a dismissive attachment style showed higher rates of infidelity in their primary relationship through student sample. Also, in the community sample, they found that individuals with dismissive attachment styles were more likely to engage in infidelity. In more recent study, Platt et al. (2008) also examined the impact of parental infidelity on adult children's attachment but results did not supported differences in the attachment style between adult children with and without knowledge of parental infidelity.

For better understanding of infidelity, researchers have also focused on justification of infidelity but very little research has been done (Drigotas, 1999). Glass and Wright (1992) defined four dimensions in which individuals defend their EMI: (1) the sexual dimension (e.g., sexual enjoyment, curiosity, and excitement), (2) the emotional dimension (e.g., intellectual sharing, understanding, companionship, and ego-bolstering aspects of self-esteem), (3) the extrinsic motivation dimension (e.g., career advancement and getting even with a spouse), and (4) the love dimension (e.g., getting love and affection and falling in love). Also, they reported that there is a gender difference on justification of EMI: women tend to justify infidelity via the emotion-related dimension, whereas men

tend to justify infidelity via the sexual rationalizations. Consistent with this, Allen and Baucom (2004) stated that “*women seem to be motivated to engage in infidelity when they desire closeness or when they sense neglect or rejection in their primary relationship*” (p. 226). In the more recent study, Yeniçeri and Kökdemir (2006) developed an Infidelity Questionnaire (INFQ) due to examine the explanations for infidelity and found six components of EMI namely legitimacy, seduction, normalization, sexuality, social background, and sensation seeking.

2.1.7 The Aftermath of Infidelity

It is generally accepted that infidelity is harmful to individuals and relationships (Whisman, Dixon, & Johnson, 1997). After the discovery of marital infidelity, only a small percentage of couples could improve their relationships but most of them suffer from the range of problems (Charny & Parnass, 1995). Only a few study supported that infidelity has positive relationship outcomes (Blow & Hartnett, 2005b). In the qualitative study, Olson et al. (2002) found that couples who were injured by EMI showed some unintended positive outcomes such as closer marital relationships, increased assertiveness, placing higher value on family, taking better care of oneself, and realizing the importance of good marital communication. Also, Atkins et al. (2005b) reported that comparing couples who were injured by EMI with other distressed couples, the former got faster progress in therapy situation.

Sweeney and Horwitz (2001) stated that there is a lack of existing research about the relationship between mental health outcomes and infidelity. In the

limited infidelity literature, depression has been frequently studied. In terms of the negative consequences of EMI, Cano and O'Leary (2000) showed that betrayed women were more likely to experience a major depressive episode. Specifically, Whisman and Wagers (2005) found that women who had experienced either their husbands' infidelity or threats of marital dissolution were six times more likely to be diagnosed with a major depressive episode than women who had not experienced either of these events. In the longitudinal study, Cano, O'Leary, and Heinz (2004) found that marital discord was also related to later depressive and anxiety symptoms for women reporting a recent severe marital stressor (e.g., infidelity, threat of separation). In addition, Charny and Parnass (1995) remarked offended partners' reactions such as rage, loss of trust, decreased personal and sexual confidence, damaged self-esteem, fear of abandonment, and overwhelming. According to Voth (2005), not only offended partners but also involved partners report negative consequences of EMI. In her qualitative study, she found that especially involved partners experienced feeling of withdrawal, depression, guilt, and shame following the dissolution of EMI. Recently, Hall and Fincham (2009) reported that individuals who engage in infidelity in their primary relationship report significantly more psychological distress than those who have not engaged in infidelity. In terms of general distress, involved partners also show greater depressive symptoms and lower general well-being than other individuals.

It is generally accepted that infidelity is an interpersonal trauma, and elicits the experience of traumatic symptoms (e.g. Ortman, 2009; Baucom, Gordon, & Snyder, 2009; Whisman & Wagers, 2005; Glass, 2003; Lusterma, 2002). Trauma is defined as a major negative event or set of events that destroys

important assumptions or fundamental beliefs about the self, the world or the others (Snyder et al., 2007). These assumptions help individuals create more predictable world and feel safe. Snyder, Gordon and Baucom (2004) posit that when these assumptions are violated, individuals can lose predictability for the future and experience a loss of control. Most of offended partners have reported the loss of the positive images of their partner and the assurance of secure, committed relationship (Meldrim, 2005). Indeed, their assumption about the relationship and his or her partner has shattered after discovering of EMI (Glass, 2003). Following to EMI, injured partner can no longer trust his or her partner or feel safe within the relationship (Blow & Harnett, 2005b). Glass and Wright (1992) reported that offended partners often experience intense anger, feeling of shame, depression, intrusive and painful memories, avoidance, emotional numbing and increased arousal. Moreover, Gordon et al. (2005a) pointed that intrusive thoughts about the event are the main disruption experienced by the injured partner. According to Ortman (2009), after the discovery of EMI, experiencing betrayal of trust makes injured partners traumatized. In his qualitative study, Meldrim (2005) examined the impact of infidelity on the offended spouses (ten women and seven men) and participants described their spouses extramarital infidelity as the most or one of the most traumatic and difficult events of their lifetime. Likewise, Schalk (2006) focused on the description and meaning of the experience of coping with marital sexual infidelity, and found that the offended partners described their experiences as traumatic. In another study, Steffens and Rennie (2006) reported that wives of sexual addicts responded to disclosure with significant trauma-related distress.

Although infidelity may not fit the PTSD criteria of trauma of a life-threatening magnitude described in DSM–IV (American Psychiatric Association, 2000), research shows that injured partners may experience the symptoms of the PTSD (Glass, 2003; Gordon, Baucom, & Snyder, 2005a; Lusterman, 1998; Meldrim, 2005). Recently, De Stefano and Oala (2008) stated that using a PTSD frame may be helpful especially where reactions of offended partner are extremely intense and cause major distress. Lusterman (1995) and Ortman (2009) support the idea of overlap between the symptoms of offended partners and PTSD symptoms.

Besides the negative impact of EMI on individuals, there are also negative outcomes of infidelity on the primary relationship (Blow & Hartnett, 2005b). Gordon, Baucom, and Snyder (2005a) reported that infidelity could be disruptive for individuals and couples to function well and interact with each other. Schneider et al. (1999) found that most of offended partners initially threaten to leave their involved partner because of the disclosure of EMI. However, only one in four couples actually separate after discovering EMI. Aftermath of EMI related divorce, the involved partner may experience lower life satisfaction and lower self-esteem (Spanier & Margolis, 1983). In addition, involved partners were more likely to experience depression after divorce. Contrarily, Sweeney and Horwitz (2001) found that offended partners who initiated a divorce experienced less depression than individuals who divorced for other reasons. Furthermore, Battleson (1997) examined the couples who decided to stay married after discovering EMI. In his qualitative study, eighth couples were interviewed both separately and together, and asked their experience. Results revealed that three interceding conditions in which couple stayed together: (1) Couples' motivation to

stay in marriage for various reasons (e.g., financial, legal, or family reason. (2) Couples needed to develop a unique combination of strategies to implement forgiveness (e.g., action, interaction, acceptance, repentance, and others). (3) Couples needed to resolve the issues of trust, forgetting, and the passing of time.

According to Meldrim (2005), offended partners with children perceive EMI not just an abandonment of them, but also an abandonment of their children. Consistently, Lusterman (2005) agrees that parents often burden their children unwittingly in the course of an EMI. Specifically, the burden on children varies as a function of the child's age, gender, culture, and other characteristics. Thus, clinicians are frequently to confront the effects of EMI not only among couples, but also among individuals, and among children affected with the parental infidelity (Snyder, 2005).

2.1.8 Healing Process and Clinical Applications

In the last two decades, there has been a growing body of literature which focuses on healing process and clinical application of infidelity (Scheinkman, 2005; DuPree et al., 2007). In this literature, the issue of disclosure of EMI has been highlighted as a part of the process of healing (Blow & Hartnett, 2005b). According to Atkins et al. (2005), couples who disclosed EMI showed better progress comparing with couples who kept the EMI as a secret. Schalk (2006) also found disclosure as an important theme through healing process. Olson et al. (2002) revealed a three-stage process following disclosure of EMI. In his model, healing process is described as follow: *"the process starts with an "emotional roller coaster" and moves through a "moratorium" before efforts at "trust*

building” are recognized” (p. 423). The other study which is counted in the practice-based evidence was completed by Gordon, Baucom, and Snyder (2004). They developed a step-by-step forgiveness-oriented approach to helping couples who injured with EMI: *“The first step of treatment deals with the impact of the infidelity; the second explores the context and meanings related to the infidelity; and step three helps the couple move on after the affair”* (p. 229). In the case study based on their model, offended partners showed significant decreases in trauma-related symptoms, depression, and initial anger toward their spouses. The other practice-based evidence is Atkins et al.’s (2005a) Integrative Behavioral Couple Therapy (IBCT) for couples who try to recover from EMI. According to them, infidelity is not solitary behaviors; it is a process in which there are six phases namely; predisposing, approach, initial involvement, maintenance, disclosure or discovery, and response. Their treatment model is based on these phases. In the recent study, Atkins et al. (2010) reported outcomes of their treatment model implemented in a community-based sample of experienced infidelity in Germany and Austria. The participants were 145 couples who reported EMI as a problem in their primary relationship and 385 couples who sought therapy for other reasons. The results revealed that couples with EMI were significantly more distressed and reported more depressive symptoms at the beginning of therapy. However, they showed improvement through the end of treatment and they were not statistically distinguishable from other couples at the six months follow-up.

DuPree et al. (2007) reviewed a number of qualitative and theoretical articles that provided guidelines for treating infidelity and identified a core set of

clinical recommendations (see Table 1). According to them, common goals for infidelity treatment were as follow:

Create a safe, trusting environment for the clients to examine and explore their relationship, (b) Provide a structured environment for the clients to feel equally validated and guided in the process of therapy, (c) Examine the emotional, behavioral, and cognitive reactions to the trauma of infidelity, (d) Explore past and present patterns of the relationship, (e) Explore past and present expectations and meanings of the relationship, (f) Provide a structured process of self-disclosure to allow for understanding and a means of rebuilding attachment and trust, (g) Examine new patterns, meanings, and expectations of the relationship on a structural, behavioral, emotional, and cognitive level in order to maintain trust, and (h) Explore the process of forgiveness and mutual healing (p. 331).

Specifically, forgiveness was a significant factor in couples staying together (Battleson, 1997). Likewise; Bagarozzi (2008) offered a multidimensional model for treating marital infidelity and considered four main factors; the types of EMI, the personality of offending partner, the spouses' perception of marriage, and the other circumstances. It is generally accepted by experts that the establishing trust, attending to the feelings of the offended partner, and using the infidelity as an opportunity to strengthen the marriage, are important areas for intervention (Nelson, 2005). Moreover, Stefano and Oala (2008) highlighted three specific aspects of working with individuals and couples who injured by EMI: handling disclosure, dealing with traumatic reactions, and fostering forgiveness.

Table 1 Themes in Clinical Guidelines for Treating Infidelity*

I. Treatment Engagement	
1. Role of Therapist	a. Direct, active, collaborative, guide, flexible, advice-giving.
2. Treatment Structure	a. Provide plan, b. Set boundaries.
3. Modality	*a. Couple, couple/individual, and sometimes individual.
II. Assessment	
1. Cognitions/Emotions	a. Thoughts/emotions before and after the affair, b. Level of crisis, c. Possible mental health disorders (e.g., major depression, bipolar disorder, addictions, personality disorders).
2. Couple/Family Relationship	a. Current and past relational patterns of the couple, b. Family of Origin.
3. Trauma Event(s)*	a. Type and length of affair(s) (disclosed in individual and/or couple sessions)*, b. Reactions to the affair.
4. Life Cycle	a. Stage of life, b. Outside events and stressors.
III. Interventions	
1. De-escalation	a. Reduce emotional crisis level, b. Engage both partners through validation.
2. Cognitive Re-framing	Understand meaning of affair in light of past expectations and patterns.
3. Systemic Restructuring	a. Create safety for re-structuring of thoughts, behaviors, and attachments, b. Create new patterns of interaction and communication while setting boundaries to reduce risk of repeat trauma.
4. Attachment Re-building	a. Strengthen new patterns of relationship, b. Use new patterns to express hurts, forgive, and rebuild new meaning in relationship.
IV. Treatment Adherence	
1. Needs of Clients	a. Consistently re-examine needs of clients, b. Collaborate with treatment process, c. Clearly communicate treatment plan.
2. Therapist Attributes	a. Non-judgmental, b. Understanding, c. Ability to focus on the affair, d. Validating, e. Observant, f. Flexible, g. Provide hope
V. Relapse Prevention	
1. Re-structuring	Restructuring of relationship patterns, irrational thoughts, and family structures.
2. Re-building	Re-building emotional bonds, level of hope, and positive behaviors.
VI. Cultural Considerations	
1. Religion/Culture	Examine beliefs, expectations, and contexts that may influence meanings of infidelity and intimacy.
VII. Ethical Dilemmas	
1. Secrets	*a. Overall, keeping secrets seem to be harmful. Disclosure to the partner seems to be beneficial when seeking relationship improvement. b. Keeping secrets may be needed when there is a risk of physical violence. Some believe that ancient affairs do need to be disclosed.* c. When the court system is involved due to custody/divorce issues, keeping secrets need to be assessed in regards to benefit of all members.
2. Confidentiality	Providing confidentiality guidelines upfront help avoid ethical/legal problems.

*DuPree et al. (2007)

2.2 Trauma and PTSD

In this section, the main aim is to explain and clarify the concepts of psychological trauma with the following topics; history of the term, traumatic events and prevalence, response to traumatic events and PTSD, diagnosis, assessment, and epidemiology of PTSD.

2.2.1 History of the Term: Trauma

Originally, “trauma” comes from an ancient Greek word having the meaning of “wound” or “pierce”. Related to the origin, “the unseen wound” is another phrase used for trauma. Moreover, it is widely accepted that trauma paradigm posits that stressful life events may result in long-term negative outcomes for individuals. Indeed, a number of authors define the term “trauma” as the reactions to the traumatic events (Kleber, Figley & Gersons, 2001). Friedman (2003) stated that the concept of trauma has changed from an external event to an individual’s psychological response to the event.

According to Herman (1992), a particular form of psychological trauma has appeared into public awareness three times over the past decades: (1) hysteria, (2) shell shock, and (3) sexual and domestic violence. The first to emerge was “hysteria” which was seen as the archetypal psychological disorder of women. The frontier of the study of hysteria was Jean-Martrín Charcot who focused on the neurological damage (motor paralyses, sensory losses, convulsions, and amnesia) instead of inner lives. Charcot also called the term as “the Great Neurosis”. Charcot’s followers, Janet, Freud, and Breuer formulated hysteria as a condition caused by psychological trauma in the mid 1890. In their view, an altered state of

consciousness was produced by emotional reactions to the traumatic events. While Janet called this alteration as “dissociation”, Breuer and Freud called that as “double consciousness”. This first attempted to explain the psychological theory of hysteria was failed by Freud’s theoretical explanation of psychoanalysis. Instead of accepting common effects of psychological trauma (such as childhood sexual abuse), he had concluded that hysterical patients’ accounts of childhood sexual abuse were just fantasies.

The second to emerge was “shell shock” after the First World War concluded by over eight million men died. Charles Myers was one of the well-known psychologists worked with the cases who exposure to violent death, and he reported nervous disorder called “shell shock”. According to Myers (cited in Herman, 1992), emotional stress created by war conditions produced a neurotic syndrome resembling hysteria in men. The followers of Myers were Levis Yealland who wrote “Hysterical Disorders of Warfare” in 1918 and Abram Kardiner who published “the Traumatic Neuroses of War” in 1941. Following the Second World War, mental health field had focused on effective treatments. Especially during the Vietnam War, these studies were elevated. After releasing of “Legacies of Vietnam” written by Egendorf et al. in 1981, the characteristic syndromes of psychological trauma become a diagnosis.

The third to emerge was “sexual and domestic violence” in which consequence of trauma to come into public awareness. As a result of the feminist movement developed in Western Europe and North America in the late nineteenth-century, it has been faded once again. Betty Friedan (1963) who wrote the “Feminist Mystique” and Diana Russell (1984) who published “Sexual

Exploitation, Rape, Child Sexual Abuse, and Sexual Harassments” were the frontiers of this movement. Especially, Russell’s survey showed that one woman in three had been sexually abused in childhood. In order to the result of feminist movement, it has been recognized that the traumatic disorders were not only for men in war but also for women in civilian life.

After these historical points, PTSD was first introduced as a psychiatric disorder in the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual, third edition (DSM-III) in 1980. Until PTSD was included to the DSM-III, symptoms of traumatic stress had been represented in the various editions of DSM. While the DSM-I conceptualized trauma symptoms as neurotic neuroses, in the DSM-II, transient situational disturbances or gross stress reactions were discussed (Deprince, 2001). PTSD is distinct from other mental health problems in the DSM-III and classified as an anxiety disorder. On the other hand, the DSM-IV (APA, 2000) has allowed for an increased number of traumatic events that can result in PTSD (Meldrim, 2005). Moreover, in the latest edition DSM-V expected in 2013, the stressor criteria have been enlarged to include a wider range of traumatic events than previous descriptions.

2.2.2 Traumatic Events and Its Prevalence

As used in daily life expression, trauma means catastrophic life events which are not rare such as deadly accident, rape, war-terror etc. The term explains the severity of events more than the effects on the victims. On the other side, “trauma” is the most commonly used as a synonym of Post Traumatic Stress Disorder (PTSD) in academic writings. Thus, there is a kind of confusion about

using the term. Toward a better understanding of psychological trauma, the characteristics of traumatic events and reactions of the victims might be explained. According to Jensen (2003), the main characteristic of traumatic events is the threat directed towards the victims' (1) life, (2) body part, (3) loved one, and (4) belief system. From this perspective, the traumatic events are categorized as an accidentally human-made (plane crash, traffic accident etc.), an intentional human-made (rape, war, torture etc.), and a nature-made (earthquake, hurricane, flood, ext).

Although there is no consistent statistics on the life-time occurrence of traumatic events, Breslau et al. (2009) reported that the lifetime cumulative exposure to any traumatic events in a national sample of the U.S. population was 82.8 percent. Much lower estimates of exposure to any traumatic event had been reported in Germany and Switzerland (20% to 28%) (Perkonigg et al., 2000). The results of lifetime prevalence of traumatic events showed that the rate of having at least one traumatic events was 76 % in Mexico (Norris et al., 2003), 80.8 % in Sweden (Frans, et al. 2005), 67 % in Israel (Amir & Sol, 1999), and 80 % in Japan (Mizuta, et al., 2005). Furthermore, Ursano et al. (2009; 2007) reported that approximately 162 million people world-wide were affected by disasters (e.g., natural disasters, industrial and other accidents, and epidemics) and over 105 thousand people died in 2005 based on the data from World Health Organization (WHO). In addition, human made disasters (war and terrorism) cause other trauma victims, and more than 30 armed conflicts are occurring in 26 countries. Therefore, two million children have been killed and six million have been

permanently disabled or injured in war. These statistics confirm that there is a high prevalence of psychological trauma.

2.2.3 Response to Traumatic Events

Herman (1992) explicates the emotional problems following the traumatic events as a normal response to the abnormal circumstances. She stated that *“traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life”* (p. 33). In the trauma literature, it is a central idea that traumatic events do not traumatize all the time. Even in the U.S. where the majority of the population has been exposed to one or more traumatic event, only a minority of trauma victims (less than 10%) has developed PTSD (Breslau, 2009). Consistent with this, the statement that the severity of traumatization depends on the balance between stressor factors (socio-economic problems, ethnic problem, previous threats etc.) and protective factors (social support, safety feeling, family support etc.) has received more support from researchers and clinicians who work in this field.

Although it is generally accepted that the emotional problems following the traumatic events are seen as a normal response, traumatic experience may lead to psychological disorders. Turner and Llyod (1995) emphasized that the traumatic events represent the main dimension for mental health risk. They reported that there is a relationship between traumatic experience and the life time risk for major depression and substance abuse. Consistent with this, Taft et al. (2009) showed the high rates of PTSD and depression comorbidity among victims of interpersonal violence. Apart from comorbid problems, trauma related

diagnoses are categorized as follows: (1) All immediate reactions to the traumatic events are called as Acute Stress Disorder (ASD), (2) After more than one month, these reactions are named as Post Traumatic Stress Disorder (PTSD), (3) If the stressor (threat) continues, trauma reactions are explained by the term Continued Stress Disorder (CSD), (4) whereas the prolonged exposure to threat is called as Complex PTSD (incest, child abuse, sexual abuse, torture etc.). Although it is not common, Traumatic Psychosis is another traumatic reaction (Jensen, 2003). Among these categories, PTSD is used as the major diagnosis in the present study.

Herman (1992) categorized all the symptoms of PTSD as follows: Hyperarousal, Intrusion (re-experiencing), and Constriction (avoidance). Hyperarousal symptoms are the main characteristic of PTSD. According to her *“hyperarousal reflects the persistent expectation of danger; intrusion reflects the indelible imprint of the traumatic moment; constriction reflects the numbing response of surrender”* (p. 35). Mainly, physiological arousal continues for a person after experiencing the traumatic event and certain physical and emotional stimuli continue to trigger the victim’s body as if there were a continuing threat. In addition, difficulty concentrating and hypervigilance are the other symptoms of this group of reactions (Friedman, 2003). Although the traumatic event is in the distant past, hyperarousal may lead to living in a state of chronic stress. Therefore, the risk of physical health problems is increased for individuals with PTSD (Meldrim, 2005).

The second category of the symptoms of PTSD is intrusion which reflects the persistence of thoughts, feelings, and behaviors specifically related to the traumatic event. People with PTSD relive the event as though it were continually

recurring or re-experiencing in the present. The intrusion symptoms include intrusive recollections, traumatic nightmares, PTSD flashbacks, trauma-related/stimulus-evoked psychological distress and physiological reactions. Finally, the last symptom group of PTSD is constriction symptoms which described as the shutting down the system of self-defense by Herman (1992): *“The helpless person escapes from her situation not by action in the world but rather by altering her states of consciousness”* (p.; 42). In addition, avoidant and numbing symptoms are the major symptoms of constriction. People with PTSD give some effort to avoid trauma-related thoughts, feelings, places and people (Friedman, 2003). Herman (1992) summarized the responses to the psychological trauma as follows: feeling powerless and disconnecting from others.

2.2.3.1 Physical Responses in PTSD

The physiological backgrounds of the PTSD symptom cluster have been explained by different models. Two major components of the human stress response to a frightening situation are the Fight-or-Flight Reaction and the General Adaptation Syndrome. The fight-or-flight reaction refers to the mobilization of brain and sympathetic nervous system (SNS) mechanisms in response to the traumatic events (Van Der Kolk, 1994). More specifically, Friedman (2003) explained the process of this reaction as follows:

During this reaction, the heart pumps more blood to the muscles, which enables them to perform defensive (“fight”) or escape (“flight”) movement necessary for survival. The fight-or-flight reaction begins in the brain via complex array of highly evolved neurobiological mechanisms that detect danger, experience fear, and set off the sequence of adaptive escape and defensive responses. When faced with a threatening situation, the central nucleus of amygdala activates a hormone called

Corticotrophin releasing factor (CRF), which stimulates the neurons in the locus coeruleus, a small cluster of nerve cells that contain most of the brain's adrenergic neurons (primarily noradrenalin and adrenaline). Locus coeruleus neurons stimulate brain centers that mediate arousal, emotional reactivity, and memory (e.g., the hypothalamus, amygdale, hippocampus and cerebral cortex) (p. 66).

The other major component of the human stress response is the General Adaptation Syndrome which focuses on hormonal activities rather than a neurotransmitter response. The Hypothalamic-Pituitary-Adrenocortical axis (HPA) is the central part of the model. Friedman (2003) explained the activities of the HPA axis as follows:

The hypothalamus releases CRF into the bloodstream, which carries it rapidly to the nearby pituitary gland where it provokes the release of adrenocorticotrophic hormone (ACTH). ACTH is carried by the blood stream to the adrenal gland which releases cortisol. Cortisol has been called the "stress hormone" because blood cortisol levels are elevated during the normal human response to stress (p. 68).

Ursano et al. (2009) stated that brain models of PTSD require understanding the phenomenology of the disorder. More recent research has started to look at other elements in the onset and triggers of PTSD such as the 5-HT2A receptor, the glucocorticoid receptor, p11, mitochondrial genes and cannabinoids. According to Bloom (1997), this extreme adjustment prepares one to make quick response to the traumatic events, and problems arise when this reaction is evoked in the absence of threat. All these physical changes elicit characteristic cognitive and affective responses in people with PTSD.

2.2.3.2 Cognitive Responses in PTSD

Numerous theoretical models have emphasized the importance of cognitive activities in the psychopathology of PTSD. Indeed, cognitive reactions which occur after traumatic events have received extensive attention by trauma researchers. The major important area of cognitive responses to the traumatic event is memory functioning. Van der Kolk (1994) describes two types of memories; declarative (explicit) and nondeclarative (implicit):

Declarative memory refers to conscious awareness of facts or events that have happened to the individual. This form of memory functioning is seriously affected by lesion of frontal lobe and hippocampus, which have also been implicated in the neurobiology of PTSD. Nondeclarative memory refers to memories of skills and habits, emotional responses, reflexive action, and classically conditioned responses. Each of these implicit memory subsystems is associated with particular areas in the central nervous system (p. 280).

Schacter (1987) has referred to scientific descriptions of traumatic memories as examples of nondeclarative memory. Consistent with this, Herman (1992) describes the traumatic memory as “*wordless and static*”. Traumatized people are not able to tell the story of trauma. Facing with frightening events, dissociation becomes the only option for the victim whose thought is “*it is not happening to me*” (Meldrim, 2005). Supporting these clinical observations, Van Der Kolk (1994) reported that dissociation may be adaptive under the extreme threat and “*the lack of integration of traumatic memories is thought to be the pathogenic agents leading to the development of complex biobehavioral changes, of which PTSD is the clinical manifestation*” (p. 282). Contradictory, the other feature of the memory in PTSD is the reliving experiences or flashbacks to the trauma. Brewin and Holmes (2003) reported that “*flashbacks are dominated by*

sensory detail such as vivid visual images and may include sound and other sensations” (p. 340). According to them, reliving of these memories is reflected in a distortion in the sense of time and triggered involuntarily by specific reminders. In addition, flashbacks were reported as the most frequent intrusive cognitions by 43% of the PTSD patients.

Cognitive theories of PTSD have tried to explain other cognitive activities. Meldrim (2005) stated that when a person is completely powerless and placed in a situation s/he has no control, a state of learned helplessness may occur. Related to helplessness, the idea of *“mental defeat”* is defined as *“the perceived loss of all autonomy, a state of giving up in one’s own mind all efforts to retain one’s identity as human being with a will of one’s own”* (p. 45, Ehlers, Maercker, & Boss, 2000). This experience shatters one’s basic beliefs and assumptions and leads traumatized people to produce dysfunctional cognition associated with the traumatic event (Bolton & Hill, 1996; Horowitz, 1986). It is generally accepted that beliefs are much more important than threat itself in PTSD (Brewin & Holmes, 2003). Foa and Rothbaum (1998) reported that people with PTSD build negative schemas about the self (e.g., “I am worthless”), the world (e.g., “The world is a dangerous”) and the other (e.g., “They are untrustable”). More negative assumptions about the self, world, and others have been found in traumatized versus nontraumatized individuals, and these assumptions have been associated with PTSD severity (Owens & Chard, 2001; Wenninger & Ehlers, 1998). Moreover, some researchers have emphasized that the traumatic experience may destroy the trust (Andrews et al., 2000; Herman, 1993). Also research has confirmed that negative interpretations of the event are seen more frequently in

the PTSD group (Ehlers et al., 2000; Dunmore, Clark, & Ehlers, 1999). Ali and Dunmore (2002) assessed the role of negative belief in physical and sexual assault victims, and their results indicated that the PTSD group reported more negative cognitions. In the recent study, Bennett, Beck, and Clapp (2009) showed that PTSD positively associated with dysfunctional cognitions.

Some researchers have investigated these cognitions within dyads, and proposed that significant others' cognitions influence individual appraisals of traumatic events (Monson et al., 2009). They examined couples' assumptions about the world and relationship in order to predict wives' PTSD symptoms after severe flooding. Although individuals' assumptions alone did not predict wives' PTSD symptoms, the interaction of husbands' and wives' benevolent world assumptions significantly predicted. Their results indicated that when husbands held less benevolent world assumptions, there was a negative association between wives' assumptions and PTSD symptoms. This result highlighted the importance of social context of PTSD.

2.2.3.3 Affective and Social Responses in PTSD

Following the traumatic event individuals respond in various emotional way. Whereas some emotions depend on an element of cognitive appraisal of event, others are the direct results of outcomes (Friedman, 2003). The basic requirement of diagnosing PTSD is to experience helplessness, intense fear, or horror during the traumatic events. These fear related emotions have been found as strong predictors of PTSD (Brewin & Holmes, 2003). In addition, anger, shame, guilt, sadness, betrayal and humiliation are also other related feelings of

experiencing trauma (Reynolds & Brewin, 1998; Freyd, 1996). Specifically, Ehlers et al. (1998) reported that high levels of anger predict a slower recovery from PTSD. In a recent study, Bennett et al. (2009) found positive associations between PTSD and worry as maladaptive intervening variable. On the contrary, numbing is another significant affective response to experiencing traumatic stress. Friedman (2003) described numbing as anesthetizing themselves against the intolerable panic, terror, and pain. It was highlighted that people with PTSD numbing not only intolerable to the trauma-related feelings but also to the loving feelings which are necessary to sustain any close relationship.

All the effects of traumatic experience (physical, cognitive and emotional) may lead the person with PTSD to become socially disconnected. Although human beings are social animals, disconnection has been found as the core of social responses for people who experienced traumatic events (Herman, 1993). It is generally accepted that the systems of attachment meaning that link individual and community are destroyed by traumatic events (Beck et al., 2009). Thus, lack of social support was shown to be one of the main predictors of PTSD symptoms (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003). A series of studies also showed that a negative aspect of support (indifference or criticism) is a better indicator of PTSD symptoms (Ullman & Filipas, 2001; Zoellner, Foa, & Bartholomew, 1999). Consistent with this, Andrews et al. (2004) reported that the relationship between negative social support and later PTSD symptoms is more vigorous for women comparing with men.

2.2.4 Diagnosing and Assessing PTSD

Consistent with the general trauma framework, in the fourth edition of Diagnostic and Statistical Manual of Mental Disorders–Text Revision (DSM-IV-TR; APA, 2000), the definition of a traumatic event consists of two components: (1) Exposure to a catastrophic event (the A1 criterion); and (2) Emotional distress due to such exposure (the A2 criterion). Thus, the DSM-IV indicates that “*the person experienced, witnessed or was confronted with an event(s) that involved actual or threatened death or serious injury or a threat to the physical integrity of self and others,*” and which evoked “*intense fear, helplessness, or horror*” (p. 179). Together, these two requirements consist the Criterion A component of PTSD. In addition, the PTSD syndromes are defined by three symptom clusters in the DSM-IV. (1) Re-experiencing the traumatic event (1 out of 5 criterion symptoms is required) which is called Criterion B. Cluster B contains intrusive symptoms such as recurrent intrusive recollections and nightmares. (2) Avoidance of stimuli that resemble the event and numbing of emotional responsiveness (3 out of 7 criterion symptoms are required) called Criterion C. Cluster C contains withdrawal symptoms such as efforts to avoid thoughts or feelings, impaired recall for traumatic event, and restricted range of affect. (3) Increased arousal (2 out of 5 symptoms are required) called Criterion D. Finally Cluster D contains symptoms of arousal such as hypervigilance, sleeping difficulties, and exaggerated startle response. Besides these three clusters, the E criterion states that symptoms must persist for more than 1 month and, the F criterion states that, “*the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning*” (p. 181) (see Table 2).

Table 2 DSM-IV-TR Criteria for PTSD

Criteria	
Criterion A (Stressor): The person has been exposed to a traumatic event in which both of the following have been present:	<ol style="list-style-type: none"> 1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others. 2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.
Criterion B (Intrusive Recollection): The traumatic event is persistently re-experienced in at least one of the following ways:	<ol style="list-style-type: none"> 1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed. 2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content 3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur. 4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. 5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
Criterion C (Avoidant/Numbing): Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:	<ol style="list-style-type: none"> 1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma 2. Efforts to avoid activities, places, or people that arouse recollections of the trauma 3. Inability to recall an important aspect of the trauma 4. Markedly diminished interest or participation in significant activities 5. Feeling of detachment or estrangement from others 6. Restricted range of affect (e.g., unable to have loving feelings) 7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
Criterion D (Hyper-arousal): Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:	<ol style="list-style-type: none"> 1. Difficulty falling or staying asleep 2. Irritability or outbursts of anger 3. Difficulty concentrating 4. Hyper-vigilance 5. Exaggerated startle response
Criterion E (Duration): Duration of the disturbance (symptoms in B, C, and D) is more than one month	
Criterion F (Functional Significance): The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	
Specify if:	<p>Acute: if duration of symptoms is less than three months</p> <p>Chronic: if duration of symptoms is three months or more</p> <p>With delay onset: if onset of symptoms at least six months after the stressor</p>

More recent research has started to look at the limitations of trauma definition of DSM-IV. Gold et al. (2005) examined whether only traumatic events defined by the DSM-IV are capable of causing PTSD symptoms. In their research, undergraduate students were assessed for psychopathology and the level of exposure to trauma. The participants were divided into two groups: Criterion A1 group who reported a traumatic event that was consistent with the DSM-IV and inconsistent group who reported a traumatic event that was not consistent with the DSM-IV. Their results showed that the latter group met criterion for PTSD and reported greater severity of PTSD symptoms. Boals and Schuettler (2009) were doubtful about these unexpected results and replicated Golden et al.'s study including A2 criterion. It was found that A1 trauma criterion had little to no relationship to PTSD symptoms when A2 criterion was considered. Although A1 criterion is an established predictor of PTSD (Breslau & Kessler, 2001), there is also theoretical and empirical support for the importance of A2 criterion. Moreover, Boals and Hathaway (2010) also emphasized the importance of the E and F criteria. They explained that the emotional reactions to obviously non-traumatic events look like PTSD with discounting of these two criteria. In their study, including duration (E criterion) and subjective impairment (F criterion) dropped the rates of those meeting PTSD criteria from 20% to 3%. These researches confirm that the relationship between PTSD and the traumatic events is not as clear-cut as the literature tends to convey.

In the light of the research questioned PTSD criteria, the American Psychiatric Association (APA) has launched the process in the publication of the fifth edition of the diagnostic and statistical manual of mental disorders (DSM-V)

in 2013. In the latest edition of DSM, the A1 criterion could make a better distinction between distressing and traumatic events (www.apa.org). In addition, DSM-V proposes fourth cluster of PTSD symptoms that consist of negative alterations in cognitions and mood.

Beyond the diagnostic argument of PTSD, there are many structured interviews and questionnaires developed for assessing and diagnosing PTSD. Friedman (2003) categorized all these instruments as (1) trauma exposure scales, (2) diagnostic instruments, and (3) symptom severity scales. The instruments of the first category are used to determine whether an individual has been exposed to a traumatic event. Some of example for these instruments as follows: Traumatic Stress Schedule (TSS) developed by Norris (1990), Traumatic Events Questionnaire (TEQ) developed by Vrana and Lauterbach (1994), and Harvard Trauma Questionnaire (Mollica et. al., 1992). The second group is diagnostic instruments such as Structured Clinical Interview for DSM-IV (SCID): PTSD Module and PTSD-Interview and Clinical Administered PTSD Scale (CAPS). The last group of instruments includes mostly self-report questionnaires such as Impact of Event Scale (IES) developed by Sundin and Horowitz (2002), Penn Inventory (Hammarberg, 1992), and PTSD Symptom Scale (PSS) (Foa et. al., 1997) which is used in the present study. All these instruments were built on DSM-IV criteria of PTSD.

2.2.6 Epidemiology of PTSD

Although overall lifetime prevalence of exposure to any traumatic event is relatively high, only a small proportion of victims of traumatic events meet

criteria for PTSD. Even in the sample of U.S. which has vast majority of the population exposed to one or more traumatic event, it has been found that less than 10% of the participant developed PTSD (Breslau, 2009). Moreover, the life time prevalence of PTSD was found as 1.3 % in German (Perkonigg, et al., 2000), 11 % in Mexican (Norris, et al., 2003), % 5.6 in Swedish (Frans, et al., 2005), and 4 % in Israeli samples (Amir & Sol, 1999).

Epidemiological studies have found that different traumas are associated with different conditional risk for developing PTSD. Kelley et al. (2009) stated that combat exposure for men, and rape and sexual molestation for women are the event types most associated with PTSD. In this study, PTSD symptom profiles were compared in three types of trauma (sexual assault, motor vehicle accident, and sudden loss of a loved one). Their results revealed that different trauma types lead to unique variants of the PTSD syndrome. In addition, Resnick et al. (1993) found that victims of crime-related traumas had a higher risk for developing PTSD than non-crime trauma victims. Besides, Breslau et al. (1998) highlighted that conditional risk for developing PTSD varied by trauma type.

The other focus of epidemiology studies is sex differences on PTSD. The results showed the higher PTSD prevalence in women comparing to men (Olf, et al., 2007; Norris, et al., 2003; Perkonigg, et al., 2000; Bernat, et al., 1998; Ullman & Siegel, 1994). Although men are more likely to suffer from trauma, the probability of developing PTSD after traumatic experience is higher for women (Breslau, 2009). In his previous study Breslau (2002) reported that the life time prevalence of PTSD varied from 10-14% for women and 5-6% for men even controlling for rape and sexual assault. Gavranidou and Rosner (2003) reviewed

the literature on gender differences and PTSD, and summarized the findings as follows: (1) men report higher numbers of traumatic events, (2) women and men differ in the types of traumatic events experienced, (3) women more often develop PTSD symptoms after a traumatic event.

When the demographic variables (age, education and income level) are considered, there are contradictory results about the risk factors for developing PTSD. However, trauma exposure level, number of life time traumatic incident, perceived life threat, peri-traumatic negative emotions, physical symptoms and dissociation are seen as the critical predictors for PTSD (Monnier, & Shaw, 2002; Bernat, et al., 1998; Freedy, Olf, et al., 1994). In addition, prior psychological adjustment, the family history of psychopathology and social support play an important role in the development of PTSD (Ozer, Best, Lipsey, & Weiss, 2003).

Another variable focused by epidemiology studies of PTSD is the coping strategies. In the recent study, Gil (2005) worked with terror victims and found that people who developed PTSD scored higher on emotion-focused coping style and lower on the problem-focused style comparing with non- PTSD group. It is generally accepted that emotional coping strategies result in higher rates of PTSD (Gavranidou & Rosner, 2003). Consistent with this, Güneş (2001) reported that problem solving/optimistic approach, fatalistic approach and helplessness coping were found to be significant predictors of intrusive symptoms. Moreover, Gray (2003) reported that both sexes use different coping strategies: women tend to use emotion focused strategies and men use problem-focused strategies mostly.

2.3 Coping Model

According to Lazarus and Folkman (1984), psychological stress refers a particular relationship between the person and the environment “*that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being*” (p. 21). Their coping model states that stress is a result of the interaction of stressful event, the cognitive appraisal of the stressor, and coping strategies. In the following section, the definition of coping is presented first. After introducing the cognitive appraisals and coping strategies, resolution of coping and coping-resource relations are emphasized.

2.3.1 Definition of Coping

Historically, the concept of coping was first formulated within the psychoanalytic ego psychology which defined coping as the realistic and flexible thoughts and acts that solve problems and reduce stress. It is generally accepted that coping consists of a hierarchy of strategies that progress from immature or primitive mechanisms to mature mechanisms (Lazarus & Folkman, 1984). Menninger (1954) who defined coping as an application of defense mechanisms identified five orders of regulatory devices. These are ranked according to the level of internal disorganization. Likewise, Vaillant (1977) who also defines coping as an adaptive application of defense mechanisms categorized the defenses in four levels progressing from psychotic mechanisms, through immature mechanisms, neurotic mechanisms, to the highest level, mature mechanisms. Consistent with this, Haan (1969) also used a hierarchical system for classifying ego processes, and proposed a tripartite hierarchical arrangement (coping,

defending, and fragmentation). In these models explained above, there is a hierarchy of coping and defense in which some processes are automatically considered superior to the others. Moreover, Kahn et al. (1964) pointed out the importance of defining coping independent outcome.

On the other hand, Lazarus and Folkman (1984) suggested that the definition of coping may include efforts of managing stressful demands, regardless of outcome. It means that no unique strategy is considered inherently better than any other. The efficacy of a strategy may be determined only by its effects in a given encounter. Thus, coping could be defined as one's cognitive and behavioral efforts to manage stress. Most approaches in coping research following Lazarus and Folkman's model (1984) have stated that coping consists of cognitive and behavioral efforts to manage specific external or internal demands. They also defined coping as an appraisal process managing the discrepancy between personal resource and demands of situation. A central idea is that coping is a cognitive activity incorporating (1) an assessment of impending harm and (2) an assessment of the consequences of any coping action. Thus, coping paradigm posits that individual differences of reactions to the stressful life events are explained by the coping strategies which people use. In general, the theory of coping is process-oriented rather than trait-oriented. In addition, the theory implies a distinction between coping and automatized adaptive behavior.

2.3.2 Cognitive Appraisal

The concept of appraisal was introduced into emotion research by Arnold (1960) and elaborated with respect to stress processes by Lazarus (1966).

Cognitive appraisal is a key factor for understanding stress-relevant transactions. Lazarus (1966; 1993; 1999; 2000, 2001) provides a number of sources for reviewing the concept of appraisal. In their pioneer study, Lazarus and Folkman (1984) distinguished two types of appraisal: primary and secondary. The primary appraisal is defined as the appraisal of environment in which the individual decides on whether or not there is a threatening event. Primary appraisal can be irrelevant, benign-positive, or stressful. Being irrelevant is assessed when an interaction with the environment has no implications for individuals. Benign-positive is a reference to an interaction that has no negative or apprehensive attributes, but is likely to result in pleasurable emotions. The stress appraisal falls into three parts including harm/loss, threat, and challenge. The first part is “harm/loss” in which the individual has experienced loss. The second part of stress appraisal is “threat” in which stressor has anticipated, but not occurred. The last part is “challenge” appraisals focused on the potential for gain and growth. On the other side, secondary appraisal is the evaluation of coping resource (physical, social, psychological, and material assets) and options. Thus, the evaluation of what can be done to handle the threatening situation is defined to be the secondary appraisal in which the individual evaluates how to cope with the stressor. Secondary appraisal is not less important than the primary appraisal, is just the next step after primary appraisal (Meldrim, 2005). In addition to both primary and secondary appraisals, Lazarus and Folkman (1984) defined reappraisal as the evaluation of new information from internal or external resources. Reappraisal makes alterations in earlier an appraisal which is a form of coping that focuses on changing one’s attitudes and beliefs toward a stressful situation. As a result, the

researcher suggested that if the evaluation of the personal resources is insufficient to cope with the threat, one will experience psychological stress.

Lazarus (1991) emphasized that there is some overlap between appraisal and cognitive coping. The overlap is that coping refers to what a person thinks and does to try to manage an emotional encounter whereas appraisal is an evaluation of what might be thought or done in that encounter. It was stated that how one person reacted to stressful conditions did not necessarily mean that others would react in the same way. The model was concluded with understanding what happens to the individual after a stressful event had to take account of “*individual differences in motivational and cognitive variables which intervened between the stressor and the reaction*” (p. 93). Furthermore, Lazarus and Folkman (1984) proposed that the factors influencing appraisal were person factor (commitment-values and belief) and situation factor (novelty, predictability, event uncertainty and temporal factors).

2.3.1.3 Coping Strategies

Following the appraisals of the stressful event, the next phase of stress response is problem-focused and emotion-focused coping which were defined by Lazarus and Folkman (1984). Problem-focused coping strategies are similar to strategies used for problem solving. Problem solving is a strategy as an effective way of attempting to control a negative situation. The strategy consists of defining the problem, generating alternative solutions, comparing these alternatives in terms of their likely costs and benefits, selecting a likely solution, coming up with a plan, and then acting on it. Other problem-focused coping strategies may be

geared toward changing one's self, such as learning new skills and procedures, thereby increasing one's coping resources. As a result, these strategies primarily attempt to directly change the actual relationship between the person and the situation.

On the other hand, emotion-focused coping strategies focus on changing emotions without addressing problems directly. The primary goal of emotion-focused coping is to decrease emotional distress. Some of the ways, this may be achieved are through avoidance, distancing, and wishful thinking. Moreover, cognitive reappraisals is a form of coping that focuses on changing one's attitudes and beliefs toward a stressful situation which involve changing the meaning of the situation without changing it objectively. There are also emotion-focused strategies directed toward diverting attention from the problem, such as engaging in physical exercise, meditating, having a drink, expressing one's anger, or seeking emotional support. Likewise problem-focused, an emotion-focused coping strategy which is helpful in one situation may be harmful in another (Lazarus & Folkman, 1984).

In the study (Lazarus & Folkman, 1980) of middle age people with stressful encounters, it was found that both functions were used by all the participants. The finding posits that people use both problem and emotion focused coping strategies to deal with the internal and/or external demands posed by real-life stressful situations. Furthermore, individuals adapted better to stress when they use more problem-focused. According to Lazarus and Folkman (1984) problem and emotion focused coping could facilitate and impede each other in the coping process. Although some people are more skilled at coping with stress than

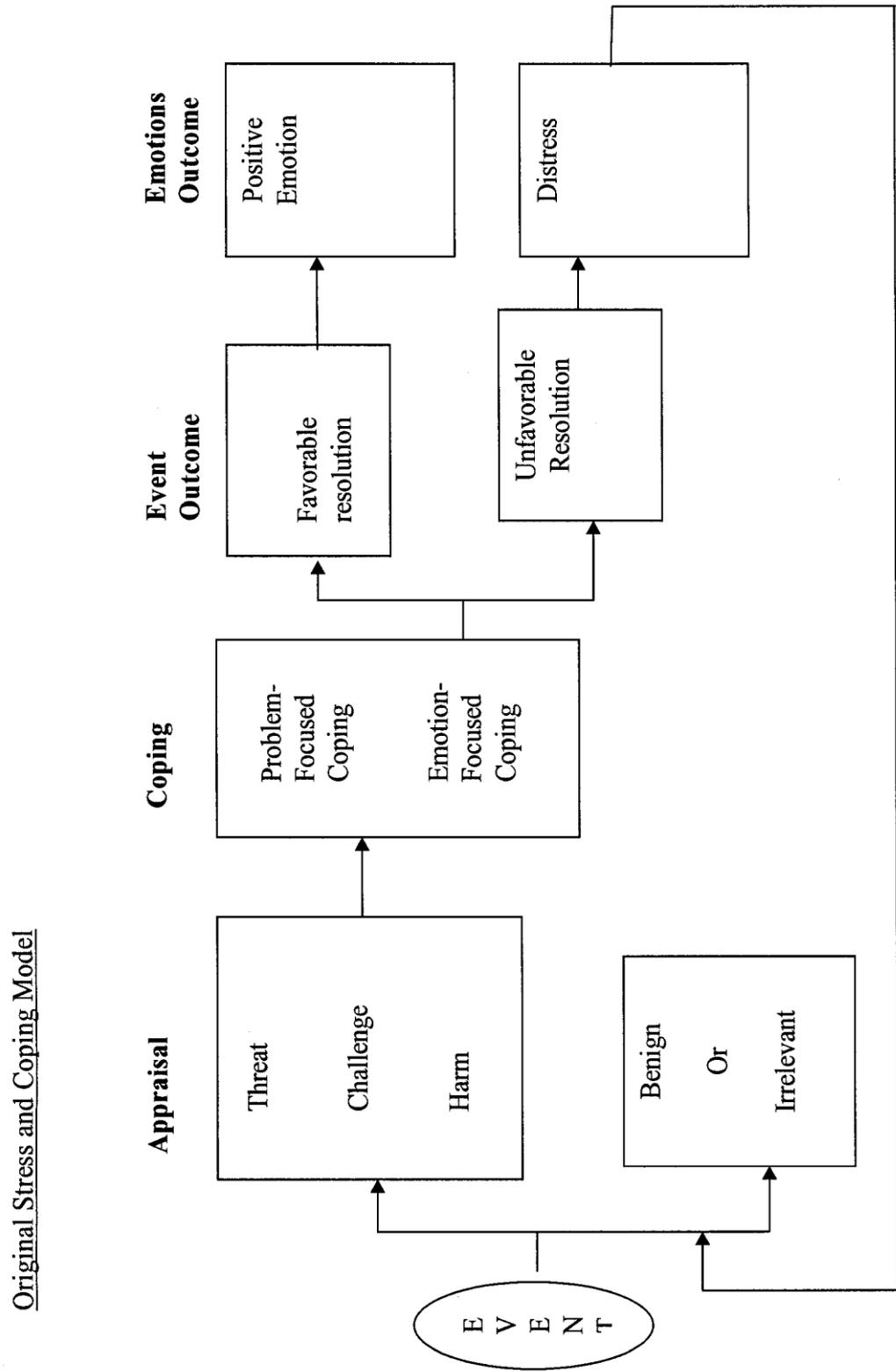
others, it is impossible to identify a set of coping strategies that can be called “good” ways of coping (Reichman, 2000). According to him, the context in which the stressful situation occurs, the type of problem, the other people involved, and the personality characteristics of the individual are only some of the factors that affect how to deal with the situation. Lazarus (1999) suggested that there are three principles of coping which are: firstly, that coping constantly changes over the course of an encounter; secondly, that coping must be assessed as an independent of its outcomes; and thirdly, that coping consists of what an individual thinks and does in an effort to deal with the demands that tax or exceed resources. With these three principles, coping might be summarized as *“constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person”* (p. 98).

2.3.4 Resolution of Coping

Following the cognitive appraisal and coping strategies, the last step of the cognitive-behavioral model of stress and coping is describes as resolution. After attempting to cope with stressful life events, the resolution may be favorable or unfavorable. Based on the model, favorable resolution occurs with positive emotion whereas unfavorable resolution creates distress (Meldrim, 2005). On the contrary with this statement, Folkman (2001) reported that unfavorable resolution may also conclude with positive emotion when the affected individual gains meaning from the experience.

There are a number of factors determined whether an individual can cope effectively with a particular stressor. The first step for effecting coping is to appraise the situation in a positive realistic manner. Further, breaking up a global stressor into those aspects might be accepted to facilitate the identification of potential coping strategies. Moreover, practicing new coping strategies, considering the possible consequences of several different approaches, and obtaining support from others may result in a reduction in the negative consequences of stress. For those situations that threaten to overwhelm, an individual's current resources, coping interventions that provide support, information, and skills training could be effective. Lazarus (1999) identified five empirical generalizations included: (1) people use a range of coping strategies in every stressful encounter, (2) some coping strategies are tied to personality variables, whereas others are tied to the social context, (3) coping strategies change from one time to another as the encounter unfolds, (4) secondary appraisals of control influence the selection of a coping strategy, and (5) coping is a powerful mediator of the emotional outcome (the model is summarized in Figure 1).

Figure 1. The Coping Model of Lazarus and Folkman*



*Meldrim (2005)

2.3.5 Measurement of Coping Strategies

In the late 1970s and 1980s, the Berkeley Stress and Coping Project was taken to create a procedure for measuring the coping process referred to as the Ways of Coping Questionnaire (Folkman and Lazarus, 1988). The original questionnaire was made up of 68 items describing, a wide range of cognitive and behavioral strategies that people used to manage the demands of stressful encounter. The items were developed in accord with the theoretical model suggested by Lazarus (1966) and the coping literature. The questionnaire is answered with a specific stressful event in mind and allowed only Yes-No response. Revisions to the original questionnaire (Folkman and Lazarus, 1985) resulted in redundant and unclear items being removed, new items being added and the response format being changed to a 4-point scale ranging from 0 (does not apply and/or not used) to 3 (used a great deal). The revised questionnaire became the most widely used measure in research on coping. The questionnaire made possible and was designed to provide a process, contextually oriented approach to coping (Lazarus, 1993). It could be used interactively during an interview or as a self administered procedure, where individuals respond to the different items. The questionnaire asked to what extent a person had used certain thoughts and actions in a particular stressful encounter. The items in the questionnaire were classified into two categories (Folkman and Lazarus, 1988). The problem-focused category included items *“that describe cognitive problem-solving efforts and behavioral strategies for altering or managing the source of the problem”* (p. 114). The emotion-focused category included *“cognitive and behavioral efforts directed at reducing or managing emotional distress”* (p. 116). The factors of coping scale

are: (1) Confronting coping, (2) Distancing, (3) Self-controlling, (4) Seeking social support, (5) Accepting responsibility, (6) Escape-avoidance, (7) Planful problem solving and (8) Positive reappraisal. These eight coping scales were, over time, found to be relatively consistent and helpful (Lazarus, 1999).

The Turkish translation of the Ways of Coping Checklist was conducted by Siva (1991). Due to Turkish people's tendency to rely on superstitious beliefs and fatalism as a coping style, six more items addressing these domains were included in the inventory. In her study, seven factors were obtained from the Turkish version of the Ways of Coping Inventory (TWCI) namely, planned behavior, fatalism, mood regulation, being reserved, acceptance, maturation, and helplessness-seeking help. This inventory was utilized with various Turkish samples (e.g., Karancı, et al., 1999; Şahin & Durak, 1995; Uçman, 1990). Some of these researchers also studied the factorial structure of the inventory with their own samples. Şahin and Durak (1995) used TWCI in a study conducted with university students and reduced the number of items to 30. The factor analysis conducted yielded five similar factors, namely, self-confidence, optimism, submissiveness, helplessness, and seeking social support. They also proposed that these factors fit into two dimensional coping styles as problem focused coping and emotion focused coping. Finally, Gençöz, Gençöz, and Bozo (2006) conducted a study which aimed to provide higher order coping dimensions in a Turkish sample. Their results indicated that the three higher-order factors, namely: Problem-Focused Coping, Emotion-Focused Coping, and Indirect Coping Style. For validity analyses, the three-factor solution of the measure showed strong correlations with related scales and also provided good reliability coefficients.

2.3.1.6 Coping and Resources

According to Lazarus and Folkman (1984) coping strategies are efforts to manage stressful demands regardless of how successful those efforts are. The ability to cope successfully with a stressful situation depends on a number of factors. The primary factor is the resources that one brings to the stressful situation. Pearlin and Schooler (1978) described the resource in the following way; *“resources are more helpful in sustaining people facing strains arising out of conditions over which they may have little direct control – finance and job. But where one is dealing with problems residing in close interpersonal relationships, it is the things one does that make the most difference”* (p. 13). The resources such as health and energy of the individual, positive beliefs, problem solving skills, social skills, social support and material resources help individuals cope with stressful life events. On the other hand, personal and environmental constraints, and the level of threat might block these resources. DeLongis and Puterman (2007) stated that the degree of stress experienced by the individual might be determined by both the resources and the subjective appraisals of the individual. Features of the situation such as the desirability, controllability and severity of the stressor, are also important in shaping coping responses.

2.4 Conservation of Resources

The Conservation of Resources (COR) theory developed by Hobfoll (1989) challenges appraisal-based stress theory with suggesting that the fit of personal, social, economic, and environmental resources. Resources are defined as those objects, personal characteristics, conditions, or energies “*that are valued in their own right, or that are valued because they act as conduits to the achievement or protection of valued resources*” (Hobfoll, 2001; p. 339). Different methods of categorization for resources have been used; internal versus external resources, a structural resource classification and centrality of resources to survival. The structural resource classification has been found more helpful for understanding the stress process and employed frequently. Moreover, the role of resources is described as the pivotal construct in COR theory.

COR theory which is one of the main integrated resource theories has seen as an alternative to appraisal-based stress theories that consider both environmental and internal processes. This resource-based theory depicts reaction differences of individuals to the stressful events. Hobfoll (2001) stated that COR theory predicts a range of stress outcomes in organizational setting, health context, following traumatic stress, and in the face of everyday stressors. The COR theory defines stress as a state “*in which valued goals are threatened or lost, or where individuals are unable to create the necessary conditions for obtaining or sustaining these goals*” (p. 41). It was also proposed that a set of tenets, principles, and corollaries which follow from COR theory. The basic tenet of COR theory is “*that individuals strive to obtain, retain, protect, and foster those things that they value*” (p. 60). Thus, Hobfoll (1989) described three situations in which

psychological stress takes place: (1) individuals' resources are threatened with loss, (2) individuals' resources are actually lost, or (3) individuals fail to gain sufficient resources.

2.4.1 Principles and Corollaries

Hobfoll (1998) proposed two major principles and four corollaries which follow from COR theory's central tenet. The first and most important principle is defined as "*resource loss is disproportionately more salient than resource gain*" (p. 62) meaning that loss of resources has greater impact on stress outcomes than resource gain. A series of studies has supported the primacy of resource loss in the stress process (Thoits, 1994; Hobfoll & Lilly, 1993; Taylor, 1991). On the other hand, resource gain has a significant importance in the context of resource loss, which means that resource gain becomes more important for individuals when they experience high level resource loss. Moreover, Hobfoll and Lilly (1993) reported that resource gain is related to psychological distress only after controlling for resource loss. Indeed, resource gain has seen to be related with psychological distress especially in the presence of resource loss.

The second principle of COR theory is that "*people must invest resource in order to protect against resource loss, recover from losses, and gain resources*" (Hobfoll, 1998; p. 73). Related to the first corollary, this principle states that "*those with greater resources are less vulnerable to resource loss and more capable of orchestrating resource gain*" (p. 80). Thus, individuals who have fewer resources possess weaker stress resistance than those with rich resources. Some other research has confirmed this principle focusing on different resources

such as self-efficacy, optimism, and self-esteem (Bandura, 1997; Scheier & Carver, 1985). According to Hobfoll (1998) resources can be invested to aid the process of stress resistance. There are two ways for resource investment; resource replacement and resource substitution. The COR theory highlighted the importance of proactive coping and suggested that resource acquisition, maintenance, and fostering are main motivational goals. The second corollary of COR theory states that *“those who lack resources are not only more vulnerable to resource loss, but that initial loss begets future loss”* (p. 81). In addition, the third corollary of COR theory mirrors the second corollary and states that *“those who possess resource are more capable of gain, and that initial resource gain begets further gain”* (p.82). Thus, loss cycles will be more potent and accelerated than gain cycles. Some researcher has confirmed the long-term impact of loss cycles (Kinh et al., 1999; Green et al., 1990). The last corollary of COR theory posits that *“those who lack resource are likely to adopt a defensive posture to conserve their resources”* (Hobfoll, 2001; p. 356). Based on this corollary, a defensive posture holds a maximum of resources in reserve for the possibility of having to prevent the impact of some future loss sequence.

2.4.2 Examination of Resources

Resources are defined as those objects, personal characteristics, conditions, or energies *“that are valued in their own right, or that are valued because they act as conduits to the achievement or protection of valued resources”* (Hobfoll, 2001; p. 339). Resources were divided into four main categories in COR theory: (1) objects resources (home, transportation, and fetish

objects), (2) personal resources (skills [occupation, leadership, etc.], and personal traits [self-esteem, optimism, etc.]), (3) condition resources (being healthy, employment, marriage, etc.), and (4) energy resources (money, credit, knowledge, etc.). In order to examine individuals' resources, Hobfoll and colleagues developed the Conservation of Resources Evaluation (COR-E) scale (Hobfoll, Lilly, & Jackson, 1992). There are two separate forms of COR-E, namely, Loss and Gain forms. On the COR-E Loss form, participants rate to what extent they have lost these items during the recent past. Whereas, the participants rate on the COR-E Gain form to what extent they have gained these items.

Findings suggest that the COR-E is a reasonable research instrument in the assessment of loss and gain of resources (Benight et al., 1999; Freedy & Hobfoll, 1994; Jackson et al., 2001; Lane & Hobfoll, 1992). The COR-E has been widely used in previous studies (Freedy, et al., 1992; Hobfoll et al., 1990) and frequently utilized to examine the COR theory in a variety of samples such as victims of disasters, chronic illness, and PTSD (Banou, Hobfoll, & Tochelman, 2009; Walter & Hobfoll, 2009; King et al., 1999; Wells, Hobfoll, & Lavin, 1999; Ironson et al., 1997).

2.4.3 Application of COR Theory

It is generally accepted that resource loss is the critical component in the stress process. A number of authors have emphasized that resource loss is the main predictor of stress outcomes in the aftermath of different natural disasters such as hurricanes (Ironson, et al., 1997), floods (Smith & Freedy, 2000) and earthquakes (Hsu, 2003). Consistent with these findings, Norris and Kaniasty

(1996) stated that the impact of disasters was higher among those who diminish their resiliency resources than those who retained their coping resources. Not only for disaster, COR theory has also used as an explanatory model for the process of burnout in organizational level (Grandey & Cropanzano, 1999; Janssen, Schaufeli, & Houkes, 1999). It was reported that burnout occurs when there is a lack of resource gain in spite of resource investment.

COR theory has been used to understand the impacts of chronic illnesses that have traumatic effects on the patients (Lane & Hobfoll, 1992). Thompson and Kyle (2000) found significant resource losses in the lives of patients with chronic health conditions such as cancer, coronary artery disease, diabetes, and arthritis. Not only the patients but also their offsprings were affected by resource loss (Leedham & Meyerowitz, 2000). Chronic illnesses such as cancer, heart disease or arthritis cause physical and psychological losses. Likewise, in a recent study of Dirik (2006), resource loss was found to be one of the significant predictors of anxiety among the patients of chronic rheumatoid arthritis.

It is also accepted that actual or threat of resource loss may result in psychological distress and outcomes (e.g., depression and PTSD) (Benight et al., 1999; Ironson et al., 1997). COR theory states that trauma can create interpersonal resource loss affecting the person's cognitive, emotional and coping functioning (King et al., 1999; Melchert, 2000). In the more recent study of Banou, Hobfoll, and Tochelman (2009), the mediator effects of recourse were examined among women with cancer and non-cancer related PTSD (physical and sexual abuse). Their results showed that only interpersonal loss mediated the relationship between earlier interpersonal trauma and current PTSD symptoms. Also, Walter

and Hobfoll (2009) examined how resource loss is related to alleviation of PTSD symptoms among inner-city women who diagnosed for PTSD aftermath of interpersonal traumatic events such as child abuse, rape, and sexual assault. The findings of their study suggest that women's material and psychosocial resource loss increases PTSD symptoms. In sum; theoretical connection between resources and PTSD is illustrated by COR theory.

2.5 Forgiveness

The term of forgiveness is used for “*replacing the bitter, angry feelings of vengefulness often resulting from a hurt, with positive feelings of goodwill toward the offender*” (Wade, Bailey, & Shaffer, 2005). Consistent with this definition, Sells and Hargrave (1998) stated that forgiveness involves overcoming anger, revenge, shame, records of wrongs and resentment. Fincham et al. (2004) added that forgiveness involves decreasing negative motivation toward the perpetrator. Although forgiveness has received growing interest, this literature is still limited. One of the main explanations of ignorance of the concept of forgiveness in mental health field might be the relations between forgiveness and religions in which the themes displayed first (Gorsuch & Hao, 1993). Since psychology is based on observed behaviors, the second cause is related to difficulty in collecting observable and reliable data about forgiveness. In addition, a definitional difficulty of forgiveness is another factor which delayed the empirical studies.

2.5.1 Forgiveness in Psychology

There are mainly two periods in the history of forgiveness studies in the psychology literature. The earliest period, between 1932 and 1980, consisted of the theoretical aspects and modest pragmatic work to illuminate the features of forgiveness. The second period, from 1980 to present, has emphasized more empirical and intensive work on the concept of forgiveness (McCullough, Pargament, & Thoresen, 2000). At the beginning of the first period, mental health professionals and psychologists mentioned the concept of forgiveness both in Europe and United States. In the 1930s, Piaget argued the ability of forgiveness originated from the development of moral judgment. Later, in the middle of 1940s Litwinsky described the affective structure of the capacity for interpersonal forgiving. On the other hand, counselors and mental health experts who are interested in religious themes highlighted the importance of forgiveness to support the well being. Likewise, Angyal claimed that clients should experience the opportunity of feeling of being forgiven for their ethical and moral failures and that of forgiving others in the 1950s. However, the first systematic study was conducted by Emerson who had examined the link between forgiveness and psychological well being in the 1960s. In this period, the term “forgiveness” was described by Heider (1985) as preceding vengeful behavior that it is an implicit expression of the victim’s self worth or an effort to be faithful to a moral standard. However, his explanation did not make enough theoretical impression. Rokeach (1973) who studied nature of human values used forgiveness in his The Rokeach Value Survey. This survey was composed of two parts; instrumental (preferred modes of conduct) and terminal values (preferred end states for life). Even many

studies were conducted by using this survey, it did not provide an important contribution for systematic research of forgiving. Similarly, other researchers (e.g., Gahagan & Tedeschi, 1968) gave a place for the concept of forgiving in their work but it was not accepted as a big theoretical and empirical topic to research until 1980s.

In the second period of forgiveness, there was a great interest in the exploration of forgiving. Thus, its theoretical and empirical popularity were growing rapidly in the field of psychology. The link between moral development and forgiveness was examined by Enright, Santos and Al-Mabuk (1989). In their study, an interview measure for evaluating the moral-cognitive development of reasoning about forgiveness was developed. Their results showed that people who were high in religion beliefs also had more sophisticated moral reasoning regarding forgiveness. The relation of lifetime development and forgiveness was taken into consideration (Spidell & Liberman, 1981). In the clinical settings, researcher began to mention the positive effects of forgiveness on mental health in the second period (Fitzgibbons, 1986). In 1990s, forgiveness was used by many practitioners in clinical settings (McCullough & Worthington, 1994). In this period, the social and psychological facts of forgiveness were investigated by researchers. One of these studies conducted by Darby and Schlenker (1982) showed that the variables of social-cognitive nature such as offender's perceived responsibility, intentionality, motives and the severity of the offence can clarify the people's motivation to forgive an offender. Recently, the literature of forgiveness psychology has grown rapidly to involve the social psychological

elements of forgiveness, neuro-imaging of forgiveness, forgiveness and health, and developmental perspective on forgiveness (Worthington, 2005).

2.5.2 Concept of Forgiveness

Although the forgiveness related research is grown, there is no consensual definition of forgiveness exists (Worthington, 1998). Most of the researchers (e.g., Elder, 1998; Enright & Coyle, 1998) agreed that forgiveness should be differed from some terms: “pardoning” (which is an official term), “condoning (which means a justification of the offence), “excusing” (which means that the offender had a good explanation for performing the offence), “forgetting” (which means that the memory of the offence has lose its strength in the conscious awareness), and “denying” (which implies a rejection perceiving the harmful damages that one has incurred). These are the terms that researchers agree on the their distinctiveness from the concept of forgiveness. Freedman (1998) also added that the meaning of forgiveness is not similar the term “reconciliation” which means the regaining of a relationship.

In the literature, forgiveness is described in various senses in which the term could be used. According to its properties as a response and as a personality disposition, forgiveness might be defined. McCullough and his colleagues (1998) provided definition of forgiveness as a prosocial change in one’s motivations (e.g., thoughts, emotions, behaviors) toward an offending relationship partner. In terms of personality disposition, it is defined as a tendency to forgive others in a variety of interpersonal contexts. In this definition, individuals might be scaled along a forgiving-unforgiving continuum with most people falling somewhere

toward mean of the population (Mullet, Houdbine, Laurmonier, & Girard, 1998). Hargrave and Sells (1997) proposed a definition for forgiveness as letting one's victimizer to reconstruct trust in the relationship through acting in a trustworthy fashion and as promoting an open discussion of the relational violation. Thus, the victim and the offender can agree to work toward an improved relationship. On the other side, Enright and Coyle (1998) offered another description: "*A willingness to abandon one's right to resentment, negative judgment, and indifferent behavior toward one who unjustly hurt us, while fostering the undeserved qualities of compassion, generosity, and even love toward him or her*" (p. 145). Friedman (2000) has used seven criteria for defining forgiveness: (1) a shift in perception and vision, (2) a shift in beliefs and attitudes, (3) a shift in affects, (4) a shift in self-empowerment and self-responsibility, (5) a shift in choice, decision and intention, (6) a shift from duality consciousness to oneness consciousness, and (7) a shift in the recognition of the core qualities of a person.

Even though definitions of forgiveness differ among researchers and clinicians, there is general consensus on some features of forgiveness (McCullough, Pargament, & Thoresen, 2000). One of the major features is that when people forgive, their responses (e.g., thoughts, feelings, intentions, and behaviors) toward people who have offended or injured them become more positive and less negative. Even in the most horrific situations, forgiveness could still include the increase in positive reactions toward the offender who would be so disturbed as to perpetrate such harmful actions (Wade, Johnson, & Meyer, 2008). The other feature of forgiveness which researchers have generally accepted is the dimensions of forgiveness. Some researchers suggest that forgiveness

consist two dimensions and it is used for examining forgiveness frequently (Fincham & Beach, 2002; Worthington, 2003). The first dimension called negative forgiveness including the degree to which an individual continues to hold feeling of resentment withdraws from the relationship, and needs vengeance or punishment against the partner for a past faithlessness. The second dimension is positive forgiveness which involves the degree to which an individual experiences a willingness to forgive, increase in empathy, and a release from anger. Moreover, Worthington and Scherer (2004) have distinguished between emotional and decisional forgiveness. Emotional forgiveness is rooted in a subset of negative emotions such as resentment, bitterness, hostility, hatred, etc., whereas decisional forgiveness is based in one's beliefs about future interactions with a transgressor.

2.5.3 The Three Stage Model

There are numbers of theoretical model of forgiveness which categorized as a process model of forgiveness and a decision model of forgiveness (Lundahl et al., 2008). While the process models accept that people go through several steps en route to forgiveness, the decision-based models emphasize the choice to make a decision to forgive (Baskin and Enright, 2004). Gordon and Baucom's (2003) the three stage forgiveness model is one of the process models which referred frequently. The three stage forgiveness model was constructed based on frameworks of a reaction to a traumatic event. The model is directly related to major betrayals (e.g., infidelities, significant deceptions, and violations of trust). According to their model, the forgiveness paradigm posits that forgiveness

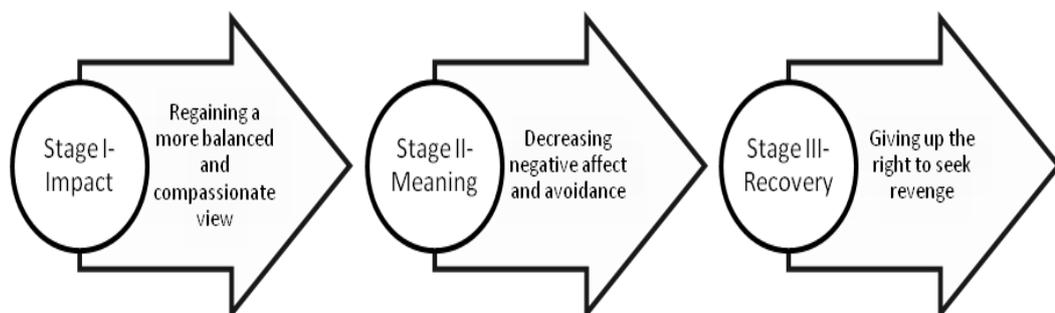
appears to help the reconstruction of the assumptions which are violated by traumatic experience. The process of forgiveness is explained as follow:

The major betrayal that requires a forgiveness process can be seen as an interpersonal trauma that disrupts the person's previous assumptions and expectations of his or her partner and their relationship in general. Therefore, the need to engage in the forgiveness process may result from an individual's attempt to reconstruct or modify these former beliefs about the partner and the relationship, and to regain a sense of interpersonal control, predictability, and safety in the relationship if the person is to effectively move on from the event (p. 181).

Likewise the typical responses to the traumatic event, forgiveness involves in three stages: the impact, search of meaning, and recovery. In the three-stage forgiveness model, the focus of Stage I (impact) is the effect of the betrayal on injured partners and their relationships. Similar to the other forgiveness stage models, this stage is described as a period of significant cognitive, emotional, and behavioral disruptions (Gordon & Baucom, 1998). Moreover, these responses indicate that important assumptions of injured partner (e.g., one's partner can be trusted, relationship is safe) have been violated. Because of these shattered assumptions, injured partners are likely to engage in a process of collecting details or to explain the negative event. They also feel out of control, powerless, and no longer able to predict future. Furthermore, in the Stage I, withdrawing is observed on offended partners in order to protect themselves. It is generally accepted that understanding why the negative life event occurred is the central theme for a violated person (Worthington, 1998; McCullough, Worthington, & Rachal, 1997; Horowitz et al., 1991). According to Gordon and Baucom (2003), the Stage II of the forgiveness model focuses on this theme. In this stage, injured partners try to discover why the betrayal occurred in order to make the partner's behavior more

understandable and predictable. Thus, understanding may help to increase sense of control over one's own life, sense of safety and security, and to decrease feeling of powerlessness. Finally, in Stage III, the injured partners move beyond the betrayal and start to take control over their life again. In this stage, the injured partners are expected to develop a non-distorted view of their partner and relationship. Also, intense negative feelings toward the partner to understand the event are seen less frequently in the Stage III. Gordon and Baucom (2003) developed a forgiveness inventory (FI) which assesses injured partners' process of forgiveness in terms of the three-stage model of forgiveness. Therefore, the need to engage in the forgiveness process may result from individuals' attempts to reconstruct or modify their former beliefs about their partner and the relationship. Gordon and her colleagues (2009) summarized that forgiveness comes out with its three elements; (1) regaining a more balanced and compassionate view of the offender and the event, (2) decreasing negative affect towards and avoidance of the offender, and (3) giving up the right to seek revenge toward the offender (see Figure 2).

Figure 2 The Three-Stage Model



In order to therapeutic application, Gordon et al.'s (2004) stated that attributions for the infidelity are investigated during the second phase of therapy which emphasizes on contextualizing and finding meaning for the event. After creating realistic attributions, the couple enters the third stage in which the concept of forgiveness is introduced and they are asked to consider the future of their relationship. Thus, this sequence parallels that the victim's attributions for the partner's infidelity facilitate forgiveness which then influences the decision to separate or reconcile. Consistent with this, in their case-study, Gordon, Snyder, and Baucom (2005) found increasing on the forgiveness level whereas decreasing trauma symptoms of betrayed partner after applied an integrative intervention developed by them.

2.5.4 Measurement of Forgiveness

Like enduring arguments in the conceptualization of forgiveness, to measure forgiveness is a second important issue in the field of forgiveness research. It is generally accepted that the measurements of forgiveness were categorized along three dimensions (McCullough, Hoyt & Rachal, 2000). The first dimension refers to the level of "specificity" which forgiveness is assessed (i.e., offences-specific measures, dispositional measures and relationship measures). Direction of measurement is the second general dimension upon which forgiveness can be classified (i.e., from the perspective of forgiver and from the perspective of offender). The third dimension refers to the method of measurement by which forgiveness assessed (i.e., self reports, partner reports, and outside observer).

Considering the taxonomy of McCullough and his colleagues (2000), offence specific measures of forgiveness are used to assess the extent to which a person has forgiven a specific offender for a specific offence. In this offence specific measure category; self report, partner report, observer report and behavioral measures are commonly used. For instance, the nine-item self report measure called “general forgiveness” was developed by Trainer (1981). In addition, she also developed three self report measures that assess motivations for forgiving; intrinsic motivation, expedient motivation and role-expected motivation. After this pioneer work, Wade (1989) developed 81-item self report measure that suggests assessing nine dimensions of the forgiveness. The subscales of this self report scale successfully discriminated between people who report having forgiven an offender and those who report not having forgiven an offender. Further, McCullough et al. (1998) developed 12-item measure based on Wade’s (1989) forgiveness scale called as Transgression–Related Interpersonal Motivations (TRIM) Inventory. Subkoviak and his colleagues (1995) also developed a further self report scale that was called as Enright Forgiveness Inventory (EFI). This 60-item inventory assessed the six different aspects of forgiving another person. More recently, the Heartland Forgiveness Scale (HFS; Thompson et al., 2005) to assess dispositional forgiveness was developed. This was an 18-item scale that assesses dispositional forgiveness of oneself, others, and situations.

Based on the three stage forgiveness model, Gordon and Baucom (2003) developed a forgiveness inventory (FI) to measure offence specific marital forgiveness. Forgiveness Inventory is a 25-item questionnaire developed to

evaluate injured partners' progress through the three stages. The FI has three subscales assessing: (a) Stage I-Impact, such as the desire to lash out at one's partner and feeling overwhelmed by affect; (b) Stage II-Search for Meaning, such as efforts to understand the traumatic event and gain increased clarity of emotion; and (c) Stage III-Recovery, such as success in relinquishing intense negative thoughts and feelings, and deciding how to move on. Progress toward forgiveness is reflected by decreases in Stage I and Stage II scores and an increase in Stage III scores. Based upon the Gordon and Baucom's theoretical model, clinical observations, and the forgiveness literature, they developed items representing each stage in the process and each component (cognitive, behavioral, and emotional) in the three stages. In contrast to the Forgiveness Inventory, the Marital Forgiveness Scale was also developed as an offence specific marital forgiveness measure (Fincham, Beach, & Davila, 2004). Marital Forgiveness Scale is a nine-item measure emphasizing on the incident when the respondent felt most wronged or injured by the partner. It yields three subscales of which two (Avoidance and Retaliation) reveal the negative dimension of forgiveness and one (Benevolence) reveal the positive dimension. Recently, Marital Offence-Specific Forgiveness Scale (MOFS), a new measure assessing offence-specific forgiveness for marital transgressions was developed by Paleari, Regalia, and Fincham (2009). MOFS is a 10-item measure that assesses forgiveness toward the partner for a specific offence. In this scale, forgiveness is assessed through the presence of benevolent motivations and the absence of avoidant, resentful, or revengeful ones.

A measure of forgiveness evaluates people's general disposition or tendency to forgive others at the dispositional level. Similar to offence specific

measures of forgiveness, there are self-report measures to assess the disposition to forgive others. Likewise, Mauger, and colleagues (1992) developed Forgiveness of Others Scale (FOS) to measure of the disposition to forgive other people. This 15 items scale which is in a true-false format investigates people's desire to revenge, hold feelings of resentment, and forgive following an interpersonal transgression. Other dispositional scales which have similar items with FOS and dissipation-rumination scales were Beliefs About Revenge Questionnaire (BARQ; Emmons, 1992) and Vengeance scale (Stuckless & Goranson, 1992). These four scales (dissipation-rumination, BARQ, FOS, Vengeance scale) demonstrate significant correlations with empathy, interpersonal trust, agreeableness, and social conformity. Another important measure disposition to forgive others was improved by Helb and Enright (1993). In this 16 items "Willingness to Forgive Scale", respondents are instructed to read 16 scenarios in which they imagine themselves to have been harmed by another person. Then respondents decide on ten hypothetical responses to each offence to specify how they expect that they would respond the offence.

Forgiveness is also being studied as a relational or dyadic process. A self-report measure of forgiveness at the dyadic level evaluates people tendency to forgive a relationship partner for interpersonal offences that happens in the relationship. Hargrave and Sells (1997) developed an instrument called Interpersonal Relationship Resolution Scale (IRRS). Items were designed to assess the degree which a person who has received severe harms from a specific family member (1) continues to feel pain because of the offences, (2) has forgiven the offending family member for the offences that happened in the past. In order

to measure forgiveness, most of the researchers dedicated themselves to develop self report measures of offence- specific forgiveness since most of the theories about forgiveness emphasized granting forgiveness as a result of offence and victimization. Although many self report tools have been used to assess offence specific and dispositional forgiveness, few research tools exist for measuring forgiveness at the relationship level.

2.5.5 Forgiveness and Well-Being

Although researcher and practitioner have understood the significance of forgiveness, it has become a major topic in the empirical and clinical literatures only in recent years. Fincham, Jackson and Beach (2005) reported that only five studies on forgiveness were published prior to 1985, a number that has since increased by over 4,000. This delayed improvement of forgiveness in the psychology literature may be caused of an aversion to the religious origins of the construct (Rye et al., 2000) or efficacy limitation of many of the early models of forgiveness experienced by clinicians (McCullough & Worthington, 1994).

Peterson and Seligman (2004) classified forgiveness as human strengths and virtues. Both theoretical and empirical works have supported the notion that forgiveness is connected with well-being (Emmons & McCullough 2003; Worthington, 2003). It was also found that these constructs are positively associated. Consistent with this, Sastre et al. (2003) and Maltby et al. (2005) examined forgiveness and well-being and sported the idea that there is an association between forgiveness and well-being. Recently, Toussaint and Friedman (2009) examined these connections and reported that forgiveness and

gratitude were both positively and strongly associated with well-being. Hamama-Raz et al. (2008) highlighted one's ability to forgive as a significant factor to show negative effects of life events.

Hargrave (1994) found that forgiveness was correlated with psychological healing and decreased in depression and anxiety. In addition, Kaminer et al. (2001) that unforgiving increased risk of developing psychological problems. Consistent with this, motivation for revenge was more frequent among individuals with PTSD (Cardozo et al., 2003). In the recent study, Hamama-Raz et al. (2008) examined PTSD symptoms and their correlates among Israeli (both Palestinian and Jewish) youth. They found that individuals with inability to forgive had higher PTSD symptoms comparing with individual who does not have inability.

Not only for individuals but also for couples' well-being is affected by ability to forgive. The capacity to seek and grant forgiveness is seen as one of the most significant factors contributing to marital longevity and marital satisfaction (Fenell, 1993). It is claimed that some conflicts often leave lasting emotional scars on marital functioning, particularly in regards to psychological closeness (Gordon & Baucom, 2003). Thus, if partners were unable to forgive each other, they may not be able to their conflicts. It has been also considered in relation to extramarital infidelity. Some of marital therapists claim that a significant part of healing process for the major relationship transgressions is forgiveness (Gordon, Baucom & Snyder, 2005b). Although the process of forgiving an unfaithful partner may appear impossible, forgiveness is an instrumental component of couple interventions for recovery from EMI which viewed as an interpersonal trauma. Forgiveness does not need an individual to pardon or condone a partner's extra

dyadic behavior, nor does it mean that a couple must reconcile in the context of infidelity. Instead, the purpose of forgiveness is for the offended spouse to gain a more balanced view of the offender and the infidelity, while decreasing negative affect toward the offender and increasing empathy. At that point, Olson et al. (2002) stated that forgiveness is a necessary part of the healing process and equally important for couples.

2.5.6 Forgiveness Based Interventions

Although helping clients who injured by the negative life experience has seen a major goal in therapy, forgiveness has not been employed enough by the schools of psychotherapy (Wade, Johnson, & Meyer, 2008). In another review, Wade and Worthington (2005) reported that almost every empirically supported treatment designed to promote forgiveness prescribed significant time and effort to help clients understand, express, and explore their reactions to the hurt.

Recently, Lundahl et al. (2008) completed a meta-analytic study in which they review fourteen published reports of process-based forgiveness interventions. Their results showed that samples that received forgiveness interventions forgave more and increased positive affect and self-esteem. One of the studies in this review, Al-Mabuk and his colleagues (1995) used forgiveness education with parentally love-deprived late adolescents. The results showed that participants who received a structured six-session intervention based on the Enright model reported significantly higher improvement relative to the control group in anxiety, forgiveness, attitude toward parents, hope, and self-esteem. In another study, Freedman and Enright (1996) worked with incest survivors, and their treatment

consisted of individual therapy which is a process model of forgiveness once a week for an average of fourteen months. Comparing with the waiting group, the experimental group showed significantly more improvement in forgiveness, hope, anxiety, and depression. Furthermore, Lin et al. (2004) examined the effects of forgiveness therapy on anger, mood, and vulnerability to substance among substance-dependent clients. The results revealed that the treatment group showed significantly greater improvement from pretest to posttest in forgiveness, anxiety, anger, depression, self-esteem, and vulnerability to drug use. Besides individual implication, there are also group applications of forgiveness interventions. In the study of Harris et al. (2006), participants were adults who had experienced a hurtful interpersonal transgression assigned to a six-week cognitive-behavior-based forgiveness intervention. Results showed that the treated group reduced negative thoughts and increased positive thoughts and feelings significantly more than the comparison group. Another forgiveness based psycho-educational group intervention was examined by Ripley and Worthington (2002). The participants of their study were married couples and intervention consisted of a hope-focused relationship enrichment model versus an empathy-centered forgiveness-based marital enrichment model. Both treatment interventions showed substantial clinical increase in couple communication relative to the waitlist control.

In addition to these studies, Reed and Enright (2006) examined the effects of forgiveness therapy on depression, anxiety, and posttraumatic stress for women after spousal emotional abuse. Participants were assigned to one of two treatment conditions: forgiveness therapy based on the Enright forgiveness process model and alternative treatment which included anger validation, assertiveness training,

and interpersonal skill building. Participants who involved one-hour individual weekly sessions (about eight months) improved in the forgiveness therapy condition compared to the alternative treatment condition for all measures (forgiveness, self-esteem, depression, and posttraumatic stress) except anxiety. In the recent study, Greenberg, Warwar, and Malcolm (2010) evaluated the effectiveness of an emotion-focused couple therapy intervention for resolving emotional injuries. The results showed that participants had a significant improvement in dyadic satisfaction, trust, and forgiveness as well as improvement on symptom and target complaint measures. Consistent with such findings, Gordon, Snyder, and Baucom (2005a) completed a case-study in which couples who injured with EMI were participants and applied an integrative intervention developed by them. They assessed the couples on pre-and-post treatment and found increasing on the forgiveness score whereas decreasing on trauma symptoms of offended partner. Sells and Hargrave (1998) stated that forgiveness involves overcoming anger, revenge, shame, record of wrongs and resentment. According to Fincham et al. (2004), forgiveness also involves decreasing negative motivation toward the offender. Overall, process-based forgiveness interventions show promise in achieving clinical treatment goals.

CHAPTER 3

METHOD

This chapter is devoted to the presentation of the methodological procedures of the present study. The first section describes the sample of the present study. The second section presents the data collection instruments used in the study. The third section introduces data collection procedures. Finally, the fourth section presents the data analysis procedures.

3.1 Participants

The participants were recruited through purposive and snowball sampling (Kerlinger, 1986; Kumar, 1996). Having minimum three years length of marriage and experiencing marital infidelity at least one month before participating in the present study were the inclusion criteria. The following exclusionary criteria were also applied: (1) On-going extramarital infidelity: This criterion may help clarifying PTSD symptoms from acute and continued stress disorders. (2) Divorced or break-up: The current study focuses on married individuals who continue their marriage after discovering EMI. (3) Multiple EMI by both partners: Because one of the aims of the present study is to examine the unique effects of EMI on the offended partners not the involved one, the participants who injured and also involved to EMI are eliminated. (4) Experiencing any one or more of the following negative life events derived from the Life Experiences Survey (Sarason, Johnson, & Siegel, 1978) within the six months: Death of close family member,

personal injury or illness resulting in loss of work for two weeks or more, being fired from a job, being arrested or spending time in a jail, or miscarriage. (5)
Chronic life stressors: (e.g., substance dependence, chronic illness).

Although the study was planned to be conducted with both sex, there were only 3 men who accepted to complete the questionnaire. After the male participants' data eliminated, the participants of the study consisted of 189 married women. The age of the total sample ranged from 22 to 54 with a mean of 36.12 years (SD = 7.50). The participants had an average of 10.67 years of education (SD = 4.15) and 11.95 years of marriage (SD = 6.35). The numbers of children of participants ranged from 0 to 5 with a mean of 1.81 (SD = 1.06). In addition, 52.8 % of the participants had a job. On the other hand, more than half of the participants (57.7%) reported that they belonged to the middle SES. The details of socio-demographic characteristics (e.g., age, years of education, level of SES) of the participants are summarized in Table 3.

Table 3 Demographic Characteristics of the Participants

Variables	Percentage	Mean	SD	Ranged
Ages		34.46	7.60	22-54
Years of Education		10.58	4.18	5-17
Years of Marriage		12.26	6.07	3-30
Numbers of Children		1.84	1.03	0-5
Working Status				
Working	52.8			
Not Working	42.1			
Retired	5.0			
SES				
Low	9.5			
Low-Middle	11.1			
Middle	57.7			
Middle-High	21.7			

3.2 Instruments

In the present study, five self-reported instruments were administered to the participants. The first one was the Demographics Information and Extramarital Infidelity Form (DI-EMI; see Appendix A) which was developed by the researcher to obtain information about some demographic characteristics of the participants and the experiences concerning with their partners' extramarital infidelity. The second one was Traumatic Stress Disorder Symptom Scale-Self Report (PSS-SR; see Appendix B) to assess the participant's levels of traumatic symptoms. Participants were also administered Turkish Ways of Coping Inventory (TWCI; see Appendix C) for evaluating the coping strategies used by them; The Conservation of Resources Evaluation (COR-E; see Appendix D) both loss and gain form for assessing the level of resources loss and gain; and

Forgiveness Inventory (FI; see Appendix E) for identifying the stages of forgiveness.

3.2.1 Demographic Information and Extramarital Infidelity Form

Demographic Information and Extramarital Infidelity Form (DI-EMI) which was developed by the researcher includes two parts. In the first part of the questionnaire, information are obtained regarding participant's age, education level, years of marriage, marital status, employment status, total number of children, socioeconomic level, and previous psychological-physical health problem. In this part of the questionnaire, participants are also asked the stressful life events that they experience during last six months. In the second part of DI-EMI, a series of questions was prepared by the researcher based on the infidelity literature. Because of the complexity of the variables of infidelity, all important aspects of infidelity suggested by many researchers are included to the second part of questionnaire. In order to overcome definitional difficulties of EMI, the participants were asked to describe their partners' EMI on the six-point continuums of Glass and Wright (1992); more emotional to more sexual. In addition, parental infidelity and EMI occurred in the prior-relationship are also asked in the second part of questionnaire.

3.2.2 Post-Traumatic Stress Disorder Symptom Scale

Post-Traumatic Stress Disorder Symptom Scale-Self Report (PSS-SR) was developed by Foa et al. (1997) to assess the participant's levels of traumatic symptoms. PSS-SR consists of four parts and 50 items. These items yield both a

PTSD diagnosis according to DSM-IV criteria and a measure of PTSD symptom severity. The first part of PSS-SR was designed to explore the type of traumatic experiences (e.g. disaster, accident, war, rape). If a person has more than one traumatic life events, the second part of PSS-SR helps to figure out which one has the most impact on them. The second part includes six Yes-No questions which called “Severity of Events Subscale” account for Criterion A. The third part of the PSS-SR is “PTSD Symptom Severity Level” subscale which includes 17 items of PTSD symptoms, each rated on a 4-point scale with the responses ranging from ‘0’ (not at all or only one time) to ‘3’ (five or more times a week / almost always). The total range of the possible scores that can be obtained from this subscale is 0 to 51; score less than 10 called “mild”, 11-20 is “average”, 21-35 is “average-severe” and up to 35 is “severe”. In addition, this subscale has three factors correspond with DSM-IV criteria for PTSD; re-experiencing/intrusive thoughts (B), avoidance/emotional numb (C) and hyper-arousal (D). Finally, the last part of PSS-SR called “Event Impacts Subscale” explore the effects of the events on person’s daily life functioning (e.g., work, household duties, friendships, leisure activities) account for F criterion of PTSD. Event Impacts Subscale includes nine Yes-No questions, and it is scored by total number of “yes” responses. The possible total scores that can be obtained from this subscale is 0 to 9; scores 1-2 called “mild”, 3-6 is “average”, and 7-9 is “severe”.

Reliability analyses of the PSS-SR were assessed by internal consistency and test-retest reliability analyses. The Cronbach’s alpha level of the three symptom clusters was .92 for Total Symptom Severity, .78 for Re-experiencing, .84 for Avoidance, and .84 for Arousal. The PSS-SR was also found diagnostic

agreement with the SCID PTSD module, and good sensitivity and specificity (Foa et al., 1997). The satisfactory validity evidence for the PSS-SR was supported by its high correlations with other measures of trauma related psychopathology. Turkish adaptation of the PSS-SR was conducted by Işıklı (2006). Likewise, in the original study, the Cronbach alpha coefficient of the Turkish version of PSS-SR was as .93 which was similar to the original study. This study also confirmed that the three factors construct validity explained the 59% of total variance. Supporting the concurrent validity, PTSD symptom severity scale was found to be correlated with Short Symptom Inventories ($r = .70$), Beck Depression Scale ($r = .60$), and Beck Anxiety Scale ($r = .63$).

3.2.3 Turkish Ways of Coping Inventory

To evaluate the cognitive coping strategies, Turkish Ways of Coping Inventory (TWCI) was used in the present study. TWCI includes three subscales (Problem-Focused Coping, Emotion-Focused Coping, and Indirect Coping Style) and 74 items with a 5-point Likert-type ranging from '1' (does not apply or not used) to '5' (used a great deal) (Gençöz, Gençöz, & Bozo, 2006). Originally, the first version of the coping inventory was Ways of Coping Checklist developed for the Berkeley Stress and Coping Project (Lazarus & Folkman, 1980). This first version of Ways of Coping Checklist includes two dimensions (problem focused and emotion focused) and 68 items with Yes-No responses which required information on coping strategies in response to stressful events. The Ways of Coping Checklist was revised with changing the response format from Yes-No to 4-point Likert-type (Folkman & Lazarus, 1985). The new version of checklist was

called as the Ways of Coping Questionnaire which includes eight factors, namely: Confrontive Coping, describing aggressive efforts in response to the stressful situation; Distancing, describing mentally distancing from the situation in order to minimize the negative effects; Self-Controlling, describing efforts to control one's actions and feelings; Seeking Social Support, describing efforts to seek advice from others; Accepting Responsibility, describing accepting one's responsibility over the problem; Escape-Avoidance, describing wishful thinking and behavioral efforts as a way of escape and avoid the problem; Planful Problem Solving, describing problem-focused efforts to deal with the problem; and Positive Reappraisal, describing efforts to gain a positive meaning from the problem situation. The Cronbach alpha coefficients for these eight scales changed between .61 (Distancing) and .79 (Positive Reappraisal).

Siva (1991) is the first researcher who examined the psychometric properties of the Turkish version of Ways of Coping Questionnaire. The questionnaire's items did not cover superstitious beliefs and fatalism, though Turkish people tend to use these coping styles. The questionnaire was added six more items representing these domains and changed the response style into a 5-point Likert scale and the scale was named as Turkish Ways of Coping Inventory (TWCI). The overall TWCI revealed a Cronbach alpha coefficient of .90 and seven factors, namely, planned behavior, fatalism, mood regulation, being reserved, acceptance, maturation, and helplessness-seeking help (Siva, 1991). Following this study, various studies were conducted in different samples with the TWCI (e.g., Sahin & Durak; 1995, Karancı et al, 1999; Kesimci, 2003) and concluded different factor structure. Finally, Gençöz, Gençöz, and Bozo (2006)

conducted a study which aimed to provide higher order coping dimensions in a Turkish sample. The reliability analyses were examined with Guttman split-half reliability coefficients and found .84, .86, and .82 for Problem-Focused Coping, Emotion-Focused Coping, and Indirect Coping Style, respectively. For validity analyses, the 3-factor solution of the measure showed significant correlations with Sociotropy-Autonomy Scale (S-AS; Beck, Epstein, Harrison, & Emery, 1983), State-Trait Anxiety Inventory (STAI-T; Spielberger, Gorsuch, & Lushene, 1970), Submissive Acts Scale (SAS; Gilbert & Allan, 1994), and Rotter's Internal-External Locus of Control Scale (Rotter, 1966) for supporting criterion validity.

3.2.4 The Conservation of Resources Evaluation

In order to examine individuals' resources, the Conservation of Resources Evaluation (COR-E) was developed by Hobfoll and his colleagues (Hobfoll, Lilly, & Jackson, 1991). COR-E is a self-administered measure that evaluates individuals' resources. Resources were divided into four main categories in COR theory: (1) objects resources (home, transportation, and fetish objects), (2) personal resources (skills [occupation, leadership, etc.], and personal traits [self-esteem, optimism, etc.]), (3) condition resources (being healthy, employment, marriage, etc.), and (4) energy resources (money, credit, knowledge, etc.). In the COR-E, these resources are more specified, namely; work resource, personal resources (self esteem, mastery and well being), material resources, energy resources, interpersonal resources (family and general). COR-E contains 74 items which are rated on a 5-point Likert type scale, with the responses ranging from '1' (not at all) to '5' (to a great degree). There are two separate forms of COR-E;

Loss and Gain. For the COR-E Loss form, participants are asked to rate what extent they have lost these resource during the recent past. Whereas, the participants rate on the COR-E Gain form to what extent they have gained these items. Cronbach alpha coefficients ranged from .85 to .91 for the COR-E Loss form, and from .91 to .93 for the COR-E Gain form. Test-retest for the recent loss and gain measures ranged from .55 to .64. In addition, test-retest for the loss and gain during the past year measures ranged from .64 to .67. A number of authors have suggested that the COR-E is a reasonable research instrument in the assessment of loss and gain of resources (e.g., Benight et al., 1999; Freedy & Hobfoll, 1994; Hobfoll & Lilly, 1993; Jackson et al., 2001; Lane & Hobfoll, 1992), and has been widely used in previous studies (e.g., Banou, Hobfoll, & Tochelman, 2009, Walter & Hobfoll, 2009; Dirik, 2006, Shteyn, et al., 2003).

Turkish adaptation study of the COR-E, conducted by Özgün and Gençöz (2005), indicating that reliability and validity coefficients of the scale were comparable to the original values. The internal consistency of COR-E indicated good results, with Cronbach's alpha coefficient of .96 for the Loss form and .98 for the Gain form. In addition, the item-total correlations ranged from .17 to .68 for the Loss form, and from .22 to .80 for the Gain form. Moreover, 3-week test-retest reliability coefficients were found as .87 for the Loss form, and .91 for the Gain form. The satisfactory concurrent validity of the both forms of COR-E was supported by its high correlations with other related constructs (e.g., self-esteem, depression, anxiety). Consistent with the original study, the Loss form scores but not the Gain form scores, effectively discriminated individuals with high symptom severity from those with low symptom severity, on the basis of the

measures of depression symptoms, and state-trait anxiety symptoms. The results of the study supported to the principles of COR theory. In the light of these findings, Turkish version of COR-E presented good test-retest, internal consistency coefficients, and also good construct, concurrent, and criterion validity information. Thus, overall Turkish version of COR-E was found to be a reliable and valid instrument.

3.2.5 Forgiveness Inventory

Forgiveness Inventory (FI; Gordon & Baucom, 2003) was developed to evaluate injured partners' progress through the 3-stage forgiveness model outlined by Gordon and Baucom (2003). The FI includes 25 items and 3 subscales assessing: (a) Stage I-Impact, such as the desire to lash out at one's partner and feeling overwhelmed by affect; (b) Stage II-Search for Meaning, such as efforts to understand the traumatic event and gain increased clarity of emotion; and (c) Stage III-Recovery, such as success in relinquishing intense negative thoughts and feelings, and deciding how to move on. Progress toward forgiveness is reflected by decreases in Stage I and Stage II scores and an increase in Stage III scores. Based upon the forgiveness literature, the theoretical models, and clinical observations, Gordon and Baucom developed items representing each stage. In order to assess content validity of FI, items were given to a group of clinical psychology doctoral students participated in the study conducted in a marital studies laboratory. After eliminating the items which were considered unclear or invalid, the final item list was judged to have good content validity. In the final form of FI, participants are asked to describe a major betrayal incident that

occurred in their current relationship. The examples of betrayals are listed (e.g., affairs, abuse, and major lies) on the form. After participants describe their betrayal experience, they are asked to rate how much they currently experience each item on a scale of 1 (almost never) to 5 (almost always).

The original reliability and validity studies were conducted by Gordon and Baucom (2003). The internal consistency reliabilities were computed for the subscales of the FI. All subscales achieved acceptable levels of reliability for the final scales. The Cronbach's alpha level of the three stages was .85 for the Stage I, .76 for the Stage II, .75 the Stage III, respectively. Moreover, a confirmatory factor analysis (CFA) supported the existence of the each three subscales which contained the cognitive, behavioral, and affective components. It was found that the final model which allowed the emotional components of Stage II and III to load negatively on the Stage I factor, obtained an adequate goodness of fit index, χ^2 ($df = 22$) = 29.45, $p = .132$. The results indicated that the proposed model did not significantly differ from the observed data. Also, this model provided a good fit to the data and a better fit to the data than a target model consisting of three factors, or a simple model consisting of one factor. In addition, the results of inter-correlations consisted that the Stage III factor was negatively correlated with the Stage I factor ($r = -.20$) and positively correlated with the Stage II factor ($r = .23$), whereas the Stage I and Stage II factors were positively correlated ($r = .66$). Adaptation and standardization studies of the Turkish version of Forgiveness Inventory were conducted in the present study. Results are summarized below.

3.2.5.1 Translation Studies of Forgiveness Inventory

In order to translate the Forgiveness Inventory into Turkish and to determine the psychometric properties in Turkish population, the permission was taken from Kristina C. Gordon who developed the scale with Baucom (2003). The first steps of the procedure included the translation into Turkish and back-translation into English (Savaşır, 1994) of the original 25-item of the FI. These techniques have been considered as basic for attaining semantic equivalence of different language versions of a measuring instrument (Brislin, 1970 & 1980; Hambleton, 1993). Translation and back-translation were carried out by following the bilingual committee approach. First, three psychologist independently translated the original English version of the FI and obtained three different translation forms. The committee was given the instructions indicating that the translation should retain the meaning of the original words. Next, the committee met to review the translation forms. Each pair of items in its Turkish and English versions was compared, and revisions of the translated items were carried out, until consensus was reached.

The Turkish version of FI was independently back-translated into English by two graduate students. Both translators and back-translators had been immersed in the source and target cultures. Next, the translated, back-translated, and original versions of the FI were reviewed in a joined meeting of the committees (five persons) and reached the final version of translation. The next step of the procedure was to assess the level of clarity of the items. The Forgiveness Inventory was given to the numbers of volunteer who asked to rate items' level of understandability on the clarity scale of 1 (totally clear-

understandable) to 5 (totally unclear-not understandable). This step was completed by the researcher using face-to-face interview. Based on the reactions of clarity of the items, translation of FI was finalized.

3.2.5.2 Psychometric Studies of the Turkish Version of Forgiveness Inventory

The Turkish version of FI was administered 284 married individuals (161 female and 123 male). The average age of participants was 34.24 years (SD = 8.12) for female and 37.24 years (SD = 9.54) for male participants. Male participants had an average of 13.59 years of education (SD = 3.14) whereas the females had an average of 12.53 years (SD = 3.68). The length of marriage for all participants was 10.82 years (SD = 8.72). The participants also reported an average of 1.46 (SD = 1.13) children.

Following the original study, three instruments were used to conduct the validity analyses of the Turkish version of FI; the Global Self-Report of Forgiveness (GSRF; Gordon & Baucom, 2003), the Dyadic Adjustment Scale (DAS; Spanier, 1976), and the Marlowe-Crowne Social Desirability Scale (M-C SDS; Crowne & Marlowe, 1960). The Global Self-Report of Forgiveness (GSRF) is a single item self-report instrument developed also by Gordon and Baucom (2003). The participants provide a rating of how much they had forgiven their partners for the incident on a single item scale ranging from “1” (not at all) to “5” (completely). Many researchers have assessed the level of forgiveness by using the same item (e.g., McCullough, et al., 1998; Boon & Sulsky, 1997; and Schlenker & Darby, 1982). The other instrument which was used in the psychometric studies of the Turkish version of FI was the Dyadic Adjustment

Scale (DAS) developed by Spanier (1976). DAS was designed to assess the perceived marital relationships and marital quality of couples. The 32-item measure is primarily utilized the 5 and 6 point response format. Only two items are answered with either “yes” or “no” and one item with 7-point response format. The DAS consists of four subscales: Dyadic Satisfaction, Dyadic Cohesion, Dyadic Consensus and Affectional Expression. The Cronbach Alpha for the DAS was founded .96 for the entire scale and the subscales ranging from .73 to .97. The possible total score obtained from the DAS changes between 0 and 151. Higher scores reflect a higher perception of the quality of the relationship. The translation of DAS into Turkish and its reliability study was conducted by Fıfılođlu and Demir (2000). The Cronbach Alpha coefficient for the DAS was .92. The criterion validity was assessed by calculating the correlation between translated DAS and Locke-Wallace Marital Adjustment Test (LWMAT), and results showed that DAS correlated ($r = .82$) with the LWMAT. In order to control desirability, the Marlowe-Crowne Social Desirability Scale (M-C SDS) was used in the psychometric studies of the Turkish version of FI. The M-C SDS was developed based on the definition of social desirability as the person’s need “*to obtain approval by responding in a culturally appropriate and acceptable manner*” (Crowne & Marlowe, 1960, p. 353). The M-C SDS contains 33 items which include descriptions of everyday behaviors and answered with either “yes” or “no”. Eighteen items refer to socially approved but infrequent behaviors. The other fifteen items refer to socially disapproved but frequent behaviors. The translation of the M-C SDS into Turkish and its reliability study was conducted by

Ural and Özbirecikli (2006). The M-C SDS has satisfactory validity and reliability with Cronbach Alpha of .70 for the entire scale.

Turkish version of FI was administered to the married individuals in Istanbul. Sample of this study was recruited through snowball sampling procedure (Kumar, 1996). In the selection of the participants, the same criteria with the original study were used. Those participants who met the criteria were given the set of the questionnaires. Participants engaged in the following activities: (a) Read the informed consent and if accepting to participate, sign the informed consent form; (b) Respond to the entire battery of questionnaire; and (c) Return the questionnaire set to the applicant or the researcher. Because of the confidentiality principle, all instruments were given with an envelope and subjects were warned to submit the instruments in closed envelopes. Prior to the analyses, the main data were examined for accuracy of data entry, missing values, and assumptions of multivariate analyses. The descriptive analyses are summarized in Table 4.

Table 4. Means and Standard Deviations of the Scales

Measures	Female		Male		Total	
	<u>M</u>	SD	<u>M</u>	SD	<u>M</u>	SD
FI Stage I Impact	20.30	6.61	17.64	6.12	19.22	6.53
FI Stage II Meaning	19.53	4.06	17.88	4.17	18.85	4.49
FI Stage III Recovery	29.48	5.64	31.10	4.97	30.14	5.42
Global Self Report Forgiveness	3.08	1.36	3.99	1.06	3.45	1.33
DAS Total	105.70	24.95	113.02	18.41	108.81	22.65
Dyadic Consensus	46.51	11.44	49.25	8.55	47.69	10.37
Dyadic Satisfaction	35.54	8.48	38.94	7.20	36.96	8.13
Affectional Expression	8.89	2.79	9.46	2.33	9.13	2.62
Dyadic Cohesion	14.57	5.05	15.12	4.06	14.81	4.66
M-C Social Desirability Scale	18.81	4.23	19.84	4.56	19.23	4.39

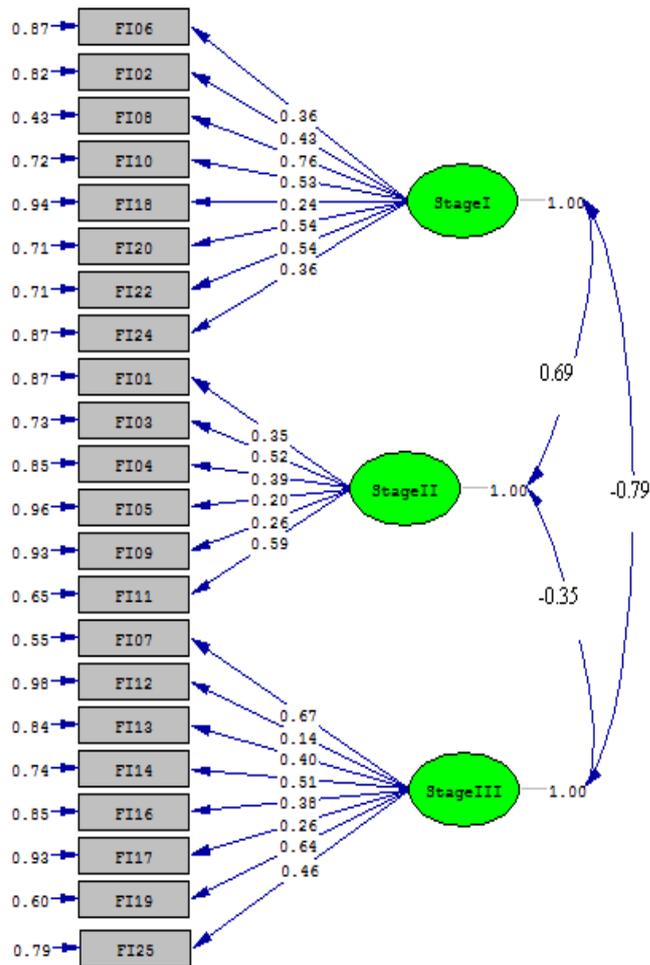
3.2.5.2.1 Validity Studies

The construct validity of the Turkish version of FI was investigated by confirmatory factor analyses, and inter-correlations among the three stages of the FI. On the other hand, convergent and concurrent validity were examined by assessing the correlations between the three dimensions of the FI and the GSRF, and subscale and total scores of the DAS. In addition, the social desirability bias was checked for the participants.

3.2.5.2.1.1 Construct Validity

Considering the original three-factor structure of FI, a confirmatory factor analysis (CFA) was performed to examine the construct validity of Turkish version of FI using Lisrel 8.7 Student Version (Joreskog & Sörbom, 1993). The measurement model was estimated using maximum-likelihood method. The initial model was then run and resulted in a poor fit. The examination of the factor loadings revealed that items 15, 21, and 23 loaded weakly on the factors (lower than .10). Therefore, these items were removed. Based on modification indices, a path of covariance was then added between error terms for items 15, 21 and 23. After omitting these three items, the CFA supported the existence of the three subscales and obtained an adequate goodness of fit index, χ^2 ($df = 206$) = 488.95, $p < .001$, and CFI = .78, RMSEA = .062, NNFI = .76, and AGFI = .87 indicated a better fitting (see Figure 3). For the following analyses, the stages score of FI were computed based on 22 items.

Figure 3 Confirmatory Factor Analysis: Three-Factor Model



Chi-Square=488.95, df=206, P-value=0.00000, RMSEA=0.062

Likewise the original studies, the significant inter-correlations among the three factors of FI were the evidence for construct validity. As predicted, results showed that the Stage III was negatively correlated with the Stage I ($r = -.49$) and the Stage II ($r = -.15$). On the other hand, the Stage I and Stage II were positively correlated ($r = .47$) with each other. All these correlations were significant at $p < .001$, except the correlation between Stage II and Stage III ($p < .01$) (see Table 5). These results were consistent with the findings of Gordon and Baucom (2003).

Table 5 Inter-correlations between the Scales

Scales	Stages I	Stages II	Stages III	GSRF	DAS
Stages I Impact	1.00	.471**	-.490**	-.492**	-.620**
Stages II Meaning		1.00	-.153*	-.230**	-.234**
Stages III Recovery			1.00	.470**	.538**
GSRF				1.00	.586**
DAS					1.00

* p<.01 **p<.001

3.2.5.2.1.2 Convergent and Concurrent Validity

In order to examine the convergent and concurrent validities of the Turkish version FI, two instruments, namely Global Self-Report of Forgiveness (GSRF) and the Dyadic Adjustment Scale (DAS), were administered to the participants. The reason for selecting these instruments as evidence of convergent and concurrent validity of the scale was theoretical. It was thought that as injured partners' score high in GSRF (high level of forgiveness) and in DAS (high level of marital adjustment) would have lower score in Stage I and Stage II but higher scores in Stage III. The correlations of the stages of FI with the Global Self-Report of Forgiveness (GSRF) and the total score of the Dyadic Adjustment Scale (DAS) are presented in Table 5. As seen in the table, the Stage I-Impact ($r = -.49$) and the Stage II-Meaning ($r = -.23$) were negatively correlated with the GSRF. Similarly, both scales were negatively correlated with DAS ($r_1 = -.62$; $r_2 = -.23$). On the contrary, the Stage III-Recovery was positively correlated with both GSRF ($r = .47$) and DAS ($r = .54$). All these correlations were at $p < .001$.

Following the procedure of the original study, each participant was also classified into the stages of forgiveness. The scales of the FI were considered separately, and raw scores were converted to z-scores. After participant's three subscale z-scores were compared, they were assigned to the group corresponding to the highest of his or her three subscale z-scores. This method suggested by Gordon and Baucom (2003) yielded a sample size of 75 for the Stage I group, 50 for the Stage II group, and 77 for the Stage III group. Concerning the construct validity, the GSRF scores of the participants in these three stages were compared. An ANOVA with stage of forgiveness as the independent variable and the GSRP score as the dependent variable revealed a significant main effect for stage of forgiveness, $F(2, 188) = 19.51, p < .001$. Similar to the finding of original study, the spouses in the Stage I group reported the lowest amount of forgiveness ($\underline{M} = 2.80$); the Stage II group reported ($\underline{M} = 3.50$) more forgiveness than the Stage I group, and less forgiveness than the Stage III group ($\underline{M} = 4.05$). All the stages differed significantly from each other. Supporting the convergent validity, a similar analysis was run with the DAS. An ANOVA with stage of forgiveness as the independent variable and the total scores of the DAS as the dependent variable revealed a significant main effect for stage of forgiveness, $F(2, 181) = 26.81, p < .001$. Likewise the results with the GSRF, the spouses in the Stage I group reported the lowest amount of marital adjustment ($\underline{M} = 92.15$); the Stage II group reported ($\underline{M} = 106.41$) more adjustment than the Stage I group, and less adjustment than the Stage III group ($\underline{M} = 118.25$). All stages differed significantly from each other. Similar to the total score of DAS, Stage I group reported the lower score than Stage II and Stage III on the subscales of DAS; Dyadic

Consensus subscale (\underline{M} = 40.88), Dyadic Satisfaction (\underline{M} = 30.76), Affectional Expression (\underline{M} = 7.30) and Dyadic Cohesion (\underline{M} = 12.43) (see Table 6).

Table 6 Comparing the FI Groups with Global Forgiveness and DAS

Measures	Stages I Group		Stages II Group		Stages III Group		FNA Group	
	\underline{M}	SD	\underline{M}	SD	\underline{M}	SD	\underline{M}	SD
GSRF	2.80*	1.32	3.50	1.18	4.05	1.02	-	-
DAS Total	92.15*	23.93	106.41	22.20	118.25	16.56	108.71	22.70
Dyadic Consensus	40.88*	11.51	45.61	9.59	51.93	8.02	52.34	6.45
Dyadic Satisfaction	30.76*	8.18	36.00	8.29	40.41	5.35	41.16	5.78
Affectional Expression	7.30*	2.94	9.18	2.55	10.01	1.95	10.26	1.57
Dyadic Cohesion	12.43*	4.83	15.66	4.55	16.16	4.35	15.38	3.86

* The lowest score

Besides comparisons between each of the three stage groups, these groups compared with the forgiveness not-applicable group (FNA) who did not reported any incident to answer the FI. Indeed, the participants were divided into four groups: Stage I, Stage II, and Stage III (forgiveness groups), and FNA (\underline{n} = 64). For conducting ANOVAs with the three stage groups and the FNA group as the four levels of the independent variable and the total scores on the DAS served as the dependent variables. Furthermore, individuals in FNA reported same level of marital adjustment (\underline{M} = 108.71) with the people in the Stage III group (\underline{M} = 118.25) and higher level of adjustment from the participants in the Stage I. These results also found applicable to the comparisons of the subscales of the DAS.

3.2.5.2.1.3 Discriminant Validity: Examination of Desirability and Gender

In order to control whether FI was affected by the social desirability bias of the participants, the correlation coefficient was calculated between the scores of FI and M-C Social Desirability Scale. The results yielded no significant correlations between the scores the M-C Social Desirability Scale and the three stages of FI. These findings might be considered as further validity evidence for the FI. On the other hand, the comparison of gender differences on the FI showed that female participants got higher score on the Stage I ($M=20.30$), whereas male participants got higher score on the Stage III ($M=31.10$) on the FI. In addition, male participants got significantly higher scores than female on the GSRF ($F(1, 191) = 24.50, p < .001$) and DAS ($F(1, 235) = 6.19, p < .05$) (see Table 4).

3.2.5.2.2 Reliability Studies

As the final stage of psychometric studies of the Turkish version of FI, the Cronbach alpha coefficients were computed for the scales. The Cronbach alpha coefficients for internal consistency of the three subscales of the Turkish version FI were .79, .60, and .70 for the Stage I, the Stage II, and the Stage III, respectively. These results are consistent with the original psychometric studies of FI which completed by Gordon and Baucom (2003). In addition, the item-total correlations for the scales were also examined. The results showed that the item-total correlations of the FI Turkish version ranged between .33-.64 for Stage I, .19-.50 for the Stage II, and .18-.51 for the Stage III subscales. These results are presented in Table 7 and 8.

Table 7 Cronbach Alpha Values for the subscales of the FI

Stages	Numbers Of Items	Cronbach Alpha
Stages I Impact	8	.79
Stages II Meaning	6	.60
Stages III Recovery	8	.70

Table 8 Item-total Correlations of the Stages of FI

Items	Stage I	Stage II	Stage III
FI Item 2	.498		
FI Item 6	.402		
FI Item 8	.635		
FI Item 10	.541		
FI Item 18	.333		
FI Item 20	.575		
FI Item 22	.490		
FI Item 24	.447		
FI Item 1		.370	
FI Item 3		.326	
FI Item 4		.502	
FI Item 5		.202	
FI Item 9		.185	
FI Item 11		.382	
FI Item 7			.482
FI Item 12			.176
FI Item 13			.411
FI Item 14			.463
FI Item 16			.442
FI Item 17			.387
FI Item 19			.511
FI Item 25			.230
Total N	8	6	8

To assess of forgiveness level of offended partners, Forgiveness Inventory was used in the present study. Since FI has not been used in the Turkish culture before, reliability and validity analyses were first conducted for the present study. The results of the psychometric study of the Turkish version of FI support the principles of forgiveness model of Gordon and Baucom (2003). In the light of these findings, the psychometric studies of the Turkish version FI present good validity (constructs, concurrent, convergent, and discriminant) information. In addition, similar to the original reliability studies of the measure, the reliability analyses of the Turkish version of FI indicated satisfactory reliable results for evaluating forgiveness level of betrayed individuals in Turkish culture. Thus, overall the Turkish version of FI was found to be a reliable and valid measure.

3.3 Data Collection Procedure

Prior to the challenge of recruiting participants, a set of participation criteria was determined in accordance with the aims and research questions of the present study. The inclusion criteria were to have minimum three years length of marriage and to experience marital infidelity at least one month before participating to the present study. Mainly, the sample of this study was recruited through purposive and snowball sampling (Kerlinger, 1986; Kumar, 1996). Because of difficulty to obtain information about individuals' intimate experience such as EMI, multiple sampling sources were used to reach participants (e.g., community centre for women, private clinics, trainee groups from mental health field, graduate and undergraduate students).

In this study, individuals, instead of couples, were studied. Sample was controlled in terms of the exclusionary criteria; such as on-going extramarital infidelity, divorced or break-up, multiple EMI by both partners, and experiencing the negative life events. After accepting to participate in the study, participants were given informed consent form, the form of demographics and EMI related questions, PSS-SR, TWCI, COR-E, and FI in an envelope. Participants engaged in the following activities: (a) Read the informed consent and if accepted to participate, sign the informed consent form; (b) Respond to the entire battery of questionnaire; and (c) Return the questionnaire set either directly to the researcher or to the contact person. Administration of the instruments took approximately 40 minutes. Because of the confidentiality, all instruments were given with an envelope and subjects were asked to submit the instruments in closed envelopes. Since the participation in the study is voluntary; the participants were offered to have short consultation about their experience of EMI. Only a few participants asked for consultation. The instruments were administered between December 2008 and March 2010, and 800 envelopes with the questionnaires were delivered during that period. Overall, return rate was approximately 25 % for the sample.

3.4 Data Analysis Procedure

Data obtained from the participants were analyzed by using the Statistical Package for the Social Sciences (SPSS) Program (Green, Salkind, & Akey, 1997). Prior to the analyses, the main data were examined for accuracy of data entry, missing values, and assumptions of multivariate analyses. Among a total of 221 returned cases, six cases were removed from the data due to a large number of

missing values. The other missing variables were substituted by the mean value of that variable. Moreover, all of the cases were examined for outliers and there were no cases identified as multivariate outliers through Mahalanobis distance. Additionally, nine cases, in which acute period of EMI experience, and eight cases who reported negative life experiences (miscarriage, domestic violence etc.) were removed from the data. Also, six cases who reported that they also had an EMI (sexual or emotional) during their marriage were eliminated. Lastly, three cases were excluded from the data due to the only three men of the participants. After the eliminations, the analyses of the present study run for 189 married women. In order to present the general characteristics of EMI experiences of the participants, descriptive statistics was run firstly. Moreover, the impact of infidelity on betrayed partners were introduced by using descriptive statistics. In accordance with the research questions of the present study, besides Pearson correlation, two statistical analyses methods were formulated. Mainly, MANCOVA analyses were applied to test the other hypotheses about the effects of the coping, resource, and forgiveness on PTSD symptoms. Finally, hierarchical multiple regression analysis were formulated and conducted to find out the best predictors of PTSD symptoms.

CHAPTER 4

RESULTS

The results are presented in four sections. In the first section, the variables related to the participants' experience of EMI are summarized. Then, in the second section, descriptive statistics and correlation matrix of the study variables are presented. In this section, also the selection procedure of covariates is explained. The third section addresses the first research question of the present study. In this section, the results of PSS-SR and DSM-IV criteria of PTSD are presented. Moreover, in the third section, the results of the other research questions which are related to the impacts of demographics, coping, resource and forgiveness on the PTSD severity are summarized. Pearson correlation coefficients and a one-way between subjects multivariate analysis of covariance (MANCOVA) were used as statistical methods. Finally, the last research question is addressed by the fourth section of the result. In this section, the results of hierarchical multiple regression analyses which used to examine the predictors of the severity of PTSD are presented. The results are given for total score of PTSD and its subscales (re-experience, avoidance, and arousal).

4.1 Descriptive Statistics of Experiencing Extramarital Infidelity

Table 9 presents the means, standard deviations and frequencies of the characteristics of EMI experienced by the participants. As seen in the table, almost half of participants ($n = 95, 50.3\%$) reported that EMI was discovered

between 7 months to 3 years prior to participate the present study. The length of the EMI of involved partners was 1.79 years ($SD = 1.47$) and 164 participants (86.8%) talked with their partner about EMI. After infidelity discovered by the participants of the present study, only 113 involved partners (59.8%) accepted their EMI. Although 88 cases were unknown, the highest frequency (37.4%) of the third parties was work colleague of the involved partner. Based on the offended partners' description, 61.2% of EMI were entirely, mainly or more sexual than emotional. In addition, the participants who had applied to professional help as an individual or couple was only 18.5% ($n = 34$). Moreover, 25 participants (13.2%) were injured with infidelity in their previous relationship. Also, 33.3% of the participants ($n = 63$) reported that one of their family member (mostly father) had an EMI in their marriages.

Table 9 Descriptive Statistic of Participants' Experience of Extramarital Infidelity

EMI	Descriptive		Frequency	
	M	SD	n	%
Discovering EMI				
			13	6.9
			32	16.9
			95	50.3
			22	11.6
			27	14.3
Length of EMI Relationship	1.79	1.47		
Talking on EMI with Partner				
			164	86.8
			25	13.2
Involved Partner's First Reaction				
			113	59.8
			76	40.2
Third Parties				
			70	37.4
			5	2.7
			4	2.1
			10	5.3
			10	5.3
			88	47.1
Description of EMI by Injured Partner				
			46	25.14
			38	20.77
			28	15.30
			23	12.57
			25	13.65
			23	12.57
Professional Help as a Couple/Individual				
			34	18.5
			154	81.5
EMI in Previous Relationship of Injured Partner				
			25	13.2
			164	86.8
EMI in Family of Injured Partner				
			63	33.3
			126	66.7

4.2 Descriptive Statistics and Correlation Matrix of the Study Variables

Descriptive statistics (scale range, obtained range, mean, and standard deviation) for the main variables used in the present study are presented in Table 10. Based on responses of the entire sample to the PSS-SR, means were 19.23

(SD = 7.76) for the total PTSD score; 7.02 (SD = 3.32) for the Re-experiencing subscale; 6.70 (SD = 3.89) for the Avoidance subscale; and 5.51 (SD = 3.09) for the Arousal subscale. Examining the TWCI scores showed that means for the subscales of TWCI were 3.26 (SD = 0.37) in Problem-Focused Coping, 2.41 (SD = 0.38) in Emotion-Focused Coping, and 3.18 (SD = 0.48) in Indirect Coping Style. Moreover, the participants' total mean scores of COR-E were 2.14 (SD = .36) in the Loss form and 1.61 (SD = 0.38) in the Gain form. Finally, the responses to the FI showed that means for the subscales of FI were 23.71 (SD = 4.74) in Stage I-Impact, 20.13 (SD = 4.34) in Stage II-Meaning, and 24.29 (SD = 4.95) in Stage III-Recovery.

Table 10 Descriptive Statistics of the Main Variables

Variables	Scale Range	Min	Max	Mean	SD
Trauma Symptom: PSS-SR					
The total PTSD score	0-51	1.00	48.00	19.23	7.76
The Re-experiencing subscale	0-15	.00	15.00	7.02	3.32
The Avoidance subscale	0-21	.00	18.00	6.70	3.89
The Arousal subscale	0-15	.00	15.00	5.51	3.09
Coping Strategies: TWCI					
Problem-Focused Coping	1-5	1.86	4.34	3.26	.37
Emotion-Focused Coping	1-5	1.00	3.32	2.41	.38
Indirect Coping Style	1-5	1.50	5.00	3.18	.48
Resources: COR-E					
Lost	1-5	1.09	3.65	2.14	.36
Gain	1-5	.43	4.46	1.61	.38
Forgiveness: FI					
Stage-I Impact	0-40	10.00	37.00	23.71	4.74
Stage-II Search for Meaning	0-30	7.00	29.00	20.13	4.34
Stage-III Recovery	0-40	12.00	36.00	24.29	4.95

Pearson correlation coefficients among demographic variables and main variables of the present study are given in Table 11. The significant correlations are explained under the related parts of results. In order to deal with covariates, a number of analyses were conducted to understand whether some of the demographic and EMI variables were significantly related to the major variables. Thus, the correlations were examined between DI-EMI variables and the variables related to severity of PTSD, Coping Strategies, Resources Loss-Gain, and Forgiveness Stages. Based on the results of correlations, all the variables with significant correlation coefficient were assigned as a covariate for the following analysis. Results indicated the following variables as covariates; “years of marriage”, “discovering of EMI”, “involved partners’ first reaction” and “professional help”.

Table 11. Inter-correlations Between the Variables

	2	3	4	5	6	7	8	9	10	11	12	13	14
1.Age	-.116	.819**	.601**	.370**	.147*	.067	.056	.040	-.003	.040	.004	-.124	.022
2.Years of Education	1	-.239**	-.355**	-.098	.156*	.089	.086	-.036	.028	-.046	.098	.069	.211**
3.Years of Marriage		1	.620	.323**	.076	.037	.055	.129	.082	.051	-.065	-.199**	.041
4.Numbers of Children			1	.244**	.090	.058	.061	.083	.089	.050	-.084	-.167	-.056
5.Work Status				1	-.139	-.074	.082	.018	-.114	-.138	-.142	-.086	.051
6.SES					1	-.015	-.139	.039	-.003	.037	.097	-.035	-.089
7.Discovering EMI						1	.144	-.020	-.148*	-.042	.099	.039	.074
8.Length of EMI							1	.259**	-.188*	-.221*	.097	-.038	-.054
9. Talking on EMI								1	.076	.010	-.066	.032	-.144*
10.Involved Partner's Reaction									1	-.013	-.133	-.145	-.061
11. Description of EMI										1	.016	.271**	-.104
12.Professional Help											1	.015	-.019
13.Previous EMI												1	.022
14.EMI in Family													1

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

Table 11. Continued

	15	16	17	18	19	20	21	22	23	24	25	26
1.Age	.093	-.086	-.101	.022	-.018	.024	-.080	.091	.051	.079	-.044	.100
2.Years of Education	.135	-.136	.010	-.073	-.102	.037	-.048	.120	-.106	-.101	-.037	-.112
3.Years of Marriage	.001	-.053	-.042	.106	-.043	.081	-.020	-.058	.162*	.162*	.057	.161*
4.Numbers of Children	.020	-.070	.026	.126	-.111	.005	-.058	-.051	.078	.089	.000	.101
5.Working Status	-.050	.112	-.046	-.012	.061	.094	.058	-.106	.127	.046	.087	.059
6.SES	.046	-.024	-.073	-.075	-.097	-.014	-.061	-.012	-.029	-.015	-.037	-.009
7.Discovering EMI	.087	.035	.028	.048	.062	-.025	-.148*	.139	-.154*	-.164*	-.036	-.166*
8.Length of EMI	.118	-.078	.137	-.123	.135	-.021	-.064	.132	-.136	-.083	-.135	-.134
9. Talking on EMI	-.047	-.044	-.052	.063	.025	.139	.021	-.096	.007	-.016	-.009	.045
10.Involved Partner's Reaction	.031	-.065	-.061	.016	-.197**	.172*	-.038	-.148*	.249**	.253**	.184	.119
11. Description of EMI	-.107	-.018	.037	.113	-.117	-.044	.045	-.093	.066	.043	.036	.075
12.Professional Help	.060	-.018	.016	-.170*	.108	-.150*	-.153*	.212**	-.485**	-.294**	-.449**	-.333**
13.Previous EMI	-.034	-.093	.046	-.053	.068	.139	-.084	-.070	-.024	.004	-.009	-.052
14.EMI in Family	-.118	.044	.045	.052	-.015	.024	-.065	.040	.040	-.037	.089	.027
15.ProblemFocus Coping	1	-.184*	-.162*	-.269**	.158	-.183*	-.013	.251**	-.227**	-.140	-.084	-.315**
16.EmotionFocus Coping		1	.192*	.097	.164*	.115	.210*	-.009	.219**	.158*	.201**	.126
17.IndirectCoping			1	.168*	.087	.041	.039	.050	.119	.089	.078	.104
18.Resource Loss				1	-.260**	.273**	.139	-.083	.282**	.181*	.173*	.297**
19.Resource Gain					1	-.187*	-.128	.230**	-.266**	-.189**	-.186*	-.232**
20.Forgiveness Stage1-Impact						1	.264**	-.251**	.376**	.258**	.268**	.327**
21.Forgiveness Stage2-Meaning							1	-.076	.244**	.240**	.142	.176*
22.Forgiveness Stage3-Recovery								1	-.314**	-.268**	-.173*	-.282**
23.The total PTSD Score									1	.720**	.815**	.705**
24.Reexperincing Subscale										1	.370**	.269**
25.Avoidance Subscale											1	.378**
26.Arousal Subscale												1

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

4.3 Results of the PSS-SR and DSM-IV Criteria for PTSD

The correlations among the three clusters and the total PTSD score are presented in Table 12. The results of the inter-correlation of PSS-SR showed that the total PTSD score had a significant positive correlation with re-experiencing subscale ($r = .72, p < .001$), avoidance subscale ($r = .82, p < .00$), and arousal subscale ($r = .71, p < .001$). Moreover, the re-experiencing subscale had a positive correlation with the avoidance subscale ($r = .37, p < .00$), and the arousal subscale ($r = .27, p < .001$). In addition, the avoidance subscale was significantly related to the arousal subscale with a positive correlations of $r = .38, p < .001$, (see Table 12). Each of the three symptom clusters had its highest correlation with the PTSD total scale. However, among the three subscales, correlations changed between .27 and .38.

Table 12. Inter-correlations of Severity of PTSD

PSS-SR	1	2	3	4
1.The Total PTSD Score	1	.720*	.815**	.705**
2. Re-experiencing Subscale		1	.370**	.269**
3. Avoidance Subscale			1	.378**
4. Arousal Subscale				1

** $p < .01$

Besides the total and subscales' score of PTSD severity of individuals summarized above, the PSS-SR assesses the DSM-IV criteria (A, B, C, D, E, and F) for PTSD. The second part of PSS-SR (questions between 17 and 22) called "Severity of Events Subscale" assesses the criterion A. The concept of traumatic

event embodied in Criterion A in DSM-IV has two parts. The results showed that 98 participants (51.9%) completed the criterion A1 and 177 participants (93.7%) completed criterion A2. Overall, 95 participants (50.7%) met the criterion A for PTSD. The third part of the PSS-SR which includes 17 items has three factors correspond with DSM-IV criteria for PTSD (criterion B, C, and D). The criterion B is intrusive recollection and was fulfilled by 185 participants (97.9%). The rates in the entire sample ranged from 54.5% for “physical reactions” to 86.3% for “emotionally upset when reminded of the trauma”. On the other hand, 161 participants (85.2%) completed the criterion C (avoidant/numbing) whereas 172 participants (91.0%) met the criterion D which called Hyper-arousal. The rates of the symptoms of criterion C ranged from 34.4% for “loss of interest” to 65.6% for “trying not to think about the trauma”. In addition, endorsement rates of Criterion D ranged 23.4% for “easily startled” to 82% for “irritability”. The criterion of duration of the disturbance which called the criterion E is more than one month for PTSD and 93.1% of participants ($n = 176$) fulfill the criterion E. The last part of PSS-SR called “Event Impacts Subscale” (questions between 42 and 50) explores the criterion F (functional significance). The results showed that 173 participants (91.5%) met the criterion F and 85.7% responded moderate or severe impact. Finally, the participants who completed the whole DSM-IV criteria for diagnosing PTSD on the PSS-SR were 65 (34.4%). However, without counting the first part of criterion A (A1; actual or threatened death or serious injury), 153 participants (81%) could be diagnosed with PTSD. These results are presented in Table 13.

Table 13. Descriptive Statistics of DSM-IV Criteria for PTSD

Criteria	No	%	Yes	%
Criterion A (Stressor)	94	49.7	95	50.3
A1 (actual or threatened death or serious injury)	91	48.1	98	51.9
A2 (fear, helplessness, or horror)	12	6.3	177	93.7
Criterion B (Intrusive Recollection)	4	2.1	185	97.9
Intrusive images	41	21.7	148	78.3
Nightmares	75	39.7	114	60.3
Reliving of the trauma	72	38.1	117	61.9
Emotionally upset when reminded of the trauma	25	13.2	164	86.3
Physical reactions when reminded of the trauma	86	45.5	103	54.5
Criterion C (Avoidant/Numbing)	28	14.8	161	85.2
Trying not to think about the trauma	63	34.4	120	65.6
Trying to avoid activities, places, or people	78	41.3	111	58.7
Memory loss	121	65.1	65	34.9
Loss of interest	124	65.6	65	34.4
Feeling distant or cut off	84	44.2	105	55.8
Feeling emotionally numb	103	54.5	86	45.5
Lack of future plans	99	52.4	90	47.6
Criterion D (Hyper-arousal)	17	9.0	172	91.0
Difficulty sleeping	90	47.4	98	52.6
Irritability	34	18.0	155	82.0
Difficulty concentrating	47	24.9	142	75.1
Overly alert	122	64.2	67	35.8
Easily startled	144	76.6	44	23.4
Criterion E (Duration)	13	6.9	176	93.1
Less than 1 month			13	6.9
Between 1-3 months			39	20.6
More than 3 months			137	72.5
Criterion F (Functional Significance)	16	8.5	173	91.5
No Impact			16	8.5
Mild			11	5.8
Moderate			118	62.4
Severe			44	23.3
PTSD	124	65.6	65	34.4
PTSD (A1 not include)	36	19.0	153	81.0

4.3.1 Severity of PTSD Symptoms and DI-EMI Variables

Demographic Information and Extramarital Infidelity form (DI-EMI) developed by the researcher included two parts. In the first part of the form, information was obtained regarding participants' general demographic variables. In the second part of DI-EMI, important aspects of infidelity were included. Pearson correlation coefficients among the PTSD total symptom severity, its three symptom clusters and DI-EMI variables, namely, age, years of education, years of marriage, numbers of children, discovering of EMI, and length of EMI are given in Table 14. Results showed that the demographic variables of "years of marriage" had a significant positive correlation with the total PTSD score ($r = .16$, $p < .05$), re-experiencing subscale ($r = .16$, $p < .05$), and arousal subscale ($r = .16$, $p < .05$). On the contrary, time passed after "discovering of EMI" variable had negatively correlated with the total PTSD score ($r = -.15$, $p < .05$), re-experiencing subscale ($r = -.16$, $p < .05$), and arousal subscale ($r = -.17$, $p < .05$). The correlations between the variables indicated that participants who had longer marriage showed higher PTSD symptoms. Also the time passed after discovering of EMI diminished the severity of PTSD.

Table 14 Correlations Between Severity of PTSD and DI-EMI Variables

DI-EMI	The Total PTSD Score	Re-experiencing Subscale	Avoidance Subscale	Arousal Subscale
Age	.051	.079	-.044	.100
Years of Education	-.106	-.101	-.037	-.112
Years of Marriage	.162*	.162*	.057	.161*
Numbers of Children	.078	.089	.000	.101
Discovering of EMI	-.154*	-.164*	-.036	-.166*
Length of EMI	-.136	-.083	-.135	-.134

* $p < .05$

A one-way between subjects analysis (ANOVA) was conducted in order to assess the group differences by the DI-EMI variables on the severity of PTSD symptoms. As can be seen in Table 15, only two variables had significant differences on the total PTSD score, namely, Involved Partner's First Reaction and Professional Help as a Couple/Individual. Results indicated that the participants whose partners accepted his extramarital involvement had significantly lower PTSD symptom severity ($\underline{M} = 17.48$) comparing with the group ($\underline{M} = 21.61$) whose partners rejected EMI ($F(1, 187) = 13.95, p < .01$). ANOVA analysis for the other variable of DI-EMI, "Professional Help as a Couple/Individual", revealed a significant main effect for professional help ($F(1, 187) = 53.62, p < .001$). As expected, after discovering of EMI, the participants who applied to professional help as a couple or individual reported lower PTSD symptom severity ($\underline{M} = 11.57$) than who did not get any help ($\underline{M} = 20.97$).

Table 15 Comparison of DI-EMI Groups on the Total PTSD Score

PSS Total Symptom Severity	n*	Mean	SD	F	p
Work Status				2.68	.10
Working	101	18.65	7.99		
Not-Working	78	20.78	7.36		
SES Group				.188	.91
Low SES	18	19.06	9.21		
Low-Mid SES	21	19.57	7.33		
Middle SES	109	19.42	6.49		
Mid-High SES	41	18.41	10.03		
Talking on EMI with Partner				.110	.74
Yes	164	19.17	7.98		
No	24	19.64	5.81		
Involved Partner's First Reaction				13.95	.00**
Accept	109	17.48	6.94		
Reject	80	21.61	8.21		
Description of EMI by Injured Partner				1.43	.23
Entirely Sexual	46	19.61	6.58		
Mainly Sexual	57	17.82	7.17		
More Emotional than Sexual	32	19.44	10.06		
Mainly Emotional	25	17.84	7.40		
Entirely Emotional	23	21.96	7.28		
EMI in Previous Relationship of Injured Partner				.167	.68
Yes	25	18.64			
No	164	19.32			
EMI in the Family of Injured Partner				.339	.56
Yes	63	19.00			
No	126	19.69			
Professional Help as a Couple/Individual				53.62	.00**
Yes	35	11.57	6.76		
No	154	20.97	6.87		

*missing data were not included, **p < .001

4.3.2 Severity of PTSD Symptoms and Coping Strategies

The results of the inter-correlation of the Turkish Ways of Coping Inventory subscales showed that problem-focused coping had a significant negative correlation with emotion-focused coping ($r = -.18, p < .05$), and indirect coping ($r = -.16, p < .05$). Moreover, emotion-focused coping was significantly related to indirect coping with a positive correlations of $r = .19, p < .05$ (see Table 11). Results indicated that individuals who were more likely to use emotion-focused coping strategies also less intended to use problem-focused and indirect coping strategies. On the other hand, the results of correlations between coping strategies and PTSD symptoms indicated that both problem-focused and emotion-focused coping had significant correlations with the total PTSD score and its symptom clusters on the opposite direction. However, indirect coping was not found correlated with any scales of PTSD. Problem-focused coping had a negative correlation with the total PTSD score ($r = -.23, p < .01$) and arousal subscale ($r = -.32, p < .01$). Contrarily, emotion-focused coping was positively correlated with the total PTSD score ($r = .22, p < .01$), re-experiencing subscale ($r = .16, p < .05$), and avoidance subscale ($r = .20, p < .01$) but not with arousal subscale (see Table 16). These mean that when individual get higher scores from emotion-focused coping, also get higher scores from the total PTSD, re-experience, and avoidance subscales. Conversely, individual who got higher scores from problem-focused coping had lower scores from the total PTSD and arousal subscales.

Table 16 Correlations Between Severity of PTSD and Coping Strategies

TWCI	The Total PTSD Score	Re-experiencing Subscale	Avoidance Subscale	Arousal Subscale
Problem-Focused Coping	-.227**	-.140	-.084	-.315**
Emotion-Focused Coping	.219**	.158*	.201**	.126
Indirect Coping	.119	.089	.078	.104

*p<.01, **p<.001

In order to support the main effect of the coping strategies on the severity of PTSD, each participant was also classified into the coping style with the following procedure. The scales of the TWCI were considered separately, and raw scores were converted to z-scores. After participant's three subscales' z-scores were compared, they were assigned to the group corresponding to the highest of her three subscales' z-scores. This method yielded a sample size of 64 for the problem-focus, 66 for the emotion-focus, and 59 for the indirect coping group. Then, the PTSD symptom clusters (the total PTSD score, re-experiencing, avoidance, and arousal subscales) were taken as the dependent variables, years of marriage, discovering EMI, involved partner's first reaction, and professional help variables were assigned as the covariate, and the coping groups (problem-focused, emotion-focused, and indirect coping) were taken as the independent variables. In addition, Bonferroni's method was applied for the post hoc analysis. The PTSD Cluster x Coping Groups MANCOVA revealed a significant main effect for groups, Wilks' Lambda = .85, Multivariate $F(2, 186) = 4.06$, $p < .05$, partial $\eta^2 = .043$. After Bonferroni's correction, a univariate analyses indicated significant

main effect for coping strategies on the total PTSD score ($F [2, 186] = 4.06, p < .05$). To interpret this main effect of the Group, Tukey's HSD was also conducted at .05 significance level. These post-hoc analyses revealed that the participants who were categorized as problem-focused group ($M = 17.93$) had higher PTSD score than emotion-focused ($M = 19.76$) and indirect coping ($M = 20.83$) groups. The results did not reveal a significant main effect for the subscales of the severity of PTSD (see Table 17).

Table 17 MANCOVA Results of Coping Groups on the PTSD Scores

Coping Strategies	n	Mean	SD	F	η^2
The total PTDS score				4.06*	.042
Problem-Focused Coping	64	17.08a	7.93		
Emotion-Focused Coping	66	19.76b	7.47		
Indirect Coping Style	59	20.83b	7.30		
The Re-experiencing subscale				2.19	.023
Problem-Focused Coping	64	6.35	3.45		
Emotion-Focused Coping	66	7.20	3.21		
Indirect Coping Style	59	7.52	3.06		
The Avoidance subscale				2.16	.023
Problem-Focused Coping	64	5.97	3.84		
Emotion-Focused Coping	66	6.73	3.79		
Indirect Coping Style	59	7.42	4.01		
The Arousal subscale				2.71	.028
Problem-Focused Coping	64	4.76	2.78		
Emotion-Focused Coping	66	5.83	3.27		
Indirect Coping Style	59	5.88	3.06		

* $p < .01$

4.3.3 Severity of PTSD Symptoms and Resource Loss and Gain

As expected, the inter-correlation of COR-E showed that resource-loss had a significant negative correlation with resource-gain ($r = -.26, p < .01$) (see Table 11). Mainly, the correlations between PSS-SR and COR-E were calculated for all the subscales and results are presented in Table 18. Both resource-loss and resource-gain had significant correlations with the total PTSD score and its symptom clusters on the opposite direction. As seen in the table, resource-loss had positive correlation with the total PTSD score ($r = .28, p < .01$), re-experiencing subscale ($r = .18, p < .05$), avoidance subscale ($r = .17, p < .05$), and arousal subscale ($r = .23, p < .01$). Furthermore, significant correlations between the subscales of COR-E Loss and all four scales of PSS-SR changed between .15 and .34. On the other hand, resource-gain was negatively correlated with the total PTSD score ($r = -.27, p < .01$), re-experiencing subscale ($r = -.19, p < .01$), avoidance subscale ($r = -.18, p < .05$), and arousal subscale ($r = -.23, p < .01$). Moreover, significant correlations between the subscales of COR-E Gain and all four scales of PSS-SR changed between -.15 and -.40. These results could be interpreted that when individual get higher score from COR-E Loss, they also get higher scores from the total PTSD and its clusters. Conversely, individual who got higher scores from COR-E Gain had lower scores from the total PTSD and its clusters.

Table 18 Correlations Between the Resource Loss-Gain and PTSD Variables

COR-E	The Total PTSD Score	Re-experiencing Subscale	Avoidance Subscale	Arousal Subscale
Total Resource Loss	.282**	.181*	.173*	.297**
Work resource	.279**	.226**	.184*	.227**
Personal resources – self esteem	.230**	.080	.119	.343**
Personal resources – mastery	.258**	.213**	.157*	.222*
Personal resources – well being	.110	.074	.101	.069
Material resources	.212**	.112	.158*	.213**
Energy resources	.104	.100	.057	.081
Interpersonal resources – family	.148*	.117	.058	.172*
Interpersonal resources – general	.135	.043	.047	.235**
Total Resource Gain	-.266**	-.189**	-.184*	-.232**
Work resource	-.248**	-.155*	-.147*	-.273*
Personal resources – self esteem	-.301**	-.217**	-.203**	-.267**
Personal resources – mastery	-.401**	-.301**	-.321**	-.305**
Personal resources – well being	-.159*	-.127	-.083	-.159*
Material resources	-.020	-.039	.010	-.022
Energy resources	-.158*	-.072	-.155**	-.122
Interpersonal resources – family	-.198**	-.090	-.194**	-.155*
Interpersonal resources – general	-.111	-.127	-.043	-.090

*p<.01, **p<.001

In addition, the descriptive analysis revealed that the items of resource-loss which had means higher than three on a 5-point Likert type (to a moderate degree) were “Good marriage”, “Hope”, “Stamina/endurance”, “Intimacy with spouse or partner”, and “Feeling that my life is peaceful”. On the other hand,

“Good relation with my children”, “Time with loved ones”, “Feeling that my future success depend on me”, “Feeling that I know who I am”, “Feeling independent”, “Knowing where I am going with my life”, “Feeling that my life has meaning/purpose”, and “Positive feeling about myself” were the items of resource-gain which had means higher than two on a 5-point Likert type (to a small degree) (see Table 19).

Table 19 Items List of Resource Loss and Gain with the Highest Mean

COR-E Items	Mean	SD
Items of Resource Loss with Higher Mean		
4. Good marriage (Interpersonal Resources – Family)	3.48	1.49
17. Hope (Personal Resources – Well-Being)	3.23	1.46
19. Stamina/endurance (Energy Resources)	3.01	1.40
31. Intimacy with spouse or partner (Interpersonal Resources – Family)	3.10	1.63
37. Feeling that my life is peaceful (Personal Resources – Well-Being)	3.39	1.26
Items of Resource Gain with Higher Mean		
14. Good relation with my children (Interpersonal Resources – Family)	2.09	1.37
15. Time with loved ones (Energy Resources)	2.06	1.27
21. Feeling that my future success depend on me (Personal Resources – Mastery)	2.05	1.41
51. Feeling that I know who I am (Personal Resources – Self-Esteem)	2.15	1.44
54. Feeling independent (Personal Resources – Mastery)	2.04	1.52
57. Knowing where I am going with my life (Personal Resources – Well-Being)	2.20	1.37
60. Feeling that my life has meaning/purpose (Personal Resources – Well-Being)	2.19	1.39
61. Positive feeling about myself (Personal Resources – Self-Esteem)	2.01	1.36

In order to support the main effect of resource loss and gain on the severity of PTSD, each participant was also classified into the resource groups (Loss and Gain) with the similar procedure which conducted for coping above. The scales of the COR-E were considered separately, and raw scores were converted to z-scores. After participant's two subscales' z-scores were compared, they were assigned to the group corresponding to the highest of her two subscales' z-scores. This method yielded a sample size of 93 for the resource loss and 96 for the resource gain group. The PTSD symptom clusters (the total PTSD score, re-experiencing, avoidance, and arousal subscales) were taken as the dependent variables, years of marriage, discovering EMI, involved partner's first reaction, and professional help variables were assigned as the covariate, and the resource groups (loss and gain) were taken as the independent variables. In addition, Bonferroni's method was applied for the post hoc analysis. The PTSD Cluster x Resource Groups MANCOVA revealed a significant main effect for group, Wilks' Lambda = .96, Multivariate F (1, 187) = 2.71, $p < .05$, partial $\eta^2 = .042$. After Bonferroni's correction, a univariate analyses indicated significant main effect for resource group on the total PTSD score ($F(1, 187) = 7.10, p < .01$). To interpret this main effect of the Group, Tukey's HSD was also conducted at .05 significance level. These post-hoc analyses revealed that the participants who were categorized as resource loss group ($M = 20.68$) had higher PTSD score than resource gain group ($M = 17.74$). The results revealed a significant main effect for the subscales of the PTSD; re-experiencing subscale ($F(1, 187) = 4.46, p < .05$), and arousal subscale ($F(1, 187) = 5.68, p < .05$) (see Table 20).

Table 20 MANCOVA Results of Resource Groups on the PTSD Scores

Resources	n	Mean	SD	F	η^2
The total PTDS score				7.10**	.037
Resource Loss	93	20.68	7.95		
Resource Gain	96	17.74	7.19		
The Re-experiencing subscale				4.46*	.023
Resource Loss	93	7.52	3.36		
Resource Gain	96	6.52	3.11		
The Avoidance subscale				2.48	.013
Resource Loss	93	7.14	3.96		
Resource Gain	96	6.25	3.80		
The Arousal subscale				5.68*	.029
Resource Loss	93	6.02	2.98		
Resource Gain	96	4.96	3.08		

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

4.3.4 Severity of PTSD Symptoms and Forgiveness Stages

As seen in Table 11, the Stage I-Impact was positively correlated with the Stage II-Meaning ($r = .26$) while negatively correlated with the Stage III-Recovery ($r = -.25$). However, the Stage II-Meaning did not have a significant correlation with the Stage III-Recovery. On the other hand, the results of correlations between the Forgiveness Inventory (FI) and PSS-SR indicated that both the Stage I-Impact and the Stage II-Meaning had positive correlations with the total PTDS score and its symptom clusters whereas the Stage III-Recovery had negative correlation. Results showed that the Stage I-Impact was significantly correlated with the total PTSD score ($r = .38$, $p < .01$), re-experiencing subscale ($r = .26$, $p < .01$), avoidance subscale ($r = .27$, $p < .01$), and arousal subscale ($r = .33$, $p < .01$). Moreover, the Stage II-Meaning had positive correlations with the total

PTSD score ($r = .24, p < .01$), re-experiencing subscale ($r = .24, p < .01$), and arousal subscale ($r = .18, p < .05$). Contrarily, the Stage III-Recovery was significantly correlated with the total PTSD score ($r = -.31, p < .01$), re-experiencing subscale ($r = -.27, p < .01$), avoidance subscale ($r = -.17, p < .05$), and Arousal Subscale ($r = -.28, p < .01$) (see Table 21). It means that when individuals get higher score on the Stage I and II their PTSD severity score also increases. Conversely, when individuals get higher score on the Stage III, their PTSD severity scores decrease.

Table 21 Correlations Between Severity of PTSD and Forgiveness Stages

Forgiveness Stage	The Total PTSD Score	Re-experiencing Subscale	Avoidance Subscale	Arousal Subscale
1. Stage I- Impact	.376**	.258**	.268**	.327**
2. Stage II - Meaning	.244**	.240**	.142	.176*
3. Stage III - Recovery	-.314**	-.268**	-.173*	-.282**

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

In order to support the main effect of the forgiveness stages on the severity of PTSD, each participant was also classified into the stages of forgiveness. The scales of the FI were considered separately, and raw scores were converted to z-scores. After participant's three subscales' z-scores were compared, they were assigned to the group corresponding to the highest of his or her three subscales' z-scores. This method yielded a sample size of 62 for the Stage I group, 59 for the Stage II group, and 68 for the Stage III group. The PTSD symptom cluster (the total PTSD score, re-experiencing, avoidance, and arousal subscales) were taken as the dependent variables, years of marriage, discovering EMI, involved partner's first reaction, and professional help variables were assigned as the covariate, and the forgiveness stages (Stage I-Impact, Stage II-Meaning, and Stage III-Recovery) were taken as the independent variables. In addition, Bonferroni's method was applied for the post hoc analysis. The PTSD Cluster x Forgiveness Stages MANCOVA revealed a significant main effect for group, Wilks' Lambda = .96, Multivariate $F(2, 186) = 4.16, p < .001$, partial $\eta^2 = .063$. After Bonferroni's correction, a univariate analyses indicated significant main effect for forgiveness stages on the total PTSD score ($F(2, 186) = 8.28, p < .001$). To interpret this main effect of the Group, Tukey's HSD was also conducted at .05 significance level. These post-hoc analyses revealed that the participants who were in Stage I-Impact ($M = 22.01$) had higher PTSD score than Stage II-Meaning ($M = 19.05$) and Stage III-Recovery ($M = 16.72$). The results revealed a significant main effect for the subscales of the severity of PTSD; re-experiencing subscale ($F[2, 186] = 4.72, p < .01$), avoidance subscale ($F[2, 186] = 3.15, p < .05$), and arousal subscale ($F[2, 186] = 8.69, p < .001$) (see Table 22).

Table 22 MANCOVA Results of Forgiveness Stage on the PTSD Scores

Forgiveness Stage	n	Mean	SD	F	η²
The total PTDS score				8.28***	.082
Stage I- Impact	62	22.01 a	7.26		
Stage II - Meaning	59	19.05ab	7.06		
Stage III - Recovery	68	16.72b	7.83		
The Re-experiencing subscale				4.72**	.048
Stage I- Impact	62	7.82a	2.78		
Stage II - Meaning	59	7.18ab	3.12		
Stage III - Recovery	68	6.12b	3.62		
The Avoidance subscale				3.15*	.033
Stage I- Impact	62	7.69a	3.96		
Stage II - Meaning	59	6.15b	3.95		
Stage III - Recovery	68	6.24b	3.66		
The Arousal subscale				8.69***	.085
Stage I- Impact	62	6.50a	3.08		
Stage II - Meaning	59	5.71a	2.90		
Stage III - Recovery	68	4.36b	2.88		

*p<.05, **p<.01,***p<.001

4.4 Predictors of the Severity of PTSD: The Results of Regression Analyses

In order to examine the predictors of the severity of PTSD and its clusters, hierarchical multiple regression analyses were conducted. For these analyses, dependent variables were set as the PTSD total symptom severity, re-experiencing subscale, avoidance subscale, and arousal subscale. Besides, years of marriage, discovering EMI, involved partner's first reaction, and professional help variables were assigned as the control variables. In the regression analyses, the same set of variables was used as predictor variables. In the first block, demographic variable, namely years of marriage was entered. In the second block, extramarital infidelity related variables, namely discovering of EMI, involved partner's first reaction (1 = accept, 2 = reject), and professional help (1 = yes, 2 = no) were assigned. For the first two steps, enter method were used while stepwise method were used for the other blocks. In the third block, coping variables, namely, the problem-focus, emotion-focus, and indirect coping were entered. While resource variables (resource- loss and resource-gain) enter in the fourth block, forgiveness variables, namely, Stage I-Impact, Stage II-Meaning, and Stage III-Recovery were entered in the final block. Thus, all together, twelve predictors were entered into the equations in five blocks (see in Table 23).

Table 23. Set of Variables Enter into the Hierarchical Multiple Regression

Block	Predictor Variables	Method
1	Demographic Variables	Enter
	Years of Marriage	
2	EMI Related Variables	Enter
	Discovering EMI	
	Involved Partner's First Reaction (1 = accept, 2 = reject)	
	Professional Help as a Couple/Individual (1 = yes, 2 = no)	
3	Coping Strategies	Stepwise
	Problem-Focused Coping	
	Emotion-Focused Coping	
	Indirect Coping Style	
4	Conservation of Resource	Stepwise
	Resource Lost	
	Resource Gain	
5	Forgiveness	Stepwise
	Stage I-Impact	
	Stage II-Search for Meaning	
	Stage III-Recovery	

4.4.1 Predictors of the PTSD Total Symptom Severity

In order to assess the predictors of the PTSD total symptom severity among demographic variables, EMI related variables, coping related variables, resource related variables, and forgiveness related variable, a hierarchical multiple regression was conducted. The total PTSD was determined as the dependent variable for the analysis. Predictor variables entered into the regression equation

in five blocks. The results of the hierarchical multiple regression analysis is presented in Table 24.

The results of the regression analysis indicated that years of marriage ($\beta = .16$, $t [186] = 2.24$, $p < .05$) entered into the equation in the first block and explained 3 % of the total variance ($F [1, 186] = 5.03$, $p < .05$). Among EMI related demographics, discovering of EMI ($\beta = -.09$, $t [183] = -1.49$, $p > .05$), involved partners' first reaction ($\beta = .18$, $t [183] = 2.76$, $p < .01$), and professional help ($\beta = -.44$, $t [183] = -6.94$, $p < .001$) that entered into the equation in the second block explained 27 % of the total variance ($F [3,183] = 15.37$, $p < .001$). The other variables related to coping strategies that entered into the equation in the third block, emotion-focused coping ($\beta = .25$, $t [182] = 4.07$, $p < .001$), and problem-focused coping ($\beta = -.17$, $t [181] = -2.75$, $p < .01$) entered into the equation as the third and fourth variables with emotion-focused coping explaining 6 % of the total variance ($F\Delta [1,182] = 16.61$, $p < .001$), and problem-focused coping explaining 2 % of the total variance ($F\Delta [1,181] = 16.61$, $p < .001$). Among variables related to resources, resource gain ($\beta = -.21$, $t [180] = -3.36$, $p < .01$) that entered into the equation in the fourth block explained 4 % of the total variance ($F\Delta [1,180] = 16.13$, $p < .00$). At last, forgiveness stages variable ($\beta = .21$, $t [179] = 3.05$, $p < .001$) that entered into the regression equation on the last step explained 4 % of the total variance ($F \Delta [1,179] = 16.71$, $p < .001$). All of the variables totally explained 46 % of the total variance in the total PTSD score reported by offended partners with EMI ($F [8,179] = 16.41$, $p < .001$).

According to final model values, this hierarchical multiple regression analysis indicated that the PTSD total symptom severity and emotion-focused

coping were positively associated while problem-focused coping negatively associated. On the other side, resource gain had negative correlation with the total PTSD whereas Stage I-Impact had positive correlation. From demographic variables, having professional help had negative and involved partner's first reaction had positive correlation with the total PTSD symptom severity. Especially the variable of "having professional help" had the highest rate of correlations with the PTSD total symptom severity. Furthermore, having professional help predicts lower the PTSD total symptom severity.

Table 24. Predictors of the PTSD Total Symptom Severity

Order of entry of set	Block	Variables	Beta	FΔ	df	t for within set	Model R2
I. Demog. Variables							
	1	Years of Marriage	.14	3.04*	1, 186	1.79	.03
II.EMI Variables							
	2	Discovering EMI	-.09	15.37***	3, 183	-1.49	.30
		Involved Partner's First Reaction	.18			2.76**	
		Professional Help	-.44			-6.94***	
III. Coping Strategies							
	3	Emotion-Focused Coping	.25	16.61***	1, 182	4.07***	.36
	4	Problem-Focused Coping	-.17	15.89***	1, 181	-2.75**	.38
IV. Resource							
	5	Resource Gain	-.21	16.13***	1, 180	-3.38**	.42
V.Forgiveness							
	6	Stage I-Impact	.21	16.71***	1, 179	3.59***	.46
		<u>Final Model Values</u>					
		Years of Marriage	.11		179	1.89	
		Discovering EMI	-.10		179	-1.71	
		Involved Partner's First Reaction	.13		179	2.23*	
		Professional Help	-.39		179	-6.85***	
		Emotion-Focused Coping	.23		179	4.01***	
		Problem-Focused Coping	-.10		179	-1.61	
		Resource Gain	-.18		179	-2.91**	

*p < .05; **p < .01; ***p < .001

4.4.2 Predictors of the Re-experience Symptom Severity

To establish a relationship between the clusters of PTSD and its potential predictors, demographic variables, EMI related variables, coping related variables, resource related variables, and forgiveness related variables were regressed on to the re-experience symptoms. For this aim, the re-experience symptom severity was determined as the dependent variable for the analysis. Predictor variables entered into the regression equation in five blocks. The results of the hierarchical multiple regression analysis is presented in Table 25.

The results of the regression analysis indicated that years of marriage ($\beta = .16$, $t [186] = 2.23$, $p < .05$) entered into the equation in the first block and explained 3 % of the total variance ($F [1, 186] = 5.01$, $p < .05$). Among EMI related demographics, discovering of EMI ($\beta = -.12$, $t [183] = -1.71$, $p > .05$), involved partners' first reaction ($\beta = .19$, $t [183] = 2.74$, $p < .01$), and professional help ($\beta = -.25$, $t [183] = -3.58$, $p < .001$) that entered into the equation in the second block explained 13 % of the total variance ($F [3,183] = 7.07$, $p < .001$). The variables related to coping strategies, emotion-focused coping ($\beta = .19$, $t [182] = 2.78$, $p < .01$) that entered into the equation in the third block explained 4 % of the total variance ($F [1,182] = 7.40$, $p < .001$). Also, resource related, resource gain ($\beta = -.15$, $t [181] = -2.14$, $p < .05$) that entered into the equation in the fourth block explained 2 % of the total variance ($F [1,181] = 7.18$, $p < .01$). Lastly, related to forgiveness stages variable that entered into the equation in the fifth block, Stage II-Meaning ($\beta = .16$, $t [180] = 2.27$, $p < .05$), and Stage III-Recovery ($\beta = -.15$, $t [179] = -2.19$, $p < .05$) entered into the equation as the fifth and sixth variables with Stage II-Meaning explaining 2 % of the total variance

($F\Delta [1,179] = 6.89, p < .05$), and Stage III-Recovery explaining 2 % of the total variance ($F\Delta [1,179] = 6.89, p < .05$). All of the variables totally explained 26 % of the total variance in the re-experiencing symptom severity reported by offended partners with EMI ($F [8,179] = 7.49, p < .01$).

According to final model values, the results indicated that the re-experiencing symptom severity and emotion-focused coping were positively associated. This association suggests that using emotion-focused coping predicts the increase in the severity of re-experience symptoms. Moreover, Stage II-Meaning had positive correlation with the re-experiencing symptom severity whereas Stage III-Recovery had negative correlation. Thus, individual who were in Stage III had less re-experiencing symptoms than who were in Stage II. From demographic variables, years of marriage and having professional help negatively and involved partner's first reaction positively correlated with the total PTSD symptom severity. It means that individuals who have longer marriage and whose partner rejects his extramarital affair show higher re-experience symptom severity while that individuals who have professional help show less symptoms.

Table 25 Predictors of the Re-experience Symptom Severity

Order of entry of set	Block	Variables	Beta	FΔ	df	t for within set	Model R2
I. Demog. Variables							
	1	Years of Marriage	.16	5.01	1, 186	2.23*	.03
II.EMI Variables							
	2			7.07***	3, 183		.16
		Discovering EMI	-.12			-1.71	
		Involved Partner's First Reaction	.19			2.74**	
		Professional Help	-.25			-3.58***	
III. Coping Strategies							
	3	Emotion-Focused Coping	.19	7.40***	1, 182	2.78**	.20
IV. Resource							
	4	Resource Gain	-.15	7.12***	1, 181	-2.14*	.22
V. Forgiveness							
	5	Stage II-Meaning	.16	7.02***	1, 180	2.27*	.24
	6	Stage III-Recovery	-.15	6.89***	1, 179	-2.19*	.26
		<u>Final Model Values</u>					
		Years of Marriage	.14		179	2.06*	
		Discovering EMI	-.09		179	-1.33	
		Involved Partner's First Reaction	.18		179	2.67**	
		Professional Help	-.19		179	-2.76**	
		Emotion-Focused Coping	.17		179	2.46*	
		Resource Gain	-.09		179	-1.28	
		Stage II-Meaning	.16		179	2.30*	

*p < .05; **p < .01; ***p < .001

4.4.3 Predictors of the Avoidance Symptom Severity

To assess the predictors of the avoidance symptoms, demographic variables, EMI related variables, coping related variables, resource related variables, and forgiveness related variables were put into the regression. The avoidance symptom severity was determined as the dependent variable for the

analysis. Predictor variables entered into the regression equation in five blocks. The results of the hierarchical multiple regression analysis is presented in Table 26.

The results of the regression analysis indicated that years of marriage ($\beta = .04$, $t [186] = .77$, $p > .05$) entered into the equation in the first block and explained 1 % of the total variance ($F [1, 186] = .59$, $p > .05$). Among EMI related demographics, discovering of EMI ($\beta = .03$, $t [183] = .40$, $p > .05$), involved partners' first reaction ($\beta = .13$, $t [183] = 1.84$, $p > .05$), and professional help ($\beta = -.43$, $t [183] = -6.46$, $p < .001$) that entered into the equation in the second block explained 21 % of the total variance ($F [3,183] = 10.09$, $p < .001$). The variables related to coping strategies, emotion-focused coping ($\beta = .21$, $t [182] = 3.21$, $p < .01$) that entered into the equation in the third block explained 4 % of the total variance ($F [1,182] = 10.55$, $p < .001$). Also, resource related, resource gain ($\beta = -.15$, $t [181] = -2.30$, $p < .05$) that entered into the equation in the fourth block explained 2 % of the total variance ($F [1,181] = 10.01$, $p < .001$). Finally, forgiveness stages variable ($\beta = .15$, $t [180] = 2.20$, $p < .05$) that entered into the regression equation on the last step explained 2 % of the total variance ($F [1,180] = 9.55$, $p < .000$). All of the variables totally explained 27 % of the total variance in the avoidance symptom severity reported by offended partners with EMI ($F [7,180] = 9.55$, $p < .001$).

This hierarchical multiple regression analysis revealed that the avoidance symptom severity and emotion-focused coping were positively associated. This association suggests that using emotion-focused coping predicts the increase in the severity of avoidance symptoms. On the contrary, Stage I-Impact had positive

correlation with the avoidance symptom severity which means that being in Stage I predicts more symptoms of avoidance. In addition, from the demographic variables, “having professional help” was the strongest predictors of the avoidance symptom severity.

Table 26. Predictors of the Avoidance Symptoms Symptom Severity

Order of entry of set	Block	Variables	Beta	FΔ	df	t for within set	Model R2
I. Demog. Variables							
	1	Years of Marriage	.04	.59	1, 186	.77	.01
II.EMI Variables							
	2			10.09***	3, 183		.22
		Discovering EMI	.03			.40	
		Involved Partner’s First Reaction	.13			1.84	
		Professional Help	-.43			-6.46***	
III. Coping Strategies							
	3	Emotion-Focused Coping	.21	10.55***	1, 182	3.21**	.26
IV. Resource							
	4	Resource Gain	-.15	10.01***	1, 181	-2.30*	.28
V. Forgiveness							
	5	Stage-I Impact	.15	9.55***	1, 180	2.20*	.30
<u>Final Model Values</u>							
		Years of Marriage	.03		180	.36	
		Discovering EMI	.02		180	.25	
		Involved Partner’s First Reaction	.09		180	1.42	
		Professional Help	-.40		180	-6.19***	
		Emotion-Focused Coping	.21		180	3.20**	
		Resource Gain	-.13		180	-1.89	

*p < .05; **p < .01; ***p < .001

4.4.4 Predictors of the Arousal Symptom Severity

In order to assess the predictors of the arousal symptoms among demographic variables, EMI related variables, coping related variables, resource related variables, and forgiveness related variables, a hierarchical multiple regression analysis was conducted. The arousal symptom severity was determined as the dependent variable for the analysis. Predictor variables entered into the regression equation in five blocks. The results of the hierarchical multiple regression analysis is presented in Table 27.

The results of the regression analysis indicated that years of marriage ($\beta = .08$, $t [186] = 2.27$, $p > .05$) entered into the equation in the first block and explained 3 % of the total variance ($F [1, 186] = 4.61$, $p < .05$). Among EMI related demographics, discovering of EMI ($\beta = -.15$, $t [183] = -2.14$, $p < .05$), involved partners' first reaction ($\beta = .08$, $t [183] = 1.12$, $p > .05$), and professional help ($\beta = -.29$, $t [183] = -4.27$, $p < .001$) that entered into the equation in the second block explained 15 % of the total variance ($F [3,183] = 7.83$, $p < .001$). The variables related to coping strategies, problem-focused coping ($\beta = -.27$, $t [182] = -4.14$, $p < .01$) that entered into the equation in the third block explained 7 % of the total variance ($F\Delta [1,182] = 9.96$, $p < .001$). Among variables related to resources, resource lost ($\beta = .19$, $t [181] = 2.88$, $p < .01$) that entered into the equation in the fourth block explained 3 % of the total variance ($F\Delta [1,181] = 9.96$, $p < .001$). Lastly, forgiveness variable, Stage I-Impact ($\beta = .20$, $t [180] = 3.04$, $p < .05$) that entered into the regression equation on the last step explained 4 % of the total variance ($F\Delta [1,180] = 10.37$, $p < .001$). All of the variables totally explained 32 % of the total variance in the arousal subscale score reported by

injured partners with EMI ($F [7,180] = 10.17, p < .001$). According to the final model values, the arousal symptom severity and problem-focused coping were negatively associated. This association suggests that using problem-focused coping predicts the decrease in the severity of arousal symptoms. Contrarily, resource lost and being in Stage I-Impact had positive correlation with the arousal subscale score. These mean that greater level of resource loss predict more symptoms of arousal. From demographic variables, discovering of EMI and having professional help were negatively correlated with avoidance symptom severity. Especially, time after discovering EMI predicts less avoidance symptoms.

Table 27. Predictors of the Arousal Symptoms Symptom Severity

Order of entry of set	Block	Variables	Beta	FΔ	df	t for within set	Model R2
I. Demog. Variables							
	1	Years of Marriage	.08	5.14*	1, 186	2.27	.03
II. EMI Variables							
	2			7.83***	3, 183		.18
		Discovering EMI	-.15			-2.14*	
		Involved Partner's First Reaction	.08			1.12	
		Professional Help	-.29			-4.27***	
III. Coping Strategies							
	3	Problem-Focused Coping	-.27	9.96***	1, 182	-4.14***	.25
IV. Resource							
	4	Resource Lost	.19	10.07***	1, 181	2.88**	.28
V. Forgiveness							
	5	Stage-I Impact	.20	10.37***	1, 180	3.04**	.32
<u>Final Model Values</u>							
		Years of Marriage	.09		180	1.32	
		Discovering EMI	-.14		180	-2.21*	
		Involved Partner's First Reaction	.05		180	.83	
		Professional Help	-.23		180	-3.63***	
		Problem-Focused Coping	-.19		180	-2.91**	
		Resource Lost	.15		180	2.21*	

*p < .05; **p < .01; ***p < .001

CHAPTER 5

DISCUSSION

The present study examined post traumatic effects of extramarital infidelity on the offended partners. Based on the statement that infidelity is an interpersonal trauma (Gordon & Baucom, 1999), this study focused on the factors affecting the severity of traumatic symptoms. These factors are coping strategies used by offended partners, resources gain and loss, and forgiveness level of the injured partners. In addition, some critical demographic variables pointed out by literature were examined. This section aimed to discuss the findings of the present study. First, a discussion of descriptive characteristics of the sample and their experience of EMI were presented. Secondly, the PTSD criteria completed by participants who injured with EMI were discussed. Thirdly, a discussion of the factors affecting the severity of traumatic symptom, coping strategies, resource, and forgiveness were presented separately. Finally, a discussion of the predictors of the PTSD total symptom severity and its clusters among the variables of demographics, coping strategies, resource, and forgiveness was presented.

5.1 Descriptive Characteristics of the Sample

Present study was mainly focused on individuals who injured by their partners' infidelity, not on the involved partner. In the literature of infidelity, there is very limited research in which sample compose of large number of individuals who actually injured by EMI (Blow & Hartnett, 2005a). At this point, the present

study provided a quantitative data in order to work with offended partners who continue their marriage after dissolution of EMI. Although there is no any controlled study which examined the relationship status and the response differences to the infidelity, the primary relationship status is another issue for infidelity research. It is generally accepted that marriage itself is the most obvious relationship status approved even by law. Because of that, marriage was focused instead of dating or cohabiting relationships in the present study. In addition, divorce or break-up after discovering EMI, on-going EMI, and multiple EMI by both partners were exclusionary criteria for the present study.

A series of studies has stated that infidelity is a painful experience especially for injured partners who would not be willing to take part research related to negative events (Schalk, 2006; Meldrim, 2005; Blow & Hartnett, 2005b). This statement was also observed during the data collection procedure of present study. Hence, the accepting rate for participating in the present study was relatively low (approximately 25%). At that point, a gender differences were obvious, only three men accepted to be participant for the present study. Comparing with women, men were seen to less willing to talk about infidelity as an injured partner. Besides, considering the general tendency of less verbalization for men (Breslau, 2009), the concept of chastity might be another reason affecting men openness on experience of EMI. In the cultural context, extramarital infidelity of women was seen as unchastity action especially by men, and to be less tolerable (TURKSTAT Family Structure Research, 2006). It was frequently observed that, following the discovering EMI, especially women might be exposed with severe violence from their betrayed partners or families. In sum, the

focus of the present study was on the post traumatic responses of women who have continued their marriage after disclosure of EMI. Other demographics were able to support the heterogeneity of the sample in the context of age, education, SES level, etc.

One of the most significant methodological critiques is the lack of operational definition of infidelity which is changed from one study to another (Blow & Hartnett, 2005a). In the present study, Glass and Wright's (1985) one item measure with the six-point continuum starting from sexual to emotional involvement was used to define extramarital infidelity. Based on the offended partners' description, 61.21% of EMI were entirely, mainly or more sexual than emotional. These results are consistent with the findings of the other studies indicating that men are more likely to engage sexual infidelity than emotional (Glass & Wright, 1985). Furthermore, almost half of participants (50.3%) discovered their partners' EMI between seven months to three years prior to be the participants of the present study which were longer than diagnose criterion of the PTSD. The length of the EMI of involved partners was 1.79 years and 164 participants (86.8%) talked with their partners about EMI. After infidelity discovered by the participants of the present study, only 113 involved partners (approximately 60%) accepted their EMI. In the analyses, accepting was found as a significant factor which was related with the severity of the impact of infidelity on the offended partner. Moreover, even 88 cases were unknown; the highest frequency (37.4%) of the third parties was work colleague of the involved partner. This result consisted with Treas and Giesen's (2000) statements that the work environment provides opportunity for EMI. In addition, the participants who had

applied to professional help as an individual or couple were only 18.5% ($n = 34$) of the participants. Previous experience of infidelity is sought as another important issue by some researcher (Blow & Hartnett, 2005b). In the present study, it was reported that 25 participants (13.2%) were injured with infidelity in their previous romantic relationship. Also, 33.3% of the participants ($n = 63$) reported that one of their family members (mostly father) had EMI in their marriages. Thus, the participants of present study had the experience of EMI which contained all the critical variables that the infidelity research underlined. These variables were discussed in the following sections.

5.2 Extramarital Infidelity and PTSD

The major research question that proposed in the present study was “Do offended partners meet the criteria for the diagnosis of PTSD after discovering EMI?” Descriptive analysis revealed that 34.4% of participants completed the whole DSM-IV criteria for PTSD which assessed with the PSS-SR (Foa et al., 1997). There is a strong agreement on the idea that infidelity is an interpersonal trauma and injured partners experience symptoms similar to other individuals struggling with PTSD (Snyder, Baucom, & Gordon, 2007; Whisman & Wagers, 2005). However, there is only limited research to examine traumatic responses of injured partners. In a qualitative study, Meldrim (2005) examined the severity of the impact of infidelity on the offended spouses. In his study, ten women and seven men were interviewed and all participants described the impact of infidelity on themselves as traumatic. In another qualitative study, Schalk (2006) interviewed both offended and involved partners (eight participants), and focused

on the description and meaning of the experience of coping with infidelity. Similar findings were reported which highlighted the traumatic experience of offended partners after discovering EMI. Likewise, Steffens and Rennie (2006) reported that wives of sexual addicts responded to disclosure with significant trauma-related distress. Consistent with these studies, the present study provided quantitative data which supported that injured partners may have met the PTSD criteria. Each criteria of PTSD were discussed below.

More specifically, the results showed that 98 participants (51.9%) completed the criterion A1 and 177 participants (93.7%) completed criterion A2. Overall, 95 participants (50.7%) met the criterion A for PTSD. In the DSM-IV (APA, 2000), the definition of a traumatic event consists of two components: (1) Exposure to a catastrophic event (the A1 criterion); and (2) Emotional distress due to such exposure (the A2 criterion). Together, these two requirements consist the criterion A component of PTSD which is the most arguable criterion. Recently, research has started to look at limitations of trauma definition of DSM-IV. Gold et al. (2005) examined whether traumatic events defined by the DSM-IV are sufficiently capable of causing PTSD symptoms. In their research, undergraduate students were assessed for psychopathology and exposure to trauma, and individuals were divided into two groups: criterion A1 group who reported a traumatic event that was consistent with the DSM-IV and inconsistent group who reported a traumatic event that was not consistent with the DSM-IV. Their results showed that the latter group met criteria for PTSD and reported greater severity of PTSD symptoms than those who reported an A1 criterion. Although EMI is a traumatic event that was inconsistent with DSM-IV, the present study revealed the

post traumatic effects of EMI. The results of present study were similar to Golden's et al. findings. Furthermore, it was not expected that any participants would met criterion A1, but approximately 52% of participants were completed the criterion. In order to explain this unexpected finding, some of the participants were interviewed about their responses to the questions which assess the criterion A1. As an explanation of "yes" responses for these questions, most of participants reported violence from their partner toward them following disclosure of EMI. At this point, it might be assumed that men tend to show violence not only as an offended but also as an involved partner. Another explanation of participants to completing A1 criterion was that having thoughts or unrealized interventions to harm herself, partner or third parties. Although infidelity conceptualized as a traumatic event that is inconsistent with DSM-IV, responses of the offended partners revealed that they have experienced infidelity as similar to other traumatic events that are defined in DSM-IV. In the latest edition DSM-V, which is expected to be published in 2013, the stressor criteria have been enlarged to include a wider range of traumatic events than previous descriptions.

Although A1 criterion is an established predictor of PTSD (Breslau & Kessler, 2001), there is also theoretical and empirical support for the importance of A2 criterion. In a recent study, Boals and Schuettler (2009) compared PTSD symptoms in response to traumatic and non-traumatic events. Unlike Gold and his colleagues (2005), Boals and Schuettler (2009) included A2 criterion and found that A1 trauma criterion had little to no relationship to PTSD symptoms when A2 criterion was considered. Consistent with these findings, in the present study, approximately 94% of participants were completed the criterion A2. Specifically,

“feeling helplessness” was a common reaction of offended partners. Traumatic effects of infidelity might be explained with this common reaction. Especially, psychological theories of PTSD have tried to explain cognitive activities. Meldrim (2005) stated that when a person is completely powerless and placed in a situation s/he has no control over on continuous basis, a state of helplessness may occur. Ortman (2009) defined the experience of offended partners as helplessness in her recent book named “Transcending post-infidelity stress disorder”. Related to helplessness, the idea of “mental defeat” is defined as *“the perceived loss of all autonomy, a state of giving up in one’s own mind all efforts to retain one’s identity as human being with a will of one’s own”* (Ehlers, Maercker, & Boss, 2000, p. 45). This experience shatters one’s basic beliefs and assumptions and leads traumatized people to produce dysfunctional cognition associated with the traumatic event (Bolton & Hill, 1996; Horowitz, 1986). In fact, Glass (2003) reported shattered assumptions about relationship and partner as a shared impact of infidelity. Furthermore, the results of present study could be interpreted along the same lines with these findings. Thus, feeling “helplessness” which is the major component of criterion A2 might be presented as a critical factor that elicits PTSD on offended partners after discovering EMI.

The criterion B for PTSD includes intrusive recollections reflecting the persistence of thoughts, feelings, and behaviors specifically related to the traumatic event. In the present study, the criterion B was fulfilled by 185 of the participants (97.9%). The rates in the entire sample of the present study ranged from 54.5% for “physical reactions” to 86.3% for “emotionally upset when reminded of the trauma”. These results are also consisted with trauma literature.

People with PTSD relive the event as though the traumatic event was continually recurring or the individuals were re-experiencing the event in the present. The symptoms include intrusive recollections, traumatic nightmares, PTSD flashbacks, trauma-related/stimulus-evoked psychological distress and physiological reactions (Herman, 1992). Glass (2003) stated that offended partner could not be able to stop obsessing about EMI until finding answers to their questions. Also, it is reported that most of flashbacks for offended partners are related to the actual or imaginative part of infidelity. Ortman (2009) discussed that the intrusive symptoms (flashbacks and nightmares) have a survival purpose in which the individual try to gain sense of mastery and control over an overwhelming event.

In the present study, 161 participants (85.2%) completed the criterion C (avoidant/numbing) for PTSD. The rates of the symptoms of Criterion C ranged from 34.4% for “loss of interest” to 65.6% for “trying not to think about the trauma”. People with PTSD give some effort to avoid trauma-related thoughts, feelings, places and people (Friedman, 2003). Herman (1992) explained that “*The helpless person escapes from her situation not by action in the world but rather by altering her states of consciousness*” (p.; 42). Glass (2003) highlighted that many offended partners “*vacillate between intrusive thoughts and excessive emotionality on the one hand and constrictive symptoms of avoidance and withdrawal on the other*” (p. 146). Thus, participants who mostly expressed “feeling helplessness” also showed symptoms such as avoidance and numbing.

In addition, 172 participants (91.0%) met the criterion D which called hyper-arousal and rates ranged from 23.4% for “easily startled” to 82% for “irritability” in the present study. Hyperarousal symptoms are the main

characteristic of PTSD. According to Herman (1992) “*hyperarousal reflects the persistent expectation of danger; intrusion reflects the indelible imprint of the traumatic moment; constriction reflects the numbing response of surrender*” (p. 35). Physiological arousal continues for a person after experiencing the traumatic event and certain physical and emotional stimuli continue to trigger the victim’s body as if there were a continuing threat (Van Der Kolk & McFarlane, 1996). In addition, difficulty in concentrating and hypervigilance are the other symptoms of this group of reactions (Friedman, 2003). Although the traumatic event is in the distant past, hyperarousal may lead to living in a state of chronic stress. According to Glass (2003), rational acts of self-preservation become exaggerated into irrational acts of overprotection due to remain supersensitive and superalert.

The criterion of duration of the disturbance (symptoms in B, C, and D) requires symptoms to continue more than one month for PTSD and 93.1% of participants ($n = 176$) of the present study fulfill the criterion E. Besides these criteria, the F criterion states that, “*the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning*” (p. 181). The results showed that 173 participants (91.5%) met the criterion F and 85.7% responded moderate or severe impact. Recently, Boals and Hathaway (2010) emphasized the importance of the E and F criteria to predict PTSD. They explained the emotional reactions to obviously non-traumatic events (e.g., watching a horror movie) look like PTSD with discounting of these two criteria. In their study, they replicated the study of Lees-Haley et al. (2001), and reported that inclusion of duration (E criterion) and subjective impairment (F criterion) criteria dropped the rates of those who are meeting PTSD criteria from

20% to 3%. With this study, they criticized misleading results of PTSD for the effects of events that in-consisted with DSM-IV. This emphasis could be explaining the traumatic effects of EMI in which the high rates for the E and F criteria by offended spouses in the present study.

Consistent with the present study, Lusterman (1995) and Ortman (2009) supported the idea that there is an overlap between the symptoms of offended partners and PTSD symptoms. In the present study, if the criterion A was just counted with criterion A2, the rate of diagnosing PTSD were elevated from %34.4 to 81% which indicates relatively high prevalence. It is generally accepted that less than 10% of individuals who exposed to one or more traumatic event develop PTSD (Breslau, 2009). More specifically, the life time prevalence of PTSD was found 1.3 % in German (Perkonigg, et al., 2000), 11 % in Mexican (Norris, et al., 2003), % 5.6 in Swedish (Frans, et al., 2005), and 4 % in Israeli (Amir & Sol, 1999). The findings relatively high rates of diagnosing PTSD could be explained within the context of infidelity, the threat (to be betrayed) is almost never end. Generalization of trigger is also found common reaction through offended partners and first and foremost, involved partner himself is seen as a trigger (Meldrim, 2005). This high prevalence that found in the present study for offended partner might be explained with the ongoing threat and living with the main trigger (partner himself) due to continuing their marriage. At this point, there is a need for further research that delves into differences between offended partners who stayed and who left their marriage. Another possible explanation for the high levels of prevalence might be that females are more likely to suffer from the effects of traumatic events and have higher tendency to develop

psychopathology (Norris, et al., 2003; Frans, et al., 2005; Bernat, et al., 1998; Olf, et al., 2007). In fact, in the present study, all participants were women and PTSD rates were higher than expected level.

The other research question proposed in the present study was “Which demographic variables are important in respect to the severity of traumatic reactions after discovering EMI?” It was found that only two variables had significant correlation with the PTSD symptoms severity. The demographic variables of “years of marriage” had a positive correlation with the total PTSD score, re-experiencing subscale, and arousal subscale. Contrarily, time past after “discovering of EMI” variable had negatively correlated to the total PTSD score, re-experiencing subscale, and arousal subscale. The correlations between the variables indicated that participants who had longer marriages showed higher PTSD symptoms after disclosure of EMI. In general, building positive beliefs and assumptions about the relationship and partners is a complex process and takes time (Gottman, 2003). The results of present study might be interpreted by the destruction of beliefs about marriage has a greater effect on the individuals who have longer marriage. In shorter marriage individuals may not completed the construction of belief and assumption about marriage and partner. Thus, shattering assumptions after discovering infidelity could be observed more clearly in longer marriage. This result is also consistent with trauma literature. Some researchers have emphasized that the traumatic experience may destroy the trust, and cause a loss of belief of other people (Andrews et al., 2000; Herman, 1993). A series of studies also revealed that more negative assumptions about the self, world, and others are found in traumatized individuals when compared to non-traumatized

individuals, and these assumptions have been associated with PTSD severity (Owens & Chard, 2001; Wenninger & Ehlers, 1998). Furthermore, the other significant correlation in the present study indicated that after time passed discovering of EMI, the severity of PTSD diminished. This result is consistent with the Kaplan–Meier (cited in Breslau, 2009) survival methods which estimated the time to remission of PTSD in persons who met criteria for the disorder. In particular, it was reported that approximately 26% of PTSD cases remitted by 6 months and 40% by 12 months after traumatic events occurred. In accordance, the correlations of the present study might be explained in a similar way, referring that the individuals remitted as the time passed.

Moreover, analyses which conducted in order to assess the group differences by the DI-EMI variables on the severity of PTSD symptoms yielded that only two variables had significantly differentiated; “involved partner’s first reaction” and “professional help”. Results indicated that the participants whose partners accepted their extramarital involvement had significantly lower severity of PTSD symptoms comparing with the group whose partners rejected the EMI. It could be assumed that being open and honest from the beginning of disclosure might protect the basic assumptions against to shatter, and thus the severity of PTSD symptoms could not have worsening. Moreover, “refusal” is sought as a law by involved partners (Vaughan, 2003). Thus, most of participants’ partners of present study reject what they involved out of their primary relationship. Although the present study showed the benefit of being opened, Upchurch (2004) showed that even psychotherapists who work with couples do not feel comfortable about the promotion of disclosure of infidelity in psychotherapy. Furthermore, the

results of present study also showed that “professional help” revealed a significant main effect which means that the participants who applied to professional help as a couple or individual reported lower symptom severity than who did not get any help. These results were also valid for the subscales of PTSD (re-experiencing subscale, avoidance subscale, and arousal subscale). Consistently, a series of studies has confirmed that PTSD symptoms are decreased with professional help such as psychotherapy, pharmacotherapy, and psycho-educations (Breslau, 2009).

5.2.1 Coping and PTSD Symptoms

The third research question of the present study was “Do offended partners who use the problem-focused coping strategies instead of the emotion-focused strategies have less PTSD symptoms?” It was found that both problem-focused and emotion-focus coping strategies were correlated on the opposite direction with the severity of PTSD symptoms. While problem-focused coping had a negative correlation, emotion-focused coping was positively correlated to the PTSD total symptom severity. It means that when individual get higher scores from problem-focused coping, also showed decrease in the total PTSD symptom severity. Contrarily, the results showed that individual get higher scores from emotion-focused coping also get higher scores from PTSD symptom severity. Consist with the results of the present study, it is generally accepted that emotional coping strategies result in higher rates of PTSD (Gil, 2005; Gavranidou & Rosner, 2003). In order to support the main effect of coping strategies on the severity of PTSD symptoms, each participant was classified into the coping style (problem-emotion-indirect coping groups) and results indicated that the

participants who were categorized as problem-focused group had lower PTSD total symptom severity than emotion-focused and indirect coping groups. More specifically, individuals who use problem-focused coping reported less severity of PTSD symptoms and hyper-arousal symptoms. On the contrary, individuals who use more likely emotion-focused coping reported higher severity of PTSD symptoms and, re-experiencing (intrusive), and avoidant symptoms. These findings support previous research that has shown people scoring higher on emotion-focused coping style are more likely to suffer from PTSD than those who adopt problem-focused coping style (Gil, 2005). However, indirect coping group did not differ for both analyses. This finding was contradictory to Güneş's (2001) results which showed that fatalistic coping was found to be associated with intrusive symptoms. The third dimension of TWCI consists of items related cultural differences such as superstitious belief, fatalistic coping, and seeking social support. At this point, contradictory results could be interpreted with that the impact of infidelity is less sensitive to the cultural issues. In other words, infidelity might be consist shared themes beyond the cultural effects. Supporting this assumption, research focused on the cultural effects has stated that infidelity is a common problem in many cultures even though there is a strong norm in society against EMI (Treas & Giesen, 2000; Vanlandingham et al., 1998; Wiederman & Allgeier, 1996).

In addition, participants of the present study were found that they mostly used problem-focused and indirect coping comparing with emotion-focused coping. Results showed that the mean scores of problem-focused ($\underline{M} = 3.26$), and indirect coping ($\underline{M} = 3.18$) coping were higher than emotion-focused coping ($\underline{M} =$

2.41) respectively. These findings were contrarily with Gray's (2006) statement that women tend to use emotion-focused strategies and men use problem-focused strategies mostly. Although gender differences could not be examined in the present study, female participants did not tend to use more likely emotion-focused coping.

5.2.2 Resources and PTSD Symptoms

Another research question that was proposed in the present study was “Does resources loss have more impact on the offended partners’ symptom level of PTSD compared to resources gain?” The results revealed that both resource loss and resource gain significantly correlated with the PTDS total symptom severity and its clusters. Specifically, it was found that while resource loss had positive correlation with the PTDS total symptom severity, re-experiencing subscale, avoidance subscale, and arousal subscale, resource gain was negatively correlated with these measures. This findings might be related to the first and most important principle of COR theory which is defined as “*resource loss is disproportionately more salient than resource gain*” (Hobfoll, 2001; p. 62) meaning that loss of resources has greater impact on stress outcomes than resource gain. A series of studies has supported the primacy of resource loss in the stress process (e.g., Thoits, 1993; Hobfoll & Lilly, 1993; Taylor, 1991). Although extramarital infidelity has not studied in the context of COR theory, the results of present study showed similar findings with other traumatic events.

Evaluation of resource was assessed with the COR-E (Hobfoll, Lilly, & Jackson, 1991) in the present study and resources were divided into (1) objects

resources, (2) personal resources and personal traits, (3) condition resources, and (4) energy resources. Specifically, the descriptive analyses of the present study revealed that the items of resource-loss which had means higher than three on a 5-point Likert type (to a moderate degree) were “Good marriage”, “Hope”, “Stamina/endurance”, “Intimacy with spouse or partner”, and “Feeling that my life is peaceful”. These items might be related to the context of extramarital infidelity. Aftermath of infidelity, it could be considered that perception of marriage, partner and future were impacted firstly. A series of clinical studies has found similar findings (Ortman, 2009; Meldrim, 2005; Snyder, Gordon, & Baucom; 2004; Glass, 2003). Most of betrayed partners have reported the loss of the positive images of their partner and the assurance of secure, committed relationship (Meldrim, 2005). Indeed, their assumption about the relationship and his or her partner has shattered after discovering of EMI (Glass, 2003). Following infidelity, betrayed partner can no longer trust his or her partner or feel safe within the relationship (Blow & Harnett, 2005b). On the other hand, “Good relation with my children”, “Time with loved ones”, “Feeling that my future success depend on me”, “Feeling that I know who I am”, “Feeling independent”, “Knowing where I am going with my life”, “Feeling that my life has meaning/purpose”, and “Positive feeling about myself” were the items of resource-gain which had means higher than two on a 5-point Likert type (to a small degree). These findings could be interpreted with the statement of Hobfoll and Lilly (1993) that resource gain is related to psychological distress only after controlling for resource loss. Indeed, resource gain has seen to be related with psychological distress especially in the presence of resource loss. Participants of the present study reported greater

resource loss after discovering the partners EMI. Thus, individuals were seen to move toward to the important others (children or loved ones) as a resource. In addition, other personal resource was also sought to play significant role to cope with the effects of EMI.

There were also other analyses to support relationship between the impact of infidelity and resource loss and gain. In order to support the main effect of resource loss and gain on the severity of PTSD, each participant was classified into the resource loss or resource gain groups. Results of the present study showed that the participants who were categorized as a resource loss group had higher PTSD total symptom severity than resource gain group. Except the avoidance symptoms, resource loss group showed higher symptoms on the clusters of PTSD. These results were parallel to other studies in the literature of stress. It is generally accepted that resource loss or threat of significant resource loss may result in psychological distress and outcomes such as depression and PTSD (Benight et al., 1999; Ironson et al., 1997). COR theory states that trauma may elicit interpersonal resource loss affecting the person's cognitive, emotional and coping functioning (King, et al., 1999; Melchert, 2000). Consistent with the present study, resource loss has been identified as a significant predictor of mental health aftermath of disasters (e.g., floods, hurricane, and earthquakes). In a more recent study of Banou, Hobfoll, and Tochelman (2009), the mediator effects of resources between interpersonal trauma (physical and sexual abuse) and traumatic symptoms among women with cancer were examined. Their results showed that only interpersonal loss mediated the relationship between earlier interpersonal trauma and current PTSD symptoms. Also, Walter and Hobfoll (2009) examines how the limiting of

resource loss is related to alleviation of PTSD symptoms among inner-city women who diagnosed for PTSD aftermath of interpersonal traumatic events such as child abuse, rape, and sexual assault. The findings of these studies showed that PTSD symptoms of injured person decrease in which situation individuals have great resource loss. Therefore, the findings of present study supported theoretical connection between resources and PTSD which is illustrated by COR theory.

5.2.3 Forgiveness and PTSD Symptoms

The fifth research question of the present study was “Could forgiveness decrease the PTSD symptoms of offended partners?” It was found that both Stage I-Impact and Stage II-Meaning had positive correlations with the PTDS total symptom severity and its symptom clusters whereas Stage III-Recovery had negative correlations. It means that when individuals get higher score on Stage I and II their PTSD severity score also increases. On the other hand, when individuals get higher score on Stage III, their PTSD severity scores decrease. More specifically, results showed that the Stage I-Impact was positively correlated with the total PTSD score, re-experiencing subscale, avoidance subscale, and arousal subscale. Moreover, the Stage II-Meaning had positive correlations with the total PTSD score, re-experiencing subscale, and arousal subscale but not with avoidance subscale. Contrarily, the Stage III-Recovery was negatively correlated with the total PTSD score, re-experiencing subscale, avoidance subscale, and arousal subscale.

The results of the present study were supported by the literature of forgiveness. Specifically, the three stages of forgiveness model were constructed

based on frameworks of a reaction to a traumatic interpersonal event. According to Gordon and Baucom (2003), the forgiveness paradigm posits that forgiveness appears to help the reconstruction of the assumptions which are violated by traumatic experience. Likewise the typical responses to the traumatic event, Gordon and Baucom (2003) proposed that forgiveness functions through three stages: the impact, search of meaning, and recovery. In the three-stage forgiveness model, the focus of Stage I is the effect of the betrayal on injured partners and their relationships and Stage II focuses on this theme. In Stage II, injured partners try to discover why the betrayal occurred in order to make the partner's behavior more understandable and predictable. Thus, understanding may help to increase sense of control over one's own life, and provides a sense of safety and security, and decrease the feelings of powerlessness. On the other hand, in Stage III, the injured partners move beyond the betrayal and start to control their life again (Gordon & Baucom, 2003). In this stage, the injured partners are expected to develop a non-distorted view of their partner and relationship. Also, intense negative feelings toward the partner are sought less frequently in the Stage III in order to understanding of the event. Therefore, the need to engage in the forgiveness process may result from individuals' attempts to reconstruct or modify their former beliefs about their partner and the relationship. Gordon and colleagues (2009) summarized that forgiveness comes out with its three elements; (1) regaining a more balanced and compassionate view of the offender and the event, (2) decreasing negative affect towards and avoidance of the offender, and (3) giving up the right to seek revenge toward the offender.

It is generally accepted that increasing on the forgiveness level may help decreasing on trauma symptoms (Gordon, Snyder, & Baucom, 2005). In order to support the main effect of forgiveness on the severity of PTSD, each participant was classified into the forgiveness stages. Results of the present study indicated that the participants who were categorized as Stage I-Impact group showed the highest PTSD total symptom severity whereas the Stage III-Recovery group showed the lowest PTSD total symptom severity. More specifically, individuals who were in the impact stage for forgiveness more likely to report PTSD total symptoms and its all three clusters (re-experiencing, avoidance and arousal symptoms). Conversely, individuals who were in the recovery stage for forgiveness less likely to report PTSD total symptoms and its clusters. Except the avoidance subscale, individuals who were in the meaning stage for forgiveness were in the middle of the severity of PTSD total score and its clusters. Consistent with such findings, Gordon, Snyder and Baucom (2005a) completed a case-study in which couples who injured with extramarital infidelity were participants and applied an integrative intervention developed by them. They assessed the couples on pre-and-post treatment and found increasing on the forgiveness score whereas decreasing on trauma symptoms of betrayed partner. In order to therapeutic application, Gordon et al.'s (2004) stated that attributions for the infidelity are investigated during the second phase of therapy which emphasizes on contextualizing and finding meaning for the event. After creating realistic attributions, the couple enters the third stage in which the concept of forgiveness is introduced and they are asked to consider the future of their relationship. Thus,

this sequence parallels that the victim's attributions for the partner's infidelity facilitate forgiveness which then influences the decision to separate or reconcile.

5.4 The Predictors of PTSD Symptoms

The last research question was “What are the main predictors of the severity of PTSD clusters on the offended partners?” In order to assess the predictors of the PTSD total symptom severity hierarchical multiple regression was conducted among demographic variables, EMI related variables, coping strategies related variables, resource related variables, and forgiveness related variable. According to the final model values, the hierarchical multiple regression analysis revealed that the PTSD total symptom severity and emotion-focused coping were positively associated. On the other hand, resource gain had negative correlation with the total PTSD whereas Stage I-Impact had positive correlation. From demographic variables, having professional help had negative and involved partner's first reaction had positive correlation with the total PTSD symptom severity. Especially the variable of “having professional help” had the highest rate of correlations with the PTSD total symptom severity. Furthermore, having professional help predicts lower the PTSD total symptom severity

These results were parallel to the previous analyses and findings. The involved partners' reaction was one of the predictors in the final model. It means that accepting their extramarital action predicted PTSD symptom level of offended partners. If the involved partners accepted EMI from the beginning, betrayed partner could manage better with PTSD symptoms. Following infidelity, betrayed partner can no longer trust his or her partner or feel safe within the

relationship (Blow & Harnett, 2005b). Probably, being open from the beginning might be helpful for individuals injured by infidelity to trust and feel safe again. In addition, having professional help for individuals was another predictor and makes them better to handle symptoms. In the last two decades, there has been a growing body of literature of infidelity which focuses on healing process and clinical application, and emphasized empirically supported treatments, evidence-based practice, and best practice guidelines (DuPree et al., 2007; Scheinkman, 2005). Consistent with the present study, a series of controlled studies has found that professional help let the individuals and couples get better (Atkins et al., 2005a; Gordon, Baucom, & Snyder, 2004; Olson et al., 2002).

In the final model, it was found that emotion-focused coping was a stronger predictor for having PTSD symptoms. Consistent with the results of the present study, it is generally accepted that emotional coping strategies result in higher rates of PTSD (Gil, 2005; Gavranidou & Rosner, 2003). Also, findings showed that being in the impact stage according to forgiveness model was one of the other predictors for higher symptom level on PTSD. In the three stage forgiveness model, the focus of Stage I is the effect of the betrayal on injured partners and their relationships. Similar to the other forgiveness stage models, this stage is described as a period of significant cognitive, emotional, and behavioral disruption (Gordon & Baucom, 1998). Moreover, these responses indicate that important assumptions of injured partner (e.g., one's partner can be trusted, relationship is safe etc.) have been violated. Because of these shattered assumptions, injured partners are likely to engage in a process of collecting details or to explain the negative event and feel out of control, powerless, and no longer

able to predict future. Furthermore, in the Stage I, withdrawing is observed on betrayed partners in order to protect themselves. In the final model of regression analyses showed that resource gain was also a better predictor comparing with recourse loss. It could be explained with the statement that resource gain has a significant importance in the context of resource loss, which means that resource gain becomes more important for individuals when they experience high level of resource loss (Hobfoll, 2001). For the participants of the present study, resource loss reported significantly higher than resource gain. In sum, all of the variables totally explained 46 % of the total variance in the PTSD total symptom severity.

Moreover, same analyses with the subscale of PTSD showed specific differences. Unlike the PTSD total symptom severity, the final model of regression with the re-experiences subscale contained the Stage II-Meaning and Stage III-Recovery instead of Impact from the forgiveness scores. It is generally accepted that understanding why the negative life event occurred is the central theme for a violated person (Worthington, 1998; McCullough, Worthington, & Rachal, 1997; Horowitz, Stinson, & Field, 1991). According to Gordon and Baucom (2003), the Stage II (meaning) of their forgiveness model focuses on this theme. In the Stage II, injured partners try to discover why the betrayal occurred in order to make the partner's behavior more understandable and predictable. On the other hand, being in the Stage-II might elevate re-experiencing the event. The Stage III-Recovery was also other predictor of having less re-experience symptoms. This could be explained with more recovery brings less re-experiencing symptoms. In Stage III, the injured partners are expected to develop a non-distorted view of their partner and relationship. Another major difference

between the final models was for arousal symptoms subscale. It was found that resource loss was in the final model as a predictor instead of resource loss. Comparing with the other clusters of PTSD, arousal symptoms were more likely to relate physiological process of trauma whereas re-experiencing and avoidance are more likely to relate cognitive response to traumatic events (Friedman, 2003). Physiological arousal continues for a person after experiencing the traumatic event and certain physical and emotional stimuli continue to trigger to victim's body as if there were a continuing threat (Van Der Kolk & McFarlane, 1996). Thus, results of the regression analyses showed that the more resource loss the higher level of arousal symptoms for individuals who injured with EMI. Contrary to the other PTSD clusters, problem-focused coping was also in the final model of arousal symptoms instead of emotion-focused. These results indicated that the arousal symptom cluster might have different process from the other clusters. Obviously, there is a need for research that delves into the processing differences between the clusters of PTSD.

5.5 Limitations

Infidelity is one of the most complex issues for researches due to interaction of variables, and controlling these variables elicits some other limitations. In the present study, the major limitations such as gender differences, relationship status, and comparing other traumatic experience are explained below. Firstly, the present study was conducted with the women who were injured by EMI. Thus, there were no chances to compare traumatic reactions to infidelity based on gender. It is generally accepted that women more often develop PTSD

symptoms after a traumatic event (Perkonigg, et al., 2000; Norris, et al., 2003; Bernat, et al., 1998; Olf, et al., 2007; Ullman & Siegel, 1994). The traumatic reactions of offended partner might be elevated with gender bias. Secondly, primary relationship status was limited by the researcher in order to control the outside effects. However, with this limitation, the results of present study only included married individuals' reactions. However, infidelity can also occur in the contexts of other than marriage like cohabitating or dating relationship. Therefore, the present study does not say anything about the differences between the relationship statuses. In addition, leaving the primary relationship after disclosure of EMI was also an exclusionary criterion. Thus, the present study was not able to assess the effects of divorce on offended partners. In the present study, there is no answer to the question about differences of individuals who choose to leave the relationship or to stay in their primary relationship. Lastly, the analysis related to different traumatic events besides infidelity could not be employed. In the present study, it was another limitation not to compare traumatic effects of infidelity with the other traumatic events.

5.6 Future Research

All the variables which are examined in the study of PTSD prevalence are untapped area for infidelity research. In the light of the limitations of the present study, gender differences is one of the major topic that needed to be examined in order to understand the differences regarding traumatic reactions to the infidelity. The results of the present study only included married individuals' reactions. Thus, it is important to study the effects of primary relationships status on

traumatic reaction to EMI. The present study was not able to assess the effects of divorce on offended partners. Especially, comparing individuals who stayed and who left their primary relationships would elicit new perspective to the field of infidelity and trauma. Finally, in the present study, infidelity was not controlled with other traumatic events. Therefore, all the similarities or differences between traumatic effects of infidelity and other traumatic events would provide information to understand the traumatic process. It may provide details account of traumatic process and a general framework in which clinical implications for infidelity may be enriched.

5.7 Clinical Implications

It is well known that infidelity is harmful to individuals and relationships (Whisman, Dixon, & Johnson, 1997). However, the emotional consequences of extramarital infidelity have been rarely studied. Blow and Hartnett (2005a) has pointed out the lack of field-specific infidelity research. There is an agreement that infidelity is an interpersonal trauma and has post traumatic effects on injured partners. However, this assumption is supported only by clinical observation, case studies, and a few qualitative research. At this point, the main significance of the present study was to provide a quantitative data for the trauma concept of infidelity. Thus, the current study might contribute to understand offended partners' traumatic reactions, specifically PTSD symptoms. Generally, psychological trauma has been studied frequently in the field of mental health. There are reliable results and numerous theoretical models which provide the process of PTSD (Brewin & Holmes, 2003; van der Kolk, 1994). However, in the

field of infidelity, most of trauma models which try to explain injured partners' reactions are just conceptual (Snyder, Baucom, & Gordon, 2007; Lusterman, 1998). Therefore, another significance of the present study is exploring the process of betrayal trauma, especially regarding the coping strategies and conservation of resource model. The current study may help to extend findings of the relationship between coping strategies and PTSD to the field of infidelity. Although problem-focused coping strategies are generally believed to have relieving effects on PTSD symptoms, the coping strategies used in response to extramarital infidelity have still remained questionable. Especially, it is important to know which coping strategies are used by betrayed partners who continue their marriages after discovering of partner's EMI.

Studies posit that the impact of the discovery of EMI is more traumatic than previously understood (Lusterman, 1995; Gordon & Baucom, 1999). However, treatment options for couples and individuals who want to recover from infidelity are so limited (Blow & Hartnett, 2005a). On the other hand, there are many well developed treatment models for trauma. Contributing to understand offended partners' traumatic reactions, specifically PTSD symptoms, may help to bring out the trauma treatment models into the field of infidelity. Thus, one of the main implications of the current study would be expanding treatment options used by clinicians for the victims of infidelity. More specifically, the present study would provide considerable information about which types of coping strategies, emotional-focused, problem-focused, or indirect, help more in dealing with the effects of EMI. In terms of generalization of the findings of the current study, clinicians could support their treatment plan as improving specific coping

strategies. On the other hand, resources are found to be significantly important for dealing with any traumatic events (Hobfoll, 1983). Knowing that which resource loss is common on betrayed partners after discovering extramarital infidelity would help underlining the critical resources. Indeed, the findings may shed light on preventing resource loss and negative consequences of EMI. In order to help couples coping with EMI, this study may lead to better understanding of the process of forgiveness. One of the main implications of this study is to make the Turkish version of Forgiveness Inventory available to the field. According to Gordon and Baucom (2003), forgiveness of infidelity involves three stages: the impact, search for meaning, and recovery phases. The main assumption is that each individual who suffers from EMI has different needs in accordance with the forgiveness stages. The Forgiveness Inventory helps clinicians to assess injured partners' current stages. Indeed, clinicians may benefit from using FI in order to identify the couples' specific needs for dealing with the negative impact of EMI. Finally, studying the critical demographic variables (types of infidelity, duration of affair, past experience with infidelity etc.) would provide information on which individual is more at risk to be traumatized following discovery of EMI. Overall, the present study would be beneficial for the clinicians in order to prevent negative effects of extramarital infidelity on both injured partners and couples before and after EMI occurs.

5.8 Conclusion

In the light of the infidelity literature, the aims of the present study were to examine the traumatic effects of extramarital infidelity on the offended partners as well as to find out the predictors (coping strategies, resources and forgiveness) of the severity of post traumatic symptoms. In addition, the current study also aimed to explore the effects of the critical demographic variables (types of infidelity, duration of affair, past experience with infidelity etc.) on the level of traumatic reactions. It is generally accepted that the EMI is seen as an interpersonal trauma and has traumatic effects on the offended spouses. Although there is a strong agreement on the idea that injured partner shows symptoms similar to PTSD, there is only limited research to examine traumatic responses of injured partners. The present study provided the data supported the statement that individuals who injured with EMI are traumatized. The results of present study indicated that approximately 35% offended partners could be diagnosed with PTSD based on DSM-IV criteria. Consistent with the trauma literature, the PTSD total symptom severity and its clusters (re-examination, avoidance and arousal) were mainly predicted by coping strategies, resource and forgiveness.

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APPENDIX A
THE DEMOGRAPHICS INFORMATION AND
EXTRAMARITAL INFIDELITY FORM (DI-EMI)

Demografik

1. Cinsiyetiniz: Kadın Erkek
2. Yaşınız: _____
3. Eğitim durumunuz:
Okur-yazar İlkokul Ortaokul
Lise ve dengi Üniversite Yüksek lisans
4. Kaç yıldır evlisiniz? _____
5. İlişki durumunuz:
İlk evlilik İkinci/(_) evlilik
İmam Nikâhlı Nikâhsız Birliktelik
6. Çalışıyor musunuz? Evet Hayır Emekli
7. Sahip olduğunuz çocuk sayısı: _____
8. Sizce hangi sosyoekonomik gelir düzeyine girersiniz?
Alt Alt-orta Orta Üst-orta Üst
9. Genel bir sağlık problemim: Yok Var (belirtiniz)....
10. Bu güne kadar psikiyatrik bir tanı ile tedavi aldınız mı? Hayır Evet
(belirtiniz)____
11. Son 6 ay içerisinde aşağıdaki olaylardan yaşadıklarınızı işaretleyiniz.
(Birden fazla seçenek işaretleyebilirsiniz)
Yakın aile üyesi ölümü Ciddi yaralanma veya hastalık Eş
tarafından dövülmek İşten atılma Düşük/Kürtaj

Evlilik Dışı İlişki Soruları

Aşağıda hem mevcut ilişkinizde hem de genel olarak yaşamınızda evlilik dışı ilişki (aldatma) ile ilgili sorular yer almaktadır. Lütfen yaşadığınız durumları açık biçimde belirtiniz.

1. Aşağıdaki boşluğa, eşinizin evlilik dışı ilişkisini ve nasıl öğrendiğinizi kısaca yazınız.

2. Eşinizin evlilik dışı ilişkisi olduğunu ne kadar zaman önce öğrendiniz?

- 1 aydan az 1-3 ay arası 3-6 ay arası 6 ay-3 yıl arası
3-5 yıl arası 5 yıldan fazla

3. Bu ilişkiye dair ilk ne zaman şüphelendiniz (ay/yıl)?.....

4. Eşinizle bu olayı konuşabildiniz mi? Hayır Evet
(*tarih belirtiniz*).....

5. Eşiniz evlilik dışı ilişkisini kabul etti mi? Evet Hayır

6. Eşinizin evlilik dışı ilişki kurduğu kişi;

- İş arkadaşı Ortak arkadaş Okul arkadaşı Eski sevgilisi
Komşu Aile Üyesi Yabancı Diğer.....

7. Eşinizin diğer kişi ile ilişkisi ne zaman başladı (ay/yıl)?.....

8. Eşinizin diğer kişi ile ilişkisi ne kadar sürdü (ay/yıl)?.....

9. Bu olayı öğrendikten sonra aşağıda belirtilen durumlardan yaşadıklarınızı işaretleyiniz (*Birden fazla seçenek işaretleyebilirsiniz*).

- Kendime fiziksel zarar verdim/vermek istedim
Eşıme fiziksel zarar verdim / vermek istedim
Üçüncü kişiye fiziksel zarar verdim/vermek istedim

10. Eşinizin, öğrendiğiniz evlilik dışı ilişkisi birden fazla ise bu ilişkilerin evliliğin kaçınıcı yıl(lar)ında gerçekleştiğini belirtiniz.

a. _____ b. _____ c. _____

11. Bu konu ile ilgili bireysel ya da çift olarak profesyonel (bir uzmandan) bir destek aldınız mı? Hayır Evet (*belirtiniz*)

12. Bazı evlilik dışı ilişkiler cinselliğin hiç yaşanmadığı ya da çok az yaşandığı duygusal ilişkiler iken diğerleri bunun tam tersi olabilir. Siz

EŞİNİZİN evlilik dışı ilişkisini nasıl tanımlıyorsunuz?

- a. Tamamen **cinsel** bir ilişki
b. Ağırlıklı olarak **cinsel** bir ilişki
c. Duygusallıktan çok **cinsel** bir ilişki
d. Cinsellikten çok **duygusal** bir ilişki
e. Ağırlıklı olarak **duygusal** bir ilişki
f. Tamamen **duygusal** bir ilişki

13. Bu olayla ilgili olarak eşinizi ne kadar affettiğinizi hissediyorsunuz?
(sadece birini işaretleyiniz)
- a. Hiç affetmedim b. Biraz affettim
c. Orta derecede affettim d. Büyük ölçüde affettim
e. Tamamen affettim
14. Mevcut evliliğinizden önceki birlikteliklerinizde aldatılma yaşadınız mı? HayırEvet (belirtiniz) _____
- 15a. Evliliğiniz devam ederken **SİZ** eşiniz dışında biriyle duygusal ya da cinsel bir ilişki yaşadınız mı?
- Cinsel ya da duygusal bir ilişki **yaşamadım**
Tamamen **cinsel** bir ilişki yaşadım
Ağırlıklı olarak **cinsel** bir ilişki yaşadım
Duygusallıktan çok **cinsel** bir ilişki yaşadım
Cinsellikten çok **duygusal** bir ilişki yaşadım
Ağırlıklı olarak **duygusal** bir ilişki yaşadım
Tamamen **duygusal** bir ilişki yaşadım
- 15b. Yaşadınız ise ne zaman gerçekleşti belirtiniz.
- Beni aldatmasından önce
 Beni aldatması sırasında
 Beni aldatmasından sonra
- 15c. Yaşadığımız evlilik dışı ilişki ne kadar sürdü (ay/yıl)?
16. Ailenizde evlilik dışı ilişki var mı? (birden fazla seçenek işaretleyebilirsiniz)
- Babamın evlilik dışı ilişkisi var(dı)
Annemin evlilik dışı ilişkisi var(dı)
Kardeş(ler)imin evlilik dışı ilişkisi var(dı)
 Anne-babamın kardeş(ler)inin evlilik dışı ilişkisi var(dı)
 Çocuklarımin evlilik dışı ilişkisi var(dı)
Evlilik dışı ilişki yok

APPENDIX B
POST-TRAUMATIC STRESS DISORDER SYMPTOM SCALE –
SELF REPORT (PSS-SR)
(TRAVMA SONRASI STRES TANI ÖLÇEĞİ)

Directions for Section III:

Aşağıda, insanların bazen bir travmatik olayın ardından yaşadığı bazı sorunlar belirtilmiştir. Her maddeyi dikkatlice okuyun ve GEÇTİĞİMİZ AY İÇİNDE bu sorunun sizi ne sıklıkta rahatsız ettiğini en iyi ifade ettiğini düşündüğünüz sayıyı (0, 1, 2 ya da 3) daire içine alın. Örneğin, söz ettiğiniz olay geçtiğimiz ay içinde aşağıda verilen sıkıntılar açısından sizi yalnızca bir kez rahatsız ettiyse 0'ı; haftada bir kez rahatsız ettiyse 1 işaretleyin. Aşağıda belirtilen olayla ilgili her sıkıntıyı 15. maddede belirttiğiniz travmatik olay açısından değerlendiriniz.

The Response Key

- 0 Hiç ya da yalnızca bir kez
- 1 Haftada bir ya da daha az/kısa bir süre
- 2 Haftada 2 – 4 kez / yarım gün
- 3 Haftada 5 ya da daha fazla / neredeyse bütün gün

(23)	0	1	2	3	Bu travmatik olay hakkında, istemediğiniz halde aklınıza rahatsız edici düşünceler ya da imgelerin gelmesi
(24)	0	1	2	3	Bu travmatik olayla ilgili kötü rüyalar ya da kabuslar görme
(25)	0	1	2	3	Bu travmatik olayı yeniden yaşama, sanki tekrar oluyormuş gibi hissetme ya da öyle davranma
(26)	0	1	2	3	Bu travmatik olayı hatırladığımızda duygusal olarak altüst olduğunuzu hissetme (örneğin, korku, öfke, üzüntü, suçluluk vb. gibi duygular yaşama)
(27)	0	1	2	3	Bu travmatik olayı hatırladığınızda vücudunuzda fiziksel tepkiler meydana gelmesi (örneğin, ter boşalması, kalbin hızlı çarpması)
(28)	0	1	2	3	Bu travmatik olayı düşünmemeye, hakkında konuşmamaya ya da hissetmemeye çalışma
(29)	0	1	2	3	Size bu travmatik olayı hatırlatan etkinliklerden, kişilerden ya da yerlerden kaçınmaya çalışma
(30)	0	1	2	3	Bu travmatik olayın önem taşıyan bir bölümünü hatırlayamama
(31)	0	1	2	3	Önemli etkinliklere çok daha az sıklıkta katılma ya da bu etkinliklere çok daha az ilgi duyma
(32)	0	1	2	3	Çevrenizdeki insanlarla aranızda bir mesafe hissetme ya da onlardan koptuğunuz duygusuna kapılma

(33)	0	1	2	3	Duygusal açıdan kendinizi donuk, uyuşuk hissetme (örneğin, ağlayamama ya da sevecen duygular yaşayamama)
(34)	0	1	2	3	Gelecekle ilgili planlarınızın ya da umutlarınızın gerçekleşmeyeceği duygusuna kapılma (örneğin, bir meslek hayatınızın olmayacağı, evlenmeyeceğiniz, çocuğunuzun olmayacağı ya da ömrünüzün uzun olmayacağı duygusu)
(35)	0	1	2	3	Uykuya dalma ya da uyumada zorluklar yaşama
(36)	0	1	2	3	Çabuk sinirlenme ya da öfke nöbetleri geçirme
(37)	0	1	2	3	Düşüncenizi ya da dikkatinizi belli bir noktada toplamada sıkıntı yaşama (örneğin, bir konuşma sırasında konuyu kaçırma, televizyondaki bir öyküyü takip edememe, okuduğunuz şeyi unutma)
(38)	0	1	2	3	Aşırı derecede tetikte olma (örneğin, çevrenizde kimin olduğunu kontrol etme, sırtınız bir kapıya dönük olduğunda rahatsız olma, vb.)
(39)	0	1	2	3	Diken üstünde olma ya da kolayca irkilme (örneğin, birisi peşinizden yürüdüğünde)

APPENDIX C
WAYS OF COPING QUESTIONNAIRE
(WAYS)

Instructions:

To respond to the statements in this questionnaire, you must have a specific stressful situation in mind. Take a few moments and think about the most stressful situation that you have experienced in the past week. By “stressful” we mean a situation that was difficult or troubling for you, either because you felt distressed about what happened, or because you had to use considerable effort to deal with the situation. The situation may have involved your family, your job, your friends, or something else important to you. Before responding to the statements, think about the details of this stressful situation, such as where it happened, who was involved, how you acted, and why it was important to you. While you may still be involved in the situation, or it could have already happened, it should be the most stressful situation that you experienced during the week. As you respond to each of the statements, please keep this stressful situation in mind. Read each statement carefully and indicate, by circling 0, 1, 2, or 3, to what extent you used it in the situation.

The Response Key:

0 = Does not apply or not used	1 = Used somewhat
2 = Used quite a bit	3 = Used a great deal

Sample Items of Emotion-Focused Coping Subscale:

I came out of the experience better than when I went in.

Wished that the situation would go away or somehow be over with.

Sample Items of Problem-Focused Coping Subscale:

I knew what had to be done, so I doubled my efforts.

I did something which I didn't think would work, but at least I was doing something.

Sample Items of Indirect Coping Subscale:

Talked to someone to find out more about the situation.

I got professional help.

APPENDIX D
THE CONSERVATION OF RESOURCES EVALUATION
(COR-E)
(KAYNAKLARIN DEĞERLENDİRİLMESİ ÖLÇEĞİ)

Direction for COR-E Loss

To what extent have I lost them during the past [specify time period here]?

Direction for COR-E Gain

To what extent have I gained them during the past [specify time period here]?

The Response Key

1 = not at all 2 = to a small degree 3 = to a moderate degree
4 = to a considerable degree 5 = to a great degree

Sample Items of Work Resource

- 16. Necessary tools for work
- 22. Positively challenging routine
- 26. Status/seniority at work

Sample Items of Personal Resources – Self-Esteem

- 2. Feeling that I am successful
- 10. Sense of pride in myself
- 13. Feeling that I am accomplishing my goals

Sample Items of Personal Resources – Mastery

- 21. Feeling that my future success depend on me
- 33. Feeling that I have control over my life
- 39. Ability to organize tasks

Sample Items of Personal Resources – Well-Being

- 17.Hope
- 25.Sense of optimism
- 29.Sense of humor

Sample Items of Material Resources

- 1.Personal transportation (car, truck, etc.)
- 5.Adequate clothing
- 9.More clothing than I need

Sample Items of Energy Resources

- 3.Time for adequate sleep
- 8.Free time
- 12.Time for work

Sample Items of Interpersonal Resources – Family

- 4.Good marriage
- 7.Family stability
- 11.Intimacy one or more family members

Sample Items of Interpersonal Resources – General

- 6.Feel valuable to others
- 42.Itimacy with at least one friend
- 55.Companionship

Sample Items of Stage I-Impact

- 8) Our relationship feels out of balance as a result of what happened.
- 18) My emotions about what happened change from day to day.
- 20) I feel like I want to punish my partner for what he/she did.

Sample Items of Stage II-Meaning

- 4) I want to find out why my partner did this.
- 23) My emotions about what happened are becoming clearer.
- 11) I find myself collecting information about my partner's behavior.

Sample Items of Stage III-Recovery

- 17) I am able to look at both good and bad qualities of my partner.
- 7) I feel I am ready to put what happened behind me.
- 13) I feel my emotions about the event are under my control.

APPENDIX F
CONSENT FORM FOR TURKISH SAMPLE

Değerli katılımcı;

Okumakta olduğunuz bu bilgi formu katılacağınız araştırmaya ilişkin temel açıklamaları içermektedir. Daha fazla bilgiye ya da açıklamaya ihtiyaç duymanız halinde araştırmacı ile iletişime geçebilirsiniz. Lütfen formu doldurmaya geçmeden önce katılımınız ile ilgili açıklamaları dikkatlice okuyunuz.

Bireysel ya da çift psikoterapi çalışmasında evlilik dışı ilişki yoğun biçimde ele alınmaktadır. Evlilik dışı ilişkinin hem ilişkiyi hem de aldatılan eşi, psikolojik olarak derinden etkilediği bilinmektedir. Edebiyat, sinema ve müzik gibi sanatın birçok dalında evlilik dışı ilişkiye dair yaşantılar geniş biçimde ele alınırken psikoloji bilimi içerisindeki çalışmalar sınırlılık göstermektedir. Tüm dünyada klinik psikologlar evlilik dışı ilişki ve etkilerini daha iyi anlamaya çalışmaktadır. Türkiye içinse bu alandaki araştırmalar bir elin parmaklarını geçmeyecek kadardır. Bunda, evlilik dışı ilişki deneyiminin dile getirilmesindeki duygusal güçlük, aldatılmaya ilişkin yükün/utancın aldatılan eşin üstünde olması ve toplumsal baskının temel rol oynadığı düşünülmektedir. İlişkilerde ve bireyde aldatma “görünmeyen yara” olarak işlemekte ve taşınmaya devam etmektedir.

Amaç: Bu araştırma, Ortadoğu Teknik Üniversitesi Psikoloji Bölümü, Klinik Psikoloji doktora programı çerçevesinde yürütülen bir tez çalışmasıdır. Katılımcısı olduğunuz bu çalışmada eşlerin aldatmadan nasıl etkilendikleri, bu etkinin derecesini belirleyen faktörler ve bu güçlüklerle baş etme yolları ile ilgili bilgi toplanması amaçlanmaktadır. Elde edilecek bulguların aldatma sürecini daha iyi anlamaya ve aldatma ile yaralanmış bireylere ve çiftlere daha etkin yardım yolları geliştirmeye katkı sağlayacağı düşünülmektedir.

Uygulama: Aşağıda bir dizi soru grubunu cevaplamanız istenmektedir. Soruların doğru ya da yanlış cevapları yoktur. Sorulara samimi cevaplar vermeniz araştırmadan elde edilecek sonuçların geçerli ve güvenilir olmasını sağlayacaktır. Cevaplanmamış soruları olan formlar değerlendirmeye alınamayacaktır. Bu nedenle tüm soruları eksiksiz doldurduğunuzdan lütfen emin olunuz. Soru gruplarını cevaplamak yaklaşık 20-30 dakika sürecektir. Bazı soru grupları genel eğiliminize ilişkin ifadeleri içerirken diğerleri evlilik dışı ilişki deneyiminizle ilgili olacaktır. Her soru grubu öncesinde açıklamaları ve cevap kalıplarını dikkatlice okumanız hatasız doldurmanıza yardım edecektir. Soru grubu, genel olarak kişisel rahatsızlık verecek soruları içermemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz cevaplama işini yarıda bırakıp çıkmakta serbestsiniz. Böyle bir durumda soru formunu uygulayan kişiye, formu tamamlamadığınızı söylemek yeterli olacaktır. Uygulama sonunda, bu çalışmayla ilgili sorularınız cevaplanacaktır.

Gizlilik: Çalışmada vereceğiniz tüm bilgiler saklı tutulacaktır. Araştırma kapsamında cevaplar grup halinde değerlendirileceği için bireysel veriler herhangi bir biçimde paylaşılmayacaktır. Dolduracağınız formda, demografik bilgiler dışında kimliğinizi belirleyecek sorular (isim, doğum yeri

vb.) yer almamaktadır. Araştırmaya katılmak tamamen gönüllülük ilkesine dayanmaktadır.

Sonuçlar: Bu araştırmaya katılımınızın bireysel olarak değerlendirmesi yapılmayacaktır. Veri toplama aşaması ardından tezin sunulması ile genel sonuçlara ulaşmak kütüphane veritabanlarından ya da araştırmacı kanalıyla genel özete ulaşmak mümkün olacaktır. Bunun için hedeflenen tarih 2009 yılı sonudur. Çalışma hakkında daha fazla bilgi almak için ODTÜ Klinik Psikoloji Doktora Öğrencisi Uzm. Psk. Serkan ÖZGÜN (Tel:212- 248 9393; E-posta: e145299@odtu.edu.tr) ile iletişim kurabilirsiniz.

Katılımınız için şimdiden teşekkür ederiz.

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum. (Formu doldurup imzaladıktan sonra uygulayıcıya geri veriniz).

İsim - Soyisim

Tarih

İmza

____/____/____

APPENDIX G
TURKISH SUMMARY
GİRİŞ

Bu çalışma evlilik dışı ilişkinin, aldatılan eş üzerindeki travmatik etkilerini incelemektedir. Aldatmanın, kişilerarası bir travma (Gordon & Baucom, 1999) olarak ele alındığı bu çalışmada, travma sonrası belirtileri etkileyen faktörlerin üzerinde durulmuştur. Söz konusu faktörler, aldatılan eşin kullandığı bilişsel-davranışsal baş etme biçimleri, kaynaklarındaki kayıp ve artışlar, ve incinen eşin affetme düzeyi olarak ele alınmaktadır. Buna ek olarak, literatür tarafından üzerinde durulan bazı önemli demografik değişkenler de incelenmiştir. İlerleyen bölümlerde öncelikle çalışmanın literatür bilgisi aktarılacak, daha sonra çalışmanın amaçları ve önemine değinilecek, son olarak da çalışmanın sonuçları tartışılacaktır.

Araştırmanın Konusuna Bağlı Literatür Bilgisi:

Aldatma, klinik psikologların oldukça yoğun çalıştıkları konulardan biri olduğu gibi araştırma yapılması da bir o kadar karmaşık bir alandır. Evlilikle ilgili aldatma oranları hakkında güvenilir veriler bulunmamakla birlikte Amerika Birleşik Devletleri'nde (ABD) yapılan çalışmalar evlilik dışı ilişki (EDİ) oranlarını erkekler için %20 - % 40 arasında, kadınlar için ise % 20 - % 25 arasında olduğu bildirilmektedir (Whisman & Snyder, 2007; Atkins, Baucom, & Jacobson, 2001; Laumann ve ark., 1994). Whisman, Dixon ve Johnson (1997)'a göre, ABD'deki çift terapistleri kendilerine başvuran çiftlerin yaklaşık % 29 ile % 65 arasında EDİ ile bağlantılı zorluklar yaşadıklarını belirtmişlerdir. Aldatma konusunun kendi başına, sanatın önemli alanlarında

(sinema, müzik, edebiyat vs.) ve magazinde yoğun dikkat çekmesinin yanı sıra, araştırmacıların bu başlığa eğilmesinin ana nedeni, bireylere ve ilişkiye oldukça zarar veriyor olmasıdır. Sadece çiftler ve bireyler değil, aynı zamanda çocuklar da ebeveynleri aracılığıyla EDİ'nin derin etkilerini yaşamaktadırlar (Lusterman, 1998).

İlgili literatür incelendiğinde, aldatmanın doğasının anlaşılması için birçok çalışma yapıldığı görülmektedir. Thompson (1984) aldatma tipolojisi tanımını ile bir çok araştırmacı tarafından yaygın bir şekilde kaynak gösterilen biridir. Thompson'a (1984) göre aldatma; sadece cinsel, sadece duygusal, ve hem cinsel hem de duygusal aldatma tipi olarak üç kategoride ele alınmaktadır. Aldatmanın "sadece cinsel" tipi, cinsel teması içeren herhangi bir davranışı kapsamaktadır (örn., dokunma, öpme ya da sadece cinsel birleşme/ilişki). Diğer yandan "sadece duygusal" tip, üçüncü kişi ile yaşanan duygusal bağlanmayı kapsar ve dışarı çıkma, flört etme ya da aşık olmayı içerebilir. Thompson'ın tipolojisinin son kategorisi cinsellik ve duygusallığı birleştirmektedir. Evlilik bağlamının dışında aldatma, birlikte yaşama ya da flört ilişkilerinde de yaşanabilmektedir. Drigotas ve Barta (2001) aldatmayı "*ilişki yaşanan eş dışındaki kişilerle duygusal ve fiziksel sınırları düzenleyici kuralların eşlerden biri tarafından yıkılması*" (p. 177) olarak tanımlamaktadır. Blow ve Hartnett (2005a) ise aldatmanın kapsamlı bir tanımını önermişlerdir. Bu tanıma göre aldatma;

Bir kişi tarafından, bağlılık ilişkisi içerisinde olunan birincil ilişki dışından birisi ile romantik, duygusal veya cinsel yakınlık içeren eşler arasındaki güveni zedeleyen ve/veya kabul edilen normları ihlal eden birlikteliktir (p. 191).

Birçok deęişken arasındaki etkileşim nedeniyle, aldatma üzerinde araştırma yapmak son derece karmaşıktır. Blow ve Hartnett'in (2005a) literatür tarama çalışmasında, birincil ilişkinin özellikleri (evlilik öncesi deneyim, evlilik doyumu, vb.) kültür, ve cinsiyet gibi önemli deęişkenlerin altı çizilmiştir. Kültürel etki üzerine odaklanan araştırmalar, EDİ' ye karşı toplumda güçlü bir norm olmasına karşın, aldatmanın birçok kültürde ortak bir sorun olduğu belirtilmiştir (Treas & Giesen, 2000; Vanlandingham ve ark., 1998; Wiederman & Allgeier, 1996). Widmer, Treas ve Newcomb (1998) 24 ülkeden örneklem ile tamamladıkları çalışmalarında, bazı ülkelerin (örneğin, Rusya, Bulgaristan, ve Çek Cumhuriyeti) diğerlerine göre EDİ konusunda daha esnek olmalarına rağmen birçok kültürde EDİ'nin güçlü bir şekilde onaylanmadığı gözlenmektedir. Aldatma araştırmalarında bir diğer önemli deęişken ise cinsiyet olarak tanımlanmıştır. Glass ve Wright'a (1985) göre, kadınlar aldatmayı cinsellikten çok duygusallığı içeren bir durum olarak tanımlasalar da, erkekler bu durumu tam tersi olarak tanımlarlar. Son zamanlarda yapılan çalışmalara göre, kadınların aldatma olgusu ilişki doyumsuzluğuyla daha yakından bağlantılı iken erkeklerin ki daha çok cinsel doyumsuzlukla ilintili bulunmuştur (Allen ve ark., 2008; Atkins, Yi, Baucom & Christensen, 2005). Buna ek olarak, cinsiyet farklılıkları aldatma-boşanma ilişkisi için de önemli bir faktör olarak görülmektedir. Boşanmış bireylerin yaklaşık % 40'ı evlilik süresince en az bir kez evlilik dışı cinsel ilişkiye girdiklerini bildirmişlerdir (Janus & Janus, 1993). Yine ilgili literatüre bakıldığında aldatmanın boşanma nedenlerinin en başında gösterilmesine karşın (Amato & Rogers, 1997), TÜİK'in (Boşanma İstatistikleri, 2006) çalışmasında Türk örnekleminde evlilik dışı ilişkiye bağlı boşanma oranları

sadece % 1 olarak gösterilmektedir. Shackelford ve Buss'da (2002) çalışmalarında erkeğin aldatmasının kadının aldatmasına göre daha kabul edilebilir olduğunu belirtmektedir. TUİK'in çalışması da buna paralel biçimde, erkek aldatmalarını boşanma nedeni olarak % 58 düzeyinde kadın aldatmasını ise % 61 düzeyinde göstermektedir (TUİK Aile Yapısı Arştırması, 2006).

Aldatma literatürüne bakıldığında çalışmaların odağında aldatmanın yordayıcıları ve risk faktörlerini belirlemeye dönük çalışmalar yer almaktadır (Drigotas ve ark., 1999; Zak ve ark., 2002). Buna benzer bir şekilde, Allen ve arkadaşları (2008) aldatmanın evlilik öncesi yordayıcıları üzerinde durmuşlar ve EDİ ve “olumsuz iletişim” arasında anlamlı bir ilişkinin olduğunu belirtmişlerdir. Diğer bir araştırmada, Shackelford, Besser ve Goetz (2008) EDİ'nin yordayıcısı olarak kişiliği incelemişlerdir. Bu araştırmanın sonuçlarına göre “düşük uyumluluk” ve “düşük açıklık” özelliklerine sahip olan kişilerin aldatma eğilimlerinin görece daha yüksek olduğunu ifade etmişlerdir. Bir başka grup araştırmacı, bu değişkenler dışında, birincil ilişkide doyumunu temel değişken olarak vurgulamışlardır. Bu araştırmalara göre, düşük evlilik doyumunu bildiren bireylerin EDİ'ye daha yüksek eğilim gösterdiği bulgulanmıştır (Polat, 2006; Atkins, Baucom & Jacobson, 2001; Shackelford & Buss, 1997; Shen, 1997; Glass & Wrigth, 1985). Ancak evlilik doyumunu ve aldatma arasındaki bağlantı tek bir değişkenle ifade edilemeyebilmektedir (Spanier & Margolis, 1983). Araştırmacılar, aldatmanın daha iyi anlaşılması için onun nedenleri üzerine de yoğunlaşmışlardır. Yeniçeri ve Kökdemir (2006) aldatmayı açıklayan durumları incelemişler ve EDİ'nin gerekçelendirilmesinde altı temel faktör. Bunlar meşruluk (legitimacy), baştan çıkarma, normalleştirme, cinsellik, sosyal arka plan ve heyecan aramadır.

Literatürdeki çalışmalar, aldatmanın sadece bireyler için değil aynı zamanda ilişkiler için de zarar verici ve yaralayıcı olduğunu vurgulamaktadır (Whisman, Dixon, & Johnson, 1997). EDİ'nin ortaya çıkmasının ardından oldukça küçük bir yüzde ilişkilerini geliştirmeyi başarabilmektedir. Çoğunlukla her iki eşte duygusal problemlerle karşı karşıya gelmektedir (Charny & Parnass, 1995). Sweeney ve Horwitz (2001) çalışmalarında aldatılma deneyiminin ruh sağlığı üzerindeki etkisine ilişkin araştırmaların sınırlılığını vurgu yapmaktadırlar. Bu sınırlı literatür içerisinde yine kendilerinin yaptıkları aldatma sonrası depresyonla ilgili çalışmaları ve Cano ve O'Leay'in (2000) çalışmaları başta gelmektedir. Bu çalışmaya göre, EDİ'nin olumsuz sonuçları açısından aldatılan kadınların majör depresyon yaşamalarının daha olası olduğu belirtilmiştir. Son yıllarda ise aldatma yine bu literatür içerisinde, kişiler arası travma olarak ele alınmakta ve bunun duygusal etkisi yoğun olarak araştırılmaktadır (Meldrim, 2006; Schalk, 2006; Whisman & Wager, 2005). Başta Gordon ve Baucom (1998) olmak üzere birçok klinisyen ve araştırmacı EDİ'nin ortaya çıkmasını travma olarak ele almakta ve bunun etkilerini incelemektedir. Glass ve Wright (1992) aldatılan eşin yoğun kızgınlık, utanç, depresyon, takıntılı acı verici düşünceler, kaçınma, duygusal küntlük ve aşırı uyarılmışlık gibi belirtiler yaşadıklarını rapor etmektedirler. Çalışmalarda, EDİ'nin travmatik etkilerinin olduğu genel olarak kabul edilmekte ve klinisyenler tarafından aldatılan eşlerin travma odaklı tedaviye alınmaları önerilmektedir (Baucom, Snyder, & Gordon, 2009, Ortman, 2009; Glass, 2003; Beadle, 2001; Lusteran, 1998; & Spring; 1996). Bu bulgular ve önerilere dayanarak, aldatmanın travmatik etkisinin daha iyi anlaşılmasına ihtiyaç duyulduğu söylenebilir.

Bu noktada Herman'ın (1992) travma yaklaşımı oldukça yardımcı bir model olarak görülmektedir. Geniş çapta kabul gören bir tanım olarak, travma modeli stresli yaşam olaylarının uzun dönem içerisinde bireylere olumsuz sonuçlar yaşatabileceğini varsaymaktadır. Herman (1992), travma kavramının bireyin dışarıda olan bir olaya psikolojik tepkisini kritik bir yaşam olayına dönüştürdüğünü ifade etmiştir.

Psikolojik travmanın daha iyi anlaşılması için travmatik olayların özellikleri ve olaylara verilen tepkiler açıklanabilir. Jensen'a (2003) göre, travmatik olayların temel özelliği kurbanın (1) yaşamına, (2) beden bütünlüğüne, (3) sevdiği kişiye ya da (4) inanç sistemleri üzerine doğrudan bir tehdit içermesidir. Bu açıdan bakıldığında travmatik olaylar insan eliyle kazara oluşanlar (uçak kazası, trafik kazası vs.), insan eliyle bilerek ve amaçlı olarak yapılanlar (tecavüz, savaş, işkence vs.) ve doğal yollarla oluşanlar (deprem, sel, kasırga vs.) olmak üzere kategorize edilebilir. Herman (1992) travmatik olayları takip eden duygusal problemleri, anormal durumlara verilen normal tepkiler olarak görmektedir. Buna ek olarak Herman travmatik yaşam olaylarının sadece nadiren ortaya çıkmasından dolayı değil, sıradan bir insanın yaşam uyumunu bozmasından ötürü anormal olaylar olarak tanımlar. Ona göre, psikolojik travmaya verilen tepki temelde iki grupta toplanır: güçsüz hissetmek ve izole olmak. Travma literatüründe ki temel kabul travmatik olayların her zaman travmatize etmediğidir. Popülasyonun büyük bir bölümünün en az bir ya da daha fazla travmatik olayla karşılaşmış ABD'de bile, travma mağdurlarının sadece küçük bir kısmı (% 10'dan daha az) bir bozukluk geliştirmektedir Bununla uyumlu olarak, travma belirtileri geliştirmenin şiddeti, stres faktörleri (sosyo-ekonomik sorunlar, etnik sorun, önceki tehditler

vs) ile koruyucu faktörler (sosyal destek, güvenlik duygusu, aile desteği vb) arasındaki denge ile açıklanması, travma literatüründen birçok bulgu ile desteklenmiştir.

Travma tanıları, travmatik olayların oluşumunun ardından geçen süreye göre ayrıştırılmaktadır. Böylece, travmatik olaya karşı gelişen tüm ani tepkiler Akut Stres Bozukluğu (ASB), bir aydan daha fazla zaman içerisinde devam eden tepkiler Travma Sonrası Stres Bozukluğu (TSSB), stresörün (tetikleyici) devam ettiği durumlarda travma tepkileri Devam Eden Stres Bozukluğu tanımı ile ifade edilmekte, ancak stres verici uyarıcıya uzun süreli maruz kalındığında da Kompleks Travma (ensest, çocuk istismarı, cinsel istismar, işkence vs.) olarak adlandırılmaktadır. Çok yaygın olmamasına rağmen, Travmatik Psikoz da bir başka travmatik tanı olarak ifade edilmektedir (Jensen, 2003). Bu çalışmada, TSSB temel travma tanısı olarak ele alınmakta ve TSSB'nin fiziksel, bilişsel, duygusal ve sosyal etkileri özetlenmektedir.

Travmatik olayın tanımı DSM-IV-TR (APA, 2000) iki bölümden oluşmaktadır: (1) Travmatik bir olaya maruz kalma (A1 kriteri); (2) Maruz kalma nedeniyle duygusal stres yaşama (A2 kriteri). DSM-IV travmatik olayı;

Kişi gerçek bir ölüm ya da ölüm tehdidi, ağır bir yaralanma ya da kendisinin ya da başkalarının fizik bütünlüğüne bir tehdit olayını yaşamış, böyle bir olaya tanık olmuş ya da böyle bir olayla karşı karşıya gelmiştir [ve] kişide yoğun korku, çaresizlik ya da dehşete düşme vardır

şeklinde tanımlamaktadır. Buna ek olarak TSSB belirtileri DSM-IV'de üç farklı belirti grubu ile tanımlanmıştır: (1) travmatik olayın yeniden

deneyimlenmesi, (2) olaya benzer uyaranlardan kaçınma ve duygusal tepkide küntlük, (3) artmış uyarılmışlık seviyesi.

Strese ilişkin önemli psikolojik teorilerinden birisi Lazarus ve Folkman (1984) tarafından geliştirilen stres ve baş etme modelidir. Lazarus (1991) baş etmeyi, kişisel kaynak ve durumun gereklilikleri arasındaki farklılıktan gelişen bir değerlendirme süreci olarak tanımlar. Baş etme, (1) zararın tehlike düzeyini değerlendirme, (2) herhangi bir baş etme eyleminin sonuçlarını değerlendirme ile temas halinde olan bilişsel bir aktivite olarak ele alınmaktadır. Baş etme modeli, stresli yaşam olaylarına verilen tepkilerin bireysel ayrılıklar uyarınca farklı baş etme stratejilerinin seçildiğini varsaymaktadır. Lazarus ve Folkman (1984) iki tip bilişsel değerlendirme sunmaktadır; birincil ve ikincil bilişsel değerlendirme. Birincil değerlendirme bağlantısız, pozitif veya stres olmak üzere üç farklı yolla gerçekleşebilir. Bağlantısız olma, çevrenin insanlar için bir uygulaması yoksa değerlendirilir. Pozitif olmak olumsuz ya da endişeli nitelikleri olmayan bir etkileşime işaret eder ama keyifli duygularla sonuçlanması muhtemeldir. Buna ek olarak, stres değerlendirmesi yine zarar/kayıp, tehdit ve meydan okumayı içeren üç ayrı parçaya bölünür. Birinci bölüm kişinin kaybı deneyimlediği “zarar/kayıp” bölümüdür. Stres değerlendirmesinin ikinci bölümü bir stresörün olacağını bekleme “tehdittir”. Son bölüm ise büyüme üzerine odaklanmış “meydan okumadır”. Diğer yandan ikincil değerlendirme, baş etme kaynaklarının değerlendirilmesi (fiziksel, sosyal, psikolojik ve maddi kaynaklar) ve seçeneklerdir.

Stresli yaşam olayının sonrasında, stres tepkisi aşaması Lazarus ve Folkman (1984) tarafından tanımlanan problem-odaklı ve duygu-odaklı baş etme stratejileri aşamasıdır. Problem-odaklı baş etme stratejisi, durum ve kişi

arasındaki gerçek ilişkideki deęişimleri içermektedir. Problem-odaklı baş etme stratejisinde sorunlu durumu tanımlama veya dięer olası sonuçlar üzerinde düşünmekten çok, sorunun kendisine odaklanma çabası temel alınmaktadır. Buna karşılık duygu-odaklı baş etme biçimi, soruna doğrudan deęinmeden, deęişen duygulara odaklanan stratejileri içermektedir. Duygu-odaklı baş etme biçimi, kaçınma, küçültme, uzaklaşma, seçici dikkat ve olumlu karşılaştırma yapma gibi stratejileri içermektedir. Lazarus'a göre (1993) belirli bir baş etme tepkisinin etkililięi, tepkinin kendi bağlamı içerisinde deęerlendirilmelidir. Travmanın olumsuz etkilerini kontrol amaçlı olarak duygu-odaklı baş etme biçimi yerine problem-odaklı baş etme biçiminin kullanılmasının fayda sağladığını belirten pek çok sayıda çalışma bulunmaktadır (Ehler, Mayou & Bryant, 1998) ancak Reichman ve arkadaşları (2000) iyi ya da kötü baş etme biçimlerinin olmadığını ifade etmektedirler. Baş etme modelinin son basamağı Lazarus ve Folkman (1987) tarafından ayrışma (resolution) olarak belirtilmiştir. Stresli yaşam olayları ile baş etme girişimleri sonrasında, söz konusu ayrışma uygun ya da uygunsuz olarak deęerlendirilebilir. Bu model temel alınarak, uygun ayrışma, olumlu duyguların ortaya çıkışı içerisinde gözlenirken uygun olmayan ayrışma rahatsızlık yaratmaktadır. Buna karşılık Folkman (2001) travmadan etkilenen kişinin bundan çıkardığı anlama göre olumsuz ayrışmanın pozitif duygu ile sonlanabileceğini rapor etmiştir.

Bu tez çalışmasında odaklanılan dięer bir stres modeli de Hobfoll (1989) tarafından geliştirilmiş Kaynakların Korunumu (Conservation of Resources (COR) teorisidir. COR teorisi hem çevresel hem de içsel süreçleri içeren entegratif bir teoridir. Kaynak tabanlı bu teori, stresli olaylara karşı kişilerin verdikleri tepkilerin farklılıklarını göstermektedir. Hobfoll'a (2001)

göre COR teorisi, stresi; kişi için önemli hedeflerin tehdit edildiği, kaybedildiği veya bireylerin bu hedefleri kazanma ya da taşıma için gerekli koşulları yaratma konusunda başarısız olması ile tanımlamaktadır. Hobfoll (1989) bu durumları psikolojik stresin oluşumuna göre tanımlamaktadır: (1) Bireylerin kaynaklarının tehdit edilmesi, (2) Bireylerin kaynaklarını kaybetmesi veya (3) Bireylerin uygun kaynak oluşturmada başarısızlık yaşaması. Ek olarak, Hobfoll (1989), COR teorisinin merkezi ilkelerinden olabilecek üç temel prensip önermektedir. İlk prensip, *“kaynakların kaybedilmesi, kaynak kazanılmasından orantısız olarak daha belirgindir”* olarak ifade edilmektedir (s.62). Yani, psikolojik sağlık üzerinde kaynak kaybı, kaynak artışında daha fazla etkiye sahiptir. Bu prensip ışığında, araştırmalar TSSB ve psikolojik stres yordayıcısı olarak kaynak artışında çok kaynak kaybı olduğunu göstermektedir (Benight ve ark., 1999; Ironson ve ark., 1997). İkinci prensip, *“kişiler, kaynak kaybından kendilerini korumak, kayıp sonrası iyileşmek ve kaynak kazanmak amacıyla kaynak yatırımı yapmalıdır”* olarak ifade edilmektedir (s. 73). Bu prensip temel alınarak, kısıtlı kaynağa sahip olan kişilerin kaynak artışı ile ilgili daha az düzeyde beceri sahibi olduğu ve kaynak kaybı yaşamaya karşı daha kırılgan olacakları beklenmektedir. Bu nedenle, daha az düzeyde kaynağa sahip olan kişiler, daha zengin kaynağa sahip olanlara kıyasla, daha az düzeyde stres direncine sahip olmaktadır. Son prensip, *“kaynak artışı ancak kaynak kaybı bağlamında önem kazanmaktadır”* (s. 80). Örneğin, tekerlekli sandalye kullanan bir insanı gören kişiler, kendi sağlık kaynakları ile kıyaslayarak, kendi sağlık durumlarını daha iyi değerlendirebilirler (Hobfoll, 1998; Wells, Hobfoll & Lavin, 1999).

Hobfoll'un modelinde (1998) dört tip kaynak tanımlamaktadır: (1) Nesne kaynakları (ev, taşıma araçları ve fetiş nesnelere), (2) Kişisel kaynaklar (beceriler [meslek, liderlik, vs.], ve kişisel özellikler [benlik saygısı, iyimserlik, vs.]), (3) Sağlık kaynakları (sağlıklı olmak, iş, evlilik, vs) ve (4) Enerji kaynakları (para, kredi, bilgi vs.). Bireylerin kaynaklarını incelemek için Hobfoll, Lilly ve Jackson (1992) "Kaynakların Değerlendirilmesi Ölçeği"ni (Conservation of Resources Evaluation [COR-E]) geliştirmişlerdir. COR-E'nin iki ayrı formu bulunmaktadır; Kayıp ve Artış formları. COR-E ölçeği, COR teorisini sınamak üzere çeşitli örneklerle kullanılsa da (Banou, Hobfoll & Tochelman, 2009; Walter & Hobfoll, 2009; King ve ark., 1999; Wells, Hobfoll & Lavin, 1999; Ironson ve ark., 1997) evlilik dışı ilişki sonrası kaynakların rolünü inceleyen herhangi bir araştırma gerçekleştirilmemiştir.

Bu tez çalışmasında son olarak Gordon ve Baucom (2003) tarafından geliştirilen üç evreli affetme modeline yer verilmiştir. Kısaca affetme, Heider (1958) tarafından kinci davranıştan vazgeçme olarak tanımlanır. Bu bağlamda affetme, genellikle bağışlama süreci olarak kabul edilir. Affetme çoğunlukla dinsel ve ruhsal bir kavram olarak düşünülmüş olsa da son on yılda bilim adamlarının ve psikologların dikkatini çekmiştir (Worthington, 2005). Klinik psikoloji alanında, affetme araştırmaları hızlı bir şekilde büyüme göstermektedir. Bugün, affetme literatürü, süreç ve sonuç çalışmalarını içeren teorik keşifleri, pratik düşünceleri ve ampirik makaleleri içermektedir (Wade, Johnson & Meyer, 2008).

Üç evreli affetme modeli (Gordon & Baucom, 2003) özellikle büyük ihanetlerle (örneğin, sadakatsizlik, yalancılık, güven ihlali) ilgilidir. Gordon ve Baucom'un modeli, affetmenin travmatik tecrübeler nedeniyle bozulan temel

kabullerin yeniden inşasına yardım etmek için ortaya çıktığını varsaymaktadır. Gerçekleşen kişiler arası travma sonrası tepkiler ile travmatik reaksiyonlar arasında bir örtüşme olduğu genel olarak kabul gören bir yaklaşımdır. Gordon ve Baucom, travmatik olaylardaki tipik tepkiler gibi affetme sürecini de üç evreyle tanımlamaktadır: etki, sorgulama ve iyileşme. Affetme sürecini şöyle açıklamışlardır:

Kişinin olay öncesindeki varsayımlarını ve genel olarak eşlerine ve ilişkilerine dair beklentilerini bozan büyük ihanetin kişiler arası travma olarak görülmesi bir affetme süreci gerektirir. Bu bakımdan, affetme süreciyle bağ kurma ihtiyacının, eğer kişi etkin biçimde olayın üzerinden geçmek amacındaysa; eşi ve ilişkileri hakkındaki önceki düşüncelerini yeniden yapılandırma veya değiştirme çabası ve ilişkide kişilerarası kontrol, yordanabilirlik ve güven hissini yeniden kazanma ihtiyacı söz konusu olmaktadır (p. 181).

Üç evreli affetme modeli, I. Evre (etki) ihanetin incinen bireylerin ve ilişkilerinin üzerinde ki etkisine odaklanır. Diğer affetme modellerine benzer şekilde, bu evre bilişsel, duygusal ve davranışsal bozulmaları içeren bir dönem olarak tanımlanır (Gordon & Baucom, 1998). Dahası bu tepkiler, incinmiş eşlerin önemli kabullerini gösterir (örn., ilişki güvenlidir, bir eş güvenilir olabilir vs.). Ayrıca aldatılmış eşlerde, I. Evre'de kendilerini korumak için geri çekilme görülür. Olumsuz yaşam olayının neden meydana geldiğini anlamak is bireylerin temel uğraşısı olduğu yaygın biçimde kabul (Worthington, 1998; McCullough, Worthington & Rachal, 1997; Horowitz ve ark., 1991). Gordon ve Baucom'a göre affetme modelinin II. Evresi bu konu üzerine

yoğunlaşmıştır. Bu aşamada, yaralanmış eşler niçin ihanete uğradıklarını, eşlerinin davranışlarını daha anlaşılır hale getirebilmek için, anlamaya çalışır. Böylece bu anlama çabası, kişinin kendi hayatı üzerinde kontrol ve güven duygusunu arttırabilirken, güçsüzlük hissinin de azalmasına yardımcı olabilir. Diğer taraftan, III. Evre'de yaralanmış eşler ihanetin ötesine geçerler ve hayatlarını tekrardan kontrol etmeye başlarlar. Bu aşamada, incinmiş bireylerden, eşlerinin ve ilişkilerinin bozulmaya uğramamış yerlerini geliştirmesi beklenir. Aynı zamanda III. Evre'de, olayı anlamak için eşe hissedilen yoğun olumsuz duygular da daha az görülmektedir.

Affetme süreci, aldatılan kişilerin eşleri ve ilişkileri hakkındaki inançlarını yeniden inşa ya da düzenleme girişimleri ile sonuçlanabilir. Yakın zamanda gerçekleştirilen bir çalışmada affetmenin, evlilikle ilgili çatışmaları azalttığı ve eşlerin birbirlerini anlamalarını geliştirdiğini gösterilmiştir (Schalk, 2006). Bu bulgulara paralel olarak, Gordon, Snyder ve Baucom (2005) yaptıkları çalışmada, aldatılan eşlerin affetme düzeylerinde artış bulunurken travma belirtilerinde düşüş olduğu gösterilmiştir. Sells ve Hargrave (1998) affetmenin, öfkeyi, intikamı, utancı ve darılmayı giderdiği fikrini kabul ederler. Fincham ve arkadaşlarına (2004) göre affetme, aldatan eşlere karşı olumsuz motivasyonu düşürür. Buna çalışmalar karşılık, birey ve çiftlerin aldatma sonrası iyileşme sürecine dair araştırmalar oldukça kısıtlıdır (Atkins ve ark., 2005; Allen & Atkins, 2005; Moultrup, 2003; Olson ve ark., 2002; Brown, 2001).

Çalışmanın Amacı:

Daha öncede belirtildiği gibi, EDİ oldukça sık oranda meydana gelmekte ve hem bireyleri hem de ilişkileri olumsuz yönde etkilemektedir (Atkins ve ark., 2005b). Whisman ve arkadaşları (1997) EDİ'nin çift yaşamında ikinci büyük yıkıcı problem, aile terapistleri için klinik uygulamada ise üçüncü büyük problem olduğunu belirtmiştir. Son on yılda, EDİ'nin tedavisi üzerine birçok akademik dergi özel sayı yayınlamış ve kitaplar yazılmaktadır (Ortman, 2009; Baucom, Snyder, & Gordon, 2009; Piercy, Hertlein, & Wetchler, 2005; Vaughan, 2003; Glass, 2003; Brown, 2001; Subotnic & Harris, 1999; Lusteran, 1998; Spring & Spring, 1996).

Önceki bölümlerde de belirtildiği gibi, evlilik dışı ilişki birçok klinisyen tarafından, kişiler arası bir travma olarak ele alınmaktadır (Whisman & Wagers, 2005). Özellikle aldatma ile yaralanmış eşlerin, travma sonrası stres bozukluğuna (TSSB) benzeyen semptomlar göstermesi üzerine güçlü bir fikir birliği olmasına karşın, aldatılan eşlerin travmatik tepkilerini açıklayan sınırlı sayıda araştırma vardır. Son yıllarda Meldrim (2005) aldatmanın etkisini açıklamak için incinmiş eşlerle (on kadın ve yedi erkek) nitel bir çalışma yapmıştır. Çalışmanın sonuçlarına bakıldığında, katılımcılar evlilik dışı ilişkiyi hayatlarının en zor ve travmatik olayı olarak tanımlamışlardır. Bunun gibi, Schalk (2006), cinsel aldatmayla baş etme sürecine odaklanmış ve aldatılan eşlerin bu deneyimlerini travmatik olarak tanımladığı görülmüştür.

Snyder ve arkadaşları (2007) travmanın, büyük bir olumsuz olay veya olaylar serisi olarak, dünya veya belli insanlar hakkında önemli varsayımları ve inançları yıktığını tanımlamıştır. Bu varsayımlar ve inançlar bireylere kontrol edilebilir bir dünya yaratmasına ve kendilerini daha güvende hissetmelerine

yardımcı olur. Travma literatürü, varsayımlar yıkıldığında ya da tehdit altında kaldığında bireylerin gelecek güvencesini ve kontrolünü kaybedebileceğini vurgular (Snyder, Gordon, & Baucom, 2004). Aldatmayı takiben ihanete uğramış eş de kendini ilişki içinde güvende hissedemez noktaya varır (Blow & Harnett, 2005b). Ortman (2009)'e göre evlilik dışı ilişki öğrenildikten sonra, güveni ihanete uğramış eş son derece yaralanmış olur. Bununla birlikte, yapılan çalışmalarda yaralanan eşlerin TSSB belirtilerini gösterebileceğini bildirmektedir (Gordon, Baucom, & Snyder, 2005a; Meldrim, 2005; Glass, 2003; Lusteran, 1998).

Aldatma ile ilgili yapılan literatür incelemesi sonrasında henüz üzerinde çalışılmayan birçok nokta olduğu sonucuna varılmıştır. Daha ayrıntılı olarak, EDİ'nin ortaya çıkmasından sonra duygusal süreçlerin keşfedilmesine ihtiyaç duyulmaktadır. Aldatmanın duygusal etkisini anlamak için kullanılan travma modelinin yararı açık olmasına karşın, EDİ sonrası gerçekleşen sürece ilişkin yeterli çalışma bulunmamaktadır (Blow & Harnett, 2005b). Aldatma literatürü ışığında, bu çalışmanın amaçları evlilik dışı ilişkinin aldatılan eş üzerindeki travmatik etkilerini, TSSB düzeyini yordayan faktörleri (başa çıkma stratejileri, kaynakların korunması, affetme evreleri) açıklamaktır. Buna ek olarak bu çalışmadaki diğer amaçlar kritik demografik değişkenlerin (aldatma türleri, ilişki süresi, önceki aldatma deneyimleri gibi) travmatik tepki düzeyindeki etkilerini ortaya çıkarmaktır. Söz konusu çalışmanın katılımcıları, eşleri evlilik hayatları sürecinde evlilik dışı ilişki deneyimi olan evli kadınlardan oluşmaktadır.

Yukarıda özetlenen amaçlar doğrultusunda bu tez çalışmasının cevap aradığı sorular aşağıdaki gibidir:

1. Evlilik dışı ilişki ortaya çıktıktan sonra aldatılan eşler TSSB semptomları sergilemekte midir?
2. EDİ ortaya çıktıktan sonra travmatik tepkilerin şiddetinde hangi demografik veriler etkindir?
3. Duygu-odaklı başa çıkma stratejileri yerine problem-odaklı başa çıkma stratejileri kullanan aldatılmış eşler daha az TSSB semptomu gösterirler mi?
4. Kaynak atışı ile karşılaştırıldığında aldatılan eşlerin TSSB düzeylerinin üzerinde kaynak kaybının daha fazla etkisi var mıdır?
5. Affediciliğin, aldatılan eşlerin ilişkilerinin ihlal edilmiş olması varsayımına bağlı olarak yaşadığı TSSB belirti düzeylerinin azalması üzerinde etkisi var mıdır?
6. Aldatılan eşler üzerinde TSSB şiddetinin ana yordayıcıları nelerdir?

YÖNTEM

Katılımcılar:

Araştırmanın kadın-erkek katılımcılarla beraber yürütülmesi planlanırken, anketleri sadece üç erkek doldurmayı kabul etmiştir. Bu veriler çıkarıldıktan sonra, araştırmanın katılımcı sayısı 189 evli kadından oluşmuştur. Örneklemin yaş aralığı 22-54, yaş ortalaması ise 36.12 yıldır ($\underline{SS} = 7.50$). Katılımcıların ortalama eğitim süresi 10.67 yıl ($\underline{SS} = 4.15$) iken ortalama evlilik süresi ise 11.95 yıldır ($\underline{SS} = 6.35$). Katılımcıların çocuk sayılarının

aralığı 0-5 iken, ortalaması 1.81'dir ($SS = 1.06$). Buna ek olarak katılımcıların % 52.8'i aktif çalışmakta ve yarısından daha fazlası (57.7%) orta SED'dedir.

Ölçüm Araçları:

Bu tez çalışmasında toplam 5 ölçüm aracı kullanılmıştır. Bunlar; Demografik Bilgi ve Evlilik Dışı İlişki Formu (DI-EMI), Travma Sonrası Stres Bozukluğu Belirti Ölçeği (PSS-SR; Foa ve ark., 1997), Başa Çıkma Yolları Envanteri (WCI, Folkman & Lazarus, 1988), Kaynakların Değerlendirilmesi Ölçeği (COR-E, Hobfoll, Lilly, & Jackson, 1991) ve Affetme Ölçeği (FI, Gordon & Baucom, 2003).

Demografik Bilgi ve Evlilik Dışı İlişki Formu (DI-EMI): Araştırmacı tarafından geliştirilen DI-EMI iki bölümden oluşmaktadır. Anketin ilk bölümünde, katılımcıların yaşı, eğitim düzeyi, evlilik süreleri, evlilik durumu, çalışma durumu, toplam çocuk sayısı, sosyo ekonomik düzeyleri gibi bilgiler toplanmaktadır. İkinci bölümde ise aldatma literatürü temel alınarak araştırmacı tarafından hazırlanan sorular bulunmaktadır.

Travma Sonrası Stres Bozukluğu Belirti Ölçeği (PSS-SR): PSS-SR dört bölümden ve 50 maddeden oluşmaktadır. Bu maddeler hem DSM-IV'e göre TSSB tanısını hem de TSSB semptom şiddetini ölçmektedir. PSS-SR'ın ilk bölümü travmatik deneyimin türünü belirlemek için tasarlanmıştır (örn. afet, kaza, savaş, tecavüz). İkinci bölüm, A Kriterini ölçen "Olayların Şiddeti Alt Ölçeği" olarak adlandırılan altı adet Evet-Hayır sorusunu içermektedir. PSS-SR'ın üçüncü bölümü "TSSB Belirti Şiddet Düzeyi" TSSB semptomlarını değerlendiren 17 maddeden oluşan bir alt ölçektir. Her bir madde 0 ile 3 aralığında 4'lü Likert tipte cevaplanmaktadır. Bu alt ölçek TSSB'nin DSM-IV

kriterlerine karşılık gelen üç faktörü de içermektedir; yeniden deneyimleme/girici düşünceler (B), kaçınma/duygusal küntlük (C) ve aşırı uyarılmışlık (D). Son olarak, PSS-SR “Olay Etkisi Alt ölçeği” olarak adlandırılan bölümü TSSB’nin F kriterini ölçmektedir. Bu bölümde kişinin günlük yaşam fonksiyonları üzerine olayların etkisi ölçülmektedir. Olay Etkisi Alt Ölçeği dokuz Evet-Hayır sorusunu içermektedir ve “evet” cevaplarının toplam sayısı sonucu belirlemektedir. PSS-SR’ın Türkçe uyarlaması Işıklı (2006) tarafından yapılmıştır.

Baş Etme Yolları Ölçeği (WCI): Bu ölçek, 74 maddeden oluşan, 5’li Likert tip yanıt anahtarı bulunan bir ölçüm aracıdır. Baş etme Yolları Ölçeği, bireylerin karşılaştıkları stresli olaylarla baş etmek için kullandıkları düşünce ve eylemleri, genel olarak basa çıkma süreçlerini değerlendirmeyi amaçlamaktadır. Baş etme Yolları Ölçeği’nin Türkçe güvenilirlik ve geçerlik çalışmaları ilk olarak Siva (1991) tarafından yapılmıştır. Daha sonra farklı örneklem gruplarıyla değişik araştırmacılar tarafından üzerinde çalışılan ölçeğin, bu tez çalışmasında, Gençöz, Gençöz ve Bozo (2006) tarafından üç alt ölçeğe (problem-odaklı, duygusal-odaklı ve dolaylı başa çıkma) indirgenmiş versiyonu kullanılmıştır.

Kaynakların Değerlendirilmesi Ölçeği (COR-E): Kaynakların Değerlendirilmesi Ölçeği (Hobfoll, Lilly, & Jackson, 1992) kişisel kaynakların değerlendirildiği 74 maddelik bir ölçektir. Cevap kalıbı 5’li Likert tiptedir. COR-E’nin kayıp ve artış olmak üzere iki ayrı formu bulunmaktadır. C. Alfa değerlerine bakıldığında her iki form içinde sırasıyla .85 ve .91 olarak belirlenmiştir. Ölçeğin Türkçe uyarlama çalışması Özgün ve Gençöz

(submitted) tarafından gerçekleştirilmiş ve orijinal forma paralel biçimde geçerlik ve güvenilirliği gösterilmiştir.

Affetme Ölçeği (FI): Affetme Ölçeği (Gordon & Baucom, 2003), Gordon ve Baucom tarafından tanımlanmış, incinmiş eşin geçtiği üç evreyi ortaya koymaya dönük, 25 soruluk bir ölçektir. FI'n ölçtüğü üç evre sırası ile: I. Evre: Yoğun duygusal etkinin yaşandığı evre; II. Evre: Travmatik olayı anlamaya ve duyguları netleştirmeye dönük evre; ve III. Evre: olumsuz duyguların terk edildiği ve harekete geçilen evre olarak tanımlanmaktadır. Tüm alt ölçeklerin C. Alfa değerleri sırasıyla .85, .76 ve .75 olarak belirlenmiştir. Affetme sürecinde gelişim, ilk iki evrede azalma üçüncü evrede ise artışla tanımlanmaktadır. Bu ölçeğin Türkçe geçerlik-güvenirlilik çalışması da mevcut tez çalışması içerisinde gerçekleştirilmiştir.

İşlemler:

Çalışmada eşi tarafında evlilik dışı ilişki ile incinmiş 189 evli kadın yer almıştır. Katılımcıların en az üç yıllık evli olması ve evlilik dışı ilişkinin en yakın bir ay önce gerçekleşmiş olması kıstas olarak belirlenmiştir. Ayrıca aşağıdaki eleme kıstasları da örneklem için uygulanmıştır: (a) Devam eden evlilik dışı ilişki, (b) Boşanma ya da ayrılma, (c) Çoklu evlilik dışı ilişkiler olması, (d) Son 6 aylık süreçte Yaşam Deneyimi Envanteri (the Life Experiences Survey; Sarason, Johnson, & Siegel, 1978) ile belirlenen olumsuz yaşam olaylarından bir ya da daha fazlasının olması ve (e) Kronik yaşam stresörü bulunmaması. Amaçlı ve kartopu örnekleme yöntemi (snowball sampling; Kumar, 1996) ile ulaşılan katılımcılar, yukarıda özetlenen örneklem katılım kriterleri ile kontrol edilmiştir. Katılımcılar çalışmaya katılmayı kabul

ettikten sonra öncelikle “gönüllü katılım formu” okutulup imzalanmış ardından ölçekleri içeren soru kitapçığını doldurmaları istenmiştir. Tamamlanan soru kitapçıkları uygulamacıya iletilmiş, katılımcının olası soruları cevaplandırıldıktan sonra çalışma sonlandırılmıştır.

İstatistiksel Analizler:

Katılımcılardan toplanan veriler Sosyal Bilimler için İstatistik Paket (SPSS) programı (Green, Salkind, & Akey, 1997) ile analiz edilmiştir. Öncelikle katılımcıların EDİ yaşantılarının genel özelliklerini sunmak için betimsel istatistiksel analizler yapılmıştır. Buna ek olarak aldatmanın travmatik etkisi de betimsel istatistikler kullanılarak elde edilmiştir. Araştırma soruları doğrultusunda, Pearson korelasyon analizinin yanında, iki istatistik analiz modeli daha kurgulanmıştır. WCI, COR-E ve FI gruplarının TSSB belirti düzeyleri arasındaki farklarla ilgili diğer hipotezleri test etmek için Çok Değişkenli Kovaryans Analizleri (MANCOVA) analizi kullanılmıştır. Son olarak, evlilik dışı ilişkinin neden olduğu travmanın en önemli yordayıcılarını öğrenmek için Aşamalı Çoklu Regresyon Analizleri yürütülmüştür.

BULGULAR

Evlilik Dışı İlişki Boyutunun Betimsel İstatistikleri

Katılımcıların hemen hemen yarısı ($n = 95$, % 50.3) bu çalışmaya katılmadan 7 ay ile 3 yıl arası bir süre de eşlerinin EDİ'lerini öğrenmişlerdir. Katılımcıların eşlerinin EDİ'ye devam etme süreleri ise ortalama 1.79 yıldır ($SS = 1.47$). Sonuçlara bakıldığında 164 katılımcı (% 86.8) ortaya çıktıktan

sonra eşiyle EDİ hakkında konuşmuş, ancak bunlardan sadece 113 koca (% 59) içinde buldukları EDİ'yi kabul etmiştir. Yine bütünde, 88 vakada üçüncü kişinin kimliği bilinmezken, tanımlana bilenler içerisinde en yüksek oran (% 37.4) dahil olan eşin iş arkadaşı olarak belirlenmiştir. Katılımcılar eşlerinin EDİ'lerini % 61.2'si tamamen ya da büyük oranda cinsel olarak tanımlamaktadır. Buna ek olarak, bireysel ya da çift olarak yardım alan kişilerin oranı sadece % 18,5'dir ($\underline{n} = 34$). Katılımcıların mevcut ilişkileri dışında EDİ deneyimlerine baktığımızda, 25 katılımcının (% 13,2) yine önceki ilişkilerinde de aldatma ile karşılaştığı belirlenmiştir. Ayrıca katılımcıların % 33.3'ü ($\underline{n} = 63$) kendi yakın aile üyesinin de (genellikle baba) EDİ deneyimi olduğunu ifade etmiştir.

DSM-IV'ün TSSB Kriterlerine Göre Betimsel İstatistikler:

Travma ölçeği PSS-SR sonuçlarına bakıldığında, katılımcıların 98'i (% 51.9) A1 kriterini, 177'i ise (% 93.7) A2 kriterini tamamlamıştır. Toplamda katılımcılardan 95'i (% 50.7) TSSB için A kriterini karşılamaktadır. B kriteri “yeniden deneyimle” katılımcıların 185'i tarafından (% 97.9) doldurulmuştur. Bu alt ölçekte en düşük % 54.5 ile “fiziksel tepkiler” yer alırken en yüksek % 86.3 ile “travmayı hatırlatan tetikleyici sonrası duygusal çöküş” maddesi yer almaktadır. Diğer yandan, 161 katılımcı (% 85.2) C kriterini (kaçınma/küntlük) doldururken 172 katılımcı da (91.0%) “aşırı uyarılma” olarak adlandırılan D kriterini karşılamaktadır. Alt ölçeklerin maddelerine bakıldığında, C kriteri için en düşük % 34.4 ile “genel ilgi düzeyinde kayıp” ve en yüksek % 65.6 ile “travma hakkında düşünmemeye çalışmak” maddesi almıştır. Buna ek olarak, D kriteri maddelerinde en düşük oran “çabuk tetiklenme” maddesi iken en

yüksek oran % 82 ile “çabuk öfkelenme” maddesi olarak gerçekleşmiştir. Bunun dışında, “rahatsızlık süresi” olarak adlandırılan E kriteri TSSB için bir aydan fazla olmalıdır ve katılımcıların % 93.1’i ($n = 176$) E kriterini doldurmuştur. PSS-SR’da “Olay Etkisi Alt Ölçeği” olarak adlandırılan son bölümü F kriteridir. Sonuçlara bakıldığında 173 katılımcı (% 91.5) F kriterini karşılamaktadır. Bu bulgular ışığında, toplamda 65 katılımcının (% 34.4) PSS-SR üzerinden TSSB tanısı için tüm DSM-IV kriterlerini tamamladığı görülmüştür. Diğer bir yandan A kriterinin ilk bölümü (A1; ölüm ya da ölüm tehdidi veya yaralanma ile karşılaşmak) bu değerlendirmenin dışında tutulursa, katılımcıların 153’ü (% 81) TSSB tanısı alabilmektedir.

TSSB Semptom Düzeyi ve DI-EMI Değişkenleri:

İstatistik analizlerin anlamlı ilişki belirlediği değişkenlere bakıldığında, “evlilik süresi” demografik değişkeni ile toplam TSSB puanı ($r = .16, p < .05$), yeniden deneyimleme alt ölçeği ($r = .16, p < .05$) ve aşırı uyarılma alt ölçeği ($r = .16, p < .05$) arasında pozitif yönde bir korelasyon belirlenmiştir. Diğer yandan, “EDI’nin ortaya çıkmasından” sonra geçen zaman değişkeni ile toplam TSSB puanı ($r = -.15, p < .05$), yeniden deneyimleme alt ölçeği ($r = -.16, p < .05$) ve aşırı uyarılma alt ölçeği ($r = -.17, p < .05$) arasında negatif yönde bir korelasyon elde edilmiştir. Veriler arasındaki bu ilişki gösteriyor ki, daha uzun evliliklere sahip katılımcılar EDI sonrasında daha fazla TSSB belirtisi göstermektedir. Buna karşın EDI’nin keşfinden sonraki geçen zamana paralel olarak, TSSB şiddetinde azalma görüldüğü söylene bilir. Demografik değişkenler içerisinde grup farklılıklarını değerlendirmek için gruplar arası tek yönlü ANOVA analizi yapılmıştır. Sonuçlar, katılımcılardan eşleri dahil oldukları EDI’yi kabul edenler ($M = 17.48$) reddeden gruba göre ($M = 21.61$)

anlamli olarak daha d̄şük TSSB semptom d̄zeyine sahip olduklarını ḡstermektedir ($F(1, 187) = 13.95, p < .01$). DI-EMI'nin dięer deęişkenler için yapılan ANOVA analizi sonuçlarına ḡre “Çift/Bireysel olarak Profesyonel Yardım” almanın istatistiksel olarak anlamli bir etkiye sahip olduęu da bulunmuştur ($F(1, 187) = 53.62, p < .001$). Beklenildięi gibi, EDİ'nin ortaya çıkmasından sonra çift ya da bireysel olarak profesyonel yardıma başvuran kişiler ($M = 11.57$) herhangi bir yardıma başvurmayan kişilere ($M = 20.97$) ḡre daha d̄şük TSSB semptom d̄zeyi bildirmişlerdir.

TSSB Semptom D̄zeyi ve Dięer Deęişkenler:

Baş etme stratejileri ve TSSB semptomları arasındaki korelasyonlara bakıldığında problem-odaklı başa çıkma ile toplam TSSB puanı ($r = -.23, p < .01$) ve aşırı uyarılma alt ölçeęi ($r = -.32, p < .01$) arasında negatif bir korelasyon vardır. Bunun aksine duygusal-odaklı başa çıkma ile toplam TSSB puanı ($r = .22, p < .01$), yeniden deneyimleme alt ölçeęi ($r = .16, p < .05$) ve kaçınma/küntlük alt ölçeęi ($r = .20, p < .01$) ile pozitif yönde bir korelasyon bulunurken aşırı uyarılma alt ölçeęi ile böyle bir ilişki görülmemiştir. Bu sonuçlar, duygusal-odaklı başa çıkmada yüksek puan alan bireylerin toplam TSSB, yeniden deneyimle ve kaçınma/küntlük alt ölçeklerinden de yüksek puanlar aldıklarını söylemektedir. TSSB d̄zeyinde başa çıkma stratejilerinin temel etkisini belirlemek için her bir katılımcı bir baş etme stratejisi içinde sınıflandırılmıştır. Yapılan grup karşılaştırması baş etme stratejilerinin TSSB puanları üzerinde farklılaştığını göstermiştir ($F(2, 186) = 4.06, p < .05$). Bunun anlamı, problem-odaklı grup ($M = 17.93$) dięer başa çıkma

gruplarından, duygu-odaklı ($\underline{M} = 19.76$) ve dolaylı başa çıkma ($\underline{M} = 20.83$), daha yüksek TSSB semptom düzeyine sahip olduğu yönündedir.

Temel olarak, PSS-SR ve COR-E arasındaki korelasyon analizleri bütün alt ölçekler için gerçekleştirilmiştir. Kaynak kaybının, toplam TSSB puanı ($\underline{r} = .28, p < .01$), yeniden deneyimle alt ölçeği ($\underline{r} = .18, p < .05$), kaçınma/küntlük alt ölçeği ($\underline{r} = .17, p < .05$) ve aşırı uyarılma alt ölçeği ($\underline{r} = .23, p < .01$) ile pozitif yönde bir korelasyon belirlenmiştir. Ayrıca COR-E kayıp alt ölçeği ile PSS-SR'ın üç alt ölçeği arasında ki korelasyon değerleri de .15 ve .34 aralığında değişmektedir. Diğer taraftan kaynak artışı ile toplam TSSB puanı ($\underline{r} = -.27, p < .01$), yeniden deneyimle alt ölçeği ($\underline{r} = -.19, p < .01$), kaçınma/küntlük alt ölçeği ($\underline{r} = -.18, p < .05$) ve uyarılma alt ölçeği ($\underline{r} = -.23, p < .01$) arasında negatif yönde korelasyon olduğu gözlenmiştir. TSSB semptom düzeyi üzerinde kaynak kaybı ve artışının temel etkisini belirlemek için her bir katılımcı kaynak grupları içerisinde sınıflandırılmıştır (Kayıp ve Artış). Yapılan grup karşılaştırması toplam TSSB puanı üzerinde kaynak gruplarının istatistiksel olarak anlamlı düzeyde farklılaştığını göstermiştir ($F(1, 187) = 7.10, p < .01$). Sonuçlara bakıldığında, kaynak kaybı grubu ($\underline{M} = 20.68$) kaynak artışı grubundan ($\underline{M} = 17.74$) daha yüksek TSSB puanına sahiptirler. Bu farklılık TSSB alt ölçeklerinden yeniden deneyimleme alt ölçeği ($F[1, 187] = 4.46, p < .05$) ve aşırı uyarılma alt ölçeği ($F[1, 187] = 5.68, p < .05$) içinde gözlenmiştir.

Diğer yandan, FI ve PSS-SR arasındaki korelasyon sonuçları I. Evre'nin (etki) toplam TSSB puanı ($\underline{r} = .38, p < .01$), yeniden deneyimleme alt ölçeği ($\underline{r} = .26, p < .01$), kaçınma/küntlük alt ölçeği ($\underline{r} = .27, p < .01$) ve aşırı uyarılma alt ölçeği ($\underline{r} = .33, p < .01$) ile anlamlı düzeyde korelasyonlara sahip

olduğunu göstermektedir. Diğer yandan, II. Evre (sorgulama) ile toplam TSSB puanı ($r = .24, p < .01$), yeniden deneyimleme alt ölçeği ($r = .24, p < .01$) ve aşırı uyarılma alt ölçeği ($r = .18, p < .05$) arasında pozitif yönde korelasyon gösterdiği bulunmuştur. Bunların aksi yönünde, III. Evre (iyileşme) ile toplam TSSB puanı ($r = -.31, p < .01$), yeniden deneyimleme alt ölçeği ($r = -.27, p < .01$), kaçınma/küntlük alt ölçeği ($r = -.17, p < .05$) ve aşırı uyarılma alt ölçeği ($r = -.28, p < .01$) arasında negatif yönde anlamlı ilişkilerin olduğu belirlenmiştir. TSSB semptom düzeyi üzerinde afetme evrelerinin temel etkisini desteklemek amacıyla katılımcılar afetme evreleri içerisine gruplandırılmıştır. Karşılaştırma sonuçlarına bakıldığında, toplam TSSB puanı üzerinde afetme evrelerinin istatistiksel olarak anlamlı bir etkisi görülmektedir ($F(2, 186) = 8.28, p < .001$). Bu sonuçlar, I. Evre ($M = 22.01$) içerisinde olan katılımcıların II. Evre ($M = 19.05$) ve III. Evre ($M = 16.72$) içerisinde olan katılımcılardan daha yüksek TSSB puanına sahip olduğunu destekler niteliktedir. Sonuçlar TSSB üç alt ölçeği için de anlamlı düzeydedir; yeniden deneyimleme alt ölçeği ($F(2, 186) = 4.72, p < .01$), kaçınma/küntlük alt ölçeği ($F(2, 186) = 3.15, p < .05$) ve aşırı uyarılma alt ölçeği ($F(2, 186) = 8.69, p < .001$).

TSSB Semptom Düzeyinin Yordayıcıları:

Yordayıcıları belirlemeye dönük yapılan aşamalı çoklu regresyon analiz sonuçlarında, duygusal odaklı başa çıkma TSSB semptom düzeyi ile pozitif yönde ilişkili bulunmuştur. Diğer taraftan kaynak artışı toplam TSSB ile negatif korelasyona sahipken, I. Evre-Etki pozitif korelasyona sahip olduğu görülmüştür. Demografik verilere göre, profesyonel yardıma sahip olmak toplam TSSB semptom düzeyi ile negatif bir korelasyona sahipken, dahil olan

eşin ilk tepkisi negatif korelasyona sahiptir. Özellikle “profesyonel yardıma sahip olmak” verisi toplam TSSB semptom düzeyi ile en yüksek korelasyon değerini göstermektedir. Diğer bir deyişle, profesyonel yardım almak düşük TSSB toplam belirti şiddetini yordamaktadır. Regresyon analizinin önerdiği ve yukarıdaki değişkenleri içeren son model toplam varyansın % 46’sını açıklamaktadır.

TARTIŞMA

Bu çalışmada cevap aranan temel sorulardan birisi: “Evlilik dışı ilişki ortaya çıktıktan sonra aldatılan eşler TSSB semptomlarını sergilemekte midir?” Betimsel istatistikler katılımcıların % 34.4’ünün TSSB tanısı almak için gereken DSM-IV kriterlerini tamamladıklarını göstermektedir. Travma alanındaki epidemiyoloji çalışmalarının gösterdiği TSSB oranına (% 10’dan daha az) göre yüksek sayılabilecek bu değer, aldatma durumunda incinen eşin temel tetikleyicisi (eşin kendisi) ile birlikte devam etmesiyle açıklana bilir. Yine tüm katılımcıların kadın olması da bu oranı ortalamadan yüksek olmasında etken olabileceği düşünülmektedir. Bu sonuçlara paralel olarak, birçok klinisyen ve araştırmacı evlilik dışı ilişkinin ortaya çıkmasını travma olarak ele almakta ve bunun etkilerini gözlemektedir (Snyder, Baucom, & Gordon, 2007; Whisman & Wagers, 2005). Ancak aldatılan eşlerin travmatik tepkilerini inceleyen sınırlı sayıda araştırma bulunmaktadır. İlgili literatürdeki açığa ışık tutan bu tez çalışması, aldatılan eşlerin TSSB tanı kriterlerini karşıladığını destekleyen nicel veriler sunmaktadır. Daha detaylı bakıldığında, katılımcıların % 51.9 ($n = 98$) A1 kriterini, % 93.7’si ($n = 177$) ise A2 kriterini doldurmuşlardır. Toplamda % 50.7 katılımcı ($n = 95$) TSSB için A kriterini

karşılmaktadır. DSM-IV’de (APA, 2000) travmatik bir olayın iki komponenti tanımlanmıştır: (1) katastrofik bir olaya maruz kalma (A1 kriteri); ve (2) Maruz kalma nedeniyle duygusal sıkıntı (A2 kriteri). A1 kriteri TSSB’nin belirleyicisi olduğu belirtilmesine karşın (Breslau & Kessler, 2001), teorik ve ampirik destek daha çok A2 kriterinin önemi üzerinedir. Son zamanlardaki araştırmalar, DSM-IV travma tanımının sınırlılıklarını tartışmaya başlamışlardır. Gold ve arkadaşları (2005) DSM-IV tarafından travma olarak tanımlanan ve tanımlanmayan negatif yaşam olaylarının TSSB semptom düzeylerini karşılaştırmış ve A1 kriterine göre travma olarak tanımlanmayan olaylara maruz kalanların daha yoğun TSSB gösterdiğini belirlemiştir. Bu çalışma doğrultusunda, Boals ve Schuettler (2009) de benzer bir karşılaştırmayı A2 kriterini ekleyerek gerçekleştirmiştir. Sonuçlar A1 kriteri ile TSSB semptomları arasında anlamlı ilişki bulunmamasına karşın, A2 kriterinin ilişkili olduğu gösterilmiştir. Bu bulgularla tutarlı olarak, yürütülen bu tez çalışmada da katılımcıların yaklaşık % 94’ü A2 kriterini karşılamışlardır. Özellikle “çaresizlik hissi” aldatılan eşlerin ortak tepkisi olarak belirlenmiştir.

İlgili literatürle tutarlı olarak, bu çalışmada problem-odaklı ve duygu-odaklı başa çıkma stratejileri ile TSSB düzeyi arasında ters yönde ilişki saptanmıştır. Problem-odaklı başa çıkma toplam TSSB semptom düzeyi ile negatif yönde ilişki gösterirken, duygu-odaklı başa çıkma stratejisi ile pozitif yönde bir ilişkisi vardır. Bunun anlamı, bireyler duygu-odaklı başa çıkmadan yüksek puanlar aldıklarında, aynı zamanda TSSB semptom düzeyinde de yüksek puan almaktadırlar. Diğer yandan problem-odaklı başa çıkmadan yüksek puanlar aldıkları zaman TSSB semptom düzeyinden düşük puan aldıkları gözlenir. Bu çalışmanın sonuçlarıyla tutarlı olarak, duygusal başa

çıkma stratejilerinin yüksek TSSB oranları ile sonuçlandığı değerlendirilmesi genel olarak kabul görmektedir (Gil, 2005; Gavranidou & Rosner, 2003).

Bilişsel-davranışsal baş etme stratejileri yanı sıra, kaynak kaybı toplam TSSB semptom düzeyi, yeniden deneyimleme alt ölçeği, kaçınma/küntlük alt ölçeği ve aşırı uyarılma alt ölçeği ile pozitif yönde bir ilişkiye sahipken, kaynak artışı bu ölçeklerle negatif yönde bir ilişkiye sahiptir. Bu sonuçlar *“kaynakların kaybedilmesi, kaynak kazanılmasından orantısız olarak daha belirgindir”* (Hobfoll, 2001; p. 62) olarak tanımlanan COR teorisinin birincil ve en önemli prensibi ile açıklanabilir. Sonuçlar göstermektedir ki, kaynak kaybı olarak kategorize edilen grup kaynak artışı olarak kategorize gruptan daha yüksek toplam TSSB semptom düzeyine sahiptir. Bu sonuçlar stresle ilgili literatürde yer alan çalışmalarla paralellik göstermektedir. COR teorisine göre, kaynak kaybı, kaynakların ya da kaynak artışının tehdidi psikolojik sıkıntı ile sonuçlanmakta ve bu durum depresyon ve TSSB gibi problemler doğurmaktadır (Benight ve ark., 1999; Ironson ve ark., 1997). Bu noktada, özellikle kaynak kaybı, felaket (örn., sel, kasırga ve deprem) sonrası akıl sağlığını yitirmenin önemli bir yordayıcısı olarak tanımlanmaktadır. Bu tez çalışmasında da bulgular, aldatılan eşlerin TSSB semptom düzeyi kaynaklarında büyük kayıplar yaşayan kişilerle karşılaştırıldığında daha düşük gerçekleşir. Bu açıdan, mevcut çalışmada elde edilen bulgular COR teorisi tarafından gösterilen kaynak ve TSSB arasındaki teorik bağlantıları destekler niteliktedir.

Affetme ile ilgili sonuçlara bakıldığında, I. Evre-Etki, toplam TSSB puanı, yeniden deneyimleme alt ölçeği, kaçınma/küntlük alt ölçeği ve aşırı uyarılma alt ölçeği ile pozitif yönde bir ilişkiye sahiptir. Buna paralel olarak, II.

Evre-Sorgulama da toplam TSSB puanı, yeniden deneyimleme alt ölçeği ve aşırı uyarılma alt ölçeği ile pozitif yönde ilişkiye sahiptir. Aksi yönde, III. Evre-İyileşme toplam TSSB puanı, yeniden deneyimleme alt ölçeği, kaçınma/küntlük alt ölçeği ve aşırı uyarılma alt ölçeği ile negatif yönde ilişkide olduğu görülmüştür. Grup karşılaştırma analizlerinde, I. Evredeki grup en yüksek düzeyde TSSB gösterirken III. Evredeki grubun en düşük düzeyi sergilediği gözlenmiştir. Mevcut çalışmanın bu sonuçları, affetmeyle ilgili literatürde yer alan bulgular tarafından da desteklenmektedir. Bu alanda, affetme düzeyinin artması travma semptomlarının azalmasına yardım edebileceği görüşü genel olarak kabul edilmektedir (Gordon, Snyder, & Baucom, 2005).

Son olarak aşamalı çoklu regresyon analizi göstermektedir ki, toplam TSSB semptom düzeyi ve duygu-odaklı başa çıkma arasında pozitif yönde bir ilişki, kaynak artışı ile negatif bir ilişki, ve I. Evre-Etki ile de yine pozitif yönde bir ilişki belirlenmiştir. Regresyon analizinin önerdiği modele giren demografik değişkenlerden profesyonel yardım almak toplam TSSB semptom düzeyi ile negatif bir ilişkiye sahipken ilgili eşin ilk tepkisi (kabul-red) negatif korelasyona sahip olduğu görülmüştür. Bunun anlamı, dahil olan eş tarafından evlilik dışı ilişkinin kabul edilmesi aldatılan eşin TSSB semptom düzeyini belirlemektedir. Tüm bu değişkenler birlikte, toplam varyansın % 46'sını açıklamaktadır. Bu sonuçlar bir önceki analizler ve bulgulara paraleldir.

SONUÇ

Aldatma literatürü ışığında, bu çalışmanın amacı, evlilik dışı ilişkinin aldatılan eş üstündeki travmatik etkilerinin incelemek kadar, TSSB semptom düzeyinin yordayıcılarını da (baş etme stratejileri, kaynaklar ve affetme) belirlemektir. Buna ek olarak yine bu çalışmanın diğer bir amacı da TSSB semptom düzeyine etken demografik değişkenleri (aldatma tipi, aldatma süresi, önceki aldatma deneyimleri vs.) belirlemektir. EDİ'nin kişiler arası bir travma olarak değerlendirilmesi ve aldatılan eşler üzerinde travmatik etkileri yaygın olarak kabul edilmektedir. EDİ ile incinen eşlerin TSSB benzeri belirtiler göstermesi üzerinde güçlü bir fikir birliği olmasına rağmen bununla ilgili sınırlı sayıda çalışma olması, mevcut tez çalışmasının çıkış noktasıdır. Bu tez çalışmasının sonuçları da aldatılan eşlerin travmatize olduğuyla ilgili genel kabulü destekler bulgular sunmaktadır. Araştırmanın sonuçlarına göre, aldatılan eşlerin yaklaşık % 35'i DSM-IV'ün TSSB tanı kriterlerini karşıladığı görülmüştür. Travma literatürü ile uyumlu olarak, toplam TSSB semptom düzeyi ve onun grupları (yeniden deneyimleme, kaçınma/küntlük ve aşırı uyarılma) duygu-odaklı başa çıkma strateji, kaynak artışı ve I. Evre affetme tarafından yordanmaktadır.

APPENDIX H CURRICULUM VITAE

PERSONAL INFORMATION

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EDUCATION

2004-present Ph.D. candidate in Clinical Psychology
Middle East Technical University
Dissertation Title: “The predictors of the traumatic effects of extramarital infidelity on married women: Coping strategies, resource, and forgiveness”
(Committee: Prof. Hürol Fıfılođlu (advisor), Prof. Esin Tezer, Prof. Tülin Gençöz, Assist. Prof. Belgin Ayvařık, Assist. Prof. řennur Kıřlak)

2000-2002 M.S. in Psychology
Istanbul University
Dissertation Title: “Communication Efficiency and Expressed Emotion in Schizophrenic Families”

1994-1998 B.A. in Psychology
İstanbul University

RESEARCH INTERESTES

- Marriage and Family Therapy
- Infidelity, Premarital and Marital Enhancement, and Couples’ Life
- Trauma and EMDR
- Sport Psychology and Performance Enhancement
- Expressed Emotion and Communication Theories

ACADEMIC/WORK EXPERIENCES

- 2009-cont. Psychotherapist and Partner – **İNDA Çözüm Odaklı Danışmanlık ve Eğitim Merkezi**
- Conducting individuals and couples psychotherapy using strategic and solution-focesed family therapy, and EMDR Therapy
 - Facilitator and Supervisor in Training Programs
- 2004-2009 Psychotherapist – **Davranış Bilimleri Enstitüsü**
- Conducting individuals and couples psychotherapy using strategic and solution-focesed family therapy, and EMDR Therapy
 - Facilitator and Supervisor in Training Programs
- 2002-2004 Research assisstant – **The Center for Family Education and Research at NY State Psychiatric Institute (PI)**
- Working a special project called “HOPE-NY”. The objective of the project is to implement and assessed a multi-session psychoeducational intervention program targeting victims affected by the September 11 attacks
 - Working on psychoeducational programs, involving in all aspect of data analysis and active participant on the coding team. Supervised by Helle Thorning, MS., CSW.
- 2000-2002 Research assisstant – **Department of Psychology, Istanbul University**

PUBLICATIONS

- Özgün, S. (2006). Modernization of the Communication Conflict Situation Method and Validity of the New Version: The Computerized Method for Communication Researches, *Journal of Psychology Studies*, 26, Istanbul University Press.
- Özgün, S. & Gençöz, T. (submitted). Psychometric Properties of the Conservation of Resources Evaluation in a Turkish Sample.

PROFESSIONAL PRESENTATIONS

Özgün, S. & Fışiloğlu, H. (2009). *An Old Topic, a New Perspective: Extramarital Affair as an Interpersonal Trauma*. Oral Presentation at the 5th National Family and Marriage Therapies Congress, İstanbul, Turkey.

Konuk, E., Özgün, S. & et al. (2009). *Perceptions of Individuals Who Have High Marital Adjustment and Individuals Who Are Divorced Towards Personality Traits of Their Partners*. Oral Presentation at the 17th World IFTA (International Family Therapy Association), Lubiana, Slovenia.

Konuk, E., Özgün, S. & et al. (2009). *The Comparison Between Married and Divorced Individuals In Terms of Their Socio-Economical and Cultural Variables*. Oral Presentation at the 11th European Congress of Psychology, EFPA (European Federation of Psychologists' Associations), Oslo, Norwegian.

Konuk, E., Özgün, S. & et al. (2007). *The New Assessment Tool for Premarital Counseling: Relationship Evaluation Inventory (IDE)*. Oral Presentation at the 4th National Marriage and Family Therapy Congress, İstanbul, Turkey.

Özgün, S., Konuk, E. & Gören, S. (2006). *The Relationship Between Personality and Workers' Satisfaction*. Oral Presentation at the 14th National Congress of Psychology, Ankara, Turkey.

Özgün, S., Pamuk, S. & et al. (2006). *Use of EMDR for Enhancing Effects of Relaxation and Imagery in a Performance Enhancement Study of Coaches and Adolescent Volleyball Players*. Oral Presentation at the 7th EMDR European Congresses, İstanbul, Turkey.

Özgün, S., Narter, M. & et al. (2004). *The Effect of Social Categorization Process on the Communication Efficiency Parameters*. Oral Presentation at the 13th National Congress of Psychology, İstanbul, Turkey.

Özgün, S. (March 2003). *Communication Efficiency and Expressed Emotion in Schizophrenic Families*. Oral Presentation at the 2nd National Marriage and Family Therapy Congress, İstanbul, Turkey.

Aycicegi, A. & Özgün, S. (September 2002). *Is This Communication Efficiency or Frontal Activity?* Oral Presentation at the 12th National Congress of Psychology, Ankara, Turkey.

PROFESSIONAL TRAININGS

- 2007 – cont. Sex Therapy Training, Sexual Education, Therapy and Research Association (CETAD), Istanbul
- 2006 - 2008 EMDR Facilitator Training, Humanitarian Assistance Programs, İstanbul
- 2004 - Trauma Based Family Therapy, National Mental Health Association and presented by Hardy, K.,PhD, New York
- 2003 – 2004 International Trauma Studies Program, (Post-Graduate Program), Supervised by Jack Soul, PhD, New York University, New York
- 2003 – 2004 Family Therapy Live Clinical Supervision, (Post-Graduate Program), Supervised by Dee-Watt Jones, PhD, Ackerman Institute for the Family, New York.
- 2002 – 2003 Foundations in Family Therapy, (Post-Graduate Program), Ackerman Institute for the Family, New York.
- 2003 – Enhancing Your Clinical Creativity, Papp, P., MSW, Ackerman Institute for the Family, New York.

LANGUAGES

Turkish (native)

English (advanced)