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The Influence of Childhood Trauma on Quality of Life and Marital Harmony*

Çocukluk Çağı Travmalarının Yaşam Kalitesi ve Evlilik Uyumuna Etkisi

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Abstract

This study aims to explore the impact of childhood traumatic experiences on both the quality of life and marital adjustment within married couples. Additionally, it seeks to ascertain whether variations exist in the quality of life and marital adjustment of married couples based on specific variables related to their childhood traumatic experiences. A total of 103 married couples (206 individuals) voluntarily participated in the study by completing online forms. Participants were asked to complete a set of instruments including a 'Sociodemographic Data Form', 'Childhood Trauma Scale', 'Quality of Life Scale', and 'Marital Adjustment Scale'. Data analysis was conducted using the SPSS 26 package program, employing various statistical techniques including the Mann-Whitney U Test, LSD Test and Spearman Correlation.

The results revealed that childhood traumatic experiences, quality of life and marital adjustment differed significantly among the participants according to the age of their spouses in the area of physical neglect; according to their psychiatric treatment history in the areas of emotional abuse, sexual abuse and physical neglect; according to their spouses' psychiatric treatment history in the areas of emotional neglect and physical neglect; according to their smoking, alcohol and substance use status in the area of marital adjustment; according to their childbearing status in the area of physical neglect. However, no significant differences were found in gender, age, education level, economic status, employment status, place of longest residence, number of years of marriage, marriage decision with spouse, and number of marriages. Finally, relationships were observed between emotional abuse and emotional neglect with marital adjustment, as well as between emotional abuse and the mental dimension.

Keywords:
Marital Adjustment, Childhood Trauma, Quality of Life, Marriage

Öz

Bu çalışma, evli çiftlerde çocukluk çağı travmatik yaşantılarının yaşam kalitesi ve evlilik uyumuna etkisini incelemek; evli çiftlerin çocukluk çağı travmatik yaşantılarının, yaşam kalitesi ve evlilik uyumlarının bazı değişkenlere göre farklılaşıp farklılaşmadığını gözlemlemek amacıyla yapılmıştır. Çalışmaya online formlar aracılığı ile gönüllü olarak 103 evli çift (206 kişi) katılım sağlamıştır.

Katılımcılara araştırmacı tarafından hazırlanmış 'Sosyodemografik Veri Formu', 'Çocukluk Çağı Travma Ölçeği', 'Yaşam Kalitesi Ölçeği' ve 'Evlilikte Uyum Ölçeği' uygulanmıştır. Verilerin çözümlenmesinde, SPSS 26 paket programı ve Student-T Testi, Anova, LSD Testi ve Spearman Korelasyon analizleri yapılmıştır.

Yapılan analizlerde çocukluk çağı travmatik yaşantıları, yaşam kalitesi ve evlilik uyumlarında katılımcıların eşlerinin yaşlarına göre, fiziksel ihmal alanında; psikiyatrik tedavi öyküsüne göre, duygusal taciz, cinsel taciz ve fiziksel ihmal alanında; eşlerinin psikiyatrik tedavi öyküsüne göre, duygusal ihmal ve fiziksel ihmal alanında; sigara, alkol ve madde kullanma durumuna göre, evlilik uyumu alanında; çocuk sahibi olma durumuna göre, fiziksel ihmal alanında anlamlı farklılıklar olduğu görülmüştür. Cinsiyet, yaş, eğitim durumu, ekonomik

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durum, çalışma durumu, en uzun yaşanan yer, kaç yıllık evli olma durumu, eşi ile evlilik kararı, kaçıncı evliliği olduğu durumlarına göre ise anlamlı farklılık saptanmamıştır. Son olarak, duygusal taciz ve duygusal ihmal ile evlilik uyumu arasında; ayrıca duygusal taciz ile mental boyut arasında da ilişkiler olduğu görülmüştür.

Anahtar Kelimeler:
Evlilik Uyumu, Çocukluk Çağı Travması, Yaşam Kalitesi, Evlilik

INTRODUCTION

It is possible to observe the profound impact of childhood traumas, which are regarded as one of the most severe forms of violence experienced during the formative years of an individual's life. These traumas can have a pervasive and lasting effect on various aspects of an individual's development, including their mental health, social relationships, and psychological well-being. Specifically, childhood traumas can lead to long-term challenges such as emotional distress, difficulties in forming and maintaining healthy relationships, and an increased risk of mental health disorders. As a result, these adverse experiences can significantly influence their overall quality of life, affecting their ability to function effectively in daily life, achieve personal and professional goals, and experience a sense of fulfillment and well-being.

Trauma encompasses various experiences, including direct personal exposure, witnessing traumatic events involving others, or repeated exposure to distressing details as part of professional duties, as well as instances of sexual assault (DSM-5, 2013). Examples of traumatic experiences, as outlined by Aker (2012), include natural disasters like earthquakes or floods, physical or sexual assault, fires, explosions, the loss of a loved one, life-threatening illnesses, and adverse childhood events such as neglect, abuse, violence, and harassment. Childhood traumas specifically refer to emotional, physical, sexual abuse, and neglect endured before the age of 18 (Herman, 1992).

Childhood traumas (CST) profoundly impact child development across various domains including behavioral, emotional, physical, social, and cognitive aspects (Carr et al., 2013). Due to their developing brains, children are particularly vulnerable to traumatic experiences and often lack the coping mechanisms to manage them effectively. Consequently, children are more susceptible to the effects of trauma compared to adults. Early-life experiences that induce negative stress can have lasting detrimental effects on the developing brain. It's observed that children who have experienced trauma often continue to grapple with its effects into the future, seeking treatment for various related complaints (Perry and Szalavitz, 2012).

According to Carr et al. (2013), individuals who have endured traumatic experiences during childhood may not necessarily exhibit symptoms directly linked to the event. However, certain indicators may manifest in both childhood and adulthood. These signs include feelings of guilt, diminished self-confidence and self-esteem, a sense of lost innocence and shattered dreams, impaired social skills, hostility and anger, anxiety, depression, fear, recurring memories of the traumatic event, as well as challenges in romantic relationships and sexual intimacy.

Childhood traumatic experiences, due to their profound and enduring impact, can have

significant effects on various aspects of an individual's life, both in the short term and over the long term. These traumatic experiences, which may include physical, emotional, or psychological abuse, can deeply affect an individual's emotional and psychological development. In the short term, they may lead to immediate challenges such as increased anxiety, depression, and difficulty in managing emotions. Over the long term, the effects can be even more far-reaching, potentially leading to persistent mental health issues, difficulties in forming and maintaining healthy relationships, and challenges in achieving personal and professional goals.

When it comes to marital adjustment, individuals who have experienced childhood trauma may face unique challenges. The emotional and psychological scars left by such traumas can influence how they perceive and interact with their partners. Issues such as trust, intimacy, and communication can be particularly affected, which may result in difficulties in achieving marital satisfaction and stability. Additionally, unresolved trauma can contribute to ongoing conflicts and stress within the marriage, further impacting the overall quality of life and marital adjustment. Therefore, addressing and working through childhood traumatic experiences is crucial for improving both individual well-being and relational dynamics.

Quality of life holds significance across various fields of study, characterized by its subjective assessment by individuals. It stands as a universal concept, a notion that finds resonance in Maslow's hierarchy of needs.

According to Abraham Maslow's hierarchy of needs theory published in most well-known work, *"Motivation and Personality"* in 1970, individuals are motivated by a series of needs arranged in a hierarchical order. This theory posits that basic physiological needs must be met before higher-level psychological needs, such as esteem and self-actualization, can become the focus of motivation (Maslow, 1970). While Maslow primarily focuses on the quantitative fulfillment of these needs, quality of life emphasizes both quantitative and qualitative aspects. Thus, quality of life emerges from the satisfaction derived from fulfilling both quantitative and qualitative needs. For instance, one's satisfaction with their material well-being holds more weight than the mere possession of material resources, and the quality of life outweighs the duration of life itself (Boylu and Paçacıoğlu, 2016).

As per Torlak and Yavuzçehre, quality of life encompasses both objective and subjective dimensions. Objectively, it entails physical well-being, while subjectively, it encompasses mental and emotional well-being. Objective indicators include financial income, educational attainment, occupation, living conditions, health status, and similar factors. Conversely, subjective indicators gauge an individual's satisfaction with these opportunities and circumstances, reflecting their perception of their quality of life (Torlak and Yavuzçehre, 2008). In addition to these aspects of overall well-being, marital adjustment plays a crucial role in shaping one's quality of life, particularly within the context of personal relationships.

Marital adjustment stands as a fundamental determinant of the quality and longevity of marital relationships. It encapsulates the spouses' capacity to engage in shared activities, collaborate on decision-making, and experience satisfaction and happiness within their marriage. In essence, marital adjustment reflects the harmony and contentment achieved by both partners in their relationship (Erbek et al., 2005).

Extensive research in the literature has delved into the numerous factors that influence marital adjustment among married individuals. These studies consistently highlight that exposure to childhood trauma has a profoundly negative impact on marital adjustment. Childhood trauma, which can encompass various forms of abuse, neglect, or other adverse experiences, often leaves lasting psychological scars. These unresolved issues can significantly affect how individuals interact with their partners in adulthood.

For instance, individuals who experienced trauma during their formative years may struggle with trust issues, emotional regulation, and intimacy in their marital relationships. They may also exhibit heightened levels of anxiety or depression, which can further strain their ability to maintain a healthy and satisfying marriage. Research has shown that these individuals are more likely to encounter difficulties in communication, experience conflicts more frequently, and face challenges in forming and sustaining emotional bonds with their spouses.

Moreover, the impact of childhood trauma on marital adjustment is not limited to the individuals directly affected; it can also influence the dynamics within the marriage, affecting both partners. Consequently, addressing the lingering effects of childhood trauma is crucial for improving marital adjustment and fostering healthier, more resilient relationships. Therefore, comprehensive therapeutic interventions and support systems are essential for individuals seeking to overcome the detrimental effects of early trauma and achieve greater marital satisfaction (Erbek et al., 2005).

Based on the insights provided, the objective of this study is to investigate the impact of childhood traumatic experiences on both quality of life and marital adjustment. Additionally, the study aims to explore potential variations in childhood traumatic experiences, quality of life, and marital adjustment across different variables.

To achieve these objectives, the study proposes the following hypotheses:

Hypothesis 1: Individuals who report higher levels of childhood traumatic experiences will exhibit lower levels of quality of life compared to those with fewer or no reported traumatic experiences.

Hypothesis 2: There will be a negative correlation between childhood traumatic experiences and marital adjustment. Specifically, individuals with a history of significant childhood trauma are expected to show poorer marital adjustment, characterized by reduced satisfaction and increased conflict within their relationships.

Hypothesis 3: The impact of childhood trauma on quality of life and marital adjustment will vary across different demographic variables, such as age, gender, and socio-economic status.

METHOD

This article is produced from the thesis titled 'The Effect of Childhood Traumatic Experiences on Quality of Life and Marital Adjustment'. The necessary ethics committee approval for the thesis study was received from the Uskudar University Graduate Education Institute Directorate on 31.12.2020.

Participants

The study comprised a total of 206 married individuals, with an equal distribution of 103 women and 103 men, ranging in age from 20 to 50 years. Participants were recruited via online announcements utilizing the convenience sampling method.

Regarding the age distribution of participants, 19.4% (n=40) were aged between 20 and 29, 22.8% (n=47) between 30 and 39, 28.6% (n=59) between 40 and 49, and 29.1% (n=60) were 50 years or older. In terms of the age of their spouses, 12.1% (n=25) were aged between 20 and 29, 31.1% (n=64) between 30 and 39, 34.0% (n=70) between 40 and 49, and 22.8% (n=47) were 50 years or older.

Regarding socioeconomic status, the majority of respondents had attained a high school education or above, with an economic income level predominantly in the middle range.

Marriage duration varied among participants, with 27.2% (n=56) married for 0-5 years, 19.9% for 6-15 years, 25.2% (n=52) for 16-25 years, and 27.7% (n=57) for 26 years or more.

Measurement Tools

In this study, several data collection tools were employed after obtaining informed consent from the participants. The tools included:

1. Sociodemographic Data Form (SDVF): This form gathered information about participants' sociodemographic characteristics such as age, gender, economic status, employment status, educational level, marital decision-making, parenthood status, number of children, duration of marriage, psychiatric diagnoses, and duration of treatment. The form was prepared by the researcher.

2. Childhood Trauma Questionnaire (CTQ-28): The CTQ-28 was utilized to retrospectively and quantitatively assess experiences of abuse and neglect before the age of 20. Originally developed by Bernstein et al. (1994) and adapted into Turkish by Şar in 1996 (Aydemir ve Köroğlu, 2012). Subsequently, a study was conducted by Şar, Öztürk, and İkikardeş (2012) to determine the validity and reliability. The CTQ-28 consists of 28 items measured on a 5-point Likert-type scale. The scale includes five subscales corresponding to physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect. Responses range from "never" to "often," with higher scores indicating greater frequency of traumatic experiences (Şar et al., 2012). In the study "Validity and reliability of the Turkish adaptation of the childhood psychological trauma scale", The Cronbach's alpha value indicating the internal consistency of the scale was found to be 0.93 for the entire group of participants (N=123). In this current study, The Childhood Trauma Questionnaire (CTQ) subscale Cronbach's alpha coefficients were calculated as follows: "Emotional Abuse 0.66," "Physical Abuse 0.81," "Physical Neglect 0.65," "Emotional Neglect 0.78," and "Sexual Abuse 0.86." Based on these results, the measurement is also deemed reliable.

3. The SF-36 Quality of Life Scale: The SF-36 Quality of Life Scale, developed by Ware et al. (1989), stands as one of the most widely utilized generic scales for assessing quality of life. This scale offers distinct advantages compared to other generic scales, as it comprehensively evaluates both negative and positive aspects of health status and can be completed

swiftly. Consisting of 36 items, the scale measures two main dimensions and eight sub-dimensions, as outlined by Ware and Sherbourne (1992) and Pınar (1995).

The two main dimensions and their corresponding sub-dimensions in the SF-36 are:

- Physical Dimension: Physical function, role limitations due to physical health problems, bodily pain, energy/vitality, general health perception.

- Mental Dimension: Social functioning, role limitations due to emotional problems, mental health, energy/vitality, general health perception.

The scale employs Likert-type scoring, with 35 of the 36 statements assessing the respondents' health status over the past four weeks. The one exception is the statement "Compared to one year ago, how do you find your current health?", which evaluates the perception of health change over the past 12 months and is not factored into the overall evaluation.

While the SF-36 does not yield a single total score, scores are calculated separately for each dimension. Scores for each sub-dimension and the two main dimensions range from 0 to 100. The scoring system is positive, meaning that higher scores on each dimension indicate better health-related quality of life. For instance, a high score on the pain scale signifies lower levels of pain.

To calculate the scores for the main dimensions, the scores of the sub-dimensions within each main dimension are summed and then divided by the number of dimensions. For example, when determining the score for the physical dimension, the scores for physical function, role limitations due to physical health problems, bodily pain, energy/vitality, and general health perception are added together and divided by 5. It's noteworthy that general health perception and energy/vitality are considered in both main dimensions (Ware & Sherbourne, 1992; Pınar, 1995).

The reliability and validity of the scale in Turkish were assessed by Koçyiğit et al. (1999). In this study, to determine the reliability and validity of the SF-36 in Turkish, 50 patients with osteoarthritis and 50 patients with chronic low back pain were evaluated. In addition to the SF-36, the Nottingham Health Profile was used. In the reliability studies, the Cronbach's alpha coefficients for each subscale were calculated separately and were found to range between 0.7324 and 0.7612. In addition, in the validity study, a multitrait-multimethod matrix was applied, and the correlation coefficients were found to range between 0.44 and 0.65. As a result, it was determined that the SF-36 is reliable and valid in Turkish and can be used with chronic physical patient groups.

However, in the current study, the Cronbach Alpha coefficient for the sub-dimensions of the Quality of Life Scale was calculated as "Physical Dimension 0.43" and "Mental Dimension 0.16". It is shown that it has poor reliability in physical dimension and not reliable in mental dimension.

4. Marital Adjustment Test (MAT): The scale in question, developed by Locke and Wallace in 1959, which is a 15-item measure of marital adjustment, relationship style, and commitment, underwent reliability and validity testing conducted by Tutarel-Kışlak in 1999. This study shows that the Cronbach's alpha coefficients are above 0.80. So, reliability

results of the original scale is good. Additionally, the Cronbach's Alpha coefficient in the current study for the marital adjustment scale was calculated to be 0.74, indicating good internal consistency reliability.

The scale consists of two factors. The first factor includes the first 9 items and is related to societal norms and general adjustment, as well as agreement on sexuality issues. The second factor includes 6 items and is associated with leisure activities, conflict resolution, sense of security, and relationship patterns (Tutarel-Kışlak, 1999).

Participants' scores on this scale can range from 0 to 58, with a score of 43 serving as the threshold distinguishing between compatible and incompatible marital relationships. Those scoring 43 or higher are deemed to have compatible marriages, while those scoring below 43 are considered to have incompatible marriages (Büyükşahin, 2004).

Data Analysis

The obtained data were analyzed using the SPSS 26 program. Descriptive statistical methods, including mean, standard deviation, median, frequency, percentage, minimum, and maximum, were employed to evaluate the study data.

To assess the normality of the data distribution, the Skewness and Kurtosis Normality Test was conducted. Based on the results of this analysis, it was determined that the data did not meet the conditions for normal distribution. Consequently, non-parametric statistical tests were utilized for further analysis.

For comparisons between two groups, the Mann-Whitney U Test was employed, while the Kruskal-Wallis Test was used for comparisons involving more than two groups.

Finally, to examine the relationships between variables, Spearman correlation analysis was conducted. These statistical techniques allowed for a comprehensive exploration of the data and relationships between variables, considering the non-normal distribution of the data.

RESULTS

The findings from the analyses regarding the impact of childhood traumatic experiences on quality of life and marital adjustment, as well as potential differences across various variables, are summarized in tables and discussed below.

Findings of Sociodemographic Data

Table 1 provides sociodemographic information such as gender, age, child status, educational status, economic status, employment status, place of residence, history of psychiatric treatment, smoking, alcohol, and substance use.

Table 1. Descriptive Statistics of Sociodemographic Data

		n	%n
Gender	Male	103	50,0
	Female	103	50,0
Age	20-29 years old	40	19,4
	30-39 years old	47	22,8
	40-49 years old	59	28,6
	50 years or older	60	29,1
Spouse's Age	20-29 years old	25	12,1
	30-39 years old	64	31,1
	40-49 years old	70	34,0
	50 years or older	47	22,8
Number of Children	No children	39	18,9
	1 child	49	23,8
	2 children	75	36,4
	3 children or more	43	20,9
Education	Primary school	10	4,9
	Middle school	14	6,8
	High school	63	30,6
	Undergraduate	96	46,6
	Master's or Doctorate	23	11,2
Spouse's Education	Primary school	42	20,4
	Middle school	20	9,7
	High school	56	27,2
	Undergraduate	74	35,9
	Master's or Doctorate	14	6,8
Financial Status	Poor	1	0,5
	Average	112	54,4
	Good	90	43,7
	Very good	3	1,5
Total		**206**	**100,0**

Table 1. (Continued) Descriptive Statistics of Sociodemographic Data

		n	% n
Employment Status	Never worked	8	3,9
	Resigned	44	21,4
	Part-time employee	18	8,3
	Full-time employee	136	66,5
Where did you live for the longest time?	Village	2	1.0
	Town	3	1,5
	City	46	22,3
	Metropolitan	155	75,2
History of Psychiatric Treatment	Yes	34	16,5
	No	172	83,5
Spouse's History of Psychiatric Treatment	Yes	22	10,7
	No	184	89,3
Smoking, Alcohol/ Substance Consumption	No	136	66,0
	Smoking	60	29,1
	Alcohol consumption	7	3,4
	Smoking and alcohol consumption	3	1,5
Duration of Marriage	0-5 years	56	27,2
	6-15 years	41	19,9
	16-25 years	52	25,2
	26 years and over	57	27,7
Number of Children	No children	39	18,9
	1 child	49	23,8
	2 children	75	36,4
	3 children or more	43	20,9
Number of Residents at Home (incl. Respondent)	1 person	6	2,9
	2 people	45	21,8
	3 people	72	35,0
	4 people	59	28,6
	5 people	20	9,7
	6 people or more	4	1,9
How respondent married their spouse	Running away	4	1,9
	Arranged marriage	61	29,6
	Meeting/flirting	141	68,4
Number of Marriages	1 marriage	194	94,2
	2 marriages	11	5,3
	3 marriages	1	0,5
Number of Spouse's Marriages	1 marriage	195	94,7
	2 marriages	9	4,4
	3 marriages	2	1,0
Total		**206**	**100,0**

50% (*n*=103) of the participants were male, and 50% (*n*=103) were female. Regarding age distribution, 19.4% (*n*=40) fell within the 20 - 29 age range, 22.8% (*n*=47) were between 30 and 39, 28.6% (*n*=59) were aged 40 to 49, and 29.1% (*n*=60) were 50 years and older. In terms of parenthood, 18.9% (*n*=39) had no children, 23.8% (*n*=49) had one child, 36.4% (*n*=75) had two children, and 20.9% (*n*=43) had three or more children.

Educational attainment varied, with 4.9% (*n*=10) having completed primary school, 6.8% (*n*=14) completing secondary school, 30.6% (*n*=63) having a high school diploma, 46.6% (*n*=96) holding a bachelor's degree, and 11.2% (*n*=23) possessing a master's or doctorate degree. Economic status distribution showed that 0.5% (*n*=1) had poor income, 54.4% (*n*=112) had moderate income, 43.7% (*n*=90) had good income, and 1.5% (*n*=3) reported very good income.

Regarding employment status, 3.9% (*n*=8) had never worked, 21.4% (*n*=44) were unemployed, 8.3% (*n*=17) were semi-employed working full-time, and 66.5% (*n*=137) were employed full-time. The majority of participants (75.2%, *n*=155) resided in metropolitan cities for the longest duration, followed by 22.3% (*n*=46) in cities, 1.5% (*n*=3) in towns, and 1.0% (*n*=2) in villages.

A subset of participants, 16.5% (*n*=34), reported a history of psychiatric treatment, while 83.5% did not. In terms of substance use, 66.0% (*n*=136) reported no smoking, alcohol, or substance use, 29.1% (*n*=60) reported smoking, 3.4% (*n*=7) reported alcohol use, and 1.5% (*n*=3) reported both smoking and alcohol use.

FINDINGS ACCORDING TO GENDER VARIABLE

The results of Mann-Whitney U analyses revealed no significant difference in the sub-dimensions of childhood traumas scale, including emotional abuse (p=0.52), physical abuse (p=*0.18*), physical neglect (p=0.10), emotional neglect (p=0.95), and sexual abuse (p=0.69), based on gender. Similarly, no significant difference was observed in the marital adjustment scale (p=0.07) and the mental dimension (p=0.75) and physical dimension (p=0.65) sub-dimensions of the quality of life scale across gender groups (p>0.05).

Table 2. Difference Test Results of Scales and Subscales According to Gender Variable

	Gender	n	Mean Rank	Row Total	U	Z	Sig. (P)
Emotional Abuse	Male	103	101,58	11884,50	4981,500	-0,630	0,529
	Female	103	106,03	9436,50			
Physical Abuse	Male	103	106,34	12442,00	4874,000	-1,317	0,188
	Female	103	99,76	8879,00			
Physical Neglect	Male	103	97,98	11464,00	4561,000	-1,611	0,107
	Female	103	110,75	9857,00			
Emotional Neglect	Male	103	103,28	12083,50	5180,500	-0,062	0,950
	Female	103	103,79	9237,50			
Sexual Abuse	Male	103	102,74	12021,00	5118,000	-0,390	0,697
	Female	103	104,49	9300,00			
Marital Adjustment Scale	Male	103	109,90	12858,00	4458,000	-1,769	0,077
	Female	103	95,09	8463,00			
Physical Dimension	Male	103	101,88	11919,50	5016,500	-0,449	0,654
	Female	103	105,63	9401,50			
Mental Dimension	Male	103	104,65	12244,50	5071,500	-0,319	0,750
	Female	103	101,98	9076,50			

Findings According to Age Variable

According to the results of the Kruskal-Wallis analyses conducted in the study, no significant differences were found in relation to the age variable for the subscales of the Childhood Trauma Questionnaire: Emotional Abuse (p=0.49), Physical Abuse (p=0.81), Physical Neglect (p=0.14), Emotional Neglect (p=0.23), and Sexual Abuse (p=0.70); the Marital Adjustment Scale (p=0.09); and the Quality of Life Scale's mental (p=0.64) and physical (p=0.62) dimensions (p>0.05).

Table 3. Difference Test Results of Scales and Subscales of the Sample According to Age Variables

	Age (Years)	n	Mean Rank	χ2	Sd	Sig. (P)
Emotional Abuse	20-29	40	94,08	2,395	3	0,495
	30-39	47	104,06			
	40-49	59	109,97			
	50+	60	102,98			
Physical Abuse	20-29	40	102,40	0,934	3	0,817
	30-39	47	100,30			
	40-49	59	103,46			
	50+	60	106,78			
Physical Neglect	20-29	40	118,06	5,469	3	0,140
	30-39	47	110,13			
	40-49	59	95,06			
	50+	60	96,90			
Emotional Neglect	20-29	40	111,06	4,303	3	0,231
	30-39	47	113,31			
	40-49	59	91,97			
	50+	60	102,11			
Sexual Abuse	20-29	40	103,45	1,420	3	0,701
	30-39	47	99,13			
	40-49	59	106,52			
	50+	60	103,99			
Marital Adjustment Scale	20-29	40	111,54	6,785	3	0,097
	30-39	47	104,19			
	40-49	59	85,20			
	50+	60	115,59			
Physical Dimension	20-29	40	100,18	1,743	3	0,628
	30-39	47	108,06			
	40-49	59	109,15			
	50+	60	96,58			
Mental Dimension	20-29	40	95,38	1,669	3	0,644
	30-39	47	109,88			
	40-49	59	107,11			
	50+	60	100,37			

Findings of Difference Test According to Education Level

According to the results of the Kruskal-Wallis analyses conducted in the study, no significant difference was found in the sub-dimensions of the childhood traumas scale, including emotional abuse (p=0.63), physical abuse (p=0.36), physical neglect (p=0.61), emotional

neglect (p=0.60), and sexual abuse (p=0.07), based on the education level of the sample. Likewise, the marital adjustment scale (p=0.44) and the physical dimension (p=0.07) and mental dimension (p=0.17) sub-dimensions of the quality of life scale did not show a significant difference according to the education level of the participants (p>0.05).

Similarly, in the study conducted with the spouses of the participants, no significant difference was found in the sub-dimensions of the childhood traumas scale or the marital adjustment scale based on the education level of the spouses (p>0.05).

Table 4. Difference Test Results of the Subscales of Childhood Traumas Questionnaire (CTQ), Quality of Life Scale and Marital Adjustment Scale of the Sample Regarding Education Level

	Level of Education	n	Mean Rank	χ2	Sd	Sig. (P)
Emotional Abuse	Primary	10	79,65	2,582	4	0,630
	Secondary	14	109,86			
	High School	63	105,40			
	Undergraduate	96	103,48			
	Master's or Doctorate	23	104,85			
Physical Abuse	Primary	10	99,60	4,302	4	0,367
	Secondary	14	119,43			
	High School	63	106,22			
	Undergraduate	96	101,13			
	Master's or Doctorate	23	97,93			
Physical Neglect	Primary	10	86,55	2,691	4	0,611
	Secondary	14	100,75			
	High School	63	97,72			
	Undergraduate	96	109,51			
	Master's or Doctorate	23	103,30			
Emotional Neglect	Primary	10	125,65	2,716	4	0,607
	Secondary	14	103,93			
	High School	63	96,47			
	Undergraduate	96	103,96			
	Master's or Doctorate	23	110,93			
Sexual Abuse	Primary	10	113,85	8,352	4	0,079
	Secondary	14	121,50			
	High School	63	103,69			
	Undergraduate	96	102,31			
	Master's or Doctorate	23	92,50			

Marital Adjustment Scale	Primary	10	112,50	3,696	4	0,449
	Secondary	14	118,00			
	High School	63	92,64			
	Undergraduate	96	105,66			
	Master's or Doctorate	23	111,50			
Physical Dimension	Primary	10	95,80	8,391	4	0,078
	Secondary	14	100,32			
	High School	63	100,67			
	Undergraduate	96	98,55			
	Master's or Doctorate	23	137,22			
Mental Dimension	Primary	10	84,40	6,419	4	0,170
	Secondary	14	108,14			
	High School	63	100,36			
	Undergraduate	96	100,32			
	Master's or Doctorate	23	130,85			

Findings Related to Economic Status

According to the results of the Kruskal-Wallis analyses conducted in the study, no significant difference was found in the sub-dimensions of the childhood traumas scale, including emotional abuse (p=0.43), physical abuse (p=0.84), physical neglect (p=0.37), emotional neglect (p=0.27), and sexual abuse (p=0.28), based on the economic status variable. Similarly, the marital adjustment scale (p=0.46) and the physical dimension (p=0.38) and mental dimension (p=0.57) sub-dimensions of the quality of life scale did not show a significant difference according to economic status (p>0.05).

Table 5. Difference Test Results of Scales and Subscales of the Sample According to Economic Status

	Economic Status	n	Mean Rank	χ2	Sd	Sig. (P)
Emotional Abuse	Poor	1	68,50	2,710	3	0,438
	Average	112	106,91			
	Good	90	100,82			
	Very good	3	68,50			
Physical Abuse	Poor	1	89,50	0,805	3	0,848
	Average	112	102,85			
	Good	90	104,93			
	Very good	3	89,50			
Physical Neglect	Poor	1	148,50	3,130	3	0,372
	Average	112	100,03			
	Good	90	105,82			
	Very good	3	148,50			

Emotional Neglect	Poor	1	51,00	3,850	3	0,278
	Average	112	97,30			
	Good	90	111,77			
	Very good	3	104,33			
Sexual Abuse	Poor	1	92,50	3,824	3	0,281
	Average	112	107,40			
	Good	90	99,13			
	Very good	3	92,50			
Marital Adjustment Scale	Poor	1	44,50	2,548	3	0,467
	Average	112	104,47			
	Good	90	104,36			
	Very good	3	61,17			
Physical Dimension	Poor	1	65,50	3,067	3	0,381
	Average	112	98,09			
	Good	90	111,20			
	Very good	3	87,00			
Mental Dimension	Poor	1	156,00	1,996	3	0,573
	Average	112	99,08			
	Good	90	108,33			
	Very good	3	106,17			

Findings Based on Psychiatric Treatment History

In the study, a statistically significant difference was observed in the "Childhood Traumas Scale" sub-dimensions of "Emotional Abuse" (p=0.01), "Physical Neglect" (p=0.02), and "Sexual Abuse" (p=0.03) based on the history of psychiatric treatment (p<0.05). Additionally, according to the results of Mann-Whitney U analyses, a significant difference was found in the "Childhood Traumas Scale" sub-dimensions of "Physical Neglect" (p=0.03) and "Emotional Neglect" (p=0.03) based on the history of psychiatric treatment in the spouse (p<0.05).

Table 6. Difference Test Results of Scales and Subscales Based on Psychiatric Treatment History

	Psychiatric Treatment History	**n**	**Mean Rank**	**Sum of Ranks**	**U**	**Z**	**Sig. (P)**
Emotional Abuse	Yes	34	123,47	4198,00	2245,000	-2,535	0,011
	No	172	99,55	17123,00			
Physical Abuse	Yes	34	110,40	3753,50	2689,500	-1,240	0,215
	No	172	102,14	17567,50			
Physical Neglect	Yes	34	83,99	2855,50	2260,500	-2,210	0,027
	No	172	107,36	18465,50			

Emotional Neglect	Yes	34	87,34	2969,50	2374,500	-1,761	0,078
	No	172	106,69	18351,50			
Sexual Abuse	Yes	34	114,34	3887,50	2555,500	-2,164	0,030
	No	172	101,36	17433,50			
Marital Adjustment Scale	Yes	34	97,15	3303,00	2708,000	-0,681	0,496
	No	172	104,76	18018,00			
Physical Dimension	Yes	34	98,21	3339,00	2744,000	-0,567	0,570
	No	172	104,55	17982,00			
Mental Dimension	Yes	34	100,84	3428,50	2833,500	-0,285	0,775
	No	172	104,03	17892,50			

Findings of Difference Test According to Alcohol, Substance, and Tobacco Use

According to the results of the Kruskal-Wallis analysis, there were no statistically significant differences observed in the sub-dimensions of the childhood traumas scale, including emotional abuse (p=0.09), physical abuse (p=0.10), sexual abuse (p=0.58), physical neglect (p=0.55), and emotional neglect (p=0.43), based on smoking, alcohol, and substance use (p>0.05). Similarly, no significant differences were found in the mental dimension (p=0.19) and physical dimension (p=0.15) sub-dimensions of the quality of life scale according to smoking, alcohol, and substance use (p>0.05).

It was observed that the Marital Adjustment Scale showed a statistically significant difference according to smoking, alcohol, and substance use (p=0.00, p<0.05).

Table 7. Findings of Difference Test According to Alcohol, Substance, and Tobacco Use

	Alcohol, Substance, and Tobacco Use	n	Mean Rank	$\chi 2$	Sd	Sig. (P)
Emotional Abuse	None	136	95,58	8,657	3	0,094
	Tobacco	60	118,38			
	Alcohol	7	130,50			
	Tobacco-Alcohol	3	101,67			
Physical Abuse	None	136	101,62	6,140	3	0,105
	Tobacco	60	103,39			
	Alcohol	7	133,71			
	Tobacco-Alcohol	3	120,50			
Physical Neglec	None	136	101,75	2,073	3	0,557
	Tobacco	60	105,74			
	Alcohol	7	128,21			
	Tobacco-Alcohol	3	80,50			

Emotional Neglect	None	136	107,67	2,735	3	0,434
	Tobacco	60	94,88			
	Alcohol	7	88,57			
	Tobacco-Alcohol	3	121,67			
Sexual Abuse	None	136	100,59	6,180	3	0,103
	Tobacco	60	106,58			
	Alcohol	7	122,14			
	Tobacco-Alcohol	3	130,33			
Marital Adjustment Scale	None	136	114,18	14,562	3	0,002
	Tobacco	60	78,98			
	Alcohol	7	105,79			
	Tobacco-Alcohol	3	104,50			
Physical Dimension	None	136	106,98	5,238	3	0,155
	Tobacco	60	95,38			
	Alcohol	7	128,50			
	Tobacco-Alcohol	3	50,00			
Mental Dimension	None	136	107,27	4,664	3	0,198
	Tobacco	60	95,58			
	Alcohol	7	121,14			
	Tobacco-Alcohol	3	49,83			

Findings Related to Correlation Relationsip *Between Childhood Traumas Scale and Marital Adjustment Scale*

As seen in the table below, there is a correlation of -0.173 between the Childhood Trauma Questionnaire subscale of emotional abuse and the Marital Adjustment Scale. Since the significance value (p=0.01) is less than 0.05, a negative relationship was found between emotional abuse and marital adjustment. This means that as emotional abuse increases, marital adjustment decreases.

There is a correlation of 0.186 between the Childhood Trauma Questionnaire subscale of emotional neglect and the Marital Adjustment Scale. Since the significance value (p=0.00) is less than 0.05, a positive and weak relationship was found between emotional neglect and marital adjustment. This means that as emotional neglect increases, marital adjustment also increases.

Table 8. Correlation Relationship Table for the Relationship between Childhood Traumas Scale and Marital Adjustment Scale

Spearman Correlation	**Marital Adjustment Scale**	
Childhood Traumas Scale	*R*	*P*
Emotional Abuse	-0,173	0,013
Physical Abuse	-0,028	0,694
Physical Neglect	0,038	0,125
Emotional Neglect	0,186	0,008
Sexual Abuse	-0,034	0,631
Quality of Life Scale		
Physical Dimension	-0,113	0,106
Mental Dimension	-0,084	0,231

Findings Related to Correlation Relationsip *Between Childhood Traumas Scale and Quality of Life Scale*

A correlation coefficient of R=0.141 was observed between the emotional abuse sub-dimension of the "Childhood Traumas Scale" and the mental dimension among the sub-dimensions of the quality of life scale. Given that the significance value (p=0.04) is less than the threshold of p<0.05, a low positive relationship was identified between emotional abuse and the mental dimension among the sub-dimensions of the quality of life scale. In other words, it can be interpreted that as emotional abuse increases, the mental dimension also increases.

Table 9. Correlation Relationship Table for the Relationship between Childhood Traumas Scale and Quality of Life Scale

Spearman Correlation	**Childhood Trauma**									
Quality of Life Scale	**Emotional Abuse**		**Physical Abuse**		**Physical Neglect**		**Emotional Neglect**		**Sexual Abuse**	
	R	**P**	**R**	**P**	**R**	**P**	**R**	**P**	**R**	**P**
Physical Dimension	0,043	0,537	-0,066	0,344	-0,126	0,071	-0,003	0,968	0,007	0,921
Mental Dimension	0,141	0,043	-0,075	0,284	-0,086	0,220	-0,044	0,532	0,018	0,798

DISCUSSION

In the study titled "The Effect of Childhood Traumatic Experiences on Quality of Life and Marital Adjustment," it was noted that the childhood trauma sub-dimensions of emotional abuse, physical abuse, sexual abuse, physical neglect, and emotional neglect, as well as the quality of life sub-dimensions of physical and mental dimensions, and the marital adjustment scale, did not exhibit a significant difference according to gender variable. This aligns with findings from previous research. For instance, Sönmez (2015) reported no significant difference between childhood traumas and gender, while a study by Peker (2017) similarly found that dimensions of sexual harassment, physical harassment, emotional harassment, and emotional neglect experienced in childhood did not differ according to gender. Although at first girls may appear to be the weaker link and more exposed to childhood abuse and neglect, the situation can actually be examined from various cultural and personal dimensions. Therefore, the fundamental characteristics of the group being studied also impact the presence of the relationship. Literature reviews support the findings of our study.

Possible reasons can be listed as below to understand why these results were found:

1. Trauma affects core psychological and emotional processes, which may lead to similar outcomes in terms of quality of life and marital adjustment for both males and females. This universality in trauma's impact might explain why no significant gender differences were found. Additionally, when the actual experience of trauma is considered, the psychological damage may manifest similarly across genders. Thus, the lack of significant differences in trauma impact by gender might reflect a common underlying vulnerability rather than a difference in response. It's also possible that the impact of trauma on quality of life and marital adjustment is more related to the severity or type of trauma rather than gender. For instance, both men and women experiencing high levels of trauma might show similar difficulties in these areas, overshadowing any potential gender differences.

2. Cultural norms and societal expectations can influence how trauma is experienced and reported. In some cultures, both genders might experience and process trauma in ways that converge rather than diverge. This can lead to similar outcomes in terms of quality of life and marital adjustment, regardless of gender.

3. The availability and effectiveness of support systems and coping mechanisms might play a significant role. If both genders have similar access to support and similar coping strategies, the differential impact of trauma on quality of life and marital adjustment might be minimized.

In the literature, various findings have emerged regarding the relationship between quality of life and the gender variable. For instance, Durademir (1998) reported no difference in quality of life based on gender. Conversely, Özer (2002) found that men perceived their quality of life to be lower than women. However, several studies, including those by Franzen et al. (2007), Rector et al. (1987), Cline et al. (1999), and Riedinger et al. (2000), concluded that men generally exhibit a lower quality of life compared to women. Additionally, Özdemir and Hocaoğlu (2009) discovered that gender influenced the emotional dimension of quality of life, with women scoring lower in this dimension compared to men. These diverse findings underscore the complex relationship between gender and quality of life,

indicating a need for further research in this area. The varied findings on the relationship between gender and quality of life underscore the complexity of this issue. Factors such as differences in measurement tools, cultural contexts, societal expectations, biological influences, and methodological approaches all contribute to the divergent results observed in the literature. Understanding these factors is crucial for interpreting the findings and guiding future research to gain a clearer and more comprehensive view of how gender impacts quality of life.

Findings from studies examining the effect of the gender variable on marital adjustment reveal a range of results. For instance, Marathe (2012) concluded that women exhibited higher marital adjustment compared to men. In contrast, Kublay (2013) found no significant difference in marital adjustment based on gender. Similarly, Çakır (2008) observed a significant difference between gender and marital adjustment, with women reporting higher marital adjustment than men.

The disparity between the findings of our study and those in the literature could potentially be attributed to differences in the sample groups. Across various studies, it is commonly noted that women tend to report higher levels of marital adjustment compared to men. This phenomenon may be influenced by the distinct responsibilities and expectations placed on individuals within marriage based on their gender. Further research is warranted to explore the intricacies of these dynamics within marital relationships.

So, the disparity in findings on the relationship between gender and marital adjustment can be attributed to multiple factors, including differences in sample characteristics, gender roles, cultural contexts and psychosocial factors. Understanding these underlying elements helps explain why some studies find women reporting higher marital adjustment while others do not observe significant gender differences. For instance, women might engage more in caregiving and emotional support, which can affect their perceptions of marital satisfaction and adjustment; or increasing gender equality today may influence how men and women experience and report marital adjustment. Moreover, cultural norms and values can influence marital adjustment and how it is reported. In cultures with traditional gender roles, there might be more pronounced differences in marital adjustment based on gender. Finally, women's higher levels of marital adjustment could be linked to the greater emotional labor they often perform within relationships. This emotional investment might lead to higher reported satisfaction and adjustment.

No significant difference was observed when evaluating the data based on the age variable. However, it was noted that physical neglect, a childhood trauma experienced by the spouses of the participants, exhibited a significant difference according to age. This finding contrasts with Peker's (2017) study, which found no significant difference in the sub-dimensions of childhood neglect and abuse, as well as the general trauma level, based on age. Similarly, Yağmur et al. (2016) determined that childhood traumas did not yield a significant difference according to age. Physical neglect may manifest differently in individuals based on their age, which could explain why significant differences were observed in one study but not in others. Also, the effects of childhood trauma can evolve over time. Older adults may have processed or coped with their traumas differently compared to younger individuals, leading to different findings across studies. It's possible that age influences

how trauma is perceived or reported, with long-term effects potentially becoming more apparent in older age. These discrepancies underscore the need for further exploration and analysis to better understand the relationship between childhood traumas, age, and their implications on various aspects of individuals' lives.

In studies investigating quality of life, consistent with our findings, it was observed that age had no significant effect on this measure. Similar results were reported in studies conducted by Özer (2002), Badır-Durademir (1998), Cline (1999), and Westlake (2002), where the age factor showed no significant influence on quality of life.

In the study conducted by Hamamcı (2005), it was observed that neither age nor gender variables significantly influenced marital adjustment. Similarly, Çavuşoğlu's (2011) findings indicated that age level did not yield a significant difference in marital adjustment or duration of marriage. Furthermore, Karpuz-İlericiler (2015) found that marital adjustment did not significantly differ across age levels. These research findings are consistent with existing literature, further underscoring the notion that age may not be a decisive factor in marital adjustment outcomes.

To delve deeper into the reasons why age might not significantly affect quality of life and marital adjustment, as observed in the studies referenced, it's useful to think some underlying factors and considerations. Some can be as below:

As people age, they might develop coping strategies and adjustments that mitigate the impact of aging on these outcomes. This could explain why age does not show a significant effect in studies.

Older individuals often adapt to changes in health, relationships, and life circumstances. This adaptability might result in similar QoL and marital adjustment levels across different age groups.

The findings indicate that emotional abuse, physical abuse, sexual abuse, physical neglect, emotional neglect, as well as the physical and mental dimensions of both childhood traumas and quality of life, along with marital adjustment, did not vary significantly based on income status. However, Karayiğit (2018) reported significant differences in mean scores of emotional abuse, physical neglect, and total abuse across income levels, while Aydın and İşmen (2003) found that individuals with lower income levels experienced higher levels of emotional and physical abuse. These outcomes diverge from the results of our study. A larger or more diverse sample might reveal income-related differences in trauma and quality of life, while a smaller or more homogeneous sample might not capture these differences. The income distribution within the sample of this current study is narower than those in Karayiğit (2018) or Aydın and İşmen (2003). So, this could impact the ability to detect significant income-related differences. In addition, our study solely focused on traumatic experiences without including posttraumatic stress disorder (PTSD), which could have potentially led to more nuanced insights. Incorporating PTSD assessment alongside traumatic experiences might yield more comprehensive and objective findings.

When considering economic status in relation to quality of life, Balcı-Durademir (1998) noted that quality of life did not vary based on economic status. Similarly, Özdemir (2009) observed that individuals who rated their economic status as "poor" were impacted in the

emotional dimension of quality of life. However, it's important to note that diverse findings exist in the literature regarding this matter.

It's evident that the participants' marital adjustment scores did not significantly differ based on their economic status. This aligns with findings from Tutarel-Kışlak and Göztepe's (2012) study, which explored the connection between empathy, emotional expression, and marital adjustment. Their results similarly indicated no significant variance in marital adjustment relative to economic level. Likewise, Çakır's (2008) examination of married individuals' marital adjustment concerning their attachment to their parents yielded comparable outcomes. In that study as well, no notable distinction was detected in marital adjustment among married individuals based on income level. While economic status might influence various aspects of life, its direct impact on marital adjustment may be moderated by other relational and psychological factors. Marital adjustment typically encompasses various aspects of relationship satisfaction, communication, intimacy, and conflict resolution. These dimensions might be influenced by numerous factors beyond economic status, such as emotional and psychological factors, which could overshadow any direct influence of income. Furthermore, marital satisfaction and adjustment may exhibit stability across different income levels if couples have developed effective coping mechanisms, communication strategies, and relationship skills. Thus, economic status might not dramatically impact marital adjustment if couples manage financial stress well.

No notable difference emerged between the participants' and their spouses' childhood trauma sub-dimensions in terms of physical abuse, quality of life sub-dimensions (physical and mental dimensions), and marital adjustment based on psychiatric diagnosis and treatment status. However, a significant disparity was observed concerning the history of psychiatric treatment and childhood trauma, particularly in emotional abuse, physical neglect, and sexual abuse. Additionally, a significant variance was noted in childhood trauma sub-dimensions of physical and emotional neglect based on the spouses' psychiatric treatment history status.

The study by Yılmaz and Irmak (2008) underscores that childhood traumas persist and exert an enduring impact on individuals, often correlating with psychological issues later in life. Similarly, Sönmez (2015) found a positive association between each subtype of childhood trauma and individuals' experiences of depression. Bülbül et al. (2013) reported that participants with recurrent or first-episode major depression exhibited higher abuse and neglect scores compared to those without psychiatric diagnoses. Özkan (2020) discovered a positive correlation between physical, emotional, and sexual abuse scores and the severity of depression and anxiety, with a particularly noteworthy relationship observed between physical abuse scores and other subcategories. While our study aligns with existing literature indicating sexual abuse as a significant risk factor for long-term psychiatric problems, variations in findings regarding the impact of different trauma types may stem from differences in sample populations and research methodologies employed across studies.

In our study, we found no significant difference in quality of life based on psychiatric treatment history. This aligns with findings from Zambroski et al. (2005), who noted common psychological symptoms like concentration difficulties, irritability, worry, and depression among individuals with lower quality of life. Similarly, Worster and Moser(2000) highlight-

ed the detrimental impact of psychological symptoms on quality of life. While Zambroski et al. (2005) reported a higher prevalence of concentration difficulties compared to other symptoms, they did not delve deeper into these symptoms. Further research in this area could offer valuable insights into understanding the intricate relationship between psychological symptoms and quality of life. The lack of significant difference in quality of life based on psychiatric treatment history in the study can be attributed to a range of factors including the nature of psychiatric treatments, the measurement tools used, sample characteristics, and the complexity of psychological symptoms. While related literature highlights the impact of psychological symptoms on quality of life, the study's findings suggest that the relationship between treatment history and quality of life might be influenced by various factors not fully captured by general assessments. Further research with a focus on specific symptoms, treatment efficacy, and detailed quality of life measures could provide deeper insights into these dynamics.

Our analyses indicate that marital adjustment does not significantly differ based on psychiatric treatment history. This is consistent with findings from Karpuz and İlericiler (2015), who noted a negative correlation between marital adjustment and anxious attachment, avoidant attachment, and relational traumatic experiences of negative emotions. Additionally, other studies have highlighted the detrimental impact of anxious and avoidant attachment patterns on marital relationships. Individuals with these attachment patterns often experience challenges in their relationships, exhibit less cooperative behaviors, and consequently, have lower levels of marital adjustment (Feenay, 1994; Marchand, 2004).

The study indicates a negative correlation between emotional abuse, a sub-dimension of childhood trauma, and marital adjustment. Conversely, a positive but weak correlation was observed between childhood trauma sub-dimension emotional neglect and marital adjustment. Additionally, a low correlation was found between emotional abuse and the mental dimension of quality of life.

According to Karpuz-İlericiler's study (2015), there exists a negative correlation between marital adjustment and traumatic experiences. The study considered events such as natural disasters, accidents, and loss of a close person as traumatic experiences, while also encompassing infidelity, violence, and emotional or physical abuse within this framework. Herman (1992) posits that traumatic experiences can induce distress in marital and familial relationships, disrupting the self-structure that shapes interpersonal connections and negatively impacting behavioral mechanisms associated with self-esteem and meaningful connections. Thus, traumatic experiences are suggested to have significant adverse effects on marriage.

When reviewing the literature, it becomes evident that various traumatic experiences such as infidelity, violence, abuse, loss of a close person, and separation exert an influence on marital adjustment. For instance, Baker and Stith (2008) discovered a negative correlation between spousal violence and marital adjustment, a finding corroborated by a similar study by İdiz (2009). İdiz's study explored the relationship between marital adjustment, relationship investment, domestic violence, and suicide attempts, revealing a negative association between marital adjustment and domestic violence, suggesting that as marital adjustment declines, instances of violence tend to increase. Similarly, in a study by Belt and Abidin

(1996), the impact of childhood emotional abuse on marital relationships was investigated. The results indicated that emotional abuse led to marital conflict among women, whereas it did not significantly affect marital relations in men. These findings provide support for the outcomes of our study.

The findings indicate that childhood trauma and quality of life do not predict marital adjustment. Specifically, emotional abuse, a sub-dimension of the childhood traumas scale, was found to have no impact on marital adjustment. Similarly, physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect showed no effect on marital adjustment. Furthermore, quality of life was not found to influence marital adjustment.

Traumas, as described by Baltaş & Baltaş (1996), are events that harm individuals' physical, emotional, and mental well-being, thereby affecting their quality of life or leading to psychological distress. According to the DSM-5, traumatic events encompass various experiences such as war, sexual and physical assault, torture, natural disasters, life-threatening injuries, and diseases. Erberk et al. (2004) highlighted domestic violence as a significant and prevalent issue affecting marriages globally, including our country. Simpson et al. (1995) found that male propensity for violence contributed to decreased marital harmony and often led to divorce. Perry et al. (2007) examined the relationship between childhood abuse and marital adjustment, concluding that emotional neglect and abuse exerted a negative impact on marital adjustment. Literature consistently suggests that trauma negatively influences marital adjustment.

Another key finding is that quality of life does not predict marital adjustment, contrasting with the findings of Erbil and Hazer (2020), who identified significant relationships between quality of life and marital adjustment. Bulut (1993) similarly found that marital adjustment suffered in marriages with poor social functionality and physical dimensions. While literature research suggests that marital adjustment impacts quality of life (Thomas, 1977), Vibha et al. (2013) observed that declining marital adjustment decreased quality of life. In contrast to our study, literature studies suggest a linkage between marital adjustment and quality of life.

CONCLUSION

Significant differences were noted in childhood traumatic experiences, quality of life, and marital adjustment based on various factors. These differences were observed in the field of physical neglect concerning the age of the participants' spouses, emotional abuse, sexual abuse, and physical neglect concerning the psychiatric diagnosis and treatment duration of the participants, emotional and physical neglect concerning the psychiatric treatment history of the participants' spouses, and marital adjustment concerning the continuous use of cigarettes, alcohol, and substances. Furthermore, differences were identified in the field of physical neglect based on the status of having children.

However, no significant differences were found based on participants' gender, age, educational status, economic variable, employment status, longest place of residence, number of years of marriage, marital status, marital decision with the spouse, and number of marriages.

A negative relationship was observed between the childhood trauma sub-dimension of

emotional abuse and marital adjustment. Conversely, a positive but weak relationship was found between the childhood trauma sub-dimension of emotional neglect and marital adjustment. Additionally, a low relationship was identified between emotional abuse, a sub-dimension of childhood trauma, and the mental dimension, a sub-dimension of quality of life.

Overall, the study concluded that childhood trauma and quality of life did not predict (affect) marital adjustment.

RECOMMENDATIONS

Given the small sample size of the study, it is advisable to enhance the generalizability of the findings by conducting research with larger and more diverse groups from various cultural backgrounds.

Considering that childhood traumas can have lasting effects on both quality of life and marital adjustment and may contribute to the development of psychopathologies later in life, it is crucial to undertake efforts aimed at preventing childhood abuse and traumas. This involves raising awareness among families, particularly parents, and society as a whole.

In our study, data collection was conducted through online forms, and participants were married individuals. It's possible that participants may have been hesitant to disclose experiences of childhood neglect and abuse, leading to potentially biased responses. For future studies, it may be beneficial to employ qualitative research methods to explore these sensitive topics in more depth.

It's evident that individuals who have experienced traumatic events in childhood are at a higher risk of experiencing psychiatric issues in adulthood. Therefore, it's important to promote awareness among trauma survivors about the importance of seeking professional support.

Psychotherapeutic interventions such as Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) may prove to be effective in addressing the needs of trauma survivors and facilitating their recovery process.

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