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Adverse Childhood Experiences and Romantic Relationship Satisfaction of Turkish Emerging Adults: The Role of Dyadic Coping

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ABSTRACT

Adverse childhood experiences (ACEs) can negatively affect relationship satisfaction and quality in adulthood. The current study aims to explore the direct and indirect associations of ACEs and romantic relationship satisfaction and examine whether dyadic coping could be a potential protective mechanism against ACEs. Participants ($N = 361$) were recruited through social media platforms and word of mouth. The study's eligibility criteria were being 18 to 30 years old, unmarried, and in a committed relationship for at least six months. Participants completed online surveys through Qualtrics. Structural equation modeling analysis revealed that ACEs were negatively associated with dyadic coping and relationship satisfaction. Besides, dyadic coping was positively associated with relationship satisfaction. Dyadic coping partially mediated the relationship between ACEs and relationship satisfaction. There were no moderating effects of gender or individual coping style in the final structural equation model. These findings illustrate that adults with a history of ACEs may be less satisfied in romantic relationships, yet they may benefit from dyadic coping strategies. Results have implications for clinical practice, underscoring the utility of assessing ACEs of partners in couples therapy, addressing ACEs and their potential spillover effects in romantic relationships, and promoting dyadic coping skills to improve couples' relational well-being.

KEYWORDS

Adverse childhood experiences; dyadic coping; gender; individual coping; relationship satisfaction; stressors

Adverse childhood experiences (ACEs) are potentially traumatic events, including maltreatment, abuse, neglect, and exposure to harmful incidents in the child's household (Boullier & Blair, 2018). The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) recognize child maltreatment as a growing public health concern. UNICEF (2017) estimates that approximately half of the children suffer some form of violence each year globally. In particular, close to 300 million children are subjected to physical punishment and psychological aggression by their parents or other caregivers at home on a regular basis (UNICEF, 2017). In addition, 25% of adults worldwide report having experienced physical abuse in childhood (World

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Health Organization, 2020). A comprehensive review of over 300 studies with adults' reports of child maltreatment has found that median estimates of neglect, emotional, physical, and sexual abuse are 7%, 8%, 12%, and 9.4% among non-clinical samples, while rates are significantly higher among clinical samples of adults (range: 19.2% to 59.1%; Moody et al., 2018). Yet, the prevalence of ACEs varies considerably across regions (Moody et al., 2018) and there is a need for further research on ACEs in a non-Western context. Consistent with the global reports, ACEs indicate a significant public health issue in Turkey. In a study conducted with 2,257 Turkish university students, 49.7% of the participants reported experiencing at least one childhood adversity (Ulukol et al., 2014). Given those estimates, understanding the correlates and consequences of ACEs in Turkey is warranted.

ACEs have adverse and lasting effects on mental health and relational well-being in adulthood. A recent scoping review of 58 studies across the globe (Tzouvara et al., 2023) has shown that adults with a history of ACEs are at greater risk of experiencing a range of mental health problems such as depression, bipolar disorder, PTSD, suicide, and substance misuse. Given the interpersonal nature of abusive experiences, ACEs are linked to future issues in intimate relationships (Wheeler et al., 2019). Indeed, ACEs may disrupt relationship quality (Shahab et al., 2021) and increase the odds of separation and divorce (Zemp et al., 2016). Adults with ACEs are more likely to experience intimate partner violence and struggle with loneliness (Tzouvara et al., 2023). Such consistent associations between ACEs and relationship functioning highlight the need to explore potential mediating mechanisms to inform future intervention efforts.

One protective mechanism that may buffer the adverse effects of ACEs is *dyadic coping*, the strategies couples use to cope with external stressors (Bodenmann, 1997; Bodenmann et al., 2019). The quality of the romantic relationship may be linked to how couples navigate the stress together, especially when one of the partners is a survivor of abuse. The current study addresses that gap and explores the role of dyadic coping as a mediating mechanism between ACEs and relationship satisfaction. In doing so, the present study focuses primarily on dyadic coping in the Turkish context. According to Bodenmann (1997), one's cultural contextual environment – family structure, gender roles, and communication – may influence how couples cope with stress in their relationship. Indeed, a multinational study (Hilpert et al., 2016) found that the link between relationship quality and dyadic coping varies across nations, with the association being more potent in Eastern European countries (p. 11). We believe Turkey is an interesting context to examine the potential protective role of dyadic coping because of its intact nuclear family structure (Ataca, 2009; TURKSTAT, 2021), relatively more traditional gender roles (O'Neil & Çarkoğlu, 2022; Sunar & Fişek, 2005), and implicit communication strategies in intimate relationships (Çorapçı

et al., 2012; Sunar, 2002). The Turkish sociocultural context is characterized by a strong emphasis on close ties with the family, relatives, and social groups, defined as an emotional interdependent model of the family (Kağıtçıbaşı, 2007). In that context, it is worth exploring the role of dyadic coping in navigating the challenges of ACEs.

Definitions of adverse childhood experiences (ACEs) and their prevalence in Turkey

In their seminal work with adults, Felitti and his colleagues (1998) defined ACEs by two main categories: experiences of abuse and household challenges/dysfunction. Childhood abuse includes psychological (i.e., insults, swears, name-calling, withdrawing love), physical (i.e., pushing, slapping, grabbing, injuring the child), and sexual abuse (i.e., touching, sexually fondling, or sexually exploiting the child or exposure to sexual images). Household challenges/dysfunction are childhood incidents and difficulties children experience in their families. Those challenges include, but are not limited to, witnessing domestic violence, having family members with substance misuse or mental illness or having committed a crime (Felitti et al., 1998), and parental divorce (Zemp et al., 2016). Boullier and Blair (2018) added neglect as a third category of the ACEs and identified emotional and physical neglect as its subcategories. Emotional neglect occurs when no member of the child's family shows love and warmth to the child or cares for their needs for connectedness. On the other hand, physical neglect is the failure of family members to take care of the child's biological and medical needs and protect them from physical harm and victimization (i.e., lacking enough food or clean clothes).

A scoping review of child maltreatment (Moody et al., 2018) has found that prevalence rates of childhood neglect, emotional, physical, and sexual abuse vary among clinical and community samples, age groups, and by region and gender across the globe. For instance, a comprehensive WHO study with 2,257 university students in Turkey found that 49.7% of respondents reported exposure to at least one type of ACE (Ulukol et al., 2014). However, the rates may be relatively higher among urban samples, with the frequencies of psychological and physical negative childhood experiences and neglect throughout life being 70.5%, 58.3%, and 42.6%, respectively (Sofuoğlu et al., 2014). Another study with a clinical sample of Turkish adults (Abacı, 2022) found that approximately 45% of the patients had 1–3 ACEs, while 24.6% reported more than four ACEs in their lifetime. Specifically, rates of emotional abuse, physical abuse, and emotional neglect varied from 32.8% to 38.3%, and 26.5% of the patients had witnessed domestic violence, and 17.1% had experienced sexual abuse in their childhood (Abacı, 2022). A UNICEF study further documented that 56% of Turkish children witnessed physical abuse and 10%

witnessed sexual abuse, while 45% reported being physically abused and 25% were neglected in the household (Korkmazlar et al., 2010). Although those studies differ by research methods, sample size, and age of participants, they shed light on the significance of ACEs in Turkey and the need to further explore their consequences for adults.

Relational consequences of ACEs

ACEs have long-term adverse effects on close relationships and social functioning in adulthood (Tzouvara et al., 2023). Adults with ACEs may develop maladaptive schemas and relational patterns (Bayar, 2021; Pilkington et al., 2021). Early trauma and victimization are associated with the expectation that others will hurt, abuse, or manipulate (Mistrust Abuse), and one is defective, bad, unwanted, inferior, or unlovable (Defectiveness Shame; Miskiewicz et al., 2016; Young, 1990). Therefore, individuals exposed to adversities in early childhood may become watchful, mistrustful, and skeptical in adulthood (Shahab et al., 2021). These tendencies are inevitably linked to difficulties forming close social ties and romantic relationships (Umberson et al., 2014). Adults with a history of ACEs struggle with trusting their partners and practicing empathic communication in romantic relationships (Shahab, et al., 2021) and report less perceived partner support and care (Wheeler et al., 2020). For instance, Bayar (2021) found that Turkish adults with early maladaptive schemas and ACEs struggled to cope with stress and reported more attachment insecurity to their partners.

Abusive experiences in childhood may also disrupt relationship quality and stability in adulthood (Wheeler et al., 2019). The cumulative stress of early childhood abuse may make individuals more prone to romantic relationship strain with struggles to seek the partner's support when dealing with external stressors (Breitenstein et al., 2018). A study with Turkish adult women (Minaz, 2023) found that childhood traumas were associated with maladaptive conflict management strategies, further decreasing relationship satisfaction. Adult intimate relationships with a history of childhood maltreatment are less stable and of lower quality than the general population (Ekşi, 2021). Both men and women who were maltreated or neglected in childhood report lower relationship satisfaction (Bayar, 2021; Shahab et al., 2021; Wheeler et al., 2020) and experience significantly higher rates of intimate partner violence (Abacı, 2022), and breakups and divorce (Boullier & Blair, 2018). Regarding household challenges and difficulties, parental divorce in childhood and childhood abuse are linked to insecure attachment behaviors and increased odds of divorce in adulthood (Zemp et al., 2016).

In sum, adverse experiences in the family of origin may distort an individual's perceptions of close relationships and impair their social skills to seek and provide support, be cognizant of and responsive to their partners' needs,

and address relational problems (Donato et al., 2011). Studies with Turkish samples also provide empirical support for the link between ACEs and relationship quality (i.e., Bayar, 2021; Ekşi, 2021; Minaz, 2023). Those findings highlight the complexity of the association between ACEs and romantic relationships in adulthood. Therefore, it is worth exploring potential mechanisms to alleviate or buffer the effects of childhood abuse. One possible mechanism pertains to dyadic coping and its role in navigating the challenges of ACEs in romantic relationships.

Dyadic coping, romantic relationship outcomes, and ACEs

Dyadic coping is characterized by supportive interactions, communication patterns, and stress management between couples when they experience external stressors (Bodenmann, 1997). Dyadic coping includes both dyadic and individual-level processes and compromises how a distressed partner communicates and discloses their stress (either positive or negative), how the other partner responds to the disclosure, and how the couple responds to a shared problem or a stressor (Falconier & Kuhn, 2019).[1]Dyadic coping includes several domains; a) stress communication (communication of the experience of stress between partners), b) individual positive dyadic coping (one partner's positive responses to help the other partner to cope with stress via support such as empathic responding, delegated dyadic coping, and active engagement), c) positive conjoint dyadic coping (what partners do together to cope with shared or dyadic stress. Examples include common, collaborative, communal dyadic coping, mutual responsiveness), d) negative individual dyadic coping (one partner's negative responses to the other partner's stress including protective buffering, overprotection, hostile/ambivalent responses, and controlling behavior, mocking the other partner's feelings and patronizing them, invalidating their experience, providing insincere, superficial, and ambivalent support), and e) negative conjoint dyadic coping (partners' conjoint negative response to deal with a shared or dyadic stress. Examples are common negative dyadic coping and disengaged avoidance; Bodenmann et al., 2019; Falconier & Kuhn, 2019).

A growing body of research lends empirical support for the link between dyadic coping and relationship quality. A systematic review of dyadic coping (Bodenmann et al., 2019) suggested that supportive and mutual coping are associated with reduced hostility and avoidance in the couple's relationship. Moreover, mutual coping was associated with increased emotional and empathic responsiveness, which, in turn, was linked to overall relationship satisfaction (Bodenmann et al., 2019; Falconier et al., 2015). Dyadic coping has been established as a significant predictor of relationship maintenance (Falconier & Kuhn, 2019). Couples who utilize positive dyadic coping strategies to deal with daily stressors or medical or mental health issues build more

constructive communication (Falconier & Kuhn, 2019). Hence, couples' strategies to manage their problems and deal with negative affect are vital to their sexual and romantic relationship satisfaction (Baucom & Atkins 2013). Those couples have more commitment to and investment in the relationship and experience more stability (Falconier & Kuhn, 2019). On the other hand, the absence of dyadic coping is the main predictor of separation and divorce in relationships (Bodenmann et al., 2019).

According to Bodenmann's (1997) Systemic Transactional Model (STM), when one partner experiences daily or chronic stressors outside of the relationship (i.e., workplace, issues with friends and family, prolonged stress with a chronic medical condition), this affects the other partner directly or indirectly in committed relationships. Given that interdependence, one partner's stress can spill over to the couple's relationship, the emotions associated with that stress can carry over into the relationship, and both partners can get affected by a shared stressor (Randall & Bodenmann, 2009). Such stress may lead to lower tolerance, make communication between the partners more difficult, and decrease relationship functioning (Falconier & Kuhn, 2019). Consistent with the STM (Bodenmann, 1997), higher levels of external stress are related to lower levels of relationship satisfaction (Randall & Bodenmann, 2009; 2017). In situations where one partner has a history of ACEs, enacting dyadic coping strategies may help to manage distress (Bodenmann et al., 2019). Effective dyadic coping strategies reduce stress for both partners and enhance relationship quality (Falconier & Kuhn, 2019). There is growing evidence that dyadic coping may buffer the detrimental effect of childhood abuse on relationship functioning (Fitzgerald & Shuler, 2022). Given the adverse consequences of ACEs on relationship quality, satisfaction, and stability (Bayar, 2021; Shahab et al., 2021; Wheeler et al., 2020), dyadic coping may be a potential pathway to mitigate the spillover effects of ACEs on the relationship. The current study addresses that gap.

The current study

Prior studies have mainly focused on ACEs and their association with mental and physical health outcomes (Tzouvara et al., 2023). However, less is known about the role of dyadic coping in alleviating the experiences of ACEs and its association with relationship satisfaction. The quality of the romantic relationship may be linked to how couples navigate the stress together, especially when one of the partners is a survivor of abuse. Understanding the role of dyadic coping may inform future intervention efforts while working with individuals and couples with trauma. The current study addresses that gap and explores the role of dyadic coping as a mediating mechanism between ACEs and relationship satisfaction in Turkey.

Bodenmann (1997) argued that cultural factors such as family structure, gender roles, and communication strategies determine couples' relationship maintenance strategies and their ways of coping. As a developing country, 64.4% of Turkish households are in a nuclear family structure (TURKSTAT, 2021). Although there is a move toward more egalitarian gender roles, and a growing number of women enter the workforce, women continue to perform the majority of the housework and childcare (O'Neil & Çarkoğlu, 2022; Sunar & Fişek, 2005), and they mediate the communication between their partners and children (Erdem et al., 2022; Sunar & Fişek). In addition, communication strategies among Turkish couples and families are more implicit where anger and other negative emotions are restrained to maintain the harmony of the family (Çorapçı et al., 2012; Sunar, 2002). Such factors may determine how individuals utilize dyadic coping strategies in coping with ACEs, and the current study explores that relationship.

Consistent with the reviewed literature, we hypothesized that H_1) ACEs would be negatively associated with relationship satisfaction; H_2) dyadic coping would be positively associated with relationship satisfaction; H_3) ACEs would be negatively related to dyadic coping; and H_4) Dyadic coping would mediate the relationship between ACEs and relationship satisfaction, buffering the negative association between ACEs and relationship satisfaction.

Additionally, we hypothesized that gender would moderate the relationship between dyadic coping and adverse childhood experiences. ACEs' impact on women would form a more significant moderating effect on dyadic coping than men's (H_6). This hypothesis was based on several studies. For example, Neff and Broady (2011) found that women (but not men) with higher dyadic coping skills experienced better relationship satisfaction. Their dyadic coping skills spilled over to their partners, creating higher relationship satisfaction for both parties. Women's dyadic coping was also found to help enrich broader relationship functioning for both partners (Papp & Witt, 2010), and women experience more complex forms of childhood adversity (Haahr-Pedersen et al., 2020). Based on prior research on coping (i.e., Herzberg, 2013), we also hypothesized that individuals with adaptive coping strategies would form a stronger dyadic coping within their relationships, resulting in higher satisfaction (H_7). The hypothesized model is shown in Figure 1.

Method

Participants and procedure

We collected data online through Qualtrics from December 2021 to May 2022. We invited participants through social media platforms (i.e., Facebook or Instagram) and word of mouth. Participation in the study was voluntary. The study's eligibility criteria were being 18 to 30

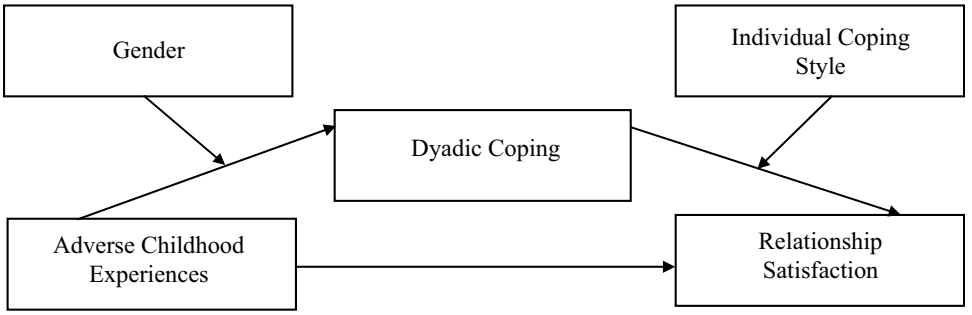


Figure 1. Hypothesized model.

years old, unmarried, and in a committed relationship for at least six months. Eligible participants signed an online consent form and completed the online survey. The study took approximately 15 minutes to complete. The Institutional Review Board of Koç University approved all study procedures (Protocol no: 2021.356.IRB3.158).

Using Fritz and MacKinnon's (2007) guidelines, we estimated that the required sample size would be 360 with an alpha of .05 and a power level of .80. We recruited 361 individuals to participate in our study. Of the total sample, 203 (56.23%) participants were women, and 158 (43.77%) were men. The average age of our participants was 24 (SD = 2.9) years. Regarding marital status, 95% of the participants (n = 345) were single and in a relationship, while the rest of the sample (5%, n = 16) was engaged. Only 2% of the sample (n = 7) reported having children. Regarding education status, 216 (59.83%) participants were university graduates, 79 (21.88%) were high school graduates, and 66 (18.3%) had a graduate degree. In addition, 197 (55%) of our participants worked full-time, 164 (45%) were not employed, and 4 (1.65%) were students. The monthly income distribution of our participants ranged from 2,900 TL (monthly minimum wage during the data collection) to 11,000 TL. Table 1 presents the sample's demographic characteristics.

Measures

The survey included a demographics form, followed by ACEs, dyadic coping, relationship satisfaction, and individual coping measures. Scales used in the current study were initially developed and psychometrically validated in English. We used the validated Turkish translations of all the scales. Higher scores on a given scale indicated a higher assessment of that construct (i.e., a high score in dyadic coping showed more dyadic coping behaviors and strategies).

Table 1. Demographic characteristics of the sample ($N = 361$)*.

	n	%
Sex		
Male	158	43.8%
Female	203	56.2%
Monthly income		
2,900 TL and below**	115	32.9%
2 901 TL – 4,999 TL	47	13.4%
5,000 TL – 7,000 TL	64	18.3%
7,001 TL – 9,000 TL	41	11.4%
9,0001 TL – 11000 TL	26	7.4%
11,000 TL and above	58	16.6%
Education level		
High School	79	21.9%
University	216	59.8%
Masters	65	18.0%
PhD	1	0.3%
Employment status		
Student	4	1.65%
Employed	197	55%
Not employed	164	45%
Having children		
Yes	7	2%
No	354	98%
Relationship Status		
In a relationship	345	95%
Engaged	16	5%

**Note:* Participants were on average 24 years old ($SD = 2.9$).
**2,900 TL represents the monthly minimum wage during the data collection (TURKSTAT, 2021).

The Childhood Trauma Questionnaire-Short Form (CTQ-SF)

The CTQ is a self-report questionnaire that retrospectively assesses adverse childhood experiences among adolescents and adults. The measure was initially developed by Fink and colleagues (1995) to assess five types of abuse and neglect (emotional neglect, emotional abuse, physical neglect, physical abuse, and sexual abuse). We used the brief version of the scale (CTQ-SF; Bernstein et al., 2003), which has 25 items on five types of abuse and neglect and three additional validity items to detect underreporting of maltreatment. All items were rated on a 5-point Likert scale with response options ranging from 1 ("never true") to 5 ("very often true"). A sample item includes "my parents wished I was never born." The CTQ-SF has demonstrated adequate reliability and validity, with internal reliability coefficients of subscales ranging from .61 to .92 and from .68 to .93 for community and clinical samples of adults, respectively (Bernstein et al., 2003). Kırlıoğlu and Tekin (2020) adapted The Turkish version of the scale and found that the scale had high internal reliability in a normative sample of adults (Cronbach alpha = .97 for the full scale, subscales alphas = .93–.96). Of note, the CTQ-SF scale primarily focuses on abuse and neglect experiences, but does not capture household challenges in childhood as a component of ACEs. Therefore, we added an item on parental divorce to inquire about a common household challenge participants

may have experienced in their childhood. In the current sample, the reliability coefficient was .89 of the full scale.

The Revised Dyadic Adjustment Scale (RDAS)

The RDAS is a 14-item self-report questionnaire that assesses overall relationship satisfaction by seven dimensions and three overarching categories. Subscales include consensus (6 items; decision-making, affection, and values), satisfaction (4 items; stability and conflict regulation), and cohesion (4 items; activities and discussion). The RDAS has a Cronbach's alpha of .90 for the full scale and has shown good construct validity with the Locke-Wallace Marital Adjustment Test (Fink & Shapiro, 2019). All items (except for the item related to engaging in outside interests together) are rated on a 6-point Likert scale. Response categories vary across subscales from 0 to 5, with "always disagree" to "always agree" for consensus, "never" to "all the time" for satisfaction, and "never" to "more often" for cohesion subscales, respectively. A sample item is "How often do you discuss or have you considered divorce, separation, or terminating your relationship?" The Turkish version of the scale was adapted by Fışıloğlu and Demir (2000), the Cronbach Alpha was .92, and the split-half reliability coefficient was .86. In our sample, the reliability coefficient was .78 of the full scale.

The Dyadic Coping Inventory (DCI)

The scale was developed by Guy Bodenmann (2008) to assess perceived communication and dyadic coping in close relationships when one or both partners are under stress. The DCI measures dyadic coping as a multidimensional construct and includes 37 items rated on a 5-point Likert scale with response categories from 1 ("very rarely") to 5 ("very often"). There are nine subscales: stress communication (self and partner), supportive dyadic coping (self and partner), delegated dyadic coping (self and partner), negative dyadic coping (self and partner), and common dyadic coping (Sample item: "My partner listens to me and gives me the opportunity to communicate what really bothers me"). A psychometric study of the original scale (Bodenmann, 2008) demonstrated adequate construct validity (.62) and internal reliability (αs ranged from .71 to .92) with adult samples. Kurt and Akbaş (2019) adapted the DCI to Turkish and found adequate reliability, with the Cronbach alphas ranging from .63 to .87 across different subscales. We used the total score of the DCI in the current study, and its internal consistency was .91.

The Brief Stress Coping Profile (BSCP)

We used the BSCP to assess our participants' coping strategies. The original version of BSCP (Kageyama et al., 2004) consists of 18 items rated on a 4-point

scale with responses from 1 ("never") to 4 ("frequently"). The scale consists of 6 subscales; active solution of the problem, seeking help, changing mood, changing a point of view, an emotional expression involving others, avoidance, and suppression. A sample item is "I try to see the positive sides of the matter." The Cronbach's alpha coefficients in the original BSCP scale ranged from .64 to .77 (Kageyama et al., 2004). The Turkish version of the BSCP scale was adapted by Örnek (2017), and the reliability of the BSCP subscales varied from .66 to .79. In our study, we used the total scale score and the reliability coefficient was .69.

Demographic variables

Participants completed a series of questions related to their demographic characteristics such as age, gender, SES, duration of the relationship (in months), number of children (if any), education level, occupation status, previous psychiatric diagnosis, and any current psychiatric medication.

Data analysis

First, we conducted preliminary data analyses to examine the participants' demographic characteristics, mental health status, and the prevalence of ACEs in the current sample. Next, we explored the distribution of variables (frequencies, means, skewness, kurtosis, and standard deviation of the continuous variables) to determine whether there was a violation of the assumption of normality (i.e., skewness and kurtosis scores being outside the range of + 1.96 and −1.96). We ran bivariate Pearson correlation analyses between study variables (dyadic coping, relationship satisfaction, adverse childhood experiences, and individual coping styles). We also conducted independent samples t-test to investigate potential gender differences.

The primary analysis utilized a Structural Equation Modelling (SEM) paradigm. We ran a series of SEMs until the adequate fit was reached at Comparative Fit Index (*CFI*) > .90, Root Mean Square Error of Approximation (*RMSEA*) < .08, and Standardized Root Mean Square Residual (*SMRM*) < .08 (Hair et al., 2010). The SEM was preferred over multiple linear regression because it allows for testing numerous associations between variables while estimating measurement errors (Nunkoo et al., 2013). All variables were observed in the moderated mediation SEM model, following Hayes and his colleagues' (2017) guidelines. The exogenous variable was a cumulative count score of ACEs; endogenous variables were relationship satisfaction and dyadic coping (also a mediator). Moderator variables included gender and individual coping. We ran a bootstrapping analysis using a 95% confidence interval (CI) and 5,000 random samples to examine direct and indirect links

between ACEs and relationship satisfaction. We used the full maximum likelihood (FML) estimation to handle missing data in the SEMs. We conducted the preliminary analysis in SPSS and the moderated mediation analysis in the R Lavaan package.

Results

Preliminary analysis

Because the primary independent variable was ACEs, we first examined the distribution of psychiatric disorders in the sample to avoid contamination with PTSD and other disorders. Of 361 adults, 15.79% ($n = 57$) reported having a psychiatric diagnosis, and 11.63% ($n = 7$) reported using psychiatric medication. The most common diagnoses were anxiety disorder (16.07%; $n = 9$), depression (12.5%; $n = 7$), and ADHD (10.71%; $n = 6$), followed by Insomnia (7.14%; $n = 4$) and OCD (5.36%; $n = 3$) in the entire sample. PTSD diagnosis was 1.79% ($n = 1$). Given the low prevalence of psychiatric diagnosis in the sample, we did not expect an interaction with or contamination of ACEs. Next, we examined whether the scales' distribution confirmed the normality assumption. As indicated in Table 2, kurtosis and skewness of scales were all in an acceptable range (+1.96 and −1.96). Therefore, it was concluded that the data were distributed normally and could be used for SEM.

Pearson correlation coefficients were computed to assess the bivariate associations between the scales (Table 2). Correlations were low to moderate in magnitude (range $r = -.30$ to .56) and were all in the expected direction. Specifically, ACEs were negatively correlated with relationship satisfaction ($r = -.36$, $p < .001$), dyadic coping ($r = -.33$, $p < .001$), and individual coping ($r = -.30$, $p < .001$). Dyadic coping ($r = .56$, $p < .001$) and individual coping ($r = .25$, $p < .001$) were positively associated with relationship satisfaction (Table 2). Overall, all bivariate correlations were in an acceptable range, indicating no sign of multicollinearity.

An independent sample t-test analysis revealed that women (*Mean* = 39.60, *SD* = 6.05) reported significantly higher relationship satisfaction than men (*Mean* = 37.07, *SD* = 6.71; t (359) = 3.75, $p < .001$). In addition, there were gender differences in dyadic coping [t (359) = 2.02, $p = .04$], with women reporting higher dyadic coping. Women and men did not differ in their reports on individual coping scores [t (359) = 0.39, $p = .68$]. To understand

Table 2. Descriptives of the scales and pearson correlations.

	Mean (SD)	Kurtosis	Skewness	1	2	3	4
1. Adverse childhood experiences	14.11 (6.76)	0.34	0.98	1			
2. Relationship satisfaction	38.49 (6.46)	0.66	−0.80	−.36***	1		
3. Dyadic coping	105.92 (16.19)	−0.61	−0.38	−.33***	.56***	1	
4. Individual coping style	54.01 (6.22)	0.38	−0.24	−.30***	.25***	.39***	1

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

Table 3. The prevalence of adverse childhood experiences in the current sample.

The CTQ Subscale	Item	*n* *f (%)*	Age of occurrence *f (%)*
Physical Neglect (with reverse coded items; *n* = 19, 5.32%)	There was someone to take me to the doctor if I needed it.*	324 89.79%	0–11: 57.14 % 12–18: 23.32 % 0–11,12–18: 19.53 %
	I knew there was someone to take care of me and protect me.*	328 90.98%	0–11: 56.97 % 12–18: 23.64 % 0–11,12–18: 19.39 %
	My parents were too drunk or high to take care of the family.	9 2.62%	0–11: 72.0 % 12–18: 20.0 % 0–11,12–18: 8.0 %
	I didn't have enough to eat.	8 2.42%	0–11: 88.88 % 12–18: 5.55 % 0–11,12–18: 5.55 %
	I had to wear dirty clothes.	8 2.34%	0–11: 60.0 % 12–18: 40.0 %
Emotional Neglect (all reverse coded; *n* = 21, 5.98%)	People in my family felt close to each other.*	344 95.40%	0–11: 55.18 % 0–11,12–18: 23.33 % 12–18: 21.48 %
	People in my family looked out for each other.*	345 95.83%	0–11: 55.52% 12–18: 23.13 % 0–11,12–18: 21.35 %
	I felt loved.*	334 92.66%	0–11: 55.69 % 12–18: 24.05 % 0–11,12–18: 20.25 %
	Someone in my family helped me feel important or special.*	336 93.10%	0–11: 58.25 % 12–18: 22.22 % 0–11,12–18: 19.53 %
	My family was a source of strength and support*	336 93.12%	0–11: 56.96 % 12–18: 22.33 % 0–11,12–18: 20.71 %
Physical Abuse (*n* = 9, 2.52%)	I believe that I was physically abused.	9 2.64%	0–11: 51.85 % 12–18: 25.92 % 0–11,12–18: 22.22 %
	Beaten so badly that a teacher/neighbor/doctor noticed it.	9 2.62%	0–11: 66.67 % 12–18: 16.67 % 0–11,12–18: 16.67 %
	I was punished with a belt/board/cord/other hard objects	9 2.57%	0–11: 57.89 % 0–11,12–18: 26.31 % 12–18: 15.79 %
	Got hit so hard that I had to see a doctor or go to the hospital	8 2.45%	0–11: 70.0 % 12–18: 23.33 % 0–11,12–18: 6.67 %
	My family hit me so hard that it left me with bruises and marks.	8 2.30%	0–11: 65.52 % 0–11,12–18: 17.24 % 12–18: 17.24 %

(*Continued*)

Table 3. (Continued).

The CTQ Subscale	Item	*n* *f (%)*	Age of occurrence *f (%)*
Emotional Abuse (*n* = 8, 2.37%)	I thought that my parents wished I had never been born.	8 2.39%	0–11: 68.25 % 12–18: 17.46 % 0–11,12–18: 14.28 %
	People in my family said hurtful or insulting things to me.	7 1.95%	0–11: 67.68 % 12–18: 19.19 % 0–11,12–18: 13.13 %
	People in my family called me "stupid," lazy," or "ugly."	7 1.93%	0–11: 65.55 % 12–18: 22.22 % 0–11,12–18: 12.22 %
	I felt that someone in my family hated me.	10 2.79%	0–11: 67.5 % 12–18: 25.0 % 0–11,12–18: 7.5 %
	I believe that I was emotionally abused.	10 2.79%	0–11: 50.45 % 12–18: 35.13 % 0–11,12–18: 14.41 %
Sexual Abuse (*n* = 10, 2.96%)	Someone tried to touch me in a sexual way/made me touch them.	11 3.23%	0–11: 52.94 % 12–18: 35.29 % 0–11,12–18: 11.76 %
	Someone molested me.	11 3.08%	0–11: 52.17 % 12–18: 32.61 % 0–11,12–18: 15.22 %
	I believe that I was sexually abused.	10 3.01%	0–11: 54.54 % 12–18: 34.09 % 0–11,12–18: 11.36 %
	Someone tried to make me do/watch sexual things.	9 2.77%	0–11: 53.66 % 12–18: 31.71 % 0–11,12–18: 14.63 %
	Someone threatened me unless I did something sexual.	9 2.70%	0–11: 52.63 % 12–18: 36.84 % 0–11,12–18: 10.53 %
Divorce** (*n* = 14, 4.15%)	My parents divorced/separated when I was little.	14 4.15%	0–11: 56.52 % 12–18: 33.33 % 0–11,12–18: 10.14 %

CTQ = Childhood Trauma Questionnaire; * Items are reverse coded prior to the analysis, and higher percentages refer to more adverse life experiences in the main analysis; ** This item is added to the original CTQ scale as a household difficulty.

the prevalence of unique adverse experiences, we analyzed the CTQ scale items and subscales frequencies. Of 361 participants, 54% ($n = 195$) reported having experienced at least one adverse childhood event in their lifetime. As shown in Table 3, the most frequent ACE was emotional neglect (5.98%; $n = 21$), followed by physical neglect (5.32%; $n = 19$) and divorce (4.15%; $n = 14$). The prevalence rates of emotional and sexual abuse were 2.37% ($n = 8$) and 2.96%

Table 4. Results of the moderated mediation structural equation modeling predicting relationship satisfaction.

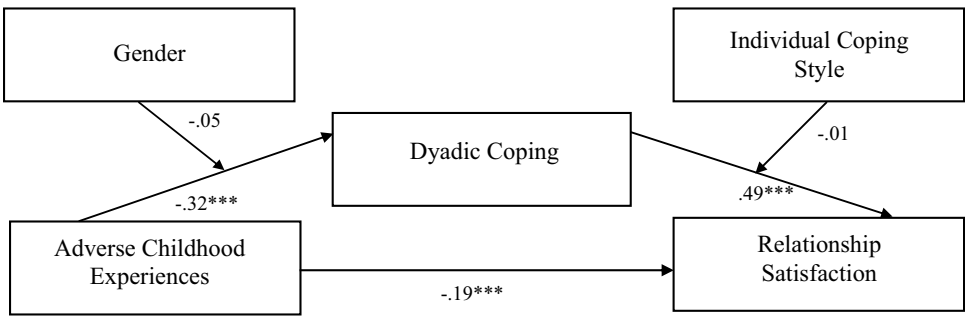
Variables	b (SE)	β	*p* value
Direct effects			
Adverse Childhood Experiences → Dyadic coping	−.77 (.15)	−.32	p < .001
Adverse Childhood Experiences → Relationship Satisfaction	−.18 (.06)	−.19	p < .001
Dyadic Coping → Relationship Satisfaction	.19 (.02)	.49	p < .001
Moderating effects			
Gender x (ACEs → Dyadic Coping)	−.80 (.96)	−.05	.40
Individual Coping Style x (Dyadic Coping → Relationship Satisfaction	−.07 (.22)	−.01	.74
Indirect effects			
Adverse Childhood Experiences → Dyadic coping → Relationship Satisfaction	−.15 (.032)	−.16	p < .001
Model fit indices			
X^2 (11) = 30.31, p < .001; *CFI* = .93; *RMSEA* = .07; *SMRM* = .07.			

(n = 10), respectively. Most adverse experiences occurred before age 12 (Table 3). We also conducted an independent sample t-test to compare ACEs across men and women. We found no gender differences in frequencies of ACEs [t (359) = −1.41, p = .61] or the age of occurrence (experiencing ACE at age 0 to 11 vs. 12 to 18 years old; p > .05).

Given those preliminary findings, we added gender and individual coping as moderating variables in the model, but the psychiatric diagnosis was not included. Therefore, the initial hypothesized model was retained and tested in the primary analysis.

Primary analysis: moderated mediation analysis via structural equation modeling

The full structural model showed that ACEs were negatively associated with relationship satisfaction (β = −.19, p < .001) and dyadic coping (β = −.32, p < .001; Table 4 and Figure 2). On the other hand, dyadic coping was positively associated with relationship satisfaction (β = .49, p < .001).



*** p < 0.001
** p < 0.01
Model fit indices: x^2(11) = 30.31, p <.001; CFI = .93; RMSEA = .07; *SMRM* = .07

Figure 2. Moderated mediation SEM model.

Mediation analysis showed that the indirect effects of ACEs on relationship satisfaction were statistically significant at $p < .001$ ($\beta = -.16$, 95% CI [.04, to .10]). We concluded that dyadic coping partially mediated the relationship between ACEs and relationship satisfaction ($\beta = -.03$, $p < .001$). The full model explained 34% of the variance in relationship satisfaction. The fit indices of the moderated mediation model to the data were adequate [X^2 (11) = 30.31, $p < .001$; *CFI* = .93; *RMSEA* = .07; *SMRM* = .07]. All moderating variables were nonsignificant in the model. Specifically, gender (0 = female, 1 = male) did not moderate the relationship between ACEs and dyadic coping ($\beta = -.05$, $p = .40$). Similarly, the moderating effect of individual coping style on the relationship between dyadic coping and relationship satisfaction was not significant ($\beta = -.01$, $p = .74$).

Discussion

The present study investigated the relationship between ACEs and relationship satisfaction through dyadic coping in a sample of partnered Turkish emerging adults. Our study has shown ACEs' direct and adverse relationship with dyadic coping and relationship satisfaction. Additionally, an increase in dyadic coping was associated with higher relationship satisfaction. Participants' gender and individual coping styles did not have moderating roles in this process.

Overall, our study demonstrated the harmful links between early childhood trauma and romantic relationships. Our study was congruent with the WHO findings indicating 49.7% of university students in Turkey were exposed to at least one adverse event during their childhood (Ulukol et al., 2014). Likewise, in our study, 54% of our participants reported having experienced at least one ACE. This indicates a relatively high prevalence of ACEs, given that our study focused on a community sample of emerging adults.

ACEs can limit an individual's access to healthy social ties and support (Umberson et al., 2014). Consequently, individuals with such childhood experiences may struggle in their relationships in adulthood (Ross et al., 2020). As congruent with the literature, our study added evidence of a negative relationship between ACEs and relationship satisfaction. Individuals who have experienced ACEs may struggle with building fulfilling relationships and experience distress in their romantic lives (Wheeler et al., 2019). The more ACEs reported, the less satisfaction our participants felt in their relationships, as chronic stress most likely spilled over to their relationships.

Additionally, the literature suggests that adults with a history of ACEs experience difficulties trusting their partners and practicing empathic communication, which are essential to accomplishing dyadic coping (Falconier & Kuhn, 2019). Congruently, our hypothesis suggesting the negative link between ACEs and dyadic coping skills was supported in the current study. Experiencing such

detrimental social encounters from an early age may have altered the development of a sense of unity, security, and trust in others (Shahab et al., 2021). When individuals have ACEs, they may be deprived of the opportunity to be reassured that they can provide and receive support from others to feel secure while facing stress (Bayar, 2021; Wheeler et al., 2020).

The link between ACEs and romantic relationships points to a developmental process. When children experience ACEs, their primary security and trust needs are unmet, compromised, or even violated. According to Whishman and Uebelacker (2006), intimacy disturbances and experiencing uncertainty about interpersonal closeness become an issue in relationships throughout one's adult life in the form of anger and suspicion. Such problems could result in difficulties in seeking help from others and fully embracing the partner's efforts to help. Likewise, it can alter skills of articulating and communicating needs to others and recognizing others' needs; for instance, maintaining positive social connections involves reading social cues, expressing the self, and finding others who will not exploit and abuse (Nelson et al., 2020). Unfortunately, the ability to create and maintain relationships is affected by past abuse (Zemp et al., 2016). Adult survivors are often in relationships with general dissatisfaction (Ekşi, 2021; Shahab et al., 2021; Wheeler et al., 2020). Such dissatisfaction can be related to the consequences of early experiences of childhood abuse and maladaptive schemas, such as perceiving oneself as damaged, unworthy, or unlovable (Minaz, 2023; Miskiewicz et al., 2016). In one study, participants disclosed that it was hard to trust a partner and be themselves because they had once trusted someone close to them who had betrayed them during childhood (Sigurdardottir et al., 2012).

Relevantly equivalent to our findings, literature has suggested that having high levels of dyadic coping results in greater relationship satisfaction (Bodenmann et al., 2019; Falconier et al., 2015). In our final model, the most robust relationship was between dyadic coping and relationship satisfaction (compared to other pathways). That is, adaptive communication skills, supportive interaction, and stress management were strongly linked to relationship satisfaction. Dyadic coping, by nature, is a shared process and requires both partners' participation and joint effort (Bodenmann, 1997). However, in the current study, participants reported dyadic coping at the couple subsystem (perceptions of their partner's and own supportive behaviors). Thus, participants may have generalized their supportive and responsive behaviors to the romantic relationship. Such generalization could be linked to relationship satisfaction such that by generalization their responsiveness, caring partners may feel more security and trust in the relationship (Falconier & Kuhn, 2019). Therefore, by the nature of our assessment in the current study, a participant's report of dyadic coping and relationship satisfaction may overlap because it reflects their overall perception of the romantic relationship.

As hypothesized, we found evidence that dyadic coping partially mediated the relationship between ACEs and relationship satisfaction. These findings are consistent with prior research (i.e., Fitzgerald & Shuler, 2022) and indicate that dyadic coping may buffer the negative association between ACEs and relationship satisfaction. Dyadic coping may appear vital in the relationship, even if a partner has early childhood traumas. Turkish emerging adults benefit from the buffering and supportive elements of dyadic coping while facing a chronic stressor like ACEs to improve their relationship satisfaction.

Contrary to our hypothesis, there was no moderating association of gender on the relationship between ACEs and dyadic coping. This finding was unexpected because an accumulation of research suggests that ACEs are more common among women (globally and also in Turkey; Moody et al., 2018; Ulukol et al., 2014) and Turkish women are socialized to conform to the gender role to maintain romantic relationships and navigate the stress in the family system (Erdem et al., 2022; Sunar & Fişek, 2005). This finding reveals that despite the empirical evidence that women are more perceptive of stress in romantic relationships (i.e., Fitzgerald & Shuler, 2022), the negative associations between ACEs and dyadic coping may still be consistent for both men and women. Another factor in this indifference could be related to how ACEs were operationalized in the current study. We assessed various ACEs varying from sexual abuse to parental divorce and used an overall score for each participant. Therefore, the overall scores might have overlooked differences between men and women.

Furthermore, we hypothesized that individuals with adaptive coping strategies would form stronger dyadic coping within their relationships and greater relationship satisfaction. This hypothesis was also not supported; the individual's coping styles did not make a difference in the positive relationship between dyadic coping and relationship satisfaction. One explanation of this finding relates the dyadic coping being a relational construct that is above and beyond each partner's features (Falconier & Kuhn, 2019). Partners are influenced by each other's levels of commitment, behaviors, communication techniques, emotion regulation techniques, reactions, and personal histories and assets (Falconier & Kuhn, 2019). Therefore, as expected, individual coping styles may not contribute to that dyadic construct. Our study suggested that dyadic coping alleviates childhood trauma's harmful effects while promoting relationship satisfaction. Accordingly, another explanation for the insignificant moderation of individual coping styles can be that the role of dyadic coping was so vital that it surpassed the potential association between personal coping and relationship satisfaction.

Limitations and strengths

One major limitation of the study was convenience sampling. The current sample only represents some of the Turkish emerging adult population, as our sample consisted of highly educated individuals in urban Turkey. Future research could investigate the possible cultural elements that interact with dyadic coping and relationship satisfaction, especially in rural Turkey. There is a need for further research to explore the role of conservatism in emerging adults' romantic relationships and examine specific dyadic coping strategies among rural emerging adults.

Another limitation in our research design relates to the sample characteristics and generalizability. The current study used a non-clinical community adult sample in which prevalence and severity of ACEs were relatively low. Therefore, our results only presents a conservative estimate of association between ACEs, dyadic coping, and relationship satisfaction and may not apply to the clinical population. Future studies should replicate the present study and use clinical samples to verify and expand our results.

In addition, our data relied on individuals' self-reports of their behavior and those of their partners. A more valid assessment of dyadic coping would include both partners' reports on their relationship. Such research would enable us to see the potential actor and partner effects on dyadic coping and relationship satisfaction. Another limitation is related to the assessment of ACEs. In the current study, the participants reported on their experiences retrospectively, which may have created a susceptibility to bias in memory recollection and retrieval (i.e., false memories, childhood amnesia). A prospective design with a long-term follow-up would control such contamination. We also acknowledge that we assessed abuse and neglect but had to rely on only one item to determine household challenges (parental divorce). Future studies can investigate ACEs more in-depth by incorporating a wide range of household challenges such as parental mental illness, suicide in the family, parental incarceration, and substance misuse.

The study was cross-sectional in its design. Therefore, the direction of our hypotheses can be in reverse. It is equally likely that participants have experienced ACEs and found themselves in unsatisfactory relationships, or they tend to recall adverse life events more often, given their current unhappy relationship. Similarly, we can't infer whether participants were more open to noticing dyadic coping strategies because they were already satisfied with the relationship. It is also likely that participants may have experienced more dyadic coping processes and felt supported, therefore, were more satisfied in the relationship. There is a need for future research with a longitudinal design to capture how dyadic coping and relationship satisfaction change over time for individuals with ACEs.

Furthermore, the study sample was not large enough to examine the role of abuse type and dyadic coping strategy in relationship satisfaction. For example, there was not enough power to explore the direct and indirect effects of physical, emotional, and sexual abuse and neglect separately for relationship satisfaction. Similarly, a more in-depth understanding of dyadic coping would examine the role of hostile or ambivalent dyadic coping styles and positive types of dyadic coping in relationship satisfaction and quality. Negative dyadic coping styles can be a warning sign for potentially abusive relationships, especially for those with histories of ACEs. A future study with a larger sample size can investigate how each subcategory of CTQ is associated explicitly with different dyadic coping strategies and overall relationship satisfaction.

Of note, the current study focused on youth in committed romantic relationships. Studies with married emerging adults testing the same model could yield different results given that individuals in long-term relationships are more invested in the relationship (Lantagne & Furman, 2017) and are more likely to perform maintenance behaviors (Chonody & Gabb, 2018) but report lower relationship satisfaction (Molero et al., 2016). Therefore, a replication study of the current study with a sample of older and married adults is essential. We acknowledge that the link between ACEs and relationship processes may differ when partners are more invested in the relationship. Lastly, we did not assess participants' past or present experiences of intimate partner violence. Research has shown that individuals with histories of ACEs are at risk of experiencing abuse in romantic relationships (Wheeler et al., 2019). Therefore, it is likely that some participants who report low positive dyadic coping may already be in dysfunctional and abusive relationships.

Despite these limitations, the current study has significant contributions to the literature. Our study expands the research on romantic relationships of Turkish emerging adults. It is known that intimacy can be challenging in this age group (Uçar & Demir, 2022). Therefore, shedding light on the importance of dyadic coping for this age group might contribute to understanding related processes such as relationship maintenance behaviors, satisfaction, and commitment. Additionally, our assessment of ACEs relied on the CTQ measure, a comprehensive tool that captures various types of abuse, compared to other measures such as the Violence Exposure Scale for Children-Revised (VEX-R; Liebschutz et al., 2018). The current study might raise awareness of ACEs' prevalence and negative consequences (Ross et al., 2020). In our study, 54% of our participants reported childhood adversity, which was alarmingly common. Also, this was directly and negatively related to their experienced satisfaction from their relationships. These findings could hopefully be beneficial for prevention work.

Our study also allowed an investigation into how related concepts of gender and individual coping play a role in the inspected relationship. Findings suggested that, regardless of gender, ACEs may detrimentally affect

individuals' romantic relationships in adulthood. This finding contributes to the literature by showing how indiscriminately damaging ACEs can be.

Implications for clinical practice

Our study has shown the harmful links between ACEs and social functioning in adulthood. These findings illustrate that in therapy, identifying and addressing ACEs are fundamental (Bethell et al., 2017). Addressing underlying trauma with techniques such as trauma-focused cognitive behavioral therapy (Mannarino et al., 2012), emotionally focused couples therapy (EFT; Johnson, 2019), or schema therapy (Young, 1990) may annihilate the adverse effects of trauma. Coulter (2011) proposes that systemic psychotherapy principles are applicable to address post-traumatic stress symptoms. Additionally, EFT can help clients make positive meaning that increases resilience by reflecting on and integrating traumatic experiences (Johnson, 2019). Schema therapy can also help to restructure early-developed maladaptive schemas related to traumatic experiences (Young, 1990; Pilkington et al., 2021). In addition, the self and attachment difficulties associated with chronic childhood abuse and other forms of pervasive trauma must be understood and addressed in the context of the therapeutic relationship (Johnson, 2019).

Additionally, our study demonstrates the buffering effects of dyadic coping for adults with childhood adversities. These findings highlight the importance of corrective experiences and social support in healing and eliminating the negative impacts of past hardships (Blair et al., 2019) and have several implications for couples' therapy. First, couples might benefit from increased awareness about the association between dyadic coping and relationship satisfaction, especially in the face of stress (Falconier et al., 2015). Couple and family therapists could incorporate psychoeducation and skills training for couples (Bodenmann et al., 2019) who may be distressed with ACEs. Several of these dyadic coping strategies may include but are not limited to communication skills, emotion regulation, providing emotional and problem-focused support, taking responsibility for the relationship and the other person, and showing conjoint effort (Bodenmann et al., 2006). These therapeutic interventions can eliminate the stress associated with ACEs while increasing relationship satisfaction for both partners.

Conclusion

The current study points out the importance of solidarity between partners in romantic relationships of emerging adults with a history of adverse childhood experiences. Therefore, it seems essential for couples to develop strategies to

cope with stress together, alleviate the traces of adverse events experienced in the past, and increase relationship satisfaction.

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Data availability statement

Data, syntax, and output are available from the first author on request.

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