EARLY MALADAPTIVE SCHEMAS AND WELL-BEING: IMPORTANCE OF PARENTING STYLES AND OTHER PSYCHOLOGICAL RESOURCES

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

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ABSTRACT

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The purpose of the present study was to examine the differences in demographic variables (i.e., gender, age, mother's and father's education level, monthly income, and residence status) on the measures of the study (i.e., parenting styles, schema domains, personality dimensions, coping styles, perceived social support, and well-being) of the study. Secondly, this study aimed to investigate the relationship between these measures and to determine the associated factors of schema domains, personality dimensions, other psychological resources namely coping strategies and perceived social support, and lastly, psychological symptoms and life satisfaction. For these purposes, data was collected from 309 university students aging between 18-33 years old, from different cities in Turkey. The results revealed that schemas were closely related to perceived negative parenting; and besides their significant effects, it was found out that personality dimensions, coping strategies, and perceived social support had important role on psychological symptoms and life satisfaction. Especially having higher levels of neuroticism, insufficient usage of coping strategies, and lower levels of perceived social support, besides perceiving

high levels of negative parenting, and having stronger schema structure in Disconnection/Rejection domain were associated with higher levels of psychological symptoms and lower levels of life satisfaction. These results indicated that psychological resources (i.e., personality, coping strategies, and perceived social support) have additional effects on well-being. Finally, implications of these results and limitations of the study were discussed in line with the literature and suggestions for future studies were mentioned.

Keywords: Parenting Styles, Early Maladaptive Schemas, Personality, Psychological Resources, Satisfaction with Life

ÖZ

ERKEN DÖNEM UYUMSUZ ŞEMALAR VE PSİKOLOJİK İYİLİK HALİ: EBEVEYN TUTUMLARI VE DİĞER PSİKOLOJİK KAYNAKLARIN ÖNEMİ

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Bu çalışmanın amacı, demografik özelliklerin (cinsiyet, yaş, anne ve baba eğitim düzeyi, aylık gelir ve ikamet edilen yer) araştırmanın ölçütleri (ebeveyn tutumları, şema alanları, kişilik boyutları, baş etme yolları, algılanan sosyal destek ve psikolojik iyilik hali) üzerindeki etkisini araştırmaktır. Bu çalışmada, ayrıca, bu ölçütler arasındaki ilişkinin incelenmesi ve şema alanları, kişilik boyutları, baş etme yolları ve algılanan sosyal desteği kapsayan diğer psikolojik kaynaklar ve psikolojik belirtiler ve yaşam doyumunu yordayan faktörlerin belirlenmesi amaçlanmıştır. Çalışmanın verisi, Türkiye'nin farklı şehirlerinde, 18-33 yaşları arasındaki 309 üniversite öğrencisinden toplanmıştır. Sonuçlar, şemaların algılanan olumsuz ebeveynlik ile yakından ilişkili olduğunu göstermiş; bunların anlamlı etkilerinin yanı sıra, kişilik boyutları, baş etme yolları ve algılanan sosyal desteğin de, psikolojik belirtiler ve yaşam doyumu üzerinde önemli bir rol oynadıkları bulunmuştur. Özellikle, olumsuz ebeveynlik algısı ve Ayrılma/Reddedilme alanında güçlü şemaların yanında, duygusal dengesizlik, etkisiz baş etme yollarının kullanımı ve algılanan düşük sosyal desteğin daha fazla psikolojik belirtiyle ve daha düşük yaşam doyumu ile ilişkili olduğu görülmüştür. Bu sonuçlar, psikolojik

kaynakların (kişilik, baş etme yolları ve algılanan sosyal destek) psikolojik iyilik hali üzerinde fazladan bir etkisi olduğunu göstermiştir. Sonuç olarak, bu bulgulara ilişkin çıkarımlar ve çalışmaya ilişkin sınırlılıklar, literatürdeki bulgularla birlikte tartışılmış ve gelecek çalışmalara yönelik önerilere yer verilmiştir.

Anahtar Kelimeler: Ebeveyn Tutumları, Erken Dönem Uyumsuz Şemalar, Kişilik, Psikolojik Kaynaklar, Yaşam Doyumu

To the funniest family ever,

with love…

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and laughter in my life. I am thankful to her for every moment we have shared together, making me a happier, stronger, and better person.

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CHAPTER 1

INTRODUCTION

Throughout the history of psychology, theorists and practitioners focused on understanding the reasons of psychological disorders. Each theory has emphasized different factors associated with personality and psychopathology. Without dating back to the early theories, for the sake of the current study, it is important to mention Cognitive Therapy (CT), which was developed by Beck in the early 1960s as a treatment for depression, focusing on the present-problems and related distorted thinking. Since then, Cognitive Behavioral Therapy (CBT) has been used for various psychiatric disorders and conditions such as anxiety disorders, eating disorders, substance abuse, and couples problems (Beck, 1995) and studies consistently revealed the efficacy of this approach. However, although limited, studies conducted with patients who have persistent problems, such as personality disorders, which are related to negative experiences in childhood, revealed mixed results related to the effectiveness of CBT in the treatment of personality disorders (Beck, Freeman, & Davis, 2004). Therefore, early negative experiences become important besides present problems and maladaptive cognitions for the treatment of these disorders. In the first part of the introduction, schema therapy, its development, and its relationship with several psychological disorders will be described. Secondly, perceived parenting styles and their psychological consequences will be presented, along with the studies related to the mediating role of schemas on this relationship. Lastly, some psychological resources having an effect on the relationship between perceived parenting styles, schemas, and psychological symptoms will be introduced, namely personality dimensions, coping styles, and perceived social support.

1.1. Early Maladaptive Schemas

Schema therapy explains the root of psychological distress with early maladaptive schemas (EMSs), which are defined as "broad, pervasive theme or pattern, comprised of memories, emotions, cognitions, and bodily sensations, regarding oneself and one's relationships with others, developed during childhood or adolescence, elaborated throughout one's lifetime and dysfunctional to a significant degree" (Young, 1999; Young, Klosko, & Weishaar, 2003). In schema therapy, it is stated that maladaptive behaviors are responses to and driven by EMSs, most of which are mainly resulted from toxic childhood experiences. From their clinical experiences, Young et al. (2003) identified five "core emotional needs" that should be met in childhood: secure attachment to others; autonomy, competence, and sense of identity; freedom to express valid needs and emotions; spontaneity and play; and realistic limits and self-control. Toxic frustration of these needs, where child experiences very few positive things, may lead to the development of several EMSs. Moreover, traumatization or victimization, where child is harmed, is related to development of EMSs as well. Thirdly, child may experience more positive things than a child normally needs; or s/he may selectively internalize his/her parents' behaviors, which are the other sources of EMSs, which will be discussed below. Apart from early childhood environment, emotional temperament of the child, which is thought to be a stable characteristic, is also associated with the development of EMSs. Individuals tend to maintain their schemas through different mechanisms, either by cognitive distortions, self-defeating patterns, or maladaptive coping styles.

Young et al. (2003) categorized 18 different EMSs into 5 domains. First of all, individuals who have schemas from "Disconnection and Rejection" domain are more likely to feel insecure about others, who are expected to meet their physiological and psychological needs. Their parents are mostly cold, rejecting, unstable, or abusive. If they have the *Abandonment/Instability* schema, these individuals believe that others will be absent or will abandon them or that others cannot be trusted because they are unpredictable about meeting their needs. Those

who have the *Mistrust/Abuse* schema, they suppose that others will hurt, humiliate, or take advantage of them on purpose. In addition, the *Emotional Deprivation* schema is about the expected lack of adequate levels of emotional support; either lack of care and affection, lack of understanding, or lack of protection and guidance from significant others, whereas the *Defectiveness/Shame* schema is about feeling worthless and inferior to others and being ashamed of one's perceived defects. Lastly, the *Social Isolation/Alienation* schema is isolating oneself from social groups and community and feeling different from others.

The second domain, which includes 4 different schemas, is "Impaired Autonomy and Performance" domain. Individuals who have schemas from this domain are less likely to function independently from their significant others, to form their own identity and to live their own life. Even in their adulthood, they are like children, who have no specific goals or no skills to attain some of them. Parents of these individuals were probably overprotective towards them, or did everything for them by not letting accomplish things by themselves, which prevented them to have self-confidence. Those who have the *Dependence/Incompetence* schema believe that they need others' help to complete their everyday responsibilities and they are helpless without them. Secondly, when they have the *Vulnerability to Harm or Illness* schemas, they are exaggeratedly afraid to confront medical, emotional, or external catastrophes that cannot be prevented because they will not be able to cope with them efficiently. Besides, third schema in this domain is the *Enmeshment/Undeveloped Self* schema, which is related to the need of enmeshed relationships with others because one cannot be happy without their constant emotional support and closeness. Lastly, *Failure* schema is assumptions that one will eventually fail and is inadequate when compared to his/her peers usually in areas which require achievement, such as school and career.

Schemas in "Impaired Limits" domain are related to inadequacies in internal limits, where individuals do not respect the rights of others, cannot cooperate with them, have impulsive behaviors, and are often seen selfish, irresponsible, or narcissistic. They were grown in permissive and indulgent families, where they

were not provided with rules, or limits that they should follow related to their own self-control or others' rights. There are two different EMSs in this domain: the *Entitlement/Grandiosity* schema and the *Insufficient Self-Control/Self-Discipline* schemas. Individuals who have the former believe that they are superior to others and they deserve some rights and privileges, without caring the rights of and the costs to others. On the other hand, the latter is about difficulty in controlling oneself or one's emotional expressions, and tolerating frustration, in order to achieve their goals.

Individuals who have schemas from "Other-Directedness" domain ignore their own needs and instead focus on others' desires and expectancies in order to be approved by and emotionally connected with them. In other words, their behaviors are externally driven. During their childhood, it is likely that their parents were concerned with their own needs or social appearances and gave conditional approval to them, where the child had to behave accordingly in order to gain love and approval. When these individuals have the *Subjugation* schema, they tend to suppress their needs and emotions, which are believed to be unimportant and invalid. Rather, they excessively comply with others, and try to avoid anger and abandonment. Secondly, the *Self-Sacrifice* schema involves voluntary meeting the needs of others, who are believed to be needy, in order to avoid guilt, to have higher self-esteem, and to be connected with them. Lastly, individuals with the *Approval-Seeking/Recognition-Seeking* schema excessively focus on their social status, appearance or success to gain approval and recognition from others, whose reactions are more important for the development of their self-esteem.

The last domain includes four different schemas and is called "Overvigilance and Inhibition" domain, in which individuals have difficulties in spontaneity and excessively try to meet some rigid rules about their own lives. They are usually pessimistic and worried about future, believing that anything could happen in case they are not careful. Their childhood environment consisted of experiences of restricted spontaneity and pleasure, where they were not reinforced to play but were taught to be alerted towards negative life events. The

Negativity/Pessimism schema is the long-lasting expectation that eventually, everything in life will go wrong, and the ignorance of positive aspects of life, which make these individuals worried, hypervigilant, and indecisive. Furthermore, individuals with the *Emotional Inhibition* schema restrict their spontaneity, including their emotions especially anger and some positive emotions (e.g., sexual excitement), avoid expressing their vulnerability, or rationalize events to ignore their emotions; all of which are for the sake of not being criticized and not losing their control. Thirdly, individuals with the *Unrelenting Standards/Hypercriticalness* schema have very high, internalized standards that they should follow in order to be approved by others. They either are perfectionist, preoccupied with time and efficiency, or have unrealistically rigid rules. Lastly, the *Punitiveness* schema is the belief that anyone who makes mistakes should be harshly punished and their mistakes should not be tolerated (Young et al., 2003).

Since the introduction of EMSs in the literature, they have been widely investigated with both community and clinical samples, in different cultures through self-report inventories. 205-item Young Schema Questionnaire (YSQ) was developed to evaluate 15 different schemas: abandonment/instability, mistrust/abuse, emotional deprivation, defectiveness, social isolation, dependency, vulnerability to harm, enmeshment/undeveloped self, failure, entitlement, insufficient self-control, subjugation, self-sacrifice, emotional inhibition, and unrelenting standards (Young, 1999). Studies with YSQ-Long Form (YSQ-LF) supported the presence of all these schemas especially in clinical samples (Lee, Taylor, & Dunn, 1999; Schmidt, Joiner, Young, & Telch, 1995). Later on, shorter version of the questionnaire, consisting 75 items and assessing same 15 EMSs, was developed by Young and Brown (1999) for research purposes and it has been revealed that factor structure of YSQ-Short Form is consistent with the longer version (Welburn, Coristine, Dagg, Pontefract, & Jordan, 2002). However, this factor structure may not be confirmed each and every time. For instance, in a study conducted with university students, factor analysis supported 14 schemas, excluding defectiveness/shame schema (Cecero, Nelson, & Gillie, 2004). In addition, Spanish

version of YSQ-SF yielded 15 comparable factors in 3 schema domains in a study conducted by Calvate, Estevez, Lopez de Arroyabe, and Ruiz (2005, cited in Oei & Baranoff, 2007) whereas another study conducted with Korean and Australian students revealed 13 schemas (Baranoff, Oei, Kwon, & Cho, 2006), excluding the Subjugation and the Dependence/Incompetence schemas.

Finally, the third version of the questionnaire (YSQ-SF3), which has 90 items and includes three remaining schemas, namely approval seeking, pessimism, and punitiveness as well, was developed by Young (2006). Turkish adaptation study of the scale was conducted with university students by Soygüt, Karaosmanoğlu, and Çakır (2009) and the results revealed 15 schemas on 5 different domains, which were consistent with the literature. On the other hand, factor analysis results of a study conducted with Turkish adolescent sample showed that 18 schemas are categorized into three domains, namely "impaired limits/exaggerated standards", "disconnection/rejection", and "impaired autonomy/other directedness" (Sarıtaş & Gençöz, 2011). For each versions of the questionnaire, the discrepancies in factor structure across different studies have been explained either through sample differences, such as clinical versus community samples, in which EMSs are believed to exist in weaker forms, or through cultural differences as it is the case in Baranoff et al. (2006), since the questionnaire was developed in a Western culture. In addition, differences in versions of the questionnaire might be another reason for these discrepancies because item numbers and compositions are different for each form, although they were shown to be consistent with each other (Sarıtaş & Gençöz, 2011).

1.1.1. Early Maladaptive Schemas and Psychological Symptomatology

Cognitive schemas have not been developed recently, but have been important concepts for Beck (1976)'s cognitive theory, in which they are believed to be the roots of development of psychological problems, and maintenance and relapses of the disorders. However, cognitive behavioral therapies mostly focus on reducing symptoms and helping patients to learn some skills and to solve their

current problems, which may not be suitable for some of the patients who do not have clear-cut problems but enduring issues, such as personality disorders. Therefore, Young (2003) integrated Beck's cognitive theory, Bowlby's attachment theory, object relations, Gestalt and psychoanalytical perspectives, and developed his schema theory, in which he could organize chronic problems into meaningful parts, which are called EMSs. Since then, many empirical studies have been conducted with both clinical and non-clinical samples in order to investigate the proposed relationship between EMSs and psychological disorders and it has been shown that schema therapy has been effective in the treatment and prevention of relapses of chronic depression and anxiety, eating disorders, substance abuse, and interpersonal problems (Young, 2003).

1.1.1.1. Personality Disorder Symptomatology

In Diagnostic and Statistical Manual of Mental Disorders, Fourth Text Edition Revision (DSM-IV-TR; American Psychiatric Association [APA], 2000), personality disorders (PD) are defined as individual's "enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" in interpersonal and social contexts. There are 10 different PDs defined in DSM-IV-TR, categorized into three clusters based on their characteristics. Cluster A (odd-eccentric) PDs includes paranoid, schizoid, and schizotypal PDs; Cluster B (dramatic-emotional) PDs includes antisocial, borderline, histrionic, and narcissistic PDs; and Cluster C (anxious-fearful) PDs includes avoidant, dependent, and obsessive-compusive PDs.

Since schema-focused therapy was proposed, the relationship between EMSs and PDs has been widely investigated. For instance, the results of the studies conducted with patients indicated that those who meet PD criteria have higher variety of EMSs than those with Axis I disorders of DSM-IV-TR (APA, 2000) and those who do not have any psychological problems (Lee et al., 1999; Schmidt et al., 1995). Moreover, the association between EMSs or schema domains and specific

types of PDs has been examined in order to understand underlying cognitive structures of these disorders. First of all, studies regarding borderline PD, the most investigated one among PDs, have found out that schemas from Disconnection/Rejection and Impaired Autonomy and Performance domains are commonly present in patients with borderline PD, although some conflicting results exist. In their study conducted with 23 substance abuse patients, Ball and Cecero (2001) have concluded that borderline PD was related to Abandonment and Mistrust/Abuse schemas from Disconnection/Rejection domain, whereas Jovey and Jackson (2004) have found that borderline PD differs from avoidant and obsessive-compulsive PDs in terms of its relationship with Defectiveness/Shame and Abandonment schemas, as well as Dependence/Incompetence schema from Impaired Autonomy and Performance domain (cited in Lawrance, Allen, & Chanen, 2011). On the other hand, Lawrance et al. (2011) found that although patients with borderline PD scored significantly higher on 11 of 15 schemas than controls, there was not any specific maladaptive schema related to borderline PD and concluded that individual examination of EMSs is important. These results are believed to arise from the differences in the combination of borderline features such as intense anger, impulsivity, and problematic interpersonal relationships in each individual.

Besides borderline PD, researchers have also investigated the relationship of EMSs with other PDs and controversial results were obtained for this comparison as well. For instance, although Ball and Cecero (2001) and Jovey and Jackson (2004) revealed that avoidant PD is related with schemas in "Disconnection Rejection" domain and the dependence/incompetence schema in "Impaired Autonomy and Performance" domain (cited in Carr & Francis, 2010), results also revealed a significant relationship between avoidant PD and the abandonment, subjugation, and emotional inhibition schemas in a non-clinical sample (Carr & Francis, 2010). On the other hand, Zeigler-Hill, Green, Arnau, Sisemore, and Myers (2011) have examined EMSs underlying normal and pathological forms of narcissism and revealed that two forms of narcissism differed in terms of their association with

EMSs and the entitlement schema was closely associated with all aspects of narcissism as it was indicated by Young et al. (2003).

Several studies have been conducted in order to examine the effectiveness of schema-focused therapy (SFT) on personality disorders. First, in a study conducted with 86 borderline PD patients, who were randomly assigned to either transference-focused psychotherapy or SFT conditions and treated for 3 years maximum, Arntz (2008) revealed that SFT has been found to be more cost-effective than transference-focused psychotherapy, with continued recovery after 1 year. In addition, Gude and Hoffart (2008) designed a quasi experimental study with two different cohorts, in which patients with agoraphobia on Axis I and Cluster C PD symptomatology on Axis II were assigned to either psychodynamic program (as a usual treatment) or cognitive and SFT program (CT group), of which first phase included the reduction of agoraphobia symptoms through cognitive restructuring and second phase included SFT directed at characterological problems. The results of this study have also indicated that the level interpersonal problems in CT decreased more than psychodynamic treatment, even at the 1-year follow-up. Similar results, which show that SFT is cost-effective in treating PDs, have been obtained in some other studies as well (van Asselt et al., 2008; van den Broek, Keulen-de Vos, & Bernstein, 2011). Therefore, the findings regarding the effectiveness of SFT on PDs are consistent with the schema theory indicating that EMSs play a crucial role on the development of long-standing personality problems.

1.1.1.2. Axis I Symptomatology

Although schema theory and schema-focused therapy (SFT) have been developed in order to overcome challenges faced when working with patients with personality problems or other chronic problems (Young, 1999; Young et al., 2003), the relationship between EMSs and Axis I disorders of DSM-IV-TR (APA, 2000) has also been investigated and there is a growing evidence that they are closely associated with each other.

1.1.1.2.1. Mood Disorders

First of all, Halvorsen, Wang, Eisemann, and Waterloo (2010) have examined depressogenic cognitions and schemas, which were assessed via YSQ-LF, in depressed individuals. The results indicated that "Undesirability" domain, which included the Defectiveness, Social Undesirability, and Failure to Achieve schemas according to Young's model in 1990 (Schmidt et al., 1995), is found to be a vulnerability factor for depression when controlled for the effects of initial depression severity and past depression, after several years. Moreover, "Impaired Limits" domain, which included the Entitlement, and Insufficient Self-Control schemas, has been also a significant predictor of depression episodes after 9-year follow-up. On the other hand, schemas in "Impaired Autonomy" domain were related to depressed mood; however, they were not remained significant during follow-ups. Besides clinical samples, student samples have been also used by researchers. For instance, Harris and Curtin (2002) have found out in a study conducted with 211 university students that the Defectiveness/Shame, Insufficient Self-Control, Vulnerability, and Incompetence/Inferority schemas in YSQ-LF are associated with depressive symtomatology. After all, three of these EMSs, excluding Vulnerability schema, are related to the negative perception of self in Beck's cognitive triad. Similarly, Roelofs, Lee, Ruijten, and Lobbastael (2011) indicated that all EMSs in YSQ-LF were significantly correlated with depression symptoms.

Though there has been limited number of studies investigating the relationship between EMSs and bipolar disorder, Hawke, Provencher, and Arntz (2011) hypothesized that patients with bipolar disorders would have higher scores of EMSs and bipolarity would be positively associated with the Entitlement/Grandiosity, Insufficient Self-Control/Self-Discipline, and Unrelenting Standards/Hypercriticalness schemas and negatively associated with the Emotional Inhibition schema, given the characteristics of bipolar disorder. The results have revealed that the Entitlement/Grandiosity and Insufficient Self-Control/Self-Discipline schemas are the core of the disorder while the Emotional Inhibition

schema has a significant negative association with bipolar disorder symptoms. However, the Unrelenting Standards/Hypercriticalness schema did not come up as a significant predictor of bipolarity. Besides the hypothesized schemas, confirmatory analyses have shown that Vulnerability to Harm and Illness, and Mistrust/Abuse schemas might be positive predictors as well, whereas Subjugation schema might be a negative predictor of risk.

1.1.1.2.2. Anxiety Disorders

The relationship between EMSs and anxiety disorders has been examined as well. In a study comparing patients with social phobia to patients with other anxiety disorders, namely panic, and obsessive-compulsive disorders, and to participants with no psychiatric conditions in terms of EMSs they have, it was first indicated that clinical groups had higher scores on EMSs than non-clinical group (Pinto-Gouveia, Castilho, Galhardo, & Cunha, 2006). In addition, patients with social phobia had higher scores than patients with other anxiety disorders as well. This difference demonstrates that social phobia is more associated to negative core beliefs about self and others than panic disorder or obsessive-compulsive disorder. Besides quantitative difference in EMSs between these two groups, they were differentiated from each other in terms of EMSs they had as well. To be precise, patients with social phobia were more likely to have schemas in "Dependence" domain than patients with other anxiety disorders, indicating social phobia is more associated with the lack of nurturing and trustworthy relationships. Similarly, Cockram, Drummond, and Lee (2010) conducted a study with Vietnam veterans, in which they examined the role of EMSs on post-traumatic stress disorder (PTSD) by comparing veterans who met the diagnosis to those who did not at the time of assessment. According to the results, high scores on EMSs are closely related to PTSD diagnosis. The most occurring schema among veterans with PTSD is the Vulnerability to Harm and Illness schema, which is followed by the Emotional Inhibition, Social Isolation, Insufficient Self-Control, Mistrust/Abuse, Negativity/Pessimism, and Abandonment schemas, although the direction of

relationship between maladaptive cognitions and PTSD remains unclear. As the second part of their study, war veterans with PTSD, who were provided SFT, were compared to a historical control group, who were provided traditional cognitive-behavioral therapy (CBT). The results showed that the reduction of PTSD, depression, and anxiety symptoms was greater in SFT when compared to CBT, even after 3-month follow-up (Cockram et al., 2010).

1.1.1.2.3. Eating Disorders

As for the eating disorders, several studies examined the association of EMSs with specific types of eating disorders, namely anorexia nervosa restricting type (ANP), anorexia nervosa binge eating/purging type (ANB/P) bulimia nervosa (BN), and binge eating disorder (BED), and with the occurrence and frequency of compensatory behaviors. It has been found that, similar to mood disorders and anxiety disorders, patients with eating disorders have more EMSs than healthy controls in general. In addition, Waller et al. (2000) revealed that Emotional Inhibition schema is related to frequency of bingeing whereas Defectiveness/Shame schema is related to frequency of vomiting (cited in Dingemans, Spinhoven, & van Furth, 2006). Besides, Dingemans et al. (2006) found that patients with both types of AN and patients with BN did not differed from each other in terms of the level of EMSs they have. However, they had more EMSs than patients with BED and participants in control group, whose scores were significantly lower than patients with BED as well. Moreover, although the frequency of binge eating periods was not related to the severity of EMSs, there was a positive association between compensatory behaviors and all domains of YSQ-LF (namely "Disconnection", "Impaired Autonomy", "Impaired Limits", and "Overcontrol" domains), which may indicate that compensatory behaviors are related to more severe psychopathology.

1.1.1.2.4. Substance-Related Disorders

Lastly, substance and alcohol dependence has been also studied in relation with cognitive schemas. Since schema theory (Young, 2003) indicates that alcohol

or drug use, which enables the individual to avoid or to compensate his problems about himself and his environment, is one of the common coping strategies, it is important to examine the relationship between dependence and EMSs. Therefore, studies have focused on differences between clinical and non-clinical groups, as well as the differences between patients with different types of dependence, such as alcohol, and opiate dependency. For instance, in a study conducted with alcohol dependent, opiate dependent, combined alcohol and opiate dependent patients, and non-clinical group, it was found out that generally, the level of EMSs was higher in clinical group compared to non-clinical group (Brotchie, Meyer, Copello, Kidney, & Waller, 2004). In addition, among clinical group, patients with alcohol dependence have the greatest level of schematic disturbance, with highest emphasis on the Vulnerability to Harm, Subjugation, and Emotional Inhibition schemas. Similarly, it has been revealed in a study conducted with alcohol dependent patients and non-clinical participants that clinical group scored higher on all EMSs except Unrelenting Standards, Self-Sacrifice, and Entitlement schemas (Roper, Dickson, Tinwell, Booth, & McGuire, 2010). However, after three-week abstinence, a significant decline was observed in some EMSs as compared to non-clinical group's level, except for the Emotional Dependence, Mistrust, Defectiveness/Shame, Functional Dependence, Vulnerability to Harm, and Subjugation schemas of YSQ, which significantly declined compared to their initial levels as well. In line with these findings, dual focus schema therapy (DFST), a 24-session manualized therapy, was designed for substance abusers with personality disorders, who might not respond well to usual treatments of substance abuse (Ball, 1998). The integration of schema therapy into the procedure makes possible to understand patients' enduring interpersonal problems leading to substance abuse and prevent the relapse. Although there is limited research on this approach, Ball and Young (2000) shared three patients treated with DFST and concluded that its focus on both overt and covert aspects of these disorders might be an advantage over behavioral, cognitive or psychoanalytic therapies.

To sum up, the results of the studies examining the relationship between EMSs and Axis I disorders of DSM-IV-TR (APA, 2000) indicates that EMSs are more activated in patients with these disorders than healthy individuals, which might be a support to schema theory, and to the different pathogenic structures of disorders (Muris, 2006). Moreover, usually different types of disorders are related to different schema domains, which can facilitate case conceptualization in clinical settings. For instance, in depression, schemas from "Disconnection and Rejection" and "Impaired Autonomy and Performance" domains tend to be mostly activated whereas in bipolar disorder schemas from "Impaired Limits" domain are more likely to come out. On the other hand, anxiety disorders seem to be mostly related to "Impaired Autonomy and Performance" and "Overvigilance and Inhibition" domains. Besides, positive results of the cost-effectiveness studies regarding to SFT in different Axis I disorders should be emphasized as well. Focus on past and current interpersonal relationships in this approach might be one of the factors preventing relapse (Ball & Young, 2000).

1.2. Perceived Parenting Styles

Researchers have been paying great attention to the effects of perceived parenting styles, since it has been known that parent-child interaction is important for the psychological health in adulthood. Bowlby (1969) claimed that the relationship between the primary caregiver and child determines child's feelings of security and helps him to form "internal working models", which defines his expectations about the availability of people who give care and support in stressful situations and which is integrated to his personality and therefore, which influences his future relationships (cited in Berk, 2006; Bretherton, 1985). For this reason, theories concerning the outcomes of different parenting styles have been developed. Baumrind (1971) identified four different parenting styles regarding the levels of acceptance and control (cited in Berk, 2006). *Authoritative parenting* involves high acceptance and high control from parents, who are sensitive to the needs of their children. This is the healthiest way of parenting. Children who perceive their

parents as authoritative tend to have higher sense of competence and higher self-esteem later in life. Second, *authoritarian parenting* involves low acceptance and high control. These parents are usually rejecting but demanding toward their children, and expect them to obey unquestioningly. If not, authoritarian parents may use punishment. Children who are raised in such families tend to have low self-esteem, and may have hostile reactions. This type of parenting inhibits child's needs of expression and individuality. Third, *permissive parenting* involves high acceptance and low control. These parents are usually overindulgent towards their children's lives. Therefore, children who perceive their parents as permissive tend to be impulsive and rebellious and tend to have poor self-control. Lastly, *uninvolved parenting* involves low acceptance and low control, in which parents are emotionally detached from their children, not giving them enough care or guidance because of some other problems such as depression, marital conflict or poverty. This is the worst type of parenting, which may result in difficulties in the cognitive, emotional, and social development of children (Berk, 2006).

Studies usually focus on the effects of parental warmth, rejection and overprotection on children's psychological health and several instruments has been developed such as Parental Bonding Instrument (PBI; Parker, Tubling, & Brown, 1979), "My Memories of Upbringing" (EMBU; Perris, Jacobsson, Lindstrom, von Knorring, & Perris, 1980) and Young Parenting Inventory (YPI; Young, 1999) in order to assess people's perceptions about their family environment mainly in terms of parental rejection –characterized by low levels of care and affection, along with negativity; and overprotection –characterized by involving parenting and not supporting individuality, during their childhood. Studies have consistently found out that both Axis I and Axis II disorders are related to perceived parenting practices.

1.2.1. Mood Disorders

As for the depression, many studies have shown that low levels of parental care and high levels of overprotection perceived in childhood period seem to

increase the vulnerability to depression in adulthood, whereas emotional warmth has a protective role against future psychological disorders. In a study conducted with women who were recently depressed and women who had never been depressed, the results of PBI revealed that recent episodes were significantly associated with low levels of maternal care and it was 4 times more likely to be depressed if low maternal care was perceived during childhood (Oakley-Browne, Joyce, Wells, Bushnell, & Hornblow, 1995). Moreover, students with different disorders, including major depression, dysthymia, oppositional disorder, conduct disorder, attention deficit hyperactivity disorder, separation anxiety and other anxiety disorders, were compared and it was found out that only major depression in adolescents was associated with low levels of maternal care (Rey, 1995). Similar with these findings, Yoshizumi, Murase, Murakami, and Takai (2007) revealed that depression was primarily predicted by low parental care both in male and female college students, although overprotective and inconsistent parenting also had an effect on depression. Similar results, which acknowledge the role of overprotective parenting on the development of depression symptoms, were obtained in several studies as well (Narita et al., 2000; Shah & Waller, 2000). For instance, in a study conducted with Turkish first grade university students, aging from 17 to 19, it was concluded that both rejection and overprotection were associated with depression and anxiety symptoms, whereas perceived emotional warmth from parents was found to be protective (Anlı & Karslı, 2010). Specifically, the results of this study indicated that mothers were more likely to be perceived as overprotective and fathers as rejecting.

Although there has been a variety of studies investigating the relationship between parenting practices and depression symptoms, bipolar disorder has not been studied widely yet. In fact, these studies present some contradicting results. Some studies revealed no difference between bipolar disorder patients and control group participants in terms of negative parenting practices, namely rejection and overprotection (Parker, 1979; Perris et al., 1986). On the other hand, the studies showing a significant association between perceived parenting styles and the

occurrence of bipolar disorder did not agree upon the effects of specific parenting behaviors. For instance, Rosenfarb et al. (1994) have found with self-report measures that less maternal (but not paternal) affection is related to bipolar depression, whereas Neeren et al. (2005) revealed that low levels of acceptance and high levels of overprotection accounted for the development of bipolar spectrum disorders (cited in Alloy, Abramson, Smith, Gibb, & Neeren, 2006).

1.2.2. Anxiety Disorders

Many studies conducted with anxious and non-anxious individuals, either using retrospective self-report measures or observational methods have revealed that anxiety disorders are more consistently associated with parental control/overprotection, but less consistently with parental care (Rapee, 1997). For instance, Duchesne, Larose, Vitaro, and Tremblay (2010) conducted a longitudinal study with 2000 kindergarten children to investigate developmental trajectories resulting anxiety disorders and concluded that children who were at higher risk of developing anxiety symptoms were more likely to have maternal control. Moreover, some of these children may also show hyperactivity, which is found to be associated with low levels of maternal affection. Besides, it has been also found in many studies that negativity, such as high levels of criticism, is associated with internalizing problems in children, including anxiety disorders (Gar & Hudson, 2008). For instance, Hudson and Rapee (2001) conducted a study with children with several types of anxiety disorders (namely separation anxiety disorder, overanxious disorder/generalized anxiety disorder, avoidant disorder/social phobia, and specific phobia), and compared them non-clinical children in terms of their interactions with their parents during a task completion. The results of this observational study indicated that during difficult tasks, mothers of children with anxiety disorders were more intrusive and criticizing than mothers of non-clinical children. As an explanation to this relationship, Rapee (2001) proposed a model regarding to the development and maintenance of generalized anxiety disorder in children, although it can explain the development of other anxiety disorders as well. According to this

model, anxious parents probably have children with genetic predisposition to anxiety, who give anxious and emotional reactions to events. Therefore, parents behave more involving and controlling in order to regulate their overreactions, which eventually increases children's perception of threat and decreases their perception of control over the events, both of which are related variables to anxiety disorders.

Studies related to the effects of perceived parenting during childhood are usually conducted with samples including different types of anxiety disorders. However, they should be investigated separately for a better understanding of possible risk factors. To begin with the obsessive compulsive disorder, although genetic factors play an important role (Taylor & Jang, 2011), identification of psychosocial factors which are responsible for the development and maintenance of the disorder is important. Research provides contradicting findings related to the effects of rejecting and overprotective parenting on the development of obsessive compulsive disorder; however, it is stated that family environment play important role on the development of a cognitive style called "inflated responsibility", which may be related to future obsessive problems (Salkovskis, Shafran, Rachman, & Freeston, 1999). Inflated responsibility is believed to be formed in early childhood through three ways: either feelings of exaggerated influence over and responsibility for negative events, perceptions regarding to the world as a dangerous place (which is mainly caused by overprotection and criticism), or extreme rules about thoughts and behaviors imposed by family, school, or other institutions, such as the church. Therefore, these approaches to the child might be a risk factor for the development of obsessive compulsive disorder in the future, besides stressful life events, and genetic predispositions, such as temperament and family's anxiety history.

As for the relationship between parenting and social anxiety, studies present more consistent results. Twin and familial studies revealed the possibility of genetic transmission for anxiousness, and not particularly for social anxiety; therefore, it should be noted that the effect might be related to the family environment (Hudson & Rapee, 2000). To be more precise, it is suggested that both high levels of parental

control and low levels of parental warmth during childhood is associated with the development of social phobia (Arrindell et al., 1989; Lieb et al., 2000; Parker, 1979; Spokas & Heimberg, 2009). These results are consistent with the results of observational studies. For instance, Attili (1989) observed from the interactions between children and their parents that overcontrolling and ignoring parenting was related to social problems, isolation, and uneasiness in preschool (cited in Hudson & Rapee, 2000). Similarly, Hummel and Gross (2008) conducted a study with 425 children and their parents, whose interactions were observed during puzzle completion tasks. The results indicated that parents of socially anxious children gave fewer verbal feedbacks, which were also less positive and more negative, than parents of non-clinical children. Therefore, besides perceived rejection from parents, high levels of negative criticism from parents are associated with social phobia as well. However, further studies found that the relationship between parenting and social phobia might be bidirectional. In other words, anxious temperament or shyness might lead to rejecting or overprotective parenting, probably from an anxious parent, which in turn increases the likelihood of development of social anxiety (Epkins & Heckler, 2011; Hudson & Rapee, 2000).

To sum up, research suggest that genetic predispositions influence the level of anxiety to some extent, however perceived parenting behaviors during childhood have also an effect on the development of psychological symptoms, as well as the effect of innate characteristics on parenting.

1.2.3. Other Axis I Disorders

Similar to mood and anxiety disorders, the effects of perceived parenting has been investigated with participants with different psychological problems, such as eating disorders and substance-related disorders, and significant associations have been found consistently. For instance, in a study conducted with anorexia nervosa patients and a non-clinical group, it has been found that higher levels of negative parenting, specifically rejecting and controlling parenting, differentiated patients from others (Deas, Power, Collin, Yellowlees, & Grierson, 2011). These results

were similar to those of many other studies conducted with individuals with eating disorders (Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2002; Turner, Rose, & Cooper, 2005). Moreover, Casper and Troiani (2001) stated that perceptions about family environment were distinguished in different types of anorexia nervosa as well. To be more specific, anorexia nervosa/bulimic type patients rated their family environment more negative than anorexia nervosa/restricting type. Similarly, in a study conducted with 127 eating disorder patients, diagnosed according DSM-IV-TR (APA, 2000) as anorexia nervosa/restrictive type, anorexia nervosa/binging-purging type, bulimia nervosa/purging type, bulimia nervosa/non-purging type, eating disorder not otherwise specified-purging (EDNOS-p), EDNOS-restrictive, and binge-eating disorder, and non-clinical individuals, in which parenting practices were evaluated through YPI (Young, 1999), it was found that negative parenting practices (i.e. emotionally depriving, overprotecting, belittling, pessimistic/fearful, controlling, emotionally inhibited, punitive, and conditional/narcissistic parenting) were higher among eating disorder patients, except perfectionist parenting style (Sheffield, Waller, Emanuelli, Murray, & Meyer, 2009), indicating that perceived parenting differentiated clinical group from non-clinical group. Moreover, the results showed that perceived punitiveness from fathers was associated with the drive for thinness in healthy individuals, whereas perceived emotional inhibition from mothers was associated with body dissatisfaction in eating disorder patients.

Second, in addition to the comorbid disorders, such as attention-deficit/hyperactivity disorder, conduct disorder, mood and anxiety disorders, and other factors, namely previous experiences, genetic predispositions, and other environmental factors, studies have been conducted to investigate the relationship between perceived parenting styles and substance-related disorders. Benchaya, Bisch, Moreira, Ferigolo, and Barros (2011) conducted a study to investigate this relationship in an adolescent sample and found that perceived authoritarian, indulgent, or neglectful parenting from mothers, but not from fathers, increased the likelihood of adolescents' drug use, which was explained through mothers' role of providing counseling and emotional support. As expected, authoritative parenting

was found to be related with not using drugs. Although there has been conflicting results regarding the effects of demanding and overprotective family environment, it was stated in a review article that non-supportive or abusive parenting was more consistently associated with substance abuse in adolescents, who did not obtain responsiveness and nurturance from their parents (Petraitis, Flay, Miller, Torpy, & Greiner, 1998). This association was found in a study conducted to investigate alcohol dependence as well (Cheng, Anthony, & Huang, 2010), which revealed a positive association between parental physical punishment and individuals' alcohol use, above all the effects of other childhood adversities, namely parental drinking problems, violence between parents, negative relationships, divorced parents, and neglect.

1.3. The Mediating Role of Early Maladaptive Schemas

As mentioned above, there have been a great number of studies emphasizing the relationship between negative parenting practices and psychological symptoms. However, recently, several factors which are associated with perceived parenting styles and which affect the occurrence of psychological symptoms have been investigated as well. It is well known through the results of several studies that parenting practices influence children's beliefs about themselves, others and the world (Creveling, Varela, Weems, & Corey, 2010) and among the most widely studied factors are early maladaptive schemas (EMSs) since they are related to the early enduring experiences with parents.

Several studies have concluded that different domains of EMSs play a mediator role on the relationship between different parenting styles and different symptomatology. Roelofs et al. (2011) have examined the relations between attachment to parents and peers, schema domains and depression in an adolescent sample and found out that the disconnection/rejection domain mediated the relationship between trust in parents and depressive symptoms; in addition to the relationship between alienation from peers and depressive symptoms. Moreover, the other directedness domain was found to work as a mediator in the latter relationship

as well; all of which are important findings implying that treatment of depression in adolescents might focus on their EMSs as a new direction in cognitive behavioral therapy. A recent study conducted by Bosmans, Braet, and Vlierberghe (2010) has revealed similar results. Especially the disconnection/rejection and other-directedness schema domains fully mediated the relationship between attachment anxiety and psychopathology, whereas the disconnection/rejection domain partially mediated attachment avoidance and psychopathology. Therefore, treatment practices might become more promising since they would focus on cognitive schemas of patients, which can be changed through several techniques, rather than focusing on parental bonding. In line with these findings, abusive parenting was found to be more highly associated with depression symptoms, which indicated a dose-response relationship, and which was mediated by the disconnection/rejection, impaired autonomy and performance, and impaired limits domains (McGinn, Cukor, & Sanderson, 2005). Unfortunately, there have been limited studies examining the mediating role of EMSs on parenting practices and other Axis I disorders, such as eating disorders, and substance-related disorders.

As for the personality disorders, Thimm (2010) conducted a study with psychiatric outpatients, 48% of which were diagnosed with at least one cluster of personality disorders. Besides other findings indicating that different parenting styles associated with different types of personality symptomatology, it has been also figured out that Cluster A symptoms were indirectly affected by parental rejection and low levels of maternal care and this relationship was mediated by disconnection/rejection domain. This finding was also valid for Cluster B symptoms, which were related to paternal rejection and the mediation effect of impaired limits schema domain as well. Lastly, for Cluster C symptoms, the mediator was disconnection/rejection domain on the parental rejection and low maternal emotional warmth. These findings are consistent with Young (1999)'s indication that schemas have a great role on the development of personality problems. To sum up, it is also important to note that schemas in

disconnection/rejection domain were most frequently found to play a role in psychopathology, especially depressive symptoms.

1.4. Possible Resources Playing Crucial Role between Early Maladaptive Schemas and Psychological Well-Being

1.4.1. Personality Dimensions

Although it is a widely studied concept, there has not been a unique definition of "personality". Personality theorists have been emphasizing different aspects of this concept for years, such as unconscious processes, learning experiences, or organization of thoughts. However, it can be generally defined as "consistent behavior patterns and intrapersonal processes originating within the individual" (Burger, 2011, p. 4). It is important to note several points of this definition. First, personality is consistent across time and situation. Second, it emphasizes intrapersonal processes, which include individuals' mood, emotions, information processing and so. Lastly, these processes originate within the individual. In other words, although they may be caused by external events, there are individual differences in expressing or dealing with these processes. Therefore, personality theories aimed to explain these issues in several ways. There are six approaches to personality: psychoanalytic, trait, biological, humanistic, behavioral/social learning, and cognitive approaches. Since this study examines the role of personality from the trait approach perspective, only this approach will be introduced and discussed below.

Individuals tend to use some adjectives to describe others. These are usually personality traits, which are defined as "dimensions of individual differences in tendencies to show consistent patterns of thoughts, feelings, and actions" (McCrae & Costa, 2003, p. 25). To be more specific, traits reflect personality characteristics, which exist in lower or higher degrees in individuals and which generally shows consistency across time and across situations. Moreover, these personality traits are different from physical, ability, or social traits and they include individuals' emotions, attitudes, and motivations. What is different from other approaches of

personality is that trait approach does not focus on understanding the underlying mechanisms of personality. On the other hand, this type of classification enables researchers to compare individuals easily on any desired area, since everyone is placed on a continuum for each trait (Burger, 2011).

Researchers have conducted many studies to determine common personality traits in the history of personality psychology. Allport and Odbert (1936) identified 18.000 trait words through a dictionary study, which was then reduced to 4.000 words. In 1946, Cattell formed 35 clusters from these words and 12 dimensions were obtained at the end of factor analysis; which were added four others. Therefore, Sixteen Personality Factor Questionnaire (16PF; Cattell, Eber, & Tatsuoka, 1970) was developed (as cited in McCrae & Costa, 2003). Further factor analysis revealed several times five-factor model (FFM); namely Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness. Neuroticism is related to individuals' emotional stability and adjustment; and emotional distress and mood swings raise Neuroticism scores. Second, Extraversion has two dimensions: extraversion and introversion. Extraverted individuals tend to be more sociable, energetic, and optimistic whereas introverted individuals are more reserved and independent. The third personality dimension is Openness (to Experience), high level of which is characterized by creative thinking, curiosity, and exploring new things. Fourth, Agreeableness is related to the individuals' level of helpfulness and trustfulness versus skepticism; as well as cooperativeness versus competitiveness. Lastly, Conscientiousness is related to self-discipline and control. Higher scores on this dimension indicate higher organization and determination whereas lower scores indicate carelessness and distractibility (Burger, 2011; McCrae & Costa, 2003).

Studies on FFM consistently revealed that higher scores on neuroticism are associated with lower levels of psychological adjustment because neuroticism is mostly related with ineffective coping strategies (McCrae & Costa, 1986). Therefore, psychological symptomatology, especially regarding to depression and anxiety, is higher in individuals with high scores of this trait. For instance, in a

recent study conducted in a nonclinical sample of university students, it was found out that neuroticism is significantly correlated with depression and anxiety symptoms, as well as ruminative thinking style, which is closely related to these symptomatologies (Roelofs, Huibers, Peeters, & Arntz, 2008). Similarly, Meyer (2002) found out that neuroticism is associated with higher levels of depression in his study conducted with participants dealing with daily stressors. Moreover, relatively weaker but statistically significant correlation was obtained between neuroticism and hypomanic symptoms. On the other hand, in the same study, it was revealed that extraversion is negatively correlated with depressive symptoms and positively correlated with hypomanic symptoms, although there are also contradicting results related to the relationship between extraversion and depression (Jorm et al., 2000). Bollen and Wojciechowski (2004) have shown that besides neuroticism, low levels of extraversion are associated with the development of anorexia nervosa as well. In addition, extraversion did not differentiate anorexia nervosa restricting subtype from binge-eating/purging subtype, although both of them scored lower than non-clinical group.

As for the other personality traits, there have been fewer studies regarding their relationships with psychological symptomatology. However, Vearing and Mak (2007) conducted a study in order to investigate employees' depression levels associated with their personality traits and work stress. As a result, they revealed that along with neuroticism, low levels of conscientiousness are related to depressive symptomatology, and that both of them accounted for 33% of the variance. Not surprisingly, Muris (2006) reported that conscientiousness was only correlated with Young's Unrelenting Standards schema, which is found to be related to depression, anxiety, and eating disorders in the same study conducted with non-clinical adolescents. In fact, Unrelenting Standards schema was positively correlated with agreeableness and openness. However, self-sacrifice, which was associated with depression, anxiety, and eating problems, for the former; and vulnerability to harm/illness, which was associated with depression and anxiety, for the latter differentiated these two personality traits from each other.

Recently, Gençöz and Öncül (2012) similarly developed a personality trait inventory in Turkish culture, called "Basic Personality Traits Inventory". At the end of the development procedure, factor analysis results revealed previously mentioned five factor and additionally "Negative Valence" factor, describing individuals' negative self-attributions. During convergent validity analysis, it was found that negative valence was positively correlated with social anxiety, depression, reassurance seeking, state and trait anxiety, emotion-focused coping, and negative affect; and negatively correlated with self-esteem, problem-focused and indirect coping, positive affect, and perceived social support. Moreover, the results of the study also revealed that negative valence is mostly associated with self-worth, whereas neuroticism is mostly associated with distress and anxiety, which represents the difference between these two personality traits.

1.4.2. Coping Styles

Individuals are faced with several stressors during their daily lives. These are ranged between usual stressors to more complicated stressful events. The way individuals cope with them affects their level of psychological adjustment during these stressful life events. According to Lazarus and Folkman (1984), coping with stress is a cognitive process, which is defined as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person". Moreover, it is emphasized that two types of coping functions exist: emotion-focused coping, in which individual evaluates stressful circumstances as unchangeable; and problem-focused coping, in which individual has an appraisal that something can be done to change the situation. The first one focuses on diminishing emotional distress by changing individual's appraisal of the event without actually changing the event through several strategies such as avoidance, distancing, and minimization. The second one, on the other hand, is similar to problem solving strategies but in a broader sense, is directed both to the problem and to the self. Problem-focused

coping strategies include information-seeking, finding alternative channels of gratification, learning new skills, and developing new behaviors.

The results of a study conducted by Folkman and Lazarus (1980) suggest that individuals tend to use both emotion-focused and problem-focused coping strategies in every stressful situations ranging from house repairs to illnesses and deaths. In fact, Sideridis (2006) showed that the interaction of problem-focused coping and emotion-focused coping is related to lower levels of negative affect and arousal; and concluded that these two coping functions have a synergistic effect when they are used together against a stressor. However, studies also focus on their differences in terms of their relationship with several stressful events and psychological symptoms. For instance, in the literature, seeking support is considered as one of the emotion-focused coping strategies. Murberg and Bru (2005) found out that seeking support from parents was associated with lowered depressive symptoms in 1-year follow up in adolescents, whereas active coping was not significantly related to low levels of depression, although in another study problem-focused coping strategies accounted for a lower variance of depressive symptoms and suicidal ideation than emotion-focused and avoidant coping strategies (Horwitz, Hill, & King, 2011).

Another psychological symptomatology frequently studied related to coping styles is post-traumatic stress disorder (PTSD). In a study conducted with 81 university students who witnessed a terrorist attack, it was revealed that students' who scored high on emotion-focused coping before the attack (as a trait characteristic), low on problem-focused coping after the attack (as a state characteristic), or high on avoidant coping both before and after the attack were more likely to present PTSD symptoms six months after the exposure (Gil, 2005). Similarly, in a study conducted with PTSD patients, other anxiety disorders patients, and non-clinical subjects, it was revealed that suppression, a coping style regarding to the avoidance of the problem, is higher in PTSD group than other anxiety disorder group and non-clinical group, although they were also significantly different from each other (Amir, Kaplan, Efroni, Levine, Benjamin, & Kotler,

1997). Moreover, this coping style is the only one significantly associated with intrusion, and avoidance scores of PTSD measure. As for the replacement coping, which was defined as finding alternative solutions to the problems, was significantly lower in PTSD patients than both other anxiety disorders group and non-clinical group. On the other hand, participants in other anxiety disorders group did not score significantly different from participants in PTSD group on minimization, help-seeking, blame, substitution, mapping, and reversal coping styles, although anxiety group scored significantly different from non-clinical group on minimization, help-seeking, mapping and reversal coping styles. Therefore, two main findings of this study indicate that PTSD is positively related with suppression, an emotion-focused coping strategy, and negatively associated with replacement, a problem-focused coping strategy. The effectiveness of these coping strategies might be related to some other factors, such as controllability of the stressful events. For instance, Göral, Kesimci, and Gençöz (2006) conducted a study with Turkish students, investigating the effects of controllability and coping on stress-related growth. Although both problem-focused and emotion-focused coping strategies were found to be associated with psychological growth, the results also indicated that in the face of an uncontrollable event, emotion-focused coping strategies were more likely to be associated with stress-related growth.

Besides psychological symptomatology, coping styles are mostly studied with individuals who have physical illnesses. For instance, Hesselink et al. (2004) were interested in the relationship between asthma patients' coping styles and their quality of life. The results of the study indicated that more emotion-focused and avoidant coping styles were associated with poorer quality of life. However, as it is the case in psychological problems, there are contradicting results as well. These differences are attributed to the differences in the nature of physical illnesses and their relationship with coping strategies and therefore, are needed to be further studied.

Recently, Gençöz, Gençöz, and Bozo (2006) conducted a psychometric study to explore factor structure of coping in a Turkish sample and the results

revealed a third factor called "Seeking social support: Indirect coping", independently from problem-focused coping and emotion-focused coping. This factor was found to be related to seeking guidance before focusing on the problems, or sharing with others. Therefore, individuals do not actively try to solve the problem, or to adjust emotionally to the stressful situation.

1.4.3. Perceived Social Support

Social support is defined as supportive actions from individuals' social environment aimed to improve their physical or psychological health. Lahey and Cohen (2000) suggested two types of social support: received social support (actual amount and frequency of social support received by others) and perceived social support (individuals' perceptions about their social environment in terms of social support available; as cited in Mackinnon, 2012). In fact, research indicates that received and perceived social supports are differently associated with other constructs and may not be highly correlated with each other (Cohen, Underwood, & Gottlieb, 2000; Haber, Cohen, Lucas, & Baltes, 2007). Moreover, perceived social support is more consistently associated with decreased levels of psychological disturbances, whereas received social support yields less stable results over time. Considering these findings, a perceived social support measure was preferred in the current study.

Many studies have shown that perceived social support is related with psychological and physical well-being. In a recent study conducted with 188 Turkish patients with cancer, it was reported that perceived social support from families is associated with lower degrees of feelings of loneliness and hopelessness, which have influences on the treatment process (Pehlivan, Ovayolu, Ovayolu, Sevinç, & Camcı, 2012). Similarly, Flynn, Kecmanovic, and Alloy (2010) found out that social support is associated with both depressive rumination and dependent interpersonal stress, which are positively related with depressive symptomatology. Besides depression, studies have consistently revealed that high levels of perceived social support from family or friends are related with better adjustment after

traumatic experiences (Robinaugh et al., 2011; Steine et al., 2012), less bulimic symptoms (Bodell, Smith, Holm-Denoma, Gordon, & Joiner, 2011), better college adjustment while experiencing discrimination (Schmidt, Miles, & Welsh, 2011), and higher academic achievement in children (Mackinnon, 2012).

Perceived social support is also studied as a moderator variable in some studies. For instance in a study conducted with 100 caregivers of children with leukemia, the role of social support on the psychological symptoms of caregivers' in relation with their level of well-being was investigated (Demirtepe-Saygılı & Bozo, 2011). The results showed that perceived social support is effective in decreasing caregivers' general psychological symptoms, only when they meet their own basic needs and pursue their daily activities. To sum up, perceived social support is an important factor on determining physical and psychological health.

1.5. The Aims of the Study

As it is suggested in the literature, negative parenting styles are more associated with psychological symptoms, especially depression, and early maladaptive schemas have a mediating effect on this relationship. Moreover, certain personality characteristics, using maladaptive coping strategies, and perceiving lower levels of social support increase the likelihood of psychological problems. However, there are limited studies investigating the associates of these factors, along with the effects of perceived parenting styles and early maladaptive schemas on the psychological well-being. Therefore, the aims of the study are:

1. To examine gender, age, mothers' education level, fathers' education level, income and residence status differences on the measures of the study
2. To examine the interrelationship between the measures of the study.
3. To determine factors associated with schema domains.
4. To determine factors associated with personality dimensions.
5. To determine factors associated with other psychological resources, namely coping strategies and perceived social support.

6. To determine factors associated with the measures of well being, namely depressive symptoms, other psychological symptoms, and level of satisfaction with life.

CHAPTER 2

METHOD

2.1. Participants

The sample of this study consisted of 309 university students, 211 (68.3%) of which were female, and 98 (31.7%) of which were male. The ages of these participants ranged from 18 to 33 (M = 22.21, SD = 2.83). 8 (2.6%) of the participants were preparatory school students, 233 (75.4%) of them were undergraduate students, and 68 (22%) of them were graduate students in 15 different universities in three different cities of Turkey (i.e., Ankara, İstanbul, and İzmir) as shown in Table 2.1. The majority of students [n = 256 (82.8%)] were from different departments in Middle East Technical University and most of the participants were from psychology department [n = 97 (31.4%); for detailed information see Table 2.1].

As for parental education level, the last degree completed was taken into account. In this regard, 141 (45.6%) of mothers were primary school graduates or below, whereas 168 (54.4%) of them were secondary school graduates or above. On the other hand, 176 (57%) of fathers were graduates of secondary school or below, whereas 133 (43%) of them were graduates of high school or above.

Participants had different current residential status as well. Out of 309 participants, 121 (39.2%) of them reported that they were living with their family, 112 (36.2%) of them in a dormitory, 76 (24.6%) of them at home with friends or alone. Their residential information regarding that they spent most of their lives is presented in Table 2. Lastly, as for the amount of monthly income of the participants, 123 (39.8%) of them reported their monthly income as lower than 1000TL, whereas 186 (61.2%) participants reported it higher than 1000TL [for detailed information see Table 2.2].

Table 2.1. Demographic Characteristics of Participants

Variables	N (309 participants)	%
Gender		
Female	211	68.3
Male	98	31.7
Age		
Young (between 18-21)	163	52.8
Old (between 22-33)	146	47.2
Participants' Education		
Preparatory class	8	2.6
Undergraduate	233	75.4
Graduate	68	22
Mother Education		
Illiterate	45	14.6
Literate	11	3.6
Primary school	85	27.5
Secondary school	62	20.1
High school	40	12.9
University or higher	66	21.4
Father Education		
Illiterate	17	5.5
Literate	13	4.2
Primary school	59	19.1
Secondary school	87	28.2
High school	43	13.9
University or higher	90	29.1
Residential Status		
With family at home	121	39.2
At dormitory	112	36.2
With friends at home	55	17.8
Alone at home	21	6.8
Income (2 missings)		
Lower than 1000 TL	123	39.8
Between 1000-3000 TL	116	37.5
Between 3000-5000 TL	40	12.9
Higher than 5000 TL	28	9.1

Table 2.2. Distribution of Schools and Departments of Participants

Variables	N (309 participants)	%
School (2 missings)		
Middle East Technical University	256	82.8
Hacettepe University	16	5.2
Gazi University	3	1
Bilkent University	5	1.6
Ankara University	4	1.3
Marmara University	5	1.6
Yeditepe University	4	1.3
İstanbul University	3	1
Maltepe University	4	1.3
Koç University	2	0.6
Doğuş University	2	0.6
Bilgi University	2	0.6
İstanbul Technical University	1	0.3
Dokuz Eylül University	3	1
Departments (8 missings)		
Psychology	97	31.4
Sociology	41	13.3
Business Administration	20	6.5
Civil Engineering	18	5.8
Geological Engineering	17	5.5
Computer Engineering	15	4.9
Physics	14	4.5
Electrical and Electronics Engineering	10	3.2
Others	69	22.33

2.2. Instruments

Data was collected through a demographic information form prepared by the researcher including questions about sex, age, school, department, educational level of the participants, their total amount of monthly income, their accommodation, their parents' educational level, and the place they spent their childhood (see Appendix B). Moreover, participants were given a set of questionnaire. It included Young Parenting Inventory (YPI) and Young Schema Questionnaire – Short Form 3 (YSQ-SF3) in order to evaluate participants' experiences with their parents and to determine the level of their early maladaptive schemas; Beck Depression Inventory (BDI), Brief Symptom Inventory (BSI), and Satisfaction with Life Scale (SWLS) in order to examine the level of participants' psychological symptoms and well-being;

and Basic Personality Traits Inventory (BPTI), Ways of Coping Inventory (WCI), and Multidimensional Scale of Perceived Social Support (MSPSS) in order to measure participants' usage of psychological resources.

2.2.1. Young Parenting Inventory (YPI): YPI was developed through Young (1999)'s clinical experiences measuring the familial roots of 18 EMSs. The scale consists 72 items rated for both mother and father on a 6-point Likert type scale ("1" for "does not describe him/her at all"; "6" for "describes him/her perfectly"), considering their behaviors during the participants' childhood. The validation study of the original scale was conducted by Sheffield et al. (2006) and revealed nine different parenting styles, all of which were with good test-retest reliability and adequate internal consistency level (Cronbach's alpha ranging between .92 and .67): emotionally depriving, overprotective, belittling, perfectionist, pessimistic/fearful, controlling, emotionally inhibited, punitive, and conditional/narcissistic parenting. In addition, this study showed that both maternal and paternal parenting styles were associated with a number of YSQ subscales, in line with clinical findings, such as the high correlation between belittling parenting and failure schema. Soygüt, Çakır, and Karaosmanoğlu (2008) adapted the scale to Turkish culture and conducted its psychometric study with university students. Factor structure of the Turkish version was found to be similar to the original version; with the exclusion of perfectionist parenting and inclusion of overpermissive/boundless parenting and exploitative/abusive parenting. Moreover, it was shown that both most of maternal and paternal subscales of YPI were significantly correlated with General Symptom Index (GSI) of SCL-90-R and with depression, anxiety and interpersonal sensitivity scores, which indicates high convergent validity level for YPI. Internal consistency coefficient for the items in maternal form ranged between α = .53 and α = .86; and in paternal form between α = .61 and α = .88. Therefore, YPI provides adequate levels of validity and reliability scores in Turkish university students samples and can be used for clinical and research purposes (For YPI, see Appendix C).

2.2.2. Young Schema Questionnaire – Short Form 3 (YSQ-SF3): The original scale was shortened and revised by Young (2006) and it includes 90 items measuring 18 different maladaptive schemas on five domains: disconnection/rejection, impaired autonomy and performance, impaired limits, other-directedness, and overvigilance and inhibition. Participants are expected to rate each item on a scale of 6 ("1" for "does not describe me at all"; "6" for "describes me perfectly"). The Turkish adaptation study of YSQ-SF3 was conducted by Soygüt, Karaosmanoğlu, and Çakır (2009) with a sample of university students and results showed high coefficients of reliability and internal consistency (α = .53 - .81; for schema domains); and significant coefficients of validity, such as convergent validity with symptom checklist inventories. This study revealed 15 different schemas on five domains. However, in a recent study conducted with high school students, it was found out that 18 maladaptive schemas were categorized into three different domains, namely "impaired limits/exaggerated standards", "disconnection/rejection", and "impaired autonomy/other directedness" (Sarıtaş & Gençöz, 2011). The first domain included entitlement, approval seeking, unrelenting standards, pessimism, insufficient self-control, and punitiveness schemas. The second one included emotional deprivation, social isolation, defectiveness/shame, emotional inhibition, mistrust/abuse, and failure schemas whereas the last one included subjugation, dependency/incompetence, enmeshment, vulnerability to harm, abandonment/instability, and self-sacrifice schemas, all of which were ordered according to their factor loadings within each domain (between .80 and .51; .76 and .55; and .75 and .44 respectively). Moreover, each domain was found to be positively correlated with the measures of anger, anxiety, and negative affect whereas Disconnection/Rejection domain was found to be negatively correlated with positive affect. In addition, after controlling the effects of positive and negative affect, schema domains were still associated with anger and anxiety measures, which indicated high concurrent validity of the instrument. It was concluded that YSQ-SF3 could be used for research and clinical purposes with adolescents and adult samples (For YSQ-SF3, see Appendix D).

2.2.3. Beck Depression Inventory (BDI): BDI was developed by Beck et al. (1961) in order to "measure behavioral manifestations of depression" such as mood, pessimism, sense of failure, crying spells, self-punitive wishes, or sleep disturbance. The first version was administered by the clinician and the patient together. In 1978, the scale was revised as a self-report questionnaire. It includes 21 items related to the symptoms of depression as forced choice format on a scale of 4 ranging according to the severity of symptoms ("0" for the least severe situation and "3" for the most severe situation for each item). Therefore, the total score from this scale ranges between 0-63; and higher scores indicate more severe depression. Split-half reliability and item-total correlation analysis of the scale yielded acceptable levels of reliability. Moreover, BDI scores of the participants were found to be highly correlated with another measure of depression, which indicated high validity of the scale (Beck et al., 1961). The scale was adapted into Turkish by Hisli (1988) and high coefficients of reliability (α = .74) were obtained. Moreover, BDI was found to be positively correlated with other measures of depression. These results supported that BDI has strong psychometric properties in Turkish sample (For BDI, see Appendix E).

2.2.4. Brief Symptom Inventory (BSI): This scale was developed by Derogatis (1975) as a self-report inventory in order to define psychological symptoms of patients. BSI is the shortened version of SCL-90-R and it includes 53 items measuring psychological distress, rated on a 5-point Likert type scale, ranging from "0" (not at all) to "4" (extremely). The scale measures 9 primary symptom dimensions, namely Somatization (SOM), Obsessive-Compulsive (O-C), Interpersonal Sensitivity (I-S), Depression (DEP), Anxiety (ANX), Hostility (HOS), Phobic Anxiety (PHOB), Paranoid Ideation, (PAR), and Psychoticism (PSY). In addition, there are three global indices of distress, the General Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST), used to assess the individual's distress level in a single score. According to Derogatis and Melisaratos (1983), internal consistency coefficients for 9 primary symptom dimensions ranged from .71 (psychoticism) to .85 (depression).

Moreover, it has been showed that the scale has a good stability over time [between .68 (psychoticism) and .91 (phobic anxiety) for symptom dimensions and .90 for GSI]. The validity analysis revealed that the scale has high convergent and construct validity as well.

Turkish adaptation study of the scale was conducted by Şahin and Durak (1994). The results of this study showed that the factor structure consists 5 different subscales: depression, anxiety, negative self, somatization, and hostility. The internal consistency for this scale has been found to vary between $\alpha = .71$ (for somatization) and $\alpha = .85$ (for depression), which indicates high reliability for each symptom dimension in a Turkish adolescent sample. Moreover, correlational analysis with some other psychological symptom related instruments has revealed statistically and theoretically meaningful results. Therefore, it can be concluded that BSI is a reliable and valid instrument in Turkish culture and can be used for research and clinical purposes with other measures of psychopathology (For BSI, see Appendix F).

2.2.5. Satisfaction with Life Scale (SWLS): SWLS was developed by Diener et al. (1985) to assess "global life satisfaction" of individuals, through 7-point Likert type items, which do not tap with other measurements of positive affect. There are 5 items and the total score for the scale ranges from 5 to 35, where higher scores indicate greater life satisfaction. It was reported that 66% of the variance is explained by one factor and that it originally has favorable psychometric properties of internal consistency and reliability. Durak, Şenol-Durak, and Gençöz (2010) adapted the scale into Turkish and conducted its validity and reliability study in three different samples: university students, correctional officers, and elderly adults. The results indicated that the internal consistency coefficient of SWLS was .81 in a university student sample. Moreover, global life satisfaction was positively correlated with self-esteem, positive affect, social support, and monthly income (with significant correlation coefficients ranging from .40 to .13), and negatively correlated with negative affect and depression ($\underline{r} = -.29$ and $\underline{r} = -.40$, respectively), as expected. Satisfactory levels of reliability and validity were obtained with

university students, correctional officers and elderly adults samples and was concluded that SWLS can be used for different purposes in Turkish culture (For SWLS, see Appendix G).

2.2.6. Basic Personality Traits Inventory: This scale was developed in a Turkish culture, based on trait approach to personality (Gençöz, & Öncül, 2012). The development of the scale was completed by three studies. First, participants were asked to list adjectives they use to describe people according to six basic emotions: happiness, sadness, anger, surprise, disgust, and fear; and 226 adjectives were obtained. In second study, participants were asked to rate these adjectives on a 5-point Likert-type scale (from "1" for "it does not represent me at all" to "5" for "it represents me very well). As a result, factor structure of the scale was determined as Extraversion, Conscientiousness, Agreeableness, Neuroticism, Openness, and a sixth factor indicating "one's negative self-attributions", Negative Valence, with good levels of internal validity coefficients ranging from .85 to .69. Totally, the scale included 45 items. Lastly, in the third study, validity and reliability analysis of the scale were conducted. Strong internal consistency coefficients and test-retest reliability coefficients, ranging from .71 to .84 were obtained. Moreover, Extraversion, Conscientiousness, Agreeableness, and Openness were correlated with several constructs such as self-esteem, problem-focused coping, positive affect, and perceived social support whereas Neuroticism and Negative Valence were significantly correlated with social anxiety, depression, reassurance seeking, trait anxiety and negative affect, parallel to the literature. Therefore, it can be concluded that Basic Personality Traits Inventory has strong psychometric characteristics (For BPTI, see Appendix H).

2.2.7. Ways of Coping Inventory (WCI): WCI was developed to define people's cognitive and behavioral strategies to cope with stressful events (Folkman & Lazarus, 1980). Original scale includes 68 items on a 4-point Likert scale, which measure different coping strategies namely defensive coping, information seeking, problem solving, palliation, inhibition of action, direct action, and magical thinking. These strategies are grouped into two broad categories: problem-focused and

emotion-focused coping. In addition, since the original scale does not include superstitious beliefs and fatalism as coping strategies, Siva (1991) added six more items to the scale for the Turkish adaptation, transformed it to a 5-point Likert-type scale ("1" for "strongly disagree"; "5" for "strongly agree") and obtained strong reliability level for the overall score (α = .90). In a recent study conducted with university students, an additional category named "Seeking Social Support: Indirect Coping" was revealed (Gençöz, Gençöz, & Bozo, 2006), as a separate higher-order construct from problem-focused and emotion-focused coping. In this study, internal consistency coefficients for Problem-Focused, Emotion-Focused, and Seeking Social Support: Indirect Coping were found to be .90, .88, and .84 respectively. Moreover, all of these higher-order factors revealed significant and meaningful correlations with other related measures, such as state and trait anxiety, submissiveness, or locus of control. Therefore, WCI has good reliability and validity properties for Turkish culture (For WCI, see Appendix I).

2.2.8. Multidimensional Scale of Perceived Social Support (MSPSS): MSPSS includes 12 items developed by Zimet, Dahlen, Zimet, and Farley (1988) to assess individuals' level of perceived social support from three different sources: family, friends, and significant other. Participants are expected to rate each item on a 7-point Likert-type scale ("1" for "Very strongly disagree" and "7" for "Very strongly agree"), where higher scores indicate higher levels of perceived social support. This scale was adapted into Turkish by Eker and Arkar (1995) with strong levels of validity and reliability (For MSPSS, see Appendix J).

2.3. Procedure:

First of all, necessary approval was taken from Middle East Technical University Human Subjects Ethics Committee. Afterwards, a booklet including above questionnaires was prepared and distributed to university students in three different cities of Turkey: Ankara, İstanbul, and İzmir. The completion of the questionnaires, which encouraged voluntary participation through informed consent forms (see Appendix A), took approximately 45 minutes for each participant.

2.4. Statistical Analysis:

In the present study, the Statistical Package for Social Sciences (SPSS), version 18 for Windows, was used during statistical analyses. In order to determine demographic differences on the measures of the study, separate Multivariate Analysis of Variance (MANOVA) and t-tests were conducted. Secondly, intercorrelations between all of these measures were examined through zero-order correlations. Consequently, associated factors of schema domains, personality, other psychological resources, and well-being were determined through four sets of hierarchical regression analysis.

CHAPTER 3

RESULTS

3.1. Descriptive Analyses for the Measures of the Study

For the descriptive characteristics of the measures of this study, means, standard deviations, minimum and maximum scores, and internal consistency coefficients (Cronbach's alpha) were calculated for Young Parenting Inventory mother (YPI-M) and father (YPI-F) forms, Young Schema Questionnaire (YSQ) with Impaired Limits/Exaggerated Standards (ILES), Disconnection/Rejection (DR), and Impaired Autonomy/Other-Directedness (IAOD) domains; Basic Personality Traits Inventory

Table 3.1: Descriptive Characteristics of the Measures

Measures	N	Mean	SD	Min-Max	Cronbach's alpha
YPI					
YPI-M	309	2.19	0.55	1-6	.93
YPI-F	309	2.29	0.59	1-6	.93
YSQ					
ILES	309	2.91	0.66	1-6	.88
DR	309	2.06	0.67	1-6	.92
IAOD	309	2.18	0.60	1-6	.88
BPTI					
E	309	3.51	0.86	1-5	.89
C	309	3.51	0.80	1-5	.85
A	309	4.19	0.53	1-5	.83
N	309	2.73	0.77	1-5	.83
O	309	3.67	0.74	1-5	.80
NV	309	1.63	0.52	1-5	.67
TWCI	309	233.12	23.44	74-370	.88
PF	309	3.43	0.50	1-5	.90
EF	309	2.36	0.50	1-5	.83
IND	309	3.40	0.65	1-5	.86
MSPSS	309	5.75	1.21	1-7	.92
BDI	309	9.12	8.19	0-42	.90
BSI	309	47.65	34.05	0-161	.96
SWLS	309	24.18	5.89	5-35	.84

Note 1. YPI-M = Young Parenting Inventory – Mother Form, YPI-F = Young Parenting Inventory – Father Form, YSQ = Young Schema Questionnaire, ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other-Directedness, BPTI = Basic Personality Traits Inventory, E = Extraversion, C = Conscientiousness, A = Agreeableness, N = Neuroticism, O = Openness to Experiences, NV = Negative Valence, TWCI = Turkish Ways of Coping Inventory, PF = Problem-Focused Coping, EF = Emotion-Focused Coping, IND = Indirect Coping, MSPSS = Multidimensional Scale of Perceived Social Support, BDI = Beck Depression Inventory, BSI = Brief Symptom Inventory, SWLS = Satisfaction with Life Scale.
Note 2. For YPI, YSQ, BPTI, and TWCI, mean scores of each subscale was used; by dividing the total score by the number of items in each subscale. For MSPSS, BDI, BSI, and SWLS, total scores of each scale was used.

(BPTI) with Extraversion, Conscientiousness, Agreeableness, Neuroticism, Openness to Experience, and Negative Valence subscales; Turkish Ways of Coping Inventory (TWCI) with Problem-Focused coping, Emotion-Focused coping, and Indirect Coping subscales; and Multidimensional Scale of Perceived Social Support (MSPSS), and well-being measures of Beck Depression Inventory (BDI), Brief Symptom Inventory (BSI), and Satisfaction with Life Scale (SWLS). The number of participants, mean and standard deviation scores, minimum and maximum values, and Cronbach's alpha coefficients of the measures are presented in Table 3.1.

3.2. The Differences of Levels of Demographic Variables on the Measures of the Study

For the purpose of examining the differences of demographic variables (namely gender, age, mother education level, father education level, residence, and monthly income) on the measures of the study, each demographic variable was categorized into different groups. This categorization is presented in the Table 3.2.

3.2.1. Gender Differences on the Measures of the Study

In order to examine gender differences (female, male) on the measures of the study, separate Multivariate Analysis of Variance and t-tests were conducted with parenting practices, schema domains, personality traits, coping styles, perceived social support, and well-being measures as the dependent variables, and significant differences are presented below.

Table 3.2. Categorization of Demographic Variables of the Study

Variables	n	%
Gender		
Female	211	68.3
Male	98	31.7
Age		
Younger (21 and lower)	163	52.8
Older (22 and higher)	146	47.2
Mother Education		
Graduate of primary school or lower	141	45.6
Graduate of secondary school or higher	168	54.4
Father Education		
Graduate of secondary school or lower	176	57
Graduate of high school or higher	133	43
Monthly Income (2 missing)		
Low (Less than 1000TL)	123	39.8
High (More than 1000TL)	184	59.5
Residence*		
With family at home	121	39.2
In a dormitory	112	36.2

Note: Participants who live with their family or in a dormitory (N = 233) were included in the analyses for this variable.

3.2.1.1. Schema Domains

In order to examine gender differences in schema domains, a one-way between subjects MANOVA was conducted with Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness as the dependent variables.

First of all, equality of covariances was controlled and a significant difference was found between groups (Box's M = 21.14, $p < .01$). Therefore, Pillai's Trace value was preferred for the interpretation. The results of the analysis revealed significant main effect of gender on schema domains [Multivariate $F(3, 305) = 5.72$, $p \leq .001$; Pillai's Trace = .05, partial $\eta^2 = .05$]. Therefore, univariate analysis was conducted with Bonferroni correction and alpha levels lower than .016 were considered significant. According to this correction, a significant difference of gender was found for Impaired Limits/Exaggerated Standards [$F(1, 307) = 8.98$, $p < .016$, partial $\eta^2 = .03$] and Disconnection/Rejection [$F(1, 307) = 9.26$, $p < .016$,

partial η^2 = .03]. For both of these schema domains, females (M = 2.83, SD = 0.05; M = 1.99, SD = 0.05 respectively) scored lower than males (M = 3.07, SD = 0.07; M = 2.23, SD = 0.07 respectively). There was no significant difference of gender in the schema domain of Impaired Autonomy/Other-Directedness.

Table 3.3: Gender Differences on Schema Domains

	Gender		Multivariate	Univariate	Pillai's	Partial
	F	M	F (3, 305)	F (1, 307)	Trace	η^2
YSQ			5.72**		.05	.05
ILES	2.83	3.07		8.98*		.03
DR	1.99	2.23		9.26*		.03
IAOD	2.16	2.23		0.98		.00

Note. *p < .16; **p < .001
Note 2. YSQ = Young Schema Questionnaire, ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other-Directedness

3.2.1.2. Personality Dimensions

To examine gender differences in personality traits, a one-way between subjects MANOVA was conducted with Extraversion, Conscientiousness, Agreeableness, Neuroticism, Openness, and Negative Valence as the dependent variables (see Table 3.4).

Table 3.4: Gender Differences on Personality Traits

	Gender		Multivariate	Univariate	Wilks'	Partial
	F	M	F(6, 302)	F(1, 307)	Lambda	η2
BPTI			5.35**		.90	.10
E	3.55	3.43		1.28		.00
C	3.58	3.38		4.09		.01
A	4.23	4.09		5.05		.02
N	2.81	2.56		7.45*		.02
O	3.62	3.76		2.45		.01
NV	1.59	1.71		3.62		.01

Note. *p < .008, **p < .001
Note 2. BPTI = Basic Personality Traits Inventory, E = Extraversion, C = Conscientiousness, A = Agreeableness, N = Neuroticism, O = Openness to Experiences, NV = Negative Valence

It was found that gender has a significant effect on personality traits [Multivariate F(6, 302) = 5.35, p < .001; Wilks' Lambda = .90; partial η^2 = .10]. The results of univariate analyses with Bonferroni correction (in which alpha levels lower than .008 were accepted as significant) revealed that there is a gender difference only in Neuroticism [F(1, 307) = 7.45, p < .008; partial η^2 = .02]. According to these results female participants scored higher (M = 2.81, SD = 0.05) than male participants (M = 2.56, SD = 0.07) on Neuroticism dimension. However, there were no significant gender differences in other personality dimensions.

3.2.1.3. Coping Styles

A one-way between subjects MANOVA was conducted with Problem-Focused Coping, Emotion-Focused Coping, and Indirect Coping as the dependent variables in order to examine gender differences on coping styles.

The results of the multivariate analysis indicated that there is a main effect of gender on this measure [Multivariate F(3, 305) = 8.24, p < .001; Wilks' Lambda = .93; partial η^2 = .08]. Therefore, univariate analyses were examined based on Bonferroni correction indicating significant results if alpha levels were lower than .016 and it was revealed that gender difference was significant only in Indirect Coping [F(1, 307) = 24.24, p < .001; partial η^2 = .07]. As it can be seen in the Table 3.5, females (M = 3.52, SD = 0.04) reported higher usage of indirect coping strategy than males (M = 3.14, SD = 0.06). However, any gender differences could not be found for two other coping strategies.

Table 3.5: Gender Differences on Coping Styles

	Gender		Multivariate	Univariate	Wilks'	Partial
	F	M	**F(3, 305)**	**F(1, 307)**	**Lambda**	**η2**
TWCI			8.24*		.93	.08
PF	3.45	3.40		0.48		.00
EF	2.38	2.32		0.90		.00
IND	3.52	3.14		24.24*		.08

Note. *p < .001
Note 2. TWCI = Turkish Ways of Coping Inventory, PF = Problem-Focused Coping, EF = Emotion-Focused Coping, IND = Indirect Coping

3.2.1.4. Perceived Social Support

To examine the possible differences of gender on the levels of perceived social support, t-test was conducted with the total score of social support as the dependent variable. Results indicated that females (M = 5.90, SD = 1.13) perceived higher levels of social support than males (M = 5.42, SD = 1.30; t(307) = 3.32, p ≤ .001).

Table 3.6: Gender Differences on Perceived Social Support

	Mean	SD	t (307)
Gender			3.32*
F	5.90	1.13	
M	5.42	1.30	

Note. *p < .001

3.2.1.5. Measures of Well-Being

Separate t-tests were conducted with depression level, general symptom level, and life satisfaction level as dependent variables, in order to examine gender differences on the measures of well-being. The results indicated that gender has a significant effect only on the life satisfaction [t(307) = 3.17, p < .01], and that female participants (M = 24.89, SD = 5.48) scored higher on life satisfaction than male participants (M = 22.64, SD = 6.46). There was not any significant difference of gender on depression and general symptom levels.

Table 3.7: Gender Differences on the Measures of Well-Being

	BDI			BSI			SWLS		
	Mean	SD	t(307)	Mean	SD	t(307)	Mean	SD	t(307)
Gender			-0.09			0.07			3.17*
F	9.09	8.22		47.74	32.77		24.89	5.48	
M	9.18	8.12		47.46	36.82		22.64	6.46	

Note. *p < .01

3.2.2. Age Differences on the Measures of the Study

In order to examine age differences on the measures of this study, several Multivariate Analysis of Variance and t-test were conducted with parenting practices, schema domains, personality traits, coping styles, perceived social support, and measures of well-being as the dependent variables. Among these

analyses, only measures of well-being yielded significant results and they are presented below.

3.2.2.1. Measures of Well-Being

In order to find out age differences on the measures of well-being, namely depression level, general symptom level, and life satisfaction, separate t-tests for each dependent variable were conducted. The results indicated that age has a significant effect only on life satisfaction level [$t(307) = 2.00$, $p < .05$], with younger participants ($M = 24.81$, $SD = 5.17$) reporting higher life satisfaction than older participants ($M = 23.47$, $SD = 6.55$). Gender differences did not yield significant differences on other measures of well-being.

Table 3.8: Age Differences on the Measures of Well-Being

	BDI			BSI			SWLS		
	Mean	**SD**	**t(307)**	**Mean**	**SD**	**t(307)**	**Mean**	**SD**	**t(307)**
Age			-1.23			0.51			2.00*
Younger	8.58	7.13		48.58	30.64		24.81	5.17	
Older	9.73	9.22		46.62	37.57		23.47	6.55	

Note. *$p < .05$

3.2.3. Mother Education Level Differences on the Measures of the Study

Differences regarding mother education level (low as graduate of primary school or below, high as graduate of secondary school or above) were examined through separate MANOVA and t-tests with parenting practices, schema domains, personality traits, coping styles, perceived social support, and measures of well-being as dependent variables. Only significant results of these analyses are reported below.

3.2.3.1. Perceived Parenting Practices

A one-way MANOVA with perceived maternal parenting practices and perceived paternal parenting practices as the dependent variables was conducted in order to find out if perceived parenting practices were differentiated with the education level of mothers.

The results yielded significant main effect of mother education level on parenting practices [F(2, 306) = 6.53, p < .01; Wilks' Lambda = .96, partial η^2 = .04]. Moreover, univariate analyses examined with Bonferroni correction (adjusting the significant level to .025) revealed that mother education has a marginally significant effect on perceived negative parenting from mothers [F(1,307) = 4.85, p = .028; partial η^2 = .02] and a significant effect on perceived negative parenting from fathers [F(1, 307) = 4.40, p < .001; partial η^2 = .04]. To be more specific, the results indicated that more negative maternal and paternal parenting were reported by the participants who had mothers with lower education level (M = 2.26, SD = 0.55; M = 2.42, SD = 0.66 respectively) than those who had mothers with higher education level (M = 2.12, SD = 0.54; M = 2.18, SD = 0.52 respectively).

Table 3.9: Mother Education Level Differences on Perceived Parenting Practices

	Mother Education		**Multivariate**	**Univariate**	**Wilks'**	**Partial**
	Low	High	**F(2, 306)**	**F(1, 307)**	**Lambda**	**η2**
YPI			6.53**		.96	.04
Mother	2.26	2.12		4.85*		.02
Father	2.42	2.18		4.40***		.04

Note. *p = .028, **p < .01, ***p < .001
Note 2. YPI = Young Parenting Inventory

3.2.3.2. Measures of Well-Being

The effects of the differences of mother education level on the measures of well-being were examined through separate t-tests with depression level, general symptom level, and life satisfaction as dependent variables.

The results of these analyses revealed that participants who had mothers with lower education level (M = 23.43, SD = 6.61) scored lower than participants

Table 3.10: Mother Education Level Differences on the Measures of Well-Being

	BDI			**BSI**			**SWLS**		
	Mean	**SD**	**t(307)**	**Mean**	**SD**	**t(307)**	**Mean**	**SD**	**t(307)**
Mother Education			1.21			0.70			-2.07*
Low	9.74	9.31		49.12	35.78		23.43	6.61	
High	8.61	7.10		46.42	32.59		24.81	5.15	

Note. *p < .05

who had mothers with higher education level (M = 24.81, SD = 5.15) only on the life satisfaction measure [t(307) = -2.07, p < .05]. As for the measures of depression level, and general symptom level, no significant difference for mother education level was observed.

3.2.4. Father Education Level Differences on the Measures of the Study

The effects of differences regarding fathers' education level (low as graduate of secondary school or below, high as graduate of high school or above) were examined through separate MANOVA and t-tests with perceived parenting practices, schema domains, personality dimensions, coping styles, perceived social support and measures of well-being as dependent variables. Significant results of these analyses are presented below.

3.2.4.1. Perceived Parenting Practices

Father education level differences on the perceived parenting practices were examined through one-way MANOVA with perceived parenting from mothers and perceived parenting from fathers as the dependent variables.

The results of multivariate analysis showed that there was a main effect of father education level on perceived parenting practices [Multivariate F(2, 306) = 5.14, p < .05; Wilks' Lambda = .97; partial η^2 = .03]. Further analysis with Bonferroni correction revealed that education level of fathers had an effect only on the perceived parenting practices from fathers [F(1, 307) = 10.30, p ≤ .001; partial η^2 = 0.03] and that individuals whose fathers' education level was lower (M = 2.38, SD = 0.04) perceived more negative parenting from their fathers than those who had

Table 3.11: Father Education Level Differences on Perceived Parenting Practices

	Father Education		Multivariate	Univariate	Wilks'	Partial
	Low	High	F(2, 306)	F(1, 307)	Lambda	η2
YPI			5.14*		.97	.03
Mother	2.24	2.11		4.39		.01
Father	2.39	2.17		10.30**		.03

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

fathers with higher education level (M = 2.17, SD = 0.05). Differences in father education level did not have an effect on perceived parenting from mothers.

3.2.4.2. Measures of Well-Being

In order to examine fathers' parenting style differences on the well-being levels of individuals, separate t-tests were conducted with depressive symptoms, psychopathology symptoms, and life satisfaction as the dependent variables.

The results yielded significant effect of perceived parenting from fathers only on the depression level of individuals [t(307) = 2.24, p < .01]. Specifically, individuals who had fathers with lower education level (M = 10.02, SD = 9.05) reported more depressive symptoms than those who had fathers with higher education level (M = 7.93, SD = 6.75). However, no significant effect of father education level was observed on general psychopathological symptoms and life satisfaction.

Table 3.12: Father Education Level Differences on the Measures of Well-Being

	BDI			BSI			SWLS		
	Mean	**SD**	**t(307)**	**Mean**	**SD**	**t(307)**	**Mean**	**SD**	**t(307)**
Father Education			2.24*			1.42			-1.69
Low	10.02	9.05		50.04	36.94		23.69	6.62	
High	7.93	6.75		44.49	29.64		24.83	4.70	

Note. *p < .01

3.2.5. Residence Differences on Measures of the Study

The results of separate MANOVA and t-tests yielded no significant differences between living with family at home and living in a dormitory in terms of perceived parenting practices from mothers and from fathers, schema domains, personality dimensions, coping strategies, perceived social support, and psycopathology and well-being.

3.2.6. Monthly Income Differences on Measures of the Study

Among the MANOVA and t-tests conducted in order to examine the effects of differences in monthly income (low, high) on the measures of the study, only

schema domains, coping styles, and measures of well-being revealed significant results, which are presented below.

3.2.6.1. Schema Domains

In order to find out monthly income differences on schema domains, a one-way MANOVA was conducted with Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness domains as the dependent variables.

First of all, Box's Test of Equality revealed significant difference between two levels of monthly income (Box's M = 18.47, $\underline{p} < .01$). Therefore, Pillai's Trace was preferred in the analyses. Secondly, the results of one-way MANOVA yielded a significant main effect of income on schema domains [Multivariate $\underline{F}(3, 303) = 3.29$, $\underline{p} < .05$; Pillai's Trace = .03; partial $\eta^2 = .03$]. As for the univariate analyses, after Bonferroni correction was taken into account, significant effect of income was found for all of the schema domains, namely Impaired Limits/Exaggerated Standards [$\underline{F}(1, 305) = 7.28$, $\underline{p} < .016$; partial $\eta^2 = .02$], Disconnection/Rejection [$\underline{F}(1, 305) = 7.69$, $\underline{p} < .016$; partial $\eta^2 = .03$], and Impaired Autonomy/Other-Directedness [$\underline{F}(1, 305) = 7.\ 05$, $\underline{p} < .016$; partial $\eta^2 = .02$]. Higher scores on these schema domains were more reported by individuals with lower monthly income ($\underline{M} = 3.03$, SD = 0.06; $\underline{M} = 2.20$, SD = 0.06; $\underline{M} = 2.30$, SD = 0.05 respectively) than individuals with higher monthly income ($\underline{M} = 2.82$, SD = 0.05; $\underline{M} = 1.98$, SD = 0.05; $\underline{M} = 2.11$, SD = 0.04).

Table 3.13: Monthly Income Differences on Schema Domains

	Income		**Multivariate**	**Univariate**	**Pillai's**	**Partial**
	Low	High	**$\underline{F}(3, 303)$**	**$\underline{F}(1, 305)$**	**Trace**	**η^2**
YSQ			3.29*		.03	.03
ILES	3.03	2.82		7.28**		.02
DR	2.20	1.98		7.69**		.03
IAOD	2.30	2.11		7.05**		.02

Note. *$\underline{p} < .05$, **$\underline{p} < .016$

3.2.6.2. Coping Styles

To see the differences between two levels of monthly income on different coping styles, a one-way MANOVA was conducted with problem-focused coping, emotion-focused coping, and indirect coping as the dependent variables.

As a result of multivariate analysis, a significant main effect of monthly income on coping strategies was found [Multivariate F(3, 303) = 2.77, p < .05; Wilks' Lambda = .97; partial η^2 = .03]. After significance level was adjusted as .016 with Bonferroni correction, univariate analysis revealed that income has a marginally significant effect on problem-focused coping [F(1, 305) = 4.34, p = .038; partial η^2 = .01] and emotion-focused coping [F(1, 305) = 4.87, p = .028; partial η^2 = .02]. To be more specific, individuals with higher levels of monthly income (M = 3.36, SD = 0.05) tended to use more problem-focused coping strategies than those with lower levels of monthly income (M = 3.48, SD = 0.04). In contrast, emotion-focused coping strategies were used more frequently by individuals with lower levels of monthly income (M = 2.44, SD = 0.05) than those with higher levels of monthly income (M = 2.31, SD = 0.04). The effect of monthly income was not found to be significant for indirect coping strategies.

Table 3.14: Monthly Income Differences on Coping Styles

	Income		Multivariate	Univariate	Wilks'	Partial
	Low	High	F(3, 303)	F(1, 305)	Lambda	η2
TWCI			2.77***		.97	.03
PF	3.36	3.48		4.34*		.01
EF	2.44	2.31		4.87**		.02
IND	3.38	3.40		0.11		.00

Note. *p = .038, **p = .028, ***p < .05
Note 2. TWCI = Turkish Ways of Coping Inventory, PF = Problem-Focused Coping, EF = Emotion-Focused Coping, IND = Indirect Coping

3.2.6.3. Measures of Well-Being

Monthly income differences on psychopathology and well-being were examined through separate t-tests conducted with depressive symptoms, psychopathology symptoms, and satisfaction with life as the dependent variables.

The results of the analyses showed that monthly income affects the level of depression [t(305) = 3.25, p ≤ .001] and the severity of psychological symptoms

[t(305) = 2.85, p < .01], as well as life satisfaction [t(305) = -3.13, p < .01] of individuals. In other words, depression level and psychological symptomatology tended to be higher for individuals with lower amount of monthly income (M = 10.97, SD = 9.11; M = 54.38, SD = 35.40 respectively) than individuals with higher amount of monthly income (M = 7.90, SD = 7.33; M = 43.18, SD = 32.61). Moreover, individuals with higher income level (M = 24.99, SD = 5.36) reported higher satisfaction with life than those with lower income level (M = 22.86, SD = 6.42).

Table 3.15: Monthly Income Differences on Measures of Well-Being

	BDI			BSI			SWLS		
	Mean	**SD**	**t(305)**	**Mean**	**SD**	**t(305)**	**Mean**	**SD**	**t(305)**
Income			3.25**			2.85*			-3.13*
Low	10.97	9.11		54.38	35.40		22.86	6.42	
High	7.90	7.33		43.18	32.61		24.99	5.36	

Note. *p < .01, **p ≤ .001

3.3. Correlation Coefficients between the Measures of the Study

In order to figure out the intercorrelations between all measures of the study, Pearson's correlation coefficients were calculated for gender, age, mother education level, father education level, residence, monthly income, and for other measures of the study, namely perceived parenting from father and mother, schema domains of Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness, personality traits of Extraversion, Conscientiousness, Agreeableness, Neuroticism, Openness to Experiences, and Negative Valence subscales, Problem-Focused Coping, Emotion-Focused Coping, and Indirect Coping styles, perceived social support, depression level, general psychological symptoms level, and life satisfaction. The results of this analysis are presented in the Table 16.3; for this analysis only, correlations with .30 and stronger coefficients will be reported.

The results of correlation analysis did not reveal any strong relationship between demographic variables and other measures of the study. On the other hand, it was found that perceived parenting practices from mothers were closely

associated with perceived parenting practices from fathers (r = .64, p < .01). This result indicates that individuals perceiving more negative parenting from their mothers reported more negative parenting practices from their fathers as well. In addition, it was found that Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness domains were correlated with both mothers' (r = .43, p < .01; r = .40, p < .01; r = .43, p < .01 respectively) and fathers' (r = .44, p <.01; r = .43, p < .01; r = .44, p < .01 respectively) parenting styles, indicating that more negative parenting practices are related with higher scores on schema domains.

Correlation analysis between parenting practices on one hand, and personality traits and coping on the other hand, did not yielded strongly significant relationship. However, perceived social support was significantly associated with both mothers' (r = -.32, p < .01) and fathers' (r = -.37, p < .01) parenting styles. These results suggest that individuals who experience less negative parenting practices tend to perceive and report higher social support.

The relationship between parenting practices of mothers and fathers and measures of well-being was examined and depression level and level of psychological symptoms were found to be significantly related with both perceived parenting from mothers (r = .32, p < .01; r = .35, p < .01, respectively) and from fathers (r = .33, p < .01; r = .33, p < .01, respectively). Therefore, higher levels of perceived negative parenting from parents are related with higher psychological symptomatology in individuals. However, the relationship between perceived parenting practices and level of satisfaction with life was not significant strong enough.

As for the schema domains, the results yielded significant associations of these domains with each other. For instance, Impaired Limits/Exaggerated Standards domain was positively correlated with Disconnection/Rejection (r = .56, p < .01) and with Impaired Autonomy/Other-Directedness (r = .65, p < .01); as well as the positive association between Disconnection/Rejection and Impaired

Autonomy/Other-Directedness domains (r = .66, p < .01). In other words, higher scores on one schema domain are related with higher scores on the other two.

The relationship between personality traits and two of the schema domains was also found significant. Although Impaired Limits/Exaggerated Standards was not strongly correlated with any personality traits, a positive association between Disconnection/Rejection domain and neuroticism (r = .37, p < .01), indicating that individuals who have stronger schema structure in Disconnection/Rejection domain tend to score higher on neuroticism. Moreover, Impaired Autonomy/Other-Directedness domain was negatively correlated with extraversion (r = -.57, p < .01), agreeableness (r = -.44, p < .01), and openness to experiences (r = -.44, p < .01); whereas it was positively correlated with negative valence (r = .38, p < .01) traits. Therefore, individuals with lower extraversion, agreeableness, and openness to experiences scores and with higher negative valence scores are more likely to maintain schemas from Impaired Autonomy/Other-Directedness domain.

Besides, the results regarding the relationship between schema domains and coping styles yielded significant results only for problem-focused coping, which was negatively associated with two schema domains; namely, Disconnection/Rejection (r = -.39, p < .01), and Impaired Autonomy/Other-Directedness (r = -.34, p < .01). In other words, weaker forms of schemas in Disconnection/Rejection and Impaired Autonomy/Other-Directedness domains are related with higher usage of problem-focused coping strategies. Similarly, social support was also negatively associated with these two domains (r = -.62, p < .01; r = -.38, p < .01, respectively), which indicates that lower levels of perceived social support is related with activation of the schemas in these domains. However, the Impaired Limits/Exaggerated Standards domain was not strongly associated with any of these measures.

The last relationship examined for schema domains was measures of well-being and the results showed that depression scores are positively associated with Impaired Limits/Exaggerated Standards (r = .41, p < .01), Disconnection/Rejection (r = .60, p < .01), and Impaired Autonomy/Other-Directedness (r = .51, p < .01)

domains. Similarly, the amount of psychological symptoms was significantly related with scores on these three schema domains (r = .52, p < .01; r = .56, p < .01; r = .57, p < .01, respectively), indicating that the presence of early maladaptive schemas in any domain is related with higher psychological distress. On the other hand, there was a negative association between Disconnection/Rejection domain and life satisfaction (r = -.40; p < .01). In other words, weaker forms of schemas in Disconnection/Rejection domain are related with higher levels of satisfaction with life.

As for the relationship of personality traits with other measures, besides significant associations with schema domains, it was also found that problem-focused coping was positively related with extraversion (r = .35, p < .01), conscientiousness (r = .36, p < .01), agreeableness (r = .39, p < .01), and openness to experiences (r = .59, p < .01). Moreover, agreeableness trait was associated with indirect coping as well (r = .36, p < .01). These results indicate that individuals who are more extraverted, conscientious, agreeable, and open are more likely to use problem-focused coping strategies. In addition, it was found that perceived social support was positively related with extraversion (r = .34, p < .01), agreeableness (r = .41, p < .01), openness to experiences (r = .33, p < .01), and negatively related with negative valence (r = -.32, p < .01), which suggests that as individuals are higher on extraversion, agreeableness, and openness to experience, and lower on negative valence, they are more likely to get or perceive social support from others.

Correlation analysis regarding the relationship between personality traits and measures of well-being yielded several significant results. First, depression level was negatively associated with extraversion (r = -.35, p < .01) and openness to experience (r = -.43, p < .01), whereas it is positively associated with neuroticism (r = .37, p < .01). Moreover, extraversion (r = -.32, p < .01) and neuroticism (r = .44, p < .01) have a similar relationship with psychological symptoms. These results indicate that especially higher levels of extraversion and lower levels of neuroticism are related with lower levels of psychological distress. Lastly, extraversion (r = .35,

p < .01) and conscientiousness (r = .35, p < .01) are positively related with life satisfaction.

The results of this analysis showed that problem-focused coping (r = .30, p < .01) and indirect coping (r = .30, p < .01) is positively related with social support. In other words, higher levels of problem-focused and indirect coping strategies are associated with higher levels of social support. Moreover, problem-focused coping is negatively associated with depression level (r = -.42, p < .01), and psychological symptoms (r = -.33, p < .01); whereas it is positively associated with life satisfaction (r = .42, p < .01). Other coping styles, namely emotion-focused, and indirect coping, are not significantly related with measures of well-being, indicating especially higher levels of problem-focused coping is associated with higher levels of psychological well-being.

Lastly, intercorrelations between measures of well-being were examined and it was found out that depressive symptomatology is positively and closely related with general psychopathological symptoms (r = .76, p < .01) and negatively related with life satisfaction (r = -.50, p < .01). Moreover, general psychopathological symptoms were also negatively related with life satisfaction (r = -.40, p < .01). These results indicate that lower levels of depressive and other psychopathological symptoms are associated with greater satisfaction with life.

The summary of intercorrelations between measures is presented in the Table 3.16.

Table 3.16: Pearson's Correlation Coefficients between Measures of the Study

	YPIM	YPIF	ILES	DR	IAOD	PF	EF	IND	SS	BDI	BSI	LS
E	.09	-.11	-.14*	-.20**	**-.57****	**.35****	-.11	.26**	**.34****	**-.35****	**-.32****	**.35****
C	.00	-.16**	-.16**	-.14*	-.29**	**.36****	-.04	.06	.22**	-.27**	-.16**	**.35****
AG	.02	-.13*	-.10	-.14*	**-.44****	**.39****	.02	**.36****	**.41****	-.19**	-.16**	.22**
N	-.06	.17**	.24**	**.37****	.27**	-.29**	.12*	.06	-.16**	**.37****	**.44****	-.15**
O	.08	-.20**	-.22**	-.21**	**-.44****	**.59****	-.04	.03	**.33****	**-.43****	-.29	.27**
NV	-.08	.22**	.20**	.26**	**.38****	-.27**	.17**	-.13*	**-.32****	.21**	.28**	-.15**
G	.02	.00	.17**	.17**	.06	-.04	-.05	-.27**	-.19**	.00	.00	-.19
A	.08	.14*	-.14*	-.08	-.11	.13*	-.01	-.04	.00	-.04	-.12*	.00
ME	-.13*	-.20*	-.03	-.07	-.10	-.05	-.06	-.04	.02	-.07	-.04	.12*
FE	-.12*	-.18**	-.08	-.08	.12*	-.03	-.02	-1.10	.10	-.13*	-.08	.10
R	.01	.05	-.07	-.02	-.09	.03	-.07	.08	.02	-.05	-.08	.00
I	-.08	-.06	-.09	-.12*	-.14*	.07	-.04	.02	.05	-.17**	-.14*	.19**
YPIM		**.64****	**.43****	**.40****	**.43****	-.15**	.17**	.05	**-.32****	**.32****	**.35****	-.15**
YPIF			**.44****	**.43****	**.44****	-.14**	.21**	.03	**-.37****	**.33****	**.33****	-.17**
ILES				**.56****	**.65****	-.19**	.24**	.13*	-.28**	**.41****	**.52****	-.17**
DR					**.66****	**-.39****	.17**	-.21**	**-.62****	**.60****	**.56****	**-.40****
IAOD						**-.34****	.26**	.05	**-.38****	**.51****	**.57****	-.21**
PF							-.12*	.20**	**.30****	**-.42****	**-.33****	**.42****
EF								.05	-.02	.04	.09	.12*
IND									**.30****	-.04	.00	.17**
SS										**-.46****	**-.39****	**.40****
BDI											**.76****	**-.50****
BSI												**-.40****

Note 1. *p < .05, **p < .01

Note 2. G = Gender, A = Age, ME = Mother Education, FE = Father Education, YPIM = Young Parenting Inventory – Mother Form, YPIF = Young Parenting Inventory – Father Form, ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other-Directedness, E = Extraversion, C = Conscientiousness, AG = Agreeableness, N = Neuroticism, O = Openness to Experiences, NV = Negative Valence, PF = Problem-Focused Coping, EF = Emotion-Focused Coping, SS = Social Support, BDI = Beck Depression Inventory, BSI = Brief Symptom Inventory, SWLS = Satisfaction with Life Scale.

3.4. Regression Analyses

Factors associated with schema domains, personality, other psychological resources (i.e., coping and social support) and psychopathology and well-being were determined through four different sets of hierarchical regression analyses.

3.4.1. Factors Associated with Schema Domains

The first set of regression analyses, regarding factors associated with schema domains, separately included Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness domains as dependent variables. In each regression analysis, the first step of regression equations involved demographic variables, namely gender, age, mother education level, father education level, residence, and income level. On the second step, perceived parenting styles from mothers and fathers were hierarchically entered into the equation for each dependent variable.

3.4.1.1. Factors Associated with Impaired Limits/Exaggerated Standards Domain

In order to determine factors associated with Impaired Limits/Exaggerated Standards domain, hierarchical regression analysis was performed. The results showed that gender [$\underline{pr}$ = .17, β = .17, $\underline{t}(307) = 3.00$, $\underline{p} < .01$] was significantly associated with this schema domain, explaining 3% of the variance [$\underline{F}(1, 307) = 8.98$, $\underline{p} < .01$]. Among demographic variables, income secondly entered into the regression equation [$\underline{pr}$ = -.15, β = -.14, $\underline{t}(306) = -2.58$, $\underline{p} \leq .01$], increasing the total variance explained to 5% [$\underline{F}_{change}(1, 306) = 6.66$, $\underline{p} < .01$]. These results indicate that being male and having lower income were associated with higher scores in Impaired Limits/Exaggerated Standards domain.

Second step of the regression analysis indicated that, after controlling for the effects of demographic variables, the association between perceived negative parenting from fathers [$\underline{pr}$ = .44, β = .43, $\underline{t}(305) = 8.66$, $\underline{p} < .001$] and Impaired Limits/Exaggerated Standard domain was significant, increasing explained variance to 24% [$\underline{F}_{change}(1, 305) = 74.90$, $\underline{p} < .001$]. Lastly, perceived negative parenting from mothers [$\underline{pr}$ = .21, β = .25, $\underline{t}(304) = 3.88$, $\underline{p} < .001$] entered into the regression

equation [$F_{change}(1, 304) = 15.07$, $p < .001$] and total explained variance increased to 27%. These results indicated that experiencing negative parenting from both mothers and fathers was also associated with higher scores in Impaired Limits/Exaggerated Standards domain.

3.4.1.2. Factors Associated with Disconnection/Rejection Domain

According to the results of regression analysis conducted to identify factors associated with Disconnection/Rejection domain, gender [$pr = .17$, $\beta = .17$, $t(307) = 30.04$, $p < .01$] initially entered into the equation and it explained 3% of the variance [$F(1, 307) = 9.26$, $p < .01$]. Secondly, income [$pr = -.15$, $\beta = -.15$, $t(306) = -2.65$, $p < .01$] entered into the regression equation [$F_{change}(1, 306) = 7.04$, $p < .01$] and the total variance explained for Disconnection/Rejection domain increased to 5%. Therefore, being male and having lower income was associated with stronger forms of schemas in Disconnection/Rejection domain.

As for the second step of the analysis, the results indicated significant association of perceived negative parenting from fathers [$pr = .43$, $\beta = .42$, $t(305) = 8.32$, $p < .001$] with this domain, increasing explained variance to 23% [$F_{change}(1, 305) = 69.20$, $p < .001$]. Lastly, after controlling the effects of previous variables, perceived negative practices from mothers [$pr = .18$, $\beta = .16$, $t(304) = 3.05$, $p \leq .01$] were also found to be significantly related with Disconnection/Rejection domain, increasing explained variance to 25% [$F_{change}(1, 304) = 9.27$, $p < .01$]. These results suggest that experiencing negative parenting from fathers and mothers were related to higher scores on Disconnection/Rejection domain.

3.4.1.3. Factors Associated with Impaired Autonomy/Other-Directedness Domain

The factors associated with Impaired Autonomy/Other-Directedness domain was examined through a hierarchical regression analysis and the results yielded significant association of income [$pr = -.15$, $\beta = -.15$, $t(307) = -2.66$, $p < .01$], as the only demographic variable entering into the equation, with this domain [$F(1, 307) = 7.06$, $p < .01$]. Income explained 2% of the variance, indicating that lower income

level was associated with higher scores in Impaired Autonomy/Other-Directedness domain.

As for the contribution of perceived parenting practices, perceived negative parenting from fathers [$\underline{pr}$ = .44, β = .44, $\underline{t}(306) = 8.52$, $\underline{p} < .001$] entered into the regression equation and increased explained variance to 21% [$\underline{F}_{change}(1, 306) = 72.63$, $\underline{p} < .001$]. The last factor associated with Impaired Autonomy/Other-Directedness domain was perceived negative parenting from mothers [$\underline{pr}$ = .21, β = .25, $\underline{t}(305) = 3.81$, $\underline{p} < .001$], increasing explained variance to 25% [$\underline{F}_{change}(1, 305) = 14.52$, $\underline{p} < .001$]. These results indicated that high levels of perceived negative parenting was associated with high levels of dependency, and low levels of assertiveness during interaction with others.

Table 3.17: Factors Associated with Schema Domains (First Set of Regression Analysis)

DV	IV	df	F_{change}	β	t	pr	R^2
A. ILES							
	I. Control Variables						
	Gender	1, 307	8.98*	.17	3.00*	.17	.03
	Income	1, 306	6.66*	-.14	-2.58*	-.15	.05
	II. Parenting Practices						
	Father	1, 305	75.90**	.43	8.66**	.44	.24
	Mother	1, 304	15.07**	.25	3.88**	.22	.27
B. DR							
	I. Control Variables						
	Gender	1, 307	9.26*	.17	3.04*	.17	.03
	Income	1, 306	7.04*	-.15	-2.65*	-.15	.05
	II. Parenting Practices						
	Father	1, 305	69.20**	.42	8.32**	.43	.23
	Mother	1, 304	9.27*	.20	3.05*	.17	.25
C. IAOD							
	I. Control Variables						
	Income	1, 307	7.07*	-.15	-2.66*	-.15	.02
	II. Parenting Practices						
	Father	1, 306	72.63**	.43	8.52**	.44	.21
	Mother	1, 305	14.52**	.25	3.81**	.21	.25

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

Note 2. ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other-Directedness

3.4.2. Factors Associated with Personality Dimensions

In order to examine associated factors of personality dimensions, six different hierarchical regression analyses were conducted with extraversion, conscientiousness, agreeableness, neuroticism, openness to experiences, and negative valence as dependent variables. Demographic variables (i.e., gender, age, mother education level, father education level, residence, and income) were entered into the analysis at the first step. Second step of the analysis included perceived parenting practices from mothers and fathers, whereas third step included schema domains namely Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness.

3.4.2.1. Factors Associated with Extraversion

The results of regression analysis conducted in order to find out factors associated with Extraversion dimension revealed that the only demographic variable entering into the regression equation was income level of individuals [pr = .12, β = .12, $t(307) = 2.09$, $p < .05$]. However, this variable explained only 1% of the variance [$F(1, 307) = 4.37$, $p < .05$], indicating that lower income level was associated with lower levels of Extraversion.

As for the contribution of perceived parenting practices, only perceived negative parenting from fathers [pr = -.12, β = -.13, $t(306) = -2.38$, $p < .05$] was significantly associated with Extraversion, [$F_{change}(1, 306) = 5.65$, $p < .05$], increasing total variance explained to 3%. This result indicated that higher levels of negative parenting from fathers were associated with lower levels of Extraversion.

Lastly, two different schema domains separately entered into the regression equation. The first one is Disconnection/Rejection domain [pr = -.56, β = -.61, $t(305) = -11.65$, $p < .001$], increasing explained variance to 33% [$F_{change}(1, 305) = 135.82$, $p < .001$]. Secondly, Impaired Limits/Exaggerated Standard domain [pr = .15, β = .15, $t(304) = 2.63$, $p < .01$] was found to be associated with this personality dimension, increasing the total variance explained in Extraversion dimension to 35% [$F_{change}(1, 304) = 6.93$, $p < .01$]. However, Impaired Autonomy/Other-Directedness domain was not significantly associated with Extraversion dimension.

Therefore, it was suggested that schemas related to rejection and being distant from others were negatively associated with being extraverted, whereas schemas related to Impaired Limits/Exaggerated Standards were positively associated with this personality domain.

3.4.2.2. Factors Associated with Conscientiousness

According to the results of regression analysis conducted to find out the factors associated with Conscientiousness, initially, gender [pr = -.12, β = -.12, t(307) = -2.02, p < .05] entered into the regression equation by explaining 1% of the variance, as the only demographic variable associated with this personality dimension [F(1, 307) = 4.09, p < .05], indicating that being female was associated with higher levels of Conscientiousness.

Secondly, perceived negative parenting from fathers [pr = -.16, β = -.16, t(306) = -2.91, p < .01] was found to be significantly associated with Conscientiousness level, increasing the explained variance to 4% [F_{change}(1, 306) = 8.44, p < .01]. This result suggests that perceived negative parenting from fathers was negatively associated with individuals' Conscientiousness level. However, no significant association of perceived negative parenting from mothers was observed.

Lastly, among three schema domains, only Disconnection/Rejection [pr = -.23, β = -.26, t(305) = -4.19, p < .001] had a significant association with Conscientiousness, increasing explained variance to 9% [F_{change}(1, 305) = 17.55, p < .001]. Therefore, having weaker forms of schemas in Disconnection/Rejection domain is associated with higher levels of Conscientiousness.

3.4.2.3. Factors Associated with Agreeableness

A hierarchical regression analysis was performed in order to examine associated factors of Agreeableness dimension of personality. The results showed that gender [pr = -.13, β = -.13, t(307) = -2.25, p < .05] was associated with this dimension, explaining 2% of the variance alone [F(1, 307) = 5.05, p < .05], indicating being female was associated with higher scores in Agreeableness dimension.

As for the perceived parenting practices [pr = -.13, β = -.13, t(306) = -2.27, p < .05], only a significant association of perceived negative parenting from mothers was observed, increasing total variance explained to 3% [F_{change}(1, 306) = 5.13, p < .05]. Therefore, lower levels of perceived negative parenting from mothers increased individuals' level of Agreeableness.

In addition, results revealed that Disconnection/Rejection [pr = -.41, β = -.45, t(305) = -7.93, p < .001] and Impaired Limits/Exagerrated Standards [pr = .14, β = .16, t(304) = 2.51, p < .05] domains separately entered into the regression equation by increasing total variance to 20% [F_{change}(1, 305) = 62.89, p < .001] and 21% [F_{change}(1, 304) = 6.29, p < .05] respectively. Therefore, lower scores in Disconnection/Rejection and higher scores in Impaired Limits/Exaggerated Standards were associated with mostly helpful and trustful personality characteristics.

3.4.2.4. Factors Associated with Neuroticism

In order to examine associated factors of Neuroticism, a hierarchical regression analysis was conducted and the results showed that two demographic variables entered into the regression. Initially, gender [pr = -.15, β = -.15, t(307) = -2.73, p < .01] was found to be associated with Neuroticism, explaining 2% of the variance [F(1, 307) = 7.45, p < . 01]. Moreover, individuals' income level [pr = -.13, β = -.13, t(306) = -2.23, p < .05] was also associated with this personality dimension and it explained another 2% of the variance [F_{change}(1, 306) = 4.96, p < .05], increasing the explained variance to 4%.

The results also revealed that after controlling the explained variance by significant demographic variables, perceived negative parenting from fathers [pr = .24, β = .23, t(305) = 4.24, p < .001] significantly increased explained variance in Neuroticism to 9% [F_{change}(1, 305) = 18.00, p < .001]. However, perceived negative parenting from mothers was not significantly associated with this dimension. Therefore, experiencing negative parenting from fathers increased individuals' Neuroticism scores.

Lastly, after controlling for the effects of other variables, among three schema domains, only Impaired Limits/Exaggerated Standards domain [pr = .33, β = .36, t(304) = 6.11, p < .001] entered into the regression equation and increased explained variance to 19% [F_{change}(1, 304) = 37.27, p < .001], indicating that maintaining schemas in Impaired Limits/Exaggerated Standards domain was associated with more distressful and anxious personality characteristics.

3.4.2.5. Factors Associated with Openness to Experiences

Associated factors of Openness to Experiences were examined through the results of a hierarchical regression analysis, which showed that no demographic variable was associated with this personality dimension.

As for the effect of perceived parenting practices, the results yielded a significant association of perceived negative parenting from fathers [pr = -.22, β = -.22, t(307) = -3.97, p < .001] and it explained 5% of the variance in Openness to Experiences [F(1, 307) = 15.78, p < .001], indicating that higher levels of perceived negative parenting from fathers were associated with lower levels of creativity and curiosity, as a personality dimension.

Moreover, all of the schema domains were found to be separately associated with Openness to Experiences. First of all, Disconnection/Rejection domain [pr = -.39, β = -.42, t(306) = -7.32, p < .001] entered into the regression equation and increased the total variance to 19% [F_{change}(1, 306) = 53.65, p < .001]. Secondly, Impaired Autonomy/Other-Directedness domain [pr = -.18, β = -.23, t(305) = -3.28, p ≤ .001] entered into the equation, by increasing total explained variance to 22% [F_{change}(1, 305) = 10.74, p < .001], whereas Impaired Limits/Exaggerated Standards domain [pr = .15, β = .18, t(304) = 2.63, p < .01] increased the total variance explained to 24% [F_{change}(1, 304) = 6.92, p < .01]. Thus, stronger forms of schemas in Disconnection/Rejection and Impaired Autonomy/Other-Directedness domains, and weaker forms of schemas in Impaired Limits/Exaggerated Standards domain was related with lower scores on Openness to Experiences dimension.

3.4.2.6. Factors Associated with Negative Valence

Results of hierarchical regression analysis conducted in order to determine associated factors to Negative Valence revealed a significant association of income levels [pr = -.12, β = -.12, $t(307) = -2.07$, $p < .05$], explaining 1% of the variance [$F(1, 307) = 4.30$, $p < .05$]. Other demographic variables were not observed to be associated with this personality dimension, indicating that individuals who have lower income scored higher on Negative Valence dimension.

Secondly, after significant demographic variables were controlled, among two sources of parenting, perceived negative parenting from mothers [pr = .22, β = .22, $t(306) = 3.90$, $p < .001$] entered into the equation and increased explained variance to 6% [$F_{change}(1, 306) = 15.20$, $p < .001$]. Therefore, as the level of perceived negative parenting from mother increased, individuals' perceptions about their own worth decreased.

As for the schema domains, after the effects of other variables were controlled, only Disconnection/Rejection domain [pr = .32, β = .34, $t(305) = 5.84$, $p < .001$] was significantly associated with Negative Valence, increasing explained variance to 16% [$F_{change}(1, 305) = 34.13$, $p < .001$]. Therefore, stronger forms of schemas in Disconnection/Rejection domain were associated with higher scores in Negative Valence dimension.

Table 3.18: Factors Associated with Personality Dimensions (Second Set of Regression Analysis)

DV	IV	df	F_{change}	β	t	pr	R^2
A. Extraversion							
	I. Control Variables						
	Income	1, 307	4.37*	.12	2.09*	.12	.01
	II. Parenting Practices						
	Father	1, 306	5.65*	-.13	-2.38*	-.14	.03
	III. Schema Domains						
	DR	1, 305	135.82***	-.61	-11.65***	-.56	.33
	ILES	1, 304	6.93**	.15	2.63**	.15	.35
B. Conscientiousness							
	I. Control Variables						
	Gender	1, 307	4.09*	-.12	-2.02*	-.12	.01
	II. Parenting Practices						
	Father	1, 306	8.44**	-.16	-2.91**	-.16	.04
	III. Schema Domains						
	DR	1, 305	17.55***	-.26	-4.19***	-.23	.09
C. Agreeableness							
	I. Control Variables						
	Gender	1, 307	5.05*	-.13	-2.25*	-.13	.02
	II. Parenting Practices						
	Mother	1, 306	5.13*	-.13	-2.27*	-.13	.03
	III. Schema Domains						
	DR	1, 305	62.89***	-.45	-7.93***	-.41	.20
	ILES	1, 304	6.29*	.16	2.51*	.14	.21

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

Note 2. DR = Disconnection/Rejection, ILES = Impaired Limits/Exaggerated Standards, IAOD = Impaired Autonomy/Other-Directedness

Table 3.18: Factors Associated with Personality Dimensions (Second Set of Regression Analysis) - Continued

DV	IV	df	F_{change}	β	t	pr	R^2
D. Neuroticism							
	I. Control Variables						
	Gender	1, 307	7.45**	-.15	-2.73**	-.15	.02
	Income	1, 306	4.96*	-.13	-2.23*	-.13	.04
	II. Parenting Practices						
	Father	1, 305	18.00***	.23	4.24***	.24	.09
	III. Schema Domains						
	ILES	1 ,304	37.27***	.36	6.11***	.33	.19
E. Openness to Experiences							
	I. Control Variables						
	None						
	II. Parenting Practices						
	Father	1, 307	15.78***	-.22	-3.97***	-.22	.05
	III. Schema Domains						
	DR	1, 306	53.65***	-.42	-7.32***	-.39	.19
	IAOD	1, 305	10.74***	-.23	-3.28***	-.18	.22
	ILES	1, 304	6.92**	.18	2.63**	.15	.24
F. Negative Valence							
	I. Control Variables						
	Income	1, 307	4.30*	-.12	-2.07*	-.12	.01
	II. Parenting Practices						
	Mother	1, 306	15.20***	.22	3.90***	.22	.06
	III. Schema Domains						
	DR	1, 305	34.13***	.34	5.84***	.32	.16

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

Note 2. DR = Disconnection/Rejection, ILES = Impaired Limits/Exaggerated Standards, IAOD = Impaired Autonomy/Other-Directedness

3.4.3. Factors Associated with Psychological Resources

As for the third set of hierarchical regression analyses with individuals' psychological resources (i.e., coping skills and perceived social support) as the dependent variables, initially demographic variables were entered into the analyses. After the effects of significant demographic variables were controlled, perceived parenting practices from mothers and fathers; schema domains, namely Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness; and personality dimensions, namely Extraversion, Conscientiousness, Agreeableness, Neuroticism, Openness to Experiences, and Negative Valence were entered into the analyses as the second, third, and fourth step respectively.

3.4.3.1. Factors Associated with Coping

In order to examine associated factors to coping, a hierarchical regression analysis was conducted with the total score of coping strategies as the dependent variable; low scores indicating insufficient coping strategies whereas high scores indicating sufficient levels of coping strategies. As for the demographic variables, only gender [$\underline{pr}$ = -.18, β = -.18, $\underline{t}(307)$ = -3.22, $\underline{p} \leq .001$] was found to be significantly associated with coping [$\underline{F}(1, 307) = 10.40$, $\underline{p} \leq .001$], explaining 3% of the variance, and indicating that being female was associated with more frequent usage of coping strategies.

After controlling the effect of gender, no significant association of perceived parenting practices was found. However, the results revealed that two of the three schema domains were significantly associated with coping. To be more precise, initially, Disconnection/Rejection domain [$\underline{pr}$ = -.18, β = -.18, $\underline{t}(306)$ = -3.14, $\underline{p} < .01$] entered into the equation by increasing explained variance to 6% [$\underline{F}_{change}(1, 306) = 9.86$, $\underline{p} < .01$], whereas Impaired Limits/Exaggerated Standards domain [$\underline{pr}$ = .30, β = .36, $\underline{t}(305)$ = 5.55, $\underline{p} < .001$] increased total variance explained to 15% [$\underline{F}_{change}(1, 305) = 30.77$, $\underline{p} < .001$]. However, Impaired Autonomy/Other-Directedness domain was not found to be significantly associated with coping. These results indicated that individuals who maintain stronger forms of schemas

from Disconnection/Rejection domain, and weaker forms of Impaired Limits/Exaggerated Standards domain tended to have lower levels of coping.

As the third step, after other variables were controlled, among six different personality dimensions, Openness to Experiences [pr = .36, β = .37, t(304) = 6.63, p < .001] entered first into the regression equation and increased explained variance to 25% [F_{change}(1, 304) = 43.95, p < .001]. Secondly, Agreeableness [pr = .25, β = .25, t(303) = 4.49, p < .001] was the last factor associated with coping, increasing explained total variance to 30% [F_{change}(1, 303) = 20.16, p < .001]. Therefore, higher levels of Openness to Experiences and Agreeableness were associated with sufficient usage of the coping strategies.

3.4.3.2. Factors Associated with Social Support

Associated factors of social support were examined through a hierarchical regression analysis and results revealed that gender [pr = -.19, β = -.19, t(307) = -3.32, p ≤ .001] entered into the regression equation as the first demographic variable [F(1, 307) = 11.04, p < .001], explaining 4% of the variance. Secondly, a significant association of father education level [pr = .14, β = .14, t(306) = 2.41, p < .05] was found and it increased total explained variance to 5% [F_{change}(1, 306) = 5.82, p < .05]. These results suggested that being female and having father with higher education level was associated with higher level of perceived social support.

As for the perceived parenting practices, after demographic variables were controlled, both negative parenting of fathers and negative parenting of mothers were separately associated with the level of perceived social support, in this order. Perceived negative parenting from fathers [pr = -.36, β = -.36, t(305) = -6.79, p < .001] increased the explained variance to 18% [F_{change}(1, 305) = 46.11, p < .001] and perceived negative parenting from mothers [pr = -.12, β = -.14, t(304) = -2.03, p < .05] increased the explained variance to 19% [F_{change}(1, 304) = 4.10, p < .05]. These results indicated that negative parenting was associated with lower levels of perceived social support.

Third, after controlling the effects of demographic variables and perceived parenting practices, the results revealed significant association of two schema

domains: Disconnection/Rejection domain [pr = -.52, β = -.53, t(303) = -10.50, p < .001] significantly increased the explained variance to 41% [$F_{change}(1, 303) = 110.14$, p < .001]. Following, Impaired Limits/Exaggerated Standards domain [pr = .17, β = .17, t(302) = 3.02, p < .01] entered into the regression equation and increased total explained variance to 42% [$F_{change}(1, 302) = 9.13$, p < .01]. These results indicate that higher scores in Disconnection/Rejection domain and lower scores in Impaired Limits/Exaggerated Standards domain were associated with lower scores in perceived social support from others.

Lastly, among six personality dimensions, after the effects of other variables were controlled, only Agreeableness [pr = .19, β = .17, t(301) = 3.40, p ≤ .001] entered into the regression equation and significantly increased explained variance to 44% [$F_{change}(1, 301) = 11.54$, p < .001]. Therefore, higher scores on Agreeableness dimension were associated with higher levels of perceived social support.

Table 3.19: Factors Associated with Psychological Resources (Third Set of Regression Analysis)

DV	IV	df	F_{change}	β	t	pr	R^2
A. Coping							
	I. Control Variables						
	Gender	1, 307	10.40***	-.18	-3.22***	-.18	.03
	II. Parenting Practices						
	None						
	III. Schema Domains						
	DR	1, 306	9.86**	-.18	-3.14**	-.18	.06
	ILES	1, 305	30.77***	.36	5.55***	.30	.15
	IV. Personality Dimensions						
	O	1, 304	43.95***	.37	6.63***	.36	.25
	A	1, 303	20.16***	.25	4.49***	.25	.30
B. Social Support							
	I. Control Variables						
	Gender	1, 307	11.04***	-.19	-3.32***	-.19	.04
	Father Education	1, 306	5.82*	.14	2.41*	.14	.05
	II. Parenting Practices						
	Father	1, 305	46.11***	-.36	-6.79***	-.36	.18
	Mother	1, 304	4.10*	-.14	-2.03*	-.12	.19
	III. Schema Domains						
	DR	1, 303	110.14***	-.53	-10.50***	-.52	.41
	ILES	1, 302	9.13**	.17	3.02**	.17	.42
	IV. Personality Dimensions						
	A	1, 301	11.54**	.17	3.40**	.19	.44

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

Note 2. DR = Disconnection/Rejection, ILES = Impaired Limits/Exaggerated Standards, O = Openness to Experiences, A = Agreeableness

3.4.4. Factors Associated with Psychological Well-Being

In order to examine associated factors of well-being, fourth set of regression analyses was conducted with depressive symptoms, psychopathological symptoms and life satisfaction as the dependent variables. In order to control for the effects of demographic variables, they were entered hierarchically in the first step. Secondly, the additional effects of perceived parenting practices from mothers and from fathers were examined. In the third step, schema domains, namely Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness were entered hierarchically into the analyses. Fourth, personality factors were taken into account and personality dimensions, namely Extraversion, Conscientiousness, Agreeableness, Neuroticism, Openness to Experiences, and Negative Valence were hierarchically entered hierarchically into the analyses. Lastly, after controlling for the effects of these factors, the contribution of psychological resources (i.e. coping and perceived social support) was examined.

3.4.4.1. Factors Associated with Depressive Symptoms

In order to determine the factors associated with depressive symptoms, a hierarchical regression analysis was conducted and results revealed that initially, income [$\underline{pr}$ = -.18, β = -.18, $\underline{t}(307) = -3.26$, $\underline{p} \leq .001$] entered into the regression equation, significantly explaining 3% of the variance [$\underline{F}(1, 307) = 10.64$, $\underline{p} < .001$]. Secondly, individuals' residence differences [$\underline{pr}$ = -.12, β = -.12, $\underline{t}(306) = -2.02$, $\underline{p} < .05$] entered into the equation and increased explained variance to 4% [$\underline{F}_{change}(1, 306) = 4.08$, $\underline{p} < .05$], indicating that lower income level, and living with family were associated with more depressive symptoms.

As for the perceived parenting practices, fathers' negative parenting [$\underline{pr}$ = .32, β = .31, $\underline{t}(305) = 5.86$, $\underline{p} < .001$] was found to be associated with depressive symptoms and increased explained variance to 14% [$\underline{F}_{change}(1, 305) = 34.33$, $\underline{p} < .001$]. In addition, mothers' negative parenting [$\underline{pr}$ = .15, β = .18, $\underline{t}(304) = 2.65$, $\underline{p} < .01$] also entered into the regression equation by significantly increasing explained

variance to 16% [$F_{change}(1, 304) = 7.03$, $p < .01$]. These results indicated that negative parenting was associated with higher depressive symptoms.

After controlling for the effects of demographic variables and perceived parenting practices, among three schema domains, Disconnection/Rejection [pr = .51, β = .53, $t(303) = 10.29$, $p < .001$] entered the regression equation and significantly increased explained variance to 38% [$F_{change}(1, 303) = 105.87$, $p < .001$]. Secondly, a significant association of Impaired Autonomy/Other-Directedness [pr = .16, β = .17, $t(302) = 2.77$, $p < .01$] was found, increasing explained variance to 39% [$F_{change}(1, 302) = 7.65$, $p < .01$]. However, Impaired Limits/Exaggerated Standards domain was not found to be associated with depressive symptoms, indicating that individuals with higher scores in Disconnection/Rejection, and Impaired Autonomy/Other-Directedness domains tended to be more depressed.

In the third step, the results showed that after controlling for the effects of these variables, four different personality dimensions entered into the regression equation. Neuroticism [pr = .24, β = .20, $t(301) = 4.23$, $p < .001$] significantly increased the variance to 43% [$F_{change}(1, 301) = 17.93$, $p < .001$]. Openness [pr = -.19, β = -.16, $t(300) = -3.30$, $p \leq .001$] and Agreeableness [pr = .17, β = .15, $t(299) = 3.05$, $p < .01$] dimensions significantly increased explained variance to 45% [$F_{change}(1, 300) = 10.87$, $p < .001$] and 47% [$F_{change}(1, 299) = 9.27$, $p < .01$] respectively, as the second and third personality dimensions entering into the regression equation. Lastly, Conscientiousness [pr = -.15, β = -.12, $t(298) = -2.53$, $p < .05$] was found to be significantly associated with depressive symptoms, increasing explained variance to 48% [$F_{change}(1, 298) = 6.41$, $p < .05$]. These results indicated that individuals who had higher scores on Neuroticism and Agreeableness, and lower scores on Openness and Conscientiousness tended to have more depressive symptoms.

Lastly, after controlling the effects of these variables, individuals' other psychological resources were also found to be associated with depressive symptomatology. Initially, social support [pr = -.19, β = -.18, $t(297) = -3.33$, $p \leq$

.001] entered into the regression equation and increased explained variance to 50% [$F_{change}(1, 297) = 11.07$, $p < .001$]. Lastly, coping [$pr = -.13$, $\beta = -.11$, $t(296) = -2.31$, $p < .05$] significantly entered into the regression equation, although explained variance was remained as 50% [$F_{change}(1, 296) = 5.34$, $p < .05$]. These results suggested that increased levels of perceived social support and coping strategies were associated with fewer depressive symptoms.

3.4.4.2. Factors Associated with Psychopathological Symptoms

The results of a hierarchical regression analysis conducted to examine associated factors of psychopathological symptoms showed that income [$pr = -.16$, $\beta = -.16$, $t(307) = -2.86$, $p < .01$] was negatively associated with these symptoms and explained 3% of the variance [$F(1, 307) = 8.17$, $p < .01$]. Secondly, individuals' residence status [$pr = -.13$, $\beta = -.14$, $t(306) = -2.35$, $p < .05$] entered into the regression equation by increasing explained variance to 4% [$F_{change}(1, 306) = 5.52$, $p < .05$]. Next, age [$pr = -.12$, $\beta = -.12$, $t(305) = -2.03$, $p < .05$] entered into the regression equation as the last demographic variable associated with psychopathological symptoms and significantly increased the explained variance to 6% [$F_{change}(1, 305) = 4.13$, $p < .05$]. These results indicated that lower income level, living with family, and being younger were associated with more severe symptoms of psychopathology.

As for the perceived parenting practices, both perceived negative parenting from mothers [$pr = .35$, $\beta = .35$, $t(304) = 6.61$, $p < .001$] and from fathers [$pr = .17$, $\beta = .20$, $t(303) = 3.01$, $p < .01$] were found to be associated with psychopathological symptoms, increasing the explained variance to 18% [$F_{change}(1, 304) = 43.69$, $p < .001$] and 20% [$F_{change}(1, 303) = 9.05$, $p < .01$], respectively. These results suggested that experiencing more negative practices from parents were related with more severe symptoms of psychopathology in individuals.

After controlling the effects of demographic variables and perceived parenting practices, all of the schema domains entered into the regression equation. Initially, Disconnection/Rejection domain [$pr = .44$, $\beta = .46$, $t(302) = 8.58$, $p < .001$] increased explained variance in psychopathological symptoms to 36% [$F_{change}(1,$

302) = 73.57, p < .001], whereas Impaired Autonomy/Other-Directedness domain [pr = .27, β = .30, t(301) = 4.77, p < .001] entered into the regression equation in the second order, increasing explained variance to 40% [F_{change}(1, 301) = 22.79, p < .001]. Next, Impaired Limits/Exaggerated Standards [pr = .17, β = .19, t(300) = 3.07, p < .01] was found to be significantly associated with psychopathological symptoms, increasing explained variance to 42% [F_{change}(1, 300) = 9.41, p < .01]. Therefore, it was indicated that stronger forms of schemas in all domains were related with more severe symptoms of psychopathology.

Lastly, among six personality domains, only Neuroticism [pr = .31, β = .25, t(299) = 5.55, p < .001] was found to be associated with psychopathological symptoms, after other variables were controlled. Neuroticism increased explained variance to 47% [F_{change}(1, 299) = 30.85, p < .001], indicating that higher scores in Neuroticism were associated with more symptoms of psychopathology. However, after controlling for the effects of demographic variables, parenting practices, schema domains, and personality dimensions, other psychological resources namely, coping, and perceived social support did not have a significant contribution on the variance.

3.4.4.3. Factors Associated with Life Satisfaction

In order to examine associated factors with life satisfaction, a hierarchical regression analysis was conducted and the results revealed that gender [pr = -.18, β = -.18, t(307) = -3.17, p < .01] was associated with life satisfaction, explaining 3% of the variance [F(1, 307) = 10.03, p < .01]. Moreover, individuals' income level [pr = .17, β = .17, t(306) = 3.03, p < .01] also entered into the regression equation, by increasing explained variance to 6% [F_{change}(1, 306) = 9.17, p < .01]. These results indicated that females who had higher income reported higher satisfaction of life.

After controlling the effects of demographic variables, only perceived negative parenting from fathers [pr = -.17, β = -.16, t(305) = -2.98, p < .01] was observed to be associated with the level of life satisfaction, increasing explained variance to 9% [F_{change}(1, 305) = 8.91, p < .01], and indicating that individuals who

perceived more negative parenting from their fathers tended to be less satisfied with their lives. This contribution increased explained variance to 9%.

As for the schema domains, only Disconnection/Rejection domain [pr = -.33, β = -.36, t(304) = -6.08, p < .001] was found to be significantly associated with life satisfaction after controlling for the effects of demographic variables and perceived parenting practices, increasing explained variance 19% [$F_{change}(1, 304) = 37.01$, p < .001]. Two other schema domains did not enter into the regression equation, indicating higher life satisfaction was associated with weaker forms of schemas in Disconnection/Rejection domain.

When the effects of these variables were controlled, two different personality dimensions entered into the regression equation. Initially, Conscientiousness [pr = .26, β = .25, t(303) = 4.75, p < .001] was observed to be associated with life satisfaction and increased explained variance to 24% [$F_{change}(1, 303) = 22.59$, p < .001]. Next, Extraversion [pr = .15, β = .16, t(302) = 2.65, p < .01] entered into the regression equation increasing explained variance to 26% [$F_{change}(1, 302) = 7.00$, p < .01]. These results suggested that individuals who scored higher on Conscientiousness and Extraversion dimensions reported higher satisfaction with life.

In the last step, after the effects of these variables were controlled, both coping and perceived social support entered into the regression equation, as other psychological resources. Individuals' level of coping [pr = .31, β = .29, t(301) = 5.62, p < .001] was found to be associated with their life satisfaction, increasing explained variance to 33% [$F_{change}(1, 301) = 31.54$, p < .001]. After that, perceived social support [pr = .15, β = .17, t(300) = 2.69, p < .01] entered into the regression equation, by increasing total variance explained by demographic variables, perceived parenting practices, personality dimensions, and other psychological resources to 35% [$F_{change}(1, 300) = 7.25$, p < .01]. These results indicated that higher levels of coping, and higher levels of perceived social support were associated with higher satisfaction with life.

Table 3.20: Factors Associated with Psychological Well-Being (Fourth Set of Regression Analysis)

DV	IV	df	F_{change}	β	t	pr	R^2
A. Depressive Symptoms							
	I. Control Variables						
	Income	1, 307	10.64***	-.18	-3.26***	-.18	.03
	Residence	1, 306	4.08*	-.12	-2.02*	-.12	.04
	II. Parenting Practices						
	Father	1, 305	34.33***	.31	5.86***	.32	.14
	Mother	1, 304	7.03**	.18	2.65**	.15	.16
	III. Schema Domains						
	DR	1, 303	105.87***	.53	10.29***	.51	.38
	IAOD	1, 302	7.65**	.17	2.77**	.16	.39
	IV. Personality Dimensions						
	N	1, 301	17.93***	.20	4.23***	.24	.43
	O	1, 300	10.87***	-.16	-3.30***	-.19	.45
	A	1, 299	9.27**	.15	3.05**	.17	.47
	C	1, 298	6.41*	-.12	-2.53*	-.15	.48
	V. Other Resources						
	Social Support	1, 297	11.07***	-.18	-3.33***	-.19	.50
	Coping	1, 296	5.34*	-.11	-2.31*	-.13	.50
B. Psychopathology Symptoms							
	I. Control Variables						
	Income	1, 307	8.17**	-.16	-2.86**	-.16	.03
	Residence	1, 306	5.52*	-.14	-2.35*	-.13	.04
	Age	1, 305	4.13*	-.12	-2.03*	-.12	.06

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

Note 2. DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other-Directedness, ILES = Impaired Limits/Exaggerated Standards, N = Neuroticism, O = Openness to Experiences, A = Agreeableness, C = Conscientiousness, E = Extraversion

Table 3.20: Factors Associated with Psychological Well-Being (Fourth Set of Regression Analysis) - Continued

DV	IV	df	F_{change}	β	t	pr	R^2
	II. Parenting Practices						
	Mother	1, 304	43.69***	.35	6.61***	.35	.18
	Father	1, 303	9.05**	.20	3.01**	.17	.20
	III. Schema Domains						
	DR	1, 302	73.57***	.46	8.58***	.44	.36
	IAOD	1, 301	22.79***	.30	4.77***	.27	.40
	ILES	1, 300	9.41**	.19	3.07**	.17	.42
	IV. Personality Dimensions						
	N	1, 299	30.85***	.25	5.55***	.31	.47
	V. Other Resources						
	None						
C. Satisfaction with Life							
	I. Control Variables						
	Gender	1, 307	10.03**	-.18	-3.17**	-.18	.03
	Income	1, 306	9.17**	.17	3.03**	.17	.06
	II. Parenting Practices						
	Father	1, 305	8.91**	-.16	-2.98**	-.17	.09
	III. Schema Domains						
	DR	1, 304	37.01***	-.36	-6.08***	-.33	.19
	IV. Personality Dimensions						
	C	1, 303	22.59***	.25	4.75***	.26	.24
	E	1, 302	7.00**	.16	2.65**	.15	.26
	V. Other Resources						
	Coping	1, 301	31.54***	.29	5.62***	.31	.33
	Social Support	1, 300	7.25**	.17	2.69**	.15	.35

Note. *p < .05, **p < .01, ***p < .001; Note 2. DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other-Directedness, ILES = Impaired Limits/Exaggerated Standards, N = Neuroticism, C = Conscientiousness, E = Extraversion

CHAPTER 4

DISCUSSION

The current study investigated the relationship between perceived parenting styles, early maladaptive schemas, and psychological well-being, and the importance of some psychological resources, namely personality, coping styles, and social support on this relationship. For this purposes, initially the differences in the levels of demographic variables were examined on the measures of the study. Secondly, intercorrelations between all the measures of the study were calculated. Lastly, associated factors of the schema domains, personality dimensions, other psychological resources, and psychopathology and well-being were determined through four different sets of hierarchical regression analyses. In this section, the results of these analyses will be discussed in the light of literature.

4.1. Findings Related to Differences in Demographic Variables on the Measures of the Study

In the current study, determining differences of the levels of demographic variables on the measures of the study was one of the main aims. Therefore, gender, age, mother education level, father education level, residence, and monthly income differences were examined on parenting practices, schema domains, personality dimensions, coping styles, perceived social support, and measures of well-being. These analyses revealed several significant results.

4.1.1. Findings Related to Gender Differences on the Measures of the Study

The results of the current study indicated that gender had significant effect on schema domains, personality dimensions, coping styles, perceived social support, and life satisfaction of individuals. First of all, it was found out that male participants scored higher on Impaired Limits/Exaggerated Standards (ILES), and Disconnection/Rejection (DR) domains than females. In fact, ILES includes some

schemas related to heightened need of being approved by others and having high standards to meet, along with a self-perception of being special and low levels of toleration to frustrations whereas DR includes schemas related to feeling different and apart from any group. This difference might be the result of sociocultural context of Turkish society, in which men are expected to be more independent and more achievement-oriented in order to take care of their families, whereas women have both interdependent and independent characteristics, especially when they have higher education level (Karakitapoğlu-Aygün, 2004), as it was the case in the current study. Therefore, it is not surprising that independence and connectedness-related schemas were more activated in male students than female students.

Secondly, the only personality dimension differed with gender difference was Neuroticism, with higher scores of female participants. This finding is comparable to the results of previous studies indicating that women score higher on neuroticism dimension even in different cultures (Lynn & Martin, 1997). Neuroticism is defined as emotional instability and the reason why women score higher on this dimension might be because of women's higher levels of sensitivity to internal and external emotional cues, which might be a source for stress and anxiety for them (Furnham & Buchanan, 2005). Moreover, in the current study, female participants reported higher levels of indirect coping and perceived social support than males. As Gençöz, Gençöz, and Bozo (2006) stated individuals who prefer indirect coping style are more likely to seek for guidance before focusing on solving problems. Gender difference on this coping style is expected when social roles are considered, since seeking social support might be seen as a sign of weakness for males (Swickert & Owens, 2010). In addition, gender differentiation in the level of perceived social support might be related with these findings because receiving social support is not a passive process. For instance, Conn and Peterson (1989) found out that individuals who asked for social support were more likely to receive it. Therefore, in the light of these findings, female participants' higher scores on both indirect coping style and perceived social support are reasonable.

As for the gender differences on the measures of well-being, the results of the study revealed that female participants reported higher satisfaction with life than males. Although this result seems to be inconsistent with the fact that depressive disorders are more prevalent among women, a possible explanation for this discrepancy may be that women experience both positive and negative emotions more intensely, which might be related their caregiving roles and societal expectations of higher responsiveness than men (Diener, Suh, Lucas, & Smith, 1999). Besides, any gender difference on the level of life satisfaction might be affected by some other variables such as perceived social support, since there has been conflicting results regarding this relationship.

4.1.2. Findings Related to Age Differences on the Measures of the Study

According to the results of the current study, age had an effect only on the participants' level of satisfaction with life, those who are younger reporting higher satisfaction. Since studies have revealed both positive and negative relationship between age and life satisfaction (see Hamarat et al., 2001; and Alston & Dudley, 1973), other variables affecting this relationship should be considered. However, for the current study, there was not any significant age difference on personality dimensions, coping styles, or perceived social support, which might be related to the restricted age range of the sample. Therefore, any other measure affecting this relationship was considered. For instance, in a study, it was found out that higher levels of perceived stress were related with lower levels of life satisfaction (Hamarat et al., 2001). In fact, in a university student sample, it is possible that older participants were less satisfied with their lives because they perceived higher stress related to their future, compared to younger participants who did not have such considerations yet, which might reflect positive association between age and psychological well-being.

4.1.3. Findings Related to Mother Education Level Differences on the Measures of the Study

The results of the current study indicated that differences in mother education level had an effect on perceived negative parenting from mothers and

fathers, as well as the level of life satisfaction of participants. Actually, the relationship between mother education level and perceived negative parenting from mothers has been well established in several studies, even with a Turkish sample. In a study conducted to compare high- and low-educated mothers' parenting styles in metropolitan and rural cities in Anatolia, it was found out that high-educated mothers in metropolitan cities tended to be less obedience-demanding and punitive, and more permissive than those with lower education (Nacak, Yağmurlu, Durgel, & van der Vijver, 2011). Moreover, such a parenting style might reinforce their children's self-development and might support their self-esteem, which was consistently found to be associated with life satisfaction because the term "self-esteem" includes personal attributes, and competencies regarding self-worth and respect (Zhang & Loung, 2002). Therefore, as for the results of this study, it is consistent with the previous findings that individuals who reported higher perceived negative parenting from their parents were less satisfied with their lives.

On the other hand, results regarding the effect of mothers' education level differences on perceived negative parenting from fathers were difficult to interpret. One possible explanation for this finding would be that negative parenting practiced by mothers with lower education level is associated with negative parenting from fathers. This explanation is supported by the premise of family systems perspective, indicating interdependence of family elements to each other (Minuchin, 1985; as cited in Gamble, Ramakumar, & Diaz, 2007). In fact, in a study conducted to examine similarities and differences in parenting styles of mothers and fathers, it was found out that authoritarian parenting from mothers and authoritarian parenting from fathers are modestly associated with each other (Winsler, Madigan, & Aquilino, 2005). Besides, mothers with higher education would play a protective role against negative parenting practices from fathers.

4.1.4. Findings Related to Father Education Level Differences on the Measures of the Study

The results of the analyses regarding fathers' education level differences on the measures of the study revealed that participants who had fathers with lower

education level tended to perceive more negative parenting from their fathers. This finding is consistent with previous studies indicating that lower levels of education is associated with authoritarian parenting, demanding obedience, and rejection (Scott-Little & Holloway, 2002). On the other hand, it is highly possible that these fathers reflect their experiences from their own upbringing, since the relationship between parenting practices and academic achievement seems to be cyclical. Many studies revealed that authoritarian and permissive parenting styles were related with lower academic achievement than authoritative parenting style, which includes involving, encouraging, democratic and nondirective practices (Ishak, Low, & Lau, 2012; Pong, Hao, & Gardner, 2005). However, in the light of these findings, it is surprising that participants perceiving high negative parenting were university students in undergraduate or higher levels. In this case, there might have been some internal or external protective factors, such as resilient personality traits, adaptive coping strategies or corrective experiences with other family members and high social support from them.

Secondly, in line with expectations, participants who had fathers with lower education level reported more depressive symptoms than those with high-educated fathers, which can be explained by the effects of negative parenting practices related to low education level of fathers. The relationship between perceived negative parenting practices from fathers and psychopathological symptoms is well-established by many studies conducted regarding different types of psychopathology, such as depression and substance abuse (Stover, Urdahl, & Easton, 2012), eating disorders (McEwen & Flouri, 2009), and anxiety disorders (Liber et al., 2008).

4.1.5. Findings Related to Monthly Income Differences on the Measures of the Study

According to the results of the study, the amount of monthly income was negatively associated with the levels of all schema domains, namely Impaired Limits/Exaggerated Standards (ILES), Disconnection/Rejection (DR), and Impaired Autonomy/Other-Directedness (IAOD). University education usually requires an

important amount of money for transportation, accommodation, clothing, entertainment, communication and other purposes. Therefore, students with financial problems might experience problems in all these domains, which might activate their schemas especially related to being autonomous and having connectedness with and approval of others in IAOD and DR domains. Besides, since they possibly experience psychological and social problems because of their financial problems, they might set higher standards for themselves along with perceptions of being special, which might increase their scores on ILES domain.

As for the monthly income level differences on coping styles, individuals who had lower monthly income reported less usage of problem-focused coping strategies and more usage of emotion-focused coping strategies. This result is consistent with the literature. For instance, in a study conducted with students from different socioeconomic levels in rural and urban residences, it was found out that those with low socioeconomic status were less likely to use problem-solving and more likely to use venting and fantasizing as coping strategies in China (Zhang, Chang, Zhang, Greenberger, & Chen, 2011), a developing country like Turkey. Generally, it is suggested that individuals with lower socioeconomic status are more viable to stressful life events (Lever, 2008). Moreover, they have restricted access to psychological and social resources, which might account for the difference in the frequency of preferred coping strategies by students with low and high monthly income.

Lastly, it was found that monthly income was associated with higher psychological symptoms and lower life satisfaction, parallel to the literature. For instance, in a study conducted with university students, it was revealed that students with higher financial struggles reported more symptoms of depression and anxiety, and higher levels of suicidality, as well as lower academic achievement (Eisenberg, Gollust, Golberstein, & Hefner, 2007), which might also precipitate psychopathological symptoms in turn. However, there might not be a direct relationship between socioeconomic status and subjective well-being, but a curvilinear relationship, which indicates that after a certain point, higher income is

associated with lower levels of well-being. Therefore, it is suggested that certain level of income is necessary to meet basic needs, but then it becomes less crucial (Jokela & Keltikangas-Järvinen, 2011). When university students were not able to meet their needs such as alimentation, accommodation, transportation, or entertainment with an income level lower than 1000 Turkish Liras, they were more likely to feel stressed and to have psychopathological symptoms. However, after these needs were met, other factors, such as personality and coping styles, as mentioned above, possibly had an effect on the relationship between socioeconomic level and psychological well-being.

4.2. Findings Related to Correlation Coefficients between Measures of the Study

Correlational analyses between measures of the current study revealed several significant results, most of which were discussed in the above sections. Besides these associations, it was found significant correlations between personality dimensions and other measures of the study. As for the relationship with schema domains, it was figured out that Disconnection/Rejection (DR) domain was positively correlated with neuroticism. This finding is consistent with the previous studies indicating that neuroticism is the most associated personality dimension with early maladaptive schemas, especially which are about the feelings of disconnection and rejection (Muris, 2006; Sava, 2009). Moreover, Impaired Autonomy/Other-Directedness (IAOD) domain was found to be positively correlated with negative valence. Considering its emphasis on the feelings of self-worth, it seems reasonable that higher scores on negative valence are associated with higher levels of dependence on others and lower levels of assertiveness because negative valence was also found to be negatively associated with measures of self-esteem, which is an important aspect of autonomy. On the other hand, a negative correlation was found between IAOD domain and the personality dimensions of extraversion, agreeableness, and openness to experiences. These dimensions are characterized with positive affectivity, self-control and social interactions, and higher intellect respectively (Gençöz & Öncül, 2012). Therefore,

their negative association with schemas related to dependence on others, and worry about future harm is consistent with the previous findings. Lastly, Impaired Limits/Exaggerated Standards (ILES) domain revealed weak but meaningful correlations with several personality dimensions namely negative correlations with extraversion, conscientiousness, and openness to experiences and positive correlations with neuroticism and negative valence, which were not mentioned in the result section.

Besides the relationship between personality dimensions and schema domains, correlational analyses revealed significant associations with coping styles and perceived social support as well. According to the results, individuals who scored higher on extraversion, conscientiousness, agreeableness, and openness to experiences were more likely to use problem-focused coping strategies. Interestingly, there was no significant correlation between these personality dimensions and emotion-focused coping. These results indicates that those who have more positive affect, who are more responsible and goal-directed, more tolerant to frustration, and more creative and intellectual mostly prefer cope with stress by focusing on the problem and trying to solve it, all of which are consistent with the literature (George & Zhou, 2001, as cited in Gençöz & Öncül, 2012; Jensen-Campbell et al., 2002). Furthermore, agreeableness was also positively associated with indirect coping style, probably because they are both related to social interactions. Therefore, individuals who have better social interactions might also prefer indirect coping style, which involves asking for guidance from others before taking any action. As for the relationship between personality dimensions and perceived social support, the results showed that extraversion, agreeableness, and openness to experiences were positively associated with the level of perceived social support as expected. On the other hand, negative valence was found to be negatively associated with perceived social support. The reason for this association might be that individuals with lower levels of self-worth do not seek for social support from their families, friends and significant others, because they might think that they do not deserve it, which affects the level of received social support as well.

Lastly, correlational analyses between personality dimensions and measures of well-being revealed several significant results. In line with the previous studies, especially higher levels of neuroticism and lower levels of extraversion were found to be associated with higher psychological distress, namely depressive and other psychological symptoms. Moreover, extraversion positively correlated with life satisfaction. These results indicate that anxious and moody individuals are more prone to psychological distress. This association might be the result of the fact that they tend to have more negative affect, lower self-esteem, and fewer social interactions and to use maladaptive coping strategies (Bouchard, 2003; Boyes & French, 2010; Verduyn & Brans, 2012). On the other hand, Verduyn and Brans (2012) also showed that extraversion is associated with higher frequency, intensity and duration of positive emotions, which can explain its negative relationship with psychopathology and positive relationship with life satisfaction. Besides, as the results of the present study revealed, individuals with higher extraversion scores tend to use problem-focused coping skills and to perceive higher social support, which might account for lower levels of psychological symptoms and higher levels of life satisfaction.

4.3. Findings Related to Regression Analyses

In order to determine factors associated with the measures of the current study, four different sets of hierarchical regression analyses were conducted with schema domains, personality dimensions, psychological resources, and psychopathology and well-being measures as the dependent variables.

4.3.1. Findings Related to the Factors Associated with Schema Domains

According to the results of the hierarchical regression analyses conducted to determine the associates of schema domains, gender and income were found to be associated with Impaired Limits/Exaggerated Standards (ILES) and Disconnection/Rejection (DR) domains, whereas only income was associated with Impaired Autonomy/Other-Directedness (IAOD) domain among all demographic variables. The relationship between these two demographic variables and schema domains was discussed above. After controlling for the effects of demographic

variables, it was revealed that perceived negative parenting from fathers had greater effect on the formation of all schema domains compared to perceived negative parenting from mothers. Actually, this result is consistent with the studies finding stronger association with fathers' negative parenting and adverse psychological symptoms. For instance, McKinney and Renk (2008) conducted a study with late adolescents, aging between 18 and 22, in order to examine the effects of consistency in parenting of mothers and fathers on the adjustment level of adolescents. The results of the study indicated that perceived negative parenting from fathers was associated with lower levels of emotional adjustment, whether or not perceived parenting from mothers was negative. Moreover, it was also shown that fathers are more likely to be perceived as authoritarian (Tein, Roosa, & Michaels, 1994), and emotionally distant from their children; besides, this kind of parenting might involve harsher practices, all of which strengthen the association between perceived negative parenting from fathers and early maladaptive schemas. On the other hand, mothers are more likely to be perceived as authoritative (Tein et al., 1994) which can be explained through evolutionary perspective, since they are supposed to take care of their children, and therefore, to be more responsive and accepting. In this case, emotional adjustment was found to be moderate among late adolescents if their fathers were perceived as authoritarian, whereas congruency between perceived negative parenting from fathers and mothers had more adverse effects on emotional adjustment of adolescents (McKinney & Renk, 2008). Therefore, it is important to take into account both mothers' and fathers' parenting practices in order to understand the effects of perceived parenting styles on children's psychological adjustment.

4.3.2. Findings Related to the Factors Associated with Personality Dimensions

Second set of hierarchical regression analysis conducted to determine associated factors of personality dimensions revealed different results for each dimensions, namely extraversion, conscientiousness, agreeableness, neuroticism, openness to experiences, and negative valence.

First of all, gender was found to be associated with conscientiousness, agreeableness, and neuroticism; in which females scored higher on all of them, indicating that females were more responsible, organized, controlled, but also anxious and moody. Besides, among all demographic variables, only monthly income level was found to be associated with extraversion and negative valence, and as the second demographic variable associated with neuroticism, indicating that higher income level was related to higher scores on extraversion and lower scores on negative valence and neuroticism. The findings related to the relationship between gender and personality dimensions are consistent with the literature. For instance, Goodwin and Gotlib (2004) also found out that conscientiousness, agreeableness, and neuroticism are higher in women. However, the reason for this difference is not known well; and might be attributed to the hormonal differences or different rearing styles. As for the effects of monthly income on personality dimensions, it is clear that higher income is associated with higher levels of extraversion in a university student sample, since this population usually needs certain level of income in order to participate in social life with their friends, after spending money for their basic needs such as nutrition, accommodation, and other academic expenses. Moreover, the finding indicating that university students with lower income feel more anxious and moody and have lower self-worth is consistent with the previous studies as well.

After controlling for the effects of demographic variables on the personality dimensions, it was found out that perceived negative parenting from fathers was negatively associated with extraversion, conscientiousness, and openness to experiences; and positively correlated with neuroticism. On the other hand, perceived negative parenting from mothers was found to be negatively related with agreeableness; and positively related with negative valence. Therefore, fathers' negative parenting practices seem to result in especially negative affect, lower levels of sense of responsibility, and anxious or stressed personality characteristics. This might be related with the fact that fathers are more likely to be perceived as authoritarian, which includes low acceptance and high control towards their

children. However, according to the results of hierarchical regression analysis, perceived negative practices from mothers were related with poorer social interactions and lower levels of self-worth. As it was mentioned earlier, mothers are expected to take care of their children, and be responsive to their needs. However, it is possible that consistent lack of this kind of attention from the primary caregiver is associated with negative perceptions of the self, which also influences social interactions indirectly. At this point, it is important to note that perceived negative parenting from fathers and mothers were found to be associated with completely different personality dimensions, which indicates that they influence individuals differently and they should be examined separately.

Lastly, as the third step, the effects of schema domains on the personality dimensions were examined through hierarchical regression analysis and the results initially showed the importance of DR domain on extraversion, conscientiousness, agreeableness, openness to experiences, and negative valence, since DR explained highest variance in these dimensions. Schemas in DR domain are resulted from unmet secure attachment needs during early years of life (Young et al., 2003). Therefore, considering feelings of disconnectedness and apartness from a group that DR includes, it is understandable that individuals who scored high on this domain were more likely to have lower scores on personality dimensions related to positive emotional adjustment (i.e., extraversion, conscientiousness, agreeableness, and openness to experiences). On the other hand, insecure attachment is characterized by negative cognitions about self and fear of abandonment by others (Lim, Adams, & Lilly, 2012), which might be associated with increased level of negative valence among individuals with high scores on DR, since they do not believe that they are worth to form secure relationships in which their needs such as love, nurturance, and safety can be met. Secondly, schemas in IAOD domain were also negatively associated with openness to experiences consistently with the previous findings. Young et al. (2003) describe the family environment of the individuals who have stronger schemas related to autonomy and other-directedness as having conditional acceptance from parents or being overprotected by them, resulting in low levels of

self-esteem (Gençöz & Öncül, 2012). Therefore, individuals who had higher scores on IAOD tended to rate themselves as less creative and less courageous than others. Moreover, ILES domain was also significantly associated with openness to experiences as the third schema domain accounting for the variance in this dimension; whereas it was associated with extraversion and agreeableness as the second schema domain after DR domain and with neuroticism as the only schema domain accounting for the variance. Interestingly, this schema domain was found to be positively related with openness to experiences, extraversion, and agreeableness; as well as with neuroticism. The reason for the positive relationship between ILES and personality dimensions related to positive emotional adjustment might be that individuals with these schemas were possibly raised as spoiled children, and they had higher levels of self-esteem, although it might be ungrounded, which might explain its relationship with anxious and stressed personality characteristics as well.

4.3.3. Findings Related to the Factors Associated with Psychological Resources

In order to determine associated factors of coping strategies and perceived social support, hierarchical regression analyses were conducted with demographic variables, perceived parenting styles, schema domains, and personality dimensions as four different steps. The results indicated that, first of all, gender was associated with both coping and social support, where females had more sufficient coping strategies and higher social support, as mentioned above. Moreover, fathers' education level was found to be associated with the level of perceived social support, which includes items about perceived support from family as well. Therefore, since fathers with lower education level were more likely to be perceived as authoritarian, obedience demanding, and rejecting (Scott-Little & Holloway, 2002), the negative relationship between fathers' education level and perceived social support is consistent with the literature. This finding can also explain the finding that individuals perceiving more negative parenting practices from both mothers and fathers reported lower levels of social support. It is also possible that such experiences with parents might affect individuals' other close relationships,

and might prevent them to get social support from friends and special others as well. However, no significant effect of perceived parenting practices was found on the coping strategies.

After controlling for the effects of demographic variables and perceived negative parenting, DR domain was found to be negatively associated with the usage of coping strategies and the level of perceived social support, whereas ILES was found to be positively associated with these psychological resources, indicating that detached, cold and rejecting parenting has more detrimental effects on individuals' psychological adjustment than permissive and overindulgent parenting, in which individuals are more able to develop sufficient coping strategies and to seek for social support from others. In fact, Wolfradt, Hempel, and Miles (2003) found out that individuals perceiving authoritative and permissive parenting showed higher usage of active coping strategies than those perceiving authoritarian or indifferent parenting. Moreover, in the same study, having permissive parents was associated with better psychological adjustment, which is parallel to the current finding that schemas in ILES domain are related with better usage of psychological resources.

Lastly, among personality dimensions, openness to experiences was associated with sufficient usage of coping strategies, after controlling for the effects of previous variables. This finding is consistent with the literature in the sense that adaptive coping strategies are more used by individuals with higher levels of creativity and intellect (Gençöz & Öncül, 2012). Moreover, the results of the hierarchical analysis also revealed that agreeableness was also associated with coping, as the second personality dimension; and with perceived social support as the only personality dimension explaining significant amount of variance. Therefore, it is suggested that individuals who emphasize the importance of social interactions over self-directedness (Wilkowski, Robinson, & Meier, 2006) are more likely to use coping strategies and perceive higher levels of social support, since they have better interpersonal skills than those who score lower on this dimension.

4.3.4. Findings Related to the Factors Associated with Psychopathology and Life Satisfaction

Associated factors of psychopathology and life satisfaction was determined through the fourth set of hierarchical analysis with demographic variables, perceived negative parenting, schema domains, personality dimensions, and other psychological resources as five consecutive steps. Initially, the results showed that gender was only significantly associated with life satisfaction and that females reported higher satisfaction with life than males. Moreover, the amount of monthly income was found to be associated with life satisfaction as the second demographic variable; and with depressive and other psychological symptoms as the first demographic variable explaining a significant amount of variance, all of which were discussed earlier. However, residence status of the participants was also found to be associated with depressive and other psychological symptoms, unexpectedly indicating that staying with family is associated with more severe symptoms than staying with homemates apart from family. More than 75% of the current sample was between 18 and 25 years old; an age range which was defined as "emerging adulthood" by Arnett (2000). This phase of life span is characterized by still being dependent to family because of not having any income and trying to form a stable identity and evaluate the possibilities for the future, which might be an additional source of stress in their lives. Therefore, students who live with their friends apart from their hometown were possibly more likely to feel as they completed this phase by having their own decisions in life and being able to manage their own lives. The lack of such control and independency for the university students who live with their family might account for the higher levels of depressive and psychological symptoms, since there was no significant difference between these two groups in terms of the other measures of the study such as personality, coping styles, and perceived social support, which might have accounted for the difference in psychological symptomatology.

As for the effects of perceived negative parenting, both mothers' and fathers' practices were positively associated with depressive and other

psychological symptoms whereas only perceived negative parenting from fathers was negatively associated with life satisfaction. Although it is interesting that perceived negative parenting from mothers did not predict the level of life satisfaction, this finding was parallel to the results of a study revealing neither positive nor negative relationship between perceived maternal restrictiveness and adolescents' life satisfaction (Leung, Chang, & Lai, 2004). In the literature, there are inconsistent studies regarding this relationship, which indicates the need of further studies in order to determine possible variables affecting the relationship.

After controlling for the effects of demographic variables and perceived negative parenting, DR and IAOD domains were found to be positively associated with depressive and other psychological symptoms, whereas only DR negatively predicted life satisfaction. Moreover, schemas in ILES domain were found to be positively related with psychological symptoms as well, as the third schema domain accounting for the variance. These relationships has been discussed several times above; however, the reason why schemas in IAOD and ILES domains predicted depressive and other psychological symptoms but not life satisfaction might be that individuals with higher scores on these schemas have better relationships with others, although being dependent, submissive, or indulgent, than those who score high on DR domain, who have troubles in forming close relationships. Moreover, considering their experiences with their parents, individuals who maintain schemas in DR domain have usually cold, rejecting, inconsistent, and abusive parents, when compared to others (Young et al., 2003). Therefore, it is understandable that they have lower levels of satisfaction with their lives.

As for the fourth step of the hierarchical regression analyses, the effects of personality dimension on the measures of psychopathology and well-being were examined. The results indicated that neuroticism positively predicted depressive and other psychological symptoms. Moreover, agreeableness was also positively associated, whereas openness to experiences and conscientiousness were negatively associated with depressive symptoms. Although, agreeableness is considered as one of the personality dimensions related to higher psychological adjustment, its

relationship with depressive symptomatology can be explained through these individuals' greater emphasis on interpersonal relationship rather than having self-centered goals (Wilkowski, Robinson, & Meier, 2006). For university students, having self-centered goals might be an important predictor of psychological adjustment. On the other hand, the results revealed that among personality dimensions, conscientiousness and extraversion are the associates of life satisfaction. Considering the education level of the sample and the findings indicating that having responsible, reliable, and goal-directed characteristics are related to higher academic achievement (Conard, 2006; O'Connor & Paunonen, 2007; Paunonen & Ashton, 2001), it is possible that academic achievement is a predictor of life satisfaction, besides having positive affect.

As the last step of this set of hierarchical regression analyses, both coping strategies and perceived social support were found to be negatively associated with the severity of depression symptoms and positively associated with life satisfaction, as expected. Although different coping strategies are more adaptive in different circumstances, it is well established that usage of any coping strategy is functional to decrease depressive symptoms and increase the level of life satisfaction, either by focusing on the solution of the problem or by regulating negative emotions. However, the mechanism of social support is less clear. One explanation is that social support plays a buffering role between stressful life events and depressive symptoms, by providing individuals an additional perspective, helping them to use adaptive coping skills, and strengthening protective factors (Ibarra-Rovillard & Kuiper, 2011), although studies have revealed contradicting results. In addition, recent studies have showed that the relationship between social support and depressive symptoms is bidirectional, indicating that depressed individuals tend to receive and perceive lower levels of social support, since they are more likely to be socially withdrawn and passive, to seek negative feedback, and to have negative perceptions about themselves (Stice, Rohde, Gau, & Ochner, 2011). Therefore, the relationship between coping strategies and social support on one hand, and psychological well-being on the other hand, needs to be further examined.

4.4. Limitations of the Study

The main limitation of the study is its cross-sectional nature, in which data was collected only at one point of time. Therefore, it is not possible to draw any cause-effect relationship or to examine changes in the measurements of the study across time. This might cause a problem especially for well-being measures, which seem to be more sensitive to situational factors, measuring the severity of symptoms during limited amount of time. It might be useful to use measures related to trait characteristics, such as State Trait Anxiety Inventory (STAI; Spielberg, Gorsuch, & Lushene, 1970). Moreover, in the present study, only associated factors of the measures were determined. Although the results revealed important associations, analyses regarding the effects of different levels of measures on the relationship between early maladaptive schemas and psychological symptoms would offer more information about individual differences.

Secondly, this study relies on self-reports of the participants. The results should be evaluated considering the fact that especially schema inventories might not detect latent schemas, especially when they are maintained through avoidance or overcompensation coping styles (Young et al., 2003). In this case, individuals might report lower levels of schemas than they actually have. In fact, these inventories are instruments to make individuals more aware about their own schemas. Therefore, other data collecting techniques (i.e., interviews) can be preferred for accurate results. Moreover, most of the participants of the study were undergraduate university students. In this age group, schemas might have not been fully developed or differentiated from each other yet. Having a sample with a broader age range could make possible age-wise comparisons and provide a better understanding of the development of early maladaptive schemas.

Lastly, there were also some limitations related to the instruments of the study. Initially, demographic form did not include questions about marital status of participants' parents, and the relationship status of participants, both of which might have an effect on the level of early maladaptive schemas. Moreover, as it was previously mentioned, perceived parenting styles and early maladaptive schemas

were closely related with several psychological conditions, which were not studied in the present study. Especially personality disorder symptomatology seems to be an important associate of early maladaptive schemas. Therefore, in a university student sample, the examination of the relationship between schemas and personality disorder symptomatology would provide an insight about their interpersonal problems, besides other psychopathologies.

4.5. Strengths of the Study

In this study, Young Parenting Inventory (YPI; Young, 1999) and Young Schema Questionnaire – Short Form 3 (YSQ-SF3; Young, 2006) were used as the measures of perceived parenting and related schemas, which are based on the same theoretical background, enabling model testing in a different culture.

Since the introduction of schema theory into the literature, the relationship between perceived negative parenting, early maladaptive schemas (EMSs) and psychological well-being has been examined extensively. The results of these studies consistently revealed that EMSs mediate the effects of perceived negative parenting on psychological symptomatology. However, there have been limited studies investigating other associated factors, which might have either positive or negative effects on this relationship, such as personality dimensions, coping strategies, or perceived social support. Therefore, to the best knowledge of the author, current study is one of the few studies examining the associated factors of psychological well-being, along with early negative experiences and maladaptive cognitions related to self, others, and the world.

4.6. Clinical Implications and Future Directions

Young et al. (2003) initially developed schema therapy for persistent problems, for which cognitive behavioral therapy (CBT) has some limitations, such as personality disorders. However, it has been also used for the treatment of depression, eating disorders, and substance abuse by identifying factors associated with these disorders, especially after symptoms were reduced to a certain level. The results of this study revealed some psychological factors, which are also related to the presence of psychological symptoms, such as neurotic personality

characteristics, less sufficient usage of coping strategies, and lower levels of perceived social support, besides early maladaptive schemas and perceived negative parenting. Therefore, the results of this study provide information about individual characteristics, which might affect the course of the clinical applications, suggesting that dealing with maladaptive cognitions might not be sufficient to decrease their level of psychological symptoms but it is also important to help individuals have a more optimistic perspective, learn sufficiently cope with stress, and seek and get higher levels of social support. This knowledge is also important for the clinicians, who might have feelings of helplessness, when working with individuals with these risky characteristics. Considering these individual differences could make easier the formation of therapeutic alliance between the clinician and his clients, which is an important aspect of therapeutic process. Moreover, the results mostly revealed stronger association of perceived negative parenting from fathers to psychological symptoms, which indicates the importance of studying perceived negative parenting from both parents in order to see the bigger picture. These findings could be useful while working with university students, by underlining psychological results of negative parenting.

As for future directions, studies should focus on the effects of psychological resources such as personality dimensions, coping styles, and perceived social support, on the relationship between early maladaptive schemas and psychological well-being. This would help to determine protective factors even after experiencing negative parenting from parents. Moreover, studies comparing non-clinical groups to different clinical groups can emphasize the roles of schemas and other psychological resources on the psychopathology with a stronger discriminative power of the schema domains. Finally, future studies should include younger participants, in order to be able to determine and intervene in schemas before they become more stable and permanent, which is important for primary prevention strategies in adolescents and young adults. In fact, in order to better understand the direction of the relationship between parenting, schemas, psychological resources, and psychological well-being, longitudinal studies can be conducted with younger

participants, with different data collecting techniques, such as multiple respondents, or interviews, which might decrease the limitations related to self-report questionnaires. These points seem to be important for a bigger and more accurate picture of the development and maintenance of early maladaptive schemas, which can be used for research and clinical purposes.

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APPENDICES

APPENDIX A

INFORMED CONSENT

Gönüllü Katılım Formu

Bu çalışma, Orta Doğu Teknik Üniversitesi Psikoloji Bölümü, Klinik Psikoloji Yüksek Lisans öğrencisi Beyza Ünal tarafından, Psikoloji Bölümü öğretim üyelerinden Prof. Dr. Tülin Gençöz'ün süpervizyonunda, tez çalışması kapsamında yürütülmektedir. Çalışmanın amacı, algılanan ebeveynlik biçimleri ve erken dönem uyumsuz şemaların psikolojik etkilerini araştırmak ve bu ilişki üzerinde etkisi olan bazı değişkenleri belirlemektir. Çalışma süresince, sizden kimlik belirleyici hiçbir bilgi istenmemektedir. Cevaplarınız tamamıyla gizli tutulacak ve toplanacak bilgiler yalnızca bilimsel amaçlarla kullanılacaktır.

Yaklaşık olarak bir saat süreceği düşünülen çalışma süresince, sizden bazı anketleri doldurmanız istenmektedir. Bu anketlerde, genel olarak kişisel rahatsızlık verecek sorular bulunmamaktadır. Ancak, katılım sırasında herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, sorumlu kişiye bu isteğinizi söyleyerek, çalışmayı yarıda bırakabilirsiniz. Çalışmayla ilgili daha fazla bilgi almak için Beyza ÜNAL (tel: 0555 677 32 23; e-posta: beyza.unal@metu.edu.tr) ile iletişime geçebilirsiniz. Çalışmaya katıldığınız için şimdiden teşekkür ederiz.

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

İsim	İmza	Tarih
		…/…/…

APPENDIX B

DEMOGRAPHIC INFORMATION FORM

1. Cinsiyetiniz: ( ) Kadın ( ) Erkek
2. Yaşınız: ……
3. Bölümünüz: ……
4. Sınıfınız: ( ) Hazırlık ( ) Lisans …… ( ) Yüksek Lisans ( ) Doktora
5. Annenizin eğitim durumu:
   ( ) Okur-yazar değil ( ) Okur-yazar ( ) İlkokul mezunu
   ( ) Ortaokul mezunu ( ) Lise mezunu ( ) Üniversite mezunu
6. Babanızın eğitim durumu:
   ( ) Okur-yazar değil ( ) Okur-yazar ( ) İlkokul mezunu
   ( ) Ortaokul mezunu ( ) Lise mezunu ( ) Üniversite mezunu
7. Yaşamınızın büyük kısmını geçirdiğiniz yer aşağıdakilerden hangisidir?
   ( ) Köy ( ) İlçe ( ) Şehir ( ) Büyükşehir
8. Şu an nerede yaşıyorsunuz?
   ( ) Ailemle/akrabalarımla birlikte
   ( ) Yurtta
   ( ) Arkadaşlarımla evde
   ( ) Tek başıma evde
   ( ) Diğer ……
9. Ortalama aylık geliriniz ne kadardır?
   ( ) 1000 liradan az
   ( ) 1000-2999 lira arası
   ( ) 3000-4999 lira arası
   ( ) 5000 liradan fazla

APPENDIX C

YOUNG PARENTING INVENTORY (YPI)

Aşağıda anne ve babanızı tarif etmekte kullanabileceğiniz tanımlamalar verilmiştir. Lütfen her tanımlamayı dikkatle okuyun ve ebeveynlerinize ne kadar uyduğuna karar verin. 1 ile 6 arasında, çocukluğunuz sırasında annenizi ve babanızı tanımlayan en yüksek dereceyi seçin. Eğer sizi anne veya babanız yerine başka insanlar büyüttü ise onları da aynı şekilde derecelendirin. Eğer anne veya babanızdan biri hiç olmadı ise o sütunu boş bırakın.

1 - Tamamı ile yanlış
2 - Çoğunlukla yanlış
3 - Uyan tarafı daha fazla
4 - Orta derecede doğru
5 - Çoğunlukla doğru
6 - Ona tamamı ile uyuyor.

	Anne	Baba	
1.	____	____	Beni sevdi ve bana özel birisi gibi davrandı.
2.	____	____	Bana vaktini ayırdı ve özen gösterdi.
3.	____	____	Bana yol gösterdi ve olumlu yönlendirdi.
4.	____	____	Beni dinledi, anladı ve duygularımızı karşılıklı paylaştık.
5.	____	____	Bana karşı sıcaktı ve fiziksel olarak şefkatliydi.
6.	____	____	Ben çocukken öldü veya evi terk etti.
7.	____	____	Dengesizdi, ne yapacağı belli olmazdı veya alkolikti.
8.	____	____	Kardeş(ler)imi bana tercih etti.
9.	____	____	Uzun süreler boyunca beni terk etti veya yalnız bıraktı.
10.	____	____	Bana yalan söyledi, beni kandırdı veya bana ihanet etti.
11.	____	____	Beni dövdü, duygusal veya cinsel olarak taciz etti.
12.	____	____	Beni kendi amaçları için kullandı.
13.	____	____	İnsanların canını yakmaktan hoşlanırdı.
14.	____	____	Bir yerimi inciteceğim diye çok endişelenirdi.
15.	____	____	Hasta olacağım diye çok endişelenirdi.
16.	____	____	Evhamlı veya fobik/korkak bir insandı.
17.	____	____	Beni aşırı korurdu.
18.	____	____	Kendi kararlarıma veya yargılarıma güvenememe neden oldu

19. ____ ____ İşleri kendi başıma yapmama fırsat vermeden çoğu işimi o yaptı.

20. ____ ____ Bana hep daha çocukmuşum gibi davrandı.

21. ____ ____ Beni çok eleştirirdi.

22. ____ ____ Bana kendimi sevilmeye layık olmayan veya dışlanmış bir gibi hissettirdi.

23. ____ ____ Bana hep bende yanlış bir şey varmış gibi davrandı.

24. ____ ____ Önemli konularda kendimden utanmama neden oldu.

25. ____ ____ Okulda başarılı olmam için gereken disiplini bana kazandırmadı.

26. ____ ____ Bana bir salakmışım veya beceriksizmişim gibi davrandı.

27. ____ ____ Başarılı olmamı gerçekten istemedi.

28. ____ ____ Hayatta başarısız olacağıma inandı.

29. ____ ____ Benim fikrim veya isteklerim önemsizmiş gibi davrandı.

30. ____ ____ Benim ihtiyaçlarımı gözetmeden kendisi ne isterse onu yaptı.

31. ____ ____ Hayatımı o kadar çok kontrol altında tuttu ki çok az seçme özgürlüğüm oldu.

32. ____ ____ Her şey onun kurallarına uymalıydı.

33. ____ ____ Aile için kendi isteklerini feda etti.

34. ___ ____ Günlük sorumluluklarının pek çoğunu yerine getiremiyordu ve ben her zaman kendime düşenden fazlasını yapmak zorunda kaldım.

35. ____ ____ Hep mutsuzdu; destek ve anlayış için hep bana dayandı.

36. ____ ____ Benim güçlü olduğumu ve diğer insanlara yardım etmem gerektiğini hissettirdi.

37. ____ ____ Kendisinden beklentisi hep çok yüksekti ve bunlar için kendini çok zorlardı.

38. ____ ____ Benden her zaman en iyisini yapmamı bekledi.

39. ____ ____ Pek çok alanda mükemmeliyetçiydi; ona göre her şey olması gerektiği gibi olmalıydı.

40. ____ ____ Yaptığım hiçbir şeyin yeterli olmadığını hissetmemi sağladı.

41. ____ ____ Neyin doğru neyin yanlış olduğu hakkında kesin ve katı kuralları vardı.

42. ____ ____ Eğer işler düzgün ve yeterince hızlı yapılmazsa sabırsızlanırdı.

43. ____ ____ İşlerin tam ve iyi olarak yapılmasına, eğlenme veya dinlenmekten daha fazla önem verdi.

44. ____ ____ Beni pek çok konuda şımarttı veya aşırı hoşgörülü davrandı.

45. ____ ____ Diğer insanlardan daha önemli ve daha iyi olduğumu hissettirdi.

46. ____ ____ Çok talepkardı; Her şeyin onun istediği gibi olmasını isterdi.

47. ____ ____ Diğer insanlara karşı sorumluklarımın olduğunu bana öğretmedi.

48. ____ ____ Bana çok az disiplin veya terbiye verdi.

49. ____ ____ Benim için çok az kural koydu veya sorumluluk verdi.

50. ____ ____ Aşırı sinirlenmeme veya kontrolümü kaybetmeme izin verirdi.

51. ____ ____ Disiplinsiz bir insandı.

52. ____ ____ Birbirimizi çok iyi anlayacak kadar yakındık.

53. ____ ___ Ondan tam olarak ayrı bir birey olduğumu hissedemedim veya bireyselliğimi yeterince yaşamadım.

54. ____ ____ Onun çok güçlü bir insan olmasından dolayı büyürken kendi yönümü belirleyemiyordum.

55. ____ ____ İçimizden birinin uzağa gitmesi durumunda, birbirimizi üzebileceğimizi hissederdim.

56. _____ ____ Ailemizin ekonomik sorunları ile ilgili çok endişeli idi.

57. ____ ____ Küçük bir hata bile yapsam kötü sonuçların ortaya çıkacağını hissettirirdi.

58. ____ ____ Kötümser bir bakışı açısı vardı, hep en kötüsünü beklerdi.

59. ____ ____ Hayatın kötü yanları veya kötü giden şeyler üzerine odaklanırdı.

60. ____ ____ Her şey onun kontrolü altında olmalıydı.

61. ____ ____ Duygularını ifade etmekten rahatsız olurdu.

62. ____ ____ Hep düzenli ve tertipliydi; değişiklik yerine bilineni tercih ederdi.

63. ____ ____ Kızgınlığını çok nadir belli ederdi.

64. ____ ____ Kapalı birisiydi; duygularını çok nadir açardı.

65. ____ ____ Yanlış bir şey yaptığımda kızar veya sert bir şekilde eleştirdiği olurdu.

66. ____ ____ Yanlış bir şey yaptığımda beni cezalandırdığı olurdu.

67. ____ ____ Yanlış yaptığımda bana aptal veya salak gibi kelimelerle hitap ettiği olurdu.

68. ____ ____ İşler kötü gittiğinde başkalarını suçlardı.

69. ____ ____ Sosyal statü ve görünüme önem verirdi.

70. ____ ____ Başarı ve rekabete çok önem verirdi.

71. ____ ____ Başkalarının gözünde benim davranışlarımın onu ne duruma düşüreceği ile çok ilgiliydi.

72. ____ ____ Başarılı olduğum zaman beni daha çok sever veya bana daha çok özen gösterirdi.

APPENDIX D

YOUNG SCHEMA QUESTIONNAIRE

Aşağıda, kişilerin kendilerini tanımlarken kullandıkları ifadeler sıralanmıştır. Lütfen her bir ifadeyi okuyun ve sizi ne kadar iyi tanımladığına karar verin. Emin olamadığınız sorularda neyin doğru olabileceğinden çok, sizin duygusal olarak ne hissettiğinize dayanarak cevap verin. Birkaç soru, anne babanızla ilişkiniz hakkındadır. Eğer biri veya her ikisi şu anda yaşamıyorlarsa, bu soruları o veya onlar hayatta iken ilişkinizi göz önüne alarak cevaplandırın. 1 den 6'ya kadar olan seçeneklerden sizi tanımlayan en yüksek şıkkı seçerek her sorudan önce yer alan boşluğa yazın.

1- Benim için tamamıyla yanlış

2- Benim için büyük ölçüde yanlış

3- Bana uyan tarafı uymayan tarafından biraz fazla

4- Benim için orta derecede doğru

5- Benim için çoğunlukla doğru

6- Beni mükemmel şekilde tanımlıyor

1. _____ Bana bakan, benimle zaman geçiren, başıma gelen olaylarla gerçekten ilgilenen kimsem olmadı.

2. _____ Beni terkedeceklerinden korktuğum için yakın olduğum insanların peşini bırakmam.

3. _____ İnsanların beni kullandıklarını hissediyorum

4. _____ Uyumsuzum.

5. _____ Beğendiğim hiçbir erkek/kadın, kusurlarımı görürse beni sevmez.

6. _____ İş (veya okul) hayatımda neredeyse hiçbir şeyi diğer insanlar kadar iyi yapamıyorum

7. _____ Günlük yaşamımı tek başıma idare edebilme becerisine sahip olduğumu hissetmiyorum.

8. _____ Kötü bir şey olacağı duygusundan kurtulamıyorum.

9. _____ Anne babamdan ayrılmayı, bağımsız hareket edebilmeyi, yaşıtlarım kadar, başaramadım.

10. _____ Eğer istediğimi yaparsam, başımı derde sokarım diye düşünürüm.

11. _____ Genellikle yakınlarıma ilgi gösteren ve bakan ben olurum.

12. _____ Olumlu duygularımı diğerlerine göstermekten utanırım (sevdiğimi, önemsediğimi göstermek gibi).

13. _____ Yaptığım çoğu şeyde en iyi olmalıyım; ikinci olmayı kabullenemem.

14. _____ Diğer insanlardan bir şeyler istediğimde bana "hayır" denilmesini çok zor kabullenirim.

15. _____ Kendimi sıradan ve sıkıcı işleri yapmaya zorlayamam.

16. _____ Paramın olması ve önemli insanlar tanıyor olmak beni değerli yapar.

17. _____ Her şey yolunda gidiyor görünse bile, bunun bozulacağını hissederim.

18. _____ Eğer bir yanlış yaparsam, cezalandırılmayı hakkederim.

19. _____ Çevremde bana sıcaklık, koruma ve duygusal yakınlık gösteren kimsem yok.

20. _____ Diğer insanlara o kadar muhtacım ki onları kaybedeceğim diye çok endişeleniyorum.

21. _____ İnsanlara karşı tedbiri elden bırakamam yoksa bana kasıtlı olarak zarar vereceklerini hissederim.

22. _____ Temel olarak diğer insanlardan farklıyım.

23. _____ Gerçek beni tanırlarsa beğendiğim hiç kimse bana yakın olmak istemez.

24. _____ İşleri halletmede son derece yetersizim.

25. _____ Gündelik işlerde kendimi başkalarına bağımlı biri olarak görüyorum.

26. _____ Her an bir felaket (doğal, adli, mali veya tıbbi) olabilir diye hissediyorum.

27. _____ Annem, babam ve ben birbirimizin hayatı ve sorunlarıyla aşırı ilgili olmaya eğilimliyiz.

28. _____ Diğer insanların isteklerine uymaktan başka yolum yokmuş gibi hissediyorum; eğer böyle yapmazsam bir şekilde beni reddederler veya intikam alırlar.

29. _____ Başkalarını kendimden daha fazla düşündüğüm için ben iyi bir insanım.

30. _____ Duygularımı diğerlerine açmayı utanç verici bulurum.

31. _____ En iyisini yapmalıyım, "yeterince iyi" ile yetinemem.

32. _____ Ben özel biriyim ve diğer insanlar için konulmuş olan kısıtlamaları veya sınırları kabul etmek zorunda değilim.

33. _____ Eğer hedefime ulaşamazsam kolaylıkla yılgınlığa düşer ve vazgeçerim.

34. _____ Başkalarının da farkında olduğu başarılar benim için en değerlisidir.

35. _____ İyi bir şey olursa, bunu kötü bir şeyin izleyeceğinden endişe ederim.

36. _____ Eğer yanlış yaparsam, bunun özürü yoktur.

37. _____ Birisi için özel olduğumu hiç hissetmedim.

38. _____ Yakınlarımın beni terk edeceği ya da ayrılacağından endişe duyarım

39. _____ Herhangi bir anda birileri beni aldatmaya kalkışabilir.

40. _____ Bir yere ait değilim, yalnızım.

41. _____ Başkalarının sevgisine, ilgisine ve saygısına değer bir insan değilim.

42. _____ İş ve başarı alanlarında birçok insan benden daha yeterli.

43. _____ Doğru ile yanlışı birbirinden ayırmakta zorlanırım.

44. _____ Fiziksel bir saldırıya uğramaktan endişe duyarım.

45. _____ Annem, babam ve ben özel hayatımız birbirimizden saklarsak, birbirimizi aldatmış hisseder veya suçluluk duyarız

46. _____ İlişkilerimde, diğer kişinin yönlendirici olmasına izin veririm.

47. _____ Yakınlarımla o kadar meşgulüm ki kendime çok az zaman kalıyor.

48. _____ İnsanlarla beraberken içten ve cana yakın olmak benim için zordur.

49. _____ Tüm sorumluluklarımı yerine getirmek zorundayım.

50. _____ İstediğimi yapmaktan alıkonulmaktan veya kısıtlanmaktan nefret ederim.

51. _____ Uzun vadeli amaçlara ulaşabilmek için şu andaki zevklerimden fedakarlık etmekte zorlanırım

52. _____ Başkalarından yoğun bir ilgi görmezsem kendimi daha az önemli hissederim.

53. _____ Yeterince dikkatli olmazsanız, neredeyse her zaman bir şeyler ters gider.

54. _____ Eğer işimi doğru yapmazsam sonuçlara katlanmam gerekir.

55. _____ Beni gerçekten dinleyen, anlayan veya benim gerçek ihtiyaçlarım ve duygularımı önemseyen kimsem olmadı.

56. _____ Önem verdiğim birisinin benden uzaklaştığını sezersem çok kötü hissederim.

57. _____ Diğer insanların niyetleriyle ilgili oldukça şüpheciyimdir.

58. _____ Kendimi diğer insanlara uzak veya kopmuş hissediyorum.

59. _____ Kendimi sevilebilecek biri gibi hissetmiyorum.

60. _____ İş (okul) hayatımda diğer insanlar kadar yetenekli değilim.

61. _____ Gündelik işler için benim kararlarıma güvenilemez.

62. _____ Tüm paramı kaybedip çok fakir veya zavallı duruma düşmekten endişe duyarım.

63. _____ Çoğunlukla annem ve babamın benimle iç içe yaşadığını hissediyorum- Benim kendime ait bir hayatım yok.

64. _____ Kendim için ne istediğimi bilmediğim için daima benim adıma diğer insanların karar vermesine izin veririm.

65. _____ Ben hep başkalarının sorunlarını dinleyen kişi oldum.

66. _____ Kendimi o kadar kontrol ederim ki insanlar beni duygusuz veya hissiz bulurlar.

67. _____ Başarmak ve bir şeyler yapmak için sürekli bir baskı altındayım.

68. _____ Diğer insanların uyduğu kurallara ve geleneklere uymak zorunda olmadığımı hissediyorum.

69. _____ Benim yararıma olduğunu bilsem bile hoşuma gitmeyen şeyleri yapmaya kendimi zorlayamam.

70. _____ Bir toplantıda fikrimi söylediğimde veya bir topluluğa tanıtıldığımda onaylanılmayı ve takdir görmeyi isterim.

71. _____ Ne kadar çok çalışırsam çalışayım, maddi olarak iflas edeceğimden ve neredeyse her şeyimi kaybedeceğimden endişe ederim.

72. _____ Neden yanlış yaptığımın önemi yoktur; eğer hata yaptıysam sonucuna da katlanmam gerekir.

73. _____ Hayatımda ne yapacağımı bilmediğim zamanlarda uygun bir öneride bulunacak veya beni yönlendirecek kimsem olmadı.

74. _____ İnsanların beni terk edeceği endişesiyle bazen onları kendimden uzaklaştırırım.

75. _____ Genellikle insanların asıl veya art niyetlerini araştırırım.

76. _____ Kendimi hep grupların dışında hissederim.

77. _____ Kabul edilemeyecek pek çok özelliğim yüzünden insanlara kendimi açamıyorum veya beni tam olarak tanımalarına izin vermiyorum.

78. _____ İş (okul) hayatımda diğer insanlar kadar zeki değilim.

79. _____ Günlük yaşamımı tek başıma idare edebilme becerisine sahip olduğumu hissetmiyorum.

80. _____ Bir doktor tarafından herhangi bir ciddi hastalık bulunmamasına rağmen bende ciddi bir hastalığın gelişmekte olduğu endişesine kapılıyorum.

81. _____ Sık sık annemden babamdan ya da eşimden ayrı bir kimliğimin olmadığını hissediyorum.

82. _____ Haklarıma saygı duyulmasını ve duygularımın hesaba katılmasını istemekte çok zorlanıyorum.

83. _____ Başkaları beni, diğerleri için çok, kendim için az şey yapan biri olarak görüyorlar.

84. _____ Diğerleri beni duygusal olarak soğuk bulurlar.

85. _____ Kendimi sorumluluktan kolayca sıyıramıyorum veya hatalarım için gerekçe bulamıyorum.

86. _____ Benim yaptıklarımın, diğer insanların katkılarından daha önemli olduğunu hissediyorum.

87. _____ Kararlarıma nadiren sadık kalabilirim.

88. _____ Bir dolu övgü ve iltifat almam kendimi değerli birisi olarak hissetmemi sağlar.

89. _____ Yanlış bir kararın bir felakete yol açabileceğinden endişe ederim.

90. _____ Ben cezalandırılmayı hakeden kötü bir insanım.

APPENDIX E

BECK DEPRESSION INVENTORY

Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde, bir çeşit ruh durumunu anlatmaktadır. Her maddede o ruh durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatle okuyunuz. Son bir hafta içindeki (su an dahil) kendi durumunuzu göz önünde bulundurarak, size en uygun ifadenin yanındaki harfin üzerine (X) işareti koyunuz.

1. (0) Üzgün ve sıkıntılı değilim.
   (1) Kendimi üzüntülü ve sıkıntılı hissediyorum.
   (2) Hep üzüntülü ve sıkıntılıyım. Bundan kurtulamıyorum.
   (3) O kadar üzgün ve sıkıntılıyım ki, artık dayanamıyorum.

2. (0) Gelecek hakkında umutsuz ve karamsar değilim.
   (1) Gelecek için karamsarım.
   (2) Gelecekten beklediğim hiçbir şey yok.
   (3) Gelecek hakkında umutsuzum ve sanki hiçbir şey düzelmeyecekmiş gibi geliyor.

3. (0) Kendimi başarısız biri olarak görmüyorum.
   (1) Başkalarından daha başarısız olduğumu hissediyorum.
   (2) Geçmişe baktığımda başarısızlıklarla dolu olduğunu görüyorum.
   (3) Kendimi tümüyle başarısız bir insan olarak görüyorum.

4. (0) Her şeyden eskisi kadar zevk alıyorum.
   (1) Birçok şeyden eskiden olduğu gibi zevk alamıyorum.
   (2) Artık hiçbir şey bana tam anlamıyla zevk vermiyor.
   (3) Her şeyden sıkılıyorum.

5. (0) Kendimi herhangi bir biçimde suçlu hissetmiyorum.
   (1) Kendimi zaman zaman suçlu hissediyorum.
   (2) Çoğu zaman kendimi suçlu hissediyorum.
   (3) Kendimi her zaman suçlu hissediyorum.

6. (0) Kendimden memnunum.
   (1) Kendimden pek memnun değilim.
   (2) Kendime kızgınım.
   (3) Kendimden nefrete ediyorum.

7. (0) Başkalarından daha kötü olduğumu sanmıyorum.
(1) Hatalarım ve zayıf taraflarım olduğunu düşünmüyorum.
(2) Hatalarımdan dolayı kendimden utanıyorum.
(3) Her şeyi yanlış yapıyormuşum gibi geliyor ve hep kendimi kabahat buluyorum.

8. (0) Kendimi öldürmek gibi düşüncülerim yok.
(1) Kimi zaman kendimi öldürmeyi düşündüğüm oluyor ama yapmıyorum.
(2) Kendimi öldürmek isterdim.
(3) Fırsatını bulsam kendimi öldürürüm.

9. (0) İçimden ağlamak geldiği pek olmuyor.
(1) Zaman zaman içimden ağlamak geliyor.
(2) Çoğu zaman ağlıyorum.
(3) Eskiden ağlayabilirdim ama şimdi istesem de ağlayamıyorum.

10. (0) Her zaman olduğumdan daha canı sıkkın ve sinirli değilim.
(1) Eskisine oranla daha kolay canım sıkılıyor ve kızıyorum.
(2) Her şey canımı sıkıyor ve kendimi hep sinirli hissediyorum.
(3) Canımı sıkan şeylere bile artık kızamıyorum.

11. (0) Başkalarıyla görüşme, konuşma isteğimi kaybetmedim.
(1) Eskisi kadar insanlarla birlikte olmak istemiyorum.
(2) Birileriyle görüşüp konuşmak hiç içimden gelmiyor.
(3) Artık çevremde hiç kimseyi istemiyorum.

12. (0) Karar verirken eskisinden fazla güçlük çekmiyorum.
(1) Eskiden olduğu kadar kolay karar veremiyorum.
(2) Eskiye kıyasla karar vermekte çok güçlük çekiyorum.
(3) Artık hiçbir konuda karar veremiyorum.

13. (0) Her zamankinden farklı göründüğümü sanmıyorum.
(1) Aynada kendime her zamankinden kötü görünüyorum.
(2) Aynaya baktığımda kendimi yaşlanmış ve çirkinleşmiş buluyorum.
(3) Kendimi çok çirkin buluyorum.

14. (0) Eskisi kadar iyi iş güç yapabiliyorum.
(1) Her zaman yaptığım işler şimdi gözümde büyüyor.
(2) Ufacık bir işi bile kendimi çok zorlayarak yapabiliyorum.
(3) Artık hiçbir iş yapamıyorum.

15. (0) Uykum her zamanki gibi.
(1) Eskisi gibi uyuyamıyorum.
(2) 1-2 saat önce uyanıyorum ve kolay kolay uykuya dalamıyorum.
(3) Sabahları çok erken uyanıyorum ve bir daha uyuyamıyorum.

16. (0) Kendimi her zamankinden yorgun hissetmiyorum.
(1) Eskiye oranla daha çabuk yoruluyorum.
(2) Her şey beni yoruyor.
(3) Kendimi hiçbir şey yapamayacak kadar yorgun ve bitkin hissediyorum.

17. (0) İştahım her zamanki gibi.
(1) Eskisinden daha iştahsızım.
(2) İştahım çok azaldı.
(3) Hiçbir şey yiyemiyorum.

18. (0) Son zamanlarda zayıflamadım.
(1) Zayıflamaya çalışmadığım halde en az 2 Kg verdim.
(2) Zayıflamaya çalışmadığım halde en az 4 Kg verdim.
(3) Zayıflamaya çalışmadığım halde en az 6 Kg verdim.

19. (0) Sağlığımla ilgili kaygılarım yok.
(1) Ağrılar, mide sancıları, kabızlık gibi şikayetlerim oluyor ve bunlar beni tasalandırıyor.
(2) Sağlığımın bozulmasından çok kaygılanıyorum ve kafamı başka şeylere vermekte zorlanıyorum.
(3) Sağlık durumum kafama o kadar takılıyor ki, başka hiçbir şey düşünemiyorum.

20. (0) Sekse karşı ilgimde herhangi bir değişiklik yok.
(1) Eskisine oranla sekse ilgim az.
(2) Cinsel isteğim çok azaldı.
(3) Hiç cinsel istek duymuyorum.

21. (0) Cezalandırılması gereken şeyler yapığımı sanmıyorum.
(1) Yaptıklarımdan dolayı cezalandırılabileceğimi düşünüyorum.
(2) Cezamı çekmeyi bekliyorum.
(3) sanki cezamı bulmuşum gibi geliyor.

APPENDIX F

BRIEF SYMPTOM INVENTORY

Aşağıda zaman zaman herkeste olabilecek yakınma ve sorunların bir listesi vardır. Lütfen her birini dikkatlice okuyunuz. Sonra bu durumun bugün de dahil olmak üzere son bir ay içinde sizi ne ölçüde huzursuz ve tedirgin ettiğini göz önüne alarak aşağıda belirtilen tanımlamalardan uygun olanının numarasının karşısındaki boşluğa yazınız. Düşüncenizi değiştirirseniz ilk yazdığınız numarayı tamamen siliniz.

0- Hiç **1-** Çok az **2-** Orta derecede **3-** Oldukça fazla **4-** İleri

1	**İçinizdeki sinirlilik ve titreme hali**	
2	Baygınlık , baş dönmesi	
3	**Bir başka kişinin sizin düşüncelerinizi kontrol edeceği fikri**	
4	Başınıza gelen sıkıntılardan dolayı başkalarının suçlu olduğu duygusu	
5	**Olayları hatırlamada güçlük**	
6	Çok kolayca kızıp öfkelenme	
7	**Göğüs (kalp) bölgesinde ağrılar**	
8	Meydanlık(açık) yerlerden korkma duygusu.	
9	**Yaşamınıza son verme düşüncesi.**	
10	İnsanların çoğuna güvenilemeyeciği hissi.	
11	**İştahta bozukluklar.**	
12	Hiçbir nedeni olmayan ani korkular.	
13	**Kontrol edemediğiniz duygu patlamaları.**	
14	Başka insanlarla beraberken bile yalnızlık hissetme.	
15	**İşleri bitirme konusunda kendini engellenmiş hissetme.**	
16	Yalnızlık hissetme.	
17	**Hüzünlü, kederli hissetme.**	
18	Hiçbir şeye ilgi duymamak.	
19	**Kendini ağlamaklı hissetme.**	
20	Kolayca incinebilme , kırılma.	
21	**İnsanların sizi sevmediğini, size kötü davrandığına inanma.**	
22	Kendini diğer insanlardan daha aşağı görmek.	
23	**Mide bozukluğu,bulantı.**	

24	Diğer insanların sizi gözlediği ya da hakkınızda konuştuğu duygusu.	
25	**Uykuya dalmada güçlük.**	
26	Yaptığınız şeyleri tekrar tekrar doğru mu diye kontrol etmek.	
27	**Karar vermede güçlükler.**	
28	Otobüs,tren, metro gibi umumi vasıtalarla seyahatlerden korkma.	
29	**Nefes darlığı , nefessiz kalma.**	
30	Sıcak,soğuk basmaları.	
31	**Sizi korkuttuğu için bazı eşya yer ya da etkinliklerden uzak kalmaya çalışmak.**	
32	Kafanızın bomboş kalması.	
33	**Bedeninizin bazı bölgelerinde uyuşmalar,karıncalanmalar.**	
34	Hatalarınız için cezalandırılmanız gerektiği düşüncesi.	
35	**Gelecekle ilgili umutsuzluk duyguları.**	
36	Dikkati bir şey üzerine toplamada güçlük.	
37	**Bedenin bazı bölgelerinde ,zayıflık, güçsüzlük hissi.**	
38	Kendini gergin ve tedirgin hissetme.	
39	**Ölme ve ölüm üzerine düşünceler.**	
40	Birini dövme, ona zarar verme yaralama isteği.	
41	**Birşeyleri kırma ,dökme isteği.**	
42	Diğer insanların yanında iken yanlış bir şey yapmamaya çalışmak.	
43	**Kalabalıklardan rahatsızlık duymak.**	
44	Başka insanlara hiç yakınlık duymamak.	
45	**Dehşet ve panik nöbetleri.**	
46	Sık sık tartışmaya girmek.	
47	**Yalnız kalındığında sinirlilik hissetme.**	
48	Başarılarınıza rağmen diğer insanlardan yeterince takdir görmemek.	
49	**Kendini yerinde duramayacak kadar tedirginlik hissetmek.**	
50	Kendini değersiz görme duygusu.	
51	**Eğer izin verirseniz insanların sizi sömüreceği duygusu.**	
52	Suçluluk duyguları.	
53	**Aklınızda bir bozukluk olduğu fikri.**	

APPENDIX G

SATISFACTION WITH LIFE SCALE

Aşağıdaki ifadelere katılıp katılmadığınızı görüşünüzü yansıtan rakamı maddenin başındaki boşluğa yazarak belirtiniz. Doğru ya da yanlış cevap yoktur. Sizin durumunuzu yansıttığını düşündüğünüz rakam bizim için en doğru yanıttır. Lütfen, açık ve dürüst şekilde yanıtlayınız.

7 = Kesinlikle katılıyorum
6 = Katılıyorum
5 = Çok az katılıyorum
4 = Ne katılıyorum ne de katılmıyorum
3 = Biraz katılmıyorum
2 = Katılmıyorum
1 = Kesinlikle katılmıyorum

_____ Pek çok açıdan ideallerime yakın bir yaşamım var
_____ Yaşam koşullarım mükemmeldir
_____ Yaşamım beni tatmin ediyor
_____ Şimdiye kadar, yaşamda istediğim önemli şeyleri elde ettim
_____ Hayatımı bir daha yaşama şansım olsaydı, hemen hemen hiçbir şeyi değiştirmezdim

APPENDIX H

BASIC PERSONALITY TRAITS INVENTORY

Aşağıda size uyan ya da uymayan pek çok kişilik özelliği bulunmaktadır. Bu özelliklerden herbirinin sizin için ne kadar uygun olduğunu ilgili rakamı daire içine alarak belirtiniz.

Örneğin;

Kendimi ..... biri olarak görüyorum.

Hiç uygun değil Uygun değil Kararsızım Uygun Çok uygun

1 **2** **3** **4** **(5)**

		Hiç uygun değil	Uygun değil	Kararsızım	Uygun	Çok uygun
1	Aceleci	1	2	3	4	5
2	Yapmacık	1	2	3	4	5
3	Duyarlı	1	2	3	4	5
4	Konuşkan	1	2	3	4	5
5	Kendine güvenen	1	2	3	4	5
6	Soğuk	1	2	3	4	5
7	Utangaç	1	2	3	4	5
8	Paylaşımcı	1	2	3	4	5
9	Geniş-rahat	1	2	3	4	5
10	Cesur	1	2	3	4	5
11	Agresif	1	2	3	4	5
12	Çalışkan	1	2	3	4	5
13	İçten pazarlıklı	1	2	3	4	5
14	Girişken	1	2	3	4	5
15	İyi niyetli	1	2	3	4	5
16	İçten	1	2	3	4	5
17	Kendinden emin	1	2	3	4	5
18	Huysuz	1	2	3	4	5
19	Yardımsever	1	2	3	4	5
20	kabiliyetli	1	2	3	4	5
21	Üşengeç	1	2	3	4	5
22	Sorumsuz	1	2	3	4	5
23	Sevecen	1	2	3	4	5
24	Pasif	1	2	3	4	5
25	Disiplinli	1	2	3	4	5
26	Açgözlü	1	2	3	4	5
27	Sinirli	1	2	3	4	5
28	Canayakın	1	2	3	4	5
29	Kızgın	1	2	3	4	5
30	Sabit fikirli	1	2	3	4	5
31	Görgüsüz	1	2	3	4	5
32	Durgun	1	2	3	4	5
33	Kaygılı	1	2	3	4	5
34	Terbiyesiz	1	2	3	4	5
35	Sabırsız	1	2	3	4	5
36	yaratıcı	1	2	3	4	5
37	Kaprisli	1	2	3	4	5
38	İçine kapanık	1	2	3	4	5
39	Çekingen	1	2	3	4	5
40	Alıngan	1	2	3	4	5
41	Hoşgörülü	1	2	3	4	5
42	Düzenli	1	2	3	4	5
43	Titiz	1	2	3	4	5
44	Tedbirli	1	2	3	4	5
45	Azimli	1	2	3	4	5

APPENDIX I

WAYS OF COPING INVENTORY

Bir genç olarak çeşitli sorunlarla karşılaşıyor ve bu sorunlarla başa çıkabilmek için çeşitli duygu, düşünce ve davranışlardan yararlanıyor olabilirsiniz. Sizden istenilen karşılaştığınız sorunlarla başa çıkabilmek için neler yaptığınızı göz önünde bulundurarak, aşağıdaki maddeleri cevap kağıdı üzerinde işaretlemenizdir. Lütfen her bir maddeyi dikkatle okuyunuz ve cevap formu üzerindeki aynı maddeye ait cevap şıklarından birini daire içine alarak cevabınızı belirtiniz. Başlamadan önce örnek maddeyi incelemeniz yararlı olacaktır.

ÖRNEK:

Madde 4. İyimser olmaya çalışırım.

	Hiç uygun değil	Pek uygun değil	uygun	oldukça uygun	çok uygun
Madde 4.	1	2	(3)	4	5

1. Aklımı kurcalayan şeylerden kurtulmak için değişik işlerle uğraşırım
1……2……..3……..4……..5
2. Bir sıkıntım olduğunu kimsenin bilmesini istemem
1……2……..3……..4……..5
3. Bir mucize olmasını beklerim.
1……2……..3……..4……..5
4. İyimser olmaya çalışırım……
1……2……..3……..4……..5
5. " Bunu da atlatırsam sırtım yere gelmez " diye düşünürüm
1……2……..3……..4……..5
6. Çevremdeki insanlardan problemi çözmede bana yardımcı olmalarını beklerim
1……2……..3……..4……..5
7. Bazı şeyleri büyütmemeye üzerinde durmamaya çalışırım
1……2……..3……..4……..5
8. Sakin kafayla düşünmeye ve öfkelenmemeye çalışırım
1……2……..3……..4……..5
9. Bu sıkıntılı dönem bir an önce geçsin isterim
1……2……..3……..4……..5
10. Olayın değerlendirmesini yaparak en iyi kararı vermeye çalışırım
1……2……..3……..4……..5
11. Konuyla ilgili olarak başkalarının ne düşündüğünü anlamaya çalışırım
1……2……..3……..4……..5
12. Problemin kendiliğinden hallolacağına inanırım
1……2……..3……..4……..5
13. Ne olursa olsun kendimde direnme ve mücadele etme gücü hissederim
1…….. ….2……..3……..4……..5
14. Başkalarının rahatlamama yardımcı olmalarını beklerim
1……2……..3……..4……..5

15. Kendime karşı hoşgörülü olmaya çalışırım
1……2……..3……..4……..5
16. Olanları unutmaya çalışırım
1……2……..3……..4……..5
17. Telaşımı belli etmemeye ve sakin olmaya çalışırım
1……2……..3……..4……..5
18. " Başa gelen çekilir " diye düşünürüm
1……2……..3……..4……..5
19. Problemin ciddiyetini anlamaya çalışırım
1……2……..3……..4……..5
20. Kendimi kapana sıkışmış gibi hissederim
1……2……..3……..4……..5
21. Duygularımı paylaştığım kişilerin bana hak vermesini isterim
1……2……..3……..4……..5
22. Hayatta neyin önemli olduğunu keşfederim
1……2……..3……..4……..5
23. " Her işte bir hayır vardır " diye düşünürüm
1……2……..3……..4……..5
24. Sıkıntılı olduğumda her zamankinden fazla uyurum
1……2……..3……..4……..5
25. İçinde bulunduğum kötü durumu kimsenin bilmesini istemem
1……2……..3……..4……..5
26. Dua ederek Allah'tan yardım dilerim
1……2……..3……..4……..5
27. Olayı yavaşlatmaya ve böylece kararı ertelemeye çalışırım
1……2……..3……..4……..5
28. Olanla yetinmeye çalışırım
1……2……..3……..4……..5
29. Olanları kafama takıp sürekli düşünmekten kendimi alamam
1……2……..3……..4……..5
30. İçimde tutmaktansa paylaşmayı tercih ederim
1……2……..3……..4……..5
31. Mutlaka bir yol bulabileceğime inanır, bu yolda uğraşırım
1……2……..3……..4……..5
32. Sanki bu bir sorun değilmiş gibi davranırım
1……2……..3……..4……..5
33. Olanlardan kimseye söz etmemeyi tercih ederim
1……2……..3……..4……..5
34. " İş olacağına varır " diye düşünürüm
1……2……..3……..4……..5
35. Neler olabileceğini düşünüp ona göre davranmaya çalışırım
1……2……..3……..4……..5
36. İşin içinden çıkamayınca " elimden birşey gelmiyor " der, durumu olduğu gibi kabullenirim
1……2……..3……..4……..5
37. İlk anda aklıma gelen kararı uygularım
1……2……..3……..4……..5
38. Ne yapacağıma karar vermeden önce arkadaşlarımın fikrini alırım
1……2……..3……..4……..5

39. Herşeye yeniden başlayacak gücü bulurum
1……2……..3……..4……..5
40. Problemin çözümü için adak adarım
1……2……..3……..4……..5
41. Olaylardan olumlu birşey çıkarmaya çalışırım
1……2……..3……..4……..5
42. Kırgınlığımı belirtirsem kendimi rahatlamış hissederim
1……2……..3……..4……..5
43. Alın yazısına ve bunun değişmeyeceğine inanırım
1……2……..3……..4……..5
44. Soruna birkaç farklı çözüm yolu ararım
1……2……..3……..4……..5
45. Başıma gelenlerin herkesin başına gelebilecek şeyler olduğuna inanırım
1……2……..3……..4……..5
46. " Olanları keşke değiştirebilseydim " derim
1……2……..3……..4……..5
47. Aile büyüklerine danışmayı tercih ederim
1……2……..3……..4……..5
48. Yaşamla ilgili yeni bir inanç geliştirmeye çalışırım
1……2……..3……..4……..5
49. " Herşeye rağmen elde ettiğim bir kazanç vardır " diye düşünürüm
1……2……..3……..4……..5
50. Gururumu koruyup güçlü görünmeye çalışırım
1……2……..3……..4……..5
51. Bu işin kefaretini (bedelini) ödemeye çalışırım
1……2……..3……..4……..5
52. Problemi adım adım çözmeye çalışırım
1……2……..3……..4……..5
53. Elimden hiç birşeyin gelmeyeceğine inanırım
1……2……..3……..4……..5
54. Problemin çözümü için bir uzmana danışmanın en iyi yol olacağına inanırım
1……2……..3……..4……..5
55. Problemin çözümü için hocaya okunurum
1……2……..3……..4……..5
56. Herşeyin istediğim gibi olmayacağına inanırım
1……2……..3……..4……..5
57. Bu dertten kurtulayım diye fakir fukaraya sadaka veririm
1……2……..3……..4……..5
58. Ne yapılacağını planlayıp ona göre davranırım
1……2……..3……..4……..5
59. Mücadeleden vazgeçerim
1……2……..3……..4……..5
60. Sorunun benden kaynaklandığını düşünürüm
1……2……..3……..4……..5
61. Olaylar karşısında " kaderim buymuş " derim
1……2……..3……..4……..5
62. Sorunun gerçek nedenini anlayabilmek için başkalarına danışırım
1……2……..3……..4……..5

63. “ Keşke daha güçlü bir insan olsaydım ” diye düşünürüm
1……2……..3……..4……..5
64. Nazarlık takarak, muska taşıyarak benzer olayların olmaması için önlemler alırım
1……2……..3……..4……..5
65. Ne olup bittiğini anlayabilmek için sorunu enine boyuna düşünürüm
1……2……..3……..4……..5
66. “ Benim suçum ne ” diye düşünürüm
1……2……..3……..4……..5
67. “ Allah’ın takdiri buymuş ” diye kendimi teselli ederim
1……2……..3……..4……..5
68. Temkinli olmaya ve yanlış yapmamaya çalışırım
1……2……..3……..4……..5
69. Bana destek olabilecek kişilerin varlığını bilmek beni rahatlatır
1……2……..3……..4……..5
70. Çözüm için kendim birşeyler yapmak istemem
1……2……..3……..4……..5
71. “ Hep benim yüzümden oldu ” diye düşünürüm
1……2……..3……..4……..5
72. Mutlu olmak için başka yollar ararım
1……2……..3……..4……..5
73. Hakkımı savunabileceğime inanırım
1……2……..3……..4……..5
74. Bir kişi olarak iyi yönde değiştiğimi ve olgunlaştığımı hissederim
1……2……..3……..4……..5

APPENDIX J

MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT

Aşağıda on iki cümle ve her birinde de cevaplarınızı işaretlemeniz için 1 den 7 ye kadar rakamlar verilmiştir. Her cümlede söylenenin sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini daire içine alarak işaretleyiniz. Bu şekilde on iki cümlenin her birinde bir işaret koyarak cevaplarınızı veriniz.

1. İhtiyacım olduğunda yanımda olan özel bir insan var.
   Kesinlikle hayır Kesinlikle evet
   1 2 3 4 5 6 7
2. Sevinç ve kederlerimi paylaşabileceğim özel bir insan var.
   Kesinlikle hayır Kesinlikle evet
   1 2 3 4 5 6 7
3. Ailem bana gerçekten yardımcı olmaya çalışır.
   Kesinlikle hayır Kesinlikle evet
   1 2 3 4 5 6 7
4. İhtiyacım olan duygusal yardımı ve desteği ailemden alırım.
   Kesinlikle hayır Kesinlikle evet
   1 2 3 4 5 6 7
5. Beni gerçekten rahatlatan özel bir insan var.
   Kesinlikle hayır Kesinlikle evet
   1 2 3 4 5 6 7
6. Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.
   Kesinlikle hayır Kesinlikle evet
   1 2 3 4 5 6 7
7. İşler kötü gittiğinde arkadaşlarıma güvenebilirim.
   Kesinlikle hayır Kesinlikle evet
   1 2 3 4 5 6 7
8. Sorunlarımı ailemle konuşabilirim.
   Kesinlikle hayır Kesinlikle evet
   1 2 3 4 5 6 7
9. Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.
   Kesinlikle hayır Kesinlikle evet
   1 2 3 4 5 6 7
10. Yaşamımda duygularıma önem veren özel bir insan var.
    Kesinlikle hayır Kesinlikle evet
    1 2 3 4 5 6 7
11. Kararlarımı vermede ailem bana yardımcı olmaya isteklidir.
    Kesinlikle hayır Kesinlikle evet
    1 2 3 4 5 6 7
12. Sorunlarımı arkadaşlarımla konuşabilirim.
    Kesinlikle hayır Kesinlikle evet
    1 2 3 4 5 6 7