THE EFFECTS OF CHILD ABUSE AND NEGLECT ON PSYCHOPATHOLOGICAL SYMPTOMATOLOGY: THE ROLES OF EARLY MALADAPTIVE SCHEMAS AND SCHEMA COPING PROCESSES

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ABSTRACT

THE EFFECTS OF CHILD ABUSE AND NEGLECT ON PSYCHOPATHOLOGICAL SYMPTOMATOLOGY: THE ROLES OF EARLY MALADAPTIVE SCHEMAS AND SCHEMA COPING PROCESSES

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The current study aimed (1) to examine gender, age, mothers' education level, fathers' education level, income, residence status and sibling number differences on Child Abuse/Neglect, Schema Domains, Schema Coping Processes, Psychopathological Symptomatology; (2) to determine the factors associated with schema domains, with schema coping processes, and with the measures of psychopathological symptomatology after controlling for other possible stressors in daily life. For these purpose, data was collected from 414 people between the ages 18-32. Results indicated that schemas were closely related to child abuse/neglect experiences. Moreover, Disconnection/Rejection schema domain and Schema Avoidance coping were associated, while Impaired Limits/Exaggerated Standards and Impaired Autonomy/Other Directedness schema domains were associated with Schema Compensation. In addition, psychopathological symptomatology was found to be associated with child abuse/neglect experiences. Moreover, Schema domains of

Disconnection/Rejection and Impaired Autonomy/Other Directedness were found to be positively associated with depression symptomatology, Impaired Autonomy/Other Directedness schema domain was found to be positively associated with anxiety symptomatology, and only Impaired Limits/Exaggerated Standards schema domain was found to be positively associated with perceived stress. There were also significant associations between schema coping processes and psychopathological symptomatology. Firstly, among schema coping processes schema avoidance was found to be associated positively with anxious symptoms whereas negatively with perceived stress. Furthermore, schema compensation was negatively associated with depressive symptoms. These results revealed that early maladaptive schemas had a crucial role on the relationship between childhood maltreatment and psychopathology; and they supported the notion that individuals' way of coping with their schemas also has an effect on psychological problems.

Keywords: Early Maladaptive Schemas, Child Abuse/Neglect, Schema Coping Processes, Psychopathology, Life Events

ÖZ

ÇOCUK İSTİSMARI VE İHMALİNİN PSİKOPATOLOJİK SEMPTOMLAR ÜZERİNDEKİ ETKİSİ: ERKEN DÖNEM UYUMSUZ ŞEMALARIN VE ŞEMA BAŞ ETME BİÇİMLERİNİN ROLÜ

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Bu çalışma kişilerin hayatlarındaki olası diğer stres faktörlerinin etkisini kontrol ettikten sonra (1) yaş, cinsiyet, gelir düzeyi, annenin eğitim durumu, babanın eğitim durumu, ikamet edilen yer ve kardeş sayısı gibi demografik değişkenlerin çocuk istismarı/ihmali, şema alanları, şema baş etme biçimleri ve psikopatolojik semptomlar üzerindeki olası etkilerini, (2) şema alanları alanları, şema baş etme biçimleri ve psikopatolojik semptomlar ile ile ilişkili faktörleri belirlemeyi amaçlamaktadır. Çalışmanın verisi yaşları 18- 32 arasında değişen 414 katılımcıdan toplanmıştır. Sonuçlar şema alanlarının çocuk istismarı/ihmali ile yakından ilişkili olduğunu göstermiştir. Bunun yanında, Ayrılma/Reddedilme şema alanı Kaçınma şema baş etme biçimi ile ilişkili bulunurken, Zedelenmiş Sınırlar/ Abartılı Standartlar ve Zedelenmiş Özerklik/Öteki Yönelimlilik şema alanları Telafi şema baş etme biçimi ile ilişkili bulunmuştur. Psikopatolojik semptomlar ve çocuk istismarı/ihmalinin, yakından alakalı olduğu görülmüştür. Sonuçlar, özellikle

Ayrılma/Reddedilme ve Zedelenmiş Özerklik/Öteki Yönelimlilik şema alanlarının depresyonla, Zedelenmiş Özerklik/Öteki Yönelimlilik şama alanının anksiyete ile Zedelenmiş Sınırlar/Abartılı Standartlar şema alanlarının algılanan stres ile pozitif yönde ilişkili olduğunu göstermiştir. Son olarak, Kaçınma şema baş etme biçimin anksiyete ile pozitif yönde, algılanan stresle ise negatif yönde ilişkili olduğu bulunurken, telafi şema baş etme biçimini depresyonla negatif yönde ilişkili olduğu görülmüştür. Bu sonuçlar, erken dönem uyumsuz şemaların çocuklukta yaşanan istismar ve ihmali ile psikopatoloji arasındaki ilişki de önemli bir rol oynadığını göstermiştir. Ayrıca, çalışma sonuçları erken dönem uyumsuz şemaların kendisi kadar kullanılan şema baş etme biçimlerinin de psikolojik problemlerde etkisi olduğunu destekler niteliktedir.

Anahtar Kelimeler: Erken Dönem Uyumsuz Şemalar, Çocuk İstismarı/İhmali, Şema Baş Etme Biçimleri, Psikopatoloji, Yaşam Olayları

To My Family

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TABLE OF CONTENTS

LIST OF TABLES

TABLES

CHAPTER 1

INTRODUCTION

The present study was conducted in order to investigate the relationships between childhood abuse/neglect and psychopathological symptomatology as well as the role of early maladaptive schemas and schema cooping processes in this relationship after controlling for the impacts of other life stressors.

For this purpose, in the following sections of the study; firstly, depression and anxiety symptomatology, diagnostic criteria and associated factors will be reviewed. Secondly, schema therapy, its concepts of early maladaptive schemas and schema coping processes along with the relationships with psychopathological symptomatology will be described. The next section will focus on child abuse/ neglect, and its association with the development of early maladaptive schemas and psychopathology. Lastly, literature related to stressful life events and psychopathology relationship will be presented.

1.1. Depression

The classification of depression as a diagnostic entity was dramatically changed since the operationalization of the third version of Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association [APA], 1997). According to revised fourth edition of DSM (DSM-IV-TR, APA, 2000), an individual has to experience five or more symptoms for at least two weeks in order to be diagnosed with major depression. Symptoms of major depression include either depressed mood, or loss of interest or pleasure. Moreover, weight loss, or decrease or increase in appetite; insomnia or hypersomnia; fatigue or loss of energy; psychomotor agitation or retardation; feelings of worthlessness, or excessive or inappropriate quilt; problems related to thinking or concentrate, or decision making; continues thoughts of death; and suicidal ideation. Furthermore, another medical illness, medications and bereavement process must not be the cause of previously cited

symptoms. Lastly, these symptoms must lead clinically significant distress for the individual or problems in social, occupational, or other important areas of life of the individual.

On the other hand, none of the criterion applied to the diagnosis of major depression has changed from DSM-IV-TR with the operationalization of the fifth and the last edition of DSM (DSM-V, APA, 2013), except from exclusion of bereavement. The first reason for this omission is that duration of bereavement is at least one-to-two year. Secondly, it was recognized that bereavement is a severe stressor which can lead to the development of depression soon after the loss. Moreover, bereavement related depression has identified as more likely to occur in individuals with past depression history. Lastly, symptoms associated with bereavement related depression were found to be responding to the same psychological and medication treatments (APA, 2013).

Based on the literature, one year prevalence of depression has been estimated at around 14 % in Europe (Wittchen, & Jacobi, 2006), and; in fact, it has been found to be the most prevalent psychological disorder among adults. Moreover, according to data of World Health Organization (WHO, 2012), it is the fourth common illness on a list for the global burden of disease and it is expected to rank as second by 2020 (as cited in Kleine-Budde, Müller, Kawohl, Bramesfeld, Moock, & Rössler, 2013). It is also a severe disorder because of its substantial negative effect on individual's functioning and quality of life (Sobocki et al., 2007) (as cited in Ekman, Granström, Omerov, Jacop, & Lande, 2013).

On the other hand, in many patients, depression symptoms persist or reoccur, and the course is characterized by fluctuation in severity (Barnhofer, Brennan, Crane, Duggan, & Williams, 2014). Moreover, comorbidity rate with other psychological disorders is high. Especially, comorbidity rates of depression with anxiety disorders are so high that 67 % of those with a depressive disorder have a current and 75 % of those have a life time comorbid anxiety disorder (Lamers et al. 2011). Moreover, depression also frequently co-occurs with substance abuse disorders (i.e., alcohol and drug abuse) (Stefanescu, Chirita, R., Chirita, V., & Chele, 2009).

With respect to demographic differences; firstly, as for gender differences, women are at greater risk than men. Women also report more symptom severity, are more likely to have a comorbid anxiety disorder, bulimia or somatoform disorder and to have past suicide attempts, while men are more likely to report substance and alcohol abuse (Marcus et al., 2008) (as cited in Altemus, Sarvaiya, & Epperson, 2014). Most of the current research revealed that gender differences are the result of interplay between psychological, social and biological factors (Velde, Bracke, & Levecque, 2010). However, with regards to age differences, there is no agreement in the literature. To illustrate, the study of Chmielewska, Szelenberger, and Wojnar (2013) indicated that age does not affect depression symptoms, while younger age was found to be associated with more prevalent in the study of Blazer and Kessler (1994).

1.2. Anxiety

Anxiety is defined in contrast to fear which is an emotional response experienced in the face of real danger. Fear is an adaptive response that helps to organize behavior for threats from the environment. In contrast, anxiety involves a more general emotional reaction that is out of proportion to threats from the environment (Barlow, 2004). Barlow (2004) defined anxiety as a future oriented mood state associated with preparation for possible negative events (as cited in Craske, Rauch, Ursano, Prenoveau, Pine, & Zinbarg, 2009). Although anxiety may be unpleasant sometimes, it is adaptive that it serves as a signal for preparation to threats. However, high levels of anxiety can also be maladaptive. High levels of anxiety may lead to disrupted concentration and performance, pessimistic thoughts and feelings, and shift of attention to a self-focus (Oltmans, & Emery, 2010).

Anxiety disorders involve disturbance in information processing that can be viewed as a preoccupation with or fixation on the concept of danger, and underestimation of ability to cope with the possible danger (Beck, Emery, & Greenberg, 1985) (as cited in Wells, 1994). Moreover, individuals with anxiety disorders have a preoccupation or persistent avoidance of situations or thoughts that lead to anxiety or fear (Oltmans & Emery, 2010).

Besides these general considerations, the diagnosis of anxiety disorder depends on several types of symptoms. DSM-IV-TR (APA, 2000), classified anxiety disorders

with specific subtypes, including panic disorder, three types of phobic disorder, obsessive-compulsive disorder, generalized anxiety disorder, posttraumatic stress disorder, and acute stress disorder. The chapter of DSM-V (APA, 2013) related to anxiety disorders, no longer includes posttraumatic stress disorder and acute stress disorder which are included under the trauma and stress related disorders category, and obsessive-compulsive disorder which is classified under the obsessive-compulsive and related disorders category (APA, 2013).

Based on the literature, prevalence rate of anxiety disorders is 28.8 % (Kessler, 2005). Thus, anxiety disorders are among one of the most prevalent psychological disorders. As for prevalence rates of specific subtypes, the life time prevalence of generalized anxiety disorder is 5 %, of social phobia is 3-13 %, of specific phobia is 7-11 %, and panic disorder is 1-2 % (Bekker, Velhust, 2007). Moreover, anxiety disorders can strongly affect the quality of life of patients (Konnopka, Leichsenring, Leibing, & König, 2009).

Furthermore, studies have consistently revealed that individuals diagnosed with any type of anxiety disorder are more likely to experience other subtypes of anxiety disorders during life time. Depression and anxiety comorbidity is also high, with 30-40 % comorbidity rate. Anxiety disorders are also highly comorbid with personality disorders with the rate of 70 %, and with substance abuse disorders (Bekker, Velhust, 2007). Moreover, with regards to gender differences, almost all types of anxiety disorders, similar to depression, have increased prevalence among females (Altemus, Sarvaiya, & Epperson, 2014).

1.3. Schema Therapy and Early Maladaptive Schemas

Schema therapy is an innovative, integrative therapy developed by Young and colleagues (Young, 1990, 1999) that explains the root of psychopathology 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 other words, EMSs are self-defeating emotional and cognitive patterns that mostly leaded by noxious

experiences that are repeated on a regular basis throughout childhood and adolescence. In fact, schemas begin to develop in early childhood or adolescence as reality-based representations of the child's environment. The schema is what the individual knows. The individual views schemas as priori truths, and thus these schemas affect the processing of later experiences. The maladaptive nature of schemas generally becomes most apparent later in life, when individuals continue to maintain their perceptions although they are no longer accurate. In addition, schemas are dimensional which means that they have different levels of severity and pervasiveness. The more severe the schema, the greater the number of situations those activate it (Young et al., 2003).

1.3.1. Acquisition of Early Maladaptive Schemas

Four types of early life experiences that foster the acquisition of schemas were proposed. The first is toxic frustration of needs namely; "core emotional needs" identified by Young et al. (2003) 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. Furthermore, traumatization or victimization is associated with the development of EMSs as well. In the third type of life experiences, child may experience more positive things than a child would normally needs, and thus the child's core emotional needs for autonomy or realistic limits might not be met. The fourth type is selective internalization or identification with one of the parents that forms schemas. In addition to early childhood environment, emotional temperament of the child is also related to the development of EMSs.

1.3.2. Early Maladaptive Schemas and Schema Domains

Young et al., (2003) categorized 18 different EMSs into five domains. These schema domains are "Disconnection and Rejection", "Impaired Autonomy and Performance", "Impaired Limits", "Other Directedness", and "Overvigilance and Inhibition" (See Table 1.1 and Table 1.2 for details). First of all, individuals with schemas in "Disconnection and Rejection" domain are incapable to form secure attachments to significant others by whom their needs for safety, stability, love

nurturance, and belonging are expected to be met. The families of these individuals are likely to be abusive, unstable, cold, rejecting or isolated from the outside world. Under this domain, five schemas namely; Abandonment/Instability, Mistrust/Abuse, The Emotional Deprivation, Defectiveness/Shame, Social Isolation/Alienation were categorized. The Abandonment/Instability schema is about the perceived instability of one's connection to significant others. If individuals have this schema, they have a perception that the important people for them will not be continue to be there. People who have the Mistrust/Abuse schema have the belief that other people can use them for their own sake and can abuse, hurt, humiliate, lie to, cheat, or can manipulate them. Moreover, the Emotional Deprivation is related to one's expectation about the deprivation of emotional needs. Individuals who have this schema expect that they will experience either lack of affection or caring, listening or understanding and strength or guidance from others. The Defectiveness/Shame schema is about feelings of inferiority, worthlessness and shame about one's perceived defects whereas The Social Isolation/Alienation schema is about the sense of being different from or the rest of the world not being part of any group or community.

The second domain including four 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. Parents of these individuals were typically overprotective towards them, did everything for them, or failed to reinforce child for performing competently, which prevented them to have self-confidence. As a consequence, these people will not be able to set personal goals, master the required skills and will remain children in their adulthood. Individuals with the Dependence/Incompetence schema believe that they are unable to handle the everyday responsibilities without the help of others, which presents them as helplessness. Secondly, if they have the Vulnerability to Harm or Illness schema, they own an exaggerated fear about medical, emotional or external catastrophes which are believed to be unpreventable. In addition, the Enmeshment/Undeveloped Self schema is related to extreme need for emotional involvement and connection with significant others at the expense of individuation because of the belief that at least one of the enmeshed partners cannot survive or be happy without the constant

support of the other. Lastly, the Failure schema is the belief that one will inevitably fail or is fundamentally inadequate relative to peers in areas of achievement.

The third domain, which includes two different schemas, is "Impaired Limits" domain. Patients with schemas in this domain have not developed adequate internal limits. They may have difficulty respecting the rights of others, cooperating, keeping commitments, or meeting long-term goals, which lead them to be called as selfish, spoiled, irresponsible, or narcissistic. Typical families of these people are overly permissive and indulgent where the rules or limits that should be followed related to their own self- control or other's rights are not provided. The first schema under this domain is the Entitlement/ Grandiosity schema which includes the assumption of superiority over other people so entitlement of special rights and privileges. Individuals who have this schema do not have the sense of reciprocity in social interactions and tend to dominate others with lack of empathy. In addition, individuals with the Insufficient Self-Control/Self-Discipline schema experience difficulty in regulating emotions and impulses, in self-control and frustration tolerance while pursuing their goals. These individuals may also avoid discomfort exaggeratedly.

Schemas in the Other Directedness domain are related to excessive emphasis on meeting the needs of others in expense of individual's own needs in order to get approval and maintain emotional connection. They usually focus on others' responses while lack of awareness of their own needs. These individuals usually grow up in families where the parents focus on their own emotional needs and social appearances; children are conditionally accepted so they need to restrict some aspects of themselves. If individuals develop the Subjugation schema they tend to suppress their own need and emotions in order to avoid anger, punishment or abandonment believing that their own needs and feelings are not valid or important. So this concludes in excessive compliance and eagerness to please which in turn usually leads to buildup of anger manifested in maladaptive symptoms **(**e.g., passive–aggressive behavior, uncontrolled tempter outbursts, psychosomatic symptoms, or withdrawal of affection). Secondly, the Self-Sacrifice schema involves voluntarily meeting the needs of other at the expense of individual's own gratification in order to spare others pain, avoid guilt, gain self-esteem, or maintain emotional connection.

Table 1.1.

18 Early Maladaptive Schemas

Early Maladaptive Schemas	Brief Description
1. Abandonment	The belief that significant others will leave
2. Mistrust/Abuse	The belief that others will lie or take advantage
3. Emotional Deprivation	The feeling that adequate emotional support is not available
4. Defectiveness/Shame	The belief that one is flawed or worthless
5. Social Isolation/Alienation	The feeling of separation from others
6. Dependence/Incompetence	The feeling one is unable to take care of oneself
7. Vulnerability to Harm or Illness	The belief that catastrophe is impending
8. Enmeshment/Undeveloped Self	The fusion of identity with a significant other
9. Failure	The belief one is inadequate compared to others
10. Entitlement/Grandiosity	The belief that one is superior to and more deserving than others
11. Insufficient Self-Control/Self-Discipline	The belief that one cannot restrain emotions or impulses
12. Subjugation	The feeling that one's own needs are less important than those of others
13. Self-Sacrifice	The focus on meeting the needs of others at the expense of one's own
14. Approval-Seeking/Recognition-Seeking	The heightened need for approval/recognition from others
15. Negativity/Pessimism	The pervasive focus on negative aspects of life
16. Emotional Inhibition	The constriction of emotional expression
17. Unrelenting Standards/Hypercriticalness	The perfectionist drive to achieve
18. Punitiveness	The belief that mistakes warrant punishment

Adapted from Hawke & Provencher (2011)

Lastly, individuals with the Approval-Seeking/Recognition-Seeking schema give more importance to approval or recognition of others so focus extensively on social status, appearance, money or success as means of gaining recognition and approval. Their self-esteem depends on the reactions of others**.**

Lastly, the Overvigilance and Inhibition domain, which includes four schemas, is related to excessive emphasis on suppressing one's spontaneous feelings and impulses, effort to meet rigid, internalized rules and expectations about performance and ethical behavior at the expense of happiness, self-expression, relaxation, close relationships, or good health. The childhood environment is typically demanding, strict and punitive where children are not encouraged to play and pursue happiness; and spontaneity and pleasure is repressed. These individuals tend to be pessimistic and worried about their lives, believing that anything can happen in their lives if they do not behave carefully. First schema under this domain is the Negativity/Pessimism schema which involves the lifelong focus on the negative events of life while ignoring positive aspects. Moreover, it is also related with an exaggerated expectation that something will sooner or later go wrong in personal situation, which present them as worried, hypervigilant, complaining, and indecisive. Secondly, individuals with the Emotional Inhibition schema restrict their spontaneity in order to prevent being criticized or losing control of their impulses. They tend to inhibit their anger as much as their joy, affection, sexual excitement and playfulness, avoid expressing vulnerability, and emphasis on rationality. Thirdly, the Unrelenting Standards/Hypercriticalness schema involves the sense that one must strive to meet very high internalized standards in order to avoid disapproval or shame. The schema typically leads to feelings of pressure and hypercriticalness toward oneself and others. The schema presents itself as perfectionism, rigid rules and unrealistically high moral, cultural, or religious standards; or preoccupation with time and efficiency. Lastly, the Punitiveness schema is the belief that people should be punished for their mistakes which usually result in anger, intolerance and difficulty in forgiving themselves and others who do not meet their standards (Young et al., 2003).

Table 1.2.

Early Maladaptive Schemas with Associated Schema Domains

Schema Domain	*Disconnection & Rejection*	*Impaired Autonomy & Performance*	*Impaired Limits*	*Other Directedness*	*Overvigilance & Inhibition*
Early Maladaptive Schemas	Abandonment/ Instability	Dependence/ Incompetence	Entitlement/ Grandiosity	Subjugation	Negativity/ Pessimism
	Mistrust/Abuse	Vulnerability to Harm or Illness	Insufficient Self-Control/ Self-Discipline	Self-Sacrifice	Emotional Inhibition
	Emotional Deprivation	Enmeshment/ Undeveloped Self		Approval Seeking/ Recognition Seeking	Unrelenting Standards/ Hypercriticalness
	Defectiveness/ Shame	Failure			Punitiveness
	Social Isolation/ Alienation				

Adapted from Young, Weishaar, & Klosko (2003)

EMSs have been found to increase vulnerability for psychological disorders so identification of these schemas gains importance for the detection and correction of cognitive distortions that may cause psychological problems (Welburn, Coristine, Dagg, Pontefract, & Jordan, 2002). For this purpose, Young developed 205-item Young Schema Questionnaire (YSQ) which is a self-report inventory assessing 15 proposed 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, unrelenting standards, and emotional inhibition (Young, 1999). Studies related to YSQ-Long Form (YSQ-LF) supported the presence of all these 15 schemas (Lee, Taylor, & Dunn, 1999; Schmidt, Joiner, Young, & Telch, 1995).

Young and Brown (1999) developed a shorter version of YSQ (YSQ-SF) consisting of 75-item covering the same 15 EMSs. The factor structures of the both form were

found as consistent with each other (as cited in Welburn et al., 2002). The psychometric properties of the different versions of the YSQ-SF were investigated, and these studies supported the reliable factor structure of 15 EMSs (e.g., Calvete, Estevez, Arroyabe, & Ruiz, 2005; Chevallet, Mauchand, Cottraux, Bouvard, & Martin, 2006; Hoffart et al., 2005; Nordahl, Holthe, & Haugum, 2005). Finally, the third version of the questionnaire, a 90-item short form (YSQ-SF3), including three remaining schemas, namely punitiveness, approval seeking, and pessimism, was developed (Young, 2006).

The Turkish adaptation study of YSQ-SF3 was conducted by Soygüt, Karaosmanoğlu, and Çakır (2009) and the results revealed 15 schemas on 5 different domains. However, in the study of Sarıtaş and Gençöz (2011) conducted with Turkish 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". "Impaired Limits/Exaggerated Standards" schema domain includes EMSs of Entitlement, Approval Seeking, Unrelenting Standards, Pessimism, Insufficient Self-control, Punitiveness; "Disconnection/Rejection" schema domain contains EMSs of Emotional Deprivation, Social Isolation, Defectiveness/Shame, Emotional Inhibition, Mistrust/Abuse, Failure; "Impaired Autonomy/Other Directedness" schema domain containing EMSs of Subjugation, Dependency/Incompetence, Enmeshment, Vulnerability to Harm, Abandonment/Instability, and Self-Sacrifice (Sarıtaş, & Gençöz, 2011). In the current study the suggested schema domains by Sarıtaş and Gençöz (2011) were used.

1.3.3. Early Maladaptive Schemas and Psychopathology

Studies indicating the association between various EMSs and depressive symptomatology are rich. Mainly, it was found that total score on the YSQ was associated with depressive symptom severity (Thimm, 2010). In particular, the studies conducted showed that the schemas of failure, defectiveness/shame, and self-sacrifice (Calvete et al., 2005), schemas of abandonment/ instability, subjugation, and vulnerability to harm (Petrocelli et al., 2001), and the schemas of insufficient

self-control and incompetence/inferiority were associated with depressive symptom severity (Shah, &Waller, 2000) (as cited in Harris, & Curtin, 2002). With regards to schema domains, in the study of Halvorsen et al. (2009), schema domains of Impaired Autonomy/Performance, Impaired Limits, and Disconnection & Rejection were found related with depression severity (as cited in Renner, Lobbestael, Peeters, Arntz, & Huibers, 2012). Therefore, studies relating schema domains and specific EMSs to depressive symptom severity revealed that a wide range of EMSs were related to depressive symptom severity, especially those belonging to the Impaired Autonomy & Performance, Impaired Limits and to the Disconnection & Rejection domains.

EMSs are also found to be related to anxiety disorders of Social Phobia, Obsessive-Compulsive Disorder, and Panic Disorder. In particular, social phobia patients have higher scores on shame, mistrust/abuse, social undesirability/defectiveness and emotional deprivation (Pinto-Gouveia, Castillo, & Galhardo, 2006). Moreover, Post Traumatic Stress Disorder (PTSD) and higher scores on EMSs were found to be related particularly with the schemas of Vulnerability to Harm and Illness, Emotional Inhibition, Social Isolation, Insufficient Self-Control, Mistrust/Abuse, Negativity/Pessimism, and Abandonment (Cockram, Drummond, & Lee, 2010). However, the findings related to relationship between EMSs and anxiety disorders are rare compared to studies related to depressive symptomatology.

Furthermore, EMSs are found associated with Eating Disorders of bulimia nervosa, restricting anorexia nervosa and binging/purging anorexia nervosa (Unoka, Tölgyes, & Czabor, 2007). Especially, the schemas of Abandonment, Defectiveness/Shame and Vulnerability to Harm (Jones, Leung, & Harris, 2006); and Mistrust/Abuse, Deprendence/Incompetence and Subjugation (Lawson, Waller, & Lockwood, 2007) were found to be associated with eating disorder symptomatology. EMSs were also found to be related to personality disorder symptomatology (Carr, & Francis, 2010)

1.4. Schema Coping Processes

There is a distinction between EMSs and schema coping processes; schema coping processes contain behavioral responses whereas EMSs include memories, emotions,

bodily sensations and cognitions. Coping responses include cognitive and emotional strategies in addition to behavioral ones but they are still not part of the schema itself. This differentiation is crucial because each individual can utilize different coping styles in different situations at different times of their lives in order to cope with the same schema. In other words, the coping style specific to one schema do not necessarily remain stable over time whereas schema itself does. Moreover, different patients can employ various types of strategies to cope with the same schema. These schema coping processes can be adaptive early in life when individuals might not have to experience the intense, overwhelming emotions that schemas usually provoke. However, they can be maladaptive later in life as they are generalized to life situations because people continue to maintain the schema, even when conditions change.

Schema coping processes are namely; schema surrender, schema avoidance and schema overcompensation (Young et al., 2003).
When people surrender to a schema, they keep it alive. They do not try to avoid it or fight it. They accept that the schema is true, and act in ways that confirm the schema. Moreover, they repeat schema driven behaviors in their lives; to specify, they choose partners most similar to their offending parents and in their relationships they act passive and compliant that maintain the schema (Young et al., 2003).

On the other hand, when people utilize "schema avoidance" as a coping style, they try to arrange their lives in a way that the schema is never activated. They block thoughts and images and avoid situations that are likely to trigger it. When related thoughts emerge they try to distract themselves. Also, they avoid feelings related to the schema by repressing them when they are activated. For this aim, they may drink, use drugs, overeat, compulsively clean, become workaholics and have promiscuous sex. They also avoid situations that might trigger the schema such as intimate relationships or work challenges. Nevertheless they may appear perfectly normal through interaction with others (Young et al., 2003). However, Young et al. (2003) theorized that schema avoidance causes to maintenance of psychological problems. Nevertheless, research related to the association between psychopathology and schema avoidance is scarce (Spranger, Waller, & Bryant-Waugh, 2001). The

findings of the Spranger et al.'s (2001) study revealed the significant role of schema avoidance in bulimic psychopathology.

Finally, as for the "schema compensation", people try to over compensate their schemas by fighting back against the schema by thinking, feeling, behaving, and relating as though the opposite of the schema were true. They struggle to be as different as possible from their childhood when the schema was developed which means counteracting when faced with the schema in adulthood. To illustrate, if they felt worthless as children, then would try to be perfect as adults. Although externally they are self-confident, internally they feel the constraint of the schema. Overcompensation can be seen as a healthier way of fighting against the schema; however, schema is still maintained (Young et al., 2003). However, research understanding contribution of schema coping processes in psychopathology is infrequent, and it is essential to highlight this for a better understanding of psychopathology (Karaosmanoğlu, Soygüt, & Kabul, 2011).

Young et al., (2003) claimed that temperament is one of the main factors in determining why individuals develop certain coping styles rather than others. To illustrate, individuals who have aggressive temperaments are more likely to overcompensate whereas individuals who have passive temperaments are more likely to surrender or avoid. Indeed, temperament probably plays a greater role in determining patients' coping styles than it does in determining their schemas. Selective internalization or modeling of behaviors exhibited by idealized parent is another factor in explaining adaptation of a given coping style.

1.5. Child Abuse and Neglect

Child abuse and neglect is a relatively common factor affecting the health of children. Unfortunately, a universal definition of child abuse and neglect does not exist. Definitions vary in several ways including whether they include harm to the child or also include children who have been endangered but not yet harmed; whether they require an intent to harm the child or include harm that is not intended, but might have been prevented; and characteristics such as the severity and frequency of a behavior (Bensley et al., 2004). Problems related to definition may be

attributed to cultural differences related to accepted principles of child rearing which define what is abusive or neglectful, and also to interdisciplinary nature of the phenomena (Bensley et al., 2004; World Health Organization [WHO], 2002). Although differences in how cultures and different disciplines define what is abusive, it appears that there is general agreement that child abuse should not be allowed. Nonetheless, the International Society for the Prevention of Child Abuse and Neglect compared descriptions of abuse from 58 countries and found some commonality between them (Bross, Miyoshi, Miyoshi, & Krugman, 2000). In 1999, the World Health Organization (WHO) Consultation on Child Abuse Prevention drafted the following definition:

> Child abuse or maltreatment constitutes all forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (p. 23).

In their study, Styron and Janoff- Bulman (1997) found that child abuse is considerably prevalent. One fourth of the participants of the study declared that they had been subjected to abuse in childhood. The most prevalent among those was emotional abuse, physical and sexual abuse.

There are four types of child maltreatment, namely: physical abuse, sexual abuse, emotional abuse and neglect. Firstly, physical abuse of a child is defined as those acts by a caregiver that cause actual physical harm or has the potential for harm and includes striking, kicking, burning, or biting the child. Secondly, sexual abuse is defined as those acts where a caregiver uses a child for sexual gratification Such acts include the employment, persuasion, seduction, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct, the rape, or other form of sexual exploitation of children in cases of caretaker or interfamilial relationships. Moreover, emotional abuse includes the failure of a caregiver to provide an appropriate and supportive environment and acts such as restricting a child's movements, ridicule, denigration, discrimination, threats and intimidation,

rejection and other non-physical forms of hostile treatment that have an adverse effect on the emotional health and development of a child.
On the other hand, neglect refers to the failure of a parent to provide for the development of the child in one or more of the following areas: health, education, emotional development, nutrition, shelter and safe living conditions. Neglect is distinguished from circumstances of poverty because neglect can occur only in cases where reasonable resources are available to caregiver (Child Welfare Information Gateway, 2011; WHO, 2002). Neglect can be classified into two different categories: physical neglect and emotional neglect. Physical neglect refers to the failure to meet the physical needs of children adequately whereas emotional neglect include acts or omissions by a caregiver that could lead the development of behavioral, cognitive, emotional or mental disorders in the child. Neglect is a difficult form of maltreatment to define because of the lack of visible injuries and often delayed effect on development (Hildyard & Wolfe, 2002).

1.5.1. Child Abuse/ Neglect and Psychopathology

Many studies have suggested links between childhood maltreatment and a number of psychological disorders in adult life including depression (e.g., Boudewyn & Liem, 1995; Gibb et al., 2001; Silverman, Reinherz, & Giaconia, 1996; Wise, Zierier, Krieger, & Harlow, 2001), anxiety disorder (e. g., MacMillan et al., 2001), eating disorders (e. g., Kendler et al., 2000), PTSD (e.g., Rodriguez, Ryan, Rowan, & Foy, 1996; Schaaf & McCanne, 1998; Widom, 1999), and various personality disorders (e.g., Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Miller & Lisak, 1999; Weaver & Clum, 1993) (as cited in Gibb, 2002; Springer, Sheridan, Kuo, & Carnes, 2007).

More recently, researchers have suggested that different types of childhood abuse may contribute to specific vulnerability to certain forms of psychopathology. Specifically, they have hypothesized that physical abuse may be most strongly related to the development of anxiety, whereas emotional abuse may be most strongly related to the development of depression. In contrast, childhood sexual abuse appears to be relatively nonspecific in terms of its psychopathological correlates (Gibb, Butler, & Beck, 2003). To illustrate, in the studies of Harkness and

Wildes (2002) and Levitan, Rector, Sheldon, and Goering (2003), a history of childhood sexual abuse has been found to predict the presence of a comorbid anxiety disorder in depression. On the other hand, in the study of Springer et al. (2007), after controlling for the effects of age, gender, family background, and childhood adversities; physical abuse found to be associated with increased depression and anxiety symptoms. Springer et al. (2007) also found that physical abuse in childhood increased the likelihood of anxiety and depression later in adulthood. In their study, McGinn, Cukor, and Sanderson (2005) found that individuals who recalled their parents as being abusive and neglectful on the Childhood Trauma Questionnaire (CTQ) reported greater depression on the Beck Depression Inventory (BDI). Gauthier, Stollak, Messé, and Aronoff (1996) found that neglect was a stronger predictor of psychological problems than physical abuse because those who experienced neglect were more likely to report current anxiety and depression. In another related study, after controlling for child physical and sexual abuse, child emotional and physical neglect was found a related with increased symptoms of anxiety and depression especially during early adolescence (Johnson, Smailes, Cohen, Brown, & Bernstein, 2000).

On the other hand, the role of child abuse/neglect on the development of PTSD, eating disorders, suicidality has been also investigated. Researchers have also focused on less pathological effects of the abuse such as low self-esteem, interpersonal conflict, interpersonal aggression, and risky sexual behavior (Roemele, & Moore, 2011). Also, a maltreatment combination that is exposure to more than one type of abuse and neglect were found to be associated with more psychological problems than the exposure to single forms of maltreatment (Higgins, & McCabe, 2001).

1.5.2. Child Abuse/Neglect and Early Maladaptive Schemas

Young et al. (2003) theorized that EMSs develop as the result of the interaction between the child's temperament and early toxic experiences. In particular, those experiences that prevent the child from satisfying core needs would play a crucial role in the development of EMSs. According to the Schema Therapy model, victimization and early traumatic experiences, including abuse are important because

they may initiate, reinforce or strengthen the EMSs. Moreover, several studies have found significant relationship between parental maltreatment and EMSs (Calvete & Orue, 2013; Harding & Burns, 2012).

A retrospective review conducted by Gibb (2002) revealed a small but significant association between emotional and sexual (but not physical) maltreatment in childhood and the development of negative cognitive styles and maladaptive schemas. In particular, it was found that experiences of emotional maltreatment and neglect were related with schemas within the Disconnection/Rejection and Impaired Autonomy domains (Calvete, & Orue, 2013). Moreover, studies have indicated that depressed individuals with a history of sexual abuse are more likely to be characterized by negative cognitive styles (Rose, Abramson, Hodulik, Halberstadt, & Leff, 1994) and that grater maltreatment in childhood is associated with more negative cognitions (Rose, & Abramson, 1995) (as cited in McGinn et al., 2005).

1.6. The Crucial Role of Early Maladaptive Schemas

As discussed before, EMSs have been linked to experiences of child abuse/neglect. Researches have been also revealed that EMSs might explain adult outcomes associated with child abuse (Lumley & Harkness, 2007). Cognitive theories proposed that the impact of childhood maltreatment on psychopathology may be mediated by cognitive vulnerabilities, which include dysfunctional schemas (Gibb, Abramson, & Alloy, 2004; Hankin, 2005; McGinn et al., 2005). In other words, it has been suggested that childhood maltreatment may contribute to the development of a negative cognitive style; that is individuals' characteristics way of interpreting the negative life events, which may then make the individual vulnerable to developing symptoms psychological disorder (Gibb, 2002).

In a study of Harris and Curtin (2002), it was found that the relationship between depression and parenting practices was mediated by four cognitive styles assessed by Young's Schema Questionnaire: Defectiveness/Shame, Insufficient Self-Control, Vulnerability, and Incompetence/Inferiority. Shah and Waller (2000) also found evidence for this relationship. Specifically, three schemas, Defectiveness/Shame, Insufficient Self-Control, and Self-Sacrifice differentiated depressive individuals and

these were originated from dysfunctional parental behaviors (as cited in McGinn et al., 2005). Wright, Crawford, and Castillo (2009) also found that both emotional neglect and emotional abuse were associated with symptoms of both depression and anxiety. This relationship was found as mediated by schemas of Vulnerability to Harm, Shame, and Self-Sacrifice. Moreover, the schemas form Disconnection/Rejection domain; namely, Mistrust/Abuse, Abandonment and Defectiveness/Shame Schemas mediated the relationship between child abuse/neglect and interpersonal conflict (Roemele, & Moore, 2011).
Taken together, these studies provided preliminary but crucial evidence for the role of EMSs in the relationship between childhood maltreatment and adult psychopathology.

1.7. Stressful Life Events and Psychopathology

Holmes and Rahe (1967) described stressful life events as occurrences likely to result in readjustment-requiring changes in people's daily activities (as cited in Liu & Miller, 2014). Especially unexpected stressful life events are known as relevant to mental health outcomes including depression and anxiety (Liu & Miller, 2014; Meng, Tao, Wan, Hu, & Wang, 2011).

It was found that individuals' score on life event inventories which indicate stressful life events experienced by them significantly predict the severity of depressive symptoms (Nakai et al., 2014). Moreover, adult's stressful life events and child abuse were found as major factors for the development of major depression (Wise et al., 2001). However, Nakai et al. (2014) identified more important effects of temperament and childhood maltreatment than stressful life events on depression symptomatology. Similarly, Power et al. (2013) suggested an interaction between adult stressful life events and childhood maltreatment on depression.

Furthermore, stressful life events have been linked with the development of anxiety symptoms (Drake, 2014; Hong et al., 2011). In particular, it was found that total number of stressful life events as well as specific life events (e.g. loss, negative family environment, death, peer rejection, and academic difficulties) were associated with anxiety symptomatology (Grover, Ginsburg, & Ialongo, 2005).

1.8. Aims of the Study

In the light of the literature given above, it was concluded that child abuse/neglect is associated with psychopathological symptoms, especially depression and anxiety, and early maladaptive schemas have a crucial effect on this relationship. Moreover, schema coping processes have role on the maintenance of psychopathological symptoms. However, there are limited studies investigating the associates of these factors, along with the effects of schema compensation and schema avoidance, after controlling for other possible stressors in the current life. Therefore, the aims of the study are:

1. To examine gender, age, mothers' education level, fathers' education level, income, residential status and sibling number differences on the measures of the study (i.e. child abuse/neglect, schema domains, schema coping processes, psychopathological symptomatology, and life events).

2. To examine the interrelationship between the measures of the study.

3. To determine the factors associated with schema domains (i.e. Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other Directedness) after controlling for other possible stressors in daily life (i.e. social and achievement related life events).

4. To determine the factors associated with schema coping processes (i.e. schema avoidance and schema compensation).

5. To determine the factors associated with the measures of psychopathological symptomatology, namely depression, anxiety and perceived stress after controlling for other possible stressors in daily life.

CHAPTER 2

METHOD

2.1. Participants

The sample of this study consisted of 414 people, 312 (75.4%) of which were female, and 102 (24.6%) of which were male. The ages of these participants ranged from 18 to 32 (*M* = 21.69, *SD* =2.08). 27 (6.5%) of them were graduate students, and 388 (93.5%) of them were undergraduate students.

As for parental education level, the last degree completed was taken into account. In this regard, 147 (35.5%) of mothers were secondary school graduates or below, whereas 267 (64.5%) of them were high school graduates or above. On the other hand, 85 (20.5%) of fathers were graduates of secondary school or below, whereas 329 (79.5%) of them were graduates of high school or above.

Participants had different current residential status as well. Out of 414 participants, 111 (26.8%) of them reported that they were living with their family, 196 (47.3%) of them in a dormitory, 101 (24.4%) of them at home with friends or alone whereas 6 (1.4%) stated their residential status as other. Lastly, as for the amount of monthly income of the participants, 212 (51.2%) of them reported their monthly income as lower than 1000TL, whereas 202 (48.8%) participants reported it higher than 1000TL.

Moreover, it is reported that only 59 (14.3 %) of the participants did not have siblings; while, 232 (56.0 %) had one sibling, 84 (20.3 %) had two siblings, 23 (5.6%) had three siblings, and the remaining 16 (3.8%) had four or more siblings. According to previous psychological and /or psychiatric treatment history, 103 (24.9%) of the participants have received treatment whereas 311 (75.1%) have not recieved any treatments (See Table 2 for details).

Table 2.1.

Demographic Characteristics of Participants

Variables	N (414 participants)	%	M	SD
Gender				
Female	312	75.4		
Male	102	24.6		
Age			21.69	2.08
Young (between 18-21)	228	55.1		
Old (between 22-32)	186	44.9		
Participants' Education				
Graduate	27	93.5		
Undergraduate	387	5.8		
Mother Education				
Illiterate	8	1.9		
Literate	14	3.4		
Primary school	89	21.5		
Secondary school	36	8.7		
High school	113	27.3		
University or higher	154	37.2		
Father Education				
Illiterate	3	0.7		
Literate	2	0.5		
Primary school	51	12.3		
Secondary school	29	7.0		
High school	109	26.3		
University or higher	220	53.2		

Table 2.1. (Continued)

Residential Status		
With family at home	111	47.3
At dormitory	196	19.1
With friends at home	79	5.3
Alone at home	22	1.4
Other	6	
Income		
Lower than 1000 TL	212	51.2
Between 1000-2999 TL	136	32.9
Between 3000- 4999 TL	46	11.1
Higher than 5000 TL	20	4.8
Number of Siblings		
0	59	14.3
1	232	56.0
2	84	20.3
3	23	5.6
4 or more	16	3.8
Previous Psychological and/or Psychiatric Treatment		
Individual Psychotherapy	40	9.7
Group Psychotherapy	0	0
Medication	62	15.0
Other	3	0.7
None	309	74.6

2.2. Measures

Data was collected through a demographic information form prepared by the researcher including questions about sex, age, educational level of the participants and their parents, number of siblings, residantial status, income and previous psychological and/or psychiatric treatment history. Moreover, participants were given a set of questionnaire. It included Childhood Trauma Questionnaire (CTQ) in

order to evaluate participants' experiences of child abuse and neglect; Young Schema Questionnaire- Short Form 3 (YSQ-SF3), Young Compensation Inventory-(YCI), and Young Rygh Avoidance Inventory (YR-AI) in order to evaluate participants' early maladaptive schemas and their coping processes. Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and Perceived Stress Scale (PSS) were administered in order to examine the level of participants' psychological distress. Also, Life Events Inventory (LEI) was used to control for any possible stressors in the current life of participants which might have an effect on psychological distress.

2.2.1. Childhood Trauma Questionnaire - Short Form (CTQ-SF)

The CTQ developed by Bernstein, et al. (1994) is a self-report instrument designed to evaluate abuse and neglect experiences of childhood and adolescence. The original version consists of 53 items, but inventory was later shortened by the original writer and reduced to 28 items. These new CTQ- SF items are rated on a 5- point Likert type scale (1 = *never*, 5 = *very often*). Five subscales derived in factor analysis namely; physical abuse, sexual abuse, emotional abuse, emotional and physical neglect. Reliability coefficients for subscales are .86 for physical abuse, .89 for emotional abuse, .95 for sexual abuse, .89 for emotional neglect and .78 for physical neglect (Bernstein et al., 2003).

The CTQ-SF adapted into Turkish by Şar, Öztürk and İkikardeş (2012) and results showed coefficient of reliability as .93, test- retest reliability as .90. Turkish version of the scale was also showed same factor structure with the original one. Correlation coefficients for subscales were .90 for physical abuse, .90 for emotional abuse, .73 for sexual abuse, .85 for emotional neglect and .71 for physical neglect. Moreover, the scale's correlation coefficient with Dissociative Experiences Scale was found to be .60 which showed high construct validity.

2.2.2. Young Schema Questionnaire – Short Form 3 (YSQ-SF3)

YSQ-SF3 was developed by Jeffrey Young (1990, 2003). 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. The items are rated on a six- point Likert-type scale (1 = *entirely untrue of me*, 6 = *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 the study of Sarıtaş and Gençöz (2011) 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". The first domain contained entitlement, approval seeking, unrelenting standards, pessimism, insufficient self-control, and punitiveness schemas. The second one contained emotional deprivation, social isolation, defectiveness/shame, emotional inhibition, mistrust/abuse, and failure schemas while the last one contained subjugation, dependency/incompetence, enmeshment, vulnerability to harm, abandonment/instability, and self-sacrifice schemas. In addition, internal reliability coefficients were found as .81 for Impaired Limits/Exaggerated Standards, .81 for disconnection/rejection, and .79 for Impaired Autonomy/Other Directedness. Schema domains showed concurrent validity with psychological distress such as anger, anxiety, positive affect, and negative affect (Sarıtaş, & Gençöz, 2011). Another study conducted by Sarıtaş & Gençöz (in press) with Turkish university students yielded to same schema domains. According to this study, internel reliability coefficients were found as .86 for Impaired Autonomy/Other Directedness, 80 for Impaired Limits/Exaggerated Standarts, and .80 for Disconnection/Rejection.

2.2.3. Young Compensation Inventory- (YCI)

Young (1995) developed Young Compensation Inventory for detecting compensation coping style in schema processes. The YCI is a 48-item self- report questionnaire. The inventory uses a six point Likert type scale (1 = *entirely untrue of me*, 6 = *describes me perfectly*) and in clinical settings, high scoring items are discussed with the patient.

Turkish adaptation of the YCI was conducted by Karaosmanoğlu et al. (2013). Seven subscales derived in factor analysis namely, status seeking, control, rebellion, counter dependency, manipulation, intolerance to criticism, egocentrism. Cronbach's alpha coefficients of the subscales ranged from .60 to .81, and split half reliability of overall inventory is .88 which indicates acceptable levels of internal consistency. It was reported that the scale has good convergent validity with depression, anxiety, obsessive-compulsive symptomatology, and Young Schema Questionnaire (correlation coefficients ranging between r = .12 - .60, p < .05) (Karaosmanoğlu et al., 2013).

2.2.4. Young Rygh Avoidance Inventory- (YR-AI)

Developed by Young and Rygh (1994), the YR-AI is a 40-item self-report questionnaire. The inventory uses a six- point Likert type scale (1 = *entirely untrue of me* and 6 = *describes me perfectly*). In clinical settings, rather than concerning with the total score, high-scoring items are discussed with the patient. However, a high total score does indicate a general pattern of schema avoidance. The inventory is not schema-specific. The psychometric studies of the original version of the scale have still been proceeding. Spranger, et al. (2001) found the YRAI to have two scales (behavioural/ somatic avoidance α =.65; cognitive/ emotional avoidance α =.78), each with acceptable levels of internal consistency and total internal consistency for YR-AI is .79. YR-AI is being adapted to Turkish by Karaosmanoğlu, Soygüt, Tuncer, Derinöz, and Yeroham (in progress, as cited in Karaosmanoğlu, et al., 2005).

2.2.5. Beck Depression Inventory (BDI)

BDI was developed by Beck, Ward, Mendelson, Mock, and Erbaug (1961). This 21-item self-report measure designed to assess the severity of depressive symptomology. The items are rated from four- point Likert- type scale (0 = *the least severe situation* and 3 = *the most severe situation*). The total score from this scale ranges between 0 - 63 with 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, Steer, & Brown, 1996).

The scale was adapted into Turkish by Hisli (1988) and the reliability was found to be .74 in this study. Moreover, according to Hisli (1988), the scale's correlation coefficient was found to be .47 with MMPI-D and .55 with STAI-T. Furthermore, the correlation coefficient between Beck Depression Inventory and Automatic Thought Scale was found to be .74. Also, BDI was found to be positively correlated with other measures of depression. These results supported that BDI has strong psychometric properties in Turkish sample.

2.2.6. Beck Anxiety Inventory (BAI)

The BAI, created by Aaron T. Beck and colleagues, is a 21-item multiple-choice self-report inventory that measures the severity of an anxiety in adults and adolescents. The inventory uses a five- point Likert type scale (0 = *not at all* and 4 = *severely*) and total score for all 21 symptoms can range between 0 and 63 points (Beck, Epstein, Brown, & Steer, 1988).The BAI is psychometrically sound. Internal consistency (Cronbach's alpha) ranges from .92 to .94 for adults and test-retest reliability is .75. Concurrent validity with the *Hamilton Anxiety Rating Scale, Revised* is .51; .58 for the *State* and .47 for the *Trait* subscales of the State-Trait Anxiety Inventory, *Form Y*, and; .54 for the mean 7 day anxiety rating of the Weekly Record of Anxiety and Depression (Osman, Kopper, Barrios, Osman, &Wade,

1997). The scale was adapted into Turkish by Ulusoy (1993) and the retest reliability was found to be .57 in this study, and internal consistency is .92 for the BAI (Savaşır, & Şahin, 1997).

2.2.7. Perceived Stress Scale (PSS-10)

The PSS was developed by Cohen, Kamarck, and Mermelstein (1983) based on Lazarus's concept of appraisal. The PSS measures the degree to which situations in one's life are appraised as stressful (Lazarus & Folkman, 1984). The 14 items in the original scale were designed to tap the degree to which respondents find their lives unpredictable, uncontrollable and overloading, and was intended for use in community samples with at least a junior high school education. The PSS was found to be a good measure to possess good psychometric qualities (e.g. adequate reliability and predicted associations with other indices of stress; Cohen & Williamson, 1988).

Factor analysis of the PSS-14 established that the scale consisted of two factors. The first factor was comprised primarily of items reflecting adaptational symptoms. The second factor was found to reflect coping ability (Hewitt, Flett, & Mosher, 1992). Extensive normative data on 2.387 respondents are available for not only the original 14-item version of the PSS, but also ten-item (PSS-10) and four-item versions. Although all three versions provide strong psychometric data and are related to relevant outcomes in expected ways, Cohen and Williamson (1988) note the relative superiority of, and therefore, recommend the 10-item version. Roberti et al. (2006) updated psychometrics of the PSS-10 and explanatory factor analysis revealed a two factor structure measuring Perceived Helplessness and Perceived Self-efficacy. In the present study, the 10-item version will be used.

In the PSS-10, participants are expected to rate how often they had experienced some feelings in the last week on a five-point Likert scale from 0 = never to 4 = very often. Total scores range from 0 to 40, with higher scores indicating greater overall distress. Coefficient alpha reliability was 0.86 for a newly diagnosed breast cancer population consistent with alphas from 0.75 to 0.86 in the general literature (Cohen, Kamarck, & Mermelstein, 1983).

The scale was adapted into Turkish by Örücü and Demir (2009) and the reliability was found to be .84 in this study. Results revealed a two-factor structure measuring Perceived Helplessness and Perceived Self-efficacy, which was in parallel with Roberti et al.'s study (2006). Moreover, for perceived helplessness factor reliability was found to be .83 and for Perceived self-efficacy factor it was .71

2.2.8. Life Events Inventory (LEI)

The LEI was developed by Oral (1999) in order to measure the frequency of significant life events within the last month. The original scale consists of 49 items and uses a five-point Likert Type Scale (1 = *never* and 5 = *always*). The internal consistency of the scale was found to be .90. The validity was also high, the correlation between the LEI and BDI was found as .52. The factor analysis of original scale did not yield sub categories. Gençöz and Dinç (2006) used the inventory and performed factor analysis. Factor analyses yielded two factors, namely achievement-related (e.g. failure at school, and discomfort due to assignments and projects) and social (e.g. loneliness, and seperation from boy/girlfriend) life events. The alpha coefficients were .88 for achievement related life events whereas .86 for social life events. In the present study, some items of LEI were changed according to targeted sample.

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 participants via Internet. 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 22 for Windows, was used during statistical analyses. In order to determine

demographic differences on the measures of the study, separate Multivariate Analysis of Variance (ANOVA) and t-tests were conducted. Secondly, intercorrelations between all of these measures were examined through zero-order correlations. Consequently, associated factors early maladaptive schemas, schema coping processes and psychological distress were determined through 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 Childhood Trauma Questionnaire (CTQ) with physical abuse, emotional abuse, sexual abuse, physical neglect and emotional neglect sub categories; Life Events Inventory (LEI) with achievement related and social life events, Young Schema Questionnaire (YSQ) with Impaired Limits/Exaggerated Standards (ILES), Disconnection/Rejection (DR), and Impaired Autonomy/Other-Directedness (IAOD) domains, Young-Rygh Avoidance Inventory (YR-AI), Young Compensation Inventory (YCI), and psychological symptomatology measures of Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and Perceived Stress Scale (PSS). 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, residential status, income, and sibling number) on the measures of the study, each demographic variable was categorized into different groups. This categorization is presented in the Table 3.2. To capture the differences, separate multivariate analyses of variances for the measures with subscales and t-test analyses for the measures yielding a single score were conducted with these categorizations, and only significant results were reported.

Table 3.1.

Descriptive Characteristics of the Measures

Measures	N	Mean	SD	Min-Max	Cronbach's alpha
CTQ	414	36.50	11.88	25-86	.73
PA	414	5.86	2.41	5-20	.89
EA	414	7.12	3.11	5-23	.81
SA	414	6.21	3.06	5-25	.93
PN	414	6.97	2.71	5-19	.67
EN	414	9.80	4.45	5-25	.88
LEI	414	2.50	.61	1-4.28	.93
A-LE	414	2.92	.69	1-4.72	.86
S-LE	414	2.19	.65	1-4.23	.87
YSQ					
ILES	414	2.99	.79	1-5.60	.90
DR	414	2.31	.87	1-5.23	.94
IAOD	414	2.36	.73	1-5.13	.91
YRAI	414	3.07	.49	1-4.70	.79
YCI	414	3.41	.62	1-5.77	.91
BDI	414	11.41	9.29	0-46	.90
BAI	414	15.78	10.96	0-57	.91
PSS	414	21.26	5.59	4-38	.34

Note. CTQ = Childhood Trauma Questionnaire, PA = Physical Abuse, EA Emotional Abuse, SA = Sexual Abuse, PN = Physical Neglect, EN = Emotional Neglect, LEI = Life Events Inventory, A-LE = achievement related life events, S-LE = social life events, YSQ = Young Schema Questionnaire, ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other-Directedness, YR-AI = Young-Rygh Avoidance Inventory, YCI = Young Compensation Inventory, BDI = Beck Depression Inventory, BAI = Beck Anxiety Inventory, PSS = Perceived Stress Scale.

Table 3.2.

Demographic Characteristics of Participants

Variables	n	%
Gender		
Female	312	75.4
Male	102	24.6
Age		
Younger (between 18-21)	228	55.1
Older (between 22-32)	186	44.9
Mother Education		
Graduate of high school and below	260	62.8
Graduate of university and above	154	37.2
Father Education		
Graduate of high school and below	194	46.9
Graduate of university and above	220	53.1
Residential Status*		
With family at home	111	26.8
At dormitory	196	47.3
Income		
Low (0-1000 TL)	348	84.1
High (1000+ TL)	66	15.9
Siblings**		
Low (2 or less)	289	69.8
High (3 or more)	124	30.0

Note. * Participants who live with their family or in a dormitory (N = 307) were included in the analyses for this variable. ; ** Total number of participants for theses analyses is 411 with one missing.

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 (MANOVA) and t-test analyses were conducted with child abuse/neglect, schema domains, schema coping strategies, life

events and psychopathological symptomatology measures as the dependent variables, and significant differences are presented below.

3.2.1.1. Child Abuse and Neglect

In order to examine gender differences in types of child abuse/neglect, a one-way between subjects MANOVA was conducted with physical abuse, emotional abuse, sexual abuse, physical neglect and emotional neglect as the dependent variables. First of all, multivariate assumption of homogeneity of variance was not met [*Box's M* = 45.79, *F* (15, 145162.277) = 2.99, $p < .001$] so Pillai's Trace value was preferred for the interpretation. The univariate assumption of homogeneity of variance was met for all of the dependent variables. Results of the analysis revealed significant main effect of Gender on Child Abuse/Neglect [*Multivariate F* (5, 408) = 6.04, $p \leq .001$; Pillai's Trace = .07, η_p^2 = .07]. Therefore, the alpha value was adjusted according to Bonferroni correction and alpha levels lower than .01 were considered significant for the following univariate analyses. Based on this correction, univariate tests revealed that a significant difference of Gender was found for Physical Neglect [*F* (1, 412) = 10.63, $p < .01$, η_p^2 = .02]. In other words, females (*M* = 6.73, *SD* = 2.62) experienced lower levels of physical neglect than males (*M* = 7.733, *SD* = 2.86). The significant difference of Gender was also found for Emotional Neglect [*F* (1, 412) = 7.73, $p < .01$, η_p^2 = .02]; indicating that females (*M* = 9.45, *SD* = 4.41) experienced lower levels of emotional neglect than males (*M* = 10.85, *SD* = 4.44).

Table 3.3.
Gender Differences on Child Abuse/Neglect

	Gender		**Multivariate**	**Univariate**	**Pillai's Trace**	η_p^2
	F	**M**	***F* (5.408)**	***F* (1, 412)**		
CTQ			**6.04****		0.07	.07
PA	5.80	6.02		0.61		.00
EA	7.20	6.89		0.73		.00
SA	6.29	5.94		1.01		.00
PN	**6.73**	**7.73**		**10.63***		**.02**
EN	**9.45**	**10.85**		**7.73***		**.02**

* $p < .01$, ** $p < .001$
Note. CTQ = Childhood Trauma Questionnaire, PA = Physical Abuse, EA = Emotional Abuse, SA = Sexual Abuse, PN = Physical Neglect, EN = Emotional Neglect.

3.2.1.2. 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 schema domains as the dependent variables. First of all, multivariate assumption of homogeneity of variance was met [*Box's M* = 5.97, *F* (6, 271989.37) = .98, *ns*]. The univariate assumption of homogeneity of variance was also met for all of the dependent variables; that is Levene's test was not significant for all of them. Results of the analysis revealed significant main effect of Gender on Schema Domains [*Multivariate F* (3, 410) = 4.50, $p < .001$; Wilk's Lambda = .97, $\eta_p^2 = .03$]. Therefore, the alpha value was adjusted according to Bonferroni correction and alpha levels lower than .016 were considered significant for the following univariate analyses. Based on this correction, univariate tests revealed that a significant difference of Gender was found for only Disconnection/Rejection domain [*F* (1, 412) = 8.29, $p < .016$, $\eta_p^2 = .02$]. For this schema domain, females (*M* = 2.24, *SD* = .87) scored lower than males (*M* = 2.53, *SD* = .82). However, males and females did not differentiate significantly on Impaired Limits/Exaggerated Standards and Impaired Autonomy/Other-Directedness schema domains.

Table 3.4.

Gender Differences on Schema Domains

	Gender		**Multivariate**	**Univariate *F***	**Wilk's**	η_p^2
	F	**M**	***F* (3.410)**	**(1, 412)**	**Lambda**	
YSQ			**4.50****		0.97	.03
ILES	2.97	3.04		0.55		.00
DR	**2.24**	**2.53**		**8.29***		**.02**
IAOD	2.35	2.40		0.46		.00

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

Note. YSQ = Young Schema Questionnaire, ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other-Directedness

3.2.1.3. Measures of Psychopathological Symptomatology

In order to examine gender differences on the measures of psychological symptomatology, separate t-test analyses were conducted with depression level, anxiety level and level of perceived stress as dependent variables. The results indicated that Gender has a significant effect only on the Perceived Stress [t (412) = 2.49, $p < .05$], revealing that male participants (M = 20.07, SD = 6.08) had lower levels of perceived stress than female participants (M = 21.65, SD = 5.37). There was no significant difference of gender on depression and anxiety levels.

Table 3.5.

Gender Differences on Psychopathological Symptomatology

		Mean	SD	*t* (412)
BDI	**Gender**			-0.74
	F	11.20	9.01	
	M	12.04	10.11	
BAI	**Gender**			1.74
	F	16.30	11.04	
	M	14.17	10.60	
PSS	**Gender**			**2.49***
	F	21.65	5.37	
	M	20.07	6.08	

* $p < .05$
Note. BDI = Beck Depression Inventory, BAI = Beck Anxiety Inventory, PSS = Perceived Stress Scale

3.2.1.4. Life Events

In order to examine gender differences in life events, a one-way between subjects MANOVA was conducted with achievement related and social life events as the dependent variables. First of all, multivariate assumption of homogeneity of variance was met [*Box's M* = 6.71, F (3, 573409.962) = 1.22, *ns*]. Results of the analysis revealed significant main effect of Gender on Life Events [*Multivariate F* (2, 411) =

6.55, $p < .05$; Wilk's Lambda = .97, $\eta_p^2 = .03$]. Therefore, the alpha value was adjusted according to Bonferroni correction and alpha levels lower than .025 were considered significant for the following univariate analyses. Based on this correction, univariate tests revealed that a significant difference of Gender was found for only Achievement Related Life Events [F (1, 412) = 11.63 $p < .025$, $\eta_p^2 = .03$], indicating that females (M = 2.98, SD = .66) scored higher than males (M = 2.71, SD = .76) on achievement related life events. However, males and females did not differentiate significantly on experienced social life events.

Table 3.6.

Gender Differences on Life Events

	Gender		**Multivariate**	**Univariate *F***	**Wilk's**	η_p^2
	F	**M**	***F* (3.410)**	**(1, 412)**	**Lambda**	
LEI			**6.55****		0.97	.03
A-LE	**2.98**	**2.71**		**11.63***		**.03**
S-LE	2.22	2.11		2.01		.00

* $p < .025$, ** $p < .05$

Note. LEI = Life Events Inventory, A-LE = Achievement Related Life Events, S-LE = Social Life Events

3.2.2. Age Differences on the Measures of the Study

In order to examine age differences (younger, older) on the measures of this study, several MANOVA and t-test analyses were conducted with child abuse/neglect, schema domains, schema coping strategies, life events and psychopathological symptomatology measures as the dependent variables. Significant differences were found only for the measures of psychological symptomatology, namely for perceived stress as presented below.

3.2.2.1. Measures of Psychopathological Symptomatology

In order to examine age differences on the measures of psychopathological symptomatology, separate t-tests analyses were conducted with depression level,

anxiety level and level of perceived stress as dependent variables. Results indicated that Age has a significant effect only on the Perceived Stress [t (412) = -2.00, p < .05], indicating that younger participants (M = 20.76, SD = 5.31) reported lower levels of perceived stress than older participants (M = 21.87, SD = 5.87). There was no significant difference of age on depression and anxiety levels.

Table 3.7.

Age Differences on Psychopathological Symptomatology

		Mean	SD	*t* (412)
BDI	**Age**			-1.82
	Y	10.66	8.75	
	O	12.33	9.86	
BAI	**Age**			0.10
	Y	15.82	11.04	
	O	15.72	10.88	
PSS	**Age**			**-2.00***
	Y	20.76	5.31	
	O	21.87	5.87	

* p < .05
Note. BDI = Beck Depression Inventory, BAI = Beck Anxiety Inventory, PSS, Perceived Stress Scale

3.2.3. Income Level Differences on the Measures of the Study

The effects of differences regarding income level (low = 1000 TL and below, high = 1000 TL and above) were examined through separate MANOVA and t-test analyses with child abuse/neglect, schema domains, schema coping strategies, life events and psychological symptomatology measures as the dependent variables. Significant results of these analyses are presented below.

3.2.3.1 Child Abuse/Neglect

In order to examine income level differences in types of child abuse/neglect, a one-way between subjects MANOVA was conducted with physical abuse, emotional

abuse, sexual abuse, physical neglect and emotional neglect as the dependent variables. First of all, multivariate assumption of homogeneity of variance was not met [*Box's M* = 64.01, *F* (15, 680009.80) = 4.21, $p < .001$] so Pillai's Trace value was preferred for the interpretation. The results of the analysis revealed significant main effect of Income level on Child Abuse/Neglect [*Multivariate F* (5, 408) = 2.75, $p < .05$; Pillai's Trace = .03, $\eta_p^2 = .03$]. Therefore, the alpha value was adjusted according to Bonferroni correction and alpha levels lower than .01 were considered significant for the following univariate analyses. Based on this correction, univariate tests revealed that there is no significant difference of Income Level for the sub categories of Child Abuse/Neglect.

Table 3.8.

Income Level Differences on Child Abuse/Neglect

	Income		**Multivariate *F* (5.408)**	**Univariate *F* (1, 412)**	**Pillai's Trace**	η_p^2
	L	**H**				
CTQ			**2.75***		0.03	.03
PA	5.72	6.00		1.48		.00
EA	6.95	7.30		1.34		.00
SA	6.19	6.22		0.01		.00
PN	7.14	6.80		1.67		.00
EN	10.12	9.46		2.33		.00

* $p < .05$

Note. CTQ = Childhood Trauma Questionnaire, PA = Physical Abuse, EA = Emotional Abuse, SA = Sexual Abuse, PN = Physical Neglect, EN = Emotional Neglect.

3.2.3.2. Schema Domains

In order to examine income level differences in schema domains, a one-way between subjects MANOVA was conducted with Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness schema domains as the dependent variables. First of all, multivariate assumption of homogeneity of variance was met [*Box's M* = 10.37, *F* (6, 1222119.75) = 1.72, *ns*]. Results of the analysis revealed significant main effect of Income Level on Schema

Domains [*Multivariate F* (3, 410) = 4.95, $p < .01$; Wilk's Lambda = .96, $\eta_p^2 = .03$]. Therefore, the alpha value was adjusted according to Bonferroni correction and alpha levels lower than .016 were considered significant for the following univariate analysis. Based on this correction, univariate tests revealed that a significant difference of Income Level was found for Disconnection/Rejection domain [*F* (1, 412) = 9.25, $p < .016$, $\eta_p^2 = .02$]. In other words, participants who had lower levels of income (*M* = 2.44, *SD* = .87) showed stronger schemas on Disconnection/Rejection domain than those who had higher levels of income (*M* = 2.18, *SD* = .84). Moreover, univariate tests also revealed the significant effect of Income Level on Impaired Autonomy/Other-Directedness schema domain [*F* (1, 412) = 9.70, $p < .016$, $\eta_p^2 = .02$]; indicating that participants who had lower levels of income (*M* = 2.47, *SD* = .78) showed stronger schemas on Impaired Autonomy/Other-Directedness domain than those who had higher levels of income (*M* = 2.24, *SD* = .67). However, participants from lower and higher income levels did not differentiate significantly on Impaired Limits/Exaggerated Standards schema domain.

Table 3.9:

Income Level Differences on Schema Domains

	Income		**Multivariate *F* (3.410)**	**Univariate *F* (1, 412)**	**Wilk's Lambda**	η_p^2
	L	**H**				
YSQ			**4.95****		0.97	.03
ILES	3.03	2.95		0.94		.00
DR	**2.44**	**2.18**		**9.25***		**.02**
IAOD	**2.47**	**2.25**		**9.70***		**.02**

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

Note. YSQ = Young Schema Questionnaire, ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other-Directedness

3.2.3.3. Measures of Psychopathological Symptomatology

In order to examine income level differences on the measures of psychopathological symptomatology, separate t-test analyses were conducted with depression level, anxiety level and level of perceived stress as dependent variables. The results yielded that Income Level has a significant effect on the Depression level [t (412) = 2.68, p < .05], indicating that participants who had lower income (M = 12.59, SD = 9.32) experienced higher levels of depression than those who had higher income (M = 10.16, SD = 9.11). Moreover, the results showed a significant difference on level of Perceived Stress with regards to Income Level differences [t (412) = 2.77, p < .05]. Therefore, it was seen that participants who had lower income (M = 22.00, SD = 5.39) reported higher scores on the level of perceived stress than those who had higher income (M = 20.49, SD = 5.67). However, there was not a significant difference on anxiety score according to income level differences.

Table 3.10.

Income Level Differences on Psychopathological Symptomatology

		Mean	SD	*t* (412)
BDI	**Income**			**2.68***
	L	12.59	9.32	
	H	10.16	9.11	
BAI	**Income**			1.44
	L	16.48	10.82	
	H	15.03	11.08	
PSS	**Income**			**2.77***
	L	22.00	5.39	
	H	20.49	5.67	

*p < .05

Note. BDI = Beck Depression Inventory, BAI = Beck Anxiety Inventory, PSS = Perceived Stress Scale

3.2.3.4. Life Events

In order to examine income level differences on life events, a one-way between subjects MANOVA was conducted with achievement related and social life events as

the dependent variables. First of all, multivariate assumption of homogeneity of variance was met [*Box's M* = .67, *F* (3, 32992360.18) = 0.22, *ns*]. The univariate assumption of homogeneity of variance was also met for all of the dependent variables; that is Levene's test was not significant for all of them. Results of the analysis revealed significant main effect of Income Level on Life Events [*Multivariate F* (2, 411) = 4.01, $p < .05$; Wilk's Lambda = .98, $\eta_p^2 = .02$]. Therefore, the alpha value was adjusted according to Bonferroni correction and alpha levels lower than .025 were considered significant for the following univariate analysis. Based on this correction, univariate tests revealed that a significant difference of Income Level was found for both Social Life Events [*F* (1, 412) = 7.65, $p < .025$, $\eta_p^2 = .02$] and Achievement Related Life Events [*F* (1, 412) = 5.42, $p < .025$, $\eta_p^2 = .01$]. These results indicated that participants who had lower income (*M* = 2.26, *SD* = .66) scored higher at social life events than those who had higher income (*M* = 2.12, *SD* = .63). Moreover, participants with lower income levels (*M* = 3.01, *SD* = .68) reported higher levels of stressful achievement related life events than those with higher income levels (*M* = 2.82, *SD* = .69).

Table 3.11.

Income Level Differences on Life Events

	Income		**Multivariate**	**Univariate *F***	**Wilk's**	η_p^2
	L	**H**	***F* (3.410)**	**(1, 412)**	**Lambda**	
LEI			**4.01****		0.98	.02
A-LE	**3.01**	**2.82**		**7.65***		**.02**
S-LE	**2.26**	**2.12**		**5.42***		**.01**

* $p < .025$, ** $p < .05$

Note. LEI = Life Events Inventory, A-LE = Achievement Related Life Events, S-LE = Social Life Events

3.2.4. Sibling Number Differences

The effects of differences regarding sibling number (low = 2 and less siblings, high = 3 and more siblings) were examined through separate MANOVA and t-test analyses with child abuse/neglect, schema domains, schema coping strategies, life events and

psychological symptomatology measures as the dependent variables. Significant results of these analyses are presented below.

3.2.4.1. Child Abuse/ Neglect

In order to examine differences with regard to the number of siblings in types of child abuse/neglect, a one-way between subjects MANOVA was conducted with physical abuse, emotional abuse, sexual abuse, physical neglect and emotional neglect as the dependent variables. First of all, multivariate assumption of homogeneity of variance was not met [*Box's M* = 48.99, *F* (15, 238168.490) = 3.21, $p < .001$] so Pillai's Trace value was preferred for the interpretation. The univariate assumption of homogeneity of variance was met for all of the dependent variables. The results of the analysis revealed significant main effect of Sibling Number on Child Abuse/Neglect [*Multivariate F* (5, 407) = 2.42, $p < .05$; Pillai's Trace = .03, $\eta_p^2 = .03$]. Therefore, the alpha value was adjusted according to Bonferroni correction and alpha levels lower than .01 were considered significant for the following univariate analyses. Bases on this correction, univariate tests revealed that a significant difference of Sibling Number was found for only Emotional Neglect [*F* (1, 411) = 11.50, $p < .01$, $\eta_p^2 = .03$]. In other words, participants with two or fewer siblings (*M* = 9.29, *SD* = 4.27) reported lower levels of emotional neglect than those who had three or more siblings (*M* = 10.89, *SD* = 4.62).

Table 3.12.

Sibling Number Differences on Child Abuse/Neglect

	Siblings		**Multivariate**	**Univariate**	**Pillai's Trace**	η_p^2
	L	**H**	***F* (5.408)**	***F* (1, 412)**		
CTQ			**2.42****		0.03	.03
PA	5.79	6.01		0.72		.00
EA	6.90	7.57		4.14		.01
SA	6.09	6.49		1.52		.00
PN	6.84	7.27		2.10		.00
EN	**9.29**	**10.89**		**11.50***		**.03**

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

Note. CTQ = Childhood Trauma Questionnaire, PA = Physical Abuse, EA = Emotional Abuse, SA = Sexual Abuse, PN = Physical Neglect, EN = Emotional Neglect.

3.2.4.2. Measures of Psychopathological Symptomatology

In order to examine differences on the measures of psychopathological symptomatology with regards to number of siblings, separate t-test analyses were conducted with depression level, anxiety level and level of perceived stress as dependent variables. The results indicated that Sibling Number has a significant effect only on the Perceived Stress [t (411) = -1.65, $p < .01$], indicating that participants with two or less siblings (M = 20.95, SD = 5.59) reported lower levels of perceived stress than participants with three or more siblings (M = 21.94, SD = 5.54). There was no significant difference of Number of Siblings on Depression and Anxiety levels.

Table 3.13.

Sibling Number Differences on Psychopathological Symptomatology

		Mean	SD	*t* (412)
BDI	**Sibling**			-1.09
	L	11.06	9.39	
	H	12.13	9.02	
BAI	**Sibling**			0.29
	L	15.86	11.31	
	H	15.53	10.17	
PSS	**Sibling**			**-1.65***
	L	20.95	5.59	
	H	21.94	5.54	

* $p < .01$
Note. BDI = Beck Depression Inventory, BAI = Beck Anxiety Inventory, PSS, Perceived Stress Scale

3.2.4.3. Life Events

In order to examine differences in life events with regards to sibling numbers, a one-way between subjects MANOVA was conducted with achievement related and social life events as the dependent variables. First of all, multivariate assumption of

homogeneity of variance was not met [*Box's M* = 10.18, *F* (3, 1162046.788) = 3.37, $p < .05$] so Pillai's Trace value was preferred for interpretation. The results of the analysis revealed significant main effect of Sibling Number on Life Events [*Multivariate F* (2, 410) = 2.93, p < .05; Pillai's Trace = .01, η_p^2 = .01]. Therefore, the alpha value was adjusted according to Bonferroni correction and alpha levels lower than .025 were considered significant for the following univariate analysis. Following this correction, univariate tests did not revealed any significant difference of Income Level for subcategories of Life Events.

Table 3.14.

Sibling Number Differences on Life Events

	Siblings		**Multivariate *F* (2,411)**	**Univariate *F* (1,412)**	**Wilk's Lambda**	η_p^2
	L	**H**				
LEI			**2.93***		0.01	.01
A-LE	2.49	2.50		0.01		.00
S-LE	2.89	2.92		1.27		.00

* $p < .05$
Note. LEI = Life Events Inventory, A-LE = Achievement Related Life Events, S-LE = Social Life Events

3.2.5. Father and Mother Education Level Differences

The results of separate MANOVA and t-test analyses yielded no significant differences of father's education and mother's education level in terms of child abuse/neglect, schema domains, schema avoidance and compensation, measures of psychopathological symptomatology and life events.

3.2.6. Residential Status Differences

The effects of differences regarding residential status (with family and friends at home, at dormitory) were examined through separate MANOVA and t-test anaylses with child abuse/neglect, schema domains, schema coping strategies, life events and

psychopathological symptomatology measures as the dependent variables. However, results did not yield any significant differences.

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, monthly income, sibling number and for other measures of the study, namely child abuse/Neglect, schema domains of Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness, schema coping processes of avoidance and compensation, depression level, anxiety level, perceived stress and life events. The results of this analysis are presented in Table 3.15; for this analysis, only correlations with .30 and stronger coefficients will be reported.

Results showed that Mother's Education Level correlated with the Father's Education Level (r = .65, p < .01), which means higher levels of mother education was associated with higher levels of father education. Moreover, Number of Siblings found to be negatively correlated with Mother's (r = -.48, p < .01) and Father's (r = -.38, p < .01) Education Levels. In other words, higher levels of father and mother education associated with lower numbers of the siblings.

Correlation analysis between child abuse/neglect and other variables of the study yielded that Child Abuse/Neglect was related to Disconnection/Rejection *(*r = .42, p < .01) and Impaired Autonomy/Other Directedness (r = .33, p < 0.1) schema domains, indicating that higher levels of child abuse/neglect was related to higher scores on schemas domains of Disconnection/Rejection, Impaired Autonomy/Other Directedness. Child abuse/neglect was also found to be correlated with Anxiety scores (r = .37, p < .01), meaning that higher levels of child abuse and neglect were associated with higher anxiety symptomatology.

Related to intercorrelations between five subtypes of child abuse/neglect, it was found that Physical Abuse was correlated with Physical Neglect (r = .67, p < .01), Emotional Abuse (r = .66, p < .01), Sexual Abuse (r = .54, p < .01), and Emotional

Neglect (r = .35, p < .01), indicating that higher levels physical abuse is related with higher levels of physical neglect, emotional abuse, sexual abuse and emotional neglect. Moreover, Emotional Abuse was associated with Emotional Neglect (r = .56, p < .01), Sexual Abuse (r = .53, p < .01), and Physical Neglect (r = .53, p < .01). These results suggested that higher levels of emotional abuse are associated with higher levels of emotional and physical neglect, and sexual abuse. Sexual abuse was also found to be correlated with Physical Neglect (r = .44, p < .01), meaning that the higher the individuals experienced sexual abuse, the higher the physical neglect they were exposed to. Lastly, Emotional and Physical Neglect was found to be associated (r = .52, p < .01), indicating that individuals experiencing higher levels of physical forms of neglect could also experience higher levels of the emotional forms.

Besides, the relationships between five subtypes of child abuse/neglect and other measures of the study were examined, and it was seen that Emotional Abuse was related to Disconnection/Rejection (r = .40, p < .01), Impaired Autonomy/Other Directedness (r = .35, p < .01) schema domains and Depression symptomatology (r = .37, p < .01). Emotional neglect was also found to be associated with Disconnection/Rejection (r = .35, p < .01) schema domain and Depression symptomatology (r = .33, p < .01). These results indicated that stronger forms of schemas in Disconnection/Rejection schema domain and higher levels of depressive symptoms were related with the higher levels of both emotional abuse and emotional neglect exposed at childhood. On the other hand, stronger forms of schemas in Impaired Autonomy/Other Directedness schema domain were related only to higher levels of emotional abuse.

As for the intercorrelations between three schema domains, it was found that Impaired Limits/Exaggerated Standards domain was correlated with Disconnection/Rejection domain (r = .64 , p < .01), Impaired Autonomy/Other Directedness domain (r = .69, p < .01); and Disconnection/Rejection domain was correlated with Impaired Autonomy/Other Directedness domain (r = .74, p < .01). Therefore, it was shown that higher scores on one schema domain were related to higher scores on the other two.

Correlation analysis regarding the relationship between two schema coping processes showed that Schema Avoidance and Schema Compensation were related ($r = .43$, $p < .01$), indicating that individuals using one strategy frequently were likely to use other strategy as well. On the other hand, Schema Avoidance and Anxiety symptomatology also found to be correlated ($r = .37$, $p < .01$); in other words, stronger tendency to avoid schema was related to higher anxiety symptoms.

Moreover, the results regarding the relationship between schema domains and schema coping processes yielded significant results. Firstly, both Schema Avoidance and Compensation were found as correlated with Impaired Limits/Exaggerated Standards ($r = .34$, $p < .01$; $r = .68$, $p < .01$, respectively), Disconnection/Rejection ($r = .39$, $p < .01$; $r = .43$, $p < .01$, respectively), and Impaired Autonomy/Other Directedness ($r = .31$, $p < .01$; $r = .37$, $p < .01$, respectively) schema domains. In other words, stronger forms of schemas in three domains were associated with stronger forms of both schema avoidance and compensation.

The relationship between schema domains and measures of psychopathological symptomatology was examined and Impaired Limits/Exaggerated Standards, Disconnection/Rejection and Impaired Autonomy/Other Directedness were found to be correlated with Depression symptomatology ($r = .49$, $p < .01$; $r = .60$, $p < .01$; $r = .56$, $p < .01$, respectively), Anxiety symptomatology ($r = .37$, $p < .01$; $r = .38$, $p < .01$; $r = .43$, $p < .01$, respectively) and Perceived Stress ($r = .39$, $p < .01$; $r = .42$, $p < .01$; $r = .40$ $p < .01$, respectively). These results indicated that stronger forms of schemas in each of three domains were associated with higher depression and anxiety symptomatology, and higher levels of perceived stress.

Problems in Achievement Related and Social Life Events were found as correlated with each other ($r = .45$, $p < .01$). Correlation analyses regarding the associations between stressful life events and other measures of the study showed that Schema Avoidance and Schema Compensation were related with problems in Achievement Related Life Events ($r = .39$, $p < .01$; $r = .34$, $p < .01$, respectively) and problems in Social Life Events ($r = .36$, $p < .01$; $r = .36$, $p < .01$, respectively), meaning that stronger tendency to both avoid or compensate schema were associated with more frequent problems in achievement related and social life events. Moreover,

Table 3.15: Pearson Correlation Coefficients between the Measures of the Study

Variables	G	A	S	ME	FE	MI	CTQ	PA	EA	SA	PN	EN	ILES	DR	IAOD	YRAI	YCI	BAI	BDI	PSS	A-LE	S-LE
G	1	.17**	.06	-.09	-.03	-.09	.06	.04	-04	-.05	.16**	.14**	.04**	**.**14**	.03	-.07	.02	-.08	.04	-.12	-.17**	-.07
A		1	.01	.00	-.00	.04	.05	-.01	.06	-.00	.00	.09	-.04	-.03	-.04	-.01	-.10*	-.07	.06	.02	.04	-.03
S			1	**-.48****	**-.38****	-.05	.17**	.14**	.12**	.06	.18**	.15	.01	.05	.02	-.06	.02	-.03	.04	.10*	.07	.01
ME				1	**.65****	.23**	-.10	-.02	-.07	-.01	-.09	.15**	.01	-.07	-02	-.03	-.06	.07	-.03	-.06	-.05	-.04
FE					1	.18**	-.14**	-.08	-.09	-.06	-.15**	-.14**	-.04	-.13*	-.06	-.06	-.06	.01	-.05	-.09	-.07	-.08
MI						1	-.03	.05	.05	-.01	-.06	-.10*	-.05	-.13**	-.12*	-.10*	-.07	-.04	-.13**	-.11*	-.12*	-.13**
CTQ							1	**.79****	**.84****	**.69****	**.79****	**.74****	.21**	**.42****	**.33****	.05	.08	.12**	**.37****	.20**	.07	.20**
PA								1	**.66****	**.54****	**.67****	**.35****	.12*	.29**	.28**	.03	.09	.07	.22**	.06	.01	.11*
EA									1	**.53****	**.53****	**.56****	.27**	**.40****	**.35****	.11*	.16**	.14**	**.37****	.23**	.13**	.28**
SA										1	**.44****	.25**	.20**	.26**	.28**	.06	.12*	.13**	.26**	.14**	.08	.10*
PN											1	**.52****	.11*	.27**	.22**	-.01	-.00	.08	.23**	.15**	.03	.12*
EN												1	.11*	**.35****	.18**	.01	-.02	.05	**.33****	.20**	.03	.16**
ILES													1	**.64****	**.69****	**.34****	**.68****	**.37****	**.49****	**.39****	**.45****	**.48****
DR														1	**.74****	**.39****	**.43****	**.38****	**.60****	**.42****	**.39****	**.57****
IAOD															1	**.31****	**.37****	**.43****	**.56****	**.40****	**.45****	**.57****
YRAI																1	**.43****	**.37****	.29**	.17**	**.38****	**.36****
YCI																	1	.26**	.24**	.23**	**.34****	**.36****
BAI																		1	**.49****	**.46****	**.48****	**.52****
BDI																			1	**.65****	**.53****	**.61****
PSS																				1	**.57****	**.60****
A-LE																					1	**.68****
S-LE																						1

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

Note. S = Number of Siblings, ME = Mother's Education, FE = Father's Education, MI: Monthly Income, CTQ = Childhood Trauma Questionnaire, PA = Physical Abuse, EA = Emotional Abuse, SA = Sexual Abuse, PN = Physical Neglect, EN = Emotional Neglect, ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other Directedness, YRAI = Young Rygh Avoidance Inventory, YCI = Young Compensation Inventory, BAI: Beck Anxiety Inventory, BDI = Beck Depression Inventory, PSS = Perceived Stress Scale, A-LE = Achievement Related Life Events, S-LE = Social Life Events

Achievement Related and Social Life Events were found to be associated with Impaired Limits/Exaggerated Standards (r = .45, p < .01; r = .48, p < .01, respectively), Disconnection/Rejection (r = .39, p < .01; r = .57, p < .01, respectively), and Impaired Autonomy/Other Directedness schema domains (r = .45, p < .01; r = .57, p < .01, respectively), indicating that individuals who had stronger schemas at each of these domains are likely to have more frequent problems related to achievement related and social life events. Lastly, Achievement Related and Social Life Events were found to be correlated with Anxiety symptomatology (r = .48, p < .01; r = .52, p < .01, respectively), Depression symptomatology (r = .53, p < .01; r = .561, p < .01, respectively) and Perceived Stress (r = .57, p < .01; r = .60, p < .01, respectively), meaning that individuals who experience more frequent problems related to achievement related and social life events were more likely to experience higher levels of depression and anxiety symptomatology and perceive higher levels of stress in their lives.

Lastly, intercorrelations between the measures of psychopathological symptomatology were examined and it was found that Depression symptomatology was correlated with Anxiety symptomatology (r = .49, p < .01) and Perceived Stress level (r = .65, p < .01). Furthermore, level of Perceived Stress was seen as related with Anxiety symptomatology (r = .46, p < .01). These results indicated that higher levels of depressive symptoms were related to anxiety symptomatology, and higher levels of depressive and anxiety symptoms were associated with higher levels of perceived stress.

The summary of intercorrelations between measures is presented in the Table 3.15.

3.4. Regression Analyses

Factors associated with schema domains, schema coping processes and psychopathological symptomatology were determined through three different sets of regression analyses.

3.4.1. Factors Associated with Schema Domains (The First Sets of Regression Analyses)

The first set of regression analyses, regarding factors associated with schema domains separately included three separate analyses with Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness domains as dependent variables. In each regression analysis, the first step of the regression equations involved related demographic variables, namely gender, age, mother education level, father education level, residence, income level and sibling number. On the second step, achievement related and social life events were hierarchically entered into the equation for each dependent variable. At the last step, physical abuse, emotional abuse, sexual abuse, physical neglect and emotional neglect hierarchically entered into the equation.

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. Social life events [$R^2 = .23$, $\beta = .48$, $t\ (412) = 11.06$, $p < .001$] initially entered into the regression equation and significantly explained 23 % of the variance [$F\ (1, 412) = 122.25$, $p < .001$]. Secondly, Achievement Related Life Events entered into the equation [$\Delta R^2 = .03$, $\beta = .24$, $t\ (411) = 4.16$, $p < .001$], increasing the explained total variance to 26 % [$F_{change}\ (1, 411) = 17.32$, $p < .001$]. These results indicated that higher levels of stressful social and achievement related life events were associated with higher scores in Impaired Limits/Exaggerated Standards domain. Thirdly, Emotional Abuse entered

into the regression equation [ΔR^2 = .02, β = .16, t (410) = 3.74, p < .001], and increasing the explained total variance to 28 % [F_{change} (1, 410) = 14.02, p < .001]. Lastly, Sexual Abuse entered into the equation [ΔR^2 = .01, β = .10, t (409) = 1.99, p < .05], increasing the explained total variance to 29 % [F_{change} (1, 409) = 3.98, p < .05]. Thus, these results indicated that participants who experienced emotional and sexual abuse tented to have stronger characteristics on Impaired Limits/Exaggerated Standards schema domain.

3.4.1.2. Factors Associated with Disconnection/Rejection Domain

According to the results of the regression analysis performed to identify factors associated with Disconnection/Rejection domain, Gender initially entered into the equation [R^2 = .02, β = .14, t (412) = 2.88, p < .01], and explained 2 % of variance [F (1, 412) = 8.29, p < .01]. Secondly, Income Level entered into the equation [ΔR^2 = .01, β = -.12, t (411) = -2.40, p < .05] and increased the explained total variance to 3 % [F_{change} (1, 411) = 5.74, p < .05]. Then, Social Life Events entered into the equation [ΔR^2 = .32, β = .57, t (410) = 14.31, p < .001] and the explained total variance increased to 35 % [F_{change} (1, 410) = 204.79, p < .001]. Thus, results indicated that male participants who had lower levels of income and experienced higher level of stressful life events tented to have stronger schemas in Disconnection/Rejection domain.

At the next step of the regression analyses, results showed a significant association of Emotional Abuse with this domain [ΔR^2 = .07, β = .28, t (409) = 7.10, p < .001] and increased the total variance accounted for to 43 % [F_{change} (1, 409) = 50.39, p < .001]. After that, Emotional Neglect entered into the equation [ΔR^2 = .01, β = .13, t (408) = 2.79, p < .05] and the explained total variance increased to 44% [F_{inc} (1, 408) = 7.76, p < .05]. Lastly, Sexual Abuse entered into the equation [ΔR^2 = .01, β = .11, t (407) = 2.40, p < .05] and increased the explained total variance to 45 % [F_{change} (1, 408) = 5.78, p < .05]. These results indicated that participants who experienced emotional abuse and emotional neglect were more likely to have stronger characteristics on Disconnection/ Rejection schema 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 with this domain [R^2 = .01, β = -.12, t (412) = -2.44, p < .05]; and explained 2% of the variance [F (1, 412) = 5.94, p < .01]. Then, Social Life Events entered into equation [ΔR^2 = .31, β = .56, t (411) = 13.78, p < .001]; and increased the explained total variance to 33% [F_{change} (1, 411) = 190.02, p < .001]. Lastly, Achievement Related Life Events entered into the equation [ΔR^2 = .01, β = .12, t (410) = 2.27, p < .05], and the explained total variance increased to 34 % [F_{change} (1, 410) = 5.14, p < .05]. In other words, those with lower income levels and those who experienced higher stressful social and achievement related life events had stronger schemas in Impaired Autonomy/Other Directedness domain.

At the next step of the regression analyses, Physical Abuse entered into the equation [ΔR^2 = .01, β = .24, t (409) = 6.13, p < .001] and the explained total variance increased to 39% [F_{change} (1, 409) = 37.52, p < .001]. Lastly, Sexual Abuse entered into the equation [ΔR^2 = .01, β = .14, t (408) = 3.00, p < .01] and increased the explained total variance to 40 % [F_{change} (1, 408) = 9.01, p < .01]. Therefore, participants who experienced higher levels of physical and sexual abuse tented to have stronger characteristics on Impaired Autonomy/Other-Directedness domain.

Table 3.16.
Factors Associated with Schema Domains (1st Set of Regression Analyses)

	IV	*df*	F_{change}	*β*	*t*	ΔR^2	R^2
A.	**ILES**						
	I. Control Variables						
	None						
	II. Life Events						
	S-LE	1, 412	122.25**	.48	11.06**	.23	.23
	A-LE	1, 411	17.32**	.24	4.16**	.03	.26
	II. Child Abuse/ Neglect						
	Emotional Abuse	1, 410	14.02**	.16	3.74**	.02	.28
	Sexual Abuse	1, 409	3.98*	.10	1.99**	.01	.29
B.	**DR**						
	I. Control Variable						
	Gender	1, 412	8.29***	.14	2.88***	.02	.02
	Income	1, 411	5.74*	-.12	-2.40*	.01	.03
	II. Life Events						
	S-LE	1, 410	204.79**	.57	14.31**	.32	.35
	III. Child Abuse/Neglect						
	Emotional Abuse	1, 409	50.39**	.28	7.10**	.08	.43
	Emotional Neglect	1, 408	7.76*	.13	2.79*	.01	.44
	Sexual Abuse	1, 407	5.78*	.11	2.40*	.01	.45

Table 3.16. (Continued)

C.	IAOD						
	I. Control Variable						
	Income	1, 412	5.94*	-.12	-2.44*	.01	.01
	II. Life Events						
	S-LE	1, 411	190.02**	.56	13.78**	.31	.33
	A-LE	1, 410	5.14*	.12	2.27*	.01	.34
	III. Child Abuse/ Neglect						
	Physical Abuse	1, 409	37.52**	.24	6.13**	.06	.39
	Sexual Abuse	1, 408	9.01***	.14	3.00***	.01	.40

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

Note. ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other Directedness, S-LE = Social Life Events, A-LE = Achievement Related life Events

3.4.2. Factors Associated with Schema Coping Processes (The Second Set of Regression Analyses)

The second set of the regression analyses, regarding factors associated with schema coping processes separately included Schema Avoidance and Schema Compensation as dependent variables. In each regression analysis, the first step of regression equations involved demographic variables. At the second step, achievement related and social life events hierarchically entered into the equation. At the next step, physical abuse, emotional abuse, sexual abuse, physical neglect and emotional neglect hierarchically entered into the equation for each dependent variable. Finally, schema domains; namely, Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other-Directedness entered into the equation for each dependent variable.

3.4.2.1. Factors Associated with Schema Avoidance

In order to determine factors associated with Schema Avoidance, a hierarchical regression analysis was performed. Income initially entered into the equation [R^2 = .01, β = -.10, t (411) = -2.12, $p < .05$]; and explained 1 % of the total variance [F (1, 411) = 4.51, $p < .05$]. Secondly, Achievement Related Life Events [ΔR^2 = .14, β = .37, t (410) = 8.24, $p < .001$] entered into the regression equation and increased the explained total variance to 15 % [F_{change} (1, 410) = 67.87, $p < .001$]. Then, Social Life Events entered into the equation [ΔR^2 = .01, β = .17, t (409) = 2.78, $p < .01$], increasing the explained total variance to 17 % [F_{change} (1, 409) = 7.56, $p < .01$]. These results indicated that higher levels of stressful social and achievement related life events were associated with higher tendency to use avoidance as schema coping. Moreover, participants who had lower income levels tended to utilize more avoidance as a schema coping strategy.

None of the third step variables entered to the equation. However, among the last step variables, Disconnection/ Rejection schema domain entered into the equation [ΔR^2 = .05, β = .28, t (408) = 5.21, $p < .001$], increasing the explained total variance

to 22 % [F_{change} (1, 408) = 27.10, $p < .001$]. Therefore, it was found that those who had stronger schemas on Disconnection/Rejection schema domain tented to utilize more avoidance as the schema coping strategy.

3.4.2.2. Factors Associated with Schema Compensation

According to the results of the regression analysis performed to identify factors associated with Schema Compensation, Age initially entered into the equation [R^2 = .01, β = -.10, t (411) = -2.12, $p < .05$]; and explained 1 % of the total variance [F (1, 411) = 4.52, $p < .05$]. Secondly, Social Life Events entered to equation [ΔR^2 = .12, β = .35, t (410) = 7.71, $p < .001$] and significantly explained 14 % of the total variance [F_{change} (1, 410) =59.52, $p < .001$]. Then, Achievement Related Life Events entered into the equation [ΔR^2 = .02, β = .20, t (409) = 3.21, $p < .01$], increased the explained total variance to 16 % [F_{change} (1, 409) = 10.32, $p < .01$]. These results indicated that younger participants who experienced more stressful social life and achievement related life events were more likely to use compensation as a way of schema coping.

At the next step of the regression analyses, none of the third step variables entered to equation. After controlling for these above stated variables Impaired Limits/Exaggerated Standards schema domain entered into the equation [ΔR^2 = .31, β = .64, t (408) = 15.28, $p < .001$] and the explained total variance increased to 46 % [F_{change} (1, 408) = 233.60, $p < .001$]. Lastly, Impaired Autonomy/Other Directedness schema domain entered into the regression equation [ΔR^2 = .02, β = -.23, t (407) = -4.33, $p < .001$] and increased the explained total variance to 49 % [F_{change} (1, 407) = 18.71, $p < .001$]. Accordingly, those who had stronger schemas on Impaired Limits/Exaggerated Standards schema domain tended to use compensation more frequently as schema coping strategy whereas those who had stronger schemas on Impaired Autonomy/Other Directedness schema domain tented to utilize less compensation schema coping style.

Table 3.17.

Factors Associated with Schema Coping Processes (2nd Set of Regression Analyses)

DV	IV	*df*	F_{change}	*β*	*t*	ΔR^2	R^2
A.	**Avoidance**						
	I. Control Variable						
	Income	1, 411	4.51*	-.10	-2.12*	.01	.01
	II. Life Events						
	A-LE	1, 410	67.87**	.37	8.24**	.14	.15
	S-LE	1, 409	7.56***	.17	2.75***	.01	.17
	III. Child Abuse/Neglect						
	None						
	IV. Schema Domains						
	DR	1, 408	27.10**	.28	5.21**	.05	.22
Compensation							
	I. Control Variable						
	Age	1, 411	4.52*	-.10	-2.12*	.01	.01
	II. Life Events						
	S-LE	1, 410	59.52**	.35	7.71**	.12	.14
	A-LE	1, 409	10.32***	.20	3.21***	.02	.16
	III. Child-Abuse/Neglect						
	None						
	IV. Schema Domains						
	ILES	1, 408	233.60**	.64	15.28**	.31	.46
	IAOD	1, 407	18.71**	-.23	-4.33**	.02	.49

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

Note. ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other Directedness, S-LE = Social Life Events, A-LE = Achievement Related life Events

3.4.3. Factors Associated with Psychopathological Symptomatology (The Third set of Regression Analyses)

As for the third and the last set of the regression analyses, three hierarchical regression analyses were performed to investigate associated factor of different measures of psychopathological symptomatology; namely, Depressive Symptomatology, Anxiety Symptomatology and Perceived Stress. For these analyses initially demographic variables (i.e., age, gender, income, mother's education, father's education, residential status and sibling number) were hierarchically entered into the regression equation. After controlling for significant demographic variables, on the second step, two types of life events (i.e., Social Life Events and Achievement Related Life Events) were hierarchically entered into the regression equation. At the third step, five types of child Abuse/neglect (Physical Abuse, Emotional Abuse, Sexual Abuse, Physical Neglect and Emotional Neglect) were hierarchically entered into the regression equation. On the fourth step, three schema domains (i.e., Impaired Limits/Exaggerated Standards, Disconnection/Rejection, Impaired Autonomy/Other Directedness) were hierarchically entered into the regression equation. Finally on the last step, schema coping processes (i.e., Compensation, Avoidance) were hierarchically entered into the regression equation.

3.4.3.1. Factors Associated with Depressive Symptomatology

Results of the regression analysis yielded that among the control variables, Income level initially entered into the regression equation [R^2 = .02, β = -.14, t (411) = -2.80, p < .01] and significantly explained 2 % of the total variance [F (1, 411) = 7.84, p < .01]. After controlling for this variable, among the second step variables, Social Life Events entered into the equation [ΔR^2 = .36, β = .61, t (410) = 15.44, p < .001] and increased the explained total variance to 38 % [F_{change} (1, 410) = 238.51, p < .001]. After controlling for these variables, Achievement Related Life Events entered into the equation [ΔR^2 = .02, β = .21, t (409) = 4.08, p < .001]; and increased the explained total variance to 40 % [F_{change} (1, 409) = 16.68, p < .001]. Therefore, participants who had lower levels of income, those who experienced higher levels of

stressful social and achievement related life events tented to show more depressive symptoms.

Among the third set of variables, Emotional Neglect initially entered into the equation [ΔR^2 = .06, β = .25, t (408) = 6.88, p < .001]; and the explained total variance increased to 47 % [F_{change} (1, 408) = 47.45, p < .001]. Then, Sexual Abuse entered into the equation [ΔR^2 = .02, β = .14, t (407) = 3.79, p < .001]; and increased the explained total variance to 48 % [F_{change} (1, 407) = 14.39, p < .001]. These results indicated that participants who experienced emotional neglect and sexual abuse tented to show higher depressive symptomatology.

After controlling for these variables, Disconnection/Rejection schema domain entered into the regression equation [ΔR^2 = .04, β = .27, t (406) = 6.15, p < .001]; and increased the explained total variance to 53 % [F_{change} (1, 406) = 37.89, p < .001]. Afterwards, Impaired Autonomy/Other Directedness schema domain entered into the equation [ΔR^2 = .01, β = .11, t (405) = 2.10, p < .05]; and the explained total variance increased to 53.3 % [F_{change} (1, 405) = 4.42, p < .05]. Thus, these results yielded those participants who had stronger scores on Disconnection/Rejection and Impaired Autonomy/Other Directedness schema domains tented to experience higher depressive symptoms.

At the last step, among the last set of variables, compensation entered into the equation [ΔR^2 = .01, β = -.08, t (404) = -2.01, p < .05]; and increased the explained total variance to 54 % [F_{change} (1, 404) = 4.04, p < .05]. In other words, participants who utilized compensation as schema coping style tented to show less depressive symptoms.

3.4.3.2. Factors Associated with Anxiety Symptomatology

Results of regression analyses yielded that Social Life Events initially entered into the regression equation [R^2 = .27, β = .52, t (411) = 12.30, p < .001] and explained 27 % of the total variance [F (1, 411) = 151.33, p < .001]. Then, Achievement Related Life Events entered into the equation [ΔR^2 = .03, β = .24, t (410) = 4.35, p < .001]; and increased the explained total variance to 30 % [F_{change} (1, 410) =18.91, p < .001].

These results indicated that participants who experienced more stressful social life events and achievement related life events were showed more anxiety symptoms.

After that, among the fourth set of the variables, Impaired Autonomy/Other Directedness schema domain entered into the equation [ΔR^2 = .02, β = .18, t (409) = 3.69, p < .001]; and the explained total variance increased to 32 % [F_{change} (1, 409) = 13.65, p < .001]. Lastly, among the fifth set of the variables, Schema Avoidance entered into the equation [ΔR^2 = .02, β = .16, t (408) = 3.59, p < .001]; and increased the explained total variance to 34 % [F_{change} (1, 408) = 12.86, p < .001]. Therefore, these results indicated that participants who had higher scores on Impaired Autonomy/Other Directedness schema domain and those who utilized schema avoidance coping strategy more frequently experience anxiety symptoms.

3.4.3.3. Factors Associated with Perceived Stress

According to the results of the regression analysis performed to identify factors associated with Perceived Stress, among demographic variables Gender initially entered into the regression equation [R^2 = .01, β = -.12, t (411) = -2.46, p < .01]; and explained 1 % of the total variance [F (1, 411) = 6.07, p < .01]. Secondly, Income entered into the equation [ΔR^2 = .01, β = -.12, t (410) = -2.45, p < .01]; and increased the explained total variance 3 % [F_{change} (1, 410) = 5.98, p < .01]. Then, Sibling Number entered into the equation [ΔR^2 = .01, β = .10, t (409) = 2.14, p < .05]; and increased the explained total variance 4 % [F_{change} (1, 409) = 4.56, p < .05]. These results indicated that participants, who were female, had lower income level and higher numbers of siblings tend to experience higher levels of perceived stress.

At the second step of the regression analyses, Social Life Events entered into the equation [ΔR^2 = .34, β = .59, t (408) = 14.88, p < .001]; and the explained total variance increased to 38 % [F_{change} (1, 408) = 221.51, p < .001]. Secondly, Achievement Related Life Events entered into the equation [ΔR^2 = .04, β = .27, t (407) = 5.14, p < .001]; and increased the explained total variance to 41 % [F_{change} (1, 407) = 26.46, p < .001]. Thus, it was indicated that participants who scored higher on social and achievement related life events experienced higher levels of perceived stress. Among the third set of the variables, only Emotional Neglect entered into the

regression equation [ΔR^2 = .01, β = .12, t (406) = 3.01, p < .01]; and increased the explained total variance to 43 % [F_{change} (1, 406) = 9.09, p < .01]. Therefore, participants who experienced more emotional neglect were more likely to perceive higher levels of stress.

After that, Impaired Limits/Exaggerated Standards schema domain entered into the equation [ΔR^2 = .01, β = .09, t (405) = 2.02, p < .05]; and the explained total variance increased to 43.4 % [F_{change} (1, 405) = 4.09, p < .05]. These results indicated that participants who have higher scores on Impaired Limits/Exaggerated Standards schema domain more likely to perceive higher levels of stress. At the last step of the regression analyses, Schema Avoidance entered in to the equation [ΔR^2 = .01, β = -.12, t (404) = -2.86, p < .01]; and increased the explained total variance to 44 % [F_{change} (1, 404) = 8.16, p < .01]. Accordingly, participants who utilized avoidance as schema coping strategy perceived higher levels of stress.

Table 3.18.

Factors Associated with Psychological Symptomatology (3rd Set of Regression Analyses)

DV	IV	*df*	F_{change}	*β*	*t*	ΔR^2	R^2
A. Depression							
	I. Control Variable						
	Income	1, 411	7.84***	-.14	-2.80***	.02	.02
	II. Life Events						
	S-LE	1, 410	238.51**	.61	15.44**	.36	.38
	A-LE	1, 409	16.68**	.21	4.08**	.02	.40
	III. Child Abuse/Neglect						
	Emotional Neglect	1, 408	47.45**	.25	6.89**	.06	.47
	Sexual Abuse	1, 407	14.39**	.14	3.79**	.02	.48
	IV. Schema Domains						
	DR	1, 406	37.89**	.27	6.15**	.04	.53
	IAOD	1, 405	4.42*	.11	2.10*	.01	
	V. Schema Coping Processes						.533
	Compensation	1, 404	4.04*	-.08	-2.01*	.01	.54
B. Anxiety							
	I. Control Variable						
	None						
	II. Life Events						
	S-LE	1, 411	151.33**	.52	12.30**	.27	.27
	A-LE	1, 410	18.91**	.24	4.35**	.03	.30
	IV. Schema Domains						
	IAOD	1, 409	13.65**	.18	3.69**	.02	.32
	V. Schema Coping Processes						
	Avoidance	1, 408	12.86**	.16	3.59**	.02	

Table 3.18. (Continued)

B. Perceived Stress						
I. Control Variable						
Gender	1, 411	6.07***	-.12	-2.46*	.01	.01
Income	1, 410	5.98***	-.12	-2.45*	.01	.03
Sibling Number	1, 409	4.56*	.10	2.14*	.01	.04
II. Life Events						
S-LE	1, 408	221.51**	.59	14.88**	.34	.38
A-LE	1, 407	26.46**	.27	5.14**	.04	.41
III. Child Abuse/Neglect						
Emotional Neglect	1, 406	9.09***	.12	3.01***	.01	.43
IV. Schema Domains						
ILES	1, 405	4.09*	.09	2.02*	.01	.434
V. Schema Coping Processes						
Avoidance	1, 404	8.16***	-.12	-2.86***	.01	.44

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

Note. ILES = Impaired Limits/Exaggerated Standards, DR = Disconnection/Rejection, IAOD = Impaired Autonomy/Other Directedness, S-LE = Social Life Events, A-LE = Achievement Related life Events

CHAPTER 4

DISCUSSION

The current study investigated the relationship between child abuse/neglect, early maladaptive schemas, psychopathological symptomatology (i.e., depression, anxiety and perceived stress), and the importance of schema coping processes (i.e., schema avoidance and schema compensation) on this relationship. For this purposes; first of all, the differences in the levels of demographic variables on the measures of the study were examined. Secondly, intercorrelations between all the measures of the study were calculated. Lastly, associated factors of the schema domains, schema coping processes, and psychopathological symptomatology were determined through three different sets of hierarchical regression analyses.

In this section, the results of these analyses will be discussed in the light of current literature. Afterwards, strengths and limitations of the study will be presented. Lastly, clinical implications of the current study and suggestions for the future research will be stated.

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

Determining differences of the levels of demographic variables on the measures of the study was one of the main aims of the current study. Therefore, gender, age, mother's education level, father's education level, residential status, monthly income, and sibling number differences were examined on child abuse/neglect, schema domains, schema coping processes, psychopathological symptomatology, and stressful life events. With this regard, results indicated no significant difference of mother's education level, father's education level, and residential status on the measures of the study. On the other hand, gender, age, income, and sibling number yielded some significant differences on the measures of the current study. However,

schema coping processes did not differentiate according to any of the demographic variables.

Results indicated significant gender differences on child abuse/neglect, schema domains, psychopathological symptomatology, and stressful life events.
First of all, it was found that males experienced higher levels of physical and emotional neglect than females. However, in the literature, there are mixed findings related to gender differences on neglect. Some of the few studies that investigated gender differences on neglect revealed that females were exposed to more neglect than males (e.g., Lee, & Kim, 2011; Keyes et al., 2012) whereas the others revealed the opposite (e.g., Choo et al., 2011) (as cited in Charak, & Koot, 2014). Secondly, results revealed that the only schema domain that is significantly differentiated according to gender was Disconnection/Rejection. In particular, males had higher scores on this domain. This difference might be result of the sociocultural context of Turkish society where men are expected to be more achievement- oriented and less emotion oriented so their needs for love, affection and connectedness were unheeded. Therefore, it is not surprising that neglect and connectedness-related schemas were more activated in males than females.

As for the gender differences on the measures of the psychopathological symptomatology, the results of the study indicated that females perceived higher levels of stress than males. Lastly, it was found that female experienced higher levels of achievement related stressful life events than males. These findings are consistent with the literature about the psychological stress. To illustrate, Moksnes, Moljord, Espnes and Bryne (2010) suggested that females had higher scores on all of the stress domains. This may be due to that females give greater importance to success and are more concerned about possible negative evaluations by others than male (Rose, & Rudolph, 2006). This is especially related to interpersonal stressors such as problems with peers, romantic relationships and family (Hankin, Mermelstein, & Roesch, 2007). Moreover, the finding that females repoted higher stress related to achievement also support previous findings (Byrne, Davenport, & Mazanov, 2007).

According to the results concerning age, its effect was found only on the participants' level of perceived stress, indicating that younger participants reported

lower levels of perceived stress than older ones. Research has established that overall level of stress tends to increase with age (Rudolph, 2002). This may be related to increasing responsibilities of life with age on work, family, financial expectations etc. Moreover, the age range of the sample corresponds to period of youth adulthood during which they are in university years. During this period, the individual often leaves their family environment. These conditions might result in the increased level of stress in their lives.

Concerning the income level, results indicated significant differences on schema domains, psychopathological symptomatology, and stressful life events. In particular, results revealed that individuals who had lower income experienced higher levels of depression than those who had higher income. It was also seen that participants who had lower income reported higher scores on the level of perceived stress than those who had higher income. Further, as for the income level differences on the stressful life events, individuals who had lower income reported higher levels of social and achievement related stressful life events. These finding are consistent with the literature about the relation between socioeconomic status and psychopathological symptomatology. Most of the related studies identified that people living in rural areas had more psychological problems than those living in cities (e.g., Gau et al., 2005; Mullick et al., 2005), which is also valid for Turkey (as cited in Aydogan et al., 2013).

According to the results of the study, individuals who had lower income scored higher on Disconnection/ Rejection (DR) and Impaired Autonomy/ Other Directedness (IAOD) schema domains. Demographic conditions that may contribute to child abuse and neglect were identified as poverty, unemployment and the type of neighborhood where families live (Kotch, et al., 1995). Moreover, child abuse/neglect was identified as a risk factor for developing maladaptive schemas especially DR and IAOD domains (McGinn et al., 2015). Therefore, this finding was expected when both of these relationships taken into account together.
Sibling number revealed significant difference on child abuse/neglect and psychopathological symptomatology, as well. First of all, individuals who had more siblings reported higher levels of emotional neglect than those had fewer siblings. Increasing family size was identified as a risk factor for child abuse and neglect in

general (Kotch et al., 1995). Family environments in which more than one child exist the care, affection, love and support of parents may be divided so this may result in unmeet emotional needs of children. Moreover, with increasing number of offsprings, an increase in the burden of the parents might be expected that could lead to focusing only on the physical needs of children such as nurturance, shelter, health while ignoring their emotional needs such as love and affection.

Furthermore, individuals who had more siblings perceived higher levels of stress than those who had fewer siblings. Research revealed that sibling relationships are also associated with stress. This association explained as a positional matter between siblings (Lampi & Nordblom, 2010). In other words, it can be concluded that first order child, who during childhood was always used to be foremost, would be eager to be more successful than others as an adult so experience stress related to defeat in competition with others. Whereas the last born, who experienced that he/she could not achieve as much as the older siblings as child, would perceive inadequacy as an adult so experience stress related to worry of being defeated in competition. Hence, no matter what the birth order is having sibling or siblings may lead perceiving more stress in live due to the competition matter that; in fact, had felt in childhood but transferred to adult life.

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

Correlational analyses between the measures of the current study yielded several significant results. Most of them were already discussed in the above sections.

Related to intercorrelations between five subtypes of child abuse/neglect, it was found that physical abuse was positively correlated with physical neglect, emotional abuse, sexual abuse, and emotional neglect. Moreover, emotional abuse was positively associated with emotional neglect, sexual abuse and physical neglect. Sexual abuse was also found to be positively correlated with physical neglect. Lastly, emotional and physical neglect was found to be positively associated. These findings can be evaluated as multiple forms of maltreatment tend to occur together in abusive and neglectful families. Moreover, when children are exposed to one type of

maltreatment they also tend to experience other types of abuse and neglect from their families (Higgins, & McCabe, 2001).

Correlation analysis between child abuse/neglect and other variables of the study yielded that child abuse/neglect was positively correlated with Disconnection/Rejection (DR) schema domain. Schema Theory supports this finding. Young et al. (2003) claimed that individuals who had schemas from DR domain had also experienced child abuse/neglect and victimization. In fact, it is not surprising that a child who had been abused by caregiver would have beliefs concerning his/her unmeet emotional needs (i.e., Emotional Deprivation schema); having a defect (i.e., Defectiveness/Shame schema); and because of all of these deprivations, feelings of being different from others (i.e., Social Isolation schema). Moreover, child abuse/neglect and Impaired Autonomy/Other Directedness (IAOD) schema domains were also found to be correlated. This finding is consistent with the suggestion of Schema Theory that traumatized or victimized children will develop schemas related to vulnerability such as Vulnerability to Harm, Dependency/Incompetence, Enmeshment schemas, and excessive compliance such as Self-Sacrifice, Subjugation (Young et al., 2003). Lastly, child abuse/neglect was also found to be positively correlated with anxiety scores. This finding is consistent with the literature.

Besides, the relationship between five subtypes of child abuse/neglect and other measures of the study was examined, and it was seen that emotional abuse was positively related with DR and IAOD schema domains and depression symptomatology. In particular, it was found that experiences of emotional maltreatment were related with schemas within the Disconnection/Rejection and Impaired Autonomy domains. (Calvete, & Orue, 2013). This finding is also consistent with the findings of Johnson et al. (2000) that child emotional abuse is related with increased depression severity. Emotional neglect was also found to be positively associated with Disconnection/ Rejection schema domain and depression symptomatology. Young (1994) suggested that parental neglect often causes development of schemas with themes of worthlessness and loss such as Social Isolation and Emotional Deprivation, which belong to DR schema domain. Moreover, it was consistent with the findings of Johnson et al. (2000) that child

emotional neglect was related with increased symptoms of depression. When these findings are brought together, they are in line with each other.

Correlation analysis regarding the relationship between two schema coping processes showed that Schema Avoidance and Schema Compensation were positively related. Moreover, both Schema Avoidance and Compensation were found to be correlated with Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other Directedness schema domains. Thus, all maladaptive coping styles serve as elements in the schema perpetuation process, and it is expected to be correlated with each other (Young et al., 2003). These results may also suggest that maladaptive schemas and schema coping strategies are developed from the same origin so this needs further investigation.

The relationship between schema domains and measures of psychopathological symptomatology was examined and Impaired Limits/Exaggerated Standards, Disconnection/Rejection and Impaired Autonomy/Other Directedness domains were found positively correlated with depression symptomatology, anxiety symptomatology, and perceived stress. Taken together, studies concerning schema domains and psychopathological symptomatology found that a wide range of EMSs to be related to depression, anxiety and stress (Wright et al., 2009), and the current study supported these findings.

Moreover, achievement related and social life events were found to be positively associated with Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy/Other Directedness schema domains. Achievement related and social life events were also seen as correlated with anxiety symptomatology, depression symptomatology and perceived stress. Zhou and Zhang (2014) claimed that depressed and anxious individuals reported more stressful life events than normal controls. It may be proposed that maltreatment history may more strongly sensitize individuals to the activation of schemas when faced with stressful situations and so they may become more prone to depressogenic and anxiety related effects of stressful life events by the activation of these maladaptive schemas.

Lastly, intercorrelations between the measures of psychopathological symptomatology were examined and it was found that depression, anxiety and perceived stress were all positively correlated with each other. Subjective perception of stress has been linked to a wide array of psychopathology, including depression (e.g. Hewitt, Flett, & Mosher, 1992), social anxiety (e.g. Cohen, Kamarck, & Mermelstein, 1983) (as cited in Bardeen, Fergus, & Orcutt, 2013). Furthermore, the correlation between anxiety and depression is not surprising because anxiety disorders and depressive disorders were found to be the most prevalent comorbid disorders (e.g., Brown et al., 2001; Brown & Barlow, 1995) (as cited in Sevink et al, 2012).

4.3. Findings Related to Regression Analyses

In order to determine factors associated with the measures of the current study, three different sets of hierarchical regression analyses were conducted with schema domains, schema coping processes, and psychopathological symptomatology as the dependent variables.

4.3.1. Findings Related to the Factors Associated with Schema Domains

Associated factors of schema domains were determined through the three hierarchical regression analysis with demographic variables, life events, child abuse/neglect as three consecutive steps.

According to the results of these hierarchical regression analyses, gender was found to be associated with Disconnection/Rejection (DR) domain, income was found to be associated with DR and Impaired Autonomy/Other Directedness (IAOD), social life events was found to be associated with DR, whereas both social and achievement related life events was found to be associated with Impaired Limits/Exaggerated Standards (ILES) and IAOD schema domains. The relationships between these two demographic variables, life events and schema domains were already discussed above.

After controlling for the effects of these control variables, it was revealed that emotional abuse was associated with ILES schema domains, and explained greatest variance on this schema domain. Sexual abuse also had a significant effect on the formation of schemas on ILES schema domain. It was an expected result because unrelenting standards schema which belongs to this domain is described as striving to meet very high internalized standards in order to avoid disapproval or shame. A child who was disapproved by caregiver may also experience fear of disapproval from others so compensate for this fear by setting higher standards for her/him. Similarly, punitiveness schema is described as a belief that they should be punished for their mistakes and the sexual assault by a significant person might be a reason in the development of this belief. However, for schemas related to impaired limits, this results was unexpected because typical families of these people are expected to be overly permissive and indulgent (Young et al., 2003).

Moreover, emotional abuse, emotional neglect and sexual abuse were found to be associated with DR schema domain. It was suggested that individuals who recalled their parents as uncaring had higher levels of dysfunctioning in the DR schema domain, implying that such individuals are more likely to have cognitive styles characterized by abandonment, mistrust, defectiveness, deprivation, and social isolation (McGinn et al., 2005). Physical abuse and sexual abuse were also found to be associated with IAOD schema domain, but physical abuse explained greater amount of variance. In other words, abuse causes harm to individual's autonomy. Moreover, it was an expected finding that physical and sexual abuses predicted other directedness because children who were not allowed to be spontaneous and repressed by others tend to develop schemas related to other directedness (Young et al., 2003).

4.3.2. Finding Related to the Factors Associated with Schema Coping Processes

Associated factors of schema coping processes were determined through two hierarchical regression analysis with demographic variables, life events, child abuse/neglect, and schema domains as four consecutive steps.

According to the results of the hierarchical regression analyses; first of all, income was found to be negatively associated with schema avoidance. Therefore, individuals

who have lower income levels tended to utilize avoidance when coping with their schemas. Moreover, both social and achievement related life events were found to be related with avoidance. It can be concluded that with increasing stress, attempts to cope with schema decrease, and avoidance is preferred in order to prevent more stress. After controlling for these variables, Disconnection/Rejection (DR) schema domain and schema avoidance was found to be associated. Avoidance may be characterized by some degree of denial, and shift of attention, which might have been easier to utilize for those who had strong schemas under the domain of DR.

On the other hand, age was negatively associated with schema compensation. Therefore, individuals who were younger tended to utilize compensation when coping with their schemas. Moreover, both social and achievement related life events were found as related with compensation. It can be concluded that with increasing stress, compensation is preferred as a coping strategy. Furthermore, Impaired Limits/Exaggerated Standards (ILES), and Impaired Autonomy/Other Directedness (IAOD) schema domains were found to be associated with schema compensation. However, ILES schema domain had a greater effect on schema compensation. Under ILES domain, schemas are related to high standards and it is expected that those who show the characteristics of these schemas try to overcompensate their schemas in order to access their own high standards. However, schemas under IAOD domain are mostly related with dependency, failure to function independently so these individuals may be expected to use avoidance.

4.3.3. Findings Related to the Factors Associated with Psychopathological Symptomatology

Associated factors of psychopathology (i.e., depression, anxiety and perceived stress) were determined through three hierarchical regression analyses with demographic variables, life events, child abuse/neglect, schema domains, and schema coping processes being the five consecutive steps.

According to the results of these analyses; first of all, income level was found to be associated with depression symptomatology and perceived stress. Gender and sibling number were also found to be associated with level of perceived stress. Moreover,

both social and achievement related life events were associated with all measures of psychological symptomatology. These associations were already discussed above.

After controlling for these control variables, with regards to associations between child abuse/neglect and psychopathological symptomatology, emotional neglect was found to be associated with depression symptomatology and level of perceived stress. Sexual abuse was also found to be associated with depression. Results also yielded significant associations between schema domains and psychopathological symptomatology. Firstly, Schema domains of Disconnection/Rejection (DR) and Impaired Autonomy/Other Directedness (IAOD) were found to be associated with depression symptomatology. Secondly, IAOD schema domain was found to be associated with anxiety symptomatology. Lastly, it was found that Impaired Limits/Exaggerated Standards (ILES) schema domain was associated with perceived stress. Significant associations between psychopathological symptomatology and schema domains were consistent with cognitive conceptualization of psychopathology, which suggests the crucial role of core beliefs in etiology of psychopathology (Wright et al., 2009). Moreover, it was claimed that maladaptive schemas are originated from adverse childhood environment; hence, it can be concluded that childhood maltreatment leads to psychological problems at adulthood, and this association is strengthened by early maladaptive schemas. This finding was also consistent with findings of Sarıtaş and Gençöz (in press) that DR and IAOD was found as to be associated with depresion while IAOD was found to be associated with anxiety.

Moreover, there were significant associations between schema coping processes and psychopathological symptomatology. Firstly, schema avoidance was found to be positively associated with anxiety symptoms whereas negatively with perceived stress. While strees is a more situation oriented mood state, anxiety is more future oriented so when individuals avoid stituations where schema could be activated, they might percieve less stress. However, avoiding a situation does not eliminate the risk of schema activation so experince of problems in the future at all, so might result in increased anxiety for individual. Furthermore, schema compensation was negatively associated with depressive symptoms. This findings is consistent with the general appereance of schema compensatiın as healtier way of coping. When they try to

compensate their schemas; in fact, individuals try to think, feel and behave as oppose to their schemas. This might cause that they experince less negative emotions which could be the results of schema activation, so could experience less depressive symptoms. Overall, these results supported the notion that individuals' way of coping with their schemas also has an effect on psychological problems yielded by EMSs (Karaosmanoğlu, Soygüt, & Kabul, 2013).

4.4. Limitations of the Study

First of all, a university sample was used in the current study, which may leads to problems when generalizing results to normal population. Moreover, gender distribution of the sample was unequal that may leads to problem related to evaluation of gender differences on the measures of the study. Another limitation of the current study is its cross-sectional nature. Thus, it is not possible to draw cause-effect relationship and observe the changes on measures in a time course.

Furthermore, in the current study, all measures relied on self-reports of the participants. Especially, the measurement of the child abuse/neglect was based on recollections and perceptions of participants so this may cause a bias in the results. Therefore, a longitudinal design may be more useful for accurately detecting effects of child abuse/neglect on psychopathology. Moreover, latent schemas might not be detected by self-reports of the participants due to the fact that latent schemas might be masked by avoidance and overcompensation (Young et al., 2003). Hence, other data collection techniques, such as interviews can be preferred for more accurate results related to schemas.

Moreover, target population of the current study was a non-clinical sample. It was claimed that schema domains might not discriminate various forms of pathologies in a non-clinical sample. Moreover, this might lead to low scores on the child abuse/neglect measure. Hence, it would be useful to compare findings from a non-clinical sample with a clinical group.

Another limitation of the present study was related to employed measures. Especially, Beck Anxiety Inventory (BAI) measures somatic symptoms of anxiety,

this may lead to problems related to fully capturing of anxiety (McGinn et al., 2005). Therefore, it might be useful to use another anxiety measures such as State Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970). Moreover, Perceived Stress Scale (PSS) showed low reliability in the current study; hence, findings related to perceived stress should be considered by caution.

Lastly, in the current study, only associated factors of the measures were examined. However, for more explanatory results meditational analyses may also be conducted.

4.5. Strengths of the Study

The main strength of this study is that other possible stressor in the current lives of the participants that may also have an effect were taken into account and controlled when investigating associated factors of psychopathology, early maladaptive schemas and schema coping processes.

Moreover, despite increasing number of studies about EMSs, the role of schema coping processes has been neglected and it is essential to highlight maladaptive schema coping processes for a better understanding of psychopathology (Karaosmanoğlu, Soygüt, & Kabul, 2013). Therefore, to the best knowledge of the author, current study is one of the few studies examining the associated factors of psychopathological symptomatology, along with schema coping processes.

4.6. Clinical Implications and Future Directions

First of all, in Schema Therapy covering of childhood experiences which are strongly related to schema development and psychological distress has a great importance (Young et al., 2003). Preliminary studies with adults have provided empirical support for the relation of Young's EMSs to psychopathology and to childhood adversity (Lumley & Harkness, 2007). Similarly, the results of the current study consistently revealed and supported that EMSs play a crucial role on the relationship between childhood adversity and psychopathological symptomatology. Hence, prevention studies related to child abuse/neglect and education of public about the negative

impacts of childhood maltreatment gain importance for prevention of psychological problems.

However, despite increasing number of studies about EMSs, the role of schema coping processes has been neglected and it is essential to highlight maladaptive schema coping processes for a better understanding of psychopathology (Karaosmanoğlu, Soygüt, & Kabul, 2013). Therefore, the current study provided support related to role of schema coping processes on psychopathology. This knowledge is important for clinicians, who might also take schema coping strategies of the individuals into account when dealing with early maladaptive schemas. Because they might exaggrete or mask the impact of schemas on the individual, identification of them and encouragament of more adaptive coping by the clinicians could ease the therapy process.

Overall, as for clinical implications, the findings of the study suggest that; firstly, when dealing with depressive patients clinicians might pay specific attention to schemas belong to Disconnection/Rejection and Impaired Autonomy/Other Directedness schema domains, and when doing so should be careful against the probability that utilization of compensation could mask the severity of depressive symptoms. Moreover, histories of emotional neglect and sexual abuse should be taken into account. Secondly, in the treatment of anxiety patients, clinicians fasten on schemas from Impaired Autonomy/Other Directedness domain might as well as utilization of schema coping strategies due to fact that schema avoidance could increase the severity of anxiety symptoms. Lastly, when evaluating perceived level of stress clinicians could take note of the history of emotional neglect, the characteristics of schemas from Impaired Limits/Exxagerated Standards, and schema avoidance.

As suggestions for future researchers; first of all, in addition the crucial role of early maladaptive schemas the effect of schema coping processes can be investigated more systematically. Furthermore, results from a clinical sample and a non-clinical sample should be compared to get more accurate results. Longitidunal studies should be conducted for a more clear understanding the relationship between childhood maltreatment, EMSs and psychopathologies. Finally, younger participants should be

included in order to be able to detect and intervene in schemas before they become stable. In fact, different data collections techniques such as interviews may also be used in order to eliminate limitations related to self-report.

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APPENDICES

Appendix A: Informed Consent Form

Gönülü Katılım Formu

Bu çalışma, Orta Doğu Teknik Üniversitesi Psikoloji Bölümü, Klinik Psikoloji Yüksek Lisans öğrencisi Elif Ünal tarafından, Psikoloji Bölümü öğretim üyelerinden Prof. Dr. Tülin Gençöz'ün süpervizyonunda, tez çalışması kapsamında yürütülmektedir. Çalışmanın amacı çeşitli çocukluk deneyimlerinin psikolojik stres üzerine etkisi ve bu ilişkili üzerinde etkisi olan diğer değişkenleri belirlemektir.

Çalışmaya katılım tamimiyle gönüllülük temelindedir. Ankette, sizden kimlik belirleyici hiçbir bilgi istenmemektedir. Cevaplarınız tamimiyle gizli tutulacak ve sadece araştırmacı tarafından değerlendirilecektir; elde edilecek bilgiler bilimsel yayımlarda kullanılacaktır.

Anket, genel olarak kişisel rahatsızlık verecek soruları içermemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz cevaplama işini yarıda bırakıp çıkabilirsiniz. Böyle bir durumda anketi uygulayan kişiye, anketi tamamlamadığınızı söylemek yeterli olacaktır. Anket sonunda, bu çalışmayla ilgili sorularınız cevaplanacaktır. Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz. Çalışma hakkında daha fazla bilgi almak için Psikoloji Bölümü araştırma görevlisi ve çalışmanın yürütücüsü Elif Ünal (Oda: B203-B Tel: 210 5962; E-posta: e160596@metu.edu.tr) ile iletişim kurabilirsiniz.

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 Soyad Tarih İmza Sınıf / No

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Appendix B: Demographic Information Form

Lütfen aşağıda istenilen bilgileri yazınız ve seçenekli sorularda size uygun olan seçeneğin yanındaki ( ) ile gösterilen alana X işareti koyarak belirtiniz.

1. *Cinsiyetiniz:* ( ) Kadın ( ) Erkek

2. *Yaşınız:* ……

3. *Eğitim Durumunuz:*

( ) Okur-yazar değil ( ) Okur-yazar ( ) İlkokul mezunu ( ) Ortaokul mezunu

( ) Lise mezunu ( ) Üniversite mezunu ( ) Yüksek Lisans mezunu ( )Doktora mezunu

4. *Annenizin eğitim durumu:*

( ) Okur-yazar değil ( ) Okur-yazar ( ) İlkokul mezunu ( ) Ortaokul mezunu

( ) Lise mezunu ( ) Üniversite mezunu ( ) Yüksek Lisans mezunu ( )Doktora mezunu

5. *Babanızın eğitim durumu:*

( ) Okur-yazar değil ( ) Okur-yazar ( ) İlkokul mezunu ( ) Ortaokul mezunu

( ) Lise mezunu ( ) Üniversite mezunu ( ) Yüksek Lisans mezunu ( )Doktora mezunu

6. *Yaşamınızın büyük kısmını geçirdiğiniz yer aşağıdakilerden hangisidir?*

( ) Köy ( ) İlçe ( ) Şehir ( ) Büyükşehir

7. *Şu an nerede yaşıyorsunuz?*

( ) Ailemle/akrabalarımla birlikte

( ) Yurtta

( ) Arkadaşlarımla evde

( ) Tek başıma evde

( ) Diğer ……

8. *Mesleğiniz:*

( ) Özel sektör ( ) Serbest meslek ( ) Öğrenci

( ) Devlet memuru ( ) Çalışmıyor

9. *Ortalama aylık geliriniz ne kadardır?*

( ) 1000 liradan az

( ) 1000-2999 lira arası

( ) 3000-4999 lira arası

( ) 5000 liradan fazla

10. *Kaç kardeşsiniz? (Kendiniz dahil)*……..

11. *Kaçıncı çocuksunuz?* ……...

12. *Üvey ebeveyniniz (anne ya da baba) var mıydı?*

( ) Evet ( ) Hayır

13. *Cevabınız evetse hangi ebeveyninizin üvey olduğunu belirtiniz.*

( ) Anne ( ) Baba

14. *Cevabınız evetse, üvey ebeveyninizle birlikte yaşadınız mı?*

( ) Evet ( ) Hayır

15. *Çocukken barınma (rahat bir biçimde bir evde yaşayabilme) açısından sıkıntınız oldu mu?*

( ) Hiç olmadı ( ) Biraz oldu ( ) Orta düzeyde oldu ( ) Çok sık oldu

16. *Daha önce psikolojik ve/veya psikiyatrik tedavi aldınız mı?*

( ) Evet ( ) Hayır

17. *Daha önce psikolojik ve/veya psikiyatrik tedavi aldıysanız, ne tür tedavi/tedaviler aldınız? (Daha önce psikolojik ve/veya psikiyatrik tedavi almadıysanız bu soruyu boş bırakınız)*

( ) Bireysel Psikoterapi

( ) Grup Psikoterapisi

( ) İlaç Tedavisi

( ) Diğer (lütfen belirtiniz):.....

Appendix C: Childhood Trauma Questionnaire (CTQ)

Bu sorular *çocukluğunuzda ve ilk gençliğinizde (20 yaşından önce)* başınıza gelmiş olabilecek bazı olaylar hakkındadır. Her bir soru için sizin durumunuza uyan rakamı daire içerisine alarak işaretleyiniz. Sorulardan bazıları özel yaşamınızla ilgilidir; lütfen elinizden geldiğince gerçeğe uygun yanıt veriniz.

Yanıtlarınız gizli tutulacaktır.

Çocukluğumda ya da ilk gençliğimde…

	1.Hiçbir Zaman	2.Nadir en	3.Kimi Zaman	4. Sık Olarak	5.Cok Sık
1.Evde yeterli yemek olmadığından aç kalırdım.	1	2	3	4	5
2.Benim bakımımı ve güvenliğimi üstlenen birinin olduğunu biliyordum	1	2	3	4	5
3. Ailemdekiler bana “salak”, “beceriksiz” ya da “tipsiz” gibi sıfatlarla seslenirlerdi	1	2	3	4	5
4. Anne ve babam ailelerine bakamayacak kadar sıklıkla sarhoş olur ya da uyuşturucu alırlardı.	1	2	3	4	5
5. Ailemde önemli ve özel biri olduğum duygusunu hissetmeme yardımcı olan biri vardı.	1	2	3	4	5
6. Yırtık, sökük ya da kirli giysiler içerisinde dolaşmak zorunda kalırdım.	1	2	3	4	5
7. Sevildiğimi hissediyordum	1	2	3	4	5
8. Anne ve babamın benim doğmuş olmamı istemediklerini düşünüyordum.	1	2	3	4	5
9. Ailemden birisi bana öyle kötü vurmuştu ki doktora ya da hastaneye gitmem gerekmişti.	1	2	3	4	5
10. Ailemde başka türlü olmasını istediğim bir şey yoktu.	1	2	3	4	5
11. Ailemdekiler bana o kadar şiddetle vuruyorlardı ki vücudumda morartı ya da sıyrıklar oluyordu	1	2	3	4	5
12. Kayış, sopa, kordon ya da başka sert bir cisimle vurularak cezalandırılıyordum.	1	2	3	4	5
13. Ailemdekiler birbirlerine ilgi gösterirlerdi.	1	2	3	4	5

14. Ailemdekiler bana kırıcı ya da saldırganca sözler söylerlerdi	1	2	3	4	5
15. Vücutça kötüye kullanılmış olduğuma (dövülme, itilip kakılma vb.) inanıyorum	1	2	3	4	5
16. Çocukluğum mükemmeldi.	1	2	3	4	5
17. Bana o kadar kötü vuruluyor ya da dövülüyordum ki öğretmen, komşu ya da bir doktorun bunu fark ettiği oluyordu.	1	2	3	4	5
18. Ailemde birisi benden nefret ederdi.	1	2	3	4	5
19. Ailemdekiler kendilerini birbirlerine yakın hissederlerdi.	1	2	3	4	5
20. Birisi bana cinsel amaçla dokundu ya da kendisine dokunmamı istedi.	1	2	3	4	5
21. Kendisi ile cinsel temas kurmadığım takdirde beni yaralamakla ya da benim hakkımda yalanlar söylemekle tehdit eden birisi vardı.	1	2	3	4	5
22. Benim ailem dünyanın en iyisiydi.	1	2	3	4	5
23. Birisi beni cinsel şeyler yapmaya ya da cinsel şeylere bakmaya zorladı.	1	2	3	4	5
24. Birisi bana cinsel tacizde bulundu.	1	2	3	4	5
25. Duygusal bakımdan kötüye kullanılmış olduğuma (hakaret, aşağılama vb.) inanıyorum.	1	2	3	4	5
26. İhtiyacım olduğunda beni doktora götürecek birisi vardı	1	2	3	4	5
27.Cinsel bakımdan kötüye kullanılmış olduğuma inanıyorum.	1	2	3	4	5
28. Ailem benim için bir güç ve destek kaynağı idi.	1	2	3	4	5

Appendix D: Young Schema Questionnaire- Short Form (YSQ-SF)

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.

Bir kaç 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.

Derecelendirme:

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 hakederim.
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. _____ Ortaya çıkan gündelik sorunları çözebilme konusunda kendime güvenmiyorum.
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: Young Compensation Inventory (YCI)

Aşağıda kişilerin kendilerini tanımlarken kullandıkları ifadeler sıralanmıştır. Lütfen her bir ifadeyi okuyun ve sizi ne kadar iyi tanımladığına karar verin. Daha sonra 1 den 6 ya kadar olan seçeneklerden sizi tanımlayan en yüksek dereceyi 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. ___ Beni üzen konular hakkında düşünmemeye çalışırım.
2. ___ Sakinleşmek için alkol alırım.
3. ___ Çoğu zaman mutluyumdur.
4. ___ Çok nadiren üzgün veya hüzünlü hissederim.
5. ___ Aklı duygulara üstün tutarım.
6. ___ Hoşlanmadığım insanlara bile kızmamam gerektiğine inanırım.
7. ___ İyi hissetmek için uyuşturucu kullanırım.
8. ___ Çocukluğumu hatırladığımda pek bir şey hissetmem.
9. ___ Sıkıldığımda sigara içerim.
10. ___ Sindirim sistemim ile ilgili şikayetlerim var (Örn: hazımsızlık, ülser, bağırsak bozulması).
11. ___ Kendimi uyuşmuş hissederim.
12. ___ Sık sık baş başım ağrır.
13. ___ Kızgınken insanlardan uzak dururum.
14. ___ Yaşıtlarım kadar enerjim yok.
15. ___ Kas ağrısı şikayetlerim var.
16. ___ Yalnızken oldukça fazla TV seyrederim.
17. ___ İnsanın duygularını kontrol altında tutmak için aklını kullanması gerektiğine inanırım.
18. ___ Hiç kimseden aşırı nefret edemem.

19. ___ Bir şeyler ters gittiğindeki felsefem, olanları bir an önce geride bırakıp yola devam etmektir.
20. ___ Kırıldığım zaman insanların yanından uzaklaşırım.
21. ___ Çocukluk yıllarımı pek hatırlamam.
22. ___ Gün içinde sık sık şekerleme yaparım veya uyurum.
23. ___ Dolaşırken veya yolculuk yaparken çok mutlu olurum.
24. ___ Kendimi önümdeki işe vererek sıkıntı hissetmekten kurtulurum.
25. ___ Zamanımın çoğunu hayal kurarak geçiririm.
26. ___ Sıkıntılı olduğumda iyi hissetmek için bir şeyler yerim.
27. ___ Geçmişimle ilgili sıkıntılı anıları düşünmemeye çalışırım.
28. ___ Kendimi sürekli bir şeylerle meşgul edip düşünmeye zaman ayırmazsam daha iyi hissederim.
29. ___ Çok mutlu bir çocukluğum oldu.
30. ___ Üzgünken insanlardan uzak dururum.
31. ___ İnsanlar kafamı sürekli kuma gömdüğümü söylerler;başka bir deyişle, hoş olmayan düşünceleri görmezden gelirim.
32. ___ Hayal kırıklıkları ve kayıplar üzerine fazla düşünmemeye eğilimliyim.
33. ___ Çoğu zaman, içinde bulunduğum durum güçlü duygular hissetmemi gerektirse de bir şey hissetmem.
34. ___ Böylesine iyi ana-babam olduğu için çok şanslıyım.
35. ___ Çoğu zaman duygusal olarak tarafsız/ nötr kalmaya çalışırım.
36. ___ İyi hissetmek için, kendimi ihtiyacım olmayan şeyler alırken bulurum.
37. ___ Beni zorlayacak veya rahatımı kaçıracak durumlara girmemeye çalışırım.
38. ___ İşler benim için iyi gitmiyorsa hastalanırım.
39. ___ İnsanlar beni terk ederse veya ölürse çok fazla üzülmem.
40. ___ Başkalarının benim hakkımda ne düşündükleri beni ilgilendirmez.
41. ___ Standartlarımı korumak ve sorumluluklarımı yerine getirmek için kendimi yoğun bir baskı altında hissederim.
42. ___ Kendimi ifade ederken sıklıkla patavatsız veya duyarsızımdır.
43. ___ Hep iyimser olmaya çalışırım; olumsuzluklara odaklanmama izin vermem.

44. ___ Ne hissettiğime aldırmadan çevremdekilere güler yüz göstermem gerektiğine inanırım.
45. ___ Başkaları benden daha başarılı veya daha fazla ilgi odağı olduğunda kıskanırım veya kötü hissederim.
46. ___ Hakkım olanı aldığımdan ve aldatılmadığımdan emin olmak için çok ileri gidebilirim.
47. ___ İnsanları gerektiğinde şaşırtıp alt edebilmek için yollar ararım, dolayısı ile benden faydalanamazlar veya bana kötülük yapamazlar.
48. ___ İnsanların benden hoşlanması için nasıl davranacağımı veya ne söyleyeceğimi bilirim.

Appendix F: Young- Rygh Avoidance Inventory

Aşağıda kişilerin kendilerini tanımlarken kullandıkları ifadeler sıralanmıştır. Lütfen her bir ifadeyi okuyun ve sizi ne kadar iyi tanımladığına karar verin. Daha sonra 1 den 6 ya kadar olan seçeneklerden sizi tanımlayan en yüksek dereceyi 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. ___ Beni üzen konular hakkında düşünmemeye çalışırım.
2. ___ Sakinleşmek için alkol alırım.
3. ___ Çoğu zaman mutluyumdur.
4. ___ Çok nadiren üzgün veya hüzünlü hissederim.
5. ___ Aklı duygulara üstün tutarım.
6. ___ Hoşlanmadığım insanlara bile kızmamam gerektiğine inanırım.
7. ___ İyi hissetmek için uyuşturucu kullanırım.
8. ___ Çocukluğumu hatırladığımda pek bir şey hissetmem.
9. ___ Sıkıldığımda sigara içerim.
10. ___ Sindirim sistemim ile ilgili şikayetlerim var (Örn: hazımsızlık, ülser, bağırsak bozulması).
11. ___ Kendimi uyuşmuş hissederim.
12. ___ Sık sık baş başım ağrır.
13. ___ Kızgınken insanlardan uzak dururum.
14. ___ Yaşıtlarım kadar enerjim yok.
15. ___ Kas ağrısı şikayetlerim var.
16. ___ Yalnızken oldukça fazla TV seyrederim.

17. ___ İnsanın duygularını kontrol altında tutmak için aklını kullanması gerektiğine inanırım.
18. ___ Hiç kimseden aşırı nefret edemem.
19. ___ Bir şeyler ters gittiğindeki felsefem, olanları bir an önce geride bırakıp yola devam etmektir.
20. ___ Kırıldığım zaman insanların yanından uzaklaşırım.
21. ___ Çocukluk yıllarımı pek hatırlamam.
22. ___ Gün içinde sık sık şekerleme yaparım veya uyurum.
23. ___ Dolaşırken veya yolculuk yaparken çok mutlu olurum.
24. ___ Kendimi önümdeki işe vererek sıkıntı hissetmekten kurtulurum.
25. ___ Zamanımın çoğunu hayal kurarak geçiririm.
26. ___ Sıkıntılı olduğumda iyi hissetmek için bir şeyler yerim.
27. ___ Geçmişimle ilgili sıkıntılı anıları düşünmemeye çalışırım.
28. ___ Kendimi sürekli bir şeylerle meşgul edip düşünmeye zaman ayırmazsam daha iyi hissederim.
29. ___ Çok mutlu bir çocukluğum oldu.
30. ___ Üzgünken insanlardan uzak dururum.
31. ___ İnsanlar kafamı sürekli kuma gömdüğümü söylerler;başka bir deyişle, hoş olmayan düşünceleri görmezden gelirim.
32. ___ Hayal kırıklıkları ve kayıplar üzerine fazla düşünmemeye eğilimliyim.
33. ___ Çoğu zaman, içinde bulunduğum durum güçlü duygular hissetmemi gerektirse de bir şey hissetmem.
34. ___ Böylesine iyi ana-babam olduğu için çok şanslıyım.
35. ___ Çoğu zaman duygusal olarak tarafsız/ nötr kalmaya çalışırım.
36. ___ İyi hissetmek için, kendimi ihtiyacım olmayan şeyler alırken bulurum.
37. ___ Beni zorlayacak veya rahatımı kaçıracak durumlara girmemeye çalışırım.
38. ___ İşler benim için iyi gitmiyorsa hastalanırım.
39. ___ İnsanlar beni terk ederse veya ölürse çok fazla üzülmem.
40. ___ Başkalarının benim hakkımda ne düşündükleri beni ilgilendirmez.

Appendix G: Beck Depression Inventory (BDI)

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 (şu an dâhil) kendi durumunuzu göz önünde bulundurarak, size en uygun ifadenin ***yanındaki harfin üzerine (X) işareti koyunuz***.

1. (a) Üzgün ve sıkıntılı değilim.
   (b) Kendimi üzüntülü ve sıkıntılı hissediyorum.
   (c) Hep üzüntülü ve sıkıntılıyım. Bundan kurtulamıyorum.
   (d) O kadar üzgün ve sıkıntılıyım ki, artık dayanamıyorum.
2. (a) Gelecek hakkında umutsuz ve karamsar değilim.
   (b) Gelecek için karamsarım.
   (c) Gelecekten beklediğim hiçbir şey yok.
   (d) Gelecek hakkında umutsuzum ve sanki hiçbir şey düzelmeyecekmiş gibi geliyor.
3. (a) Kendimi başarısız biri olarak görmüyorum.
   (b) Başkalarından daha başarısız olduğumu hissediyorum.
   (c) Geçmişe baktığımda başarısızlıklarla dolu olduğunu görüyorum.
   (d) Kendimi tümüyle başarısız bir insan olarak görüyorum.
4. (a) Her şeyden eskisi kadar zevk alıyorum.
   (b) Birçok şeyden eskiden olduğu gibi zevk alamıyorum.
   (c) Artık hiçbir şey bana tam anlamıyla zevk vermiyor.
   (d) Her şeyden sıkılıyorum.
5. (a) Kendimi herhangi bir biçimde suçlu hissetmiyorum.
   (b) Kendimi zaman zaman suçlu hissediyorum.
   (c) Çoğu zaman kendimi suçlu hissediyorum.
   (d) Kendimi her zaman suçlu hissediyorum.
6. (a) Kendimden memnunum.
   (b) Kendimden pek memnun değilim.
   (c) Kendime kızgınım.

(d) Kendimden nefret ediyorum.

7. (a) Başkalarından daha kötü olduğumu sanmıyorum.
   (b) Hatalarım ve zayıf taraflarım olduğunu düşünmüyorum.
   (c) Hatalarımdan dolayı kendimden utanıyorum.
   (d) Her şeyi yanlış yapıyormuşum gibi geliyor ve hep kendimi kabahat buluyorum.
8. (a) Kendimi öldürmek gibi düşüncülerim yok.
   (b) Kimi zaman kendimi öldürmeyi düşündüğüm oluyor ama yapmıyorum.
   (c) Kendimi öldürmek isterdim.
   (d) Fırsatını bulsam kendimi öldürürüm.
9. (a) İçimden ağlamak geldiği pek olmuyor.
   (b) Zaman zaman içimden ağlamak geliyor.
   (c) Çoğu zaman ağlıyorum.
   (d) Eskiden ağlayabilirdim ama şimdi istesem de ağlayamıyorum.
10. (a) Her zaman olduğumdan daha canı sıkkın ve sinirli değilim.
    (b) Eskisine oranla daha kolay canım sıkılıyor ve kızıyorum.
    (c) Her şey canımı sıkıyor ve kendimi hep sinirli hissediyorum.
    (d) Canımı sıkan şeylere bile artık kızamıyorum.
11. (0) Başkalarıyla görüşme, konuşma isteğimi kaybetmedim.
    (b) Eskisi kadar insanlarla birlikte olmak istemiyorum.
    (c) Birileriyle görüşüp konuşmak hiç içimden gelmiyor.
    (d) Artık çevremde hiç kimseyi istemiyorum.
12. (a) Karar verirken eskisinden fazla güçlük çekmiyorum.
    (b) Eskiden olduğu kadar kolay karar veremiyorum.
    (c) Eskiye kıyasla karar vermekte çok güçlük çekiyorum.
    (d) Artık hiçbir konuda karar veremiyorum.
13. (a) Her zamankinden farklı göründüğümü sanmıyorum.
    (b) Aynada kendime her zamankinden kötü görünüyorum.
    (c) Aynaya baktığımda kendimi yaşlanmış ve çirkinleşmiş buluyorum.
    (d) Kendimi çok çirkin buluyorum.
14. (a) Eskisi kadar iyi iş güç yapabiliyorum.
    (b) Her zaman yaptığım işler şimdi gözümde büyüyor.
    (c) Ufacık bir işi bile kendimi çok zorlayarak yapabiliyorum.
    (d) Artık hiçbir iş yapamıyorum.
15. (a) Uykum her zamanki gibi.

(b) Eskisi gibi uyuyamıyorum.

(c) 1-2 saat önce uyanıyorum ve kolay kolay uykuya dalamıyorum.

(d) Sabahları çok erken uyanıyorum ve bir daha uyuyamıyorum.

16. (a) Kendimi her zamankinden yorgun hissetmiyorum.

(b) Eskiye oranla daha çabuk yoruluyorum.

(c) Her şey beni yoruyor.

(d) Kendimi hiçbir şey yapamayacak kadar yorgun ve bitkin hissediyorum.

17. (a) İştahım her zamanki gibi.

(b) Eskisinden daha iştahsızım.

(c) İştahım çok azaldı.

(d) Hiçbir şey yiyemiyorum.

18. (a) Son zamanlarda zayıflamadım.

(b) Zayıflamaya çalışmadığım halde en az 2 Kg verdim.

(c) Zayıflamaya çalışmadığım halde en az 4 Kg verdim.

(d) Zayıflamaya çalışmadığım halde en az 6 Kg verdim.

19. (a) Sağlığımla ilgili kaygılarım yok.

(b) Ağrılar, mide sancıları, kabızlık gibi şikayetlerim oluyor ve bunlar beni tasalandırıyor.

(c) Sağlığımın bozulmasından çok kaygılanıyorum ve kafamı başka şeylere vermekte zorlanıyorum.

(d) Sağlık durumum kafama o kadar takılıyor ki, başka hiçbir şey düşünemiyorum.

20. (a) Sekse karşı ilgimde herhangi bir değişiklik yok.

(b) Eskisine oranla sekse ilgim az.

(c) Cinsel isteğim çok azaldı.

(d) Hiç cinsel istek duymuyorum.

21. (a) Cezalandırılması gereken şeyler yapığımı sanmıyorum.

(b) Yaptıklarımdan dolayı cezalandırılabileceğimi düşünüyorum.

(c) Cezamı çekmeyi bekliyorum.

(d) Sanki cezamı bulmuşum gibi geliyor.

Appendix H: Beck Anxiety Inventory

Aşağıda insanların kaygılı ya da endişeli oldukları zamanlarda yaşadıkları bazı belirtiler verilmiştir. Lütfen her maddeyi dikkatle okuyunuz. Daha sonra, her maddedeki belirtinin (bugün dâhil) son bir haftadır sizi ne kadar rahatsız ettiğini aşağıdaki ölçekten yararlanarak maddelerin yanındaki cevabı yuvarlak içine alarak belirleyiniz.

0. Hiç 1. Hafif derecede 2. Orta derecede 3. Ciddi derecede
Sizi ne kadar rahatsız etti?

1. Bedeninizin herhangi bir yerinde uyuma veya karıncalanma .....0.....1.....2.....3
2. Sıcak / ateş basmaları .....0.....1.....2.....3
3. Bacaklarda halsizlik, titreme.....0.....1.....2.....3
4. Gevşeyememe .....0.....1.....2.....3
5. Çok kötü şeyler olacak korkusu .....0.....1.....2.....3
6. Baş dönmesi veya sersemlik .....0.....1.....2.....3
7. Kalp çarpıntısı .....0.....1.....2.....3
8. Dengeyi kaybetme duygusu .....0.....1.....2.....3
9. Dehşete kapılma .....0.....1.....2.....3
10. Sinirlilik .....0.....1.....2.....3
11. Boğuluyormuş gibi olma duygusu .....0.....1.....2.....3
12. Ellerde titreme .....0.....1.....2.....3
13. Titreklik .....0.....1.....2.....3
14. Kontrolü kaybetme korkusu.....0.....1.....2.....3
15. Nefes almada güçlük .....0.....1.....2.....3
16. Ölüm korkusu.....0.....1.....2.....3
17. Korkuya kapılma .....0.....1.....2.....3
18. Midede hazımsızlık ya da rahatsızlık hissi .....0.....1.....2.....3
19. Baygınlık.....0.....1.....2.....3
20. Yüzün kızarması.....0.....1.....2.....3
21. Terleme (sıcağa bağlı olmayan) .....0.....1.....2.....3

Appendix I: Perceived Stress Scale (PSS-10)

Aşağıdaki sorular ***son bir ay içindeki*** düşünceleriniz ve duygularınızla ilgilidir. Her bir soruda sizden bu düşünceyi ya da duyguyu ne sıklıkta yaşadığınızı belirtmeniz istenmektedir. Bazı sorular birbirine benzer gibi görünse de aralarında farklılıklar vardır ve her soruyu ayrı bir soru olarak değerlendirmeniz gerekmektedir. Soruyu okuduktan sonra seçenekler arasında en uygun gördüğünüz seçeneği işaretlemeniz uygun olacaktır.

	HİÇ	**NEREDEYSE HİÇ**	**BAZEN**	**SIKÇA**	**ÇOK SIK**
1. Son bir ay içinde, beklenmedik şekilde gerçekleşen olaylardan dolayı ne sıklıkta üzüldünüz?					
2. Son bir ay içinde ne sıklıkta, yaşamınızdaki önemli şeyleri kontrol edemediğinizi hissettiniz?					
3. Son bir ay içinde kendinizi ne sıklıkta, gergin ve stresli hissettiniz?					
4. Son bir ay içinde ne sıklıkta, kişisel sorunlarınızla baş etme yeteneğinizden emin oldunuz?					
5. Son bir ay içinde ne sıklıkta, işlerin istediğiniz gibi gittiğini hissettiniz?					
6. Son bir ay içinde ne sıklıkta, yapmak zorunda olduğunuz her şeyin üstesinden gelemeyeceğinizi düşündünüz?					
7. Son bir ay içinde yaşamınızdaki rahatsız edici olayları ne sıklıkta kontrol edebildiniz?					
8. Son bir ay içinde ne sıklıkta, yaşamınızdaki olaylara hâkim olduğunuzu hissettiniz?					
9. Son bir ay içinde, kontrolünüz dışında gerçekleşen şeylerden dolayı ne sıklıkta öfkelendiniz?					
10. Zamanınızı nasıl geçirdiğinizi son bir ay içinde ne sıklıkta kontrol edebildiniz?					

Appendix J: Life Events Inventory

Aşağıda günlük yaşantınızda size sıkıntı verebilecek bazı olaylar ve sorunlardan bahsedilmektedir. Her maddeyi dikkatli bir şekilde okuyarak, ***son bir ay içerisinde*** bu olay ya da sorunun size ne yoğunlukta bir sıkıntı yaşattığını ve ne kadar sıklıkla böyle bir olay ya da sorunla karşılaştığınızı maddelerin karşılarında bulunan seçeneklerden uygun rakamları işaretleyerek belirtiniz.

	Bu sorun size ne yoğunlukta bir sıkıntı yaşattı veya yaşatmakta?				
	Hiç	Az	Orta	Fazla	Çok fazla
1. Genel sağlık problemleri	1	2	3	4	5
2. Kız/erkek arkadaşımla olan problemler	1	2	3	4	5
3. Barınma ile ilgili sorunlar	1	2	3	4	5
4. Ulaşım sorunu	1	2	3	4	5
5. Zamanın sıkışıklığı	1	2	3	4	5
6. Anne ve babamla aramızdaki çatışmalar	1	2	3	4	5
7. Gelecekle ilgili kaygılar	1	2	3	4	5
8. Arkadaş ilişkilerinde yaşanan sorunlar	1	2	3	4	5
9. Ülkedeki olumsuz siyasi gelişmeler	1	2	3	4	5
10. Sevdiğim insanlardan ayrı olmak (Aile, arkadaşlar vs.)	1	2	3	4	5
11. Çevresel koşullardan (Gürültü, havalar, kirlilik vs.) dolayı yaşanan sorunlar	1	2	3	4	5
12. Okula/işe uyum sağlayamamak	1	2	3	4	5
13. Maddi problemler	1	2	3	4	5
14. Sosyal faaliyetlere katılamamak (spor, sinemaya, tiyatroya gitmek vs.)	1	2	3	4	5

15. İnsanların birbirine karşı duyarsız olmaları	1	2	3	4	5
16. Yalnızlık kaygıları	1	2	3	4	5
17. Kişiliğimle ilgili kendimi sorgulamak	1	2	3	4	5
18. Yorgunluk	1	2	3	4	5
19. İçki, sigara ve benzeri alışkanlıkların verdiği rahatsızlıklar	1	2	3	4	5
20. Karar vermekte güçlük çekmek	1	2	3	4	5
21. Uykusuzluk	1	2	3	4	5
22. Beslenme problemi	1	2	3	4	5
23. Sorumluluklarımı yerine getirememek	1	2	3	4	5
24. Reddedilme korkusu	1	2	3	4	5
25. Fiziksel görünüşümle ilgili endişeler	1	2	3	4	5
26. Okulda/işte başarısız olmak	1	2	3	4	5
27. Aile üyelerinden birinin rahatsızlığı	1	2	3	4	5
28. Ödevler ya da projelerin verdiği rahatsızlıklar	1	2	3	4	5
29. Okulumdan/işimden memnun olmamak	1	2	3	4	5
30. Tüm ya da bazı konularda emeğimin karşılığını alamama	1	2	3	4	5
31. Yeterince ders çalışamamak	1	2	3	4	5
32. Sınavların sıkışıklığı, sınav kaygısı	1	2	3	4	5
33. Arkadaşlarımla aramızdaki sorunlar	1	2	3	4	5
34. Kardeşim/lerimle ilgili sorunlar	1	2	3	4	5
35. Zamanımı yeterince iyi değerlendirememek	1	2	3	4	5
36. Kendimi insanlara yeterince ifade edememek	1	2	3	4	5
37. Ailevi problemler	1	2	3	4	5

38. Çalıştığım işle ilgili sorunlar...	1	2	3	4	5
39. İş görüşmeleri ile ilgili kaygılar	1	2	3	4	5
40. Yayın organlarındaki kötü haberlerle ilişkili kaygılar	1	2	3	4	5
41. Başarılı olamama kaygısı	1	2	3	4	5
42. Hata yapma kaygısı	1	2	3	4	5
43. Eleştirilmekten duyduğum rahatsızlık	1	2	3	4	5
44. Tatmin edici ilişkiler kuramama / bulamama	1	2	3	4	5
45. Kız/erkek arkadaştan ayrılma	1	2	3	4	5
46. Ailemin beklentilerini yerine getirememe kaygısı	1	2	3	4	5
47. Yaşadığım yere uyum sağlayamamak	1	2	3	4	5

Appendix K: Ethics Committee Approval

Appendix L: Turkish Summary

1. GİRİŞ

Bu çalışma çocukluk dönemi istismarı/ihmali ve psikopatolojik semptomlar arasındaki ilişkileri, bunun yanısıra erken dönem uyumsuz şemalar ve şema baş etme biçimlerinin bu ilişkideki rollerini kişilerin hayatlarındaki diğer olası stres faktörlerini de kontrol ettikten sonra incelemek amacıyla yürütülmüştür.

1.1. Depresyon

Major depresyon Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, American Psychiartic Association (APA), 2000)' e göre kişi en az beş semptomu aynı iki haftalık süre içinde gösterirse major depresyon tanısı konur. Semptomlar depresif duygudurum; etkinliklere ilgide azalma, eskisi kadar zevk alamama; önemli derecede kilo kaybı ya da kilo alımı; uykusuzluk ya da aşırı uyuma; psikomotor ajitasyon ya da reterdasyon; yorgunluk, bitkinlik ve enerji kaybı; değersizlik, aşırı ya da uygun olmayan suçluluk duyguları; düşencesini yoğunlaştırmada azalma ya da kararsızlık ve yineleyen ölüm düşünceleri (intihara ilişkin)ni içermektedir. Ek olarak bu semptomlar madde kullanımına, genel tıbbi duruma ya da yasa bağlı oluşmuş olmamalıdır. Diğer yandan DSM-V (APA, 2013)'in kullanımı ile bu kriterlerden hiç biri değişmemiş sadece yasa bağlı oluşmama kriteri çıkarılmıştır. Literatürdeki araştırmalara göre depresyonun bir yıllık görülme sıklığı % 14'ür, ki bu depresyonu en sık rastlanan psikolojik bozukluklardan biri yapar (Wittchen, ve Jacobi, 2006). Benzer şekilde depresyon kişilerin hayat kalitelerini ve ,işlevsellikliklerini olumsuz yönde etkilediği bilinmektedir (Ekman, Granström, Omerov, Jacop ve Lande, 2013).

1.2. Anksiyete

Ankisiyete tanımlanırken korku ile farkı üzerinde durulmuştur. Korku gerçek bir tehlike karşısında verilen bir duygusal tepkiyken, anksiyete ise gerçeklikte var olan tehditler ile orantısız verilen duygusal tepkidir ve Barlow (2004) tarafından gelecek oriyantosyonlu bir duygudurum olarak tanımlanmıştır (Akt., in Craske, Rauch,

Ursano, Prenoveau, Pine ve Zinbarg, 2009). Yüksek seviyede anksiyete konsentrasyon ya da performansta bozukluklara, karamsar düşünce ve hislere ve kişinin dikkatinin kendisi odaklı olmasına neden olabilir (Oltmans ve Emery, 2010). Anksiyete bozuklukları tanısı ise birçok farklı semptoma bağlı olarak konur ve farklı alt tipler olarak sınıflandırılmıştır. DSM-IV-TR (APA, 2000)'e gore, bu alt tipler, panik bozukluk, üç tip fobik bozukluk, obsesif-kompulsif bozukluk, yaygın anksiyete bozukluğu, travma sonrası stress bozukluğu ve akut stress bozukluğunu içermektedir. DSM –V (APA, 2013)' teki anksiyete bozuklukları bölümü ise artık travma sonrası ve akut stress bozukluklarını kapsamamaktadır. Literatürdeki araştırmalara gore, anksiyete bozukluklarının görülme sıklığı % 28.8 dir ve bu oran anksiyete bozukluklarını en yaygın psikolojik bozukluklardan biri yapmakatadır (Kessler, 2005). Ayrıca, depresyonda da olduğu gibi anksiyete bozuklukları da kişinin hayat kalitesini ve işlevselliğini olumsuz yönde etkilemektedir (Altemus, Sarvaiya ve Epperson, 2014).

1.3. Şema Terapi ve Erken Dönem Uyumsuz Şemalar

Young ve arkadaşları (1990, 1999) tarafından geliştirilen Şema Terapi modeli psikopatolojinin kökenlerini erken dönem uyumsuz şemalar ile açıklamaktadır. Erken dönem uyum bozucu şemalar kişinin çocukluk ve ergenlik döneminde kendiliğe ve diğerlerine dair geliştirdiği, uzun vadede ise bireyin psikolojik uyumunu bozan genel yaygın bilişsel temalardır. Bununla birlikte bu şemalar sadece bilişsel düzeyde gelişmekle kalmayıp ; anılar, duygular ve bedensel duyumlardan da oluşur. Kişinin yaşamı boyunca gittikçe karmaşıklaşır ve önemli bir dereceye kadar işlev Bozucudur (Young, 1999; Young, Klosko ve Weishaar, 2003).Çocukluk ve ergenlik döneminde oluşan bu şemalar daha sonra yaşanan olaylarla tetiklenerek aktive olmakta ve kişinin davranışlarına yön vermektedir (Young et al., 2003).

1.3.1. Erken Dönem Uyumsuz Şemaların Gelişimi

Şema terapi çocukluk döneminde karşılanması gereken temel duygusal ihtiyaçlardan bahsetmektedir. Bu ihtiyaçlar diğerlerin güvenli bağlanma; otonomi, yeterlilik ve olumlu kimlik algısı; duygu ve ihtiyaçları ifade etme özgürlüğü; kendiliğindelik ve oyun; gerçekçi sınırlar ve özdenetim olarak tanımlanmıştır. Bu ihtiyaçların karşılanmaması, engellenmesi ya da aşırı karşılanması gibi durumlarda ise erken

dönem uyum bozucu şemaların geliştiği öne sürülmektedir. Travmatize edilme ya da kurbanlaştırılma, ihtiyaçların gerektiğinden fazla karşılanmaya çalışılması, aşırı korunma ve aşırı doyurulması ve seçici içselleştirme / önemli diğeriyle özdeşleşme de erken dönem şemaların gelişimi ile ilişkili bulunmuşlardır. Bunların yanı sıra duygusal mizaç ve çocukluk dönemi ortamı da şema gelişimi ile ilişkilidir.

1.3.2. Erken Dönem Şemalar ve Şema Alanları

Şema Terapi modelinde 18 erken dönem uyum bozucu şema tanımlanmış ve bu şemalar şema alanı olarak adlandırılan beş alana kategorize edilmiştir.

Bu alanlardan ilki Ayrılma ve Reddedilme Alanı'ndan şemalara sahip olan kişiler genellikle diğerlerine güvenli bağlanma konusunda sorun yaşarlar. Bu bireylerin genellikle istismarcı, tutarsız, reddedici, duygusal açıdan soğuk, dış dünyadan yalıtılmış aileleri olduğu belirtilmektedir. Bu şema alanında yer alan şemalar şunlardır: Terkedilme/İstikrarsızlık, Güvensizlik/Suistimal Edilme, Duygusal Yoksunluk, Kusurluluk/Utanç ve Sosyal İzolasyon/Yabancılaşma. Dört farklı şemayı içeren ikinci şema alanı Zedelenmiş Özerklik ve Performans Alanı'dır. Bu alandan şemalara sahip olan bireyler bağımsız olarak hareket edebilme konusunda sorun yaşarlar. Aşırı koruyucu, çocuğun bireyselleşme yönünde aie dışındaki davranışlarının pekiştirilmediği, her şeyin çocuğun yerine yapıldığı aile ortamları bu alandan şemaların gelişiminde etkili bulunmuştur. Bu alanda yer alan şemalar şunlardır: Bağımlılık/Yetersizlik, Hastalıklar-Tehditler Karşısında Dayanıksızlık, İç İçe Geçme/Gelişmemiş Benlik, Başarısızlık. Üçüncü şema alanı olan Zedelenmiş Sınırlar Alanı karşılıklılık ve öz disiplinle ilgili içsel sınırlardan yoksun olmakla ilgilidir. Bu alanda şemalar olanlar diğerlerinin haklarına saygı duymakta, işbirliği yapmakta, sözünde durmakta ya da uzun vadeli planlara uymakta zorluk çekerler. Ailesel kökeni incelendiğinde aşırı izin verici ve yönlendirici olmayan ebeveynlik tarzları ile karşılaşılmıştır. Bu alandaki şemalar ise şunlardır: Hak Görme/Büyüklük, Yetersiz Özdenetim. Kendi ihtiyaçları yerine diğer insanların ihtiyaçlarını karşılamak adına aşırı çaba harcayan bireylerin sahip olduğu şema alanı Öteki Yönelimlilik Alanı'dır. Bu kişiler aslında onaylanma ve bağ kurma ihtiyacındadırlar. Bu bireyler ebeveynlerin kendi duygusal ihtiyaçlarına ve sosyal görünümlerine odaklı olduğu ve çocukların şartlı kabul gördüğü aile ortamlarında yetişmişlerdir. Boyun Eğicilik,

Kendini Feda ve Onay Arayıcılık bu alandaki şemalardır. Karamsarlık, Duyguları Bastırma, Yüksek Standartlar/Aşırı Eleştiricilik ve Cezalandırılma şemalarını içeren beşinci ve son şema alanı ise Aşırı Tetikte Olma ve Bastırılmışlık Alanı'dır. Bu alandaki şemalar bireyin kendiliğinden duygu ve dürtüleri ifade etmeyip bastırmasına neden olur. Tipik olarak kuralcı ve sert olan, özdenetim ve özverinin kendiliğindenlik ve memnuniyetten üstün tutulduğu ebeveynlik çocuğun bu alandan şemalar geliştirmesine zemin hazırlar. Çocuğun oyun, haz ve mutluluğun peşinden gitmesi istenmez. Aksine olumsuzluklara karşı kontrollü ve tetikte olması öğretilir.

Bu şemaları ayırt edebilmek için Young 205 maddelik Young Şema Ölçeği (YSÖ) geliştirmiştir. Daha sonra Young ve Brown (1999) daha kısa bir versiyon olan 75 maddelik şema ölçeğini geliştirmişler. Bu ölçeklerin faktör yapılarının 15 şemayı kapsadığı ve benzer olduğu görülmüştür (Akt., Welburn ve ark., 2002). Ölçeğin üçüncü ve son versiyonu ise 90 maddeliktir ve 18 şemayı da kapsamaktadır. Ölçeğin Türkçe'ye uyarlama çalışması Soygüt, Karaosmanoğlu ve Çakır (2009) tarafındanyürütülmüş ve sonuçlar beş şema alanı altında sınıflandırılabilen 18 şema olduğunu göstermiştir. Ancak Sarıtaş ve Gençöz (2011)'ün çalışmasında bu 18 şemanın üç şema alanına kategorize edildiği görülmüştür. Bu şema alanları Zedelenmiş Sınırlar/Abartılı Standartlar (ZSAS) , Ayrılma/Reddedilme (AR)ve Zedelenmiş Özerklik/Öteki Yönelimlilik (ZÖÖY)tir. Bu çalışmada önerilen bu şema alanları kullanılmıştır.

1.3.3. Erken Dönem Uyumsuz Şemalar ve Psikopatoloji

Araştırmalar erken dönem uyumsuz şemaların depresif semptomlar ve anksiyete bozuklukları ile ilişkili olduğunu göstermektedir. Özellikle Zedelenmiş Özerklik/Performans, Zedelenmiş Sınırlar, ve AR şema alanlarının depresyon şiddeti ile ilişkili olduğu belirlenmiştir (Akt., Renner, Lobbestael, Peeters, Arntz ve Huibers, 2012). Anksiyete bozukluklarından Travma Sonrası Stress Bozukluğu Hastalıklar-Tehditler Karşısında Dayanıksızlık, Duyguları Bastırma Sosyal İzolasyon, Yetersiz Özdenetim, Güvensizlik/Suistimal Edilme, Terkedilme ve Karamsarlık şemaları ile ilişkili bulunurken (Cockram, Drummond ve Lee, 2010).; Sosyal Fobi Utanç, Güvensizlik/Suistimal Edilme, Kusurluluk ve Duygusal Yoksunluk şemaları ile ilişkili bulunmuştur (Pinto-Gouveia, Castillo and Galhardo, 2006).

1.4. Şema Baş Etme Biçimleri

Şema Terapi modeline göre şemanın kendisi ve şema baş etme stratejileri arasında farklar vardır. Şema anılar, duygular, bedensel duyular ve bilişleri içerirken, şema baş etme biçimleri bireyin şemaya yönelik davranışsal tepkilerini içerir. Her birey aynı şema ile farklı düzeylerde, ortamlarda ve zamanlarda farklı baş etme biçimlerini kullanabilir. Üç uyumsuz baş etme biçimi vardır, bunlar Şemaya Teslim Olma, Şema Kaçınması ve Şema Aşırı Telafisidir. Kişiler şemaya teslim olduklarında ona uyum sağlarlar, ondan kaçınmaya ya da onunla savaşmaya çalışmazlar ve şemanın doğru olduğunu kabul ederler. Diğer yandan baş etme biçimi olarak kaçınmayı kullandıklarında ise yaşantılarını şemanın hiç aktive olmayacağı şekilde düzenlemeye çalışırlar ve onun hakkında düşünmekten kaçınırlar. Son olarak bireyler aşırı telafide bulunurlarsa, şemanın zıttı doğruymuş gibi düşünerek, hissederek ve hareket ederek şema ile savaşırlar (Young ve ark., 2003).

Young ve ark. (2003) şema kaçınması ve aşırı telafisinin psikolojik problemlerin süregelmesine neden olduğunu öne sürmektedirler. Fakat şema kaçınması ve aşırı telafisinin psikopatolojisine ilişkin araştırma bulgularına çok nadir rastlanmaktadır (Spranger, Waller ve Bryant-Waugh, 2001). Bu nedenle şema baş etme biçimleri ve psikopatoloji ilişkisini anlamaya yönelik yürütülecek çalışmalar büyük bir önem teşkil etmektedir (Karaosmanoğlu, Soygüt ve Kabul, 2011).

1.5. Çocuk İstismarı ve İhmali

Çocuk istismarı ve ihmali çocuk sağlığını etkileyen önemli bir faktördür. Dünya Sağlık Örgütü (World Health Organization [WHO], 1999) çocuk istismarı kavramını şu şekilde açıklar:

> Çocukların ana-babaları gibi, onlara bakıp gözetmek ve eğitmekle görevli sorumluluk, güç ve güven ilişkisi içinde oldukları kişiler ya da yabancılar tarafından: bedensel ve/veya psikolojik sağlıklarına zarar verecek, sosyal gelişimlerini engelleyecek şekilde uygulanan tüm fiziksel, duygusal veya cinsel tutumları, ihmâli, ticari amaçlı sömürüyü kapsar (s.23).

Dört tip çocuk istismarı tanımlanmıştır, bunlar fiziksel istismar, cinsel istismar, duygusal istismar ve ihmaldir. İlk olarak fiziksel istismar bakım veren kişi tarafından çocuğa uygulanan ve ona fiziksel zarar veren ya da verme potansiyeli olan davranışlar olarak tanımlanmıştır. Cinsel istismar ise çocuğun bakım veren tarafından cinsel doyum sağlamak amacıyla kullanmasını içermektedir. Duygusal istismar ise bakım verenin çocuğa uygun ve yeterli çevreyi sağlayamamasını ve çocuğun duygusal sağlığı ve gelişimini olumsuz etkileyecek diğer fiziksel olmayan düşmanca davranışlarını içerir. Son olarak ihmal, çocuğa bakmakla yükümlü kişinin bu sorumluluğunu yerine getirmemesi, çocuğun beslenme, giyim, ilgi gibi tıbbi, sosyal ve duygusal gereksinimlerini karşılamaması gibi çocuğun fiziksel ve duygusal yönden bakımsız bırakılmasıdır (WHO, 2002).

1.5.1. Çocukluk İstismarı/İhmali ve Psikopatoloji

Birçok çalışma çocukluk dönemi örselenme yaşantıları ile depresyon ve anksiyete bozukluklarını da içeren birçok sayıda psikolojik bozukluk arasında bağlantı olduğunu göstermektedir (Gibb, 2002). Örnek olarak, fiziksel istismar anksiyete ile duygusal istismar ise depresyonla ilişkili bulunmuştur. Cinsel istismar ise depresyonla aynı anda anksiyete bozukluğunun da gözükmesini yordamaktadır (Gibb, Butler ve Beck, 2003). Aynı zamanda bir çok istismar ve ihmal yaşantısının aynı anda deneyimlenmiş olması da daha çok psikolojik problemle ilişkili olduğu görülmektedir (Higigns ve McCabe, 2001).

1.5.2. Çocukluk İstismarı/İhmali ve Erken Dönem Uyumsuz Şemalar

Daha önce de değinildiği gibi Şema Terapi modeline göre istismar ve ihmali de içeren erken dönem travmatik yaşantıları erken dönem uyumsuz şemaların gelişmesi ve güçlenmesinde önemli rol oynamaktadırlar (Young ve ark., 2003). Benzer şekilde birçok çalışmada ebeveynlerden görülen kötü muamele ve erken dönem uyumsuz şemalar arasında anlamlı ilişkiler bulunmuştur (Calvete ve Orue, 2013; Harding ve Burns, 2012). Özellikle, istismar deneyimlerinin AR ve Zedelenmiş Özerklik şema alanlarındaki şemalar ile ilişkili olduğu görülmektedir.

1.6. Erken Dönem Uyumsuz Şemaların Önemli Rolü

Araştırmalar aynı zamanda erken dönem uyumsuz şemaların çocukluk istismar/ihmali ve psikopatolojik semptomlar arasındaki bağlantıyı açıklayabileceğini göstermektedir (Lumley ve Harkness, 2007). Harris v Curtin (2002) yürüttüğü araştırmada depresyon ve çocukluk yaşantıları arasındaki ilişkinin özellikle Kusurluluk/Utanç, Yetersiz Özdenetim, Dayanıksızlık ve Yetersizlik şemalarının aracı rol oynadığı bulunmuştur. Diğer yandan Wright, Crawford ve Castillo (2009) duygusal istismar ve ihmal ile anksiyete arasındaki ilişkideyse Dayanıksızlık, Utanç ve Kendini Feda şemalarının aracı rolü olduğunu saptamışlardır. Sonuç olarak, bu ve benzeri birçok çalışma erken dönem uyumsuz şemaların çocuklukta maruz kalınan kötü muamele ve yetişkinlikte deneyimlenen psikolojik problem arasındaki ilişkide önemli bir role aldığını destekler niteliktedir.

1.7. Stresli Yaşam Olayları ve Psikopatoloji

Holmes ve Rahe (1967) stresli yaşam olaylarını kişilerin günlük aktivitelerinde yeniden uyuma yönelik değişiklikler gerektirecek olaylar olarak tanımlamışlardır. Özellikle beklenmedik stresli yaşam olaylarının depresyon ve anksiyeteyi de içeren ruhsal sağlık sonuçları ile ilişkili olduğu bilinmektedir (Liu ve Miller, 2014). Bu nedenle psikopatolojik semptomlarla ilişkili faktörler araştırılırken stresli yaşam olaylarının dikkate alınması önem taşımaktadır.

1.8. Çalışmanın Amaçları

Yukarda tartışılan literatüre bulguların doğrultusunda , çalışmanın amaçları:

1. Cinsiyet, yaş, annenin eğitim düzeyi, babanın eğitim düzeyi, gelir düzeyi, yaşanan yer ve kardeş sayısı açısından çalışmanın diğer değişkenlerindeki (çocuk istismarı/ihmali, şema alanları, şema baş etme biçimleri, psikopatolojik semptomlar ve yaşam olayları) farkları incelemek.

2. Çalışmanın değişkenleri arasındaki ilişkileri incelemek.

Kişilerin hayatlarındaki stresli yaşam olaylarının olası etkilerini kontrol ettikten sonra,

3. Şema alanları ile ilişkili faktörleri belirlemek.

4. Şema baş etme biçimleri ile ilişkili faktörleri belirlemek.

5. Psikopatoloji ölçümleri olan depresyon, anksiyete ve algılanan stres ile ilişkili faktörleri belirlemektir.

2. YÖNTEM

2.1. Katılımcılar

Mevcut çalışmanın katılımcıları 18 ve 32 yaşları arasında olan 414 kişiden oluşmaktadır. Bu kişilerin 312'si kadın iken (% 75.4), 102'si erkektir (% 24.6). Katılımcılardan 388'si lisans (% 93.5), 27'si yüksek lisans öğrencisidir (% 6.5).

2.2. Ölçüm Araçları

Katılımcılara internet yolu ile ulaştırılan ölçek paketi Demografik Bilgi Formu, Çocukluk Travmları Ölçeği, Young Şema Ölçeği, Young Telafi Ölçeği, Young-Rygh Kaçınma Ölçeği, Yaşam Olayları Envanteri, Beck Depresyon Ölçeği, Beck Anksiyete Ölçeği ve Algılanan Stress Ölçeği'nden oluşmaktadır.

2.2.1. Çocukluk Travmaları Ölçeği- Kısa Form

Bu ölçek çocukluk ve ergenlikte yaşanan istismar ve ihmal deneyimlerinin değerlendirmek amacıyla Bernstein ve arkadaşları (1994) tarafından geliştirilmiştir. 5'li Likert üzerinden puanlanan ölçek 28 maddeden oluşmaktadır. Yapılan faktör analizleri ölçeğin fiziksel, duygusal, cinsel istismar ve duygusal ve fiziksel ihmal olmak üzere 5 alt ölçekten oluştuğunu göstermiştir. Alt ölçekler için Cronbach alpha

güvenirlik puanları .78 ile .95 arasındadır. Tükçeye Şar, Öztürk ve İkikardeş (2012) tarafından uyarlanan ölçeğin Cronbach alpha güvenirlik puanları alt ölçekler için .71 ile .90 arasındadır.

2.2.2. Young Şema Ölçeği- Kısa Form 3

Young (2006) tarafından geliştirilen ölçek 6'li Likert üzerinden puanlanan 90 maddeden oluşmakta ve beş şema alanında ayrılabilen 18 şemayı kapsamaktadır. Soygüt, Karaosmanoğlu ve Çakır (2009) tarafından Türkçeye uyarlanan ölçeğin beş şema alanına sınıflandırılabilen 15 şemayı kapsadığı ve Cronbach alpha güvenirlilik puanı şema alt alanları için .53 ile .81 arasındadır. Fakat Sarıtaş ve Gençöz (2009) tarafından Türk lise öğrencileri ile yürütülen çalışmada ise 18 şemanın üç şema alanına sınıflandırılabildiği görülmüştür. Cronbach alpha güvenirlilik puanları şema alanları için .79 ile .81 arasındadır.

2.2.3. Young Telafi Ölçeği

Young (1995) tarafından geliştirilen ölçek 6'li Likert üzerinden değerlendirilen 48 maddeden oluşmaktadır. Ölçek Türkçeye Karaosmanoğlu ve arkadaşları (2013) tarafından uyarlanmış ve alt ölçekler için Cronbach alpha güvenirlilik puanları .60 ile .81 arasındadır.

2.2.4. Young-Rygh Kaçınma Ölçeği

6'lı Likert üzerinden değerlendirilen 40 maddeden oluşan ölçek Young ve Rygh (1994) tarafından geliştirilmiştir. Ölçeğin orjinal formunun psikometrik çalışmaları halen devam etmektedir. Ancak Spranger ve arkadaşları (2001) ölçeğin iki alt ölçeğe sahip olduğunu ve Cronbach alpha güvenirlilik puanlarının . 65 ve .78 olduğunu saptamışlardır. Ölçeğin Türkçeye uyarlanma çalışması Karaosmanoğlu, Soygüt, Tuncer, Derinöz, ve Yeroham yürütülmektedir (Akt., Karaosmanoğlu, et al., 2005).

2.2.5. Beck Depresyon Ölçeği

Beck, Ward, Mendelson, Mock ve Erbaug (1961) tarafından geliştirilen ölçek 4'lü Likert üzerinde değerlendirilen 21 maddeden oluşmaktadır. Hisli (1988) tarafındn Türkçeye uyarlanan ölçeğin iç güvenirlilik ve tutarlılık puanları oldukça yüksek bulunmuştur.

2.2.6. Beck Anksiyete Ölçeği

Beck ve arkadaşları tarafından geliştirilen ölçek 21 maddeden oluşmakta ve 5'li Likert üzerinden değerlendirilmektedir. Cronbach alpha puanı .94'tür. Türkçeye Ulusoy (1993) tarafından uyarlanan ölçeğin Cronbach alpha güvenirlilik puanı .92'dir.

2.2.7. Algılanan Stres Ölçeği

Cohen, Kamarck ve Mermelstein (1983) tarafından geliştirilen ölçek 5'li Likert üzeriden değerledirilen 10 maddeden oluşmaktadır. Cronbach alpha puanı .86'dır. Türkçeye Örücü ve Demir (2009) tarafından uyarlanan ölçeğin iki alt ölçeği olduğu ve Cronbach alpha güvenirlilik puanlarının .83 ve .71 olduğu saptanmıştır.

2.2.8. Yaşam Olayları Envanteri

Oral (1999) tarafından geliştirilen ölçek 5'li Likert üzerinden değerlendirilen 49 maddeden oluşmaktadır. Cronbach alpha puanı.90 olarak bulunmuştur. Gençöz ve Dinç (2006) yürüttükleri faktör analizinde ölçeğin başarı-ilişkili ve sosyal yaşam olayları olmak üzere iki faktörlü yapıda olduğununu ve Cronbach alpha değerlerinin sırasıyla .88 ve .86 olduğunu saptamışlardır.

2.3. Prosedür

ODTÜ Etik Komitesi'nden alınan izinlerin ardından yukarıda sözü geçen ölçek paketi katılımcılara internet üzerinden ulaştırılmıştır. Çalışmaya katılan katılımcılar önce bilgilendirme yazısını okumuşlar ardından ise ölçeklerin bulunduğu soru setini ortalama olarak 45 dakika da tamamlamışlardır.

2.4. İstatiktiksel Analizler

İlk olarak demografik değişkenlere göre faklılıkları saptamak amacıyla Çoklu Varynas Analizleri (MANOVA) ve t-test analizleri yürütülmüştür. Değişkenler arasındaki ilişkiler ise korelasyon analizleri ile incelenmiştir. Son olarak şema alanları, şema baş etme biçimleri ve psikopatolojik semptomlarla ilişkili faktörler hiyerarşik regresyon analizleri yürütülerek incelenmiştir.

3. BULGULAR

3.1. Çalışmanın Değişkenlerine Dair Betimleyici Analizler

Bu amaçla çalışmanın değişkenlerine dair ortalama skorlar, standart sapma değerleri, minimum ve maksimum değerler, Cronbach alpha puanları hesaplanmıştır. Alakalı değerler Tablo 3.1.'e görülebilir**.**

3.2. Çalışmanın Değişkenlerinin Demografik Değişkenler Açısından Karşılaştırılması

Bu amaçla demografik değişkenler farkli iki gruba kategorize edilmişlerdir. Bu kategorizayson Tablo 3.2.'de görülebilir. Anlamlı farklılık olup olmadığının görülmesi amacıyla tek puan veren değişkenler için t-testi alt ölçekleri olan değişkenler içinse çok yönlü varyans analizi (MANOVA) yapılmıştır. Analizler çalışmanının değişkenlerinin cinsiyet, yaş, gelir düzeyi ve kardeş sayısı açısından

farklılıklar gösterirken; anne-babanın eğitim seviyesi ve yaşanılan yer açısından farklılaşmadığını göstermiştir. Anlamlı farklara ilişkin sonuçlar aşağıda belirtilmiştir.

3.2.1. Cinsiyet Faklılıkları

Analiz sonuçları kadınlar ve erkekler arasında çocuk istismarı ihmali, şema alanları, psikopatolojik semptomplar ve yaşam olayları açısından anlamlı farklılıklar olduğunu göstermiştir. İlk olarak erkeklerin kadınlardan daha fazla duyugusal ihmal ve duygusal isismara maruz oldukları görülmüştür. Şema alanları içinse erkeklerin kadınlara göre Ayrılama/Reddilme şema alanında daha güçlü şemalara sahiptirler. Son olarak kadınların erkeklerden daha yüksek seviyede stres algıladıkları ve başarya ilişkin stresli yaşam olayları deneyimledikleri saptanmıştır.

3.2.2. Yaş Farklılıkları

Daha genç ve daha yaşlı katılımcılar arasında sadece algılanan stres açısından faklılık olduğu görülmüştür. Öyle ki daha yaşlı olan kişilerin daha genç kişilere göre daha yüksek seviyede stres algıladıkları bulunmuştur.

3.2.3. Gelir Düzeyi Faklılıkları

Yüksek ve düşük gelir düzeyindeki katılımcılar arasında şema alanları, psikopatolojik semptomplar, ve yaşam olayları açısından anlamlı farklılıklar olduğu bulunmuştur. Daha düşük gelir düzeyine sahip olan katılımcıların daha yüksek gelir düzeyine sahip olanlara göre AR ve ZÖÖY şema alanlarındaki şemaların özelliklerini daha çok gösterdikleri, daha yüksek seviyede stress algıladıkları ve daha çok başarıya ilişkin ve sosyla stresli yaşam olayı deneyimledikleri görülmüştür.

3.2.4. Kardeş Sayısı Farklılıkları

Daha çok ve daha az kardeşe sahip olan katılımcıların çocuk istismarı/ihmali ve psikopatolojik semptomplar açısından farklılık gösterdikleri saptanmıştır. Daha çok kardeşe sahip olan bireylerin daha çok duygusal ihmal deneyimine maruz kaldıkları ve daha yüksek seviyede stres algıladıkları bulunmuştur.

3.3. Değişkenler Arası Korelasyon Değerleri

Korelasyon analizlerinin sonuçları ilk olarak anne-babanın eğitim seviyelerin pozitif yönde anlamlı bir ilişki olduğunu göstermektedir, bu annenin eğitim seviyesi artıkça babanın eğitim seviyesinin arttığı anlamına gelmektedir. Ek olarak anne-babanın eğtim seviyesi ve kardeş sayısı ters yönde ilişkilidir, yani anne-babanın eğitim seviyesi arttıkça, kardeş sayısı azalmaktadır.

Yapılan analizler çocuk istismarı ve ihmalinin AR, ZÖÖY şema alanları ve anksiyete skorları ile pozitif yönde ilişkili bulunmuştur. Bir başka deyişle, daha yüksek seviyedeki istismar ve ihmal deneyimi yetişkinlikte bu iki şema alanından şemaların daha fazla gelişimi ve daha ciddi anksiyete semptomları ile ilişkilidir. Çocuk İstismarı/ihmalinin faklı alt tiplerinden fiziksel istismar, fiziksel ihmal, duygusal istismar, cinsel istismar ve duygusal ihmal arasında anlamlı pozitif yönde ilişkililer saptanmıştır. Bu her hangi bir alt alandaki istismar ya da ihmal deneyimi arttıkça, diğer alanlardaki deneyimlerin de arttığını göstermektedir. Bunun yanısıra duygusal istismar ve duygusal ihmalin AR, ZÖÖY şema alanları ve depresyon ile pozitif yönde ilişkili olduğu bulunmuştur. Bu sonuçlar özellikle ihmal ve istismarın duygusal türlerinin deneyimlenmesinin bu alanlardaki şema gelişimi daha fazla olması ve daha şiddetli depresyon semptomları ile alakalı olduğunu göstermektedir.

Şema alanlarının üçünün de birbiri ile pozitif yönde ilişkili olduğu, benzer şekilde şema baş etme biçimlerinin de birbirleri ile pozitif yönde ilişkili olduğu saptanmıştır. Bu bulgular şema alanlarından birinden alınan yüksek puanın diğer alanlardaki yüksek puanla ilişki olduğu ve şema baş etme biçimlerinden birinin fazla kullanımınn diğerin de fazla kullanımı ile ilişkili oduğu anlamına gelmektedir. Bunların yanı sıra tüm şema alanları ve tüm şema baş etme biçimleri arasında anlamlı pozitif ilişkiler bulunmuştur. Bu her iç alandan şemaların da şema kaçınma ve telafisinin daha fazla kullanılmasıyla ilişkili olduğunu göstermiştir.
Tüm şema alanlarının tüm psikopatolojik semptomlar ile ilişkili olduğu saptanmıştır. Diğer bir deyişle herhangi bir alandan güçlü şemalara sahip olunulması daha çok depresyon ve anksiyete semptomu ve daha yüksek seviyede stres algılanması ile

ilişkilidir. Son olarak depresyon, anksiyete ve algılanan stres puanlarının birbiri ile pozitif yönde ve anlamlı düzeyde ilişkili olduğu saptanmıştır.

3.4. Regresyon Analizleri

Şema alanları, şema baş etme biçimleri ve psikopatolojik semptomları yordayan faktörleri saptamak için farklı üç grupta regresyon analizi yürütülmüştür.

3.4.1. Şema Alanlarını Yordayan Faktörler

Analiz sonuçlarına göre ilk olarak yüksek düzeydeki sosyal ve başarıya ilişkin stresli yaşam olaylarının, duygusal ihmal ve cinsel istismar deneyimlerinin ZSAS şema alanında daha güçlü şemaları yordadıkları belirlenmiştir.

İkinci olarak, erkek olmanın, daha düşük gelir seviyesinden gelmenin ve yüksek oranda stresli yaşam olayı deneyimlemenin AR şema alanında güçlü şemaları yordadığı görülmüştür. Ayrıca, çocukluktaki duygusal istismar, duygusal ihmal ve cinsel istismar deneyimlerinin de bu alanda daha güçlü şema gelişimini yordadığı bulunmuştur.

Son olarak düşük gelir düzeyinin ve yüksek orandaki stresli yaşam olayları deneyimlerinin ZÖÖY şema alanında daha güçlü şema gelişimini yordadığı saptanmıştır. Bunun yanı sıra, çocukluktaki fiziksel istismar ve cinsel istismar deneyimlerinin de bu alanda daha güçlü şema gelişimini yordadığı görülmüştür.

3.4.2. Şema Baş Etme Biçimlerini Yordayan Faktörler

Regresyon analizlerinin ikinci grubu öncelikle, gelir düzeyinin şema kaçınmasını negatif yönde, stresli yaşam olaylarının ise pozitif yönde yordadığını göstermiştir. AR şema alanından daha güçlü şemalara sahip olmanın da şema kaçınmasının daha fazla kullanımını yordadığı saptanmıştır.

Diğer yandan yaşın negatif, stresli yaşam olaylarının ise pozitif yönde şema telafisi kullanımını yordadığı bulunmuştur. ZSAS şema alanındaki daha güçlü şemalar şema telafisinin daha fazla kullanımını yordarken, ZÖÖY şema alanındaki daha güçlü şemaların şema telafisinin daha az kullanımını yordadığı belirlenmiştir.

3.4.3 Psikopatolojik Semptomları Yordayan Faktörler

İlk olarak daha yüksek seviyede depresyonu yordayan faktörler düşük eğitim seviyesi ve stresli yaşam olaylarında artış olarak bulunmuştur. Bunun yanısıra duygusal ihmal ve cinsel istismar deneyimlerin fazla olmasının, AR ve ZÖÖY alanlarında güçlü şemalara sahip olmanın daha şiddetli depresyon semptomlarını yordadığı görülmüştür. Şema kaçınmasının daha fazla kullanımın ise depresif semptomlarda azalmayı yordadığı saptanmıştır.

Diğer yandan, kadın olmanın, düşük gelir seviyesine ve daha çok kardeşe sahip olmanın ve daha yüksek seviyede stresli yaşam olayı deneyimlemenin daha çok stres algılamayı yordadığı bulunmuştur. Duygusal ihmal deneyimleri, ZSAS şema alanından güçlü şemaları stres algısını pozitif yönde yordarken, şema kaçınması kullanımın ise negatif yönde yordadığı belirlenmiştir.

Son olarak daha fazla stresli yaşam olayı deneyiminin, ZÖÖY şema alanından güçlü şema özelliklerinin ve şema kaçınmasının anksiyete seviyesinin artışını yordadığı görülmüştür.

4. TARTIŞMA

Duygusal ve cinsel istismarın ZSAS şema alanında daha güçlü şemalar ile ilişkili olduğuna dair bulgular literatüre bulguları tarafından desteklenmektedir. Özellikle bakım veren tarafından onaylanmamış çocukların yetişkin olarak diğer insanlardan onay alabilmek için kendilerine yüksek standartlar koymaları beklendiktir (Young ve ark., 2003). Benzer şekilde duygusal istismar ve ihmal ve cinsel istismar deneyimlerinin AR alanından şemalar geliştirilmiş olması da benzer başka çalışmalar tarafından varılan sonuçlarca desteklenmektedir (McGinn ve ark., 2005). Fiziksel ve cinsel istismara maruz kalmış kişilerin özerkliklerinin zara görmüş olması ve

ihtiyaçları bastırılan bu kişilerin diğerleri yönelimli olmaları, yani AR alanında şemalar geliştirmeleri şaşırtıcı bir sonuç değildir (Young ve ark., 2003).

Şema kaçınması ve AR şema alanı arasındaki ilişki kaçınmanın inkar ve dikkatin yön değiştirmesini içerdiği düşünüldüğünde anlam kazanmaktadır. ZSAS şema alanının şema telafisi ile ilişkili çıkması bu alandaki şemaların yüksek standartlarla ilişkili olması ile açıklanabilir. Diğer yandan ZÖÖY şema alanının şema kaçınması ile negatif ilişkili olması ise bu kişilerin işlevselliklerinde görülen sorunlar ile bağlantılı olabilir.

AR ve ZÖÖY alanlarının depresyon, yine ZÖÖY alanının anksiyete ve ZSAS alanının algılanan stresle ilişkili bulunması temel inançların psikopatoloji gelişiminde önemli yer tuttuğunu öneren bilişsel modeli destekler niteliktedir (Wright ve ark., 2009).

Son olarak şema kaçınmasının anksiyete ile negatif, algılanan stres ile pozitif ilişkili bulunması, anksiyetenin gelecek yönelimli bir duygu olması ve kaçınmanın gelecek riskleri ortadan kaldıramaması ile açıklanabilir. Şema telafisinin depresyon semptomlarında azalma ile ilişkili olması ise telafinin şema ile ilişkili negatif duyguların deneyimlenmesini engellemesi ile bağlantılı düşünülebilir.

4.4. Çalışmanın Sınırlılıkları

Hasta örnekleminin değil de üniversite örnekleminin kullanılması, cinsiyet dağılımın eşit olmayışı, kesitsel bir çalışma yürütülmesi ve kişilerin kendi beyanatlarına dayalı ölçümler kullanılması bu çalışmanın sınırlılıkları olarak düşünülebilir.

4.5. Çalışmanın Güçlü Yönleri

Çalışmada kişilerin hayatlarındaki olası diğer stres faktörlerinin kontrol edilmiş olması bu çalışmanın güçlü bir yanıdır. Ayrıca mevcut çalışma şema baş etme biçimlerinin psikopatoloji gelişimindeki rolüyle ilişkili yürütülen çok nadir çalışamadan biridir.

4.6. Çalışmanın Katkıları ve Gelecek Çalışmalar için Öneriler

Çalışma bulguları klinisyenlerin depresyon ile çalışırken AR ve ZÖÖY alanlarından şemaların, şema kaçınması kullanımının ve duygusal ihmal ve cinsel istismar öykülerinin üzerinde özellikle durmaları gerekebileceğini göstermiştir. Diğer yandan anksiyete ile çalışırken ise ZÖÖY alanından şemaların varlığının ve şema kaçınmasın kullanımın dikkatle değerlendirilmesi gerektiği saptanmıştır. Son olarak kişilerin algılanan stres seviyelerini değerlendirken ise duygusal ihmal deneyimlerine, ZSAS alanından şemalara ve şema kaçınması kullanımına özellikle dikkat edilmelidir.

Gelecek çalışmaları yürütecek araştırmacıların şema baş etme biçimlerinin psikoloji gelişimi ve erken dönem uyumsuz şemalar arasında aracı bir rolü olmadığını daha detaylı inceleyebilir, boylamsal çalışmalar yürütebilir, hasta örneklemi kullanabilir ve görüşme gibi teknikler kullanabilirler.

Appendix M: Thesis Photocopying Permission Form

TEZ FOTOKOPİSİ İZİN FORMU

ENSTİTÜ

Fen Bilimleri Enstitüsü	
Sosyal Bilimler Enstitüsü	X
Uygulamalı Matematik Enstitüsü	
Enformatik Enstitüsü	
Deniz Bilimleri Enstitüsü	

YAZARIN

Soyadı: ÜNAL

Adı : ELİF

Bölümü: PSİKOLOJİ

TEZİN ADI (İngilizce): The Effects of Child Abuse and Neglect on Psychopathological Symptomatology: The Roles of Early Maladaptive Schemas and Schema Coping Processes

TEZİN TÜRÜ: Yüksek Lisans [X] Doktora [ ]

1. Tezimin tamamından kaynak gösterilmek şartıyla fotokopi alınabilir. [X]
2. Tezimin içindekiler sayfası, özet, indeks sayfalarından ve/veya bir bölümünden kaynak gösterilmek şartıyla fotokopi alınabilir. [ ]
3. Tezimden bir bir (1) yıl süreyle fotokopi alınamaz. [ ]

TEZİN KÜTÜPHANEYE TESLİM TARİHİ: