TOWARDS AN INTEGRATIVE PERSPECTIVE ON THE INTERPLAY BETWEEN EARLY MALADAPTIVE SCHEMAS AND WELL-BEING: THE ROLE OF EARLY RECOLLECTIONS, SELF-COMPASSION AND EMOTION REGULATION

A THESIS SUBMITTED TO
THE GRADUATE SCHOOL OF SOCIAL SCIENCES
OF
MIDDLE EAST TECHNICAL UNIVERSITY

BY

DUYGU YAKIN

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY
IN
THE DEPARTMENT OF PSYCHOLOGY

DECEMBER 2015

Approval of the Graduate School of Social Sciences

Prof. Dr. Meliha Altunışık
Director

I certify that this thesis satisfies all the requirements as a thesis for the degree of Doctor of Philosophy.

Prof. Dr. Tülin Gençöz
Head of the Department

This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality as a thesis for the degree of Doctor of Philosophy.

Prof. Dr. Tülin Gençöz
Supervisor

Examining Committee Members

Prof. Dr. Bengi Öner Özkan (METU, PSY) _____

Prof. Dr. Tülin Gençöz (METU, PSY) _____

Assoc. Prof. Dr. Sait Uluç (HU, PSY) _____

Assoc. Prof. Dr. Özlem Bozo (METU, PSY) _____

Assoc. Dr. Müjgan İnözü (HU, PSY) _____

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

Name, Last Name: Duygu Yakın

Signature:

ABSTRACT

TOWARDS AN INTEGRATIVE PERSPECTIVE ON THE INTERPLAY BETWEEN EARLY MALADAPTIVE SCHEMAS AND WELL-BEING: THE ROLE OF EARLY RECOLLECTIONS, SELF-COMPASSION AND EMOTION REGULATION

Yakın, Duygu
PhD, Department of Psychology
Supervisor: Prof. Dr. Tülin Gençöz

December 2015, 159 pages

The present study was designed as a mixed method study, and was built upon two data sets, one of which was quantitative and the other qualitative. The first study aims to emphasize resourcefulness factors in schema theory from a positive psychology perspective, and emotion regulation and self-compassion were utilized as the indicators of the healthy adult mode. The data was gathered from 296 adults (179 female, 117 male). Accordingly, the mediator roles of self-compassion and emotion regulation were examined via Hayes' procedure for parallel multiple mediation. Thus, emotion regulation and self-compassion altogether mediated the relation between all three schema domains and well-being. More importantly, self-compassion was identified as more critical than emotional regulation in terms of life satisfaction, whereas, emotion regulation was more critical in terms of psychopathological symptoms.

The second study was like using a magnifying glass to understand the dynamics of the people who scored high in the disconnection/rejection domain. It is aimed to identify themes represented in memory narratives of the participants. In order to trigger related memories, Bernstein Schema Mode Cards were utilized and the

results were analyzed via deductive qualitative content analysis using MAXQDA. The second study includes interviews of 10 (5 female, 5 male) participants who were chosen considering the similarity of their high scores in the disconnection-rejection domain, as well as their age and gender. Accordingly, the frequency of EMS themes were more balanced across schemas when a quantitative assessment was applied to the qualitative data.

Keywords: Early maladaptive schemas, early recollections, emotion regulation, self-compassion, well-being

ÖZ

ERKEN DÖNEM UYUMSUZ ŞEMALAR VE İYI OLUŞ ARASINDAKI İLİŞKIYE YÖNELIK BÜTÜNLEYICI BIR BAKIŞ: ERKEN DÖNEM ANILAR, ÖZ-ŞEFKAT VE DUYGU DÜZENLEME

Yakın, Duygu
Doktora, Psikoloji Bölümü
Tez Yöneticisi, Prof. Dr. Tülin Gençöz

Aralık 2015, 159 Sayfa

Mevcut çalışmada karma yöntem kullanılarak planlanmıştır ve iki veri setinden oluşmaktadır. Birinci çalışmada şema terapide ele alınan güçlülük faktörlerini pozitif psikoloji bakış açısıyla vurgulanması hedeflenmiştir. Bu amaçla, duygu düzenleme ve öz-şefkat sağlıklı yetişkin modunun belirleyicileri olarak ele alınmıştır. Böylelikle, mevcut çalışmada 296 yetişkinden (179 kadın, 117 erkek) veri toplanmıştır. Bu çerçevede, öz-şefkat ve duygu düzenlemenin olası aracı rolü Hayes'in paralel çoklu aracılık yöntemiyle incelenmiştir. Buna göre kopukluk/reddedilme boyutunun en çok problem sergileyen ve yoksun bırakılan katılımcı grubu olduğu gözlenmiştir. Yanı sıra, duygu düzenleme ve öz-şefkatin birlikte bütün şema boyutlarıyla iyi-oluş arasındaki ilişkide aracılık rolü üstlenmiştir. Daha da önemlisi, duygu düzenleme öz-şefkate göre psikopatolojik belirtilerin gelişimi açısından daha önemli bulunurken, öz-şefkat de yaşam doyumu açısından daha kritik bulunmuştur.

İkinci çalışma kopukluk/reddedilme alanında yüksek puan alan katılımcıların dinamiklerine yakından bakmayı hedeflemektedir. Bu çerçevede, mevcut çalışmanın ikinci bölümünde erken dönem anı anlatımlarında ortaya çıkan temaların belirlenmesidir. İlgili anıları tetikleyebilmek için Bernstein Şema Mod Kartları kullanılmıştır ve sonuçlar MAXQDA ile tümden gelimci nitel veri analizi

yöntemiyle analiz edilmiştir. İkinci çalışma kopukluk/reddedilme şema boyutunda alınan yüksek puanlar, yaş ve cinsiyet açısından benzer 10 katılımcıyla (5 kadın, 5 erkek) yüz yüze yapılan görüşmeleri içermektedir. Buna göre nitel veriye nicel değerlendirme uygulandığında elde edilen sonuçların şemalar arasında daha dengeli bir şekilde dağıldığı gözlenmiştir.

Anahtar Kelimeler: Erken dönem uyumsuz şemalar, erken dönem anılar, duygu düzenleme, öz-şefkat, iyi-oluş

To my mom…

ACKNOWLEDGEMENTS

I would like to express my gratitude to my dear advisor Prof. Tülin Gençöz. I had always felt secure under her compassionate wings while I still had the chance to draw my own way autonomously. If there is a will, there is a way they say… She has always ensured my will about the completion of this dissertation. There were times she believed in me more than I believed in myself.

I am also heartily thankful to my examining committee members; Prof. Bengi Öner-Özkan for her beautiful smile, which made me braver on walking the paths I had chosen; Assoc. Dr. Özlem Bozo for her supportive encouragements at the exact times when they were needed; Assoc. Dr. Sait Uluç for being a role model since my undergraduate years, and; Assoc. Dr. Müjgan İnözü for her constructive feedbacks.

I owe my appreciation to Prof. David Bernstein for sharing his valuable ideas and feedbacks about my study. It was very kind of him to let me use his Schema Mode Cards, and it was a great opportunity to work with him. I am also thankful to Assoc. Dr. Azmi Varan for sharing his wisdom about life and helping me to make my own way despite other people's demands. I also thank to Dr. Elif Kuş Salliard for teaching me to conduct qualitative data analysis and answering all of my questions with patience.

I am grateful to Süleyman Turan for doing the arrangements of my dissertation, but more importantly, for being a real brother to me and making me the super-aunt of his little boy.

The biggest thanks goes to my amazing mother, Türkan Yakın (RIP), who had the greatest contribution in raising me as a strong and independent woman by teaching me that falling only makes me stronger. Armağan Yakın-Doğan, I would like you to know that I love you more than you will ever know; you are my precious, my hero. Zuhan Yakın, they say that my playful child mode is inherited from you. I'm grateful to you for our special night walks together. Yalçın Doğan, thank you for the

cozy feeling of having an elder brother who always takes care of you. Mehmet Çınar Doğan, thank you for all the happiness and joy you spread around.

I am also grateful to Özge Kantaş (aka. Kandaş) for making me believe that I have a life-long sister who always cares for my smile. I hope that our sleepless nights caused by the ability to endlessly chat about simple things lasts forever. Sevtap Yeşil, thank you for teaching me that there are unique relationships in which you discover yourself again and again throughout the years. Your presence means a lot to me. Çiğdem Koşe-Demiray, thanks for being such fun! You are a cool combination of nurturance of a mother, genuine support of a great friend and joy of a crazy little girl. Lastly, I am thankful to Ece Tathan for her great ability of empathy, Yağmur Ar for suffering together within the same dynamics, Deniz Çoğulu for all the laughs, and Oganalp Canatan for always being there.

Four years ago, this journey meant only a PhD degree to me, but it turned out to be a mystic battle with mighty dragons, lizard kings, white rabbits, and dust bunnies. Words cannot express my gratitude to those who stood by me in any aspect while I am sorry for those who cannot make it through the whole way… But here it is. As it is said in the legend, I am happy to hand over this torch and leave it on your doorstep with weary hands… I have been living with it for so long. I need to sleep…

This thesis was supported by The Scientific and Technological Research Council of Turkey (TÜBİTAK).

TABLE OF CONTENTS

LIST OF TABLES

TABLES

LIST OF FIGURES

FIGURES

CHAPTER 1

INTRODUCTION

The origin of psychopathological problems has been an outstanding research topic in multiple fields of psychology. Actually, the main obstacle about that is these problems are as old as the first person who came into existence on earth. While that first person was striving to survive on planet earth, that individual made meaning out of extrinsic factors and started to "remember" things. However, as we all know, emotional problems were not the focus of interest for a long time. Even today, although the idea that mental health problems may lead to serious combination of physical problems and lead devastating outcomes gain importance and publicity, still authorities often warn people about the impotence of that issue.

From the clinical perspective, early childhood experiences are probably the trendiest topic when it comes to understanding the development of serious pathologies. They are considered crucial for understanding the individual's inner structure since the very beginning of the studies on psychology. Hence, bonding with the primary caregiver is accepted as a major area of interest for different theories (see Freud, 1923/1962; Bowlby, 1951; Beck, 1967/1973; Rohner, 1975/2000). However, the link between the emotional burden of early childhood experiences and current psychopathological condition heavily relies on the individual's personality and coping styles as well (O'Connor& Dvorak, 2001). In line with the current norms in society that require being stronger, healthier, more successful, etc… than anybody else, almost every theory is designed to have its own coping and resilience model to understand the people-environment interaction and explain the people who have suffered a lot as children and have not become "a real mess" when grown up. Therefore, identifying the pitfalls that plots a person's future mental condition becomes more of an issue. In this respect, although different theories provide distinctive perspectives, many of them reach a consensus on that

problems related to the representations of early experiences with significant others alter people's later relational experiences in a bidirectional way (McLean, Bailey, & Lumley, 2014).

There is constant debate in the literature about the way early experiences shape different cognitive structures and the principals that make people display psychopathological symptoms. In addition, plenty of research has been conducted on individuals who have become "healthy adults" despite their adverse childhood experiences and recurrent memories of those experiences. On the other hand, according to Bruhn (1990), emphasized the importance of information regarding the operation of autobiographical memory within individual's belief system. Hence, an integrated view within a theoretical perspective seems to be lacking.

Beck's cognitive theory of personality (1967/1973), which suggests working on cognitive, affective and behavioral elements regarding psychopathological symptoms, substantially stands out amongst others. Although Beck's cognitive therapy is respected as an empirically validated treatment technique for Axis I disorders, Young and colleagues (2003) propose that certain patients with chronic pathologies often fail to benefit from cognitive therapy. Therefore, Schema therapy came to the stage as a solution for patients who were labelled as "treatment-resistant clients", and who had inability to access and make sense of their cognitions and emotions (cited in Hawke & Provencher, 2011; Young, 1990/1999; Young, Klosko, & Weishaar, 2003). In schema therapy, the main emphasis is on unmet needs of early childhood and adverse childhood experiences that lead to the formation of early maladaptive schemas (EMS). As a therapeutic approach, Young (1994) propose an integration of therapeutic techniques derived from elements of cognitive and gestalt therapy, object relations and psychoanalysis (Hawke & Provencher, 2011; cited in Wegener et al., 2013). Accordingly, global level of functioning is determined according to the core themes that are present in an individual's life (Thimm, 2011). However, regardless of the amount of adverse experiences as a child, schema therapists believe that every person has a side that has healthy, balanced and realistic perceptions about one's self and the environment. This side,

which is responsible for self-regulation, generates reasonable instructions using realistic perceptions (Roediger, 2012; Rafaeli, Bernstein, & Young, 2011). Based on the main assumptions of schema theory, one can easily guess that healthy emotion regulation strategies and constructive skills to display self-compassion are reasonably accepted as main elements that can reduce the effects of negative childhood experiences. In this respect, the path between memories of early maladaptive experiences, current coping skills and psychopathological symptoms become evident. In this respect, identifying labyrinthical interactions that enlighten the path from the first step of a baby to a grown up human being with all the complicated mentality should be touched by early childhood memories, resilience skills and current mental status.

However, despite growing literature, identifying the elements specifying the underlying mechanism is still important, especially within the hypotheses derived from schema theory (Pretzer & Beck, 2004; Lumley, & Harkness, 2007). Moreover, future research on schema theory is needed to provide valuable insights using self-report and memory retrieval tools (Hawke & Provencher, 2011). In this respect, the current research trend in schema therapy involves clinical information that links particular memories to specific schema themes (Lumney & Harkness, 2007). Young (1994) proposed that specific cognitive themes should be examined because cognitive therapy is mainly interested in identification and modification of these cognitive themes, which are seen as the main contributing factors of psychopathology. Within this frame, current research aims to identify cognitive themes derived from early childhood memories and self-reported maladaptive schemas in relation with psychopathology. Moreover, the role of self-compassion skills and emotion regulation strategies is identified within the assumptions of schema formulization. For this purpose, firstly, Young's (1990/1999) original Schema Theory postulations will be described as the main theoretical basis. Later on, the first and second studies will be introduced with their hypotheses, findings and implications.

1.1. Schema Theory

Recently, “third wave” cognitive therapies are accepted as a crucial research area of modern psychotherapy literature in order to gather empirical evidence regarding mental problems. In this respect, the diversity of different techniques that are touched by metacognitions, acceptance, thought-emotion suppression, compassion, and rumination is presented. These new areas of treatment techniques allowed clinicians to work with patients who suffer from more severe and chronical disorders. Although these techniques still lack empirical support compared to cognitive therapy, they substantially influenced clinicians’ point of view and gave way to the emergence of a diversity of theories namely, Mindfulness-Based Cognitive Theory, Acceptance and Commitment Therapy and Dialectical Behavioral Therapy and Schema Therapy (Kahl, Winter, & Schweiger, 2012; Norcross, Pfund, Prochaska, 2013).

As an integrative treatment approach, schema therapy substantially draws attention from clinicians. Although schema therapy was developed for those who have severe mental disorders and personality problems, recent research concludes that it is an effective technique for a variety of different axis I disorders, namely depression, anxiety disorders, substance abuse and eating disorders (Luck, et. al., 2005; Hoffart, 2012; Ball & Cecero, 2001; Cockram, Drummond & Lee, 2010). Moreover, research that integrates schema therapy with other therapy practices such as cognitive therapy, mindfulness based therapies, acceptance and commitment therapy and Adlerian therapy is also present (Benesch, 2012; Vreeswijk, Broersen, & Nadort 2012; Parfy, 2012).

1.1.1. Origin of Early Maladaptive Schemas

A schema, in the broadest sense, can be explained as an internalized structure of representations regarding the outer world. In this regard, people form scripts and rules regarding their representations and interpret their experiences in line with them. These scripts and rules are unique for each person (Widmayer, 2007). However, an individual’s rules and scripts may lead to the distortion of perception

and meaning as well. The idea that these structures shape the way people organize and guide their behavior is not new. It is theorized from different perspectives in different areas (Baldwin, 1992). The concept was firstly introduced by early studies of Piaget (1952) and Bartlett (1932) in the field of psychology. In these studies, it was mentioned that ambiguous information is processed via schematization while interacting with the environment. It is also mentioned that this process mainly predicated on recalled memories that form a narrative pattern in order to process and organize information that is derived from new experiences (Bartlett, 1932). Later on, Piaget mentions innate schemas that interact with the child's environment. However, schema research mainly found broad interest in clinical science via Beck's cognitive approach to schema concept (cited in Thimm, 2011). Although many different schema definitions are present in literature, Beck's (1996) definition of schemas is an important part of his cognitive theory of personality in terms of clinical psychology (cited in Baldwin, 1992). Accordingly, cognitive schemas provide templates for information processing. These templates consist of unconditional themes that are utilized to process future experiences and feelings. Hence, behaviors and thoughts are shaped according to these templates (Mc Ginn & Young, 1996). Influenced by Bowlby's (1951) Attachment Theory, and Beck's (1996) Cognitive Behavioral Therapy, Young (1990/1999) proposed that the child forms scripts and rules based upon the "reality based representations" of the outer environment. Accordingly, every child has fundamental needs such as a loving environment, which is free from traumatization, victimization and extreme identification of significant others. If the child's basic needs are frustrated, it leads to the formation of EMSs. EMSs are defined as "a broad pervasive theme or pattern; comprised of memories, emotions, cognitions, and bodily sensations; regarding one's self and one's relationship with others; developed during childhood or adolescence; elaborated through one's life time; dysfunctional to some degree". These schemas are usually functional for children in order to survive to become an adult. However, when children reach adulthood, the rules and scripts of the childhood should be modified according to the requirements of adult life. That is, behaving in line with the rules of EMSs can be problematic in adult life (Young,

Kolosko, & Weishaar, 2003, p. 7). Young (1990/1999) proposed that in order to solve chronic problems, the therapy process should mainly focus on early childhood experiences and identify rigid themes and scripts that are fundamental elements of an individual's sense of self concept. In light of this, it was postulated that the examination of the link between adverse experiences and particular schema themes is vital because an effective treatment technique should mainly focus on the identification and modification of this link.

1.1.2 Early Maladaptive Schema Domains

Conducting research based on the schema model is crucial in order to obtain empirical evidence on the connection between childhood and current problems. Therefore, developing a substantial theoretical model regarding the structure of EMS is crucial (Hoffart et al., 2005). Young's schema model originally has five schema domains based on the five fundamental needs of children. These are secure attachment, autonomy, freedom to express needs and emotions, spontaneity and realistic limits. Accordingly, five schema domains are presented by Young and colleagues (2003):

The disconnection rejection domain is characterized with problems regarding attachment stability. This domain contains EMSs such as Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, and Social Isolation/ Alienation. In this regard, these individuals lack feelings of acceptance, nurturance, stability and belonging as children. Compared to others, this domain is the most important domain due to its association with psychological impairment.

The impaired autonomy and performance domain involves lack of perceived ability to be able to maintain one's life without the help of any other person. These people usually have problems regarding separation, and they usually do not believe that they can handle their responsibilities successfully. This domain consists of EMSs like Dependence/Incompetence, Vulnerability to Harm or Illness, Enmeshment/Undeveloped Self, and Failure. The children of enmeshed or/and overprotective families usually score high in this domain.

The other-directedness domain is characterized with an excessive effort to satisfy other's needs at the cost of sacrificing one's own needs. That is, these individuals have lower levels of awareness about their own mental conditions. This domain contains EMSs such as Other-Directedness, Subjugation, Self-Sacrifice and Approval-Seeking. These individuals are typical children of parents who employ conditional acceptance towards their children. Therefore, these children become experts on suppressing their needs and emotions in order to obtain approval from their parents.

The impaired limits domain refers to impairment regarding one's own limits and responsibility-taking and problems related to goal setting and perseverance. This domain contains Entitlement/Grandiosity and Insufficient Self Control/Self Discipline schemas. These individual's parents would typically lack setting adequate rules, and rather, they would induce self-righteousness and superiority. Hence, the child barely learns to regulate negative emotions.

The overvigilance and inhibition domain refers lack of joy, spontaneity and self-expression. These individuals limit their impulses and emotions with perfectionist, rigid rules that leave no room for relaxation and happiness. The EMSs that belong to this domain are Negativity/Pessimism, Emotional Inhibition, and Unrelenting Standards. These individual's families usually display punitive and demanding behaviors and perfectionistic standards. People who score higher on over-vigilance and inhibition domain are often concerned over their mistakes and have a latent pessimism about violation of their rules.

1.1.3. The Maladaptive Schema Coping Styles

In Schema Theory, three types of different coping styles are described. The first coping style is schema surrender. In this coping mechanism, the individuals basically give in, completely acknowledge the content of their schemas and act in line with the commands of the schemas. For example, if the individual has a failure schema, the individual can identify with the sense of failure and frequently expresses that he or she does not have the qualities to achieve success. The second

coping mechanism is avoidance. Accordingly, if the same individual tries to cope with the failure schema through schema avoidance, he or she can either consciously (by not attending an exam) or unconsciously (by oversleeping in the exam day) can avoid the possible conditions that the individual may experience failure. The last coping mechanism is overcompensation. Accordingly, the individual can excessively strive to do to the opposite of what the schema commands. If the individual utilizes schema overcompensation, the individual excessively tries to get higher grades and overworks for the exam. Thus, although the results take the troubled emotions away caused by EMSs, they are only effective for a limited time, and in the long run, they contribute to the reinforcement of EMSs. By utilizing different coping mechanisms, actually the individuals desperately put themselves in difficult positions which broadly resemble the adverse experiences of their childhood. Therefore, during therapy process, the individuals are supported to realize the problems caused by maladaptive coping mechanisms and are encouraged to change them.

1.1.4. Early Maladaptive Schema Modes

Along with the recent developments, schema therapists prefer to work with schema modes, rather than schemas while working with chronic disorders. In contrast with the schemas, which are considered as stable during an individual's life, "modes refer to the predominant emotional state, schemas, and coping reactions that are active for an individual at a particular time" (Rafaeli, Bernstein, & Young, 2011, p. 47). Hence, modes are derived from schemas and coping responses, but at the same time, they are differentiated from schemas based on their state-like nature (cited in Hawke & Provencher, 2011). Schema modes consist of thoughts, emotions and behaviors that characterize an individual state of being at a particular time. While a schema is related to the specific themes such as abandonment or failure, a schema mode can contain different themes regarding schemas and coping styles that are closely associated with the emotional condition of the patient. According to Young and colleagues (2003), every person has different facets within, and usually the transition from one facet to the other is nearly invisible for people who have

successfully accomplished to integrate different parts of their identity adaptively. However, it can be more complicated when the individual has problems regarding the integration of different parts. In this case, the transmission between different facets can take place all of a sudden, and these rapid mood swings usually cause adverse problems in interpersonal relationships.

Although the mode model was developed to treat more serious problems, recently it is also employed for patients with higher levels of functioning. In Young and colleagues (2003), in the original mode model only 10 schema modes are described;

The child modes are acquired in childhood as a coping strategy in order to deal with unmet emotional needs. These modes display innate emotions such as anger, disgust, happiness, etc. *The Vulnerable Child* mode represents a scared little child who desperately needs an adult for protection. Since most schemas are accounted as vulnerable child modes, it is accepted as the core mode for therapeutic process that leads to healing. *The Angry Child* mode stands for the anger, frustration and impatience which have originated from unmet emotional needs of childhood. *The Impulsive/undisciplined Child* mode represents a selfish, irresponsible and unlimited state with low frustration tolerance. Lastly, *The Happy Child* mode represents a child whose emotional needs are met adequately.

The dysfunctional parent modes stand for the internalized representations of significant others. In this mode, the individuals treat themselves as their parents have treated them earlier. Hence, introjected dysfunctional parenting attitudes continue to impair the individual's current function. *The Punitive Parent* mode involves harsh criticism and punishment of even little mistakes. *The Demanding Parent* mode involves striving to achieve perfectionistic standards. If these standards cannot be fulfilled, the child feels deeply ashamed.

The maladaptive coping modes represent the child's coping behaviors in order to get over extreme stress caused by unmet childhood needs. These modes originate from spontaneous fight-freeze-flight responses. Although these modes function as a survival strategy in childhood, they become dysfunctional in adult life. *The*

Compliant Surrender mode involves repression of emotions caused by schema-activation to avoid conflict. The person is passive and obedient due to the feelings of inadequateness and inferiority. Therefore, any conflict can be seen as a possible fiasco. *The Detached Protector* mode represents psychological isolation from the heavy emotions of the adverse experiences. It is the most problematic mode since it prevents the establishment of a healthy therapeutic relationship, which is one the most fundamental elements of change in schema therapy. This mode is characterized with withdrawal and feelings of emptiness. *The Overcompensation* mode refers to the substitution of schema-related emotions with the opposite of these emotions. For instance, if an individual has negative feelings about himself such as defectiveness or inferiority, these emotions can be replaced with behaviors that characterize superiority and high self-esteem as a coping reaction. They can either appear obsessively involved with their routine, and can strive for control or behave agreeable while covertly laying a snare under others.

Lastly, *The Healthy Adult* mode is the integrated, wise and healthy side of the individual. As might be expected, this is the key mode that leads to the improvement of the individual within the therapeutic process.

During schema therapy, child modes are aimed to be identified, nurtured and reduced: whereas, dysfunctional parent and coping modes are aimed to be limited and negative sides of the modes are discussed by utilizing emphatic confrontation, and finally, an integrative identity is formed through the healthy integration of different modes (Young, Kolosko, & Weishaar, 2003).

1.2. Change Mechanism of Schema Therapy and The Healthy Adult Mode

Recently, schema therapy has strengthened its place among modern psychotherapeutic approaches. The idea that EMSs are closely associated with the development of a range of serious disorders is empirically validated (Nordahl, Holthe, & Haugum, 2005). On the other hand, little research has focused on the elements that promote resilience in terms of well-being and satisfaction with life.In fact, resilience is a critical term because an individual’s life satisfaction is closely

associated with the ability to cope with adversity rather than the distress caused by adverse childhood experiences (Keyfitz, Lumley, Hennig, & Dozois, 2013).

Getting a better understanding of the relationship between EMSs and the development of psychopathology has important implications in clinical practice. Similarly, identifying resilience factors is considered as vital. Therefore, self-empowerment becomes a critical milestone in terms of both preventive actions and relapse-prevention strategies. These postulations are usually valid for any psychotherapy theory. As it is expected, the importance of self-empowerment is also emphasized in schema therapy. Accordingly, an effective treatment process should involve supporting the healthy side of the patient.

The change mechanism in schema therapy is based upon strengthening the rational and healthy part of the patient in order to have control upon emotional ups and downs. In light of this, negotiation, nurturance and moderation are accepted as fundamental elements to relief from psychological impairment.

According to the postulations of Schema Therapy, every single individual has a healthy adult mode. Unfortunately, not everyone has the opportunity to use that mode effectively because, getting back in touch with early emotional needs is not that easy for every individual, especially, if the past is full of adverse experiences.

Schema therapy aims to help patients strengthen their healthy adult mode, recognize their core emotional needs, and hence, heal EMSs. During this process, with the help of healthy adult mode, the individual is able to identify the problem, look from a different perspective to the present problem, and is able to employ a healthier coping strategy. In this respect, the healthy adult mode functions like a "good enough" parent via organizing the functions of different modes. Accordingly, the functions of healthy adult modes are as follows:

1. Nurturance, affirmation and protection of the Vulnerable Child,

2. Induction of self-discipline and limit-setting for the Angry Child and the Impulsive/Undisciplined Child.

3. Taking a stand against and moderation of maladaptive coping modes and dysfunctional parent modes (Young, Kolosko, & Weishaar, 2003, pp. 278).

The healthy adult mode also gets stronger by the internalization of the therapist's attitudes towards the patient. In this regard, the therapist should be a role model. Gradually, the patient internalizes these behavior patterns and schema change is acquired with the employment of new behaviors. This process is called limited reparenting. In this process, as a role model, the therapist tries to validate the patient's emotions and shows compassion towards the patient via limited re-parenting. Similarly, imaginary exercises are utilized as a way to practice self-compassion, which is viewed as the beginning of a process that leads to a stronger healthy adult mode. In imaginary exercises, which is a technique that aims to meet the patient's emotional needs by visualizing earlier memories of maltreatment and traumas, the therapist defends, nurtures and helps the patient to oppose the arguments of the critical side of the patient. For instance, the change process in schema therapy of patients with borderline personality disorder involves learning of emotion regulation, bonding with the therapist, schema mode change and helping the individual to gain autonomy, respectively (Young, Kolosko, & Weishaar, 2003).

On the bases of the main postulations of schema therapy, one can foresee that people who have healthy emotion regulation strategies and higher levels of compassion and mindfulness are more likely to overcome the disruptive effects of early maladaptive schemas, and they are less likely to display psychopathological symptoms. Emotion regulation is considered crucial for self-discipline and battling with the emotions; whereas, self-compassion is a critical element for nurturance and protection of the vulnerable child mode.

In literature, self-compassion is viewed as an emotion regulation strategy. However, Finlay-Jones and colleagues (2015) posit that self-compassion involves self-to-self relation; whereas, emotion regulation only involves one's emotions. Therefore, self-compassion involves further positive outcomes in addition to emotion regulation. Hence, these two interrelated constructs are included separately in the present study.

1.2.1. Emotion Regulation

The idea that personal control is strongly associated with reduction in stress reactions has become popular. However, it's a known fact that perceiving an event as controllable is not sufficient for coping with the stress caused by adverse events (Folkman, 1984). In this regard, emotion regulation theory emphasizes the importance of the severity and duration regarding emotional responses rather than the type of emotional responses. That is, when the individual faces stressful experiences, the most delicate part of giving an adaptive response is to have control over the severity and duration of the individual's responses. Otherwise, responding with unsuccessful strategies such as rumination or avoidance may increase negative affections and escalate into more serious psychological health problems (Finlay-Jones et al., 2015).

Research regarding emotion regulation has its roots from psychoanalytic theorizing of defense mechanisms. More recently, it is identified with the management of emotions and linked to a diversity of psychopathological symptoms (for an extensive review, see Koole, 2009). In this regard, emotion regulation can be defined as a combination of cognitive and behavioral reactions that limit the spontaneous flow of emotions via modifying the way people experience and give reactions (cited in Koole, 2009). On the other hand, literature regarding emotion regulation has expanded and the term is defined within a diversity of theories. Therefore, sometimes, these definitions can appear as inconsistent (Sarıtaş-Atalar, Gençöz, & Özen, 2015). In light of this, researchers generally emphasize three considerations. Firstly, an individual should try to regulate extreme emotions on both the positive and negative sides because experiencing higher levels of positive

emotions can cause detrimental effects as well. Secondly, emotion regulation should be made at both conscious and unconscious levels. This means that we can regulate emotions in line with socially acceptable rules either on purpose or without. Thirdly, emotion regulation is neither good nor bad because problematic emotion regulation strategies can cause a disruptive response style as well. For instance, emotion regulation can sometimes cause numbness instead of giving emphatic responses to the people who experience adverse life events (cited in Gross, 2002). In all conditions, cognitive emotion regulation interacts with a diversity of different structures namely; memory, attention and conscientiousness. Moreover, emotion regulation does not always mean diminishing negative emotions. Valuing and accepting emotions is also an important part of the emotion regulation process. Despite the different conceptualizations of the concept, all theories appreciate the importance of non-judgmental acceptance of emotions (cited in Gratz & Roemer, 2004; Masomi, Hejazi, & Sobhi, 2014). Therefore, utilizing an adaptive coping strategy involves a complicated activation of different systems.

1.2.1.1. Emotion Regulation and Schema Theory

When schemas are triggered, they can give rise to strong emotions. Therefore, an important part of the healing mechanism focuses on the role of emotions in the schema therapy process (Kellogg & Young, 2006). Patients who have problems regarding emotion regulation and higher levels of EMSs lack identifying and utilizing adequate emotional responses to external stimuli. Therefore, they have great difficulties in their interpersonal relationships, including the therapy relationship as well (Young, Kolosko, & Weishaar, 2003). When faced with intense emotions caused by the activation of early maladaptive schemata, the individual can react in three different ways. The first one is surrender, in which individuals give in to and accept the disruptive thinking patterns of relevant schemata. The second one is avoidance. Avoidance involves avoidance of the activation of schemata, which results in the absence of contradictory evidence to schema related irrational beliefs. The last one is overcompensation, which means battling with the schema by behaving in the opposite way the schema enforces. Although these coping

mechanisms are effective in the short term, they cause the escalation and maintenance of the schema related maladaptive behavior patterns. Therefore, teaching effective coping and emotion regulation strategies to the patients is an important part of schema therapy. In this regard, schema therapy offers different techniques such as imaginary restrictiping, empty chair technique and mindfulness based interventions in order to help with difficulties in emotion regulation and empowerment of the healthy adult mode (van Genderen, Rijkeboer, & Arntz, 2012). Moreover, in schema therapy practice, rather than characterizing a person's personality as problematic, labeling the problematic behaviors with caution seems to be more appropriate because it promotes mentalization, which effectively contributes to emotion regulation by emphasizing the distance between the emotional experience and the individual's self (cited in Cousineau, 2012).

1.2.1.2. Emotion Regulation and Well Being

Emotion regulation is substantially emphasized for the development and maintenance of psychopathology. In literature, the relationship between emotion regulation and psychopathology is empirically validated in terms of different disorders, namely borderline personality disorder, emotional disorders, anxiety disorders, eating disorders, substance abuse and sleep problems (for an in-depth review see Aldao, Nolen-hoeksema, & Schweizer, 2010).

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV), nearly three quarters of the diagnostic categories involve problems related to emotion regulation. In this regard, the trans-diagnostic nature of the concept makes emotion regulation-based strategies vital for the treatment process. In terms of clinical psychology, identifying specific difficulties in emotion regulation is the first step of planning an effective treatment strategy (cited in Kring & Sloan, 2010). According to Gratz and Roemer (2004), difficulties in emotion regulation difficulties involve problems regarding awareness and acceptance of the emotions, and utilization of inappropriate and impulsive behaviors triggered by strong

emotions. Th, rather than the type of emotional regulation, specific dysfunctional parts of emotion regulation strategies are the main interest of the current study.

1.2.2. Self-Compassion

Self- Compassion is considered as an adaptive coping strategy that involves soothing oneself with warmth, acceptance and caring. While relating self-to-self, the individual is able to handle adverse emotions in a more constructive way. Hence, rather than desperately battling with these emotions, self-compassion provides an objective stand and a safe emotional distance from problematic events in order to get a more realistic understanding of the issue. Hence, the individual may display more adaptive behavioral responds rather than struggling with self-criticism, self-blame and irrational thoughts (Finlay-Jones et al., 2015).

Neff's (2003) definition of self-compassion involves three main components in bipolar continuums. The first one is self-kindness versus self-judgement. This continuum involves the ability to treat oneself with gentleness and acceptance rather than employing a belittling and critical stance. The second continuum involves common humanity versus isolation. Accordingly, adverse life events caused by failures or imperfections are acknowledged as shared human experiences that can be experienced by anybody. At the other end of the continuum, isolation leads to pessimism and sense of loneliness. The third continuum is about mindfulness versus over-identification. This continuum emphasizes the importance of balance between appraisal and the suppression of emotions. That is, having a realistic perspective and becoming aware of emotions in a non-judgmental way is recommended rather than pessimistic self-victimization.

Although self-compassion is substantially associated with self-esteem, the biggest difference between these two similar concepts is that self-esteem is related to social comparison, standards and self-evaluation; whereas, from a compassionate perspective, failures and imperfections are considered as common human experiences. Although self-esteem has been accepted as an important indicator for psychological health for many years, researchers recently start to warn about the

negative effects of inflated self-esteem, namely prejudices, ego-centrism, narcissism and violence regarding possible threats (cited in Neff, Kirkpatrick, & Rude, 2007; Neff, 2003). Hence, self-compassion promotes self-awareness and self-soothing. Therefore, it provides emotional safety that leads to the modification of problematic behaviors, rather than being caught up in self-pity and feelings of defectiveness (Neff, 2003).

1.2.2.1. Self-Compassion and Schema Theory

Compassion has an important place in schema theory. It is accepted crucial for the sake of the patient, the therapeutic relationship and the therapist's own self-care because nearly all experiential strategies aim to make the patients capable of feeling compassionate towards their childhood self. The childhood experiences are targeted because the development of both EMSs and lower levels of self-compassion are associated with adverse childhood experiences and maltreatment (Young, 1990/1999; Vettese et al., 2011). In order to heal the traces of these adverse experiences, schema therapy process primarily focuses on the relationship between the patient and the therapist in terms of the process of limited reparenting. With this respect, the bonding between the patient and the therapist is crucial and the relationship cannot be established without the therapist's compassion towards the patient because compassion provides an emphatic understanding of the problems of the patient. Lastly, for the sake of this change process, the therapist should utilize self-compassion strategies in order to satisfy her/his own core emotional needs and become a role model to the patient (Young, Kolosko, & Weishaar, 2003).

Self-compassion is also an important component for the implementation of schema therapy interventions as well. For instance, the therapist should treat the patient with compassion rather than a judgmental attitude. Similarly, forming a safe environment based on compassion will lessen the psychological pain caused by imaginary work as well (Hoffart, 2012). Moreover, emphatic confrontation cannot succeed without adequate level of compassion. Therefore, the therapist should adapt an objective and emphatic stance at the same time (Rafaeli, Bernstein, & Young, 2011). Hence, self-

compassion exercises are strongly recommended to empower healthy adult mode in schema therapy (Vreeswijk, Broersen, & Nadort, 2012). In light of this, it can be postulated that self-compassion helps to modify the process that contributes to the development and maintenance of EMSs.

1.2.2.2. Self-Compassion and Well Being

Although the need of empirical research on self-compassion is still needed, the concept is becoming popular with the new "third wave" trend of cognitive psychology. In this regard, there is growing literature on the relationship with self-compassion and psychopathology. Self-compassion is found to be strongly associated with depression and anxiety, and its effects on psychopathology maintains even after the effects of self-esteem and self-criticism are controlled. In this respect, self-compassion is accepted as a diverse concept, which contributes to the development of psychopathology (Neff, 2003; Neff et al., 2007).

In a recent review of MacBeth and Gumley (2012), it was found that self-compassion has considerable effects on depression, and it is also related to anxiety and stress respectively. In another study, self-compassion is associated with maladaptive emotion regulation strategies. For instance, rumination, suppression of emotions and avoidance are found to be negatively correlated with self-compassion (Finlay-Jones et al., 2015). Similarly, Neff, Hsieh and Dejitterat (2005) found that self-compassion is negatively associated with avoidance and positively correlated with adaptive coping strategies such as acceptance and optimism when the participants experience academic failure. In addition, Vettese and colleagues (2011) found a mediation effect of self-compassion between childhood maltreatment and later emotion regulation difficulties. I t was also found that self-compassion has a mediator role between childhood emotional abuse and later problematic alcohol use in female college students (Miron, Orcutt, Hannan, & Thompson, 2014). In terms of personality characteristics, Neff and colleagues (2007) found that self-compassion is related to positive personality characteristics such as extroversion and conscientiousness.

In terms of clinical samples, Costa and Pinto-Gouveia (2011) conducted their research with chronic pain patients and found that self-compassion is positively correlated with the acceptance of pain, which is also found to be related to lower levels of depression and stress. Hence, despite the scarcity of the empirical research using clinical populations, self-compassion is accepted as an important contributor the development and maintenance of psychopathology.

1.3. Problems Regarding Psychometric Assessment of Early Maladaptive Schemas

Recently, interest in schema research has increased as little is known about the underlying mechanism of the relationship between EMSs and personality psychopathology in terms of empirical trials. In this respect, research is still limited in terms of the predictive validity of Young Schema Questionnaire (YSQ) (Nordahl, Holthe, & Haugum, 2005).

Different versions of YSQ is widely utilized in schema research. It was substantially displayed that YSQ is an adequate measurement tool to dicriminate people with psychopathological symptoms from those who do not display psychopathological symptoms (see Rijkeboer & Van Den Bergh, 2006). However, it is a known fact that schema coping responses can intervene with the assesment process and cause faulty judgement while trying to elicit an individual's EMSs via YSQ. Moreover, schemas are accepted as latent structures that exist outside of the individual's awareness. Therefore, when activated, these schemas intervene with the information process and the individuals may not be able to make rational and realistic judgements about what they have been through. Therefore, by relying competely on self-reports, a large amount of risk is taken during the assessment process. This problem is adressed by a diversity of researchers, who claim that despite its practicality, self-report measures only present decriptive information rather than providing evidence on relationships regarding self-structure (cited in Schmidt et al, 1995). In this respect, different assessment methods are recommended to measure EMSs, namely dreams (Young, Kolosko, & Weishaar, 2003), stroop test (Nordahl, Holthe, &

Haugum, 2005), cross-validation (Roelofs, Onckels & Muris, 2013) and memories (Beck,1996). Therefore, research utilizing different methods is needed for further validation of the schema model.

1.3.1. Reliability of the Schema Domains

Despite Problems regarding YSQ as a psychometric assessment tool, the first-order factor structure of the EMSs is empirically validated with a diversity of languages and populations. On the other hand, results are not that consistent in terms of second-order dimensions as there are three-factor (Schmidt et al, 1995; Cecero, Nelson, & Gillie, 2004), four-factor (Lee, Taylor, & Dunn 1999; Hoffart et al., 2005), and five-factor solutions (Young, 1990/1999) suggested in different studies. This argument is also valid for the research that is conducted with the Turkish population. The first adaptation study was conducted by Soygüt and colleagues (2009). Accordingly, fourteen EMSs and five schema domains were suggested. On the other hand, in a more recent study, eighteen EMSs were suggested within three higher order domains with an adolescent sample (Sarıtaş, & Gençöz, 2011).

According to Hoffard and colleagues (2005), different conclusions regarding schema domains can be drawn based on the possible interplay between EMSs. Negative self-image is an underlying common factor for all EMSs. Therefore, this problem causes multicollinearity and makes obtaining a consistent schema domain structure very difficult. Although Hoffard and colleagues suggest a four-factor solution regarding schema domains, the multicollinearity is still the main problem, and the result of the study is substantially criticized by Kriston and colleagues (2012). Accordingly, the model suggested by Hoffard and colleagues is an "overfitting" model, and the generalizability of the results is overemphasized. Hence, Kriston and colleagues (2012) emphasized the heterogeneity of the results obtained in different studies. They argue that there are a large number of schemas, which are measured as observed variables, theorized with complex models. They also highlight the considerable multicollinearity between both observed and latent structures, and negative beliefs and negative self-images are identified as common

factors. Therefore, they postulated that the results obtained from such a complicated analyses with many different pitfalls usually reflect the researchers' own decisions rather than a robust statistical pattern regarding factorial structure. Consequently, they do not suggest a definite higher-order schema domain and question the existence of higher domains.

Despite the contrasting postulations in the theoretical and statistical area, schema domains are currently used in a diversity of different research areas regarding schema theory because reducing 18 schemas to five factors increases the power of statistical analysis. Unfortunately, present research regarding schema domains lacks a substantial structure. Hence, it was suggested that rather than using domains, a researcher could select EMSs based on theoretical relevance of their subject in order to reduce the number of variables (Hawke & Provencher, 2011).

1.3.1.1. The Disconnection/rejection Domain: Identifying "The Broken Ones"

It is known from literature that the disconnection/rejection domain, which is closely associated with psychopathology, is the most problematical schema domain (Young, Klosko, & Weishaar, 2003). However, it is still hard to define what we refer to by saying "participants who have higher scores on disconnection-rejection dimension". When we look back at the early studies regarding schema dimensions, Schmidt and colleagues (1995) defined the disconnection-rejection domain with abandonment/instability, mistrust/abuse, emotional deprivation, defectiveness, emotional inhibition, fear of losing control, and insufficient self-control; whereas, Lee and colleagues (1999) defined disconnection-rejection domain with abandonment/instability, mistrust/abuse, emotional deprivation, defectiveness, social isolation/alienation and emotional deprivation. Furthermore, Cecero and colleagues (2004) do not even have a domain named disconnection/rejection in their conceptualization of EMSs (cited in Soygüt, Karaosmanoğlu & Çakır, 2009). In a more recent study, Hoffard and colleagues (2005) investigated whether schemas can be organized into domains. Accordingly, the results of thirteen previous studies including second-order factor analyses with EMSs were discussed with the results

of their study, which “do not provide unequivocal support for the presence of a second-order domain structure” (pp. 684). Consequently, it was proposed that models that utilize first-order schema factors provide a better fit that the model aims to organize schemas into domains via second-order factor analysis. Similarly, according to Rijkeboer (Personal communication, June, 2014), a consistent factor structure in terms of schema domains is really hard to obtain. The same problems are pretty much valid for adaptation studies with Turkish population. Soygüt and colleagues (2009) proposed a four-factor-solution in terms of schema domains, namely impaired autonomy, disconnection, unrelenting standards, impaired limits and other directedness, and they identified fourteen EMSs, which presents a different first-order factor structure than the original 18 EMSs. On the other hand, Sarıtaş and Gençöz (2011) also investigated the factor structure of YSQ with an adolescent sample. They utilized the first-factor structure of the revised theory of Young and colleagues (2003) to obtain 18 schemas. Later on, a second-order factor analysis was conducted to identify schema domains. Accordingly, three schema domains were derived, namely impaired limits/exaggerated standards, disconnection/rejection and impaired autonomy/other directedness. Thus, the intellectual polyphony of the studies is evident in terms of the disconnection/rejection domain as well.

1.3.2. Ranking up the Past: Childhood Memories

Moreover, while forming Schema Theory, Young (1990/1999) proposes different assessment procedures to identify the EMSs of an individual. Early childhood memories and dreams are two different elements that are recommended to understand the development and maintenance of early maladaptive schemas. Similarly, Beck (1996) viewed early memories as important resources to elicit EMSs as well. By confirming Young’s and Beck’s postulations, Cousineau (2012) argues that implicit memory is related to bodily sensations, emotions, perceptual categorization, mental models, behavior tendencies, and behavior responses; whereas, explicit memory is conceptual and narrative. Thus, maladaptive schemas are mainly present in implicit memory, and they are hard to reach by using self-

report. Actually, despite its clinical utility, schema assessment based on a paper-pencil test has many disadvantages. For instance, individuals actively utilize maladaptive coping behaviors in order to avoid the negative emotions caused by schema activation. Therefore, getting a high score on an EMS does not reassure having that schema. For instance, if an individual scores high on the items regarding unrelenting standards schema, one cannot specifically say if it is a schema surrender or it is an overcompensation for the failure schema. This is important because Young and colleagues (2003) have emphasized the essentiality of accurate identification of schemas in order to be able to tailor individualized treatment interventions according to case conceptualization. Moreover, especially in prison populations, participants usually try to create a desirable form of themselves, and they can answer the questions accordingly. In this regard, implicit measures are recommended within the forensic field. Furthermore, it was argued that themes related to internalization problems are frequently addressed in YSQ; whereas, the case is not the same for themes related to externalization problems such as anger and hostility. Therefore, the need for more balanced models was emphasized. (Rijkeboer, 2012). All in all, alternative methods were suggested not to lose valuable information in terms of schema assessment. That is, in line with the abovementioned recommendations, a new assessment procedure that enables researchers to look at the problem from different angles, could be a good idea.

Memories, especially early memories play a crucial role in the conceptualization of every psychotherapy model. In this regard, processing and re-interpreting childhood memories is an essential part of modifying EMSs in schema therapy. Actually, it is recommended to start schema work with the treatment of childhood memories because memories also play a crucial role in triggering fundamental emotions that contribute to the development of EMSs (Weertman & Arntz, 2007). Therefore, in this particular study, focusing on childhood memories was thought of to gather richer information about EMSs.

1.3.2.1. The Early Theories Regarding Childhood Memories

Early recollections were firstly used as a projective therapeutic tool by Adler. Until then, Freud had already mentioned them, but rather than reminisce, he mainly focused on the repression of these memories. He believed that these memories are repressed because they have a latent content, and he considered the early recollections as unconscious screen memories that concealed and substituted sexual conflicts (cited in Mosak & Di Pietro, 2006). On the other hand, Adler considered utilizing early recollections as one of the most trustworthy approaches to identify personality structures. Accordingly, if the basic themes in an early childhood memory can be identified, the individual's future life can be predicted because memories indicate an individual's goals as well as the possible obstacles while striving for these life goals. He also recommended to focus on the first memories of an individual because these memories are seen as more compressed and simple. Accordingly, the first memories give opinion about the individual's life story because usually, the general attitude of the individual is confirmed by that specific crystalized memory as a starting point. Thus, the fundamental dilemmas of a person is usually represented in retained memories (Adler, 1927/1997; Adler, 1956). More specifically, Adler recommended working with memories before the age of ten because at those ages, the sequence of the events cannot be remembered precisely. Therefore, these memories leave place for the individual's projection while talking about an early memory (cited in Mosak & Di Pietro, 2006). Another milestone of Adlerian Theory is understanding the patient's lifestyle, which is accepted as a combination of "one's private logic, develops out of one's life plan, and is powered by the fictional goal one established for oneself" (Dinkmeyer & Sperry, 2000, p.33). In order to evaluate a person's lifestyle, a semi-structured assessment procedure was utilized that contains family history and dynamics, perceptions regarding the self and the outer environment, problems and coping styles etc. (Dinkmeyer & Sperry, 2000). In line with the ideas of Adler, Bartlett (1932) also emphasizes the modification of the worldview based on the data that is gathered from new experiences. Accordingly, individuals actively modify their memories in order to get

a coherent understanding regarding their self and the environment. Thus, early recollections were employed by a variety of different therapists as a reliable and valid projective tool in clinical practice (see Mosak & Di Pietro, 2006). Built upon the ideas of Bartlett (1932), the significance of early recollections is also emphasized within attachment literature. In this respect, early repeated experiences with significant others are internalized and shape the individual's expectancies. Hence, these early memories were considered as a combination of the individual's assumptions and internal working models (cited in Androutsopoulou, 2013). From an object-relations perspective, Mayman (1968) also emphasizes thematic representations in early childhood memories. Accordingly, early memories provide data to construct transference patterns that are carried into adult life, and they have a high possibility to be reenacted with significant others. In terms of their innovative technique, Mayman and Faris (1960) initiate the multidisciplinary utilization of early memories in the interpersonal matrix. In this procedure, namely Early Memory Test, the early recollections of the patients were gathered from different sources (i.e., the patient, and the patient's parents) and analyzed with a qualitative method that is similar to the TAT procedure. Hence, throughout years, an individual's experiences are accepted as fundamental indicators of the individual's present and future decisions.

More recently, Bruhn (1990) has emphasized the importance of early collections within an autobiographical memory perspective. He argues that information regarding the operation of autobiographical memory within an individual's belief system is usually overlooked in the clinical perspective. He proposed that although many clinicians report working with early maladaptive experiences during the course of therapy, they are usually not clear about what they use the past for, how they use early memories and how they view early childhood memories. According to his Cognitive-Perceptual Theory, memory content consists of the fantasies about the past that significantly interact with the present concerns. Hence, in order to identify the subject's current process of perception, one should investigate how the data is organized while processing an autobiographical memory. Therefore,

autobiographical memory is conceptualized as a stable schemata that filters the data obtained via the perceptual structure of the individual. Thus, it was postulated that information that falls outside of the perceptive boundaries of present schemas tend to be neglected. In this regard, the individual adopts attitudes in line with the information derived from perceptual filtering of the memories. Thus, these attitudes work as "gatekeepers" of the autobiographical memory because they process the new information and decide whether data will be collected or not. Hence, filtered memories are collected as important life lessons regarding the individual's self and the outer environment, which in turn, shape the individual's worldview. Moreover, the system also intervenes with the individual's decisions, and hence, shapes the individual's future experiences. In light of this, present life lessons derived from memories shape the individual's future life choices. In this regard, autobiographical memories are important as a projective tool for clinicians in order to assess current problems of the individuals (Bluck et al., 2005). That is, the clinical use of memory content becomes a current issue.

1.3.2.2. Early Childhood Memories within Clinical Perspective

As mentioned earlier, early memories have been appealing to clinicians' interest since the very beginning. Actually, being a psychologist is directly linked with going back to one's childhood for the majority of people. In this regard, respectable amount of research focuses on the functions of memory and mainly involves why humans significantly remember certain important life events and why these memories are retained while others are deleted (Bluck et al., 2005). Prominent cognitive theories are interested in the same question and utilize memories for understanding cognitive biases regarding selective perception and selective recollection of memories, which in turn, results in focusing on the memory retrieval process. For instance, according to Teasdale's Differential Activation Hypothesis, which is one of the most popular cognitive vulnerability models, rumination can alter the memory retrieval process in terms of the type and specifity of the memory (cited in Teasdale et al., 2000). Given that depression and rumination quite often occurred as concomitant to other types of psychopathologies, several studies focus

on this process within other psychopathologies as well, namely eating disorder (Cooper & Wade, 2015) and post-traumatic stress disorder (Bryant, Sutherland, & Guthrie, 2007). On the other hand, Clark (2002) argues that contemporary therapies are putting less emphasis on a detailed childhood history, but rather they take the history of the patient roughly and usually inquire in line with the possible symptoms of a diagnosis. Moreover, he argued that despite their clinical utility, it is not a popular topic for contemporary clinicians directly. According to him, this can be due to two different reasons. Firstly, he proposed that there are lack of extensive theoretical framings and extensive case examples. Secondly, it was perceived as risky by contemporary postmodern clinicians because early recollections are considered as entirely associated with individualistic and modernist approaches (cited in Androutsopoulou, 2013).

On the other hand, Singer and Bonalume (2010) proposed that early memories have been utilized by contemporary psychotherapy approaches, providing emotional pathways to the core of the present problems. Interestingly enough, early memories are central therapeutic material in many different psychotherapy approaches. Moreover, the content of memory narratives continue to play a critical role in crucial therapeutic techniques in contemporary therapy; namely role-plays, emphatic dialogues, and imaginative techniques. Early memories can even be used as a predictor of therapeutic alliance. In a study of Ryan and Cicchetti (1985), they found that object-relations scores derived from early recollections account for 30% of variance in therapeutic relationship and the findings are replicated by later research (cited in Pinsker-Aspen, Stein, & Hilsenroth, 2007).

1.3.2.3. Early Memories and Schema Therapy

The importance of early recollections is also mentioned in Schema Theory because early memories are crucial elements that provide acquiring of the EMSs. Thus, in order to deal with EMSs, schema therapy techniques should aim to deal with adverse childhood experiences; therefore, schema work with modes and imaginary techniques usually focus on the early recollection of adverse memories (Young, Klosko, Weishaar, 2003). Hence, although the contents of early recollections do not

seem to be the focus of contemporary theories, they are broadly utilized within different brand-new techniques.

Up to now, different researchers addressed this obvious resemblance between theories of memory and schema theory. For instance, Clark (2002) mentioned that schema conceptualization is quite similar to the Adlerian lifestyle construct consisting of early memories. Moreover, Benesch (2012) propose an integration of schema therapy with Adlerian Psychology. In that study, Adlerian psychology terms are integrated into schema therapy techniques and the similarities are emphasized. Similar to the Adlerian view regarding memory as described in Mosak and Di Pietro's (2006) procedure, schema therapy techniques also focus on the representation of the memory constructed by the individual rather than "true" events. Considering memory work, the important thing is identifying the themes that are quite often presented in the adverse childhood experiences because they contribute to the development of EMSs. This link works similar to the mechanism of traumatic memories: adverse childhood experiences usually are usually not processed adequately and continue to intervene with the individuals' present life. In this regard, working on early memories has a high possibility to stir up problematic patterns that need to be altered (Padmanabhanunni, & Edwards, 2014). According to Young and colleagues (2003), specific memories are also used in schema therapy to work with the problem at an emotional level. Working on early memories is conceptualized as turning "cold cognitions to hot ones" in order to identify the fundamental unmet childhood needs (cited in Bamber, 2004). The obvious connection between Adlerian Theory and Schema Theory is also highlighted by Dinkmeyer and Sperry (2000). In this regard, Young's (1990/1999) definition of early maladaptive schemas "reflects Adlerian lifestyle convictions" and Young's (1990/1999) point of view is "strikingly similar to Adlerian formulations of various personality disorders" (p.18).

Although the link between memories and EMSs was theoretically established, it was investigated by only a few researchers. Two studies conducted by Jacquin (1985) and Brandon (2000) examined whether negative memories prime EMSs.

Both studies failed to find a priming effect, meaning that EMSs are trait-like structures (cited in Rijkeboer, 2012). Moreover, from a technical perspective, Arntz and Weertman (1999) utilized early memories for imaginary rescripting and historical role-play and produced guidelines for standardization of the techniques. Accordingly, working on early memories is considered as an effective tool for the treatment process of chronic psychopathologies originated in childhood. To my knowledge, only one study investigated the role of memory content. Accordingly, Theiler (2005) investigated maladaptive schemas of disconnection-rejection domain represented in early memories in line with the procedures of object relations themes described by Bruhn (1990). In Theiler's study, exploring childhood memories isrecommended as a stronger tool to obtain extensive information at both the conscious and unconscious levels. However, the results of self-report measures and the results derived from early memories were identified as considerably different. Some participants did not report having a maladaptive schema via self-report assessment tool (YSQ), but the examination of the childhood memories revealed maladaptive schemas. More interestingly, some self-reported schemas were not identified in the examination of childhood memories. Therefore, they emphasize the need for further research for different cultures, techniques and populations. Thus, the present study aims to provide a new assessment procedure in order to get an extensive information about the EMSs of an individual.

1.4. Significance of Choosing a Mixed Method Design

Mixed method research is a relatively new approach, which has gradually gained acceptance in modern psychology research. Accordingly, choosing the analysis based on the type of data is viewed as a surreally sterile point of view. Rather, the researcher should focus on the interpretation of meaning in the results of quantitative processing (Kuckartz, 2014). As was already discussed, EMSs are hard to reach via self-report. Therefore, the researcher should involve the reporting process via actual human interaction (semi-structured questions, images etc.). Otherwise, schema-related emotions cause subtle biases towards the information process regarding interpretations and remembrance of the events. Unfortunately,

these possible biases can be undetectable via self-report questionnaires as previously addressed (Hedlund & Rude, 1995).

A conventional solution to this problem is content analysis, a social science research method decribed by Weber (1910), who considers thematic analysis as a mainly quantitative argumentation. On the other hand, the describtion of a classical content analysis is accepted as the initial step of the development of a qualitative analysis. Kraucer (1952) was the first person who emphasized the importance of identifying the latent content and subjective interpretation of the text rather than relying solely on objective content (numerical values) of the data. Hence, qualitative content analysis was suggested as an alternative to mainstream content analysis. Accordingly, traditional content analysis was considered as non-reactive, in which the researcher has little or no effect on the communication process. However, Kracauer proposed that text analysis cannot be conducted by ignoring the subjective interpretation of the text (cited in Kuckartz, 2014). Therefore, qualitative content analysis was considered as vital in social sciences research because research in social sciences obligated to include interpretation of the researcher in any case. Hence, qualitative content analysis was defined as "a qualitative text analysis in which an understanding and interpretation of the text play a far larger role than in classical content analysis, which is more limited to the so-called "manifest content". Recently, rather than strict quantitative analyses, qualitative analysis began to attract attention of the researchers in the area of psychology. In a recent form of classical content analysis, computers do the coding of the text based on specific dictionaries. On the other hand, qualitative content analysis was an interpretative form of analysis that is linked to human understanding (Kuckartz, 2014).

Considering the information derived from theoretical and methodological readings, rather than just empirical quantitative research, combining both perspectives and utilizing a mixed paradigm seems to provide an integrated and a more reliable view of the early maladaptive schema structures and schema theory.

1.5. The Aims of the 1st and 2nd Studies

Theoretical interest in schema theory mainly focused on the link between early childhood memories, development of relevant EMSs, and the resilience factors. However, it is striking that the connection was neglected in terms of empirical evidence. Although early childhood memories are postulated as a part of EMSs, research is limited in terms of the link between childhood memories and EMSs. Similarly, although the healthy adult mode is theorized substantially, research regarding associates of this concept is scarce. In this respect, the current study aims to fill the obvious gaps in the literature via two connected studies:

The first study aims to provide empirical evidence on positivity and the well-being part of schema theory, which is an important area that remains untouched. Based on the main postulations of schema theory, the present study aims to elicit resilience factors that lead to a way to escape from the detrimental effects of EMSs. Moreover, the first study focuses on the role of different constructs that are postulated to be related to healthy adult mode (i.e., self-compassion and emotion regulation), the relationship between early maladaptive schema domains (i.e., the disconnection/rejection domain, the impaired autonomy/other directedness domain, the impaired limits/exaggerated standards domain), psychopathology and life satisfaction. To my knowledge, this is the first study that utilizes a positive psychology perspective within schema theory, and it is the first attempt to gather empirical data on the indicators of healthy adult mode. In the present study, it is hypothesized that:

Higher scores in early maladaptive schema domains predict lower levels of self-compassion and life satisfaction, and higher levels of difficulties in emotion regulation and psychopathological symptoms.

Higher levels of self-compassion and lower levels of difficulties in emotion regulation predict higher levels of life satisfaction and lower levels of psychopathological symptoms.

The relationship between higher levels of early maladaptive schema domains and higher levels of psychopathological symptoms and lower levels of life satisfaction is mediated by difficulties in emotion regulation and self-compassion.

Following the model presented in Figure 1.1, two sets of hierarchical regression analyses were conducted to examine the paths of early maladaptive schema domains, difficulties in emotion regulation, and the symptoms of psychopathology and life satisfaction.

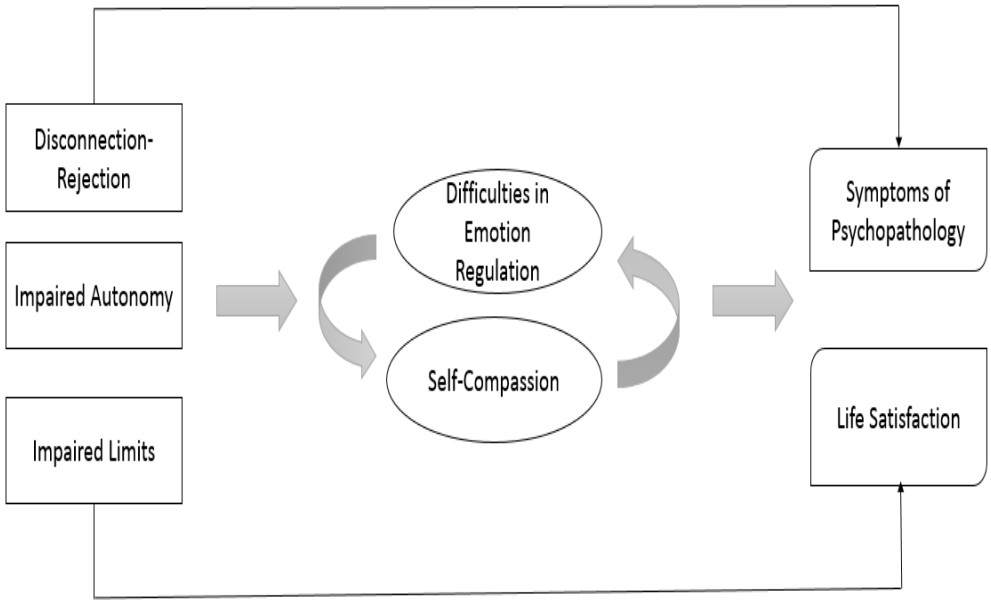

Figure 1. *The Model of The Study*

Accordingly, the first set of regression was conducted to identify associates of self-compassion and difficulties in emotion regulation. The second set of analyses was conducted to identify the associates of the psychopathological symptoms and life satisfaction. As suggested by the model, self-compassion and difficulties in emotion regulation scores were controlled for the second set of analyses. Lastly, the mediator role of self-compassion and emotion regulation difficulties were tested via several multiple mediation analyses.

With respect to the abovementioned problems regarding a quantitative assessment of the EMSs, a second study was planned in order to provide an integrated

understanding regarding the most important EMSs in terms of the individual's well-being. Hence, the aim of the second study was to investigate prominent themes and emotions regarding EMSs, and interpret their latent meanings. In order to trigger schema related memories, Schema Mode Cards were utilized. Since the EMSs that we aim to identify in the data was decided based on the results of the first study, a deductive qualitative content analysis perspective was employed as recommended by the steps described by Mayring (2000) as presented in Figure 1.2.

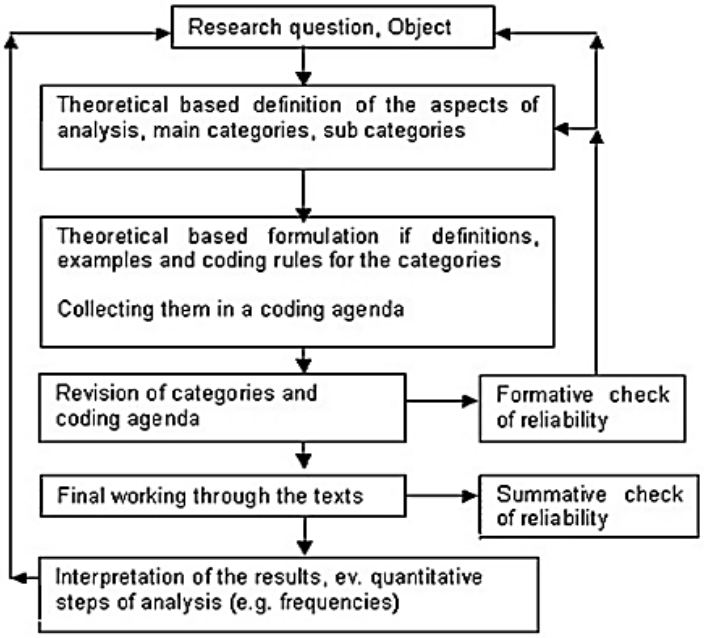

Figure 2. *Steps of Deductive Qualitative Content Analysis (Mayring, 2000)*

CHAPTER 2

FIRST STUDY: STAYING ON THE SAFE PATH: THE INTERPLAY BETWEEN EMSs, SELF-COMPASSION, EMOTION REGULATION AND WELL-BEING

2.1. Method

2.1.1. Sample

In the present study, data was collected from 305 participants and after data cleaning acts, 296 of them were included in the analyses. The sample consisted of 117 (39,5%) males and 179 (60,5%) females between the ages of 17 and 52 (M = 26.79, SD = 7.032). Detailed characteristics of the subjects are presented in Table 1.

2.1.2. Materials

In the current study, participants filled out a package of questionnaires, namely Young Schema Questionnaire (YSQ-S3) (See Appendix C), Self-compassion Scale (SCS) (See Appendix E), Difficulties in Emotion Regulation Scale (DERS) (See Appendix D), Brief Symptom Inventory (BSI) (See Appendix F), and Satisfaction with Life Scale (LWLS) (See Appendix G).

Table 1. Demographic Characteristics of the Sample

Variables		**N**	**%**
Gender	Female	179	60.5
	Male	117	39.5
	Missing	0	0
	Total	296	100
Age	17 to 25	155	52.4
	26 to 52	141	47.6
	Missing	0	0
	Total	296	100

Table 1. Continued

Variables	N	%	Variables
Family Income	Below 1000 TL	3	1.1
	Between 1000-3000 TL	94	31.8
	Between 3000-5000 TL	97	32.8
	Above 5000 TL	102	34.5
	Missing	0	0
	Total	296	100
Maternal Education Level	Illiterate	22	7.4
	Literate	15	5.1
	Primary School	78	26.4
	Secondary School	40	13.5
	High School	68	23.0
	University	72	24.3
	Missing	1	0.3
	Total	296	100
Paternal Education Level	Illiterate	2	0.3
	Literate	9	0.7
	Primary School	70	23.6
	Secondary School	29	9.8
	High School	87	29.4
	University	98	33.1
	Missing	1	0.3
	Total	296	100
History of Psychological Help	Yes	72	24.3
	No	224	75.7
	Missing	0	0
	Total	296	100

2.1.2.1. Young Schema Questionnaire (YSQ-S3)

Young Schema Questionnaire was developed by Young and Brown (1990, revised in 1994) to evaluate the level of EMSs. It was developed as a 6-point likert scale, and higher scores represent higher levels of EMSs. The first study regarding the psychometric properties of the scale was conducted by Schmidt and colleagues (1995). In the study, which was based on a 205-item questionnaire representing 18 schemas and conducted with both clinical and non-clinical samples, they found 15 EMSs and the internal consistencies were found to be ranging from .83 (enmeshment) to .96 (defectiveness). Similarly, Lee, Taylor and Dunn (1999)

replicated their findings with a factor structure of 15 EMSs. Later on, a 75-item short form of the questionnaire was developed due to practical reasons, and this shortened version was also considered to have similar psychometric properties with the longer version of the scale, again with 15 EMSs that have previously been found (Waller, Meyer, & Ohanian, 2001).

Turkish adaptation study utilizing the 90-item-short version of the YSQ was conducted by Soygüt, Karaosmanoğlu and Çakır (2009). Soygüt and colleagues found a 14-factor-solution that has internal consistencies ranging from .53 (unrelenting standards) to .81 (impaired autonomy). Also, test-retest reliability of the EMSs were found to be ranging from .66 (insufficient self-control) to .83 (disconnection). More recently, Sarıtaş and Gençöz (2011) conducted another study using the original 18-factor-solution with an adolescent population. According to the higher order factor analysis, three schema domains were extracted, namely impaired limits/exaggerated standards, disconnection/rejection and impaired autonomy/other directedness. The internal consistency of the first factor was found to be ranging between .50 and .63, the internal consistency of the second factor was found to be ranging between .48 and .69, and the last factor's internal consistency was found to be ranging between .44 to .64, respectively. In the present study, internal consistency of the scale was .96 for the whole scale, and the internal consistency coefficients of EMSs were found to be ranging from .57 (insufficient self-control/self-discipline) to .85 (Failure). In the present study, the three-factor-solution of Sarıtaş and Gençöz (2011) was utilized, and the internal consistency of the disconnection/rejection domain was found to be .83, the internal consistency of the impaired limits/exaggerated standards domain was found to be .81, and lastly, internal consistency of the impaired autonomy/other directedness domain was found to be .84.

2.1.2.2. Difficulties in Emotion Regulation Scale (DERS)

Difficulties in Emotion Regulation Scale is a 5-point likert scale that was developed by Gratz and Roemer (2004) to asses six different facets of emotion regulation, namely non-acceptance of emotional responses (nonacceptance), difficulties

engaging in goal-directed behavior (goals), impulse control difficulties (impulse), lack of emotional awareness (awareness), limited access to emotion regulation strategies (strategies), and lack of emotional clarity (clarity). Internal consistency of the original scale was found to be .93 for the whole scale; whereas, internal consistency of the subscales was found to be ranging from .80 (awareness) to .89 (goals). Moreover, test-retest reliability was found as .88 for the whole scale and test-retest reliability scores of the subscales were found to be ranging from .57 to .89.

Turkish adaptation of the scale was conducted by Rugancı and Gençöz (2010). In the study, internal consistency of the original scales was found to be .94 for the whole scale while internal consistency of the subscales were found to be ranging from .75 (awareness) to .90 (impulse). In terms of test-retest reliability, .83 was found for the whole scale and the test-retest reliability of the subscales was found to be ranging from .60 to .8. In the present study, revised version of the scale by Kavcıoğlu & Gençöz (2011) was utilized. More recently, the factor structure of the scale was examined with an adolescent sample as well (Sarıtaş-Atalar, Gençöz, & Özen, 2015). Accordingly, internal consistency was found to be .93 in total; whereas, internal consistency of the subscales was found to be ranging from .60 (Awareness) to .85 (Impulse).

In the present study, internal consistency of the original scale was found to be .94 for the whole scale; whereas, internal consistency of the subscales was found to be ranging from .75 (awareness) to .90 (impulse).

2.1.2.3. Self-compassion Scale (SCS)

Self-compassion Scale is a 5-point likert scale that was developed by Neff (2003) to evaluate self-compassion within three dimensions. Each of these three dimensions is considered as continuums with two ends (i.e., positive side self -kindness, negative side self-judgement). In this regard, six subscales, namely self-kindness vs. self judgement, common humanity vs. isolation and mindfulness vs. over-identification were established. Internal consistency of the original scale was found as .92 for the whole scale; whereas, internal consistency of the subscales were

found to be ranging from .75 to .81. Test-retest reliability was found to be .93 in total, and it was found to be ranging from .80 to .88 for the subscales.

The scale was adapted to Turkish populations several times (i.e. Öveç, Akın & Abacı, 2007; Deniz, Kesici & Sümer 2008; Kantaş, 2013). In the first study, six-factor solution is supported and internal consistency of the subscales were found to be ranging from .72 to .80, and test-retest reliability of the subscales were found to be ranging from .58 to .69. In the second study, a one-factor solution was recommended. According to the results, internal consistency was .89, and test-retest reliability was .83. Thus, in literature, research usually polyphonies in terms of translation variations and factor structure. The last study offered an alternation to the present adaptation studies. In this regard, reliability and validity of SCS-Turkish version was examined again with a new translation. Accordingly, a one-factor-solution was recommended with an internal consistency of .94; whereas, the internal consistency of the subscales was found to be ranging from .69 to .85. The latest version was utilized within the current study. In the present study, internal consistency of the scale was .94 for the whole scale, and it was found to be ranging from .79 (mindfulness) to .85 (self-judgement) for the subscales.

2.1.2.4. Brief Symptom Inventory (BSI)

Brief Symptom Inventory, which is the shortened version of the Symptom Checklist (SCL-90-R), is a 5-point likert type scale developed by Derogatis (1975). Accordingly, nine subscales were extracted, namely somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. In this study, which was conducted with 1002 outpatients, the internal consistency of the subscales was found to be ranging from .71 (psychoticism) to .85(depression). Test-retest reliability of the subscales was found to be ranging from .68 to .91 (cited in Derogatis, & Melisaratos 1983).

Turkish adaptation of the study was conducted by Şahin and Durak (1994). Factor analysis revealed five different subscales, namely depression, anxiety, somatization, negative self and hostility. Internal consistency of the scale was found to be ranging from .95 to .96 in different studies, and internal consistency of the subscales was

found to be ranging from .75 to .88. In the present study, internal consistency of the scale was found as .97 for the whole scale, and it was found to be ranging from .79 (hostility) to .92 (depression) for the subscales.

2.1.2.5. Satisfaction with Life Scale (SWLS)

Satisfaction with Life Scale is a 7-point likert type scale developed by Diener and colleagues (1985), and internal consistency of the scale was found to be .87; whereas, test-retest reliability correlation was found to be. 82.

Turkish adaptation of the study was conducted by Durak, Senol-Durak, and Gencoz (2010). In their study, factor analysis revealed a one-factor solution, and internal consistency of the scale was examined utilizing different populations, namely university students, correctional officers and elderly adults. Accordingly, internal consistency of the scales was found as .81, .82 and .89 respectively. In the present study, internal consistency of the scale was found to be .86.

2.1.3. Procedure

Firstly, referenced procedures for research with human participants was fulfilled from the Applied Ethics Research Center of Middle East Technical University. Later on, the scales were uploaded to an online survey site. Participants, who were informed via the snowball sampling procedure, filled the online survey. Participants were given the required information that contained the aims of the study and the instructions about how to fill the scales, and online informed consents were taken from each of the participants prior to their participation.

2.1.4. Statistical Analyses

The filled scales were controlled in terms of the accuracy of data entry and the presence of missing data for each case. Among a total of 305 variables, 9 cases that were identified as both univariate (Z scores smaller than -3.29 and larger than +3.29) and multivariate (Mahalonobis distance with $p < .001$) outliers according to the procedures that are described in Tabachnick and Fidell (1996) were deleted. Moreover, the cases were excluded if the participants responded to less than 75% of each scale. For the remaining 296 cases, the sum score was computed by

multiplying the mean score of this minimum amount of answers with the number of questions in that scale. Hence, based on an advice of Gençöz that is given within the scope of Research Methods in Clinical Psychology (October, 2011 personal communication), the mean score was obtained by considering the within-case variance, which provides a more sensitive score in terms of type one error caused by regression to the mean. As a result, further analyses were conducted with 296 cases. Afterwards, the analyses were conducted to test the assumptions of multivariate analysis. In terms of main analyses, several hierarchical regression analyses were conducted. Later on, a bootstrapping procedure (with N = 5,000 bootstrap re-samples) with multivariate mediators was utilized following the procedure described by Preacher and Hayes (2008) in order to test whether difficulties in emotion regulation and self-compassion mediated the link between schema domains, psychopathology and life satisfaction. Accordingly, although simple mediation is utilized broadly within a diversity of areas, it has the problem of oversimplification regarding the proposed model. However, multiple mediation models give opportunity to identify the simultaneous links between multiple variables within an integrated view that fits the nature of the variables studied in the field of social sciences. According to Hayes (2013), ranging mediation effects as "full" or "partial" are outdated; thus, he supports to investigate the degree of importance for each mediator. According to the assessment of the indirect effects of bootstrapping procedure, confidence intervals were estimated for mediating variables and the mediator was accepted as significant if the confidence intervals did not include zero. Hence, this point of view is respected in line with the research question of the present research.

2.2. Results

2.2.1. Descriptive Information about the Major Variables of the Study

In order to obtain descriptive characteristics of the measures that were used in the study, means, standard deviations and ranges were computed for the disconnection/rejection, the impaired limits/exaggerated standards and the impaired

autonomy/other directedness domains of the Young Schema Questionnaire, lack of emotional awareness, lack of emotional clarity, non-acceptance of negative emotions, lack of strategy building, lack of control on impulsive behaviors, and lack of ability to behave in accordance with the goals subscales of the Difficulties in Emotion Regulation Scale, self-kindness, self-judgement, common humanity, isolation, mindfulness and over-identification subscales of the Self-Compassion Scale, depression, anxiety, somatization, negative self and hostility subscales of the Brief Symptom Inventory and Satisfaction with Life Scale (See table 2).

Table 2. Descriptive Information for the Major Variables in the Study

Measures	Subscales	N	Mean	SD	Range
YSQ	**IMPAUT**	296	68.05	19.81	34-147
	DR	296	58.47	18.68	30-144
	IMPLIM	296	86.39	20.83	37-142
DERS	**CLA**	296	18.96	3.86	5-25
	AWA	296	21.86	3.81	9-30
	IMP	296	12.66	4.77	6-30
	NAE	296	11.47	4.93	6-30
	GOAL	296	14.65	4.70	5-25
	STR	296	16.87	6.78	8-40
	TOTAL	296	84.92	19.12	51.69-143.08
SCS	**SK**	296	16.08	4.28	5-25
	SJ	296	11.73	4.53	5-25
	CH	296	13.28	3.68	4-20
	IS	296	9.52	3.74	4-20
	MND	296	13.94	3.32	4-20
	OID	296	10.32	4.05	4-20
	TOTAL	296	89.73	18.80	33-128
BSI		296	38.76	33.09	0-197
SWLS		296	23.20	6.85	5-35

Note. YSQ: Young Schema Questionnaire, IMPAUT: The Impaired autonomy/other directedness domain, DISREJ: The disconnection/rejection domain, IMPLIM: The impaired limits/exaggerated standards domain, DERS: The difficulties in emotion regulation scale, CLA: Lack of clarity of emotional responses, AWA: Lack of awareness of emotional responses, IMP: Difficulties in controlling impulses when experiencing negative affect, NAE: Non-acceptance of emotional responses, GOAL: difficulties in engaging goal directed behavior when experiencing negative affect, STR: limited access to effective strategies, SCS: Self compassion scale, SK: Self-kindness, SJ: Self-judgement, CH: Common humanity, IS: Isolation, MND:

Mindfulness, OID: Over-identification. BSI: Brief symptom inventory, SWLS: Satisfaction with life scale.

2.2.2. Inter-Correlations among Major Variables of the Study

Examination of the relationship between major variables of the study was obtained via Pearson Correlation analysis for the major variables of the study. These were namely, the impaired autonomy/other directedness domain, the disconnection/rejection domain, the impaired limits/exaggerated standards domains of schemas, lack of clarity of emotional responses (clarity), lack of awareness of emotional responses (awareness), difficulties in controlling impulses when experiencing negative affect (impulse), non-acceptance of emotional responses (non-acceptance) difficulties in engaging goal directed behavior when experiencing negative affect (goal), limited access to effective strategies (strategies) subscales of difficulties in emotion regulation, Self Kindness/ Self Judgement, Common Humanity/ Isolation, Mindfulness/ Over-Identification dimensions of self-compassion, and the total scores for emotion regulation, self-compassion, psychological symptoms and life satisfaction.

As can be seen in Table 3, the variables in the study was moderately and significantly correlated to each other. In terms of schema domains, the impaired autonomy/other directedness domain was positively correlated with negative subscales of difficulties of emotion regulation, namely, impulse (r = .43, $p < .001$), non-acceptance ($r = .45$, $p < .001$), goal ($r = .44$, $p < .001$) and strategies ($r = .52$, $p < .001$). On the other hand, it was negatively correlated with the two subscales, which were awareness ($r = -.16$, $p < .001$) and clarity ($r =.-.38$, $p < .001$). It was also highly correlated with the total score of difficulties in emotion regulation ($r = .56$, $p < .001$). Thus, higher scores in the impaired autonomy/other directedness domain was associated with lower levels of awareness and clarity, and higher levels of overall difficulties in emotion regulation, impulse, non-acceptance, goal and

Table 3. Inter-Correlations among Major Variables of the Study

	IAOD	DSRJ	ILES	CLA	AWA	IMP	NAE	GL	STR	ERT	SKSJ	CHI	MI	SCT	BSI	SWLS
IAOD	-	.67**	.77**	-.38 *	-.16*	.43**	.45**	.44**	.52**	.56**	.-.43**	-.44**	-.48**	-.49**	.58**	-.10
DSRJ		-	.62**	-.46**	-.27**	.47**	.49**	.36**	.56**	.59**	-.54**	-.55**	-.50**	-.58**	.60**	-.29**
ILES			-	-.25**	-.03	.45**	. 49**	.43**	.51**	.53**	-.44**	-.44**	-.47**	-.47**	.53**	-.08
CLA				-	.55**	-.50**	-.43**	-.43**	-.54**	-.71**	.54**	.52**	.60**	.60**	-.45**	.20**
AWA					-	-.21**	-.19**	-.18*	-.22**	-.41**	.41**	. 35**	.38**	.42**	-.18*	.11
IMP						-	.58**	.65**	.76**	.86**	-.54**	-.52**	-.60**	-.54**	.40**	-.17*
NAE							-	.36**	.62**	.75**	-.55**	-.43**	-.55**	-.56**	.47**	-.18**
GL								-	.64**	.75**	-.44**	-.46**	-.60**	-.54**	.40**	-.10
STR									-	.90**	-.64**	-.63**	-.75**	-.74**	.65**	-.25**
ERT										-	-.70**	-.64**	-.80**	-.78**	.63**	-.23**
SKSJ											-	.72**	.78**	.92**	-.52**	.25**
CHI												-	.78**	.90**	-.49**	.27**
MI													-	.93**	-.53**	.20**
SCT														-	-.56**	.26**
BSI															-	-.25**
SWLS																-

Note. ** p < .001 * p < .01, IPAT: Impaired autonomy/other directedness, DSRJ: Disconnection/rejection, IPLM: Impaired limits/exaggerated standards, CLA: Clarity AWA: Awareness , IMP: Impulse, NAE: Non-acceptance, GL: Goal, STR: Strategies, ERT: Difficulties in Emotion regulation Total Score, SKSJ: Self Kindness, CHI: Common Humanity, MI: Mindfulness/over-Identification, SCT: Self-compassion Total Score, BSI: Brief Symptom Inventory, SWLS: Satisfaction with Life Score

strategies. Similarly, it was moderately and negatively associated with self-kindness (r = -.43, p < .001), common humanity (r = -.44, p < .001), and mindfulness (r = -.48, p < .001) dimensions of self-compassion. In addition, it was negatively correlated to the total score on self-compassion (r = -.49, p < .001). Accordingly, as the level of the impaired autonomy/other directedness increases, self-compassion decreases.

Apart from that, the impaired autonomy/other directedness domain was found to be highly correlated with psychopathology (r = .58, p < .001); whereas, it did not have a significant correlation with life satisfaction (r = -.10, p > .05). The results were pretty much the same for the impaired limits/exaggerated standards domain. It was positively correlated with impulse (r = .45, p < .001), non-acceptance (r = .4, p < .001), goal (r = .43, p < .001) and strategies (r = .51, p < .001) subscales of difficulties in emotion regulation; whereas, it was negatively correlated with the subscale of clarity (r =.-.25, p < .001). On the other hand, no significant correlation was found between the impaired limits/exaggerated standards domain and awareness (r = -.10, p > .05) subscale of the difficulties in emotion regulation. Apart from that, impaired limits/exaggerated standards domain was also highly correlated with the total score of difficulties in emotion regulation (r = .53, p < .001). Similarly, it was moderately and negatively correlated with all of the subscales of self-compassion, namely self-kindness (r = -.44, p < .001), common humanity (r = -.44, p < .001), and mindfulness (r = -.47, p < .001) and the total score of the self-compassion (r = -.47, p < .001). Accordingly, people, who score high in the impaired limits/exaggerated standards domain are more likely to display higher levels of difficulties in emotion regulation, and lower levels of self-compassion. Similar to the impaired autonomy/other directedness domain, the impaired limits/exaggerated standards domain was also highly correlated with psychopathological symptoms (r = .53, p < .001); whereas, its correlation with life satisfaction (r = -.08, p > .05) was not significant. On the other hand, the disconnection/rejection domain was significantly correlated with all of the major variables. It was correlated with all the subscales of difficulties in emotion

regulation, namely awareness (r = -.27, p < .001), clarity (r = -.46, p < .001), impulse (r = .47, p < .001), non-acceptance (r = .49, p < .001), goal (r = .36, p < .001), and strategies (r = .56, p < .001) as well as the total emotion regulation score. (r = .59, p < .001). Similarly, the disconnection/ rejection domain was significantly and negatively correlated with all the subscales of self-compassion, namely; self-kindness (r = -.54, p < .001), common humanity (r = -.55, p < .001), mindfulness (r = -.50, p < .001) and the total score of self-compassion (r = -.58, p < .001). The disconnection/rejection domain was the only schema domain which was correlated with both life satisfaction (r = -.29, p < .001) and psychopathology (r = .60, p < .001). Thus, it can be concluded that the disconnection/rejection domain was the most problematic schema domain that was positively correlated with all of the negative structures that are closely associated with psychopathology and negatively associated with the positive structures that are associated with life satisfaction.

On the other hand, the difficulties in emotion regulation showed significantly negative correlation with all of the self-compassion subscales, namely; self-kindness (r = -.70, p < .001), common humanity (r = -.64, p < .001), and mindfulness (r = -.80, p < .001), as well as the total score of self-compassion (r = -.78, p < .001). It was also positively correlated with psychopathology (r = .63, p < .001); whereas, it is negatively correlated with life satisfaction (r = -.23, p < .001). In this respect, participants with higher levels of difficulties in emotion regulation were found to be more likely to display lower levels of self-compassion. Similarly, self-compassion was found to be negatively correlated with psychopathology, (r = -.56, p < .001), and it showed positive correlation with life satisfaction (r = -.26, p < .001). Thus, participants with higher levels of self-compassion are more likely to display lower levels of psychopathological symptoms and higher levels of self-compassion.

2.2.3. Hierarchical Multiple Regression Analyses

In line with the model presented in the introduction section, two sets of hierarchical regression via stepwise method were conducted. In line with the theoretical

information derived from literature, emotion regulation was considered as a more general term that also contained elements which are relevant to self-compassion. Therefore, in order to identify the specific effect of self-compassion beyond emotion regulation, emotion regulation theoretically hypothesized to enter the equation in the first sequence. Later on, self-compassion was entered into the equation in order to see the further effects of self-compassion on psychopathological symptoms and satisfaction with life. Therefore, in the first part, associates of self-compassion and emotion regulation were examined respectively, and later on, the second sets of hierarchical regression analyses were conducted for psychopathological symptoms and life satisfaction.

2.2.3.1. Associated Factors for Difficulties in Emotion Regulation

The first hierarchical multiple regression analysis was conducted to examine the associates of difficulties in emotion regulation. Prior to the main variables, the effects of socio-demographic variables (i.e., gender, age, number of siblings, maternal education, paternal education, family income and psychological history of the participants) were hierarchically entered into the equation in the first sequence. Later on, the effects of schema dimensions (i.e., the impaired limits/exaggerated standards, the disconnection/rejection and the impaired autonomy-other directedness) were hierarchically entered into the equation via stepwise method.

As can be seen in Table 4, the first variable which entered into the equation was age (β = -.19, t [257] = -3.10, p < .01), explaining 3% of the variance (F [1,257] = 9.63, p < .01). Subsequently, psychological history (β = -.18, t [256] = -3.01, p < .01), entered into the equation and explained variance increased to 6% (F_{change} [1,256] = 9.08, p < .01). Accordingly, both age and psychological history were negatively associated with difficulties in emotion regulation. After controlling the effects of demographic variables, schema domains were entered into the equation hierarchically. Accordingly, the first domain that entered into the equation was the disconnection/rejection domain (β = .57, t [255] = 11.57, p < .001), and consequently, explained variance increased to 38% (F_{change} [1,255] = 133.85, p <

.001). The entrance of the disconnection rejection domain was followed by the entrance of impaired autonomy/other directedness domain (β = .28, t [254] = 4.35, p < .001). Finally, the explained variance increased to 42% (F_{change} [1,254] = 18.94, p < .001).

Hence, a total of four variables are accounted for the 42% of the total variance in difficulties in emotion regulation, namely; age, psychological history, the disconnection/rejection domain and the impaired autonomy/other directedness domain of EMSs. Accordingly, younger participants who have a psychological history and those who have higher scores on the disconnection rejection and the impaired autonomy/other directedness domains of EMSs are more likely to display higher levels of difficulties in emotion regulation.

Table 4. Associates of Difficulties in Emotion Regulation

Order of Entry		***β***	***t***	***df***	F_{change}	***pr***	R^2
I.	**Demographic Variables**						
	Age	-19	-3.10**	1,257	9.63**	-.19	.03
	Psychological History	-.18	-3.01**	1,256	9.08**	-.18	.06
I I.	**Schema Domains**						
	Disconnection/Rejection	.57	11.57***	1,255	133.85***	.59	.38
	Impaired Autonomy/ Other Directedness	.28	4.35***	1,254	18.94***	.26	.42

Note. ***p<.001; **p<.01

2.2.3.2. Associated Factors for Self-compassion

The second hierarchical multiple regression analysis was conducted to examine the associates of self-compassion. Prior to the main variables, the effects of socio-demographic variables (i.e., gender, age, number of siblings, maternal education, paternal education, family income and psychological history of the participants) were hierarchically entered into the equation in the first sequence. Later on, schema dimensions were hierarchically entered into the equation. After controlling the effects of demographic variables, the effects of schema domains (i.e., the impaired

limits/exaggerated standards, the disconnection/rejection and the impaired autonomy-other directedness) were entered into the equation hierarchically. Finally, the effects of difficulties in emotion regulation (i.e., Non-acceptance, Goals, Impulse, Awareness, Strategies, Clarity) were entered into the equation via stepwise method.

As can be seen in Table 5, the first variable that entered into the equation was psychological history (β = .17, t [257] = -2.79, p < .01), explaining 3% of the variance (F [1,257] = 7.78, p < .01). Subsequently, age (β = .18, t [256] = 2.95, p < .01), entered into the equation and the explained variance increased to 6% (F_{change} [1,256] = 8.72, p < .01). Thus, both age and psychological history were associated positively with self-compassion. After controlling the effects of demographic variables, schema domains were entered into the equation hierarchically. In this regard, the first domain that entered into the equation was the disconnection/rejection domain (β = -.57, t [255] = -11.57, p < .001), and the explained variance increased to 38% (F_{change} [1,255] = 133.97, p < .001). The entrance of the disconnection rejection domain was followed by the impaired limits/exaggerated standards domain (β = -.15, t [254] = -2.36, p < .05), and the explained variance increased to 39% (F_{change} [1,254] = 5.58, p < .05). In terms of difficulties in emotion regulation, the first variable that entered into the equation was strategies (β = -.56, t [253] = -10.76, p < .001), and the explained variance increased to 58% (F_{change} [1,253] =115.74, p < .001). Subsequently, awareness entered into the equation (β = .25, t [252] = 5.94, p < .001), and the explained variance increased to 63% (F_{change} [1,252] =35.30, p < .001). Finally, clarity entered to the equation (β = .15, t [251] = 2.77, p < .01), and the explained variance increased to 64% (F_{change} [1,251] =7.67, p < .01).

Hence, a total of seven variables accounted for the 64% of the total variance in self-compassion, namely; psychological history, age, the disconnection/rejection and the impaired limits/exaggerated standards domains of EMSs, and strategies, awareness and clarity dimensions of difficulties in emotion regulation. Accordingly, older participants with a psychological history, and the participants who have high scores

on the disconnection/rejection and the impaired limits/exaggerated standards domains of EMSs, and who have limited access to emotion regulation strategies and who have higher levels of emotional awareness and clarity are more likely to display higher levels of self-compassion.

Table 5. Associates of Self-compassion

Order of Entry		*β*	*t*	*df*	F_{change}	*pr*	R^2
I.	**Demographic Variables**						
	Psychological History	.17	-2.79**	1,257	7.78**	-.19	.03
	Age	.18	2.95**	1,256	8.72**	-.18	.06
I I.	**Schema Domains**						
	Disconnection/Rejection	-.57	-11.57***	1,255	133.97***	.59	.38
	Impaired Limits/ Exaggerated Standards	-.15	-2.36*	1,254	5.58*	.26	.39
III.	**Difficulties in Emotion Regulation**						
	Strategies	-.56	-10.76***	1,253	115.74***		.58
	Awareness	.25	5.94***	1,252	35.30***		.63
	Clarity	.15	2.77**	1,251	7.67**		.64

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

2.2.3.3. Associated Factors for Psychopathological Symptoms

In order to examine the associates of psychopathological symptoms, variables were entered into the equation in five steps utilizing hierarchical regression and stepwise method. Firstly, the effects of socio-demographic variables (i.e., gender, age, number of siblings, maternal education, paternal education, family income and psychological history of the participants) were entered into the equation. In the second step, schema domains (i.e., the impaired limits/exaggerated standards, the disconnection/rejection and the impaired autonomy/other directedness) were entered into the equation. In the third step the effects of difficulties in emotion regulation (i.e., non-acceptance, goals, impulse, awareness, strategies, and clarity) were entered into the equation. In the last step, the effects of self-compassion (i.e., self-kindness, self-judgement, common humanity, isolation and mindfulness, over-identification) were entered into the equation via stepwise method.

As can be seen in Table 6, the first variable that entered into the equation was age (β = -.21, t [257] = -3.53, p < .001), explaining 4% of the variance (F [1,257] = 12.49, p < .001). Subsequently, paternal education (β = -.13, t [256] = -2.09, p < .05) entered into the equation, and the explained variance increased to 6% (F_{change} [1,256] = 4.35, p < .05). Accordingly, both age and paternal education were negatively associated with difficulties in emotion regulation. After controlling the effects of demographic variables, schema domains were entered into the equation hierarchically. In this regard, the first domain that entered into the equation was the disconnection/rejection domain (β = .58, t [255] = 11.78, p < .001), and the explained variance increased to 39% (F_{change} [1,255] = 138.86, p < .001). The entrance of the disconnection rejection domain was followed by the entrance of the impaired autonomy/other directedness domain (β = .26, t [254] = 4.00, p < .05), and the explained variance increased to 42% (F_{change} [1,254] = 15.99, p < .05).

Table 6. Associates of Psychopathological Symptoms

Order of Entry		***β***	***T***	***df***	F_{change}	***pr***	R^2
I.	**Demographic Variables**						
	Age	-.21	-3.53***	1,257	12.49***	-.21	.04
	Paternal Education	-.13	-2.09*	1,256	4.35*	-.13	.06
I I.	**Schema Domains**						
	Disconnection/Rejection	.58	11.78***	1,255	138.86***	.59	.39
	Impaired Autonomy/ Other Directedness	.26	4.00*	1,254	15.99***	.24	.42
III.	**Difficulties in Emotion Regulation**						
	Strategies	.39	7.23***	1,253	52.28***	.42	.52
IV.	**Self-compassion**						
	Self-judgement	.13	2.09*	1,252	4.38*	.13	.52

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

In terms of emotion regulation difficulties, only the strategies (β = .39, t [253] = 7.23, p < .001) dimension entered into the equation, increasing the explained variance up to 52% (F_{change} [1,253] = 52.28, p < .001). Lastly, only self-judgement

dimension of self-compassion (β = .13, t [252] = 2.09, p < .05) entered into the equation. Hence, the explained variance stayed as 52%, with an increase hardly visible (F_{change} [1,252] = 4.38, p < .05).

Overall, six variables accounted for the 52% of the variance in psychopathological symptoms, namely, age, paternal education, the disconnection/rejection and the impaired autonomy/other directedness domains of EMSs, strategies dimension of difficulties in emotion regulation, and self-judgement dimension of self-compassion. Accordingly, younger participants who have fathers with lower levels of education, who have high scores on the disconnection/rejection and impaired autonomy/other directedness domains of EMSs, who have limited access to emotion regulation strategies, and who have higher levels of self-judgement are found to be more likely to display psychopathological symptoms.

2.2.3.4. Associated Factors for Satisfaction with Life

In order to examine the associates of satisfaction with life, variables were entered into the equation in five steps utilizing hierarchical regression and stepwise method. Firstly, socio-demographic variables (i.e., gender, age, number of siblings, maternal education, paternal education, family income and psychological history of the participants) were entered into the equation. In the second step, schema domains (i.e., the impaired limits/exaggerated standards, the disconnection/rejection and the impaired autonomy/other directedness) were entered into the equation. In the third step, difficulties in emotion regulation (i.e., non-acceptance, goals, impulse, awareness, strategies, and clarity) were entered into the equation. Lastly, self-compassion (i.e., self-kindness, self-judgement, common humanity, isolation and mindfulness, over-identification) were entered into the equation.

As can be seen in Table 7, the first variable that entered into the equation was gender (β = -.18, t [257] = -2.91, p < .01), explaining 3% of the variance (F [1,257] = 8.46, p < .01). Subsequently, psychological history (β = .22, t [256] = 3.53, p < .001) entered into the equation and explained variance increased to 8% (F_{change} [1,256] = 12.47, p < .001). The last demographic variable which entered the

equation was income (β = .15, t [255] = 2.54, p < .01), and the explained variance increased to 10% (F_{change} [1,255] = 6.44, p < .01). In terms of schema domains, the disconnection/rejection (β = -.36, t [254] = -6.34, p < .001) domain entered the equation in the first place, and the explained variance increased to 22% (F_{change} [1,254] = 40.22, p < .001). It was followed by the impaired autonomy/other directedness domain (β = .15, t [253] = 2.05, p < .05), and the explained variance increased to 24% (F_{change} [1,253] = 4.12, p < .05). In terms of difficulties in emotion regulation, clarity (β = .21, t [252] = 3.46, p < .001) and strategies (β = -.16, t [251] =-2.28, p < .05) dimensions entered into the equation respectively. Clarity increase explained variance to 27% (F_{change} [1,252] = 12.00, p < .001); whereas, with the inclusion of strategies, explained variance went up to 28% (F_{change} [1,251] =5.12, p < .05). Finally, only the isolation dimension of self-compassion (β = -.22, t [250] = -2.82, p < .01) entered into the equation, making the total explained variance 31% (F_{change} [1,250] =7.94, p < .01).

Table 7. Associates of Satisfaction with Life

Order of Entry		***β***	***t***	***df***	F_{change}	***pr***	R^2
I.	**Demographic Variables**						
	Gender	-.18	-2.91**	1,257	8.46**	-.18	.03
	Psychological History	.22	3.53***	1,256	12.47***	.22	.08
	Income	.15	2.54**	1,255	6.44**	.16	.10
I I.	**Schema Domains**						
	Disconnection/Rejection	-.36	-6.34***	1,254	40.22***	-.37	.22
	Impaired Autonomy/ Other Directedness	.15	2.05*	1,253	4.12*	.13	.24
III.	**Difficulties in Emotion Regulation**						
	Clarity	.21	3.46***	1,252	12.00***	.21	.27
	Strategies	-.16	-2.28*	1,251	5.12*	-.14	.28
IV.	**Self-compassion**						
	Isolation	-.22	-2.82**	1,250	7.94**	-.18	.31

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

Hence, overall eight variables accounted for the 31% of the variance in life satisfaction, namely; gender, psychological history, income, the disconnection/ rejection and the impaired autonomy/other directedness domains of EMSs, clarity and strategies factors of difficulties in emotion regulation and isolation dimension of self-compassion. In this regard, women participants who don't have any psychological history, and have a higher income; who have lower scores on the disconnection/rejection and higher scores on the impaired autonomy/other directedness domains of EMSs, who have higher levels of emotional clarity and lower levels of limited access to emotion regulation strategies; and who have lower levels of isolation are more likely to be satisfied with theirselves.

2.2.4. Mediation Analyses

According to the model presented in the introduction section, the aim of the study was to test whether emotion regulation and self-compassion, which were hypothesized to be considered as the indicators of healthy adult mode, had a mediator role in the link between EMSs, psychopathology and life satisfaction.

In order to investigate the possible mediation effects of emotion regulation and self-compassion in a single integrated model, the procedure proposed by Hayes (2013) was utilized. According to Hayes, "causal steps approach" was outdated; thus, in his multiple mediator model, the predictor variable is accepted to have both direct and indirect effects via one or more mediators on the consequent dependent variable. Preacher and Hayes (2008) argue that, multiple mediation consists of two parts; the first part involves identifying the total indirect effect and tests the role of the mediators in the relationship between the independent variable and the dependent variable. The second part involves testing the effects of mediators within a multiple mediator model simultaneously and identifies the indirect of each mediator specifically through the presence of another mediator. Specifically, bootstrapping is highly recommended in order to obtain robust confidence limits for specific indirect effects. Moreover, according to Hayes (2013), statistically, there is no difference between testing the direct and indirect effects simultaneously or separately in terms

of the results. Therefore, he recommended running the analysis for each multiple independent and depended variables. Thus, in the present study, five separate multiple mediation models through the use of bootstrapping were tested in order to investigate the indirect effects of emotion regulation and self-compassion in relation to the relationship between dimensions of EMSs, psychopathology, and life satisfaction.

2.2.4.1. The Impaired Limits/Exaggerated Standards Domain and Symptoms of Psychopathology

The indirect effects of the impaired limits/exaggerated standards domain on psychopathological symptoms through difficulties in emotion regulation and self-compassion were examined utilizing multiple mediation analyses with a bootstrapping procedure proposed by Preacher and Hayes (2008). Based on the results of the prior regression analyses regarding symptoms of psychopathology, participants' age and paternal education level were included in the analysis. Accordingly, only age (B = -.50, SE = .20, p < .05) had a partial effect on symptoms of psychopathology. Accordingly, as the participant's age increases, his/her psychological symptoms tend to decrease. Thus, in line with the suggestions of Hayes (2013), only age was included to the final multivariate mediation model in order to be parsimonious (see Figure 3).

Accordingly, the impaired limits/exaggerated standards domain had a direct positive effect on the difficulties in emotion regulation (a_1 = .46, SE = .05, p < .001), and it had a direct negative effect on self-compassion (a_2 = -.41 SE = .05, p < .001). Hence, it was found that participants who score high in the impaired limits/exaggerated standards domain of the EMSs are more likely to display higher levels of difficulties in emotion regulation and lover levels of self-compassion. Moreover, emotion regulation (b_1 = .63, SE = .12, p < .001) had a positive direct effect on psychopathology, whereas self-compassion (b_2 = -.24, SE = .12, p < .001) had a negative direct effect on symptoms of psychopathology. Accordingly, higher levels of difficulties in emotion regulation and lower levels of self-compassion

predicted higher levels of psychopathological symptoms. Both the total (c = .80, SE = .09, p < .001) and the direct effects (c' = .40, SE = .08, p < .001) of the impaired limits/exaggerated standards domain on symptoms of psychopathology through mediators were found to be significant.

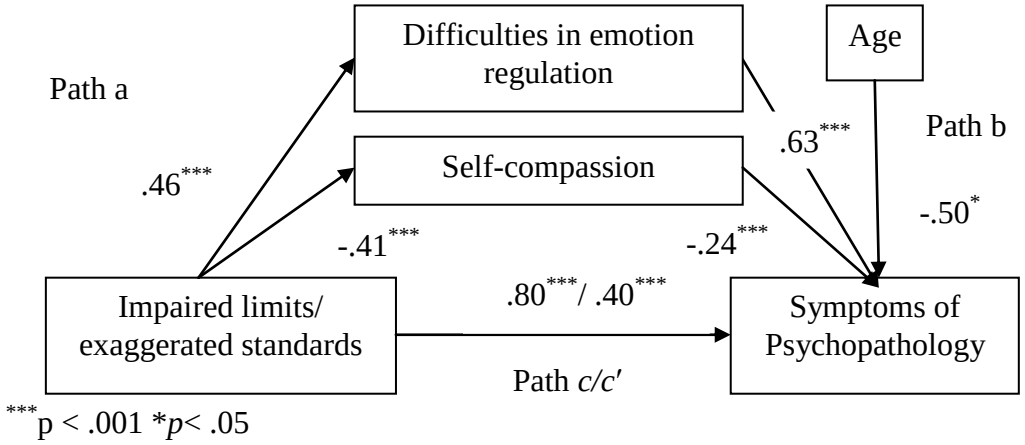

Figure 3. *Multiple Mediation Model of the Relationship between the Impaired Limits/ Exaggerated Standards Domain and Symptoms of Psychopathology*

Moreover, the model in general was significant (F [4,291] = 64.51, p < .001), meaning that 47% of the variance in psychological symptoms can be explained by the impaired limits/exaggerated standards through emotion regulation and self-compassion. The bootstrapping analysis with 5000 resamples for indirect effects revealed a significant total indirect effect (a x b = .39, SE = .07, 95% BCa CI [.27, .54]). Accordingly, difficulties in emotion regulation and self-compassion altogether mediated the relationship between the impaired limits/exaggerated standards domain and symptoms of psychopathology. Higher scores on the impaired limits/ exaggerated standards domain predicts higher levels of difficulties in emotion regulation and lower levels of self-compassion, which in turn leads to higher levels of psychological symptoms. Furthermore, difficulties in emotion regulation (a_1 x b_1 = .29, SE = .08, 95% BCa CI [.15, .49]) had a mediator effect in the relationship between the impaired limits/exaggerated standards domain and symptoms of

psychopathology. Investigation of pairwise contrasts of the indirect effects of the mediators was not significant. Results are presented in Table 8.

Table 8. Mediation (indirect effects) of the Relationship between the Impaired limits/ exaggerated Standards Domain and Symptoms of Psychopathology

	Standardized coefficients		**Bootstrapping (BCa 95% CI)**	
	Effect	**SE**	**Lower**	**Upper**
Total indirect effects	.39*	.07	.27	.54
Difficulties in emotion regulation (DERS)	.29*	.08	.15	.49
Self-compassion (SC)	.10	.06	-.002	.21
DERS vs SC	.19	.13	-.03	.47

Note. * $p < .05$, CI = confidence interval, BCa = bias corrected and accelerated.

2.2.4.2. The Disconnection/Rejection Domain and Symptoms of Psychopathology

The indirect effects of the disconnection/rejection domain on psychopathological symptoms through difficulties in emotion regulation and self-compassion were examined utilizing multiple mediation analyses with a bootstrapping procedure proposed by Preacher and Hayes (2008). Based on the results of the prior regression analyses regarding symptoms of psychopathology, participants' age and fathers' education level were included into the analysis. However, since no significant effect was found regarding symptoms of psychopathology, none of these variables were included into the model in order to be parsimonious (see Figure 4).

Accordingly, the disconnection/rejection domain had a direct positive effect on emotion regulation (a_1 = .60, *SE* = .05, $p < .001$) and a direct negative effect on self-compassion (a_2 = -.58, *SE* = .05, $p < .001$). In this regard, higher scores in the disconnection/rejection domain predicted higher levels of difficulties in emotion regulation and lower levels of self-compassion. Moreover, only difficulties in emotion regulation (b_1 = .64, *SE* = .12, $p < .001$) had a direct effect on symptoms of psychopathology; whereas, self-compassion (b_2 = -.14, *SE* = .12, $p > .05$) failed to have direct effect on symptoms of psychopathology. Accordingly, higher levels of

difficulties in emotion regulation predicted higher levels of psychopathology. Both the total (c = 1.06, SE = .08, p < .001) and direct effects (c' = .59, SE = .10, p < .001) of the disconnection/rejection domain through mediators on symptoms of psychopathology were found to be significant.

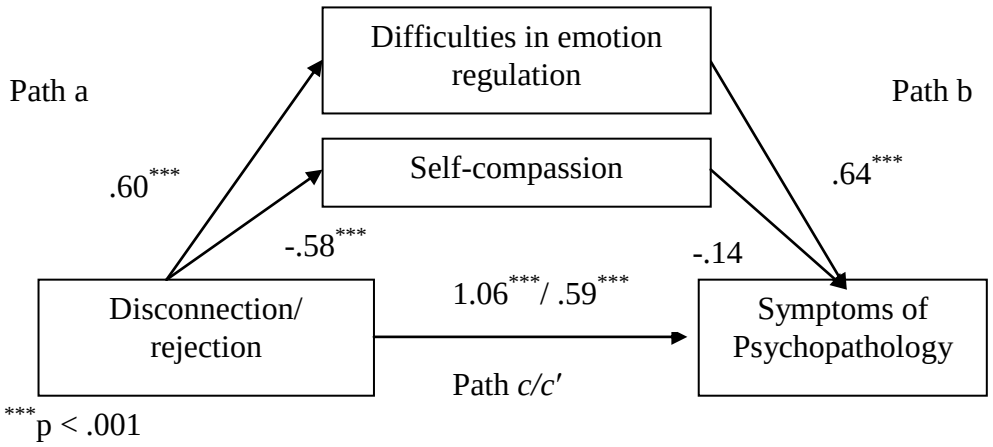

Figure 4. *Multiple Mediation Model of the Relationship between the Disconnection/ rejection Domain and Symptoms of Psychopathology*

Moreover, the model in general was significant (F [3,292] = 89.22, p < .001), meaning that 47% of the variance in psychological symptoms can be explained by the disconnection/rejection domain through difficulties in emotion regulation and self-compassion. The bootstrapping analysis with 5000 resamples for indirect effects revealed a significant total indirect effect (a x b= .47, SE = .07, 95% BCa CI [.34, .64]). Accordingly, difficulties in emotion regulation and self-compassion altogether mediated the relationship between the disconnection/rejection domain and symptoms of psychopathology. Thus, higher scores on the disconnection/rejection domain lead to higher levels of difficulties in emotion regulation and lower levels of self-compassion, which in turn lead to higher levels of psychopathological symptoms. Furthermore, difficulties in emotion regulation (a_1 x b_1 = .39, SE = .10, 95% BCa CI [.22, .61]) had a mediator effect between the disconnection/rejection domain and symptoms of psychopathology. Investigation of pairwise contrasts of the indirect effects of the mediators revealed that specific indirect effect through difficulties in emotion regulation is larger than the specific

indirect effect through self-compassion (c_1 = .31, *SE* = .16 % CI [.01, .65]). Results are presented in Table 9.

Table 9. Mediation (indirect effects) of the Relationship between the Disconnection/rejection Domain and Symptoms of Psychopathology

	Standardized coefficients		**Bootstrapping (BCa 95% CI)**	
	Effect	**SE**	**Lower**	**Upper**
Total indirect effects	.47*	.07	.34	.64
Difficulties in emotion regulation (DERS)	.39*	.10	.22	.61
Self-compassion (SC)	.08	.08	-.06	.24
DERS vs SC	.31*	.16	.01	.65

Note. * $p < .05$, CI = confidence interval, BCa = bias corrected and accelerated.

2.2.4.3. The Impaired Autonomy/ Other Directedness Domain and Symptoms of Psychopathology

The indirect effects of the impaired autonomy/other directedness domain on psychopathological symptoms through difficulties in emotion regulation and self-compassion were examined utilizing multiple mediation analyses with a bootstrapping procedure proposed by Preacher and Hayes (2008). Based on the results of the prior regression analyses regarding symptoms of psychopathology, participants' age and paternal education level were included into the analysis. Accordingly, only age (*B* = -.48, *SE* = .20, $p < .05$) had a partial effect on symptoms of psychopathology. In this regard, as the participants age increases, the possibility to display psychopathological symptoms decreases. Thus, in line with the suggestions of Hayes (2013), only age is included to the final multivariate mediation model in order to act as parsimonious (see Figure 5). Accordingly, the impaired autonomy/other directedness domain had a direct positive effect on emotion regulation (a_1 = .51, *SE* = .05, $p < .001$) and a direct negative effect on self-compassion (a_2 = -.44, *SE* = .05, $p < .001$). Thus, higher levels of difficulties in emotion regulation and lower levels of self-compassion predicted the level of psychopathological symptoms. Moreover, both the difficulties in emotion regulation

(b_1 = .57, *SE* = .12, $p < .001$) and self-compassion (b_2 = -.24, *SE* = .12, $p < .05$) had a direct effect on symptoms of psychopathology. Similarly, the total (c = .91, *SE* = .08, $p < .001$) and direct effects (c' = .51, *SE* = .08, $p < .001$) of the the impaired autonomy/other directedness domain on symptoms of psychopathology were found to be significant.

Moreover, the model in general was significant (F [4,291] = 69.51, $p < .001$), meaning that 49% of the variance in psychopathological symptoms was explained by the impaired autonomy/other directedness domain through difficulties in emotion regulation and self-compassion. The bootstrapping analysis with 5000 resamples for indirect effects revealed a significant total indirect effect (a x b= .40, *SE* = .06, 95% BCa CI [.28, .54]).

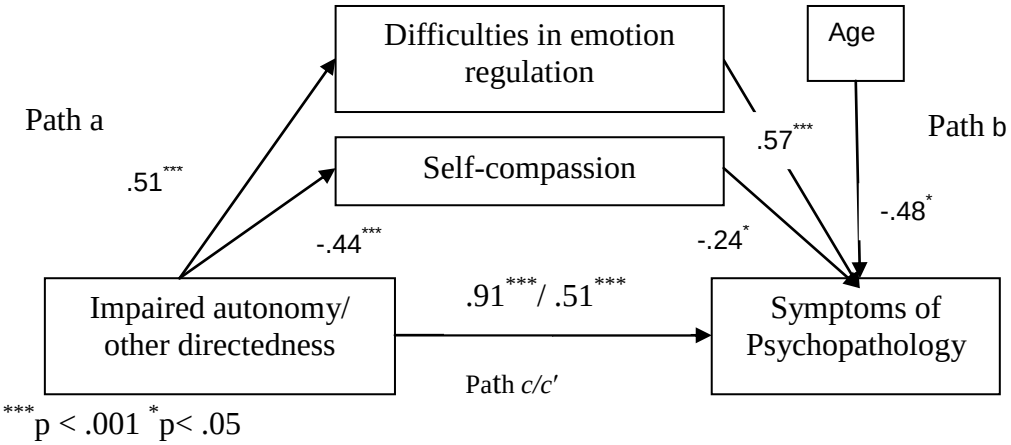

Figure 5. *Multiple Mediation Model of the Relationship between the Impaired Autonomy/ other Directedness Domain and Symptoms of Psychopathology*

Accordingly, difficulties in emotion regulation and self-compassion altogether mediated the relationship between the impaired autonomy/other directedness domain and symptoms of psychopathology. Thus, higher scores on the impaired autonomy/other directedness domain lead to higher levels of difficulties in emotion regulation and lower levels of self-compassion, which in turn lead to higher levels of psychological symptoms. Furthermore, difficulties in emotion regulation (a_1 x b_1 = .29, *SE* = .09, 95% BCa CI [.14, .49]) had a mediator effect between the impaired

autonomy/other directedness domain and symptoms of psychopathology. Investigation of pairwise contrasts of the indirect effects of the mediators was not significant. Results are presented in Table 10.

Table 10. Mediation (indirect effects) of the Relationship between the Impaired Autonomy/ other Directedness Domain and Symptoms of Psychopathology

	Standardized coefficients		**Bootstrapping (BCa 95% CI)**	
	Effect	**SE**	**Lower**	**Upper**
Total indirect effects	.40*	.06	.28	.54
Difficulties in emotion regulation (DERS)	.29*	.09	.14	.49
Self-compassion (SC)	.11	.06	-.01	.23
DERS vs SC	.19	.14	-.07	.47

Note. * p < .05, CI = confidence interval, BCa = bias corrected and accelerated.

2.2.4.4. The Impaired Limits/Exaggerated Standards Domain and Satisfaction with Life

The indirect effects of the impaired limits/exaggerated standards domain on satisfaction with life through difficulties in emotion regulation and self-compassion were examined utilizing multiple mediation analyses with a bootstrapping procedure proposed by Preacher and Hayes (2008). Based on the results of the prior regression analyses regarding satisfaction with life, participants' gender, psychological history and income were included into the analysis. Accordingly, only gender (B = -4.34, SE = .76, p < .001) had a partial effect on satisfaction with life. In this regard, female participants were more likely to be satisfied with their life compared to male participants. Thus, in line with the suggestions of Hayes (2013), only gender was included to the final multivariate mediation model in order to be parsimonious (see Figure 2.3.4). Accordingly, the impaired limits/exaggerated standards domain had a direct positive effect on emotion regulation (a_1 = .49, SE = .04, p < .001) and a direct negative effect on self-compassion (a_2 = -.44, SE = .04, p < .001). Thus, higher scores on the impaired limits/exaggerated standards domain predicted higher levels of difficulties in emotion regulation and lower levels of self-

compassion. Moreover, only self-compassion (b_2 = .11, *SE* = .03, p < .01) had a direct effect on satisfaction with life, meaning that as the participants self-compassion increases, she/he is more likely to display higher levels of life satisfaction. However, emotion regulation (b_1 = -.03, *SE* = .03, p > .05) failed to predict life satisfaction. In terms of total and direct effects of the impaired limits/exaggerated standards domain on satisfaction with life, only direct effect (c' = .04, SE = .02, p < .05) was significant; whereas, the total effect was not significant (c = -.02, SE = .02, p > .05). In this regard, the impaired limits/exaggerated standards domain did not predict life satisfaction without the mediator effects of difficulties in emotion regulation and self-compassion.

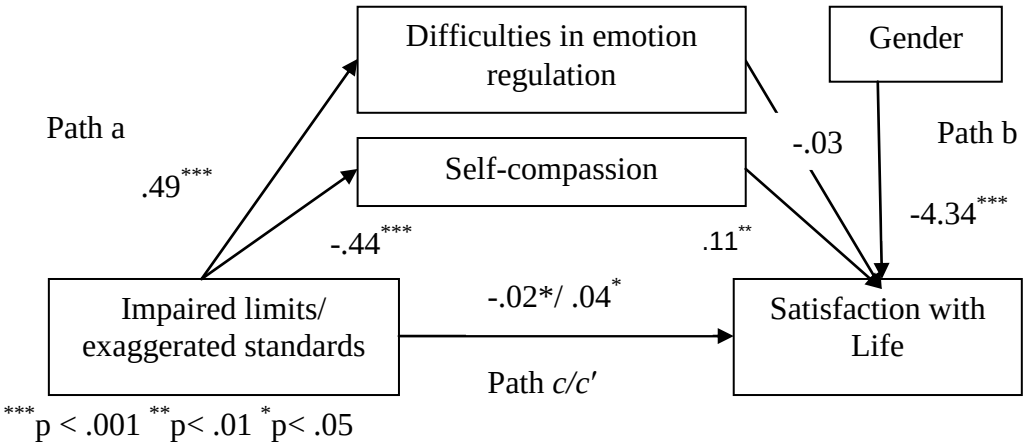

Figure 6. *Multiple Mediation Model of the Relationship between the Impaired Limits/ exaggerated Standards Domain and Satisfaction with Life*

Similarly, the model in general was significant (F [4,291] = 14.49, p < .001), meaning that 15% of the variance in satisfaction with life was explained by the impaired limits/exaggerated standards domain through difficulties in emotion regulation and self-compassion. Similarly, the bootstrap results for indirect effects revealed a significant total indirect effect (*a* x *b* = -.06, *SE* = .01, 95% BCa CI [-.09, -.04]). Accordingly, difficulties in emotion regulation and self-compassion altogether mediated the relationship between the impaired limits/exaggerated standards domain and satisfaction with life. Thus, higher scores on impaired limits/exaggerated standards domain lead to higher levels of difficulties in emotion

regulation and lower levels of self-compassion, which in turn, lead to lower levels of satisfaction with life. Furthermore, self-compassion (a_2 x b_2 = -.05, *SE* = .02, 95% BCa CI -08, -.02]) had a mediator effect between the impaired limits/exaggerated standards domain and satisfaction with life. Investigation of pairwise contrasts of the indirect effects of the mediators was not significant. Results are presented in Table 11.

Table 11. Mediation (indirect effects) of the Relationship between the Impaired Limits/ exaggerated Standards Domain and Satisfaction with Life

	Standardized coefficients		**Bootstrapping (BCa 95% CI)**	
	Effect	**SE**	**Lower**	**Upper**
Total indirect effects	-.06*	.01	-.09	-.04
Difficulties in emotion regulation (DERS)	-.01	.01	-.05	.01
Self-compassion (SC)	-.05*	.02	-.07	-.01
DERS vs SC	.03	.03	-.02	.09

Note. * $p < .05$, CI = confidence interval, BCa = bias corrected and accelerated.

2.2.4.5. The Disconnection/Rejection Domain and Satisfaction with Life

The indirect effects of the disconnection/rejection domain on satisfaction with life through difficulties in emotion regulation and self-compassion were examined utilizing multiple mediation analyses with a bootstrapping procedure proposed by Preacher and Hayes (2008). Based on the results of the prior regression analyses regarding satisfaction with life, participants' gender, psychological history and income were included into the analysis. Accordingly, only gender (B = -3.80, SE = .77, p < .001) had a partial effect on satisfaction with life. In this regard, women participants were more likely to display higher levels of satisfaction with their life compared to male participants. Thus, in line with the suggestions of Hayes (2013), only gender was included to the final multivariate mediation model in order to be parsimonious (see Figure 7).

Accordingly, the disconnection/rejection domain had a direct positive effect on emotion regulation (a_1 = .62, *SE* = .03, $p < .001$) and a direct negative effect on self-

compassion (a_2 = -.61, *SE* = .05, p < .001). Thus, higher scores on the disconnection/rejection domain level predicted higher levels of difficulties in emotion regulation and lower levels of self-compassion. Moreover, only self-compassion (b_2 = .08, *SE* = .03, p < .05) had a direct effect on satisfaction with life, meaning that as the participants' self-compassion increases, the participant is more likely to display higher levels of life satisfaction. However, emotion regulation (b_1 = .00, *SE* = .03, p > .05) failed to predict life satisfaction. In terms of total and direct effects of the disconnection/rejection domain on satisfaction with life, only total effect (c = -.10, *SE* = .02, p < .001) was found to be significant; whereas, direct effect (c' = -.05, *SE* = .02, p > .05) was not significant. In this regard, the significant direct effect of the disconnection/rejection domain on satisfaction with life disappeared within the inclusion of self-compassion and emotion regulation into the equation as the mediators.

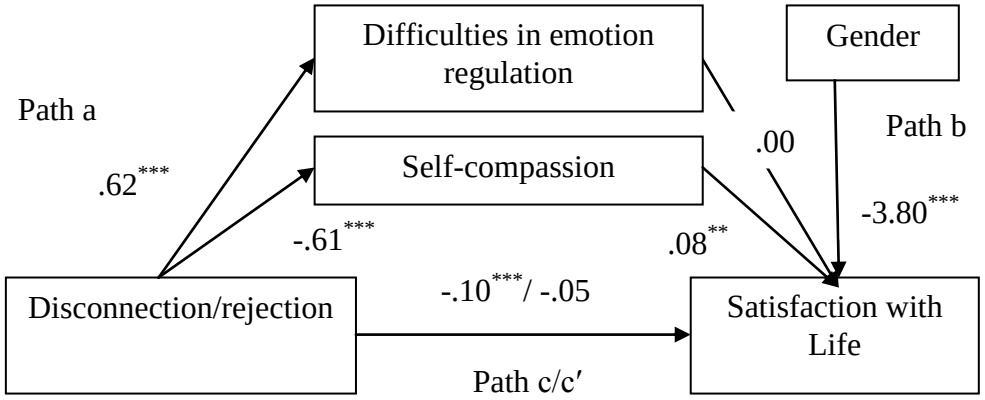

Figure 7. *Multiple Mediation Model of the Relationship between the Disconnection/rejection Domain and Satisfaction with Life*

The general model was significant (F [4,291] = 14.43, p < .001), meaning that 15% of the variance in satisfaction with life was explained by the disconnection/ rejection domain through difficulties in emotion regulation and self-compassion. The bootstrap results for indirect effects revealed a significant total indirect effect (a x b = -.05, *SE* = .02, 95% BCa CI [-.08, -.01]), meaning that difficulties in emotion

regulation and self-compassion altogether mediated the relationship between the disconnection/rejection domain and satisfaction with life. Thus, higher scores on the disconnection/rejection domain lead to higher levels of difficulties in emotion regulation and lower levels of self-compassion, which in turn, lead to lower levels of satisfaction with life. Furthermore, self-compassion (a_2 x b_2 = -.05, *SE* = .02, 95% BCa CI -09, -.01]) had a mediator effect between the disconnection/rejection domain and satisfaction with life. Investigation of pairwise contrasts of the indirect effects of the mediators was not significant. Results are presented in Table 12.

Table 12. Mediation (indirect effects) of the Relationship between the Disconnection/rejection Domain and Satisfaction with Life

	Standardized coefficients		**Bootstrapping (BCa 95% CI)**	
	Effect	**SE**	**Lower**	**Upper**
Total indirect effects	-.05*	.02	-.08	-.01
Difficulties in emotion regulation (DERS)	.00	.02	-.03	.04
Self-compassion (SC)	-.05*	.02	-.09	-.01
DERS vs SC	.05	.04	-.01	.12

Note. * $p < .05$, CI = confidence interval, BCa = bias corrected and accelerated.

2.2.4.6. The Impaired Autonomy/ Other Directedness Domain and Satisfaction with Life

The indirect effects of the impaired autonomy/other directedness domain on satisfaction with life through difficulties in emotion regulation and self-compassion were examined utilizing multiple mediation analyses with a bootstrapping procedure proposed by Preacher and Hayes (2008). Based on the results of the prior regression analyses regarding satisfaction with life, participants' gender, psychological history and income were included into the analysis. Accordingly, only gender (*B* = -4.22, *SE* = .76, $p < .001$) had a partial effect on satisfaction with life. In this regard, it was found that women participants are more likely to display higher levels of satisfaction with their life compared to male participants. Thus, in line with the suggestions of Hayes (2013), only gender was included to the final multivariate mediation model in order to be parsimonious (see Figure 8).

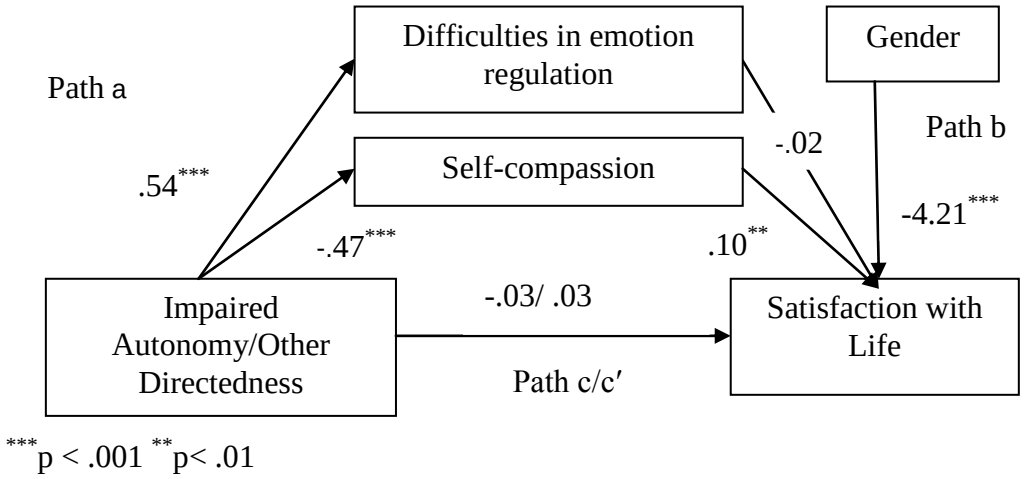

Figure 8. *Multiple Mediation Model of the Relationship between the Impaired Autonomy/ other Directedness Domain and Satisfaction with Life*

Accordingly, the impaired autonomy/other directedness domain had a direct positive effect on emotion regulation (a_1 = .54, *SE* = .05, p < .001) and a direct negative effect on self-compassion (a_2 = -.47, *SE* = .05, p < .001). Accordingly, higher scores on the impaired autonomy/other directedness domain predict higher levels of difficulties in emotion regulation and lower levels of self-compassion. Moreover, only self-compassion (b_2 = .10, *SE* = .03, p < .001) had a direct effect on satisfaction with life, meaning that as the participants self-compassion increases, the participant is more likely to display higher levels of life satisfaction. However, emotion regulation (b_1 = -.02, *SE* = .03, p > .05) failed to predict life satisfaction. Similarly, both total (c = -.03, *SE* = .02, p > .05) and direct (c' = .03, *SE* = .02, p > .05) effects were found to be non-significant.

On the other hand, the general model was found to be significant (F [4,291] = 13.87, p < .001), meaning that 15% of the variance in life satisfaction is explained by the impaired autonomy/other directedness domain through difficulties in emotion regulation and self-compassion. Moreover, the bootstrap results for indirect effects revealed a significant total indirect effect (a x b = -.06, *SE* = .01, 95% BCa CI [-.09, -.04]). According to Rucker and colleagues (2011), an indirect effect can be obtained despite the non-significant total or direct effects. They postulate that

statistical power to identify total and direct effects can be less than the power to identify the indirect effect. This condition might occur due to measurement precision, strength of the relationship, sample size, and size of the total effect (see also Hayes, 2013). In this regard, although the direct and total effects of the impaired autonomy/other directedness domain on satisfaction with life were not found to be significant, the indirect effects of the impaired autonomy/other directedness domain on life satisfaction through self-compassion and emotion regulation were significant. Thus, higher scores on the disconnection/rejection domain lead to higher levels of difficulties in emotion regulation and lower self-compassion, which in turn, lead to lower levels of satisfaction with life. Hence, emotion regulation and self-compassion altogether mediated the relationship between impaired autonomy/other directedness domain and satisfaction with life. Furthermore, self-compassion (a_2 x b_2 = -.05, *SE* = .02, 95% BCa CI -08, -.02]) has a mediator effect, between the impaired autonomy/other directedness domain and satisfaction with life; whereas, the effect of difficulties in emotion regulation was not significant. Pairwise contrasts of the indirect effects of the mediators was not significant. Results are presented in Table 13.

Table 13. Mediation (indirect effects) of the Relationship between the Impaired Autonomy/ other Directedness Domain and Satisfaction with Life

	Standardized coefficients		**Bootstrapping (BCa 95% CI)**	
	Effect	**SE**	**Lower**	**Upper**
Total indirect effects	-.06*	.01	-.09	-.03
Difficulties in emotion regulation (DERS)	-.01	.02	-.05	.02
Self-compassion (SC)	-.05*	.02	-.08	-.01
DERS vs SC	.03	.03	-.02	.10

Note. * $p < .05$, CI = confidence interval, BCa = bias corrected and accelerated.

Table 14. General Summary of Hierarchical Regression Analysis

		Emotion Regulation	Self-compassion	Brief Symptom Inventory	Life Satisfaction
Demographic Variables	Gender				x
	Age	x	x	x	
	Number of Siblings				
	Maternal Education				
	Paternal Education			x	
	Family Income				x
	Psychological History	x	x		x
Early Maladaptive Schema Domains	Impaired Autonomy/Other	x			
	Directedness			x	x
	Disconnection/Rejection	x	x	x	x
	Impaired Limits/Exaggerated Standards		x		
Emotion Regulation	Clarity	-	x		x
	Awareness	-	x		
	Impulse	-			
	Non-acceptance	-			
	Goals	-			
	Strategies	-	x	x	x
Self-Compassion	Self-kindness	-	-		
	Self-judgement	-	-	x	
	Common Humanity	-	-		
	Isolation	-	-		x
	Mindfulness	-	-		
	Over-identification		-		
Well-being	Symptoms of Psychopathology	-	-	-	-
	Satisfaction with Life	-	-	-	-

Table 15. General Summary of Parallel Multiple Regression Analysis

Independent Variable	**Mediators**	**Dependent Variable**	**Mediation**	
			Total indirect effect	**Indirect effect of Mediators**
Impaired limits/ Exaggerated Standards	Difficulties in Emotion Regulation	Symptoms of Psychopathology	Yes	Yes
	Self-compassion			No
Disconnection/ Rejection	Difficulties in Emotion Regulation	Symptoms of Psychopathology	Yes	Yes
	Self-compassion			No
Impaired Autonomy/ Other Directedness	Difficulties in Emotion Regulation	Symptoms of Psychopathology	Yes	Yes
	Self-compassion			No
Impaired limits/ Exaggerated Standards	Difficulties in Emotion Regulation	Satisfaction with Life	Yes	No
	Self-compassion			Yes
Disconnection/ Rejection	Difficulties in Emotion Regulation	Satisfaction with Life	Yes	No
	Self-compassion			Yes
Impaired Autonomy/ Other Directedness	Difficulties in Emotion Regulation	Satisfaction with Life	Yes	No
	Self-compassion			Yes

2.3. Discussion

Based on plenty of readings on Schema Theory, the recurrent themes regarding being compassionate with the inner child and the importance of emotion regulation difficulties caused by unmet needs of childhood together draw a new path and hypotheses of the present study, because it was logical to go back to the point that where it was blown at the first place. Hence, the path that the therapist takes with his/her patient becomes a long journey that leads to the dark rooms of the childhood. Thus, the main idea behind all this was that research should emphasize the tools that they can be utilized during this journey. Therefore, the main emphasis of this study is to identify resilience factors in order to overcome with the disruptive effects of early maladaptive schemas. Consequently, the aim of the present study evolved to develop a relatively new point of view and a new model in terms of Schema Theory. With this respect, the mediating role of emotion-regulation and self-compassion altogether in the relationship between early maladaptive schema domains and well-being of the individual presented by lack of psychopathological symptoms and satisfaction with life is the main investigation.

Thus, the results obtained from the present study were discussed with the current literature. Afterwards, important findings were discussed within their therapeutic implications. Finally, limitations of the present study were presented and the rationale to design a second study was discussed.

2.3.1. Findings Regarding Correlation Coefficients between Groups of Variables

In the present study, Pearson's correlation analysis was conducted to investigate the inter-correlations between early maladaptive schema domains, difficulties in emotion regulation, self-compassion, psychopathological symptoms and satisfaction with life. At first glance, all of the major variables seem to be moderately correlated with each other. Unfortunately, although it can be interpreted as an indicator of being on the right track, attempts to make correct inferences and draw precise conclusions with variables with high inter-correlations is not easy. Therefore, the

results should be interpreted with caution. Moreover, only the striking findings and the strongest relationships are discussed within the scope of this chapter in order to act parsimonious.

In terms of schema domains, inter-correlations between variables range from strong positive to very strong positive. This finding seems to be consistent with literature, which recommends using theoretically relevant schemas to the subject of the study rather than utilizing schema domains if the researcher wants to work with a reduced number of variables (Hawke & Provencher, 2011). Among schema domains, the disconnection/rejection domain had the highest correlations of nearly all of the subscales of difficulties in emotion regulation, all of the subscales of self-compassion, symptoms of psychopathology and satisfaction with life, meaning that people with higher levels of disconnection rejection tend to display higher levels of difficulties in emotion regulation and psychopathological symptoms, and lower levels of self-compassion and life satisfaction. This relationship with negative dimensions seems to confirm the previous postulations (Young, 1990/1999; Young, Klosko, & Weishaar, 2003) that are saying that the disconnection/rejection domain includes the most troublesome schemas that cause disruptive effects on an individual. On the other hand, the striking finding of the present study is that despite the fact that all schema domains strongly related to symptoms of psychopathology, only the disconnection rejection domain was found to be associated with life satisfaction. Accordingly, EMSs that belong to these dimensions actively continue to interfere with the participants overall life satisfaction actively. One possible explanation for this finding can be found in the notions of Schema Theory. Patients that are high on disconnection rejection domain are badly damaged, and they frequently have traumatic childhood memories. Therefore, unlike participants who scored high in other schema domains, these individual's adult life consists of self-destructive relationships, where they unconsciously avoid close relationships (Young, Klosko, & Weishaar, 2003). Thus, these individuals are basically unable to have a satisfactory relationship with others due to their fears of rejection. In light of this, it can be postulated that these kinds of individuals have the possibility to

experience higher numbers of traumatic experiences that prevents them from enjoying their life. The only dimension that the impaired autonomy/other directedness and the impaired limits/exaggerated standards domains displayed stronger relationship than the disconnection/rejection domain was difficulties in engaging goal directed behavior when experiencing negative affect subscale of emotion regulation. This notion seems to confirm the previous postulations because it can be postulated that the "disconnected" individuals tend to avoid any kind of relationship which has the possibility to evoke strong negative feelings. In this respect, engaging in a goal directed behavior within the presence of negative emotions can provide a way to cope with the present situation.

In terms of emotion regulation, the findings broadly overlap with the literature; in particular, the strongest inter-correlation was observed between awareness of emotional responses and lesser difficulties to control impulsive behavior when experiencing a negative affect. This finding is also consistent with the literature. In a study conducted with alcohol abusers, it was reported that impulsive drinking behavior decreased as the patients' emotional awareness levels increase (Fox, Hong, & Sinha, 2008). Among the subscales of difficulties in emotion regulation, limited access to effective strategies had the strongest association with the total difficulties in emotion regulation score and other variables. It also had the strongest association with symptoms of psychology among all of the major variables of the study. Thus, lack of ability to adapt effective emotion regulation strategies seems to be one of the most important indicators that contribute to the well-being of an individual. In terms of self-compassion, the subscales are strongly associated with each other. As theorized (Neff, 2003), as the level of self-compassion increases, symptoms of psychopathology tends to decrease; whereas, life satisfaction is more likely to increase.

Finally, in terms of well-being, symptoms of psychopathology displayed strong associations with all of the major variables of the study. On the other hand, satisfaction with life displayed lower associations. Actually, these lower associations are mostly valid for strategies regarding emotion regulation. It can be

postulated that this difference can be attributed to the content of the two indicators of well-being. Accordingly, satisfaction with life is a subjective and general concept that can be effected by a diversity of elements. On the other hand, symptoms of psychopathology measured by Brief Symptom Inventory include very specific questions that can be answered objectively. Given that, the difference between correlation coefficients can be expected.

2.3.2. Findings Regarding Hierarchical Multiple Regression Analyses

In the present study, several hierarchical regression analysis were conducted to identify the role of major variables in the hypothesized relationships. Accordingly firstly, demographic variables were entered into the equation. Later on, the effects of early maladaptive schema domains on emotion regulation was investigated. Emotion regulation was chosen to be entered previous to self-compassion because although self-compassion was accounted as an emotion regulation strategy by some researchers (see, Finlay-Jones, Rees, & Kane, 2015), it was hypothesized that self-compassion has further effects beyond emotion regulation on the well-being of individuals. In the second sets of analyses, hypothesized pats were tested for psychological symptoms and life satisfaction separately.

Results of the first regression analysis revealed that age and younger age and the presence of psychological treatment history predicted higher levels of difficulties in emotion regulation. Older age is a frequently cited element in the literature in terms of employing better emotion regulation strategies in terms of the content, duration and intensity of their responses (Blanchard-Fields, Stein, & Watson, 2004). Given the strong association between emotion regulation and psychopathology, the results were as expected.

In terms of schema domains, the disconnection/rejection domain was the most important contributor to difficulties with emotion regulation; which is also consistent with literature findings, which was already discussed in the previous section. People with higher levels of disconnection/rejection are usually believed to be defective, and it is assumed that they avoid close relationships; they are more

vulnerable to control and they regulate their emotions in times of psychological distress. Furthermore, the impaired autonomy/other directedness domain predicted difficulties on emotion regulation. This finding makes sense because these individuals usually lack the ability to maintain their physical and emotional life without the help of any other person. Therefore, they have a higher possibility to experience difficulties with emotion regulation, especially within the absence of a "supporter". Moreover, DeOliveira and colleagues (2004) proposed that the caregiver's proper mirroring of the child's emotional state plays an essential role in shaping the child's emotion regulation. Similarly, the early parent-child relationship is considered as the strongest predictor of later dependency. Accordingly, an authoritarian rearing style with tough overprotection is associated with increased dependency. Such parenting interferes with sense of self-efficacy by preventing the child from gaining autonomy (Arntz, 2012; Bornstein, 2011). Thus, the individual would become easily distressed by negative life events and feel insufficient to cope with them.

Similar to the results of the first regression analysis, age and psychological treatment history were found to be associated with self-compassion. Accordingly, older age and the absence of psychological history were found to be associated with increased self-compassion. This finding makes sense because as people get older, their levels of acceptance of themselves usually increases. Moreover, although the possibility of a life crisis increases (i.e., the death of a loved one, health problems etc.), they usually become free of most of the responsibilities (i.e., conflicts of work, striving to build a reliable future). Thus, as they become used to their emotional reactions and personality, they have no need to worry about their performance anymore. Therefore, it can be expected that they become more mind-full and less criticizing towards themselves. Similarly Neff posited that adolescent usually have the lowest self-compassion scores due to their anxiety regarding self-evaluation (Neff, 2003).

In terms of schema domains, the disconnection/rejection domain was the most important contributor to difficulties with emotion regulation; which is also

consistent with literature findings (Young, Klosko, & Weishaar, 2003). When we take a closer look to the maladaptive subscales of self-compassion, namely, self-judgement, isolation and over identification, we would see that the disconnection rejection domain would contain all of these dimensions within different schemas like defectiveness, failure, mistrust/abuse etc. Hence, it would be expected that presence of the schemas included in the disconnection/rejection schema would be a strong predictor for lower levels of self-compassion. Moreover, the impaired limits/exaggerated standards domain predicted lower levels of self-compassion. Although, to my knowledge, no study was examined this relation the results can be interpreted by using the disruptive effect of self-evaluation on self-compassion that was emphasized by Neff (2003). According to Young and colleagues (2003), individuals who have higher levels of impaired limits usually internalize rigid rules about their performance, and they also believe in their superiority to other people. Thus, it can be postulated that they can easily become overwhelmed by their perfectionistic performance criteria they set for themselves, and it can be expected that these individuals are very sensitive to narcissistic breakdowns. Therefore, they are more likely to experience lower levels of self-compassion.

In terms of difficulties in emotion regulation, increased clarity and awareness predicted higher levels of self-compassion; whereas, limited access to effective strategies predicted lower levels of self-compassion. A possible interpretation of this result would be that when individuals become aware of their emotions clearly, they are more likely to find suitable coping strategies to battle with the negative effects of adverse life events. Thus, they are more likely to be self-compassionate towards themselves, rather than being obsessed and over identifying with their problems. In literature, vice versa of this relationship was examined and self-compassion was found to predict emotion regulation beyond current psychological distress and addiction severity (Vettese, Dyer, Li, & Wekerle, 2011). In light of this, the relationship between emotion regulation and self-compassion can be considered as interactive constructs.

In the third analysis, the associates of psychopathological symptoms were investigated. In terms of demographic variables, lower levels of paternal education and younger age predicted symptoms of psychopathology. It is known that psychological distress tends to decrease with age (Jorm et al., 2005). On the other hand, the finding regarding the relationship between paternal education and psychological distress can be attributed to the psychological distress of the fathers caused by lower socioeconomic situation. Hence, the children of these parents would experience much more challenges that cause them to display higher levels of psychopathological symptoms. In terms of schema domains, the disconnection/rejection domain was the stronger predictor of psychological symptoms. As was already discussed, the individuals that have higher levels of disconnection/rejection are the most troubled in terms of interpersonal relationships, and hence, experience psychological distress. The impaired autonomy/other directedness domain also predicted psychopathological symptoms. It would be because their feelings of inability to cope with the negative events on their own. Having psychopathological symptoms provides schema maintenance by confirming their sense of low self-efficacy, and schemas lead to faulty cognitions about the individual's self and the environment, making the individual vulnerable to psychological distress. In this vicious cycle would be the explanation for the present findings. Moreover, people who have higher levels of impaired autonomy and other directedness may sacrifice the things that make them happy in order not to be let down by their significant others. Thus, they would be unable to experience self-fulfillment, and increase their level of psychological distress. In terms of difficulties in emotion regulation only limited access to emotion regulation strategies predicted psychopathological symptoms. In this regard, Gratz and Roemer (2004) postulated that regulation of emotions are most needed in terms of distress. Employment of an emotion regulation strategy, even though an unhealthy one, prevents the experience of emotional distress for a limited time. However, the absence of any strategy would cause extreme psychological distress that lead to a psychopathological symptom. Similarly, in terms of self-compassion, only the self-judgement dimension predicted psychological symptoms. Accordingly, being over criticized towards oneself and

feelings of guilt were identified as the strongest predictors of psychopathological symptoms. This finding seems to be consistant with the literature because Neff (2003) postulated that self-compassion activates the self-soothing system that provides feelings of secure attachment and safeness while deactivating the threat system. In this regard, lack of self-compassion and the presence of self-judgement would prevent the effective coping mechanisms with the distress. Thus, similar to limited access of emotion regulation strategies, self-judgement would make individuals vulnerable to psychopathology.

The last regression analysis was aimed to investigate associates of life satisfaction. In terms of demographic variables, being female, having higher income and the absence of psychological treatment history predicted life satisfaction. It would be expected that higher income decreases the level of psychological distress and people who do not have psychological history are more likely to be satisfied with life. In literature, gender is a frequently cited variable in terms of life satisfaction. In light of this, usually, being a woman is identified to be associated with higher life satisfaction. However, employing a critical understanding of the present literature findings, Della Guista and colleagues (2011) proposed that the importance of life dimensions are quite different for men and woman. Therefore, the results regarding gender should be interpreted by caution.

In terms of schema domains, the disconnection/rejection dimension was identified as the stronger predictor of life satisfaction because this domain causes faulty judgements that would seriously interfere with the daily functioning of the individual. Therefore, individuals with higher levels of disconnection/rejection would be more likely to miss out the joy of experiencing a secure attachment. An interesting finding of the study was people who have higher levels of impaired autonomy/other directedness reported higher levels of life satisfaction. This would be interpreted as the term conformism. People who go with the flow and let go of their own choices in favor of the others may never leave their “comfort zone”, and hence, experience lesser psychological distress. Moreover, it would create a fake sense of belonging, and dependent relationships would be rated as a matches made

in heaven. Thus, despite their distorted cognitions, these individuals reported higher levels of satisfaction with their life.

In terms of emotion regulation, the clarity of emotional responses predicted higher levels of satisfaction with life; whereas, limited access to emotion regulation strategies predicted lower levels of life satisfaction. The two dimension would be connected to each other, because as individuals become clear about their emotions, they would be more likely to choose adaptive coping strategies, and hence,experience higher levels of satisfaction with life. The last predictor was the isolation dimension of self-compassion. This finding is quite understandable, when the positive relationships between the impaired autonomy/otherdirectedness and life satisfaction is thought about. All in all, it can be concluded that feeling lonely seems to be an important predictor of lower levels of life satisfaction.

2.3.3. Findings Regarding Mediation Analyses

Multiple mediation analysis was conducted to identify the mediator role of emotion regulation and self-compassion in the relationship between early maladaptive schema domains and psychological well-being. While forming the hypotheses of the study, emotion regulation and self-compassion were chosen with regard to the postulations of schema therapy. Accordingly, functions of healthy adult mode include nurturance of the vulnerable child while setting limits to impulsive child and battling with parent modes. Thus, the healthy adult mode's functions were conceptualized as regulation of negative emotions in order to effectively cope with the present situation and being compassionate towards oneself. In this regard, emotional regulation and self-compassion were altogether considered to present the function of the healthy adult mode. The discussion regarding the associations between schema dimensions and indicators of well-being were extensively covered in the previous section. Therefore, only the mediation results are discussed within this part of the dissertation.

In terms of psychopathological symptoms, emotion regulation and self-compassion altogether mediated the relation between all three schema domains and

psychopathology. The same results were obtained in terms of satisfaction with life as well. Thus, the main hypotheses of the study were confirmed. Even though self-compassion and emotion regulation are theoretically associated with the healthy adult mode by the researcher, it can be empirically concluded that these two variables have a mediator effect altogether. Actually, emotion regulation was cited as an associated factor for early maladaptive schemas several times. For instance, Masomi and colleagues (2014) postulated that emotional responses of the individuals are determined according to the rules drawn by the EMSs. More specifically, the mediator role of difficulties in emotion regulation in the relationship between early maladaptive schemas and symptoms of social phobia was investigated with Turkish university student population (Eldoğan & Barışkın, 2014). However, the aim of the present study was not to identify associated difficulties associated to the coping mechanisms regarding schemas because Schema Theory has tools to identify these relationships within schema surrender, avoidance or overcompensation. Rather, the aim of the present study is to widen the perspective of the theory by understanding the functions of the healthy adult mode by indicating associated factors. Although identifying the mechanism that functions between the EMSs and psychopathology is important, it was known that schemas are present in every single individual within various levels (Young, 1990/1999). Thus, an expanded view that enriches schema therapy within a positive psychology perspective becomes crucial. In this regard, results regarding the mediator role of emotion regulation and self-compassion obtained from the mediation analyses are very important. Accordingly, only emotion regulation mediated the relationship between the EMS domains and symptoms of psychopathology within the presence of self-compassion; whereas, only self-compassion has mediated the relationship between the EMS domains and satisfaction with life. Accordingly, although emotion regulation was identified as a more serious problem in terms of the development of psychopathological symptoms, self-compassion seems to be more critical in terms of life satisfaction. Thus, consistent with the hypotheses of the study, the results elicited an important function of healthy adult, which is usually neglected. Although schema therapy was developed to work with patients that suffer from chronical and

serious problems (Young, 1990/1999), the present results emphasized the importance of the relationship between EMSs and self-compassion in terms of daily life satisfaction. Thus, it can be concluded that having difficulties about identifying negative emotions caused by EMSs and employing an emotion regulation strategy accordingly to lessen the disruptive effects of EMSs would cause serious mental health problems. However, the absence of a psychopathological symptom does not mean being free of the EMSs' effects. Therefore, the individuals' well-being should not be reduced to the presence or absence of a psychopathological symptom. The present results also pointed out that self-compassion had effects beyond emotion regulation in terms of life satisfaction. Although, in literature, self-compassion is accepted as an emotion regulation strategy by some researchers (e.g., Diedrich et. al., 2014) the present results provide evidence to view this concept from different angles. Being kind towards oneself, sense of common humanity and mindfulness seem to be critical for the individuals' subjective understanding of themselves, and their psychopathological symptoms.

All in all, the present study provides empirical evidence in terms of the essentiality of the effects of EMSs in the general population. Therefore, it can be concluded that disruptive effects of EMSs lead to serious results in terms of the general well-being of individuals. Moreover, based on the results of the present study, it can be postulated that well-being of an individual cannot be defined solely by the absence of psychopathological symptoms, but it is a general term that has a diversity of indicators. In relation to that, the role of self-compassion, as a relatively new concept was identified to have further implications than just an emotion regulation strategy.

2.3.4. EMSs within Positive Psychology Persective

Generally, EMSs schema patterns are accepted as fundamental building blocks of an individual's personality. Therefore, every individual has problems regarding EMSs to some degree. As emphasized in the introduction, the main aim of the first study is identifying factors that promote resilience; rather than focusing on the distruptive

effects of EMSs. The results of the present study support the idea that all people suffer because of their schemas. Some display psychopathological symptoms, others do not, but this does not mean that they are free of emotional problems. On the other hand, empowerment of the healthy adult mode, in the scope of the present study healthy emotion regulation strategies and self-compassion, illuminate the path to mental health and life satisfaction.

Thus, having an EMSs should not be accepted as the main source of the problem; the individual's coping style might be more significant. From this point of view, the focus on schema therapy should be shifted to working with modes and ineffective coping strategies that serve only to twist the knife into old emotional scars. Schema therapy provides a variety of clinical tools that can help any individual to empower healthy modes by promoting self-compassion, spontaneity, and playfulness. Hence, individuals may come to treat their emotional scars as reminders of past difficulties without being pulled down by them.

2.3.5. Clinical Implications of the 1st Study

Due to growing interest in Schema Theory, research usually lacks to view the EMSs within different theoretical perspectives. In this regard, the present study provides implications for both the treatment process of the patients and mental health promotion.

Most of the success of a therapeutic process can be explained by tailoring treatment with regard to the patients' needs. In light of this, to make meaning out of the chaotic relationship that lead to the improvement, it is extremely important to identify core emotional needs that lead to the present problems of the patients. In this regard, enlightening the path between different EMSs domains and related problem areas are very important to employ suitable treatment strategies. In the present study, different EMS domains are clearly associated with different elements in terms of emotion regulation and self-compassion, which provides clinical utilization to tailor schema therapy of the patients that display different EMSs patterns. More specifically, the importance of overcoming with the negative

consequences of self-judgement and being mindfulness are among the frequently mentioned aims in schema therapy. Similarly, common humanity is an important element to empower nurturing parent and healthy adult modes.

Recently, psychopathological symptom relief was frequently accepted as the main focus of especially short-term therapies. Training of adaptive emotion regulation strategies play a crucial role in the treatment process. However, the current results indicate that as well as the absence of psychopathological symptoms, the presence of positive emotions is also critical for individual's well-being. Therefore, beyond emotion regulation strategies, self-compassion training should be included to the therapy process in order to increase its effectiveness.

More generally, the present study provides evidence-based risk and protective factors in terms of the individual's well-being. Given the major social and economic costs that mental health problems cause, it was important to identify that EMSs have negative effects on every individual, even when they do not cause psychopathological symptoms. Therefore, schema therapy practices should be included to the integrated community training programs that contain the teaching the essentiality of EMSs and the functions of emotion-regulation and self-compassion.

2.3.6. Limitations and Strengths of the 1st Study

The present study was designed to obtain empirical evidence for the theoretically drawn hypotheses of the researcher. With this regard, an explanatory model that aimed to identify the role of emotion regulation and self-compassion together in terms of EMS and well-being of the individual was constructed. The results of the present study generally supported the hypotheses. However, the results are mainly descriptive and need to be replicated across different populations in terms of psychopathological background, culture, age groups etc.

The nature of correlational relationships between major variables in a study is frequently cited as a limitation by researchers. It is usually followed by future

suggestions of conducting experimental research in order to drawn causal relationships between variables. The same criticism is also valid for the present research. However, beyond the limitations caused by correlational relationships between variables, these limitations become a little bit more serious in terms of the present research because the main interest in the present study is EMSs with regard to schema theory. This means that the researcher tried to uncover a structure that consisted of the combination of both conscious and unconscious elements. In this regard, relying completely on self-report is an important limitation. In literature, researchers reported similar results regarding self-compassion in terms of self-report and therapist ratings (Neff, Kirkpatrik, & Rude, 2007). However, the condition is not the same for EMSs and emotion regulation. It was reported that social-desirability might cause problems in terms of the measurements of EMSs (Rijkeboer, 2012). Similarly, it was argued that complete reliance on self-report while assessing emotion regulation causes problems because individuals do not usually become fully aware of their emotional responses (Gratz & Roemer, 2004). Moreover, the data of the present study was collected via an online survey. Therefore, a high dropout rate was one of the most important limitations of the present study, because although 426 people were interested in the study and began to answer questions, only 315 of the participants completed all of the questionnaires. Moreover, online surveys allow multiple submissions to the same administration in different times, which may cause some problems in terms of inter-correlations between variables.

Based on the abovementioned limitations and general limitations of the assessment of the related variables, a second study was designed to provide answers to these limitations, with a complete qualitative research perspective.

CHAPTER 3

SECOND STUDY: THE EARLY CHILDHOOD MEMORIES EVOKED BY THE SCHEMA MODE CARDS: EARLY MALADAPTIVE SCHEMA THEMES

3.1. Method

3.1.1. Sample

In the second study, the researcher got in touch with sixteen participants out of 296 people, who participated in the first study. Based on the results of the first study, the primary inclusion criteria for the second study was having the highest scores in the disconnection-rejection domain. The participants previously informed about the presence of a second study, were asked for their contact information, and agreed to participate in the second part of the study if they are called back. In this regard, sixteen participants were called back with respect to their scores on the disconnection/ rejection domain. All in all, a total of ten (5 male, 5 female) participants agreed to participate in the present study. The participants were chosen considering the similarity of their scores on the disconnection-rejection domain, as well as age and gender. Characteristics of the sample is displayed in (Table 16).

Table 16. Demographic Characteristics of the Sample

AN	Age	Gdr	D/R	MA	ED	DS	SI	EI	*FA*
Green	21	F	4.27	3.40	4.00	3.60	4.80	4.80	5.00
Purple	27	F	4.80	4.60	5.00	5.20	5.00	4.40	4.60
Pink	21	F	3.00	4.40	2.20	1.60	3.60	4.40	1.80
Red	32	F	3.73	4.60	2.40	3.40	3.80	4.20	4.00
Yellow	22	F	3.13	3.40	3.80	2.40	4.00	4.20	1.00
Blue	24	M	4.07	4.40	4.80	4.00	4.40	2.80	4.00
Maroon	20	M	3.40	5.80	2.00	2.20	4.60	2.80	3.00
Black	27	M	2.90	4.00	3.00	2.80	3.80	1.80	2.00

Table 16. Continued

AN	*Age*	*Gdr*	*D/R*	*MA*	*ED*	*DS*	*SI*	*EI*	**FA**
Navy	32	M	3.33	3.40	4.00	2.40	4.00	4.20	1.00
Grey	24	M	3.43	3.20	4.20	2.0	4.60	2.40	4.20

Note. AN: Anonymous name, Gdr: Gender, Mean Scores for D/R: Disconnection/rejection, M/A: Mistrust/abuse ED: Emotional deprivation DS: Defectiveness/shame SI: Social isolation EI: Emotional Inhibition FA: Failure.

3.1.2. Materials

3.1.2.1. Schema Mode Cards

Schema mode Cards were developed by Bernstein (2014) with a comic strip artist to portray 23 different schema modes. Accordingly, eight cards aimed to portray the child modes (abandoned child mode, abused child mode, humiliated child mode, lonely child mode, angry child mode, impulsive child mode, undisciplined child mode, happy, playful child mode), two cards aimed to portray the parent modes (punitive, critical parent mode, demanding parent mode), twelve cards aimed to portray the coping modes (detached protector mode, detached self-soother mode, angry protector mode, complaining protector, compliant surrender mode, self-aggrandizer mode, bully and attack mode, paranoid over controller mode, obsessive-compulsive mode, conning manipulator mode, predator mode), and one card aimed to portray the healthy adult mode. Bernstein proposed that the cards were basically developed to be utilized in schema therapy process to help patients to identify their schema modes Each card is identified to be associated with certain adjectives. The validation of the assessment and scoring process is done by Bernstein (May, 2014, personal communication). The present study is the first study that utilized selected Schema Mode Cards in Turkish Culture. The validation process of the assessment and the scoring procedure for the complete set of 23 cards was done by Yakın, Güneş, Gençöz and Bernstein (2015).

3.1.3. Procedure

Early Memories were collected by utilizing semi-structured interviews conducted by the researcher. The first pilot study was conducted with 20 participants, each

participant was asked without any previous manipulation to describe his/her early recollections in a written form. According to the results of the study and feedbacks from participants, two things were clear. Firstly, nearly all the participants posited that talking on their memories could be more easy and natural with a face-to-face conversation. Secondly, the length and content of the written memories display a great diversity and most of them do not include any theme that can be connected with any of the EMSs. According to Lobbestael and colleagues (2007), experiential exercises can be used to trigger schema modes. In this regard, it can be hypothesized that it can be quite logical that being exposed to certain images that portray schema modes can stimulate early recollections that contain different themes representing basic EMSs which an individual has. Thus, the new assessment procedure is designed to use schema mode images to evoke childhood memories. Therefore, ten clinical psychologists, who have experience in schema therapy, were asked to choose five cards from Schema Mode images that can be closely associated to the EMSs in disconnection rejection dimension. Accordingly, seven cards were chosen. However, in literature, it was advised that asking for more than four memory would not be a good idea (Clark, 2002). Therefore, the options were limited to four cards that were chosen by the researcher and the advisor. These cards were aimed to portray abandoned child mode, abused child mode, humiliated child mode, lonely child mode, and happy, playful child mode. The administration was designed as a semi-structured interview and questions are inspired from a combination of Young's (1990/1999) Shema Theory, Adlerian Life Style Assessment and Mosak and Di Pietro's (2006) assessment procedure for early recollections. In this regard, participants were asked to tell the earliest childhood memories when they felt just like the same situations portrayed in the schema mode cards. If needed, a part of the instruction was repeated and participants were encouraged to take their time to remember a relevant earliest memory. After the participants told their memory, based on the procedure described by Clark (2002), they were asked four follow-up questions:

Is there anything else that you can recall in the memory?

What part do you remember most in the memory?

How were you feeling at that point?

What feelings do you remember having then?

Later on, the participants were presented with the healthy adult mode card and asked to tell a story about the man portrayed in the card. This procedure is also inspired from the Adlerian assessment to evaluate a person's lifestyle, which is considered as strikingly similar to Young's view of an EMS (Dinkmeyer & Sperry, 2000). In order to get relevant information about emotion regulation, self-compassion, psychopathological symptoms and life satisfaction, four follow-up questions were asked:

How does this person cope with emotional problems?

How does this person treat himself/herself through hard times?

Do you think this person has any psychological problems?

Do you think this person is satisfied with life?

Lastly, the participants were presented with a blank card and asked to dream a human being, and the same procedure was repeated with the same follow-up questions. Moreover, participants were allowed to talk freely about their memories and express their emotions. This semi-structured interview lasted approximately 30 minutes. Data collection last 3 weeks, and all the participants were interviewed by the the researcher individually. All interviews were audiotaped and transcribed. The analysis reported in the result section was conducted by the researcher and her supervisor, who are both qualified in schema therapy. Besides, a respected qualitative research expert supervised the coding process and revisions were done with regard to the feedbacks. Later on, the data was analyzed in line with the rules of deductive qualitative content analysis by utilizing MAXQDA.

3.2. Results

Firstly, individual case analyses were conducted in order to get an understanding of the participants and highlight the important parts of the text. By following the

procedure described by Mayring (2000), main categories were described based on Schema Theory and a code agenda was developed. Accordingly, sub-categories were extracted from the text based on the definition of each EMS.

3.2.1. Results regarding Mistrust/Abuse Schema

Mistrust/Abuse schema is displayed as hypersensitivity in interpersonal relationships. People with this schema tend to expect that others will hurt or manipulate them intentionally or others will be unresponsive to their suffering (Young, Klosko, & Weishaar, 2003). Therefore, subcategories for this schema were decided as expectation of harm, being suspicious of others, perceiving negligence and resentment caused by abusive memories. In order to code a passage within mistrust/abuse, the individual should think that they are either harmed by others intentionally or others are indifferent to their suffering. For instance, Ms. Pink said that:

> "I usually feel lonely. For example, I don't trust anyone. Like, I am always skeptical towards others because I am someone who did not get my parents' support adequately. That feels really, really bad…"/"Ben genelde kendimi hep yalnız hissederim mesela hiçbir insana güvenmem. Böyle hep insanlarda kuşku ararım çünkü hani gerçekten böyle doğru düzgün annemin babamın desteğini almamış biriyim.

Ms. Pink's answer was coded within being suspicious of others. Similarly, themes in early recollections reported by Ms. Green involve the expectation of an intentional harm from her father when he finds out she has a boyfriend:

> "Let me put in this way; I remember I was really afraid when my father had taken me to the roof and I asked myself if he was going to throw me down from somewhere… Because you know the families that live in that area… I was thinking that he would throw me down off the roof or would do something bad to me. I remember that" / "Size şöyle diyeyim hani korkmuştum da aslında hani babam beni dama götürüp hani acaba beni bi

yerden mi atacak? Çünkü hani oradaki aileleri bir doğudan geliyor hani acaba kötü bir şey mi yapacak bana beni damdan mı atacak gibi düşünceler de geçmişti kafamdan. Öyle onu hatırlıyorum"

Ms. Green also posited a good example regarding the connection between earlier experiences and schema maintenance because she expressed the same kind of fear about her boyfriend as well. Moreover, in order to code a passage within mistrust/abuse schema, the effects of a prior traumatic experience should have still been affecting the individual like it was in the memory of Mr. Black:

"My father was beaten by the police because he had done smuggling… Hatred accumulates within me towards the police. Still the same despair. If they took my father away again today, I would still feel exactly like that." / "Babam kaçakçılık yaptığı için polislerden dayak yemişti… Polislere karşı nefret birikiyor içimde, yine aynı çaresizlik. Yine alıp babamı götürseler yine böyle hissederim."

Later on, crosstabs regarding the relationship between mistrust/abuse schema and gender (see table 17) revealed that male participants reported more mistrust/abuse related themes compared to female participants in general.

Table 17. Crosstabs for Mistrust/Abuse Schema and Gender

EMS	**Gender**		∑
	Female	**Male**	
Mistrust/Abuse			
Being suspicious of others	3	3	6
Perceiving negligence	5	-	5
Resentment caused by abusive memories	-	11	11
Expectation of harm	2	7	9
Total	10	21	31

Accordingly, male participants talked about their memories that contain themes regarding mistrust/abuse schema more frequently than female participants do in the study. Moreover, female participants reported themes regarding negligence

memories; whereas, male participants reported anger and resentment while talking about their early recollections.

3.2.2. Results regarding Emotional Deprivation Schema

Emotional deprivation schema was defined by Young and colleagues (2003) as feelings of loneliness and depression and lack of awareness about one's own needs and emotions. These people often avoid disclosing themselves to others because they do not think others will give them enough nurturance, empathy, guidance or protection. In this respect, three different subcategories were decided for the code manual; these were deprivation of guidance, deprivation of understanding and deprivation of warmth. In his regard, two coding rules for emotional deprivation schema were identified. If the individual mentions absence of nurturance, empathy and protection, and the level of the expected need is within normal limits, the theme in the memory or life style story was coded within emotional deprivation schema. For instance, while talking about the lifestyle of the imagined figure by looking on an empty card, Ms. Yellow gave a typical example of emotional deprivation schema:

> "Yes, there is something here… There is a blonde child. When I say child, there is someone around 25-26, and he never smiles even when he is happy. He is always making a face. He is distant towards others because he thinks that others around him are like that, and he doesn't get intimacy from anyone; just behaving towards everyone as it is meant to be… Nobody has taken an interest in him…" / "Evet burada şimdi şey var sarışın bir çocuk var, çocuk dediğim 25-26 yaşlarında birisi ve mutlu bile olsa hiç gülmüyor, sürekli somurtuyor. İnsanlara karşı çok mesafeli bunun sebebi de çevresindeki herkesin öyle olduğunu düşünmesi, kimseden samimiyet göremiyor, herkese sadece davranması gerektiği gibi davranıyor… Kimse onunla ilgilenmemiş"

The projected figure lacks proper nurturance or adult supervision. Moreover, during the generation of the code manual, psychological and behavioral control was also

included as a subcategory. In this regard, if the individual emphasized despair and deprivation in the memory content in a more general way, it was coded within psychological/behavioral control. For instance, Ms. Pink got watery eyes while talking about how she was deprived of emotional support by her father:

> "My father has constantly directed me. When his demands were not met, he got mad at me; there were times when he did not talk to me for days. Like he never tried to understand and because of that I generally feel myself alone." / "Hani sürekli bir yönlendirdi beni… Kendi isteği olmayınca hep bir kızdı, azarladı günlerce konuşmadığı oldu. Hani hiç anlamaya çalışmadı o yüzden ben genelde kendimi hep yalnız hissederim."

The response of Ms. Pink corresponds to more than one subcategory. Therefore, the passage was coded within psychological/behavioral control subcategory. Later, crosstabs were generated to present relationships between sub-codes of emotional deprivation schema and gender (see table 18). Accordingly, female participants reported more themes related to emotional deprivation than male participants in terms of all subcategories, meaning that female participants talked about their memories regarding emotional deprivation more frequently than male participants did.

Table 18. Crosstabs for Emotion Deprivation Schema and Gender

EMS	**Gender**		∑
	Female	**Male**	
Emotional Deprivation			
Absence of understanding	15	6	21
Absence of guidance	5	2	7
Absence of warmth	16	10	26
Behavioral& psychological control	8	4	12
Total	44	22	66

3.2.3. Results regarding Defectiveness/Shame Schema

Defectiveness/shame schema is closely associated with feelings of inferiority and shame. People who have higher levels of defectiveness/shame schema constantly worry about their flaws and fear that other people will discover their imperfections. Hence, they are sensitive to rejection and vulnerable to abusive behaviors (Young, Klosko, Weishaar, 2003). In this regard, feelings of inferiority, shame regarding flaws and feeling unlovable were decided as the subcategories of the code manual. In order to code a passage with the defectiveness/shame schema, the individual should feel inferior regarding a real or perceived flaw and display an increased level of self-conscientiousness. For instance, Ms. Pink's lifestyle story as a respond to the healthy adult mode card is a good example for defectiveness/shame schema:

> "I cannot handle my emotional problems. I mean I'm not that strong…For example, when I am depressed, I cannot laugh like that woman when I'm out on street. I can be easily affected from anything like it is the end of the world like I would cry for days and would not leave the bed for days." / "Baş edemiyorum, yani o kadar güçlü biri değilim… Mesela ben o kadın gibi mesela gülemem dışarıda hani moralim bozuk olunca. Hemen bir olaydan etkilenirim hani dünya bitmiş gibi hissederim böyle gerçekten günlerce falan böyle ağlarım yataktan çıkmam."

The response of Ms. Pink includes themes regarding inferiority in terms of emotion regulation as a result of comparison with others. On the other hand, Mr. Navy complained about his impulsiveness, which is seen as a flaw:

> "It was like an unexpected presence of a really unwanted situation… That desperation… It was the first time I experienced regret intensely; I remember it that way… Why do I have to do something in unusual and exotic ways rather than doing the things that were meant to be done? And then, I feel the regret that I feel when the results of my behaviors have negative impacts." / "Tam istemediğimiz ya da hiç beklenmeyen durumun istemsiz şekilde olması… O çaresizlik… Belki de ilk yoğun pişmanlığım o

olabilir yani öyle hatırlıyorum…Neden yapılması gerekeni de asortik değişik bir şekilde yapmaya çalışıyorum? Ve o negatif bir etki yapınca yaşadığım pişmanlığı hissediyorum"

Although the respond does not contain an overt expression of shame, apparently, Mr. Navy was heavily blaming himself about his private "defect". Lastly, crosstabs were generated to present the relationships between subcategories of defectiveness/shame schema and gender (see table 19). Thus, it was concluded that female participants generally reported more themes related to defectiveness/shame than male participants did, meaning that female participants' responds included more themes regarding defectiveness/shame than male participants' did. Moreover, female participants frequently mentioned their feelings of unlovability; whereas, none of the male participants talked about it.

Table 19. Crosstabs for Defectiveness/shame Schema and Gender

EMS	**Gender**		∑
	Female	**Male**	
Defectiveness			
Shame regarding perceived flaws	8	8	16
Inferiority	6	5	11
Feeling unlovable	5	-	5
Total	19	13	31

3.2.4. Results regarding Social Isolation Schema

Social Isolation schema is associated with constant strangeness and not fitting in. They usually lack sense of belongingness and are disconnected from the outer social world (Young, Klosko, & Weishaar, 2003). Based on the definition, a code manual was developed with the sense of loneliness, absence of belonging, and withdrawal subcategories. In order to code a passage within social isolation schema, the individual should either prefer to be alone or has to have difficulties regarding the sense of belonging. For example, Ms. Red described an imagined figure as a response to the blank card, which displayed typical characteristics of social isolation schema:

> "This woman might be experiencing emotional problems because of the lack of a complete sense of belonging. There are times she can get more melancholic. In these times, she could be withdrawing into her shell, listening to herself, trying to give time to herself and try to sooth herself… Later, when she feels that energy and strength, she can go out." / "Bu kadın bir öncekine göre daha fazla duygusal sıkıntı yaşıyor olabilir. Tam olarak bir yere ait olmama halinden dolayı. Kimi zamanlarda böyle daha melankolik olduğu durumlar falan oluyordur. Öyle durumlarda da biraz daha kendi kabuğuna çekilip kendini dinleyip iyileştirmeye biraz zaman vermeye çalışıyordur kendisine. Sonrasında tekrar o enerjisini gücünü bulduğunda tekrar o dışarıya açılıyordur."

The respond that was given by Ms. Red includes an intentional withdrawal from the outer world. People with social isolation schema frequently talk about the ability to take care of their problems all by themselves. However, these themes can be displayed in a more desperate way rather than as intentional choices as Mr. Grey described:

> "I've just mentioned that I was physically abused from time to time. This photo reminds me of these memories: the withdrawal of a child who is sad and who experiences a traumatic experience or focuses the feelings that were experienced then. When I go back to the past, from time to time, I also feel withdrawn as a result to my experiences ……and as the time passes, I become disconnected with my friends, my best friends." / "Zaman zaman şiddet gördüğümden bahsettim. Bu fotoğraf şunu hatırlatıyor, bir üzülen ya da örseleyici olay yaşayan çocuğun içine kapanması, ya da yaşadığı duygulara odaklanmasını gösteriyor. Geçmişe döndüğümde, tabii ben de yaşadığım olaylar sonucunda zaman zaman içe kapandım… Yıllar geçtikçe, dışarıdaki arkadaşlarım en iyi arkadaşlarımla bir kopukluk yaşadım."

Lastly, crosstabs regarding the relationship between social isolation schema and gender was generated (See table 20). Accordingly, female and male participants

displayed similar frequency patterns in terms of mentioning themes regarding social isolation schema. On the other hand, female participants reported more themes related to the withdrawal subcategory than male participants did ; whereas, male participants reported more themes regarding loneliness subcategory than female participants did..

Table 20. Crosstabs for Social Isolation Schema and Gender

EMS	**Gender**		∑
	Female	**Male**	
Social Isolation			
Loneliness	3	7	10
Withdrawal	7	4	11
Absence of Belonging	2	1	3
Total	12	12	24

3.2.5. Results regarding Emotional Inhibition Schema

According to Young and colleagues (2003), emotional inhibition schema was a part of the over-vigilance and inhibition domain. However, it was grouped under the disconnection/rejection domain as a result of a higher order factor analysis in both of the two adaptation studies conducted in Turkey (Soygüt, Karaosmanğlu, & Çakır, 2009; Sarıtaş, Gençöz, 2011). Therefore, this schema was included as a part of the disconnection/rejection domain. Emotional inhibition was defined as an excessive effort for inhibition of a spontaneous feeling or action. Generally, emotional inhibition was active within four domains, which are inhibition of anger and aggression, inhibition of positive responses and difficulty in sharing spontaneous feelings and needs, and rationalism without mentioning emotions (Young, Klosko, Weishaar, 2003). In this regard, inhibition of actions, inhibition of feelings and difficulty in expressing vulnerability were identified as the subcategories. Mr. Maroon's respond regarding the memory of losing his best friend because of a sudden heart attack at the age of 17 involves themes regarding emotional inhibition:

> "I was 17 when I heard that my best friend was dead. I cried a lot at that time, but I never cried again. I ran away from my hometown … For three

years, I went there only two or three times… In summertime, I usually find a job here and there, and tell my family I cannot make it there. Let me not lie, but I ran away like that for 1 or 2 years" / "17 yaşındaydım en yakın arkadaşım kalp krizi geçirdiğinde böyle çok fazla ağlamıştım. Zaten o günden sonra da hiç ağlamamaya başladım… Kaçtım mı, memleketten kaçtım. Üç yılda oraya toplasan iki ya da üç kere gitmiştim sadece… Ben yazın burada iş buluyordum veya işte annemlere söylüyordum ben işte şuraya gidiyorum hani bayağı bir 1 yıl 2 yıl kaçmıştım yani."

Mr. Maroon's response was a good example for inhibition of the negative feelings and spontaneous actions. Similarly, Ms. Red also told a memory about how she had to stop herself from behaving spontaneously:

"Seeing an old wrinkled scraggy hand reaching out to me, I was disturbed, actually disguised. I wanted to say, "I don't want to kiss your hand" but if I said so, I was afraid that everyone would turn against me and will ask: "Why on earth are you acting like this? Shame on you!" because it was bairam… Therefore, I felt stuck. I wanted to rebel but I could not. It was frustrating." / "Kemikli kemikli buruşuk buruşuk yaşlı bir elin bana uzanması, çok rahatsız oldum. Hatta tiksindiğimi hatırlıyorum. Hani, böyle 'istemiyorum öpmek elini' demek istemiştim ama öyle yapacak olursam da bu sefer hani "aa ayıp. Neden öyle yapıyorsun?" şeklinde düşüneceklerini herkesin işte, aile, hep beraber bayram şeysiydi çünkü. Onun için böyle sıkışmış hissetmiştim kendimi. İsyan etmek istiyorum ama edemiyorum şeklinde böyle 'frustration' hissi tam olarak öyle bir şey yaşamıştım."

On the other hand, while individual case analysis was being conducted, it was interesting to see that some participants tended to utilize intellectualization or they had a really hard time to remember their memories. Therefore, inhibition of memories and intellectualization were included as the subcategories during the revision of the categories. Concordantly, some of the participants revealed lots of themes regarding schemas; whereas, some of the participants barely remembered

their memories. For example, Mr. Blue usually asked for close ended questions and slided over his memories or talked about them in an over general way.

> "Actually, I do not know how to feel about them… These memories were long ago, I don't actually take a step back and think about them..." / "Aslına bakarsanız bunlar… Tabii yani nasıl hissettiğimi yani bilmiyorum, çok da olmuş geçmiş yani, çok da üzerinde durup düşündüğüm anılar değil bunlar…"
> "Mr. Blue: Actually I was angry at them then…/Ya ben ona o zaman kızmıştım aslında ya…
> Researcher: How old were you?/ Kaç yaşındaydınız?...
> Mr. Blue: Eight or nine I guess. / Sekiz dokuz herhalde…
> Researcher: You were angry, and what? / Kızgın hissettiniz, başka?
> Mr. Blue: Actually I was not angry, or was I... not that much… only I felt a little… Actually I didn't care about that much. Yes you can write he didn't care. / Kızgınlık hissetmedim ya… O kadar çok böyle şey değil sadece biraz şey yapmıştım çok da umursamadım o zaman yani, çok umursamamış yazabilirsiniz yani."

These two examples from the passage pretty sum up the attitude that Mr. Blue displayed during the administration that were driven by a combination of different schemas including emotional inhibition schema. Lastly, crosstabs were generated to identify the link between emotional inhibition schema and gender (see table 21). Accordingly, male participants displayed more themes in their responses regarding emotional inhibitions compared to female participants, especially in terms of inhibition of feelings and intellectualization/rationalization subcategories. On the other hand, both male and female participants seem to display similar themes in their responses in terms of inhibition of memory and inhibition of actions subcategories.

Table 21. Crosstabs for Emotional Inhibition and Gender

EMS	Gender		∑
	Female	**Male**	
Emotional Inhibition			
Inhibition of actions	6	6	12
Inhibition of feelings	5	15	20
Difficulty in expressing vulnerability	2	5	7
Inhibition of memory	4	6	10
Intellectualiztion and rationalization	2	10	12
Total	19	42	61

3.2.6. Results regarding Failure Schema

Similar to emotional inhibition schema, failure schema also did not take place in the disconnection/rejection domain. However, based on the higher order factor analysis (Sarıtaş & Gençöz, 2011) that was utilized in the first study, themes regarding failure schema were also identified in the second study. Young and colleagues define failure schema, which is originally designed as a part of the impaired autonomy and performance domain, as the expectation that one will eventually experience failure as a result of a fundamental shortcoming relative to others. With this respect, subcategories of the failure schema were identified as expectation of failure and a sense of inadequacy as a result of comparison. Mr. Black's memories involve themes related to failure schema:

> "In primary school, I didn't know how to speak Turkish. I was trying to say something… I was trying to say a proverb. I stood up, because I didn't know how to get permission to speak in the classroom. I was walking behind the teacher and my hands were in my pockets. I stood behind the teacher and said the proverb. He turned to me and slapped me… I think the reflections of this event are still continuing in my life and they continue to affect me… Being in such a situation in front of my peers, seen as powerless and growing into a powerless person upsets me." / "İlkokulda, Türkçe bilmediğim zamanlarda bir şey söylemeye çalışmıştım sınıfta, sanıyorum

dördüncü sınıf. Altı yaşında başladım, on yaşına denk geliyor. Bir atasözü söylemeye çalışmıştım. İzin almayı bilmediğim için ayağa kalkmıştım. Öğretmenimin arkasında ellerim cebimde yürümüştüm. Onun arkasında durup o atasözünü söylemiştim. Dönüp bana bu hareketi yapıp tokat atmıştı bunu hatırlıyorum. Geriye dönüp baktığımda da üzüntü görüyorum. Hayatımda bazı yansımalarının şu an sürdüğünü ve beni etkilediğini düşünüyorum."

"I was totally untalented in football. I have never played football in my whole life." / "Beceriksizdim o açıdan. Hiç futbol oynamadım hayatım boyunca."

The memories of Mr. Black displays expectation of failure in both academic and sports areas. Lastly, crosstabs were generated to identify the link between failure schema and gender (see table 22). In this regard, the themes regarding failure schema were displayed in similar frequency patterns in female and male participants.

Table 22. Crosstabs for Failure and Gender

EMS	**Gender**		∑
	Female	**Male**	
Failure			
Expectation of failure	3	2	5
Inadequacy based on comparison	6	8	14
Total	9	10	19

3.3. Discussion

The aim of the present study was to investigate the schemas, which are hard to reach via solely self-report tools. In order to eliminate the disadvantages of paper-pencil tests, a new assessment procedure was suggested by utilizing elements derived from a combination of different perspectives. Hence, the results revealed important implications regarding the assessment of EMSs that forms the disconnection/rejection domain.

3.3.1. Results regarding EMSs and Gender

Although there has been a significant increase in research regarding schema therapy recently, gender difference is not a frequently cited factor in schema research because basic needs are considered as vital independently of the gender of the person. However, the present results revealed that the themes that refer EMSs vary in terms of the responses of female and male participants. For example, the themes that represent certain schemas were considerably different between male and female participants. Female participant's responses that are associated with mistrust involved fears of being left alone in their time of need and the belief that significant attachment figures always have the potential of being unresponsive to their problems and pain. On the other hand, male participant's responses that are coded within mistrust/abuse schema involved overt anger and resentment expressed directly to the abusive attachment figure. Besides, male participants report overall themes regarding mistrust/abuse schema more frequently compared to female participants. More interestingly, female participants do not express any anger or resentment while they were talking about their attachment figures, even abusive ones. Similarly, none of the male participants' response included themes involving perceived negligence. This difference would be attributed to the present role models accepted by society. Unfortunately, anger is the easiest emotion to be expressed by a man rather than other "fragile" emotions. On the other hand, it was not a socially desirable emotion for a woman. The results regarding the second schema, emotional deprivation, seem to confirm this interpretation. Female participants reported themes regarding their deprivation of understanding and warmth considerably more frequently compared to male participants. On the other hand, female participants' responses involve more themes regarding both behavioral and psychological control. Similarly, themes regarding a subcategory of defectiveness/shame, and feeling unlovable could not be coded in the responses of male participants. More obviously, results associated with inhibition of feelings subcategory, which is a subcategory for emotional inhibition schema, revealed that male participants displayed themes related to inhibition of their spontaneous feelings considerably

more frequently. We've known for years now that basic human needs cannot vanish into thin air when the suitable conditions to meet these needs do not occur. In such a condition, the individual should push the environmental conditions all the way through. This way can be a long and deteriorating for some individuals, and only a few of these individuals have a chance to understand the actual needs underneath their visible behaviors. Thus, although basic needs are generally the same, every single individual tries to fulfill these needs within the rules that are defined by the social environment they are in. Therefore, schema therapists should be aware of the fact that same schemas can be described or displayed within a variety of emotions, behaviors, and/or memory contents.

3.3.2. The Prevalence of the Themes from a Qualitative Perspective

EMSs that are discussed within the present study can be summed up as being exposed to ineffective parenting practices such as childhood abuse, neglect and control; and a combination of ineffective emotion regulation strategies such as withdrawal and emotional inhibition. According to me, as a clinician, after reading the interviews repeatedly several times, the participants made it clear that they don't trust other people easily and they have problems expressing their spontaneous emotions. Moreover, they also posited that they would tend to inhibit their emotions time to time because their fundamental needs haven't been satisfied for a long time and now they believe that it is meaningless to ask for these needs to be met. Therefore, any type of human contact would be distressing to these individuals.

Yound and collegues (2003) postulated that therapeutic relationship is central in the treatment of patients with high levels of EMSs of the disconnection/rejection schema domain. It can be guessed that the same condition would likely to be valid for the assessment procedure as well. Since the visible signs of themes regarding EMSs can be displayed as a variety of different ways according to the individual's schema coping responses, the accurate assessment of the schemas can be challenging, but very important at the same time. The most frequently coded schemas were emotional deprivation and emotional inhibition in the present study,

and the code frequency of these schemas were very similar. This finding can be interpreted as that participants are more likely to reveal their deprived side while talking with the researcher. Moreover, results regarding defectiveness also seem to confirm the interpretation. On the other hand, the themes regarding emotional inhibition schema are still the most frequently coded themes. Actually, it is not shocking because one single interview cannot eliminate the maladaptive coping modes of the participant. Moreover, the presence of non-verbal cues about the schemas and schema coping responses would increase the frequency of codes due to the qualitative nature of the data. For example, coping responses like rationalization and denial were coded with emotional inhibition schema. Thus, emotional deprivation seems to be the most prevalent theme of the interviews because nearly all of the participants expressed their hurt feelings about their parents while talking about their early recollections. The code frequency of mistrust/abuse, defectiveness/shame is the same. Despite gender differences that was extensively discussed in the previous section, these schemas are accepted among possible results of traumatization or victimization; therefore, it makes sense that they are closely associated with each other. The next frequently coded schema, social isolation was theorized to emerge later in life, and hence does not cue the dynamics of a nuclear family (Young, Klosko, Weishaar, 2003). In this regard, it would be expected that the social isolation schema will less frequently emerge while talking abut early recollections. Themes regarding failure schema were the least frequently mentioned ones. It might be because most of the participants were extremely involved with their self rather than a specific achievement in a particular achievement. Deep inside they might be suffering from feelings for a complete defectiveness as a person rather than just the fear of being a failure at a mission. Thus, themes regarding failure were embedded into the themes of the defectiveness schema. Therefore the frequency of the codings of failure might decrease.

3.3.3. Clinical Implications of the 2nd Study

Young and colleagues (2003) define the relationship dynamics of the patients with higher levels of schemas in the disconnection/rejection domain as follows: “they

tend to rush headlong from one self-destructive relationship to another or to avoid close relationship altogether". Therefore, maintaining a working alliance can get very challenging. In this regard, I think understanding the dynamics of a therapeutic relationship without building any kind of relationship with the participants is really hard and misleading. Schema Therapy is an empirically validated treatment style for chronical and challenging problems (Young, 1990/1999), and the success of the treatment mainly relies on the accurate assessment of the EMS. Therefore, the present study provides information about the manifestation of EMSs in early recollections and life styles.

A qualitative research perspective is usually criticized in terms of trustworthiness of the results. As a clinician, I find this notion confusing because the qualitative research process (asking open-ended questions, inquiring, making inferences on the patients' responses) is closely associated with the clinical assessment procedure, in which theoretical background and theoretical knowledge is tailored in accordance with the patients' –thought to be- needs. Thus, when a patient and a therapist start to work together on an issue, subjectivity cannot be eliminated. Therefore, I think the results of the study provides more realistic results regarding the prevalence and the assessment of the schemas in clinical practices. Moreover, identified themes provide a more integrated clinical perspective to the EMS in the disconnection rejection domain.

The present study provides a new assessment procedure for the EMSs. This is the first study, which utilized schema mode cards to evoke schema-related early recollections and lifestyle stories. In this regard, a procedure that utilize schema modes to stimulate early recollections can provide dual advantages. Firstly, content-relevant early recollections can be obtained more easily. Thus, obtaining content-relevant early recollections to identify EMSs becomes possible. Secondly, gathering childhood history with the help of schema mode cards can be used as a therapeutic technique while working with resistant patients.

All in all, the present study provides a new assessment procedure and valuable insights regarding schema assessment and the manifestation of schemas in a non-clinical population. Moreover, the role of emotion inhabitation was identified as an important element in the present study. Based on the findings, relevant precautions should be considered while conducting schema assessment, especially while working with high-risk populations (e.g. forensic evaluation) in order to eliminate either conscious or unconscious manipulations.

3.3.4. Limitations and Strengths of the 2nd Study

As a trendy research area, the advantages and disadvantages of utilizing a qualitative research perspective can be found anywhere (see Creswell, 1994), the advantages and the disadvantages of this method can be summed in one sentence: the present study provides extensive information for a small group of participants. On the other hand, it has also discussed that rather than a strict –and somehow false-dichotomy between qualitative and quantitative research methodology, qualitative and quantitative methodologies have been conceptualized within a continuum, in which the present study easily takes its place because present study employs quantitative analysis using qualitative data.

While working with schema therapy, the therapists are frequently warned about being aware of triggering of their own schemas. This is especially an important issue while conducting qualitative research. Similar to the processes displayed in the responses of the participants, the therapist's schema coping responses can cause faulty judgments as well. In order to eliminate the possibility of such a problem, a code manual was supervised by the advisor, who is an experienced clinician and another academician, who studies sociology, and who is known as a qualitative data specialist. However, as a result of the nature of a doctoral study, multiple perspectives from people who specialized in different theoretical orientations were not included in the coding manual process. Nonetheless, having multiple perspectives is not an essential process in qualitative research perspective, which appreciates subjectivity.

Lastly, although working with a non-clinical group has its advantages in terms of identifying common themes, the code manual in the present study was usually theory-driven and extreme cases were rare. Thus, the present study is an initial step for a standardized assessment procedure of EMSs, and further research is needed for alternative ways of identifying EMSs more accurately.

CHAPTER IV

GENERAL DISCUSSION

4.1. Putting Together 1st and 2nd Studies

The present study aims to enrich research on Schema Theory from an innovative perspective. Therefore, both studies within the project have been designed designed with the goal of helping to fill gaps in the literature on schema therapy.

The idea of the first study was to emphasize resourcefulness factors in schema theory from a positive psychology perspective. Therefore, two groups of modes became critical: child modes in order to understand the fundamental needs of individuals that have remained unmet, and the healthy adult mode, which helps individuals to overcome the disruptive effects of EMSs. However, problems with the quantitative data on EMSs have been cited extensively in schema literature. Hence, two main research fields were raised. The first one identifies the dynamics that catalyze the functions of healthy adult mode and the second one is an accurate assessment of EMSs in order to gain valuable insight into schema therapy practices.

Thus, the present study was designed as a mixed method study, and was built upon two data sets, one of which was quantitative and the other qualitative. The data collection and analysis were performed for each study, and their implications were discussed separately. In this regard, this chapter aims to compare, contrast and embed results from the qualitative and quantitative perspectives.

The first study emphasizes the dynamics of resourcefulness within schema theory. As was already dscussed, a minority of adults have become free of the effects of maladaptive childhood experiences, those in which their fundamental needs were not met. For instance, Rohner (1975/2000) defined *copers* as people who function well in their adult lifes, although they had felt rejected by their parents as a child.

On the other hand, from a schema theory perspective, unmet childhood needs of the individuals can be met through the proper functioning of the healthy adult mode and people who actively suffer from the negative effects of schemas can become *copers* with the help of Schema Theory. In light of this, the results of the first study revealed that self-compassion was more critical than emotional regulation in terms of life satisfaction, whereas emotion regulation was more critical in terms of symptoms of psychopathology. This would be because life satisfaction was mainly related to the individuals' internal processes; whereas, emotion regulation was more likely to affect relationships with others. That is, the emotional dysregulation of an individual can be easily observed and labeled by other people; thus, they are more likely to be diagnosed with a psychological disorder. On the other hand, self-compassion refers to a more internal process because self-compassion is not visible to others, yet continues to affect the individual's quality of life.

According to the results of the first study, which perfectly fit the original postulation of Young (1990/1999), people with higher levels of EMSs that are in the disconnection/rejection schema are the most problematic, and are seriously deprived. Similarly, Rohner (1986/2000) postulated that rejected adults and children display dependence or defensive independence, impaired self-esteem and self-adequacy, emotional unresponsiveness, hostility and aggression, emotional instability, and a negative worldview towards all cultures, races, and languages. It can be readily observed by the attentive eye that this pattern considerably overlaps with the people, who have higher levels of EMSs of the disconnection/rejection domain. On the other hand, when the separate YSQ-assessed schema scores of individuals were examined, it was seen that rather than being deprived, defective, or needy individuals reported being mistrustful, emotionally inhibited and socially isolated. Therefore, in order to understand these dynamics clearly, the quantitative results were supplemented with qualitative research.

The second part of the study was like using a magnifying glass to understand the dynamics of the people that have higher levels of EMSs in the disconnection/rejection domain. The YSQ scores of the participants who were

chosen for the second study reveal that schemas like mistrust/abuse, and emotional inhibition were reflecte d at the highest level, in other words, they made it clear that they don't trust other people easily, and they have problems expressing spontaneous emotions. In this respect, working with these populations requires more effort in order to get accurate information. On the other hand, the frequency patterns of these themes was more balanced across schemas when a quantitative assessment was applied to the qualitative data. This finding can be interpreted as participants being more likely to reveal their sense of deprivation when they are in an actual communication. For instance, the results regarding defectiveness seem to confirm this interpretation because YSQ-based defectiveness scores were considerably low in nearly all of the participants chosen for the second study. However, they display defectiveness-related themes more frequently than they did in their YSQ scores. Additionally, there is a wide gap between the YSQ scores for the mistrust/abuse and defectiveness/shame schemas. On the other hand, the same frequency for each theme did not carry over into the second study. This would be attributed to obtain richer responses in terms of both verbal and non-verbal cues. Also, this should be considered as a two way effect; Mehrebian (1971) long ago found that 93% of a person's credibility can be attributed to non-verbal communication. Thus, if the participants trust the researcher they feel safer and express more geniunine responses. The same idea was also emphasized by Young and collegues (2003), who accept that the therapeutic relationship is a central element in the treatment of patients, especially those who have higher levels of EMSs in the disconnection/rejection schema domain. Thus, it can be postulated that the same condition may be valid for the assessment procedure as well. All in all, qualitative assessment procedures seem to reveal more sophisticated responses, especially for the schemas that people saw as a weakness to be talked about. In this regard, the effects of emotional inhibition, which are identified as an important challenge when gathering schema-relevant information could be lessened with trusting communication.

Lastly, a few things should be emphasized regarding schema domains. Unlike the theory (Young, 1990/1999; Young, Klosko, Weisharr, 2003), two Turkish adaptation studies accept emotional inhibition as an EMS related to the disconnection/rejection domain. Similarly, emotional inhibition schema was among the highest schema scores in terms of both the YSQ and the frequency of schema themes. Thus, EMSs in the disconnection/rejection domain should be considered to be closely assocated with emotional inhibition for the Turkish participants of the present study. However, it should also take into account the socio-cultural pattern of our country, in which emotional appraisal is not appreciated as well. A variety of statistical analyses have been conducted in literature to validate the presence of the schema domains in different cultures. Utilizing schema domains helps sketch out the relationship between EMS and different variables; it is also easier to handle three to five variables for statistical analysis rather than eighteen EMSs. However, in the light of the findings of the present study, the suggestion by Hawke and Provencher (2011) to chose EMSs based on theoretical relevance to the research seems to be a better option than utilizing schema domains.

4.2. Implications and Future Suggestions

The present study is a result of thinking through schema theory. Therefore, the aim was to propose a solution to problems regarding assessment and treatment procedures within schema therapy. Thus, a combination of solutions was suggested utilizing perspectives from different theories and emphasizing the importance of schema modes. However, the presented ideas and solutions were being tested empirically for the first time. For example, the relationship between EMSs and the well-being of individuals is usually researched in the context of schema coping responses. On the other hand, recently, schema modes have become the trendiest area in schema research because modes have been newly added to schema theory and have quickly become the main focus of interest in treatment processes (Hawke & Provencher, 2011). The present study was originally designed to investigate schema modes. However, the schema mode inventory could not be used because it was learnt that Turkish adaptation studies of the Schema Mode Inventory had long

been postponed (Tuncer, personal communication, February 23, 2015). Therefore, rather than measuring modes with the Schema Mode Inventory, particular variables were chosen based on theoretical inferences. Thus, future replication studies are needed when utilizing schema mode inventory in order to get an accurate understanding of what constitutes a healthy adult mode.

Schema mode cards have been newly developed and the present study is a part of ongoing validation studies as well. Therefore, this is the first study that utilizes schema mode cards from a qualitative research perspective in order to access schema-related memories. It is also the first study to utilize schema mode cards with a Turkish population. Thus, although the present study provides emotions and memories that are triggered by the child mode cards, more extensive research is needed to compare the results obtained from the child, parent and maladaptive coping mode evaluations

Qualitative and mixed method research has also been becoming popular lately. When working with qualitative data, the number of participants inevitably drops. The present study selected its "small number of participants" based on their YSQ scores. However, future studies should be designed with clinical populations in order to make the obtained content regarding the themes richer. Moreover, future studies can be designed completely from the qualitative research perspective in terms of both data collection and data analysis. Findings obtained from such research can provide valuable information that enables modifications regarding the postulations of schema theory accordantly, again especially with research utilizing clinical populations.

Lastly, future studies should employ more representative samples by reaching out to participants from lower socio-economic levels or disabled populations in order to identify resilience factors and the representations of the EMSs more specifically.

REFERENCES

Adler, A. (1927/1997). *Understanding life.* C. Brett (Eds.). Oxford, England: Oneworld Publications.

Adler, A. (1956). *The individual psychology of Alfred Adler: A systematic presentation in selections from his writings*. H. L. Ansbacher, & R. R. Ansbacher (Eds.).New York, NY: Basic Books, Inc.

Aldao, A., Nolen-hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology : A meta-analytic review. *Clinical Psychology Review*, *30*(2), 217–237.

Androutsopoulou, A. (2013). The use of early recollections as a narrative aid in psychotherapy. *Counselling Psychology Quarterly*, *26*(3-4), 313–329.

Arntz, A., & Weertman, A. (1999). Treatment of childhood memories: Theory and practice. *Behaviour*, *37*, 1999.

Arntz, A. (2012). Schema therapy for cluster C personality disorders. *The wiley-blackwell handbook of schema therapy: Theory, research, and practice*, (pp. 397–414). Oxford, UK: Wiley-Blackwell.

Ball, S. A., & Cecero, J. J. (2001). Addicted patients with personality disorders: traits, schemas, and presenting problems. *Journal of Personality Disorders, 15*,72–83.

Baldwin, M. W. (1992). Relational schemas and the processing of social information. *Psychological Bulletin, 112(3*), 461–484.

Bamber, M. (2004)**.** 'The good, the bad and defenceless Jimmy' – A single case study of schema mode therapy. *Clinical Psychology and Psychotherapy, 11*, 425–438.

Bartlett, F.C. (1932). *Remembering: A study in experimental and social psychology*. Cambridge, England: Cambridge University Press.

Beck, A. T. (1967/1973). *The diagnosis and management of depression*. Cinnaminson, NJ: Weidner Associates, Inc.

Beck, A.T. (1996). Beyond belief: A theory of modes, personality, and psychopathology. In P.M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 1-25). New York, NY: The Guilford Press.

Benesch, T. K. (2012). *Integrating Schema Therapy with Adlerian Psychology*. (Unpublished master' thesis). The Faculty of the Adler Graduate School, Minneapolis.

Blanchard-Fields F., Stein R., Watson T.L. (2004). Age differences in emotion-regulation strategies in handling everyday problems. *Journals of Gerontology: Series B, 59* (6), 261–269.

Bluck, S., Alea, N., Habermas, T., & Rubin, D. C. (2005). A TALE of three functions: The self–reported uses of autobiographical memory. *Social Cognition, 23*(1), 91–117.

Bornstein, R. F. (2011). An interactionist perspective on interpersonal dependency. *Current Directions in Psychological Science, 20*(2), 124–128.

Bowlby, J. (1951). Maternal care and mental health. *Bulletin of the World Health Organization, 3*, 355–534.

Bruhn, A. R. (1990). Cognitive-perceptual theory and the projective use of autobiographical memory. *Journal of Personality Assessment, 55(1&2),* 95–114.

Bryant, R. A, Sutherland, K., & Guthrie, R. M. (2007). Autobiographical memory in the development, maintenance, and resolution of posttraumatic stress disorder after trauma. In Einstein, D. A. (Eds), *Innovations and advances in cognitive behaviour therapy*. 1st ed. (pp.235–244). Bowen Hills, Qld.: Australian Academic Press.

Cecero, J. J., Nelson, J. D., & Gillie, J. M. (2004). Tools and tenets of schema herapy: Toward the construct validity of the early maladaptive schema questionnaire-research version (EMSQ-R), *Clinical Psychology & Psychotherapy*, *11*(5), 344–357.

Clark, A. J. (2002). *Early recollections: Theory and practice in counseling and psychotherapy*. New York, NY: Routledge.

Cockram, D. M., Drummond, P. D., & Lee, C. W. (2010). Role and treatment of early maladaptive schemas in vietnam veterans with ptsd. *Clinical Psychology and Psychotherapy*, *17*(3), 165–182.

Cooper, J. L., & Wade, T. D. (2015). The relationship between memory and interpretation biases, difficulties with emotion regulation, and disordered eating in young women. *Cognitive Therapy and Research, 39*(6), 853-862.

Costa, J., & Pinto-Gouveia, J. (2011). Acceptance of pain, self-compassion and psychopathology: Using the chronic pain acceptance questionnaire to identify patients' subgroups. *Clinical Psychology and Psychotherapy*, *18*(4), 292–302.

Cousineau, C. (2012). Mindfulness and ACT as strategies to enhance the healthy adult mode the use of the mindfulness flash card as an example. *The wiley-blackwell handbook of schema therapy: Theory, research, and practice* (pp. 249–257). Oxford, UK: Wiley-Blackwell.

Creswell, J. W. (1994). *Research design: Qalitative and quantitative approaches.* Thousans Oaks, CA: Sage.

Della Giusta, M., Jewell S. L. & Kambhampati U. S. (2011) Gender and Life Satisfaction in the UK, *Feminist Economics 17*(3):1–34.

Deniz, M., E., Kesici, & Sümer, A., S. (2008). The validity and reliability of the Turkish version of the self-compassion scale. *Social Behavior and Personality, 36*(9), 1151–1160.

DeOliveira, C.A., Bailey, H.N., Moran, G., & Pederson, D.R. (2004). Emotion socialization as a framework for understanding the development of disorganized attachment. *Social Development, 13*, 437–467.

Derogatis, L. R., & Melisaratos, N. (1983). The brief symptom inventory: an introductory report. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences, 13*(3), 595– 605.

Diedrich A., Grant M., Hoffman S. G., Hiller W., & Berking M.(2014). Self compassion as an emotion regulation strategy in major depressive disorder. *Behavior Research and Therapy*, *58*, 43–51.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment, 49*, 71–75.

Dinkmeyer, J. D., & Sperry, L. (2000). *Counseling and psychotherapy: An integrated, individual psychology approach* (3rd ed.). Upper Saddle River, NJ: Prentice-Hall, Inc.

Durak, M., Senol-Durak, E., & Gençoz, T. (2010). Psychometric properties of the Satisfaction with Life Scale (SWLS) among Turkish university students, correctional officers, and elderly adults. *Social Indicators Research, 99,* 413–429.

Eldoğan, D. & Barışkın, E. (2014). Erken dönem uyumsuz şema alanları ve sosyal fobi belirtileri: Duygu düzenleme güçlüğünün aracı rolü var mı? Türk Psikoloji Dergisi, 29(74): 108–11.

Finlay-Jones, A., Rees, C. S., & Kane, R. T. (2015). Self-compassion, emotion regulation and stress among australian psychologists : Testing an emotion regulation model of self- compassion using structural equation modeling. *PloS One*, *10*(7), e0133481.

Folkman, S. (1984). Personal control and stress and coping processes : a theoretical analysis. *Journal of Personality and Social Psychology*, *46*(4), 839–852.

Fox, H. C., Hong, K. A., & Sinha, R. (2008). Difficulties in emotion regulation and impulse control in recently abstinent alcoholics compared with social drinkers. *Addictive Behaviors*, *33*(2), 388–394.

Freud, S. (1923/1962). *The ego and the id*. New York, NY: Norton.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation. *Journal of Psychopathology and Behavioral Assessment*, *26*(1), 41–54.

Gross, J. J. (2002). Emotion regulation: affective, cognitive, and social consequences. *Psychophysiology*, *39*(3), 281–91.

Hawke, L. D., & Provencher, M. D. (2011). Schema theory and schema therapy in mood and anxiety disorders: A review. *Journal of Cognitive Psychotherapy*, *25*(4), 257–276.

Hayes, A.F. (2013). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach*. New York, NY: Guilford Press.

Hedlund, S., & Rude, S. S. (1995). Evidence of Latent Depressive Schemas in Formerly Depressed Individuals. *Journal of Abnormal Psychology*, *104*(3), 517–525.

Hoffart, A., Sexton H., Hedley, L. M., Wang, C. E., Holthe, H., Haugum, J. A., Nordahl, H. M., Hovland, O. J. & Holte, A. (2005). The structure of maladaptive schemas: A confirmatory factor analysis and a psychometric evaluation of factor-derived scales. *Cognitive Therapy and Research*, *29*(6), 627– 644.

Hoffart, A. (2012).The case formulation process in schema therapy of chronic axis 1 disorder (affective/anxiety disorder). In M. van Vreswijk, J. Broersen, & M. Nadort (Eds.), *The wiley-blackwell handbook of schema therapy : Theory, research and practic*e (pp. 101-109). Oxford, UK: Wiley-Blackwell.

Jorm, A. F., Windsor, T. D., Dear K. B. G., Anstey, K. J., Christensen, H., & Rodgers, B. (2005). Age group differences in psychological distress: The role of psychosocial risk factors that vary with age. *Psychological Medicine, 09*, 1253–1263.

Kahl, K. G., Winter, L., & Schweiger, U. (2012). The third wave of cognitive behavioural therapies. *Current Opinion in Psychiatry*, *25*(6), 522–528.

Kantaş, Ö. (2013). Impact of relational and individuational selforientatıons on the well-being of academicians: The roles of ego- or eco- system motivations, self-transcendence, self-compassion and burnout. (Unpublished Master's Thesis). Middle East Technical University, Ankara.

Kavcıoğlu, F. C., & Gençöz, T. (2011). Psychometric characteristics of Difficulties in Emotion Regulation Scale in a Turkish sample: New suggestions. Unpublished raw data.

Kellogg, S. H., & Young, J. E. (2006). Schema therapy for borderline personality disorder. *Journal of Clinical Psychology, 62*, 445–458.

Keyfitz, L., Lumley, M. N., Hennig, K. H., & Dozois, D. J. A. (2013). The role of positive schemas in child psychopathology and resilience. *Cognitive Therapy and Research, 37*(1), 97–108.

Koole, S. L. (2009). The psychology of emotion regulation : An integrative review, *Cognition and Emotion, 23*(1), 4–41.

Kring, A. M., & Sloan, D. S. (2010). E*motion regulation and psychopathology*. New York, NY: Guilford Press.

Kriston, L., Schäfer, J., von Wolff, A., Härter, M., & Hölzel, L. P. (2012). The latent factor structure of Young's early maladaptive schemas: Are schemas organized into domains? *Journal of Clinical Psychology, 68*(6), 684–698.

Kuckartz, U. (2014). *Qualitative text analysis: A guide to methods, practice & using software*. London, England: Sage.

Lee, C. W., Taylor, G., & Dunn, J. (1999). Factor structure of the Schema Questionnaire in a large clinical sample. *Cognitive Therapy and Research, 23*(4), 441–451.

Lobbestael, J., Vreeswijk, M. F. van, & Arntz, A. (2007) Shedding light on schema modes: a clarification of the mode concept and its current research status. *Netherlands Journal of Psychology, 63*, 76–85.

Luck, A., Waller, G., Meyer, C., Ussher, M., & Lacey, H. (2005). The role of schema processes in the eating disorders. *Cognitive Therapy and Research, 29*(6), 717–732.

Lumley, M., & Harkness, K. (2007). Specificity in the relations among childhood adversity, early maladaptive schemas, and symptom profiles in adolescent depression. *Cognitive Therapy and Research, 31*(5), 639–657.

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*(6), 545–552.

Masomi, R., Hejazi, M., & Sobhi, A. (2014). The relationship between depression and early maladaptive schemas, obsessive rumination and cognitive emotion regulation. *Indian Journal of Fundamental and Applied Life Sciences, 4*(3), 1159–1170.

Mayman, M. (1968). Early memories and character structure. *Journal of Projective Techniques, 32*(4), 303–316.

Mayman, M. & Faris, M. (1960). Early memories and relationship paradigms. *American Journal of Orthopsychiatry, 30*, 507–520.

Mayring, P. (2000). Qualitative Content Analysis. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 1*(2), retrieved from http://nbn-resolving.de/urn:nbn:de:0114-fqs0002204.

McGinn, L.K., & Young, J.E. (1996). Schema-focused therapy. In P.M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 182-207). New York, NY: Guilford Press.

McLean, H. R., Bailey, H. N., & Lumley, M. N. (2014). The secure base script: associated with early maladaptive schemas related to attachment. *Psychology and Psychotherapy*, *87*(4), 425–46.

Mehrabian, A. (1971). *Silent messages.* Belmont, CA: Wadsworth.

Miron, L. R., Orcutt, H. K., Hannan, S. M., & Thompson, K. L. (2014). Childhood abuse and problematic alcohol use in college females: The role of self-compassion. *Self and Identity*, *13*(3), 364–379.

Mosak, H.H., & Di Pietro, R. (2006). *Early recollections: Interpretive method and application*. New York, NY: Routledge.

Neff, K. (2003). Self-compassion : An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, *2*, 85–101.

Neff, K. D., Hseih, Y., & Dejitthirat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity*, *4*, 263–287.

Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality*, *41*(1), 139–154.

Norcross, J. C., Pfund, R. A., & Prochaska, J. O. (2013). Psychotherapy in 2022: A Delphi poll on its future. *Professional Psychology: Research and Practice*, *44*(5), 363–370.

Nordahl, H. M., Holthe, H., & Haugum, J. A. (2005). Early maladaptive schemas in patients with or without personality disorders: Does schema modification predict symptomatic relief? *Clinical Psychology and Psychotherapy*, *12*, 142–149.

O'Connor, B. P., & Dvorak, T. (2001). Conditional associations between parental behavior and adolescent problems: A search for personality-environment interactions. *Journal of Research in Personality, 35*, 1-26.

Öveç, Ü., Akın, A., & Abacı, R. (2007). Self-compassion scale: The study of validity and reliability. Paper presented at 16th National Congress of Educational Sciences, Gaziosmanpaşa University, Tokat, Turkey.

Padmanabhanunni, A., & Edwars, D. (2014). A phenonenological case study of the therapeutic impact of imagery rescripting of memories of a rape and episodes of childhood abuse and neglect, *Indo-Pacific Journal of Phenomenology, 14*(1), 1–16.

Parfy, E. (2012). Schema Therapy, Mindfullness, and ACT- Differences and Points of Contact. In M. van Vreswijk, J. Broersen, & M. Nadort (Eds.), *The Wiley-Blackwell handbook of Schema Therapy : Theory, research and practic*e (pp. 101-109). Oxford, UK: Wiley-Blackwell.

Piaget, J. P. (1952). *The origins of intelligence in children*. New York, NY: International Universities Press.

Pinsker, J., Stein, M., & Hilsenroth, M. (2007). The clinical utility of early memories as predictors of therapeutic alliance. *Psychotherapy, 44*(1), 96–109.

Preacher, K. J., & Hayes, A. F. (2008). Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behavior Research Methods, 40*, 879-891.

Pretzer, J. L., & Beck, A. T. (2004). A *cognitive theory of personality disorders*. In J. F. Clarkin & M. F. Lenzenweger (Eds.), Major *theories of personality disorders* (pp. 36–105). New York: Guilford.

Rafaeli , E. , Bernstein , D. & Young , J. (2011) *Schema therapy: Distinctive features* . London :Routledge.

Rijkeboer, M. M., & Van Den Bergh, H. (2006). Multiple group confirmatory factor analysis of the Young Schema-Questionnaire in a Dutch clinical versus non-clinical population. *Cognitive Therapy and Research, 30*(3), 263–278.

Rijkeboer, M. M. (2012). Validation of the Young Schema Questionnaire. In M. van Vreswijk, J. Broersen, & M. Nadort (Eds.), *The Wiley-Blackwell handbook of Schema Therapy : Theory, research and practic*e (pp. 531-541). Oxford, UK: Wiley-Blackwell.

Roediger, E. (2012). Why are mindfulness and acceptance central elements for therapeutic change? An integrative perspective. In M. van Vreswijk, J. Broersen, & M. Nadort (Eds.), *The Wiley-Blackwell handbook of Schema Therapy : Theory, research and practic*e (pp. 101-109). Oxford, UK: Wiley-Blackwell.

Roelofs, J., Onckels, L., & Muris, P. (2013). Attachment quality and psychopathological symptoms in clinically referred adolescents: The mediating role of early maladaptive schema. *Journal of Child and Family Studies, 22*(3), 377–385.

Rohner, R. P. (1975/2000). *They Love Me, They Love Me Not: A Worldwide Study of the Effects of Parental Acceptance and Rejection.* New Haven: HRAF Press.

Rucker, D. D., Preacher, K. J., Tormala, Z. L., & Petty, R. E. (2011). Mediation analysis in social psychology: Current practices and new recommendations: *Social and Personality Psychology Compass, 5*(6), 359–371.

Rugancı, R. N., & Gençöz, T. (2010). Psychometric properties of the difficulty of emotion regulation scale in a Turkish sample. *Journal of Clinical Psychology, 66*(4), 442–455.

Saritaş, D., & Gençöz, T. (2011). Psychometric properties of "Young Schema Questionnaire-short form 3" in a Turkish adolescent sample. *Journal of Cognitive and Behavioral Psychotherapies, 11*(1), 83–96.

Sarıtaş-Atalar, D., Gençöz, T., & Özen, A. (2015). Confirmatory factor analyses of the difficulties in emotion regulation scale (DERS) in a Turkish adolescent sample. *European Journal of Psychological Assessment*, *31*(1), 12–19.

Schmidt, N. B., Joiner, T. E., Young, J. E., & Telch, M. J. (1995). The schema questionnaire: Investigation of psychometric properties and the hierarchical structure of a measure of maladaptive schemas. *Cognitive Therapy and Research*, *19*(3), 295–321.

Singer, J. A., & Bonalume, L. (2010). Autobiographical memory narratives in psychotherapy:A coding system applied to the case of Cynthia. *Pragmatic Case Studies in Psychotherapy, 6*, 134–188.

Soygüt, G., Karaosmanoglu, A., & Cakır, Z. (2009). Assessment of early maladaptive schemas: A psychometric study of the Turkish Young Schema Questionnaire-short form-3. *Turkish Journal of Psychiatry*, *20*(1), 144-152.

Şahin, N.H. & Durak, A. (1994). Adaptation of the Brief Symptom Inventory for the Turkish youth. *Türk Psikoloji Dergisi (Turkish Journal of Psychology)*, *9*(31), 44–56.

Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, J. G., Soulsby, J. M., Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, *68*(4), 615- 623.

Theiler, S. (2005). The efficacy of Early Childhood Memories as indicators of current maladaptive schemas and psychological health. Unpublished doctoral dissertation, Swinburne University of Technology Hawthorn, Victoria, Australia

Thimm, J. C. (2011). *A study of the associations between early maladaptive schemas, developmental task resolution, and personality traits in a psychiatric outpatient sample.* (Unpublished doctoral dissertation). Norwegian University of Science and Technology. Trondheim, Norway.

Van Genderen, H. Rijkeboer, M., & Arntz, A. (2012). Theoretical model: Schemas, coping styles and modes. In M. van Vreswijk, J. Broersen, & M. Nadort (Eds.), *The Wiley-Blackwell handbook of Schema Therapy : Theory, research and practic*e (pp. 101-109). Oxford, UK: Wiley-Blackwell.

Vettese, L. C., Dyer, C. E., Li, W. L., & Wekerle, C. (2011). Does self-compassion mitigate the association between childhood maltreatment and later emotion regulation difficulties? A preliminary ınvestigation. *International Journal of Mental Health and Addiction*, *9*(5), 480–491.

Vreeswijk, van M., Broersen J., & Nadort, M. (2012). *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice*. Oxford, UK: Wiley-Blackwell.

Waller, G., Meyer, C., & Ohanian, V. (2001). Psychometric properties of the long and short versions of the Young Schema-Questionnaire: Core beliefs among bulimic and comparison women. *Cognitive Therapy and Research, 25*, 137–147.

Weertman, A., & Arntz, A. (2007). Effectiveness of treatment of childhood memories in cognitive therapy for personality disorders: A controlled study contrasting methods focusing on the present and methods focusing on childhood memories. *Behaviour Research and Therapy, 45,* 2133–2143.

Wegener, I., Alfter, S., Geiser, F., Liedtke, R., & Conrad, R. (2013). Schema change without schema therapy: the role of early maladaptive schemata for a successful treatment of major depression. *Psychiatry, 76*(1), 1–17.

Widmayer, S. A. (2007). Schema theory: An introduction. Retrieved August 24, 2015, from http://www.saber2.net/Archivos/Schema-Theory-Intro.pdf

Yakın, Güneş, Gençöz and Bernstein (2015). Şema Mod Kartlarının tetiklediği duygular üzerine bir inceleme. Unpublished manuscript.

Young, J. E. (1990/1999). *Cognitive therapy for personality disorders*. Sarasota, FL: Professional Resources Press.

Young, J. E. (1994). Cognitive therapy for personality disorders: A schema-focused approach (revised): Professional Resource Press/Professional Resource Exchange.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). Schema therapy: A practitioner's guide: Guilford Press.

Young, J. E., & Brown, G. (1994). Young Schema Questionnaire. In J. E. Young (Eds.), *Cognitive therapy for personality disorders: A schema-focused approach (2nd ed.).* Sarasota, FL: Professional Resource Pres

APPENDICES

APPENDIX A: Informed Consent Form

Değerli Katılımcı,

Bu çalışma, Prof.Dr. Tülin Gençöz danışmanlığında Orta Doğu Teknik Üniversitesi, Psikoloji Bölümü, Klinik Psikoloji Doktora programı öğrencisi Uzman Psikolog Duygu Yakın tarafından yürütülen bir tez çalışmasıdır. Çalışmanın amacı, katılımcıların temel bilişsel yapılarının öz-şefkat düzeyi, duygu düzenleme stratejileri ve psikolojik iyilik hali üzerine etkilerini araştırmaktır. Araştırmaya katılımınız tamamen gönüllülük esasına dayanmaktadır. Araştırma sırasında sizden alınan bilgiler grup halinde değerlendirilecek ve bu değerlendirme sonucunda bazı kişiler ikinci bir uygulama için çağırılacaktır. Bu yüzden katılımcılardan kimlik bilgisi istenmeyecek, ancak katılımcıları geri çağırabilmek için bir takma isimle telefon ve e-posta adres bilgileri istenecektir. Cevaplarınız gizli tutulacak ve sadece araştırmacı tarafından bilimsel çalışmalarda kullanılacaktır. Bu anlamda, araştırma sonuçlarından sağlıklı bilgiler edinilebilmesi için soruların samimi bir şekilde doldurulması ve boş bırakılmaması oldukça önemlidir. Anket genel olarak kişisel rahatsızlık teşkil edecek soruları içermemektedir. Ancak araştırma sırasında herhangi bir nedenden dolayı rahatsızlık hissederseniz, katılımınızı sonlandırabilirsiniz.

Çalışma sırasında sizden istenen, verilen ölçeği boş madde bırakmamaya özen göstererek samimi bir şekilde doldurmanızdır. Çalışmaya katılım yaklaşık 20 dakika sürecektir. Çalışma hakkında daha fazla bilgi almak için Duygu Yakın'a (E-posta: duygu.yakin@hotmail.com; Tel: 0212 540 96) ulaşabilirsiniz.

Katılımınız için şimdiden teşekkür ederiz.

Duygu Yakın

Orta Doğu Teknik Üniversitesi, Psikoloji Bölümü

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman katılımımı sonlandırabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı kullanımını kabul ediyorum.

Katılımcının Telefonu: Katılımcının E-mail Adresi:

APPENDIX B: Demographic Information Form

01. Cinsiyetiniz: ( ) Kadın ( ) Erkek

02. Yaşınız:……..

03. Kaç kardeşsiniz?.....

04. Kaçıncı çocuksunuz?.....

04. İlişki durumunuz nedir?
( )Bekar ( ) İlişkisi var ( ) Sözlü/nişanlı ( ) Evli ( ) Boşanmış/Dul

05. Ailenizin toplam aylık geliri ne kadardır?
( ) 1000 YTL'nin altında
( ) 1000-3000 YTL arası
( ) 3000-5000 YTL arası
( ) 5000 YTL üstü

06. Devam etmekte olduğunuz
Üniversite:……
Bölüm: ……
Aşama: ( )Üniversite öğrencisi
( )Yüksek Lisans öğrencisi
( ) Doktora Öğrencisi

07. Annenizin eğitim durumu:
( ) Okur-yazar değil
( ) Okur-yazar
( ) İlkokul mezunu
( ) Ortaokul mezunu
( ) Lise mezunu
( ) Üniversite veya yüksek okul mezunu

08. Babanızın eğitim durumu:
( ) Okur-yazar değil
( ) Okur-yazar
( ) İlkokul mezunu
( ) Ortaokul mezunu
( ) Lise mezunu
( ) Üniversite veya yüksek okul mezunu

10. Daha önce Psikiyatrik bir tedavi aldınız mı? ( ) Evet ( )Hayır

Cevabınız evet ise ne tür tedavi/tedaviler aldınız? ( ) Bireysel Psikoterapi
( ) İlaç tedavisi ( ) Grup terapisi ( ) Diğer (Belirtiniz)

APPENDIX C: Young Schema Questionnaire (YSQ-S3)

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 terk edeceklerinden 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 hak ederim.
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 onaylanmayı ve takdir görmeyi isterim.
71.		Ne kadar çok çalışırsam çalışayım, maddi olarak iflas edeceğimden ve neredeyse her şeyimi kaybedeceğimden endişe ederim.
72.		Neden yanlış yaptığımın önemi yoktur; eğer hata yaptıysam sonucuna da katlanmam gerekir.
73.		Hayatımda ne yapacağımı bilmediğim zamanlarda uygun bir öneride bulunacak veya beni yönlendirecek kimsem olmadı.
74.		İnsanların beni terk edeceği endişesiyle bazen onları kendimden uzaklaştırırım.
75.		Genellikle insanların asıl veya art niyetlerini araştırırım.
76.		Kendimi hep grupların dışında hissederim.
77.		Kabul edilemeyecek pek çok özelliğim yüzünden insanlara kendimi açamıyorum veya beni tam olarak tanımalarına izin vermiyorum.
78.		İş (okul) hayatımda diğer insanlar kadar zeki değilim.

79.		Günlük yaşamımı tek başıma idare edebilme becerisine sahip olduğumu hissetmiyorum.
80.		Bir doktor tarafından herhangi bir ciddi hastalık bulunmamasına rağmen bende ciddi bir hastalığın gelişmekte olduğu endişesine kapılıyorum.
81.		Sık sık annemden babamdan ya da eşimden ayrı bir kimliğimin olmadığını hissediyorum.
82.		Haklarıma saygı duyulmasını ve duygularımın hesaba katılmasını istemekte çok zorlanıyorum.
83.		Başkaları beni, diğerleri için çok, kendim için az şey yapan biri olarak görüyorlar.
84.		Diğerleri beni duygusal olarak soğuk bulurlar.
85.		Kendimi sorumluluktan kolayca sıyıramıyorum veya hatalarım için gerekçe bulamıyorum.
86.		Benim yaptıklarımın, diğer insanların katkılarından daha önemli olduğunu hissediyorum.
87.		Kararlarıma nadiren sadık kalabilirim.
88.		Bir dolu övgüler ve iltifat almam kendimi değerli birisi olarak hissetmemi sağlar.
89.		Yanlış bir kararın bir felakete yol açabileceğinden endişe ederim.
90.		Ben cezalandırılmayı hak eden kötü bir insanım.

APPENDIX D: Difficulties in Emotion Regulation Scale (DERS)

Aşağıda insanların duygularını kontrol etmekte kullandıkları bazı yöntemler verilmiştir. Lütfen her durumu dikkatlice okuyunuz ve her birinin sizin için ne kadar doğru olduğunu içtenlikle değerlendiriniz. Değerlendirmenizi uygun cevap önündeki yuvarlak üzerine çarpı (X) koyarak işaretleyiniz.

1. Ne hissettiğim konusunda netimdir.

○ Neredeyse Hiçbir zaman	○Bazen	○ Yaklaşık Yarı yarıya	○ Çoğu zaman	○ Neredeyse Her zaman

2. Ne hissettiğimi dikkate alırım.

○ Neredeyse Hiçbir zaman	○Bazen	○ Yaklaşık Yarı yarıya	○ Çoğu zaman	○ Neredeyse Her zaman

3. Duygularım bana dayanılmaz ve kontrolsüz gelir.

○ Neredeyse Hiçbir zaman	○Bazen	○ Yaklaşık Yarı yarıya	○ Çoğu zaman	○ Neredeyse Her zaman

4. Ne hissettiğim konusunda net bir fikrim vardır.

○ Neredeyse Hiçbir zaman	○Bazen	○ Yaklaşık Yarı yarıya	○ Çoğu zaman	○ Neredeyse Her zaman

5. Duygularıma bir anlam vermekte zorlanırım.

○ Neredeyse Hiçbir zaman	○Bazen	○ Yaklaşık Yarı yarıya	○ Çoğu zaman	○ Neredeyse Her zaman

6. Ne hissettiğime dikkat ederim.

○ Neredeyse Hiçbir zaman	○Bazen	○ Yaklaşık Yarı yarıya	○ Çoğu zaman	○ Neredeyse Her zaman

7. Ne hissettiğimi tam olarak bilirim.

○ Neredeyse Hiçbir zaman	○Bazen	○ Yaklaşık Yarı yarıya	○ Çoğu zaman	○ Neredeyse Her zaman

8. Ne hissettiğimi önemserim.

○ Neredeyse Hiçbir zaman	○Bazen	○ Yaklaşık Yarı yarıya	○ Çoğu zaman	○ Neredeyse Her zaman

9. Ne hissettiğim konusunda karmaşa yaşarım.

○ Neredeyse Hiçbir zaman	○Bazen	○ Yaklaşık Yarı yarıya	○ Çoğu zaman	○ Neredeyse Her zaman

10. Kendimi kötü hissettiğimde, bu duygularımı kabul ederim.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

11. Kendimi kötü hissettiğimde, böyle hissettiğim için kendime kızarım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

12. Kendimi kötü hissettiğimde, böyle hissettiğim için utanırım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

13. Kendimi kötü hissettiğimde, işlerimi yapmakta zorlanırım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

14. Kendimi kötü hissettiğimde, kontrolümü kaybederim.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

15. Kendimi kötü hissettiğimde, uzun süre böyle kalacağıma inanırım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

16. Kendimi kötü hissettiğimde, sonuç olarak yoğun depresif duygular içinde olacağıma inanırım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

17. Kendimi kötü hissettiğimde, duygularımın yerinde ve önemli olduğuna inanırım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

18. Kendimi kötü hissettiğimde, başka şeylere odaklanmakta zorlanırım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

19. Kendimi kötü hissettiğimde, kendimi kontrolden çıkmış hissederim.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

20. Kendimi kötü hissettiğimde, halen işlerimi sürdürebilirim.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

21. Kendimi kötü hissettiğimde, bu duygumdan dolayı kendimden utanırım.

○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

22. Kendimi kötü hissettiğimde, eninde sonunda kendimi daha iyi hissetmenin bir yolunu bulacağımı bilirim.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

23. Kendimi kötü hissettiğimde, zayıf biri olduğum duygusuna kapılırım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

24. Kendimi kötü hissettiğimde, davranışlarımı kontrol altında tutabileceğimi hissederim.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

25. Kendimi kötü hissettiğimde, böyle hissettiğim için suçluluk duyarım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

26. Kendimi kötü hissettiğimde, konsantre olmakta zorlanırım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

27. Kendimi kötü hissettiğimde, davranışlarımı kontrol etmekte zorlanırım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

28. Kendimi kötü hissettiğimde, daha iyi hissetmem için yapacağım hiç bir şey olmadığına inanırım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

29. Kendimi kötü hissettiğimde, böyle hissettiğim için kendimden rahatsız olurum.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

30. Kendimi kötü hissettiğimde, kendim için çok fazla endişelenmeye başlarım.
○ Neredeyse Hiçbir zaman ○Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

31. Kendimi kötü hissettiğimde, kendimi bu duyguya bırakmaktan başka yapabileceğim birşey olmadığına inanırım.
○ Neredeyse ○Bazen ○ Yaklaşık ○ Çoğu zaman ○ Neredeyse

Hiçbir zaman Yarı yarıya Her zaman

32. Kendimi kötü hissettiğimde, davranışlarım üzerindeki kontrolümü kaybederim.
○ Neredeyse ○Bazen ○ Yaklaşık ○ Çoğu zaman ○ Neredeyse
Hiçbir zaman Yarı yarıya Her zaman

33. Kendimi kötü hissettiğimde, başka bir şey düşünmekte zorlanırım.
○ Neredeyse ○Bazen ○ Yaklaşık ○ Çoğu zaman ○ Neredeyse
Hiçbir zaman Yarı yarıya Her zaman

34. Kendimi kötü hissettiğimde, duygumun gerçekte ne olduğunu anlamak için zaman ayırırım.
○ Neredeyse ○Bazen ○ Yaklaşık ○ Çoğu zaman ○ Neredeyse
Hiçbir zaman Yarı yarıya Her zaman

35. Kendimi kötü hissettiğimde, kendimi daha iyi hissetmem uzun zaman alır.
○ Neredeyse ○Bazen ○ Yaklaşık ○ Çoğu zaman ○ Neredeyse
Hiçbir zaman Yarı yarıya Her zaman

36. Kendimi kötü hissettiğimde, duygularım dayanılmaz olur.
○ Neredeyse ○Bazen ○ Yaklaşık ○ Çoğu zaman ○ Neredeyse
Hiçbir zaman Yarı yarıya Her zaman

APPENDIX E: Self-compassion Scale (SCS)

Aşağıdaki cümleler, <u>zor durumlar karşısında kendinize</u> genel olarak nasıl davrandığınızla ilgilidir. Ne sıklıkla aşağıda belirtildiği şekilde davranma eğilimde olduğunuzu daire içine alarak belirtiniz.

1	2	3	4	5
Neredeyse hiçbir zaman	Nadiren	Ara sıra	Çoğu zaman	Neredeyse her zaman

1. Kişiliğimin beğenmediğim yanlarına karşı anlayışlı ve sabırlı olmaya çalışırım.	1	2	3	4	5
2. Kendimi bir şekilde yetersiz hissettiğimde, çoğu insanın da böylesi yetersizlik duyguları yaşayabileceğini kendime hatırlatmaya çalışırım.	1	2	3	4	5
3. Kendimi üzgün hissettiğimde, yanlış giden her şeyi kafama takma ve kurma eğilimindeyimdir.	1	2	3	4	5
4. Ben zorluklarla mücadele ederken, başka insanların yaşam koşullarının benimkinden daha kolay olduğunu hissetme eğilimi gösteririm.	1	2	3	4	5
5. Acı veren bir şey olduğunda, durumu belirli bir zihinsel mesafeden, dengeli bir bakış açısıyla görmeye çalışırım.	1	2	3	4	5
6. Sıkıntı çektiğim dönemlerimde, kendime karşı biraz katı yürekli olabilirim.	1	2	3	4	5
7. Kendimi üzgün ve her şeyden kopmuş hissettiğimde, dünyada benim gibi hisseden daha pek çok insan olduğunu kendime hatırlatırım.	1	2	3	4	5
8. Duygusal olarak acı çektiğim zamanlarda kendime karşı sevecen olmaya çalışırım.	1	2	3	4	5
9. Yetersizliklerimi düşünmek, kendimi daha yalnız ve dünyadan kopuk gibi hissetmeme neden olur.	1	2	3	4	5
10. Kişiliğimin beğenmediğim yanlarına karşı hoşgörüsüz ve sabırsızımdır.	1	2	3	4	5
11. Benim için önemli olan bir şeyde başarısız olduğumda, yetersizlik hisleriyle kendimi tüketirim.	1	2	3	4	5

1	2	3	4	5
Neredeyse hiçbir zaman	Nadiren	Ara sıra	Çoğu zaman	Neredeyse her zaman

12. Kendi hatalarıma ve yetersizliklerime karşı hoşgörülüyümdür.	1	2	3	4	5
13. Benim için önemli olan bir şeyde başarısız olduğumda, bu konudaki duygularımı bastırmak veya abartmak yerine durumu olduğu gibi açık yüreklilikle anlayıp kabullenmeye çalışırım.	1	2	3	4	5
14. Sıkıntılı dönemlerimde kendime karşı şefkatliyimdir.	1	2	3	4	5
15. Benim için önemli bir şeyde başarısız olduğumda, bu başarısızlığın yalnız benim başıma geldiğini hissetme eğiliminde olurum.	1	2	3	4	5
16. Hatalarıma ve yetersizliklerime karşı kınayıcı ve yargılayıcıyımdır.	1	2	3	4	5
17. Beğenmediğim yanlarımı gördüğümde kendime yüklenir, moralimi bozarım.	1	2	3	4	5
18. Kendimi üzgün hissettiğimde, duygularımı merakla ve açık yüreklilikle anlamaya çalışırım.	1	2	3	4	5
19. İşler benim için kötü gittiğinde, bu zorlukların, yaşamın bir parçası olarak, herkesin başına gelebileceğini düşünürüm.	1	2	3	4	5
20. Acı veren bir şey olduğunda, olayı gereğinden fazla büyütme eğilimi gösteririm.	1	2	3	4	5
21. Kendimi üzgün hissettiğimde, diğer insanların çoğunun benden daha mutlu olduğunu düşünme eğilimi gösteririm.	1	2	3	4	5
22. Bir şey beni üzdüğünde, kendimi duygularıma kaptırır giderim.	1	2	3	4	5
23. Çok zor bir dönemden geçerken kendime ihtiyacım olan duyarlılık ve sevecenliği gösteririm.	1	2	3	4	5
24. Başarısızlıklarımı insanlık halinin bir parçası olarak görmeye çalışırım.	1	2	3	4	5
25. Herhangi bir şey beni üzdüğünde, duygularımı bir denge içerisinde tutmaya çalışırım.	1	2	3	4	5
26. Gerçekten zor zamanlarda, kendime karşı sert ve acımasız olma eğilimindeyim.	1	2	3	4	5

APPENDIX F: Brief Symptom Inventory (BSI)

Aşağıda, insanların bazen yaşadıkları belirtilerin ve yakınmaların bir listesi verilmiştir. Listedeki her maddeyi lütfen dikkatle okuyun. Daha sonra o belirtinin SİZDE BUGÜN DAHİL SON BİR HAFTADIR NE KADAR VAR OLDUĞUNU yandaki bölmede uygun olan yere işaretleyin. Her belirti için sadece bir yeri işaretlemeye ve hiçbir maddeyi atlamamaya özen gösterin.
DEĞERLENDİRME:

0. Hiç yok
1. Biraz var
2. Orta derecede var
3. Epey var
4. Çok fazla var

1	İçinizdeki sinirlilik ve titreme hali	0	1	2	3	4
2	Baygınlık, baş dönmesi	0	1	2	3	4
3	Bir başka kişinin sizin düşüncelerinizi kontrol edeceği fikri	0	1	2	3	4
4	Başınıza gelen sıkıntılardan dolayı başkalarının suçlu olduğu duygusu	0	1	2	3	4
5	Olayları hatırlamada güçlük	0	1	2	3	4
6	Çok kolayca kızıp öfkelenme	0	1	2	3	4
7	Göğüs (kalp) bölgesinde ağrılar	0	1	2	3	4
8	Meydanlık (açık) yerlerden korkma duygusu	0	1	2	3	4
9	Yaşamınıza son verme düşüncesi	0	1	2	3	4
10	İnsanların çoğuna güvenilemeyeceği hissi	0	1	2	3	4
11	İştahta bozukluklar	0	1	2	3	4
12	Hiçbir nedeni olmayan ani korkular	0	1	2	3	4
13	Kontrol edemediğiniz duygu patlamaları	0	1	2	3	4
14	Başka insanlarla beraberken bile yalnızlık hissetmek	0	1	2	3	4
15	İşleri bitirme konusunda kendini engellenmiş hissetmek	0	1	2	3	4
16	Yalnızlık hissetmek	0	1	2	3	4
17	Hüzünlü, kederli hissetmek	0	1	2	3	4
18	Hiçbir şeye ilgi duymamak	0	1	2	3	4
19	Ağlamaklı hissetmek	0	1	2	3	4

20	Kolayca incinebilme, kırılma	0	1	2	3	4
21	İnsanların sizi sevmediğine, size kötü davrandığına inanmak	0	1	2	3	4
22	Kendini diğer insanlardan daha aşağı görme	0	1	2	3	4
23	Mide bozukluğu, bulantı	0	1	2	3	4
24	Diğer insanların sizi gözlediği ya da hakkınızda konuştuğu duygusu	0	1	2	3	4
25	Uykuya dalmada güçlük	0	1	2	3	4
26	Yaptığınız şeyleri tekrar tekrar doğru mu diye kontrol etmek	0	1	2	3	4
27	Karar vermede güçlükler	0	1	2	3	4
28	Otobüs, tren, metro gibi umumi vasıtalarla seyahatlerden korkmak	0	1	2	3	4
29	Nefes darlığı, nefessiz kalma	0	1	2	3	4
30	Sıcak, soğuk basmaları	0	1	2	3	4
31	Sizi korkuttuğu için bazı eşya yer ya da etkinliklerden uzak kalmaya çalışmak	0	1	2	3	4
32	Kafanızın “bomboş” olması	0	1	2	3	4
33	Bedeninizin bazı bölgelerinde uyuşmalar, karıncalanmalar	0	1	2	3	4
34	Günahlarınız için cezalandırılmanız gerektiği düşüncesi	0	1	2	3	4
35	Gelecekle ilgili umutsuzluk duyguları	0	1	2	3	4
36	Konsantrasyonda (dikkati bir şey üzerine toplama) güçlük/ zorlanmak	0	1	2	3	4
37	Bedenin bazı bölgelerinde zayıflık, güçsüzlük hissi	0	1	2	3	4
38	Kendini gergin ve tedirgin hissetmek	0	1	2	3	4
39	Ölüm ve ölme üzerine düşünceler	0	1	2	3	4
40	Birini dövme, ona zarar verme yaralama isteği	0	1	2	3	4
41	Bir şeyleri kırma, dökme isteği	0	1	2	3	4
42	Diğerlerinin yanındayken yanlış bir şey yapmamaya çalışmak	0	1	2	3	4
43	Kalabalıklardan rahatsızlık duymak	0	1	2	3	4
44	Başka insanlara hiç yakınlık duymamak	0	1	2	3	4
45	Dehşet ve panik nöbetleri	0	1	2	3	4
46	Sık sık tartışmaya girmek	0	1	2	3	4

47	Yalnız bırakıldığında/ kalındığında sinirlilik hissetmek	0	1	2	3	4
48	Başarılarınız için diğer insanlardan yeterince takdir görmemek	0	1	2	3	4
49	Yerinde duramayacak kadar tedirginlik hissetmek	0	1	2	3	4
50	Kendini değersiz görmek/ değersizlik duyguları	0	1	2	3	4
51	Eğer izin verirseniz insanların sizi sömüreceği duygusu	0	1	2	3	4
52	Suçluluk duyguları	0	1	2	3	4
53	Aklınızda bir bozukluk olduğu duygusu	0	1	2	3	4

APPENDIX G: Satisfaction with Life Scale (SWLS)

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

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

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

APPENDIX H: CURRICULUM VITAE

PERSONAL INFORMATION

Surname, Name: Yakın, Duygu
Nationality: Turkish (TC)
Date and Place of Birth: 04 May 1987, İzmir
Marital Status: Single
Phone: +90 212 540 96 96
email:psyduygu@gmail.com

EDUCATION

Degree	Institution	Year of Graduation
PhD	METU Clinical Psychology	2015
MS	METU Clinical Psychology	2011
BS	Hacettepe Psychology	2009
High School	İzmir Anatolian High School	2005

WORK EXPERIENCE

Year	Place	Enrollment
2014-Present	İstanbul Arel University	Lecturer
2012-2013	ODTÜ Ayna CPU	Clinical Psychologist & Supervisor
2011-2012	Madalyon Psychiatry Center	Clinical Psychologist

FOREIGN LANGUAGES

Advanced English

PUBLICATIONS

Yakın, D. (2014). A Review of the Relationship between Dependent Personality Disorder and Therapeutic Alliance: An Illustration of Schema-Based Cognitive Therapy. *Ayna Clinical Psychology Journal*, *1*(2), 1-13.

APPENDIX I: TURKISH SUMMARY

Her bireyin doğuştan getirdiği olmazsa olmaz belirli temel ihtiyaçlar vardır. Young (1990) bu ihtiyaçları güvenli bir alana sahip olma, sevilme, bakım görme, kabullenilme, empati ve korunma olarak belirlemiştir. Bu ihtiyaçların gerektiği ölçüde karşılanmaması, yıkıcı bir şekilde engellenmesi, travmatize edilmesi, kişiye kötü davranılması ya da bu ihtiyaçların gereğinden fazla verilmesi sonucu seçici algılama ve özdeşleşme gibi mekanizmalar aracılığıyla kişinin kendisini ve dış dünyayı algı ve anlayışında merkez görevi gören ve kendini devam ettiren yapılar meydana gelir. Bu yapılar erken dönem uyumsuz şemalar olarak adlandırılmaktadır. Erken dönem deneyimler, davranışlar, duygular ve bilişlerden oluşan bu yapılar kişinin yeni deneyimleri algılamasında ve kişiliğinin şekillenmesinde hayati bir rol oynar. Bu yapıların özellikle kişilik bozukluklarının gelişmesinde ve sürdürülmesinde önemli rol oynadığı belirtilmektedir (Young, Kolosko, & Weishaar, 2003). Öte yandan şema terapistleri son dönemlerde şemalar yerine şema modları ile çalışmayı tercih etmektedirler. Şemaların aksine şema modları belirli bir süre için aktif hale gelen duygusal durum, şemalar ve başa çıkma becerilerini içerir (Rafaeli, Bernstein, & Young, 2011).

Şema terapi temel olarak ağır zihinsel problemlerle baş etmek için geliştirilmiş olsa da son dönem araştırmalar pek çok farklı alanda şema terapinin etkili bir terapi türü olduğunu doğrulamaktadır (Young, Kolosko, & Weishaar, 2003). Şema terapinin yanısıra, kişinin bağlanma figürü ile arasındaki ilişkinin psikopatolojinin gelişimi açısından önemli faktörlerin başında geldiği bilinmektedir (Freud, 1923/1962; Bowlby, 1951; Beck, 1967/1973; Rohner, 1975/2000). Öte yandan, kişinin çocukluk yaşantılarındaki karşılanmayan ihtiyaçlarının sebep olabileceği patolojilerin gelişimi kişilik örüntülerinin yapılanması ve baş etme mekanizmalarıyla yakından ilgilidir ve kişinin yaşam doyumunda da oldukça belirleyici olduğu bilinmektedir (O'Connor& Dvorak, 2001; Keyfitz, Lumley, Hennig, & Dozois, 2013). Young (1990) kişinin genel işlevsellik düzeyinin büyük ölçüde çocukluğunda karşılanmayan, karşılanması engellenen, zaman zaman da gereğinden fazla

karşılanan ihtiyaçlara bağlı olduğunu belirtmektedir. Bununla birlikte şema terapistleri her insanın kendi iç dünyasına ve etrafında olup bitenlere dair gerçekçi bir algı oluşturabilen sağlıklı ve dengeli sağlıklı yetişkin modu olduğuna inanmaktadırlar. Bu modun uygun duygu düzenleme stratejilerini devreye sokma, bakım verme, anlayış ve şefkat gösterme ve yol gösterme gibi işlevlerinin güçlendirilmesinin kişinin gösterdiği patolojik belirtilerde önemli ölçüde azalma sağlayabileceği düşünülmektedir (Rafaeli, Bernstein, & Young, 2011). Şemalar ve kişinin mevcut iyi oluşu arasındaki ilişkiye yönelik dinamiklerin incelenmesi klinik pratikte oldukça etkilidir. Bu anlamda kişinin güçlülük faktörlerini ortaya çıkarmanın da önemi aşikardır. Bu yüzden, kişinin sağlıklı yetişkin modunun güçlendirilmesinin hem önleyici hem de nüksü önleyici müdahaleler açısından kritik öneme sahip olduğu bilinmektedir. Bu çerçevede sağlıklı yetişkin modu "yeterince iyi" bir ebeveyn işlevi görerek diğer modların işlevselliğini denetler ve kontrolsüz şekilde tetiklenen modları kontrol altına alır. Sağlıklı yetişkin modu ayrıca terapistin model alınması aracılığıyla bakım verici ve sınır koyucu tarafların içselleştirilmesiyle güçlenebilir (Young, Kolosko, & Weishaar, 2003). Burada terapistin sınır koyucu davranışları kişinin öz-disiplinini desteklerken, bakım veren davranışları da kişinin öz-şefkatinin gelişmesine katkıda bulunur. Şema terapinin temel varsayımları göz önüne alındığında sağlıklı yetişkin modunun uygun duygu düzenleme stratejileri ve yüksek öz-şefkat düzeyi ile yakından ilişkili olduğu görülmektedir. Bu çerçevede ilk araştırmanın amacı sağlıklı yetişkin modunun belirleyicilerini ve bu belirleyicilerin erken dönem uyumsuz şemalar ve kişinin iyi oluş düzeyi arasındaki ilişkideki rolünü açığa çıkarmaktır. Şema terapinin baş etme davranışlarına yönelik oldukça detaylı bir kuramı vardır. Ancak burada kişinin duygu düzenlemedeki güçlüklerinin ve kişinin öz-şefkatin aracı rolünün çoklu aracılık analizi ile araştırılmasındaki temel amaç bu iki değişkenin sağlıklı yetişkin modunun gözlenen değişkenleri olarak değerlendirilmeleridir.

Duygu Düzenleme

Kişisel kontrolün stres tepkilerinde azalmaya neden olduğu bilinmektedir. Bu anlamda stres tepkisinin varlığındansa, bu tepkilerin süresinin ve yoğunluğunun

önemli olduğu üzerinde durulmaktadır (Finlay-Jones et al., 2015). Şemalar tetiklendiğinde oldukça güçlü duygusal dürtüler meydana gelir. Bu yüzden şema terapide sağaltımın önemli bir parçası duygu düzenleme üzerine yoğunlaşır (Kellogg & Young, 2006). Güçlü şemalara sahip bireylerin uygun duygu düzenleme stratejilerine erişimi zor olduğundan hem kişilerarası ilişkilerde hem de terapi ilişkisinde zorlanmaları söz konusu olabilir. Bu tarz bir duygusal tetiklenme yaşandığında şema teorisine göre kişiler evrimsel olarak kaçma, savaşma ve donakalma tepkilerinden yola çıkarak kavramsallaştırılan şema teslimi, şema kaçınması ya da şema telafisi stratejilerinden birini uygular (Young, Kolosko, & Weishaar, 2003). Şema terapide bu noktada bireyin kişiliğini "problemli" olarak etiketlemektense kişinin başa çıkma modunu belirleme ve isimlendirmenin önemli olduğu vurgulanmaktadır. Böylelikle kişinin sorunlarıyla arasına mesafe koyabilmesinin duygu düzenlemesine yardımcı olacağı belirtilmektedir (cited in Cousineau, 2012).

Öz-şefkat

Öz-şefkat kişinin kendisini yatıştırmak için kendi kendine sıcaklık, kabul ve anlayış gösterebilmesini sağlayan uyumlu bir başa çıkma stratejisidir. Kişi kendisiyle ilişki kurarken olumsuz duyguların daha yapıcı bir şeklide üstesinden gelebilir. Böylelikle kişi öz-eleştiri, kendini suçlama ve mantıksız düşüncelerdense daha uyumlu başa çıkma mekanizmaları seçebilir (Finlay-Jones et al., 2015). Neff 'in (2003) öz şefkat tanımı iki uçlu üç ana boyutu içerir. Bunlardan ilki kendine iyi davranmaya karşılık kendini eleştirmeyi içerir. İkinci boyut ortak insanlık hissiyatına karşı yalıtılmışlıktır. Buna göre başarısızlıklar ve mükemmel olmayan taraflar tüm insanlar tarafından deneyimlenebilecek durumlar olarak değerlendirilir. Son boyut ise farkındalığa karşı aşırı özdeşleşmedir. Bu boyut duyguların ifade edilmesi ve bastırılması arasındaki dengeyle ilişkilidir. Bu çerçevede, kişi kendini kurbanlaştırmaktansa, duygularının gerçekçi bir şekilde ve yargılamadan farkına varmalıdır. Aslında öz-şefkat bazı araştırmacılar tarafından duygu düzenlemeye dahil olarak ele alınır ancak diğer bir grup araştırmacı da öz-şefkatin duygu

düzenlemenin ötesinde etkileri olduğunu savunmaktadır (Finlay-Jones, Rees, & Kane, 2015). Mevcut çalışmada ikinci grubun görüşü benimsenmiştir.

Mevcut çalışmada karışık yöntem seçilmesinin önemi

Son dönemlerde şema araştırmaları fark edilir şekilde artsa da, erken dönem şemalar ve psikopatoloji hakkındaki bilgiler hala çok kısıtlıdır. Bu anlamda Young Şema Ölçeği'nin (YŞÖ) yordama geçerliği ile ilişkili araştırmalar hala kısıtlıdır (Nordahl, Holthe, & Haugum, 2005). YŞÖ psikopatolojik belirtler gösteren bireyleri göstermeyenlerden ayrımada belirgin ölçüde başarılı olsa da şema başa çıkma tepkilerinin öz-bildirim ölçekleriyle ölçülen şemaların yanlış değerlendirilmesine yol açabileceği düşünülmektedir. Yanısıra, şemalar tetiklendiğinde bilgi işleme sürecine etki etmekte ve kişinin mantıklı ve gerçekçi değerlendirmeler yapmasına sebep olmaktadır. Bu yüzden sadece öz-bildirim ölçeklerine bağlı kalmanın araştırma alanında ciddi problemlere yol açabileceği düşünülmektedir. Bu probleme pek çok araştırmacı tarafından değinilmiştir ve bu anlamda rüyalar (Young, Kolosko, & Weishaar, 2003), Stroop Testi (Nordahl, Holthe, & Haugum, 2005), çapraz geçerlilik (Roelofs, Onckels & Muris, 2013) ve anılar (Beck,1996) gibi alternatif yöntemlerin kullanımı desteklenmiştir.

Benzer bir durum şema boyutları açısından da geçerlidir. Buna göre birinci düzey faktör analizi birçok farklı dilde ve örneklemlerde geçerli bulunmuştur. Ancak ikinci düzey faktör analizinin sonuçları çalışmalar arasında farklılık göstermektedir (Schmidt et al, 1995; Cecero, Nelson, & Gillie, 2004; Lee, Taylor, & Dunn 1999; Young, 1990). Türk örnekleminde yapılan çalışmalarda da ikinci düzey faktör analizleriyle ilgili benzer problemler rapor edilmiştir (Sarıtaş 2007; Soygüt, Karaosmanoğlu, Çakır, 2009; Sarıtaş, & Gençöz, 2011). Bu çerçevede, Kriston ve arkadaşları (2012) tüm şemaların ikinci düzey bir analiz yapılmadan tek boyut olarak değerlendirilmesini, Hawke ve Provencher (2011) ise değişken sayısını azaltıp analiz gücünü arttırmak için araştırmacıların teorik olarak çalıştıkları konuyla görece daha ilişkili buldukları şemaları çalışmalarına dahil etmelerini önermiştir. Şema değerlendirmesine yönelik bu problemler birlikte

düşünüldüğünde, mevcut çalışmada elde edilecek sonuçların güvenirliği açısından şema değerlendirmesine yönelik alternatif bir yöntem kullanılmasının uygun olacağı düşünülmüştür.

Erken dönem uyumsuz şemalar ve Erken dönem anılar

Beck'in (1996) şema değerlendirmesinde otobiyografik anıların önemine yönelik fikirlerinden yola çıkarak mevcut araştırmada şema değerlendirmesinin anılar üzerinden yapılması hedeflenmiştir. Güncel psikoterapi teorilerinde doğrudan erken dönem anıların içeriği çalışılmasa da özellikle son dönemde erken dönem anıların çalışıldığı yeni teknikler geliştirilmektedir. Şema teorisinde de erken dönem uyumsuz şemaların kazanılması açısından çocukluk anılarının önemi büyüktür. Şema terapi sürecinde aktif olarak kullanılan mod ve imajinasyon çalışmalarında bu anıların ele alınması sağaltımın temel ayaklarından biridir. Ancak teorik olarak erken dönem uyumuz şemalar ve anılar arasındaki bağlantı kurulmuş olsa da bu konudaki ampirik çalışmalar oldukça kısıtlıdır. Bilindiği kadarıyla anıların içeriğini şema terapi çerçevesinde ele alan tek çalışma Theiler'ın (2005) çalışmasıdır. Bu çalışmada çocukluk anıları kişinin şemalarına yönelik hem bilinç hem de bilinçdışı düzeyde kapsamlı bilgi alabilmek açısından önemli bir araç olduğu vurgulanmıştır. Ancak bu çalışmada da katılımcılarla birebir görüşme yapılmamış ve katılımcılardan anılarını yazmaları istenmiştir.

Birinci ve ikinci çalışmaların amaçları

Teorik olarak şemaların gelişiminde çocukluk anılarının belli şemaların önemi üzerinde durulmuş ve güçlülük faktörlerine ilişkin olası değişkenler detaylı olarak tanımlanmıştır. Ancak, bu konudaki ampirik çalışmaların kısıtlı olması şaşırtıcıdır. Mesela çocukluk dönemi yaşantıları erken dönem uyumsuz şemaların ana bileşeni olarak tanımlanmıştır, ancak bununla ilgili araştırma desteği kısıtlıdır. Benzer şekilde sağlık yetişkin modunun güçlendirilmesinin şema terapi sürecinin bel kemiği olduğu sıkça vurgulanmakta ve bu moda ilişkin olası değişkenler teoride belirtilmektedir. Ancak buna yönelik ampirik araştırmalar görece daha fazla olmakta birlikte, özellikle de Türk örnekleminde kısıtlıdır. Bu çerçevede mevcut araştırma

birbiriyle bağlantılı iki çalışmayla yazındaki bu boşluğun doldurulmasına katkıda bulunmayı hedeflemektedir.

Birinci çalışma şema terapi kavramlarının pozitiflik ve iyi-oluş düzeyi açısından incelenmesini ve güçlülük faktörlerinin belirlenmesine katkıda bulunmayı amaçlamaktadır. Bu yüzden şema boyutları (kopukluk/reddedilme, zedelenmiş otonomi/diğeri yönelimlilik, zedelenmiş sınırlar/yüksek standartlar) ile psikopatolojik belirtiler ve yaşam doyumu arasındaki ilişkide sağlıklı yetişkin modunun belirleyicileri olarak duygu düzenleme ve öz-şefkatin rolünü araştırmayı hedeflenmektedir.

İkinci çalışmada ise şema değerlendirmesine yönelik belirtilen problemleri bertaraf edebilmek ve kişinin bilişsel yapılanması hakkında daha bütüncül bir yargıya varabilmek açısından çocukluk anılarında yer alan erken dönem uyumsuz şemalara işaret eden temaların ortaya çıkarılması hedeflenmiştir. Şemalarla ilişkili çocukluk anılarının ortaya çıkarılmasına yardımcı olması için şema mod kartları kullanılmış ve elde edilen veri tümden gelimci nitel içerik analiziyle analiz edilmiştir.

İlk çalışma

Katılımcılar

Mevcut çalışmada 305 kişiden veri toplanmıştır. Veri temizleme işleminden sonra 296 katılımcıdan elde edilen veri analiz edilmiştir. Çalışmanın örneklemini yaşları 17 ve 52 (M = 26.79, SS = 7.032).arasında değişen 117 (%39,5) erkek ve 179 (%60,5) kadın oluşturmaktadır.

Araçlar

Mevcut çalışmada kullanılan ölçek kitapçığı Young Şema Ölçeği, Duygu Düzenlemede Güçlükler Ölçeği, Öz-şefkat Ölçeği, Kısa Semptom Envanteri ve Yaşam Doyumu Ölçeğinden oluşmaktadır.

Young şema ölçeği Young ve Brown tarafından 1990 yılında geliştirilmiş ve 1994 yılında revize edilmiştir. Ölçeğin Türkçe standardizasyonu Soygüt, Karaosmanoğlu ve Çakır tarafından yapılmıştır ve iç tutarlılık katsayılarının. 53 ve. 81 arasında değiştiği gözlenmiştir. Mevcut çalışmada ise Sarıtaş ve Gençöz (2011) tarafından önerilen üç boyutlu ikinci düzey faktör analizi kullanılmıştır. Buna göre kopukluk ve reddedilme boyutunun iç tutarlılık katsayısı. 83, zedelenmiş sınırlar/yüksek standartlar boyutunun iç tutarlılık katsayısı. 81 ve zedelenmiş otonomi ve diğeri yönelimlilik boyutunun iç tutarlılık katsayısı. 84 olarak belirlenmiştir.

Duygu Düzenlemede Güçlükler Ölçeği Gratz ve Roemer (2004) tarafından geliştirilmiş ve iç tutarlılık katsayısı. 93 olarak bulunmuştur. Ölçeğin Türkçe standardizasyonu Rugancı ve Gençöz tarafından yapılmış ve iç tutarlılık katsayısı. 94 bulunmuştur. Mevcut çalışmada iç tutarlılık katsayısı. 94 olarak bulunmuştur.

Öz-şefkat Ölçeği Neff (2003) tarafından geliştirilmiştir. Ölçeğin iç tutarlılık katsayısı. 92 olarak bulunmuştur. Mevcut çalışmada ölçeğin Kantaş (2013) tarafından adapte edilen versiyonu kullanılmıştır. Ölçeğin iç tutarlılık katsayısı Türkçe standardizasyon çalışmasında da, mevcut çalışmada da ise .94 bulunmuştur.

Kısa Semptom Envanteri Derogatis tarafından geliştirilmiştir (Derogatis, & Melisaratos 1983). Türkçe standardizasyonu Şahin ve Durak (1994) tarafından yapılmış ve iç tutarlılık katsayısı .95-.96 aralığında bulunmuştur. Mevcut çalışmada ise iç tutarlılık katsayısı. 97 bulunmuştur.

Yaşam doyum ölçeği Diener ve arkadaşları (1985) tarafından geliştirilmiştir. Türkçe standardizasyonu Durak, Şenol-Durak, ve Gençöz (2010) tarafından yapılmıştır ve iç tutarlılık katsayılarının .81 ile .89 arasında değiştiği gözlemlenmiştir. Mevcut çalışmada da iç tutarlık katsayısı .86 bulunmuştur.

Uygulama

Öncelikle Orta Doğu Teknik Üniversitesi Uygulamalı Etik Araştırma Merkezi'nden gerekli izinle alınmıştır. Sonrasında ölçekler katılımcılara internet aracılığıyla

ulaştırılmış ve elektronik ortamda doldurulmuştur. Katılımcılar ayrıca çalışmanın ikinci ayağı ile ilgili bilgilendirilmiş ve telefon numaraları ile e-mail adresleri istenmiş, bu süreçte anonimliğin korunabilmesi için takma isimler kullanılmıştır.

Analiz

Data temizleme sürecinden sonra ana analizler yapılmıştır. Öncelikle erken dönem uyumsuz şema boyutları, duygu düzenleme ve öz-şefkatin kişinin psikopatolojik belirtileri ve yaşam doyumunu üzerindeki yordayıcı rolünü anlayabilmek açısından regresyon analizleri yapılmıştır. Sonrasında da Hayes'in (2014) önerdiği çoklu aracılık analizi kullanılarak duygu düzenleme güçlüğünün ve öz-şefkatin erken dönem uyumsuz şema boyutları ve kişinin patolojik belirtileri ile yaşam doyumu üzerindeki etkisi birlikte incelenmiştir.

Sonuçlar

Hiyerarşik Regresyon Analizleri

Mevcut çalışmada psikopatolojik belirtiler ve yaşam doyumunun belirleyicilerinin ortaya çıkarılması amacıyla stepwise yöntemi kullanılarak hiyerarşik regresyon analizi uygulanmıştır. Teorik olarak öz-şefkat bir duygu düzenleme stratejisi olarak düşünülse de, mevcut araştırmada öz-şefkatin duygu düzenlemenin ötesindeki etkilerinin de incelenmesi hedeflenmektedir. Bu yüzden öz-şefkatin eşitliğe duygu düzenlemedeki zorluklardan sonra girmesi tasarlanmıştır. Bu yüzden ilk regresyon setinde öz-şefkat ve duygu düzenlemenin belirleyicileri incelenmiş, ikinci sette de psikopatolojik belirtiler ve yaşam doyumunun belirleyicilerinin ortaya çıkarılması hedeflenmiştir.

İlk analizde duygu düzenlemede güçlüklerin belirleyicileri araştırılmıştır. Buna göre eşitliğe giren demografik değişkenler sırasıyla yaş (β = -.19, t [257] = -3.10, p < .01) ve psikiyatrik öykünün varlığıdır (β = -.18, t [256] = -3.01, p < .01). Demografik değişkenler toplam varyansın %6'sını açıklamaktadır. Eşitliğe giren ilk

şema boyutu kopukluk/reddedilmedir (β = .57, t [255] = 11.57, *p* < .001) ve açıklanan varyansı %32'ye (F_{change} [1,255] = 133.85, *p* < .001) çıkarmıştır. Eşitliğe giren diğer şema alanı zedelenmiş otonomi/diğeri yönelimliliktir (β = .28, t [254] = 4.35, *p* < .001). Şema boyutlarıyla birlikte açıklanan varyans %42'ye çıkmıştır. Böylelikle, görece genç olmanın, psikiyatrik öyküye sahip olmanın ve kopukluk/reddedilme ve zedelenmiş otonomi/diğeri yönelimlilik alanlarında yüksek puan almanın duygu düzenlemede güçlük yaşamanın belirleyicileri olduğu bulunmuştur.

İkinci regresyon analizi öz-şefkatin belirleyicilerini bulmak için yapılmıştır. Buna göre demografik değişkenlerden eşitliğe sırasıyla psikiyatrik öykünün varlığı (β = .17, t [257] = -2.79, *p* < .01) ve yaş (β = .18, t [256] = 2.95, *p* < .01) eşitliğe girmiştir. Demografik değişkenler toplam varyansın %6'sını açıklamaktadır. Eşitliğe giren ilk şema boyutu kopukluk/reddedilmedir (β = -.57, t [255] = -11.57, *p* < .001) ve açıklanan varyansı %38'e (F_{change} [1,255] = 133.97, *p* < .001) çıkarmıştır. Eşitliğe giren diğer şema alanı zedelenmiş sınırlar/yüksek standartlardır (β = -.15, t [254] = -2.36, *p* < .05). Şema boyutlarıyla birlikte açıklanan varyans %39'a çıkmıştır. Duygu düzenleme zorluklarının alt boyutlarından eşitliğe giren değişkenler sırasıyla duygu düzenleme stratejilerine kısıtlı erişim (β = -.56, t [253] = -10.76, *p* < .001), duygusal farkındalık (β = .25, t [252] = 5.94, *p* < .001) ve duygusal açıklıktır (β = .15, t [251] = 2.77, *p* < .01). Duygu düzenleme boyutlarıyla birlikte açıklanan varyans %64'e (F_{change} [1,251] =7.67, *p* < .01) çıkmıştır. Buna göre, görece daha yaşlı olan ve psikiyatrik öyküsü bulunmayan, kopukluk/reddedilme ve zedelenmiş sınırlar/yüksek standartlar alanlarından yüksek puan alan, duygu düzenleme stratejilerine erişimi kısıtlı olmayan, duygularına yönelik farkındalığı ve açıklığı yüksek olan bireylerin öz-şefkat düzeylerinin de yüksek olduğu gözlenmiştir.

Üçüncü regresyon analizi psikopatolojik belirtilerin ilişkili olduğu faktörleri belirlemek amacıyla yapılmıştır. Buna göre demografik değişkenlerden sırasıyla yaş (β = -.21, t [257] = -3.53, *p* < .001) ve baba eğitiminin (β = -.13, t [256] = -2.09, p < .05) eşitliğe girdiği gözlenmiştir. Bu iki değişken toplan varyansın %4'ünü açıklamaktadır. Eşitliğe giren ilk şema boyutu kopukluk/reddedilmedir (β = .58, t

[255] = 11.78, $p < .001$) ve açıklanan varyansı %39'a (F_{change} [1,255] = 138,86, $p < .001$) çıkarmıştır. Duygu düzenleme boyutlarından sadece duygu düzenleme stratejilerine kısıtlı erişimin (β = .39, t [253] = 7.23, $p < .001$) eşitliğe girdiği gözlenmiştir. Benzer şekilde, öz-şefkatin alt boyutlarından da sadece kendini yargılamanın (β = .13, t [252] = 2.09, $p < .05$) eşitliğe girdiği gözlenmiştir. Sonuçta, altı değişkenin dahil olmasıyla psikopatolojik belirtilerdeki varyansın %52'si açıklanmıştır. Buna göre, babasının eğitim düzeyi düşük olan, görece genç yaşta olan, kopukluk/reddedilme ve zedelenmiş sınırlar/yüksek standartlar alanlarından yüksek puan alan, duygusal düzenleme stratejilerine erişimi sıkıntılı olan ve kendini yargılama eğiliminde olan katılımcıların daha yüksek düzeyde psikopatolojik belirti sergilediği bulunmuştur.

Son regresyon analizinde yaşam doyumunun belirleyicilerinin ortaya çıkarılması hedeflenmiştir. Buna göre demografik değişkenlerden sırasıyla cinsiyet (β = -.18, t [257] = -2.91, $p < .01$), psikiyatrik öykünün varlığı (β = .22, t [256] = 3.53, $p < .001$) ve gelir düzeyinin (β = .15, t [255] = 2.54, $p < .01$) eşitliğe girdiği gözlenmiştir. Hep birlikte demografik bilgiler toplam varyansın %10'unu açıklamaktadır. Eşitliğe giren ilk şema boyutu kopukluk/reddedilmedir (β = -.36, t [254] = -6.34, $p < .001$) ve açıklanan varyansı %22'ye (F_{change} [1,254] = 40.22, $p < .001$) çıkarmıştır. Eşitliğe giren ikinci şema boyutu zedelenmiş otonomi/diğeri yönelimliliktir (β = .15, t [253] = 2.05, $p < .05$). Duygu düzenleme alt alanlarından sırasıyla duygusal tepkilerin açıklığı (β = .21, t [252] = 3.46, $p < .001$) ve duygu düzenleme stratejilerine kısıtlı erişimin (β = -.16, t [251] =-2.28, $p < .05$) eşitliğe girdiği gözlenmiştir. Son basamakta, öz-şefkatin sadece yalıtılmışlık(β = -.22, t [250] = -2.82, $p < .01$) alt boyutunun eşitliğe girdiği gözlenmiştir. Sonuç olarak, sekiz değişkenin dahil olmasıyla yaşam doyumundaki varyansın %31'inin açıklandığı gözlenmiştir. Buna göre, psikiyatrik öyküsü olmayan, gelir düzeyi yüksek, reddedilme/kopukluk ve zedelenmiş otonomi/diğeri yönelimlilik boyutlarında düşük puan alma eğiliminde olan, duygusal tepkilerinin açıklığı yüksek, duygu düzenleme stratejilerine ulaşımı kısıtlı olmayan, yalıtılmışlık düzeyi

düşük kadın katılımcıların hayattan aldıkları doyumun daha yüksek olduğu bulunmuştur.

Aracılık Analizleri

Mevcut araştırmada şema teorisinin varsayımlarından yola çıkarak öz-şefkat ve duygu düzenleme sağlıklı yetişkin modunun belirleyicileri olarak kabul edilmiştir. Bu anlamda, temel hedef ise erken dönem uyumsuz şemalar ve psikopatolojik belirtiler ile yaşam doyumu arasındaki ilişkide sağlıklı yetişkin modunun aracı rolünü anlamaktır. Bu doğrultuda, öz-şefkat ve duygu düzenlemenin birlikte test edilebilmesi ve her iki aracı değişkenin ilişkiye katkısının belirlenmesi açısından aracılık ilişkisi Hayes'in (2014) paralel çoklu aracılık yöntemi kullanılarak test edilmiştir. Aracılık ilişkisi her üç şema boyutu, psikopatolojik belirtiler ve yaşam doyumu için Preacher and Hayes (2008)'in önerdiği öz yükleme (bootstrapping) prosedürü kullanılarak ayrı ayrı test edilmiştir. Daha önce uygulanan regresyon analizinin sonuçlarından yola çıkarak belirli demografik değişkenler aracılık analizinde eş değişken olarak dahil edilmiştir.

Zedelenmiş sınırlar/yüksek standartlar boyutunun psikopatolojik belirtiler üzerine duygu düzenleme ve öz-şefkat üzerinden dolaylı etkisinin incelenmesinde katılımcıların yaşı ve babalarının eğitim düzeyi analize dahil edilmiş ancak yapılan analiz sonucunda sadece yaşın (B = -.50, SE = .20, p < .05) anlamlı bir etkisinin olduğunun bulunması sonucunda parsimoni ilkesi uyarınca sadece yaş eş değişken olarak ana analize dahil edilmiştir. Buna göre zedelenmiş sınırlar/yüksek standartlar boyutunun duygu düzenleme (a_1 = .46, SE = .05, p < .001) ve öz-şefkat (a_2 = -.41 SE = .05, p < .001) üzerinde doğrudan etkisinin olduğu bulunmuştur. Yanı sıra, hem duygu düzenleme (b_1 = .63, SE = .12, p < .001) hem de öz-şefkatin (b_2 = -.24, SE = .12, p < .05) psikopatolojik belirtiler üzerinde doğrudan etkisi olduğu gözlenmiştir. Benzer şekilde, zedelenmiş sınırlar/yüksek standartlar boyutunun psikopatolojik belirtiler üzerindeki toplam (c = .80, SE = .09, p < .001) ve doğrudan (c' = .40, SE = .08, p < .001) etkisi de anlamlı bulunmuştur. Genel olarak model (F [4,291] = 64.51, p < .001) anlamlı bulunmuştur. Buna göre, mevcut model zedelenmiş

sınırlar/yüksek standartlar boyutunun duygu düzenleme güçlüğü ve öz-şefkat aracılığıyla psikopatolojik belirtiler üzerindeki etkisinin %47'sini açıklamaktadır. 500 kişilik öz yükleme örnekleminin dolaylı etkisinin (*a* x *b* = .29, *SE* = .08, 95% BCa CI [.15, .49]) de anlamlı olduğu bulunmuştur. Buna göre, zedelenmiş sınırlar/yüksek standartlar boyutu ve psikopatolojik belirtiler arasındaki ilişkide duygu düzenleme ve öz-şefkatin birlikte aracılık rolü olduğu gözlenmiştir. Buna göre yüksek düzey zedelenmiş sınırlar/yüksek standartlar boyutu, yüksek düzey duygu düzenleme güçlüğü ve düşük düzey öz-şefkatin daha yüksek psikopatolojik belirtilere yol açabileceği bulunmuştur. Daha da önemlisi, yalnızca duygu düzenlemenin (a_1 x b_1 = .29, *SE* = .08, 95% BCa CI [.15, .49]) zedelenmiş sınırlar/yüksek standartlar boyutu ve psikopatolojik belirtiler arasındaki ilişkide aracı rolü olduğu gözlenmiştir.

Kopukluk/reddedilme boyutunun psikopatolojik belirtiler üzerine duygu düzenleme ve öz-şefkat üzerinden dolaylı etkisinin incelenmesinde katılımcıların yaşı ve babalarının eğitim düzeyi analize dahil edilmiş ancak yapılan analiz sonucu hiçbir değişkenle ilgili anlamlı bir etki edile edilmediğinden analize herhangi bir eş değişken dahil edilmemiştir. Buna göre kopukluk/reddedilme boyutunun duygu düzenleme (a_1 = .60, *SE* = .05, $p < .001$) ve öz-şefkat (a_2 = -.58, *SE* = .05, $p < .001$) üzerinde doğrudan etkisinin olduğu bulunmuştur. Yanı sıra, yalnızca duygu düzenleme güçlüğünün (b_1 = .64, *SE* = .12, $p < .001$) psikopatolojik belirtiler üzerinde olumlu bir etkisinin olduğu bulunmuştur. Benzer şekilde, kopukluk/reddedilme boyutunun psikopatolojik belirtiler üzerindeki toplam (c = 1.06, *SE* = .08, $p < .001$) ve doğrudan (c' = .59, *SE* = .10, $p < .001$) etkisi de anlamlı bulunmuştur. Genel olarak model (F [3,292] = 89.22, p < .001) anlamlı bulunmuştur. Buna göre, mevcut model kopukluk/reddedilme boyutunun duygu düzenleme güçlüğü ve öz-şefkat aracılığıyla psikopatolojik belirtiler üzerindeki etkisinin %47'sini açıklamaktadır. 500 kişilik öz yükleme örnekleminin dolaylı etkisinin (*a* x *b*= .47, SE = .07, 95% BCa CI [.34, .64]) de anlamlı olduğu bulunmuştur. Buna göre, kopukluk/reddedilme boyutunun ve psikopatolojik belirtiler arasındaki ilişkide duygu düzenleme güçlüğü ve öz-şefkatin birlikte

aracılık rolü olduğu gözlenmiştir. Buna göre, yüksek düzey kopukluk/reddedilme boyutu, yüksek düzey duygu düzenleme güçlüğü ve düşük düzey öz-şefkatin daha yüksek psikopatolojik belirtilere yol açabileceği bulunmuştur. Daha da önemlisi, yalnızca duygu düzenlemenin (a_1 x b_1 = .39, *SE* = .10, 95% BCa CI [.22, .61]) zedelenmiş sınırlar/yüksek standartlar boyutu ve psikopatolojik belirtiler arasındaki ilişkide aracı rolü olduğu gözlenmiştir.

Zedelenmiş otonomi/diğeri yönelimlilik boyutunun psikopatolojik belirtiler üzerine duygu düzenleme ve öz-şefkat üzerinden dolaylı etkisinin incelenmesinde katılımcıların yaşı ve babalarının eğitim düzeyi analize dahil edilmiş ancak yapılan analiz sonucunda sadece yaşın (*B* = -.48, *SE* = .20, $p < .05$) anlamlı bir etkisinin olduğunun bulunması sonucunda parsimoni ilkesi uyarınca sadece yaş eş değişken olarak ana analize dahil edilmiştir. Buna göre zedelenmiş otonomi/diğeri yönelimlilik boyutunun duygu düzenleme (a_1 = .51, *SE* = .05, $p < .001$) ve öz-şefkat (a_2 = -.44, *SE* = .05, $p < .001$) üzerinde doğrudan etkisinin olduğu bulunmuştur. Yanı sıra, hem duygu düzenleme (b_1 = .57, *SE* = .12, $p < .001$) hem de öz-şefkatin (b_2 = -.24, *SE* = .12, $p < .05$) psikopatolojik belirtiler üzerinde doğrudan etkisi olduğu gözlenmiştir. Benzer şekilde, zedelenmiş otonomi/diğeri yönelimlilik boyutunun psikopatolojik belirtiler üzerindeki toplam (*c* = .91, *SE* = .08, $p < .001$) ve doğrudan (c' = .51, *SE* = .08, $p < .001$) etkisi de anlamlı bulunmuştur. Genel olarak model (F [4,291] = 69.51, $p < .001$) anlamlı bulunmuştur. Buna göre, mevcut model zedelenmiş otonomi/diğeri yönelimlilik boyutunun duygu düzenleme güçlüğü ve öz-şefkat aracılığıyla psikopatolojik belirtiler üzerindeki etkisinin %49'unu açıklamaktadır. 500 kişilik öz yükleme örnekleminin dolaylı etkisinin (*a* x *b*= .40, *SE* = .06, 95% BCa CI [.28, .54]) de anlamlı olduğu bulunmuştur. Buna göre, zedelenmiş otonomi/diğeri yönelimlilik boyutu ve psikopatolojik belirtiler arasındaki ilişkide duygu düzenleme ve öz-şefkatin birlikte aracılık rolü olduğu gözlenmiştir. Buna göre yüksek düzey zedelenmiş otonomi/diğeri yönelimlilik boyutu, yüksek düzey duygu düzenleme güçlüğü ve düşük düzey öz-şefkatin daha yüksek psikopatolojik belirtilere yol açabileceği bulunmuştur. Daha da önemlisi, yalnızca duygu düzenlemenin (a_1 x b_1 = .29, *SE* = .09, 95% BCa CI [.14, .49])

zedelenmiş otonomi/diğeri yönelimlilik boyutu ve psikopatolojik belirtiler arasındaki ilişkide aracı rolü olduğu gözlenmiştir.

Zedelenmiş sınırlar/yüksek standartlar boyutunun yaşam doyumu üzerine duygu düzenleme ve öz-şefkat üzerinden dolaylı etkisinin incelenmesinde katılımcıların cinsiyeti, geçmiş psikiyatrik öykünün varlığı ve gelir düzeyi analize dahil edilmiş ancak yapılan analiz sonucunda sadece cinsiyetin (B = -4.34, SE = .76, p < .001) anlamlı bir etkisinin olduğunun bulunması sonucunda parsimoni ilkesi uyarınca sadece cinsiyet eş değişken olarak ana analize dahil edilmiştir. Buna göre zedelenmiş sınırlar/yüksek standartlar boyutunun duygu düzenleme (a_1 = .49, SE = .04, p < .001) ve öz-şefkat (a_2 = -.44, SE = .04, p < .001) üzerinde doğrudan etkisinin olduğu bulunmuştur. Yanı sıra, yalnızca öz-şefkatin (b_2 = .11, SE = .03, p < .01) yaşam doyumu üzerinde olumlu bir etkisinin olduğu gözlenmiştir. Ayrıca, zedelenmiş sınırlar/yüksek standartlar boyutunun yaşam doyumu üzerindeki toplam (c = -.02, SE = .02, p > .05) etkisi anlamlı değilken, yalnızca doğrudan etkisi (c' = .04, SE = .02, p < .05) anlamlı bulunmuştur. Buna göre, zedelenmiş sınırlar/yüksek standartlar boyutu yalnızca aracı değişkenlerin varlığında yaşam doyumunu yordamaktadır. Genel olarak model (F [4,291] = 14.49, p < .001) anlamlı bulunmuştur. Buna göre, mevcut model zedelenmiş sınırlar/yüksek standartlar boyutunun duygu düzenleme güçlüğü ve öz-şefkat aracılığıyla yaşam doyumu üzerindeki etkisinin %15'ini açıklamaktadır. 500 kişilik öz yükleme örnekleminin dolaylı etkisinin (a x b = -.06, SE = .01, 95% BCa CI [-.09, -.04]) de anlamlı olduğu bulunmuştur. Buna göre, zedelenmiş sınırlar/yüksek standartlar boyutu ve yaşam doyumu arasındaki ilişkide duygu düzenleme ve öz-şefkatin birlikte aracılık rolü olduğu gözlenmiştir. Buna göre yüksek düzey zedelenmiş sınırlar/yüksek standartlar boyutu, yüksek düzey duygu düzenleme güçlüğü ve düşük düzey öz-şefkatin daha düşük yaşam doyumuna yol açacağı düşünülmektedir. Daha da önemlisi, yalnızca öz şefkatin (a_2 x b_2 = -.05, SE = .02, 95% BCa CI -08, -.02]) zedelenmiş sınırlar/yüksek standartlar boyutu ve yaşam doyumu arasındaki ilişkide aracı rolü olduğu gözlenmiştir.

Kopukluk/reddedilme boyutunun yaşam doyumu üzerine duygu düzenleme ve öz-şefkat üzerinden dolaylı etkisinin incelenmesinde katılımcıların cinsiyeti, geçmiş psikiyatrik öykünün varlığı ve gelir düzeyi analize dahil edilmiş ancak yapılan analiz sonucu sadece cinsiyetin (B = -3.80, SE = .77, p < .001) anlamlı bir etkisinin olduğunun bulunması sonucunda parsimoni ilkesi uyarınca sadece cinsiyet eş değişken olarak ana analize dahil edilmiştir. Buna göre kopukluk/reddedilme boyutunun duygu düzenleme (a_1 = .62, *SE* = .03, p < .001) ve öz-şefkat (a_2 = -.61, *SE* = .05, p < .001) üzerinde doğrudan etkisinin olduğu bulunmuştur. Yanı sıra, yalnızca öz-şefkatin (b_2 = .08, *SE* = .03, p < .05) yaşam doyumu üzerinde olumlu bir etkisinin olduğu bulunmuştur. Benzer şekilde, kopukluk/reddedilme boyutunun yalnızca yaşam doyumu üzerindeki toplam (c = -.10, *SE* = .02, p < .001) etkisi anlamlı bulunmuştur. Genel olarak model (F [4,291] = 14.43, p < .001) anlamlı bulunmuştur. Buna göre, mevcut model kopukluk/reddedilme boyutunun duygu düzenleme güçlüğü ve öz-şefkat aracılığıyla yaşam doyumu üzerindeki etkisinin %15'ini açıklamaktadır. 500 kişilik öz yükleme örnekleminin dolaylı etkisinin (a x b = -.05, *SE* = .02, 95% BCa CI [-.08, -.01]) de anlamlı olduğu bulunmuştur. Buna göre, kopukluk/reddedilme boyutunun ve yaşam doyumu arasındaki ilişkide duygu düzenleme güçlüğü ve öz-şefkatin birlikte aracılık rolü olduğu gözlenmiştir. Buna göre, yüksek düzey kopukluk/reddedilme boyutu, yüksek düzey duygu düzenleme güçlüğü ve düşük düzey öz-şefkatin daha düşük yaşam doyumuna yol açacağı düşünülmektedir. Daha da önemlisi, yalnızca öz-şefkatin (a_2 x b_2 = -.05, *SE* = .02, 95% BCa CI -09, -.01]) kopukluk/reddedilme boyutu ve yaşam doyumu arasındaki ilişkide aracı rolü olduğu gözlenmiştir.

Zedelenmiş otonomi/diğeri yönelimlilik boyutunun yaşam doyumu üzerine duygu düzenleme ve öz-şefkat üzerinden dolaylı etkisinin incelenmesinde katılımcıların cinsiyeti, geçmiş psikiyatrik öykünün varlığı ve gelir düzeyi analize dahil edilmiş ancak yapılan analiz sonucu sadece cinsiyetin (B = -4.22, *SE* = .76, p < .001) anlamlı bir etkisinin olduğunun bulunması sonucunda parsimoni ilkesi uyarınca sadece cinsiyet eş değişken olarak ana analize dahil edilmiştir. Buna göre zedelenmiş otonomi/diğeri yönelimlilik boyutunun duygu düzenleme (a_1 = .54, *SE*

= .05, p < .001) ve öz-şefkat (a_2 = -.47, SE = .05, p < .001) üzerinde doğrudan etkisinin olduğu bulunmuştur. Yanı sıra, yalnızca öz-şefkatin (b_2 = .10, SE = .03, p < .001) yaşam doyumu üzerinde doğrudan etkisi olduğu gözlenmiştir. Öte yandan zedelenmiş otonomi/diğeri yönelimlilik boyutunun yaşam doyumu üzerindeki toplam (c = -.03, SE = .02, p > .05) ve doğrudan (c' = .03, SE = .02, p > .05) etkisinin de anlamlı olmadığı bulunmuştur ancak, genel olarak model (F [4,291] = 13.87, p < .001) anlamlı bulunmuştur. Buna göre, mevcut model zedelenmiş otonomi/diğeri yönelimlilik boyutunun duygu düzenleme güçlüğü ve öz-şefkat aracılığıyla yaşam doyumu üzerindeki etkisinin %15'ini açıklamaktadır. 500 kişilik öz yükleme örnekleminin dolaylı etkisinin (a x b = -.06, SE = .01, 95% BCa CI [-.09, -.04]) anlamlı olduğu bulunmuştur. Buna göre, zedelenmiş otonomi/diğeri yönelimlilik boyutu ve yaşam doyumu arasındaki ilişkide duygu düzenleme ve öz-şefkatin birlikte aracılık rolü olduğu gözlenmiştir. Buna göre yüksek düzey zedelenmiş otonomi/diğeri yönelimlilik boyutu, yüksek düzey duygu düzenleme güçlüğü ve düşük düzey öz-şefkatin daha düşük yaşam doyumuna yol açacağı düşünülmektedir. Daha da önemlisi, yalnızca öz-şefkatin (a_2 x b_2 = -.05, SE = .02, 95% BCa CI -08, -.02]) zedelenmiş otonomi/diğeri yönelimlilik boyutu ve yaşam doyumu arasındaki ilişkide aracı rolü olduğu gözlenmiştir.

İkinci çalışma

Katılımcılar

Birinci çalışmada kopukluk/reddedilme boyutunun en sorunlu şema alanı olarak belirlenmiştir. Çalışmaya katılan 296 kişiden bu boyutta en yüksek puan alan gruptan, yaş ve cinsiyet etmenlerinin eşdeğerliği de gözetilerek seçilen on kişi (5 kadın, 5 erkek) ikinci çalışmanın örneklemini oluşturmuştur.

Araçlar

Şema Mod Kartları Bernstein (2014) tarafından bir karikatüristle birlikte şema terapi pratiklerinde kullanılmak üzere oluşturulmuştur. Buna göre oluşturulan seri, çocuk, ebeveyn, yetişkin ve başa çıkma modlarına yönelik 23 farklı karttan

oluşmaktadır. Her kartın belirli sıfatlara ve duygulara işaret etmesi amaçlanmıştır. Mevcut çalışma bu kartların Türk örnekleminde kullanıldığı ilk çalışmadır.

Uygulama ve analiz

Erken dönem çocukluk anılarından kopukluk/reddedilme boyutundaki şemalarla ilişkili anıların tetiklenmesini sağlayabileceği düşünülen beş kart seçilmiş ve katılımcılardan aynı karttaki gibi hissettikleri bir anısını anlatmaları istenmiştir. Katılımcıların anlatımlarını zenginleştirebilmek açısından başka hatırlayabildikleri bir şey olup olmadığı, mevcut anının en iyi hatırladıkları kısmı, o anda nasıl hissettikleri, o döneme dair ne gibi duygular hissettikleri sorulmuştur. Sonrasında sağlıklı yetişkin kartı ve boş kart gösterilerek katılımcılardan bir hikaye anlatmaları istenmiştir. Katılımcılarla yapılan görüşme MAXQDA kullanılarak tümden gelimci nitel veri analiziyle kodlanmıştır.

Sonuçlar

Katılımcıların verdiği cevaplar kodlanırken iki farklı alan göz önüne alınmıştır. Bunlardan ilki cinsiyete ilişkin farklılıklar, ikincisi de nicel ve nitel ölçümler arasındaki farklılıklardır. Buna göre:

Güvensizlik/kötüye kullanılma şemasına yönelik temaların erkekler tarafından kadınlara göre daha sıklıkla kullanıldığı ulunmuştur. Yanı sıra, kadınların genellikle ihmal edilmeyle ilişkili temaları daha sık kullandığı, erkeklerin ise öfke tepkilerini daha çok ifade ettiği gözlenmiştir. Duygusal yoksunluk şemasına yönelik temaların her alt boyutta kadınlar tarafından erkeklere oranla daha sık kullanıldığı gözlenmiştir. Kusurluluk/utanç şemasına yönelik temaların kadınlar tarafından erkeklere oranla daha çok kullanıldığı gözlenmiştir. Özellikle sevilmeye değer hissetmeme temasının erkeklerde hiç kodlanmadığı, kadınlarda ise sıklıkla kodlandığı gözlenmektedir. Sosyal yalıtılmışlık açısından kadın ve erkeklerde kodlanan temalar açısından farklılık gözlenmemiştir. Öte yandan kadınlar daha çok içe çekilmeyle ilişkili temalardan bahsederken, erkeklerin daha çok yalnızlıkla ilgili temaları ifade ettiği gözlenmiştir. Duygusal ketleme şemasına yönelik temaların

erkeklerde, özellikle de entellektüalizasyon ve rasyonalizayon açısından kadınlara göre daha fazla kodlandığı gözlenmiştir. Ancak diğer alt boyutların kodlanma sıklığının erkek ve kadınlar açısından birbirine yakın olduğu gözlenmiştir. Başarısızlık şemasına yönelik temaların da kadın ver erkekler açısından benzer sıklıkta kodlandığı gözlemiştir.

Katılımcıların nicel ve nitel verileri arasındaki farklılıklara bakıldığında katılımcıların bireysel görüşmelerde kağıt-kalem testlerine oranla "yaralı" taraflarını açmakta daha az zorlandıkları izlenimi edinilmiştir. Benzer şekilde nicel ölçümlerde güvensizlik/kötüye kullanılma, duygusal ketleme, sosyal yalıtılmışlık gibi şemalar ön plana çıkarken, nitel ölçümlerde duygusal yoksunluk ve kusurluluk/utanç gibi şemaların daha sıklıkla kodlandığı gözlenmektedir. Buradan hareketle bireysel görüşmelerde kişilerin daha kapsamlı ve dengeli bir değerlendirmesinin yapıldığı düşünülmektedir.

Tartışma

İki çalışmadan oluşan mevcut araştırmada, şema teorisine yenilikçi bir bakış açısının geliştirilmesi hedeflenmiştir. Bu yüzden iki ayrı çalışma da şema yazınında eksik kalan noktaların tamamlanmasına yardımcı olmak amacıyla tasarlanmıştır.

İlk çalışmada şemalara yönelik güçlülük faktörlerinin ele alınması hedeflenmiştir. Bu yüzden duygu düzenleme ve öz-şefkat sağlıklı yetişkin modunun belirleyicileri olarak ele alınmış ve hipotez edilen aracılık rolü çalışmanın sonuçlarıyla desteklenmiştir. Ancak daha önemlisi mevcut araştırmadaki aracılık analizlerinin duygu düzenlemenin psikopatolojik belirtiler açısından, öz-şefkatin ise yaşam doyumu açısından kritik olduğunu göstermesidir. Bu sonuç, muhtemelen yaşam doyumunun çoğunlukla kişinin içsel süreçleriyle, duygu düzenlemenin de kişilerarası ilişkilerle alakalı olmasıyla açıklanabilir. Mesela, bir birey duygu düzenleme süreçleriyle ilişkili bir problem yaşadığında bu çoğunlukla dışarıdan gözlenebilir ve teşhis edilebilir. Bu yüzden bu kişilerin psikolojik bir tanı alma olasılığı çok daha yüksektir. Öte yandan, öz-şefkat çok daha içsel dinamikleri ilgilendirdiğinden, kişinin öz-şefkat düzeyi diğerleri tarafından görülebilir değildir.

Ancak, bu durum belirli bir psikolojik tanı almasa da, kişinin yaşam kalitesini etkilemeye devam eder.

Mevcut araştırmanın önemli bulgularından biri de nicel veri analizlerine dikkatle bakılmasının altını çizmesidir. Buna göre birinci araştırmada güvensiz, duygusal açıdan ketlenmiş ve sosyal açıdan yalıtılmış azledilen katılımcıların ikinci çalışmada yüz yüze iletişimin sağladığı güven ilişkisiyle kişilerin yoksun bırakılmış, kusurlu ve ilgi bekleyen taraflarının da varlığının ortaya çıkması şemaların doğru değerlendirilmesi açısından oldukça önemli bir bulgudur. Çünkü şema terapi sürecinde üzerine çalışılacak şemaların doğru bir şekilde belirlenmesi hayati önem taşır. Bu yüzden, nicel veri sonuçlarının değerlendirilmesinde nitel veri analizinden alınan destek büyük önem taşımaktadır.

Sınırlılıklar

Mevcut çalışmada şema terapi uygulamalarından ve okumalarından yola çıkarak tasarlanan hipotezler ve özellikle şema mod kartlarıyla ilişkili veriler ilk kez ampirik olarak test edilmiştir. Dolayısıyla bu alanda farklı örneklemler kullanılarak daha ayrıntılı replikasyon çalışmalarının yapılmasına ihtiyaç vardır.

Nitel yöntem ve karma metot Türk psikoloji yazınında yeni yeni kendini göstermektedir. Nitel veriyle çalışırken, katılımcı sayısı kaçınılmaz olarak düşmektedir. Bu yüzden belirli bir katılımcıdan alınan bilginin önemi artmaktadır. Bu anlamda gelecek çalışmalarda klinik hasta örnekleminden elde edilecek nitel verilerin şema değerlendirmesi açısından daha zengin bir içerik sağlayabileceği öngörülmektedir.

Son dönemde şema terapistleri şemalar yerine şema modlarıyla çalışmaya başladıklarından beri sağlıklı yetişkin modunun belirleyicileri uygulamada daha çok önem kazanmıştır. Mevcut araştırmada şema mod ölçeği kullanılamadığından güçlülük faktörlerine yönelik değerli bilgiler elde edilmiştir, ancak şema modlarına odaklanan daha fazla çalışmaya ihtiyaç duyulduğu düşünülmektedir.

APPENDIX J: TEZ FOTOKOPİSİ İZİN FORMU

TEZ FOTOKOPİSİ İZİN FORMU

ENSTİTÜ

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

YAZARIN

Soyadı : Yakın
Adı : Duygu
Bölümü : Psikoloji

TEZİN ADI (İngilizce) : Towards An Integrative Perspective on the Interplay between Early Maladaptive Schemas And Well-Being: The Role of Early Recollections, Self-Compassion and Emotion Regulation

TEZİN TÜRÜ : Yüksek Lisans [ ] Doktora [X]

1. Tezimin tamamından kaynak gösterilmek şartıyla fotokopi alınabilir. [ ]
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. [X]

TEZİN KÜTÜPHANEYE TESLİM TARİHİ: