RISK AND PROTECTIVE FACTORS IN THE RELATION BETWEEN EARLY MALADAPTIVE SCHEMAS AND EMERGING ADULTHOOD PSYCHOLOGICAL WELL-BEING

A THESIS SUBMITTED TO

THE GRADUATE SCHOOL OF SOCIAL SCIENCES

OF

TED UNIVERSITY

BY

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR

THE DEGREE OF MASTER OF SCIENCE

IN

THE DEPARTMENT OF PSYCHOLOGY

FEBRUARY 2019

Approval of the Institute of Graduate School

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ABSTRACT

RISK AND PROTECTIVE FACTORS IN THE RELATION BETWEEN EARLY MALADAPTIVE SCHEMAS AND EMERGING ADULTHOOD PSYCHOLOGICAL WELL-BEING

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February 2019, 111 pages

Early Maladaptive Schemas (EMS) relate to psychological well-being, but little is known about which factors may mediate this relation. The purpose of this study was to examine to what extent cognitive flexibility, emotion regulation difficulties and perceived social support may explain why EMS as formed in early childhood may relate to psychological well-being during adolescence and early adulthood. Data were collected from two different samples, a clinical sample (N = 106) and a non-clinical one (N = 286). Regression analyses have shown that impaired autonomy was the most consistent predictor of life satisfaction and depression and that emotion regulation difficulties and perceived social support were the most consistent mediators of the relation of impaired autonomy to depression and life satisfaction in both samples. The findings were discussed in light of the EMS literature, followed by future research suggestions.

Keywords: Early Maladaptive Schemas (EMS), cognitive flexibility, perceived social support, emotion regulation difficulties, depression, life satisfaction

ÖZ

ERKEN DÖNEM UYUMSUZ ŞEMALAR VE BELİREN YETİŞKİNLİK DÖNEMİ PSİKOLOJİK İYİ OLUŞ ARASINDAKİ RİSK FAKTÖRLERİ VE KORUYUCU FAKTÖRLER

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Şubat 2019, 111 sayfa

Erken dönem uyumsuz şemalar psikolojik iyi oluş ile ilişkilidir ancak bu ilişkide aracı rol oynayabilecek faktörler hakkındaki bilgi kısıtlıdır. Bu araştırmanın amacı bilişsel esneklik, duygu düzenleme güçlüğü ve algılanan sosyal desteğin, kişilerin erken yaşantılarında oluşmaya başlayan erken dönem uyumsuz şemalar ve psikolojik iyi oluş arasındaki ilişkide aracı role sahip olup olmadığını incelemektir. Araştırmanın örneklemini iki ayrı grup oluşturmaktadır; klinik grup (N = 106) ve klinik olmayan grup (N = 286). Regresyon analizlerinin sonuçlarına göre, zedelenmiş otonominin yaşam doyumunu ve depresyonu yordamada en tutarlı yordayıcı değişken olduğu gözlenmiştir. Bunun yanı sıra, iki grupta da, duygu düzenleme güçlüğü ve algılanan sosyal desteğin de sözü edilen ilişkide en tutarlı aracı değişkenler olduğu göze çarpmaktadır. Sonuçlar erken dönem uyumsuz şemalar literatürü ışığında tartışılmış ve gelecek çalışmalar için önerilerde de bulunulmuştur.

Anahtar Sözcükler: Erken dönem uyumsuz şemalar, bilişsel esneklik, duygu düzenleme güçlüğü ve algılanan sosyal destek, depresyon, yaşam doyumu

To all the people who are trying to find themselves

ACKNOWLEDGMENTS

First of all, I would like to express my sincere thanks to Asst. Prof. Athanasios Mouratidis. In this process, he was not only a supervisor, but also my supporter at any time while I am trying to improve myself on this path. I have always had support for every question and for every problem. He is an invaluable person who knows how to motivate a student through the ups and downs of the academic journey. I am more than lucky to be his student and would like to be able to follow his footsteps for the rest of my life.

At the same time, I would like to express my sincere gratitude to my esteemed Prof. Dr. Nilhan Sezgin who has accepted going through this process with me. She supported me since my undergraduate life without any conditions and showed unconditional love to me. She followed my steps through the whole process I am very grateful for the effort with which she encouraged me to draw my own way.

Additionally I would like to thank to Prof. Dr. Gülsen Erden and Asst. Prof. Ilgın Gökler Danışman who helped me to improve my thesis by agreeing to take part in my jury committee. They have supported my educational process over the years and have always taken us further. I was very luck to collect data from Gülhane Training and Research Hospital, therefore, special thanks to the psychiatry department.

I have to emphasize the names of my beloved friends: Ecem Altop, Efsane Akıncı, Görkem Göven, Gülfem Tanrıkulu, Hazal Akoğlu, Cumali Balcı, Melisa Tansu Çetin; I do not think that I could go on alone in this process if your emotional support was not with me. I would like to thank you for all the answers for my questions and for your existence in my life, especially during the times when I think I can not do anymore. Thanks to Meryem Dedeler as well, who replied to all my questions in every moment and for being my "social support". The person who taught me how to "knock it out of the park" was dear Jeffrey LeClaire who spent lots of time to make my work better. I would like to send my warm wishes to Gamze Akıncı who psychologically supported our "girls team" since undergraduate like a friend.

During my thesis process, I had the opportunity to do my internship in Ruhr University. That's why I would also like to thank Prof. Dr. Jürgen Margraf, who accepted me to the program. Also, to Julia Brailovskaia and Xiao Chi Zhang who helped me in my analysis process and to my dear supervisor Michael Lippert and Katharina Sommer. Lastly, many thanks to my dear family Ioana Yıldızhan and Rıza Yıldızhan...

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CHAPTER 1

INTRODUCTION

Research has shown that early maladaptive schemas (EMS) - emotional and cognitive constructs that take shape in the early stages of people's lives and are repeated afterwards (Young, Klosko, & Weishaar, 2003) - are linked with adults' and adolescents' psychological well-being (Alba, Calvete, Wante, Van Beveren, & Braet, 2018; Martin, Blair, Clark, Rock, & Hunter, 2018; Van Vlierberghe, Braet, Bosmans, Rosseel & Bögels, 2010). Many scholars agree that distorted early experiences with significant others could predict future adjustment and functioning (McLean, Bailey, & Lumley, 2014; Thimm, 2013). For example, the vulnerability schema (characterized by exaggerated fear that a sudden unavoidable misfortune will happen), has been found to associate with anxiety disorders and depressive symptoms (Brawman-Mintzer, Emmanuel, Jarrell, & Ballenger, 1993). Likewise, failure schema (the belief that the person has failed, considering himself/herself incompetent compared to others) (Young et al., 2003) has been found to be associated with depression in older adults (Tandetnik, Hergueta, Bonnet, Dubois & Bungener, 2017). Yet, although the link between EMS and psychological symptoms in adulthood is well known (Harris & Curtin, 2002), a pertinent question that has remained relatively underexplored is which processes may lie in between.

Specifically, it has not been thoroughly investigated whether the relation between maladaptive schemas (or some of them) and indices of well-being (such as depressive symptoms and life satisfaction) are mediated by aspects of social environment (such as perceived social support), and personal attributes (such as emotion regulation difficulties and cognitive flexibility). Perceived social support refers to the resources that one feels that one gets from his one's family, friends, and significant others (Zimet, Dahlem, Zimet & Farley, 1988). Emotion regulation refers to the process through which a person determines which

emotions he or she experiences, when he or she experiences them, and how he or she expresses them and people who have problem in regulating their emotions are considered to face emotion regulation difficulties (Gratz & Roemer, 2004; Gross, 1998). Cognitive flexibility represents a form of fluid intelligence that enables the person to consider alternative solutions when encountering a problem (Silver, Hughes, Bornstein, & Beversdorf, 2004). Research has shown that perceived social support, emotion regulation difficulties, and cognitive flexibility are important correlates of psychological well-being. Specifically, psychological well-being has been found to relate, among others, to one's network of social support (Friedlander, Reid, Shupak, & Cribbie, 2007), as well as on his or her cognitive characteristics (such as cognitive flexibility) and coping strategies (such as emotion regulation difficulties) (O'Connor & Dvorak, 2001).

A relevant and equally important question also is whether the potential mediating role of perceived social support, emotion regulation difficulties, and cognitive flexibility applies not only to healthy, non-clinical individuals but also to those who have been clinically diagnosed as suffering from certain disorders such as depressive and anxious symptoms. This is an interesting research question because the bulk of research that has been conducted so far mainly involves typical population samples. Therefore, it is unclear whether a similar pattern of relations can be readily generalized to clinical populations. Studying EMS only with healthy populations may misinform us about the severity of the existence of EMS and whether perceived social support, emotion regulation difficulties, and cognitive flexibility may indeed mediate the relation between EMS and well-being among people with psychological disorders. Examining these relations in both clinical and non-clinical population samples could provide more accurate answers and useful hints for future interventions. Given that some maladaptive schemas are hard to change, it could be especially useful for clinical therapists to know whether perceived social support, emotion regulation

difficulties, or cognitive flexibility mediate the links between maladaptive schemas and well-being (Young et al., 2003). Such knowledge could lead clinicians to focus on these mediators as an effective strategy when dealing with people suffering from EMS. All in all, the aim of the present study is to investigate how cognitive flexibility, emotion regulation difficulties, and perceived social support may explain the relation between EMS and psychological well-being among emerging adults (see Figure 1).

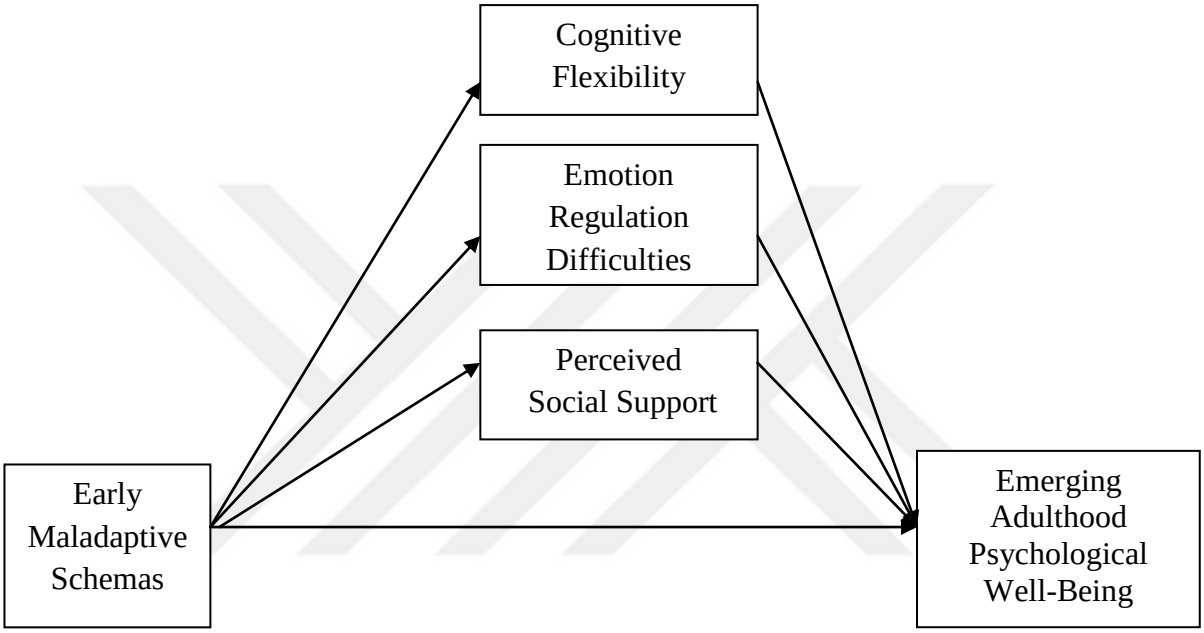

Figure 1.1. The Model of the Study

1.1. Early Maladaptive Schemas

According to Young et al. (2003), there are 18 EMS, classified under five general schema domains. The 5 schema domains and their sub-categories are provided in Table 1.

Table 1.

Classification of EMS and Descriptions According to Young et al. (2003)

Classification of Schemas	**Description**
A- Disconnection Rejection	Refers to people's inability to form secure and satisfying attachment bonds with others, and to the beliefs that love and belonging needs will remain unmet.
1. Abandonment / instability	One's belief that the people one cares about are unreliable. Fear that emotional support / commitment will not continue because one will be abandoned.
2. Mistrust / abuse	One's belief that he or she will be intentionally harmed or abused.
3. Emotional deprivation	One's belief that emotional support won't be fully met. Emotional deprivation can be characterized by lack of interest, empathy and protection.
4.Defectiveness/Shame	One's belief that one is unwanted and unlovable.
5.Social Isolation/Alienation	One's belief that one cannot belong to any group; that he or she differs from the society.
B- Impaired autonomy and performance	Refers to problems about separation, functioning independently, performing successfully.
6. Dependence / incompetence	One's feelings that one is dependent on others to make decisions and expecting other's help.
7. Vulnerability to Harm or Illness	One's belief that some kind of accident or illness will find one at any moment.
8. Enmeshment / Undeveloped Self	Undeveloped identity perceptions and depending on other people which they are close to.
9. Failure	One's belief that one will fail in areas such as academia, sports etc.

C- Impaired Limits	Refers to emphasis on deficits in respect to rights of others.
10.Entitlement/ Grandiosity	One's beliefs that one is superior to others and that rules that apply to other people do not apply to them.
11. Insufficient Self Control / Self Discipline	Difficulties to control oneself while expressing emotions and when attaining goals.
D- Other-directedness	Focusing on desires, feelings and responses of others to gain love and acceptance.
12.Subjugation	The feelings and the decisions of others become more important than one's own decisions causing one to be overwhelmed.
13.Self-Sacrifice	One's attributing extreme importance to others and their needs.
14. Approval-Seeking / Recognition-Seeking	One's seeking approval, recognition, and attention from others.
E- Over vigilance and Inhibition	Refers to excessive internalizing of rules on behavior and suppression of feelings to the detriment of happiness and close relationships.
15. Negativity / Pessimism	Focusing on negative rather than positive aspects of a situation, even when things go well.
16.Emotional Inhibition	Suppressing feelings because of shyness and worrying about "rejection".
17. Unrelenting standards / Hypercriticalness	Having high standards to avoid criticism.
18. Punitiveness	One's belief that strict punishment should be applied whenever one makes a mistake.

EMS are cognitive structures and characteristics which are formed when the core emotional needs are not fully met, formed by negative experiences in the early period of individuals (since the dynamics in the nuclear family are related with later dynamics of individuals) and formed by emotional temperament characteristics (Young et al., 2003). Early childhood experiences such as insecure attachment, negative perception of identity, inability to express own needs, irrational limits set by the caregiver may result in EMS (Young et al., 2003) and eventually to several psychological disorders such as depression and other psychological problems (Muris, 2006). For instance, the vulnerability schema has been found

to be most powerful predictor of depression (Harris & Curtin, 2002). It is important to highlight that depression is highly comorbid with anxiety disorders (Brown, Kroenke, Theobald, Wu, & Tu, 2010) and it has been known that EMS are linked to anxiety disorders besides depression (Shorey, Elmquist, Anderson, & Stuart, 2015).

Similar results have been obtained with clinical samples. For example, in a study of eighty-two adolescents having different kinds of disorders such as peer and emotional problems, all the schema domains were found to correlate positively with emotional problems (Roelofs, Onckels, & Muris, 2013). In similar studies, it is found that EMS are related to anxious symptomatology (Lumley & Harkness, 2007) and depressive symptoms (Konukçu, Akkoyunlu, & Türkçapar, 2013; Roelofs et al., 2013). Likewise, EMS and some personality disorders such as borderline personality disorder, obsessive compulsive disorder, and avoidant personality disorder have also been found correlated (Jovev & Jackson, 2004). Apart from the relation between EMS and psychopathology, Cukor and his colleagues (2007) found significant differences in impaired autonomy between a depressed group and a group with no psychopathology, depressive patients having higher scores of impaired autonomy.

Impaired autonomy schema domain was found to predict depression among American university students (Haugh, Miceli, & DeLorme, 2017; Renner, Lobbestael, Peeters, Arntz, & Huibers, 2012) and the same was true for the dependency schema (Schmidt, Joinel, Young, & Telch, 1995), abandonment (Glaser, Campbell, Calhoun, Bates, & Petrocelli, 2002; Petrocelli, Glaser, Calhoun & Campbell, 2001; Welburn, Coristine, Dagg, Pontefract, & Jordan, 2002), and failure (Renner et al., 2012) and unrelenting standards (Muris, 2006). In parallel with these results, a study of Australian adults showed that they most intensively experience the schemas of unrelenting standards and self-sacrifice (Martin, Blair, Clark, Rock, & Hunter, 2018).

Consistent with the results with non-clinical sample, a study conducted with depressive individuals showed impaired autonomy to be the most powerful predictor of depression among the schema domains while, pessimism was found to predict depressive symptoms as well (Özdemir, 2015). In a study with Turkish university students, Sarıtaş-Atalar & Gençöz (2015) also found that the correlations between depression and impaired autonomy-other directedness was higher than the correlations with the other schema domains.

Psychological well-being is considered under two sub-dimensions. First, there is the negative measurement of psychological well being: the absence of psychopathology as depression. Second, there is the positive measurement: the presence of life satisfaction. Since EMS are associated with depression and depression is adversely related to life satisfaction (Gündoğar, Gül, Uskun, Demirci, & Keçeci, 2007), It may be postulated that EMS should be negatively associated with life satisfaction as people with high life satisfaction are less associated with psychological problems (Eid & Larsen, 2008). Indeed, several studies have found a negative relation between EMS and life satisfaction (Gök, 2012; Ünal, 2012). In a similar vein, failure and pessimism which are considered sub-components of impaired autonomy have been found to relate negatively to happiness (Yalçın, Ak, Kavaklı, & Kesici, 2018).

To sum up, literature suggests that the negative link between EMS and well-being seems to be quite clear and consistent. Given the existing evidence regarding the relation between EMS and well-being, the rest of the introduction focuses on the variables that may mediate these relations.

1.2. Emotion Regulation Difficulties

Emotion regulation (ER) is the internal and external processes that enable the person to monitor his or her emotional reactions, to evaluate these reactions, and to change them (Thompson, 1994). Similar to this definition, Gross (1998) defines emotion regulation as

one's ability to determine which emotions to experience and how to express them. On the basis of these definitions, Gratz and Roemer (2004) proposed six components of emotion regulation; ability to accept negative emotions (non-acceptance) , ability to inhibit one's own behaviors and move towards a goal in a negative circumstances (goals), ability to control impulsive behaviors (impulse), awareness of what emotion the individual is experiencing in a particular moment (awareness), use of appropriate emotion regulation strategies (strategies), and clarity about which emotion the person has and understanding those emotions (clarity).

According to Schema Therapy (Young et al., 2003), people who can regulate their emotions in a healthy way can better cope with problems they might face in their lives. Gross and Thompson (2007), argue that people regulate not only their negative emotions but also the positive ones. Through emotion regulation a person can either amplify (up-regulate) or reduce (down-regulate) the intensity and the duration of experienced emotions (Gyurak, Goodkind, Kramer, Miller, & Levenson, 2012). For example, if a situation requires a happy mood, one may need to regulate her emotions accordingly– for instance by showing her joy – though she might not in fact feel as happy as the situation may warrant. Typically, emotion regulation aims to increase pleasure and decrease pain through different strategies (Gross, 2001) that may involve either internal or external processes (Gross, 2014). As an example, thinking about something funny while feeling down reflects mainly an internal process, whereas focusing more on the task while being under stress represents more an external process.

While up-regulation strategies aim at exhibiting feelings and thoughts, down-regulation strategies are known to work for hiding our emotions and feelings. In short, people use different emotion regulation strategies such as rumination, distraction, expressive suppression, cognitive reappraisal, acceptance, avoidance and problem solving (Aldao, Nolen-Hoeksema, & Schweizer, 2010), with some of them being more adaptive than some others. As an example, rumination is considered a maladaptive emotional regulation strategy as it has

been found to correlate positively to depression and anxiety (Fresco, Frankel, Mennin, Turk, & Heimberg, 2002) and negatively to life satisfaction (Emmons & King, 1988; McCullough et al., 2001). Likewise, suppression is related to low life satisfaction and higher depressive symptoms (Gross & John, 2003). Also, research has shown that distraction might be more positive than rumination as it relates positively to well-being and life satisfaction (Quoidbach, Berry, Hansenne, & Mikolajczak, 2010; Webb, Miles, & Sheeran, 2012). According to Saxena, Dubey and Pandey (2011), emotion regulation difficulties are negatively associated with mental health. The aggregate score of Difficulties in Emotion Regulation Scale (DERS) was correlated negatively with life satisfaction and correlated positively with depression. In their study, not being able to access appropriate emotion regulation strategies positively predicted depression and not being able to show goal-directed behavior predicted life satisfaction negatively.

Research (e.g., Dadomo et al., 2016) has shown that EMS are associated with emotion regulation difficulties and eventually with psychological ill-being. Similar results have been reported with Turkish female university students (Sapmaz Yurtsever and Tekinsav Sütcü, 2017) where pessimism, abandonment and failure schemas (which are considered sub-components of impaired autonomy in the Turkish culture given in the Turkish version of the EMS questionnaire) (Soygüt, Karaosmanoğlu, & Çakır, 2009) have been found to relate to emotion regulation difficulties. Also a study conducted with people using drugs (Mc Donnell, Hevey, McCauley, & Noel Ducray, 2018), showed that emotion regulation difficulty scores were most predicted by the unrelenting standards and the vulnerability to harm or illness maladaptive schemas.

Emotion regulation difficulties have been found to mediate the relation between EMS and well-being (Eldoğan & Barışkın, 2014). For example, emotion regulation difficulties have been found to mediate the relation of impaired autonomy-other directedness schema domain

to well-being (Yakın, 2015). It has been found the mediating role of emotion regulation difficulties in the relation between Disconnection, Impaired Autonomy and Impaired Limits schema domains and negative outcomes such as social phobia (Eldoğan & Barışkın, 2014).

While trying to regulate their emotions, depressive patients tend to exhibit more frequent use of maladaptive strategies (Joormann & Stanton, 2016). For example, in the study of Millgram and his colleagues (2015), depressed patients tended to direct their attention to "sad images" more than non-depressed patients. We have assessed the relation between EMS and emotion regulation difficulties; a relevant question then, is whether emotion regulation mediates the relation between EMS and well-being not only among clinically diagnosed people but also healthy ones. That is why I have assessed this relation in two groups, studying clinical and non-clinical groups can show us the answer. Particularly, one of the contributions of this study will be determining if emotion regulation difficulties can be a link between EMS and one's psychological well-being in both clinical and non-clinical samples. For the clinical population, duration of the clinic and even the rate of referral to the clinic can decline by giving priority to emotion regulation difficulties in intervention programs.

Research has shown that mood and anxiety disorders relate to both EMS and emotion regulation (Eldoğan & Barışkın, 2014). Namely, depression has been found to positively relate to emotion regulation strategies such as rumination (Desrosiers, Vine, Klemanski, & Nolen-Hoeksema, 2013) and suppression (Joorman & Gotlib, 2010); negatively to cognitive reappraisal (Martin & Dahlen 2005). In contrast, adaptive emotion regulation such as cognitive reappraisal has been found to positively predict life satisfaction (Perrone-McGovern, Simon-Dack, Beduna, Williams, & Esche, 2015). Given past research findings, it is apparent that difficulties in emotion regulation (such as lack of adaptive regulation strategies) may negatively predict life satisfaction and that it may mediate the relation between EMS and life satisfaction. As these issues have not been studied enough, the present

thesis aimed to investigate emotion regulation difficulties as a 'mediator' in the relation between EMS and well-being.

1.3. Perceived Social Support

Another factor that may mediate the relation between EMS and well-being could be the social context, measured as perceived social support. Perceived social support which herein is defined as the resources that a person feels that he or she gets from his or her family, friends, and significant others (Zimet, et al., 1988). According to the social support model (Stice, Ragan & Randall, 2004), lack of perceived parental support predicts future depression, whereas presence of perceived parental support decreases the risk of depression, and the same is true for perceived social support from close relations (Aneshensel & Stone, 1982).

Although perceived social support has not been thoroughly investigated with respect to EMS, it can be assumed that perceived social support can be a linkage that might partly explain the relation between EMS and people's psychological adjustment. One of the explanations which can contribute to this assumption may be that, according to the Self Determination Theory (Deci & Ryan, 2000), satisfactory relationships with significant others has an impact on one's psychological well-being if one has a sense of autonomy and competence. The existence of good and qualified relations in one's life, the feeling of intimacy, and being bonded with someone in life shapes life satisfaction (Kasprzak, 2010). Moreover, high levels of perceived social support seem to ameliorate psychological symptoms and to protect individuals from negative consequences such as depression (Frasure-Smith et al., 2000). In a study conducted with adolescents in Turkey, it was found that perceived family and teacher support predicted depression (Doğan, 2008; Yıldırım, 2004), whereas a meta-analysis conducted in Turkey has revealed a strong positive relation between perceived family support and well-being, and strong negative relation between support from friends and depression (Yalçın, 2014). In line with these results, a few recent studies showed

perceived social support to positively predict life satisfaction among Turkish university students (Topkaya & Büyükgöze Kavas, 2015; Yildiz, 2017) and similar results were found in a study conducted with 892 students from the United States (Shelton, Wang, & Zhu, 2017). Considering all these studies, it is clear that perceived social support is an important factor for mental health. This environmental factor is seen to be associated with both positive mental health (life satisfaction) and negative outcomes (depression).

Harris and Curtin (2002) called for more research investigating whether aspects of perceived social support such as perceived parental care, produce changes in depressive symptoms. This is an important issue because family members who do not provide social support to each other have been found to suffer from psychological symptoms (Goodyer, 1997), while it is known that perceived social support from both families and friends is negatively correlated with stress-related symptoms (Prodicano & Heller, 1983).

It should be noted however that EMS may relate to lower perception of social support. That is, people who may suffer from EMS may hold a distorted perception about the social support they may get from their family and friends. Even so, it can be assumed that perceived social support can be a key factor that could mediate and, thus, explain the relation between EMS and well-being. Therefore, perceived social support should be taken into account while working with individuals who suffer from EMS.

1.4. Cognitive flexibility

Cognitive flexibility (CF) can be defined as the ability to adapt and consider alternatives when encountering a challenging situation. There are two sub-dimensions of cognitive flexibility: first, alternatives, and second, control (Dennis & Vander Wal, 2010). The alternatives component refers to a person's ability to produce other alternatives when faced with difficulties or difficult situations, while the control component refers to a person's ability to have control over difficult situations.

Research has pointed out that individuals who lack cognitive flexibility suffer from depression when encountering stressful life events (Fresco, Rytwinski, & Craighead, 2007) and experience emotion regulation problems (Joormann & D 'Avanzato, 2010). Also, it has been shown that that depressive patients are less capable of shifting their attention from one situation to another (Murphy, Michael & Sahakian, 2012), most likely because cognitive flexibility is one of the executive functions where depressive adults are deficient (Johnco, Wuthrich, Ronald & Rapee, 2015). The negative relation between cognitive flexibility and depression is being further researched (Deveney & Deldin, 2006; Palm & Follette, 2011).

To my knowledge, there is no study testing the relation among cognitive flexibility, EMS and well-being. Indirect evidence that cognitive flexibility relates to well-being is coming also from studies on psychological flexibility. This term refers to being fully conscious in the moment, acceptance, and adaptation, and it is also related to mindfulness (Levin, Hildebrandt, Lillis, & Hayes, 2012). Given that cognitive flexibility and psychological flexibility are closely related (Kashdan & Rottenberg, 2010), some studies have shown that psychological flexibility mediates the relation between EMS and psychopathology (Fischer, Smout & Delfabbro, 2016). Also, research has shown that unrelenting standards and self-sacrifice were found to predict adaptive coping approach (Mc Donnell, Hevey, McCauley, & Noel Ducray, 2018), part of which is considered cognitive flexibility (Elen, Stahl, Bromme, & Clarebout, 2011). Therefore, it can be assumed that cognitive flexibility could mediate the relation between EMS and well-being as well.

In support of this view, a study by Dağ and Gülüm (2013) showed that the control dimension of cognitive flexibility mediated the relation between anxious attachment (which is highly correlated to EMS) and depression. Since attachment relates to EMS, it can be deduced that cognitive flexibility might take a mediator role between EMS and depression. Since cognitive flexibility has been found to have a mediating role in the relation between childhood

experiences and future psychological symptoms (Dağ & Gülüm, 2013), then cognitive flexibility may also act as a mediator between EMS and aspects of well-being, such as life satisfaction and depression. Indeed, in a recent study (Çikrikci, 2018), life satisfaction has been found to relate positively to the alternatives sub-domain and negatively to the control sub-domain of cognitive flexibility. As Cikrikci argued, through cognitive flexibility people can reach their goals more easily and thus experience more life satisfaction.

Cognitive therapy emphasis on cognitive components in the treatment of depression (Alford & Beck, 1998). At the same time, cognitions are related to the schemas of one's life (Young et al., 2003). That is why while working on psychological well-being issues, enough importance should be given in the area of cognitive factors. Since cognitive flexibility is linked with finding alternatives as a coping skill, this variable was choosen apart from other cognitive variables (such as metacognition) as a mediator. Because, it has been known that coping skills are linked with mental health (Frydenberg, Care Freeman, & Chan, 2009).

People who suffer from EMS may have deficits in cognitive flexibility. For example, because they may not easily think of alternative solutions when facing a difficult situation, they may be unable to achieve their goals, and thus to experience lower life satisfaction. Therefore, when people have some certain EMS, this can be linked to cognitive flexibility and cognitive flexibility can also be linked to adults' psychological well-being. It is highly likely, therefore, that cognitive flexibility may act as a mediator of the relation between maladaptive schemas and well-being. Given that such an assumption linking EMS with life satisfaction or depression through cognitive flexibility has not been extensively studied, this issue has been investigated in this thesis.

1.5. The Present Study

In this thesis, I aimed to investigate the relationship between EMS and well-being (represented through depression and life satisfaction) among Turkish emerging adults. More importantly, I also aimed to find out to what extent certain psychological mechanisms or processes may mediate the relation between maladaptive schemas and psychological well-being. In particular, I aimed to investigate the likely mediating role of perceived social support, emotion regulation difficulties and cognitive flexibility in the relation between EMS and well-being.

In addition, I aimed to examine whether the same pattern would exist between healthy, non-clinical participants and participants who have been referred for clinical support. Thus, two different samples have been used. Given the difficulty to reach clinical samples, and the fact that most studies rely on non-clinical population samples, this thesis tries to test whether the relations that are typically reported in studies using non-clinical participants exist as well among participants who are referred for psychological problems such as depression, anxiety and adjustment disorders.

This is an important issue because it is known that people with psychological disorders, such as depressive symptoms, frequently use various maladaptive strategies such as rumination (Joormann & Stanton, 2016). In this thesis, it was aimed to see if schema domains relate to emotion regulation problems which can result in negative outcomes such as depression. The findings of the study may help us in the clinical area; it can also help in the therapy process to focus more on emotion regulation difficulties. For example, a therapist may more effectively help a person with EMS who suffers from depressed feelings if he or she puts more emphasis on the use of effective emotion regulation strategies, for example, by training the patient to accept his or her emotions or be aware of that emotion in a particular moment.

Interestingly, a linkage between EMS and perceived social support has not been extensively studied. In addition, the existence of schemas may relate to perceived social support; in other words, people may perceive less social support than they actually get. Because of this they are expected also to experience more depressive feelings and lower life satisfaction. So that, investigating the mediating role of perceived social support between EMS and the outcomes could be informative for the clinicians.

The association between cognitive flexibility and depression is well known but, to my knowledge, no study has directly examined whether cognitive flexibility might explain the relation between EMS and depression or life satisfaction. Cognitive flexibility has been found to be a mediator between childhood experiences (specifically, attachment history) and future psychological symptoms (Dağ & Gülüm, 2013). As mentioned before, the origin of EMS also comes from an individual's attachment history; therefore, it is postulated that cognitive flexibility may hold a mediator role between EMS and psychological well-being. Whether there is such an explanatory factor in that specific relation or not is an important question. If cognitive flexibility can arise as an explanatory factor, then intervention programs may need to aim at cognitive flexibility, alongside schema focused therapies. Such a mediation process will indicate that whether these two factors are important to one's psychological well-being and whether both should be considered as constructs that should be treated during psychotherapy.

Since it is known that EMS predict one's future social interactions and maladjustment (Kobak & Sceery, 1988), we can better predict people's future adjustment by looking at their EMS and the likely explanatory factors that may give us further information about this relation. This study aims to be instrumental in developing a preventive intervention plan.

It is important to highlight that, in this thesis, only three of the five schema domains; the impaired autonomy, other-directedness, and unrelenting standards schema domains that

are found to be mostly related to depression in the Turkish adaptation of Young Schema Questionnaire Short Form-3 (Soygüt et al., 2009) are used.

The hypotheses of this study are as follows:

1- All schema domains would be associated positively with depression and negatively with life satisfaction both for non-clinical sample and clinical sample.

2- EMS would be related negatively to perceived social support and cognitive flexibility and positively to emotion regulation difficulties both for non-clinical sample and clinical sample.

3- Depression scores would relate positively to emotion regulation difficulties. In contrast, depression scores would relate negatively to perceived social support and cognitive flexibility both for non-clinical sample and clinical sample.

4- Life satisfaction relates positively to perceived social support and cognitive flexibility and negatively to emotion regulation difficulties both for non-clinical sample and clinical sample.

5- As for cognitive flexibility, emotion regulation difficulties and perceived social support; it was expected that they would mediate the relation between EMS and life satisfaction, and also between EMS and depression both for non-clinical sample and clinical sample.

CHAPTER 2

METHOD

2.1. Participants and Procedure

Data were collected from two samples. The first sample included 286 emerging adults who were mostly students from different universities in Ankara, with their ages ranging between 18-22 years (*M* = 20.43 years old, *SD* = 1.13). Two hundred and twenty participants were female (76.9 %) and 66 participants were males (23.1 %). After getting permission from the lecturer of the class, the paper-based survey was given to the students before or after the classes. After they finished, the surveys were collected by the author of this thesis.

The second sample consisted of 106 clinically diagnosed participants. Their age was ranging between 18 to 22 years (*M* = 20.33 years old, *SD* = 1.35), with 56 of them being females (52.8 %) and 49 being males (46.2 %), while one participant did not mention his/her gender. 33 of the clinical sample had been diagnosed as anxiety disorders, 22 as depression disorders, 15 as both depression and anxiety, 17 as adjustment disorder, 6 as personality, four as obsessive-compulsive. The remaining 9 participants had been diagnosed as environmental or acute stress, neurotic, dissociative disorder. Diagnoses that did not fall under the category of neuroticism were excluded from the study. For instance, schizophrenia and bipolar disorder were not included. Participants in the clinical sample were all diagnosed based on interviews with psychiatrists. The clinical sample participants included both in patients (21 patients) and out patients (85 patients) of Gülhane Training and Research Hospital. They all completed the survey by the supervision of the researcher. Although information about the duration of diagnosis and medication might have some impact on the clinical group, due to the busy schedule of the clinic it was not possible for the researcher to collect these informations. However, as a general information, it has been known that 30% of the clinical sample was

coming to intake interview and 70% was control patients. In the clinical sample, 80% of the patients were using medications.

Before the participants filled out the consent form (see appendix A) it was made clear to them that their participation would be on a voluntary basis, that their response would remain anonymous and confidential and that there would be no wrong or right answers. Permission to conduct the study was obtained from the ethics committee of TED University.

2.2. Materials

2.2.1. Demographic form. The first section included questions that referred to participants' age, gender, education, perceived socio-economic status, marriage status and families' education level (see appendix B).

2.2.2. Young Schema Questionnaire. The 90-item short version of the Young Schema Questionnaire which was developed within the scope of Schema Therapy was used (Young et al., 2003). The questionnaire is in a 6-point Likert-type format and ranges from 1 to 6 (*1= completely untrue of me; to 6= describes me perfectly*). When comparing two versions (short and the long version) of the questionnaire it can be said that both have similar psychometric properties, and both can be used in a clinical area (Waller, Meyer, & Ohanian, 2001). The short version of the scale has 18 different EMS under 5 domains: disconnection/rejection, impaired autonomy and performance, impaired limits, other-directedness and over-vigilance and inhibition (Young et al., 2003). Higher scores in a schema show the possible relation related to that specific schema area.

A study of the validity and the reliability of the Turkish version of the questionnaire was conducted by Soygüt et al. (2009). In Turkey, 5 schema domains are seen to cover 14 EMS: Emotional Deprivation, Failure to Achieve, Pessimism, Social Isolation/ Mistrust, Emotional Inhibition, Approval-Seeking, Dependence/Incompetence, Insufficient Self Control/Entitlement, Self-Sacrifice, Abandonment, Punitiveness, Defectiveness, Vulnerability

to Harm, and Unrelenting Standards. The internal consistency coefficient for the sub-scales was found to range from α = .63 to .80, and for the schema domains it ranged from α = .53 to .81. Test re-test reliability for schema sub-scales was found as r = .66-.83; for schema domains r = .66-.82 (Soygüt et al., 2009). In this thesis, the Cronbach alpha for the total scale was found as .94.

For the purposes of the current study, only the subscales of impaired autonomy, other-directedness and unrelenting standards were considered and analyzed (Soygüt et al., 2009). The first domain is called impaired autonomy and refers to problems about separation, functioning independently, and performing successfully. The domain had a Cronbach alpha of .94 and included the sub-domains of enmeshment/dependence (9 items; e.g., "I do not feel capable of getting by on my own in everyday life."; a = .85*)*, abandonment (5 items; e.g., "I need other people so much that I worry about losing them."; a = .90*)*, failure (6 items; e.g., "I'm incompetent when it comes to achievement."; a = .84*)*, pessimism (5 items; e.g., "I can't seem to escape the feeling that something bad is about to happen", *a = .90),* and vulnerability to harm or illness (5 items; e.g., "I worry about being physically attacked by people" , *a = .76*).

The second domain is called unrelenting standards and refers to having high standards to avoid criticism. This domain had a Cronbach alpha of α = .84, and consisted of the sub-domains of unrelenting standards (3 items, e.g., "I must be the best at most of what I do; I can't accept second best" *a = .78),* and approval-seeking (6 items, e.g., "Accomplishments are most valuable to me if other people notice them", *a = .81).*

The third and last schema domain that was considered in this thesis was other-directedness, which represents one's focusing on desires, feelings and responses of others to gain love and acceptance. The Cronbach alpha was .81. The sub-domains of other-directedness are self-sacrifice (5 items, e.g., "I am the one who usually ends up taking care of

the people I am close to", *a = .78),* and punitiveness (6 items, e.g., "If I make a mistake, I deserve to be punished" *a = .79).*

Unlike the English version, as mentioned above, I considered abandonment and pessimism as parts of impaired autonomy; punitiveness as part of other-directedness; unrelenting standards and approval-seeking as parts of unrelenting standards schema domain given the previous research findings conducted with Turkish participants (Soygüt et al., 2009).

The correlation coefficient for the sub-categories of impaired autonomy ranges from r = .52 to r = .67, and so these sub-domains are taken under the domain of impaired autonomy. The correlation between unrelenting standards and approval-seeking is r = .49; thus, these sub-domains are taken together under the domain of unrelenting standards (Soygüt et al., 2009). The correlation between self-sacrifice and punitiveness is r = .35 and, according to Soygüt et al. (2009), the two sub-domains belong to the same class. For these reasons, these sub-domains are taken together under the domain of other-directedness (see appendix C).

2.2.3. Difficulties in Emotion Regulation. The Difficulties in Emotion Regulation Scale (DERS-16; Bjureberg et al., 2016) was used to measure difficulties in emotional regulation. The scale has 16 Likert-type items with 5 points (1 = *Almost never*, 5 = *Almost always*). The adaptation study in Turkish was conducted by Yiğit and Yiğit (2017) and the internal consistency coefficient was found as .92. The subscales of the DERS-16 show high internal consistency with alpha coefficients ranging from .78 to .87. The scale includes 5 subscales; (1) lack of clarity of emotional responses (2 items; e.g. "I am confused about how I feel" *(a =.86))* (2) non-acceptance of emotional responses (3 items; e.g., "When I'm upset, I feel like I am weak" (*a = .79))* (3) limited access to effective strategies (5 items; e.g., "When I'm upset, I start to feel very bad about myself" *(a =.89))* (4) difficulties in controlling impulses when experiencing negative affect (3 items; e.g., "When I'm upset, I feel out of

control" *(a = .87))*, and (5) difficulties in engaging goal directed behavior when experiencing negative affect (3 items; e.g., "When I'm upset, I have difficulty getting work done" *(a =.86))*. The correlation between sub-scales ranged from .37 to .73 for this study. The original scale has been found to yield a high internal consistency (α = .92) (Bjureberg et al., 2016), something which was also true for the present study (α = .94). High scores on the scale implied more difficulties in emotion regulation (see appendix D).

2.2.4. Perceived Social Support. The multidimensional perceived social support scale is a 7-point Likert-type self-report measure of perceived social support and has 12 items (Zimet et al., 1988). The scale consists of 3 subscales, with each of them consisting of 4 items that refer to the social support that a person believes he or she enjoys from his or her family, friends and significant others. In this study, only the friend and family sub-groups have been measured in order to keep the survey short. The original scale was developed by Zimet et al. (1988) who found the reliability to be .88 and the test re-test value was .85. The scale was adapted to the Turkish context by Eker and Arkar (1995). In their study, the internal consistency coefficient was found to be between .77 and .92 across different sample groups, a result which indicates good internal consistency. Perceived social support has been measured in terms of perceived social support from family (*a = .88) (*"*My family really tries to help me*"*)* and friends (*a = .92) (*"*I can count on my friends when things go wrong*"*)*. Also, the correlation between family and friend sub-groups was *r* = .48. In this study, internal consistency was found as .88. On the basis of the responses on the scale, the sum of the scores of each subgroup was taken into consideration; the higher the score obtained, the higher social support was assumed (see appendix E).

2.2.5. Cognitive Flexibility. The cognitive flexibility inventory has been developed by Dennis and Vander Wal (2010) to determine the ability of people to produce alternative, appropriate and harmonious thinking in the face of difficult situations. An adaptation study of

this inventory for Turkish people was done by Gulum and Dag (2012). In the adaptation study, the internal consistency coefficients obtained with the Cronbach alpha for all cognitive flexibility inventory, alternatives and control subscales and found as following; .90, .89 and .85, respectively. The scale contains twenty 5-point Likert-type items that comprise two subscales. The first subscale refers to searching for the ability to produce solutions in difficult situations: alternatives sub-scale (13 items; e.g., "I consider multiple options before making a decision"; a = .90*)* and the other subscale refers to faith in the ability of people to control difficult situations: control sub-scale (7 items; "When I encounter difficult situations I feel like I am losing control"; a = .83*)*. High scores imply high cognitive flexibility (possible points are between 20-100). Given that the correlation between the two sub-scales was found to be *r* = .42, the two sub-scales were combined to give a single measure of cognitive flexibility. Gulum and Dag (2012) have provided evidence for the concurrent validity of the scale, which means this scale has been successfully adapted (see appendix F).

2.2.6. Satisfaction with Life. A scale capturing satisfaction with life was developed by Diener, Emmons, Larsen and Griffin (1985) in order to determine the satisfaction which is received from life. The scale is based on participants' general and subjective assessments of their own lives. The Turkish version of the scale was made by Köker in 1991 (as cited in Çivitçi, 2012). The scale has five items and it is based on a 7-point Likert type (1 = *Strongly disagree*, 7 = *Strongly agree*). On the scale, there are such items as "I am satisfied with my life" and "In most ways my life is close to my ideal" (as cited in Çivitçi, 2012). An increase in the scores indicates an increase in general life satisfaction of the individual. In the Turkish form of the scale, the item-test correlation varies between .71 and .80. In this study, the internal consistency coefficient was found as .84 (see appendix G).

2.2.7. Depression. The Beck Depression Inventory is a self-report instrument which tries to measure depression from the emotional, cognitive and motivational perspective (Beck,

Steer and Garbin, 1988). The scale consists of 21 items with likert 4 type which participants can choose based on intensity *(example for option a:* "*I don't feel I am being punished* ", *option b:* "*I feel I may be punished* ", *option c:* "*I expected to be punished* "*option d:* "*I feel I am being punished* "*).* High scores from the scale indicate more severe depressive symptoms. Participants who score between 0 and 9 points are considered not depressed; those who score between 10 and 18 are considered mildly depressed, those between 19 and 25 points are considered moderately depressed, and those with a score of 26 or more are considered severely depressed (Beck et al., 1988). The internal consistency coefficient was found to be .86 for the psychiatric sample, and .81 for the normal population. (Beck, Steer, & Garbin, 1988). The Turkish adaptation of inventory was conducted in the doctorate thesis of Tegin in 1980 (as cited in Hisli, 1989) and further statistical analysis (reliability and validity) was conducted by Hisli (1988; 1989). In the present study the Cronbach alpha was $\alpha = .94$ (see appendix H). It is also worth mentioning that depression is highly comorbid with anxiety disorders (Brown et al., 2010; Kaufman & Charney, 2000). Beck Depression Inventory is also measuring anxious symptoms. It was an appropriate material to use in the current study since the clinical sample includes the individuals with comorbidity of depression and anxiety disorders.

CHAPTER 3

RESULTS

The results section will explain descriptive statistics and the correlation analyses for the measured variables, followed by regression analyses and the associated mediation tests.

3.1. Descriptive Statistics and Correlations of the Measured Variables in The Study

Table 2 illustrates means, standard deviations and Table 3 illustrates Pearson correlations among all the measured variables of the study and separated by sub-groups (clinical and non-clinical). As can be seen from the Table 3, most of the variables (except age and gender) were positively correlated to each other.

3.1.1. Correlations for the Clinical Sample

As concerns the clinical sample, unrelenting standards were correlated positively with difficulties in emotion regulation and with depression, and correlated negatively with perceived social support. Thus, people who had high scores on unrelenting standards scored also high in emotion regulation difficulties and depression and low in perceived social support. However, the Pearson's correlation between unrelenting standards and cognitive flexibility and life satisfaction was non-significant.

Table 2.

Means (M) and Standard deviations (SD) of the Measured Variables of the Study among Clinical Sample and Non-Clinical Sample

	Non-Clinical Sample		Clinical Sample	
Variables	*M*	*SD*	*M*	*SD*
1. Age	20.43	1.13	20.33	1.34
Predictors				
2. Unrelenting Standards	3.22	0.98	3.68	1.07
3. Impaired Autonomy	1.95	0.64	2.82	1.08
4. Other-directedness	3.26	0.80	3.71	1.06
5. Cognitive Flexibility	3.78	0.53	3.40	0.70
6. Emotion Regulation	2.49	0.81	3.29	0.97
7. Social Support	5.58	1.10	4.49	1.73
Correlates				
8. Depression	1.57	0.47	2.23	0.63
9. Life Satisfaction	2.88	0.85	2.26	0.95

Note. Gender was dummy-coded as 1 = female; 2 = male

Table 3.

Bivariate Correlations of the Measured Variables of the Study among Clinical Sample (Upper Diagonal) and Non-Clinical (Lower Diagonal)

Variables	1	2	3	4	5	6	7	8	9
1. Age	-	-.00	-.06	.08	-.00	-.16	.12	-.19	**.24***
Predictors									
2. Unrelenting Standards	**-.16****	-	**.38****	**.41****	-.12	**.28****	**-.21***	**.21***	.02
3. Impaired Autonomy	-.04	**.44****	-	**.39****	**-.55****	**.65****	**-.35****	**.62****	**-.45****
4. Other-directedness	-.07	**.44****	**.51****	-	.10	**.24***	-.17	**.21***	-.04
5. Cognitive Flexibility	.03	**-.23****	**-.52****	**-.22****	-	**-.52****	**.22***	**-.48****	**.46****
6. Emotion Regulation	-.03	**.38****	**.63****	**.39****	**-.51****	-	**-.28****	**.63****	**-.48****
7. Social Support	-.03	-.05	**-.28****	**-.12***	**.26****	**-.26****	-	**-.46****	**.51****
Correlates									
8. Depression	.08	**.24****	**.59****	**.35****	**-.42****	**.63****	**-.37****	-	**-.53****
9. Life Satisfaction	-.11	-.09	**-.33****	**-.15***	**.37****	**-.30****	**.30****	**-.47****	-

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

Other-directedness schema domain was correlated positively with difficulties in emotion regulation and depression but had no correlation with cognitive flexibility, perceived social support and life satisfaction. These correlations suggest that people who scored high in other-directedness schema domain were more likely scored higher on emotion regulation difficulties and depression too.

Impaired autonomy schema domain was significantly correlated with all the study variables. Namely, it was correlated negatively with cognitive flexibility, perceived social support and life satisfaction and positively with emotion regulation difficulties and depression. Therefore, it could be said that impaired autonomy was the most problematic schema domain as it was correlated positively with negative concepts (such as difficulties in emotion regulation and depression), and negatively with positive ones (such as cognitive flexibility, perceived social support and life satisfaction).

As concerns cognitive flexibility, this was correlated negatively with depression, and positively with life satisfaction. A similar pattern was found for perceived social support, which was correlated negatively with depression and positively with life satisfaction. In contrast, difficulties in emotion regulation were correlated positively with depression and negatively with life satisfaction. Accordingly, as the level of cognitive flexibility increases, life satisfaction also increases while depression decreases. Similarly, as perceived social support increases, life satisfaction increases, and depression decreases with it. Moreover, while the levels of emotion regulation difficulties increase, the level of depression increases also, while life satisfaction decreases.

3.1.2. Correlations for the Non-Clinical Sample

The results are given were for clinical sample. From now on, the correlations for the non-clinical sample will be presented. Unrelenting standards was correlated positively with difficulties in emotion regulation and depression. Also, it was correlated negatively with

cognitive flexibility. However, the relation of unrelenting standards to perceived social support and life satisfaction was non-significant. In this respect, participants in the non-clinical sample who were higher in unrelenting standards found to be also higher in emotion regulation difficulties and depression, in contrast their cognitive flexibility was lower.

Non-clinical sample results for the other-directedness schema domain had some differences compared with the results for the clinical sample, as in the non-clinical sample it was correlated negatively with cognitive flexibility, perceived social support, and life satisfaction. On the other hand, other-directedness was found to be correlated positively with difficulties in emotion regulation and depression. This indicates that participants who are higher in other-directedness schema may also have more problems with emotion regulation and higher depression scores, less cognitive flexibility, less perceived social support and less life satisfaction.

Impaired autonomy schema domain was significantly correlated with all the study variables. It was correlated negatively with cognitive flexibility, perceived social support and life satisfaction. On the other hand, impaired autonomy was found to be correlated positively with difficulties in emotion regulation and depression. According to these results, people who scored high in impaired autonomy exhibited lower levels of cognitive flexibility, perceived social support and life satisfaction; however, these people got higher scores on emotion regulation difficulties and depression.

Depression was correlated negatively with cognitive flexibility and perceived social support, and positively with difficulties in emotion regulation. Life satisfaction was correlated positively with cognitive flexibility and perceived social support; however, it was correlated negatively with difficulties in emotion regulation. That means high depression scores are more related to higher scores in emotion regulation problems, but lower scores in perceived social support and cognitive flexibility. However, it also highlights that people who are more

satisfied with their lives have a tendency to show cognitive flexibility, feel more social support, and tend to show less emotion regulation difficulties.

Table 4.

A Hierarchical Regression Analysis for Depression and Life Satisfaction for the Clinical and Non-Clinical Sample

Predictors	Depression						Life satisfaction					
	Clinical			Non-clinical			Clinical			Non-clinical		
	B	*SE*	B	*B*	*SE*	B	*B*	*SE*	B	*B*	*SE*	B
Step 1												
1. Age	-0.07	0.04	-.15	0.03	0.02	.08	0.14	0.06	**.20***	-0.10	0.04	**-.13***
2. Gender	0.09	0.10	.07	0.10	0.05	.09	-0.01	0.17	-.00	0.14	0.12	.07
3. Impaired autonomy	0.37	0.05	**.64****	0.41	0.04	**.56****	-0.45	0.09	**-.52****	-0.47	0.09	**-.36****
4. Unrelenting standards	0.00	0.05	.00	-0.02	0.03	-.03	0.14	0.09	.16	0.04	0.06	.05
5. Other-directedness	-0.00	0.05	-.00	0.04	0.03	.08	0.04	0.09	.05	-0.02	0.07	-.02
F change	F(5, 95) = 15.28**			F(5, 278) = 31.21**			F(5, 95) = 6,82**			F(5, 277) = 8.72**		
Adjusted R^2	0.42			0.35			0.23			0.12		
Step 2												
1. Age	-0.05	0.03	-.11	0.03	0.02	.08	0.11	0.06	0.15	-0.10	0.04	**-.13***
2. Gender	0.12	0.09	.10	0.06	0.05	.05	-0.00	0.15	-.00	0.21	0.11	.11
3. Impaired autonomy	0.16	0.07	**.27***	0.19	0.05	**.26****	-0.10	0.11	-.11	-0.18	0.11	-.13
4. Unrelenting standards	-0.02	0.05	-.04	-0.03	0.02	-.07	0.20	0.08	**.22***	0.04	0.06	.05
5. Other-directedness	0.03	0.05	.05	0.04	0.03	.06	-0.02	0.08	-.02	-0.03	0.07	-.03
6. Cognitive flexibility	-0.13	0.08	-.14	-0.05	0.05	-.05	0.32	0.14	**.23***	0.36	0.11	**.22****
7. Emotion dysregulation	0.21	0.06	**.33****	0.23	0.03	**.39****	-0.22	0.10	**-.23***	-0.08	0.08	-.08
8. Perceived social support	-0.08	0.03	**-.21****	-0.07	0.02	**-.17****	0.21	0.05	**.38****	0.15	0.05	**.19****
F change	F(3, 92) = 9.22**			F(3, 275) = 25.42**			F(3,92) = 12.83**			F(3,274) = 10.91**		
Adjusted R^2	0.54			0.48			0.44			0.21		

Note. * p< .05, ** p< .01, Gender was dummy-coded as 1 = female; 2 = male

3.2. Regression Analyses

Two-step hierarchical regression analyses were conducted for the two dependent variables and for each sample separately. These analyses are shown in Table 4. Specifically, in Step 1, age and gender were included as covariates along with the three schema domains. In Step 2, the three variables that were hypothesized to serve as mediators (i.e., cognitive flexibility, emotion regulation difficulties, and perceived social support) were included.

3.2.1. Regression Analyses for Depression

In the non-clinical group, impaired autonomy schema domain was a significant predictor of depression in Step 1; in addition to impaired autonomy, both perceived social support and emotion regulation difficulties were significant predictors of depression in Step 2. The same pattern was found also in the clinical group.

3.2.2. Regression Analyses for Life Satisfaction

Next, life satisfaction was regressed on the same predictors as before. For the non-clinical sample, age and impaired autonomy were significant predictors of life satisfaction in the first step. However, in the second step, impaired autonomy became non-significant, while cognitive flexibility and perceived social support emerged as significant predictors of life satisfaction. In the clinical sample, age and impaired autonomy were again significant predictors in the first step; however, when the three potential mediators were added in Step 2, unrelenting standards became significant predictors of life satisfaction, along with cognitive flexibility, social support and emotion regulation difficulties.

The regression model implies mediating effects of cognitive flexibility, emotion regulation difficulties and perceived social support in the relation of the three schema domains to the two outcomes (i.e., depression and life satisfaction). The focus was especially on impaired

autonomy, given that it was the sole predictor of the two outcomes in Step 1 and that its relation to these outcomes became weaker and sometimes even non-significant when cognitive flexibility, emotion regulation difficulties and perceived social support were entered in Step 2.

3.3. Mediation Analyses

The Hayes' Process (2013) statistical approach was used to test a mediator role of cognitive flexibility, emotion regulation difficulties and perceived social support in the relation between EMS and depression as well as life satisfaction. For both groups (i.e., clinical and non-clinical samples), each of the two dependent variables (i.e., depression and life satisfaction) was first regressed in Step 1 on one particular schema domain at a time (e.g., impaired autonomy), followed in Step 2 by the three mediators (i.e., cognitive flexibility, emotion regulation difficulties, and perceived social support). In all analyses, age, gender and the other two schema domains were entered as covariates. In that way, it was possible to examine the unique contribution of each schema and each of the three mediators in the explanation of variance of depression and life satisfaction, after controlling for age and gender differences.

3.3.1. Mediation Analyses for the Non-Clinical Sample

3.3.1.1. Impaired Autonomy and Depression

As shown in Figure 2 (and in Table 4) when depression was regressed on impaired autonomy without the mediators the relation was statistically significant (see Table 4 and Figure 2) (b = 0.41, SE = 0.04, t = 9.69, p < .001; 95 % CI [.326, 492]). Also, as can be noticed, impaired autonomy was related negatively to cognitive flexibility (b = -0.44, SE = 0.05, β = -0.53) and perceived social support (b = -0.55, SE = 0.12, β = -0.32) and positively to emotion regulation difficulties (b = 0.70, SE = 0.07, β = 0.55). When depression was regressed on impaired autonomy and the mediators (after controlling for the covariates), emotion regulation

difficulties was positive predictor (b = 0.23, SE = 0.03, β = 0.39) and perceived social support was negative predictor (b = -0.07, SE = 0.02, β = -0.17) of depression. Furthermore, the direct effect of impaired autonomy on depression was also significant, but lower than in the model without the three mediators (b = 0.19, SE = 0.05, t = 4.14, p < .001; 95 % CI [.100, .283]). This finding suggests that the two mediators (emotion regulation difficulties and perceived social support) mediated the relation between impaired autonomy and depression in the non-clinical group. The indirect effect for emotion regulation difficulties was positive as its 95% confidence interval did not include the zero (a_2* b_2 = 0.16, SE = 0.03; 95 % CI [.105, .224]) and the same was true for perceived social support (a_3* b_3 = 0.04, SE = 0.02; 95 % CI [.013, .080]) but for cognitive flexibility, 95% confidence interval included zero (a_1* b_1 = 0.02, SE = 0.02; 95 % CI [-.024, .065]). The full model accounted for 50% of the variance in depression and the model was statistically significant (F (8, 275) = 34.17, p < .001).

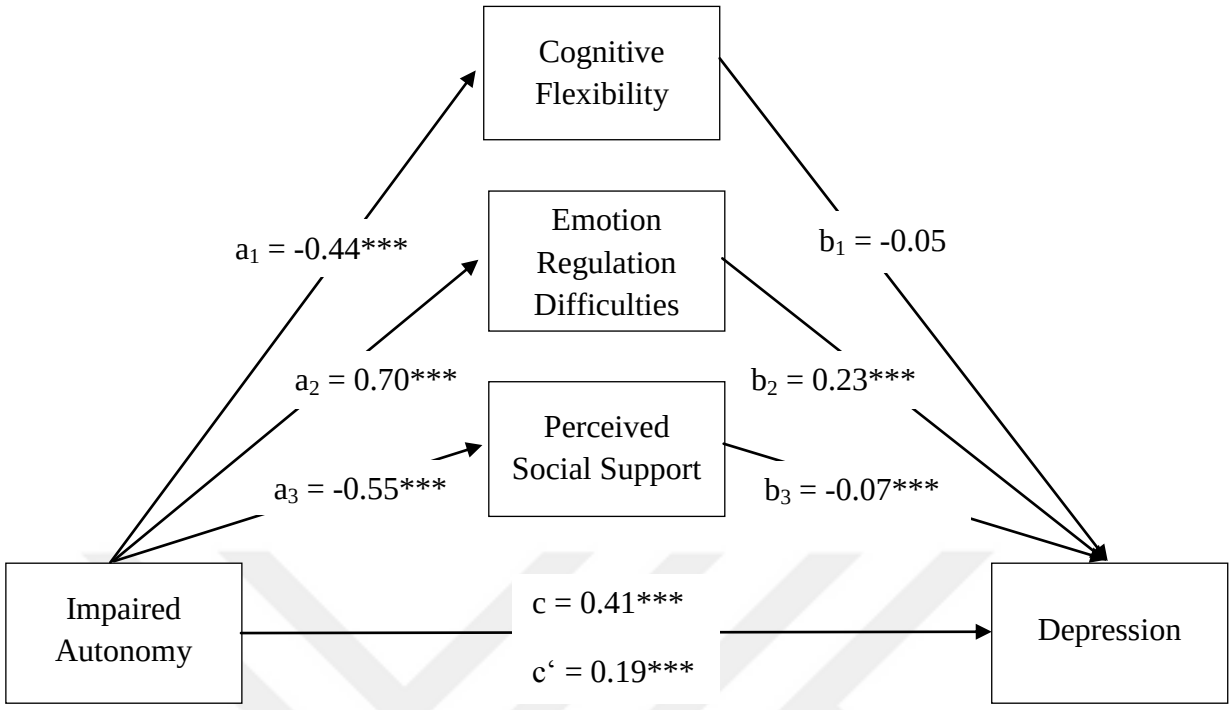

Figure 2. Regression coefficients for the relation between Impaired Autonomy (IA) and Depression (DEA) in Non-Clinical Group as mediated by Cognitive Flexibility, Emotion Regulation Difficulties, Perceived Social Support and controlled for age, gender, Unrelenting standards and Other-directedness. ***$p < .001$, * $p < .05$

3.3.1.2. Impaired Autonomy and Life Satisfaction

As can be seen in Figure 3 (and in Table 4) when life satisfaction was regressed on impaired autonomy without the mediators the relation was statistically significant (b = -0.47, SE = 0.09, t = -5.31, $p < .001$; 95 % CI [-.650, -.298]). When life satisfaction was regressed on impaired autonomy and the mediators (after controlling for the covariates), cognitive flexibility (b = 0.36, SE = 0.11, β = 0.22) and perceived social support (b = 0.15, SE = 0.05, β = 0.19) was positive predictors of life satisfaction. However, the direct effect of impaired autonomy on depression was non-significant (b = -0.18, SE = 0.10, t = -1.71, $p > .05$; 95 % CI [-.385, 027]), which shows us that cognitive flexibility and perceived social support mediated the relation between impaired autonomy and life satisfaction. The indirect effect for both cognitive flexibility

(a_1* b_1 = -0.16, *SE* = 0.05; 95 % *CI* [-.267, -056]) and for perceived social support (a_3* b_3 = -0.08, *SE* = 0.03; 95 % *CI* [-.155, -.032]) was negative as their 95% confidence interval did not include zero. For emotion regulation difficulties, 95% confidence interval included zero (a_2* b_2 = 0.06, *SE* = 0.06; 95 % *CI* [-174, .055]). The full model explained 23% of the variance in life satisfaction and the model statistically was significant (*F* (8, 274) = 10.12, $p < .001$).

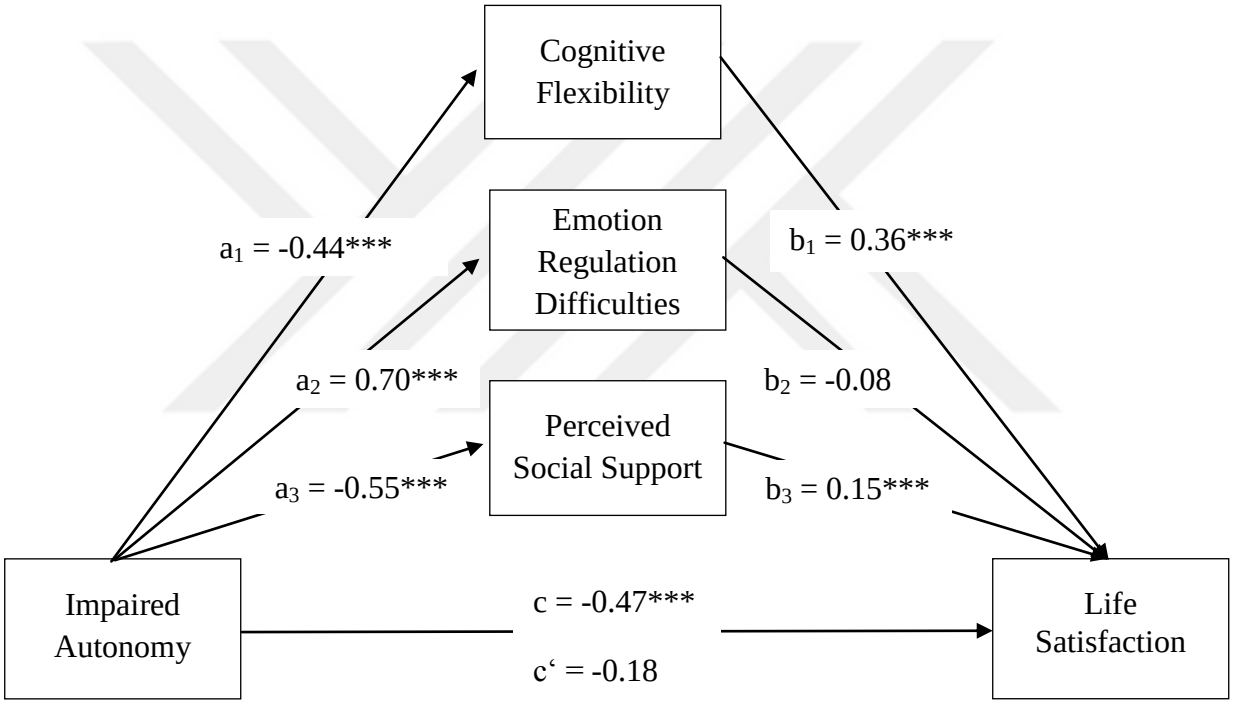

Figure 3. Regression coefficients for the relation between Impaired Autonomy (IA) and Life Satisfaction (LF) in Non-Clinical Group as mediated by Cognitive Flexibility, Emotion Regulation Difficulties, Perceived Social Support and controlled for age, gender, Unrelenting standards and Other-directedness. ***$p < .001$, * $p < .05$

3.3.1.3. Unrelenting Standards and Depression

Figure 4 illustrates that unrelenting standards were related positively to emotion regulation difficulties (*b* = 0.10, *SE* = 0.04, β = 0.12). When depression was regressed on unrelenting standards and the mediators (after controlling for the covariates), emotion regulation

difficulties was positive predictor (*b* = 0.23, *SE* = 0.03, β = 0.39) and perceived social support was negative predictor (*b* = -0.07, *SE* = 0.02, β = -0.17) of depression. When depression was regressed on unrelenting standards without the mediators the relation was statistically non-significant (*b* = -0.02, *SE* = 0.03, *t* = .60, *p* > .05; 95% *CI* [-.069,.037]) which indicates that cognitive flexibility, emotion regulation difficulties and perceived social support did not mediate the relation between unrelenting standards and depression. The 95% confidence intervals included zero for the indirect effects.

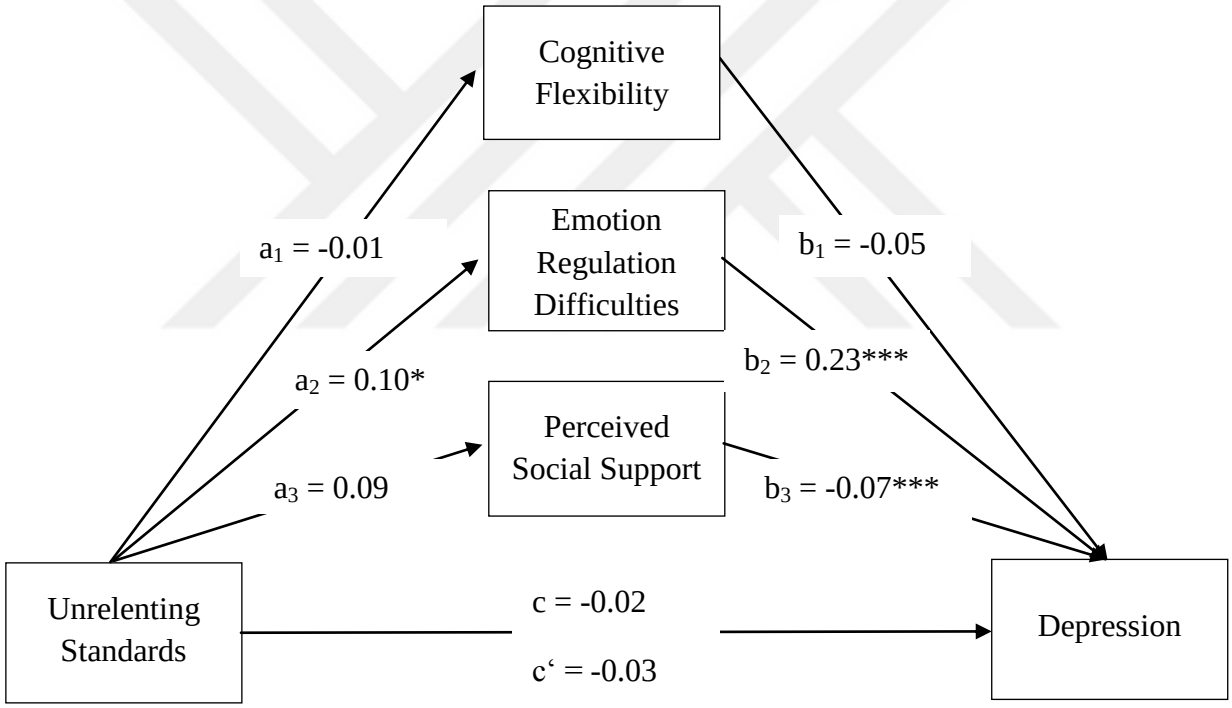

Figure 4. Regression coefficients for the relation between Unrelenting standards (US) and Depression (DEA) in Non-Clinical Group as mediated by Cognitive Flexibility, Emotion Regulation Difficulties, Perceived Social Support and controlled for age, gender, Impaired Autonomy and Other-directedness. ***$p < .001$, * $p < .05$

3.3.2. Mediation Analyses for the Clinical Sample

3.3.2.1. Impaired Autonomy and Depression

As Figure 5 shows (and Table 4) when depression was regressed on impaired autonomy without the mediators the relation was statistically significant in the clinical sample (b = 0.37, SE = 0.05, t = 7.17, p <.001; 95 % CI [.267, .472]). Also, the model showed that impaired autonomy was related negatively to cognitive flexibility (b = -0.45, SE = 0.06, β = -0.70) and perceived social support (b = -0.36, SE = 0.17, β = -0.23) and positively to emotion regulation difficulties (b = 0.62, SE = 0.08, β = 0.67). When depression was regressed on impaired autonomy and the mediators (after controlling for the covariates), emotion regulation difficulties was positive predictor (b = 0.21, SE = 0.06, β = 0.33) and perceived social support was negative predictor (b = -0.08, SE = 0.03, β = -0.21) of depression. Moreover, the direct effect of impaired autonomy on depression was also significant, but lower than in the model without the three mediators (b = 0.16, SE = 0.07, t = 2.43, p < .05; 95 % CI [.029, .287]), suggesting that three mediators mediated the relation between impaired autonomy and depression for the clinical group. The indirect effects were positive for both emotion regulation difficulties (a_2* b_2 = 0.13, SE = 0.04; 95 % CI [.056, .235]) and perceived social support as their 95% confidence interval did not include zero (a_3* b_3 = 0.03, SE = 0.02; 95 % CI [.000, .089]); but for cognitive flexibility, 95% confidence interval included zero (a_1* b_1 = 0.06, SE = 0.03; 95 % CI [-.007, .128]). The full model accounted for 57% of the variance in depression and the model was statistically significant (F (8, 92) = 15.48, p < .001).

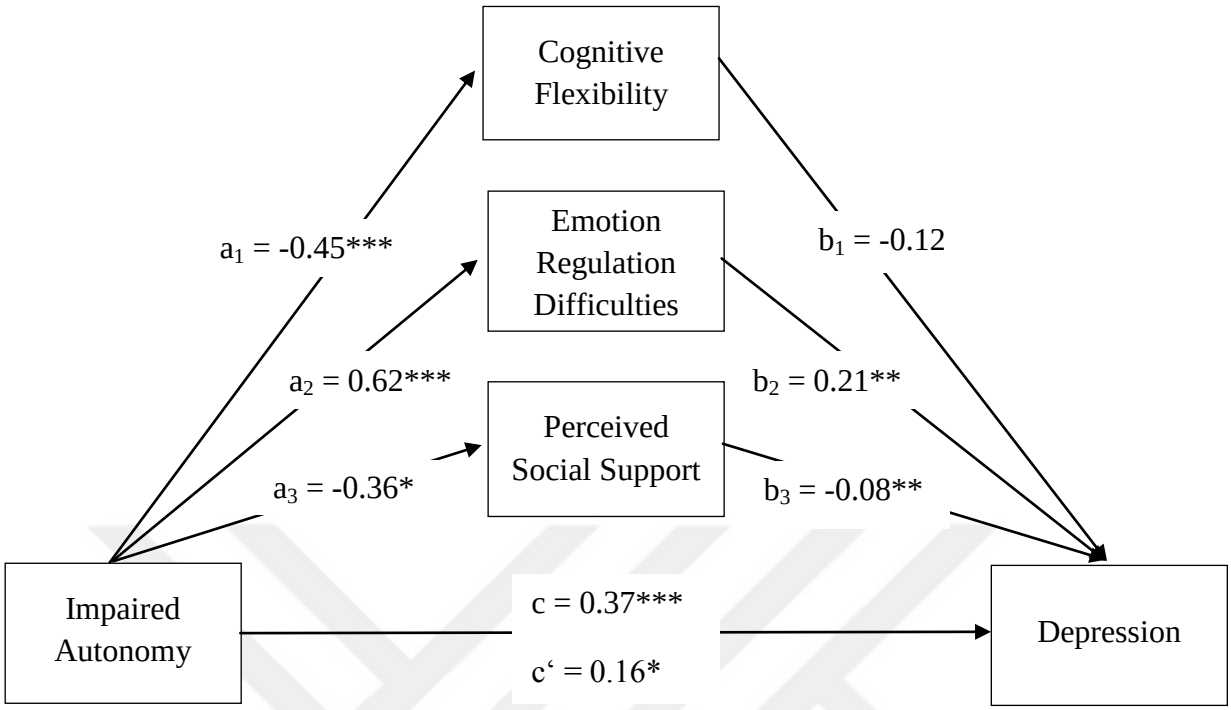

Figure 5. Regression coefficients for the relation between Impaired Autonomy (IA) and Depression (DEA) in Clinical Group as mediated by Cognitive Flexibility, Emotion Regulation Difficulties, Perceived Social Support and controlled for age, gender, Unrelenting standards and Other-directedness. ***$p < .001$, * $p < .05$

3.3.2.2. Impaired Autonomy and Life Satisfaction

Figure 6 (and Table 4) showed that when life satisfaction was regressed on impaired autonomy without the mediators the relation was statistically significant in the clinical sample (*b* = -0.45, *SE* = 0.09, *t* = -5.03, *p* < .001; 95 % *CI* [-.625, -.271]). When life satisfaction was regressed on impaired autonomy and the mediators (after controlling for the covariates), cognitive flexibility and perceived social support was positive predictor (*b* = -0.07, *SE* = 0.02, β = -0.17) and emotion regulation difficulties was negative predictor (*b* = 0.23, *SE* = 0.03, β = 0.39) of depression. When the mediators were taken into account, the direct effect of impaired autonomy on life satisfaction was found non-significant (*b* = -0.10, *SE* =0.11, *t* = -.88, *p* >.05; 95 % *CI* [-.309, 119]), which illustrates that three mediators mediated the relation between impaired

autonomy and life satisfaction. The indirect effects for both cognitive flexibility (a_1* b_1 = -0.14, *SE* = 0.07; 95 % *CI* [-.293, -.010]) and emotion regulation difficulties was negative as their 95% confidence interval did not include zero (a_2* b_2 = -0.13, *SE* = 0.07; 95 % *CI* [-.290, -.006]) but for perceived social support, the 95% confidence interval included zero (a_3* b_3 = -0.08, *SE* = 0.06; 95 % *CI* [-215, .008]). However, confidence interval for perceived social support was in marginal point as .008; therefore, it can be accepted as a significant indirect effect. The model accounted for 48% of the variance in life satisfaction and it was statistically significant (*F* (8, 92) = 10.67, $p < .001$).

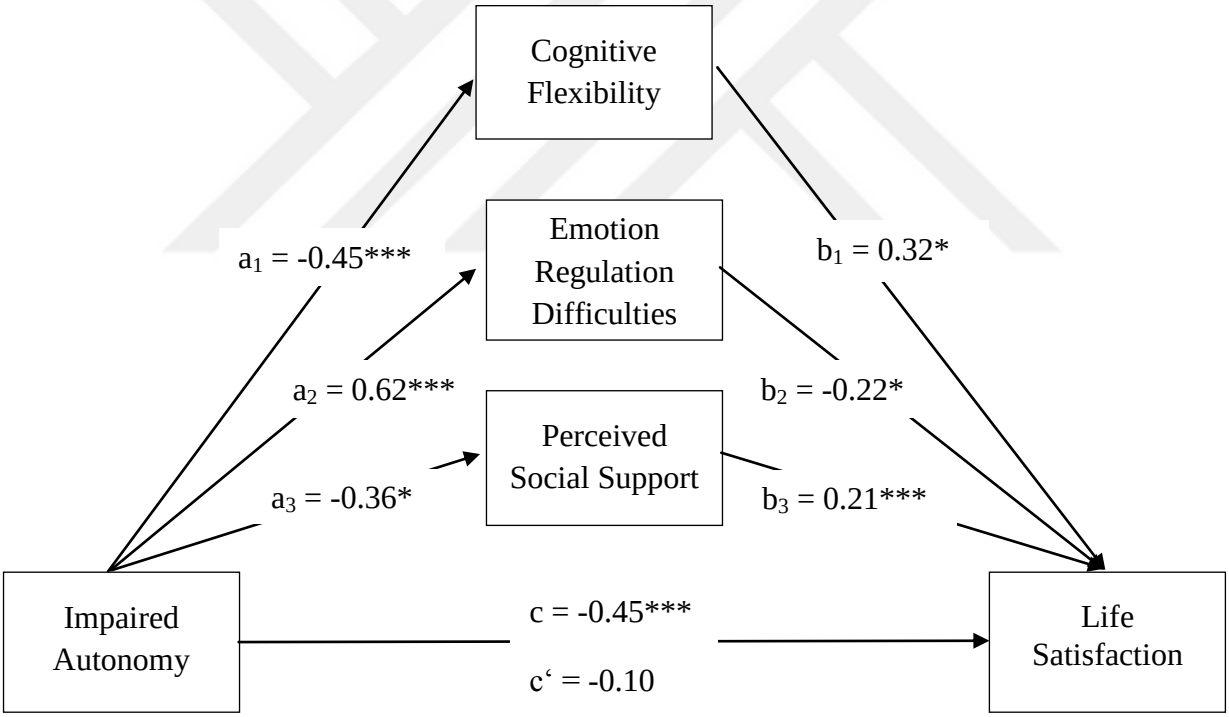

Figure 6. Regression coefficients for the relation between Impaired Autonomy (IA) and Life Satisfaction (LF) in Clinical Group as mediated by Cognitive Flexibility, Emotion Regulation Difficulties, Perceived Social Support and controlled for age, gender, Unrelenting standards and Other-directedness. ***p < .001, * p < .05

3.3.2.3. Other-directedness and Depression

Figure 7 illustrates that other-directedness were related negatively to cognitive flexibility (*b* = 0.25, *SE* = 0.06, β = 0.38). When depression was regressed on other-directedness and the mediators (after controlling for the covariates), emotion regulation difficulties was positive predictor (*b* = 0.21, *SE* = 0.06, β = 0.33) and perceived social support was negative predictor (*b* = -0.08, *SE* = 0.03, β = -0.21) of depression. When depression was regressed on other-directedness without the mediators the relation was statistically non-significant (*b* = -0.00, *SE* = 0.05, *t* = -0.02, *p* > .05; 95 % *CI* [-.104, .101]) which indicates that cognitive flexibility, emotion regulation difficulties and perceived social support did not mediate the relation between unrelenting standards and depression. The 95% confidence intervals included zero for the indirect effects

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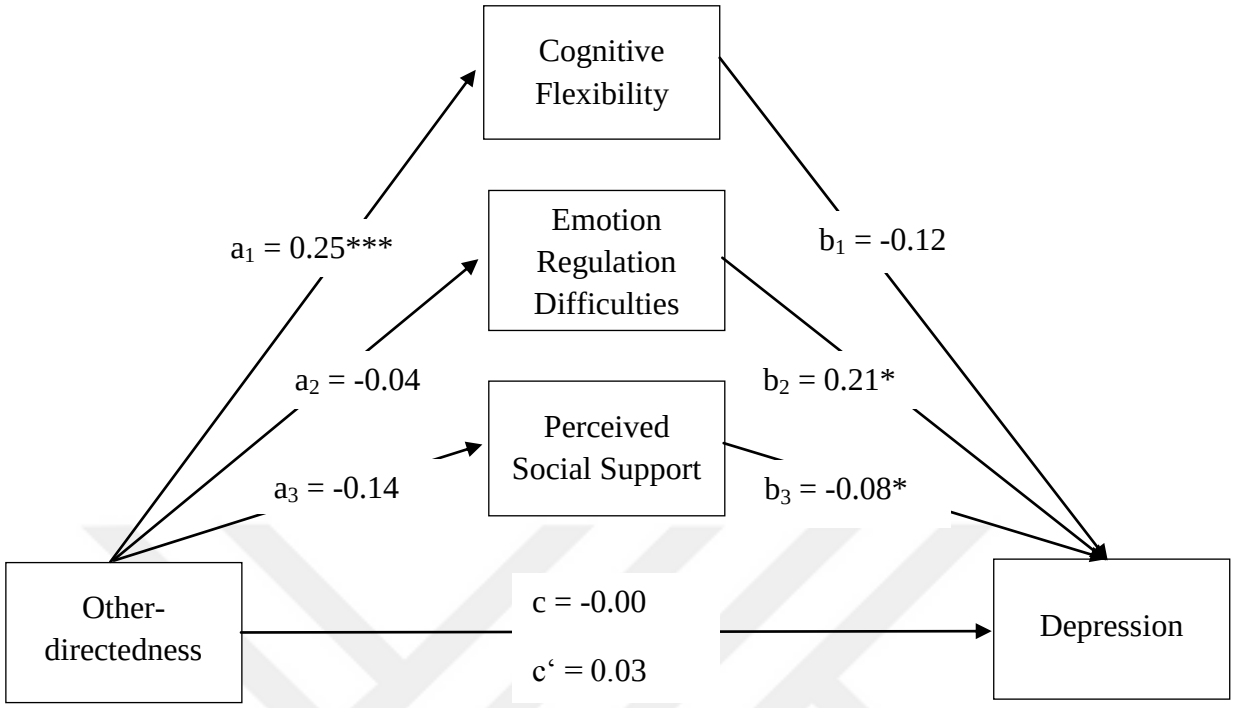

Figure 7. Regression coefficients for the relation between Other-directedness and Depression (DEA) in Clinical Group as mediated by Cognitive Flexibility, Emotion Regulation Difficulties, Perceived Social Support and controlled for age, gender, Impaired Autonomy and Unrelenting standards. ****p*< .001, * *p*< .05.

Firstly, since the correlation between other-directedness and life satisfaction in clinical group (*p* = .703) was non-significant; secondly, the correlation between unrelenting standards and life satisfaction in the clinical group (*p* = .860) was non-significant; lastly, the correlation between unrelenting standards schema domain and life satisfaction in the non-clinical group (*p* = .125) was non-significant; the mediation model was not conducted for these variables because of these non-significant correlations.

According to Baron and Kenny (1986), to conduct a mediation analysis, there should be a relation between independent variable and the mediator. Since unrelenting standards does not significantly predict all the mediators in the clinical group and other-directedness does not significantly predict all the mediators in the non-clinical group, these mediation models were not

tested (the significance level (*p*) of all regression coefficients from independent variable to mediator was >.05).

As can be seen, when all the three mediators were taken into account, some of the mediators were statistically non-significant, suggesting that some mediators may not be significant at all. For that reason, in the next step cognitive flexibility and emotion regulation difficulties were tested as stand-alone mediators in separate mediation models.

3.3.3. Cognitive Flexibility as a Single Mediator

As can be seen from the Table 5; when depression was regressed on impaired autonomy without cognitive flexibility the relation was statistically significant in the non-clinical sample (*b* = 0.41, *SE* = 0.04, *t* = 9.69, *p* < .001; 95 % *CI* [.326, .492]). Also, impaired autonomy was related negatively to cognitive flexibility (*b* = -0.44, *SE* = 0.05, β = -0.53). When depression was regressed on impaired autonomy and cognitive flexibility (after controlling for the covariates), cognitive flexibility was negative predictor (*b* = -0.16, *SE* = 0.05, β = -0.18) of depression. Further to that, the direct effect of impaired autonomy on depression was also significant (*b* = 0.34, *SE* = 0.05, *t* = 7.28, *p* < .001; 95 % *CI* [.248,.433]), which indicates that cognitive flexibility mediated the relation between impaired autonomy and depression in non-clinical group. The indirect effect for cognitive flexibility was positive as its 95% confidence interval did not include the zero (*a* b* = 0.07, *SE* = 0.02; 95 % *CI* [.025, .123]). The full model accounted for 38% of the variance in depression and the model was statistically significant (*F* (6, 277) = 28.53, *p* < .001).

As shown in Table 5, when depression was regressed on impaired autonomy without cognitive flexibility the relation was statistically significant also for the clinical sample (*b* = 0.37, *SE* = 0.05, *t* = 7.17, *p* < .001; 95 % *CI* [.267, .472]). It also showed that impaired autonomy was

related negatively to cognitive flexibility (b = -0.45, SE = 0.06, β = -0.70). When depression was regressed on impaired autonomy and cognitive flexibility (after controlling for the covariates), cognitive flexibility was negative predictor (b = -0.22, SE = 0.09, β = -0.24) of depression. Moreover, the direct effect of impaired autonomy on depression was also significant (b = 0.27, SE = 0.06, t = 4.24, p < .001; 95 % CI [.144, .399]), which implies that cognitive flexibility mediated the relation between impaired autonomy and depression in the clinical sample like it was in the non-clinical sample. The indirect effect for cognitive flexibility was positive as its 95% confidence interval did not include the zero (a* b = 0.10, SE = 0.04; 95 % CI [.031, 181]). The full model accounted for 48% of the variance in depression and the model was statistically significant (F (6, 94) = 14.44, p < .001).

Table 5.

Mediation Effect of Cognitive Flexibility (CF) in the Relation between Impaired Autonomy (IA) and Depression (DEA) in Non- Clinical Sample (Upper Part) and Clinical Sample (Lower Part)

Outcome: Depression			
Non-Clinical Sample			
Regression paths	*B*	*T*	*P*
Mediation *a* path (IA on CF)	-0.44	-8.64	< .01
Mediation *b* path (CF on DEA)	-0.16	-3.18	< .01
Total effect, *c* path (IA on DEA; No Mediator)	0.41	9.69	< .01
Direct effect *c'* (IA on DEA; including CF as mediator)	0.34	7.28	< .01
Indirect effect bootstrapped (*c – c'*) with bootstrapped 95% CI	.068	[.025, .123]	
Effect Size - P_M	.167	[.057, .314]	
Fit for the model $R^2 = 0.38$, F (6, 277) = 28.53, $p < .001$.			
Clinical Sample			
Mediation *a* path (IA on CF)	-0.45	-7.71	< .01
Mediation *b* path (CF on DEA)	-0.22	-2.48	< .05
Total effect, *c* path (IA on DEA; No Mediator)	0.37	7.17	< .01
Direct effect *c'* (IA on DEA; including CF as mediator)	0.27	4.24	< .01
Indirect effect bootstrapped (*c – c'*) with bootstrapped 95% CI	.098	[.031, 181]	
Effect Size - P_M	.266	[.082,.498]	
Fit for the model $R^2 = 0.48$, F (6, 94) = 14.44, $p < .001$.			

3.3.4. Emotion Regulation Difficulties as a Single Mediator

Table 6 shows that when life satisfaction was regressed on impaired autonomy without emotion regulation difficulties the relation was statistically significant in the non-clinical sample (*b* = -0.47, *SE* = 0.09, *t* = -5.31, *p* < .001; 95 % *CI* [-649, -298]). Besides, impaired autonomy was related positively to emotion regulation difficulties (*b* = 0.70, *SE* = 0.07, β = 0.55). When life satisfaction was regressed on impaired autonomy and emotion regulation difficulties (after controlling for the covariates), emotion regulation difficulties were negative predictor (*b* = -0.18, *SE* = 0.08, β = -0.17) of life satisfaction. Additionally, the direct effect of impaired autonomy on life satisfaction was also significant (*b* = -0.35, *SE* = 0.10, *t* = -3.36, *p* < .001; 95 % *CI* [-.549, -.144]), which demonstrates that emotion regulation difficulties mediated the relation between impaired autonomy and life satisfaction in the non-clinical group. The indirect effect for emotion regulation difficulties was negative as its 95% confidence interval did not include the zero (*a* b* = -0.13, *SE* = 0.06; 95 % *CI* [-.245, -.018]). The full model accounted for 15% of the variance in life satisfaction and the model was statistically significant (*F* (6, 276) = 8.35, *p* < .001).

Table 6.

Mediation Effect of Emotion Regulation Difficulties (ER) in the Relation between Impaired Autonomy (IA) and Life Satisfaction (LS) in Non-Clinical Sample

Outcome: Life Satisfaction Non-Clinical Sample			
Regression paths	*B*	*T*	*P*
Mediation *a* path (IA on ER)	0.70	9.95	< .01
Mediation *b* path (ER on LS)	-0.18	-2.41	< .05
Total effect, *c* path (IA on LS; No mediator)	-0.47	-5.31	< .01
Direct effect *c'* (IA on LS including ER as mediator)	-0.35	-3.36	< .01
Indirect effect bootstrapped (*c* – *c'*) with bootstrapped 95% CI	-.127	[-.245, -.018]	
Effect Size - P_M	.269	[.035, .569]	

Fit for the model $R^2 = 0.15$, F (6, 276) = 8.35, $p < .001$.

Supplementary analyses were conducted with a group membership added as a predictor and moderator. Also, interaction between IV and group membership was added into the model to see if the significant paths across the groups were significantly differ to each other. But none of them was significant which shows us that the groups had similar paths (only for significant mediation models; when independent variable was impaired autonomy). The same supplementary analyses were conducted with gender to see if the significant paths across the genders significantly differed to each other in the non-clinical group (this was especially needed, given that in the non-clinical group females outnumbered males). However, these paths are also failed to be significant. Thus it can be concluded that both genders have similar paths.

CHAPTER 4

DISCUSSION

The purpose of this study was to determine to what extent EMS predict during emerging adulthood cognitive flexibility, perceived social support and emotion regulation difficulties and how these structures predict in turn depression and life satisfaction. This study was tested on two separate groups, a clinical sample and a non-clinical one. Firstly, the possible predictors of depression and life satisfaction were entered in the model in the first step of regression analyses. Afterwards, cognitive flexibility, perceived social support and emotion regulation difficulties were entered into the second step to examine whether these variables could account for the variance of depression and life satisfaction. Finally, mediation analysis was conducted and the possible mediating role of cognitive flexibility, perceived social support and emotion regulation difficulties were tested in the relation between each EMS separately and aspects of well-being (depression and life satisfaction). In each mediation analysis that concerned each separate EMS, age, gender and the two other schema domains were statistically controlled for. The analysis was conducted separately for the clinical and non-clinical groups.

4.1. EMS and Depression

The domain of impaired autonomy was found to have a positive relation to depression in both clinical and non-clinical groups. When cognitive flexibility, emotion regulation difficulties and perceived social support were entered into the model, these relations remained statistically significant. This finding suggests that impaired autonomy might be a critical predictor of people's well-being as it continues being related positively to life satisfaction and negatively to depression even when mechanisms that are positive (such as cognitive flexibility and perceived social support) or negative (such as emotion regulation difficulties) are taken into account.

For the clinical sample this finding is consistent with the literature. For example, some studies on depression, showed that impaired autonomy schema domain was positively associated with depression among adolescents (Lumley & Harkness, 2007; Van Vlieberghe, Braet, Bosmans, Rosseel & Bögels, 2010) and older adults (Petrocelli et al., 2001). Also, the present findings concerning the non-clinical group, are consistent with the literature as impaired autonomy has been found to relate positively to depression in university students (Eberhart, Auerbach, Peyton & Abela, 2011; Harris & Curtin, 2002; Schmidt, Joiner, Young & Telch, 1995). Moreover, the unique role of impaired autonomy that it was found in the present thesis was also reported in some previous studies. Specifically, it was impaired autonomy, rather than unrelenting standards or other-directedness that was found to predict depression in a study which conducted before and after the treatment with 132 depressed outpatients in Netherlands (Renner et al., 2012). Apparently these findings are consistent with the results of this thesis as they highlight the key role of impaired autonomy in the prediction of well-being.

Apart from the relation between impaired autonomy and depression, unrelenting standards was not found to predict depression in both samples. In line with this result, Konukçu et al. (2013) found either a weak relation between unrelenting standards and depression in a healthy group, or null relation in a clinically depressed group.

As for the other-directedness schema domain, this also failed to predict depression in both groups. There are some similar results which show that some sub-components of other-directedness, such as self-sacrifice and punitiveness, are not related to depression in clinically depressed group, though some other sub-components such, as self-sacrifice did moderately relate to depression in a control group (Konukçu et al., 2013). On the other hand, some researchers found other-directedness as a significant predictor of depression (Calvete, Orue, & Hankin, 2013,

2015). The difference between previous findings and the current ones, could be because of the difference in the adaptation of the Young Schema Questionnaire Short Form-3 into the Turkish culture, as in Turkish adaptation, other-directedness schema domain does not include subjugation, approval-seeking/recognition-seeking EMS (Soygüt, et al., 2009). Perhaps this is the reason why there is some inconsistency between the present findings and previous ones, as the two versions of the Young Schema Questionnaire Short Form-3, the English one and the Turkish one, do not include the same sub-components of other-directedness.

In a study conducted with Turkish young adults, the relations of unrelenting standards, approval-seeking (which is a subcomponent of unrelenting standards) and self-sacrifice and punitiveness (which are subcomponents of other-directedness) to depression were non-significant (Taşçı, 2014). As in the current study no other schema domain than impaired autonomy seems to predict depression when these schemas are considered jointly, it may be concluded that impaired autonomy is the more reliable predictor of depression (at least as concerns the Turkish version of the Young Schema Questionnaire Short Form-3). It may show the importance of impaired autonomy schema domain in the mental health issues.

4.2. EMS and Life Satisfaction

As a result of regression analyses, impaired autonomy negatively predicted life satisfaction in both groups. In a study which was conducted with young adults (Yakın, 2015) it was indicated that impaired autonomy (combined however with other-directedness) positively predicted life satisfaction. In a similar fashion with the present findings which show impaired autonomy to uniquely predict life satisfaction, other studies found as well impaired autonomy to have the strongest relation to life satisfaction, as compared to unrelenting standards and other-directedness (Sevim, 2018; Tutal, 2015).

The relation between schemas and life satisfaction has not been widely researched. Thus, this thesis aimed to contribute to the clinical area by showing this relation and the key role that impaired autonomy could play in improving well-being of individuals. In both samples, impaired autonomy significantly predicted life satisfaction. However, the other two schema domains (other-directedness and unrelenting standards) did not predict life satisfaction when all the three schema domains were jointly considered. This may be due to the fact that impaired autonomy schema domain is a "core" schema area in a person's life which occurs in earlier periods of an individual's life and play a critical role. Unlike sub-categories of impaired autonomy, self-sacrifice, unrelenting standards and approval-seeking are presumed to develop later in one's life. (Young et al., 2003). Also, from the Self-Determination Theory (Ryan & Deci, 2017) standpoint, the need for autonomy seems to play a key role in people's life and well-being. Scores of studies have shown that when the need for autonomy is not satisfied depression is more likely to emerge and life satisfaction to be undermined (Vansteenkiste & Ryan, 2013).

As can be seen from the Correlation Table (Table 4), impaired autonomy and other-directedness were correlated to life satisfaction in the clinical sample, while in the non-clinical sample, only impaired autonomy was correlated to life satisfaction. One of the reasons for these non-significant relations could be attributed to the structure of Young Schema Questionnaire Short Form-3. The questionnaire revealed that the domains of other-directedness and unrelenting standards had fewer sub-schemas than the domain of impaired autonomy (e.g. other-directedness has two EMS while impaired autonomy has five EMS) (Soygüt et al., 2009). As such, the higher number of subcomponents may cover more holistically the underlying construct of impaired autonomy than the respective subcomponents do for other-directedness and unrelenting standards. Thus, impaired autonomy could be highly correlated to both depression and life

satisfaction. It is also important to note that participants in the clinical group reported higher depressive feelings and less life satisfaction compared to the participants in the non-clinical sample. Such differences across groups were expected, given that previous research implied that clinical samples showed higher scores of depression and negative feelings while non-clinical ones showed more positive feelings (Franken, Rassin, & Muris, 2007; Murphy & Murphy, 2006).

4.3. EMS, Cognitive Flexibility, Emotion Regulation Difficulties and Perceived Social Support

In addition to regression analyses, mediation models were conducted to test the possible mediator role of cognitive flexibility, emotion regulation difficulties and perceived social support in the relation between EMS and depression. In all mediation models, age, gender and the other two schema domains, were statistically controlled for. In this section, the results of both regression analyses and the results of mediation analysis will be discussed together. The model which was conducted to see the mediating roles in the relation between impaired autonomy and depression showed that impaired autonomy predicted all the mediator variables (namely, cognitive flexibility, emotion regulation difficulties and perceived social support).

Cognitive flexibility has been defined as the ability to produce solutions and to "cope" with difficult situations (Dağ & Gülüm 2013) and as such it is expected to relate negatively to EMS, given that EMS are known to negatively predict coping strategies (Boysan, 2012). Indeed, consistent with this expectation, the present thesis showed that impaired autonomy negatively predicted cognitive flexibility. Moreover, psychological mindedness (i.e., believing in benefits of discussing problems and being open to alternative ideas) (Conte, Ratto, & Karasu, 1996) was seen as a correlate of cognitive flexibility (Beitel, Ferrer, & Cecero, 2004; Cecero, Beitel, &

Prout, 2008). So EMS was found to negatively predict psychological mindedness (Cecero et al., 2008). In the context of the research cited above, it was not surprising that impaired autonomy negatively predicted cognitive flexibility in both samples. This is because people suffering from impaired autonomy have distorted beliefs that they have difficulties in carrying out life independently something which may make them to think that they cannot cope effectively with daily life events; such distorted beliefs may make them unable producing alternative solutions (which is considered a component of cognitive flexibility) to overcome the everyday problems.

The correlation between impaired autonomy and emotion regulation difficulties was found to be high in this thesis, a finding which is similar to previous results (Şenkal Ertürk, Kahya, & Gör, 2018). In general, it is known that EMS is a predictor of emotion regulation difficulties (Gaffrey, 2009). To be more specific, studies have shown that impaired autonomy predicted emotion regulation difficulties (Eldoğan & Barışkın, 2014; Yanıkkol İşler, 2018). Individuals who have impaired autonomy may also be characterized by pessimism (Young et al., 2003). This maladaptive thinking might also be related to people's inability to accept their emotions, to control their negative emotions and to control themselves, issues which eventually denote emotion regulation difficulties.

There is not enough in the literature about the relation between impaired autonomy and perceived social support. The few studies that have examined this issue have shown a negative relation between abandonment schema (a subcomponent of impaired autonomy) and peer connectedness (Yoo, Park, & Yun, 2014). Also, impaired autonomy has been associated with lower trust towards peers and ineffective communication with peers during adolescence (Roelofs, Onckels, & Muris, 2013). Moreover, impaired autonomy is known to relate to abusive (Tezel, Kışlak, & Boysan, 2015), socially avoidant and cold interpersonal behavioral styles

(Thimm, 2013) something which may undermine social support. All of these findings were consistent with the present results as impaired autonomy negatively predicted perceived social support. Possible explanations could be applied to this finding, such as; individuals who had impaired autonomy could perceive less favorably the social support they actually receive. Another explanation could be that since impaired autonomy is also characterized by thoughts of abandonment, unfortunate events and failure (Young et al., 2003), individuals with impaired autonomy could distance themselves from people who might provide them some social support, in an attempt to 'self-fulfill their prophecy' (defined as "a false definition of the situation evoking a new behavior which makes the originally false conception come true" [Merton, 1948, pp. 195]). Another possible explanation could be people with impaired autonomy may perceive their environment as insecure and unsupportive, given that EMS have been closely linked with insecure attachment (Young et al., 2003).

While working with EMS, the sources of social support, coping strategies and emotion regulation processes should be taken into account during the therapy sessions. As the current study shows, impaired autonomy is related negatively to cognitive flexibility and perceived social support and positively to emotion regulation difficulties. So, it may be necessary to focus on these mediators as a preventive intervention even if the client does not bring any problem about these issues into the sessions.

4.4. Cognitive Flexibility, Emotion Regulation Difficulties and Perceived Social Support and Depression

When it comes to the relation between emotion regulation difficulties and depression, there were consistent results across the non-clinical and the clinical sample, as emotion regulation difficulties predicted positively depression. Similar to the present results, a study has

indicated that emotion regulation difficulties predicted depression (Goldsmith, Chesney, Heath, & Barlow, 2013). Likewise, other studies have also shown that emotion regulation in total, or sub-domains of it, such as non-acceptance, clarity (Marques, Monteiro, Canavarro, & Fonseca, 2018) strategies and awareness, positively predict depression (Alpay, Aydın, & Bellur, 2017; Markarian, Pickett, Deveson, & Kanona, 2013; Owens, Held, Hamrick, & Keller, 2018).

Emotion regulation difficulties predicted depression both in the non-clinical and the clinical group. To sum up, individuals who had emotion regulation problems are less likely to accept their negative emotions, to use appropriate regulation strategies and to keep pursuing their goals in stressful situations. Because of this maladaptive regulation process, they might not achieve their life goals (especially emerging adults, since they made decisions about their new goals every single day). They might face severe negative emotions which they could not overcome by using adaptive regulation which possibly result in negative emotions like depression.

Apart from these, perceived social support also negatively predicted depression in both groups like emotion regulation difficulties did. The negative correlation between perceived social support and depression in adolescents is known from previous reports with Turkish participants (Şireli, Çolak, Orak, & Sakına, 2015). Also negative associations have been found between perceived friend support or perceived family support and depression among Turkish university students (Eldeleklioğlu, 2006). Similar findings have been reported in different cultures as perceived social support was found negatively relate to depression among Chinese middle school students (Wang et al, 2018) and Malaysian undergraduate students (Talwar, 2016), suggesting its cross-cultural effects.

Perceived social support was found to be a protective factor in mental health issues (Brown, 2008). Perceived social support is known to be positively correlated to coping strategies and especially to family support, which is considered as one of the most powerful factors against mental illness. Besides, support from friends has been reported to reduce the risk of maladaptive coping strategies and in turn to depression (Roohafza et al, 2014). Perceived social support has been also found to predict resilience (Şahin Baltacı & Karataş, 2015) which in turn enabled individuals to cope with depressive situations more easily. However, it was obvious that when people feel not enough support they might feel lonely. Because, in general, people need to feel someone beside them (Goldsmith, 2004) and when this need is not met individuals might easily fall victims of depressive situations (Kara & Mirici, 2004). Especially, the protective role of social support could be really important for those who were clinically diagnosed as in the present study. Therefore, therapists should pay special attention to the issue of perceived social support when dealing with clinically diagnosed individuals. Professionals may work on increasing possible sources which individuals receive support.

In addition to these findings, and in contrast to the literature, depression was not predicted by cognitive flexibility in both samples, once perceived social support and emotion regulation difficulties were also taken into account. In the literature, it was stated that difficulties in emotion regulation predict depression in university students (Zarei, Momeni, & Mohammadkhani, 2018). Also, cognitive flexibility-control sub-domain are known to negatively predict depression in adults (Dağ & Gülüm, 2013) and in adolescents (Rahimi, Meration, & Mahmoodabadi, 2018). In line with these findings, the present thesis showed that cognitive flexibility was negatively correlated to depression in both the clinical and the non-clinical groups. However, when perceived social support and emotion regulation difficulties were taken

into account in the second step of the regression analyses, depression was not predicted by cognitive flexibility in either group. The possible reason for the no-prediction in the clinical group could be attributed to the small sample size due to loss of statistical power. Even so, however, this null prediction was also found in the non-clinical group. Therefore, it seems that cognitive flexibility may not be as much critical mediating mechanism in the relation between EMS and depression as emotion perceived social support and regulation difficulties are.

Group therapies which are especially focused on emotions can be considered as protective programs for undiagnosed university students and supportive for diagnosed clinical groups. In these group therapies, individuals can share their emotions and possibly learn to consider their negative emotions as normal as every person can have similar ones while they may also feel more social support in these groups.

4.5. Cognitive Flexibility, Emotion Regulation Difficulties and Perceived Social Support and Life Satisfaction

Consistent with the literature, perceived social support positively predicted life satisfaction (Chen et al., 2017). Feeling social support when it is needed can provide an optimistic outlook about people's lives. Also, when individuals face a stressful life situation or some situation which they could not overcome, the social support they receive by the others can create a buffer effect thereby helping them (Iso-Ahola & Park, 1996). Thus, life satisfaction could be increased. Besides, feeling attached to some kind of group is known to increase individuals' enjoyment in life (Oh, Ozkaya, & LaRose, 2014).

The relation between cognitive flexibility and life satisfaction has not been directly investigated. However, it is known that cognitive flexibility predicts well-being in university students (Satan, 2014). Also, cognitive flexibility was found to positively relate to happiness

which means when cognitive flexibility increases in individuals, increase in happiness is possible (Asıcı & İkiz, 2015). Similar to these findings, the present results of this thesis, pointed out that cognitive flexibility positively predicted life satisfaction in both samples. The linkage between cognitive flexibility and positive mood is known, as positive mood positively predicts cognitive flexibility (Fleisher, 2004). To sum up, the literature supported the findings of this thesis with respect to the positive association between cognitive flexibility and life satisfaction. People who could be more cognitively flexible in their life, might be able to cope more effectively with stressful daily life events and could produce different kind of alternatives solutions when some of them did not work well. Coping with stress, finding alternatives easily, behaving in a goal-directed way and achieving goals could increase the likelihood of life satisfaction of individuals.

With respect to the relation between emotion regulation difficulties and life satisfaction, there is some research, showing that they are negatively correlated to each other (Saxena, et al., 2011). Maladaptive emotion regulation processes, such as using "fault finding" is known to negatively predict life satisfaction in adult samples (Quoidbach, Berry, Hansenne, & Mikolajczak, 2010). Another maladaptive emotion regulation strategy which was called suppression also negatively correlated to well-being (Haga, Kraft, & Corby, 2009; Karreman & Vingerhoets, 2012). This relation has been indirectly found among Turkish participants as emotion regulation difficulties have been found to correlate negatively to positive affect and positively to negatively affect (Sarıtaş, 2012). Since these findings confirmed the relation between emotion regulation and well-being, it can be thought that emotion regulation difficulties could negatively predict life satisfaction. It should be noted however that the results in this thesis confirmed the idea but only in clinical sample.

The research which compared non-clinical and clinical samples showed that maladaptive emotion regulation strategies such as rumination, was higher in clinical group (which includes depression and anxiety) (Garnefski et al., 2002). Poor emotion regulation was found to be associated with psychiatric impairment (Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008). Researches which examined emotion regulation difficulties, revealed that clinical sample had higher scores in emotion regulation difficulties compared to non-clinical samples (Ehring, Fischer, Schnülle, Bösterling & Tuschen-Caffier, 2008; Quetsch, 2015; Vatan, 2016). Those results were consistent with this thesis's findings. Non-clinical university students may be more capable of realizing their emotions, overcoming stress via their possible social interactions, remaining hopeful about their goals and coping with emotion regulation difficulties. Furthermore, cognitive flexibility and perceived social support could be more important rather than emotion regulation difficulties to predict life satisfaction in the non-clinical group. When they were analyzed together, emotion regulation difficulties did not predict life satisfaction. Taken together, the present findings suggest that informative seminars, group works and role-playing based on coping-strategies can be effective in how people can cope with difficult situations in order to increase their life satisfaction and happiness.

4.6. The Mediating Role of Cognitive Flexibility, Emotion Regulation Difficulties and Perceived Social Support in the relation between Impaired Autonomy and Depression

Every single path from impaired autonomy to mediators (in the sub-section of 4.3.) or the path from mediators to depression (in the sub-section of 4.5.) was explained in the previous sections. This sub-section will mainly focus on the mediator roles of cognitive flexibility, emotion regulation difficulties and perceived social support. It is important to remind that impaired autonomy significantly predicted depression. However, when cognitive flexibility,

emotion regulation difficulties and perceived social support was taken into account as a mediator in the same model, the strength of the association between impaired autonomy and depression decreased, though it remained statistically significant. The test of indirect effects showed that emotion regulation difficulties and perceived social support partially mediate the relation between impaired autonomy and depression. However, cognitive flexibility was not a significant mediator in that relation.

The explanation why cognitive flexibility was not a significant mediator could be "shared variance" that the other mediators (namely, emotion regulation difficulties and perceived social support) possibly explained more variance than cognitive flexibility explained. Supplementary analyses showed that when cognitive flexibility was taken into account as a single mediator, it partially mediated the relation between impaired autonomy and depression. This shows that the other two mediators are much more important in the relation between impaired autonomy and depression. This finding was not surprising as emotion regulation difficulties was highly correlated to depression in both groups. Also, perceived social support is considered an important factor in reducing the risk of depression (Aneshensel & Stone, 1982). A research which was conducted with university students showed that perceived family support mediates the relation between child abuse and depression (Lagdon et al., 2018). Being exposed to abuse in early periods of life could result in impairment in schemas (Messman-Moore & Coates, 2007). Thus, actual support could perceive lower by university students who have been exposed to abuse and possibly depressive feelings could occur.

While working with depressed emerging adults in the therapy programs (such as Schema Therapy, Cognitive Behavioral Therapy and Acceptance & Commitment Therapy), emotion regulation difficulties and perceived social support seem to be crucial both for university

students and clinical groups. As the current study demonstrates, perceived social support is associated with depression. Thus, referring depressed emerging adults where they can receive social support, such as a sports club, art activity groups or psychodrama, may be an effective strategy that could decrease the depression level of individuals. In addition to perceived social support, this thesis has shown the association between EMS and emotion regulation difficulties which increase depressive symptoms. Therefore, working on "emotions" such as being aware of negative and positive emotions and sharing them with others, in addition to structured therapies could be beneficial. As a suggestion for clinicians who mainly work on depression, combining both perceived social support and emotion regulation difficulties may be even more important. Therefore, individuals may be encouraged to share their feelings, being clear about what are their emotions or talking with their close relations (their partners, best friends or family members) about possible alternatives to their negative thoughts as individuals may get ideas from their supports about how they think from other perspectives. However, more mediators between impaired autonomy and depression could be also studied to further explain this relation.

4.7. The Mediating Role of Cognitive Flexibility, Emotion Regulation Difficulties and Perceived Social Support in the relation between Impaired Autonomy and Life Satisfaction

The paths from possible mediators to life satisfaction were explained in the previous sections (in the sub-section of 4.5.). The direct relation between impaired autonomy and life satisfaction was significant. However, when cognitive flexibility, emotion regulation difficulties and perceived social support were taken into account, this direct relation became non-significant. Therefore, it was obvious that cognitive flexibility and perceived social support fully mediated the relation between impaired autonomy and life satisfaction in both groups. However, emotion regulation difficulties were a significant mediator only in the clinical group but not in the non-

clinical group. Emotion regulation difficulties did not predict life satisfaction in the non-clinical group. As mentioned earlier it may be because cognitive flexibility was a more important correlate of life satisfaction in that specific sample. Thus, when emotion regulation difficulties, cognitive flexibility and perceived social support are taken into account together, emotion regulation may become a non-significant predictor of life satisfaction. The statistically non-significant path between emotion regulation difficulties and life satisfaction certainly explains why emotion regulation difficulties did not mediate the relation between impaired autonomy and life satisfaction in the non-clinical sample. The other explanation could be that the role of cognitive flexibility and perceived social support might be more important in the relation between impaired autonomy and life satisfaction in non-clinical sample. When emotion regulation difficulties were tested as a single mediator of the relation between impaired autonomy and life satisfaction, it was found that they did mediate this relation. This result can show that when all the three mediators were taken together in the mediation model, the other two mediators (namely, cognitive flexibility and perceived social support) were more significant mediators than emotion regulation difficulties.

The reason why cognitive flexibility emerged as a significant mediator in the non-clinical group (consisted of university students) could be due to the fact that cognitive flexibility might be more developed among university students as they have abilities on problem solving (Gotlib & Asarnow, 1979). As they possibly move from their family place to a new one, they need to cope with new situations by themselves and they have to undertake new responsibilities in their life. Such new life demands are very likely to improve their ability to find alternative solutions in every kind of problems they face and thus exercise their skills in cognitive flexibility. Since they could become gradually more flexible cognitively, this can increase their well-being as they may

feel more competence by overcoming difficult situations by themselves. Because of these reasons, cognitive flexibility could be a "must" in university students' lives and as a result could mediate the relation between impaired autonomy and life satisfaction. Therefore, protective intervention programs may need to focus on cognitive flexibility, along with social support which is considered next.

Perceived social support could be an important issue in university students' lives as students could be far from their families and also being attached to social groups could make them feel better and more secured. These possible reasons could be the answers why cognitive flexibility and perceived social support might be more crucial for university students. On the other hand, emotion regulation difficulties could be an important factor for clinical sample, besides cognitive flexibility and perceived social support. Because, clinical sample was characterized by some kind of psychological disorders such as anxiety disorders, depression or adjustment disorders, this group is more likely to encounter difficulties in emotion regulation (Gross & Munoz, 1995) which in turn may results in less life enjoyment. Because of this reason, emotion regulation difficulties could be a significant mediator and thus a potential candidate for treatment in clinical therapy sessions for people diagnosed with some kind of psychological disorders.

For the clinical sample, all the three mediators fully mediated the relation between impaired autonomy and life satisfaction. Hence, therapy programs cannot underestimate the importance of cognitive flexibility, emotion regulation difficulties and perceived social support while working with clinically diagnosed people. From the perspective of positive psychology, to increase the life satisfaction of individuals, professionals need to give importance on these

issues. Thus, it could be much easier and more effective to gain achievement in therapies.

4.8. Clinical Implications

EMS is known to have an important impact on one's life and adjustment (Jovev & Jackson, 2004). This effect can be seen on aggression, phobias, substance use (Frias et al., 2018); eating disorders (Pawels et al., 2018), depression and anxiety (Gong & Chan, 2018; Haugh, Miceli, & DeLorme, 2017) or overall psychopathological symptoms (Bosmans, Braet, & Vlieberghe, 2010). Besides the relation between EMS and negative outcomes (such as depression), it is important to note that EMS can have impact on positive aspects of one's psychology (such as life satisfaction). Thus, while working with individuals to decrease the severity of possible negative outcomes in therapies, the therapist may need to take also the perspective of Positive Psychology and therefore aim to enhance enjoyment of life. Combining these two sides may help individuals to go further in terms of psychological mental health.

However, there are other factors which should be given enough importance. As this thesis shows, some factors which contributes to that relation are lying under one's cognitive abilities (cognitive flexibility), social environment (perceived social support) and one's coping strategies (emotion regulation difficulties). Cognitive Behavioral Therapy (Ellis, Hickie, & Smith, 2003) is useful while working with depression and also for other disorders such as anxiety (Hofmann & Smits, 2008) and acute stress (Bryant, Harvey, Dang, Sackville & Basten, 1998). Besides, Schema Therapy was also found to be an essential tool to help people for serious psychological problems such as anxiety, eating disorders (Young et al., 2003) and depression (Carter, 2013). However, as the results of this thesis imply, it may be beneficial to enrich these therapy structures with consideration of some other key factors. One of the factors that could help clinically diagnosed people is cognitive flexibility, that is, people’s ability to produce alternative

solutions when encountering stressful situations. It could be deduced thus, that having people learn how to produce these alternatives and then letting them put in practice what they learnt through role-playing might be a useful strategy for clinical therapists where their ultimate goal would be to help people maintain these skills and use them in their life without the help of therapist. Moreover, working on cognitive flexibility, emotion regulation difficulties and social support may improve people's overall psychological well-being in short-term therapy programs or other situations where it is hard to directly deal with schemas. Therapists should be sensitive on the issues of support and emotion regulation during the prevention programs. For example, in informative seminars or group work, they can emphasize the importance of cognitive flexibility, social support, and emotion regulation. In addition, given that EMS are negatively associated with individuals' perception of support, their emotions and coping skills, , these issues should be emphasized during the prevention/information programs. In order to prevent these possible negative associations, clinicians might want to emphasize the critical role that mother-child and father-child relationships (Yiğit & Erden, 2015) can play in the early stages of people lives since EMS are linked to early interactions of individuals (Young et al., 2003).

A second factor that could be combined into therapy programs could be social support. In this phase, professionals may work on interpersonal problems related to low social support. Thus, the need of support of individuals could be met and clients may be possibly encouraged to have more intimate relations, something which is expected to enhance their well-being (Siedlecki, Salthouse, Oishi, & Jeswani, 2014; Walen & Lachman, 2000). Lastly, helping people to regulate effectively their emotions could be added to structured therapies. Helping people to control their negative emotions, to learn how to achieve their goals (without ruminate on

negative daily-life events), and through which strategies, would lead to reduced negative feelings and to increased positive ones.

In addition to Cognitive Behavioral Therapy and Schema Therapy, Acceptance and Commitment Therapy is one of the new therapy models (Hayes & Strosahl, 2004), an important technique of which is considered psychological flexibility (Valdivia-Salas, Sheppard, & Forsyth, 2010). As mentioned before, psychological flexibility and cognitive flexibility are related to each other (Kashdan & Rottenberg, 2010). Thus, cognitive flexibility can also be considered in Acceptance and Commitment Therapy programs to achieve more effective gains in positive mental health. The same holds true for "acceptance" which seems to play a crucial role as a component of emotion regulation in that kind of therapy (Blackledge & Hayes, 2001). As a result of the findings of this study, it could be important not to underestimate the role of emotion regulation under the programs of Acceptance and Commitment Therapy. This could be especially helpful for clinically diagnosed people who might especially need to decrease their negative feelings and increase the positive ones.

Moreover, another prominent issue is that, these steps could be applied not only on clinically diagnosed people but also to non-clinical, university students exhibiting temporary depressive feelings or suffering from temporary low life satisfaction. Group therapies in universities, workshops, seminars or protective intervention programs can aim to work on the above-mentioned factors for protective mental health.

4.9. Limitations in the Study and Future Directions

While conducting this research, some kind of limitations had occurred. One of them, and probably the most important, is that this thesis cannot claim causal relations. Another issue was the unequal sample sizes and specifically the small sample size of the clinical sample. Because of

the limited access time to the clinical sample, it was not possible to keep equal number of participants in both samples. Another issue might be the gender inequality as females were more than male participants. Because of this, the findings may not be extensively generalized across genders and samples and therefore future research needs to take these issues into account.

Moreover, not all the schema domains were investigated, while the focus was only on depression and life satisfaction as indices of well-being. At the same time, as schema domains are examined in this study, further studies can examine each sub-schema. Therefore, future studies should investigate the mediating role of possible factors, by including all the five schema domains and a wider set of psychological outcomes, such as anxiety or social problems. In addition to depression and life satisfaction, a wider set of outcomes need to be examined to compare whether certain psychological outcomes are especially related to certain schemas (or sub-schemas). Thus, future studies could take into account these variables to further explore the relations between EMS and well-being.

Even though there are some limitations, this thesis seems to be among the first ones which explores the mediating role of three factors – cognitive flexibility, perceived social support and emotion regulation – in the relation between EMS and the well-being in emerging adulthood. Knowing these factors could help professionals and therapist to work more efficiently with individuals in the clinical area. In addition, being aware of the same associations in non-clinical sample, could help us to provide possible protective intervention programs to protect individuals from negative outcomes such as depression. Professionals may work on increasing life quality of individuals by knowing the potential contribution of cognitive flexibility, emotion regulation difficulties and perceived social support in life satisfaction that these factors can be related to people's well-being. It is also important to highlight that researches mostly rely on

typical samples as they use university students or non-diagnosed individuals. Research which uses clinically diagnosed samples is fewer. In this thesis, the aim was to reach both samples to see if the same patterns can be applied in both samples. Therefore, this is another one contributions of this study.

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A. BİLGİLENDİRİLMİŞ ONAM FORMU

Bu çalışma, TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Bölümü öğretim üyesi Yrd. Doç. Dr. Athanasios Mouratidis ve Ankara Üniversitesi Psikoloji Bölümü öğretim üyesi Prof. Nilhan Sezgin danışmanlığında TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi yüksek lisans öğrencisi Psk. Zeynep YILDIZHAN tarafından yürütülmektedir. Çalışmada genç yetişkinlikteki duygu durumu etkileyen farklı faktörler araştırılacaktır. Araştırma yaklaşık 30 dakika sürmektedir. Araştırma sırasında toplanan veriler bireysel olarak değerlendirilmeyecek, yanıtlar toplu olarak değerlendirilecektir. Bulgular araştırma kapsamında kullanılacak ve gizlilik ilkesine bağlı kalınacaktır. Bu kapsamda elde edilen veriler TED Üniversitesi'nde kilitli dolaplarda saklanacaktır.

Çalışmaya katılım gönüllülük esasına dayanmaktadır. Anket, genel olarak kişisel rahatsızlık verecek sorular içermemektedir. Katılım sırasında, sorulardan ya da başka bir nedenden ötürü kendinizi rahatsız hissederseniz cevaplama işini yarıda bırakmakta serbestsiniz. Araştırmanın doğru ve geçerli sonuçlar verebilmesi için cevaplarınızın samimi olması büyük önem taşımaktadır. Lütfen hiçbir soruyu atlamadan dikkatle okuyup tam olarak yanıtlamaya çalışınız. Çalışma hakkında daha fazla bilgi sahibi olmak için zeynep.yildizhan@tedu.edu.tr adresinden araştırmacı ile iletişime geçebilirsiniz.

Araştırmaya katılmayı gönüllü olarak kabul ediyorsanız lütfen aşağıdaki ifadenin yanındaki kutucuğu işaretleyiniz.

Katılımınız için teşekkür ederim.

Psk. Zeynep YILDIZHAN

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum ( )

B. Demografik Bilgi Formu

Cinsiyetiniz: Kadın ( ) Erkek ( )

Yaşınız: **Medeni Durum:**

Okuduğunuz okul ya da mesleğiniz:

Okuyorsanız sınıfınız:

Annenizin eğitim durumu:

Okur-yazar değil ( ) Okuryazar ( )

İlkokul ( ) Ortaokul ( )

Lise ( ) Yüksekokul ( )

Üniversite mezunu ( ) Yüksek lisans mezunu ( )

Doktora mezunu ( )

Babanızın eğitim durumu:

Okur-yazar değil ( ) Okuryazar ( )

İlkokul ( ) Ortaokul ( )

Lise ( ) Yüksekokul ( )

Üniversite mezunu ( ) Yüksek lisans mezunu ( )

Doktora mezunu ( )

Çevrenizle karşılaştırdığınızda gelir düzeyinizi nasıl değerlendirirsiniz?

Alt ( ) Alt-Orta ( ) Orta ( ) Orta-Üst ( ) Üst ()

En uzun süre yaşadığınız yerleşim birimini belirtiniz.

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

C. YSÖ Kısa Form-3

Yönerge: Aşağıda, kişilerin kendilerini tanımlarken kullandıkları ifadeler sıralanmıştır. Lütfen her bir ifadeyi okuyun ve sizi ne kadar iyi tanımladığına karar verin. Emin olamadığınız sorularda neyin doğru olabileceğinden çok, sizin **duygusal olarak** ne hissettiğinize dayanarak cevap verin.

Birkaç soru, anne babanızla ilişkiniz hakkındadır. Eğer biri veya her ikisi şu anda yaşamıyorlarsa, bu soruları o veya onlar hayatta iken ilişkinizi göz önüne alarak cevaplandırın.

1'den 6'ya kadar olan seçeneklerden sizi tanımlayan en yüksek şıkkı seçerek her sorudan önce yer alan boşluğa yazın.

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

SORULAR ARKA TARAFTADIR.

1. _____Günlük yaşamımı tek başıma idare edebilme becerisine sahip olduğumu hissetmiyorum.

2. _____Anne babamdan ayrılmayı, bağımsız hareket edebilmeyi, yaşıtlarım kadar başaramadım.

3. _____Eğer istediğimi yaparsam, başımı derde sokarım diye düşünürüm.

4. _____Gündelik işlerde kendimi başkalarına bağımlı biri olarak görüyorum.

5. _____Çoğunlukla annem ve babamın benimle iç içe yaşadığını hissediyorum. Benim kendime ait bir hayatım yok.

6. _____Kendim için ne istediğimi bilmediğim için daima benim adıma diğer insanların karar vermesine izin veririm

7. _____Ortaya çıkan gündelik sorunları çözebilme konusunda kendime güvenmiyorum.

8. _____Beni terk edeceklerinden korktuğum için yakın olduğum insanların peşini bırakmam.

9. _____Diğer insanlara o kadar muhtacım ki onları kaybedeceğim diye çok endişeleniyorum.

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

11. _____İnsanların beni terk edeceği endişesiyle bazen onları kendimden uzaklaştırırım.

12. _____Yakınlarımın beni terk edeceği ya da ayrılacağından endişe duyarım

13. _____Sık sık annemden babamdan ya da eşimden ayrı bir kimliğimin olmadığını hissediyorum.

14. _____Haklarıma saygı duyulmasını ve duygularımın hesaba katılmasını istemekte çok zorlanıyorum.

15. _____İş (veya okul) hayatımda neredeyse hiçbir şeyi diğer insanlar kadar iyi yapamıyorum.

16. _____İşleri halletmede son derece yetersizim.

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

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

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

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

21. _____ Kötü bir şey olacağı duygusundan kurtulamıyorum.

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

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

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

25. _____Bir doktor tarafından herhangi bir ciddi hastalık bulunmamasına rağmen bende ciddi bir hastalığın gelişmekte olduğu endişesine kapılıyorum.

26. _____Eğer bir yanlış yaparsam, cezalandırılmayı hak ederim.

27. _____Tüm sorumluluklarımı yerine getirmek zorundayım.

28. _____Yeterince dikkatli olmazsanız, neredeyse her zaman bir şeyler ters gider.

29. _____Eğer işimi doğru yapmazsam sonuçlara katlanmam gerekir.

30. _____Neden yanlış yaptığımın önemi yoktur; eğer hata yaptıysam sonucuna da katlanmam gerekir.

31. _____Yanlış bir kararın bir felakete yol açabileceğinden endişe ederim.

32. _____Genellikle yakınlarıma ilgi gösteren ve bakan ben olurum.

33. _____Başkalarını kendimden daha fazla düşündüğüm için ben iyi bir insanım.

34. _____Yakınlarımla o kadar meşgulüm ki kendime çok az zaman kalıyor.

35. _____Ben hep başkalarının sorunlarını dinleyen kişi oldum.

36. _____Başkaları beni, diğerleri için çok, kendim için az şey yapan biri olarak görüyorlar.

37. _____İnsanlara karşı tedbiri elden bırakamam yoksa bana kasıtlı olarak zarar vereceklerini hissederim.

38. _____Herhangi bir anda birileri beni aldatmaya kalkışabilir.

39. _____Fiziksel bir saldırıya uğramaktan endişe duyarım.

40. _____Tüm paramı kaybedip çok fakir veya zavallı duruma düşmekten endişe duyarım.

41. _____Ne kadar çok çalışırsam çalışayım, maddi olarak iflas edeceğimden ve neredeyse her şeyimi kaybedeceğimden endişe ederim.

42. _____Paramın olması ve önemli insanlar tanıyor olmak beni değerli yapar.

43. _____Başkalarının da farkında olduğu başarılar benim için en değerlisidir.

44. _____Başkalarından yoğun bir ilgi görmezsem kendimi daha az önemli hissederim.

45. _____Önem verdiğim birisinin benden uzaklaştığını sezersem çok kötü hissederim.

46. _____Bir toplantıda fikrimi söylediğimde veya bir topluluğa tanıtıldığımda onaylanılmayı ve takdir görmeyi isterim.

47. _____Bir dolu övgü ve iltifat almam kendimi değerli birisi olarak hissetmemi sağlar.

48. _____Yaptığım çoğu şeyde en iyi olmalıyım; ikinci olmayı kabullenemem.

49. _____Diğer insanlardan bir şeyler istediğimde bana "hayır" denilmesini çok zor kabullenirim.

50. _____En iyisini yapmalıyım, "yeterince iyi" ile yetinemem.

D. DDGÖ Kısa Form

Aşağıdaki ifadelerin size ne sıklıkla uyduğunu, her ifadenin yanında yer alan 5 dereceli ölçek üzerinden değerlendiriniz. Her bir ifadenin altındaki 5 noktalı ölçekten, size uygunluk yüzdesini de dikkate alarak, yalnızca bir tek rakamı yuvarlak içine alarak işaretleyiniz.

	Hemen hemen hiç **(%0-%10)**	Bazen **(%11-%35)**	Yaklaşık Yarı yarıya **(%36-%65)**	Çoğu zaman **(%66-%90)**	Hemen hemen her zaman **(%91-%100)**
1. Duygularıma bir anlam vermekte zorlanırım.	1	2	3	4	5
2. Ne hissettiğim konusunda karmaşa yaşarım	1	2	3	4	5
3. Kendimi kötü hissettiğimde işlerimi bitirmekte zorlanırım.	1	2	3	4	5
4. Kendimi kötü hissettiğimde kontrolden çıkarım.	1	2	3	4	5
5. Kendimi kötü hissettiğimde uzun süre böyle kalacağına inanırım.	1	2	3	4	5
6. Kendimi kötü hissetmenin yoğun depresif duyguyla sonuçlanacağına inanırım.	1	2	3	4	5
7. Kendimi kötü hissederken başka şeylere odaklanmakta zorlanırım.	1	2	3	4	5
8. Kendimi kötü hissederken kontrolden çıktığım korkusu yaşarım.	1	2	3	4	5
9. Kendimi kötü hissettiğimde bu duygumdan dolayı kendimden utanırım.	1	2	3	4	5
10. Kendimi kötü hissettiğimde zayıf biri olduğum duygusuna kapılırım.	1	2	3	4	5
11. Kendimi kötü hissettiğimde davranışlarımı kontrol etmekte zorlanırım.	1	2	3	4	5
12. Kendimi kötü hissettiğimde daha iyi hissetmem için yapabileceğim hiçbir şey olmadığına inanırım.	1	2	3	4	5

13. Kendimi kötü hissettiğimde böyle hissettiğim için kendimden rahatsız olurum	1	2	3	4	5
14. Kendimi kötü hissettiğimde kendimle ilgili olarak çok fazla endişelenmeye başlarım.	1	2	3	4	5
15. Kendimi kötü hissettiğimde başka bir şey düşünmekte zorlanırım.	1	2	3	4	5
16. Kendimi kötü hissettiğimde duygularım dayanılmaz olur.	1	2	3	4	5

E. ÇBASDÖ

Aşağıda 12 cümle ve her bir cümle altında da cevaplarınızı işaretlemeniz için 1"den 7"ye kadar rakamlar verilmiştir. Her cümlede söylenenin sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini daire içine alarak işaretleyiniz. Lütfen hiçbir cümleyi cevapsız bırakmayınız. Sizce doğruya en yakın olan rakamı işaretleyiniz.

1= Kesinlikle Hayır ⟶ 7=Kesinlikle Evet

1. Ailem ve arkadaşlarım dışında olan ve ihtiyacım olduğunda yanımda olan bir insan var.	1	2	3	4	5	6	7
2. Ailem ve arkadaşlarım dışında olan ve sevinç ve kederlerimi paylaşabileceğim bir insan var.	1	2	3	4	5	6	7
3. Ailem bana gerçekten yardımcı olmaya çalışır.	1	2	3	4	5	6	7
4. İhtiyacım olan duygusal yardımı ve desteği ailemden alırım.	1	2	3	4	5	6	7
5. Ailem ve arkadaşlarım dışında olan ve beni gerçekten rahatlatan bir insan var.	1	2	3	4	5	6	7
6. Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.	1	2	3	4	5	6	7
7. İşler kötü gittiğinde arkadaşlarıma güvenebilirim.	1	2	3	4	5	6	7
8. Sorunlarımı ailemle (örneğin; annemle, babamla, eşimle, çocuklarımla, kardeşlerimle) konuşabilirim.	1	2	3	4	5	6	7
9. Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.	1	2	3	4	5	6	7
10. Ailem ve arkadaşlarım dışında olan ve duygularıma önem veren bir insan var.	1	2	3	4	5	6	7
11. Kararlarımı vermede ailem bana yardımcı olmaya isteklidir.	1	2	3	4	5	6	7
12. Sorunlarımı arkadaşlarımla konuşabilirim.	1	2	3	4	5	6	7

F. BEE

Yönerge: Aşağıdaki ifadelerin size ne kadar uygun olduğunu göstermek için lütfen ifadelerin sağında yer alan ölçeği kullanınız.

Derecelendirme: 1. Hiç uygun değil, 2. Pek uygun değil, 3. Kararsızım, 4. Uygun, 5. Tamamen uygun

1.Durumları "tartma" konusunda iyiyimdir.	1	2	3	4	5
2.Zor durumlarla karşılaştığımda karar vermekte güçlük çekerim.	1	2	3	4	5
3.Karar vermeden önce çok sayıda seçeneği dikkate alırım.	1	2	3	4	5
4.Zor durumlarla karşılaştığımda kontrolümü kaybediyormuşum gibi hissederim.	1	2	3	4	5
5.Zor durumlara değişik açılardan bakmayı tercih ederim.	1	2	3	4	5
6.Bir davranışın nedenini anlamak için önce, elimdekinin dışında ek bilgi edinmeye çalışırım.	1	2	3	4	5
7.Zor durumlarla karşılaştığımda öyle strese girerim ki sorunu çözecek bir yol bulamam.	1	2	3	4	5
8.Olaylara başkalarının bakış açısından bakmayı denerim.	1	2	3	4	5
9.Zor durumlarla baş etmek için çok sayıda değişik seçeneğin olması beni sıkıntıya sokar.	1	2	3	4	5
10.Kendimi başkalarının yerine koymakta başarılıyımdır.	1	2	3	4	5
11.Zor durumlarla karşılaştığımda ne yapacağımı bilemem.	1	2	3	4	5
12.Zor durumlara farklı açılardan bakmak önemlidir.	1	2	3	4	5
13.Zor durumlarda nasıl davranacağıma karar vermeden önce birçok seçeneği dikkate alırım.	1	2	3	4	5

14.Durumlara farklı bakış açılarından bakarım.	1	2	3	4	5
15.Hayatta karşılaştığım zorlukların üstesinden gelmeyi becerebilirim	1	2	3	4	5
16.Bir davranışın nedenini düşünürken mevcut bütün bilgileri ve gerçekleri dikkate alırım.	1	2	3	4	5
17.Zor durumlarda, şartları değiştirecek gücümün olmadığını hissederim.	1	2	3	4	5
18.Zor durumlarla karşılaştığımda önce bir durup çözüm için farklı yollar düşünmeye çalışırım.	1	2	3	4	5
19.Zor durumlarla karşılaştığımda birden çok çözüm yolu bulabilirim	1	2	3	4	5
20.Zor durumlara tepki vermeden önce birçok seçeneği dikkate alırım.	1	2	3	4	5

G. BDE

Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde bir çeşit ruh durumunu anlatmaktadır. Her maddede o ruh durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatle okuyunuz. Son bir hafta içindeki (şu an dahil) kendi ruh durumunuzu göz önünde bulundurarak, size en uygun olan ifadeyi bulunuz. Daha sonra, o maddenin yanındaki harfin üzerine (X) işareti koyunuz. Yalnızca 1 şık işaretleyiniz.

1) a. Kendimi üzgün hissetmiyorum
   b. Kendimi üzgün hissediyorum
   c. Her zaman için üzgünüm ve kendimi bu duygudan kurtaramıyorum
   d. Öylesine üzgün ve mutsuzum ki dayanamıyorum
2) a. Gelecekten umutsuz değilim
   b. Gelecek konusunda umutsuzum
   c. Gelecekten beklediğim hiçbir şey yok
   d. Benim için bir gelecek olmadığı gibi bu durum değişmeyecek
3) a. Kendimi başarısız görmüyorum
   b. Herkesten daha fazla başarısızlıklarım oldu sayılır
   c. Geriye dönüp baktığımda, pek çok başarısızlıklarımın olduğunu görüyorum
   d. Kendimi bir insan olarak tümüyle başarısız görüyorum
4) a. Her şeyden eskisi kadar doyum (zevk) alabiliyorum
   b. Her şeyden eskisi kadar doyum alamıyorum
   c. Artık hiçbir şeyden gerçek bir doyum alamıyorum
   d. Bana doyum veren hiçbir şey yok. Her şey çok sıkıcı
5) a. Kendimi suçlu hissetmiyorum
   b. Arada bir kendimi suçlu hissettiğim oluyor
   c. Kendimi çoğunlukla suçlu hissediyorum
   d. Kendimi her an için suçlu hissediyorum

6) a. Cezalandırılıyormuşum gibi duygular içinde değilim

b. Sanki bazı şeyler için cezalandırılabilirmişim gibi duygular içindeyim

c. Cezalandırılacakmışım gibi duygular yaşıyorum

d. Bazı şeyler için cezalandırılıyorum

7) a. Kendimi hayal kırıklığına uğratmadım

b. Kendimi hayal kırıklığına uğrattım

c. Kendimden hiç hoşlanmıyorum

d. Kendimden nefret ediyorum

8) a. Kendimi diğer insanlardan daha kötü durumda görmüyorum

b. Kendimi zayıflıklarım ve hatalarım için eleştiriyorum

c. Kendimi hatalarım için her zaman suçluyorum

d. Her kötü olayda kendimi suçluyorum

9) a. Kendimi öldürmek gibi düşüncelerim yok

b. Bazen kendimi öldürmeyi düşünüyorum ama böyle bir şey yapamam

c. Kendimi öldürebilmeyi çok isterdim

d. Eğer bir fırsatını bulursam kendimi öldürürüm

10) a. Herkesten daha fazla ağladığımı sanmıyorum

b. Eskisine göre şimdilerde daha çok ağlıyorum

c. Şimdilerde her an ağlıyorum

d. Eskiden ağlayabilirdim. Şimdilerde istesem de ağlayamıyorum

11) a. Eskisine göre daha sinirli veya tedirgin sayılmam

b. Her zamankinden biraz daha fazla tedirginim

c. Çoğu zaman sinirli ve tedirginim

d. Şimdilerde her an için tedirgin ve sinirliyim

12) a. Diğer insanlara karşı ilgimi kaybetmedim

b. Eskisine göre insanlarla daha az ilgiliyim

c. Diğer insanlara karşı ilgimin çoğunu kaybettim

d. Diğer insanlara karşı hiç ilgim kalmadı

13) a. Eskisi gibi rahat ve kolay kararlar verebiliyorum

b. Eskisine kıyasla şimdilerde karar vermeyi daha çok erteliyorum

c. Eskisine göre karar vermekte oldukça güçlük çekiyorum

d. Artık hiç karar veremiyorum

14) a. Eskisinden daha kötü bir dış görünüşüm olduğunu sanmıyorum

b. Sanki yaşlanmış ve çekiciliğimi kaybetmişim gibi düşünüyor ve üzülüyorum

c. Dış görünüşümde artık değiştirilmesi mümkün olmayan ve beni çirkinleştiren değişiklikler olduğunu hissediyorum

d. Çok çirkin olduğumu düşünüyorum

15) a. Eskisi kadar iyi çalışabiliyorum

b. Bir işe başlayabilmek için eskisine göre daha çok çaba harcıyorum

c. Ne olursa olsun, yapabilmek için kendimi çok zorluyorum

d. Artık hiç çalışamıyorum

16) a. Eskisi kadar kolay ve rahat uyuyabiliyorum

b. Şimdilerde eskisi kadar kolay ve rahat uyuyamıyorum

c. Eskisine göre bir veya iki saat erken uyanıyor, tekrar uyumakta güçlük çekiyorum

d. Eskisine göre çok erken uyanıyor ve tekrar uyuyamıyorum

17) a. Eskisine göre daha çabuk yorulduğumu sanmıyorum

b. Eskisinden daha çabuk ve kolay yoruluyorum

c. Şimdilerde neredeyse her şeyden, kolayca ve çabuk yoruluyorum

d. Artık hiçbir şey yapamayacak kadar yorgunum

18) a. İştahım eskisinden pek farklı değil

b. İştahım eskisi kadar iyi değil

c. Şimdilerde iştahım epey kötü

d. Artık hiç iştahım yok

19) a. Son zamanlarda pek fazla kilo kaybettiğimi/aldığımı sanmıyorum

b. Son zamanlarda istemediğim halde iki buçuk kilodan fazla kaybettim/aldım

c. Son zamanlarda beş kilodan fazla kaybettim/aldım

d. Son zamanlarda yedi buçuk kilodan fazla kaybettim/aldım

20) a. Sağlığım beni pek endişelendirmiyor

b. Son zamanlarda ağrı, sızı, mide bozukluğu, kabızlık gibi sıkıntılarım var

c. Ağrı sızı gibi bu sıkıntılarım beni çok endişelendiriyor

d. Bu tür sıkıntılar beni öylesine endişelendiriyor ki başka bir şey düşünemiyorum

21) a. Son zamanlarda cinsel yaşantımda dikkatimi çeken bir şey yok

b. Eskisine göre cinsel konularla daha az ilgileniyorum

c. Şimdilerde cinsellikle pek ilgili değilim

d. Artık cinsellikle hiçbir ilgim kalmadı

H. YDÖ

Aşağıda, yaşamınızdan ne derece hoşnut olduğunuzu yansıtan bazı ifadeler yer almaktadır. Her bir ifadeyi okuduktan sonra o ifadeye ilişkin düşüncenizi ve duygunuzu en iyi yansıtan seçeneği (X) işareti koyarak belirtiniz. Lütfen tüm ifadeleri değerlendiriniz.

		Hiç uygun değil	**Kısmen uygun**	**Uygun**	**Oldukça uygun**	**Tamamen Uygun**
1	Yaşamım idealime (hayallerime) büyük ölçüde yaklaşıyor.	☐	☐	☐	☐	☐
2	Yaşam koşullarım mükemmel.	☐	☐	☐	☐	☐
3	Yaşamımdan memnunum.	☐	☐	☐	☐	☐
4	Hayatta şu ana kadar istediğim önemli şeylere sahip oldum.	☐	☐	☐	☐	☐
5	Bu hayatı bir daha yaşasaydım hiçbir şeyi değiştirmek istemezdim.	☐	☐	☐	☐	☐

I. TED University Ethical Approval

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İNSAN ARAŞTIRMALARI ETİK KURULU

29.03.2018

Sayı:76

Konu: Etik Kurul Kararı

Sayın

Zeynep YILDIZHAN
Sosyal Bilimler Enstitüsü
Psikoloji Anabilim Dalı
Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Programı Öğrencisi

TED Üniversitesi İnsan Araştırmaları Etik Kurulunun **29.03.2018** tarih ve **2018/116** sayılı kararı ekte sunulmuştur.

Prof. Dr. Melike SAYIL
TED Üniversitesi
İnsan Araştırmaları Etik Kurul Başkanı

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İNSAN ARAŞTIRMALARI ETİK KURULU

ETİK KURUL KARARLARI

Toplantı Tarihi: **29.03.2018** Toplantı Sayısı: **2018/76**

TED Üniversitesi İnsan Araştırmaları Etik Kurulu **29.03.2018** Perşembe günü saat 14:00'de toplanarak aşağıdaki kararları almıştır.

Karar:(116) TED Üniversitesi, Eğitim Fakültesi, Sosyal Bilimler Enstitüsü , Psikoloji Anabilim Dalı, Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Programı öğrencisi **Zeynep YILDIZHAN**'ın sahibi olduğu "Erken Dönem Uyumsuz Şemalar ve Beliren Yetişkinlik Dönemi Psikolojik İyi Oluş Arasındaki Risk ve Koruyucu Faktörler" başlıklı yüksek lisans tez çalışmasında yapılan zorunlu değişikliklere ilişkin 15.03.2018-947 tarih ve sayılı etik kurul onay talebiniz görüşülmüş ve araştırma kapsamında uygulanacağı beyan edilen değişikliklerin uygun olduğuna, araştırma etiği açısından sorun yaratmadığına OYBİRLİĞİ ile karar verilmiştir.

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Başkan

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Üye

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Enstitü / *Institute*	**Eğitim Bilimleri** ☐ *Education Sciences* **Fen Bilimleri** ☐ *Sciences* **Sosyal Bilimler** ☒ *Social Sciences*
Tez Türü / *Degree*	**Yüksek Lisans** / *Master* ☒ **Doktora** / *PhD* ☐
Tez Başlığı / *Title Of The Thesis*	Risk and Protective Factors in the relation between Early Maladaptive Schemas and Emerging Adulthood Psychological Well-Being

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