THE MEDIATING ROLE OF SCHEMA THERAPY MODE MODEL IN THE RELATIONSHIP BETWEEN INTOLERANCE OF UNCERTAINTY AND GENERALIZED ANXIETY DISORDER SYMPTOMS

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ABSTRACT

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Master's Program in Clinical Psychology

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The aim of the present study was to examine the mediating roles of Schema Modes and Schema Parenting Factors in the relationship between Intolerance of Uncertainty (IU) and Generalized Anxiety Disorder Symptoms (GADS). The data was collected from 380 individuals ranging in age from 18 to 65. The Generalized Anxiety Disorder Scale (GAD-7), Intolerance of Uncertainty Scale Short Form (IUS-12), Young Parenting Inventory (YPI) and Short Schema Mode Inventory (SMI) were used to collect data in this research. The results showed that all of the Schema Parenting Factors and Schema Modes except Healthy Adult Mode and Happy Child Mode were significantly positively correlated with Generalized Anxiety Disorder Symptoms. When the parents were compared to high groups of IU and GADS, Overprotective Anxious Mother scores were found to be significantly higher than Overprotective Anxious Father scores. Parallel Multiple Mediation Analyses were conducted to test the mediation of Schema Modes and Schema Parenting Factors. According to the

results, the relationship between IU and GADS was mediated by Overpermissive/Boundless and Conditional/Achievement Focused for the mother and Overprotective/Anxious and Conditional/Achievement Focused for the father. In Schema Modes, Enraged Child Mode, Vulnerable Child Mode, Detached Protector Mode, Demanding Parent Mode, Punitive Parent Mode and Happy Child Mode mediate the relationship between IU and GADS. The findings of the study are discussed within the framework of the literature.

Keywords: Generalized Anxiety Disorder Symptoms, Intolerance of Uncertainty, Schema Therapy, Schema Modes, Perceived Parenting Style

ÖZET

BELİRSİZLİĞE TAHAMMÜLSÜZLÜK VE YAYGIN ANKSİYETE BOZUKLUĞU SEMPTOMLARI ARASINDAKİ İLİŞKİDE ŞEMA TERAPİ MOD MODELİNİN ARACI ROLÜ

Şendülger, Yamaç

Klinik Psikoloji Yüksek Lisans Programı

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Bu çalışmanın amacı, Belirsizliğe Tahammülsüzlük (BT) ve Yaygın Anksiyete Bozukluğu Semptomları (YABS) arasındaki ilişkide Şema Modları ve Şema Ebeveynlik Faktörlerinin aracı rollerini incelemektir. Veriler 18-65 yaşları arasındaki 380 katılımcıdan toplanmıştır. Yaygın Anksiyete Bozukluğu Ölçeği (YAB-7), Belirsizliğe Tahammülsüzlük Ölçeği Kısa Formu (BTÖ-12), Young Ebeveynlik Ölçeği (YEBÖ) ve Kısa Şema Mod Envanteri (ŞME) bu araştırmada veri toplamak için kullanılmıştır. Sonuçlar, Sağlıklı Yetişkin Modu ve Mutlu Çocuk Modu dışındaki tüm Şema Modları ve Şema Ebeveynlik Faktörlerinin Yaygın Anksiyete Bozukluğu Semptomları ile anlamlı ölçüde pozitif ilişkili olduğunu göstermiştir. Ebeveynler BT ve YABS'ın yüksek olduğu gruplarla karşılaştırıldığında Aşırı Korumacı Kaygılı Anne puanları Aşırı Korumacı Kaygılı Baba puanlarından anlamlı düzeyde yüksek bulunmuştur. Şema Modları ve Şema Ebeveynlik Faktörlerinin aracılığını test etmek için Paralel Çoklu Aracılık Analizleri yapılmıştır. Elde edilen sonuçlara göre, Yaygın Anksiyete Bozukluğu Semptomları ile Belirsizliğe Tahammülsüzlük arasındaki ilişkiye baba için Koşullu/Başarıya Odaklı ve Aşırı Koruyucu/Kaygılı faktörler, anne

için Aşırı İzin Veren/Sınırsız ve Koşullu/Başarıya Odaklı faktörler aracılık etmiştir. Şema Modlarında, Öfkeli Çocuk Modu, İncinmiş Çocuk Modu, Kopuk Korungan Mod, Talepkar Ebeveyn Modu, Cezalandırıcı Ebeveyn Modu ve Mutlu Çocuk Modu aracılık etmiştir. Çalışmanın bulguları literatür çerçevesinde tartışılmıştır.

Anahtar Sözcükler: Yaygın Anksiyete Bozukluğu Semptomları, Belirsizliğe Tahammülsüzlük, Şema Terapi, Şema Modları, Algılanan Ebeveynlik Tutumu

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CHAPTER 1: INTRODUCTION

Anxiety is an emotion defined as concern about an anticipated problem (Davison and Neale, 2001). Anxiety is adaptive in that it helps people identify and plan for anticipated threats. Anxiety helps us to be more prepared, to avoid potential problems and to think about future problems before they occur. Worry is defined as a series of thoughts and images affected by being overwhelmed. (Borkovec et al., 1983). Worry is frequently thought to be a cognitive expression of anxiety (Antony and Swinson, 1996). It is a basic human experience and is normal for all people (Dugas, Gosselin and Ladouceur, 2001). Tallis et al. found that 38% of the non-clinical sample aged 18-59 reported worrying every day at least once (Tallis, Davey and Capuzzo, 1994). Worry is a cognitive process and is related to and has possible negative consequences in the future (Robichaud and Dugas, 2019). As a result, it began with the question, 'What if?'. In addition to this, worry is triggered by events that lead to uncertainty, such as unpredictable, ambiguous things and novelties. Uncertainty is one of the constructs of worry as an intolerance of uncertainty (Dugas et al., 1998). When these concepts become excessive and uncontrollable, pathology may develop (Robichaud and Dugas, 2019). Also, chronic intense worry about life distinguishes Generalized Anxiety Disorder from other anxiety disorders (Sanderson and Barlow, 1990). In this part, these concepts related to Generalized Anxiety Disorder (GAD) will be explained. Cognitive Behavioral Therapy (CBT) was found to be efficacious for clinical improvement in anxiety. Although it is known that CBT has shown effectiveness for the treatment of GAD, it is also known that there are some drawbacks to CBT that clients sometimes fail to gain benefits (Newman et al., 2013). These drawbacks to CBT will be given regarding interpersonal problems and emotional processing. Thus, the current study aims to investigate GADS within the scope of Schema Theory. Schema Parenting Factors and Schema Modes are concepts included in Schema Therapy. This study will be recognized as the first to investigate the relationship between IU and GADS from the perspective of Schema Therapy, using Schema Modes specifically.

In this part, Generalized Anxiety Disorder, Intolerance of Uncertainty and Schema Therapy will be described respectively.

1.1 Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is one of the anxiety disorders and is defined by worries about everyday life events. In the next paragraph, the definition of GAD will be presented. The epidemiology, comorbidity, risk factors and cognitive theories will follow the definition.

1.1.1 Definition of Generalized Anxiety Disorder

Generalized Anxiety Disorders in DSM-5 is defined as the following:

Table 1. The Diagnostic Criteria of Generalized Anxiety Disorder (Source: APA, 2013)

A. Generalized Anxiety Disorder (GAD) is characterized by excessive anxiety and worry about a number of events or activities, such as performances at work or school and lasting more than 6 months.
B. Anxiety or physical symptoms create clinically significant suffering or poor performance in daily life conditions such as financial or health issues, as well as school or work performance.
C. This anxiety is accompanied by at least three of the symptoms listed below: 1- Irritability. 2- Sleep disturbance. 3- Muscle tension. 4- Restlessness. 5- Difficulty concentrating. 6- Being easily fatigued.
D. The disorder is not caused by the physiological effects of a substance (e.g., a drug) or another health issue (eg, hyperthyroidism).

Note. Adapted from American Psychological Association, 2013.

The symptoms of GAD are emotional, somatic, cognitive and behavioral. The most frequent 5 GAD symptoms related to emotional and somatic are given with their frequency respectively. Inability to relax (96.6%), Tension (86.2%), Fear (79.3%), Irritability (72.4%) and Tremor (62.1%). In addition to this, the most frequent GAD symptoms related Cognitive and Behavioral are given with their frequency. Difficulty of Concentration (86.2%), Fear of Losing Control (75.9%), Fear of Rejection (72.4%),

Not Controlling Thoughts (72.4%) and Confusion (69%) (Beck and Emery, 2019, p. 165-167).

1.1.2 Epidemiology

According to Wittchen (2002), the life-time prevalence of GAD was found at 5.1% and the 12-month prevalence of GAD was found at 3.1%. The 12-month prevalence of GAD in the general population of the United States was found as 2.9% among adults (American Psychiatric Association, 2013). Females experience GAD two times more than males. The prevalence of GAD is at its peak in the middle-aged group. According to Ruscio et al. (2017), the life-time prevalence of GAD was found at 3.7% and the 12-month prevalence of GAD was found at 1.8%. The lowest prevalence age group was found at the ages of 15-24 at 2% and the highest prevalence age group was found at the ages of 45-55 and 6.9%. The mean and median onset ages for GAD were 32.7 and 30.6 years old, respectively. GAD is significantly more prevalent in white adults than Asian, Hispanic and black adults (Grant et al. 2005). In Turkey, according to Kılıç (1998), the 12-month prevalence of GAD was found at 0.7% and Doğan et al. (2002) found it at 10.5% for last one year and 12.1% for life-time prevalence (as cited in Ünsalver and Balcıoğlu, 2006).

1.1.3 Comorbidity of GAD

Regarding comorbidity, several psychological problems were found to co-occur with GAD. Noyes (2001) stated that comorbidity in GAD is related to greater impairment, worse outcomes and more treatment seeking than in pure GAD. Patients with GAD were significantly more likely than patients without GAD to have at least one additional psychological disorder diagnosis. Comorbidity in any comorbid anxiety disorder was found to be 55.9% in patients with GAD and 59% in patients with any depressive disorder (Carter, 2001). Wittchen et al. (1994) found that the additional diagnoses for GAD were at 66% and 90% for lifetime diagnoses. Garyfallos et al. (1999) found that 65% and 78% of the patients had at least one additional psychological disorder, including panic disorder with or without agoraphobia and dysthymia, followed by social phobia and major depression current and lifetime diagnoses, respectively. In the study of Garyfallos et al. (1999), for patients with GAD, it was found that the rate of comorbidity in any comorbid anxiety disorders was at 37% and the rate of comorbidity in any depressive disorders was at 51%. In anxiety

disorders, the percentage of comorbidity was found to be 27% for Panic Disorder, 14% for Social Phobia and 11% for Simple Phobia. In depressive disorders, the percentage of comorbidity for Major Depression and Dysthmia was 23% and 21% respectively. GAD patients with personality disorders had more severe general psychopathology than those without GAD (Garyfallos et al., 1999). According to the findings, 37% of the patients had at least one PD diagnosis (Mavisakallian et al., 1995). The most common diagnostic was avoidant (26%) followed by paranoid (10%), schizotypal (10%) and histrionic (9%). Patients with a larger number of personality characteristics had a higher level of sym ptomatology. In a Turkish study (Özcan, Uğuz and Çilli, 2006), the rate of comorbidity with any depressive disorder or any anxiety disorder in GAD patients was 90.8 percent during a 12-month period. The number of additional diagnoses for one additional diagnosis was 37.8%, for two additional diagnoses was 37.8% and for three or more additional diagnoses was 15.3% in patients. The rate of comorbidity in any anxiety disorder was found to be 56.1% and the rate of comorbidity in any depressive disorder was 84.7%. In anxiety disorders, the most common comorbid anxiety disorders were social phobia (30.6%), obsessive-compulsive disorder (19.4%), specific phobia (17.4%), panic disorder (8.2%) and posttraumatic stress disorder (3.1%), with other less common anxiety disorders. The association of GAD with major depression and dysthymic disorder was found to be 83.7% and 3.1%, respectively (Özcan, Uğuz and Çilli, 2006).

1.1.4 Risk Factors of GAD

According to DSM-V, there are temperamental, environmental and genetic risk factors for GAD (American Psychiatric Association, 2013). Regarding temperamental risk factors, GAD is related to neuroticism, behavioral inhibition and avoidance of harm. Approximately 20% of healthy children are born with a temperamental predisposition that predisposes them to being extremely reactive to unexpected stimuli as well as to avoiding novel situations and people (Kagan and Snidman, 1999). Furthermore, GAD is associated with environmental factors such as threatening experiences and negative life events. Being overprotective, controlling and over involved are features of parent influences on GAD (Nordahl et al., 2010). Silove et al. (1991), for example, claimed that anxious children's parents are less loving and overprotective. Also, Generalized Anxiety symptoms were predicted by loss (Kendler et al., 2003). Adverse family

environment like low socioeconomical status and maltreatment have an impact on GAD (Moffitt et al., 2007). According to the APA, one-third of the risk for GAD is genetic (American Psychiatric Association, 2013). According to family and twin studies, genetic heritability is 31.6% (Gottschalk and Domschke, 2017). Noyes et al. (1987) found that the prevalence of generalized anxiety disorder in first-degree relatives is 5 times higher than in other relatives. The most frequent content category for GAD patients was found to be interpersonal issues (Roemer, Molina and Borkovec, 1997). For instance, marital stress (Whisman, 2007), marital dissatisfaction and lack of intimate friendship (Whisman, Sheldon and Goering, 2000) and greater rates of relationship problems with spouses and children (Ben-Noun, 1998) all have an influence on GAD. Changes in interpersonal difficulties are related with improvements in symptoms and worry (Crits-Christoph et al., 2005). According to Pincus and Borkovec (1994), GAD patients have higher levels of interpersonal anxiety and rigidity (as cited in Newman et al., 2008). Therefore, it can be understood that GAD may be vulnerable to interpersonal factors (Borkovec et al., 2002).

1.1.5 Cognitive Theories on GAD

In this part, GAD will be explained in terms of cognitive theories, namely Metacognitive theory, Emotion Regulation Theory and Intolerance of Uncertainty Model.

Metacognitive Theory

Firstly, metacognition theory is given. Flavell (1979) defined metacognition as thinking about thoughts. Metacognition is the component of cognition that is in charge of evaluating, monitoring and managing one's thoughts. GAD is associated with the use of concern as a coping technique, negative appraisal of worry and worry management attempts, according to the metacognitive model (Wells, 1995). There are two types of worry. Type 1 worry is related to worrying about external events and noncognitive internal events. For instance, ‘Worrying helps me to deal' and ‘If I worry about danger in the future, I will be able to avoid it when it arrives'. However, Type 2 worry is meta-worry, which is worrying about a person’s own worrisome thinking (Wells, 1995). For instance, ‘I have no control over my worries' and ‘Worrying will make me crazy.' In addition, GAD sufferers have both positive and negative attitudes regarding their worries. Positive worry beliefs indicate that patients believe their

worries to be useful, protective and that they serve as a coping role. Positive belies are related to Type 1 worry. Negative beliefs, on the other hand, result in a negative evaluation of worry as uncontrolled and harmful (Wells, 2010). These negative assessments are linked to Type 2 worry. Negative beliefs about worrying reduce a person's feeling of security and assurance in coping. According to Wells (2010), there are two problems, which are coping behaviors and thought control strategies. When GAD patients use worry as a coping function, this strategy is problematic in some ways. Wells (2010) explained the paradox of worry. In pathological worry, worrying attempts to repress doubts or thoughts about worry-related topics. Patients focus more on the detection of threatening information when they use worry as a coping strategy. If a thought cannot be suppressed, the GAD patient does not stop or alleviate their anxiety. As a result of this, the detection of threatening information is maintained and triggers worry again. In the study of Wells and Carter (2009), it was found that maladaptive thought control strategies and punishment for negative thoughts were used highly in GAD patients.

Emotion Regulation Theory

Emotion Regulation is defined as an ongoing act of regulating an individual's emotional patterns in response to moment-to-moment contextual needs (Cole, Michel and Teti, 1994). These needs, as well as the individual's resources for regulating the associated emotions, differ. Individual differences in emotion control patterns become traits of personality. Patterns of emotion regulation impair functioning and may become symptoms of psychopathology under specific conditions. Mennin et al. (2002) assumed that GAD patients may struggle to understand and modulate their emotional experiences. They may perceive emotions as subjectively aversive and use defensive strategies such as controlling and avoiding emotional experiences, as well as worrying and maladaptive interpersonal behaviors. Worry permits people to perceive emotional experiences at an abstract level and leads to avoiding unpleasant feelings, autonomic arousal and severe unpleasant feelings in the short term (Borkovec et al., 2004). Cicchetti, Ackerman and Izard (1995) identify two emotion regulation issues: difficulty in modulating or expressing emotional experiences and attempts to repress emotional experiences. In problems related to modulation or expression, although individuals experience emotions intensely, they cannot modulate them. For instance, individuals are unable to soothe themselves. In another problem related to suppressing

emotional experiences, individuals try to prevent their emotional experiences. In this way, emotion is avoided (Cicchetti, Ackerman and Izard, 1995). Newman et al. (2004) assumed that attempting to escape painful feelings has negative interpersonal outcomes. To protect themselves from the criticism and rejection they expect from others, GAD patients avoid telling others how they feel, need, or want in relationships, yet nevertheless display rage and frustration when their emotional demands are not met (Newman et al., 2004). As a result, it would be advantageous in the therapy of GAD to assist GAD patients in being more comfortable with stimulating emotional experiences, more capable of being aware of emotional information in adaptive problem solving and more able to moderate emotional experiences (Mennin et al., 2002).

Intolerance of Uncertainty

Uncertainty is described as the absence of precise expectations about the future. (Sarıçam et al., 2014). Küçükkömürler (2017) defined uncertainty as a phenomenon that is frequently encountered in daily life and that is needed to manage or reduce it. Uncertainty, which has become a part of daily life, includes situations that can be experienced socially or individually related to oneself, relationships and the environment. For example, relocating to another city, waiting for the result of an important exam and meeting someone are examples of individual uncertainties in daily life. Sometimes, societal uncertainties may happen. To illustrate, unemployment, legal or judicial insecurity and economic fluctuations can lead to the perception of uncertainty in society (Küçükkömürler, 2017). Budner (1962) identified uncertainty with three features, such as novelty, complexity and unsolvable. When a new, complex, or unsolvable ambiguous situation occurs, an individual may be considered as intolerant to uncertainty. Intolerance of Uncertainty (IU) is the excessive tendency of people to consider negative events as unacceptable, although the possibility of the occurrence of negative events is small (Dugas, Gosselin and Ladouceur, 2001). When people show IU, they evaluate the situation as disturbing and need to be avoided (Ladouceur, Gosselin and Dugas, 2000). Also, Liao and Wei (2011) assumed that for people, who show intolerance of uncertainty, uncertainty is bothering and may be seen as a source of anxiety, negative mood and stress. In societies where avoidance of uncertainty is high, individuals feel insecure and threatened in uncertain situations. According to Ladouceur, Gosselin and Dugas (2000), the tolerance threshold of an

individual who is intolerant of uncertainty is lower than an individual who can tolerate uncertainty. In addition to this, uncertainty is a subjective situation for individuals and the level of tolerance differs from individuals' perception of uncertain situations (Ladouceur, Gosselin and Dugas, 2000). IU was divided into two subscales, which are prospective anxiety and inhibitory anxiety by Carleton, Norton and Asmundson (2007). Prospective anxiety is described as fear and anxiety in the face of future ambiguity, whereas inhibitory anxiety is characterized by inaction in the face of uncertainty.

The Intolerance of Uncertainty Model (IUM) (GAD) attributes an essential role to Intolerance of Uncertainty (IU) and additional roles to Positive Beliefs about Worry, Negative Problem Orientation and Cognitive Avoidance, in the development and maintenance of worry, which is the basic feature of GAD (Bottesi et al., 2016). Dugas et al. (1998) described four features of GAD, which are intolerance of uncertainty, beliefs about worry, poor problem orientation and cognitive avoidance. Firstly, Intolerance of Uncertainty (IU) is the excessive tendency of people to consider negative events as unacceptable, although the possibility of the occurrence of negative events is small (Dugas, Gosselin and Ladouceur, 2001). Secondly, beliefs about worry also contribute to GAD. Freeston et al. (1994) found that if people believe that worrying prevents negative outcomes from expected negative events or minimizes the effects, like guilt or disappointment, worrying can give people a sense of control. In contrast, Davey, Tallis and Capuzzo (1996) assumed that positive results of worry are also related to poor psychological outcomes. People with both positive and negative attitudes about the outcomes of worrying score higher on psychopathology scores than people with just negative ideas about the outcomes of worrying. It means that pathological worry can be maintained by dysfunctional positive beliefs about the results of worry (Davey, Tallis and Capuzzo, 1996). The third concept is poor problem orientation. Patients with GAD have a lower problem orientation than moderate worriers (Ladouceur et al., 1998). Poor problem solving confidence and poor perceived control over problem solving were found to be highly related to levels of worry (Davey, 1994). Both of them are related to poor problem orientation. The last concept of GAD is cognitive avoidance. According to the Cognitive Avoidance Model of GAD (Stapinski, Abbott and Rapee, 2010), worry is negatively reinforcing for chronic worriers as a self-perpetuating process because of suppressed anxious arousal and

consequent disruption of effective fear exposure. According to Dugas et al. (1998), all the main components of GAD, such as intolerance of uncertainty, beliefs about worry, poor problem orientation and cognitive avoidance, are highly related to the discriminant function in classifying GAD patients from the control group. Furthermore, intolerance of uncertainty is the most essential concept for GAD since it is pivotal in differentiating GAD patients.

Intolerance of uncertainty is the milestone of the model of GAD because IU contributes to the other three concepts, which are beliefs about worry, cognitive avoidance and poor problem orientation (Dugas and Ladouceur, 2000). According to these authors, IU contributes to faulty beliefs about worry. To illustrate, GAD patients have a belief that 'if I worry, this may protect people all around me', because GAD patients actually face the possibility that something will happen to loved ones around them. Secondly, cognitive avoidance is related to the avoidance of threat perceptions of mental images. IU contributes to cognitive avoidance when people try to avoid images of threatening future events. Moreover, IU may lead to poor problem orientation (Dugas, Freeston and Ladouceur, 1997). To illustrate, focusing on ambiguity in a problem situation is related to the threat perception of uncertainty. This contributes to poor problem orientation.

As a result, among these theories, it was decided to use the IU as a variable in this study. Because IU appears to be a distinguishing factor for an individuals with GAD symptoms, according to IUM, IU especially contributes to the other constructs like Cognitive Avoidance, Poor Problem Orientation and Beliefs about Worry. Therefore, it is thought that IU is more specific for GAD.

1.1.6 The Relationship Between Intolerance of Uncertainty and Worry

Worry is a mental act in response to the possibility of the occurrence of negative events (Dugas, Buhr and Ladouceur, 2004). However, IU emphasizes a low threshold of tolerance for the possibility of the occurrence of negative events (Dugas, Gosselin and Ladouceur, 2001). Ladouceur, Gosselin and Dugas (2000) found that the more the increase in intolerance of uncertainty, the more the increase in worry. Therefore, it is suggested that IU, which is already included in the conceptual model of GAD (Dugas et al., 1998). Worry causes decreased sensitivity to ambiguity. This leads to performance impairment. For example, when an ambigious decision is needed, the

response time of people is increased (Metzger et al., 1990). Because high-worriers need more evidence to decide about something than low-worriers need to decide about something (Tallis, Eysenck and Matthews, 1991). According to Tallis et al. (1991), uncertainty makes life difficult for worriers. Generally, women report more worry than men (Freeston et al., 1994), but in intolerance of uncertainty, there is no gender difference that is significant (Robichaud and Dugas, 2000). Then, previous studies compared the relationship between IU and worry with the relationship between IU and other psychological disorders like OCD, Panic Disorder, Agoraphobia and Depression. Dugas, Gossselin and Ladouceur (2001) examined the correlation of IU with worry, obsessions/compulsions and panic symptoms. It was revealed that intolerance of uncertainty is strongly related to worry, modestly related to obsessions and compulsions and slightly related to panic. Dugas, Marchand and Ladouceur (2005) compared the IU between GAD and Panic Disorder with Agoraphobia. The authors found that GAD patients show a higher IU score than comorbid panic disorder with agoraphobia patients. IU was found to be related to worry but not related to fear of bodily sensations, or agoraphobic cognitions (Dugas, Marchand and Ladouceur, 2005). The relationship between IU and worry regarding depression was examined by Dugas, Schwartz and Francis (2004). It was found that IU was more highly and specifically related to worry than to depression and worry was more highly and specifically related to IU than to dysfunctional attitudes. IU also contributes to the prediction of worry larger than dysfunctional attitudes. Thus, intolerance of uncertainty was found as an important component in GAD than in other disorders. This means that IU is specifically related to GAD.

1.1.7 The Relationship Between Intolerance of Uncertainty and Generalized Anxiety Disorder

IU plays an active role in the development of both generalized anxiety and pathological worry (Dugas et al., 1998). Dugas et al. (1998) compared IU in patients with GAD and nonclinical controls. It was found that IU scores were significantly higher in GAD patients than in the control group. In addition to this, individuals meeting the diagnostical criteria for GAD report significantly higher scores for IU than nonclinical individuals and subclinical individuals meeting only somatic criteria (Buhr and Dugas, 2002). Also, IU is helpful in distinguishing between clinical and nonclinical/subclinical GAD by classifying 82% of GAD patients (Dugas et al., 1998).

In the study of Ladouceur et al. (1999), the uniqueness of intolerance of uncertainty was assessed. The authors created four groups, which are patients with primary GAD, patients with secondary GAD, patients with other anxiety disorders, including obsessive-compulsive disorder, social phobia and panic disorder and nonclinical controls. Intolerance of Uncertainty was found in most patients with primary and secondary GAD, followed by other anxiety disorders and lastly by the control group. As a result of Ladouceur's study, it can be said that IU can differentiate GAD patients from other anxiety disorder patients (Ladouceur et al., 1999). IU is also related to the severity of GAD and this means that individuals who have more severe GAD have more difficulty tolerating uncertainty than individuals who have less severe GAD (Dugas et al., 2007). IU may be specific to GAD mostly (Dugas, Buhr and Ladouceur, 2004; Starcevic and Berle, 2006). Dugas, Buhr and Ladouceur (2004) assumed that GAD patients may be intolerant of uncertainty in their relationships, work performance, health and many other areas of their lives. This means that intolerance of uncertainty for GAD patients may be more pervasive than for patients with other anxiety disorders.

1.2 Treatment of GAD

Witchen (2002) stated that psychological treatments and antidepressants can improve both anxiety symptoms and can also play a role in preventing comorbid major depression in GAD. Furthermore, Starcevic (2006) reported that the optimal treatment approaches for anxiety are cognitive–behavioral therapy and pharmacotherapy. In this part, the treatment of GAD will be explained in terms of Pharmacotherapy and Cognitive-Behavioral Therapy. Pharmacotherapy was found more effective than placebo in all symptoms, especially benzodiazepine was found effective (Mitte et al., 2005). According to Katzman et al. (2011), antidepressants such as selective serotonin reuptake inhibitors (SSRI) and serotonin norepinephrine reuptake inhibitors (SNRI) can be used as first-line treatment. (as cited in Newman, 2013). Relapse rates after discontinuation of treatment (Roy-Byrne et al., 2005) and incomplete treatments (Kane and Leucht, 2008) are also drawbacks of pharmacotherapy. Another treatment option is Cognitive Behavioral Therapy. Beck created a therapy approach called Cognitive Behavioral Therapy focusing on solving current problems and maladaptive thinking and behavior in the early 1960s (Beck, 2019). Self-monitoring, stimulus control, relaxation, self-control desensitization and cognitive therapy are included in Cognitive

Behavioral Therapy (CBT) (Newman and Borkovec, 2002). It is suggested that if individuals are assisted in becoming tolerant of uncertainty, it will be beneficial to them in preventing the development of GAD. Dugas and Ladouceur (2000) designed the study for the purpose of evaluating the efficacy of CBT for GAD. In that study, the treatment goal was to help GAD patients become more tolerant of uncertainty. They found remarkably that the treatment outcome is associated highly with modification in IU. Likewise, IU changes preceded time spent worrying about changes. As a result of their study, working with IU could be an important strategy for the treatment of GAD. Also, Ladouceur, Gosselin and Dugas (2000) proposed that IU should be the focus in the treatment of GAD in an attempt to reduce anxiety. In conclusion, intolerance of uncertainty can be a causal risk factor for GAD and should be used in the treatment of GAD. CBT was found to be efficacious for clinical improvement in anxiety. CBT is more effective than no treatment and non-specific control conditions like behavioral therapy alone or cognitive therapy alone in both posttherapy and follow-up (Borkovec and Ruscio, 2001). Mitte (2005) reported that CBT is a successful therapy for GAD, reducing not only the core anxiety symptoms but also the accompanying depressive symptoms. In addition to this, Borkovec, Abel and Newman (1995) also found that the presence of additional diagnoses decreased dramatically from pretherapy to follow-up in clients who had received successful GAD treatment with CBT. However, although CBT has shown effectiveness for the treatment of GAD, lots of clients fail to gain full benefit from CBT (Newman et al., 2013). Patients with GAD responded to CBT at a lower rate than those with other anxiety disorders (Brown, Barlow and Liebowitz, 1994). Durham et al. (2003) investigated if CBT had any impact on the long-term outcome of GAD. It was found that 50% of patients improved noticeably and 30% of these patients recovered with complete relief from symptoms. However, this means that the rest of the patients were unable to benefit from the CBT (Durham et al., 2003). A moderate amount of clinically significant change has occurred, with around half of patients still experiencing some clinical symptoms after treatment (Chambless and Gillis, 1993). Hoffart (2012) asserted that although traditional CBT is effective for many patients, there are also patients who may suffer from chronic anxiety even if they have received adequate psychological or pharmacological treatment. In addition, it was advocated that if the schemas that maintain the pathology are not changed, the completely recovery of the existing disorders may not occur (Hoffart, 2012). Interpersonal issues and emotional processing are related to the maintenance of GAD,

but CBT is limited in these areas. Borkovec et al. (2002) reported that interpersonal difficulties are negatively related to progression and recovery, so Borkovec suggested that adding interpersonal treatment, based on exploring issues in relationships with other people, to CBT may increase the effectiveness of treatment. In addition to this, when interpersonal problems change, GAD symptoms and worry may decrease (Christoph et al., 2005). However, in CBT, therapists focus on intrapersonal functioning, which is a psychological process that takes place within the person rather than interpersonal functioning (Castonguay et al., 1995). For example, in interpersonal factors, marital status and marital tension are two of the most powerful predictors of improvement and relapse in Cognitive Therapy for GAD (Durham, Allan and Hackett, 1997). Dropouts in treatment are also predicted by interpersonal issues (Sanderson et al., 1994). Interpersonal techniques may not be sufficient in CBT for GAD clients (Newman et al., 2011). On the other hand, Borkovec and Roemer (1995) found that worry may prevent GAD patients from experiencing negative feelings. They may see emotions as undesirable, so they use worry and maladaptive interpersonal behaviors as defensive attempts to manage and avoid emotional experiences (Mennin et al., 2002). This means the more use of worry, the more distraction from emotional issues in GAD patients. In addition to this, one of the functions of worry is the avoidance of aversive images and other negative emotions. However, this avoidance may strengthten worry as it is negatively reinforced (Borkovec and Newman, 1998). Additionally, Mennin et al. (2005) stated that people who met the GAD criteria had higher emotional intensity and a greater predisposition to expressing their emotions. However, they face difficulties in identifying, describing and clarifying their emotions. Although clients with GAD are avoidant and uncomfortable with their emotions, CBT is a failure to intervene in emotional avoidance and discomfort (Newman et al., 2004). In CBT, therapists see lower degrees of affective experience as therapeutically more significant (Wiser and Goldfried, 1993). Lastly, working with emotions is important for treatment because childhood emotional maltreatment is strongly related to the present negative cognitive style of patients (Gibb, 2002). As a result, CBT is effective in treating GAD, but not all patients benefit from CBT. Especially regarding emotions and interpersonal issues, CBT is not enough alone. Schema therapy comes into play here. Schema therapy might be beneficial for patients who deal with interpersonal issues and do not benefit enough from CBT. Therefore, the next paragraph will focus on Schema Therapy.

1.3 Schema Therapy

The Schema Therapy Model is given in this part. Early Maladaptive Schemas, Schema Modes, Therapeutic Factors in Schema Therapy and Perceived Parenting Experiences will follow the Schema Therapy Model.

1.3.1 Schema Therapy Model

Jeffrey Young developed Schema Therapy for individuals suffering from more severe and persistent psychological problems who are unable to benefit from traditional cognitive treatments (Young, Klosko and Weishaar, 2019). Schema therapy provides a novel psychotherapy method that is particularly well suited for those suffering from long-standing, difficult-to-treat psychological issues. The purpose of Schema Therapy does not challenge Beck's Cognitive Behavioral Therapy, but expands the traditional cognitive therapies by integrating with cognitive-behavioral therapy, gestalt therapy, attachment and object-relations theories from pyschoanalytic school approaches. Traditional cognitive therapies are expanded by emphasizing the past origins of psychological problems by using emotional techniques, therapeutic relationships and maladaptive coping styles to address the core psychological themes. Therefore, the length of treatment in Schema Therapy depends on the patient and Schema Therapy usually takes longer than CBT.

In the model, the core psychological themes are called as Early Maladaptive Schemas, which develop mostly during childhood and adolescence (Young, Klosko and Weishaar, 2019). Emotions, cognitions, recollections and sensory experiences are all components of early maladaptive schemas, which represent a wide and comprehensive theme. Commonly, early maladaptive schemas are destructive as schemas can be a part of individuals' life. To illustrate, a person who is harmed because of being abandoned, exploited or overprotected may create an environment that is mistreated, neglected, humiliated, or overcontrolled for himself/herself in future.

There are five schema domains and 18 different maladaptive schemas are shown in Table 2. (Young, Klosko and Weishaar, 2019). The first domain is Disconnection/Rejection, referring to the needs for security, safety, stability, nurturance, empathy, acceptance and respect. This domain consists of schemas which are Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation,

Defectiveness/Shame and Social Isolation/Alienation. The second domain is Impaired Autonomy and Performance, which prevemts the ability to separate, survive, function independently, or perform successfully. This domain consists of schemas which are Dependence/Incompetence, Vulnerability to Harm or Illness, Enmeshment/Undeveloped Self and Failure. The third domain is Impaired Limits, which cause disability in internal limits and responsibility to others. Respecting the rights of others, establishing commitments and attaining reasonable personal goals are all difficult for a person. This domain is related to the schemas of Entitlement/Grandiosity and Insufficient Self-Control/Self-Discipline. Other-Directedness is another domain that is concerned with the need to have the love and approval of others for the sake of one's own feelings and desires. This domain includes the schemas of Subjugation, Self-Sacrifice and Approval-seeking/Recognition-seeking. The final domain is Overvigilance and Inhibition, which refers to the suppression of one's own feelings and desires in order to conform to rigid, internalized rules and performance expectations at the expense of one's own happiness, self-expression and relaxation. For this domain, the related schemas are Negativity/Pessimism, Emotional Inhibition, Unrelenting Standards/Hypercriticalness and Punitiveness.

Table 2. Early Maladaptive Schemas and related Schema Domains

SCHEMA DOMAIN	EARLY MALADAPTIVE SCHEMAS
Disconnection / Rejection	Abandonment/Instability Mistrust/Abuse Emotional Deprivation Defectiveness/Shame Social Isolation/Alienation.
Impaired Autonomy and Performance	Dependence / Incompetence Vulnerability to Harm or Illness Enmeshment / Undeveloped Self Failure
Impaired Limits	Entitlement/Grandiosity Insufficient Self-Control/Self-Discipline
Other-Directedness	Subjugation

Table 2. (continued) Early Maladaptive Schemas and related Schema Domains

	Self-Sacrifice Approval-Seeking/Recognition Seeking
Overvigilance and Inhibition	Negativity/PessimismEmotional Inhibition Unrelenting Standards/Hypercriticalness Punitiveness

The origins of schemas are based on the concepts of needs and rights. According to Schema Therapy, schemas result from not meeting the core emotional needs of childhood (Young, Klosko and Weishaar, 2019). There are 5 emotional core needs which are universal.

1. Secure attachments to others
2. Autonomy, competence and a sense of identity
3. Freedom to express needs and emotions
4. Spontaneity and play
5. Realistic limits and self-control

In other words, toxic childhood experiences create Early Maladaptive Schemas as a primary source (Young, Klosko and Weishaar, 2019). Generally, these themes occur within the elementary family. There are four types of early childhood experiences that increase schema development (Rafaeli, Bernstein and Young, 2019). The first one is toxic frustration of needs. The child's environment lacks important concepts such as stability, understanding or love. The second one is traumatization. The child is harmed or victimized. The need for security as one of the most basic emotional needs, has not been met. Experiencing too much of a good thing is another type of early life experience. Parents served their children too much. These children are pampered or overwhelmed. Hence, their most basic emotional needs such as autonomy and realistic limits have not been met. The last one is selective internalization or identification with significant others. The child internalizes the thoughts, feelings, experiences and behaviors of the adult, who is usually his parent. It's like modeling. Some of these identification and internalizations may turn into schemas.

According to Schema Therapy, behavior is not related to the schema itself, it is related to coping responses. Maladaptive coping styles are used to adapt and perpetuate schemas. The difference between schemas and maladaptive coping styles is stability. Although schemas remain stable, the maladaptive coping styles for schemas can vary. Therefore, different maladaptive coping styles can be used for the same schema. There are three maladaptive coping styles, which are Overcompensation, Avoidance and Surrender, related to responses to threats such as fight, freeze and flight (Young, Klosko and Weishaar, 2019). The first maladaptive coping style is Overcompensation, which is the response that the opposite of the schema is true. In this, people fight the schema by overcompensating their thoughts and feelings in order to falsify their actual schema. Avoidance is the second one. People avoid situations triggering the schema by trying to block the feelings and thinking about the schema. They avoid bringing the existing schema to the surface by engaging in activities such as using drugs, drinking alcohol, playing video games, or eating excessively. The last one is Surrender, which means that the schema is correct and there is no need to avoid or fight it. People behave as if they are validating the existing schema. For example, for the Defectiveness Schema, which is the belief that one is defective, bad, or worthless and others will not love the person if he/she opens himself/herself, the person uses Avoidance coping style may avoid the environment, making him/herself feel as defected. The person who use Surrender coping style may find the environment make feels himself/herself as defected by critical partners or friends. The person who use Overcompensation may behave as critical or grandiose for coping with own feelings of defected.

1.3.2 Schema Modes

The second central concept is Schema Modes, which represent cognitive, emotional and momentary situations that are active at a given point in time and are coping responses. Both schema modes can switch from one to the other (Lobbestael et al., 2010) and schema modes can be in a single dominant mode (Young, Klosko and Weishaar, 2019). Life situations which in people are overly sensitive activate schema modes (Young, Klosko and Weishaar, 2019). Schema Modes are active when individuals try to deal with Early Maladaptive Schemas. The Schema Mode approach is considered to be more practical and useful than working with the original schemas (Jacob, Genderen and Seebauer, 2019). For example, people can feel and distinguish which schema mode they are in to a certain extent more easily. Thus, it is often easier

to work with emotions using this classification in a direct and goal-oriented way than with Schemas. The Schema Therapy process involves working with both adaptive and maladaptive modes. The schema healing process includes the switching from maladaptive modes to healthy modes. Young and colleagues (2019) defined 10 different schema modes in four categories : 1) Child modes, 2) Maladaptive Coping modes, 3) Maladaptive Parent modes and 4) Healthy Adult mode.

The first category includes Child Modes, which are universal and innate because all children have emotional needs requiring to be satisfied. Child Modes, which include Angry Child, Impulsive Child, Vulnerable Child and Happy Child, appear when their emotional needs are not met. The definitons of these modes are given in Table 3. Child Modes are divided into three types (Jacob, Genderen and Seebauer, 2019). First, Vulnerable Child Mode accompanied by challenging and painful emotions such as shame, loneliness, fear, or feeling insecure. For example, these expressions that 'I feel hopeless and weak', 'I feel alone in the world', 'I feel that no one loves me' belong to Vulnerable Child Mode. The second category is characterized by emotions such as aggression, anger, impulsivity. These are referred to as Angry or Impulsive Child Modes. For example, the sentences "When I am upset, I cannot control myself" and "I do whatever I want regardless of others' feelings and needs" belong to the Angry / Impulsive Child Modes. The third child mode type is the healthy and adaptive inner side of person, which is called Happy Child Mode. While individuals were in this mode, they enjoyed their experiences. Happy Child Mode is the only adaptive one in the Child Modes. Happy Child Mode statements include, for example, 'I feel liked and approved,' 'I am cheerful and pleasant,' 'I can trust most people,' and 'I can be spontaneous and vivacious.'

Table 3. The Child Modes and Definitions

CHILD MODE	DEFINITION
Angry Child	A person who feels and expresses anger or rage in response basic needs which are not met.
Impulsive Child	A person who acts impulsively and has difficulty withstanding frustration. He wants to get what he wants whenever he wants.

Table 3. (continued) The Child Modes and Definitions

Vulnerable Child	A person feels weak, hurt and vulnerable. It comes from a time when he needed his parents' care to live as a child but was not able to get it.
Happy Child	This is an adaptive mode. People feel at peace because their basic emotional needs are met. Because of their sense of security, they feel satisfied, valued and confident.

Maladaptive Coping Modes comprise of Detached Protector Mode, Compliant Surrenderer Mode and Overcompensator Mode are the second mode category. These modes are like coping responses such as avoidance, surrender and overcompensation. The definitions of maladaptive coping modes are given in Table 4. The Detached Protector mode withdraws psychologically from the schema's pain by avoiding individuals, stimulating himself, using substances and experiencing emotional detachment. These are some expressions of Detached Protector Mode : 'I do too much exercise or work too much in order to escape thinking negative experiences' or 'I do especially soothing activities like shopping and sex to escape negative feelings'. Compliant Surrenderer Mode is related to Surrender. Individuals conform to others' desires or behaviors, even if they are not individuals' own desires. For example, consider undesired sexual contact, individuals may create strategies like taking too much alcohol to conform. In this way, they may not feel negative emotions like hopelessness. Mostly, these individuals feel unhappy with their behavior. In Overcompensator Mode, individuals behave as if the opposite of the schema is true. Common attitudes related to Overcompensation are overcontrolling, aggressiveness, fraud, grandiosity, seeking approval and attention (Jacob, Genderen and Seebauer, 2019)

Table 4. The Maladaptive Coping Modes and Definitions

MALADAPTIVE COPING MODES	DEFINITION

Table 5. (continued) The Maladaptive Coping Modes and Definitions

Detached Protector	It is an emotional avoidance situation. People reject feelings and problems. Their features are emotionally disconnected, numb, distant, or excessively rational
Compliant Surrenderer	It is a mode of adaptation. It is an effort to meet others' expectations and demands at the expense of one's own needs. Their characteristics are passive, helpless, submissive. They behave in accordance with their schemas.
Overcompensation	It involves doing the opposite in order to escape the painful emotions related to the schemas.

The third category is Maladaptive Parent Modes, which reveal when parents' behaviors are internalized during childhood. Punitive Parent Mode and Demanding Parent Mode are included in Maladaptive Parent Modes. The definitions of maladaptive parent modes are given in Table 5. The common point of these modes is the internalized parental voice that criticizes, discredit for Punitive Parent Mode or imputes almost impossible demands on the person for Demanding Parent (Rafaeli, Bernstein and Young, 2019). In Schema Therapy, these modes are thought to be based on memories of being criticized, punished, or abused by their parents or other caregivers, such as a relative or teacher. While individuals are in these modes, they feel as if they are being scolded, as if they are worthless or useless and that they are screwing everything up.

Table 6. The Maladaptive Parent Modes and Definitions

MALADAPTIVE PARENT MODES	DEFINITON

Table 5. (continued) The Maladaptive Parent Modes and Definitions

Punitive Parent Mode	Their parents angrily punish, criticize or restrict the child for expressing his needs or for making mistakes. People become abusive parents and punish themselves or others
Demanding Parent Mode	Their parents have unrealistic parental expectations for their children. The person believes that the "proper" way to be is to be perfect and that being "wrong" is to be imperfect or spontaneous.

The final one is Healthy Adult Mode includes the functional cognition and behaviors required to maintain appropriate adult functions such as working, parenting, taking responsibility and being faithful to both people and actions (Rafaeli, Bernstein and Young, 2019). Working schema modes aim to create and reinforce Healthy Adult Mode (Young, Klosko and Weishaar, 2019). In this mode, behaviors and emotions are experienced appropriately. For example, a rejection response won't ruin life. Individuals can deal with conflicts and establish a balance between their desires and the needs of others. Individuals with a developed Healthy Adult Mode had fewer mental health issues than those with a less developed Healthy Adult Mode (Jacob, Genderen and Seebauer, 2019).

In addition to these schema modes, there are also other schema modes added later, like Enraged Child Mode, Undisciplined Child Mode, Bully and Attack Mode, Detached Self Soother Mode and Self Aggrandiser Mode. Enraged Child Mode and Undisciplined Child Mode are included in Child Modes (Arntz and Jacob, 2019). In Enraged Child Mode, the person feels rage, furious and frustrated because the needs of Vulnerable Child are not met. When the Enraged Child Mode is active, the person expresses the repressed rage maladaptively. In Undisciplined Child Mode, individuals cannot force themselves to complete ordinary and boring tasks. Also, when the Undisciplined Child Mode is active, the person is defeated in short run or renounce easily. The rest of schema modes that are included in Maladaptive Coping Modes related with Over-Compensatory Modes (Bernstein, 2005). People in Self-Aggrandiser Schema Mode are almost entirely selfish, with little empathy for the needs

and feelings of others. They do not believe that they have to follow the rules that are applied to everyone. They behave in a competitive, grandiose, slanderous way to get whatever they want. In Bully and Attack Mode, people behave as aggressors and bullies to get what they want or to protect themselves from perceived or real harm. In Detached Self Soother Mode, people escape from emotions by engaging in activities that will sooth and stimulate their attention. These behaviors include dangerous sports, gambling, random sex, binge eating, playing computer games and watching television (Arntz and Jacob, 2019). Although these schema modes were added later as additional to primary schema modes, they are included in the study.

1.3.3 Therapeutic Factors in Schema Therapy

Schema Therapy adopts two therapeutic attitudes, which are Limited Reparenting and Empathic Confrontation (Rafaeli, Bernstein and Young, 2019). A therapy relationship includes the needs of the client are acknowledged, clearly expressed, approved and met within certain limits. The most important sense of fulfillment is realized when satisfying the needs which were not met in early childhood by their parents. The satisfaction of needs within a certain frame is called Limited Reparenting, which is like a corrective emotional experience (Alexander and French, 1946) (as cited by Rafaeli, Bernstein and Young, 2019). This satisfaction of needs depends on the activation of early maladaptive schemas or schema modes. When the patient's effort is insufficient to be a Healthy Adult, therapist takes on the task. Through limited reparenting, the patient internalizes the warmth and care. This situation is becoming part of the patient's own Healthy Adult Mode.

The second therapeutic attitude is Empathic Confrontation. The therapist confronts the patients with their maladaptive behavior and cognitions in an empathically and non-judgemental way (Rafeli, Bernstein and Young, 2019). This technique only works if the therapist has genuine compassion for the patient. In Empathic Confrontation, therapists empathize with the cause of a patient's maladaptive behaviors but also emphasize the self-destructive nature of these behaviors and the need to change.

1.3.4 Perceived Parenting Experiences

Schema Therapy is an integrative and innovative model that combines some conceptual models, including Attachment Theory perspective (Young, Klosko and Weishaar, 2019). Schemas are formed in early childhood as representations of the

child's environment. Also, these schemas reflect childhood early environment truly (Young, Klosko and Weishaar, 2019). Children learn through their early experiences in their environment, especially significant ones, according to Beck's model. These early experiences can sometimes lead to the development of maladaptive attitudes, beliefs and schemas (Beck and Young, 1985). According to Attachment Theory (Bowlby, 1980), there is a connection between early childhood experiences with parents, adulthood relationships and mental health in adulthood. First, attachment behavior results in the formation of affectional bonds or attachments between the child and the parent. Then, attachment behavior contributes to the development of an affectional bond or attachment between an adult and an adult. These behaviors and attachments exist and are active throughout the life cycle. This is related to continuity of development and this means childhood experiences with parents create a model for further relationships and interactions. According to analysts, there is a strong tendency toward continuity in early years, which has an effect on individuals' internal world and how individuals respond or construe new situations (Bowlby, 1988). On the other hand, the attachment model is associated with interpersonal functioning as peers (Bartholomew and Horowitz, 1991) and romantic relationships as love (Hazan and Shaver, 1987). Ainsworth (1970) explored 3 attachment styles, which are Secure Attachment, Avoidant Attachment and Anxious Attachment. Kobak and Sceery (1988) found that secure attachment groups are less anxious, less hostile and cause little distress, but have high levels of social support. However, avoidant attachment groups show higher hostility, distress and loneliness but have low levels of social support. On the other hand, the anxious attachment group is more anxious and reports high distress (Kobak and Sceery, 1988).

There are two main sources of parental behavior and attitudes (Roe and Siegelman, 1963; Schaefer, 1965). The first suggests a dimension of psychological control and overprotection, while the second suggests a dimension of care. Anxious parents may present their specific fears as a model and transfer them to their children, or they may fail to teach them to face anxiety and fear (Navaro, 1989). In protective parenting, parents overprotect and interfere with children. Navaro (1989) suggests that many things that children can do are done by parents, thus preventing children from learning by living. Over-intervening and over-involvement by parents in all areas prevents children from becoming self-

sufficient and learning to trust themselves (as cited in Erozkan, 2012). In the study of Erozkan (2012), parenting attitudes and anxiety sensitivity were examined. Erozkan assumed that the relationship between anxiety sensitivity and protecting parenting attitude was a significant positive correlation and protecting parenting attitude predicts anxiety sensitivity significantly. The Parental Bonding Instrument (Parker, Tupling and Brown, 1979) defines four parenting styles: optimal parenting (high care and low overprotection), affectionate constraint (high care and high overprotection), negligent parenting (low care and low overprotection) and affectionless control (low care and high overprotection). Parker (1983) identifies affectionless control (low care, high overprotection) as the most pathogenic style. Parker (1984) found that low care-high overprotection showed a risk for disorders such as Social Phobia, Depressive Disorders, Anxiety Disorders and Agoraphobia. For all of the disorders except psychosis, mothers have higher scores than fathers for low care-high overprotection (affectionless control). In addition, Lizardi et al. (1995) assessed the relationship between the child's home environment and the pathologies of dysthymia and major depression. It was revealed that patients with dysthmia received much less care and more overprotection from both mothers and fathers than the control group, while patients with major depression received significantly more Maternal Overprotection than the control group. Borelli, Margolin and Rasmussen (2014) investigarted parental overcontrol in anxiety. The authors found that having one parent who reported extremely controlling parenting was linked to chronic anxiety symptoms during this developmental phase. Also, Borelli, Margolin and Rasmussen (2014) found that when both mother and father perceived overcontroller, maternal overcontrol had an indirect effect on child anxiety. Whishman and Kwon (1992) also assumed that parental overprotection was associated with depressive symptoms. Mothers were found to be substantially more overprotective than fathers in the Parental Bonding Instrument study. Overprotection is not the same as excessive care, but it is associated with interference and dependency encouragement, resulting in a restriction of the child's needs (Parker, Tupling and Brown, 1979). Maternal overprotection is related to low care rather than high maternal care (Parker and Lipscombe, 1981). When the relationship between maternal control and the autonomy of the child was examined, it was found that there was a negative correlation (Ceylan et al., 2016). These authors also found that when examining the relationship between psychological control and peer relationships, perceived maternal psychological control was negatively related to

peer relationships; perceived father psychological control was found to be positively related to peer relationships. As a result of the information obtained from literature, maternal overprotection seems to be perceived as more pathological than paternal overprotection. In this study, the difference between Schema Parenting Factors, especially maternal overprotection and paternal overprotection, will be investigated regarding GADS.

1.3.5 The Literature Related Schema Therapy and Generalized Anxiety Disorder

Researchers have recently begun to explain the link between early maladaptive schemas and psychopathologies such as anxiety disorders. Thus, research in the fields of Schema Therapy and GAD is limited. Studies investigating the effectiveness of Schema Therapy found it effective for anxiety disorders (Hawke and Provencher, 2011). In the study of Glaser et al. (2002), the authors assessed the Early Maladaptive Schemas by their ability to predict the symptoms of general anxiety. It was found that 50% of anxiety scores were accounted for by all early maladaptive schemas. There were two maladaptive schemas that contributed to anxiety significantly, which are abandonment/instability and vulnerability to harm or illness (Glaser et al., 2002). Welburn et al. (2002) investigated the relationship between EMS and psychiatric symptoms. The authors assumed that Early Maladaptive Schemas accounted for 52% of the general anxiety symptoms. Abandonment, Vulnerability to Harm or Illness, Failure, Self-Sacrifice and Emotional Inhibition schemas are the significant ones predicted to cause anxiety. Schmidt et al. (1995) investigated anxiety disorders using the Beck Anxiety Scale regarding early maladaptive schemas. Emotional deprivation, insufficient self-control and vulnerability to harm or illness were found to be significantly positive correlated with general anxiety symptoms. There is a common maladaptive schema related to anxiety in these studies called Vulnerability to Harm or Illness. As a result of these studies, Hawke and Provencher (2011) assumed that people with anxiety disorders present high levels of early maladaptive schemas. As a result, it was intended to broaden schema therapy, which has been shown to be effective in treating anxiety disorders.

Schema modes have been added to the schema model more recently. Therefore, research has only just started in this area. Lobbestael et al. (2010) compared the groups, which are nonpsychiatric control, patients with anxiety and mood disorders and

patients with personality disorders, regarding Schema Modes. The presence of all dysfunctional modes increased dramatically from the non-patient control group through anxiety and mood disorders to personality disorders, while functional modes dropped in a similar manner. Karaca and Ateş (2019) aimed to treat a client who had GAD using a Schema Therapy approach. The therapy process's goal was to strengthen the Healthy Adult Mode. At the end of treatment, the client adopted the idea of "starting to be a parent on their own." In this case study (Karaca and Ateş, 2019), schema therapy was found to be effective for GAD. Hamidpour et al. (2011) investigated the role of Schema Therapy in the treatment of GAD in women. Schema Therapy has been proven to be useful in the treatment of GAD in women.

Although there are some studies examining the effect of Schema Therapy on GAD, there is a deficiency in the literature (Taylor and Harper, 2016; Karaca and Ateş, 2019). In particular, the study examining the relationship between Schema Modes and IU and GADS was not found. Hawke and Provencher (2011) indicated that schema modes should be explored in GAD because no studies have been conducted on this psychological disorder.

1.4 The Purpose of Research, Research Questions and Hypotheses

GAD is distinct from other anxiety disorders in that it is marked by chronic and severe worry about one's future. In distinguishing GAD from other anxiety disorders, IU is also essential. GAD patients may be intolerant of uncertainty in their relationships, work performance, health and many other areas of their lives. Although Cognitive Behavioral Therapy was found to be effective for treating GAD, there are important drawbacks. Some patients are unable to benefit from CBT, especially those who suffer from chronic anxiety even if adequate treatment is obtained. Interpersonal issues and emotional processing were limited in CBT, although these are related to the maintenance of GAD. As a result, it is thought that Schema Therapy may be effective for GAD.

The study’s goal is to deterime whether schema therapy concepts are suitable with IU for individuals with generalized anxiety symptoms. The aim of the study is to investigate the role of schema therapy concepts, which are Perceived Parenting Experiences and Schema Modes, in the relationship between IU and GADS. Although Yolalan (2020) examined Schema Modes regarding differences in gender, the current

study also examined whether Schema Modes differed by gender variable for the purpose of replicating the previous study. Hawke and Provencher (2011) indicated that schema modes should be explored in GAD because no studies have been conducted on this psychological disorder. Therefore, it is planned to contribute the literature to studying Schema Mode concepts, which are needed to study IU and GAD.

On the other hand, Parker, Tupling and Brown (1979) indicated that overprotection was resulting in restriction of children's needs. In the study of Parker (1983), overprotective parenting style was found to be the most pathogenic and associated with anxiety disorders. Mothers are perceived as more overprotective than fathers in anxiety disorders (1984). In the literature, there were not found any studies examining the comparison of parents in Schema Parenting Factors in IU and GADS. It was also aimed to investigate Schema Parenting Factors in high groups of IU and GADS. In this way, it was planned to contribute to the literature.

In accordance with these purposes, the research questions are the followings:

1- Are there significant relationships between IU, GADS, Schema Modes and Schema Parenting Factors?
2- Are there significant differences between Schema Modes in terms of gender ?
3- Which parent's perceived parenting experience have higher scores in high IU and high GADS groups ?
4- Do Schema Modes or Schema Parenting Factors mediate the relationship between IU and GADS ?

Based on these research questions, the main hypotheses of this thesis are the followings:

H1: Overprotective Anxious Mother Factor in Schema Parenting Factors is expected to have higher scores on the high GADS and high IU groups, than the Father counterpart.

H2: Schema Modes are expected to mediate the relationship between IU and GADS.

H3: Schema Parenting Factors are expected to mediate the relationship between IU and GADS.

CHAPTER 2: METHOD

In this part, participants, measurements, data collection methods and statistical analysis are given.

2.1 Participants

The sample of the study was composed of adults between the ages of 18-65 with a mean age of 34.09 and a standard deviation of 13.02. Participants does not consist of clinical cases. Participation in the current study was on a voluntary basis. A total of 380 people participated in the study. 21 individuals were excluded because of missing values. One person was excluded for not meeting the inclusion criteria as aging between 18-65, 10 individuals were identified as outliers and, therefore, they were excluded. The sample included in the analysis consists of 348 individuals. 238 participants (68.4%) were women; 110 (31.6%) were men. The sample was selected randomly and most of them were selected from Izmir.

The frequency and percentage values regarding the socio-demographic information of the participants are presented in Table 6.

Table 7. The Sociodemographic Information of the Participants

Variable	Levels	Frequency	Percentage
Gender			
	Women	244	68.2
	Men	114	31.8
Last School Graduate From			
	Primary School	1	0.3
	Secondary School	4	1.1
	High School	83	23.2
	Bachelor	225	62.8
	Master Programme	40	11.2
	Doctorate	5	1.4
Marital Status			
	Married	136	38.0
	Single	205	57.3

Table 6. (continued) The Sociodemographic Informataion of the Participants

	Separated	15	4.2
	Widow	2	0.6
Relationship Status			
	Yes	179	50
	No	179	50
Working Status			
	Working	175	48.9
	Not Working	102	28.5
	Student	81	22.6
Birth Order in Family			
	1	164	45.8
	2	129	36.0
	3	43	12.0
	4	10	2.8
	5	8	2.2
	Other	4	1.1
Mother and Father			
	Married	249	69.6
	Separated	29	8.1
	One of them or both of them are dead	80	22.3
Level of Income			
	High Income Group	18	5.0
	More than Middle Income Group	106	29.6
	Middle Income Group	189	52.8
	Less Than Middle Income Group	36	10.1
	Low Income group	9	2.5
Level of Income of Family When You Are A Child			
	High Income Group	18	5.0
	More than Middle Income Group	88	24.6
	Middle Income Group	182	50.8
	Less Than Middle Income Group	47	13.1
	Low Income group	23	6.4
Physical Problem			
	Yes	28	7.8

Table 6. (continued) The Sociodemographic Informataion of the Participants

	No	330	92.2
Psychological Problem			
	Yes	33	9.2
	No	325	90.8
Any Traumatic Experience in Childhood or Adolescence			
	Yes	89	24.9
	No	269	75.1
Psychotherapy Experience			
	Yes	103	28.8
	No	255	71.2

2.2 Instruments

2.2.1 Sociodemographic Questionnaire

To obtain detailed information about the participants' demographic variables, a sociodemographic form was developed by the researcher. It consists of 20 questions relating to gender, age, education and income level, psychological and physical disorders and information about parents.

2.2.2 Young Parenting Inventory (YPI)

The Young Parenting Inventory was developed by Jeffrey Young (Young, 1994) in order to measure perceived parental attitudes. The YPI is a self-report questionnaire that consists of 72 items and includes various behaviors of parents that are thought to form the basis of early maladaptive schemas. The items are rated on a 6-point Likert scale (1-completely untrue and 6-describe my mother/my father perfectly). The items describe the participant's mother or participant's father in their childhood. Highly scored items indicate negative parenting attitudes. The original form of the scale consists of 17 sub-dimensions corresponding to parenting styles, which are thought to form the basis of 17 early maladaptive schemas. The scale is calculated according to

the subscales, not the total score. The study on the validity and reliability of the YPI (1994) was conducted by Sheffield et al. (2005). It was found that the internal consistency of these dimensions varied between .67 and .92 and the correlation coefficients for the test-retest reliability sub-dimensions were between .53 and .85. The adaptation of YPI to Turkish was carried out by Soygüt, Çakır and Karaosmanoğlu (2008). There are 10 factors for both mother and father forms: Emotionally Depriving Parenting (He/She loved me and treated me like someone special), Overprotective/Anxious Parenting (He/She overprotected me), Belittling/Criticizing Parenting (He/She used to criticize me a lot), Pessimistic/Worried Parenting (He/She focused on the bad aspects of life or the things that went wrong), Normative Parenting (Everything must follow his/her rules), Restricted/Emotionally Inhibited Parenting (He/She would be uncomfortable expressing her feelings), Punitive Parenting (He/She would call me stupid when I was wrong), Conditional/Achievement focused (He/She placed great emphasis on success and competition.), Overpermissive/Boundless Parenting (He/She allowed me to become overly angry or lose control) and Exploitative/Abusive Parenting (He/She lied to me, deceived me or betrayed me). Among the sub-dimensions, only the Emotionally Depriving Parenting dimension is reverse coded. All items (1, 2, 3, 4, 5, 36, 45 and 52) in the Emotionally Depriving Parenting dimension of Turkish Young Parenting Inventory are reverse scored. In addition to these reverse coded items, item 63 also should be calculated as reverse. In the study conducted by Soygüt (2008), test-retest reliability coefficients were r = .38 to .83 for the mother and r = .56 to .85 for the father; internal consistency coefficients were found in the range of α = .53 to .86 for the mother and α = .61 to .88 for the father. In the current study, internal consistency coefficients are in the range of α = .59 to .91

for mother and α = .66 to .94 for father. Cronbach α value is calculated as .96 for all scales.

2.2.3 Short Schema Mode Inventory (SMI)

The Schema Mode Inventory measuring 16 schema modes was developed by Young et al. (2007) and included 270 items. Based on this first long scale, Short Schema Mode Inventory (SMI) was developed by Lobbestael et al. (2010). The SMI is a self-report questionnaire and consists of 118 items measuring 14 dimensions. The items are rated on a 6-point Likert scale (1-never and 6-always). The higher the score, the more frequent the appearance of the modes. In the study of Schema Mode Inventory conducted by Lobbestael (2010), the internal consistency values were between.79 and .96 and test–retest reliability values ranged from .65 to.92. In addition, Cronbach's α value was calculated as .87. The adaptation of SMI to Turkish was carried out by Aytaç, Karaca and Karaosmanoğlu (2020). The Turkish version of the SMI consists of 113 items and 14 dimensions: Vulnerable Child Mode (I feel powerless and helpless), Angry Child Mode (I am angry at someone for left me alone or abandoned me), Happy Child Mode (I feel loved and accepted), Impulsive Child Mode (I do first, then I think), Undisciplined Child Mode (I cannot force myself to do boring tasks, even if I know the task is beneficial for me), Compliant Surrenderer Mode (I have to accept everything about the people who are important to me), Detached Protector Mode (I do not feel anything), Detached Self-Soother Mode (I work too hard or exercise so much that I cannot think about my disturbing feelings), Self-Aggrandizer Mode (I do whatever I want, regardless of other people's needs and feelings), Bully and Attack Mode (I make fun of others), Punitive Parent Mode (I withhold pleasure from myself because I do not deserve it), Demanding Parent Mode (I do not allow myself to rest or have fun until I have finished what I have to do), Healthy Adult Mode (I can defend

myself when I am unfairly criticized or abused) and Enraged Child Mode (I can get angry enough to kill someone). The scale is calculated according to the subscales, not the total score. In the Turkish SMI conducted by Aytaç, Karaca and Karaosmanoğlu (2020), Cronbach's α value for all scale was calculated as .96 and for the subscales ranging between .67 and .92. In addition, test-retest reliability values ranged from .66 to .89. In the current study, Cronbach's α value is calculated as .95 and for the subscales ranging between .57 and .94.

2.2.4 Intolerance of Uncertainty Scale Short Form (IUS-12)

When Carleton, Norton and Asmundson (2007) created the short form of the Intolerance of Uncertainty Scale Short Form (IUS-12), they based on the first 27-item scale developed by Freeston et al. (1994). This scale was adapted to Turkish by Sarıçam, Erguvan, Akın and Akça (2014), in order to measure individuals' intolerance to uncertainty as BTÖ-12. The self-reported scale consists of 12 items on a 5-point likert scale (1-not at all characteristics of me/5-completely characteristic of me). There are no reverse coded items. The highest score that can be obtained from the scale is 60 and the lowest score is 12. The higher the scores obtained from the scale, the higher the intolerance of uncertainty. It was found two factors which are Prospective Anxiety (I always want to know what the future will bring for me) and Inhibitory Anxiety (Uncertainty keeps me from living a full life). The Prospective Anxiety is related to IU with future events and the Inhibitory Anxiety is related to IU with blocking actions and experiences. Prospective anxiety items are items 1, 2, 3, 4, 5, 6 and 7, while inhibitory anxiety items are items 8, 9, 10, 11 and 12. In the study of Sarıçam, Erguvan, Akın and Akça (2014), cronbach alpha internal consistency coefficient of .88 were found for all scale, .84 for prospective anxiety and .77 for inhibitory anxiety subscale. A test-retest correlation coefficient was found .74 for all scale, .75 for prospective

anxiety and .71 for inhibitory anxiety. In the current study, Cronbach's α value is calculated as .89 for all scale, .78 for prospective anxiety and .89 for inhibitory anxiety.

2.2.5 Generalized Anxiety Disorder Scale (GAD-7)

The Generalized Anxiety Disorder Scale (GAD-7) is a practical self-report anxiety questionnaire that was developed by Spitzer, Kroenke, Williams and Löwe (2006) in order to measure the anxiety levels of the participants. Subjects are asked how often, during the last 2 weeks, they have been bothered by each of the 7 items (e.g., "Becoming easily annoyed or irritable of scale."). Response options are "not at all," "several days," "more than half the days," and "almost every day," scored as 0, 1, 2 and 3, respectively. For the original scale of GAD-7, internal consistency coefficient was found .92 and test-retest reliability was found .83. The Turkish version of GAD-7 was carried out by Konkan et al. (2013). The most acceptable cut-off value for the GAD-7 test was 8 in Turkish study (Konkan et al., 2013). In the Turkish version, cronbach alpha internal consistency coefficient was found .85. The construct validity was found .90. In the current study, Cronbach's α internal consistency is calculated as .90.

2.3 Procedure

The study started after obtaining permission from the Izmir University of Economics Ethics Committee (see Appendix A). The study data was collected from volunteer individuals over the age of 18 whose native language is Turkish. Participants were reached by social media such as instagram, twitter, whatsapp, linkedin and e-mail groups.

The study was conducted online via Google Forms. All participants signed the informed consent form (see Appendix B), giving information about confidentiality,

purpose of the study, how long it would take and voluntary participation. After that, the sociodemograpic form (see Appendix C), Intolerance of Uncertainty Scale-12 (see Appendix D), Generalized Anxiety Disorder-7 (see Appendix E), Turkish Young Parenting Inventory (see Appendix F) and The Short Schema Mode Inventory (see Appendix G) were given to the participants. The filling out of questionnaires lasted 20 minutes on average. The data was collected in February 2021.

2.4 Statistical Analysis

First of all, G-Power analyses were done to find out how many participants are required for study. A minimum of 210 participants were required in order to do t-test analysis. Data analysis was done using SPSS version 20 for Windows. Firstly, normality was checked. People who exceed 10% of emptiness and have an extreme score were excluded from the study. In order to investigate the distribution of the data, descriptive statistics were analyzed and the skewness and kurtosis values of the variables were examined. The evaluation of skewness and kurtosis values regarding normal distribution in the range of +1.5 and -1.5 values is accepted as normal distribution (Tabachnick and Fidell, 2013). Secondly, Pearson Correlation Analysis was used to investigate correlations between Intolerance of Uncertainty, Generalized Anxiety Disorder Symptoms, Short Schema Mode Inventory and Turkish Young Parenting Inventory. Furthermore, Spearman Analysis was used for subscales that did not have a normal distribution, such as Belittling Critizing Mother, Belittling Criticizing Father, Exploitative Abusive Mother and Exploitative Abusive Father, to see if there was a correlation with other scales. Next, participants were separated into high and low groups according to their IU and GADS scores. For GADS, the cut-off point given in the Turkish version as 8 was used (Konkan et al., 2013). Participants with GADS scores greater than 8 were classified as having high GADS, while those

with GADS scores less than 8 are classified as having low GADS. For IU, the cut-off point was decided to be median as 3.34. Participants whose scores are over median for IU are included in the high IU group and participants whose scores are lower than median are included in the low IU group. The Independent T-Test, was used to see differences between gender on IU, GADS and Schema Modes. In addition, the Paired Sample T-Test and Wilcoxon Signed-Rank Test were used to determine whether the mother or father factor has higher scores for high groups of IU and GADS in using split file method in order to select only high groups of IU and GADS. In this way, low groups of IU and GADS were inactivated. In order to respond to the main analysis, PROCESS version 3.4 by Andrew Hayes (Hayes, 2013) was used to conduct mediation analysis in order to see whether Schema Modes and Schema Parenting Factors mediate the relationship between IU and GADS. When PROCESS is used, all Schema Modes and Schema Parenting Factors are included in mediation analyses. In PROCESS Macro, the Bootstrap Method is recommended because it does not require the assumption of normal distribution. The indirect effects are estimated at the desired level of significance by randomly multiplying the sample with bootstrapping. Thus, a Bootstrap confidence interval is calculated for each indirect effect. If there is no zero in the bootstrap confidence interval, the indirect effect is statistically significant. If the bootstrap confidence interval include zero, the indirect effect is interpreted to be statistically insignificant (Preacher and Hayes, 2008).

CHAPTER 3: RESULTS

The findings will be presented in this chapter. Mean, minimum and maximum values and standard deviation of scales will be presented in the section of Descriptive Statistics of Variables. Next, T-test results will be given to compare the variables such as Schema Modes, Intolerance of Uncertainty (IU) and Generalized Anxiety Disorder Symptoms (GADS) regarding gender. Then, the correlation analysis will be given in order to understand the relationship between Schema Modes, Parenting Factors, GADS and IU based on Pearson and Spearman correlation coefficients. Following, Schema Parenting Factors will be compared based on high generalized anxiety symptoms group or high intolerance of uncertainty group. In this way, it can be understood that which parent has more scores on high generalized anxiety symptoms or high intolerance of uncertainty. Lastly, mediation analysis was made using PROCESS (Hayes, 2013) in order to see whether Schema Modes or Parenting Factors mediate between relationship of IU and GADS.

3.1 Descriptive Statistics of Variables

The descriptive statistic of measurement variables which are the mean, maximum and minimum values and standard deviation is presented in Table 7.

Table 8. The Descriptive Statistics of Variables

	N	*MIN*	*MAX*	*MEAN*	*SD*
GAD_Total	348	0	21	9.01	5.23
IU_Total	348	1.33	5	3.22	.79
IU_Prospective	348	1.14	5	3.34	.74
IU_Inhibitory	348	1	5	3.06	1.02
CHILD MODES					
Angry Child	348	1.1	5.50	2.81	.99
Vulnerable Child	348	1.1	6	2.13	1.11
Impulsive Child	348	1.1	5.13	2.07	.85
Undisciplined Child	348	1.1	6	2.82	1.3
Enraged Child	348	1	4.56	1.73	.81

Table 7. (continued) The Descriptive Statistics of Variables

MALADAPTIVE COPING MODES					
Compliant Surrenderer	348	1.1	5.14	2.45	.79
Detached Protector	348	1.1	6	2.21	1.11
Detached Self Soother	348	1.1	6	3.02	.94
Self Aggrandizer	348	1.11	5.44	2.90	.83
Bully / Attack	348	1.1	5.38	2.26	.80
PARENT MODES					
Punitive Parent	348	1.1	4.40	1.76	.72
Demanding Parent	348	1.1	6	3.16	.98
ADAPTIVE MODES					
Happy Child	348	1.11	6	4.38	.91
Healthy Adult Mode	348	2.67	6	4.82	.65
MOTHER					
Normative	348	1	5.42	2.47	1.06
Belittling_Criticizing	348	1	5.89	1.54	.83
Exploitative_Abusive	348	1	5.57	1.17	.47
Overprotective_Anxious	348	1	5.86	2.89	1.04
Conditional_Achievement_Focused	348	1	6	3.05	1.22
Overpermissive_Boundless	348	1	4.17	1.69	.71
Emotional_Depriving	348	1	5.38	2.54	1.08
Punitive	348	1	6	2.54	1.02
Pessimistic_Worried	348	1	6	2.46	1.26
Restricted_Emotional_Inhibited	348	1	6	2.84	1.12
FATHER					
Normative	348	1	6	2.60	1.16
Belittling_Criticizing	348	1	5.89	1.64	.99
Exploitative_Abusive	348	1	5.29	1.36	.68
Overprotective_Anxious	348	1	5.86	2.63	.97
Conditional_Achievement_Focused	348	1	6	3.03	1.21
Overpermissive_Boundless	348	1	4.50	1.73	.72
Emotional_Depriving	348	1	6	2.97	1.24
Punitive	348	1	6	2.66	1.12
Pessimistic_Worried	348	1	6	2.46	1.26
Restricted_Emotional_Inhibited	348	1	6	3.20	1.36

The participant characteristics as levels for IU and GADS are given in Table 8

Table 9. Participants Characteristics for Levels of GADS and IU

	Level	*Female*	*Male*	*N*	*M*
GADS					
	High	141	54	195	31.77
	Low	97	56	153	37.12

Table 8. (continued) Participant Characteristics for Levels of GADS and IU

IU					
	High	104	48	152	35.64
	Low	134	62	196	32.95

3.2 The Comparison of Gender on Variables

3.2.1 Gender on IU and GADS

Independent Samples t-test was conducted in order to investigate the gender differences regarding GADS, IU, IU Prospective and IU Inhibitory and these information are given in Table 9. Female participants had more GADS (M = 9.38, SE = .35) than male participants (M = 8.20, SE = .44). This difference, 1.18, was found significant, $t(246) = 2.09$, $p < .05$. For IU, Female participants had slightly more IU (M = 3.22, SE = .05) than male participants (M = 3.22, SE = .07). This difference, 0.01, was not significant, $t(245) = 0.06$, $p > .05$. Also, female participants had more IU Inhibitory scores (M = 3.07, SE = .07) than male participants (M = 3.03, SE = .09). This difference, 0.04, was not significant, $t(346) = 0.32$, $p > .05$. In contrast, male participants had higher score for IU Prospective (M = 3.35, SE = .07) than female participants (M = 3.34, SE = .05). This difference, 0.02, was not significant, $t(346) = 0.20$, $p > .05$.

Table 10. The Mean Difference of IU and GADS to Gender

	Gender	*N*	*Mean*	*SD*	*t*	*p*	*d*
GADS	Female	238	9.38	5.45	2.09	.04	.23
	Male	110	8.20	4.64			
IUS	Female	238	3.22	0.82	0.06	.95	0
	Male	110	3.22	0.71			
IUS_P	Female	238	3.34	0.76	0.20	.84	.01
	Male	110	3.35	0.70			
IUS_I	Female	238	3.07	1.05	0.32	.75	.04
	Male	110	3.03	0.95			

**p < .05*

3.2.2. Gender on Schema Modes

Secondly, the Independent Samples t-test was used to compare Schema Modes to gender variables and these scores are shown in Table 10. For impulsive child mode, male participants (M = 2.21, SE = .08) had higher scores than female participants (M

= 2.01, *SE* = .06) and this difference, 0.20, was found significant, *t*(346) = -2.05, *p* < .05. For Enraged Child Mode, male participants (*M* = 1.87, *SE* = .08) had higher scores than female participants (*M* = 1.67, *SE* = .05) and this difference, 0.20, was found significant, *t*(346) = -2.17, *p* < .05. In maladaptive parent modes, male participants (*M* = 1.88, *SE* = .07) had higher punitive parent mode scores than female participants (*M* = 1.7, *SE* = .04) and their difference, 0.19, was significant, *t*(346) = -2.27, *p* < .05. Moreover, for maladaptive coping modes, male participants (*M* = 3.12, *SE* = .08) had higher self-aggrandizer mode scores than female participants (*M* = 2.8, *SE* = .06) and their difference, 0.33, was significant, *t*(346) = -3.39, *p* < .05. For Bully and Attack mode, male participants (*M* = 2.54, *SE* = .08) had higher scores than female participants (*M* = 2.13, *SE* = .05), their difference, .41, is significant, *t*(346) = -1.61, *p* < .05. The final maladaptive coping mode which had different mean to being male or being female is Compliant Surrenderer Mode. Male participants (*M* = 2.61, *SE* = .07) had higher scores than female participants (*M* = 2.38, *SE* = .05) and their difference as .24 was significant, *t*(346) = -2.63, *p* < .05.

Table 11. The Mean Difference in Schema Modes to Gender

	Gender	*N*	*Mean*	*SD*	*t*	*p*	*d*
Angry Child	Female	238	2.82	1.04	0.24	.81	.02
	Male	110	2.8	0.88			
Vulnerable Child	Female	238	2.16	1.13	0.73	.47	.09
	Male	110	2.06	1.07			
Happy Child	Female	238	4.38	0.96	- 0.03	.97	0
	Male	110	4.38	0.78			
Impulsive Child	Female	238	2.01	0.87	- 2.05	.04*	.24
	Male	110	2.21	0.80			
Undisciplined Child	Female	238	2.8	1.04	- 0.44	.66	.05
	Male	110	2.85	1.03			
Compliant Surrenderer	Female	238	2.38	0.81	- 2.63	.01*	.30
	Male	110	2.61	0.71			
Detached Protector	Female	238	2.15	1.11	- 1.53	.13	.18
	Male	110	2.35	1.11			
Detached Self Soother	Female	238	2.96	0.94	-1.71	.09	.19
	Male	110	3.14	0.91			
Self Aggrandizer	Female	238	2.8	0.84	- 3.39	.00*	.39
	Male	110	3.12	0.80			
Bully Attack	Female	238	2.13	0.77	- 1.61	.00*	.52
	Male	110	2.54	0.79			
Punitive Parent	Female	238	1.7	0.69	- 2.27	.02*	.25

Table 10. (continued) The Mean Difference in Schema Modes to Gender

	Male	110	1.88	0.77			
Demanding Parent	Female	238	3.16	1.04	0.24	.81	.02
	Male	110	3.14	0.84			
Healthy Adult	Female	238	4.84	0.63	0.55	.59	.08
	Male	110	4.79	0.70			
Enraged Child	Female	238	1.67	0.80	- 2.17	.03*	.24
	Male	110	1.87	0.84			

*$p < .05$

3.3 High Level of IU and GADS Regarding Schema Parenting Factors

The Paired Sample T-test, which is shown in Table 11, was used to assess the high GADS group and the high IU group regarding parenting. Firstly, the scores of high GADS group were analyzed. Normative Fathers (M = 2.88, SE = .09) were significantly more than Normative Mothers (M = 2.69, SE = .08), $t(194) = -2.41$, $p < .05$. Restricted Emotional Inhibited Fathers (M = 3.34, SE = .10) were also more than Restricted Emotional Inhibited Mothers (M = 2.99, SE = .08) significantly, $t(194) = -3.58$, $p < .05$. Emotionally Depriving Fathers (M = 3.15, SE = .08) had significantly higher scores on Emotionally Depriving Mothers (M = 2.61, SE = .09), $t(194) = -6.70$, $p < .05$. The last significant variable was Overprotective/Anxious, $t(194) = 5.02$, $p < .05$. Overprotective and Anxious Mothers (M = 3.13, SE = .07) were more than Overprotective and Anxious Fathers (M = 2.86, SE = .07). In contrast, there was no significant results for parenting factors of Pessimistic Worried, $t(194) = -0.06$, $p > .05$, Overpermissive Boundless, $t(194) = -1.34$, $p > .05$, Conditional Achievement Focused, t (204) = -0.00, p = 1 and Punitive, $t(194) = -1.56$, $p > .05$.

Table 12. The Comparison of Parents on High GADS Group

		M	*SD*	*t*	*p*	*d*
PAIR 1	Normative_M	2.69	1.08	- 2.41	.02*	.17
	Normative_F	2.88	1.20			
PAIR 2	Overprotective_Anxious_M	3.13	1.03	5.02	.00*	.26
	Overprotective_Anxious_F	2.86	1.02			
PAIR 3	Conditional_Achievement_M	3.19	1.20	0.09	0.93	.01
	Conditional_Achievement_F	3.18	1.21			
PAIR 4	Overpermissive_Boundless_M	1.82	0.77	- 1.34	.18	.05
	Overpermissive_Boundless_F	1.86	0.79			
PAIR 5	EmotDepriving_M	2.61	1.15	- 6.70	.00*	.44
	EmotDepriving_F	3.15	1.30			
PAIR 6	Punitive_M	2.69	1.07	- 1.56	.12	.12

Table 11. (continued) The Comparison of Parents on High GAD Group

	Punitive_F	2.83	1.17			
PAIR 7	Pessimistic_Worried_M	2.69	1.29	- 0.06	.95	.01
	Pessimistic_Worried_F	2.70	1.30			
PAIR 8	Restricted_EmInhibited_M	2.99	1.16	- 3.58	.00*	.27
	Restricted_EmInhibited_F	3.34	1.38			

*$p < .05$; N = 195

Wilcoxon signed-rank test was used to assess 2 parenting factors which are Exploitative/Abusive and Belittling/Criticizing for high GADS group. These scores were given in Table 12. Exploitative Abusive Mothers (*Mdn* = 1.00) had significantly lower scores than Exploitative Abusive Fathers (*Mdn* =1.14), $Z = -6.29$, $p < .05$. In contrast, there was no significant results for Belittling Critizing, $Z = -1.55$, $p > .05$.

Table 13. The Comparison of Parents on High GADS Group in Nonparametric Factors

		M	*SD*	*Z*	*p*
PAIR 1	Belittling_Criticizing_M	1.69	0.93	- 1.55	.12
	Belittling_Criticizing_F	1.79	1.06		
PAIR 2	Exploitative_Abusive_M	1.20	0.47	- 6.29	.00*
	Exploitative_Abusive_F	1.44	0.74		

*$p < .05$; N = 195

For IU, Paired sample t-test was used to compare Schema Parenting Factors. The scores were given in Table 13. It was found that there was no significant results for Pessimistic Worried factors, $t(151) = -1.17$, $p > .05$, Overpermissive Boundless factors, $t(151) = -1.20$, $p > .05$, Conditional Achievement Focused factors, $t(151) = -1.30$, $p > .05$ and Punitive factors, $t(151) = -2.02$, $p > .05$. However, Normative Fathers ($M = 2.86$, $SE = .09$) were significantly more than Normative Mothers ($M = 2.59$, SE = .08), $t(151) = -3.14$, $p < .05$. Restricted Emotional Inhibited Fathers ($M = 3.42$, $SE = .11$) were also more than Restricted Emotional Inhibited Mothers ($M = 3.03$, $SE = .09$) significantly, $t(151) = -3.69$, $p < .05$. Emotionally Depriving Fathers ($M = 3.07$, $SE = .11$) had significantly more scores on Emotionally Depriving Mothers ($M = 2.63$, $SE = .09$), $t(150) = -4.96$, $p < .05$. In addition to this, Overprotective Anxious Mothers ($M = 3.08$, $SE = .09$) were significantly more than Overprotective Anxious Fathers ($M = 2.95$, $SE = .09$), $t(151) = 2.39$, $p < .05$.

Table 14. The Comparison of Parents on High IU Group

		M	*SD*	*t*	*p*	*d*
PAIR 1	Normative_M	2.59	1.07	- 3.14	.00*	0.24
	Normative_F	2.86	1.17			
PAIR 2	Overprotective_Anxious_M	3.08	1.05	2.39	.02*	0.12
	Overprotective_Anxious_F	2.95	1.06			
PAIR 3	Conditional_Achievement_M	3.12	1.17	- 1.30	.20	0.08
	Conditional_Achievement_F	3.21	1.20			
PAIR 4	Overpermissive_Boundless_M	1.86	0.80	- 1.20	.23	0.06
	Overpermissive_Boundless_F	1.91	0.83			
PAIR 5	EmotDepriving_M	2.63	1.18	- 4.96	.00*	0.35
	EmotDepriving_F	3.07	1.31			
PAIR 6	Punitive_M	2.54	1.04	- 2.02	.05	0.19
	Punitive_F	2.76	1.22			
PAIR 7	Pessimistic_Worried_M	2.64	1.25	- 1.17	.25	0.09
	Pessimistic_Worried_F	2.76	1.31			
PAIR 8	Restricted_EmInhibited_M	3.03	1.16	- 3.69	.00*	0.31
	Restricted_EmInhibited_F	3.42	1.32			

*$p < .05$; N = 152

Wilcoxon signed-rank test was used to assess 2 parenting factors which are Exploitative/Abusive and Belittling/Criticizing for high IU group. These scores are given in Table 14. Exploitative Abusive Mothers (*Mdn* = 1.14) had significantly lower scores than Exploitative Abusive Fathers (*Mdn* = 1.63), $Z = -5.33$, $p < .05$. Belittling Critizing Mothers (*Mdn* = 1.22) had significantly lower than Belittling Critizing Fathers (*Mdn* = 1.33), $Z = -2.19$, $p < .05$.

Table 15. The Comparison of Parents on High IU Group in Nonparametric Factors

		M	*SD*	*Z*	*p*
PAIR 1	Belittling_Criticizing_M	1.60	0.90	- 2.19	.03*
	Belittling_Criticizing_F	1.76	1.05		
PAIR 2	Exploitative_Abusive_M	1.20	0.48	- 5.33	.00*
	Exploitative_Abusive_F	1.39	0.62		

*$p < .05$; N = 152

3.4 Correlation Between Variables

Intolerance of Uncertainty Scale, Generalized Anxiety Disorder Scale and all Schema Modes are in the range between -1.5 and +1.5. However, there are 4 subscales are not in the range between -1.5 and +1.5. These are Belittling and Critizing Mother,

Belittling and Critizing Father, Exploitative and Abusive Mother and Exploitative and Abusive Father. The rest of Parenting Factors are in the range of -1.5 and +1.5. Therefore, variables which show normal distribution are analyzed using with Pearson Correlation analysis but variables which do not show normal distribution are analyzed using Spearman Correlation analysis.

3.4.1 Correlation between IU, Schema Modes and GADS

Pearson Correlation analysis is showed to see relationship between Generalized Anxiety Disorder Symptoms, Intolerance of Uncertainty and Schema Modes in Table 15. The subscales of Intolerance of Uncertainty and the subscales of Schema Modes are given. Firstly, when the relationship between IU and GADS are examined, it was found that there is a statistically significant relationship between GADS, IU, IU Prospective and IU Inhibitory. Secondly, there was a statistically significant positive relationship between GADS and all Schema Modes except Happy Child Modes and Healthy Adult Modes were significantly positively correlated with GADS. In contrast, there was a statistically significant negative relationship between GADS and Happy Child Mode. In addition, there is a significant negative relationship between GADS and Healthy Adult Mode. On the other hand, there was a significant relationship between IU and two subscales of IU which are IU Prospective and IU Inhibitory. Also, there was a statistically significant positive relationship between IU and all Schema Modes except Happy Child Mode and Healthy Adult Mode. In contrast, the relationship between IU and Happy Child Mode was statistically significant negative relationship. However, there was no significant relationship between Healthy Adult Mode and IU. Moreover, significant positive relationship was found between Healthy Adult Mode and Happy Child Mode. Some of Schema Modes which are Angry Child Mode, Vulnerable Child Mode, Impulsive Child Mode, Undisciplined Child Mode, Enraged Child Mode, Compliant Surrenderer Mode, Detached Protector Mode and Punitive Parent Mode had statisticaly significant negative relationship with Healthy Adult Mode, however some of schema modes which are Self Aggrandizer Mode, Bully and Attack Mode and Demanding Parent Mode had not statistically significant negative relationship with Healthy Adult Mode. There was also one exception related with Detached Self Soother Mode. The relationship between Detached Self Soother Mode and Healthy Adult Mode was not statistically significant and positive.

Table 16. The Relationship Between IU, GADS and Schema Modes

	1	2	3	4	5	6	7	8	9	10	11	12
1 GADS	1											
2 IU	.54**	1										
3 IU_P	.46**	.92**	1									
4 IU_I	.53**	.92**	.69**	1								
5 ACM	.58**	.38**	.36**	.34**	1							
6 VCM	.62**	.33**	.27**	.33**	.72**	1						
7 HCM	- .55**	- .25**	- .17**	- .28**	- .50**	- .68**	1					
8 ICM	.52**	.34**	.32**	.32**	.68**	.64**	- .42**	1				
9 UCM	.43**	.23**	.20**	.22**	.57**	.56**	- .32**	.64**	1			
10 ECM	.51**	.33**	.30**	.30**	.63**	.50**	- .29**	.70**	.49**	1		
11 CSM	.27**	.19**	.18**	.17**	.47**	.56**	- .32**	.40**	.39**	.28**	1	
12 DPM	.52**	.32**	.28**	.31**	.68**	.82**	- .60**	.66**	.54**	.50**	.44**	1
13 DSSM	.33**	.28**	.27**	.24**	.52**	.43**	- .21**	.43**	.36**	.35**	.33**	.47**
14 SAM	.30**	.39**	.40**	.32**	.47**	.32**	- .10**	.49**	.39**	.43**	.28**	.37**
15 BAM	.28**	.33**	.34**	.27**	.54**	.41**	- .18**	.52**	.40**	.50**	.31**	.51**
16 PPM	.51**	.33**	.28**	.32**	.65**	.78**	- .54**	.62**	.47**	.54**	.62**	.67**
17 DPAM	.45**	.36**	.34**	.31**	.59**	.60**	- .36**	.41**	.28**	.31**	.48**	.51**
18 HAM	- .32**	- .09	- .06	- .12*	- .18**	- .38**	.62**	- .33**	- .19**	- .31**	- .25**	- .29**

Table 15. (continued) The Relationship Between IU, GADS and Schema Modes

	13	14	15	16	17	18
1 GADS						
2 IU						
3 IU_P						
4 IU_I						
5 ACM						
6 VCM						
7 HCM						
8 ICM						
9 UCM						
10 ECM						
11 CSM						
12 DPM						
13 DSSM	1					
14 SAM	.44**	1				
15 BAM	.37**	.66**	1			
16 PPM	.48**	.34**	.46**	1		
17 DPAM	.51**	.42**	.37**	.60**	1	
18 HAM	.03	- .02	- .06	- .36**	- .07	1

**$p < .01$; $p < .05$; N = 348; IU_P = Intolerance of Uncertainty Prospective, IU_P = Intolerance of Uncertainty Inhibitory, ACM= Angry Child Mode, VCM= Vulnerable Child Mode, HCM= Happy Child Mode, ICM = Impulsive Child Mode, UCM= Undisciplined Child Mode, ECM= Enraged Child Mode, CSM= Compliant Surrenderer Mode, DPM= Detached Protector Mode, DSSM= Detached Self Soother Mode, SAM= Self Aggrandizer Mode, BAM= Bully Attack Mode, PPM= Punitive Parent Mode, DPAM= Demanding Parent Mode, HAM= Health Adult Mode

3.4.2 Correlation between IU, Schema Parenting Factors and GADS

Another Pearson Correlation analysis was made to see the relationship between Parenting Factors, Generalized Anxiety Disorder Symptoms and Intolerance of Uncertainty is showed in Table 16. Generalized Anxiety Disorder Symptoms had statistically significant positive relationship with all Parenting Factors including both Normative Mother and Normative Father, Overprotective Anxious Mother, Overprotective Anxious Father, both Conditional Achievement Focused Mother and Conditional Achievement Focused Father, Overpermissive Boundless Mother, Overpermissive Boundless, Emotional Depriving Mother, Emotional Depriving Father, Punitive Mother, Punitive Father, Pessimistic Worried Mother, Pessimistic Worried Father, Restricted Emotionally Inhibited Mother and Restricted Emotionally Inhibited Father. Also, there was a statistically significant relationship between Intolerance of Uncertainty and Parenting Factors including Normative Mother, Normative Father, Overprotective Anxious Mother, Overprotective Anxious Father, Conditional Achievement Focused Mother, Conditional Achievement Focused Father, Overpermissive Boundless Mother, Overpermissive Boundless, Pessimistic Worried Mother, Pessimistic Worried Father, Restricted Emotionally Inhibited Mother and Restricted Emotionally Inhibited Father except Emotionally Depriving Parenting Factors for both Mother and Father and Punitive Parenting Factors for both Mother and Father

Table 17. The Relationship Between IU, GADS and Schema Parenting Factors

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1 GADS	1													
2 IU	.54**	1												
3 IU_P	.46**	.92**	1											
4 IU_I	.53**	.92**	.69**	1										
5 Nor_M	.27**	.16**	.14*	.17**	1									
6 Nor_F	.27**	.22**	.20**	.21**	.57**	1								
7 OA_M	.28**	.17**	.09	.22**	.53**	.38**	1							
8 OA_F	.32**	.26**	.20**	.27**	.41**	.49**	.74**	1						
9 CAF_M	.13*	.15**	.14**	.14**	.68**	.48**	.40**	.31**	1					
10 CAF_F	.13*	.22**	.22**	.18**	.42**	.70**	.26**	.35**	.72**	1				
11 OB_M	.26**	.15**	.10	.18**	.18**	.22**	.28**	.24**	.10	.11*	1			
12 OB_F	.29**	.19**	.14*	.21**	.16**	.24**	.27**	.22**	.09	.12*	.83**	1		
13 ED_M	.13*	.03	.02	.04	.24**	.06	- .02	- .06	.06	- .02	.29**	.20**	1	
14 ED_F	.20**	.07	.06	.07	.15**	.26**	.04	- .05	.06	.08	.24**	.35**	.63**	1
15 Pun_M	.20**	.04	.04	.05.	.60**	.26**	.31**	.16**	.38**	.16**	.25**	.18**	.46**	.30**
16 Pun_F	.22**	.10	.09	.10	.24.**	.59**	.13*	.20**	.23**	.37**	.23**	.33**	.20**	.48**
17 PW_M	.28**	.17**	.16**	.15**	.59**	.38**	.44**	.30**	.41**	.31**	.31**	.26**	.27**	.22**
18 PW_F	.29**	.20**	.17**	.19**	.39**	.60**	.32**	.41**	.29**	.40**	.27**	.30**	.12*	.24**
19 REI_M	.19**	.16**	.17**	.14*	.56**	.38**	.32**	.24**	.37**	.31**	.25**	.22**	.27**	.21**
20 REI_F	.15**	.14**	.15**	.12*	.31**	.56**	.24**	.28**	.26**	.41**	.20**	.17**	.09	.27**

Table 16. (continued) The Relationship Between IU, GADS and Schema Parenting Factors

	15	16	17	18	19	20
1 GADS						
2 IU						
3 IU_P						
4 IU_I						
5 Nor_M						
6 Nor_F						
7 OA_M						
8 OA_F						
9 CAF_M						
10 CAF_F						
11 OB_M						
12 OB_F						
13 ED_M						
14 ED_F						
15 Pun_M	1					
16 Pun_F	.43**	1				
17 PW_M	.45**	.25**	1			
18 PW_F	.27**	.53**	.59**	1		
19 REI_M	.30**	.10	.49**	.33**	1	
20 REI_F	.17**	.33**	.33**	.56**	.46**	1

**$p < .01$; $p < .05$; $N = 348$; IU_P = Intolerance of Uncertainty Prospective, IU_I = Intolerance of Uncertainty Inhibitory, Nor_M= Normative Mother, Nor_F= Normative Father, OA_M= Overprotective Anxious Mother, OA_F= Overprotective Anxious Father, CAF_M= Conditional Achievement Focused Mother, CAF_F= Conditional Achievement Focused Father, OB_M= Overpermissive Boundless Mother, OB_F= Overpermissive Boundless Father, ED_M= Emotional

Depriving Mother, ED_F= Emotional Depriving Father, Pun_M= Punitive Mother, Pun_F= Punitive Father, PW_M= Pessimistic Worried Mother, PW_F= Pessimistic Worried Father, REI_M= Restricted Emotionally Inhibited Mother, REI_F= Restricted Emotionally Inhibited Father

Spearman Correlation Analysis is seen in Table 17. was made for parenting factors which distributed not normally as Belittling Critizing Mother, Belittling Criticizing Father, Exploitative Mother and Exploitative Father. Using with Spearman analysis, the relationship between GADS, IU and these 4 parenting factors were examined. There is a significant positive relationship between GADS and these parenting factors as Belittling Critizing Mother, Belittling Criticizing Father, Exploitative Mother and Exploitative Father. On the other hand, there is significant relationship between IU and Belittling Critizing Father and Exploitative Abusive Father. However, there is no significant relationship between IU and Belittling Criticizing Mother and Exploitative Abusive Mother.

Table 18. The Relationship Between IU, GADS and Schema Parenting Factors as Nonparametric Factors

	1	2	3	4	5	6	7	8
1 GADS	1							
2 IU	.52**	1						
3 IU_P	.45**	.91**	1					
4 IU_I	.52**	.92**	.69**	1				
5 BC_M	.27**	.09	.04	.13*	1			.
6 BC_F	.29**	.16**	.11*	.18.**	.68**	1		
7 EA_M	.16**	.08	.03	.11*	.50**	.41**	1	
8 EA_F	.23**	.11*	.07	.12*	.29**	.46**	.59**	1

** $p < .01$, * $p < .05$ BC_M= Belittling Critizing Mother, BC_F = Belittling Critizing Father, EA_M = Exploitative Abusive Mother, EA_F= Exploitative Anxious Father

3.5 The Mediation of Schema Modes and Schema Parenting Factors on Relationship Between IU and GADS

A parallel mediation analyses was used by using the PROCESS version 3.4 by Hayes to investigate whether Schema Modes or Schema Parenting Factors mediated relationship between IU and GADS. Schema Modes analyses were categorized into four modes as Child Modes, Parent Modes, Maladaptive Coping Modes and Adaptive Modes. Schema Parenting Factors analyses were categorized into two modes as Mother Factors and Father Factors.

The analyses were made to find whether Schema Modes mediated the relationship between IU and GADS. Child Modes such as Angry Child Mode, Vulnerable Child Mode, Impulsive Child Mode, Undisciplined Child Mode and Enraged Child Mode

were entered the model as mediators and this model is shown in Figure 1. The model was significantly predicted and explained the 54% of the variance, $R^2 = .54$, $F(6, 341) = 67.19$, $p < .001$. There were found two mediators among Child Modes. For Enraged Child Mode, there was a significant indirect effect of IU on GADS, $b = .35$, 95% BCa CI [0.015, 0.125]. There was also significant indirect effect of IU on GADS through Vulnerable Child Mode, $b = .81$, 95% BCa CI [0.504, 1.168].

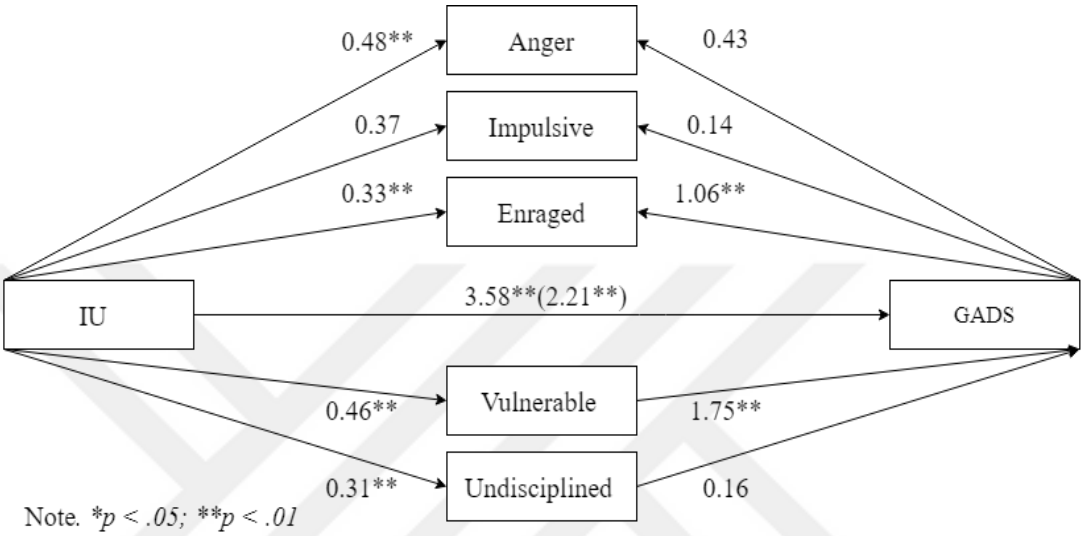

Figure 1. The mediating role of Child Modes on the relationship between IU and GADS

Parent Modes such as Demanding Parent Mode and Punitive Parent Mode were entered the model as mediators and this is shown in Figure 2. The model was significantly predicted and explained the 43% of the variance, $R^2 = .43$, $F(3, 344) = 85.23$, $p < .001$. For Demanding Parent Mode, there was a significant indirect effect of IU on GADS, $b = .31$, 95% BCa CI [0.037, 0.612]. There was also significant indirect effect of IU on GADS through Punitive Parent Mode, $b = .67$, 95% BCa CI [0.504, 1.168].

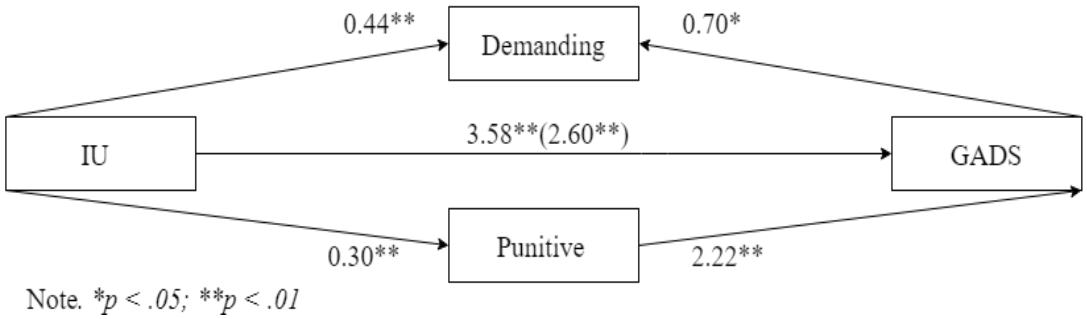

Figure 2. The mediating role of Parent Modes on the relationship between IU and GADS

Maladaptive Coping Modes such as Compliant Surrenderer Mode, Detached Protector Mode, Detached Self Soother Mode, Bully Attack Mode, Self-Aggrandizer Mode were entered the model as mediators and this is shown in Figure 3. The model was significantly predicted and explained the 43% of the variance, R^2 = .43, F(6, 341) = 43.01, p < .001. There is found only Detached Protector Mode as mediator. For Detached Protector Mode, there was a significant indirect effect of IU on GADS, b = .85, 95% BCa CI [0.507, 1.241].

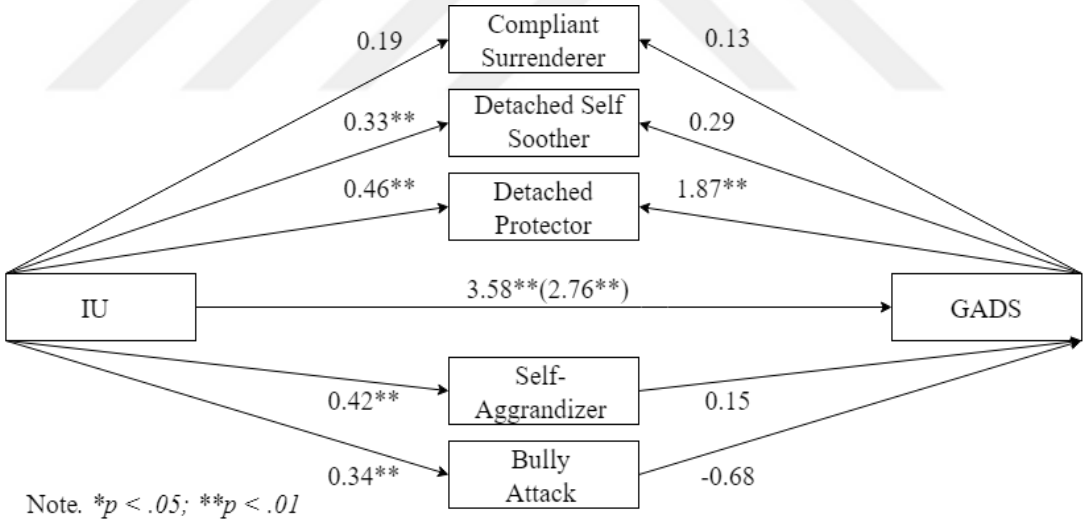

Figure 3. The mediating role of Maladaptive Coping Modes on the relationship between IU and GADS

Adaptive Modes such as Healthy Adult Mode and Happy Child Mode were entered to the model as mediators and this is shown in Figure 4. The model was significantly predicted and explained the 47% of the variance, R^2 = .47, F(3, 344) = 103.26, p < .001. There was found only Happy Child Mode as mediator. For Happy Child Mode,

there was a significant indirect effect of IU on GADS, *b* = .72, 95% BCa CI [0.384, 1.112].

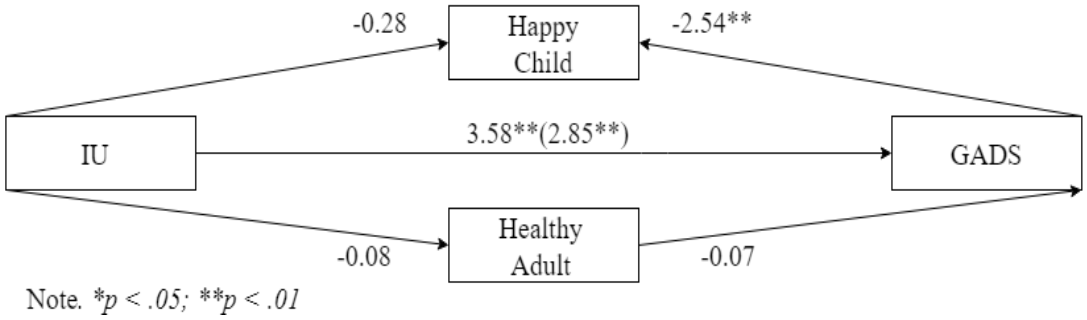

Figure 4. The mediating role of Adaptive Modes on the relationship between IU and GADS

On the other side, mediation analyses were made to find whether Mother Factors mediated the relationship between IU and GADS in Figure 5. The model was significantly predicted and explained the 38% of the variance, R^2 = .38, $F(11, 336)$ = 18.58, p < .01. Among all Mother Factors, there was found Overpermissive Boundless Mother and Conditional Achievement Focused Mother as mediators. For Overpermissive Boundless Mother, there was a significant indirect effect of IU on GADS, *b* = .11, 95% BCa CI [0.004, 0.280]. For Conditional Achievement Focused Mother, there was a significant indirect effect of IU on GADS, *b* = - .13, 95% BCa CI [0.004, 0.280].

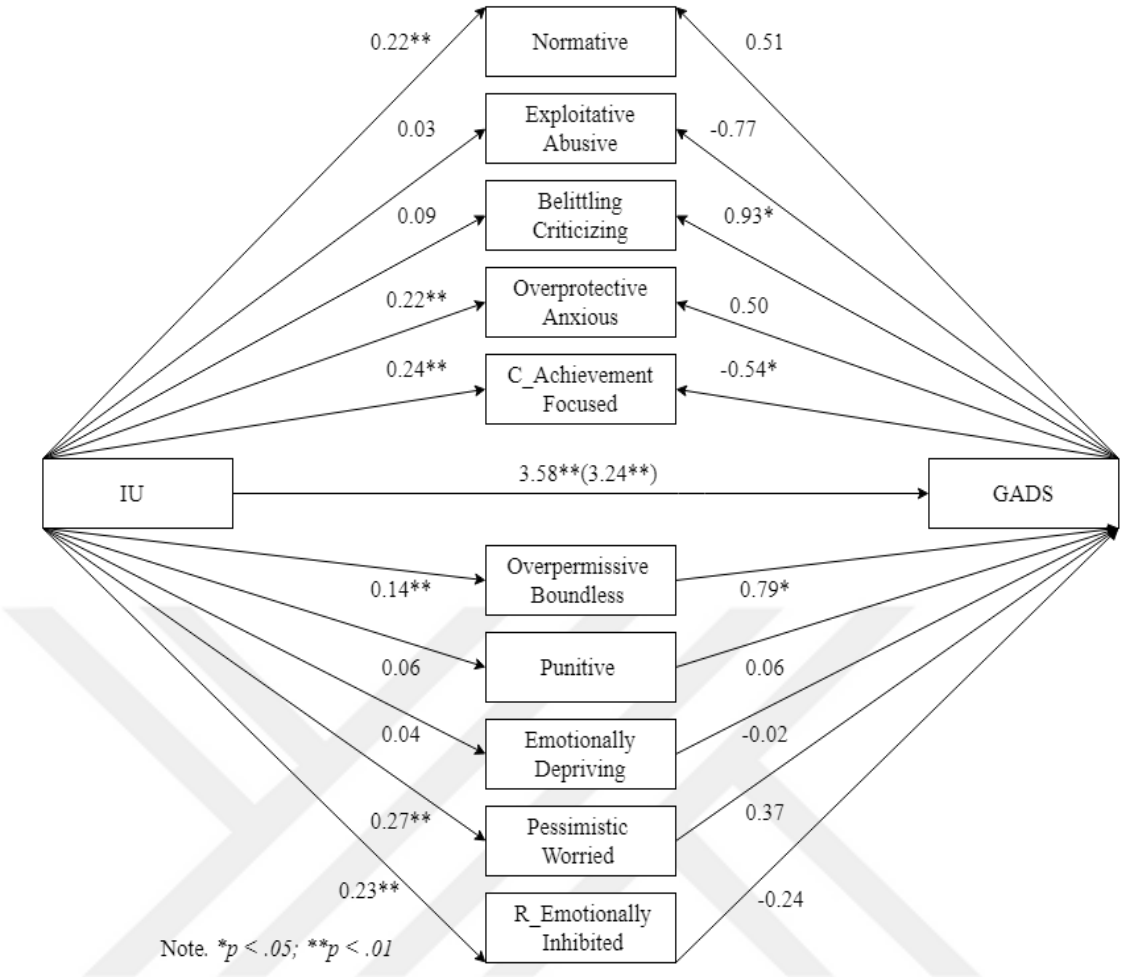

Figure 5. The mediating role of Mother Factors on the relationship between IU and GADS

Finally, mediation analyses were made to find whether Father Factors mediated the relationship between IU and GADS in Figure 6. The model was significantly predicted and explained the 39% of the variance, $R^2 = .39$, $F(11, 335) = 19.35$, $p < .01$. Among the all Father Factors, there was found Overprotective Anxious Father and Conditional Achievement Focused Father as mediator. For Overprotective Anxious Father, there was a significant indirect effect of IU on GADS, $b = .28$, 95% BCa CI [0.085, 0.541]. For Conditional Achievement Focused Father, there was a significant indirect effect of IU on GADS, $b = -.18$, 95% BCa CI [-0.423, -0.010].

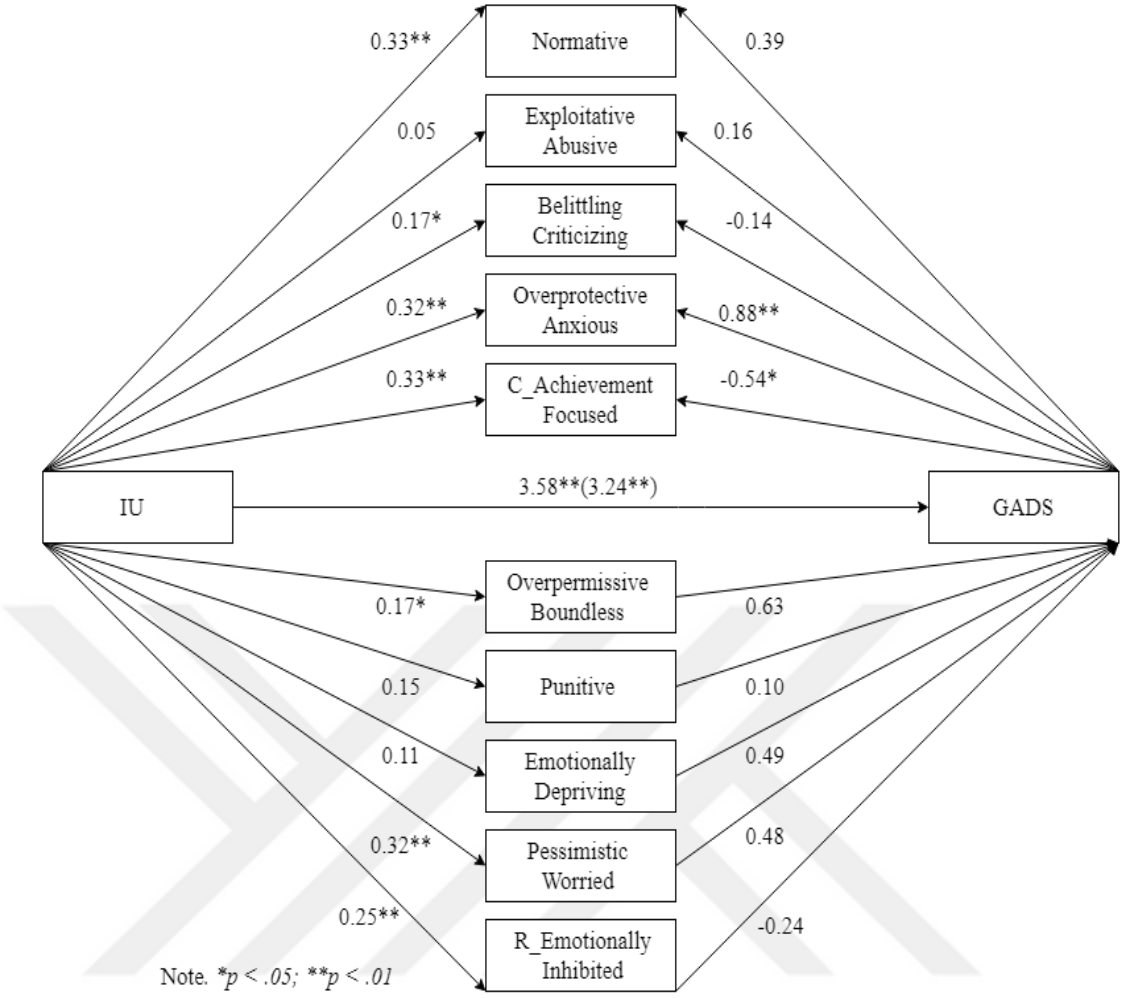

Figure 6. The mediating role of Father Factors on the relationship between IU and GADS

CHAPTER 4: DISCUSSION

The purpose of this study was to investigate IU and GADS in the Schema Therapy Model. For this reason, it was examined whether Schema Modes and Schema Parenting Factors mediate the relationship between IU and GADS. Also, the comparison of parents to perceived parenting styles in high groups of IU and GADS was investigated. Each research question tested whether it was supported or not was examined within the framework of the relevant literature. However, because of the limited number of studies related to the subject, fewer previous findings have been given to discuss the findings related to the relations between variables, especially related to Schema Modes, by comparing them with the results of previous studies. For this reason, the findings of the study have been handled by being limited to the theoretical context. After the findings were discussed, the clinical implications of the study, the limitations of the study and suggestions for future studies were presented.

4.1 The Evaluation of Comparison of Gender on Variables

4.1.1 Gender on IU and GADS

Intolerance of Uncertainty, Generalized Anxiety Disorder Symptoms and Schema Modes were compared to gender, respectively. The difference between males and females in GADS was found to be significant. GADS scores are higher in females than in males. This result is consistent with previous findings that GAD is significantly higher in women than in men (Farrer et al., 2016; McLean et al., 2011; Vesga-Lopez et al., 2008; American Psychiatric Association, 2013). In previous studies, the ratio of differences between males and females was found to be 1:2 (Bruce et al., 2005; Angst and Mikola, 1985).

Although GADS was found to be significant for gender, there were no significant results for IU, IU Prospective and IU Inhibitory. Females and males showed roughly equal IU and IU Prospective scores. For IU Inhibitors, females were slightly more than males. Findings from some studies in the literature indicate that IU does not show a significant difference in gender. In a study examining the relationship between intolerance of uncertainty and psychological symptoms, gender did not have a significant effect on IU (Armutlu, 2019). In another study investigating the mediator role of psychological flexibility in the relationship between IU and trait anxiety, the

IU levels of women and men were close to each other (Özkan, 2020). Thus, although IU is seen as a determining feature in GAD and gender differences in GADS were found, IU scores seem to be similar in females and males.

4.1.2 Gender on Schema Modes

For Impulsive Child Mode, Enraged Child Mode, Self-Aggrandizer Mode, Bully and Attack Mode, Compliant Surrenderer Mode and Punitive Parent Mode, males and females had significantly different results. All these schema modes are more active in males. However, adaptive modes such as Healthy Adult Mode and Happy Child Mode do not depend on gender variables. While the scores are approximately equal for Happy Child Mode, Healthy Adult Mode is more active in females, even if the difference is not significant. Yolalan (2020) examined Schema Modes. It was found that Bully and Attack Mode and Self-Aggrandizer Mode were considerably higher in males than in females. In the non-clinical sample, Bully and Attack Mode, Self Aggrandizer Mode, Compliant Surrenderer Mode and Punitive Parent Mode were found to be significantly more active for males than for females. In addition, Healthy Adult Mode and Happy Child Mode were found to be considerably higher in females than in males. It can be evaluated that gender roles play an important role in the Self-Aggrandizer Mode, Bully and Attack Mode, Enraged Child Mode and Compliant Surrenderer being seen more in men than in women. On the other hand, there are different gender roles, which are roles imposed on men and women by society, expected by men and women by society. The desired features to be created for women are victims, shy, submissive, powerless, followers, soft, passive, while the desired features to be created for men are harsh, strong, judgemental, independent and dominating (Navaro, 1997). These actions are regarded as more socially acceptable (Morf and Rhodewalt, 2001). Therefore, it is not surprising that schema modes such as Impulsive Child Mode, Enraged Child Mode, Self-Aggrandizer Mode and Bully and Attack Mode based on being more active rather than passive have higher scores in males.

4.2 The Evaluation of Difference in Individuals Regarding Perceived Parenting Attitudes on High Levels of IU and GADS

H1: Overprotective Anxious Mother Factor in Schema Parenting Factors is expected to have more scores on the groups, high GADS and high IU, than the Father counterpart

In the study, maternal and paternal factors were compared to see if there was any difference in perceived parenting factors in the high IU and high GADS groups. For the high GADS group, the significant differences between mother and father were found in Normative Parenting, Exploitative and Abusive Parenting, Emotional Depriving Parenting, Restricted Emotionally Inhibited Parenting and Overprotective Anxious Parenting. Fathers are perceived as more normative, exploitative and abusive, emotional depriving, restricted and emotionally inhibited, while mothers are perceived as more overprotective and anxious in the high GADS group. For the high IU group, there was also a significant difference between parental and maternal factors in Normative Parenting, Exploitative and Abusive Parenting, Emotional Depriving Parenting, Restricted Emotionally Inhibited Parenting, Belittling and Criticizing Parenting and Overprotective Anxious Parenting. Mothers are perceived as more overprotective and anxious than fathers in Overprotective Anxious Parenting for participants whose scores are high in IU. However, fathers are perceived more in the rest of the parenting factors which were found significant.

When the results were evaluated, it can be seen that only in Overprotective Anxious Parenting, mothers are perceived as higher even when all parenting factors are included for both high IU and high GADS. The hypothesis (H1) was also supported by the fact that the Overprotective Anxious Mother Factor in Schema Parenting Factors has higher scores for the groups, high IU and high GADS, than the father's counterpart.

The findings related to Overprotective and Anxious Parenting Factors were consistent with previous studies. Early-life experiences learned from parents may result in maladaptive cognition (Beck and Young, 1995). These early experiences are also linked to mental transitions from childhood to adulthood (Bowlby, 1980). According to Parker, Tupling and Brown (1979), Overprotection was associated with interference

and dependency encouragement, resulting in a restriction of the child's needs. In the study of Erozkan (2012), parenting attitudes were examined. Overprotective parenting, according to Erozkan (2012), was associated with anxiety sensitivity and had the ability to predict anxiety sensitivity, which is the belief that anxiety symptoms are harmful. Anxiety sensitivity is known to be a risk factor for anxiety disorders (Mantar, Yemez and Alkın, 2011). There is a parenting style called Affectionless Control that includes low care and high overprotection (Parker, 1983). This parenting style was found to be the most pathogenic among all parenting styles because it was associated with anxiety disorders. In addition, a comparison between a mother and a father in affectionless control was made. The result was that mothers had higher scores for anxiety disorders (Parker, 1984). Also, maternal control was negatively associated with the autonomy of the child (Ceylan et al., 2016). As a result, it was thought that mothers would score higher than fathers in Overprotective Anxious Parenting. Overprotective parenting is also involved in pathological situations. In the study of Lizardi et al. (1995), patients with major depression perceived their mothers as significantly more overprotective than their fathers were. In addition, when overcontrolling parenting was examined for anxiety, maternal overcontrol had an indirect effect on anxiety. As a result of these findings, for participants with high GADS or IU scores, the mother's factors in Overprotective Anxious Parenting were expected to have higher scores than the father's counterpart.

On the other hand, fathers are more perceived as Normative, Exploitative and Abusive, Emotional Depriving and Restricted Emotionally Inhibited than mothers for participants whose GADS scores were high. For the high IU group, paternal factors found significantly more than maternal factors for parenting of Normative, Exploitative and Abusive, Emotional Depriving, Restricted Emotionally Inhibited and Belittling Criticizing. In the study of Yolalan (2020), it was found that paternal parenting styles were more associated with depression than maternal parenting styles. In the current study, paternal parenting styles were more associated with GADS than maternal parenting styles, except for Overprotective Anxious Parenting.

4.3 The Evaluation of Correlations Between Variables

4.3.1 The Discussion of Correlations Between GADS, IU, IU Prospective and IU Inhibitory

According to the study's findings, GADS, IU, IU Prospective and IU Inhibitory have a strong positive association. When the intoleration of uncertainty increases, GADS scores also increase. IU Inibitory was found to be more associated with GADS than IU Prospective.

These findings are consistent with the previous findings. According to the literature, IU and GAD were associated and IU was one of the main components of GAD (Dugas et al., 1998; Ladouceur et al., 1999; Buhr and Dugas, 2002; Dugas, Buhr and Ladouceur, 2004; Starcevic and Berle, 2006). However, Carleton, Norton and Asmundson (2012) investigated the relationship between subscales of IU and GAD. IU Prospective was found to be more related to GAD than IU Inhibitory. However, in this study, IU Inhibitory was found to be more related to GADS. IU Inhibitory includes the perception of restriction on something in individuals. This restriction may be related to preventing them from meeting their needs. In this way, individuals may face higher anxiety.

4.3.2 The Discussion of Correlations Between Schema Modes, IU and GADS

When the relationship between Schema Modes, GADS and IU was examined, there was a significant positive correlation between all of the schema modes, except the adaptive modes and either GADS or IU. When these schema modes are increased, the severity of IU and GADS are increased. Therefore, it can be said that schema modes are maladaptive and using these schema modes leads to more dysfunction in an individual’s life, as IU and GADS are not functional concepts. The adaptive modes were Healthy Adult Mode and Happy Child Mode. As expected, these adaptive modes were found to be negatively related to GADS. However, although Happy Child Mode was found to be significantly negatively correlated with IU, Healthy Adult Mode was not. Nevertheless, it can be concluded that individuals who have more adaptive modes also have lower scores on IU and GADS.

In the literature, there are no studies examining the relationship between Schema Modes, IU and GADS specifically. In the study of Yolalan (2020), the correlations

between Schema Modes and Depression were given. The results showed that all Schema Modes were correlated with depression significantly. While maladaptive schema modes were positively correlated, adaptive schema modes such as Healthy Adult Mode and Happy Child Mode were negatively correlated. Therefore, Yolalan (2020) also found that when maladaptive schema modes increased, the psychopathology scores also increased. In addition, when Healthy Adult Mode and Happy Child Mode are more active, psychopathology is weakened. Young (2019) explained the healing process as a switching from maladaptive modes to adaptive modes. Therefore, the findings that maladaptive modes are positively correlated with IU and GADS and adaptive modes as Healthy Adult Mode and Happy Child Mode are negatively correlated with IU and GADS were expected and in line with the literature.

4.3.3 The Discussion of Correlations Between Schema Parenting Factors, GADS and IU

The relationship between all Schema Parenting Factors and GADS was found to be significantly positive. The more participants perceive their parents to be among the parenting factors, the higher their GADS scores will be. For IU, a significant positive relationship was found for all parenting factors except Punitive Parenting and Emotionally Depriving Parenting for both mother and father, Belittling Criticizing Mother and Exploitative Abusive Mother. When participants perceive their parents' parenting attitudes higher, their IU scores increase.

Parenting schemas that are excessively strict or simplistic, contain incorrect content, or are dominated by negative effects can be dysfunctional (Azar, Nix and Makin-Byrd, 2005). Strict parenting is synonymous with harsh parenting. Shen et al. (2020) compared parenting attitudes which are supportive, disengaged and harsh. According to the authors, harsh parental attitudes were linked to higher levels of IU, which may be specific to GAD. In this study, all of the schema parenting factors positively correlated with IU. When individuals perceive higher parenting attitudes, their intolerance of uncertainty increases. Moreover, considering all schema parenting factors are correlated with each other and GADS, getting high scores on all perceived parenting factors may lead to dysfunction in an individual’s life.

4.4 The Evaluation of the Mediator Role of Schema Modes or Schema Parenting Factors in the Relationship Between IU and GADS

Multiple parallel mediation analyses were conducted to see whether Schema Modes and Schema Parenting Factors mediate the relationship between IU and GADS. When Schema Parenting Factors were entered into the mediation analysis, they were divided into two categories: Mother Factors and Father Factors. There were ten parenting factors for each category. When investigating mediator roles for links between IU and GADS, Schema Modes were classified into four categories, which are Child Modes, Maladaptive Coping Modes, Parent Modes and Adaptive Modes.

4.4.1 The Mediation of Schema Modes in the relationship between IU and GADS

H2: Schema Modes are expected to mediate the relationship between IU and GADS

The hypothesis was supported that at least one Schema Mode was found as a mediator in the relationship between IU and GADS. The first category is Child Modes, including Vulnerable Child Mode, Enraged Child Mode, Angry Child Mode, Undisciplined Child Mode and Impulsive Child Mode for multiple parallel mediation analysis. The findings revealed that there were two mediators, which are Enraged Child Mode and Vulnerable Child Mode, in the relationship between IU and GADS.

In the treatment of Vulnerable Child Mode, the main purpose of working with Vulnerable Child Mode is to validate them, address traumatic experiences and related emotions and cognitions and enable patients to experience them in a stable and caring therapeutic relationship with a therapist (Arntz and Jacob, 2019). Patients are encouraged and supported to care for their own inner feelings and needs, which are not met in unhealthy relationships. Therefore, the care that is shown in the Vulnerable Child Mode includes establishing more healthy interpersonal relationships. When discussing GADS related interpersonal issues, it was discovered that interpersonal issues are the most common concern for GAD patients (Roemer, Molina and Borkovec, 1997). Also, GAD patients are vulnerable to interpersonal factors (Borkovec et al., 2002). For example, marital stress (Whisman, 2007), marital dissatisfaction and lack of intimate friendship (Whisman, Sheldon and Goering, 2000) and greater rates of relationship problems with spouses and children (Ben-Noun, 1998) are factors that influence GAD. Although improvements in symptoms and worry are

associated with changes in interpersonal issues, interpersonal techniques may not be sufficient in CBT (Crits-Christoph et al., 2005; Newman et al., 2011). Therefore, Schema Therapy may work on patients' Vulnerable Child Mode in treating GADS. On the other hand, working with Enraged Child Mode entails validating the feelings of rage, allowing the rage to unfold and assisting patients who are unable to express and experience the rage (Arntz and Jacob, 2019). There is also a link between Enraged Child Mode and Vulnerable Child Mode because the feelings of the Vulnerable Child Mode often hide behind the Enraged Child Mode (Jacob, Genderen and Seebauer, 2019). Therefore, the goal of working Child Modes is to reach the Vulnerable Child Mode after the Enraged Child Mode is worked and meet the core emotional needs. When considering that GAD patients have difficulties with emotions, Schema Therapy may be useful in working with Enraged Child Mode. Patients with GAD, in particular, have higher emotional intensity and a greater predisposition to expressing their emotions (Mennin et al., 2005). Also, in the study of Mennin et al. (2002), it was assumed that GAD patients may see emotions as undesirable. Therefore, they use worry as a defensive attempt to manage and avoid emotional experiences. As a result, validating and allowing rage to be expressed and experienced may be beneficial for these patients. However, there are some disadvantages to using CBT to treat patients' emotions. For example, Wiser and Goldfried (1993) assumed that CBT therapists see lower degrees of affective experience as therapeutically more significant. Also, Jones and Pulos (1993) stated that negative affect was considered as an epiphenomenon to be controlled by CBT. Furthermore, Newman et al. (2011) discovered that CBT failed to intervene in emotional avoidance in GAD patients.

In Maladaptive Coping Modes, Detached Protector Mode, Detached Self Soother Mode, Bully and Attack Mode, Self Aggrandizer Mode and Compliant Surrender Mode entered the analysis. It was found that only the Detached Protector Mode mediated.

Detached Protector is a state of emotional avoidance (Rafaeli, Bernstein and Young, 2019). In this situation, patients deny their feelings and problems, or patients are emotionally distant, aloof, apathetic, or intellectualized and overly rational. It can be said that the Detached Protector Mode involves an active effort that keeps emotions at a distance and results in numbness. According to Arntz and Jacob (2019), patients

should be confronted with this mode empathetically. Why this mode was important in the patient's childhood and how it was protective during that period should be discussed. At the same time, the negative consequences of this mode should be mentioned. The goal is to reduce the impact of this mode in order that patients can behave more flexibly and react more appropriately. When considering Detached Protector Mode, this mode is similar to a coping style called Avoidance. According to the Intolerance of Uncertainty Model, Cognitive Avoidance is one of the GAD concepts (Bottesi et al., 2016). According to Dugas et al. (1997), cognitive avoidance is related to avoidance of threat perceptions of mental images. In the study of Dugas et al. (1997), IU was found as a contributor to cognitive avoidance when people try to avoid images of threatening future events. Liao and Wei (2011) asserted that individuals in a society where the avoidance of uncertainty is high, feel insecure and endangered in uncertain situations. Therefore, when GAD patients perceive that their emotional childhood needs, like security needs, are unmet, Schema Therapy may be useful in re-experiencing with imagination. In addition, according to the Emotion Regulation theory for GAD, Borkovec et al. (2004) assumed that GAD patients perceive emotional experiences at an abstract level and this leads to avoiding unpleasant feelings, autonomic arousal and severe unpleasant feelings in the short term. All of these avoidances may strengthen anxiety as they are negatively reinforced (Borkovec and Newman, 1998). Although Newman et al. (2004) assumed that CBT was a failure for emotional avoidance, Schema Therapy may work on emotional avoidance with imagination or the empty-chair technique.

Another category was Parenting Modes, including Punitive Parent Mode and Demanding Parent Mode. Both, Punitive Parent Mode and Demanding Parent Mode were found to be mediators in the relationship between IU and GADS.

The common point of these modes is the internalized parental voice that criticizes or disparages the patient or places almost impossible demands on the patient (Rafaeli, Bernstein and Young, 2019). GAD patients highly used punishment for negative thoughts (Wells and Carter, 2009). Therefore, GAD patients may criticize or punish themselves when negative thoughts are active, especially in uncertain situations, if they evaluate the ambiguous situtations as a danger or threat to themselves. For Demanding Parent Mode, when patients who cannot tolerate ambiguous situations

cannot reach certainty, they may be under pressure to set high expectations, high responsibilities and achieve them and it may lead to more anxiety. Also, punishment involves taking something good or desirable away. Patients who cannot tolerate uncertainty may use negative punishment on themselves, so they do not meet their needs intentionally and it leads them to face more anxiety. Therefore, criticizing and punishing the inner voices of GAD patients should be decreased. In Schema Therapy, these modes are thought to be based on memories of being criticized, punished, or abused by patients' parents or significant other carers. Schema Therapy aims to reduce the Punitive or Demanding Parent influence by feeling a sense of meaning in the patient's emotions, increasing self-confidence and empowering the healthy adult mode, including acceptance of the patient's own needs and feelings, in the treatment of these maladaptive modes that mediate the relationship between IU and GADS (Arntz and Jacob, 2019).

The fourth category was Adaptive Modes, which are Healthy Adult Mode and Happy Child Mode for multiple mediation analysis. According to the findings, Happy Child Mode served as a mediator. The difference between Happy Child Mode and other Schema Modes is that the pathways between Happy Child mode and GADS and Happy Child Mode and IU were negative, whereas all other mediators' pathways were positive.

Individuals feel peaceful when happy child mode is activated because their basic needs are fulfilled (Rafaeli, Bernstein and Young, 2019). Others are perceived as loving and protective; they feel connected, cared for, supported and validated. They are satisfied, appreciated and confident as a result of this sense of security and they have feelings of optimism, spontaneity and satisfaction. When this mode is evaluated with IU and GADS, being spontaneous and having a sense of security may provide tolerance for the possibility of the occurrence of negative events like ambiguous situations. Also, when there is an ambiguity, fear and anxiety may be present in some individuals. In contrast, anxiety may not be present in people who are spontaneous and feel secure. According to the literature, there have been studies related to the Schema Modes. When Happy Child Mode gets more active, life satisfaction level also increases. (Bitmiş, 2019). Also, Khalily, Wota and Hallahan (2011) investigated the relationship between Schema Modes and Psychiatric Disorders. The authors found that there was

a significant negative relationship between Happy Child Mode and depression. In the study of Oğuz (2020), it was examined the relationship between levels of anxiety and avoidance with Schema Modes. Happy Child Mode had considerably negative relationship with anxiety and avoidance. Therefore, it can be said that when people are in Happy Child Mode, they may not perceive uncertain situations as danger and so they do not avoid ambiguous situations. These are consistent with the current study. In this study, Happy Child Mode predicted IU and GADS negatively.

On the other hand, when considering GADS maintained by interpersonal issues and emotional processing, Schema Therapy may intervene in interpersonal issues and emotional processing by working on Schema Modes, which is thought to be more practical and useful than working with Early Maladaptive Schemas. In the Schema Mode treatment of GADS, For Vulnerable Child Mode, patients need to cognitively learn about children's rights and needs and relate these to their child's inner side. The patient visualizes a difficult experience associated with anxiety through imagery techniques. This scene has been adapted to fit the needs of the Vulnerable Child. While the perception of threat, anxiety, shame and guilt are reduced, it is aimed at increasing trust and secure attachment. For the Enraged Child Mode, how to express rage, what kind of anger expression is socially acceptable, or the meaning and importance of rage should be taught to patients cognitively. In this way, patients can be aware of their unmet needs, because anger is an emotion that arises when individuals' needs are not met. Emotional techniques such as chair dialogues help the enraged child be more noticeable, validated and encouraged to experience and express anger. In addition to these Schema Modes, Maladaptive Parenting Modes such as Demanding Parent and Punitive Parent should also be struggled to reduce their impacts. The goal is to completely remove these modes from the patient and replace them with healthier and more functional types. Parental Modes are thought to be active because punishment for their negative thoughts is known to be common in GAD patients. Demanding Parent Mode and Punitive Parent Mode are differentiated with the chair dialogue technique. For example, Enraged Child Mode and Vulnerable Child Mode are revealed and confirmed, while Punitive or Demanding Parent Mode is restricted. Moreover, the function of the Detached Protector Mode, which is like a defense mechanism for the patient, both in his childhood and in his present life, should be discussed. The patient is confronted with this mode. Because the Detached Protector Mode is a sort of

avoidance, it is commonly found in GAD patients in order to avoid experiencing intense anxiety. When these Schema Modes are worked with the emotional techniques of Schema Therapy, GAD patients can express negative emotions that they view as undesirable or that they are trying to avoid and prevent. Furthermore, Happy Child Mode involves meeting one's needs. For this reason, it is a mode aimed at therapy. When the person's needs are met and this mode is active, the GAD patient will not experience dysfunctional anxiety at that time. All these schema modes are mediators in the relationship between IU and GADS. Therefore these Schema Modes are discussed especially. However, Healthy Adult Mode was not found as a mediator. Nevertheless, this mode is also so important for Schema Mode treatment because Healthy Adult Mode was negatively correlated with nearly all other Schema Modes except Happy Child Mode. As increased, the Healthy Adult Mode, Vulnerable Child Mode, Enraged Child Mode, Detached Protector Mode, Punitive Parent Mode and Demanding Parent Mode are also decreased. In this way, GAD patients who are unable to benefit from CBT may be treated by using Schema Modes.

As a result, in addition to research showing that IU is specifically related to GAD, Vulnerable Child Mode, Enraged Child Mode, Detached Protector Mode, Maladaptive Parent Modes and Happy Child Mode also play a role in this relationship.

4.4.2 The Mediation of Schema Parenting Factors in the relationship between IU and GADS

H3: Schema Parenting Factors mediate the relationship between IU and GADS

The hypothesis was supported by the finding that at least one Schema Parenting Factor was found as a mediator in the relationship between IU and GADS. In Schema Parenting factors, Overprotective/Anxious Father, Overpermissive/Boundless Mother and Conditional Achievement Focused factors for both mother and father were found as mediators in the relationship between IU and GADS.

In the literature, there are no studies examining Schema Parenting Factors in IU and GADS. Therefore, the findings were discussed as contextual. According to Schema Therapy (Young, Klosko and Weishaar, 2019), all children have needs such as autonomy, freedom to express needs, spontaneity and self-control. However, if children perceive their father to be overly protective and anxious, these needs may be

unmet during their childhood. Because overprotection is associated with the restriction of the child's needs (Parker, Tupling and Brown, 1979). Also, this experience is transitable to adulthood (Bowlby, 1980). Because this is related to the continuity of development. For example, anxious fathers are models for their specific fears, so they transfer their coping with anxiety and fear to their children (Navaro, 1989). As a result, these children may fail to handle anxiety and fear in the long term. Children who have unmet needs may lack autonomy, fail to express their own needs, fail to provide for their own self-control and be less spontaneous. When children are less spontaneous, they may perceive uncertainty as a danger. Therefore, they cannot tolerate the uncertainty. Also, these children may avoid situations that make them feel anxious, because they cannot learn how to cope with problems. Moreover, when the parenting style was examined, it was found that high overprotection was the most pathogenic style (Parker, 1983). In the study of Parker (1983), high overprotection was found to be risky for anxiety disorders. Jami and Zafar (2017) investigated the relationship between anxiety, IU and parental behaviors. The authors found that perceiving parents as overprotective is highly associated with anxiety and IU. All these findings were consistent with the proposed hypothesis.

The Overpermisive Boundless Mother was also found as a mediator. In this parental factor, the child's negative behavior can be ignored and no feedback is given to the child. As a result, children may not learn which behaviors are functional or which behaviors are dysfunctional. Especially when they come to the stage of meeting their own needs, they have difficulty following the limits and rules. This is also not compatible with the child's core emotional needs in Schema Therapy. According to Schema Therapy, pathologies may arise from not being able to meet the core emotional needs in childhood. Also, in Schema Therapy, there are toxic childhood experiences which occur generally in elementary families. Experiencing too much of a good thing is another type of early life experience. Parents serve their children too much. These children are pampered or overwhelmed. Individuals may experience this when their mother was overpermissive and boundless. Therefore, their most basic emotional needs, such as autonomy, self-control and realistic limits, have not been met. Children may perceive that they are taking infinite freedom instead of responsibility. Since this will not be achieved in every environment, it will be difficult and disappointing in the long run. For this reason, problem-solving skills and self-discipline do not develop.

They may have difficulty learning social rules. When these children get used to getting everything they want and meeting their needs with ease, they may not be able to tolerate it when they get into an uncertain situation. For this reason, they may experience more anxiety. Also, if they develop an addiction to their Overpermissive/Boundless mother, they cannot learn how to cope when the time is required to be autonomous and experience uncertainty. Therefore, they might feel more anxious. In the literature, Başbuğ, Cesur and Batıgün (2017) studied the relationship between perceived parenting style and adult separation anxiety in college students. The authors found that the Overpermissive/Boundless Mother's parenting style is positively associated with adult separation anxiety. This finding is compatible with Schema Theory. All children have a need for security. It was thought in line with findings that Overpermissive/Boundless Mothers may be unable to meet the security needs of their children, therefore the children may face separation anxiety in the future. Founding the Overpermissive/Boundless Mother as the mediator in the relationship between IU and GADS is understandable.

Another mediator was found as Conditional Achievement Focused parenting factors for both mother and father. Although Conditional Achievement Factors were predicted positively by IU, they predicted negatively GADS as unexpected. According to the literature, Dost, Aytaç and Uysal (2019) investigated the Schema Parenting Factors on Personality Traits. Conditional Achievement Focused for father was found to be positively associated with openness to new experiences. It means when fathers behave more conditional and achievement-focused, personality traits of openness to new experiences are increased in individuals. These authors evaluated this finding as unexpected. Also, Komarraju and Karau (2005) examine the relationship between avoidance and personality traits. It was found that avoidance was negatively related to openness. Avoidance was also included in the features of GAD (Dugas et al., 1998). Considering the findings in the literature, it can be said that individuals perceive their father as conditional/achievement-focused and have openness to new experiences and personality traits. Therefore, these individuals may be more open to new and different things and attentive to their inner feelings. In this way, avoidance behavior may be seen less in these individuals. These situations may have indirectly led to a decrease in GAD. Because avoidance behavior is also a feature that maintains GAD. In the absence of avoidance behavior, when people are exposed to activities or thoughts that

cause anxiety, they have the chance to evaluate the situation objectively. Thus, GAD may be reduced. Future studies should examine this parenting factor in IU and GADS.

As a result, in addition to research showing that IU is specifically related to GAD, Overprotective Anxious Father, Overpermissive Boundless Mother, Conditional Achievement Focused Mother and Conditional Achievement Focused Father also play a role in this relationship.

4.5 Limitations and Further Studies

Limitations of the study and suggestions for further studies will be discussed in this part.

The number of male participants is less than half the number of female participants. Therefore, the gender distribution is not equal. Furthermore, the majority of the sample has a bachelor's or master's degree as well as a doctorate and lives in Izmir, which may limit the study's generalizability. The participants are at a higher socio-economic and intellectual level because of the sample. The number of participants at low education levels and low socioeconomic levels is very small. Also, the participants are not clinical populations. Therefore, the study cannot be generalized to GAD patients directly.

When the data was collected, there was a pandemic all over the world called Covid-19. The cut-off point of the GAD-7 scale-Turkish version was found to be 8 (Konkan et al., 2011). In the current study, the general mean GADS score was found to be greater than 9. This value is more than the cut-off point. It is considered that the GADS scores of participants may have been affected by the pandemic. According to Skoda et al. (2020), the COVID-19 pandemic dramatically increased psychometric scores that indicate generalized anxiety, depressive symptoms and psychological distress. Also, individuals disposed to GAD reported significantly more concerns related to the pandemic (Cordaro et al., 2021).

Another study limitation is connected to the characteristics of the data collection techniques. The scales based on self-reporting and remembering the past may have affected the participant's real score. The scales used are not in a structure to control the possibility of the participants being biased and defensive, which is thought to limit the study. According to Arntz and Jacob (2019), self-report scales are not sufficient

because they do not contain qualitative information about the particular meaning of a particular mode for the patient in question. Also, people may not be aware of the signs of the modes or do not want to point them out clearly. Another limitation of the data collection is the length of the research questions, especially the scales related to Schema Therapy. The variables were only examined for the relationship. Therefore, there is no causal inference made from the study.

There are few studies in the literature in terms of perceived parenting styles and schema modes, creating limitations in terms of comparing and evaluating study findings. In particular, there are no studies examining Schema Modes and Generalized Anxiety Disorder Symptoms and Intolerance of Uncertainty together in the literature. The schema mode model is also a newly studied subject in Turkey and more research is needed.

Psyhchotherapy studies should be done with IU and GADS using Schema Modes. For example, future research should examine the effectiveness of a targeted Schema Mode approach designed to reduce IU and GADS scores and GADS in clinical case studies. Also, comparison studies between GADS and other psychological disorders like depression, social anxiety and panic disorder can be conducted. Moreover, the effectiveness of CBT and Schema Therapy in GAD patients can be compared. On the other hand, the current study may be replicated in clinical GAD cases. It has been evaluated that the number of studies on schema mode therapy in Turkey and international literature is insufficient. It was concluded that further research into this area is necessary.

CHAPTER 5: CONCLUSION

The present study investigated the mediating roles of Schema Modes and Schema Parenting Factors in the relationship between IU and GADS. The results showed that there are mediators among Schema Modes, which are Vulnerable Child Mode, Enraged Child Mode, Detached Protector Mode, Demanding Parent Mode, Punitive Parent Mode and Happy Child Mode in the relationship between IU and GADS. Also, Overpermissive Boundless Mother, Conditional Achievement Focused Mother, Overprotective Anxious Father and Conditional Achievement Focused Father factors mediated the relationship between IU and GADS. As a result, the main hypotheses were found as expected. For the first hypothesis, when the Schema Parenting Factors were examined in both high groups of IU and GADS, the mother factor had significantly higher scores only in Overprotective Anxious than the father factor. Although it is known from research that the IU is pivotal or specific for GAD, it has been shown that mediating variables abovementioned Schema Modes and Schema Parenting Factors that also play a role in the relationship between IU and GADS.

5.1 Implications

The Schema Modes have never worked before for IU and GADS. Therefore, the current study is the first study to investigate IU and GADS regarding Schema Modes. It was mentioned that there was a gap in Schema Therapy for GAD in the literature (Taylor and Harper, 2016; Karaca and Ateş, 2019). Also, Hawke and Provencher (2011) indicated that Schema Therapy should be explored in GAD. This study is an attempt to fill the gaps in the literature. In this way, it is known whether Schema Modes mediate the relationship between IU and GADS. In addition, although perceived parenting style was examined with mood disorders and anxiety disorders, Schema Parenting Factors were used for the first time for IU and GADS in this study. Thus, it was learned which parent has higher scores in Schema Parenting Factors for high groups of IU and GADS and whether Schema Parenting Factors mediate the relationship between IU and GADS.

There are also clinical implications from the study. Schema Therapy may work for patients, especially with GADS. It is known that GAD patients have more comorbidity. Also CBT had lower response rate for GAD and even GAD patients received adequate

treatment with CBT, some patients still suffer from chronic anxiety. This information is compatible with the emergence of Schema Therapy, which was created for patients who could not benefit from traditional cognitive therapies with more severe and chronic psychological problems. In this way, GAD patients who are unable to benefit from CBT may be treated with using Schema Modes.

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APPENDICES

Appendix A: Ethics Committee Approval

SAYI : B.30.2.İEÜ.0.05.05-**020**-*109* 22.01.2021

KONU : Etik Kurul Kararı hk.

Sayın Yamaç Şendülger,

"The Role of Schema Therapy Concepts on the Relationship betweeen Generalized Anxiety Disorder and Intolerance of Uncertainty " başlıklı projenizin etik uygunluğu konusundaki başvurunuz sonuçlanmıştır.

Etik Kurulumuz 25.12.2020 tarihinde sizin başvurunuzun da içinde bulunduğu bir gündemle toplanmış ve projenin incelenmesi için bir alt komisyon oluşturmuştur. Projenizin detayları alt komisyon üyelerine gönderilerek görüş istenmiştir. Üyelerden gelen raporlar doğrultusunda Etik Kurul 22.01.2021 tarihinde tekrar toplanmış ve raporları gözden geçirmiştir.

Sonuçta 22.01.2021 tarih ve 116 numaralı "**The Role of Schema Therapy Concepts on the Relationship betweeen Generalized Anxiety Disorder and Intolerance of Uncertainty "** konulu projenizin etik açıdan uygun olduğuna oy birliği ile karar verilmiştir.

Gereği için bilgilerinize sunarım.

Saygılarımla,

[redacted]

Prof. Dr. Murat Bengisu

Etik Kurul Başkanı

Appendix B: Informed Consent Form

BİLGİLENDİRİLMİŞ ONAM FORMU
Sayın Katılımcı,

Bu çalışma, İzmir Ekonomi Üniversitesi Klinik Psikoloji Yüksek Lisans programı kapsamında, Dr. Öğretim Üyesi Yasemin Meral Öğütçü danışmanlığında, Yamaç Şendülger tarafından hazırlanan bir tez çalışmasıdır. Çalışma yaklaşık 25 dakika sürecektir. Çalışmaya katılabilmeniz için 18-35 yaş arasında olmanız gerekmektedir.

Bu araştırmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Araştırmaya katılmama veya katıldıktan sonra istediğiniz herhangi bir anda araştırmadan ayrılma hakkına sahipsinizdir.
Araştırmayı yürütürken sizden hiçbir kimlik bilgisi talep edilmeyecektir. Cevaplarınız gizli tutulacak, yalnızca araştırma görevlisi tarafından değerlendirilecektir. Bu anketten elde edilen sonuçlar, yalnızca bilimsel amaçlar doğrultusunda kullanılacaktır. Ankette bulunan sorulara vereceğiniz yanıtların doğruluğu, araştırmanın niteliği açısından oldukça önemlidir. Bu çalışma birden fazla anket içermektedir. Lütfen her bir testin başındaki yönergeyi dikkatli okuyunuz ve sorulara sizi en iyi ifade eden cevabı vermeye çalışınız.

Çalışmaya katılımınız için şimdiden teşekkür ederiz. Çalışmaya yönelik sorularınız için Yamaç Şendülger (yamacsendulger@gmail.com) ile iletişime geçebilirsiniz. * Gerekli

1. ÇALIŞMAYA KATILMAK İSTİYORUM *

Yalnızca bir şıkkı işaretleyin.

- ◯ EVET
- ◯ HAYIR

Appendix C: Sociodemographical Questionnaires

1 Cinsiyet

Yalnızca bir şıkkı işaretleyin.

- ◯ Erkek
- ◯ Kadın
- ◯ Belirtmek İstemiyorum.

2. Yaşınız ?

_____

3. En son mezun olduğunuz okul ?

Yalnızca bir şıkkı işaretleyin.

- ◯ İlkokul
- ◯ Ortaokul
- ◯ Lise
- ◯ Lisans Mezunu
- ◯ Yüksek Lisans Mezunu
- ◯ Doktora

4. Medeni Durumunuz ?

Yalnızca bir şıkkı işaretleyin.

- ◯ Evli
- ◯ Bekar
- ◯ Boşanmış
- ◯ Dul

5. İlişkiniz var mı ?

Yalnızca bir şıkkı işaretleyin.

- Evet
- Hayır

6. Anneniz

Yalnızca bir şıkkı işaretleyin.

- Hayatta
- Hayatta Değil

7. Anneniz

Yalnızca bir şıkkı işaretleyin.

- Öz
- Üvey

8. Babanız

Yalnızca bir şıkkı işaretleyin.

- Hayatta
- Hayatta değil

9. Babanız

Yalnızca bir şıkkı işaretleyin.

- Öz
- Üvey

10. Kaç kardeşsiniz ? (kendinizi sayarak)

11. Ailenizin Kaçıncı Çocuğusunuz ?

Yalnızca bir şıkkı işaretleyin.

- 1
- 2
- 3
- 4
- 5
- Diğer

12. Anneniz ve Babanız

Yalnızca bir şıkkı işaretleyin.

- Evli
- Ayrı
- Biri veya İkisi de Hayatta değil

13. Şu anda yaşadığınız yer

Yalnızca bir şıkkı işaretleyin.

- Yalnız
- Aile üyeleri ile
- Arkadaşlarla
- Partner ile
- Akrabalarının yanında

14. Size göre SİZ ÇOCUKKEN ailenizin ekonomik durumu nasıldı ? *

Yalnızca bir şıkkı işaretleyin.

- [ ] Alt gelir grubu
- [ ] Ortanın altı gelir grubu
- [ ] Orta gelir grubu
- [ ] Ortanın üstü gelir grubu
- [ ] Üst gelir grubu

15. Annenizin Eğitim Durumu

Yalnızca bir şıkkı işaretleyin.

- [ ] Okur Yazar Değil
- [ ] İlkokul Mezunu
- [ ] Orta Okul Mezunu
- [ ] Lise Mezunu
- [ ] Üniversite Mezunu
- [ ] Yüksek Lisans Mezunu
- [ ] Doktora Mezunu

16. Babanızın Eğitim Durumu

Yalnızca bir şıkkı işaretleyin.

- [ ] Okur Yazar Değil
- [ ] İlkokul Mezunu
- [ ] Orta Okul Mezunu
- [ ] Lise Mezunu
- [ ] Üniversite Mezunu
- [ ] Yüksek Lisans Mezunu
- [ ] Doktora Mezunu

17. Fiziksel bir rahatlığınız var mı ?

Yalnızca bir şıkkı işaretleyin.

Evet

Hayır

18. Psikolojik bir rahatsızlığınız var mı ?

Yalnızca bir şıkkı işaretleyin.

Evet

Hayır

19. Çocukluk ya da ergenlik döneminde travmatik yaşam öykünüz var mı? (cinsel ya da fiziksel istismar, doğal felakaetler, kaza, ciddi bir hastalık, işkence, ölüm tehditi, yakın kaybı, vb)

Yalnızca bir şıkkı işaretleyin.

Evet

Hayır

20. Daha önce psikoterapi hizmeti aldınız mı ?

Yalnızca bir şıkkı işaretleyin.

Evet

Hayır

Appendix D: Intolerance of Uncertainty Scale

Lütfen aşağıdaki maddelerin karşısında bulunan ve maddelere ne kadar katıldığınızı gösteren sayılardan size en uygun olanını işaretleyiniz. (1) Bana hiç uygun değil, (2) Bana çok az uygun, (3) Bana biraz uygun, (4) Bana çok uygun ve (5) Bana tamamen uygun anlamına gelmektedir.					
1. Beklenmedik olaylar canımı çok sıkar.	1	2	3	4	5
2.Bir durumda ihtiyacım olan tüm bilgilere sahip değilsem sinirlerim bozulur.	1	2	3	4	5
3.İnsan sürprizlerden kaçınmak için daima ileriye bakmalıdır.	1	2	3	4	5
4. En iyi planlamayı yapsam bile beklenmedik küçük bir olay her şeyi mahvedebilir.	1	2	3	4	5
5.Geleceğin bana neler getireceğini her zaman bilmek isterim.	1	2	3	4	5
6.Bir duruma hazırlıksız yakalanmaya katlanamam.	1	2	3	4	5
7.Her şeyi önceden ayrıntılı bir şekilde organize edebilmeliyim.	1	2	3	4	5
8.Belirsizlik beni hayatı dolu dolu yaşamaktan alıkoyar.	1	2	3	4	5
9.Harekete geçme zamanı geldiğinde, belirsizlik elimi kolumu bağlar.	1	2	3	4	5
10.Belirsizlik yaşadığımda pekiyi çalışamam.	1	2	3	4	5
11.En küçük bir şüphe bile hareket etmemi engeller.	1	2	3	4	5
12.Tüm belirsiz durumlardan uzak durmak zorundayım.	1	2	3	4	5

Appendix E: Generalized Anxiety Disorder

Madde	**0** =Hiç	**1** =Bir çok gün	**2** =Günlerin Yarısından fazlasında	**3** = Hemen hemen her gün
1-Sinirli, kaygılı ve endişeli misiniz?				
2-Endişelerinizi kontrol edememe, durduramama?				
3-Farklı konularda çok fazla endişelenme?				
4-Gevşeyip, rahatlayamama?				
5-Yerinizde duramayacak kadar kıpır, kıpır huzursuz olma?				
6-Çabuk sinirlenme, kızma yada huzursuz olma?				
7-Çok kötü bir şey olacak diye korkma?				
TOPLAM				

Appendix F: Schema Parenting Factors

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

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

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

16. ____ ____ Evhamlı veya fobik/korkak bir insandı.

17. ____ ____ Beni aşırı korurdu.

18. ____ ____ Kendi kararlarıma veya yargılarıma güvenememe neden oldu

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

20. ____ ____ Bana hep daha çocukmuşum gibi davrandı.

21. ____ ____ Beni çok eleştirirdi.

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

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

24. ____ ____ Önemli konularda kendimden utanmama neden oldu.

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

26. ____ ____ Bana salakmışım veya beceriksizmişim gibi davrandı.

27. ____ ____ Başarılı olmamı gerçekten istemedi.

28. ____ ____ Hayatta başarısız olacağıma inandı.

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

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

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

32. ____ ____ Her şey onun kurallarına uymalıydı.

33. ____ ____ Aile için kendi isteklerini feda etti.

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

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

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

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

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

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

40. ____ ____ Yaptığım hiçbir şeyin yeterli olmadığını hissetmeme sebep oldu.

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

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

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

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

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

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

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

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

49. __ __ ____ Bana çok az kural koydu veya sorumluluk verdi.

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

51. ____ ____ Disiplinsiz bir insandı.

52. ____ ____ Birbirimizi çok iyi anlayacak kadar yakındık.

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

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

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

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

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

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

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

60. ____ ____ Her şey onun kontrolü altında olmalıydı.

61. ____ ____ Duygularını ifade etmekten rahatsız olurdu.

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

63. ____ ____ Kızgınlığını çok nadir belli ederdi.

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

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

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

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

68. ____ ____ İşler kötü gittiğinde başkalarını suçlardı.

69. _____ Sosyal statü ve görünüme önem verirdi.

70. _____ _____ Başarı ve rekabete çok önem verirdi.

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

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

Appendix G: Short Schema Modes Inventory

SIKLIK: genellikle

1= Hiçbir zaman ya da neredeyse hiçbir zaman	4= Sık sık
2= Nadiren	5= Çoğu zaman
3= Bazen	6= Her zaman

Sıklık	**Genellikle**
MÇ	1. Sevildiğimi ve kabul edildiğimi hissediyorum.
CEM	2. Kendimden zevk alacak şeyleri esirgiyorum çünkü hak etmiyorum.
İÇM	3. Oldum olası yetersiz, kusurlu veya eksik hissediyorum.
CEM	4. Kendimi cezalandırmaya yönelik bedenime/kendime zarar verme eğilimlerim var (örn., kendimi kesmek).
İÇM	5. Kaybolmuş hissediyorum.
BEM	6. Kendime karşı çok katıyım.
UTM	7. Çatışmak, terslenmek veya dışlanmak istemediğim için diğer insanları memnun etmeye çok uğraşırım.
CEM	8. Kendimi affedemiyorum.
BÜM	9. İlginin benim üstünde olmasını sağlayacak şeyler yaparım.
BÜM	10. İnsanlar dediğimi yapmadıkları zaman sinirlenirim.
DÜRT	11. Kendimi kontrol etmekte zorlanıyorum.
DİSÇ	12. Eğer amacıma ulaşamazsam, kolayca hayal kırıklığına uğrar ve vazgeçerim.
ÖFÇ	13. Şiddet içeren patlamalarım oluyor.
DÜRT	14. Başımı derde sokacak veya insanları kıracak şekilde dürtüsel davranırım veya duygularımı ifade ederim.
CEM	15. Kötü bir şey olursa benim hatamdır.
MÇ	16. Kendimi hoşnut ve rahat hissediyorum.
UTM	17. Beraber olduğum insanlara göre kendimi değiştiririm, böylece benden hoşlanırlar veya beni onaylarlar.
MÇ	18. Diğer insanlarla aramda bir bağ olduğunu hissediyorum.
KÇ	19. Mücadele etmezsem insanlar beni ya istismar eder/kullanır ya da ihmal ederler.

ZSM	20. Kendisi ile dalga geçilmesine izin veren kişi bir hiçtir.
ÖFÇ	21. Beni kızdıran insanlara fiziksel olarak saldırıda bulunurum.
ÖFÇ	22. Bir kez sinirlenmeye başlarsam, genellikle kızgınlığımı kontrol edemem ve kendimi kaybederim.
BÜM	23. Benim için Bir Numara olmak önemlidir (örn. en popüler, en başarılı, en varlıklı, en güçlü).
KK	24. Kayıtsız / duygusuz hissediyorum.
SY	25. Duygularımın beni etkilemesine izin vermeden sorunları mantıksal bir şekilde çözebiliyorum.
BÜM	26. İkinci sırada olmakla yetinmem.
ZSM	27. Saldırı en iyi savunmadır.
KK	28. Diğer insanlara karşı soğuk hissediyorum.
KK	29. Kendimi kopmuş hissediyorum (kendimle, duygularımla veya diğer insanlarla aramda bir bağ yok).
DÜRT	30. Duygularımı körlemesine izlerim.
İÇM	31. Çaresiz hissediyorum.
UTM	32. Başka insanların beni eleştirmesine veya aşağılamasına izin veririm.
UTM	33. İlişkilerimde, diğer kişinin daha üstte /hakimiyeti ele almasına olmasına izin veririm.
KK	34. Diğer insanlardan uzak hissediyorum.
DÜRT	35. Düşünmeden konuşurum ve bu nedenle ya başımı derde sokarım ya da başkalarını incitirim.
KKA	36. Rahatsız edici duygularımı düşünmemi engelleyecek kadar kendimi aşırı düzeyde çalışmaya veririm veya spor yaparım.
KÇ	37. Özgürlüğümü veya bağımsızlığımı engelleyen insanlara kızgınım.
KK	38. Hiçbir şey hissetmiyorum.
BÜM	39. Diğer insanların ihtiyaçlarına ve duygularına aldırmaksızın ne istersem onu yaparım.
BEM	40. Yapmam gerekenleri bitirmedikçe dinlenmeme veya eğlenmeme izin vermem.
ÖFÇ	41. Sinirlendiğimde etrafta ne varsa fırlatırım.
KÇ	42. Birisine öfkelenmiş hissediyorum.
MÇ	43. Diğer insanlarla uyum içinde olduğumu hissediyorum.

KÇ	44. İçimde boşaltmak istediğim yoğun bir öfke var.
İÇM	45. Yalnız hissediyorum.
KKA	46. Duygularımdan kaçınmak için beni uyaran veya sakinleştiren şeyler yapmayı severim (örn. çalışmak, kumar oynamak, yemek, alışveriş, cinsel etkinlikler, TV seyretmek).
ZSM	47. Eşitlik diye bir şey yoktur, bu nedenle en iyisi diğerlerinden üstte olmaktır.
ÖFÇ	48. Sinirlendiğimde kendimi kaybederim ve diğer insanları tehdit ederim.
UTM	49. Kendi isteklerimi söylemektense, diğer insanların istediklerini yapmasına izin veririm.
KÇ	50. Birisi benim yanımda değilse bana karşıdır.
KKA	51. Canımı sıkan düşünceler veya duygularım beni rahatsız etmesin diye kendimi hep bir işle meşgul ederim.
CEM	52. Başkalarına sinirlenirsem ben kötü bir insanımdır.
KK	53. İnsanlarla bir arada olmak istemiyorum.
MÇ	54. Hayatımda tam bir istikrar, denge ve emniyet/güven olduğunu hissediyorum.
SY	55. Duygularımı ne zaman açıp ne zaman açmayacağımı bilirim.
KÇ	56. Beni yalnız bıraktığı veya terk ettiği için birisine kızgınım.
KK	57. Diğer insanlarla aramda bir bağ olduğunu hissetmiyorum.
DİSÇ	58. Benim yararıma olduğunu bilsem bile, sıkıcı işleri yapmak için kendimi zorlayamam.
DÜRT	59. Kuralları çiğnerim ve sonra bundan pişman olurum.
İÇM	60. Aşağılanmış hissediyorum.
DÜRT	61. Önce yapar sonra düşünürüm.
DİSÇ	62. Kolay sıkılırım ve ilgim çabuk kaybolur.
İÇM	63. Çevremde insanlar varken bile kendimi yalnız hissederim.
CEM	64. Başka insanların yaptığı zevk veren/ hoşa giden şeyleri yapmak için kendime izin vermiyorum çünkü ben kötüyüm.
SY	65. Aşırıya kaçmadan ihtiyaçlarımın karşılanmasını sağlarım.
BÜM	66. Pek çok insandan daha değerli ve daha iyiyim.
KK	67. Hiçbir şeyi önemsemiyorum, benim için ne olsa fark etmez.
KÇ	68. Birisi, nasıl hissetmem veya davranmam gerektiğini söylerse sinirlenirim.

ZSM	69. Diğer insanları yönetmezsen, sen yönetilirsin.
DÜRT	70. Sonuçlarını düşünmeden, ne hissedersem söylerim veya dürtülerimle / düşünmeden / içimden nasıl gelirse öyle davranırım.
KÇ	71. Bana yaptıklarından dolayı insanları azarlayasım; bana yaptıklarını yüzlerine vurasım geliyor.
SY	72. Kendime bakabilirim.
BÜM	73. Başkalarına karşı oldukça eleştirelimdir.
BEM	74. Başarmak ve işleri bitirmek için sürekli bir baskı altındayım.
BEM	75. Hata yapmamaya çalışırım, aksi halde moralim bozulur, çökerim.
CEM	76. Cezalandırılmayı hak ediyorum.
SY	77. Öğrenebilirim, olgunlaşabilirim ve değişebilirim.
KKA	78. Üzücü düşünceler ve duygulardan kurtulmak için dikkatimi başka şeylere veririm.
CEM	79. Kendime kızgınım.
KK	80. Tek düze / donuk hissediyorum.
BÜM	81. Yaptığım her şeyde en iyi olmalıyım.
BEM	82. Standartlarımı tutturmak için zevkten, sağlıktan veya mutluluktan vazgeçiyorum.
BÜM	83. İnsanlara karşı talepkarımdır.
ÖFÇ	84. Sinirlenirsem insanları kıracak kadar kontrolden çıkarım.
ZSM	85. Kimse bana dokunamaz.
CEM	86. Ben kötü bir insanım.
MÇ	87. Kendimi güvende hissediyorum.
MÇ	88. Dinlenildiğimi, anlaşıldığımı, değer verildiğimi hissediyorum.
DÜRT	89. Dürtülerimi kontrol etmek benim için imkânsızdır.
ÖFÇ	90. Sinirlendiğimde bir şeyler kırarım.
ZSM	91. Başkalarına hükmettiğiniz sürece size bir şey olmaz.
UTM	92. İşler istediğim gibi olmasa bile sesim çıkmaz, geride dururum
ÖFÇ	93. Kızgınlığımın kontrolden çıktığı olur.
ZSM	94. Başkaları ile dalga geçerim.
KÇ	95. Bana yaptıklarından dolayı, birisine vuracak veya zarar verecek gibi hissediyorum.

BEM	96. İşleri yapmak için bir doğru ve bir de yanlış yol olduğunu biliyorum; ben, yaptıklarımı doğru şekilde yapmak için çok çalışırım yoksa kendimi eleştirmeye başlarım.
İÇM	97. Çoğu zaman kendimi dünyada yapayalnız hissederim.
İÇM	98. Güçsüz ve aciz hissediyorum.
DİSÇ	99. Tembelim.
UTM	100. Benim için önemli olan insanlarla ilgili her şeyi kabullenmem gerekir.
KÇ	101. Kandırıldım veya bana dürüst davranılmadı.
İÇM	102. Kenara atılmış veya dışlanmış hissediyorum.
ZSM	103. Başkalarını küçümserim.
MÇ	104. İyimser hissediyorum.
BEM	105. Çoğu insandan daha fazla sorumluluk sahibi olmaya kendimi zorluyorum.
SY	106. Haksız bir şekilde eleştirildiğimde, tacize uğradığımda veya kullanıldığımda kendimi savunabilirim.
CEM	107. Bana kötü bir şey olduğunda anlayışı hak etmiyorum.
İÇM	108. Kimsenin beni sevmediğini hissediyorum.
SY	109. Özünde iyi bir insan olduğumu hissediyorum.
SY	110. Değer verdiğim şeylere ulaşmak için, gerektiğinde, sıkıcı ve rutin işleri tamamlamaya tahammülüm vardır.
MÇ	111. Kendimi doğal ve neşeli hissediyorum.
ÖFÇ	112. Birisini öldürebilecek kadar sinirlenebiliyorum.
SY	113. Kim olduğumu ve kendimi mutlu etmek için ne yapmam gerektiğini bilirim.