THE INVESTIGATION OF THE RELATIONSHIP BETWEEN SOCIAL ANXIETY, PSYCHOLOGICAL FLEXIBILITY, PERCEIVED PARENTING ATTITUDES, AND EMOTION REGULATION

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ETHICAL DECLARATION

I hereby declare that I am the sole author of this thesis and that I have conducted my work in accordance with academic rules and ethical behavior at every stage from the planning of the thesis to its defence. I confirm that I have cited all ideas, information and findings that are not specific to my study, as required by the code of ethical behavior, and that all statements not cited are my own.

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Date: 12.10.2023

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ABSTRACT

THE INVESTIGATION OF THE RELATIONSHIP BETWEEN SOCIAL ANXIETY, PSYCHOLOGICAL FLEXIBILITY, PERCEIVED PARENTING ATTITUDES, AND EMOTION REGULATION

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Master's Program in Clinical Psychology

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This study investigates relationship between social anxiety, psychological flexibility, perceived parenting attitudes and emotion regulation in the light of cognitive and relational frame theories. The sample of the study consisted of a total of 215 people between the ages of 18 and 75, 118 women and 97 men. A total of 5 scales were used to collect data on the variables in the study, including the Demographical Information Form, the Liebowitz Social Anxiety Scale, the Psychological Flexibility Scale, the Perceived Parental Attitudes Scale, and the Emotion Regulation Questionnaire. As a result of the analyses, significant correlations were found between social anxiety and emotional warmth, overprotection, rejection, psychological flexibility, and its concepts. In addition, the results showed that overprotection, psychological flexibility, and reappraisal significantly predicted social anxiety. Psychological flexibility predicted social anxiety with a much higher variance than other variables. These findings were discussed in the light of the literature, the clinical significance of the study, limitations, and suggestions for future research. In this context, it is thought that this study makes an important contribution to understanding the complexity of social anxiety and to enriching treatment approaches and adds a new dimension to the

literature in this area by highlighting the power of psychological flexibility on social anxiety. It also points the importance of further research into how these findings can be reflected in clinical practice and contribute to the development of more effective interventions for social anxiety.

Keywords: Cognitive Theory, Relational Frame Theory, social anxiety, psychological flexibility, perceived parenting attitudes, emotion Regulation

ÖZET

SOSYAL KAYGI, PSİKOLOJİK ESNEKLİK, ALGILANAN EBEVEYN TUTUMLARI VE DUYGU DÜZENLEME ARASINDAKİ İLİŞKİNİN İNCELENMESİ

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Bu çalışma sosyal kaygı, psikolojik esneklik, algılanan ebeyen tutumları ve duygu düzenlemenin arasındaki ilişkiyi bilişsel ve ilişkisel çerçeve teorileri ışığında incelemektedir. Çalışmanın örneklemi 18-75 yaş arası 118 kadın, 97 erkek toplam 215 kişiden oluşmaktadır. Araştırmada değişkenlerle ilgili veri toplamak amacıyla Katılımcı Bilgi Formu, Liebowitz Sosyal Kaygı Ölçeği, Psikolojik Esneklik Ölçeği, Algılanan Ebeveyn Tutumları Ölçeği ve Duygu Düzenleme Anketi olmak üzere toplam 5 ölçek kullanılmıştır. Yapılan analizler sonucunda sosyal kaygı ile duygusal sıcaklık, aşırı koruma, reddedilme, psikolojik esneklik ve kavramları arasında anlamlı korelasyonlar bulunmuştur. Ek olarak, sonuçlar aşırıkoruyuculuğun, psikolojik esnekliğin ve yeniden yapılandırmanın sosyal kaygıyı anlamlı şekilde yordadığını ortaya koymuştur. Özellikle psikolojik esnekliğin sosyal kaygıyı diğer değişkenlerden çok daha yüksek bir varyansla yordadığı görülmüştür. Çalışmada ulaşılan bu bulgular alanyazın ışığında tartışılmış, çalışmanın klinik önemi, sınırlılıkları ve gelecek çalışmalar için öneriler ele alınmıştır. Bu bağlamda bu çalışmanın, sosyal kaygının karmaşıklığını anlama ve tedavi yaklaşımlarını zenginleştirme açısından önemli bir katkı sağlayacağı ve psikolojik esnekliğin sosyal kaygı üzerindeki etkisini özellikle

vurgulayarak, bu alandaki literatüre yeni bir boyut kazandıracağı düşünülmektedir. Ayrıca, bu bulguların klinik uygulamalara nasıl yansıtılabileceği ve sosyal kaygının yönetiminde daha etkili müdahalelerin geliştirilmesine nasıl katkıda bulunabileceği üzerine ilerleyen araştırmaların önemine işaret etmektedir.

Anahtar Kelimeler: Bilişsel Teori, İlişkisel Çerçeve Teorisi, sosyal kaygı, psikolojik esneklik, algılanan ebeveyn tutumları, duygu düzenleme

Dedicated to Karizma…

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

For many people, undesirable emotional states and dysfunctional social actions have historically been recognized as serious, life-altering difficulties. Considering the social nature of people and the significance of social relationships, social discomfort is particularly challenging since, unlike other anxiety disorders like some phobias, socialization cannot be effortlessly disregarded. According to Clark and Wells (1995), social anxiety disorder contains an individual's negative expectations about poor social performance, negative criticism from others, and uncontrollable anxiety in social settings. In addition, these negative expectations lead people to avoid social situations that fulfill their expectations. One of the elements that contributes to the emergence of social anxiety is parental attitudes. Lieb et al. (2000) found that children exposed to overprotective and rejecting parental attitudes faced an increased likelihood of having social anxiety disorder in comparison to their peers. In a study, as well as rejection and overprotection attitudes, low levels of emotional warmth were associated with social anxiety disorder (Kapur and Rai, 2013). To gain a comprehensive overview of social anxiety, it is critical to examine the reasons that maintain social anxiety as well as the causes of its emergence. A low level of psychological flexibility is one of the most prominent perpetuators of social anxiety (Biglan, Hayes and Pistorello, 2008). It refers to a cognitive, emotional, and behavioral pattern that limits a person's capacity to select a reaction that most closely represents their values (Hayes et al., 2013). Tillfors et al. (2015), demonstrated a powerful positive association among psychological inflexibility and fear and avoidance in social settings. Difficulty in regulating emotions is another major perpetuator of social anxiety disorder. It means that individuals have difficulty observing, evaluating, and changing their emotions while determining their life goals (Thompson, 1994). Individuals with social anxiety use more suppression in the process of emotion regulation than cognitive reappraisal (Werner et al., 2011; Goldin et al., 2009) and they tend to suppress more positive emotions due to their discomfort with sustaining and sharing positive emotions, particularly in settings involving social evaluation (Turk et al., 2005). In the literature, there are lot of studies on parental attitudes and social anxiety (Rork and Morris, 2009; Spokas and Heimberg, 2009; Lieb et al., 2000; Parvez and Irshad, 2013; Kapur and Rai, 2013), but the number of research examining the associations between emotion regulation, psychological flexibility, and social anxiety separately is insufficient.

Considering the reasons mentioned above, it would be valuable to examine the relationship between parental attitudes, psychological flexibility, and emotion regulation in detail for a better understand of social anxiety and to produce effective solutions to improve its effects. Also, so far, no study was found relating the association between parenting attitudes, social anxiety, psychological flexibility, and emotion regulation. In the present research, in addition to investigating these relationships, it was also aimed to explore gender differences regarding the main variables. Social anxiety, parenting attitudes, psychological flexibility, and emotion regulation will be introduced in detail in the following section.

1.1. Social Anxiety

Social anxiety is a widespread human occurrence marked by a strong dread of being judged by others in social settings. Individuals encounter anxiety across a range of social scenarios, spanning from significant and meaningful interactions to everyday and seemingly unimportant ones. Whether it's feeling uneasy during job interviews, dates, meetings with bosses, public speaking or performing, leading discussions, or simply chatting with unfamiliar people, anxiety can arise in numerous social contexts. Social anxieties and fears come in different levels of intensity. Some can be helpful, like when they make you more alert in uncertain social situations. Others can be very debilitating, like when they stop you from forming or keeping close relationships even when you're lonely (McNeil, 2010). These difficult feelings and unhelpful behaviors in social situations can be very challenging for many people, affecting their lives in a major way. Because humans are naturally social creatures and our relationships with others are important, it can be tough to deal with the discomfort that comes from social interactions. On the other hand, when this anxiety becomes so severe that it disrupts a person's ability to function, it's labeled as social anxiety disorder or social phobia. Social anxiety disorder is defined as significant anxiety or fear of social conditions in which a person is judged by others, such as social interactions, social performance, or observation circumstances (APA, 2013). The DSM-V describes social anxiety as a marked and persistent fear of the scenario in which he or she performs the action, as well as social anxiety that happens when the individual encounters unfamiliar individuals, the potential that others may be observing you, one or more social situations, or one or more social situations.

It is seen that social anxiety can have a significant impact on an individual's daily life, affecting areas such as relationships, work, and academic performance, which make up the majority of an individual's life. For this reason, conducting a comprehensive investigation into this subject, which poses significant challenges for many individuals, will contribute to the development of effective methods for addressing this issue. Today, despite many people experiencing social anxiety, they often do not seek treatment either because they perceive it as a personality trait or fail to recognize it as a psychological issue, resulting in many cases going undiagnosed (Acarturk et al., 2009). However, when we examine the number of diagnosed individuals, it remains quite common. For this reason, this study utilized a sample from the general population, but social anxiety disorder will also be mentioned to enhance our understanding of its epidemiology and etiology.

In the following of this section, diagnostic criteria, epidemiology, and etiology of social anxiety disorder are examined in detail below.

1.1.1. Diagnostic Criteria of Social Anxiety Disorder

In DSM-5 (APA, 2013), the word social anxiety disorder has taken the role of social phobia, and it was demonstrated that changing the name of the diagnostic category would enable the anxiety felt in social situations to be more effectively articulated. The DSM-5 also did not include the criterion of "the belief that the anxiety and fear experienced in social settings are excessive and unwarranted", which was included in previous editions, and included the criterion that the anxiety and fear experienced may be disproportionate to the actual threat in question. DSM-5 also made a change to the determinant in the social anxiety disorder diagnostic category, adding the determinant "only during the performance of an action" instead of the general determinant, and clinicians were expected to specify this condition separately if social anxiety was experienced only during the performance of an action. The latest edition of the DSM, DSM-5, social anxiety disorder is included with the following diagnostic criteria (Table 1).

Table 1. The Diagnostic Criteria of Social Anxiety Disorder (APA, 2013)

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).
B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing: will lead to rejection or offend others).
C. The social situations almost always provoke fear or anxiety. Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.
D. The social situations are avoided or endured with intense fear or anxiety.
E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from bums or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.
Specify if: Performance only: If the fear is restricted to speaking or performing in public.

1.1.2. Epidemiology of Social Anxiety Disorder

In this section of the study, the epidemiology of social anxiety disorder is examined including onset, prevalence, demographic differences, genetic, and comorbidities.

Onset

The average age at which social anxiety disorders first appear varies between 13-24 years (Rapee, 1995). Rare cases of onset occur after age 25. Social anxiety disorder commonly begins in childhood or adolescence, and most people with social anxiety report symptoms at an average age of 10-13 years (Nelson et al., 2000). Childhood and the first few years of adolescence are regarded as crucial developmental periods for the emergence of symptoms as these are the times when social interaction is most prevalent (Rapee and Spence, 2004; Hofmann, Gutner and Fang, 2012). The age of presentation is usually 15-25 years after the disorder first appears, around the age of 30 (Stein and Stein, 2008; Fehm et al., 2008). This delay can be interpreted by the fact that social anxiety disorder is not well-known as a treatable condition and individuals with social phobia believe that it is a trait of their personality.

Prevalence

In epidemiological studies conducted before the publication of DSM-III in 1980, anxiety disorders were grouped under the title of anxiety neuroses. In their analysis of the findings from five population surveys done between 1943 and 1966, Marks and Lader (1973) determined that the prevalence of anxiety states ranged from 2.0 to 4.7%. According to Weissman et al. (1988), the first study to use specific classifications, the prevalence of any anxiety disorder was 4.3% and that of any phobic disorder was 1.4%. Kessler et al. (2005), stated that social anxiety disorder has a lifetime occurrence rate of 12%, which is higher than that of other mental disorders such as post-traumatic stress disorder (7%), generalized anxiety disorder (6%), panic disorder (5%), and obsessive-compulsive disorder (2%) and discovered that social anxiety disorder ranks as the fourth most prevalent mental disorder, behind major depressive disorder, alcoholism, and specific phobia. According to research executed by Ruscio et al. (2008), the occurrence rates of social anxiety disorder were discovered to be 12.1% for lifetime prevalence and 7.1% for 12-month prevalence. The study also revealed that 25% of participants reported experiencing at least one social fear throughout their lives. Among these fears, speaking in a group emerged as one of the most common, while using public restrooms and performing tasks like writing, eating, or drinking

under observation were less common fears. Another study conducted on the inhabitants of Australia by McEvoy, Grove and Slade (2011) reported a 12-month occurrence rate of 4.2% and a lifetime occurrence rate of 8.4% for social anxiety disorder. In a range of community studies examined by Wittchen et al. (2011), the occurrence rates of social anxiety varied from 0.6% to 7.9%. In a study conducted on the Turkish population by Erol et al., 1998 as cited in Soykan, Özgüven and Gençöz (2003), the occurrence rate of social anxiety disorder was identified as 1.8%. Similarly, a study focusing on Turkish college students aged 17 years and older, conducted by İzgic et al. (2000), explored the lifetime occurrence rate of social anxiety disorder and found the occurrence of it as 9.6%. Another study by Demir et al. (2013) investigated social anxiety disorder and associated psychosocial factors among Turkish children and adolescents and revealed a prevalence rate of 3.9%.

Demographic Differences

According to the findings of field studies, social anxiety disorder is generally more common in women, young and single people, and people with low education and income levels (Stein and Stein, 2008). Although field studies suggest that women have a greater tendency to have a social anxiety disorder (62.7–70%) than men, clinical studies reveal that males show more tendency than women to report having social anxiety and seek treatment for it (Ruscio et al. 2008; Kessler et al., 2012). Epidemiological data demonstrate that those who suffer from social anxiety disorder are more likely to be single than controls and those who suffer from any anxiety disorder (Schneier et al., 1992). Social anxiety is more prevalent in women within the Turkish population, the lifetime occurrence rate of social anxiety disorder is 9.8% for women and 9.4% for men. In recent years, the prevalence rates were recorded as 8.9% for women and 7.1% for men, as reported by İzgic et al. (2000).

Genetic

To better understand how genetic variables might be involved in the cause of social anxiety disorder, family studies, and twin studies were carried out. The findings of these studies revealed that genetic factors have a moderate influence in all cases. It was determined that monozygotic twin concordance rates were 24.4% and dizygotic twin concordance rates were 15.3%, and it was hypothesized that the hereditary

transmission index for social anxiety disorder was around 30% (Kendler, Gardner and Lichtenstein, 2008). Results related to inheritance range between 50% (Nelson et al. 2000) to 22% (Warren, Schmitz and Emde, 1999) in research on social phobias. Evidence for intergenerational transmission is provided by the increased relative risk of social anxiety disorder (Stein and Stein, 2008). The results from the study in which it was stated that the prevalence of social anxiety disorder among family members of those who have it was significantly higher than in the control group should be reproduced in other studies (Chavira and Stein, 2002) to accept the familial transmission hypothesis. In their investigation of the familial transmission of generalized and non-formularized social anxiety disorder, Tillfors et al. (2001) stated that the occurrence rate of social anxiety disorder among family members of people with generalized social anxiety was significantly greater than that people with non-formularized social anxiety. Finally, it is stated that environmental and, to some extent, inherited factors affect shyness (Henderson and Zimbargo, 2010). Linkage studies have not been carried out because social anxiety disorder has a mild (30%) heritability component.

Comorbidity

Only 29% of patients with social phobia in 1992, as determined by the Epidemiological Area Survey (ECA), had no other chronic condition. Pure social phobia was shown to be present in 19% of those who participated in the National Comorbidity Survey (NCS) (Magee et al. 1996). Social anxiety disorder typically appears before other psychiatric problems (77% of the time) (Schneier et al., 1992). According to (Lecrubier et al., 2000), social anxiety disorder (particularly depression) is associated with psychiatric illnesses quite frequently. Major depression, drug, and alcohol abuse, and other anxiety disorders are all at greater risk (Fehm et al., 2008; Grant et al., 2005). The studies indicated that socially anxious individuals have a high tendency to have depressive symptoms, the risk of substance abuse, nicotine addiction, and internet addiction (Beesdo et al., 2007; Sonntag et al., 2000; Farevelli et al., 2000; Weinstein et al., 2015).

1.1.3. Etiology of Social Anxiety Disorder

There are different theories explaining the development and maintenance of social anxiety disorder. In the following section, behavioral and social skills theory will be

briefly introduced. On the other hand, because the present study focuses on cognitive and relational frame theory, these will be presented more in detail.

Behavioral Model

It is crucial to assume that social anxiety disorder may arise from one or more traumatic conditioning experiences, much like other particular phobias. Individuals with social anxiety disorder have ability to remember the events that gave rise to their phobias through direct traumatic learning. In observational or vicarious conditioning, the conditioning of a fear or anxiety disorder is accomplished by only observing another person's fear of a certain circumstance or object (Mineka and Zinbarg, 1995). On the other hand, the self-presentation hypothesis of social anxiety states that individuals experience social anxiety when the following two circumstances take place simultaneously. The person is particularly anxious to leave a positive impression on others and has doubts about achieving the desired impression. Social anxiety does not occur if none of these two circumstances exists (Leary and Kowalski, 1995).

Social Skills Model

According to Heimberg ve Juster, (1995), theory claims that a lack of social abilities is the fundamental cause of social anxiety. According to this approach, the epiphenomenon of the primary issue is comprised of both periods of conditioning and anxiety of receiving a poor rating. Earlier attempts to treat social anxiety centered on the idea that these patients' anxiety was caused by a lack of social abilities, both verbal (e.g., appropriate speech content) and non-verbal (e.g., eye contact, posture, gestures, and facial expressions). It was thought that Social Skills Training (SST) would enhance these behavioral abilities. As a result, the fundamental cause of anxiety was removed, increasing the likelihood that social interactions would proceed successfully. Treatment for social behavior involves developing social abilities, role-playing, behavior practice, feedback for improvement and social support.

Cognitive Theory

According to the theory of Clark and Wells (1995), the foundation of social anxiety disorder is individuals' negative expectations about social conditions. These expectations include worries about having poor social performance ("I must not make any mistakes. I will forget words and be unable to continue speaking"), that others will

criticize them in a negative perspective (“they will think that I am boring”), and uncontrollable anxiety (“they will notice my excessive sweating and assume I am ill”). An increase in anxiety results naturally from these unpleasant estimates. An individual with social anxiety is continuously on alert even if they enter social situations hoping that nothing bad will happen. This state of alertness can have a negative impact on the individual in two ways: first, it disturbs the individual from engaging in social behaviors like conversation, eye contact, and reacting to social cues. Second, even the smallest negative events are identified and taken as signs of anxiety (Clark and Wells, 1995). False beliefs fuel anxiety and negativity in individuals with social anxiety disorder. They amplify emotional reactions to minor errors or social worries, driven by three main beliefs: First, even tiny mistakes signal social ineptitude. Second, anxiety in social situations indicates personal inadequacy. Third, any deviation from "normal" behavior confirms personal flaws. These thoughts lead to self-perceived social failure based on insignificant cues, regardless of actual social performance (McEwin and Devins, 1983). Avoidance of social situations stems from negative expectations, fear of consequences, heightened symptoms, and misinterpretations. While avoidance initially eases anxiety, it perpetuates social concerns as individuals fail to realize their expectations rarely materialize. This avoidance behavior, often involving "safety behaviors" like leaning for support or avoiding eye contact, temporarily boosts self-esteem but reinforces the belief that they can avoid potentially threatening social situations, thus perpetuating social anxiety (Clark and Wells, 1995; Otto, 1999). These continuous, heightened expectations keep individuals on edge in social settings, impairing their performance and making them hypersensitive to social cues, even minor ones. This cycle of anxiety, avoidance, and perceived failure hinders skill development, further cementing negative expectations (Clark and Wells, 1995). More in detail, according to the model of Clark and Wells, when socially anxious individuals enter a feared social situation (e.g., a presentation), their assumptions about the situation are activated. These assumptions are mostly biased, such as “they will think that I am boring”. Thus, the social situation is perceived as a social danger and socially anxious individuals experience anxiety symptoms (e.g., increased heart rate, blushing) and engage in safety behaviors (e.g., no eye contact with the audience). On the other hand, the attention of the individuals shifts to detailed monitoring and observation of themselves, and processing of self as a social object. To make an idea about how they appear to others, they use self-referent information produced by this

self-monitoring (somatic symptoms and safety behavior). Thus, this enhanced self-focused attention leads to the maintenance of social anxiety. At the same time, it hinders individuals from making an objective perception of the feared social situation, which in turn may lead to poorer social performance (Clark and Wells, 1995).

For individuals without social anxiety, social performance is not linked to undesirable feelings or unrealistic expectations. Direct attention is given to social cues, and this attention is increased in the presence of autonomic arousal. An appropriate and non-aversive social performance is the end consequence. The cognitive model of social anxiety developed by Clark and Wells (1995) is represented in Figure 1.

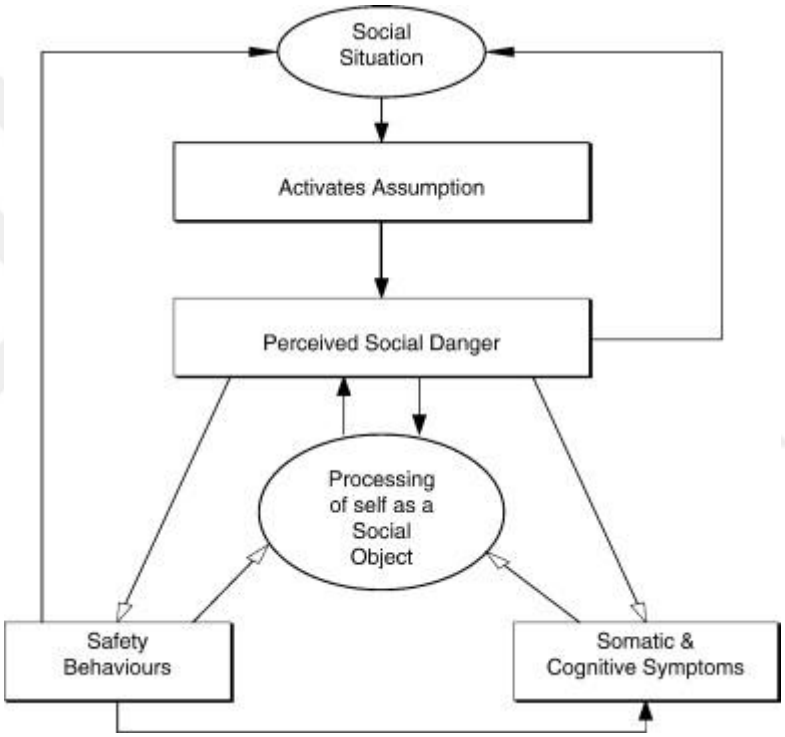

Figure 1. The cognitive model of social anxiety (Source: Clark, 2001).

According to the cognitive model of social anxiety disorders, studies have shown that individuals with social anxiety indeed report higher self-focused attention (Schreiber et al., 2012; Miers et al., 2014), use more safety-behaviors (Cuming et al., 2009; Pinto-Gouveia, Cunha and do Céu Salvador, 2003), and experience anxiety and physical symptoms (Hofmann, 2007) in social situations. Similar results were also found in non-clinical socially anxious individuals (Meral and Vriends, 2021; Vriends et al., 2017; Morrison and Heimberg, 2013).

Relational Frame Theory

Relational Frame Theory (RFT) is the theoretical foundation of Acceptance and Commitment Therapy (ACT; Hayes, 2004). RFT suggests that language and cognition are central to human, allowing them to connect and change the meaning of events based on their relationships with other events (Allen, 2016). People quickly learn to link different inputs together, influencing how events affect them, not just through direct experience but also through their thoughts about them (Hayes and Wilson, 1995). Instead of events themselves, our reactions are shaped by associations with other events (Burke, 2013). Language is how we create and give meaning to our world, and it can either help us or cause problems (Köroğlu, 2009). RFT discusses the basic linguistic mechanisms that lead to human suffering and defines language as behavior influenced by context (Ciarrochi, Bilich and Godsel, 2010). This approach does not directly attribute issues to cognitive content. The real issue arises when our thoughts guide our behavior in a dysfunctional way (Hayes et al., 2006). RFT groups together sensations, ideas, behaviors, and environmental factors using verbal labels, often sorting them into categories like 'positive or negative' or 'pleasant or unpleasant'. This labeling allows us to rationalize and emotionalize our actions. In essence, the theory is based on a comprehensive study of human language and its impact on our lives (Blackledge and Hayes 2001).

RFT suggests that language and cognition are learned through a process of relational framing. (Hayes, 2004). Social anxiety can be seen as a result of negative verbal conditioning, where individuals form negative relational frames about social situations, themselves, or others. For example, they might develop a frame that associates social interactions with fear or humiliation. In addition, RFT emphasizes rule-governed behavior, where individuals follow verbal rules and instructions. In the context of social anxiety, individuals may adhere to rules such as "Don't make a fool of yourself in public" or "Always appear confident." These rules can lead to avoidance behaviors and heightened anxiety in social situations. RFT also explains experiential avoidance, where individuals try to avoid or suppress uncomfortable thoughts, feelings, or sensations. In social anxiety, individuals may try to avoid social situations or use safety behaviors (e.g., excessive self-monitoring) to cope with anxiety-provoking thoughts and feelings. Furthermore, RFT posits that individuals can derive new relations or meanings from previously learned ones. This means that a single negative social experience can lead to the formation of many related negative

associations, amplifying social anxiety. Moreover, RFT can help explain how individuals develop negative self-concepts or self-images related to social interactions. Negative self-relations may lead to self-criticism and low self-esteem, contributing to social anxiety. Lastly, RFT considers contextual control over behavior. People with social anxiety may have difficulty flexibly adapting their behavior in different social contexts due to rigid verbal rules and frames (Norton et al., 2015).

In summary, social anxiety is a debilitating psychological state defined as extreme fear and inconvenience in social situations. Individuals who have social anxiety disorder often suffer from excessive self-consciousness, worry about being negatively evaluated, and fear humiliation or embarrassment. These fears can have a substantial impact on their day-to-day existence, resulting in the avoidance of social interactions and causing difficulties in multiple aspects of life, including work, education, and relationships. Social anxiety is a prevalent mental health disorder and understanding its nature and underlying factors is crucial for developing effective interventions and improving the overall well-being of those affected.

Among these theories explaining social anxiety, the present thesis will adopt the ACT philosophy to examine psychological flexibility. Thus, in the following section, psychological flexibility will be explained and discussed in detail.

1.2. Psychological Flexibility

Psychological flexibility is the fundamental principle of Acceptance and Commitment Therapy (ACT), which was created by Hayes, Strosahl and Wilson (1999). It is identified as being fully aware of emotions, feelings, and thoughts, being in touch with the present, owning undesirable behaviors, and acting within a pattern of behavior shaped by chosen values (Hayes, Strosahl and Wilson, 1999). In comprehensive and conscious awareness, "moment-oriented" activities that are constructed under the direction of values are associated with psychological flexibility. It describes the act of demonstrating tenacity in sustaining behaviors that will improve one's life by recognizing what is beyond one's control and using one's own personal values as a road map when it comes to changing behaviors (Harris, 2018). The psychological flexibility approach considers the individual's capacity to alter problematic life orientations when required as a part of their journey when they control their lives in accordance with their values (Whittingham et al., 2013). According to Strosahl and

Robinson (2009), the purpose of ACT is to help people to build psychological flexibility so they can make determined decisions based on acceptance, awareness of the present moment, and fundamental values.

According to Hayes et al. (2013), the psychological flexibility model identifies the interrelated mechanisms that underlie human adaptation, operation, and/or suffering. Acceptance, cognitive fusion, being present, self as context, value, and committed action are six interconnected and interdependent essential processes that psychological flexibility uses in practice. This model of ACT involves six fundamental concepts called the "flexible hexagon model" which is presented in Figure 2. These concepts refer to the ability to be present, the ability to distance dysfunctional thoughts and continue daily life activities, the ability to accept life events that are not within the control of the individual, the ability to observe the self in the context, the ability to determine the values that are the guide of life and the ability to demonstrate behaviors in line with these values (Harris, 2018). These skills that constitute psychological flexibility contribute to increasing the level of coping with stress (Burton and Bonanno, 2016). According to these concepts, the individual has a powerful psychological flexibility structure (Ciarrochi, Bilich and Godsel, 2010; Hayes, Strosahl and Wilson, 2012).

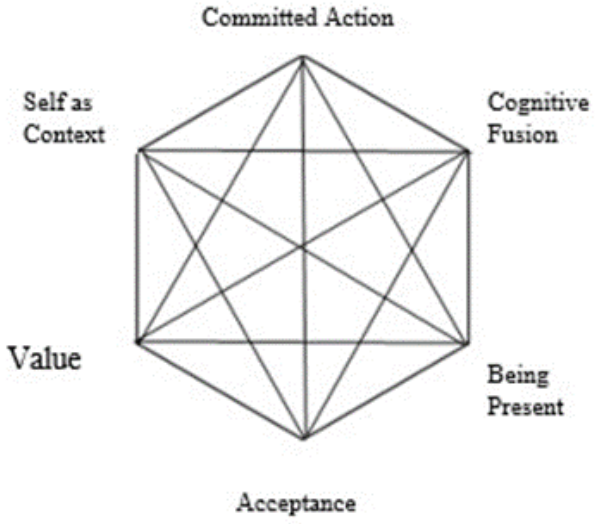

Figure 2. The hexagon of the psychological flexibility model of ACT (Source: Hayes et al., 2006)

Masuda and Tully (2012) consider high psychological flexibility during stressful life events as a protective factor in meeting negative emotions, managing negative situations, and improving mental health. On the other hand, according to ACT (Hayes, Strosahl and Wilson, 2012), psychological rigidity is the primary source of people's suffering and dysfunctional operation. Because in a person's life, their emotions, thoughts, and sensations can cause a variety of discomfort and maladaptive actions that cause further issues or prolong existing issues. The dysfunction and incapacity of the individual to behave in accordance with their values are the results of this process (Burke, 2013). According to Bond et al. (2011), psychological rigidity is the strict control of psychological reactions over specific values, options, and leading actions. When cognitive dissociation cannot be made, people become intertwined with their thoughts and perceive these thoughts as reality and feel that they must necessarily behave according to these thoughts (Harris, 2018). For example, a person with social anxiety, combined with the thought that people will make fun of him or her and that he or she will be humiliated, will withdraw from his or her social environment. Individuals with a high level of psychological rigidity develop a behavioral repertoire according to their thoughts and feelings, and therefore they move away from the values they have created for themselves without realizing it. For example, a person who has a value such as establishing sincere relationships but has social anxiety, merging with the thoughts of being unloved and disliked, and as a result, distancing from relationships will result in a life away from one's values. People who cannot separate from their thoughts stay away from the behaviors they attach importance to because of their negative thoughts. As a result of this situation, values and goals are overlooked because the main point on which people base their behaviors is their cognitions. Because these people have linked the measure of a quality life to the control of emotions and cognitions. Psychological rigidity ultimately results in experiential avoidance (Harris, 2018). When the literature on social anxiety is examined, it is seen that experiential avoidance is a critical factor in the continuation of social anxiety. As frequently supported in the literature, it is stated that low levels of psychological flexibility are found to be closely related to various psychological problems (Masuda and Tully, 2012). Studies in the literature have found that psychological inflexibility is associated with various psychological problems, especially major psychological disorders (Hayes et al., 2006), such as mood and anxiety disorders (e.g., Venta, Sharp and Hart, 2012), substance use disorders (e.g.,

Levin et al., 2012), eating disorders (e.g., Rawal, Park and Williams, 2010), and psychotic disorders (e.g., Goldstone, Farhall and Ong, 2011). Some studies point out that psychological flexibility is an important component in recovery after traumas and coping with psychological difficulties (Benight et al., 2000). It can be said that the fact that psychological flexibility is an auxiliary element in coping competence is related to the multifaceted structure of this concept.

1.2.1. Studies about Psychological Flexibility and Social Anxiety

An examination of the literature demonstrated that studies investigating the association between psychological flexibility and social anxiety are limited. However, conducted studies have revealed important findings regarding the association between psychological flexibility and social anxiety.

Fergus et al. (2012), proposed that a low level of psychological flexibility was related to depression, social anxiety, nonspecific anxiety, and panic scores involving individuals with anxiety disorders including social anxiety disorder. According to Biglan, Hayes and Pistorello (2008), a deficiency of psychological flexibility is a determining factor leading to the continuity and strengthening of social anxiety disorder. A non-clinical adult sample used in a study by Tillfors et al. (2015), found a strong positive correlation between social anxiety/fear, avoidance in social settings, and psychological inflexibility. Furthermore, it was demonstrated that social interaction anxiety and fear of scrutiny were negatively associated with the acceptance of socially anxious ideas and feelings in the college sample (Flynn, Bordieri and Berkout, 2019). Also, the low level of psychological flexibility stated by individuals who have a social anxiety disorder may indicate a major psychological impairment that may be unique for people with a social anxiety disorder who are most afraid of blushing (Gloster et al., 2011). In studies with adults, there is more evidence that directing psychological flexibility is helpful for social anxiety disorder along with various other anxiety disorders (Gloster et al., 2020; Khoramnia et al., 2020; Yadegari, Hashemiyan and Abolmaali, 2014).

Forman et al. (2012) demonstrated that the elements of ACT influence improvement in the treatment of a variety of psychological disorders, while Kocovski et al. (2019) observed that high levels of acceptance resulted in reductions in social anxiety as stated by individuals completing an intervention based on self-help books. In addition, a

study found that ACT is functional when working with individuals with social anxiety disorder, in comparison to the group under normal conditions (Oyetunde and Ajibola, 2019). According to Roohi et al. (2019), ACT may crucially impact on decreasing social anxiety and improving an individual's ability to cope with stress and regulate their feelings. In a study with high school girls with social anxiety disorder, ACT was discovered to be efficient for girls' relational issues and psychological flexibility (Azadeh, Kazemi-Zahrani and Besharat, 2016). Dalrymple and Herbert (2007) discovered that following ACT, individuals with social anxiety reported much fewer symptoms and an improvement in their standard of living.

The finding of the studies mentioned in this section has shown that psychological flexibility can have a significant place in the treatment of social anxiety. However, the limited number of studies points to the need for further investigations to explore this relationship. Especially, as in this study, examining the association between the sub-concepts of psychological flexibility and social anxiety will be valuable for selecting the techniques to be used in the treatment of social anxiety.

1.3. Perceived Parenting Attitudes

A child who grows up in a supportive environment and has stable and secure relationships with parents is essential for socialization (Vandeleur, Perrez and Schoebi, 2007). Socialization is the process by which people take the cultural norms, behaviors, and beliefs of a society (Tolan, 1996) and integrate into it (Kağıtçıbaşı, 1999). The family is where the socialization process is built. Parents have expectations about the types of individuals and values their children will become in the future, and they employ various techniques to meet these goals. Attitudes of parents toward raising their children are mirrored in these techniques (Varıcıer, 2019).

According to Parsons and Bales (1955), "the factory where personality is formed" is the family. Darling and Steinberg (1993) defined parental attitude as the sum of parents' attitudes, beliefs, expectations, and behaviors connected to raising children. According to Krohne (1988), parental attitudes are a set of behaviors that parents exhibit when interacting with their children in particular circumstances. He emphasized that parents could exhibit a uniform set of behaviors in a particular setting. Parenting attitudes are a parent's propensity to react in a positive or negative way to

specific individuals, items, or situations in a way that will influence their child's development, specifically in the psychological and social domains (Yavuzer, 1998).

Parental behavior is one of the most crucial aspects of a child's psychosocial development. For that reason, maladaptive parenting may result in psychopathology in children (Perris, Arrindell and Eisemann, 1994). In the opinion of Rohner (1980), adult personalities are negatively influenced by parental rejection as children. Individuals who feel rejected by their parents are more likely to experience behavioral issues, depressive symptoms, and abuse of substances (Rohner, Khaleque and Cournoyer, 2005). In addition, individuals who have been subjected to rejection and excessive control from their parents in childhood than others are more probable to experience anxiety problems in adulthood (Hudson and Rapee, 2005; Rork and Morris, 2009; Spokas and Heimberg, 2009; Lieb et al., 2000; Parvez and Irshad, 2013). From the past to the present, there have been various theories and theorists dealing with parental attitudes. According to Bowlby's Attachment Theory, the relationship that a person establishes with his/her caregiver in the early period plays a decisive and important role in the feelings, thoughts and behaviors of the person in the later periods of his/her life (Bowlby, 1969; as cited in Batıgün and BüyükŞahin, 2008). Based on the model developed by Baumrind (1966), parental attitudes are categorized under three groups: authoritarian parenting, permissive parenting, and democratic parenting. In the light of the Schema Model of Parenting Attitudes proposed by Young and colleagues (2003), there are five essential and universally recognized emotional needs in childhood that must be met for healthy development: secure attachment (trust, stability, care, and acceptance), autonomy and identity, emotional expression and freedom, spontaneity and play, and realistic boundaries and self-control. Finally, Rohner’s Parental Acceptance-Rejection Theory, which is the basis of this thesis, focuses on how children perceive their parents' attitudes and behaviors in terms of acceptance, rejection, and related sub-dimensions. (Rohner and Rohner, 1980). Emotional warmth, overprotection, and rejection are key sub-dimensions within this theory. Rohner's theory posits that the quality of the parent-child relationship and the child's perception of acceptance or rejection from their parents can have profound and lasting effects on the child's psychological and emotional development. The components of perceived parental attitudes will be explained in more detail below.

Emotional Warmth

The importance of parental warmth in a child's psychological development has been acknowledged. As stated by Rohner, Khaleque and Cournoyer (2005), emotional warmth is related to the level of affection and closeness in the parent-child relationship, as well as the ways in which parents communicate and demonstrate these emotions through physical and verbal actions. According to Muris et al. (2000), "parental warmth" is defined as "parental behaviors associated with accepting the child's emotions and behaviors, showing emotional warmth, and expressing love." Authoritative parenting, characterized by a balance of parental warmth and control, is widely regarded as the most effective parenting style (Baumrind, 1991).

Rejection

In the view of Dirik, Yorulmaz and Karancı (2015), rejection means the critical and judgmental behavioral style of parents toward their offspring. In the words of Rapee (1997), parental rejection usually involves actions like disagreement, criticism, unjustified blame, or punishment. Parental rejection is "the deficiency that results from the failure of children to get enough warmth, love, care, comfort, and support from their parents and other caregivers as well as the psychologically harmful attitudes they are subjected to by their parents." (Rohner, Khaleque and Cournoyer, 2005). Muris et al. (2000) defined parental rejection as conduct that is chilly, hostile, critical, condescending, or judgemental toward children. Rohner, Khaleque and Cournoyer, 2005), discovered that people who were subjected to parental rejection had four common ways of acting toward their parents. "Cold, hostile and aggressive," "indifferent and neglectful," and "undifferentiated rejection". Out of these, the undifferentiated rejection that individuals experience refers to a consequence of their believing that they do not receive care and love from their parents, even though they do not subject to any neglect and aggressive attitude.

Children may feel abandoned and unloved by their parents when they are neglected by their parents. Children who grow up in loving families can also experience these unpleasant emotions. Regardless of whether it is true, a child's sense of parental rejection needs to be considered for a better understanding of their emotions (Rohner, Khaleque and Cournoyer, 2005). As Kagan describes, "Parental rejection is an idea believed by the child, not a particular sequence of behaviors performed by the parents"

(Kagan, 1978). According to research by Hoeve and colleagues (2009), criminal attitudes are linked to parental conflict, rejection, and neglect. Based on the findings, even though paternal rejection has a crucial role in the emergence and growth of symptomatology in children, the child's perception of mother rejection has more power in this process than paternal rejection (Perris et al., 1980; Yahav, 2007).

Overprotection

The term "parental overprotection" refers to protective actions that are extreme in the development of children. The concerned attitude of parents toward the security of their children is linked to this parental style (Thomasgard et al., 1995). Based on a study, overprotective parents severely worry about their children and discourage them from exhibiting independent actions. Children may experience emotions of deprivation of acceptance because of their parents' overprotectiveness (Hullmann et al., 2010).

According to a study, people who thought their parents were overly protective felt like they were immature and had no personal life because of their parent's behaviors (Parker, Tupling and Brown, 1979). In addition, Holmbeck et al., (2002), discovered that there was a negative correlation between overprotection and behavioral autonomy. The findings of other studies indicated that criminal actions, anxiety, and depression have a relationship with parental overprotection (Biggam and Power, 1998; Burbach, Kashani and Rosenberg, 1989; Hudson and Rapee, 2005).

1.3.1. Studies about Parenting Attitudes and Social Anxiety

Perceived parenting attitudes can contribute to the development of social anxiety through various psychological and behavioral mechanisms. Firstly, overprotective parenting attitudes can result in children perceiving the world as a dangerous place, leading to avoidance behaviors. When parents restrict their child's exposure to challenging social situations, the child may not have the opportunity to develop social skills and confidence. Over time, this avoidance can contribute to the development of social anxiety (Manassis and Bradley, 1994). Following that, children who perceive their parents as rejecting, critical, or judgmental may internalize these negative evaluations and develop a heightened fear of judgment from others. This fear of negative evaluation is a central feature of social anxiety (Rapee and Spence, 2004). In addition, children often model their behaviors after their parents. If parents exhibit

anxious behaviors in social situations, children may learn to do the same. This modeling can lead to the development of social anxiety (Bandura, 1977). Furthermore, perceived parenting attitudes can influence the development of attachment styles. Insecure attachment styles, such as anxious or avoidant, have been associated with social anxiety. These attachment styles can affect how individuals relate to others in social situations (Mikulincer and Shaver, 2007). Lastly, perceived parenting attitudes can shape a child's cognitive processing of social information. Children who perceive their parents as anxious or critical may develop cognitive biases that lead them to interpret social situations as more threatening or negative (Cartwright-Hatton and Wells, 1997).

In studies examining the association between parental attitudes and social anxiety, it was concluded that rejection (Lieb et al., 2000; Parvez and Irshad, 2013) and overprotective attitudes (Rork and Morris, 2009; Spokas and Heimberg, 2009) were more common in socially anxious people. Kapur and Rai, (2013) discovered that as well as rejection and overprotective attitudes, low levels of emotional warmth were associated with social anxiety. Children who are raised with a careless and rejectionist attitude may be quiet, honest, well-behaved, and kind; however, they may be resentful, shy, unable to say no, and have an overly emotional mood (Kulaksızoğlu, 2011; Yavuzer, 2000). At the same time, these children may also have elevated levels of social anxiety (Hale, 2008). In studies, it is observed that parents of individuals who have high social anxiety show fewer tendencies to have democratic attitudes and are more likely to have protective and authoritarian attitudes than parents of individuals who have low social anxiety (Erkan, 2002). Studies reveal that parental rearing behaviors, especially the evaluation of parental rejection, are positively related to child anxiety (Brown and Whiteside, 2008). Supporting the data in the literature, a study conducted on socially anxious adolescents showed that their perceptions of their parents were lack of social interaction, excessively preoccupied with others' opinions, and burdened by shame regarding their shyness and low performance (Caster, Inderbitzen and Hope, 1999). Studies have described anxious children’s parents as domineering, over-intrusive, not showing enough affection and love, and too demanding (Güçray and Sabahattin, 2002; Özyürek and Demiray, 2010). Studies show that the parents of individuals who have social anxiety tend to be overprotective, indifferent, rejecting, and embarrassing (Hudson and Rapee, 2000). In addition, it was

found that socially anxious individuals perceived their parents as more protective (Bruch and Heimberg, 1994), more rejecting, and less emotionally supportive in their childhood (Bögels et al., 2001). Lieb et al. (2000) also discovered that overprotective and rejecting parental attitudes were associated with an enlargement in social phobia in children. Accordingly, children who are subjected to aggressive and refusal attitudes by their parents develop insecure and shy personality traits by believing that they will not be approved by other people. As a result, it was observed that the families of anxious children were interfering, overprotective, demanding, encouraging avoidance behavior, not supporting social and active behaviors, and anxious (Dadds et al., 1996; Rappe, 1997; Woodruff-Borden et al., 2002).

The results of the studies analyzed in this section have shown that parental attitudes have a major influence in the emergence and development of social anxiety and are among the causes. Therefore, it would be valuable to consider the effect of emotional warmth, rejection, and overprotection sub-dimensions of perceived parental attitudes on social anxiety while exploring the concept of social anxiety.

1.3.2. Studies about Psychological Flexibility and Parenting Attitudes

Psychological flexibility is considered a skill that can be acquired and is influenced by various contextual factors throughout one's life. Parenting experiences play a significant role in this, encompassing both traditional parenting attitudes as defined by Fogle and Sandoz in 2017 and more adaptable approaches as outlined by Williams and colleagues in 2012. These parenting attitudes have an impact on the psychological flexibility of their offspring. Specifically, higher levels of personal care and not being overly protective (characteristic of flexible or authoritative parenting) are associated with a positive influence on psychological flexibility (Fogle and Sandoz, 2017; Martín-Asuero and García-Banda, 2010; Williams, Ciarrochi and Heaven, 2012). Parents who exhibit inflexibility themselves may indirectly affect their children by experiencing greater parental distress, which in turn leads to increased inflexibility in their children (Leeming and Hayes, 2016). Additionally, the level of psychological flexibility in parents mediates the connection between low overprotective parenting practices and negative behavioral and emotional outcomes in children (Leeming and Hayes, 2016).

While the impact of mindful parenting on the psychological flexibility of children and adolescents remains unexplored, a study conducted over a 6-year period by Williams

and colleagues in 2012 delved into the long-term connections between adolescents' perceptions of parenting attitudes and their psychological flexibility. The findings from this study revealed that authoritarian parenting was linked to lower levels of psychological flexibility, whereas authoritative parenting was associated with higher psychological flexibility. This suggests that when adolescents perceive their parents as engaging in psychologically controlling behavior and lacking warmth, it hampers the development of their psychological flexibility over time.

A review of the literature revealed that there is a paucity of research examining the relationship between psychological flexibility and parental attitudes, and it is hoped that the findings of this study will contribute to the literature and draw attention to this deficiency.

1.4. Emotion Regulation

Emotion regulation is a set of internal and external response mechanisms for observing, assessing, and changing responses to emotions that are particularly strong and transitory for an individual in identifying his or her goals (Thompson, 1994). People attempt to control their emotional states, identified as emotion regulation (Koole, 2010). In the most general sense, emotion regulation refers to the control of all emotionally charged situations, which consists of mood, stress, and either positive or negative emotions (Koole, 2010). According to Cole et al. (2008), the best way to understand emotion regulation is as a dynamic process that evolves in a non-linear pattern between emotional, cognitive, and behavioral functions as well as within each function. According to Gross (1998), emotion regulation is the process that includes the way we perceive emotions, the way we share emotions, and the way we attempt to control our emotions. Therefore, emotion regulation's primary goal is to naturally modify emotional responses (Gross, 2002). Research emphasizes that the aim might be the circumstance as well as the expression of the emotion, which highlights that both positive and negative emotions can be managed (Gross, 1998). People may preserve, reduce, or raise their pleasant or unpleasant feelings through emotion regulation. Accordingly, modifying emotional responses is usually a part of emotion regulation. These changes may show up in the kinds of emotions people feel the sequence in which they experience them, and the ways in which they are expressed (Gross, 1999). Since processing one's own emotions is an essential aspect of emotion

regulation, its impacts can be seen in many aspects of emotional response, including thought, behavior, physiology, and emotions (Koole, 2010).

Gross (1998) developed the process model, which demonstrates how different emotional responses depend on the circumstances under which emotion regulation techniques are employed. Based on this model, when emotion regulation techniques are applied, it is crucial in terms of the variety of responses since emotions are frequent responses that happen throughout the relationship between the organism and its environment (Gross, 2001; Gross, 2002). The process model states that the moment a person experiences a behavioral, physiological, or experiential stimulus that will cause their emotions to be activated, the emotion regulation process begins (Gross, 2001). Following the triggering of the emotions, the individual employs one or more emotion control techniques that correspond to the distinctive features of the period during which the emotions are managed. Antecedent-focused and consequence-focused techniques are the two broad kinds of emotion regulation techniques based on when they are applied by the user. Antecedent-focused techniques are employed before emotional responses are fully triggered and before actions or physiological responses are modified. However, when emotions are present and after potential behavioral and physiological reactions have appeared, consequence-focused techniques are observed (Gross, 2001).

Gross (1999) defined within the context of the process model, Reappraisal and Suppression are the two key concepts of the emotion regulation system. First, "reappraisal," refers to the current circumstance, and the incident that triggered the feeling are usually rejected. In contrast, the person modifies his or her feelings through examining the circumstance which is the reason for the appearance of the feeling. For this reason, reappraisal is a strong tool for managing emotions. Reappraisal is crucial to emotion-based techniques (Lazarus, 1991) and stress management (Gross, 1999). In the view of Gross (2002), reappraisal, is the process of making meaning of a potentially highly emotional circumstance in a rational and unemotional context. Second, "suppression" is described as the inhibition of emotional expression behavior, which is another emotion regulation process (Gross, 2002). Gross (2002) states that emotion dysregulation is a prominent feature of many types of psychopathologies. As a result of many studies in the literature, it has been observed that emotion regulation is associated with many psychopathological outcomes. In these studies, they found

significant relationships between emotion regulation and impulsivity (Schreiber et al., 2012), borderline personality disorder, posttraumatic stress disorder or alcohol intoxication (Thompson and Goodman, 2010), depressive symptoms (Beblo et al., 2012), panic disorder (Tull and Roemer, 2007), general anxiety level (Mennin et al., 2004), anxiety in children and adolescents (Bender et al., 2012), depression, anxiety, and eating disorders (Aldao, Nolen-Hoeksema and Schweizer, 2010). Also, more than 75% of the diagnostic criteria for psychopathology are characterized by issues with emotion or emotion regulation in the DSM-V. Internalizing and externalizing disorders (such as conduct disorder, post-traumatic stress disorder, and attention deficit hyperactivity disorder) are described as a failure to manage feelings, and many major affective disorders (depression, bipolar disorder, and anxiety disorders) contain challenges in managing emotions (Thompson and Goodman, 2010). Werner and Gross (2010) emphasize that difficulties in emotion regulation are at the center of many psychopathologies and may play a key role in their treatment.

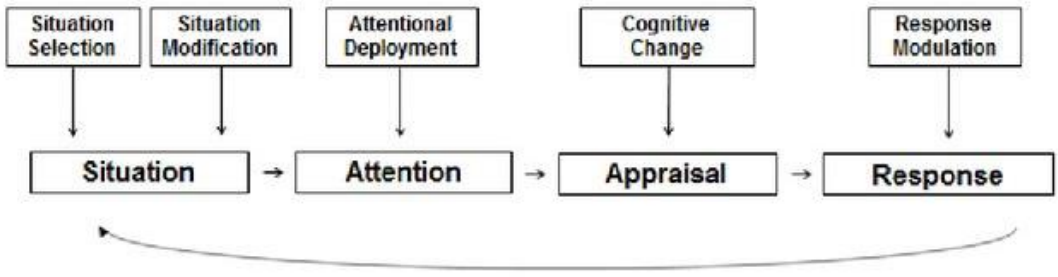

Figure 3. The process model of emotion regulation (Source: Gross and Thompson, 2007)

1.4.1. Studies about Emotion Regulation and Social Anxiety

Based on the literature review, studies investigating the association between emotion regulation and social anxiety are presented below.

Individuals who have difficulty managing their emotions are more likely to have severe and long-lasting maladaptive emotions and they tend to have a range of psychological disorders, such as personality disorders (Putnam and Silk, 2005), depression (Campbell Sills et al., 2006), and anxiety (Mennin et al., 2002). Having difficulty managing one's emotions is a common characteristic of anxiety disorders, including social anxiety disorder (Turk et al. 2005; Kashdan et al. 2013). Based on the

findings of studies, emotion dysregulation is one of the primary attributes of social anxiety disorder from the perspective of the cognitive model of social anxiety (Hermann, Ofer and Flor, 2004; Hofmann, 2004). Kashdan et al. (2007) discovered that socially anxious individuals showed greater scores in suppression and fewer scores in pleasant experiences in a daily diary study. In addition, individuals who were highly anxious in social circumstances stated fewer positive situations on days when they used suppression to control their anxiety, and this dysfunctional emotion regulation had an overall negative effect on their positive experiences in their daily life (Kashdan and Steger, 2006). According to the results of many studies in the literature, it has been revealed that people who are diagnosed with social anxiety disorder generally suppress both negative (Erwin et al., 2003; Spokas, Luterek and Heimberg, 2009) and positive feelings (Turk et al., 2005; Werner and Gross, 2010). People who have high levels of social anxiety showed a greater extent of suppression of their positive feelings due to their discomfort with sustaining and sharing positive feelings, particularly in settings involving social evaluation (Turk et al., 2005). Moreover, socially anxious individuals vary from others in their use of cognitive reappraisal and suppression, they use suppression more and cognitive reappraisal less (Werner et al., 2011; Goldin et al., 2009). Individuals with high levels of social anxiety think they are less competent at using cognitive reappraisal (Werner et al., 2011). Individuals who have social anxiety disorder might proceed to have distorted impressions of their use of emotion regulation strategies, emphasizing the negative effects of using maladaptive approaches while disregarding the positive effects of using healthy approaches (Hofmann, 2007; Rapee and Heimberg, 1997).

As in many psychological disorders, emotion regulation has a major place in the emergence and sustaining of social anxiety. For this reason, in addition to the studies in the literature, there is a need for research that examines the association between emotion regulation and social anxiety in more detail.

1.4.2. Studies about Emotion Regulation and Psychological Flexibility

Emotional dysregulation and psychological inflexibility are both factors that have been identified as common contributors to various mental health conditions (Aldao et al., 2016). Maladaptive ways of regulating emotions, such as rumination, reappraisal, and emotional suppression, have been associated with anxiety, depression, and eating

disorders (Aldao and Nolen-Hoeksema and Schweizer, 2010; Aldao, Sheppes and Gross, 2015). Similarly, psychological inflexibility has been linked to depression, anxiety, schizophrenia, attention deficit hyperactivity disorder, and substance abuse (Kashdan and Rottenberg, 2010). Studies found a significant correlation between challenges in emotion regulation and psychological inflexibility and both of them have been associated with different types of mental disorders, particularly anxiety and depression (Aldao and Nolen-Hoeksema and Schweizer, 2010; Kashdan and Rottenberg 2010). There are some studies in the literature that link psychological flexibility as an effective emotion regulation strategy (García-Gómez et al., 2019; Kashdan and Rottenberg 2010; Seligowski and Orcutt 2015). In a study conducted with adolescents, found a significant connection between processes of psychological inflexibility and challenges in managing emotions (Paulus et al., 2016). In addition, individuals who possess psychological flexibility tend to employ more suitable and adaptive strategies for regulating their emotions (Moreira and Canavarro, 2020). Acceptance, which is a component of psychological flexibility, has been shown to yield positive outcomes as an approach to regulating emotions (Hayes, Strosahl and Wilson, 1999; Heffner et al., 2003). On the contrary, maladaptive emotion regulation procedures such as suppression, avoidance, and rumination, which are associated with psychological rigidity, have been identified as well as maladaptive responses to various stressors (e.g., depression and anxiety), considered risk factors for undesirable behaviors, particularly substance abuse (Carver et al., 1989; Folkman and Lazarus, 1980; Mayer and Stevens, 1994). Psychological flexibility has been linked to adaptive strategies of emotion regulation, promoting positive health and well-being outcomes for individuals (Aldao, Nolen-Hoeksema and Schweizer, 2010).

In the literature, there are not many studies investigating the association between psychological flexibility and emotion regulation. Rather, the relationship between cognitive flexibility and emotion regulation has been widely examined. However, based on the existing research, it has been revealed that psychological inflexibility and emotion dysregulation are the main factors of many psychological disorders, especially depression, and anxiety. In addition, studies have found significant links between psychological flexibility and emotion regulation. For these reasons, there is a need for studies that examine the relationship among psychological flexibility and emotion regulation.

1.4.3. Studies about Emotion Regulation and Parenting Attitudes

The family, where the first socialization experiences take place, plays an important role in the development of the emotional skills of the child (Eisenberg, Cumberland and Spinrad, 1998). Accordingly, it is emphasized that the family context is one of the factors that shape the individual's emotion regulation skills. The emotional climate of families formed through factors such as child-rearing attitude, attachment style, marital relationship, the way they react to emotional messages (emotion socialization), and their behaviors and being a model affect the development of emotion regulation skills of children (Morris et al., 2007). Therefore, parental attitudes and behaviors gain importance in understanding emotion regulation skills. Family context affects the development of emotion regulation skills in three important ways (Morris et al., 2007). Firstly, children learn about emotion regulation through observation. Second, specific parenting practices and behaviors related to the socialization of emotions affect emotion regulation. Finally, emotion regulation is influenced by the emotional climate of the family, which reflects the attachment relationship, parenting styles, whether the family expresses emotion, and the emotional quality of the marital relationship (Morris et al., 2007). The development of emotion regulation skills is strongly dependent on the child's relationship with the caregiver and the family environment (Greenspan and Shanker, 2004).

When the literature is examined, it is stated that the behaviors of accepting the needs of the child, providing support to the child, and sympathizing with the child's emotions, which represent parental sensitivity, have positive effects on emotion regulation skills; whereas negative parenting, which is characterized by hostility, psychological control and negative discipline methods and low sensitivity, is associated with insufficient development of emotion regulation skills (Morris et al., 2007). It is stated that indifferent parental attitude may be the biggest risk factor for emotion regulation difficulties by causing adolescents to experience a high degree of adjustment problems due to a lack of boundaries (Maccoby and Martin, 1983; Morris et al., 2007). As a matter of fact, it has been found that the individual's difficulty in emotion regulation is associated with various psychopathologies as a result of the parent's inadequacy in giving care and showing warmth, and having difficulty in exercising control (Betts, Gullone and Allen, 2009; Karaer and Akdemir, 2019). There are also studies evaluating different results of maternal and paternal influence on emotion regulation skills. The

mother's adoption of an authoritarian attitude, psychological control, and hostile attitudes are associated with internalization and externalization problems, which are symptoms of emotion regulation difficulties (Morris et al., 2007). Although it is emphasized that mothers are more effective in children's emotion regulation skills than fathers (Bariola, Hughes and Gullone, 2012); it is stated that fathers also affect emotion regulation skills with the discipline methods they apply (Mcewen and Flouri, 2009) and the behaviors they exhibit (Mcdowell et al., 2002). Similarly, in the study conducted by Tani, Pascuzzi and Raffagnino (2018), it was concluded that there is a close relationship between perceived paternal care and emotion regulation difficulties of adult individuals, and that there are relationships between perceived maternal care and some sub-dimensions of emotion regulation.

Aka (2011) found that participants who perceived their parents as warmer were more likely to use the cognitive reappraisal strategy than participants who perceived their parents as less warm. These findings are consistent with the literature indicating that parental warmth in childhood contributes positively to the development of emotion regulation (Morris et al., 2007). According to Aka (2011), if emotionally warm parents act as role models in emotion regulation processes in terms of understanding and acting according to their children's emotions beyond expressing their own thoughts and feelings openly, children can use cognitive reappraisal by learning to evaluate situations from different perspectives. In the same study, it was found that participants who perceived their fathers as more protective tended to use suppression as an emotion regulation strategy compared to participants who perceived their fathers as less protective. It can be argued that children may learn to suppress their emotions to avoid excessive parental control. When there is no emotion or behavior clearly expressed by the child, the areas that the parent can control are limited (Aka, 2011).

Parents play an important role in the development of children's emotion regulation skills (Morris et al., 2017). The quality of parent-child interaction forms the basis of the attachment relationship, and this relationship is known to have great effects on the child's experience, expression, and regulation of emotion (Jaffe, Gullone and Hughes, 2010).

1.5. Aim of the Present Study

Social anxiety is characterized by intense fear and avoidance of being negatively evaluated by others in situations that require social performance and interaction (APA, 2013). Individuals with social anxiety disorder have more social and occupational impairment than individuals with other anxiety disorders because they experience intense anxiety even in situations that people frequently perform in everyday life such as communication at work, eating, and drinking in front of others (Magee et al., 1996). It should also be mentioned that individuals with social anxiety may not be recognized and get undiagnosed because they don't seek help. Therefore, investigating nonclinical socially anxious individuals is crucial. Furthermore, studies have indicated that gender plays a role in the prevalence and expression of social anxiety. For instance, research suggests that women tend to report higher levels of social anxiety than men (Ruscio et al., 2008). In the literature, the effect of gender on other study variables; psychological flexibility, perceived parenting attitudes, and emotion regulation has not been studied as much as social anxiety and there are mixed results. For this reason, when examining the relationship between the study variables, it is believed that investigating the gender differences of each variable will enhance the overall findings.

On the other hand, the causes for the emergence of a disorder that affect human functioning include social, psychological, and biological factors, like other psychological problems (Beidel, 1998). Especially, parental attitudes have a crucial place in the emergence and development of social anxiety. Lieb et al. (2000) found that children exposed to overprotective and rejecting parental attitudes had a higher risk of developing social anxiety disorder compared to other children. Indeed, studies have found that individuals with high social anxiety experience overprotection and rejection attitudes from their parents more than their peers in their childhood. Therefore, the present study is interested to investigate the relationship between perceived parenting attitudes and social anxiety.

Furthermore, many forms of psychopathology are conceptualized in terms of reduced psychological flexibility, marked by an excess of dysfunctional emotion and behavioral regulation and a lack of value-congruent behavior. One key aspect contributing to the persistence and intensification of social anxiety disorder is a lack of psychological flexibility (Biglan, Hayes and Pistorello, 2008). Psychological

inflexibility refers to a cognitive, emotional, and behavioral pattern that limits a person's capacity to select a reaction that most closely represents their values (Hayes et al., 2013). Tillfors et al. (2015), found a strong positive correlation between social fear and avoidance in social settings, and psychological inflexibility. In the studies with individuals with a social anxiety disorder who receive ACT, it was observed that the psychological flexibility of individuals increased, and this had a significant effect on the improvement of social anxiety (Forman et al., 2012; Kocovski et al., 2019). Therefore, techniques that strengthen psychological flexibility can be a promising factor in the treatment of social anxiety. Accordingly, to gain a better understanding, the present study will focus on how psychological flexibility and its concepts relate to social anxiety.

On the other hand, socially anxious individuals have difficulty with the regulation of their emotions. This difficulty causes these individuals to form distorted impressions about their process of emotion regulation. Distorted impressions are cognitive structures formed by significant beliefs of individuals when maladaptive information processing occurs (Beck, 2011). For instance, people with high levels of social anxiety are more likely to emphasize the negative effects of using emotion regulation strategies while disregarding positive ones (Hofmann, 2007; Rapee and Heimberg, 1997). In addition, individuals with social anxiety use more suppression in the process of emotion regulation than cognitive reappraisal (Werner et al., 2011; Goldin et al., 2009) and they tend to suppress more positive emotions due to their discomfort with sustaining and sharing positive emotions, particularly in settings involving social evaluation (Turk et al., 2005). These maladaptive emotion regulation strategies play a major part in the persistence and increase the level of social anxiety. For that reason, the present study aimed to examine how social anxiety is related to emotion regulation and its strategies.

In sum, social anxiety disorder is a psychopathology with a very long history. Therefore, for hundreds of years, people have been suffering from the effects of this disorder. There are many articles in the literature on the treatment of social anxiety disorder, but still, it is the most prevalent anxiety disorder (Stein and Stein, 2008). The lifetime occurrence rate of social anxiety disorder ranges between 4% to 13% in the general population (Morrison, 2019). Although the present study does not focus on individuals diagnosed with social anxiety disorder, investigating social anxiety is

important because many socially anxious individuals do not seek treatment, however, they still experience various dysfunctions in their lives. Related to social anxiety, studies have shown that parental attitudes have a major place in the emergence of social anxiety (Lieb et al., 2000). Additionally, the effect of psychological flexibility and emotion regulation on social anxiety has been found by researchers (Biglan, Hayes and Pistorello, 2008; Turk et al., 2005; Kashdan et al., 2013). Although all these concepts were investigated in studies before, they were not examined within the same study. In this context, the main purpose of the present study is to examine the relationship between social anxiety, perceived parenting attitudes, psychological flexibility, and emotion regulation. More specifically, the focus of interest is to investigate how much perceived mother and father attitudes (overprotection, rejection, warmth), psychological flexibility, and emotion regulation (reappraisal and suppression) accounts for social anxiety. It is thought that the results may contribute to a better understanding of social anxiety, and in turn, to targeted treatments for social anxiety.

Based on the assumptions, the following hypotheses of the present study are determined.

1.6. Hypotheses

H1: Social anxiety will positively correlate with overprotection and rejection sub-dimensions of parental attitudes, for mother and for father.

H2: Social anxiety will negatively correlate with emotional warmth sub-dimension of parental attitudes, for mother and for father.

H3: Social anxiety will positively correlate with suppression sub-dimension of emotion regulation.

H4: Social anxiety will negatively correlate with reappraisal sub-dimension of emotion regulation.

H5: Social anxiety will negatively correlate with psychological flexibility, and its sub-dimensions.

H6: There will be significant difference between women and men participants in the scores of social anxiety, psychological flexibility, parenting attitudes, and emotion regulation.

H7: Perceived mother attitudes (emotional warmth, overprotectiveness, rejection), psychological flexibility, and emotion regulation (reappraisal and suppression) will predict social anxiety.

H8: Perceived father attitudes (emotional warmth, overprotectiveness, rejection), psychological flexibility, and emotion regulation (reappraisal and suppression) will predict social anxiety.

CHAPTER 2: METHOD

In this chapter, participants, materials, procedure, and statistical analysis of the present study will be covered, respectively.

2.1. Participants

In the present study, a total of 217 participants were included. The inclusion criteria were 18 years of age and above and volunteering to participate in the study. In the normality and outlier detection procedure, it was determined that there were 2 outlier participants in the Perceived Parental Attitudes Scale, so the participants were excluded from the study. Therefore, analyses were conducted with 215 participants. The data included 118 female (54.9 %) and 97 male (45.1 %) participants. Participants were between the ages of 18 and 75 (M = 38.03, SD = 12.30). Regarding the educational level, 12 (5.6 %) participants had completed primary school, 10 (4.7 %) had completed secondary school, 52 (24.2 %) had completed high school, 113 (52.6 %) had completed university, 21 (9.8 %) had completed a master's degree, and 7 (3.3 %) had completed a PhD. Considering the marital status of the participants; 137 (63.7 %) of them were married, 51 (23.7 %) of them were single, 7 (3.3 %) of them were divorced, 20 (9.3 %) of them were in a relationship. Demographic characteristics of 215 participants (gender, level of education, marital status, whether they have a chronic disease or not, whether they have a psychiatric diagnosis or not, whether they have a family history of psychiatric illness or not) were summarized in Table 2.

Table 2. Demographic Characteristics of the Participants

Study Variables		F	%
Gender	Women	118	54.9
	Men	97	45.1
Level of education	Primary school	12	5.6
	Secondary school	10	4.7
	High school	52	24.2
	University	113	52.6
	Master's degree	21	9.8
	Doctoral degree	7	3.3
Marital status	Married	137	63.7
	Single	51	23.7

Table 2. (continued) Demographic Characteristics of the Participants

	Divorced	7	3.3
	In relationship	20	9.3
Chronic Physical Illness	Yes	33	15.3
	No	182	84.7
Psychiatric Diagnosis	Yes	17	7.9
	No	198	92.1
Psychiatric History of The Family	Yes	27	12.6
	No	188	87.4

2.2. Materials

In the present study, data collection from participants was carried out by the following instruments: Informed Consent Form (See Appendix B), Demographical Information Form (See Appendix C), Liebowitz Social Anxiety Scale (See Appendix D), Psychological Flexibility Scale (See Appendix E), Perceived Parenting Attitudes Scale (See Appendix F), Emotion Regulation Questionnaire (See Appendix G). All these scales will be presented in detail in the following section.

2.2.1. Demographical Information Form

To obtain detailed information about the demographic characteristics of participants, the researcher developed a demographical information form including questions about participants' age, gender, level of education, occupation, marital status, psychiatric/medical diagnosis, and family psychopathology.

2.2.2. Liebowitz Social Anxiety Scale

Liebowitz Social Anxiety Scale was developed in 1987 by Micheal Liebowitz and aims to assess social situations including interaction and performance in which individuals with social phobia may indicate fear/anxiety and/or avoidance (Liebowitz, 1987). Liebowitz Social Anxiety Scale consists of two subscales: 1) social interaction situations, and 2) performance situations. It contains a total of twenty-four items on a four-point Likert scale (Fear/Anxiety: 0 = none, 1 = mild, 2 = moderate, 3 = severe; Avoidance: 0 = never, 1= occasionally, 2 = often, 3 = usually). Each item represents a situation that has been experienced or assumed to have been experienced and

participants were asked to assess these items accordingly the level of fear/anxiety and frequency of avoidance behavior. Summing item scores of two subscales creates the scale's total score and it can range between 0 and 144. An increase in the total scale score indicates that participants have high levels of social anxiety. The scale's Cronbach's alpha coefficient values ranged between .81 and .92 (Heimberg et al, 1999).

Turkish adaptation of the Liebowitz Social Anxiety Scale was conducted by Soykan, Özgüven and Gençöz (2003). Reliability analysis indicated that the fear/anxiety and avoidance subscales' Cronbach's alpha coefficients were .96 and .95 and the whole scale's Cronbach's alpha coefficient was .98. The fear/anxiety and avoidance subscales and whole scale's test-retest reliability coefficients were .96. The fear/anxiety subscale and whole scale's interrater reliability coefficients were .96 and interrater reliability coefficient for anxious subscale was .95. The fear/anxiety and avoidance subscales suggested a cut-off score of 25 and a cut-off score 50 for the whole scale. In the present study, Cronbach's alpha value for social anxiety was found as .96.

2.2.3. Psychological Flexibility Scale

Psychological Flexibility Scale was developed in 2016 by Francis, Dawson and Golijani Moghaddam, and aims to create a comprehensive measure of Acceptance and Commitment Therapy components for adult individuals. The scale consists of three subscales: 1) openness to experience, 2) behavioral awareness, and 3) valued action. It contains a total of twenty-three items on a seven-point Likert scale (0 = Strongly Disagree, 1 = Disagree, 2 = Slightly Disagree, 3 = Neither Agree Nor Disagree, 4 = Slightly Agree, 5 = Agree, 6 = Strongly Agree). In the evaluation of the scale, an increase in the total scale score indicates that participants are psychologically flexible which briefly means the capacity to engage with the present moment consciously as a human being and to modify or persist in actions that align with valued goals. In addition, lower levels of psychological flexibility refer to psychological inflexibility and it would be correlated with higher levels of psychological distress and lower levels of well-being. The whole scale's Cronbach's alpha coefficient value was .91 (Francis, Dawson and Golijani-Moghaddam, 2016).

Turkish adaptation of the Psychological Flexibility Scale was conducted by Karakuş and Akbay (2020). The data obtained from the study were analyzed and adjustments

were made to increase the cultural and linguistic suitability of the original scale for the Turkish population. Five items and two sub-dimensions were added to represent the items appropriately. The adjusted version of the scale consists of five subscales: 1) Values and behaviors, 2) getting in contact with the present moment, 3) acceptance, 4) self as context, and 5) cognitive decomposition. It contains twenty-eight items and items were renumbered. The scale contains reversed items (2, 3, 5, 6, 8, 18, 20, 22, 23, 24 and 25). The lowest score that can be obtained from the scale is 28 and the highest score is 196. High scores indicate that the participants are psychologically flexible. The whole scale's Cronbach's alpha coefficient value for adapted scale was .79 (Karakuş and Akbay, 2020). In the present study, Cronbach alpha value for psychological flexibility was .75.

2.2.4. Perceived Parenting Attitudes

The Perceived Parenting Attitudes Scale was developed in 1980 by Perris et al. assessing adults' perceptions of their parents' attitudes during childhood. The scale consists of three subscales, namely: 1) emotional warmth, 2) overprotection and 3) rejection for each parent. The first version of the scale contains eighty-one items but in view of time consumption, the scale items were adapted into a shorter version (Arrindell et al. 1999). The short version of the scale contains twenty-three items on a four-point Likert scale (1 = Never, 2 = Sometimes, 3 = Often, 4 = Most of the time). Item 17 is the only reversed item in the scale. Scale scores were calculated separately for each parent and for each subscale. In the evaluation of the scale, high scores for the emotional warmth subscale indicate more accepting, supportive, and caring attitudes. High scores for the overprotection subscale indicate more anxious attitudes from parents about children's safety, and high scores for the rejection subscale indicate more critical and judgmental attitudes toward children. The Cronbach's alpha coefficient values of all subscales were higher than .72 (Arrindell et al., 1999).

Turkish adaptation of the Perceived Parenting Attitudes Scale was conducted by Dirik, Yorulmaz and Karancı (2015). Initially, a pilot study reported certain findings regarding the psychometric properties of the scale, which were subsequently expanded upon in a more extensive study involving a different sample. The studies conducted using this scale, for both mothers and fathers, revealed three consistent factors that mirrored the ones found in the original scale (Dirik, Karancı and Yorulmaz, 2004,

Dirik, Yorulmaz and Karancı, 2015). The scale itself comprises 23 questions and encompasses three subscales: rejection, emotional warmth, and overprotection, which align with the subscales present in the original version of the scale. Internal consistency values were calculated separately for mother and father. Reliability analysis indicated that maternal emotional warmth, overprotection, and rejection Cronbach's alpha values were .75, .72, and .64, respectively. Paternal emotional warmth, overprotection, and rejection Cronbach's alpha values were .79, .73, and .71 (Dirik, Karancı and Yorulmaz, 2004). In the present study, Cronbach's alpha values for the emotional warmth sub-dimension was .91, for the overprotection sub-dimension was .88, and for the rejection sub-dimension was .88.

2.2.5. Emotion Regulation Questionnaire

The Emotion Regulation Questionnaire was developed in 2003 by Gross and John and aims to assess two strategies to regulate emotions. The two strategies are in the two following subscales: 1) reappraisal and 2) suppression. It contains a total of ten items on a seven-point Likert scale, ranging from 1 ("strongly disagree") to 7 ("strongly agree"). In the evaluation of scale, the scores obtained from each sub-dimension are summed separately and the total score of the sub-dimensions is obtained. The lowest score that can be obtained from the reappraisal subscale is 6 and the highest is 42. The lowest score that can be obtained from the suppression subscale is 4 and the highest is 28. High scores in the subscales indicate participants' tendency towards cognitive reappraisal or suppression strategies in emotion regulation. The Cronbach's alpha values for the reappraisal subscale ranges between .80 and .82, and for the suppression subscale ranges between .73 and .76 (Gross and John, 2003).

Turkish adaptation of the Emotion Regulation Questionnaire was conducted by Eldeleklioğlu and Eroğlu (2015). Reliability analysis indicated that Cronbach's alpha value for the reappraisal subscale was .78 and for the suppression subscale was .73. Test-retest reliabilities for the reappraisal subscale was .74 and for the suppression subscale was .72 (Eldeleklioğlu and Eroğlu, 2015). In the present study, Cronbach's alpha value for the reappraisal sub-dimension was .72 and for suppression sub-dimension was .72.

2.3. Procedure

The Ethics Committee at Izmir University of Economics gave its approval to the present study. Social media platforms were used to reach the participants and data was collected via Google Forms. The inclusion criteria were to be 18 years of age and above and volunteer to participate in the study. Individuals were informed at the beginning of the study by an informed consent which included details of the study such as the aim of the study, the procedure, duration of the study, voluntary participation, confidentiality, anonymity, and the right to withdraw from the study. Individuals who read and accepted the informed consent were included in the study as participants and answered the scale questions in this order: Participant Information Form, Perceived Parenting Attitudes Scale, Liebowitz Social Anxiety Scale, Psychological Flexibility Scale, and Emotion Regulation Questionnaire. The study took about 10 to 15 minutes.

2.4. Statistical Analysis

Statistical Analysis was conducted through The Statistical Package for Social Sciences (SPSS) version 20. The data were first examined to see whether any values were missing, and no missing values were found. Descriptive statistics, such as frequency scores, percentage, mean scores, and standard deviation were calculated to look at the basic features of the data. Normality tests were carried out for each scale by examining the skewness and kurtosis values. All skewness and kurtosis values fell between +1.50 and -1.50 which were expected to be normally distributed except Perceived Parenting Attitudes Scale (Tabachnick and Fidell, 2007). The outlier detection procedure was applied, and 2 outlier participants were determined in the Perceived Parental Attitudes Scale. These two participants were excluded from the study. The skewness and kurtosis values for Perceived Parental Attitudes Scale after exclusion fell between +1.50 and -1.50. The Cronbach's alpha values were examined for reliability analysis and all values were within the reliable range (Cronbach, 1951). For the examination of the relationships between the scores obtained from the scales: Perceived Parenting Attitudes Scale, Social Anxiety Scale, Psychological Flexibility Scale, Emotion Regulation Questionnaire, correlation analyses were conducted. Furthermore, an independent t-test analysis was carried out to examine the gender differences in study variables. Finally, for the main analysis, two hierarchical regression analyses was conducted to investigate the predictive power of perceived parenting attitudes,

psychological flexibility, and emotion regulation scores together for social anxiety scores. The perceived parenting attitudes scale scores were calculated for mother (first hierarchical regression analysis) and father (second hierarchical regression analysis), separately. In addition, since no sum scores can be obtained for perceived parenting attitudes scale and emotion regulation scale, the subscales emotional warmth, overprotection, and rejection (perceived parenting attitudes) and reappraisal and suppression (emotion regulation) were included in the hierarchical regression.

CHAPTER 3: RESULTS

The results of the present study are reported in this chapter. First, to examine the relationships between the main variables perceived parenting attitudes (EMBU-C), social anxiety (LSAS), psychological flexibility (PFS), emotion regulation (ERQ), and their sub-dimensions, the results of the correlation analysis are presented. After that, the results of the t-test analyses are presented to examine the gender differences in study variables. As last, for the main analysis, results of the hierarchical regression analyses are presented to examine the predictive power of emotional warmth, overprotection, rejection, psychological flexibility, reappraisal, and suppression scores together for social anxiety scores.

3.1. Correlation Analyses

Pearson correlation analysis was carried out to investigate the relationships between social anxiety and other study variables (emotional warmth, overprotection, rejection, psychological flexibility, values, and behaviors, getting in contact with the present moment, acceptance, self as context, cognitive decomposition, reappraisal and suppression). Results are presented in Table 3.

First, correlations between sub-dimensions of social anxiety (anxiety and avoidance) and sub-dimensions of perceived parenting attitudes (overprotection, rejection, and emotional warmth) were evaluated. According to the scores of perceived mother attitudes, anxiety (r = -.15, p < .05) and avoidance (r = -.14, p < .05) sub-dimensions have been found to be significantly correlated with the emotional warmth sub-dimension at a negative and weak level. The more emotional warmth the participants experienced from their mothers, the less anxiety and avoidance they showed. In addition, there were weak positive correlations between both anxiety (r = .28, p < .05) and avoidance (r = .26, p < .05) and overprotection, showing that the higher overprotection the participants experienced from their mothers, the more anxiety and avoidance they showed. Likewise, there were weak positive correlations between both anxiety (r = .18, p > .05) and avoidance (r = .18, p > .05) and rejection. Participants who experienced more rejection from their mothers also reported higher anxiety and avoidance. According to the scores of perceived father attitudes, anxiety (r = .27, p < .05) and avoidance (r = .26, p < .05) sub-dimensions have been found to be significantly correlated with overprotection at a positive and weak level. The more

overprotection the participants experienced from their fathers, the more anxiety and avoidance they showed. In addition, there were weak positive correlations between both anxiety ($r = .18$, $p < .05$) and avoidance ($r = .18$, $p < .05$) and rejection, indicating that the higher rejection the participants experienced from their fathers, the more anxiety and avoidance they reported. On the other hand, there was no correlation between both anxiety ($r = -.09$, $p > .05$) and avoidance ($r = -.10$, $p > .05$) sub-dimensions and emotional warmth.

There was a moderate negative correlation between social anxiety and psychological flexibility, $r = -.44$, $p < .05$, demonstrating that as social anxiety increased, psychological flexibility decreased. Next, correlations between sub-dimensions of social anxiety (anxiety and avoidance) and sub-dimensions of psychological flexibility (values and behaviors, getting in contact with the present moment, cognitive decomposition, acceptance, and self as context) were assessed. Both anxiety ($r = -.33$, $p < .05$) and avoidance ($r = -.33$, $p < .05$) sub-dimensions have been found to be significantly correlated with the values and behaviors sub-dimension at a negative and moderate level. As scores of values and behaviors increased, anxiety and avoidance decreased. Similarly, there were moderate negative correlations between both anxiety ($r = -.32$, $p < .05$) and avoidance ($r = -.33$, $p < .05$) and getting in contact with the present moment, demonstrating that the higher participants get in contact with the present moment, the less anxiety and avoidance they showed. In addition, there were weak negative correlations between both anxiety ($r = -.25$, $p < .05$) and avoidance ($r = -.23$, $p < .05$) and cognitive decomposition, showing that higher cognitive decomposition was related to decreased anxiety and avoidance. On the other hand, there was no correlation between both anxiety ($r = -.10$, $p > .05$) and avoidance ($r = -.10$, $p > .05$) sub-dimensions and acceptance. Likewise, there was no correlation between both anxiety ($r = -.10$, $p > .05$) and avoidance ($r = -.09$, $p > .05$) sub-dimensions and self as context.

As last, correlations between sub-dimensions of social anxiety (anxiety and avoidance) and the emotion regulation strategies reappraisal and suppression were examined. Only the avoidance sub-dimension has found to be significantly correlated with reappraisal at a negative and weak level, $r = -.16$, $p < .05$. As the level of reappraisal of participants increased, the less avoidance they reported. On the contrary, there was no correlation between the anxiety sub-dimension and reappraisal, $r = -.12$, $p > .05$.

Also, there was no correlation between both anxiety ($r = .10$, $p > .05$) and avoidance ($r = .13$, $p > .05$) and suppression.

Table 3. Pearson Correlation Coefficients Among Variables

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	Social Anxiety	1																
2	Anxiety	.99**	1															
3	Avoidance	.99**	.96**	1														
4	Maternal Emotional Warmth	-.15*	-.15*	-.14*	1													
5	Maternal Overprotection	.27**	.28**	.26**	-.18**	1												
6	Maternal Rejection	.19**	.18**	.18**	-.54**	.50**	1											
7	Paternal Emotional Warmth	-.10	-.09	-.10	.74**	-.18**	-.39**	1										
8	Paternal Overprotection	.27**	.27**	.26**	-.14*	.76**	.29**	-.15*	1									
9	Paternal Rejection	.19**	.18**	.19**	-.35**	.33**	.63**	-.47**	.47**	1								
10	Psychological Flexibility	-.44**	-.44**	-.44**	.24**	-.19**	-.18**	.26**	-.20**	-.23**	1							
11	Values and Behaviors	-.33**	-.33**	-.33**	.30**	-.09	-.16*	.29**	-.06	-.18**	.73**	1						
12	Present Moment	-.33**	-.32**	-.33**	.18**	-.13	-.14*	.13	-.19**	-.19**	.61**	.22**	1					
13	Acceptance	-.10	-.10	-.10	-.05	-.05	-.02	-.05	-.07	-.02	.30**	-.23**	.22**	1				
14	Self as Context	-.10	-.10	-.09	.06	-.08	-.14*	.15*	-.02	-.11	.47**	.38**	-.13	-.01	1			
15	Cognitive Decomposition	-.24**	-.25**	-.24**	.01	-.19**	.02	.14*	-.20**	-.04	.47***	.39**	-.03	-.16*	.39**	1		
16	Reappraisal	-.14*	-.12	-.16*	.17*	-.04	-.06	.21**	-.03	-.11	.10	.39**	-.05	-.57**	.21**	.30**	1	
17	Suppression	.12	.11	.13	-.02	-.06	.07	.07	-.05	.07	-.18**	-.07	-.31**	-.29**	.16*	.29**	.30**	1

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

3.2. Gender Differences

An independent samples *t*-test was carried out to determine whether there were statistically significant differences between women and men in levels of social anxiety, perceived parenting attitudes, psychological flexibility, and emotion regulation. Results are presented in Table 4. According to the perceived mother attitudes, in the overprotection sub-dimension, women ($M = 21.17$, $SD = 5.61$) scored higher than men ($M = 18.79$, $SD = 4.57$), and only this difference was found significant among sub-dimensions, $t(213) = 3.36$, $p < .05$. The difference in emotional warmth and rejection was not found significant, $t(213) = .25$, $p > .05$, $t(213) = 1.41$, $p > .05$. According to the perceived father attitudes, similarly, in the overprotection sub-dimension, women ($M = 19.74$, $SD = 5.34$) scored higher than men ($M = 17.47$, $SD = 4.39$), and only this difference was found significant among sub-dimensions, $t(213) = 3.35$, $p < .05$. The difference in emotional warmth and rejection was not found significant, $t(213) = 1.47$, $p > .05$, $t(213) = 1.03$, $p > .05$. Furthermore, on social anxiety scores, women ($M = 40.31$, $SD = 25.96$) scored significantly higher than men ($M = 33.35$, $SD = 23.58$), $t(213) = 2.04$, $p < .05$. As well, there was a significant difference between women participants ($M = 20.70$, $SD = 13.00$) and men participants ($M = 16.64$, $SD = 11.87$) in anxiety sub-dimension of social anxiety, $t(213) = 2.37$, $p < .05$. However, a significant difference was not found in avoidance sub-dimension of social anxiety, $t(213) = 1.67$, $p > .05$. On the other hand, there were no significant difference of gender in psychological flexibility scores, $t(213) = -.54$, $p < .05$. Likewise, there were no significant difference of gender in sub-dimensions of psychological flexibility; values and behaviors $t(213) = -.70$, $p > .05$, getting in contact with the present moment $t(213) = -.60$, $p > .05$, acceptance $t(213) = .54$, $p > .05$, self as context $t(213) = .57$, $p > .05$ and cognitive decomposition $t(213) = -1.00$, $p > .05$. Moreover, there were no significant difference of gender in reappraisal sub-dimension of emotion regulation, $t(213) = -.10$, $p > .05$. Last of all, in suppression sub-dimension of emotion regulation, men ($M = 16.90$, $SD = 5.84$) scored higher than women ($M = 14.71$, $SD = 5.79$), and this difference was found significant, $t(213) = -2.74$, $p < .05$.

Table 4. Independent Samples T-Tests Results Regarding Study Variables and Gender

Variables		Women		Men			
		M	*SD*	*M*	*SD*	*t*	*p*
Perceived Mother Attitudes							
	Emotional Warmth	18.88	4.83	18.72	4.53	.25	.804
	Overprotection	21.17	5.61	18.79	4.57	3.36	.001**
	Rejection	10.35	3.56	9.64	3.80	1.41	.160
Perceived Father Attitudes							
	Emotional Warmth	18.05	4.90	17.08	4.71	1.47	.143
	Overprotection	19.74	5.34	17.47	4.39	3.35	.001**
	Rejection	10.02	3.42	9.57	2.89	1.03	.305
Social Anxiety		40.31	25.96	33.35	23.58	2.04	.043*
	Anxiety	20.70	13.00	16.64	11.87	2.37	.019*
	Avoidance	19.61	13.19	16.71	11.96	1.67	.096
Psychological Flexibility		129.49	18.46	130.81	17.18	-.54	.590
	Values and Behaviors	55.77	9.53	56.68	9.49	-.70	.486
	Present Moment	30.52	8.18	31.18	7.94	-.60	.553
	Acceptance	16.79	6.69	16.30	6.48	.54	.589
	Self as Context	13.22	4.30	12.89	4.22	.57	.569
	Cognitive decomposition	13.19	4.22	13.77	4.27	-1.00	.321
Emotion Regulation							
	Reappraisal	28.72	6.61	28.81	6.69	-.10	.918
	Suppression	14.71	5.79	16.90	5.84	-2.74	.007**

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

3.3. Hierarchical Regression Analyses

Hierarchical regression analysis was conducted to examine the predictive power of perceived parenting attitudes, psychological flexibility, and emotion regulation scores together for social anxiety scores. In this study, two separate hierarchical regression

analyses were conducted, one for the mother's part and one for the father's part of the perceived parenting attitudes scale.

The order of entry of the variables into the hierarchical regression equation is shown in the figure 4. This ranking was determined in accordance with the literature. The independent variables of the hierarchal regression were emotional warmth, overprotection, rejection, psychological flexibility, reappraisal and suppression scores and social anxiety scores were the dependent variable.

Model 1	Emotional warmth
	Overprotection
	Rejection
Model 2	Psychological Flexibility
Model 3	Reappraisal
	Suppression

Figure 4. Order of the Predictor Variables in Regression Equation

The results of the first hierarchical regression analysis are represented in Table 5.

In model 1, which is the first step of the hierarchical regression, the sub-dimensions of perceived parenting attitudes were analyzed. The results of the first step of hierarchical regression analysis revealed a model to be statistically significant ($p < .05$). Additionally, the R^2 value of .08 associated with this regression model suggests that the sub-dimension of perceived parenting attitudes accounts for 8% of the variation in social anxiety ($R^2 = .08$; F (3, 211) = 6.47; $p < .05$).

In model 2, the psychological flexibility was added to the analysis. The results of the second step of hierarchical regression analysis revealed a model to be statistically significant ($p < .05$). Furthermore, the R^2 change value of .23 associated with this regression model suggests that the addition of psychological flexibility to the first step model accounts for 23% of the variation in social anxiety ($R^2 = .23$; F (4, 210) = 15.93; $p < .05$).

When the sub-dimensions of emotion regulation, namely suppression and reappraisal, were added to the analysis in model 3, the explained variance in social anxiety increased by 2%. The 2% variance explained by the addition of reappraisal and suppression turned out to be statistically insignificant ($p > .05$). That means, emotion

regulation did not predict social anxiety beyond the effect of perceived parenting attitudes and psychological flexibility.

Table 5. Model Summary of First Hierarchical Regression Analysis

				Std. Error of the	Change Statistics				
Model	R	R Square	Adjusted R Square	Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.29[a]	.08	.07	24.19	.08	6.47	3	211	.000
2	.48[b]	.23	.22	22.19	.15	40.65	1	210	.000
3	.50[c]	.25	.23	22.03	.02	2.51	2	208	.084

Notes. Predictors: (Constant), Emotional Warmth [a], Overprotection [a], Rejection [a], Psychological Flexibility [b], Reappraisal [c], Suppression [c] Dependent Variable: Social Anxiety

The coefficients of the regression analysis are shown in table 6. According to the results, in the first step of the hierarchical regression, only the overprotection sub-dimension significantly predicted social anxiety scores (β = .25; t = 3.29; p < .05), while emotional warmth (β = -.09; t = -1.19; p > .05) and rejection (β = .01; t = .10; p > .05) sub-dimensions did not significantly predict social anxiety scores. On the other hand, psychological flexibility significantly predicted the increase in social anxiety scores after controlling for emotional warmth, overprotection, and rejection (β = -.40; t = -6.38; p < .05). Lastly, in model 3, only the reappraisal sub-dimension significantly predicted social anxiety scores (β = -.13; t = -2.03; p < .05), while the suppression sub-dimension did not significantly predict social anxiety scores (β = .10; t = 1.56; p > .05).

Table 6. Coefficients of First Hierarchical Regression Analysis

		Unstandardized Coefficients		Standardized Coefficients		
Model		*B*	*SE*	*ß*	*t*	*p*
1	(Constant)	22.01	12.28		1.79	.08
	emotional warmth	-.50	.42	-.09	-1.19	.23
	overprotection	1.20	.36	.25	3.29	.001
	rejection	.06	.61	.01	.10	.92

Table 6. (continued) Coefficients of First Hierarchical Regression Analysis

2	(Constant)	92.36	15.77		5.86	.000
	emotional warmth	-.04	.40	-.01	-.09	.93
	overprotection	0.89	.34	.19	2.65	.009
	rejection	.10	.56	.01	.18	.86
	psychological flexibility	-.56	.09	-.40	-6.38	.000
3	(Constant)	92.42	17.09		5.41	.000
	emotional warmth	.05	.40	.01	.11	.91
	overprotection	.95	.34	.20	2.82	.005
	rejection	.04	.56	.01	.08	.94
	psychological flexibility	-.52	.09	-.37	-5.80	.000
	reappraisal	-.50	.24	-.13	-2.03	.044
	suppression	.43	.28	.10	1.56	.121

Notes. Dependent Variable: Social Anxiety

The results of the second hierarchical regression analysis are represented in Table 7.

In model 1, which is the first step of the hierarchical regression, the sub-dimensions of perceived parenting attitudes were analyzed. The results of the first step of hierarchical regression analysis revealed a model to be statistically significant ($p < .05$). In addition, the R^2 value of .08 associated with this regression model suggests that the sub-dimension of perceived parenting attitudes accounts for 8% of the variation in social anxiety ($R^2 = .08$; F (3,211) = 5.79; $p < .05$).

In model 2, psychological flexibility was added to the analysis. The results of the second step of hierarchical regression analysis revealed a model to be statistically significant ($p < .05$). Furthermore, the R^2 change value of .23 associated with this regression model suggests that the addition of psychological flexibility to the first step model accounts for 23% of the variation in social anxiety ($R^2 = .23$; F (4,210) = 15.80; $p < .05$).

When the sub-dimensions of emotion regulation were added to the analysis in model 3, the explained variance in social anxiety increased by 2%. The 2% variance explained by the addition of reappraisal and suppression turned out to be statistically insignificant ($p > .05$). That means, emotion regulation did not predict social anxiety beyond the effect of perceived parenting attitudes and psychological flexibility.

Table 7. Model Summary of Second Hierarchical Regression Analysis

				Std. Error of the	Change Statistics				
Model	R	R Square	Adjusted R Square	Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.28[a]	.08	.06	24.30	.08	5.79	3	211	.001
2	.48[b]	.23	.22	22.21	.16	42.43	1	210	.000
3	.50[c]	.25	.23	22.04	.02	2.65	2	208	.073

Notes. Predictors: (Constant), Emotional Warmth [a], Overprotection [a], Rejection [a], Psychological Flexibility [b], Reappraisal [c], Suppression [c] Dependent Variable: Social Anxiety

The coefficients of the regression analysis are shown in table 8. According to the results, in the first step of the hierarchical regression, only the overprotection sub-dimension significantly predicted social anxiety scores ($\beta = .23$; $t = 3.07$; $p < .05$) while emotional warmth ($\beta = -.03$; $t = -.44$; $p > .05$) and rejection ($\beta = .06$; $t = .72$; $p < .05$) sub-dimensions did not significantly predict social anxiety scores. On the other hand, psychological flexibility significantly predicted the increase in social anxiety scores after controlling for emotional warmth, overprotection, and rejection ($\beta = -.42$; $t = -6.51$; $p < .05$). Lastly, in model 3, only the reappraisal sub-dimension significantly predicted social anxiety scores ($\beta = -.14$; $t = -2.17$; $p < .05$) while the suppression sub-dimension did not significantly predict social anxiety scores ($\beta = .09$; $t = 1.42$; $p > .05$).

Table 8. Coefficients of Second Hierarchical Regression Analysis

		Unstandardized Coefficients		Standardized Coefficients		
Model		*B*	*SE*	*ß*	*t*	*p*
1	(Constant)	13.92	11.46		1.21	.23
	emotional warmth	-.17	.39	-.03	-.44	.66
	overprotection	1.15	.38	.23	3.07	.002
	rejection	.48	.66	.06	.72	.47

Table 8. (continued) Coefficients of Second Hierarchical Regression Analysis

2	(Constant)	88.68	15.54		5.71	.000
	emotional warmth	.29	.37	.06	.80	.43
	overprotection	.87	.35	.18	2.53	.012
	rejection	.29	.61	.04	.47	.64
	psychological flexibility	-.58	.09	-.42	-6.51	.000
3	(Constant)	91.95	16.79		5.48	.000
	emotional warmth	.35	.37	.07	.93	.35
	overprotection	.95	.35	.19	2.74	.007
	rejection	.14	.61	.02	.23	.82
	psychological flexibility	-.55	.09	-.39	-5.96	.000
	reappraisal	-.53	.25	-.14	-2.17	.031
	suppression	.40	.28	.09	1.42	.16

Notes. Dependent Variable: Social Anxiety

CHAPTER 4: DISCUSSION

The aim of the present study was to investigate how much perceived mother and father attitudes (emotional warmth, overprotection, rejection), psychological flexibility, and emotion regulation (reappraisal and suppression) account for social anxiety. In the first place, the correlations between social anxiety and other study variables will be examined. Next, the gender differences in social anxiety, perceived parenting attitudes, psychological flexibility, and emotion regulation will be discussed. Finally, the predictive power of perceived parenting attitudes, psychological flexibility, and emotion regulation scores together for social anxiety scores will be reviewed. All these discussions will be carried out within the framework of the literature. At the end of the chapter, the strengths of the study, limitations, and future suggestions will be provided.

4.1. Correlations

According to the results of the correlation analysis, there are significant correlations between social anxiety and emotional warmth, overprotection, rejection, psychological flexibility, and its concepts; values and behaviors, getting in contact with the present moment, and cognitive decomposition. However, there is no correlation between social anxiety and acceptance, self as context, and suppression sub-dimensions.

The results of the perceived mother attitudes scores indicated a negative correlation between both anxiety and avoidance and emotional warmth. Also, both anxiety and avoidance were found positively correlated with overprotection and rejection. Similarly, the results of the perceived father attitudes scores revealed both anxiety and avoidance positively correlated between overprotection and rejection. However, there was no correlation between anxiety and avoidance, and emotional warmth. In the present study, participants who were subjected more to overprotection and rejection parental attitudes showed greater anxiety and avoidance scores on the scale. These findings are broadly consistent with the literature. Overprotective (Rork and Morris, 2009; Spokas and Heimberg, 2009) and rejection (Lieb et al., 2000; Parvez and Irshad, 2013) parental attitudes were found to be more common in socially anxious people. Furthermore, a study revealed that the parents of individuals who have high social anxiety have a greater tendency to be overprotective and rejecting (Hudson and Rapee, 2000). Studies showed that authoritarian and rejectionist parental attitudes can lead to the formation of introverted, excessively emotional structure and social anxiety in

children (Kulaksızoğlu, 2011; Yavuzer, 2000; Hale, 2008). In addition to these findings, Whaley, Pinto and Sigman (1999), while investigating maternal warmth, found that mothers of non-anxious children showed more warmth during their interactions than mothers of anxious children. Studies have also shown that low levels of emotional warmth are related to social anxiety (Kapur and Rai, 2013). Similarly, Bögels et al. (2001) found that low levels of emotional support from parents are associated with social anxiety as well as overprotection and rejection. Contrary to the literature, no significant relationship was found between paternal emotional warmth and social anxiety in our study, which may be because emotional warmth is a parental attitude that is generally associated with the mother in Turkish culture (Demirsu, 2018). According to the findings of these studies, it can be observed that as parental overprotectiveness and rejection increase, social anxiety increases so there is a positive relationship between them. Also, as emotional warmth decreases, social anxiety increases.

A moderate negative correlation between social anxiety and psychological flexibility was demonstrated by the results. This result means that individuals with heightened social anxiety show lower levels of psychological flexibility, which is consistent with the literature. According to Tillfors et al. (2015), psychological flexibility has a strong negative association with anxiety and avoidance in social settings. In addition, Biglan, Hayes and Pistorello (2008) revealed that a deficiency of psychological flexibility is a crucial factor in social anxiety. Furthermore, individuals with a social anxiety disorder reported low levels of psychological flexibility (Gloster et al., 2011). When the sub-dimensions of the variables are considered, the values and behaviors, getting in contact with the present moment, and cognitive decomposition were found to be negatively correlated with the anxiety and avoidance. However, acceptance and self as context were not significantly correlated with anxiety and avoidance. In the literature, there is no research examining the correlations between the sub-dimensions of social anxiety and the sub-dimensions of psychological flexibility. Although, since psychological flexibility is the main component of acceptance and commitment therapy, the associations between the sub-dimensions can be examined through articles investigating the effectiveness of Acceptance and Commitment Therapy (ACT) on social anxiety. Studies demonstrated that ACT has been highly effective in improving the social experience by reducing the primary symptoms of social anxiety and

enhancing motivation to participate in social and performance settings (Block and Wulfert, 2000; Kocovski, Fleming and Rector, 2009; Ossman et al., 2006). According to Dalrymple and Herbert (2007), a significant reduction of symptoms and a significant increase in quality of life were observed in individuals with social anxiety disorder after ACT. In addition, Pourfaraj (2011) found that the individuals with social anxiety disorder showed significantly less symptoms at the end of ACT. In these studies, values, and behaviors, getting in contact with the present moment, cognitive decomposition, acceptance, and self as context, are applied as metaphors, experiential exercises, and logical contradictions in ACT when treating social anxiety disorder. Therefore, based on the results of the summarized studies, it has been observed that the sub-dimensions of psychological flexibility are related to social anxiety indicating a protective effect, but further research is necessary. In sum, according to the literature and our study, there is a correlation between the two variables. It is thought that even if individuals with social anxiety are anxious, they can cope with this situation better if they can show flexibility in social situations. This is also confirmed by the results. When we look at ACT, the aim is not to reduce anxiety, but to be able to act in the direction of values even if there is anxiety. In this study, anxiety and values were found to be negatively correlated. In other words, it is thought that when people act in accordance with their values, their anxiety may decrease. Therefore, based on the findings, ACT may be useful as an important therapy method for social anxiety.

Regarding the results of emotion regulation and social anxiety, the results demonstrated that only the avoidance was negatively correlated with the reappraisal whereas there was no correlation between anxiety and reappraisal. Also, both anxiety and avoidance were not significantly correlated with the suppression. Contrary to these results, Mathews, Kerns and Ciesla (2014) found that social anxiety is related to emotion regulation difficulties. Additionally, it has been indicated that people who have difficulty regulating their emotions are prone to anxiety and ultimately anxiety and dysfunctional use of emotion regulation affect each other (Pektaş, 2015). In one study, it was stated that socially anxious individuals used avoidance strategy to regulate their emotions to keep their excessive anxiety under control (Mineka and Zinbarg, 2006). It was observed that individuals with social anxiety used the suppression strategy more (Kashdan and Steger, 2006) and the cognitive reappraisal strategy less (Werner et. al. 2011). Considering these results, it is seen that the results

of the present study are not consistent with the literature. However, the reason for this could be that most of the studies which examine the associations between social anxiety and emotion regulation include clinical samples, but the sample of the present study was not clinical. Therefore, it is thought that because of the sample feature, there was no correlation between social anxiety and emotion regulation. It would be useful to examine this relationship with the non-clinical population in future studies. Another reason may be that two different strategies of emotion regulation were measured in this study, but it was observed that most of the studies in the literature used instruments measuring emotion regulation difficulties. For this reason, although the studies found a relationship with the difficulties, it is thought that it cannot be fully compared since different scales are used.

4.2. Gender Differences

According to the results, there are gender differences in overprotection and social anxiety, showing that women participants reported higher scores than men participants. In addition, there is a gender difference in suppression, indicating that men participants scored higher than women participants. However, psychological flexibility did not differ by gender. In this section, all of these are explained in detail.

According to both mother and father scores of parental attitudes, a significant difference was only found in the overprotection, where women participants showed higher scores than men participants. It means that women participants experienced more anxious attitudes from their parents about their own safety. In contrast, no significant difference was found in emotional warmth and rejection. The related literature has shown inconsistent results regarding gender differences in perceived parenting attitudes. While some studies found significant gender differences in perceived parental attitudes (Sarı, 2007; Ünlü, 2020), other studies did not find significant differences (Baumrind, 1966; Ersoy, 2013; Karabulut Demir, 2007; Özyürek and Tezel Şahin, 2005; Safalı, 2021; Uji et al., 2014). Like the results of the present study, in the study of Domenech Rodríguez, Donovick and Crowley, 2009, it was observed that women perceived their parents as more protective than men. According to Kaplan (2021), it was found that the overprotective parental attitude perceived by women for both mother and father was higher than that of men. In a study, perceived parental overprotectiveness was found to be higher in females than in males

(Ünüvar, 2023). In addition, a study examined the relationship between perceived parental attitudes and social anxiety levels in university students and found that males perceived authoritarian attitudes from their parents and females perceived overprotective attitudes from their parents at higher levels (Yıldırım Muti, 2022). On the other hand, it was found that men had a higher perceived overprotectiveness level for the mother and a lower emotional warmth level for the father compared to women (McKinney, Donnelly and Renk, 2008). Similarly, in Fan and Zhang's (2014) study, male participants perceived their parents as more protective than female participants. In a study conducted on adolescents, it was observed that boys perceived their parents as more rejecting than girls (Buschgens et al., 2010). An examination of the relevant literature and the results of the present study show that the effect of gender on scale variables differs according to the research designs and the culture in which the research is conducted. It is thought that different findings conducted both in Turkey and abroad are related to gender perception and social norms which represents the thought patterns about the roles of women and men. In Turkey, women are perceived as vulnerable and in need of protection from dangers, while men are perceived as more independent and powerful individuals compared to women. This perception is reflected in the fact that girls are raised with an overprotective attitude that prevents them from making their own decisions and becoming independent, where parental control is very high, while boys are encouraged to become independent (Yavuzer, 2003).

In the whole social anxiety scale, women participants got higher scores than men participants. When examining the scale's sub-dimensions, a significant difference was found between women and men participants in anxiety, but no significant difference was found in avoidance. These results are consistent with the existing body of literature (Furmark, 2002; Schneier et al., 1992; Asher and Aderka, 2018; Fehm et al., 2008; Xu et al., 2012). In addition, social anxiety disorder is more prevalent in females and is more common in adolescents (American Psychiatric Association, 2013). Similar findings were found in a study with adults which data obtained from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), women are significantly more likely than men to have a social anxiety disorder, with a lifetime prevalence of 4.2% for men compared to 5.7% for women (Xu et al., 2012). Studies conducted not only in the United States but also in other countries have found similar results. The results of these studies conducted in the United Kingdom, Germany, Italy,

Spain, Portugal, Switzerland, France, Canada, Russia, and Korea demonstrated that higher lifetime prevalence rates of social anxiety disorder were found in women compared to men (Ohayon and Schatzberg, 2010; Merikangas et al.,2002; Lépine and Lellouch, 1995; MacKenzie and Fowler, 2013; Pakriev et al., 2000; Cho et al., 2007). In addition, a review of many epidemiological studies has shown that women have a higher tendency to have a social anxiety disorder than men (Fehm et al., 2005). Furthermore, a study discovered that women who received treatment for social anxiety disorder showed more severe symptoms compared to men (Turk et al., 1998). Moreover, a study conducted with socially anxious adults revealed that compared to men, women generally experienced greater levels of social fear (Crome, Baillie and Taylor, 2012). Cuming and Rapee (2010) demonstrated that women's social anxiety is linked to lower levels of honesty and transparency in their relationships than men. Regarding the results of avoidance, the study of Ranta et al. (2007) found that women and men participants had similar levels of avoidance of social environments. In studies conducted with adolescent girls and boys, no gender difference was found in avoidance levels in public and performance situations (Essau, Conradt and Petermann, 1999; Wittchen, Stein and Kessler, 1999). When the results of the studies are examined, there is sufficient research in the literature that social anxiety varies according to gender. Although the participants were not a clinical population in the present study, the results were comparable to a clinical population because one-third of the participants reported social anxiety levels over the cut-off points on the Liebowitz Social Anxiety Scale (Soykan, Özgüven and Gençöz, 2003). It is thought that one of the reasons why social anxiety is more common in women than in men is that women are expected to conform more to social standards, which is common in many cultures as in Turkey, and this expectation may create additional pressure on women and cause increased anxiety. In addition, it is believed that gendered expectations, whereby girls are often encouraged to be more sensitive and empathic than boys, may lead to increased self-consciousness in social situations and heightened fear of negative evaluation. In contrast, boys may be encouraged to be more assertive and less emotionally expressive, potentially reducing their susceptibility to social anxiety.

The results indicated that there was no significant gender difference in the psychological flexibility scale with all its sub-dimensions. In the literature, studies examining psychological flexibility in terms of gender have revealed mixed results.

The results of the present study are in line with most of the studies in the literature. Studies demonstrated that the psychological flexibility levels of the participants do not show a difference according to gender (Bond et al. 2011; Karekla and Panayiotou, 2011; Hulbert-Williams, Storey and Wilson, 2015; Acar, 2022; Çetinkaya, 2022). According to studies among university students, there were also no gender differences found in psychological flexibility (Özkan, 2020; Toprak, Arıcak and Yavuz, 2020). In studies with occupational groups, it has been revealed that there is no difference in the psychological flexibility levels of women and men adults (Aciksari and Karatepe, 2020; Aktepe, 2016; Bond et. al. 2011; Çalışkan, 2020; Engle, 2019; Kuşçu, 2019; Önen, 2021; Yorulmaz, 2019). On the other hand, in the study conducted by İnce (2020) on online game playing, it was found that the psychological flexibility of men was higher than that of women; and in the study conducted by Ottenbreit and Dobson (2004) in which they developed a measurement tool to measure psychological flexibility, it was found that the psychological flexibility of women was higher than that of men. Furthermore, Çiçek (2021) found that the psychological flexibility of men is higher than that of women. Also, a study investigated that men have more acceptance skills, a crucial component of psychological flexibility than women (Cobos-Sánchez, Flujas-Contreras and Becerra, 2020). When the literature is analyzed, although many studies have reached similar results, studies in which psychological flexibility is addressed according to gender variables show different results. This may be related to the texture of the selected samples and perceived gender roles. For instance, in Akkoç Arabacı's (2020) study, in which men's psychological flexibility was found to be higher than women's, the reason for this difference is explained as the expanding effect of gender roles on men's behavioral repertoires and the narrowing effect on women's behavioral repertoires. Similarly, in the study by Hayes, Follette and Linehan (2004), the reason why men's psychological flexibility is higher than women's is explained by the fact that disadvantaged groups such as women are exposed to more challenging experiences and these lead to the development of psychological rigidity in them. To acquire more comprehensive information on the difference between women and men in terms of psychological flexibility, additional research is required.

Furthermore, the results showed that gender didn't make a difference in reappraisal. Despite that, gender significantly differs in suppression where men participants scored higher than women participants. This indicates that men participants tend to use

suppression as an emotion regulation strategy more than women participants. These results are partially consistent with the literature. Similar to the results of the present study, in a study conducted with adolescents, there was no difference between girls and boys in the reappraisal subscale, but it was observed that boys used the suppression dimension more than girls (Özgüle and Sümer, 2017). Likewise, in the study examining the relationship between emotion regulation strategies and gender, although there was no relationship between gender and cognitive reappraisal, it was observed that the mean scores of men were higher than women in emotion suppression (Demirtaş, 2018). In addition, Kwon et al. (2013), in their study comparing Korean and American cultures, showed that men in general suppress their emotions, especially anger, more than women. It has been supported by many empirical studies that men use less emotional expression in daily communication and use more emotional suppression than women (Chaplin and Aldao, 2013; Hess et al., 2000; Parkins, 2012). Also, Hsieh and Stright (2012) found that women and men participants got similar scores in the cognitive reappraisal strategy of emotion regulation and that there is no significant difference in gender. However, it has been argued that women are particularly prone to use reappraisal because they will evaluate events as more stressful (Tamres, Janicki and Helgeson, 2002). The findings of the present study are consistent with research in which men report more emotional suppression, whereas they differ from research in which women report more cognitive reappraisal (Flynn, Hollenstein and Mackey, 2010; Gross, 1998; Rogier, Garofalo and Velotti, 2017). It is thought that men may use distraction and suppression more because they are not given much space to show their emotions.

4.3. Hierarchical Regression Analyses

According to the results of the first hierarchical regression analysis, emotional warmth, overprotection, and rejection of mother attitudes in model 1 explained 8% of the variance in social anxiety. When psychological flexibility was added in model 2, the explained variance increased to 23%. However, the addition of reappraisal and suppression did not significantly increase the explained variance in social anxiety. Similarly, the results of the second hierarchical regression analysis revealed that emotional warmth, overprotection, and rejection of father attitudes in model 1 explained 8% of the variance in social anxiety. When psychological flexibility was added in model 2, the explained variance increased to 23%. On the other hand, the

addition of reappraisal and suppression did not significantly increase the explained variance in social anxiety.

Based on the results, it was concluded that the variance values and significant variables of the first hierarchical regression including the mother's attitudes, and the second hierarchical regression including the father's attitudes were the same, in other words, there was no social anxiety difference according to the attitudes of mother and father. Therefore, the two hierarchical regression analyses will be discussed together. When we consider the variables in model 1, only the overprotection variable predicted social anxiety at a significant level. When the literature on overprotective parental attitudes is examined, Erkan (2002) found that authoritarian and overprotective parenting styles are risk factors for social anxiety. Similarly, Ballash et al. (2006) reported that parental control and overprotection led to the development of social anxiety. Furthermore, other studies have shown that overprotective parental attitudes are effective in the development of social anxiety and worry by preventing children's exploratory experiences and preventing the learning of action-oriented coping strategies (Cheron, Ehrenreich and Pincus, 2009; Nolen-Hoeksema et al., 1995). Rork and Morris (2009) found that adults with high levels of social anxiety perceived their parents as more protective and controlling. Moreover, Spokas and Heimberg (2009) reported that high levels of control and protection among the dimensions of perceived parental attitudes were associated with social anxiety in adulthood. Parental control may prevent the development of healthy autonomy in children and may result in children having insufficient control over situations. This situation may lead children to remain in a vulnerable situation and to develop anxiety disorders (Chorpita and Barlow, 2018). The results are in line with the literature. In accordance with these results, it is thought that children who are exposed to overprotective parental attitudes are more likely to develop social anxiety disorder compared to children who are not exposed. For this reason, it is thought that it would be beneficial to work with the families of children with social anxiety symptoms and to develop intervention methods when overprotective attitudes are identified in the family. In addition, it was thought that more studies such as more seminars on parenting could be conducted in schools for parents of all children to prevent social anxiety, not only for children with social anxiety symptoms.

On the other hand, emotional warmth and rejection did not significantly predict social anxiety. However, emotional warmth and rejection have been found to be associated with social anxiety in previous literature. Lieb et al., (2000) found that parental rejection was more common in people with social anxiety symptoms. In addition, children who are subjected to rejection attitudes from parents are more likely to develop social anxiety disorder (Arrindell, et al., 1989). Kapur and Rai, (2013) discovered that as well as rejection attitudes, low levels of emotional warmth were associated with social anxiety. Wolfradt, Hempel and Miles (2003) found that parental emotional warmth negatively predicted social anxiety level. Children who are raised with a careless and rejectionist attitude may be quiet, honest, well-behaved, and kind; however, they may be resentful, shy, unable to say no, and have an overly emotional structure (Kulaksızoğlu, 2011; Yavuzer, 2000). At the same time, these children may also have elevated levels of social anxiety (Hale, 2008). Furthermore, Bögels et al., (2001) found that socially anxious individuals perceived their parents as more rejecting, and less emotionally supportive in their childhood. The results are not consistent with the literature. Most studies in the literature have been conducted in clinical populations. As the clinical population was not used in this study, the results may not be compatible with the literature. Another reason why the results of the present study do not overlap with the existing studies could be that sample characteristics and perceived parental attitudes may vary according to culture. According to a study conducted in Turkey, perceived parental attitudes were found to be influenced by the social norms in that country (Yavuzer, 2003). For example, emotional warmth from mother and father is not very common parental behavior in Turkey. On the contrary, the rejection parental attitude is quite common and is often a disciplinary tool that parents see as a necessity when raising their children for instance, "Let's not accept everything he wants, he will be spoilt". In other words, the interpretation of the parental attitudes we experience due to these stereotypical child-rearing and social norms may differ according to the society we live in.

According to the results of model 2, psychological flexibility significantly predicted social anxiety. A review of the literature shows that there is an insufficient amount of studies investigating this relationship nevertheless the results of the study are consistent with the existing literature. Fergus et al. (2012), suggested that a low level of psychological flexibility was related to and strongly estimated depression, social

anxiety, nonspecific anxiety, and panic scores involving individuals with anxiety disorders including social anxiety disorder. According to Biglan, Hayes and Pistorello (2008), a deficiency of psychological flexibility is a crucial factor leading to the persistence and intensification of social anxiety disorder. A non-clinical adult sample used in a study by Tillfors et al. (2015), demonstrated a strong positive association between social anxiety/fear, avoidance in social settings, and a low level of psychological flexibility. Furthermore, it was discovered that social interaction anxiety and fear of scrutiny were negatively correlated with the acceptance of socially anxious ideas and feelings in the college sample (Flynn, Bordieri and Berkout, 2019). Also, the low level of psychological flexibility stated by individuals who have a social anxiety disorder may indicate a major psychological impairment that may be unique for people with a social anxiety disorder who are most afraid of blushing (Gloster et al., 2011). In studies with adults, there is more evidence that directing psychological flexibility is helpful for social anxiety disorder along with various other anxiety disorders (Gloster et al., 2020, Khoramnia et al., 2020; Yadegari, Hashemiyan and Abolmaali, 2014). Based on both the literature and the results of this study, we can say that low psychological flexibility may play a role in the development of social anxiety, and at the same time, individuals with high social anxiety may have low psychological flexibility. Furthermore, when we look at the variance of psychological flexibility in predicting social anxiety, we see that it predicts social anxiety at a much higher level than other variables. This suggests that psychological flexibility may play a greater role in social anxiety than many of the variables examined in the literature so far. Therefore, there is a need for more research examining the relationship between psychological flexibility and social anxiety in detail. These results of the present study will be an important gain as it draws attention to the deficiency in this field in the literature and the techniques to be used in the process of treatment of social anxiety can be selected in the light of these results. In addition, since it explained the highest variance, it was thought that even in the presence of overprotective parental attitudes, an individual's psychological flexibility could serve as a potential preventive factor. Although we have not conducted direct measurements to confirm this hypothesis, it is thought to be an indicator. Therefore, it will be very useful to make interventions to increase psychological flexibility in prevention studies. It is also known that psychological flexibility is not only associated with social anxiety but also with many psychopathologies and can be a preventive factor in them.

According to the results of model 3, reappraisal significantly predicted social anxiety while suppression did not. When examining the literature, there is more research on the relationship between suppression and psychopathologies compared to reappraisal, this may be because studies show that suppression plays a greater role in psychological disorders such as social anxiety disorder and causes more psychological impairment than low-level reappraisal. Although the number of studies is small compared to suppression, some studies examining this relationship in the literature found a significant relationship between reappraisal and social anxiety and revealed that reappraisal has a significant effect, especially in symptom reduction. In the light of cognitive models and literature, individuals with high social anxiety suffer from dysfunctional emotion regulation strategies such as unsuccessful cognitive reappraisal, immoderate avoidance of particular social situations, excessive suppression, and biased and rigid attention distribution (Clark and Wells, 1995; Heimberg, Brozovich and Rapee, 2010; Hofmann, 2007). According to a study comparing healthy adults with individuals diagnosed with social anxiety disorder, it was found that individuals with a diagnosis used the suppression emotion regulation strategy more and cognitive reappraisal less (Werner et al., 2011). Similarly, in another study, it was reported that individuals with social anxiety disorder suppressed positive and negative emotions more in general and reappraised these emotions less (Goldin et al., 2009). Unlike the results of the present study, studies found that suppression emotion regulation strategy is more commonly used by individuals with a social anxiety disorder than those without (Blalock, Kashdan and Farmer, 2016; D'Avanzato et al., 2013; Farmer and Kashdan, 2012; Kashdan and Breen, 2008; Spokas, Luterek and Heimberg, 2009; Werner et al., 2011). Furthermore, many studies have shown that individuals with high and low social anxiety differ significantly in the frequency with which they use suppression strategies on an attribute, situation, and a day-to-day basis (Aldao and Dixon-Gordon, 2014; De France and Hollenstein, 2017; Kashdan and Steger, 2006; Kivity and Huppert, 2016; Kneeland et al., 2016; McLean, Miller and Hope, 2007). On the other hand, in line with the results of the present study, some studies including self-reports have revealed that individuals with social anxiety disorder show less reappraisal success compared to the control group (Ziv et al., 2013; Goldin et al., 2009). In addition, a study involving continuous measurements of social anxiety disorder symptom severity found a relationship between decreased reappraisal success and increased symptom load (Goldin et al., 2009). Werner et al. (2011) revealed that

individuals with high levels of social anxiety think they're less capable of using cognitive reappraisal than other people. Moreover, studies have shown that when instructed to utilize reappraisal, individuals with social anxiety disorder can successfully down-modulate unpleasant emotions (Goldin et al., 2009). The research shows that when techniques to increase cognitive reappraisal were added to the treatment, social anxiety symptoms decreased significantly (Goldin et al., 2012). The results are partially compatible with the literature. The reason for this may be that the number of items on the emotion regulation scale used was very low and the items on the scale were not understood correctly. Another reason may be that almost all of the studies in the literature were conducted with a clinical population and in this study clinical population was not used.

In summary, the results of the present study indicated that there are significant correlations between social anxiety and emotional warmth, overprotection, rejection, psychological flexibility, and its concepts; values and behaviors, getting in contact with the present moment, and cognitive decomposition. In addition, gender differences were found in overprotection, social anxiety, and suppression. Lastly, when we examined the predictive powers of the study variables on social anxiety, overprotection, psychological flexibility, and reappraisal significantly predicted social anxiety.

4.4. Strengths of the Present Study

In the present study, there are some strengths in the descriptive features of the study's sample, the uniqueness of some hypotheses of the study, and the applicability of results to practice.

The sample of the study includes close numbers of female and male participants, and it creates a balanced gender distribution with 118 of the participants being female and 97 being male. Furthermore, the effect of gender differences on the study variables constitutes an important part of this research because it can be seen from the results that gender made a significant difference, especially in social anxiety, as in the studies in the literature. Therefore, gender differences should be considered when discussing new advances in the process of treatment of social anxiety. Also, a large part of the study contains variables that have not been studied before. In the literature, the main variables of this study have been examined separately, but there is no study that

examines all of them together and with their sub-dimensions. Especially, the relationship between social anxiety and psychological flexibility is needed. Lastly, considering the role of emotion regulation and psychological flexibility in social anxiety disorder, it is thought that determining the techniques to be used in the interventions of social anxiety considering research results will significantly affect the development of treatment. Which techniques can be used will be discussed in detail in the next chapter on clinical implications.

4.5. Limitations and Future Suggestions

The present study has several limitations along with its contributions to the literature and clinical practice. These limitations should be considered while assessing the study's results.

One of the potential limitations of the current study is the distribution of low and high social anxiety scores within the sample. The study sample consisted of 215 participants, 147 of the participants had low social anxiety and 68 had high social anxiety. This ratio may make it difficult to generalize the findings to a wider range of individuals. Therefore, larger sample sizes with relatively close numbers of low and high social anxiety participants are recommended for future research. Along with that, another possible limitation is also related to the study's sample. The study sample is not drawn from a clinical population. Findings derived from non-clinical samples may not be directly applicable to clinical populations, even though the scores of socially anxious individuals were over the cut-off score of the Liebowitz anxiety scale indicating clinical relevance. The characteristics, experiences, and behaviors of individuals in clinical settings might differ from those in the general population. For this reason, it is suggested to include individuals diagnosed with social anxiety disorder in the sample of future studies. One other possible limitation is cross-cultural variation in the interpretation of a perceived parenting attitudes scale used in the study. Cultural factors can influence how individuals interpret and respond to the items or statements presented in the scale. Therefore, further research is needed to examine how the structures of the culture in which the scale is used affect the answers and their interpretation. It would be interesting to investigate also cultural factors. The last possible limitation is that the study data were collected after a major earthquake in Turkey. On February 6th, 2023, an earthquake centered in Kahramanmaraş affected not

only the 11 provinces (Hatay, Adıyaman, Osmaniye, Gaziantep, Adana, Kilis, Malatya, Diyarbakır, Şanlıurfa, Elazığ, Kahramanmaraş) in Turkey but also the people living in various cities. Following this devastating earthquake, most people experienced significant levels of anxiety, displacement, relocation, or trauma, leading to changes in the demographic structure and characteristics of the population. Thus, maybe the results were altered by the effects of such an important incidence it is recommended to take this effect into consideration when analyzing the results of the present study.

CHAPTER 5: CONCLUSION

The present study was the first to investigate the relationship between social anxiety, perceived parenting attitudes, psychological flexibility, and emotion regulation. It also compares the gender differences of all the main variables and their sub-dimensions. Lastly, the predictive powers of the study variables on social anxiety were examined.

In summary, the present study indicated a significant positive correlation between social anxiety and overprotection and rejection. Furthermore, a negative correlation was found between social anxiety and emotional warmth, psychological flexibility and its values and behaviors, getting in contact with the present moment, and cognitive decomposition sub-dimensions, and only reappraisal. Therefore, it was observed that perceived parenting attitudes and psychological flexibility play a critical role in social anxiety, while emotion regulation does partially. On the other hand, the present study highlights gender differences in overprotection, social anxiety, and suppression. Consistent with the literature, women participants scored higher than men participants in overprotection and social anxiety; also, men participants scored higher than women participants in suppression. Finally, the hierarchical regression analyses showed that overprotection, psychological flexibility, and reappraisal significantly predicted social anxiety while emotional warmth, rejection, and suppression did not. The finding that psychological flexibility predicted social anxiety with a much higher variance than the other variables showed that psychological flexibility is an important factor in social anxiety, and this thesis emphasized this once again.

In summary, the results enhance our knowledge and comprehension of the relationship between social anxiety, perceived parenting attitudes, psychological flexibility, and emotion regulation, offering valuable contributions to the literature and clinical applications.

5.1. Clinical implications

There have been many attempts to treat social anxiety over the years. Considering how many people are still affected today, it is understandable that the literature is exploring alternative ways alongside the current ones. CBT and medication treatment are already widely used approaches, but it appears that ACT, which has recently been extensively researched in the literature, can be effective in treating social anxiety as well.

The results of the present study indicated that the values and behaviors, getting in contact with the present moment, and cognitive decomposition sub-dimensions of psychological flexibility have a significant correlation with social anxiety and that social anxiety can be reduced by improving these sub-dimensions. Therefore, techniques that will increase these sub-dimensions can be used in the treatment of social anxiety, especially in ACT and, other psychotherapy approaches. Seeking meaning and purpose and distinguishing them from avoidance, helping clients identify and choose aspects of life such as family, career, and spirituality, and providing exercises to act on these values can be techniques to strengthen one's values and behaviors. In addition, directing attention in a focused and flexible way to the experience of the present moment, bodily postures, tone of voice, and giving contemplative and mindfulness homework can be used to develop getting in contact with the present moment. Also, techniques such as expressing gratitude to one's mind for a thought, viewing ideas pass by as if they were written on leaves drifting down a stream, speaking words aloud until just the sound remains, or giving ideas a shape, size, and texture can be used to improve one's cognitive decomposition. The results showed that psychological flexibility predicts social anxiety with a significantly higher variance than other variables. As increasing psychological flexibility is seen to play an important role in social anxiety, it is thought that the use of these techniques will have a positive impact on the treatment process, both in terms of reducing symptoms and making the individual more resilient to social anxiety. On the other hand, when we look at the results of the relationship between social anxiety and emotion regulation, we see that the reappraisal sub-dimension significantly predicted social anxiety. For this reason, it is thought that the development of cognitive reappraisal, which is an important tool to reduce symptoms, in the treatment of social anxiety may lead to effective results. Perspective-taking, challenging interpretation, and reframing the meaning of situations techniques can be used to practice reappraisal. In the literature, there is no research that examines the relationship between social anxiety, perceived parenting attitudes, psychological flexibility, and emotion regulation. For this reason, it is thought that the knowledge gained from the results will both provide a new perspective on the interventions of social anxiety and be beneficial for clinicians in ACT and other therapy approaches.

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APPENDICES

APPENDIX A – ETHICS COMMITTEE APPROVAL

SAYI : B.30.2.İEÜ.0.05.05-**020**-*276*
28.03.2023

KONU : Etik Kurul Kararı hk.

Sayın Dr. Öğr. Üyesi Yasemin MERAL ÖĞÜTÇÜ ve Beste Miray Erkul,

"Algılanan Ebeveyn Tutumları Ile Sosyal Kaygı Arasındaki Ilişkide Psikolojik Esneklik ve Duygu Düzenlemenin Aracı Rolü" başlıklı projenizin etik uygunluğu konusundaki başvurunuz sonuçlanmıştır.

Etik Kurulumuz 28.03.2023 tarihinde sizin başvurunuzun da içinde bulunduğu bir gündemle toplanmış ve Etik Kurul üyeleri projeleri incelemiştir.

Sonuçta 28.03.2023 tarihinde **"Algılanan Ebeveyn Tutumları Ile Sosyal Kaygı Arasındaki Ilişkide Psikolojik Esneklik ve Duygu Düzenlemenin Aracı Rolü"** konulu projenizin etik açıdan uygun olduğuna oy birliğiyle karar verilmiştir.

Gereği için bilgilerinize sunarım.

Saygılarımla,

Prof. Dr. Murat Bengisu

Etik Kurul Başkanı

APPENDIX B – INFORMED CONSENT FORM

Sayın Katılımcı,

Bu çalışma, İzmir Ekonomi Üniversitesi Klinik Psikoloji Yüksek Lisans programı öğrencisi Beste Miray Erkul tarafından yürütülen ve Dr. Öğretim Üyesi Yasemin Meral Öğütçü danışmanlığında sürdürülen bir tez çalışmasıdır. Çalışma kapsamında algılanan ebeveyn tutumları ile sosyal kaygı arasındaki ilişkide psikolojik esnekliğin ve duygu düzenlemenin aracı rolüne ilişkin bilgi toplamak amaçlanmaktadır.

Bu çalışmada sizden, ekte sunulacak olan ölçekleri eksiksiz olarak doldurmanız beklenmektedir. Çalışma toplamda 5 bölümden oluşmakta ve yaklaşık olarak 10 ila 15 dakika arası sürmektedir. Çalışmaya katılabilmeniz için 18 yaş ve üstü olmanız gerekmektedir.

Katılımınız araştırma hipotezinin test edilmesi ve yukarıda açıklanan amaçlar doğrultusunda literatüre sağlayacağı katkılar ve klinik uygulamalar bakımından oldukça önemlidir. Bu sebeple, soruların samimi bir şekilde ve eksiksiz doldurulması büyük önem arz etmektedir. Ölçekleri doldururken sizi tam olarak yansıtmadığını düşündüğünüz durumlarda size en yakın yanıtı işaretleyiniz.

Çalışma kapsamında katılımcılardan elde edilen veriler isim kullanılmaksızın analizlere dahil edilecektir; yani çalışma sürecinde size bir katılımcı numarası verilecek ve isminiz araştırma raporunda yer almayacaktır.

Çalışmaya katılmanız tamamen kendi isteğinize bağlıdır. Katılımı reddetme ya da çalışma sürecinde herhangi bir zaman diliminde devam etmeme hakkına sahipsiniz. Eğer görüşme esnasında katılımınıza ilişkin herhangi bir sorunuz olursa, araştırmacıyla e-posta adresi üzerinden iletişime geçebilirsiniz.

Bu çalışmaya tamamen gönüllü olarak katılmayı kabul ediyorum ve verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

EVET ☐ HAYIR☐

APPENDIX C – DEMOGRAPHICAL INFORMATION FORM

Yaş :

Cinsiyet : Kadın ☐ Erkek ☐ Diğer ☐

Eğitim seviyesi : İlkokul ☐ Ortaokul ☐ Lise ☐ Üniversite ☐

Yüksek Lisans ☐ Doktora ☐

Meslek :

Medeni durum : Evli ☐ Bekar ☐ Boşanmış ☐ Dul ☐ İlişkisi var ☐

Herhangi bir kronik rahatsızlığınız var mı?

Evet ☐ Belirtiniz: Hayır ☐

Herhangi bir psikiyatrik tanı aldınız mı?

Evet ☐ Belirtiniz: Hayır ☐

Ailenizde psikiyatrik hastalık öyküsü var mıdır?

Evet ☐ Belirtiniz: Hayır ☐

APPENDIX D – LIEBOWITZ SOCIAL ANXIETY SCALE

Aşağıda belirtilen durumlarda duyduğunuz kaygının şiddetine göre puan verin.

		Yok ya da çok hafif	**Hafif**	**Orta derecede**	**Şiddetli**
1	Önceden hazırlanmaksızın bir toplantıda kalkıp konuşmak				
2	Seyirci önünde hareket, gösteri ya dakonuşma yapmak				
3	Dikkatleri üzerinde toplamak				
4	Romantik veya cinsel bir ilişki kurmakamacıyla birisiyle tanışmaya çalışmak				
5	Bir gruba önceden hazırlanmış sözlü bilgi sunmak				
6	Başkaları içerdeyken bir odaya girmek				
7	Kendisinden daha yetkili biriyle konuşmak				
8	Satın aldığı bir malı, ödediği parayı gerialmak üzere mağazaya iade etmek				
9	Çok iyi tanımadığı birisine fikir ayrılığıveya hoşnutsuzluğun ifade edilmesi				
10	Gözlendiği sırada çalışmak				
11	Çok iyi tanımadığı bir kişiyle yüz yüzekonuşmak				
12	Bir eğlenceye gitmek				
13	Çok iyi tanımadığı birisinin gözlerininiçine doğrudan bakmak				
14	Yetenek, beceri ya da bilginin sınanması				
15	Gözlendiği sırada yazı yazmak				
16	Çok iyi tanımadığı bir kişiyle telefonlakonuşmak				
17	Umumi yerlerde yemek yemek				
18	Evde misafir ağırlamak				
19	Küçük bir grup faaliyetine katılmak				
20	Umumi yerlerde bir şeyler içmek				

21	Umumi telefonları kullanmak				
22	Yabancılarla konuşmak				
23	Satış elemanının yoğun baskısına karşı koymak				
24	Umumi tuvalette idrar yapmak				

Lütfen aynı formu şimdi de belirtilen durumlarda duyduğunuz kaçınmanın şiddetine göre değerlendirin.

		Yok ya da çok hafif	**Hafif**	**Orta derecede**	**Şiddetli**
1	Önceden hazırlanmaksızın bir toplantıda kalkıp konuşmak				
2	Seyirci önünde hareket, gösteri ya dakonuşma yapmak				
3	Dikkatleri üzerinde toplamak				
4	Romantik veya cinsel bir ilişki kurmakamacıyla birisiyle tanışmaya çalışmak				
5	Bir gruba önceden hazırlanmış sözlü bilgi sunmak				
6	Başkaları içerdeyken bir odaya girmek				
7	Kendisinden daha yetkili biriyle konuşmak				
8	Satın aldığı bir malı, ödediği parayı gerialmak üzere mağazaya iade etmek				
9	Çok iyi tanımadığı birisine fikir ayrılığıveya hoşnutsuzluğun ifade edilmesi				
10	Gözlendiği sırada çalışmak				
11	Çok iyi tanımadığı bir kişiyle yüz yüzekonuşmak				
12	Bir eğlenceye gitmek				
13	Çok iyi tanımadığı birisinin gözlerininiçine doğrudan bakmak				
14	Yetenek, beceri ya da bilginin sınanması				
15	Gözlendiği sırada yazı yazmak				

16	Çok iyi tanımadığı bir kişiyle telefonlakonuşmak				
17	Umumi yerlerde yemek yemek				
18	Evde misafir ağırlamak				
19	Küçük bir grup faaliyetine katılmak				
20	Umumi yerlerde bir şeyler içmek				
21	Umumi telefonları kullanmak				
22	Yabancılarla konuşmak				
23	Satış elemanının yoğun baskısına karşı koymak				
24	Umumi tuvalette idrar yapmak				

APPENDIX E – PSYCHOLOGICAL FLEXIBILITY SCALE

	Hiç Tamamen Katılmıyorum Katılıyorum 1 2 3 4 5 6 7	Hiç katılmıyorum						Tamamen katılıyorum
1.	Benim için neyin önemli olduğunu ve hayatımda gelmekistediğim noktayı biliyorum.	1	2	3	4	5	6	7
2.	Duygu ve düşüncelerin ortaya çıkmasını engellemek için birşeylerle meşgul olmaya çalışırım.	1	2	3	4	5	6	7
3.	Olumsuz duygular hissettiğimde dikkatimi dağıtmayaçalışırım.	1	2	3	4	5	6	7
4.	Duygu ve düşüncelerimi değiştirmeksizin, onları olduğugibi kabullenebilirim.	1	2	3	4	5	6	7
5.	Zorlayıcı duygu, düşünce veya hisleri ortaya çıkarabilecekdurumlardan kaçınmaya çalışırım.	1	2	3	4	5	6	7
6.	Üzüntü verici duyguları uzak tutmak için elimden geleniyaparım.	1	2	3	4	5	6	7
7.	Stresli olsa bile, tercihlerimi benim için neyin önemliolduğuna dayanarak yaparım.	1	2	3	4	5	6	7
8.	İş veya görevlerimi, ne yaptığımın farkında olmaksızın,otomatik bir şekilde yaparım.	1	2	3	4	5	6	7
9.	Yaşamayı seçtiğim önemli değerlere sahibim.	1	2	3	4	5	6	7
10.	Duygu ve düşüncelerimi kontrol etmek ya da onlardankaçınmak yerine, onları olduğu gibi kabul edebilirim.	1	2	3	4	5	6	7
11.	Düşünceler sadece düşüncelerdir-yaptıklarımıkontrol etmezler.	1	2	3	4	5	6	7
12.	Aklıma gelen düşünce, duygu ve hisler ne olursa olsun, onları değiştirmeden ve onlara karşı çıkmadan tam anlamıyla deneyimlemeye razıyım.	1	2	3	4	5	6	7
13.	Kişisel değerlerim doğrultusunda hareket ederim.	1	2	3	4	5	6	7
14.	Düşüncelerime öyle takılırım ki en çok yapmak istediğimşeyleri yapamam.	1	2	3	4	5	6	7
15.	Düşüncelerimin, yapmak istediğim şeyleri engellemesineizin vermem.	1	2	3	4	5	6	7
16.	Yapması zor olsa bile, benim için anlamlı olan şeylerinsorumluluğunu alırım.	1	2	3	4	5	6	7

17.	Kendim hakkındaki bir düşünceme tam olarak uymakzorunda değilim.	1	2	3	4	5	6	7
18.	Ne yaptığımın pek farkında olmadan otomatik hareketediyormuşum gibi görünür.	1	2	3	4	5	6	7
19.	Hayatta benim için gerçekten önemli olan şeyleri belirler veonların peşinden giderim.	1	2	3	4	5	6	7
20.	Benim için anlamlı olan etkinlikleri çok dikkatimivermeden aceleyle yaparım.	1	2	3	4	5	6	7
21.	Bir şey benim için önemli ise onu yapmaya devamedebilirim.	1	2	3	4	5	6	7
22.	Şu anda yaşananlara odaklanmakta zorlanırım.	1	2	3	4	5	6	7
23.	Geçmiş ya da gelecek ile çok meşgul olduğumdan,kendimi şu an olanları kaçırırken bulurum.	1	2	3	4	5	6	7
24.	En büyük hedeflerimden biri bana acı veren duygularımdankurtulmaktır.	1	2	3	4	5	6	7
25.	Benim için oldukça önemli olsalarda, kendimi, o işidikkatimi vermeden yaparken bulurum.	1	2	3	4	5	6	7
26.	Değerlerim, davranışlarıma tamamıyla yansır.	1	2	3	4	5	6	7
27.	İlerleme yavaş olsa bile, zaman gerektiren uzun vadeliplanlarıma sadık kalabilirim.	1	2	3	4	5	6	7
28.	Hayatımı nasıl yaşamak istediğimle uyumlu bir şekildehareket ederim.	1	2	3	4	5	6	7

APPENDIX F – PERCEIVED PARENTING ATTITUDES SCALE

		Hayır, hiçbir zaman	Evet, arada sırada	Evet, sık sık	Evet, Çoğu zaman
1. Anne ve babam, nedenini söylemeden bana kızarlardı ya da ters davranırlardı.	Baba	1	2	3	4
	Anne	1	2	3	4
2. Anne ve babambeni överlerdi.	Baba	1	2	3	4
	Anne	1	2	3	4
3. Anne ve babamın yaptıklarım konusunda daha az endişeli olmasını isterdim.	Baba	1	2	3	4
	Anne	1	2	3	4
4. Anne ve babam,bana hak ettiğimden daha çok fiziksel ceza verirlerdi.	Baba	1	2	3	4
	Anne	1	2	3	4
5. Eve geldiğimde,anne ve babama ne yaptığımın hesabını vermek zorundaydım.	Baba	1	2	3	4
	Anne	1	2	3	4
6. Anne ve babam ergenliğimin uyarıcı, ilginç ve eğitici olması için çalışırlardı.	Baba	1	2	3	4
	Anne	1	2	3	4

7. Anne ve babam, benibaşkalarının önünde eleştirirlerdi.	Baba	1	2	3	4
	Anne	1	2	3	4
8. Anne ve babam, bana birşey olur korkusuyla başkaçocukların yapmasına izin verilen şeyleri yapmamı yasaklarlardı.	Baba	1	2	3	4
	Anne	1	2	3	4
9. Anne ve babam, herşeyde en iyi olmam için beni teşvik ederlerdi.	Baba	1	2	3	4
	Anne	1	2	3	4
10. Anne ve babam davranışları ile, örneğin üzgün görünerek, onlara kötü davrandığım için kendimi suçluhissetmeme neden olurlardı.	Baba	1	2	3	4
	Anne	1	2	3	4
11. Anne ve babamın bana birşey olacağına ilişkin endişeleri abartılıydı.	Baba	1	2	3	4
	Anne	1	2	3	4
12. Benim içim bir şeyler kötü gittiğinde, anne ve babamın beni rahatlatmaya ve yüreklendirmeye çalıştığını hissederdim.	Baba	1	2	3	4
	Anne	1	2	3	4

13. Bana ailenin 'yüz karası' ya da'günah keçisi' gibi davranılırdı.	Baba	1	2	3	4
	Anne	1	2	3	4
14. Anne ve babam, sözleri ve hareketleriyle beni sevdiklerini gösterirlerdi.	Baba	1	2	3	4
	Anne	1	2	3	4
15. Anne ve babamın, erkek yada kız kardeşimi(lerimi) beni sevdiklerinden daha çok sevdiklerini hissederdim.	Baba	1	2	3	4
	Anne	1	2	3	4
16. Anne ve babam, kendimdenutanmama neden olurlardı.	Baba	1	2	3	4
	Anne	1	2	3	4
17. Anne ve babam,pek fazla umursamadan, istediğim yere gitmeme izin verirlerdi.	Baba	1	2	3	4
	Anne	1	2	3	4
18. Anne ve babamın, yaptığımher şeye karıştıklarını hissederdim.	Baba	1	2	3	4
	Anne	1	2	3	4
19. Anne ve babamlaaramda sıcaklık ve sevecenlik olduğunu hissederdim.	Baba	1	2	3	4
	Anne	1	2	3	4

20. Anne ve babam, yapabileceklerim ve yapamayacaklarımlailgili kesin sınırlar koyar ve bunlara titizlikle uyarlardı.	Baba	1	2	3	4
	Anne	1	2	3	4
21. Anne ve babam,küçük kabahatlerimiçin bile beni cezalandırırlardı.	Baba	1	2	3	4
	Anne	1	2	3	4
22. Anne ve babam,nasıl giyinmem ve görünmem gerektiğikonusunda karar vermek isterlerdi.	Baba	1	2	3	4
	Anne	1	2	3	4
23. Yaptığım bir şeyde başarılı olduğumda, anne ve babamın benimle gurur duyduklarını hissederdim.	Baba	1	2	3	4
	Anne	1	2	3	4

APPENDIX G – EMOTION REGULATION QUESTIONNAIRE

Maddeler	Hiç Doğru	Doğru Değil	Biraz Doğru	Kararsızım	Biraz Doğru	Doğru	Tamamen Doğru
1- Daha olumlu duygular hissetmek istediğimde (keyif veya eğlence gibi) düşünüyor olduğum şeyi değiştiririm.	1	2	3	4	5	6	7
2- Duygularımı kendime saklarım.	1	2	3	4	5	6	7
3- Daha olumsuz duygu hissetmek istediğimde (üzüntü ve öfke gibi) düşünüyor olduğum şeyi değiştiririm.	1	2	3	4	5	6	7
4- Olumlu duygular hissettiğimde onları ifade etmemeye özen gösteririm.	1	2	3	4	5	6	7
5- Stresli bir durumla karşılaştığımda sakin kalmama yardım edecek biçimde düşünmeye çalışırım.	1	2	3	4	5	6	7
6- Duygularımı onları açıklamayarak kontrol ederim.	1	2	3	4	5	6	7
7- Daha fazla olumlu duygu hissetmek istediğimde, durum hakkındaki düşünme biçimimi değiştiririm.	1	2	3	4	5	6	7
8- Duygularımı içinde bulunduğum durumla ilgili düşünme biçimimi değiştirerek kontrol ederim.	1	2	3	4	5	6	7
9- Olumsuz duygular hissediyorsam kesinlikle onları ifade etmem.	1	2	3	4	5	6	7
10- Daha az olumsuz duygu hissetmek istediğimde durumla ilgili düşünme biçimimi değiştiririm.	1	2	3	4	5	6	7