

T.C.
ABANT IZZET BAYSAL UNIVERSITY
INSTITUTE OF SOCIAL SCIENCES

**FACTORS AFFECTING DEPRESSION IN CLINICAL AND
NON-CLINICAL SAMPLES: EARLY MALADAPTİVE SCHEMAS AND
SOCIOTROPY AUTONOMY PERSONALITY TRAITS**

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INSTITUTE OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY
CLINICAL PSYCHOLOGY

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NON-CLINICAL SAMPLES: EARLY MALADAPTİVE SCHEMAS
AND SOCIOTROPY AUTONOMY PERSONALITY TRAITS**

MASTER THESIS

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The study titled “Factors Affecting Depression in Clinical And Non-Clinical Samples: Early Maladaptive Schemas And Sociotropy Autonomy Personality Traits”, which belongs to Emre ÖZDEMİR, was certified as fully adequate in scope and quality, and as a **thesis for the degree of Master of Science** by the examining committee members.

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06.25.2015

ABSTRACT

FACTORS AFFECTING DEPRESSION IN CLINICAL AND NON-CLINICAL SAMPLES: EARLY MALADAPTIVE SCHEMAS AND SOCIOTROPY AUTONOMY PERSONALITY TRAITS

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There have been several studies that question the role of early maladaptive schemas on developing several psychopathologies, such as depression. Apart from early maladaptive schemas, some personality factors such as sociotropy-autonomy on depression have been investigated. On the other hand, roles of both early maladaptive schemas and sociotropy-autonomy personality on depression have not been investigated into same study either depressed patients or non-clinical individuals. Although early maladaptive schemas might be associated with some personality factors, EMSs have not been examined yet in terms of sociotropy autonomy personality traits. Therefore, exploring the associations between variables on depression and also affects of early maladaptive schemas on the types of personality are aimed to explore in the present study.

Participants consisted of depressed patients receiving treatment (N = 105) and non-clinical individuals being healthy (N = 110). Demographical Information Form, Beck Depression Inventory II, Young Schema Questionnaire III, Sociotropy Autonomy Scale were used as measures in this study. Correlation analysis, Independent samples t-tests, One-Way ANOVAs, Two-Way ANOVA, Multiple Hierarchical Regression Analyses and Simple Linear Regression were performed in this study.

Depressed patients had dissatisfaction of social support, had sociotropy personality and stronger impaired autonomy schema domain and specific schemas of dependence, vulnerability to harm, insufficient self-control, pessimism, and emotional inhibition had higher scores of depression. In addition, nonclinical individuals experienced stressful life events and had stronger disconnection and rejection schema domain, schemas of defectiveness, failure, self-sacrifice, pessimism, emotional inhibition, punitiveness had higher scores of depression.

In terms of sociotropy, early maladaptive schemas domains of other directedness, and subdomains of abandonment, self sacrifice, approval seeking were related to sociotropy for depressed patients. In addition, schema domains of impaired autonomy and performance and other directedness, and subdomains of approval seeking and punitiveness were associated with higher scores on sociotropy in nonclinical individuals. As for autonomy, schema domains of impaired limits, overvigilance and inhibition, and also subdomains of insufficient self-control, self sacrifice and punitiveness were associated with autonomy in the sample of depressed patients. Besides, weaker impaired autonomy and performance, and stronger schema domains scores on impaired limits, overvigilance and inhibition, and subdomains of social isolation, insufficient self-control, pessimism and punitiveness were related to autonomy in the sample of nonclinical individuals.

All findings are consistent with earlier research on EMSs except emotional inhibition for both samples and schemas of pessimism and punitiveness for non-clinical individuals. Moreover, since which schemas are related to sociotropy and autonomy has been conducted first for literature, findings were exploratory for literature.

Key words: Depression, Early Maladaptive Schemas and Personality Traits

ÖZET

KLİNİK OLAN VE OLMAYAN ÖRNEKLEMDE DEPRESYONU ETKİLEYEN FAKTÖRLER: ERKEN DÖNEM UYUMSUZ ŞEMALAR VE SOSYOTROPİ - OTONOMİ KİŞİLİK ÖZELLİĞİ

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Literatürde çeşitli psikopatolojilerin (ör, depresyon) gelişmesinde erken dönem uyum bozucu şemaların etkisini inceleyen çeşitli çalışmalar bulunmaktadır. Erken dönem uyum bozucu şemaların yanı sıra ayrıca bazı kişilik özelliklerinin de depresyon üzerindeki etkisini inceleyen çalışmalar mevcuttur. Ancak, erken dönem uyum bozucu şemaların ve sosyotropi otonomi kişilik özelliğinin depresyon üzerindeki etkisi ayrı çalışılmış olsa da, tek bir çalışmada bu iki faktörün depresyon üzerindeki etkisi daha önce hiç incelenmemiştir. Bu tezle birlikte ilgili değişkenlerin depresyon üzerinde etkisi hem klinik olan (depresyon hastaları) hem de klinik olmayan (sağlıklı bireyler) örneklemde araştırılmıştır. Buna ek olarak, erken dönem uyum bozucu şemaların

sosyotrop ve otonom kişilik üzerindeki etkisi de ayrıncıncelenmiştir. Bu tezin amacı, hem depresyonu etkileyen değişkenlerin hem de sosyotrop otonom kişilik özelliğini etkileyen şemaların ilişkisini açıklamaktır.

Katılımcılar tedaviye başlamış 105 depresyon hastasından ve herhangi bir psikiyatrik tanısı olmayan 110 sağlıklı bireyden oluşmaktadır. Bu çalışmada, Demografik Bilgi Formu, Beck Depresyon Envanteri, Young Şema Ölçeği ve Sosyotropi Otonomi Ölçeği kullanılmıştır. Çalışmanın amacı doğrultusunda korelasyon analizleri, bağımsız gruplar t-testleri, tek yönlü ANOVA, faktöriyel ANOVA ve hiyerarşik çoklu regresyon analizleri gerçekleştirilmiştir.

Depresyon hastalarında; düşük sosyal destek, sosyotropi kişilik özelliği, zedelenmiş özerklik ve kendini ortaya koyma şema alanı ve bağımlılık, zarar görmeye karşı dayanıksızlık, yetersiz öz denetim ve duyguları bastırma şemaları depresyon ile ilişkili çıkmıştır. Klinik olmayan sağlıklı örneklemde ise; stresli yaşam olaylarının olumsuz etkisi, ayrılma ve reddedilme şema alanı, kusurluluk, başarısızlık, kendini feda, karamsarlık, duyguları bastırma ve cezalandırıcılık şemaları depresyon ile ilişkili bulunmuştur.

Sosyotrop kişilik özelliği açısından, depresyon hastalarında, güçlü diğeri yönelimlilik şema alanı, spesifik şemalardan güçlü terk edilme, kendini feda ve onay arayıcılık şemaları, klinik olmayan sağlıklı örneklemde ise güçlü zedelenmiş özerklik ve kendini ortaya koyma ile diğeri yönelimlilik şema alanları, spesifik şemalardan ise güçlü onay arayıcılık, cezalandırıcılık şemaları sosyotropi ile ilişkili çıkmıştır.

Otonom kişilik özelliği açısından, depresyon hastalarında, zayıf zedelenmiş sınırlar ile güçlü aşırı tetikte olma ve bastırılmışlık şema alanları, spesifik şemalardan terk edilme, kendini feda ve onay arayıcılık şemaları, spesifik şemalardan güçlü yetersiz öz denetim, kendini feda ve cezalandırıcılık şemaları, klinik olmayan sağlıklı örneklemde ise zayıf zedelenmiş özerklik ve kendini ortaya koyma ile güçlü zedelenmiş sınırlar, aşırı tetikte olma ve bastırılmışlık şema alanları, spesifik şemalardan ise sosyal izolasyon, yetersiz öz denetim, karamsarlık ve cezalandırıcılık otonomi ile ilişkili bulunmuştur.

Erken dönem uyumsuz şemalarla ilgili tüm bulgular literatürle tutarlı çıkmıştır. Ancak her iki örneklem için duygusal bastırma şeması, klinik olmayan örneklem içinse hem cezalandırıcılık hem de karamsarlık şemaları ilk defa bu çalışmada depresyonla ilişkili bulunmuştur. Buna ek olarak, hangi erken dönem uyum bozucu şemanın sosyotropi ve otonomi ile ilişkili olduğuna literatür de ilk defa bu tez ile bakıldığı için keşifsel bir sonuç elde edilmiştir.

Anahtar kelimeler: Depresyon, Erken Dönem Uyumsuz Şemalar ve Kişilik Özelliği

*To my lovely father, mother, sister and
my wise grandfather*

PREFACE

The current study was prepared as a master thesis, and examined explanatory roles of early maladaptive schemas and sociotropy autonomy personality traits on depression among depressed patients and non-clinical individuals. 105 depressed patients from hospital and 110 non-clinical individuals from community have participated in this study, and they were asked specific questions about their demographics and presense of stressful life events and satisfaction of social support through the aim of the study.

Depression is accepted one of the most common psychological disorder. Hence, understanding causes of depression could provide researches and practitioners with knowledge about the significant point for treatment of the disorder. Therefore, the current study examined explanatory roles of these factors on depression both clinical and non-clinical individuals.

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ABBREVIATION LIST

ANOVA	: Analysis of Variance
BDI	: Beck Depression Inventory
CBT	: Cognitive Behavioral Therapy
ES	: Effect of the Stress
EMS	: Early Maladaptive Schema
M	: Mean
Max	: Maximum
Min	: Minimum
N	: Number
SAS	: Sociotropy Autonomy Scale
SD	: Standard Deviation
Std	: Standard
YSQ - SF	: Young Schema Questionnaire Short Form III

INTRODUCTION

Depression is one of the mood disorders that is characterized by feelings of sadness, anxiety, guilt and worthlessness, being away from others, decreased sleep and appetite, loss of sexual desire or indifference against usual activities (Davison & Neale 2004). Core features underlying depression is generally mentioned as loss or perceived loss. More specifically, depression is more likely to appear after death of someone, end of the relationship, dismissal and stay away from home. Prognosis and severity of depression usually depends on the current life circumstances. According to the depression model of Beck (1967), thoughts of depressed patients are based on the content of their loss. Patients have lost their sense of happiness and configure it with the cognitive triad (Becker 1979) which is known as negatively evaluating the self, world, and future. Basically, depression is characterized by the following symptoms by Aydın & Bozkurt (2007).

According to Aydın & Bozkurt (2007) after long-term feelings of sadness and helplessness, regarding unrest and unwillingness, these individuals feel depressed. Also they cry constantly and get more angry about life difficulties. Because of the perceptions about uncontrollability these individuals are more likely to be dependent on others. Hopelessness, worthlessness, guilt, and thoughts of self-harm are seen among these individuals since they evaluate their future as in a negative manner. Even, these individuals define everything as worse than as it looks. In addition to this by Aydın and Bozkurt (2007), depressed people show less eagerness to be with people due to having self-devaluation and feelings of guilt without reason. Inability to tolerate these feelings, suicide are typically seen among these individuals. Associated with lack of interest in life, activities that were once pleasurable are not seen as enjoyable after a while. These individuals are more likely to feel tired. Personal responsibility is forced to fulfill. However, these individuals have difficulty in considering their responsibility (e.g., bills - rent payments) and giving importance to self-care (e.g., going out with wrinkled clothes). Finally, loss of appetite or overeating, insomnia or hypersomnia, concentration

problems, remembering details or making decisions, aches, pains, fatigue, digestive problems or reduced energy are also be seen in the frame of depression. As well as clinical appearance of depression, history, epidemiology, comorbidity and etiology of depression are also important for disease (Aydin and Bozkurt (2007) In this thesis, general information about disease, and early maladaptive schemas and sociotropy autonomy personality traits which were two of the factors affecting depression were given in light of the literature. It was supported by previous scientific studies and also importance of relationship between early maladaptive schemas and this personality type on depression was mentioned because of the first study in literature.

In the light of the information mentioned above, the current study aimed to explanatory roles of early maladaptive schemas and sociotropy autonomy personality traits on depression among depressed patients and non-clinical individuals. 105 depressed patients and 110 non-clinical individuals have participated in this study, and they were asked specific questions about their demographics and some scales. Data was analyzed by using correlation analysis, independent samples t-tests, One-Way analysis of variances, Two-Way analysis of variances, hierarchical multiple regression analyses. The results of the current study were as expected and satisfactory. Also finding about which early maladaptive schemas are related to sociotropy and autonomy personality has been found firstly for both depressed patients and non-clinical individuals in the present study for literature

CHEAPTER I

1. LITERATURE REVIEW

1.1. Historical Roots of Depression.

Mood disorders have been mentioned since ancient times. Patients who have depression and manic episodes were identified in Greek artworks. The name of Melancholy including descriptions of severe depression had been mentioned by Hippocrates. He mentioned that black bile cause the incidence of this mood. Identification of melancholy symptoms, prognosis and termination has succeeded by Kraepelin later on (Berrios 1996). He described melancholy as a separate clinical condition which is different from manic-depressive psychosis (Kraepelin 1896). Afterwards, Brown (1984) redefined depression considering age related symptoms. He mentioned that elderly or late middle-aged people typically have depressive features with paranoia symptom. In addition to this, earlier in 60's, Beck worked on dreams to explain depression based on psychoanalytic theory. While behavioral theories were becoming more dominant in psychology, he shifted empirical studies to study on mood. Therefore, his scientific-based studies on depression were mainly framed by his cognitive approach (Beck1976).

1.2.Epidemiology of Depression

Depression is accepted as a common health problem for community both in Turkey and around the World (Küey 1998). It is particularly noted that depression is the fifth disease among ten highly prevalent diseases (Bruntland 2000).

The prevalence of depression over 30 years has increased significantly and consistently (Goodwin et al. 2007). According to the World Health Organization (2001) survey about mental disorders conducted on 14 countries, depression was found the most common mental illness (10.4%). Similar findings obtained in other studies conducted with larger sample size (Marneros 2006). WHO has projections for future that depression will be the second common disease in the World in 2020 and the suicidal depression will be the second death cause for humans after heart disease. Further, recent epidemiological studies demonstrated that age onset of depression decreased in adolescent period (Cole et al. 1993; Costello et al. 2003). Studies shown in Turkish population that depression is two times more common among adult women and adolescent girls than their counterparts (Öztürk 2001). According to the Koroğlu (2007) the average age of onset of depression is the mid-twenties. Controversial findings reveal that, depression was more prevalent over 40 years (Güleç 1981) and between 55-65 ages in another study (Doğan et al. 1995).

In addition, Koroğlu (2007) stressed that, new symptoms of major depression often develop in the range of few days to a few weeks. As he mentioned that, previous depressive episode increases 50 % of future depression. This probability increased to 70 % when individuals suffered depression at their past twice. Therefore, untreated depression are experienced approximately 6-24 months. However, as he mentioned that 66 % of individuals diagnosed with depression are more likely return to the previous functionality without receiving any treatment. The rate of depression were common among widowed and divorced individuals (Andrade 2003; Dogan et al. 1995; Erol et al. 1998 & Güleç 1981). Moreover, Ohayon (2007) found prevalence estimate of 5.2 % by using 6694 American adults. According to the Alonso, Angermeyer & Bernert's (2004) the European Study on the Epidemiology of Mental Disorders – ESEMED, lifetime prevalence of any mood disorder was found 14 % in a study conducted with 21,425 individuals living in six European countries. Similar to ESEMED, the Ministry of

Health conducted a "Mental Health Profile of Turkey" study. By using the Composite International Diagnostic Interview over 7,479 of Turkish individuals, the prevalence of depression was found as 5.4% for women and 2.3% for men. The risk of depression when living place is at the center of the city, this ratio was reported to be higher (Erol et al. 1998).

1.3.Comorbidity of Depression

Regarding comorbidity, it might be useful to highlight the difference between the terms of primary and secondary depression terms. Primary depression is not triggered by any other psychological or medical cause. However, in secondary depression, depression is as a result of a physical / organic disorder or other psychiatric disorders. Thus, at this point it is also crucial to know accompanying organic disorders (Weissman et al. 1977).

Depression is a disease with high comorbidity. More than 40% of depressive patients have been diagnosed more than one mental disorders such as, depression due to general medical condition (Landing, Alzheimer, Parkinson, Diabetes, Coronary Artery Disease, Cancer, Chronic Fatigue Syndrome, Fibromyalgia), eating disorders, alcohol / substance abuse, post-traumatic stress disorder, panic / phobias / generalized anxiety disorder, somatization disorder, obsessive-compulsive disorder, personality disorders (Köroğlu 2007).

1.4. Etiology of Depression

Different approaches and different perspectives have been tried to clarify etiology of depression with their emphasis. In this section, at first biological, and secondly psycho-social factors have been summarized extensively.

1.4.1. Biological Factors

Theories related to the presence of biological factors is demonstrated for many years. In the 1950s, monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCA) has been used in the treatment of psychiatric disorders and "Monoamine hypothesis" has been proposed. According to the hypothesis, three biogenic amines which are serotonin, dopamine and noradrenaline lead to depression (Racagni & Brunella 1999). Lack of dopamine (Akkaya 2005) and serotonin in the limbic area (Kessel 2000) effects nature of disease. There has been effective volumetric abnormalities in subcortical structures such as the amygdala and ventral striatum and also anterior cingulate cortex, orbitofrontal cortex and volumetric abnormalities in cortical regions for depression (Hajek et al. 2008).

In terms of genetics factors, studies investigating the relationship between depression are family studies, adoption, twin, and linkage studies. Having a family history of depression was noted to increase the risk of developing depression (Gelder et al. 1989; Kaplan et al. 1995). Furthermore, the risk of disease increases 2 -5 percentages among biological relatives with depression compared to the community (Aşkın 2000). Especially risk of depression is noted as two-three times common in the first-degree relatives of patients. Rate of depression was 9.4% for patients who have a depressed first-degree family member and 4.5% for relatives of the control group (Rothschild 1999).

1.4.2. Psycho-Social Factors

1.4.2.1. Stressful Life Events

There are wide range of meanings of stress, as a general description, stress is a difficulty based on appraisals which are caused damage to oneself with interaction on environment – individual, endangering of person's adjustment, forcing or exceeding of available resources (Lazarus & Folkman 1984). Negative life events and stressful

situations play an play a significant role in the development process of depression from childhood to adulthood. Many clinicians and researchers assumed that there is a significant relationship between stressful life events and occurrence of depression (i.e. Fergusson & Horwood 1984 & Holahan & Moos, 1987). Brown and Harris (1978) were mentioned firstly effects of stressful events such as poverty, medical disabilities, marital dysfunctions, financial problems etc. Some researchers highlighted that stressful life events might generate a predisposition and serve as a triggering stimuli to depression (Gelder et al. 1989; Kaplan et al., 1995; Reyes-Rodríguez, et al. 2013; Rothschild 1999; Sokratous et al. 2015; Ünal et al. 2002;). Additionally, stressful life events were studied as a factor among people with depressed and non-depressed in this research.

1.4.2.2. Personality Traits

It is suggested that having certain personality types are associated with depression. Several studies have revealed that some personality traits could be a risk factor for depression. These are obsessive, dependent, histrionic personality traits and introversion and neuroticism personality (Gelder, Gath & Mayou 1989, Kaplan, Sadock & Grebb 1995). According to the Beck's (1983) depression theory which is related to cognitive vulnerability, higher sociotropy and autonomy are associated with higher depression. Sociotropy dimension refers to personality associated with giving importance to relationships with people, feeling the need for social security; need to be in a positive relationship. Autonomy dimension refers to independence, attainment of goals and ability to management. It is also important that matching between various stressor like loss or failure and sociotrophic or autonomous personality are so crucial to develop depression (Beck 1983). In this study, the impact of these two traits on depression will be investigated therefore.

1.4.2.3. Social Support

Social support is an important protective factor for depression. When become depressed, oneself isolate from life, and feel disconnected and rejected from other people. As a definition social support is an acquisition from environment based on social and psychological support such as being cared (Cobb 1976). It provides emotional, physical and cognitive support in all interpersonal relationships (Sorias 1988). Social supports affects mental health and behavior pattern, and also provide protection and prevention for depression (Thoits 2011).

It has also been known that social support moderates the stressful situations. That is, social support buffer serves as a buffer for negative psychological outcomes of stressful life events (Cohen & Wills 1985). Besides, stressful life events (Lin & Ensel 1989) or life changes (Sarason, Johnson & Siegel 1978) are two of the important sources of stress concept. Presence of low level of perceived support have predicted depressive symptoms (Grav et al. 2011; Windle 1992; Stice & Bearman 2001). Similarly, there was negative correlation between perceived low social support and high depression for non clinical adolescent (Vaananen et al. 2014), and for fathers with postpartum depression (Kamalifard et al. 2014). According to Clara and her colleagues' (2003) study, high perceived social support was relation with low depression for depressed patients. Therefore, low perceived support predicted greater depression 18 months later (Leskela et al. 2006). In another study which was conducted with community sample family social support was found protective factors for depression (Roohafza et al. 2014)

Eker & Arkar (1995) also found a significant relationship between social support and depression in the sample of university students. Çakır & Palabıyıkoglu (1997) found that high perceived social support was negatively correlated with depression. In addition, there was negative significant relationship between depression scores and social support (Eldeleklioğlu 2006). Likewise, Sayar (2006) reported significant negative correlation between perceived social support and depression in adolescents. In conclusion, results can be explain that depressed individuals either receive insufficient social support from others or seek support with maladaptive manner. Moreover, one of

the aim of this study is to investigate the relations between satisfaction of social support and depression for both depressed patients and non-clinical individuals.

1.4.3. Cognitive Theories

To explanation of this disorder, there can be suggest many theories. Cognitive theories stress mental events in the context of the learning theory. So, depressed people think differently than non-depressed people, and it is this difference in thinking that causes them to become depressed. In this frame, it will be described both “Learned Helplessness Theory and Beck’s Theory”.

1.4.3.1.Learned helplessness

Seligman (1972) mainly emphasize the importance of learned helplessness on human behaviors after performing several experiments with animals. After facing with repetitive aversive stimuli, animals did not try more. To transfer the learned helplessness into human life, after repetitive aversive experiences, individuals have loss of energy to deal with negative experiences which result in higher depression . On the basis of Abramson, Seligman & Teasdale’s (1978) revised theory, in response to deal with life events being unable to cope in a similar manner continuously, individuals are more likely to suffer from depression which is accompanied by a feeling of helplessness. Abramson, Metalsky & Alloy (1989) added hopelessness concept to this theory. If Individual's attribution are personal and permanent in response to negative life events, depression are more likely to seen since these negative life events include hopelessness feelings.

1.4.3.2.Beck’s Cognitive Theory

Beck's depression model has been investigated for 1960’s by means of his systematic clinical observations and experimental studies. According to Beck's theory of depression (1963, 1967, 1987; Kovacs & Beck, 1978) cognitive structures are

particularly important for onset, development and relapse of the diseases. These structures are cognitive triad, schemas and cognitive distortions all of which are explained below.

Cognitive Triad: Beck, Rush, Shaw and Emery (1979) suggested that cognitive triad consist of basic three cognitive patterns that reflects negative thoughts about the self (seeing themselves as inadequate, unlovable, worthless, deficient), environment or the World (perceiving as overwhelming, filled with obstacles and failure), and the future (perceiving as hopeless, no effort will change the course of their lives). The first part of the triad is negative perspective about their selves. Patient feels defective, insufficient and thinks as a sick person. Because of these view, patients believe that they are undesirable and worthless people. So patients tend to be criticize themselves. They believe that the required attributes are not enough for themselves to achieve happiness and being valuable (Beck et al. 1979).

The second part of the cognitive triad includes negative interpretation about their experiences (Beck et al. 1979). A person considers that either the world is a place that offers opportunities to overcome obstacles while reaching life goals or demands from the outside World are extremely diminishing for oneself. If patients evaluate environment in a negative way, it is possible for them to see these negative misinterpretations quickly (Beck et al.. 1979)

The third part of the cognitive triad consists of negative view for the future. Depressed people believe that experienced difficulties or problems will be continuing on forever. Also they supposed that challenges, obstacles and deprivations will be proceed without any interruption (Beck et al. 1979). They also consider that when undertaking the task in near future, they would not succeed it (Beck et al. 1979).

Cognitive Schemas: The second important part of Beck's model is about schemas. Concept of schema is used for explanation that despite the presence of many objective positive factor in depressed people's life why self-destructive and painful attitudes is still maintained (Beck et al. 1979). Whenever a person face with a certain situation or stimulant, schema is activated related with that situation. So, individuals determine how to react. Beck and his colleagues'' (1979) indicate that because of the

presence of dysfunctional schemas of depressed individual, conceptualization of situation can be degenerated. Thus, these specific schemas lead to the distortion of reality and systematic bias of their thoughts. Although, different people can be conceptualized in different ways, , an individual is able to give responses consistently to the same type of event. Schema type that they used determines, how to configure different experiences of individual (Beck et al. 1979)

In addition to the concept of cognitive schemas, Young (1990) suggested that these schemas are developed in early life period and these lead to dysfunction of schemas since using these schemas might lead to decrement in functionality. Early life and personal experiences surrounds major schemas which lead to identifications of one selves. These schemas are consolidated with similar experiences and repeated in future life. In other words, schemas are formed by personal experiences in early life and these identifications are reinforced by close people and using through similar experiences. As being permanent cognitive structures, they can sometimes be use for coping mechanism both functionally and dysfunctionally (Young & Lindermann 1992). Young (1990) named Early Maladaptive Schemas (EMS) as a structure. These are self-sustaining and stable since childhood and also stay vivid with additional recent experiences. Therefore, satisfaction about early life experiences and satisfaction about social support might be important. Young formed the hypothesis about causes of early maladaptive schemas on the basis of all psychological disorders and defined 18 schemas which were categorized five main schema domains. These domains and schemas will be explained next title in detail. Studied effects of all EMSs on the depression by using different samples were one of the most important steps in this study.

Cognitive Distortions: The last part of the psychological structure of depression is incorrect information processing which maintains the beliefs about validity of negative thoughts (Beck et al.. 1979). There are distortions about individual's perceptions, evaluations, comments related with the self and others. These distortions triggers feelings of helplessness and pessimism.

Beck's (1967) cognitive theory, cognitive distortions play an important role in the progression and maintenance of emotional disorders. Cognitive distortions cognitive distortions refer to thoughts which cause individuals to negatively perceive the reality

and those lead the individuals to be convinced that they are right in terms of their views. In spite of the presence of opposite evidence, these distortions lead to maintain patient's negative beliefs (Burns, 1980). These distortions can be listed; all or nothing thinking (or dichotomous reasoning), should statements, filtering, overgeneralization, emotional reasoning, magnification and minimization, labeling and mislabeling, blaming and personalization (Beck et al. 1979). Studies have found a significant relationship between stress, cognitive distortion, and depression (Deal & Williams, 1998; Smith, O'Keefe & Christensen 1994). According to the Roberts's study (2014) by using non-clinical individuals, high level of cognitive distortion predict to perceived life events as more stressful.

1.5. Early Maladaptive Schemas

Beck's cognitive theory (1967) based on depression and emphasize that negative self-schemas as the vulnerability factors. As a cognitive structure, schema can be labeled as a structure to survive or kind of cognitive compatibility. Young's schema theory has been developed on the basis of Beck's cognitive therapy. Although it inspired by many therapeutic approaches, this theory contains a systematically different dynamics within itself (Young 1990, 1999).

The theory assumes that, schemas are caused by failure to meet the basic emotional needs in childhood. These needs are trust, integrity, compassion, autonomy, competence and sense of uniqueness and realistic limits. Also the needs related with a child's emotional temperament and early interaction with the environment are not satisfied. Therefore, lack of some essential and universal needs and "toxic" childhood experiences reinforces this formation (Young, 2003, p.10). The theory addresses psychological central core themes that has been specific to patients disorders. They labelled these themes as Early Maladaptive Schemas (EMS) (Young et al. 2003). The EMS are personal conclusions of psychologically devastating, toxic, repetitive negative experiences in addition to be traumatic childhood experiences. Therefore these schemas have influence on the meaning of the World and self (Arntz, Klokman & Sieswerda 2005). Besides, the EMS are formed by temperament and parenting styles and these factors effect to interpersonal relationship (Young et al. 2003). In schema therapy, it has

been occurred to improve the effectiveness of the interventions to overcome to the pathologic interpersonal problems that has been settled chronically and become typically to the individual's life and personality based emotional problems. Young (1999) have proposed the existence of 18 schemas grouped into five domains, these domains are other directedness, disconnection and rejection, impaired limits, overvigilance and inhibition and impaired autonomy and performance.

To begin with, “*Disconnection and Rejection*” domain, people who experienced this schemas have intensive problems and concern about developing reliable and satisfied relationships with other people. The presence of this belief caused by experiencing earlier traumatic life events or insecure attachment style. Generally, family origin is unsteady, abusive, cold, rejecting and isolated. This schema domain includes “Abandonment /Instability”, “Mistrust /Abuse”, “Emotional Deprivation”, “Defectiveness /Shame”, and “Social Isolation” (Young, Kolosko, & Weishaar 2003). “*Abandonment / Instability*” schema, especially contains perceptions about expecting support and intimacy from some close friends. When needs about intimacy are not fulfilled, person considers they are unstable and unreliable and do not continue to provide emotional support, intimacy, power or protection. “*Mistrust /Abuse*” includes expectation that others will hurt, abuse, humiliate, cheat, lie and manipulate. “*Emotional Deprivation*” schema includes the beliefs about not finding enough love and closeness from others. Deprivation of care (attention, love / compassion, warmth and friendship), empathy (understanding, listening, self-disclosure, or mutual sharing of emotions from others) and protection (strength, direction, or guidance) are three forms of deficiency. “*Defectiveness /Shame*” contains emotions about themselves as being incomplete, bad, insufficient, worthless, not understandable by anyone. They believe that they would not be loved anymore. Since these individuals are sensitive to criticism, rejection, blame, benchmarking and mistrust, these defects may show itself implicitly (selfishness, anger impulses, unacceptable sexual desires) or explicitly (unpleasant physical appearance, clumsiness). “*Social Isolation /Alienation*” schema is a sense of isolation from the rest of the world particularly social world, except for the family. Also they believe that they are different from other people or not part of any social group (Young, Kolosko & Weishaar 2003).

Secondly, “*Impaired Autonomy and Performance*” domain implies beliefs that people unable to fulfill their responsibilities, cannot stand by themselves. These schemas that are related with negative effect of child's self-confidence in case growing in a overprotective family or failing to provide the self outside the family. There are four subdimensions which are “Dependence/ incompetence”, “Vulnerability to Harm/ Illness”, “Enmeshment/Undeveloped Self”, “Failure” (Young, Kolosko & Weishaar 2003). “*Dependence/ Incompetence*” schema involves maladaptive beliefs about inability to solve daily life problems without others help, such as, self-care and making the right decisions. This sense of helplessness can sometimes be more limited and can only be triggered in certain situations or places (e.g. choosing spouse). “*Vulnerability to Harm/Illness*” is based on the fear of irrepressible catastrophe which can be happen suddenly and affect to oneself at any time. Expecting an externally originated catastrophe can be focused more than one thing. Some of these catastrophes are medical catastrophe (heart attacks, AIDS), emotional catastrophe (freaking out), environmental catastrophe (earthquake, be the victim of murder). “*Enmeshment/Undeveloped Self*” schema refers to extreme involvement with others who are generally close relatives. People with this schema prefer enmeshed relationship instead of being one or self individuation. Regularly, at least one of the enmeshed people cannot survive without the steady support of the other. Likewise, individuals having this schema can feel combining with others or lacking own individual identity. Frequently this schema is experienced as feelings of emptiness and aimlessness. “*Failure*” schema based on the belief that one has failure, will inescapably to failure or feel insufficient some area as sports, carrier or school. People with this schema consider that they are stupid, incompetent and incapable (Young, Kolosko & Weishaar 2003).

“*The Impaired Limits*” domain includes schemas indicates a deficiency in internal limits, responsibility to others or long- term goal directedness. Young, Kolosko & Weishaar (2003) identify four subcategories which are Insufficient Self-control/Self-discipline and Entitlement/Grandiosity. Generally family environment is based on permissions and perception of superiority. Families having lack of the discipline and little boundary cannot be role model on behaviors such as taking responsibility, cooperating with others and setting targets. “*Entitlement/Grandiosity*” schema which are characterized by beliefs that one is superior to other people and exempt from social

rules. Obtaining power and control (e.g., the most successful and most popular) are the main motivation for these people. “*Insufficient Self-control/Self Discipline*” schema includes that one does not have required self-control to achieve the personal goals and will not be able to control emotions and impulses against frustration (Young, Kolosko & Weishaar 2003).

The fourth domain is “*Other-Directedness*”. People with this schema focus on other people's wishes, feelings and reactions to be loved and approved at the expense of own needs. It usually emerges when has been grown in conditional respect and acceptance environment. There are three schemas in this domain, which are “Subjugation”, “Approval-Seeking/Recognition-Seeking” and “Self-Sacrifice” (Young, Kolosko & Weishaar 2003). “*Subjugation*” schema can be explained as releasing control to others. Since one believes that own ideas, feelings and desires would be insignificant for others, he/she behaves extremely harmonious and so decreases possibility of abandonment. This cycle causes suppressing needs and emotions regularly. “*Self-sacrifice*” schema is about the belief that giving up subjective satisfaction to focus on others' needs. People who have this schema have avoided distress for others, defend oneself from feeling guilty and selfish and protect themselves to situations. “*Approval Seeking/Recognition Seeking*” schema is characterized with extreme efforts toward to be approved, recognized or drawn attention by other people. Approval-Seeking has been the most important thing instead of creating real and safety self-perception. Thus, social context, such as status, appearance, social acceptance and money largely determine self-esteem and personal attitudes (Young, Kolosko & Weishaar 2003)

“*The Overvigilance and Inhibition*” domain imply giving up happiness, comfort, freedom to express self, possibility of having healthy relationships causes suppression and rigid behavior patterns. These schemas generally occur in ruthless, demanding and punitive families. Hiding feelings, staying away from mistakes and perfectionism are mostly expected by families in childhood. “Emotional Inhibition”, “Punitiveness”, “Unrelenting Standards/ Hypercriticalness”, and “Negativism/Pessimism” are schemas of this domain (Young, Kolosko & Weishaar 2003). “*Negativism/Pessimism*” schema is related to the expectation about something will happen such as disaster and negative life

events. While ignoring the positive and optimistic situations, focusing the negative side of life (e.g., pain, death, loss, disappointment, conflict, guilt, anger, unresolved problems, possible errors, leaves act). “*Emotional Inhibition*” schema manifests itself that the suppression of anger, positive affect, emotional and physical needs because of feelings of shame, losing control and disapproval by others. “*Unrelenting Standards/Hypercriticalness*” schema includes the beliefs that are extremely high standard such as perfectionism, strict rules and giving importance more than necessary to competence for the purpose of abstain from criticism. The last one is “*Punitiveness*” schema which is believed about if people make mistakes, they can be punished ruthlessly. Because these people can not forgive for their and others mistakes and tend to be angry, intolerant, punitive and impatient (Young, Kolosko & Weishaar 2003)

1.5.1. Early Maladaptive Schemas and Depression

According to the Young, Kolosko & Weishaar (2003), the EMS is a vulnerability factor to develop psychopathological disorders like depression. Some EMSs have been cited as closely related with mood disorders especially depression. However, inadequate number of studies have been carried out by using both clinical and non-clinical samples.

Shah & Waller reported that (2000), it has been shown that depressed participants had self-sacrifice, insufficient self-control and defectiveness/shame, schemas. Similarly, defectiveness/shame, subjugation, failure, , abandonment/instability and vulnerability to harm were associated with depression severity in depressed patients (Petrocelli et al., 2001a). When looking at schema domain, disconnection and rejection, impaired autonomy and performance, and impaired limits were related to depressive symptoms in clinical sample (Halvorsen et al. 2009).

There have been several studies with non-clinical samples. For instance, the EMS has been investigated to determine its role on depression severity in non-clinical undergraduate students (Harris and Curtin 2002). The study found that insufficient self-control, vulnerability to harm, and defectiveness/shame schemas were related to depression. Calvete et al. (2005) found that defectiveness/shame, self- sacrifice and

failure schemas were associated with depression severity in non clinical sample. In other words, higher scores obtained from these schema domains had higher depression scores. Colman (2010) has studied by using an undergraduate sample for depression. She found that abandonment/instability, social isolation, defectiveness/shame and failure schemas in disconnection and rejection domain, and dependence/incompetence, vulnerability to harm schemas in impaired autonomy and performance were predictive to depression. Another study showed that impact of stressors on depressive symptoms has been moderated by abandonment and emotional deprivation schemas (Calvete & Camara 2011).

Moreover, mistrust/abuse, social isolation, defectiveness, failure schemas were found significantly correlated with depression but emotional deprivation schema and subjugation schemas marginally correlated to depression (Eberhart, et al. 2011). Likewise, another study in a clinical sample illustrates that, when looking at schema domain; impaired autonomy & performance, and disconnection & rejection domains and also when looking at schema; emotional deprivation, abandonment/instability and failure were found connected to depression (Renner et al. 2014). Calvete, Orue & Hankin (2013) found that depressive and social anxiety symptoms has been predicted by impaired autonomy and performance, other-directedness and disconnection/rejection schema domain in adolescents. Trincas and colleagues (2014) conducted a study for the purpose of which EMSs predict to specific depressive symptoms in community samples. Sadness by negativity/pessimism; anhedonia by failure; self-harm by emotional deprivation and vulnerability to harm; illness; worthlessness by failure and negativity/pessimism; psychomotor retardation/restlessness by vulnerability to harm and entitlement/grandiosity; and poor concentration by insufficient self-control/self-discipline.

1.6. Sociotropy and Autonomy Personality Traits

Various theories such as Beck's (1967) depressive cognitive style, Abramson, Metalsky & Alloy's (1989) hopelessness theory of depression based on the negative life events and Nolen - Hoeksema's (1991) the concept of rumination have emphasized the

role of personality on depression. Particularly, role of personality patterns like emotional weakness, low self esteem, failure of social skills, increased interpersonal dependency, being overly considerate, perfectionism, pessimism, introversion and neurotic personality traits have been mentioned in the onset of the depressive illness (Akiskal, Hirschfeld & Yerevanian, 1983; Newton - Howes, Tyrer & Johnson 2006; Öztürk, 1992; Pilkonis ve Frank 1988). In addition, there has been numerous studies about comorbidity with depression and personality disorders which may be a predictor of risk factor, as well as poor prognosis for depression (Hirschfeld et al. 1989). According to Chodoff (1972) individuals with dependent and obsessive characteristic are dependent on others to maintain their self-esteem and to meet their narcissistic needs. If these requirements are not met, the risk of developing depression is high possibility. Similarly, Hirschfeld and Klerman (1979) found that people with depressive personality was more dependent, avoidant and introverted. Besides, recovery time is more slowly on depression comorbidity with Cluster C personality than pure depression (Vinamaki, Tanskanen & Koivumaa - Honkanen 2003).

When investigate history of appearances of sociotropy autonomy concepts, Blatt (1974) described dependent and self-critical personalities which are impacted as a precipitating factor for depression based on the psychoanalytic theory. Dependency occurs of situation of interpersonal abandonment or rejection, while self-critical personality also occurs situation of loosing of auto-control, individuality and achievement because of other people. Besides, respectively, traits are accompanied by a sense of helplessness, fears of abandonment and guilt and worthlessness (Blatt, D'Afflitti, & Quinlan 1976).

Then, Beck (1983) defined two types personality traits which are sociotropy and autonomy associated with depression based on diathesis-stress model. those factors of personality develops in childhood and maintains during lifespan (Clark & Beck 1999). The most important difference of these traits is that sociotropic individuals are sustaining their relationships, autonomous individuals are sustaining their independence from others. Higher sociotrophic individuals are mostly experiences anxieties of the rejection by others, so they are not stubborn people. To strengthen and guarantee interpersonal relationship, they exhibit behavior like closeness in which intend to satisfy

others. Sociotropic individuals expect to be interested, noticed and approved by other people (Fairbrother and Moretti, 1998). They are more likely to be used by others and also have demanding behavior (Lynch, Robbins & Morse 2000). Thus, life satisfaction and positive self-image depend on others (Gorski and Young 2002).

Autonomous individuals are success oriented and being controlled is very important for them (Beck 1983). For being successful and perfect, they make a plan in their life with high standards (Çetin 2008). They feel anxiety because of the possibility of personal failure and exhibit behavior to minimize probability of their failure by controlling the maximum level of the environment (Robins et al. 1989). They avoid under the control of their partners, may exhibit distanced attitude and withdrawn behavior. Besides, they seem to be cold, censorious, independent, negligent and diffident (Sato 2003; Sato & Gonzales 2009 & Sato, McCann, & Ferguson-Isaac, 2004). Autonomy as a word is related to these words; independence, assertion, detachment, locus of control, self-monitoring, self-reliance, freedom, privacy, self-sufficiency and individual achievement (Otacioğlu 2008).

Moreover, according to the Beck's (1983) observation, because of their predisposition, depressed patients with sociotropy are more easily adopt to therapists' suggestions or directions as a related to relationship than autonomous depressives. Sociotropics are more prone in group study process rather than individual and independent works than autonomous people (Barutçu & Öktem 2003).

In conclusion, when face with loss or a threat to their personal interests (sociotropy or autonomous), they are more likely to experience depression. For example, substantial loss of a person can lead to depression in sociotropic people, while repeated failure to perform personal tasks can lead to depression in autonomous people (Sato & McCann 2007).

1.6.1. Sociotropy and Autonomy Personality Traits and Depression

Researchers have demonstrated that the presence of sociotropy and autonomy traits were shown to be vulnerability factors for depression. Various researches

concerning the different variables have been made by using sociotropy-autonomy scale. There has been numerous studies about relations between depression and this types of personalities. Using a depressed patient population, Robins et al. (1997) examined the relationship between depressive symptoms and sociotropy – autonomy personality. The results shown that sociotropy was positively correlated with depressive symptoms such interpersonal guilt, self-blame and sensitivity. Autonomy was positively correlated with low positive affectivity such as hopelessness/ suicidality, interpersonal distance and feelings of failure, hostility and anhedonia. Moreover, Fairbrother & Moretti (1998) compared depressed, depressed in remission, and healthy people. Results indicated that depressed people were more socitropic and autonomous than healthy people and also both the depressed and depressed in remission people were found no difference between these two personality. Consistent with this research outputs, Sato & McCann (2000) found that there was positive correlation between sociotropy and depression in the sample of students and also they investigated to relations between Beck Depression Inventory (BDI) and Beck sociotropy Autonomy scale (SAS). They have pointed out BDI was associated with sociotropy rather than autonomy. In another study, relationship between marriage satisfactions, communication, problem solving skills and sociotropy - autonomy personality traits were examined in the sample of depressed individuals. Results revealed that sociotropy was associated with people's own behavior as demanding and their partners' behavior as withdrawing (Lynch, Robbins & Morse 2001).

Bieling & Alden (2001) also compared depressed patients and healthy people based on the their sociotropy and autonomy personality traits by using a brief interactional task. Results indicated that effects of depression on social behavior and social rejection were modified by an interaction between depression and autonomous personality features. According to Alford & Gerrity (2003), only sociotropy was related to depression whereas autonomy. Mongrain & Blackburn (2005) found that, in a sample of graduate students, sociotropy was associated with the number of previous episodes of depression, and autonomy with recurrence of the disorder. In addition, Bakshani (2007) mentioned that effects of social support and personality traits in depressed patients. Negative life events and social support was significant in high sociotropy for depressed patients but social support is not significant in high autonomy for depressed patients.

1.7. Aim of the Study

There have been several studies that question the role of early maladaptive schemas on developing several psychopathologies, such as depression. Apart from early maladaptive schemas, some personality factors such as sociotropy-autonomy on depression have been investigated. On the other hand, roles of both early maladaptive schemas and sociotropy-autonomy on depression have not been investigated into same study. Also, although early maladaptive schemas might be associated with some personality factors, this have not been examined yet. Therefore, exploring the associations between variables on depression and also affects of early maladaptive schemas on the traits of personality are aimed to explore in the present study. Because findings associated with the results will be obtained for the first time in literature, information about sociotropy and autonomy personality traits is predicted which EMSs on depressed patients will be very important.

When looking at studies including either early maladaptive schemas or sociotropy-autonomy. These studies were conducted mainly with either university students or depressed patients. Therefore, two samples are selected in the present study to reveal depressed patients and non-clinical individuals. Examining possible roles of EMSs and personality will provide clinical implications regarding to depression. Also it supports to understand nature of disorder. Adding to this, examining association with non-clinical individuals will contribute to develop prevention strategies in further studies.

Present study is investigated factors affecting depression in clinical and non-clinical sample. In the literature, although early maladaptive schemas and depression have been examined in a specific sample, there were little study that compare scores of clinical and non-clinical sample. Identifying specific features of clinical samples (depressed patients) and non clinical individuals is the main aim of the present study.

In addition to main aims defined above, the general aims of the study are to examine possible influence of demographic variables of gender, marital status, working status etc., other variables related to depression such as having chronic disease, status of psychological treatment previously, presence of stressful life events, satisfaction about social support and satisfaction about early childhood experiences, Sociotropy –

Autonomy Personality Trait, Schema Domains (i.e., impaired limits/, impaired autonomy & performance , other directedness, overvigilance & inhibition, disconnection/rejection) and specific maladaptive schemas (emotional deprivation, abandonment, defectiveness, social isolation, failure, dependence, vulnerability to harm, , insufficient self-control, self-sacrifice, approval seeking, unrelenting standards, pessimism, emotional inhibition and punitiveness) on depression in both depressed patients and non-clinical individuals.

1.8. Hypotheses of the Present Study

To determine there were a significant group difference between depressed and non-depressed group, and gender difference on variables in the present study, there were two sets of hypotheses,

Hypothesis 1: Are there any significant difference between depressed patients and non-clinical individuals with respect to depression, sociotropy autonomy personality traits, early maladaptive schemas domains and subdomains, effects of stressful life events and satisfaction of social support?

Depressed patients will have higher scores obtained from depression, sociotropy autonomy personality traits, early maladaptive schemas domains and subdomains, effects of stressful life events and satisfaction of social support than non-clinical individuals.

Hypothesis 2: Are there any significant difference between female and male with respect to severity of depression, sociotropy autonomy personality traits, early maladaptive schemas domains and subdomains, effects of stressful life events and satisfaction of social support?

In depressed patients, females will have higher scores obtained from depression, sociotropy autonomy personality traits, early maladaptive schemas domains and subdomains, effects of stressful life events and satisfaction of social support than males.

In non-clinical patients, females will have higher scores obtained from depression, sociotropy autonomy personality traits, early maladaptive schemas domains and subdomains, presence of stressful life events and satisfaction of social support than males.

Second, hypothesis tested below will be tested by One way anova (s). marital status, working status and received psychological treatment previously will be examined in respect to on depression for both depressed patients and non-clinical individuals.

Hypothesis 3: Are there any significant marital status difference on depression for both depressed patients and non-clinical individuals?

In depressed patients, divorced or widowed patients will have significantly higher scores than married on depression.

In non-clinical individuals, divorced or widowed patients will have significantly higher scores than married on depression. Hypothesis 4: Are there any significant working status difference on depression for both depressed patients and non-clinical individuals?

Hypothesis 4: Are there any significant working status difference on depression for both depressed patients and non-clinical individuals?

In depressed patients, patients who reported working status as never worked will have significantly higher scores of depression than patients who reported as working currently and patients who reported as not working currently.

In non-clinical individuals, individuals who reported working status as never worked will have significantly higher scores of depression than individuals who reported as working currently and patients who reported as not working currently.

Hypothesis 5: Are there any significant difference about receiving psychological treatment previously on depression for both depressed patients and non-clinical individuals?

In depressed patients, patients receiving both psychopharmacology and psychotherapy previously will significantly higher scores from patients receiving only psychopharmacology and patients receiving only psychotherapy and patients receiving no treatment on depression.

In non-clinical individuals, non-clinical individuals receiving both psychopharmacology and psychotherapy previously will significantly higher scores from individuals receiving only psychopharmacology and individuals received only psychotherapy and individuals received no treatment on depression.

Thirdly, The following hypotheses will be tested by using hierarchical regression analyses in 3 sets run for the data obtained from both patients with depression and non-clinical individuals.

Hypothesis 6: After controlling social support- stress variables, whether sociotropy – autonomy personality traits, early maladaptive schema domains will be significantly associated with depression scores in the sample of both depressed patients and non-clinical individuals.

After controlling social support- stress variables, sociotropy – autonomy personality traits, will be significantly associated with depression scores in the sample of both depressed patients and non-clinical individuals.

Hypothesis 7: After controlling social support- stress variables, whether sociotropy – autonomy personality traits, specific early maladaptive schemas subdomains will be significantly associated with depression scores in the sample of both depressed patients and non-depressed individuals.

After controlling social support- stress variables, Sociotropy – Autonomy Personality Traits, emotional deprivation, abandonment, defectiveness, social isolation, failure, dependence, vulnerability to harm, insufficient self-control, self-sacrifice, approval seeking, unrelenting standards, pessimism, emotional inhibition and punitiveness will be significantly associated with depression scores in the sample of both depressed patients and non-depressed individuals.

Lastly, the following hypotheses will be tested by using regression analysis in run for the data obtained from both depressed patients and non-clinical individuals.

Hypothesis 8: Early maladaptive schema domains will be significantly associated with sociotropy scores in the sample of both depressed patients and non-clinical individuals.

Hypothesis 9: Early maladaptive schema domains will be significantly associated with autonomy scores in the sample of both depressed patients and non-clinical individuals

Hypothesis 10: Early maladaptive schema subdomains will be significantly associated with sociotropy scores in the sample of both depressed patients and non-clinical individuals.

Hypothesis 11: Early maladaptive schema subdomains will be significantly associated with autonomy scores in the sample of both depressed patients and non-clinical individuals.

CHAPTER II

2. METHOD

This chapter will be giving information about the participants, measurements that were used, and procedure of the present study.

2.1. Participants

In the current study, there were two groups of participants namely depressed patients and non-clinical individuals. Depressed patients who are clinical sample consisted of 105 adults diagnosed with depression and 110 non-clinical individuals who are healthy and totally all individuals are 205. Patients not only diagnosed with depression but also actively engage in treatment were chosen for depressed patients. Furthermore, non-clinical individuals who were not diagnosed with any psychological disease were chosen. The socio-demographic information about the individuals was presented in Table 2.1 and Table 2.2

2.1.1. Depressed Patients

Volunteer study group having diagnosis of depression were selected from inpatient services and psychiatry polyclinics at Izzet Baysal Mental Health and

Neurological Diseases Education and Research Hospital in Bolu. Patients were selected to this research when they were diagnosed by psychiatrist on the basis of having only major depression according to DSM-V (American Psychiatric Association, 2013) diagnostic criteria. Five patients were excluded from our depressed patient sample because they had a comorbid disorders which this situation was not conform the criteriof study. All of the patients were under psychological treatment.

On the basis socio-demographic variables, 105 depressed participants were (67.6 % women and 32.4 % men) between ages of 18 to 65 ($M = 35.44$, $SD = 11.13$). According to the education level of the participants, 22.9 % ($n = 24$) were graduated from primary school, 13.3 % ($n = 14$) were graduated from secondary school, 40 % ($n = 42$) were graduated from high school, 6.7 ($n = 7$) were from college and 17.1 % ($n = 18$) were from university graduates. Marital status of the participants, 30.5 % ($n = 32$) were single while 52.4 % ($n = 55$) were married and 17.1 % ($n = 18$) were divorced. According to working status of the sample, were employed 38.1 % ($n = 40$) while 44.8 % ($n = 47$) were unemployed and 17.1 % ($n = 18$) never worked. The reported family/household income was between 200 and 7000 Turkish liras and the mean average salary of the participants was 2128.7 Turkish Lira ($SD = 1270.79$).

On tha basis of health related variables, 51.4 % of the patients ($n = 54$) have a chronic illness and 48.6 % ($n = 51$) of them have not. In the terms of types of diseases, 19 % ($n = 20$) were Cardiovascular / respiratory system, 11.4 % ($n = 12$) were Digestive system, 4.8 % ($n = 5$) were Musculoskeletal system, 6.7 % ($n = 7$) were Sensory system, 2.9 % ($n = 3$) were Endocrine system, 2.9 % ($n = 3$) were Neurological, and 1 % ($n = 1$) were Excretory system.

In terms of recieved psychological treatment previously , 77 (73.3) participants received while 28 (26.7) participans did not receive it. Among types of treatment, pharmacotherapy was 42 (40 %), psychotherapy was 5 (4.8 %) and both psychotherapy and pharmacotherapy were 30 (28.6 %).

The mean degree of individualss' assessment about satisfaction of early childhood experiences (1 = *very negative*, 10 = *very positive*) was 5.88 ($SD = 2.72$). The mean degree of individualss' assessment about satisfaction of social support (1 = *not at all satisfied*, 10 = *very satisfied*) was 5.91 ($SD = 2.91$).

Table 2.1: The mean, standard deviation and range values of the demographic variables

Variables	Depressed Patients (N = 105)			Non-clinical Individuals (N = 110)		
	M	SD	Range	M	SD	Range
Age	35.44	11.13	18 - 65	31.86	10.39	18 - 56
Monthly income (Turkish Liras)	2128.7	1270.79	200 - 7000	2696.27	1541.77	750 - 13000
Satisfaction of early childhood experiences	5.88	2.72	1 - 10	6.95	2.22	1 - 10
Satisfaction of social support	5.91	2.99	1 - 10	7.7	1.79	1 - 10

2.1.2. Non-Clinical Individuals

Volunteer non-clinical individuals consisted of 110 non depressed adults having no any psychiatric diagnosis currently. Non-clinical individuals were women 69.1 % (N= 76) and male 30.9 % (N= 34), ranging from 18 to 56 years of age (M = 31.86, SD = 10.39). According to the education level of the individuals, 6.4 % (N= 7) were graduate of primary school, 8.2 % (N=9) were graduate of secondary school, 38.2 % (N= 42) were graduate of high school, 22.7 % (N=25) were college and 24.5 % (N=27) were university graduates. Marital status of the healthy individuals, 51.8 % (N= 57) were single while 42.7 % (N= 47) were married and 5.5 % (N= 6) were divorced. Regarding working status of the sample, most of the participants were employed 52.7 % (N= 58) while 22.7 % (N= 25) were unemployed and 24.5 % (N= 27) never worked. The reported family/household income was between 750 and 130000 Turkish Lira and the mean average salary of the individuals was 2696.27 Turkish Lira (SD = 1541.76).

Regarding the health status of the nonclinical participant, most of them have 71.8 % (N=79) a chronic illness while 28.2 % (N=31) were not. In the terms of types of diseases, 9.1 % (N= 10) were Cardiovascular / respiratory system, 7.3 % (N= 9) were Digestive system, 1.8 % (N= 2) were Musculoskeletal system, 0.9 % (N= 1) were Sensory system, 7.3 % (N= 8) were Endocrine system and 1.8 % (N= 2) were Neurological.

In terms of status of received psychological treatment previously in non-clinical individuals, 80 % (N= 88) individuals received while 20 % (N= 22) individuals did not receive it. Among types of treatment, pharmacotherapy was 10 % (N= 11), psychotherapy was 6.4 % (N= 7) and both psychotherapy and pharmacotherapy were 3.6 % (N= 4).

The mean degree of individuals' assessment about satisfaction of early childhood experiences (1 = *very negative*, 10 = *very positive*) was 6.95 (SD = 2.22). The mean degree of individuals' assessment about satisfaction of social support (1 = *not at all satisfied*, 10 = *very satisfied*) was 7.7 (SD = 1.79).

Table 2.2: Demographic characteristics of the participants

Variables	Depressed Patients (N = 105)		Non-Clinical Individuals (N = 110)	
	Frequencies (N)	Percentages (%)	Frequencies (N)	Percentages (%)
<i>Gender</i>				
Women	71	67.6	76	69.1
Male	34	32.4	34	30.9
<i>Education</i>				
Primary School	24	22.9	7	6.4
Secondary School	14	13.3	9	8.2
High School	42	40	42	38.2
College	7	6.7	25	22.7
University	18	17.1	27	24.5
<i>Marital Status</i>				
Single	32	30.5	57	51.8
Married	55	52.4	47	42.7
Divorced or Widowed	18	17.1	6	5.5
<i>Employment Status</i>				
Housewife	29	27.6	16	14.5
Retired	10	9.5	7	6.4
Student	12	11.4	29	26.4
Worker	10	9.5	8	7.3
Self-Employed	6	5.7	3	2.7
Civil Servant	17	16.2	21	19.1
Private Sector	11	10.5	24	21.8

Table 2.2: Continue

Unemployed	10	9.5	2	1.8
<i>Chronic Illness</i>				
No	54	51.4	79	71.8
Yes	51	48.6	31	28.2
Cardiovascular System	20	19.0	10	9.1
Digestive System	12	11.4	8	7.3
Musculoskeletal System	5	4.8	2	1.8
Sensory System	7	6.7	1	0.9
Endocrine System	3	2.9	8	7.3
Neurological	3	2.9	2	1.8
Excretory System	1	1.0	-	-
<i>Received Psychological Treatment Previously</i>				
No	28	26.7	88	80
Yes	77	73.3	22	20
Psychopharmacology	42	40	11	10.0
Psychotherapy	5	4.8	7	6.4
Both of them	30	28.6	4	3.6
<i>Situation of <u>Bereavement</u></i>				
No	48	45.7	70	63.6
Yes	57	54.3	40	36.4
Mother	18	17.1	12	10.9
Father	21	20.0	13	11.8
Relatives	11	10.5	8	7.3
Sibling	3	2.9	2	1.8
Partner	3	2.9	2	1.8
Friends	1	1.0	3	2.7
<i>Presence of Stressful Life Events</i>				
No	33	31.4	78	70.9
Yes	72	68.6	32	29.1
Problem With Couple	30	28.6	8	7.3
Problem With Friends	7	6.7	6	5.5
Financial Difficulties	18	17.1	8	7.3
Others	17	16.2	10	9.1

2.2. Measurements

Demographical Information Form, Beck Depression Inventory II, Young Schema Questionnaire Short Form III, Sociotropy Autonomy Scale were used as a measures in this study.

2.2.1. Demographical Information Form

A brief questionnaire including individuals' age, gender, marital status, education level, working status, monthly income, etc were questioned. In addition, variables related to depression such as having cronic disease, status of psychological treatment previously, situation of bereavement , presence of stressful life events, satisfaction of social support and satisfaction of early childhood experiences were asked battery of self-report measures.

2.2.2. Beck Depression Inventory II (BDI –II)

Beck Depression Inventory was firstly developed by Beck, Rush, Shaw and Emery (1979). The BDI is a 21-item self-report inventory for assessing the severity of depression. The items are rated from 0 to 3, based on the severity of the symptoms. Total scores can range from 0 to 63 and can be grouped into four levels of severity: minimal depression (total score of 0-13), mild depression (total score of 14-19), moderate depression (total score of 20-28), and severe depression (total score of ≥ 29). The BDI has well-established psychometric properties (Beck, Steer, & Garbin, 1988). Turkish version of the scale was adapted by Hisli (1988) and internal consistency was found .88, test re-test reliability was found .80. Later, scale was revised and the last form was obtained known as BDI II (Beck, Steer, & Brown, 1996). Kapci, Uslu, Türkçapar & Karaoğlu (2008) the revised scale of BDI II was adapted to Turkish language. In the present study, this inventory was used. The internal consistency coefficient was .89 for clinical samples, .90 for non-clinical college students and test-retest reliability was found to be .94. Moreover, validity analysis was .81, construct validity was .39 and discriminant validity .39, .49, .42. respectively. In the current

study, internal consistency of the BDI was strong for both depressed patients (Cronbach's $\alpha = .84$) and healthy people (Cronbach's $\alpha = .82$)

2.2.3. Sociotropy Autonomy Scale (SAS)

Beck, Epstein, Harrison and Emery (1983) developed SAS to evaluate two different types of personality traits related to depression which are sociotropy and autonomy. Sociotropy means being dependent to others whereas autonomy means being independent from others. This self-report questionnaire composed of 60 items which are 30 items for sociotropy and 30 items for autonomy. Internal consistency of the scale was between .89 and .94 for Sociotropy and between .83 and .95 for Autonomy and test-retest reliability coefficients were .65 - .88 for Sociotropy and .66 - .75 for Autonomy.

Turkish adaptation study of the scale was conducted by Şahin, Ulusoy & Şahin (2003). It is scored on a 5 point interval Likert scale ranging between 0 (not at all) to 100 (completely) and obtained two total score of two subscales with 60 items. High scores obtained from two subscales indicating the high sociotropic - autonomous personality traits. Turkish version of SAS appears to be a highly reliable instrument with coefficients of internal consistency .70 for patients and .83 for university students on sociotropy, and .81 for patients and .81 for for university students on autonomy. Sociotropy subscale were found to distinguish between healthy and patient groups ($t=6.82, p<.01$), while autonomy subscale were not. Therefore, sociotropy is more closely associated with depression than autonomy. In the present study, internal consistencies of sociotropy, autonomy, and the total scale were .84, .89, and .91, respectively for depressed patients and healthy people .87, .89, .90

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

This original shortened scale was developed by Young (2006) as a self-report measure that measures early maladaptive schemas. The scale assesses 5 schema domain 18 Early Maladaptive Schemas and includes 90 items on a 6-point Likert scale ("1" for "does not describe me at all"; "6" for "describes me perfectly").

Soygüt, Karaosmanoğlu, and Çakır (2009) adapted the this shortened scale into Turkish and conducted its validity and reliability study in sample of university students. High order factor structure of the Turkish version was found to be similar to the original version. This shortened version of scale is consists of 5 schema domain and 14 subdomain which are early maladaptive schemas. High scores indicate more numerous and more severe presence of early maladaptive schemas. The scale was found to high internal consistency (.53 to .81) for subdomain and (.63 to .80) for schema domain. Test-retest reliability of the Turkish form of EMSs was found to vary between 0.66 to 0.83. for schema domain and .66 to .82 for subdomain. In this version, internal consistency for emotional deprivation was .78, for failure was .80, for pessimism was .79, for social isolation was .78, for emotional inhibition was .72, for approval seeking was .74, for dependency/incompetence was .80, for insufficient self-control was .72, for self-sacrifice was .74, for abandonment/instability was .73, for punitiveness was .71, for defectiveness/shame was .68, for vulnerability to harm was .63, for unrelenting standards was .70. This form was used in this study.

According to Sarıtaş & Gençöz (2011), all early maladaptive schemas were categorized into three different domains and internal consistency was .81 for Impaired Limits-Exaggerated Standards, .81 for Disconnection-Rejection, and .79 for Impaired Autonomy-Other Directedness. In Boysan's (2012) study, reliability and internal consistency for five schema domains respectively were found .92 for disconnection and rejection, .87 for impaired autonomy and performance, .71 for impaired Limits, .80, other directedness, .84 for overvigilance and inhibition.

Additionally, in the present study, it was found the internal consistency of the disconnection & rejection, Impaired Autonomy & Performance, Impaired Limits, Other Directedness and Overvigilance & Inhibition were .87, .85, .65, .71 and .78 for depressed patients, respectively. Besides, internal consistency was found in the same domains .86, .88, .71, .76 and .82 for healthy people, respectively.

2.3. Procedure

The questionnaires used in the current study were first submitted for Human Researches Ethic Committee of Abant Izzet Baysal University. Then researcher or psychologist explained the aim of the present study and asked the participants (both depressed patients and healthy people) who want to be volunteer in the study to take a questionnaire to be filled. It was also stressed that they were free to end whenever they want. After brief explanation about the questionnaire, the volunteers answered to questions by their selves. The administration of questionnaire took approximately 45 minutes. After they signed the consent form, participants were asked to fill out a questionnaire packet that consisted of the Beck Depression Inventory II (BDI II), Young Schema Questionnaire Short Form III (YSQ – SF) and Sociotropy Autonomy Scale (SAS).

CHAPTER III

3. RESULTS

This study results were analyzed by using IBM Statistical Package for the Social Sciences (SPSS) 21 programme for Windows.

3.1. Data Screening and Cleaning

Data were analyzed for univariate and multivariate outliers using Mahalanobis distance. None of cases were identified as univariate or multivariate outliers and having high z-scores higher than ± 3.30 . Since, there was no univariate or multivariate outliers and all variables were acceptable range in terms of normality, a total of 215 participants including 105 patients and 110 healthy people were used to analyze data. The skewness and kurtosis for all variables levels were in the acceptable ranges indicating the normality of distributions.

3.2. Descriptive Statistics

Descriptive statistics for main variables were presented in Table 3.1

Table 3.1: Descriptive information of the main variables

Variables	Depressed Patients (N = 105)			Nonclinical Individuals (N = 110)		
	M	SD	Min - Max	M	SD	Min - Max
<i>Depression</i>	24.1	9.76	0 – 48	7.72	6.62	0 – 48
<i>Sociotropy</i>	1839.09	389.19	850 – 2775	1517.51	390.79	25 – 2525
<i>Autonomy</i>	1970.24	438.41	1050 – 2900	1888.36	416.88	0 – 2700
<i>Disconnection and Rejection</i>	65.21	20.39	22 – 117	40.86	13.80	22 – 86
Emotional Deprivation	15.71	6.57	5 – 30	9.28	4.65	5 – 23
Abandonment	14.54	6.25	5 – 30	8.49	3.41	5 – 21
Defectiveness	15.48	6.86	6 – 32	10.14	4.45	6 - 29
Social Isolation	19.47	6.31	6 – 36	12.94	5.36	6 – 27
<i>Impaired Autonomy and Performance</i>	58.79	17.39	20 – 97	37.96	13.29	20 – 85
Failure	17.36	6.65	6 – 31	11.53	4.59	6 – 27
Dependence	25.81	8.99	9 – 50	15.78	6.45	9 - 39
Vulnerability to harm	15.62	5.85	5 – 30	10.65	4.64	5 – 23
<i>Impaired Limits</i>	25.83	6.68	9 – 42	22.10	6.58	7 – 36
Insufficient Self-control	25.83	6.68	9 – 42	22.10	6.58	7 – 36
<i>Other Directedness</i>	43.49	9.03	15 – 63	34.17	8.72	11 – 56
Self-Sacrifice	19.72	4.91	6 – 30	15.77	4.81	5 – 29
Approval Seeking	23.77	6.32	6 – 35	18.40	5.32	6 – 32
<i>Overvigilance and Inhibition</i>	65.82	14.30	31 – 95	53.03	13.48	19 – 83
Unrelenting Standards	10.68	3.64	3 – 18	8.56	3.85	3 – 18
Pessimism	16.62	5.92	5 – 29	10.92	4.57	5 – 27
Emotional Inhibition	14.69	4.96	5 – 25	12.28	4.83	5 – 25
Punitiveness	23.82	5.92	8 – 36	21.27	5.87	6 - 34

3.3. Bivariate Correlations among Variables for Depressed Patients and Nonclinical Individuals

3.3.1. Depressed Patients

According to the results for depressed patients as shown in Table 3.2. Depression was significantly positively correlated with Sociotropy ($r = .18, p \leq .05$). When looking at depression and EMS domains relationship, depression was significantly positively correlated with disconnection and rejection schema domain ($r = .41, p \leq .01$), impaired autonomy and performance domain ($r = .50, p \leq .01$), impaired limits domain ($r = .26, p < .001$), overvigilance and inhibition domain ($r = .39, p \leq .001$). Besides, according to the analyses of depression and specific EMS subdomain, depression was significantly positively correlated with emotional deprivation ($r = .27, p \leq .01$), abandonment ($r = .35, p \leq .001$), defectiveness ($r = .34, p \leq .001$), social isolation ($r = .34, p \leq .001$), failure ($r = .29, p \leq .01$), dependence ($r = .447, p \leq .001$), vulnerability to harm ($r = .43, p \leq .001$), insufficient self-control ($r = .28, p \leq .01$), pessimism ($r = .34, p \leq .001$), and emotional inhibition ($r = .44, p \leq .001$). Moreover, there was significant negative relation between depression and satisfaction of social support ($r = -.23, p \leq .05$).

Sociotropy was significantly positively correlated with autonomy ($r = .46, p \leq .001$), disconnection and rejection ($r = .39, p \leq .001$), impaired autonomy performance ($r = .36, p \leq .001$), impaired limits ($r = .32, p \leq .001$), other directedness ($r = .59, p \leq .001$), overvigilance and inhibition ($r = .48, p \leq .001$). More specifically, when looking at sociotropy and EMS subdomains relationship, sociotropy was positively correlated with social isolation ($r = .31, p \leq .001$), abandonment ($r = .41, p \leq .001$), defectiveness ($r = .24, p \leq .001$), emotional deprivation ($r = .29, p \leq .01$), failure ($r = .22, p \leq .05$), dependence ($r = .39, p \leq .001$), vulnerability to harm ($r = .23, p \leq .05$), insufficient self-control ($r = .32, p \leq .001$), self-sacrifice ($r = .36, p \leq .001$), approval seeking ($r = .56, p \leq .001$), pessimism ($r = .29, p < .01$), punitiveness ($r = .47, p \leq .001$), and unrelenting standards ($r = .42, p \leq .001$). Further in terms of autonomy, autonomy was significantly positively correlated with impaired limits ($r = .46, p \leq .001$), other

directedness ($r = .40, p \leq .001$), overvigilance and inhibition ($r = .44, p \leq .001$), social isolation ($r = .21, p \leq .05$), insufficient self-control ($r = .46, p \leq .001$), self-sacrifice ($r = .41, p \leq .001$), approval seeking ($r = .25, p \leq .05$), emotional inhibition ($r = .19, p \leq .05$), punitiveness ($r = .49, p \leq .001$), and unrelenting standards ($r = .39, p \leq .001$).

3.3.2 Nonclinical Individuals

According to the results for nonclinical individuals as shown in Table 3.2, depression was positively correlated disconnection and rejection schema domain ($r = .36, p \leq .001$), impaired autonomy and performance ($r = .32, p \leq .001$), other directedness ($r = .26, p \leq .01$), and overvigilance and inhibition ($r = .22, p \leq .05$).

Correlations between depression and EMS subdomains were analyzed. Depression was significantly positively correlated with emotional deprivation ($r = .25, p \leq .01$), defectiveness ($r = .42, p \leq .001$), social isolation ($r = .25, p \leq .01$), failure ($r = .38, p \leq .01$), dependence ($r = .29, p \leq .01$), self-sacrifice ($r = .42, p \leq .001$), pessimism ($r = .34, p < .001$), and punitiveness ($r = .27, p \leq .01$).

Sociotropy was significantly positively correlated with autonomy ($r = .37, p \leq .001$), disconnection and rejection schema domain ($r = .30, p \leq .001$), impaired autonomy and performance ($r = .46, p \leq .001$), impaired limits ($r = .24, p \leq .05$), other directedness ($r = .63, p \leq .001$), and overvigilance and inhibition ($r = .49, p \leq .001$). More specifically, sociotropy was positively correlated with social isolation ($r = .21, p \leq .05$), abandonment ($r = .32, p \leq .001$), defectiveness ($r = .30, p \leq .01$), failure ($r = .34, p \leq .001$), dependence ($r = .39, p \leq .001$), vulnerability to harm ($r = .33, p \leq .001$), insufficient self-control ($r = .24, p \leq .05$), self-sacrifice ($r = .43, p \leq .001$), approval seeking ($r = .65, p \leq .001$), pessimism ($r = .32, p \leq .001$), punitiveness ($r = .55, p \leq .001$), and unrelenting standards ($r = .28, p \leq .01$). Thus, in terms of autonomy, autonomy was significantly positively correlated with disconnection and rejection ($r = .21, p \leq .05$), impaired limits ($r = .53, p \leq .001$), other directedness ($r = .37, p \leq .001$), overvigilance and inhibition ($r = .32, p \leq .001$), more specifically, social isolation ($r = .32, p \leq .001$), emotional deprivation ($r = .20, p \leq .05$), vulnerability to harm ($r = .25, p \leq .01$), insufficient self-control ($r = .53, p \leq .001$), self-sacrifice ($r =$

.22, $p \leq .05$), approval seeking ($r = .42$, $p \leq .05$), emotional inhibition ($r = .27$, $p \leq .01$), punitiveness ($r = .46$, $p \leq .001$), and unrelenting standards ($r = .28$, $p < .01$).

Table 3.2: Pearson correlations between depression, sociotropy, autonomy, early maladaptive schemas and socio – stress variables

	1	2	3	4	5	6	7	8	9	10	11	12
1. Depression		.18***	-.02	.42***	.34***	.36***	.35***	.27**	.50***	.29**	.48***	.43***
2. Sociotropy	.14		.46***	.39***	.31***	.41***	.24*	.29**	.36***	.22*	.39***	.23*
3. Autonomy	-.06	.37***		.12	.21*	.03	-.03	.17	.03	-.02	.01	.10
4. Disconnection and Rejection	.35***	.30***	.21*		.78***	.80***	.81***	.74***	.75***	.53***	.68***	.60***
5. Social Isolation	.25**	.21*	.32***	.81***		.51***	.53***	.43***	.54***	.35***	.43***	.56***
6. Abandonment	.14	.32***	.09	.72***	.46***		.56***	.47***	.67***	.47***	.64***	.47***
7. Defectiveness	.42***	.30*	-.01	.76***	.45***	.45***		.43***	.66***	.51***	.62***	.42***
8. Emotional Deprivation	.25**	.13	.20*	.77***	.48***	.44***	.45***		.50***	.33***	.44***	.42***
9. Impaired Autonomy	.32***	.46***	.09	.73***	.54***	.63***	.71***	.41***		.78***	.90***	.71***
10.Failure	.38***	.34***	-.01	.60***	.41***	.45***	.70***	.31***	.84***		.56***	.32***
11.Dependence	.29**	.39***	.02	.59***	.33***	.55***	.64***	.36***	.90***	.64***		.49***
12.Vulnerability to Harm	.14	.43***	.25***	.69***	.68***	.59***	.47***	.37***	.79***	.51***	.54***	

Note 1. *** $p \leq .001$, ** $p \leq .01$, * $p \leq .05$

Note 2. The upper diagonal indicates the results for depressed sample and the below indicates the results for non-clinical individuals.

Table 3.2: Continue

	13	14	15	16	17	18	19	20	21	22	23	24
1. Depression	.26**	.26**	.17	.08	.17	.39***	.34***	.44***	.17	.11	.11	-.23*
2. Sociotropy	.32***	.32***	.59***	.36***	.56***	.48***	.29**	.17	.47***	.42***	-.01	.02
3. Autonomy	.46***	.46***	.40***	.41***	.25*	.44***	.16	.19*	.49***	.39***	.02	.03
4. Disconnection and Rejection	.49***	.49***	.46***	.22*	.48***	.62***	.51***	.45***	.38***	.38***	.19	-.42***
5. Social Isolation	.47***	.47***	.36***	.28**	.30**	.60***	.48***	.36***	.42***	.40***	.28***	-.38***
6. Abandonment	.36***	.36***	.37***	.11	.44***	.50***	.49***	.35***	.25*	.30**	.05	-.18
7. Defectiveness	.29**	.29**	.26**	.01	.36***	.45***	.33***	.45***	.21*	.29**	.14	-.36***
8. Emotional Deprivation	.42***	.42***	.45***	.31***	.41***	.39***	.30**	.25*	.32***	.21*	.13	-.40***
9. Impaired Autonomy	.47***	.47***	.38***	.11	.46***	.61***	.50***	.48***	.34***	.37***	.08	-.35***
10.Failure	.32***	.32***	.23*	.03	.30**	.36***	.33***	.32***	.14	.23*	.10	-.26***
11.Dependence	.37***	.37***	.37***	.11	.45***	.58***	.43***	.49***	.34***	.36***	-.01	-.32***
12.Vulnerability to Harm	.47***	.47***	.31***	.13	.35***	.50***	.45***	.30**	.33***	.27*	.15	-.26**

Note 1. *** $p \leq .001$, ** $p \leq .01$, * $p \leq .05$

Note 2. 13. Impaired Limits, 14. Insufficient Self-control, 15. Other Directedness, 16. Self-sacrifice, 17. Approval Seeking, 18. Overvigilance and Inhibition, 19. Pessimism, 20. Emotional Inhibition, 21. Punitiveness, 22. Unrelenting Standards, 23. Satisfaction of social support, 24. Presence of Stressful Life Events

Note 3. These table indicates the correlations results for depressed patients

Table 3.2: Continue

	13	14	15	16	17	18	19	20	21	22	23	24
13.Impaired Limits		1.00***	.49***	.28**	.49***	.61***	.67***	.39***	.46***	.54***	.17	-.23*
14.Insufficient Self-control	1.00***		.49***	.28**	.49***	.61***	.37***	.39***	.46***	.54***	.17	-.23*
15.Other Directedness	.46***	.46***		.74***	.85***	.59***	.42***	.19	.59***	.39***	.08	-.17
16.Self-sacrifice	.26**	.26***	.85***		.28**	.39***	.30**	.08	.56***	.19*	.19*	-.11
17.Approval Seeking	.52***	.52***	.88***	.48***		.53***	.37***	.20*	.49***	.41***	-.03	-.16
18.Overvigilance and Inhibition	.49***	.49***	.66***	.56***	.57***		.70***	.59***	.81***	.68***	.10	-.17
19.Pessimism	.31***	.31***	.47***	.48***	.33***	.70***		.13	.39***	.31***	.19	-.20*
20.Emotional Inhibition	.22*	.22*	.29**	.29**	.21*	.69***	.31***		.30**	.26**	-.07	-.14
21.Punitiveness	.41***	.41***	.64***	.52***	.58***	.80***	.43***	.37***		.50***	.02	-.01
22.Unrelenting Standards	.45***	.45***	.40***	.22*	.46***	.58***	.23*	.24*	.31***		.15	-.12
23.Satisfaction of social support	.18*	.18*	.12	.15	.0,	.21	.25*	.10	.15	.10		-.19
24. Presence of Stressful Life Events	-.04	-.04	-.18	-.11	-.19*	-.16	-.16	-.05	-.14	-.11	-.09	

Note 1. *** $p \leq .001$, ** $p \leq .01$, * $p \leq .05$

Note 2. The upper diagonal indicates the results for depressed sample and the below indicates the results for non-clinical individuals.

Table 3.2: Continue

	13	14	15	16	17	18	19	20	21	22	23	24
1. Depression	.09	.09	.26**	.42***	.06	.22*	.34***	-.08	.27**	.05	.29**	-.12
2. Sociotropy	.24*	.24*	.63***	.43***	.65***	.49***	.32***	.16	.55***	.28**	-.03	-.14
3. Autonomy	.53***	.53***	.37***	.22*	.42***	.41***	.11	.27**	.46***	.27**	.11	-.05
4. Disconnection and Rejection	.34***	.34***	.51***	.43***	.45***	.69***	.60***	.46***	.48***	.39***	.21*	-.40***
5. Social Isolation	.34***	.34***	.41***	.31***	.40***	.57***	.50***	.42***	.32***	.39***	.13	-.37***
6. Abandonment	.20*	.20*	.47***	.31***	.49***	.51***	.40***	.25**	.42***	.35***	.04	-.15
7. Defectiveness	.13	.13	.33***	.37***	.21*	.52***	.44***	.42***	.40***	.16	.15	-.26**
8. Emotional Deprivation	.33***	.33***	.39***	.35***	.32***	.51***	.49***	.29**	.37***	.31***	.30***	-.39***
9. Impaired Autonomy	.29***	.29***	.50***	.39***	.46***	.62***	.58***	.37***	.51***	.25**	.19*	-.27**
10.Failure	.16	.16	.34***	.31**	.28**	.47***	.42***	.33***	.38***	.14	.17	-.20*
11.Dependence	.24*	.24*	.43***	.38***	.36***	.53***	.49***	.32***	.45***	.20*	.18*	-.23*
12.Vulnerability to Harm	.34***	.34***	.49***	.28***	.55***	.57***	.55***	.28***	.45***	.30***	.11	-.26**

Note 1. *** $p \leq .001$, ** $p \leq .01$, * $p \leq .05$

Note 2. 13. Impaired Limits, 14. Insufficient Self-control, 15. Other Directedness, 16. Self-sacrifice, 17. Approval Seeking, 18. Overvigilance and Inhibition, 19. Pessimism, 20. Emotional Inhibition, 21. Punitiveness, 22. Unrelenting Standards, 23. Satisfaction of social support, 24. Presence of Stressful Life Events

Note 3. These table indicates the correlations results for non- clinical individuals.

3.4. Independent Samples T-Tests for Main Variables

Several independent sample t-tests were conducted to evaluate the group differences in terms of groups (depressed patients and nonclinical individuals) and gender (woman and men) on the measures of depression, sociotropy, autonomy, domains of early maladaptive schemas, subdomains of early maladaptive schemas, satisfaction of social support and effects of stressful life events.

3.4.1. Group Differences on Dependent Variables

In terms of groups (depressed patients and nonclinical individuals), group differences were found to be significant on the following analyses:

There was a significant group difference on depression scores [$t(213) = 14.45$, $p \leq .001$]. Depressed patients ($M = 24.09$; $SD = 9.76$) had higher depression score than nonclinical individuals ($M = 7.73$; $SD = 6.62$).

Independent samples t-tests were used to test whether there were any differences between depressed patients and nonclinical individuals on sociotropy and autonomy. There was a significant difference of group on sociotropy [$t(213) = 6.04$, $p \leq .001$]. Depressed patients ($M = 1839.09$; $SD = 389.20$) were more sociotropic than nonclinical individuals ($M = 1517.50$; $SD = 390.79$). However, there was no significant difference of groups on autonomy [$t(213) = 1.40$, $p = n.s.$].

Independent samples t-tests were used to test whether there were any differences between depressed patients and nonclinical individuals on early maladaptive schema domains; disconnection and rejection, impaired autonomy and performance, impaired limits, other directedness, overvigilance and inhibition. There was a significant difference of group on disconnection and rejection [$t(213) = 10.29$, $p \leq .001$]. Depressed Patients ($M = 65.21$; $SD = 20.39$) had significantly higher scores on disconnection and rejection than nonclinical individuals ($M = 40.86$; $SD = 13.80$). In addition, there was a significant difference of group on impaired autonomy and performance [$t(213) = 9.89$, $p \leq .001$]. Depressed Patients ($M = 58.79$; $SD = 17.39$) had

significantly higher scores on impaired autonomy schema than nonclinical individuals ($M = 37.96$; $SD = 13.29$). Also, there was a significant difference of group on impaired limits [$t(213) = 4.12$, $p \leq .001$]. Depressed Patients ($M = 25.83$; $SD = 6.68$) had significantly higher scores on impaired limits schema than nonclinical individuals ($M = 22.10$; $SD = 6.58$). Adding to this, there was a significant difference of group on other directedness [$t(213) = 7.69$, $p \leq .001$]. Depressed Patients ($M = 43.49$; $SD = 9.03$) had significantly higher scores on other directedness schema than nonclinical individuals ($M = 34.17$; $SD = 8.72$). Lastly, there was a significant difference of group on overvigilance and inhibition [$t(213) = 6.75$, $p \leq .001$]. Depressed Patients ($M = 65.82$; $SD = 14.30$) had significantly higher scores overvigilance and inhibition schema than nonclinical individuals ($M = 53.03$; $SD = 13.48$).

Independent samples t-tests were used to test whether there were any differences between depressed patients and nonclinical individuals on subdomain early maladaptive schemas; emotional deprivation, abandonment, defectiveness, social isolation, failure, dependence, vulnerability to harm, , insufficient self-control, self-sacrifice, approval seeking, unrelenting standards, pessimism, emotional inhibition and punitiveness. There was a significant difference of groups on emotional deprivation schema [$t(213) = 8.31$, $p \leq .001$]. Depressed patients ($M = 15.71$; $SD = 6.57$) had significantly higher scores emotional deprivation than nonclinical individuals ($M = 9.28$; $SD = 4.65$). There was a significant difference of groups on abandonment [$t(213) = 8.85$, $p \leq .001$]. Depressed patients ($M = 14.54$; $SD = 6.25$) had significantly higher scores abandonment schema than nonclinical individuals ($M = 8.49$; $SD = 3.41$). There was a significant difference of groups on defectiveness [$t(213) = 6.80$, $p \leq .001$]. Depressed patients ($M = 14.48$; $SD = 6.86$) had significantly higher scores defectiveness schema than nonclinical individuals ($M = 10.14$; $SD = 4.45$). There was a significant difference of groups on social isolation [$t(213) = 8.18$, $p \leq .001$]. Depressed patients ($M = 19.47$; $SD = 6.30$) had significantly higher scores social isolation schema than nonclinical individuals ($M = 12.94$; $SD = 5.37$). There was a significant difference of groups on failure [$t(213) = 7.51$, $p \leq .001$]. Depressed patients ($M = 17.36$; $SD = 6.54$) had significantly higher scores failure schema than nonclinical individuals ($M = 11.52$; $SD = 4.59$). There was a significant difference of groups on dependence [$t(213) = 9.43$, $p \leq .001$]. Depressed patients ($M = 25.81$; $SD = 8.99$) had significantly higher scores dependence schema

than nonclinical individuals ($M = 15.78$; $SD = 6.45$). There was a significant difference of groups on vulnerability to harm [$t(213) = 6.91$, $p \leq .001$]. Depressed patients ($M = 15.62$; $SD = 5.84$) had significantly higher scores vulnerability to harm schema than nonclinical individuals ($M = 10.65$; $SD = 4.63$). There was a significant difference of groups on insufficient self-control [$t(213) = 4.12$, $p \leq .001$]. Depressed patients ($M = 25.83$; $SD = 6.68$) had significantly higher scores insufficient self-control schema than nonclinical individuals ($M = 22.10$; $SD = 6.58$). There was a significant difference of groups on self-sacrifice [$t(213) = 5.95$, $p \leq .001$]. Depressed patients ($M = 19.72$; $SD = 4.92$) had significantly higher scores self-sacrifice schema than nonclinical individuals ($M = 15.77$; $SD = 4.81$). There was a significant difference of groups on approval seeking [$t(213) = 6.75$, $p \leq .001$]. Depressed patients ($M = 23.78$; $SD = 6.32$) had significantly higher scores approval seeking schema than nonclinical individuals ($M = 18.40$; $SD = 5.32$). There was a significant difference of groups on unrelenting standards [$t(213) = 4.15$, $p \leq .001$]. Depressed patients ($M = 10.68$; $SD = 3.64$) had significantly higher scores unrelenting standards schema than nonclinical individuals ($M = 8.56$; $SD = 3.85$). There was a significant difference of groups on pessimism [$t(213) = 7.93$, $p \leq .001$]. Depressed patients ($M = 16.62$; $SD = 5.92$) had significantly higher scores negativism schema than nonclinical individuals ($M = 10.91$; $SD = 4.57$). There was a significant difference of groups on emotional inhibition [$t(213) = 3.61$, $p \leq .001$]. Depressed patients ($M = 25.83$; $SD = 6.68$) had significantly higher scores emotional inhibition schema than nonclinical individuals ($M = 12.28$; $SD = 4.83$). There was a significant difference of groups on punitiveness [$t(213) = 3.16$, $p \leq .001$]. Depressed patients ($M = 23.81$; $SD = 5.92$) had significantly higher scores punitiveness schema than nonclinical individuals ($M = 21.28$; $SD = 5.87$).

An independent t-test between groups and socio stress variables were analyzed. According to the results, an independent t-test revealed a significant groups on satisfaction of social support [$t(213) = -5.33$, $p \leq .001$]. Depressed patients ($M = 5.91$; $SD = 2.99$) were lower satisfied about social support than nonclinical individuals ($M = 7.70$; $SD = 1.79$). Finally, there was a significant difference of groups on effects of stressful life events [$t(102) = -3.08$, $p \leq .001$].

Depressed patients ($M = 8.22$; $SD = 2.19$) experienced more stressful life events than nonclinical individuals ($M = 6.78$; $SD = 2.22$). The results of the independent sample t-test analyses are given below and in Table 3.3.

Table 3.3: Examination of group differences between depressed and nonclinical individuals on several DVs

Dependent Variables	Depressed Patients M (SD)	Nonclinical Individuals M (SD)	t (213)
<i>Depression</i>	24.09 (9.76)	7.73 (6.62)	14.45***
<i>Sociotropy</i>	1839.09 (389.20)	1517.50(390.79)	6.04***
<i>Autonomy</i>	1970.24 (438.41)	1888.36 (416.88)	1.40
<i>Disconnection and Rejection</i>	65.21 (20.39)	40.86 (13.80)	10.29***
Emotional deprivation	15.71 (6.57)	9.28 (4.65)	8.31***
Abandonment	14.54 (6.25)	8.49 (3.41)	8.85***
Defectiveness	14.48 (6.86)	10.14 (4.45)	6.80***
Social Isolation	19.47 (6.30)	12.94 (5.37)	8.18***
<i>Impaired Autonomy</i>	58.79 (17.39)	37.96 (13.29)	9.89***
Failure	17.36 (6.54)	11.52 (4.59)	7.51***
Dependence	25.81 (8.99)	15.78 (6.45)	9.43***
Vulnerability to harm	15.62 (5.84)	10.65 (4.63)	6.91***
<i>Impaired Limits</i>	25.83 (6.68)	22.10 (6.58)	4.12***
Insufficient self-control	25.83 (6.68)	22.10 (6.58)	4.12***
<i>Other Directedness</i>	43.49 (9.03)	34.17 (8.72)	7.69***
Self-sacrifice	19.72 (4.92)	15.77 (4.81)	5.95***
Approval Seeking	23.78 (6.32)	18.40 (5.32)	6.75***
<i>Overvigilance and Inhibition</i>	65.82 (14.30)	53.03 (13.48)	6.75***
Unrelenting Standards	10.68 (3.64)	8.56 (3.85)	4.15***
Pessimism	16.62 (5.92)	10.91 (4.57)	7.93***
Emotional Inhibition	25.83 (6.68)	12.28 (4.83)	3.61***
Punitiveness	23.81 (5.92)	21.28 (5.87)	3.16***
<i>Satisfaction of Social Support</i>	5.91 (2.99)	7.70 (1.79)	- 5.33***
<i>Effects of Stressful Life Events</i>	8.22 (2.19)	6.78 (2.22)	3.08***

*** $p \leq .001$, ** $p \leq .01$, * $p \leq .05$

3.4.2. Gender Differences on Dependent Variables

In terms of differences between woman and men on depression, sociotropy, autonomy, domains of early maladaptive schemas, subdomain of early maladaptive schemas, satisfaction of social support and effects of stressful life events an independent t-test was conducted both depressed patients and nonclinical individuals. The results of the independent sample t-test analyses are given below and in Table 3.4.

According to results, differences between woman and men on depression were no significant for both depressed patients [$t(103) = -0.04$, $p = \text{n.s.}$] and nonclinical individuals [$t(108) = -1.35$, $p = \text{n.s.}$].

There was a significant difference between woman and men in terms of autonomy personality only for depressed patients [$t(103) = 2.17$, $p \leq .05$]. Woman ($M = 2033.45$; $SD = 432.01$) tend to have higher scores in autonomy than men ($M = 1838.24$; $SD = 428.14$). But, there was no significant gender difference on sociotropy [$t(103) = 1.66$, $p = \text{n.s.}$] for depressed patients. Similarly, gender differences were not found to be significant on neither sociotropy [$t(108) = .74$, $p = \text{n.s.}$] nor autonomy [$t(108) = .90$, $p = \text{n.s.}$] for nonclinical individuals.

There was no significant gender difference on Early Maladaptive Schema domains for both depressed patients and nonclinical individuals. For depressed patients; disconnection and rejection [$t(103) = -1.24$, $p = \text{n.s.}$], impaired autonomy [$t(108) = -1.30$, $p = \text{n.s.}$], impaired limits [$t(108) = -.40$, $p = \text{n.s.}$], other directedness [$t(108) = .64$, $p = \text{n.s.}$], overvigilance and inhibition [$t(108) = -.95$, $p = \text{n.s.}$] and for healthy people, disconnection and rejection [$t(108) = -.71$, $p = \text{n.s.}$], impaired autonomy [$t(103) = -.33$, $p = \text{n.s.}$], impaired limits [$t(108) = -.21$, $p = \text{n.s.}$], other directedness [$t(108) = -.81$, $p = \text{n.s.}$], overvigilance and inhibition [$t(108) = -1.21$, $p = \text{n.s.}$]

Independent samples t-tests were used to test whether there were any differences between women and men on specific Early Maladaptive Schemas. More specifically, in depressed patients, there was a gender difference only on emotional deprivation [$t(103) = -1.99$, $p \leq .05$] and emotional inhibition [$t(103) = -2.79$, $p \leq .01$] for depressed patients, respectively. Men ($M = 17.53$; $SD = 6.04$) had higher emotional deprivation score than women ($M = 14.01$; $SD = 6.68$) and men ($M = 16.59$; $SD = 3.96$) had higher

emotional inhibition score than women ($M = 13.79$; $SD = 5.16$). However, the other specific schemas were no significant; abandonment [$t(103) = -.52$, $p = n.s.$], defectiveness [$t(103) = -1.02$, $p = n.s.$], social isolation [$t(103) = -.33$, $p = n.s.$], failure [$t(103) = -.55$, $p = n.s.$], dependence [$t(103) = -.46$, $p = n.s.$], vulnerability to harm [$t(103) = -1.36$, $p = n.s.$], insufficient self-control [$t(103) = -.40$, $p = n.s.$], self-sacrifice [$t(103) = 1.35$, $p = n.s.$], approval seeking [$t(103) = -.12$, $p = n.s.$], unrelenting standards [$t(103) = -.50$, $p = n.s.$], pessimism [$t(103) = .42$, $p = n.s.$], and punitiveness [$t(103) = -.15$, $p = n.s.$]. As for nonclinical individuals, there was a gender differences only on punitiveness [$t(108) = -2.13$, $p \leq .05$] and unrelenting standards [$t(108) = -1.89$, $p \leq .05$] for nonclinical individuals, respectively. Men ($M = 23.03$; $SD = 6.54$) had higher punitiveness score than women ($M = 20.49$; $SD = 5.41$). Similarly, men ($M = 9.59$; $SD = 4.21$) had higher unrelenting standards score than women ($M = 8.11$; $SD = 3.61$). However, the other specific schemas were no significant; emotional inhibition [$t(108) = .58$, $p = n.s.$], emotional deprivation [$t(108) = .58$, $p = n.s.$], abandonment [$t(108) = -1.48$, $p = n.s.$], defectiveness [$t(108) = -1.31$, $p = n.s.$], social isolation [$t(108) = 1.24$, $p = n.s.$], failure [$t(108) = -.54$, $p = n.s.$], dependence [$t(108) = -1.07$, $p = n.s.$], vulnerability to harm [$t(108) = 1.08$, $p = n.s.$], insufficient self-control [$t(108) = -.21$, $p = n.s.$], self-sacrifice [$t(108) = -1.58$, $p = n.s.$], approval seeking [$t(108) = .10$, $p = n.s.$] and pessimism [$t(108) = .10$, $p = n.s.$].

At last, there was no significant gender difference on socio – stress variables for both depressed patients and healthy people. Neither satisfaction of social support nor effects of stressful life events were significant for depressed patients [$t(103) = .98$, $p = n.s.$], [$t(70) = .87$, $p = n.s.$] respectively. Similarly, neither satisfaction of social support nor effects of stressful life events were significant for nonclinical individuals [$t(108) = .78$, $p = n.s.$], [$t(30) = -.34$, $p = n.s.$] respectively.

Table 3.4: Examination of gender differences between depressed and nonclinical individuals on several DVs

Dependent Variables	Depressed Patients			Nonclinical Individual		
	Women M (SD)	Men M (SD)	t (103)	Women M (SD)	Men M (SD)	t (108)
<i>Depression</i>	24.07 (10.03)	24.15 (6.62)	- 0.04	7.16 (5.04)	9.00 (9.20)	- 1.35
<i>Sociotropy</i>	1882.32 (396.19)	1748.82 (363.31)	1.66	1535.86 (369.67)	1476.50 (437.44)	.74
<i>Autonomy</i>	2033.45 (432.00)	1838.24 (428.14)	2.17*	1912.30 (383.57)	1834.85 (485.16)	.90
<i>Disconnection and Rejection</i>	63.51 (20.65)	68.76 (19.67)	- 1.24	40.24 (12.75)	42.26 (16.01)	-.71
Social Isolation	19.32 (6.38)	19.76 (6.24)	- 0.33	8.92 (4.61)	10.09 (4.69)	1.24
Abandonment	14.32 (6.34)	15.00 (6.15)	- 0.52	8.17 (2.93)	9.21 (4.27)	-1.48
Defectiveness	15.01 (6.81)	16.47 (6.96)	- 1.01	9.78 (3.55)	10.97 (5.98)	-1.31
Emotional deprivation	14.85 (6.68)	17.53 (6.04)	- 1.99*	13.37 (5.33)	12.00 (5.41)	-1.22
<i>Impaired Autonomy</i>	57.27 (17.70)	61.97 (16.54)	- 1.30	37.68 (12.75)	38.59 (14.61)	-.33
Failure	17.11 (6.74)	17.88 (6.54)	- 0.55	11.37 (4.50)	11.88 (4.85)	-.54
Dependence	25.07 (9.43)	27.35 (7.92)	- 1.22	15.34 (6.04)	16.76 (7.27)	-1.07
Vulnerability to harm	15.08 (6.27)	10.74 (4.76)	- 1.36	10.97 (4.72)	9.94 (4.43)	1.08
<i>Impaired Limits</i>	25.65 (6.89)	26.21 (6.31)	- 0.40	22.01 (6.47)	22.29 (6.92)	-.21
Insufficient self-control	25.65 (6.88)	26.21 (6.31)	- 0.40	22.01 (6.47)	22.29 (6.92)	-.21
<i>Other Directedness</i>	43.89 (9.65)	42.68 (7.64)	0.64	33.72 (8.80)	35.18 (8.60)	-.81
Self-sacrifice	20.17 (5.36)	23.88 (5.79)	1.35	15.28 (4.62)	16.85 (5.14)	-1.58
Approval Seeking	23.72 (6.60)	23.88 (5.79)	- 0.12	23.78 (6.32)	18.40 (5.32)	.10
<i>Overvigilance and Inhibition</i>	64.90 (15.50)	67.73 (13.35)	- 0.95	52.00 (12.92)	55.35 (14.60)	-.121
Unrelenting Standards	10.56 (3.69)	10.94 (3.58)	- 0.50	8.11 (3.61)	9.59 (4.21)	-1.89*
Pessimism	16.79 (5.95)	16.26 (5.93)	0.42	10.95 (4.56)	10.85 (4.65)	.10
Emotional Inhibition	13.79 (5.16)	12.28 (4.83)	- 2.79**	12.46 (4.77)	11.88 (5.00)	.58
Punitiveness	23.76 (6.41)	23.94 (4.82)	- 0.15	20.49 (5.41)	23.03 (6.54)	-2.13*
<i>Satisfaction of Social Support</i>	6.11 (2.90)	5.50 (3.18)	.98	7.79 (1.89)	7.50 (1.56)	.78
<i>Effects of Stressful Life Events</i>	8.35 (2.08)	7.83 (2.53)	.87	6.70 (2.12)	7.00 (2.60)	-.34

***p ≤ .001, **p ≤ .01, *p ≤ .05

3.5. Analysis of Variance (ANOVA)

In order to determine whether depressed patients were different from nonclinical individuals in terms of marital status, working status and received psychological treatment previously, three separate one-way ANOVA's were conducted. One-way ANOVA's results for these factors are displayed in Table 3.5.

3.5.1. One Way ANOVA's for Marital Status, Working Status and Received Psychological Treatment Previously on Depression

The effect of marital status on depression for depressed patients was significant [$F(2, 102) = 3.12, p \leq .05$]. Post hoc analyses using Bonferroni test revealed that divorced or widowed individuals ($M = 28.44, SD = 11.59$) had significantly higher depression scores than married individuals ($M = 22.16, SD = 9.04$). On the other hand, married ($M = 22.16, SD = 9.04$) and single individuals ($M = 24.97, SD = 9.21$) did not significantly differ from each other. Furthermore, the effect of marital status on depression for nonclinical individuals was significant [$F(2, 107) = 7.19, p \leq .001$]. Post hoc analyses using Bonferroni test revealed that divorced or widowed individuals ($M = 17.00, SD = 16.20$) had significantly higher depression scores than married ($M = 7.68, SD = 6.28$) and single ($M = 6.79, SD = 4.41$) individuals. But then, married ($M = 7.68, SD = 6.28$) and single ($M = 6.79, SD = 4.41$) individuals did not significantly differ from each other.

The result for the one way ANOVA indicated a significant working status for only depressed patients, [$F(2, 102) = 3.33, p \leq 0.05$]. According to the Bonferroni post-hoc results, patients who reported working status as never worked ($M = 28.94, SD = 8.62$) had significantly higher depression scores from patients who reported as working currently ($M = 21.95, SD = 9.10$) and patients who reported as not working currently ($M = 24.06, SD = 9.88$). While, the effect of working status on depression for nonclinical individuals was not significant [$F(2, 107) = 0.04, p \leq n.s.$].

A significant receiving psychological treatment previously was observed for the depression score only for nonclinical individuals [$F(3, 106) = 3.40, p \leq 0.05$], whereas for depressed patients [$F(3, 101) = 0.40, p \leq n.s.$]. To determine which types of treatment are significantly different from each other on depression for nonclinical individuals,

post-hoc tests (Bonferroni) were conducted. The Bonferroni post hoc analysis revealed that individuals received both pharmacotherapy and psychotherapy previously ($M = 18.5$, $SD = 19.96$) scored significantly higher depression from individuals received only pharmacotherapy ($M = 7.91$, $SD = 5.39$), individuals received only psychotherapy ($M = 7.14$, $SD = 1.95$) and individuals received no treatment ($M = 7.26$, $SD = 5.66$). However, individuals received only psychopharmacology, only psychotherapy and no treatment did not significantly different from each other.

Table 3.5: One Way ANOVAs results for marital status, working status and received psychological treatment previously on depression

	Depressed Patients				Nonclinical Individuals			
	M	SD	F	df	M	SD	F	df
<i>Marital Status</i>			3.12*	2, 102			7.19***	2, 107
Single	24.97	9.21			6.79	4.41		
Married	22.16	9.04			7.68	6.28		
Divorced or Widowed	28.44	11.59			17.00	16.20		
<i>Working Status</i>			3.33*	2, 102			.05	2, 107
Never worked	28.94	9.62			7.96	9.66		
Working currently	21.95	9.10			7.76	5.49		
Not working currently	24.06	9.88			7.44	5.60		
<i>Received Psychological Treatment Previously</i>			.40	3, 101			4.00*	3, 106
Pharmacotherapy	23.24	9.46			7.91	5.39		
Psychotherapy	22.00	11.73			7.14	1.95		
Both of them	25.53	12.60			18.50	19.96		

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

3.5.2. Two Way ANOVA for Groups and Stressful Life Events on Depression

A 2 x 2 ANOVA of group (depressed patients; nonclinical individuals) and presence of stressful life events (yes, no) on depression was found a significant main effect of both variables. Group difference was significantly related with depression, [$F(1, 211) = 152.92, p \leq .001, \eta^2 = .42$], in a way that depressed patients ($M = 23.65, SD = .86$), reported more depression scores than nonclinical individuals ($M = 8.61, SD = .96$). Besides, presence of stressful life events was significantly related to depression, [$F(1, 211) = 7.39, p \leq .01, \eta^2 = .03$], in that, individuals experienced stressful life events ($M = 17.78, SD = .87$) reported more depression scores than individuals inexperienced stressful life events ($M = 14.48, SD = .85$). But, there was no found interaction effect (see figure 3.1) between group and presence of stressful life events. The results were presented in Table 3.6.

Table 3.6: Two Way ANOVA results

	df	F	η^2
Resources			
<i>Depression</i>			
Group	1	152.92***	.42
Presence of stressful life events	1	7.39**	.03
Groups * Presence of stressful life events	1	.56	.00

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

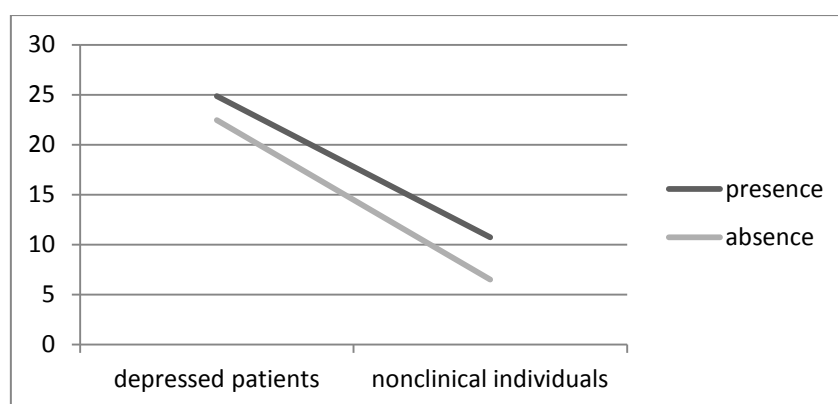


Figure 3.1: Group types and presence of stressful life events.

3.6. Regression Analyses

In order to examine the associated factors of depression regression analyses were performed two times both depressed patients and nonclinical individuals. In this respect, three sets of hierarchical multiple regression analyses were conducted to examine the association among the variables of the study. These sets includes firstly (i) control variables (satisfaction of social support and presence of stressful life events, (ii) personality, (iii) five schema domains of early maladaptive schemas (EMS) and more specifically fourteen specific early maladaptive schema subdomains related to domains.

Moreover, simple linear regression analyses were conducted to examine which EMS domains and subdomains were predict to both sociotropy personality and autonomy personality.

3.6.1. Regression Analyses Including Social Support-Stress Variables, Sociotropy, Autonomy and Early Maladaptive Schema Domains on Depression for Depressed Patients and Nonclinical Individuals

After controlling social support-stress variables; satisfaction of social support (i.e., from family, friends and the others) and presence of stressful life events (i.e. financial problems, problems with couple), sociotropy and autonomy personality of were entered into the equation on the second step. Finally, the factors of the five schema domains of early EMS (disconnection and rejection, impaired autonomy and performance, impaired limits, other directedness, overvigilance and inhibition) were entered into the equation on the third step. In all analyses, “Enter method” is used. The results of the the results of the standardized regression coefficients (Beta), t value, F change and R^2 , for each step was seen in table 3.7 for both samples.

3.6.1.1. Regression Analyses Including Social Support-Stress Variable, Sociotropy Autonomy Personality and Early Maladaptive Schema Domains on Depression for Depressed Patients

Hierarchical regression analyses run for the depression revealed that, among the control variables, low satisfaction of social support had a significant association with depression, ($\beta = -.22$, $t(102) = -2.20$, $p \leq .05$) and this variable explained 7 % of the variance ($F[2, 102] = 3.13$, $p \leq .05$).

On the second step, only sociotropy ($\beta = .25$, $t(100) = 2.35$, $p \leq .05$) was found to be significantly associated with depression, and increased the explained variance to 11 % ($F[2, 100] = 2.79$, $p \leq .05$).

On the third step, in terms of schema domains of EMS, only impaired autonomy and performance schema domain which is including those failure, dependence and vulnerability to harm schemas ($\beta = .34$, $t(95) = 3.30$, $p \leq .05$), was found to be significantly associated with depression, and these schema domain increased the explained variance to 29% ($F[5,95] = 4.88$, $p \leq .001$).

Hence, these results revealed that depressed patients who had unsatisfied of social support, had sociotropy personality and stronger impaired autonomy schema domain had higher scores of depression.

3.6.1.2. Regression Analyses Including Social Support-Stress Variable, Sociotropy Autonomy Personality and Early Maladaptive Schema Domains on Depression for Non-Clinical Individuals

Hierarchical regression analyses run for the depression revealed that, presence of stressful life events had a significant association with depression, ($\beta = .28$, $t(107) = 3.04$, $p \leq .01$) and this variable explained 9 % of the variance ($F[2, 107] = 5.55$, $p \leq .01$).

Table 3.7: Social support-stress variables, sociotropy autonomy and early maladaptive schema domains associated with depression (3rd set of Regression Analyses).

Depressed Patients						Nonclinical Individuals				
Predictors in set	F for set	t	df	β	R2	F for set	t	df	β	R2
Dependent Variable: DEPRESSION										
<i>I. Control Variable</i>	3.13*		2, 102		.07	5.55**		2, 107		.09
Satisfaction of Social support		-2.20*		-.22			-1.06		-.10	
The presence of stressful life events		.76		.08			3.05**		.28	
<i>II. Personality</i>	2.79*		2, 100		.11	2.50		2, 105		.14
Sociotropy		2.36*		.25			2.00		.20	
Autonomy		-1.22		-.13			-1.67		-.16	
<i>III. EMS Domain</i>	4.88***		5, 95		.29	2.34*		5, 100		.23
Disconnection and Rejection		-.01		-.00			1.90*		.30	
Impaired Autonomy and Performance		2.30*		.34			.33		.05	
Impaired Limits		.12		.02			-.04		-.01	
Other Directedness		-1.03		-.13			1.33		.18	
Overvigilance and Inhibition		1.76		.25			-.91		-.14	
Note-1. ***p ≤ .001, **p ≤ .01, *p ≤ .05										

On the second step, neither sociotropy nor autonomy was found to be significantly associated with depression, though this sociotropy - autonomy personality totally explained variance to 14 % ($F [2, 105] = 2.50, p \leq .05$).

On the third step, in terms of schema domains of EMS, only disconnection and rejection schema domain which is including those emotional deprivation, abandonment, defectiveness, social isolation schemas ($\beta = .30, t (100) = 1.90, p \leq .05$), was found to

be significantly associated with depression, and these schema domain increased the explained variance to 23% ($F [5, 100] = 2.84, p \leq .05$).

Thereby, these results revealed that nonclinical individuals who experienced stressful life events and had stronger disconnection rejection schema domain might be develop depression.

3.6.2. Regression Analyses Including Socio Support - Stress Variables, Sociotropy Autonomy Personality and Each Early Maladaptive Schema Subdomains on Depression for Depressed Patients

To begin with, after controlling the social support - stress variables which includes satisfaction of social support (i.e., from family, friends and the others) and presence of stressful life events (i.e. financial problems, problems with couple), on the second step, sociotropy and autonomy personality were entered into the equation. Finally, the factors of subdomains (table 3.8) related to each schema domains (disconnection and rejection: emotional deprivation, abandonment, defectiveness, social isolation; impaired autonomy and performance: failure, dependence, vulnerability to harm; impaired limits: insufficient self-control; other directedness: self-sacrifice, approval seeking; overvigilance and inhibition: unrelenting standards, pessimism, emotional inhibition and punitiveness) were entered into the equation on the third step at five different times. In order to analyze, first and second steps are kept constant but third step was changed 5 times in terms of fourteen subdomains associated under each five domains. In all analyses, “Enter method” was used. The results of the standardized regression coefficients (Beta), t value, F Change and R^2 for each step was seen in table 3.9 or both samples.

Table 3.8: Schema domains and early maladaptive schemas subdomains (Young, Kolosko, & Weishaar, 2003)

Disconnection And Rejection	Impaired Autonomy and Performance	Impaired Limits	Other Directedness	Overvigilance and Inhibition
Abandonment	Dependence	Insufficient Self Control	Self Sacrifice	Pessimism
Emotional Deprivation	Vulnerability to Harm		Approval Seeking	Emotional Inhibition
Defectiveness	Failure			Unrelenting Standards
Social Isolation				Punitiveness

3.6.2.1. Regression Analyses Including Social Support-Stress Variable, Sociotropy, Autonomy Personality and Early Maladaptive Schema Subdomains Related to Each Domains on Depression for Depressed Patients

Hierarchical regression analyses run for the depression scores of depressed patient revealed that, among the control variables, low satisfaction of social support had a significant association with higher depression, ($\beta = -.215$, $t(102) = -2.20$, $p \leq .05$) and this variable explained 5.8 % of the variance ($F[2, 102] = 3.13$, $p \leq .05$).

On the second step, only sociotropy ($\beta = .25$, $t(102) = 2.36$, $p \leq .05$) was found to be significantly associated with depression, and increased the explained variance to 10.8 % ($F[2, 100] = 2.79$, $p \leq .05$).

On the third step, in terms of subdomains of emotional deprivation, abandonment, defectiveness, social isolation which were categorized under disconnection and rejection, none subdomains were found to be significantly associated with depression, though these subdomains of emotional deprivation, abandonment, defectiveness, social isolation totally explained variance to 19 % ($F[4, 96] = 2.46$, $p \leq .05$).

In terms of subdomains of failure, dependence, vulnerability to harm which were categorized under impaired autonomy and performance, dependence and vulnerability to harm, Both dependence ($\beta = .34$, $t(100) = 2.70$, $p \leq .01$) and vulnerability to harm ($\beta = .25$, $t(100) = 2.47$, $p \leq .05$) were found to be significantly associated with depression, and explained variance to 29.1 % ($F[3, 97] = 8.34$, $p \leq .001$).

In terms of subdomain of insufficient self-control which was categorized under impaired limits, insufficient self-control ($\beta = .25$, $t(100) = 2.53$, $p \leq .05$) was found to be significantly associated with depression, and explained variance to 15.1 % ($F[1, 99] = 5.08$, $p \leq .05$).

In terms of subdomains of self-sacrifice, approval seeking which were categorized under other directedness, none subdomains were found to be significantly associated with depression, and though these subdomains explained variance to 11 % ($F[2, 98] = 0.11$, $p \leq .05$).

In terms of subdomains of unrelenting standards, pessimism, emotional inhibition and punitiveness which were categorized by overvigilance and inhibition, pessimism ($\beta = .26$, $t(100) = 2.76$, $p \leq .01$) and emotional inhibition ($\beta = .43$, $t(100) = 4.80$, $p \leq .001$) were found to be significantly associated with depression, and explained variance to 33.5 % ($F[4, 96] = 8.19$, $p \leq .001$).

Thus, these results revealed that depressed patients who had lower levels of satisfaction about social support, had sociotropy personality and who had stronger dependence, vulnerability to harm, insufficient self-control, pessimism, and emotional inhibition from specific early maladaptive schemas had higher scores of depression.

3.6.2.2. Regression Analyses Including Social Support-Stress Variable, Sociotropy, Autonomy Personality and Early Maladaptive Schemas Subdomains Related to Each Domains on Depression for Non-Clinical Individuals

Hierarchical regression analyses run for the depression revealed that, among social support-stress variable, presence of stressful life events had a significant association with depression, ($\beta = .28$, $t(109) = 3.04$, $p \leq .01$) and this variable explained 9 % of the variance ($F[2, 107] = 5.55$, $p \leq .01$).

On the second step, neither sociotropy nor autonomy was found to be significantly associated with depression, though sociotropy - autonomy personality traits totally explained variance to 13.5 % ($F[2, 105] = 2.50$, $p \leq .05$).

On the third step, in terms of subdomains of emotional deprivation, abandonment, defectiveness and social isolation which were categorized under disconnection and rejection, only defectiveness had a significant association with depression, ($\beta = .33$, $t(105) = 2.96$, $p \leq .01$) and this variable explained 26 % of the variance ($F[4, 101] = 4.24$, $p \leq .01$).

In terms of subdomains of failure, dependence, vulnerability to harm which were categorized under impaired autonomy and performance, only failure had a significant association with depression, ($\beta = .33$, $t(105) = 2.73$, $p \leq .01$) and this variable explained 22 % of the variance ($F[3, 102] = 3.63$, $p \leq .05$).

In terms of subdomain of insufficient self-control which was categorized under impaired limits, insufficient self-control was no found to be significantly associated with depression, though insufficient self-control totally explained variance to 14 % ($F[1, 104] = 0.88$, $p \leq .05$).

In terms of subdomains of self-sacrifice, approval seeking which were categorized under other directedness, only self-sacrifice had a significant association with depression, ($\beta = .45$, $t(105) = 4.58$, $p \leq .001$) and this variable explained 28 % of the variance ($F[2, 103] = 10.67$, $p \leq .001$).

In terms of subdomains of unrelenting standards, pessimism, emotional inhibition and punitiveness which were categorized under overvigilance and inhibition, pessimism had a significant association with depression, ($\beta = .25$, $t(105) = 2.44$, $p \leq .05$), and emotional inhibition had a significant association with depression, ($\beta = -.23$, $t(105) = -2.44$, $p \leq .05$), and punitiveness had a significant association with depression, ($\beta = .29$, $t(105) = 2.47$, $p \leq .001$), and these variables explained 26 % of the variance ($F[4, 101] = 4.36$, $p \leq .001$).

Therefore, these results revealed that non-clinical individuals who experienced stressful life events and had stronger defectiveness, failure, self-sacrifice, pessimism, emotional inhibition, punitiveness from specific schemas had higher scores of depression.

Table 3.9: Social support-stress variables, sociotropy, autonomy and early maladaptive schemas subdomains associated with depression (3rd set of Regression Analyses).

Predictors in set	Depressed Patients					Nonclinical Individuals				
	F for set	T	df	β	R2	F for set	t	df	β	R2
Dependent Variable: DEPRESSION										
<i>I. Control Variable</i>	3.13*		2, 102		.04	5.55*		2, 107		.09
Satisfaction of social support		-2.20*		-.22			-1.06		-.10	
The presence of stressful life events		.76		.08			3.05**		.28	
<i>II. Personality</i>	2.79*		2, 100		.07	2.50		2, 105		.14
Sociotropy		2.36*		.25			2.00		.20	
Autonomy		-1.22		-.13			-1.67		-.16	
<i>III. EMS subdomains</i>										
<i>Disconnection and Rejection</i>	2.46		4, 96		.19	4.24**		4, 101		.26
Social Isolation		1.01		.20			2.92**		.38	
Abandonment		1.20		.20			-.71		-.08	

Table 3.9: Continue

Defectiveness		.91		.18			2.09*		.26	
Emotional Deprivation		.38		.17			-.12		-.01	
<i>Impaired Autonomy and Performance</i>	8.34***		3, 97		.29	3.63*		3,102		.22
Failure		-.03		-.01			2.73**		.33	
Dependence		2.70**		.34			.39		.05	
Vulnerability to harm		2.47*		.25			-.97		-.11	
<i>Impaired Limits</i>	5.08*		1, 99		.15	.88		1, 104		.14
Insufficient self-control		2.25*		.16			.94		.10	
<i>Other Directedness</i>	.11		2, 105		.11	10.69***		2, 103		.28
Self-sacrifice		.04		.00			4.58***		.13	
Approval Seeking		.45		.18			-1.86		.15	
<i>Overvigilance and Inhibition</i>	8.19***		4, 96		.34	4.36**		4, 101		.26
Pessimism		2.76**		.26			2.44*		.25	
Emotional Inhibition		4.80***		.43			-2.44*		-.23	
Puniteveness		-.07		-.01			2.47*		.29	
Unrelenting Standards		-.11		-.11			-.27		-.03	
Note-1. ***p ≤ .001, **p ≤ .01, *p ≤ .05										

3.6.3. Regression Analyses Including Early Maladaptive Schema Domains and Subdomains on Sociotropy for Depressed Patients and Non-Clinical Individuals

In order to explore Early Maladaptive Schemas domains and subdomains related to sociotropy personality trait, simple linear regression analyses were performed for two different samples.

The results of the standardized regression coefficients (Beta), t value, F change and R², for each step was seen in tables 3.10 for both samples.

3.6.3.1. Regression Analyses Including Early Maladaptive Schema Domains and Subdomains on Sociotropy for Depressed Patients

Regression analyses run for the sociotropy revealed that, in terms of schema domains of EMS, other directedness ($\beta = .17$, $t(99) = 4.67$, $p \leq .001$) was found to be significantly associated with sociotropy and these variable explained 38% of the variance ($F[5, 99] = 12.23$, $p \leq .001$).

In terms of specific EMS, abandonment ($\beta = .24$, $t(90) = 2.01$, $p \leq .05$), self-sacrifice ($\beta = .19$, $t(90) = 2.04$, $p \leq .05$), and approval seeking ($\beta = .34$, $t(90) = 3.19$, $p \leq .01$) were found to be significantly associated with sociotropy. These variables explained 45.1% of the variance ($F[14, 90] = 5.31$, $p \leq .001$).

3.6.3.2. Regression Analyses Including Early Maladaptive Schema Domains and Subdomains on Sociotropy for Non-Clinical Individuals

Regression analyses run for the sociotropy revealed that, in terms of schema domains of EMS, disconnection and rejection ($\beta = -.32$, $t(104) = -2.77$, $p \leq .01$), impaired autonomy and performance ($\beta = .33$, $t(104) = 3.04$, $p \leq .01$), other directedness ($\beta = .56$, $t(104) = 5.70$, $p \leq .001$) were found to be significantly associated with sociotropy and these variable explained 47.3 % of the variance ($F[5, 104] = 18.65$, $p \leq .001$).

In terms of specific EMS's, approval seeking ($\beta = .56$, $t(95) = 5.09$, $p \leq .001$) and punitiveness ($\beta = .23$, $t(95) = 2.31$, $p \leq .05$) were found to be significantly associated with sociotropy. These variables explained 55.5 % of the variance ($F[14, 95] = 8.47$, $p \leq .001$).

Table 3.10: Schema domains and subdomains related to sociotropy

	Depressed Patients					Nonclinical Individuals				
Predictors in set	F for set	t	df	β	R2	F for set	t	df	β	R2
Dependent Variable: SOCIOTROPY										
<i>I.EMS Domains</i>	12.23***		5, 99		.38	18.65***		5, 104		.47
Disconnection and Rejection		.38		.05			-2.77**		-.32	
Impaired Autonomy and Performance		.63		.08			3.04**		.33	
Impaired Limits		-.73		-.08			-1.04		-.09	
Other Directedness		.47***		.47			5.70***		.56	
Overvigilance and Inhibition		.17		.17			1.53		.18	
<i>I. EMS Subdomains</i>	5.31***		14, 90		.45	8.47***		14, 95		.56
Social Isolation		.42		.05			-1.26		-.14	
Abandonment		2.01*		.34			-1.25		-.12	
Defectiveness		-.78		-.09			1.19		.14	
Emotional Deprivation		-.44		-.05			-1.90		-.17	
Failure		.05		.01			.43		.05	
Dependence		1.10		.14			.55		.06	
Vulnerability to harm		-.54		-.06			.87		.11	
Insufficient self-control		-.75		-.09			-1.73		-.15	
Self-sacrifice		2.04*		.19			.68		.06	
Approval Seeking		3.19**		.34			5.09***		.56	
Pessimism		-.96		-.10			.91		.09	
Emotional Inhibition		-.54		-.05			-.68		-.06	
Punitiveness		1.35		.15			2.31*		.23	
Unrelenting Standards		1.62		.17			.85		.07	

Note-1. ***p ≤ .001, **p ≤ .01, *p ≤ .05

3.6.4. Regression analyses including Early Maladaptive Schema Domains and Subdomain on Autonomy for Depressed Patients and Non-Clinical Individuals

In order to explore EMS domains and subdomains related to autonomy personality trait, regression analyses were performed for two different samples. The results of the standardized regression coefficients for each step was seen in tables 3.11.

3.6.4.1. Regression analyses including Early Maladaptive Schema Domains and Subdomains on Autonomy for Depressed Patients

Regression analyses run for the autonomy revealed that, in terms of schema domains of EMS, impaired autonomy and performance ($\beta = -.37$, $t(99) = -2.98$, $p \leq .01$), impaired limits ($\beta = .36$, $t(99) = 3.45$, $p \leq .001$), overvigilance and inhibition ($\beta = .41$, $t(99) = 3.38$, $p \leq .001$) were found to be significantly associated with autonomy and these variable explained 39 % of the variance ($F[5, 99] = 12.71$, $p \leq .001$).

In terms of specific EMS, insufficient self-control ($\beta = .32$, $t(90) = 2.75$, $p \leq .01$), self-sacrifice ($\beta = .20$, $t(90) = 2.08$, $p \leq .05$), and punitiveness ($\beta = .27$, $t(90) = 2.39$, $p \leq .05$) were found to be significantly associated with autonomy. These variables explained 43.8 % of the variance ($F[14, 90] = 5.01$, $p \leq .001$).

3.6.4.2. Regression analyses including Early Maladaptive Schema Domains and Subdomains on Autonomy for Non-Clinical Individuals

Regression analyses run for the autonomy revealed that, in terms of schema domains of EMS, impaired autonomy and performance ($\beta = -.28$, $t(104) = -2.32$, $p \leq .05$), impaired limits ($\beta = .40$, $t(104) = 4.33$, $p \leq .001$), overvigilance and inhibition ($\beta = .29$, $t(104) = 2.26$, $p \leq .05$) were found to be significantly associated with autonomy and these variable explained 35.4 % of the variance ($F[5, 104] = 11.42$, $p \leq .001$).

Table 3.11: Schema domains and subdomains related to autonomy

	Depressed Patients					Nonclinical Individuals				
Predictors in set	F for set	t	df	β	R2	F for set	t	df	β	R2
Dependent Variable: AUTONOMY										
<i>EMS Domain</i>	12.71***		5, 99		.39	11.42***		5, 104		.35
Disconnection and Rejection		-.87		-.11			.12		.12	
Impaired Autonomy		-2.98**		-.37			-2.32*		-2.32	
Impaired Limits		3.45***		.36			4.32***		4.33	
Other Directedness		1.77		.17			1.16		1.16	
Overvigilance and Inhibition		3.38***		.41			2.26*		2.26	
<i>EMS Subdomains</i>	5.01***		14, 90		.44	6.46***		14, 95		.49
Social Isolation		-.29		-.03			1.84*		.22	
Abandonment		-.25		-.03			-1.18		-.12	
Defectiveness		-.57		-.07			-1.09		-.13	
Emotional Deprivation		.29		.03			.42		.04	
Failure		-.48		-.05			-1.05		-.12	
Dependence		-1.60		-.21			-1.11		-.13	
Vulnerability to harm		-.74		-.08			.76		.10	
Insufficient self-control		2.75**		.32			3.71***		.35	
Self-sacrifice		2.08*		.20			.09		.01	
Approval Seeking		-.17		-.02			.62		.07	
Pessimism		.06		.01			-1.79*		-.19	
Emotional Inhibition		1.21		.12			1.58		.14	
Punitiveness		2.39*		.27			3.72***		.39	
Unrelenting Standards		1.63		.17			-.62		-.06	
Note-1. ***p $\leq$.001, **p $\leq$.01, *p $\leq$.05										

In terms of specific EMS, social isolation ($\beta = .22$, $t(95) = 1.84$, $p \leq .05$), insufficient self-control ($\beta = .35$, $t(95) = 3.71$, $p \leq .001$), pessimism ($\beta = -.19$, $t(95) = -1.79$, $p \leq .05$) and punitiveness ($\beta = .39$, $t(90) = 3.71$, $p \leq .001$) were found to be significantly associated with autonomy. These variables explained 48.8 % of the variance ($F[14, 95] = 6.46$, $p \leq .001$).

CHEAPTER IV

4. DISCUSSION

Early maladaptive schemas have investigated before in terms of its role on developing several psychopathologies. More specifically, early maladaptive schemas have been emphasized to provide vulnerability to depression. In addition to early maladaptive schemas, some personality factors have been mentioned in the literature as associated with depression. Among these variables, sociotropy and autonomy personality have highlighted. Although early maladaptive schemas and personality factors such as sociotropy and autonomy are suggested to explore, as known, relationship between these two factors have not been studied yet. Therefore, exploring the associations between variables on depression and which kinds of early maladaptive schemas are related to sociotropy and autonomy are aimed to investigated in the present study. In this regard, findings of the present study are discussed in the light of the current literature. Afterwards, strengths and limitations of the study are explained. Finally, clinical implications for future research are stated below.

In the present study, the general aims are initially examining possible relations of demographic variables which are gender, marital status, working status, having chronic disease, status of psychological treatment previously and other main variables (effects of stressful life events, satisfaction about social support, sociotropy - autonomy personality traits and early maladaptive schemas domains and subdomains).

Fourthly, examining the differences of presence of stressful life events, satisfaction about social support, sociotropy – autonomy personality traits, schema domains (i.e., impaired limits, impaired autonomy & performance, other directedness, overvigilance & inhibition, disconnection/rejection) and specific early maladaptive schemas subdomains (emotional deprivation, abandonment, defectiveness, social isolation, failure, dependence, vulnerability to harm, insufficient self-control, self-sacrifice, approval seeking, unrelenting standards, pessimism, emotional inhibition and punitiveness) on depression in both depressed patients and non-clinical individuals.

At last, in this study we aimed to compare EMS domains and schema subdomains of depressed patients with nonclinical individuals and determine which schema scores are related to sociotropy and autonomy personality traits.

Correlations between variables were found as expectedly. Almost all schemas correlated highly and statistically significantly with the depression and with each other of schemas. There were significant relationships between depression, sociotropy – autonomy and early maladaptive schemas domains and subdomains. Depression was positively associated with EMS domains and subdomains. In present study, there were found among sociotropy-depression relationship, however in literature there has not been found any study about these relations, since it has never been conducted.

It was expected that almost all schemas were associated with each other since they are mostly traced back to childhood environment and toxic experiences (Young, 2003). Besides, all these high scores of schemas also remind the cognitive triad of Beck (Beck 2005) who highlighted the connection between self, world and future resulting in several psychopathologies. Therefore, while EMS domains about impaired autonomy are associated with self, social isolation are associated with self and others, for instance. In other words, schema domains actually representing three triad were associated with each other. These connections between dimensions were still found in between EMS when controlling the severity of depression (Renner et al. 2012). As a result, correlations between variables are coherent with relevant literature.

4.1. Independent Samples T-Tests for Dependent Variables

T-test analysis were conducted to evaluate the group differences in terms of groups (depressed patients and nonclinical individuals) and gender (women and men) on the measures of depression, sociotropy, autonomy, domains of early maladaptive schemas, subdomains of early maladaptive schemas, satisfaction of social support and effects of stressful life events.

4.1.1 Group Differences on Dependent Variables

Group differences among depressed patients and nonclinical individuals were compared on dependent variables depression, sociotropy personality traits, autonomy personality trait, schema domains (i.e., impaired limits, impaired autonomy & performance, other directedness, overvigilance & inhibition, disconnection/rejection), specific early maladaptive schemas subdomains (emotional deprivation, abandonment, defectiveness, social isolation, failure, dependence, vulnerability to harm, insufficient self-control, self-sacrifice, approval seeking, unrelenting standards, pessimism, emotional inhibition and punitiveness), effects of stressful life events and satisfaction of social support. Several independent sample t-test was performed for both depressed patients and nonclinical individuals.

There was a significant group difference on depression and sociotropy scores. Depressed patients were more depressed than nonclinical individuals. This difference was expected since depressed patients had diagnosis of depression, their depression scores were expected to be higher than counterparts. In addition, depressed patients were more sociotropic than nonclinical individuals. Similar findings were found in the literature (Bieling & Alden, 2001; Fairbrother & Moretti, 1998; Lynch et al. 2000; Robins et al. 1997). Therefore, professionals should evaluate this personality type when patient with depression needs psychological treatment. Besides, on the basis of culture, while individualist societies have more heavily value of autonomy, collectivist societies place more importance to common identity and close social relationships (Brewer & Chen 2007). Also, some studies indicate that sociotropy does not have any function as an “universal” vulnerability to depressed mood in daily life (Stewart et al. 2004;

Swendsen & Compagnone 2000). Even though sociotropy may be considered as a trait, evidence that its severity may be partially determined by cultural factors. Based on all these results, when considering that Turkish people are collectivist community and display close social relationship, they might tend to be more sociotropic individuals.

In terms of EMS, depressed patients had higher scores from domains of disconnection and rejection, impaired autonomy and performance, other directedness and overvigilance and inhibition than non-clinical individuals. Similar group difference were found on all specific early maladaptive schemas which are emotional deprivation, abandonment, defectiveness, social isolation, failure, dependence, vulnerability to harm, insufficient self-control, self sacrifice, approval seeking, unrelenting standards, pessimism, emotional inhibition, punitiveness and defectiveness. Depressed patients had higher scores from these all schema subdomains than nonclinical individuals. Significant associations between group types (depressed patients and nonclinical individuals) and EMSs were consistent with literature (Lapsekili & Ak 2012; Riso et al. 2003). Lapseki's study shown that, people with diagnosis with unipolar depression had higher scores of from all specific schemas than control group. Similarly, according to Bağcıçek (2009), except punitiveness schema, all EMSs were found related to depression for more depressed patients than control group at the beginning of treatment.

Lastly, group types (depressed patients and nonclinical individuals) on satisfaction of social support and effects of stressful life events were examined. Depressed patients had lower satisfaction of social support and higher effects of stressful life events than nonclinical individuals. These results of group differences on satisfaction of social support (i.e. Vaananen et al. 2014) and effects of stressful life events (i.e. Sokratous, Anastasios et al. 2015; Gelder et al. 1989) are consisted with literature. Difference obtained from satisfaction of social support might be due to the fact that depressed patients either had lower support from others or perceived lower support from others owing to their pessimistic approach.

4.1.2. Gender Differences on Dependent Variables

Independent samples t-tests were used to test whether there were any differences between women and men on dependent variables; namely depression, sociotropy, autonomy, domains of early maladaptive schemas, subdomain of early maladaptive schemas, satisfaction of social support and effects of stressful life events an independent. Therefore, independent sample t-test was conducted both depressed patients and nonclinical individuals.

When examining the gender difference on depression, there were no significant difference between gender. One possible explanation of this finding is the unequal number of women and men. Insignificance occurred not only depressed patients ($N_w = 71$, $N_M = 34$) but also nonclinical individuals ($N_w = 76$, $N_M = 34$).

In terms of depressed patients, women were only significantly different from men on the basis of autonomy not on sociotropy. To begin with latter, sociotropy gender interaction was not observed in the present study which is inconsistent with the previous results (Akkaya 2009). Also, regarding former relationship, gender and autonomy was not expected in range. For example, most of studies were found that men were more autonomous than women (Bride, Bacchioni & Bagby 2005; Serinkan & Barutçu 2006). However, Akkaya (2009) found that there was no difference between woman and men. As shown, it does not have enough output to make certain comments whether gender is important variable in respect to autonomy personality trait. Therefore, further studies are encouraged to examine autonomous personality trait.

In point of EMS, men had higher scores from emotional deprivation and emotional inhibition schema than women in depressed patients. Besides, punitiveness and unrelenting standards schemas were had higher by male than woman for non-clinical individuals. As a possible explanation, these four schemas are mostly related actually independence, detachment and self reliance. Men are more rational rather than emotional and committed to strict life rules. Therefore, while working with men individuals, these emotional sides are needed to focus during intervention. Also perfectionistic attitude toward self might be at the therapy agenda while working with

men. Results of the present study showed that woman and men did not differ on their scores of other schemas.

4.2. ANOVA analysis variables on depression

To examine marital status, working status and recieved psychological treatment previously on depression, one way ANOVA's were conducted.

The effect of marital status on depression was significant that divorced or widowed patients had significantly higher depression scores than married for depressed patients. Similar with depressed patients, the effect of marital status on depression was significant that divorced or widowed non-clinical individuals had significantly higher depression scores than married. As being consistant in the literature (i.e. Rotterman 2007), marriage provides an important source of social support to men and women in later life (Arber 2004). Similarly, lack of couple support increased risk of depression due to loss of financial, emotional, physical, and instrumental support (Levenson et al. 1993, Mineau et al. 2002). Clinicians should be aware of marital status on impact of major depression. Result revealed that marriage might be rise their positive emotions (happiness, well being, intimacy, love) and couple support.

Adding to marital status, the effect of working status on depression was significant only for depressed patients. Patients who reported working status as never worked had significantly higher depression scores from patients who reported as working currently and patients who reported as not working currently. This result was expected that those patients suffering from more depression, since their resources might be less. Therefore working actively or in the past create opportunity to prevent obtaining higher scores (i.e. Cuijpers et al. 2012; Waddell et al. 2006). In other words, working might provide patients to social enviroment or kind of activity or income. Therefore, deprivation from these factors and increment of depression was associated.

In addition to working status, the effects received psychological treatment previously was significantly associated with depression only for nonclinical individuals. Nonclinical indivuals received both psychopharmacotherapy and psychotherapy

previously had higher depression from individuals received only psychopharmacotherapy, individuals received only psychotherapy and individuals received no treatment. Receiving both psychopharmacotherapy and psychotherapy previously and higher scores of depression could be explained the situation as being more chronic and more resistant to change. Therefore scores of these groups were higher than counterparts.

4.3. Multiple Regression Analysis on Depression

In order to examine the associated factors of depression, regression analyses were performed at two times for both depressed patients and nonclinical individuals. In this respect, three sets of hierarchical multiple regression analyses were conducted to examine the association among the variables of the study. These sets includes firstly (i) control variables which are satisfaction of social support variable (i.e..from family, friends and the others) and presence of stressful life events variable (i.e.. financial problems, problems with couple) (ii) sociotropy autonomy personality, (iii) five schema domains of early maladaptive schemas and more specifically fourteen specific early maladaptive schemas (EMS)

4.3.1. Depressed Patients

When looking at depression scores of depressed patients, lower satisfaction scores of social support were associated with higher depression. This result were consistent with previous literature (i.e. Clara et al. 2003; Eldeleklioğlu 2006; Grav, et al. 2011; Stice & Bearman 2001). Additionally, as could be seen among significance level, working with depressed patient social network (primarily working with their family) is so crucial. When considering behavioral intervention, promoting interaction can be supported through having some hobbies like painting, writing, going cinema, fishing and cooking. Also, acquisition of new skills improves confidence, and social interaction becomes more pleasurable. On the the other hand, whether patients reported the presence or absence of stressful life events were not meaningful. Inconsistent findings

about role of stress (Rodriguez et al. 2013; Rothschild 1999; Sadock & Sadock, 2002; Sokratous et al. 2015; Ünal et al. 2002) reveal that this variable is needed to be tested in the future studies.

Also, adding to satisfaction of social support variable, higher sociotropy scores were significantly associated with higher depression scores. This is commonly seen among other studies conducted with either depressed (Bieling and Alden, 2001; Fairbrother & Moretti 1998; Lynch et al. 2000; Robins et al. 1997) or non-depressed samples (Alford and Gerrity 2003; Mongrain & Blackburn 2005; Sato & McCann 2000). When considering depressed people are tend to be sociotropic individuals, these people are sensitive about interpersonal abandonment or rejection. Also, they might be weak getting of autocontrol. As expressed for sociotropic individuals, these individuals' life satisfaction and positive self-image depend on others (Gorski and Young 2002), deprivation of this needs were highly associated with higher depression.

After controlling social support-stress variable, and sociotropy-autonomy, specific early maladaptive schemas and EMS domains were still associated with depression scores. Among these schema domains, only higher impaired autonomy and performance were associated with higher depression. More specifically, among schema subdomains, higher vulnerability to harm scores, higher negativity and higher emotional inhibition were found to be significantly associated with higher depression scores. In terms of schema domains, this finding is consistent with earlier research on EMSs which is impaired autonomy and performance schema domain (i.e.. Halvorsen et al. 2009; Renner et al. 2012). Since they are under control by professionals, this domain might be activated. Moreover, an explanation of impaired autonomy and performance finding is that patients who had higher scores on this schema domain are typically unable to fulfill their responsibilities and stand by themselves. This domain is formed by deprivation of child's self-confidence in the family or failure to provide the self outside the family in case growing in a overprotective family (Young et al. 2003). To dealing with autonomy and performance schema domain, assertiveness training and behavioral modifications can be used in the process of treatment. In terms of specific EMSs, findings are consistent with earlier research on EMSs which are dependence subdomain (Colman 2010), vulnerability to harm subdomain (Calvete et. al., 2005;

Colmani 2010; Petrocelli et al. 2001a), insufficient self-control subdomain (Shah & Waller 2010), pessimism subdomain (Trincas 2014).

To begin with, dependence schema refers to inability to solve daily life problems without others help. Therefore, this schema is characterized by a fear of being abandoned or separated from important individuals in his or her life (Young, Klosko & Weishaar 2003). Because patients with this schema have difficulty in making decisions and expressing disagreement with others, they feel uncomfortable or helpless and exaggerate fears of being unable to care for themselves. Hence, lack of these maladaptive needs might be associated with depression in the present study. In therapy, especially, assertiveness training to build self-confidence and group therapy can also be helpful.

Further, high vulnerability to harm scores includes the importance of control perception (i.e. such as, trusting others, threat to uncontrollable situation) or expectation of disaster since they are anxious and fearful when encountered to uncontrollable situations such as health problem, financial problem (Young, Klosko & Weishaar 2003). It is also assumed that, they have catastrophizing thinking style (Beck 1979) and use frequently avoidance to struggle with this schema (Young, Klosko & Weishaar 2003). Patients with this schema may feel both exaggerate risk of danger and underestimate of their capacity of coping with problems which are related to control perception (i.e. such as, trusting others, threat to uncontrollable situation). Depression comorbidity with anxiety should be questioned in the presence of vulnerability to harm in the EMSs. Moreover, existence of vulnerability to harm and presence of dependence schema, such as found in the present study, is evaluated as essential for bad prognosis for these patients.

In addition, insufficient self-control is characterized by inability to achieve the personal goals and not be able to control emotions and impulses against frustration (Young, Klosko & Weishaar 2003). Since they have low self-worth and feel powerlessness, they project their feelings of incompetence into others as a way to avoid difficult emotions, or they may attempt to control others or their environment. Hence, this schema might also contribute to higher depression scores. Building a sense of competence is one of the most important step for patients with this schema in therapy.

Moreover, higher pessimism and depression relationship reveal that although depressed patients receive medical treatment, still their negativity continues. Because, their schema might be focused on expectation about something will happen such as disaster and negative life events (i.e. death, disappointment about career, problems with financial or interpersonal). To deal with pessimism, activity scheduling can be used to promote their mood and energy.

Besides, emotional inhibition was found significantly related to depression. This schema is associated with difficulties in emotional control which serves a kind of cognitive control (Young, Klosko & Weishaar, 2003). Although, emotional inhibition domain was not found significant in previous studies, this schema domain was significant in the present study due to cultural aspects about certain cultural beliefs such as demonstrating emotions to others can create harms. However, further elaboration in other studies are needed in respect to this schema subdomain. Patients with high scores on this schema can behave by a suppression of spontaneous feelings and impulses to avoid from real emotions. Due to, existing feelings is not processed or ignored or suppressed by their self, and needs of ego is not met, they can easily receive higher scores from depression. In this respect, helping these patients to express their emotions might decrease their depression scores. When working on disclosure to emotional aspects might be encouraged in psychotherapy.

Thus, these results revealed that depressed patients who had dissatisfaction about social support, had sociotropy personality and who had stronger impaired autonomy and performance schema domain, and also who had vulnerability to harm, pessimism and emotional inhibition schemas subdomains tended to develop depression. These findings are considered as important for clinical intervention as expressed above. Lastly, in terms of Beck's (1973) cognitive triad, these effective schemas are consistent with the cognitive model of depression. In other words, results revealed the distortion (such as being vulnerability) about self-perception and negativity to others or the World. Also, schema therapy approach emphasizes chronically settled and typically seen schema domains to deal with depression (Young 1999). It can be concluded that chronically settled and typically seen schema domains in depressed patients are impaired autonomy

and performance, vulnerability to harm, pessimism and emotional inhibition all of which should be sensitively evaluated in the process of psychotherapy.

4.3.2. Non-Clinical Individuals

When looking at depression scores of nonclinical individuals, presence of stressful life events scores were associated with higher depression. This result were consistent with previous literature (i.e. Rodriguez et al. 2013; Rothschild 1999; Sadock & Sadock, 2002; Sokratous et al. 2015; Ünal et al. 2002). Additionally, as reported by aforementioned studies, presence of stressful life events can be accepted as vulnerability factor for major depression in the sample of nonclinical individuals. Depends on the type and effect of stressors, different life events might contribute to depression. Adding to this, significant variance in stressful life events is significant for only nonclinical individuals. When looking at the frequency about -stressful life event reports, although there was an imbalance between depressed patients ($N_{yes}= 72$, $N_{no}= 33$) and non-clinical ($N_{yes}= 32$, $N_{no}= 78$) individuals, presence of stress was important for non-clinical individuals. In this respect, on the basis of types of problems (such as; bereavement, retirement, or illness) support groups for these people can be helpful. However, these variables should be investigated in the future studies with perceived severity of stress and frequency of stress at certain times.

The effect of presence of stress might be due to limited coping ability. Therefore, when nonclinical sample encounter stressful life events, giving psychoeducation about coping styles might seem crucial. On the other hand, the satisfaction of social support was not associated with depression in nonclinical individuals. This variable was significant in depressed patients. This finding shows that amount of satisfaction of social support was good enough in nonclinical individuals since they might have extensive network.

Moreover, adding to presence of stressful life events variable, neither sociotropy scores nor autonomy scores were significantly associated with depression scores. However, there have been controversial findings in the literature. According to some studies, presence of sociotropy personality trait was found significantly in non depressed sample (Alford and Gerrity 2003; Mongrain & Blackburn 2005; Sato &

McCann, 2000). In the present study, absence of these types of personality might be due to the nature of this sample. Therefore, sociotropy which is related to dependence and autonomy which is related to individuality or independence are not close to depression for nonclinical individuals.

After controlling social support-stress variable, and sociotropy-autonomy, EMS domains and subdomains were still associated with depression scores in nonclinical individuals. Among these schema domains, only higher disconnection and rejection, and more specifically among schema subdomains, higher defectiveness, higher failure, higher self sacrifice, higher pessimism, higher emotional inhibition and higher punitiveness were found to be significantly associated with higher depression scores. Though six schemas was found associated with depression, scores of depression has been found low ($M_{\text{Depression}} = 7.72$) for non-clinical individuals shows that these schemas might be a factor of well being to continue life in a balance. Thus, they do not feel depressed or not engage to psychological treatment.

In terms of schema domains, this finding is consistent with earlier research on disconnection and rejection EMS (i.e. Calvete et al. 2013; Halvorsen et al. 2009; Renner et al. 2012). An explanation of disconnection and rejection finding is that individuals whose score is high on this schema domain have concerns about developing reliable and satisfied relationships with other people (Young, Klosko & Weishaar 2003). It is reported that these individuals have experience about earlier traumatic life events or insecure attachment style. Generally, people's with this schema family origin is unsteady, abusive, cold, rejecting and isolated (Young, Klosko & Weishaar 2003).

In addition to disconnection-rejection domain, in terms of specific EMSs, present results are consistent with earlier research on EMS that defectiveness subdomain (Calvete et al. 2005; Colman 2010; Eberhart et al. 2011; Harris and Curtin 2002), failure subdomain (Calvete et al. 2005; Colman 2010; Petrocelli et al. 2001a; Renner et al. 2012), self sacrifice subdomain (Calvete et al. 2005) were associated with higher depression. On the other hand, emotional inhibition, punitiveness and pessimism subdomain have not been mentioned as important in the relevant literature.

To begin with, higher defectiveness demonstrate that, according to Young, Klosko & Weishaar (2003), schema has been formed by condescending family. When they become adults, these defects are seen either implicitly (selfishness, anger impulses,

unacceptable sexual desires) or explicitly (unpleasant physical appearance, clumsiness). These implicit and explicit clues can be considered throughout psychotherapy.

Moreover, failure schema refers to belief about inability (Young, Klosko & Weishaar 2003). This schema is also a symptom which seen together low self confidence on depression (Beck 1979). Individuals loss of their energy to deal with negative experiences which can result in possible depression (Seligman 1972). Continuity these negative experiences or emotions about failure can trigger a negative emotional reaction such as sadness which is main symptoms of depression.

Besides, higher vulnerability to harm schema is related with higher depression. However, this schema primarily includes anxiety emotion. In this respect, people with this schema both exaggerate risk of danger and underestimate of their capacity of coping with problems. Young, Klosko & Weishaar (2003) further defines four types of vulnerability; health and disease, danger, poverty and losing control. Type of health and disease refers to obsession, hypochondriac and panic attack, type of danger refers to fobia, type poverty refers to depression and type of losing control refers to panic attack or nervous breakdown. When considered the nature of schema, depression comorbidity with anxiety is encouraged to evaluate.

In addition, individuals with higher self sacrifice feel probably virtuous by disregarding their self. Instability of cost and benefits might lead to anger to others, because other's needs are priority by these people (Young, Klosko & Weishaar 2003). This schema can be worked by feeling of guilty, self expression (i.e. request or reject to something) and giving importance to self. Lack or littleness of these behaviors or thoughts can make them more depressed in nonclinical individuals.

Further, lower emotional inhibition demonstrate that, people having this schema avoid from environment where experiencing negative feelings (such as anger and aggression) or suppress positive impulse (such as happiness, emotions, sexual excitement) (Young, Klosko & Weishaar 2003). Negative relationship between this schema and depression has been shown that when emotional inhibition increases, depression scores decreases. One possible explanation can be that related questions can not be understood by participant. In addition, since depression as a psychopathologic

disorder can not be explained by presence of only one schema, there may be moderator variables between this schema and depression. As a final explanation, inhibition or suppression can be a coping strategy for depression.

Pessimism is associated with underestimation of positive aspects of life (Young, Klosko & Weishaar 2003). Also filtering, polarizing was used by individuals with this schema, because probably they focus mostly negative things instead of positive things. Since depression leads to negative thinking or feeling, and negative thinking or feeling makes individuals even more depressed, these relationship between pessimism and depression can be important for developing possible this disorder.

Finally, higher punitiveness demonstrate that it's a combination of being in the dismals, feeling of guilty, paying mistakes and thinking punishment (Young, Klosko & Weishaar 2003). Punitiveness can set individuals into a cycle of negative thinking; each thought worsening into a deeper, more hopeless frame of thinking. Also, catastrophizing thinking style which is stressed by Beck (1979) manipulates to depressed mood. Considering self-compassion as a way to deal with punitiveness is encouraged.

Thereby, these results revealed that nonclinical individuals who experienced stressful life events and had stronger disconnection and rejection, social isolation, defectiveness, vulnerability to harm, self sacrifice, emotional inhibition, punitiveness.

4.4. Regression Analysis of EMSs on Sociotropy and Autonomy

In order to explore Early Maladaptive Schemas domains and subdomains related to sociotropy and autonomy personality traits, regression analyses were performed for two different samples to examine EMSs on personality traits. This analysis has not been conducted before either with depressed patients or nonclinical individuals. Thus, this analysis about which EMS is related to sociotropy and autonomy has been exploratory for literature.

4.4.1. EMS on Sociotropy for depressed patients and nonclinical individuals

In point of sociotropy, depressed patients had higher EMS domain of other directedness, and subdomain of abandonment, self sacrifice, approval seeking on sociotropy. To begin with other directedness, results reveal that sociotropy was associated with the term of ‘dependency’. This evaluation is based on findings of Corral & Andrew’s (2014) study in which higher sociotropy scores indicated dependent personality trait. In that study, other directedness domain was related with dependent personality trait on convicted men. Therefore present results might illuminate dependent style of depressed patient due to other directedness schema. In addition it demonstrates that, people with this schema domain can be observed in thought and behavior with the influence of external things (oversensitive to others’ behavior), since having deprivation of some needs like love, approving or taking attention. Additionally, abandonment, self sacrifice and approval seeking schemas can explain that, they may sacrifice themselves to avoid possible abandonment and get approval by others. Also, similar to other directedness, Carr & Andrew (2010) stressed that abandonment was positively related with dependent personality disorder.

In addition to patient sample, higher scores of EMS domain of impaired autonomy and performance and other directedness, and subdomains of approval seeking and punitiveness were associated with higher scores on sociotropy in nonclinical individuals. However, lower scores on disconnection and rejection were associated with higher scores of sociotropy. Findings are similar to previous studies in respect to domain of impaired autonomy and performance (Schmidt 1994) and disconnection and rejection (Nordahl, Holthe & Haugum 2005; Petrocelli et al. 2001b; Reeves & Taylor 2007) that these studies evaluate these domains as an indication of dependent personality disorder. For nonclinical individuals, all these significant schemas were collected around fear of the rejection, taking an attention and love, having alike positive self perception and belief about they dependent on others owing to their mistakes.

4.4.2. EMS on Autonomy for depressed patients and nonclinical individuals

Concerning autonomy, lower scores of impaired autonomy and performance, and higher EMS domain scores on impaired limits, overvigilance and inhibition, and also subdomain of insufficient self-control, self sacrifice and punitiveness were associated with higher scores of autonomy in the sample of depressed patients. Besides, lower scores of of impaired autonomy and performance, and higher EMS domain scores on impaired limits, overvigilance and inhibition, and subdomain of social isolation, insufficient self-control, pessimism and punitiveness were related with higher scores of autonomy in the sample of nonclinical individuals. To begin with, lower scores of impaired autonomy was associated with higher scores of autonomy in both samples. This is expected that, these individuals are highly independent, trusting their self-confidence therefore they were likely to have higher autonomy which is defined as independence, assertion, detachment, locus of control, self-monitoring, self-reliance and self-sufficiency (Otacıoğlu 2008). In addition to this, in both samples higher scores of impaired limits and overvigilance inhibition were associated with higher scores of autonomy. In that case, individuals with deficiency in internal limits and freedom to express self were likely to have higher scores of autonomy which is composed of freedom (Otacıoğlu 2008). Therefore, increasing self awareness about how their autonomy or freedom destroys other sides might be crucial. Moreover, similar to this, insufficient self-control and punitiveness and higher autonomy relations again questioned self awareness of these individuals. In other words, these two schemas are look like the two edges of one line. Either deficiency in self-control on one line or not forgiving self about mistakes are associated with being autonomous. Lastly, social isolation and pessimism in nonclinical individuals and self sacrifice in depressed patients were associated with autonomy. However, findings about these schemas actually contradictory with autonomy definition. One of the most possible explanation might be that, these patient in reality may act as vice versa. In other words, they pretending opposite of having these schemas to fight through thinking, feeling and behaving which is defined an overcompensation coping strategy by Young (2003). To give an example of this strategy, patient with insufficient self-control may become overly self-controlled or self-disciplined, and patient with self sacrifice gives as little to others as possible. In short, knowledge of which coping strategies were used by these

people can have a mediator role in the relationship between EMSs and autonomy. Therefore, they may protect their autonomy by acting as a counterattack to real self.

As a result in generally, inability to meet core emotional needs throughout one's childhood and adolescence results in the development of one or more early maladaptive schemas. Hence, EMSs are the driving force behind the maladaptive behaviours with the evident in the personality (Young, Klosko & Weishaar 2003).

4.5. Strengths and Limitations of the Present Study

On the basis of these variables, studies have been conducted with either clinical sample or non-clinical samples which limits comparison. However this study is conducted with both clinical sample and nonclinical sample. This is an important strength. Regarding the limitations, firstly, for the present study is that all the measures were self-report. Second, it was not assessed Axis - II psychopathology. According Nordahl et al. (2005), patients with Axis-II psychopathology generally indicates high scores of EMSs. Accordingly, it is important to assess and control for Axis-II comorbidity when studying the relation between EMSs and depressive symptoms. Thirdly, gender distribution of both depressed sample and nonclinical sample were unequal and the number of difference between women and men limit findings. Furthermore, Young and colleagues (2003) emphasize the importance of coping with schemas by using schema avoidance and schema overcompensation that might be leading to non significance in some EMS scores despite these schemas are strong. Final limitation, cross-sectional study design is used in the present study. Hence, causal relationships could not be observed. Longitudinal studies are recommended to examine cause-effect relationships.

4.6. Clinical Implications and Future Directions

In the literature, there is no study investigating the relationship between EMSs, sociotropy autonomy personality traits and depression for both depressed patients and nonclinical individuals. Moreover, the findings of the present study appear to have some

implications for psychotherapy. More specifically, by exploring specific features to clinical and non-clinical sample, it is possible to determine the effective psychotherapeutic targets for the depression. Framework of CBT, cognitive techniques like practice and rehearsal, cognitive and behavioural patterns can be modified with collaboration of the clients. Depending on depression which is studied as main parameter of this research, CBT is quite effective approach of psychotherapy. As well as CBT, Young's schema therapy (1991) can be used on depression which is curative technique. In this approach, EMSs are transformed by early life experiences. Although EMSs help individuals to deal with early life difficulties, they are resistant to change day by day (Young, Klosko & Weishaar 2003). Therefore, in facing with changing schema, therapist should aware resistancy in the process of psychotherapy.

The current study provides further empirical support that specific EMSs are related to depressive symptoms. In this study there has been found some schema domains and subdomain associated with depression for both samples but particularly, emotional inhibition schema was significantly associated with depression on both depressed patients and nonclinical individuals with high *t* values. This *t* values demonstrated that this domain is so important for both samples. Therefore, clinicians are encouraged to dealt with this schema domain.

In terms of emotional inhibition, knowledge about emotion regulation is not only characterized currently with depressed people, but also following the recovery from this disorder (Ehring et al. 2008). This makes emotion regulation and emotional approach coping as important to use emotion expression and reappraisal instead of suppression or ignorance. Cognitions are related to this schema and depression may influence negatively emotion regulation strategies directly or indirectly. In this respect Beck's (1983) argue that emotional inhibition creates anger. So, focusing sense of feelings may be one of the most important step for being healthy.

More specifically, symptoms of depression and EMS relationship were investigated in the study belonging to Trincas and colleagues (2014). According to study, sadness emotion was predicted by negativity/pessimism; anhedonia by failure; self-harm by emotional deprivation and vulnerability to harm; illness or worthlessness by failure and negativity/pessimism; psychomotor retardation/restlessness by vulnerability

to harm and entitlement/grandiosity; and poor concentration by insufficient self-control. In psychotherapy, depending on which symptoms of depression are active, used techniques are interchangeable since symptoms differ according to EMSs.

In Bağcıçek's (2012) study while almost all schema domains were higher among depressed patients in compared with control groups at the beginning of treatment, depressed patients had higher scores obtained after treatment from just 5 schema subdomains (abandonment, emotional deprivation, vulnerability to harm, failure and subjugation schemas) than control group. This result showed that the importance of dealing with schema domains. In that study, higher scores obtained from these five schema subdomains were explained by difficulty to obtain change event though clients received treatment. Therefore, clinical psychologist should consider other psychotherapeutic techniques such as schema therapy to create schema change in the process of depression psychotherapy.

In terms of sociotropy, because of their predisposition, depressed patients with sociotropy are more easily adopt to therapists' suggestions or directions as related to relationship than autonomous depressives (Beck 1983). Also, sociotropic individuals are more prone to join group study process rather than individual and independent works than autonomous people (Barutçu & Öktem 2003). Psychotherapist should focus on patterns of maladaptive thinking and feeling and behaviour, when work with these sociotropic people since our study revealed some significant EMSs (approval seeking in both samples) and sociotropy relationship. Besides, decision making, assertiveness training and group psychotherapy can be helpful. Challenging dependent relationships may be unhealthy for these people and so clients should generally be avoided at the onset of therapy. Sociotropy and autonomy personality traits (Clark & Beck 1999) and EMSs (Young 2003) develop during childhood and maintain through lifespan. They are formed on early life periods. Therefore, because of permanent and resistant of this personality needs to long-term therapy or treatment.

Finally, lower social support satisfaction was associated with higher depression. Therefore, working with social support networks are essential in the process on depression treatment. Also, relationship between sociotropy-autonomy and depression revealed the importance of evaluation of sociotropy in the sample of depressed sample.

As for future directions, studies should be conducted with less number of patients for intervention. Accordingly, EMSs subdomains should be evaluated by conducting qualitative research. At last, when looking at percentage of explained variance of EMSs on depression for depressed patients, affects of other variables such as early traumatic life events on depression should be investigated.

4.7. Conclusion

Present study, aimed to investigate the role of EMSs and personality traits on depression. In a general sense, while little EMS dimensions were associated with depression in the sample of depressed patients, few dimensions were related to depression in the sample of non-clinical individuals. Therefore, it can be said that individuals not receiving any treatment are more prone to suffer from depression.

Depressed patients who had unsatisfaction of social support, had sociotropy personality and stronger impaired autonomy schema domain and vulnerability to harm, pessimism and emotional inhibition from specific early maladaptive schemas had higher scores of depression. In addition, nonclinical individuals experienced stressful life events and had stronger social isolation, defectiveness, vulnerability to harm, self sacrifice, emotional inhibition, punitiveness from specific schemas had higher scores of depression.

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APPENDICES

Appendix A: Informed Consent Form

Abant İzzet Baysal Üniversitesi Fen Edebiyat Fakültesi Psikoloji Bölümü Klinik Psikoloji Anabilim Dalı Yüksek Lisans Tezi olarak Doç. Dr. Emre Şenol-Durak danışmanlığında yürütülmekte olan, Psikolog Emre Özdemir'in "Klinik Olan ve Olmayan Örneklemde Depresyonu Etkileyen Faktörler: Erken Dönem Uyumsuz Şemalar ve Sosyotropi - Otonomi Kişilik Özelliği" isimli tez çalışmasına davet edilmektesiniz.

Depresyon duygusal, zihinsel, davranışsal ve bedensel bazı belirtilerle kendisini gösteren, çökkün ruh hali ile ilgi ve zevk almada belirgin azalmayla kendini gösteren bir rahatsızlıktır. Bu hastalığa neden olan birçok faktör bulunmaktadır. Ancak bu tez çalışmasında; uyumsuz şemaların ve kişilik özelliğinin nasıl değerlendirildiğinin depresyon üzerindeki etkisi incelenecektir.

Bu çalışmada vermiş olduğunuz tüm cevaplar tamamen gizli kalacak ve sadece bu araştırmanın kapsamı içinde kullanılacaktır. Tüm veriler, size verilecek bir katılımcı kodu ile saklanacak, kimsenin ulaşamayacağı kapalı bir yerde muhafaza edilecek, hiç bir yerde kimliğinize ilişkin herhangi bir bilgi kullanılmayacaktır.

Çalışmaya katılım tamamen gönüllülük esasına dayanmaktadır. Araştırmadan hiçbir gerekçe belirtmeden istediğiniz noktada geri çekilebilirsiniz. Çalışmaya katılmanın size hemen dönecek bir faydası bulunmamakla beraber, çalışma sonuçlarımızın gelecekte sağlık alanına, topluma veya bilime depresyon hastalığını etkileyen faktörler tespit edilerek hastalık için etkili olabilecek tedavi hedeflerinin belirlenmesine katkı sağlayacaktır. Çalışma hakkında her türlü bilgi ve sorularınızı Abant İzzet Baysal Üniversitesi Yüksek Lisans Öğrencisi Emre Özdemir'e (emrest41@hotmail.com) iletebilirsiniz.

Bu araştırma "Abant İzzet Baysal Üniversitesi İnsan Araştırmaları Etik Kurulu" tarafından onaylanmıştır. Araştırmaya katılımınızla ilgili her hangi bir şikâyetiniz varsa Sosyal Psikoloji Anabilim Dalı Başkanı Prof. Dr. Hamit COŞKUN (Tel: 03742541310) bildirebilirsiniz. Her tür şikâyetiniz gizlilikle değerlendirilecek, araştırılacak ve sonuç hakkında tarafınıza bilgi verilecektir. Bu yüksek lisans tez araştırmasına vermiş olduğunuz destek ve yardım için teşekkür ederim.

Bilgi – onam formunu okudum ve bu çalışmaya katılmakla ilgili olarak sormak istediğim soruları araştırmacının kendisine veya görevli olan kişiye (psikiyatr veya psikolog) sorarak öğrenme fırsatım olduğunu ve çalışmadan herhangi bir neden belirtmeksizin istediğim her aşamada çekilebileceğimi biliyorum. Çalışmanın Abant İzzet Baysal Üniversitesi Etik Komitesi tarafından onaylandığı bilgisi benimle paylaşılmış olup, Emre Özdemir tarafından yapılan bu tez çalışmasına gönüllü olarak katılmayı kabul ediyorum.

Katılımcının adı soyadı (lütfen yazınız):

Katılımcının imzası:

Tarih:

Appendix B: Demographical Information Form

Sayın Katılımcı,

Lütfen soruların başlarındaki yönergeleri dikkatlice okuyunuz ve size en uygun gelen seçeneği işaretleyiniz. Soruların doğru veya yanlış yanıtı yoktur, önemli olan sizin ne düşündüğünüz ve ne hissettiğinizdir. Çalışmaya olan katkınız ve verdiğiniz cevaplardaki samimiyetiniz için teşekkür ederim.

1) Yaşınız: _____

2) Cinsiyetiniz: ☐ Kadın ☐ Erkek

3) Medeni Haliniz: ☐ Bekar ☐ Evli ☐ Boşanmış ☐ Eşi vefat etmiş

4) Eğitim Durumunuz:

☐ İlkokul mezunu

☐ Ortaokul mezunu

☐ Lise mezunu

☐ Yüksek okul mezunu (ön lisans)

☐ Üniversite mezunu

☐ Yüksek Lisans veya Doktora Mezunu

5) Mesleğiniz:

☐ Memur

☐ İşçi

☐ Ev hanımı

☐ Serbest Meslek (esnaf)

☐ Öğrenci

☐ Emekli

☐ İşsiz

☐ Özel sektör

☐ Diğer _____

6) Halen çalışıyor musunuz?

☐ Hayır

☐ Evet

☐ Hiç çalışmadım.

7) En uzun süre yaşadığınız yer

☐ Köy

☐ Kasaba

☐ Şehir

8) Ailenizin toplam AYLIK gelir düzeyi: _____ TL (Toplam miktar belirtiniz.

9) Kronik bir rahatsızlığınız var mı?

☐ Hayır ☐ Evet Nedir? (Yuvarlak içine alınız)

- 1) Kalp-Dolaşım /Solunum sistemi (kalp, tansiyon, kolesterol, damar tıkanıklığı, hemoroid, nefes darlığı vb.)
- 2) Sindirim sistemi (ülser, gastrit, siroz, idrar, safra vb.)
- 3) Kas-iskelet sistemi (kas, kemik, bağ doku hastalıkları vb.)
- 4) Duyu sistemi (görme, işitme, koku, tat, cilt bozuk vb.)
- 5) Endokrin sistemi (Diyabet, obezite, tiroid, dahili bilimler vb)
- 6) Nörolojik (Demans, Alzheimer, Parkinson, denge bozuk.)
- 7) Boşaltım sistemi sorunları (idrar kaçırma ve idrara çıkamama)
- 8) Diğer: _____

10) Psikolojik olarak aldığınız herhangi bir ek tanı var mı?

☐ Hayır ☐ Evet Nedir?

Evet ise; _____

11) Daha önce herhangi bir uzmandan (psikolog, psikiyatr, psikolojik danışman) psikolojik yardım (psikoterapi, psikiyatrik ilaç, vb.) aldınız mı?

☐ Hayır ☐ Evet

Evet ise;

- ☐ İlaç tedavisi
- ☐ Psikoterapi
- ☐ Hem ilaç tedavisi hem de psikoterapi
- ☐

12) Yakın zamanda sizi etkileyen bir stres yaşadınız mı? Yaşamınızda sizi etkileyen önemli bir olay oldu mu?

☐ Hayır ☐ Evet

Evet ise;

- ☐ Kız/erkek arkadaşıyla veya eşimle problem yaşama
- ☐ Arkadaşlarla problem yaşama
- ☐ Diğer (lütfen spesifik tek bir durum belirtiniz) _____

Bu olay sizi ne kadar etkiledi?

Hiç Etkilemedi

Çok Etkiledi

11 22 33 44 55 66 77 88 99 110

13) Yakın aile üyelerinden birini kaybettiniz mi?

☐ Hayır ☐ Evet _____ Yakınlık dereceniz nedir?

Bu olay sizi ne kadar etkiledi?

Hiç Etkilemedi

Çok Etkiledi

11 22 33 44 55 66 77 88 99 110

14) Çocukluk deneyimlerinizi göz önünde bulunduracak olsanız nasıl değerlendirirsiniz?

Çok olumsuz

Çok olumlu

11 22 33 44 55 66 77 88 99 110

15) Genel olarak ailenizden ve arkadaşlarınız aldığınız sosyal destekten ne derece memnunsunuz?

Hiç memnun değilim

Çok memnunum

11 22 33 44 55 66 77 88 99 110

Appendix C: Sociotropy Autonomy Scale (SAS)

Aşağıda bir dizi ifade verilmektedir. Lütfen her ifadeyi okuduktan sonra o ifadenin sizi ne kadar iyi tanımladığını yandaki derecelendirilmiş cetvel üzerinde işaretleyiniz.

Examples of items:

Aşağıdaki ifade sizi ne kadar tanımlıyor?	%0	%25	%50	%75	%100
1. Kendimi diğer insanlara hep iyi davranmak zorundaymış gibi hissedirim.	()	()	()	()	()
2.Özgür ve bağımsız olmak benim için çok önemlidir.	()	()	()	()	()
3. İyi bir iş yaptığımda bunu benim bilmem, başkalarının bilmesinden daha önemlidir.	()	()	()	()	()
4.Yaşadığım güzel olayları başka insanlarla paylaştığımda o olaylar bana daha da güzel gelir.	()	()	()	()	()
5. Diğer insanların duygularını incitmekten korkarım.	()	()	()	()	()
6. İnsanlar benim davranışlarımı ya da yaptığım işleri yönetmeye kalkarlarsa rahatsız olurum.	()	()	()	()	()
7. İnsanlara “hayır” demek bana zor gelir	()	()	()	()	()

Appendix D: Young Schema Questionere Short Form (YSQ – SF)

Aşağıda, kişilerin kendilerini tanımlarken kullandıkları ifadeler sıralanmıştır. Lütfen her bir ifadeyi okuyun ve sizi ne kadar iyi tanımladığına karar verin. Emin olamadığınız sorularda neyin doğru olabileceğinden çok, sizin **duygusal olarak** ne hissettiğinize dayanarak cevap verin. Bir kaç soru, anne babanızla ilişkiniz hakkındadır. Eğer biri veya her ikisi şu anda yaşamıyorlarsa, bu soruları o veya onlar hayatta iken ilişkinizi göz önüne alarak cevaplandırın.

1 den 6'ya kadar olan seçeneklerden sizi tanımlayan en yüksek şıkkı seçerek yuvarlak içine alınız.

Examples of items:

DEĞERLENDİRME:

1. Benim için tamamıyla yanlış
2. Benim için büyük ölçüde yanlış
3. Bana uyan tarafı uymayan tarafından biraz fazla
4. Benim için orta derecede doğru
5. Benim için çoğunlukla doğru
6. Beni mükemmel şekilde tanımlıyor

1. _____ Bana bakan, benimle zaman geçiren, başıma gelen olaylarla gerçekten ilgilenen kimsem olmadı.
2. _____ Beni terkedeceklerinden korktuğum için yakın olduğum insanların peşini bırakmam.
3. _____ İnsanların beni kullandıklarını hissediyorum.
4. _____ Uyumsuzum.
5. _____ Beğendiğim hiçbir erkek/kadın, kusurlarımı görürse beni sevmez.
6. _____ İş (veya okul) hayatımda neredeyse hiçbir şeyi diğer insanlar kadar iyi yapamıyorum.

Appendix E: Beck Depression Inventory II (BDI – II)

Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde, bir çeşit ruh durumunu anlatmaktadır. Her maddede o duygu durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatlice okuyunuz. **SON BİR HAFTA içindeki (şu an dahil)** kendi duygu durumunuzu göz önünde bulundurarak, size uygun olan ifadeyi bulunuz. Daha sonra, o madde numarasının karşısında, size uygun ifadeye karşılık gelen seçeneği bulup işaretleyiniz.

Examples of items:

1. a) Kendimi üzgün hissetmiyorum.
b) Kendimi üzgün hissediyorum.
c) Her zaman için üzgünüm ve kendimi bu duygudan kurtaramıyorum.
d) Öylesine üzgün ve mutsuzum ki dayanamıyorum.
2. a) Gelecekte umutsuz değilim.
b) Geleceğe biraz umutsuz bakıyorum.
c) Gelecekte beklediğim hiçbir şey yok.
d) Benim için bir gelecek yok ve bu durum düzelmeyecek.
3. a) Kendimi başarısız görmüyorum.
b) Çevremdeki birçok kişiden daha fazla başarısızlıklarım oldu sayılır.
c) Geriye dönüp baktığımda, çok fazla başarısızlığımın olduğunu görüyorum.
d) Kendimi tümüyle başarısız bir insan olarak görüyorum.
4. a) Her şeyden eskisi kadar zevk alabiliyorum.
b) Her şeyden eskisi kadar zevk alamıyorum.
c) Artık hiçbir şeyden gerçek bir zevk alamıyorum.
d) Bana zevk veren hiçbir şey yok. Her şey çok sıkıcı.