BAŞKENT UNIVERSITY
INSTITUTE OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY
MASTER'S IN CLINICAL PSYCHOLOGY WITH THESIS

MEDIATING ROLE OF SELF-COMPASSION ON THE RELATIONSHIP BETWEEN EARLY MALADAPTIVE SCHEMA DOMAINS AND SECONDARY TRAUMATIC STRESS OF REFUGEE AID WORKERS

MASTER'S THESIS

PREPARED BY

AYÇA GÜZEY

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ASSOC. PROF. OKAN CEM ÇIRAKOĞLU

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Yukarıda başlığı belirtilen Yüksek Lisans tez çalışmamın; Giriş, Ana Bölümler ve Sonuç Bölümünden oluşan, toplam 61 sayfalık kısmına ilişkin, 26/07/2020 tarihinde tez danışmanım tarafından Turnitin adlı intihal tespit programından aşağıda belirtilen filtrelemeler uygulanarak alınmış olan orijinallik raporuna göre, tezimin benzerlik oranı % 14'dür.

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To Memory of Kenan Güzey and İlyas Özbek

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ÖZET

GÜZEY, Ayça. Erken Dönem Uyum Bozucu Şema Alanları ile Mülteci Yardım Çalışanlarındaki İkincil Travmatik Stresi Arasındaki İlişki Üzerinde Öz-şefkatin Aracı Rolü. Başkent Üniversitesi, Sosyal Bilimler Enstitüsü, Klinik Psikoloji Yüksek Lisans Programı, 2020.

Bu çalışmanın amacı, erken dönem uyum bozucu şema alanları ile mülteci yardım çalışanlarındaki ikincil travmatik stresi arasındaki ilişki üzerinde öz-şefkatin rolünü incelemektir. Bu korelasyon çalışmasında amaçlı örnekleme kullanılmıştır. Araştırmaya, Türkiye'nin farklı kurumlarından 116 katılımcı gönüllü olarak katılmıştır. Katılımcıların yaşları 23 ile 64 arasında değişmektedir. Veriler, Young Şema Ölçeği (YSQ-SF3), İkincil Travmatik Stres Ölçeği (STSS), ve Öz-duyarlılık Ölçeğinin (SCS) Türkçe'ye uyarlanmış versiyonlarıyla toplanmıştır. Katılımcıların demografik bilgileri araştırmacı tarafından geliştirilen form aracılığıyla toplanmıştır. Araştırmanın sonuçları, değişkenler arasında anlamlı ilişkiler olduğunu göstermiştir. Ayrıca, öz-şefkatin erken dönem uyum bozucu şema alanları ve ikincil travmatik stres arasındaki ilişkideki aracı rolü göz önüne alındığında, öz-şefkatin, erken dönem uyum bozucu şema alanları (Zedelenmiş Sınırlar hariç) ile mülteci yardım çalışanlarındaki ikincil travmatik stres arasındaki ilişkide orta ve büyük etki büyüklüğüne sahip olduğu bulunmuştur. Mevcut çalışmanın bulguları, ilgili literatür kapsamında tartışılmıştır. Klinik çıkarımlar, sınırlılıklar ve gelecek çalışmalar için öneriler sunulmuştur.

Anahtar Kelimeler: İkincil Travmatik Stres, Erken Uyum Bozucu Şema Alanları, Öz-şefkat

ABSTRACT

GÜZEY, Ayça. Mediating Role of Self-compassion on the Relationship between Early Maladaptive Schema Domains and Secondary Traumatic Stress of Refugee Aid Workers. Başkent University, Institute of Social Sciences, Master of Arts in Clinical Psychology, 2020.

The present study aimed to examine the role of self-compassion on the relationship between early maladaptive schema domains and secondary traumatic stress of refugee aid workers. In this correlational study, purposive sampling was used. 116 participants from different institutions in Turkey participated voluntarily in the research. Their age range was between 23 and 64. The data was collected through Turkish versions of Young Schema Questionnaire-Short Form Version 3 (YSQ-SF3), Secondary Traumatic Stress Scale (STSS), and Self-compassion Scale (SCS). The demographic information of the participants was collected through the form developed by the researcher. The results of the research showed that there are significant relationships among the variables. Moreover, self-compassion had a medium to large effect size on the relationship between early maladaptive schema domains except for Impaired Limits and secondary traumatic stress of refugee aid workers considering the mediating role of self-compassion in the relationship between early maladaptive schema domains and secondary traumatic stress. The findings of the current study were discussed within the scope of relevant literature. Implications of the study, limitations of the study, and future suggestions were presented.

Keywords: Secondary Traumatic Stress, Early Maladaptive Schema Domains, Self-compassion

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LIST OF ABBREVIATIONS

AFAD	Afet ve Acil Durum Yönetimi Başkanlığı
APA	American Psychiatric Association
CS	Conditioned Stimulus
DSM	Diagnostic and Statistical Manual of Mental Disorders
EMS	Early Maladaptive Schema
PTSD	Post-traumatic Stress Disorder
SCS	Self-compassion Scale
STS	Secondary Traumatic Stress
STSS	Secondary Traumatic Stress Scale
UCS	Unconditioned Stimulus
UNHCR	United Nations High Commissioner for Refugees
YSQ-SF3	Young Schema Questionnaire- Short Form Version 3

CHAPTER I
INTRODUCTION

Because of learning loved or cared about one's traumatic experience, some natural behaviors and emotions occur. This situation is named as secondary traumatic stress (STS) (Figley, 1998). Stress in secondary trauma arises from caring for a traumatized person that needs help (Dirkzwager, Bramsen, Adér, & van der Ploeg, 2005). Bride (2007) indicated to what extent social workers are influenced by STS. It was revealed that 88.9 percent of participants worked with traumatized clients. This result shows us the level of risk of social workers for STS. Moreover, it was reported that participants who experienced minimum a symptom in the last week were 70.2 percent, participants who have met the criteria for minimum one of the core clusters was 55 percent and lastly, 15.2 percent of these participants have matched the core criteria for diagnosing post-traumatic stress disorder (PTSD) (Bride, 2007). These findings can show us how secondary traumatic stress is frequent and serious.

When examining the statistical data about refugees and asylum-seekers, it can be easily said that lots of people are forced to displace until today. According to United Nations High Commissioner for Refugees (UNHCR) (2020), it was recorded that by the end of 2018, 70.8 million people were forced to migrate their country to other countries because of oppression (persecution), war. Furthermore, Turkey is defined as a country where hosts the largest refugee population. To be more specific, in accordance with records, there are above 3.6 million Syrian refugees and approximately 400,000 refugees and asylum-seekers from other nationalities in Turkey (UNHCR, 2020). Unfortunately, refugees or asylum-seekers are exposed to multiple traumas before and after immigration (Demirbaş & Bekaroğlu, 2013). In Turkey, there are lots of institutions that provide refugees and asylum-seekers with health, education, legal service, and psychological support. During providing these services, it is highlighted that employees who are responsible for refugee registration, psycho-social support team, translators, and law enforcement officers who fight against human trafficking are the most likely to be exposed to the traumatic experiences of refugees or asylum-seekers (Çırakoğlu, 2018). Moreover, it is emphasized that these specialists are the most likely to be emotionally influenced by their traumatic experiences. Thus, it is claimed that refugee aid workers are under the risk of STS (Çırakoğlu, 2018).

Self-compassion is defined as some basic components which are "self-kindness versus self-judgment", "a sense of common humanity versus isolation", and "mindfulness

versus over-identification" (Neff, 2003a). According to Figley (2002), when working with traumatized groups, experts may feel preoccupied because of re-experiencing traumatic events, avoidance/numbing of reminders, continuous arousal which is related to a traumatized person. This situation is defined as compassion fatigue (Figley, 2002). As far as I read, although the possibility of experiencing compassion fatigue among the experts working with traumatized groups is reviewed, the role of self-compassion was not examined in terms of secondary traumatic stress among these experts.

"Early maladaptive schemas (EMS) are self-defeating, emotional, and cognitive patterns that begin early in our development and repeat throughout life" (Young, Klosko, & Weishaar, 2003, pp. 7). In light of the research, EMS and self-compassion are related to each other. For instance, Thimm (2017) revealed that except for two schemas which were named as enmeshment and entitlement, it was found that EMS was negatively correlated with self-compassion. However, the relationship between EMS and the STS was not studied directly. Therefore, in the current study, it is aimed to understand the relationship between early maladaptive schemas and self-compassion on secondary traumatic stress of refuge aid workers.

The introduction will firstly present basic information that is necessary to know for understanding secondary traumatization. These are trauma definition, post-traumatic stress disorder (PTSD), and psychological theories about PTSD. In addition, since the sample in this study will be refugee aid workers, refugees, and asylum-seekers and their psychological problems will be clarified. Subsequently, secondary traumatic stress will be referred to in detail. Secondly, self-compassion will be defined and its role in well-being will be stated. Thirdly, EMS will be represented and supporting the current study, studies about EMS, and self-compassion will be mentioned. Finally, the importance of the thesis, the purpose of the thesis and hypotheses will be presented.

1.1. Secondary Traumatization

1.1.1. Trauma

Trauma is defined as a situation that causes important and forceful impacts of injury in terms of body and psyche (Türk Dil Kurumu, n.d.). The traumatic event can be explained as the event which is outside of daily life leads to a significant and high level of stress (AFAD, n.d.). A traumatic event is experienced in different ways. A person may be subject

to the traumatic event, witness it, or learn someone else who is important for himself or herself experienced the traumatic event (AFAD, n.d.)

1.1.2. Clinical appearance of trauma

The results of being exposed to a traumatic event in terms of psychology have been studied for many years. These studies make evidence that posttraumatic stress reactions are seen in the initial weeks after being exposed to the trauma (Bryant & Keane, 2013). Previous conceptualizations about traumatic stress recognized these reactions as temporary after being exposed to the traumatic event. In the first edition of the DSM (APA, 1952), it is mentioned that traumatic stress reactions were categorized as "acute post-trauma responses" with an obvious stress reaction yet reactions that last longer are sorted under the anxiety or "depressive neuroses". However, with DSM-III (APA, 1980), PTSD was added. "PTSD describes with severe and persistent stress reactions after exposure to the traumatic event" (Bryant & Keane, 2013, pp. 172).

In the DSM-5 (Amerikan Psikayatri Birliği, 2014), there are five symptom clusters to make diagnose for PTSD. Cluster A is defined as being exposed to an event that threatens someone's life directly or by witnessing or learning indirectly. Other clusters in the DSM-5 are specified as "intrusive symptoms (Cluster B)", "avoidance symptoms (Cluster C)", "negative alterations in mood and cognitions (Cluster D)", and "alterations in arousal and reactivity (Cluster E)". Intrusive symptoms which are related to Cluster B includes having intrusive and distressing memories about the traumatic event. These memories are experienced with repeated and distressing dreams, nightmares, and flashbacks. These experiences are assumed as reminders. When dreams, nightmares, or flashbacks are experienced, the traumatic event is recapitulated in a dissociative manner. People who are exposed to these reminders, they feel intense stress with physical reactions. Cluster C is defined as avoiding the stimuli which are reminders of the traumatic event. This cluster also involves avoiding the thoughts or feelings, and external reminders which are related to that event. Cluster D is identified as separating avoidance from other emotional parts of the condition. In other words, negative changes in cognitions and moods are seen. For instance, remembering the important parts of the event is getting harder. Continuous and inflated beliefs about self, world, or others appear. Moreover, distorted self-blame or distortions in blaming others because of the traumatic event are seen continuously. Persistency in a negative emotional state is experienced whereas having difficulty in experiencing positive

emotions is observed. In addition to these changes, interest in activities decreases whereas the feeling of detachment or alienation increases (Bryant & Keane, 2013). Cluster E is related to changes in arousal and reactions. These changes involve verbal or nonverbal aggressive expressions, the burst of anger, self-destructive behavior, being on the alert at any moment, heightened startle response, concentration difficulties, and sleep disturbances (Amerikan Psikiyatri Birliği, 2014).

1.1.3. Psychological theories about posttraumatic stress disorder

According to "Mowrer's two-factor learning theory" (1960; as cited in Foa, Steketee, & Rothbaum, 1989), while fear and avoidance are acquired, two types of learning styles which are classical, and instrumental are seen. In the first factor, a stimulus that is neutral previously is paired with an unconditioned stimulus (UCS) that naturally produces discomfort or fear through temporal contiguity. Afterward, the neutral stimulus gains some aversive qualities which lead anxiety; therefore, this stimulus is transformed into a conditioned stimulus (CS) for fear responses. When this conditioned stimulus is associated with a new neutral stimulus, aversive qualities are also seen in the second one and so feeling anxiety is occurred by the presence of it. Moreover, because of the stimulus generalization, some stimuli that are similar to the first conditioning stimulus acquire features that create anxiety. Since feeling anxiety or discomfort affects someone in an aversive or uncomfortable way, some learned responses that are avoidance or escape start to develop in order to diminish or restrict these uncomfortable feelings which are caused by the existence of conditioned stimuli (Foa, Steketee, & Rothbaum, 1989).

Emotional processing theory originated from Lang's conceptualization of fear was proposed by Foa and Kozak (1985; 1986) to explain how anxiety and its related disorders are treated via exposure and differences between pathological and normal fear (as cited in Foa, Huppert, & Cahill, 2006). It is mentioned that two conditions are essential for emotional processing. Firstly, the fear structure is activated and secondly, new information that is conflicting with the pathological components of the fear structure is combined (Foa & Kozak, 1986). According to Foa and Kozak (1986), pathological fear occurs when threat is represented incorrectly, threatening events are evaluated in a highly negative way, and/ or extreme responses such as physiological avoidance after facing the threat are seen. Furthermore, it is stated that pathological fear structures show resistance for modification. Foa, Huppert, and Cahill (2006) indicate that resistance for modification occurs because of

avoidance responses which are seen in behavioral and/or cognitive ways. Moreover, it is expressed that cognitive biases during different stages of information processing such as encoding, interpretation, and retrieval play a role in pathological fear persistency. To be detailed, gaining related information that is inappropriate to the current components of the pathological fear structure is irrupted by the avoidance and cognitive biases and this is essential for recovery or emotional processing (Foa, Huppert, & Cahill, 2006). It is claimed that particular pathological fear structures are a background of different anxiety disorders. It is highlighted that in order to treat successfully pathological fear, pathological components in this fear structure should be modified (Foa & Kozak, 1985; as cited in Foa, Huppert, & Cahill, 2006). Moreover, although there are identical components among anxiety disorders such as physiological reactions and escape or avoidance reactions, specific disorder-related components and associations are seen. To illustrate, fear structure in PTSD is defined with a pathological association between reminders. Namely, safe situations or imagery is associated with a hazard or a sense of incompetence. On the other hand, fear components of panic disorder are explained with the psychological association between response components. These components are exemplified as difficulty in breathing, death threat, or becoming crazy (Foa & Kozak, 1985; as cited in Foa, Huppert, & Cahill, 2006).

The natural healing process of trauma and how PTSD severity is reduced by exposure therapy is explicated with three factors (Foa, 1997). Firstly, engaging emotionally with the trauma memory is emphasized. For instance, in the natural healing process, engaging emotionally with the trauma memory means fear activation. This fear activation happens when somebody faces with a trauma reminiscent in his or her natural environment. In light of the literature, it was discovered that fear activation has a positive relationship with the outcome of the trauma treatment (Foa, Riggs, Massie, & Yarczower, 1995; Pitman et al., 1996). Therefore, Foa, Huppert, and Cahill (2006) state that it may be hypothesized that after being exposed to a traumatic event if someone cannot engage emotionally with his or her trauma, the natural healing process may not occur adequately. Secondly, alteration in cognitions that are related to trauma is seen as an associative factor with the natural healing process and outcome of the treatment (Foa, 1997). It is thought that two fundamental meaning components are at the center of the fear structure for PTSD (Foa & Rothbaum, 1998; Foa & Riggs, 1993). These meanings components are the fact that the world is entirely unsafe and that the self is completely inadequate. Moreover, it is represented that people who are diagnosed with PTSD may have more negative cognitions about the world and themselves in comparison to others who are exposed to trauma without having PTSD or who

are never exposed to the trauma. In parallel with this, it is suggested that when alterations in the structure of the fear which is about these two meanings components happen, natural healing after the trauma and healing of chronic PTSD after the treatment are seen (Foa, Huppert, & Cahill, 2006). Thirdly, organization of the trauma narratives is hypothesized as the related factor with both natural healing and healing after treatment for the trauma (Foa, 1997) About this factor, it was found that when trauma narratives were articulated right after experiencing a related event, healing was greater and reduction of PTSD symptom severity was seen 3 months later (Amir, Stafford, Freshman, & Foa, 1998). In addition to this study, Foa, Molnar, and Cashman (1995) showed that via exposure therapy, trauma narratives could be organized. As an illustration Foa, Huppert, Cahill (2006) emphasized that in course of imaginal exposure, a repetitive narration of the traumatic memory and reviewing this memory with the therapist provide alterations in the association between retrieving the trauma and threat and pieces of traumatic narratives may be a whole with this way (Foa, Huppert, & Cahill, 2006). It is suggested that while traumatic thoughts and feelings are touched and shared with others and facing daily reminder stimuli that are related to the trauma, emotional processing which causes natural healing occurs (Foa & Cahill, 2001).

A cognitive model that aims to explain why some people experience persistent PTSD after experience trauma and why others do not is constituted by Ehlers and Clark (2000). This model stated that if a traumatic event is perceived as a "sense of current threat", PTSD is experienced persistent. Mainly, there are two points in a "sense of current threat". These are indicated as appraising trauma and/or its sequelae excessively negative and impairment in autobiographical memory which is explained with limited "elaboration and contextualization, strong associative memory, and perceptual priming" (Ehlers & Clark, 2000, pp.319). To give an example of negative appraisal, people who have persistent PTSD suppose that the trauma which is not seen as- a time-limited event causes global negative consequences for their future. It is stated that "sense of current threat" which can be either external or internal is due to their "negative appraisals of the traumatic event and/or its sequelae". Seeing the world is more dangerous is an external threat, whereas threatening to one's inner capacity for viewing oneself to achieve substantial life goal is seen as an internal threat. Impairment of autobiographical memory, on the other hand, is seen important to explain due to discrepancy between involuntary and voluntary recalling. It is mentioned that intentionally remembering the whole traumatic event is found difficult by people with PTSD, whereas they are disturbed by unintentional memories of that trauma (Ehlers & Clark, 2000). These memories are defined intrusive and occur like re-experiencing that trauma in a real

and emotional way. To be clearer, the characteristics of involuntary reexperiencing the traumatic event can be explained briefly. Involuntary reexperiencing involves sensory impressions that can be experienced here and now. These impressions retrieve with a lack of awareness (Foa & Rothbaum, 1998). Also, even if it is known that sensory impressions and emotions are not true or do not overlap with reality, these sensory impressions and original emotional still reexperience. Recollection is not necessary for physical sensations and emotions about the traumatic event. Moreover, involuntary re-experiencing can be induced by various stimuli that have a temporal relationship with trauma rather than semantic. Ehlers and Clark (2000) propose that intrusion features and the type of retrieval which are assumed as relating with persistent PTSD are caused by how the traumatic event is processed and preserved in memory.

When this cognitive model processes, people experience a sense of current threat with "intrusions and other re-experiencing symptoms, symptoms related to arousal, anxiety, and other emotional responses". Moreover, a sense of current threat impels various behaviors and cognitions to decrease this threat in a little while. However, because of these responses, changes in cognitions that are needed to recover cannot occur and then PTSD becomes persistent (Ehlers & Clark, 2000, pp.320).

According to Gillihan, Cahill, and Foa (2014), interpreting post-trauma reactions in the light of social psychology and personality gave birth to the concept of schemas in order to clarify the psychological effects of trauma. It is mentioned that schemas are assumed as core assumptions and beliefs and our perception and how we interpret the information which is gained from outside ware guided. Gillihan, Cahill, and Foa (2014) summarize these theories into two common points. These common points are that traumatic event generally conflicts with existing assumption or belief and when the existing assumption is modified, a traumatic experience is processed.

Horowitz who proposes one of the early schema theories to the area of post-trauma psychopathology combined psychoanalytic and the concept of information-processing (Gillihan, Cahill, & Foa, 2014). In accordance with Horowitz (1986), individuals basically want for matching their information that is related to the trauma with inner models that are constituted from their old information. For the healing process, revisions in both old and traumatic information sources until they reach an agreement are required. It can be implicated from Horowitz's theory that is information processing about the trauma is intervened by avoidance strategies. Therefore, the resolution of divergence between the present inner models and the new information that comes from the trauma is prevented

(Gillihan, Cahill, & Foa, 2014). Moreover, Epstein (1991) proposed that after being exposed to the traumatic event, four core beliefs change. For instance, believing that the world is riskless and meaningful, that the self is precious, and that people are safe can be changed after the traumatic event (Epstein, 1991). Additionally, McCann and Pearlman (1990) suggested fundamental psychological needs which are safety, power, and independence. It is also argued that people develop schemas that contain beliefs, assumptions, and expectations related to each of these needs. In terms of the healing process, it is claimed that because these areas are disrupted by experiencing the trauma, accommodating the schemas to the new information is seen crucial focus during the therapy (McCann & Pearlman, 1990). On the other hand, McCann and Pearlman (1990) recommend that when existing negative schemas are strengthened due to experience repetitive traumas, distressing emotions, thoughts, or images occurs.

1.1.4. Refugees and asylum-seekers

According to the United Nations High Commissioner for Refugees (UNHCR) (2020), refugee means that a person who is compelled to leave his or her hometown due to violence, persecution, or war. It is stated that refugees feel fear of persecution because of his or her "race, religion, nationality, political opinion, or membership in a particular social group". Moreover, it is mentioned that the refugees generally cannot go back to their hometown or they are afraid to return to their country (UNHCR, 2020). Additionally, in accordance with UNHCR (2006), to be refugee, appropriate criteria under the accepted refugee definition that is indicated in international or local refugee documents, under UNHCR's mandate, and/ or in national legislation should be met. On the other hand, asylum-seeker means that a person is asking for international protection (UNHCR, 2006). In countries that have individualized procedures, an asylum-seeker is seen as a person whose application has not yet been definitely determined by the country that he or she makes an application for asylum. Moreover, there is a thin line between the definitions of refugee and asylum seekers. That is each refugee is accepted as an asylum-seeker in the beginning, whereas an asylum-seeker may not be approved as a refugee at the end (UNHCR, 2006). In this study instead of using both words of refugee and asylum-seeker, the word of the refugee is used.

When examining the statistical data about refugees and asylum-seekers, it can be easily said that lots of people are forced to displace until today. According to UNHCR (2020), it was recorded that 70.8 million people were forced to migrate because of oppression

(persecution), war at the end of 2018. It is stated that unfortunately an increase of 2.3 million in the people who forcibly left their country was seen when comparing the recent data with the previous year's one. Specifically, this total number includes "25.9 million refugees, 41.3 million internally displaced people, and 3.5 million asylum seekers in the world" (UNHCR, 2020). Furthermore, it is indicated that Syria and Afghanistan are considered among the top five countries that include two-thirds of all refugees in the world (UNHCR, 2020). Furthermore, Turkey is defined as a country where hosts the largest refugee population. To be more specific, in accordance with records, there are above 3.6 million Syrian refugees and approximately 400,000 refugees and asylum-seekers from other nationalities in Turkey (UNHCR, 2020).

1.1.5. Psychological health of refugees and asylum-seekers

Demirbaş and Bekaroğlu (2013) mention that risk factors for the psychological health of refugees can be examined in terms of before immigration, during immigration, and after immigration. It is argued that lots of refugees are exposed to multiple traumas before and after immigration. Kirmayer and his colleagues (2011) defined risk factors before immigration as negative economic, educational, and occupational conditions in their own country, political situations, social support, roles, and impairments in the social network. In parallel to this pre-migration time, Nicholl and Thompson (2004) highlight that many refugees are exposed to or bear witness to various traumatic events such as rape, torture, imprisonment, bodily injury, homicide, and genocide before leaving their country. On the other hand, risk factors after immigration are described as the route of migration and amount of passing time during migration, difficult living conditions such as living in camps of refugees, being subjected to violence, impairments in relationship with family and society, uncertainty about after immigration, traumatic experiences when they come to the country of asylum and during escaping (Kirmayer et al., 2011). Finally, risk factors after immigration are indicated as uncertainty about the statue of migration and refugee, unemployment, social statue, loss of familial and social support, feeling nervous about loved ones who were left behind, worries about not come together with loved ones, having difficulty in elements for adaptation such as learning a language or changes in gender roles (Kirmayer et al., 2011). As it is mentioned, refugees or asylum-seekers are not only exposed to negative events for their psychological health during immigration but also before and after immigration.

In the related literature, it is revealed that people who experienced domestic or external migration or were forced to immigrate commonly suffer from posttraumatic stress disorder, depression, somatization, and relationship problems, and feel intense anxiety and hopelessness (Aydoğdu & Polat, 2018). As it is understood from these studies, experts who provide help for refugees contact with refugees' psychological health problems.

1.1.6. Secondary traumatic stress

As it is mentioned earlier, both directly experiencing the traumatic event and learning loved or cared about one's traumatic experience leaves a scar in people's lives. Because of learning loved or cared about one's traumatic event experience, some natural behaviors and emotions occur. This situation is named as secondary traumatic stress (Figley, 1998). Stress in secondary trauma arises from caring for a traumatized person that needs help (Dirkzwager, Bramsen, Adér, & Van der Ploeg, 2005). If secondary traumatic stress is intense, it can cause emotional exhaustion and emotional burnout. Therefore, in such cases, it is named as secondary traumatic stress disorder (Figley, 1998).

There are lots of studies about families of veterans in terms of secondary traumatization (Jordan et al., 1992; Riggs, Byrne, Weathers, & Litz, 1998). It is clearly seen that partners of veterans who had PTSD experienced more health and social problems. Furthermore, Chrestman (1999) stated that secondary traumatization involves similar symptoms which are seen in traumatized people. Specifically, secondary traumatic stress has common symptoms like "intrusion, avoidance, and arousal" with PTSD (Figley, 1999).

Unfortunately, family members are not the only group who is affected by the traumatized person. Bride (2007) mentions by considering statistics about traumatic events that experience traumatic events in higher in the population, social workers are exposed frequently by traumatized people. Nowadays, social workers are specialized for an injured group such as being subjected to childhood abuse, natural disasters, and war (Bride, 2007). In short, the role of STS on social workers became an important topic. A study which was conducted by Bride in 2007 analyzed how STS is widespread among social workers. The results of this study revealed that 88.9 percent of participants worked with traumatized clients. This result shows us the level of risk of social workers for STS. Moreover, it was reported that participants who experienced minimum one symptom in the last week were 70.2 percent, participants who have met the criteria for minimum one of the core clusters

was 55 percent and lastly, 15.2 percent of these participants were matched the core criteria for diagnosing PTSD (Bride, 2007).

Working with a traumatized group may also cause compassion fatigue. According to Figley (2002), when working with traumatized groups, workers may feel preoccupied because of "re-experiencing traumatic events, avoidance/numbing of reminders, continuous arousal" which is related to a traumatized person. This situation is defined as compassion fatigue (Figley, 2002, pp. 11). Being compassionate and emphatic can be tiring and backbreaking. Figley (2002) states that the capacity of having an interest in others' suffering is diminished by compassion fatigue. Therefore, it can be thought that self-compassion is seen resilient factor for people who are working with traumatized groups to be well.

1.1.7. Terms related to secondary traumatic stress

In the literature, several terms are related to STS. To avoid confusion and clarify the topic of STS some of the terms will be mentioned.

Bride (2012) mentions that compassion fatigue is seen as an alternative term to state STS. The term compassion fatigue was presented because it was aimed that being labeled due to experiencing STS was reduced. Compassion fatigue and STS can be reported as interchangeable terms in some documents (Bride, 2012). In addition to this term, vicarious traumatization is the other term related to STS. Vicarious traumatization means that because of being exposed to someone's traumatic experiences, alterations in cognitions, and belief systems occur (Bride, 2012). It is thought that vicarious traumatization leads to crucial changes in one's sense of meaning, bond, identity, and worldview. Although it is suggested that STS and vicarious traumatization is the same due to changes in cognitions, other experts state these two terms are separate but related to each other (Bride, 2012). Another term that is related to STS is countertransference reaction. Countertransference reaction is also seen as the negative effect of experiencing other's traumatic materials. This reaction is traditionally defined as distorted therapist's unconscious and neurotic reactions to the client because of the therapist's unfinished businesses or unconscious conflicts and worries (Bride, 2012). On the other hand, contemporary approaches do not pay attention to the source of countertransference, but it is claimed that countertransference is just a therapist's emotional reactions to the client. There are three main differences between countertransference and secondary traumatic stress (Bride, 2012). Firstly, it is emphasized that countertransference only occurs in the therapy room, whereas secondary traumatic stress spreads over one's all

sides of life. In other words, secondary traumatic stress influences both one's professional and personal life. Secondly, secondary traumatic stress occurs only when working with the traumatic groups, whereas there is no such condition for experiencing countertransference. Finally, countertransference is only seen in the therapeutic relationship. Therefore, it does not focus on the experiences of traumatized groups' relatives (Bride, 2012). Another term about STS is burnout. Burnout involves emotional exhaustion and cynicism. Even though emotional exhaustion may be seen during secondary traumatic stress, an increased feeling of emotional exhaustion is a key feature in this concept (Bride, 2012). Mainly, the difference between burnout and STS is that burnout is seen due to increased work conditions and feeling stress about work yet STS is risen by being exposed to the client's traumatic history (Bride, 2012).

1.1.8. Approaches for secondary traumatic stress

In the literature, there are various approaches to explaining STS. In this section, the "ripple effect" (Remer & Ferguson, 1995), "trauma transmission model" (Figley, 1998), and "emotional contagion" (Miller, Stiff, & Ellis, 1988) will be mentioned in order to clarify STS deeply.

Remer and Ferguson (1995) claimed that the trauma process is like a wave that moves from victims to others who have a close relationship with the victims. Moreover, these close relatives who are illustrated as family and friends are evaluated as secondary victims because they were not directly exposed to the trauma (Remer & Ferguson, 1995).

Figley (1998) mentioned the trauma transmission model. By this model, people who are around the traumatized person have an effort to understand his or her experiences and they are motivated to show their empathy for the traumatized one. As a result, these people strikingly experience the same emotions with the traumatized one. Moreover, they may visualize images about that traumatic event, experience sleep disturbances, depression, and other symptoms that are caused by visualizing that traumatic experiences, being exposed to the symptoms of the traumatized one, or both (Figley, 1998).

Before explaining emotion contagion, it should be highlighted that secondary traumatic stress was accepted as clinic symptoms of burnout (Peeples, 2000). According to the model which was constituted and tested by Miller, Stiff, and Ellis (1988), communicative responsiveness, empathic concern, and emotional contagion can have a role for predicting experiencing burnout. As a result of their research, although empathic concern makes

contributions for communicative responsiveness, emotional contagion impairs this communicative responsiveness. In other words, when emotions are shared between experts and the client or client's emotions are transferred to professional caregivers, their communicative skills which are needed to be crucial for healing the client can be destroyed (Miller, Stiff, & Ellis, 1988).

1.1.9. Factors affecting secondary traumatic stress formation

It is seen that there are lots of demographic factors that have a role in STS. In the current section, gender, age, education and experience level, frequency of exposure, receiving training or supervision, and sense of competency will be explained in terms of their roles on STS.

In terms of the relationship between gender and STS, there are conflicting findings in the literature. According to a study which was conducted by Sprang, Craig, and Clark (2011), male participants reported a higher level of STS than female participants. On the other hand, Ivicic and Motta (2017) revealed that secondary trauma is more common in women. MacEachern, Dennis, Jackson, and Jindal-Snape (2019) found no significant difference in respect to the relationship between gender and STS. However, it is highlighted that only female participants' scores matched the criteria for severe STS. This result was also supported by Creamer and Liddle (2005).

As in the gender variable, different results related to the role of age on STS were found. As a result of their study, Creamer and Liddle (2005) indicated that there was a negative relationship between age and STS. This means that being young predicts a high level of STS. Conversely, another study didn't find any relationship between age and STS (Adams, Figley, & Boscarino, 2008).

Considering the role of educational level on STS, findings differing from each other are seen. Creamer and Liddle (2005) found that there was no significant relationship between education levels such as having a master's degree or doctorate and STS. Similarly, according to the results of their study, Ghahramanlou and Brodbeck (2000) mention that education level has no predictive role for STS. In contrast with this study, it is stated that if the education level becomes higher, people experience secondary traumatic stress less (Baird & Jenkins, 2003).

There are also mixed findings of the experience factor in the literature. It was revealed that lack of experience was significantly related to higher STS (Cunningham, 2003; Creamer

& Liddle, 2005). Bride (2012) also notices younger and less experienced experts have a higher risk of STS. He explained this finding by highlighting coping mechanisms that are developed with the experiences. This means that when experts are exposed to work with the traumatic groups, they begin to develop coping skills against these difficult working conditions. On the other hand, Meldrum, King, and Spooner (2002) found that there was no relationship between these two variables.

With regard to the role of exposure frequency on secondary traumatic stress, Creamer and Liddle (2005) claimed that being exposed to traumatic cases (heavier caseloads) too often has a role in experiencing higher secondary traumatic stress. Moreover, Baird and Kracen (2006) revealed that how much being exposed to traumatic material is an important determinant for developing secondary traumatic stress. In contrast with these findings, exposure frequency of case overload was not found as related to signs of STS (Adams, Figley, & Boscarino, 2006).

Another important factor is receiving training or supervision about working with traumatized groups. Pearlman and Mac Ian (1995) mention that if experts are not trained about their hard conditions of work such as the effects of being exposed to traumatic material, they may be influenced negatively. Moreover, in favor of this training, experts may be protected against side effects of working with this special population (Pearlman & Mac Ian, 1995).

The last factor which is mentioned in the current paper is competency. In light of the literature, it is seen that there is a relationship between competency and STS. For instance, Choi (2017) discovered that having higher levels of psychological empowerment that is thought to be caused by a sense of competency and other related factors such as self-determination is a protective factor against STS. According to this, having a sense of competency may be considered as having a protective role on secondary traumatic stress.

In sum, STS was explained detailly by mentioning PTSD and its related theories, factors for STS, and approaches that explained STS. It is thought that working with traumatized groups cause compassion fatigue among professionals (Figley, 2002). Therefore, in the following section, self-compassion and the role of self-compassion on well-being will be mentioned.

1.2. Self-compassion

For many years, different notions about a healthy attitude toward the self which are thought of as self-respect (Seligman, 1995), self-efficacy (Bandura, 1990), and true self-esteem (Deci & Ryan, 1995) have been established. Apart from these conceptualizations, self-compassion which is seen as a crucial concept in Buddhist philosophy was drawn attention (Rosenberg, 2000). The concept of self-compassion is newer for Western psychology than its original existence in Eastern philosophical thought (Neff, 2003a). Neff (2003a) states that with the contributions of interactions between Buddhism and psychology, approaching mental well-being is widen and moreover, new research ways and different treatments for mental disorders came to exist.

In accordance with Germer (2019), self-compassion is a procedure of accepting thought or emotion. Self-compassion means accepting directly our self that suffers. Self-compassion is defined in relation to compassion (Neff, 2003a). Germer (2019) underlines that the word of compassion is composed of two Latin words, com which means with and pati which means suffering. Therefore, this whole word means suffering together (Germer, 2019). In the definition of compassion, there are some components. These components are explained as "being touched by the suffering of others", "opening one's awareness to others' pain and not avoiding or disconnecting from it so that feelings of kindness toward others, and the desire to alleviate their suffering emerge" (Wispe, 1991). It is mentioned that compassion offers people a non-judgmental approaching to those who fail or make a mistake. In this way, they can see that their actions and behaviors may share fallibility which is seen among others (Neff, 2003a).

Starting from this point of view, "self-compassion involves being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering, and to heal oneself with kindness" (Neff, 2003a, pp. 87). With self-compassion, people show a nonjudgmental understanding of their pain, deficiencies, and unsuccess. Since therefore, they can understand that they are not the only ones who live these unpleasant experiences (Neff, 2003a). In light of this information, self-compassion has been operationalized with three major elements by Neff (2003a). Neff (2003a) claims that these major elements of self-compassion are indicated as "self-kindness versus self-judgment", "a sense of common humanity versus isolation", and "mindfulness versus over-identification". For creating compassion in oneself, these elements connect and there is a mutual relationship among them. It can be said that with mindfulness, self-kindness is improved (Neff, 2003a)

because Jopling (2000) revealed that self-criticism is decreased by mindfulness whereas self-understanding is increased by mindfulness. Furthermore, mindfulness provides a well-balanced perspective. In this way, the sense of isolation and separated which are caused by egocentrism are inhibited, and thus, feeling of interconnectedness becomes strong (Elkind, 1967). Mindfulness is also fed by being kind toward the self and sense of connectedness (Neff, 2003a). It is illustrated that when someone keeps away from self-judgment enough to accept himself or herself, negative influences of emotional experience become less and this makes balance our awareness about emotions (Fredrickson, 2001).

With self-kindness, the first element of self-compassion, gentle, supportive, and understanding attitudes for oneself is laid emphasis on. If someone has self-kindness, he or she can accept his or herself unconditionally and sincerely rather than criticizing or judging him or herself harshly. This person can also calm himself or herself when faced with distress (Neff, 2003a). Common humanity, the second element, highlights comprehending "the common human experience". When someone comprehends this idea, he or she can see that he or she is not the only person who fails and makes mistakes. With common humanity idea, when facing personal inadequacy and complications, people do not feel isolated in their faultiness (Neff, 2003a). Mindfulness, the third element, provides clear awareness of one's current experience of suffering. People who are mindful do not ignore or ruminate about negative aspects of their selves or their life experiences (Neff, 2003a). Sometimes external circumstances of life are seen hard or difficult to handle with it or people may suffer because of another reason aside from themselves. At this stage, self-compassion has a part in the self (Neff, 2003a). Sun, Chan, and Chan (2016) showed gender difference is a reality while getting benefits from the components of self-compassion to be psychologically well. They found that the mindfulness component provides maximum benefit for boys whereas the common humanity component provides maximum benefit for girls to facilitate psychological well-being (Sun, Chan, & Chan, 2016).

1.2.1. The role of self-compassion on psychological health

Self-compassion is studied in terms of its contributions to well-being. Neff and Costigan (2014) indicate that research shows a high level of self-compassion is negatively related to negative states of mind which are depression, anxiety, and stress. MacBeth and Gumley (2012) found a large effect size in self-compassion and psychopathology. According to Neff and Costigan (2014), self-criticism is seen as a key factor in terms of the relationship

between self-compassion and well-being because Blatt (1995) mentions that self-criticism is substantial for anxiety and depression. Fortunately, self-compassion was found to have a protective role against anxiety and depression when self-criticism and negative affect are controlled (Neff, 2003b; Neff, Kirkpatrick, & Rude, 2007). Moreover, it is claimed that when self-compassion is higher, being ruminative, perfectionist, and fearing of failure are diminished (Neff, 2003b; Neff, Hsieh, & Dejitterat, 2005). Moreover, Neff and Costigan (2014) state that different reactions to negative events and self-compassion are related. In accordance with the study which was conducted by Leary, Tate, Adams, Allen, and Hancock (2007), it is revealed that negative emotions and extreme reactions were decreased with high self-compassion and accepting thoughts, taking perspective for own problems were increased with high self-compassion. In another study which was conducted by Finlay-Jones, Rees, and Kane (2015) it was found that through decreasing emotion regulation difficulties, stress symptoms are influenced by self-compassion. It should be noted that having fewer negative emotions does not mean that self-compassion extinguishes negative emotions totally (Neff & Costigan, 2014). Indeed, when a person has self-compassion, his or her tendency to suppress unwanted thoughts and emotions is less than others (Neff, 2003b). In fact, self-compassionate people are more likely to identify and confirm the significance of their affects (Leary et al, 2007; Neff, Hseih, & Dejitterat, 2005). Apart from these studies, Wu, Chi, Lin, and Du (2018) investigated whether there are protective roles of self-compassion and gratitude in the relationship between maltreatment in childhood and depression during adulthood or not. It was explored that self-compassion was positively associated with gratitude and self-compassion and gratitude were correlated with depressive signs in a negative way. Self-compassion also was discovered to have a negative relationship between emotional abuse and emotional neglect. Overall results highlighted those depressive symptoms during adulthood were related to emotional abuse and emotional neglect via diminished self-compassion (Wu, Chi, Lin, & Du, 2018).

Neff and Costigan (2014) also indicate that self-compassion and various positive psychological strengths are associated. It is stated that a high level of self-compassion is associated with happiness (Hollis-Walker, & Colosimo, 2011; Neff, Rude, & Kirkpatrick, 2007; Shapira & Mongrain, 2010; Smeets, Neff, Alberts, & Peters, 2014). Furthermore, self-compassionate people are seen as more emotionally intelligent, wisdom, sociable, curious, flexible intelligent, satisfying about their life and feeling socially connected (Heffernan, Griffin, McNulty, & Fitzpatrick, 2010; Martin, Staggers, & Anderson, 2011; Neff, 2003b; Neff, Rude, & Kirkpatrick, 2007). In addition, it is mentioned that people with compassion

toward themselves, experience more autonomy, competency, relatedness, and self-determination (Magnus, Kowalski, & McHugh, 2010; Neff, 2003b).

In the current section, because it was thought that STS and self-compassion might be related, self-compassion and its role on psychological health was stated. Based on research findings that were mentioned above, EMS will be explained in the following section. Moreover, the relationship between EMS and self-compassion will be clarified with studies.

1.3. Early Maladaptive Schemas

Schema is a term that is widely used in the cognitive development area. In this area, a schema is explained as a pattern which influences the reality or helping to explain experiences, mediating perception, and directing responses to experiences. A schema comprises "an abstract representation" of different features. Mostly, a schema contains parts of obvious elements of events (Young, Klosko, & Weishaar, 2003, pp. 6).

In terms of psychology and psychotherapy, a schema can be seen as an extensive regulatory principle that gives the meaning for one's life experience. It is claimed that although many schemas are shaped in early life, they continue to be detailed, and they are combined with later life experiences even if these schemas lose their applicability. This condition shows the need for "cognitive consistency". Cognitive consistency is needed to continue consistent self-image and world view, even though in reality, it is faulty or distorted. According to this, a schema can be favorable or unfavorable, "adaptive, or maladaptive". Furthermore, schemas can be shaped either "in childhood or later in life" (Young, Klosko, & Weishaar, 2003, pp. 7).

According to Young (1990,1999), some of the schemas which are specially developed by toxic childhood experiences might be an important factor for some psychopathological disorders such as personality disorders, problems related to someone's character, and various chronic disorders that are listed in Axis I. Therefore, a subset of schemas which was labeled as Early Maladaptive Schemas (EMS) was defined in order to investigate this idea. According to Young, Klosko, and Weishaar (2003), EMS is defined as a "broad, pervasive pattern" that consists of "memories", "emotions", "cognition", and "bodily sensations". This pattern which is developed during childhood or adolescence is thought about oneself and one's relationships with others. Moreover, this pattern is detailed throughout one's life. In addition to all these, this pattern has a dysfunctional effect on one's life to a significant degree. In sum, EMS is seen as "self-defeating emotional and cognitive

patterns" that are developed early in life and are repeated during life (Young, Klosko, & Weishaar, 2003, pp. 7). In light of this definition, it is emphasized that behavior is driven by schemas. To be more specific, Young theorizes that maladaptive behaviors are responses that are developed as a result of a schema. But they are not a part of schemas (Young, Klosko, & Weishaar, 2003).

Young, Klosko, and Weishaar (2003) state three main factors to explain the origin of schemas. Firstly, unfulfilled core emotional needs in childhood are seen to have a crucial role in schemas. Young and colleagues (2003) have dwelled on five core emotional needs. These are "secure attachments to others which comprises safety, stability, nurturance, and acceptance", "autonomy, competence, and sense of identity", "freedom to express valid needs and emotions", "spontaneity and play", and "realistic limits and self-control" (pp. 10). It is highlighted that even though some people have more emotional needs than others, everybody owns these needs. Thus, they claim that core emotional needs are universal (Young, Klosko, & Weishaar, 2003). In terms of psychological health, it is expected that people can easily fulfill their needs. It is mentioned that when the child's innate temperament and his or her early environment have interacted, frustration in these emotional needs occurs. Concordantly, schema therapy purposes helping people to learn a different way of fulfilling their core emotional needs (Young, Klosko, & Weishaar, 2003). Secondly, early life experiences, especially toxic ones, are thought to be crucial in the origin of schemas. Early experiences are underlined because Young, Klosko, and Weishaar (2003) indicate that current experiences are not as effective as early experiences on schemas. They divided early life experiences into four groups. "Toxic frustration of needs", the first one, happen when the child is destitute of stable and understanding relationship, or love (pp. 10). "Traumatization or victimization", the second one, is seen when the child gets harmed or is victimized (pp. 10). Thereby, some schemas such as Mistrust/Abuse or Defectiveness/Shame is developed. "Experiencing too much good thing" is the third type of early life experiences. Because parents provide everything of a child's needs or beyond, a child's realistic limits, freedom concept, and autonomy cannot be developed in a healthy way. Therefore, some schemas like Dependence/Incompetence or Entitlement/Grandiosity come into existence. Lastly, "selective internalization or identification with significant others" means that child selects his or her "parent's thoughts, emotions, experiences", and responses to internalize them and identify with them (Young, Klosko, & Weishaar, 2003) (pp.11). Lastly, Young, Klosko, and Weishaar (2003) express the importance of emotional temperament on the origins of schemas. It is underlined that child's temperament differs

from each other and everyone has a unique temperament from birth. In addition, during developing schemas, there is an interaction between emotional temperament and severe early life experiences. It is stated that different temperament causes experiencing different events. Moreover, it is argued that when different people experience the same event, they may not respond same because of their different temperaments (Young, Klosko, & Weishaar, 2003).

1.3.1. Early maladaptive schemas and schema domains

The 18 schemas are divided into five groups which are about unfulfilled emotional needs (Young, Klosko, & Weishaar, 2003) (see Table 1). Young, Klosko, and Weishaar (2003) define these categories as schema domains.

Table 1

Early Maladaptive Schemas

Schema Domains	Early Maladaptive Schemas
Disconnection and Rejection	Abandonment/Instability
	Mistrust/Abuse
	Emotional Deprivation
	Defectiveness/Shame
	Social Isolation/Alienation
Impaired Autonomy and Performance	Dependence/ Incompetence
	Vulnerability to Harm or Illness
	Enmeshment/ Undeveloped Self
	Failure
Impaired Limits	Entitlement/Grandiosity
	Insufficient Self-control/ Self-discipline
	Subjugation
Other-Directedness	Self-sacrifice
	Approval-seeking/ Recognition-seeking
	Negativity/ Pessimism
Overvigilance and Inhibition	Emotional Inhibition
	Unrelenting Standards/Hypercriticalness
	Punitiveness

Disconnection and rejection domain: The first schema domain is "disconnection and rejection". People who have these schemas of disconnection and rejection do not have secure and satisfying attachments with others. They think that "their needs for stability, safety, nurturance, love, and belonging" will not be fulfilled by others (pp. 13). It is seen that people in this domain have commonly unstable, abusive, cold, rejecting, or isolated family relationships in the past. In this domain, "Abandonment/Instability Schema, Mistrust/Abuse Schema, Emotional Deprivation Schema, Defectiveness/Shame Schema, and Social Isolation/Alienation Schema" take apart.

Firstly, the Abandonment/Instability Schema is defined as perceiving unstable attachment with significant others. People who have this schema believe that people who are significant for their lives will not continue to be there. The reasons why they think this way is because they are not emotionally predictable, and they are unstable, they will die, or they leave them for better ones (Young, Klosko, & Weishaar, 2003). Secondly, in the Mistrust/Abuse Schema, people have a belief about the fact that other people will use them for their own selfish benefits. They think that they will be abused, humiliated, lied, cheated, and manipulated by others. Thirdly, in the "Emotional Deprivation Schema", people expect that their desire for emotional attachment will meet inadequately. This schema is divided into three groups which are "deprivation of nurturance", "deprivation of empathy", and "deprivation of protection". Fourthly, in the "Defectiveness/Shame Schema", people think that they are faulty, bad, or worthless. Therefore, if they disclose themselves, they believe that they are not be loved by others. This schema generally includes a feeling of embarrassment about perceived inadequacies that may be personal such as "selfishness, aggressive impulses, unacceptable sexual desires" (pp. 13) or general such as bad physical appearance, social inadequacies (Young, Klosko, & Weishaar, 2019). Finally, in the Social Isolation/Alienation Schema, people think that they are not proper for fitting into the large social or external world except for family. These kinds of people see themselves differently from others (Young, Klosko, & Weishaar, 2003).

Impaired Autonomy and Performance Domain: The second domain is named as "impaired autonomy and performance". People who have schemas in this domain have difficulties in differentiating themselves from their parent figures and behaving independently. These kinds of people could be overprotected or neglected when they were children. "The Dependence/Incompetence Schema, Vulnerability to Harm or Illness

Schema, Enmeshment/Undeveloped Self Schema, and the Failure Schema" are in this domain (Young, Klosko, & Weishaar, 2003).

Firstly, in the "Dependence/Incompetence Schema", people think that they are unable to manage their causal responsibilities without getting adequate assist from others (Young, Klosko, & Weishaar, 2003). Secondly, in the "Vulnerability to Harm or Illness Schema", people have overrated fear about being exposed to a disaster or the possibility of the disaster. Moreover, they think that they are not enough strong to cope with this disaster. Fears about the disaster are divided into three medical categories (e.g., having a heart attack or terminal disease like AIDS), emotional (e.g., going mad or losing control), and external (e.g., having an accident, crime, or being exposed to natural disaster) (Young, Klosko, & Weishaar, 2003). Thirdly, in the "Enmeshment/Undeveloped Self Schema", people are often extremely close with significant others and therefore their individuation and social development are damaged. Especially this extremely close relationship is established between themselves and their family members (Young, Klosko, & Weishaar, 2003). Finally, the Failure Schema is about believing that one will fatally be failed when trying to achieve something. Moreover, people who have this schema see themselves are inadequate when comparing themselves with others (Young, Klosko, & Weishaar, 2003).

Impaired Limits Domain: The third domain is "impaired limits". Creating internal limits adequately for reciprocity or self-discipline is found difficult by people who have schemas from this domain. They may experience difficulty in showing respect for others, collaborating, continuing to commit to someone, or performing long-dated goals. Selfishness, pertness, dutifulness, and narcissism are commonly seen in them. This kind of person was exposed to extremely permissive and indulgent parents (Young, Klosko, & Weishaar, 2003). There are two schemas in this domain. The first one is the "Entitlement/Grandiosity Schema". In this schema, people see themselves as outstanding than others. Because of this, they think that they should have exclusive rights and privileges (Young, Klosko, & Weishaar, 2003). People who have this schema do not feel a limitation in the rule of reciprocity that is necessary for normal social interaction. Even if they endanger the other, they insist do whatever they want. They lack empathy and dominant (Young, Klosko, & Weishaar, 2019). The second one is the "Insufficient Self-Control/Self-Discipline Schema". In this schema, people experience difficulty in making enough self-control and they have difficulty in controlling frustration tolerance to gain their achievements (Young,

Klosko, & Weishaar, 2003). Furthermore, they cannot regulate their expression of impulses and emotions (Young, Klosko, & Weishaar, 2019). Avoiding conflict or responsibility is common in a moderate version of this schema (Young, Klosko, & Weishaar, 2019).

Other-directedness Domain: The fourth schema domain is named as "other-directedness". In this domain, people see more important "the needs of others rather than their own needs" because of gaining approval, not losing emotional connection, or avoiding revenge. Moreover, due to focusing on others' needs excessively, they have lack of self-awareness about their anger and choices (Young, Klosko, & Weishaar, 2003, pp. 19). In the family background of the other-directedness domain, conditional love is seen. In childhood, people who have schemas from this domain are not free to pursue their natural disposition. In adulthood, they are oriented externally and therefore they conform to other desires (Young, Klosko, & Weishaar, 2019). There are three schemas in the other-directedness domain. The first one is the "Subjugation Schema". People who have this schema resign themselves to others' control due to feeling forced. These people tend to perceive their needs and feelings less important. They subjugate their needs because they think that anger, retaliation, or abandonment can be avoided in this way. This schema has two main forms which are "subjugation of needs: suppressing one's preferences or desires" and "subjugation of emotions: suppressing one's emotional responses, especially anger" (pp. 19) (Young, Klosko, & Weishaar, 2003). The second one is the "Self-Sacrifice Schema". In this schema, people sacrifice themselves to others' needs to "avoid guilt, gain self-esteem", or continue an emotional relationship with someone who is perceived as indigent. Even if they will lose their gratification, they are willing to fulfill the others' needs (Young, Klosko, & Weishaar, 2003). The third one is "approval-seeking/Recognition-Seeking Schema". People who have this schema place emphasis on "gaining approval" from others rather than forming a "secure and genuine sense of self". For instance, behaviors or responses of others are pursued developing their self-esteem by comparison with their responses (Young, Klosko, & Weishaar, 2003, pp. 20). People with this schema usually focus on social status, money, or success extremely in order to be accepted by others (Young, Klosko, & Weishaar, 2019).

Over Vigilance and Inhibition: The fifth schema domain is called as "over vigilance and inhibition". Pressing natural feelings and impulses is commonly seen in people who

have schemas from this domain. They have unchangeable and internalized rules about their actions. Even if they are "expense of happiness", "self-expression", feeling relax, "close relationships", or having "good health", they tend to make an effort to fulfill their rigid standards (Young, Klosko, & Weishaar, 2003, pp. 20). During childhood, people with this schema domain were suppressed and were exposed to strict rules by their parents. They were not encouraged to play and pursue happiness. In parallel to this, they learned to be hypervigilant towards negative daily events and view life in a negative way (Young, Klosko, & Weishaar, 2019). There are four schemas in this domain. Firstly, people who have "Negativity/Pessimism Schema" focalize on unfavorable aspects of life which can be illustrated as death, loss, betrayal during their life. When focusing on these adverse ones, they ignore favorable aspects of life. They also have exaggerated expectations that somethings will go from bad to worse (Young, Klosko, & Weishaar, 2003). Secondly, people who have "Emotional Inhibition Schema" block their natural behaviors, emotions, and communication. In this schema, the main aim is to avoid being criticized by others or hinder losing control of their impulses (Young, Klosko, & Weishaar, 2003). Thirdly, people with "Unrelenting Standards/ Hypercriticalness Schema" endeavor to reach their very high internalized standards to prevent experiencing disapproval or feeling shame. They usually feel pressure and they behave hypercritically toward themselves and others. "perfectionism", "rigid rules and should in many areas of life", and "preoccupation with time and efficiency" are the main characteristics of this schema (Young, Klosko, & Weishaar, 2003, pp. 21). Finally, in "Punitiveness Schema", people have a belief about being severely punished because of making mistakes. They tend to be angry and intolerant towards both themselves and others who do not reach one's standard. Forgiveness is difficult for them because of being unwilling to conceive attenuation circumstances, to permit for human imperfection, or consider one's intentions (Young, Klosko, & Weishaar, 2003).

In the current study, the Turkish adaptation of the "Young Schema Scale-Short Form" will be used. Therefore, it is important to note that after Soygüt and her colleagues (2009) made the adaptation of this scale, they found that five schema domains and fourteen schemas were appropriate for Turkish culture. These schema domains are named as "Impaired Autonomy and Performance", "Disconnection/Rejection", "Unrelenting Standards", "Other-directedness", and "Impaired Limits". Moreover, appropriate schema dimensions for Turkish culture are "Emotional Deprivation", "Emotional Inhibition", "Social Isolation/Mistrust", "Defectiveness", "Enmeshment/Dependency", "Abandonment",

"Failure", "Pessimism", "Vulnerability to harm", "Insufficient Self-control/Self-discipline", "Self-sacrifice", "Punitiveness", "Unrelenting Standards", and "Approval-seeking" (see Table 2.) (Soygüt et al., 2009).

Table 2

Turkish Adaptation of Early Maladaptive Schemas by Soygüt et al. (2009)

Schema Domains	Early Maladaptive Schemas
Disconnection and Rejection	Emotional Deprivation
	Emotional Inhibition
	Social Isolation/ Mistrust
	Defectiveness
Impaired Autonomy and Performance	Enmeshment/ Dependency
	Abandonment
	Failure
	Pessimism
	Vulnerability to Harm
Impaired Limits	Insufficient Self-Control/ Self-Discipline
Other-Directedness	Self-Sacrifice
	Punitiveness
Unrelenting Standards	Unrelenting Standards
	Approval-Seeking

1.3.2. Early maladaptive schemas and self-compassion

As it is seen, EMS is a broad and important topic in terms of psychological well-being. There are various studies about early maladaptive schemas and their relational topics. As it is mentioned above, it can be said that self-compassion is necessary for well-being. There is a role of EMS on self-compassion. A study which was conducted by Thimm in 2017 analyzed relationships between EMS, mindfulness, self-compassion, and psychological distress. The results show a negative relationship between EMS, mindfulness, and self-compassion, and the relationship between EMS and psychological distress is mediated by self-compassion and mindfulness (Thimm, 2017). To be more specific, except for two schemas that were named as enmeshment and entitlement, EMS was negatively correlated

with self-compassion. This finding shows that because of these EMS people tend to have a self-critical and harsh attitude for themselves (Thimm, 2017). Another one of the studies about early maladaptive schemas and self-compassion was conducted by Yakın in 2015. This study investigated the role of early recollections which are assumed as EMS, self-compassion, and emotion regulation (Yakın, 2015). It was found that the relationship between three schema domains which were "disconnection/rejection, impaired autonomy and performance, and impaired limits domain" and well-being was mediated emotion regulation and self-compassion. Moreover, it was emphasized that self-compassion was seen as more crucial for life satisfaction than emotion regulation (Yakın, 2015). About Fırıncı (2019), it was revealed that the relationship between all EMS domains and break-up adjustment in adolescents was mediated by self-compassion and gratitude. According to the study that was conducted by Konuş (2019), a positive dimension of self-compassion has a mediation role on the relationship between childhood traumas and "disconnection/rejection" in individuals who have a substance addiction.

1. 4. The Importance of Thesis

Experiencing trauma indirectly might be devastating for psychological health. People's traumatic experiences influence their families (Jordan et al., 1992; Riggs, Byrne, Weathers, & Litz, 1998) and professionals who are responsible for helping them (Bride, 2007) as secondary traumatic stress. Like PTSD, in STS people experience "intrusion, avoidance, and arousal" symptoms (Figley, 1999). Moreover, it is highlighted that working with traumatized groups might cause compassion fatigue (Figley, 2002). Studies about self-compassion show that self-compassion has healing role for lots of psychopathologies such as depression and anxiety (Neff & Costigan, 2014), rumination (Neff, 2003b), and emotion regulation difficulties (Finlay-Jones, Rees, & Kane, 2015). Although the relationship between self-compassion and well-being has been studied so far and compassion fatigue because of STS has been highlighted in the literature, the role of self-compassion for STS has not been examined.

EMS are "self-defeating, emotional, and cognitive patterns that begin early in our development and repeat throughout life" (Young, Klosko, & Weishaar, 2003, pp. 7). There are various studies that indicate the relationship between EMS and self-compassion (Thimm, 2017; Yakın, 2015; Fırıncı, 2019; Konuş, 2019). For instance, Yakın (2015) found that "disconnection/rejection, impaired autonomy and performance, and impaired limits domain"

and well-being was mediated emotion regulation and self-compassion. In another study, it was revealed that the relationship between all EMS domains and break-up adjustment was mediated by self-compassion and gratitude (Fırıncı, 2019). Apart from the relationship between EMS and self-compassion, emotional abuse and neglect was discovered to be negatively related with self-compassion (Wu, Chi, Lin, & Du, 2018).

As it is understood, self-compassion is important factor for psychological well-being and EMS is related to self-compassion. Moreover, STS is serious and common problem for professionals. Although the relationship between some variables such as EMS domains and self-compassion or compassion fatigue which is seen as being related to STS among experts who are working with traumatized groups were examined up to now, studies related to the relationship among EMS, self-compassion, and STS among these experts are barely found in the literature. Therefore, it is thought that this study will make a significant contribution to the related literature.

In Turkey, there are above 3.6 million Syrian refugees and approximately 400,000 refugees and asylum-seekers from other nationalities (UNHCR, 2020). Taking into consideration that refugees have had many traumatic experiences (Demirbaş & Bekaroğlu, 2013), refugee aid workers in Turkey are thought to be at high risk for STS (Çırakoğlu, 2018). Therefore, in parallel with making a contribution to the literature, it is assumed that this study will present beneficial information to refugee aid workers by emphasizing the existence of self-compassion. In favor of this study, the importance of self-compassion training programs may be highlighted for protecting refugee aid workers against STS.

1. 5. The Purpose of the Thesis

Lots of experts provide health, education, legal service, and psychological support for refugees and asylum-seekers. While providing these, refugee aid workers are exposed to refugees and asylum-seekers' traumatic experiences. Therefore, it is stated that these aid workers have a high level of risk for STS (Çırakoğlu, 2018). There are various studies that remark the powerful role of self-compassion on psychological health (Neff & Costigan, 2014; Finlay-Jones, Rees, & Kane, 2015; MacBeth & Gumley, 2012). Taking into account all of these studies, it may be thought self-compassion has a protective role against STS. According to Young (1990,1999), some of the schemas which are specially developed by toxic childhood experiences might be an important factor for personality disorders, problems related to someone's character, and various chronic disorders that are listed in Axis I. When

surveying the related literature, it is seen that there is a relationship between these schemas that result from toxic childhood and self-compassion (Thimm, 2017; Yakın, 2015; Konuş, 2019). Also, it is seen that self-compassion has a mediation role in the relationships between early maladaptive schema domains and well-being, and break-up adjustment (Yakın, 2015; Fırıncı, 2019). However, in accordance with the literature review, both the relationship between EMS and its domains and STS and the relationship among self-compassion, EMS, and its domains and STS were not studied directly.

In light of the literature, the aim of this thesis, therefore, is examining the mediating role of self-compassion on the relationship between EMS domains and STS of refugee aid workers. In line with this aim, the proposed model of this thesis is represented in Figure 1.

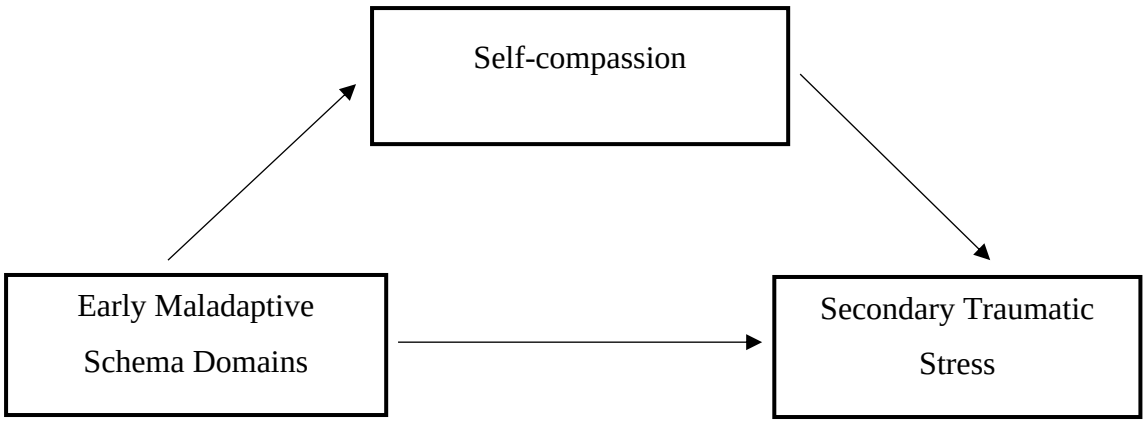


Figure 1. The mediation role of self-compassion on the relationship between early maladaptive schema domains and secondary traumatic stress.

1. 5. 1. Research questions/ hypotheses

In line with the purpose of this thesis, research questions written below will be answered:

1) Is there a significant difference in secondary traumatic stress in terms of gender, age, receiving in-service training, sense of competence, working experience?

2) Is the relationship between variables that are early maladaptive schema domains, self-compassion, and secondary traumatic stress significant in this study?

a) There is a negative and significant relationship between early maladaptive schema domains and self-compassion.

b) It is expected that secondary traumatic stress is correlated significantly and negatively with self-compassion. In other words, it is believed that if the experts have compassion for themselves, they are likely to handle the difficult aspects of working with traumatized groups which are assumed as experiencing secondary traumatic stress.

c) It is hypothesized that there is a significant and positive relationship between early maladaptive schema domains and secondary traumatic stress of refugee aid workers.

3) Is the mediation model significant?

a) It is expected that secondary traumatic stress is predicted by early maladaptive schema domains with the mediator role of self-compassion. In other words, early maladaptive schema domains increase secondary traumatic stress via decreasing self-compassion.

CHAPTER II
METHOD

This chapter was included design, sample, instruments, and procedure parts of the current study.

2. 1. Design

In this cross-sectional study, a quantitative and correlational research method was used. The reason for selecting this method was the underlying nature of the problem and data collection procedures. Time limitations and lack of trained personal for the data gathering process were precluded to make this study quantitative. Also, nearly all of the variables such as early maladaptive schema domains, self-compassion, and STS were abstract concepts, and this makes these variables unobservable. Hypotheses of the current study were suitable for correlational design because there is no manipulation among variables. Moreover, hypotheses were constructed to examine the existing relationship between variables.

2. 2. Sample

In the study, 116 people who are working with traumatized groups as an expert have participated. These participants comprised of refugee aid workers who have at least a bachelor's degree. These refugee aid workers were working in the office environment or the field. Their in-service-training about working with refugees who are assumed as the traumatized group asked at demographic form. The sample included 83 (71.6%) females and 33 (28.4) male participants. Their age range was between 23 and 64 (M = 29.6, SD = 5.5). While selecting participants, purposive sampling was used. The reason for using purposive sampling was to examine determined people who experience secondary traumatic stress because of their occupation. Detailed information about the demographics of the participants is demonstrated in Table 3.

Table 3

Demographic Information Table

		N	%	Missing Data
Sex	Male	33	28,4	
	Female	83	71,6	
Age	22-30	86	74,1	
	31-40	26	22,4	
	41-above	4	3,4	
Educational Status	Undergraduate	76	65,5	
	Postgraduate	33	28,4	
	Doctorate	7	6	
Workplace	Non-Governmental Organization	99	85,3	
	Governmental Organization	17	14,7	
Working Environment	Office	84	72,4	
	Field	32	27,6	
Work Experience	Less than 1 year	45	38,8	
	1-3 Years	42	36,2	
	More than 3 years	29	25	
Exposure time (Weekly)	Less than 10 hours	25	21,6	
	11-20 hours	15	12,9	
	More than 21 hours	76	65,5	
Inservice-Training	Yes	84	72,4	
	No	32	27,6	
Perceived Competence	Completely Incompetent	0	0	
	Incompetent	8	6,9	
	Average	33	28,4	
	Competent	58	50	
	Completely Competent	17	14,7	

2. 3. Instruments

In the current research, data collection was completed via Demographic Questionnaire, Young Schema Questionnaire- Short Form Version 3 (YSQ-SF3), Secondary Traumatic

Stress Scale (STSS), and Self-compassion Scale. Moreover, the informed consent form was shared and permission about participating in the study was obtained from participants.

2. 3. 1. Informed consent form

With this form, participants informed about the study topic and they approved being participated voluntarily. Informed Consent Form was demonstrated in Appendix 1.

2. 3. 2. Demographic questionnaire

This questionnaire included questions about gender, age, education level, which department they graduate from, type of institution such as non-governmental organization and governmental institution, duty at their work and their work environment, working experience with the traumatic groups in terms months, how many hours per day and week they are exposed to these groups, in-service training, and their degree of feeling competent. Demographic Questionnaire was demonstrated in Appendix 2.

2. 3. 3. Self-compassion Scale

The self-compassion scale was developed by Neff (2003b). On this scale, there are 26 items. These items were rated based on a five-point Likert scale. Moreover, these items were grouped into six subdimensions which are named “self-kindness”, “self-judgment”,” common humanity”, “isolation”, “mindfulness”, and “over-identification” (Neff, 2003b). Internal consistency coefficients for subdimensions were found respectively as .78, .77, .80, .79, .75, and .81. The Turkish adaptation of the Self-compassion scale was conducted by Akın, Akın, and Abacı (2007). The Turkish version of this scale was named as “Öz-duyarlık Ölçeği”. Internal consistency of “Öz-duyarlık Ölçeği” was calculated between .72 and .80. In this scale, scores for each sub-dimension and the overall score are calculated. The lowest total score is between 1 and 2.5 whereas the highest total score is between 3.5 and 5. The high scores which were obtained by a participant from each subscale indicate that the participant has the characteristics of the related subscale. Lowest scores that are between 1 and 2.5 mean low level of self-compassion, scores between 2.5 and 3.5 mean middle level of self-compassion and highest scores between 3.5 and 5 mean high level of self-compassion. In the current study, internal consistency coefficients for sub-dimensions were found

respectively as .84, .85, .73, .72, .78, and .74. Cronbach's alpha coefficient for the total scale was calculated as .94. Turkish version of the Self-compassion Scale is demonstrated in Appendix 3.

2. 3. 4. Secondary Traumatic Stress Scale (STSS)

The secondary traumatic stress scale was originally developed by Bride and his colleagues in 2004. On this scale, there are 17 items. These items are rated based on a five-point Likert scale. There are three sub-dimension which are named as an intrusion, avoidance, and arousal. The minimum score on this scale is 17 whereas the maximum score is 85. A higher score means being higher effected by STS. The internal consistency coefficient for STSS was calculated as 0.94, whereas internal consistency coefficients for intrusion, avoidance, and arousal were calculated respectively as 0.83, 0.89, and 0.85 (Bride and his colleagues, 2004). The Turkish version of STSS was adapted by Kahil and Palabıyıkoğlu in 2018. The reliability coefficient for the whole scale was calculated as 0.94 (Kahil & Palabıyıkoğlu, 2018). Differently from the Bride's scale, this adaptation of STSS was stated as one dimensional (Kahil & Palabıyıkoğlu, 2018). In the current study, Cronbach's alpha coefficient for the Secondary Traumatic Stress Scale was found as .93. Turkish version of the STSS is demonstrated in Appendix 4.

2. 3. 5. Young Schema Questionnaire- Short Form Version 3 (YSQ-SF3)

Young Schema Scale was developed by Young in 1990. In the long version of the Young Schema Scale, there are 16 schema domains and 205 items. The last version of the Young Schema Scale which includes 5 schema domains and 18 schema dimensions will be used (Young, 1990; Young and his colleagues, 2003). In the last version, YSQ-SF3, 90 items are rated based on a six-point Likert Scale. Higher scores mean increase in the number and severity of maladaptive schemas. This measurement was studied in terms of reliability and validity analyses in Turkey by Soygüt and her colleagues in 2009. Their analyses revealed that 5 schema domain and 14 schema dimensions were suitable for Turkish culture. These schema dimensions are "emotional deprivation", "failure", "pessimism", "social isolation/insecurity", "suppressing emotions", "approval-seeking", "dependence/incompetence", "cliquishness/insufficient self-control", "self-sacrificing", "abandonment, punitiveness", "imperfection", "vulnerability to harm or illness", and

“unrelenting standard/hypercriticalness”. Although item numbers did not change in the Turkish version of YSQ-SF3, item distributions became different. As a result of their analyses, internal consistency coefficient for schema dimensions was found between α=.67 and α=.81 and internal consistency coefficient for schema domains was calculated as between α=.70 and α=.90 (Soygüt et al., 2009). In the current study, Cronbach’s alpha coefficient of internal consistency for schemas was found between .74 and .93, whereas Cronbach’s alpha coefficients for schema domains were calculated as between .74 and .94. and Cronbach’s alpha coefficient for the total scale was found as .97. Turkish version of YSQ-SF3 is demonstrated in Appendix 5.

2. 4. Procedure

Firstly, before collecting the data, necessary permission was obtained from the Başkent University Social and Human Sciences and Art Research Committee. The battery which was prepared for the current study includes 133 items. The data from participants were collected via the online method or paper-pencil method. For online data collection, the battery was adapted for Qualtrics.com and this web site was used to collect online data. Personal identifying information is not taken from the participants and the identity of the participants was kept anonymous. IBM SPSS Statistics 24.0 package software and Process Macro for SPSS (Process v3.5) were used to analyses the data.

CHAPTER III
RESULTS

In this chapter, the results obtained from the statistical analysis was provided in relation to the research questions. First of all, the necessary assumptions were checked that were uncorrelatedness of residuals, absence of strong multicollinearity, homoscedasticity, normality, linearity, and outliers. Later, the descriptive analysis was conducted, and the analysis of the descriptive statistics was provided for each scale. And then, to check the second research question, a Pearson R Correlation Analysis was performed, and the results were presented in a correlation table. Finally, in order to examine the mediating role of self-compassion on the relationship between early maladaptive schema domains and secondary traumatic stress, the results of regression analysis that were conducted via using with SPSS process macro v3.5 (Hayes, 2020) and based on bootstrapping procedure were presented.

3.1. Descriptive Statistics

Before analyzing the data, outliers were calculated with multivariate outlier analysis. For missing data, participants/data who were left 10% and more of scales blank were eliminated from the data set. The average of responses that participants gave to the related question was assigned for data that where less than 10 % of scales are left blank (Hair, Black, Babin, & Anderson, 2010). Then, to test whether each variable was normally distributed or not Skewness and Kurtosis values were calculated. In accordance with George and Mallery (2010), the fact that Skewness and Kurtosis values are located between +2 and -2 means that the relevant variable shows the normal distribution. It was found that all variables were normally distributed. Finally, the total score of each scale was calculated and reliability analysis for scales was conducted. Descriptive statistics related to variables in this study were represented in Table 4.

Table 4

Descriptive Statistics

Variable	*n*	*M*	*SD*	Variance	Range	Min	Max	Skewness	Kurtosis
Age	116	29.6	5.51	30.38	41	23	64	2.78	12.88
Working Experience (Month)	116	26.82	26.83	719.74	119	1	120	1.96	4.14
Exposure Time (Weekly)	116	28.64	14.78	218.39	70	0	70	-.25	-.80
SCS Total Score	116	3.5	.63	.40	2,95	2.01	4.96	-.33	-.45
STSS Total Score	116	37.09	12.48	155.70	61	17	78	.62	.09
YSQ-SF3 Disconnection and rejection	116	49.56	19.18	367.68	90	23	113	1.04	.80
YSQ-SF3 Impaired autonomy and performance	116	61.43	22.42	502.7	93	30	123	.82	.03
YSQ-SF3 Impaired limits	116	23.60	6.56	43.02	35	7	42	.03	.08
YSQ-SF3 Other-directedness	116	35.61	9.37	87.84	50	11	61	-.13	-.10
YSQ-SF3 Unrelenting standards	116	27.79	8.56	73.23	44	9	53	.47	.11

Note. SCS: Self-compassion Scale, STSS: Secondary traumatic stress scale, YSQ-SF3: Young schema questionnaire - Short Form Version 3

3.2. Inter-correlations among Variables of The Study

In this part, the relationships between the main variables of this study that are early maladaptive schema domains, self-compassion, secondary traumatic stress, gender, and working experience were examined. To find the relationship between them, the Pearson Correlation Analysis was conducted. The results of correlation analysis between these main variables were represented in Table 7.

According to the results of Pearson's Correlation Analysis, it was found that the "disconnection and rejection schema domain" was significantly and positively correlated with STS (r=.359, p<.01) and significantly and negatively correlated with self-compassion (r=-.573, p<.01).

It was discovered that "impaired autonomy and performance schema domain" was significantly and negatively associated with self-compassion (r=-.628, p<.01) whereas "impaired autonomy and performance" were significantly and positively correlated with STS (r=.489, p<.01).

It was revealed that "impaired limits schema domain" was significantly and negatively correlated with self-compassion (r=-.191, p<.05). In terms of the relationship between "impaired limits" and STS, a significant correlation could not be found.

It was detected that the "other-directedness schema domain" was significantly and positively correlated with STS (r=.348, p<.01) and significantly and negatively associated with self-compassion (r=-.482, p<.01).

It was found that the "unrelenting standards schema domain" was significantly and negatively correlated with self-compassion (r=-.519, p<.01) and significantly and positively associated with STS (r=.408, p<.01).

It was discovered that self-compassion and STS were correlated with each other significantly and negatively (r=-.470, p<.01).

Table 5

Inter-correlations among Variables of The Study

Variables	*M*	*SD*	1	2	3	4	5	6	7	8	9
1. Gender	.72	.45	-								
2. Working Experience	26.82	26.83	-.02	-							
3. Disconnection and rejection	49.56	19.18	-.01	.01	-						
4. Impaired autonomy and performance	61.43	22.42	.11	.07	.80**	-					
5. Impaired limits	23.60	6.56	.08	.00	.39**	.35**	-				
6. Other-directedness	35.61	9.37	.16*	.18*	.47**	.60**	.44**	-			
7. Unrelenting standards	27.79	8.56	.16*	.01	.56**	.65**	.49**	.64**	-		
8. STSS Total Score	37.09	12.48	.17*	.18*	.36**	49**	.14	.35**	.41**	-	
9. SCS Total Score	3.50	.63	-.18*	-.04	-57**	-.63**	-.19*	-.48**	-.52**	-.47**	-

Note. SCS: Self-compassion Scale, STSS: Secondary traumatic stress scale, $N = 116$ *$p < .05$, **$p < .01$

3. 3. Comparison of Secondary Traumatic Stress in Terms of Demographic Variables

In the current part, whether there were group differences on STS in terms of gender and receiving in-service training, Mann-Whitney U Test was used because gender and receiving in-service training were not distributed normally according to skewness and kurtosis values. Results that were related to the Mann-Whitney U test are presented in Table 5. On the other hand, whether there were significant differences on secondary traumatic stress in terms of age, education level, sense of competence, and working experience was tested by using One-way ANOVA. Results obtained from the One-way ANOVA test are demonstrated in Table 6.

Table 6

Comparison of both Gender and Received In-service Training with Secondary Traumatic Stress

	N	Mean Rank	Sum of Mean Ranks	U	Z score	P-value
Gender						
Male	33	61.98	5144	1081	-1.77	.08
Female	83	49.76	1642	1642		
In-service Training						
Trained	84	52.65	4423	853	-3.04	.002*
Not trained	32	73.84	2363			

Note. *p<.05

Primarily, the Mann-Whitney U test was conducted to discover whether there were gender differences in STS. The results of the test showed that females (*M*=38.43) did not differ from males (*M*=33.70) in terms of STS (U= 1081, z=-1.77, *p*>.05) (see Table 5). Then, the Mann-Whitney U test was conducted to test whether receiving in-service training made differences on secondary traumatic stress. The results of this analysis showed that there was a significant difference between participants who received in-service training (*M*=34.89) and others who did not receive (*M*=42.84) in terms of STS (U=853, z=-3.04, *p*<.05) (see Table 5).

Table 7

One-Way Analysis of Variance of Secondary Traumatic Stress by Age, Education Level, Sense of Competence and Work Experience

Source	*df*	*SS*	*MS*	*F*	*p*
Age					
Between groups	2	198.50	99.25	.63	.53
Within groups	113	17706.64	156.70		
Total	115	17905.14			
Education Level					
Between groups	2	93.53	46.77	.30	.74
Within groups	113	17811.61	157.63		
Total	115	17905.14			
Sense of Competence					
Between groups	3	753.90	251.30	1.64	.18
Within groups	112	17151.25	153.14		
Total	115	17905.14			
Work Experience					
Between groups	2	140.04	70.02	.45	.64
Within groups	113	17765.10	157.21		
Total	115	17905.14			

After conducting the analyzes with Mann-Whitney U Test, Firstly, the effect of age on STS was tested. In accordance with Levene Statistic, the data were found to provide homogeneity of variances ($p>.05$). One-way Anova analysis revealed that there was not a significant effect of age on STS at the $p<.05$ level for the three conditions [F (2, 113) = .63, $p=.53$] (see Table 6). Secondly, the effect of education level on STS was tested. Accordingly, Levene Statistic, the data were found to provide homogeneity of variances ($p>.05$). One-way ANOVA analysis showed that there was not a significant effect of education level on STS at the $p<.05$ level for the three conditions [F (2, 113) = .30, $p=.74$] (see Table 6). Thirdly, the effect of feeling a sense of competence on STS was analyzed. About Levene Statistic, the data were found to provide homogeneity of variances ($p>.05$). It was found that there was no significant effect of feeling a sense of competence on STS at the $p<.05$ level for four conditions [F (3,112) = 1.64, $p=.18$] (see Table 6). Then, the effect of work experience on

STS was examined. In accordance with Levene Statistic, the data were found to provide homogeneity of variances (p>.05). Similarly, the other results, there was no significant effect of work experience on STS at the p<.05 level for the three conditions [F (2, 113) = .45, p=.64] (see Table 6).

The data were re-analyzed repeatedly with the Mann-Whitney U and One-way Anova tests via randomly selecting different parts from the half of the data. After comparing the results of these analysis with the primary results, significant differences were not found. In this way, results of Mann-Whitney U and One-way Anova tests were crosschecked.

Consequently, it was only found that receiving in-service training had a significant effect on secondary traumatic stress.

3.4. The Mediation Analysis

Mediation analysis aims to test hypotheses that related to whether causal antecedent X variable conveys its impact on a result/outcome Y variable. In the simple mediation model, two result variables are M and Y and two antecedent variables that are X and M. Also, it is stated that the X variable causatively affects Y and M variables whereas M variable causatively affects Y. In other words, with a simple mediation model, whether at least one antecedent variable called X affects an outcome variable called Y via one intervening variable called M can be tested. Therefore, the M variable is named as a mediator variable. The number of paths that X can affect Y is two. One pathway (*c'*) is called a direct effect because the X variable goes to the directly Y variable without visiting the M variable. When the antecedent X variable goes to the M variable that becomes an outcome, this path is named as *a* and when antecedent M variables go to outcome Y variable, this path is called *b*. The other pathway is called the indirect effect (*ab*) because the antecedent X variable first goes to outcome M variable and then the M variable that becomes antecedent variable goes to outcome Y variable. The total effect, on the other hand, is the path that X goes to Y (*c*) (Hayes, 2018).

In the current thesis, the main aim is to examine whether there is a mediating role of self-compassion on the relationship between early maladaptive schema domains and secondary traumatic stress. Therefore, independent variables are EMS domains ("Disconnection and Rejection, Impaired Autonomy and Performance, Impaired Limits, Other-Directedness, and Unrelenting Standards"), the dependent variable is STS, and

mediation variable is self-compassion. In order to test all EMS domains, 5 different mediation models will be designed.

In accordance with this purpose, the regression analysis based on the bootstrap method was performed. To perform this regression analysis, SPSS Process macro version 3.5 that was developed by Hayes (2020) was used and for each schema domain, 5 different mediation models were constituted and each of them was tested via regression analysis based on the bootstrap method. Specifically, for mediation analysis, 5 mediation models were studied with Model 4. It is argued that the bootstrap method is more reliable than Baron and Kenny's traditional method and Sobel Test (1986) (Gürbüz, 2019; Hayes, 2018; Preacher, Rucker ve Hayes, 2007; Zhao, Lynch ve Chen, 2010). In the current analyses, the bootstrap method and 5000 resamplings were chosen. In the mediation analyses that were conducted with the bootstrap method, to support the research hypothesis, it is seen necessary that there should not include zero (0) between values in 95% confidence interval (CI) (MacKinnon, Lockwood, &Williams, 2004). Therefore, the results of mediation analysis via Model 4 were evaluated in parallel with this information. The effect size of mediation models were interpreted following values that are represented in Table 9 (Preacher & Kelley, 2011). In Table 8, mediation models that were tested were presented.

Table 8

Mediation Models

	Independent Variable	Mediator	Dependent Variable
Mediation Model 1*	Disconnection and Rejection	Self-compassion	Secondary Traumatic Stress
Mediation Model 2*	Impaired Autonomy and Performance	Self-compassion	Secondary Traumatic Stress
Mediation Model 3	Impaired Limits	Self-compassion	Secondary Traumatic Stress
Mediation Model 4*	Other-directedness	Self-compassion	Secondary Traumatic Stress
Mediation Model 5*	Unrelenting Standards	Self-compassion	Secondary Traumatic Stress

Note. * The models in which the mediation relationship is significantly marked based on the analysis results.

Table 9

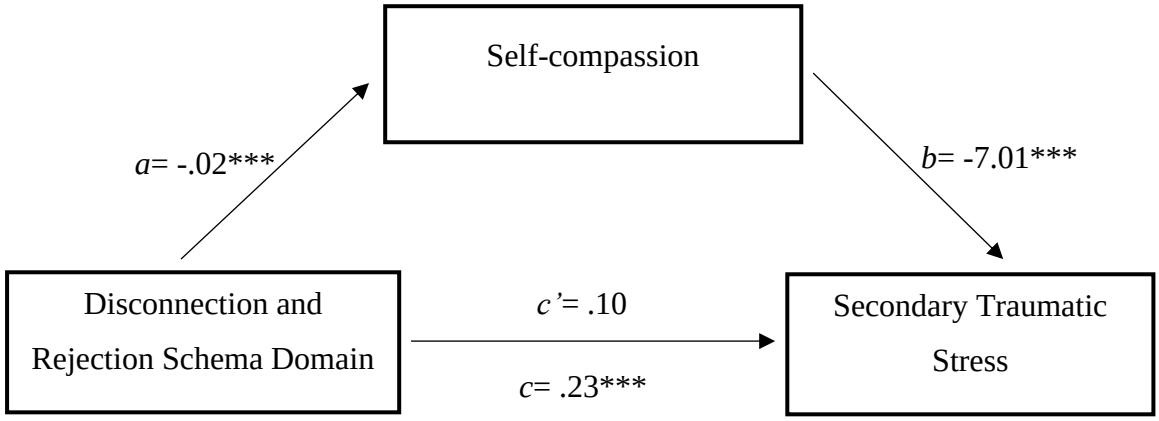
Effect Size of Mediation Models

K^2	Interpretation
Approximate to .01	Small Effect
Approximate to .09	Medium Effect
Approximate to .25	Large Effect

Note. The stated values are created according to Preacher and Kelley (2011).

3.4.1. The mediating role of self-compassion in the relationship between disconnection and rejection schema domain and secondary traumatic stress

In the Mediation Model 1, whether the "Disconnection and Rejection schema domain" predicts STS with the mediating role of self-compassion was tested. After statistically controlling for covariates (gender and working experience), according to direct paths for mediation model 1, firstly, it was seen that "disconnection and rejection schema domain" predicted self-compassion significantly and negatively (B = -.019, 95% CI [-.0235, -.0143], t = -8.178, p < .001). Secondly, it was found that self-compassion predicted secondary traumatic stress significantly and negatively (B = -7,013, 95% CI [-10,6463, -3,3786], t = -3,8240, p<.001]. Thirdly, it was shown that the "disconnection and rejection schema domain" predicted secondary traumatic stress significantly and positively (B = .2334, 95% CI [.1037, .3630], t = 3.5663, p<.001]. Finally, when examining indirect effect to decide whether there is a significant mediation effect of self-compassion, it was discovered that self-compassion significantly mediated the relationship between "disconnection and rejection schema domain" and STS [(b = .133, 95%BCA CI (.0605, .2199)]. Completely standardized indirect effect (K^2) was found as .204. According to Preacher and Kelley (2011), when the effect size is close to K^2=.01, it can be interpreted as small, when it is close to K^2=.09, it can be interpreted as a medium, and when it is close to K^2=.25, it can be interpreted as large. Therefore, it can be stated that the mediation effect in the current model is close to the large value (see Table 9). This result of the mediation analysis supported the third hypothesis that was related to the "disconnection and rejection schema domain". It was also found that the total model is significant [F (3,112) = 7.21, p<.001], and it is seen that it explains 19% of secondary traumatic stress (R^2=.19). Mediation Model 1 is represented in Figure 2.

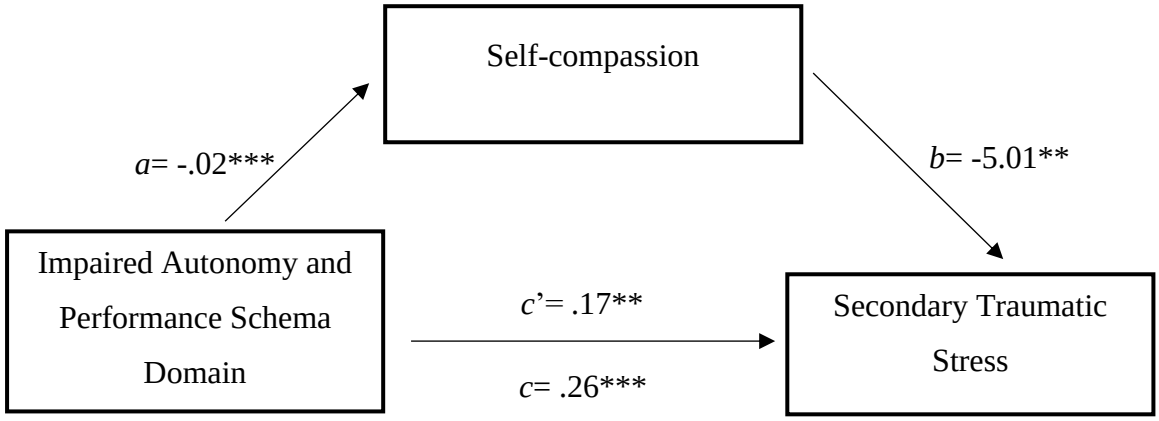


Note. *p < .05, **p < .01, ***p < .001; Non-standardized beta coefficients were used.

Figure 2. The mediation role of self-compassion on the relationship between disconnection and rejection schema domain and secondary traumatic stress.

3.4.2. The mediating role of self-compassion in the relationship between impaired autonomy and performance schema domain and secondary traumatic stress

In the Mediation Model 2, whether "impaired autonomy and performance schema domain" predicts STS with the mediating role of self-compassion was tested. After statistically controlling for covariates (gender and working experience), according to direct paths for mediation model 2, firstly, it was found that "impaired autonomy and performance schema domain" predicted self-compassion significantly and negatively (*B*= -.017, 95%CI [-.0216, -.0131], *t*=-8.127, *p*< .001). Secondly, it was discovered that self-compassion predicted STS significantly and negatively (*B*= -5.006, 95%CI [-8.6164, -1.3964], *t*=-2.748, *p*< .01). Thirdly, it was revealed that "impaired autonomy and performance schema domain" predicted STS significantly and positively (*B*=.259, 95%CI [.1557, .3615], t=4.978, *p*< .001). Finally, according to the indirect effect in the Mediation Model 2, it was seen that self-compassion significantly mediated the relationship between "impaired autonomy and performance schema domain" and STS [(b=.087, 95%BCA CI (.0221, .1672)]. Moreover, a completely standardized indirect effect (K^2) was found as .156. Thus, it can be stated that the effect of mediation in Model 2 is close to the medium value (see Table 9). This result of the mediation analysis supported the third hypothesis that was related to "impaired autonomy and performance schema domain". It was also found that the total model is significant [*F* (3,112) = 10.74, *p*<.001], and it is seen that it explains 28% of STS (R^2=.28). Mediation Model 2 is represented in Figure 3.

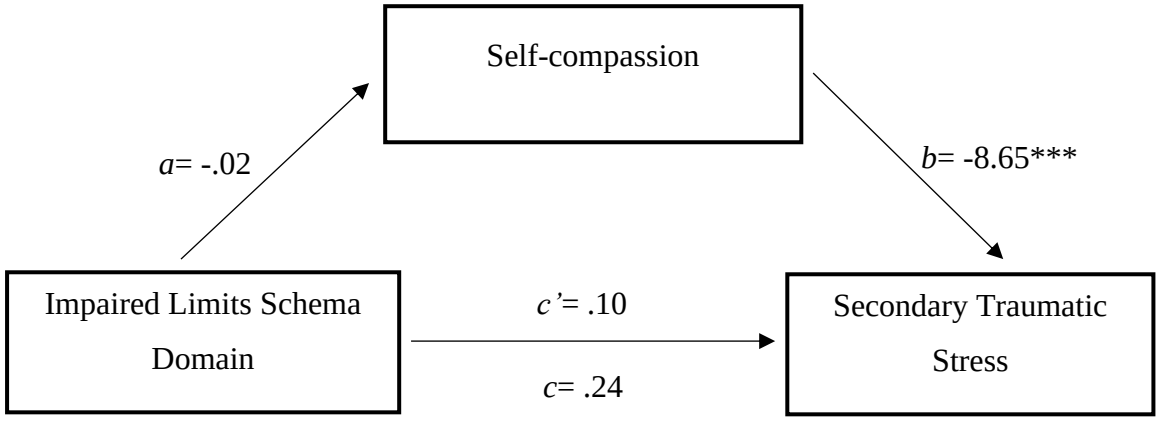


Note. *p < .05, **p < .01, ***p < .001; Non-standardized beta coefficients were used.

Figure 3. The mediation role of self-compassion on the relationship between impaired autonomy and performance schema domain and secondary traumatic stress.

3.4.3. The mediating role of self-compassion in the relationship between impaired limits schema domain and secondary traumatic stress

In the Mediation Model 3, the fact that "impaired limits schema domain" predicts STS via the mediating role of self-compassion was analyzed. After holding covariates (gender and working experience) constant, accordingly direct paths for mediation model 3, firstly, it was revealed that impaired limits did not significantly predict self-compassion (B= -.017, 95%CI [-.0392, .0050], t=-1.534, p> .05). Secondly, it was found that self-compassion significantly predicted STS (B= -8.653, 95%CI [-12.0211, -5.2848], t=-5.091, p<.001). Thirdly, it was discovered that impaired limits did not significantly predict STS (B= .243, 95%CI [-.1243, .6111], t=1.312, p> .05). Finally, according to the indirect effect of the Mediation Model 3, it was found that the relationship between impaired limits and STS was not mediated by self-compassion [(b=.148, 95%BCA CI (-.0294, .3519)]. For this reason, the fourth hypothesis in the current study was not supported. It was also found that the total model is significant [F (3,112) = 3.08, p<.05], and it is seen that it explains 8% of STS (R^2=.08). Mediation Model 3 is represented in Figure 4.

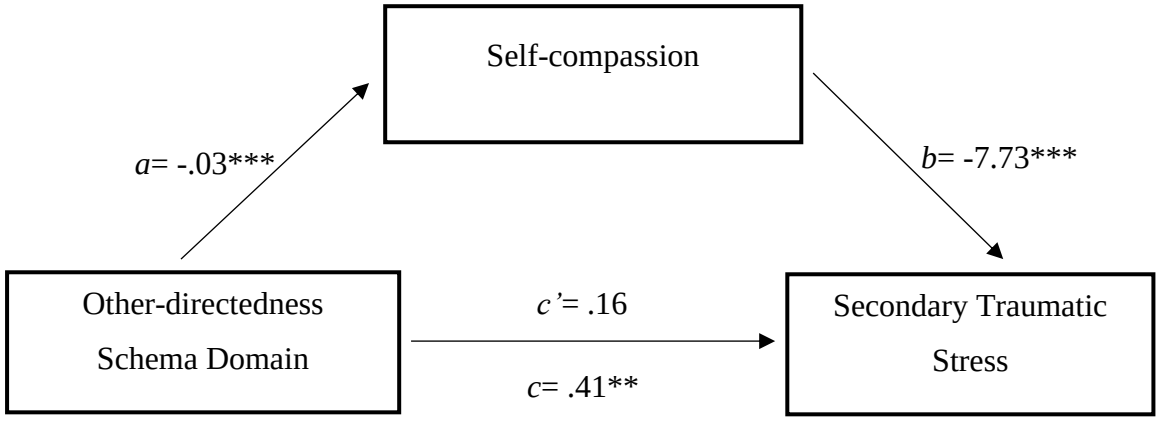


Note. *p < .05, **p < .01, ***p < .001; Non-standardized beta coefficients were used.

Figure 4. The mediation role of self-compassion on the relationship between impaired limits schema domain and secondary traumatic stress.

3.4.4. The mediating role of self-compassion in the relationship between other-directedness schema domain and secondary traumatic stress

In the Mediation Model 4, whether there was a mediating role of self-compassion on the relationship between the "other-directedness schema domain" and STS was analyzed. After holding covariates (gender and working experience) constant, in accordance with direct paths for mediation model 4, firstly, it was found that "other-directedness schema domain" predicted self-compassion significantly and negatively (*B*= -.032, 95%CI [-.0443, -.0195], *t*=-5.107, *p*<.001). Secondly, it was shown that self-compassion predicted STS significantly and negatively (*B*= -7.732, 95%CI [-11.2913, -4.1727], *t*=-4.305, *p*<.001). Thirdly, it was revealed that other-directedness predicted STS significantly and positively (*B*= .407, 95%CI [.1397, .6743], *t*=3.017, *p*<.01). Finally, in accordance with the indirect effect of the Mediation Model 4, it was discovered that the relationship between other-directedness and STS was mediated by self-compassion [(b=.247, 95%BCA CI (.1117, .3997)]. Completely standardized indirect effect (K^2) was found as .185. Thus, it can be stated that the effect of mediation in Model 4 is close to the medium value (see Table 9). This result of the mediation analysis supported the fifth hypothesis that was related to the "other-directedness schema domain". It was also found that the total model is significant [*F* (3,112) = 5.57, *p*<.01], and it is seen that it explains 15% of STS (R^2=.15). Mediation Model 4 is represented in Figure 5.

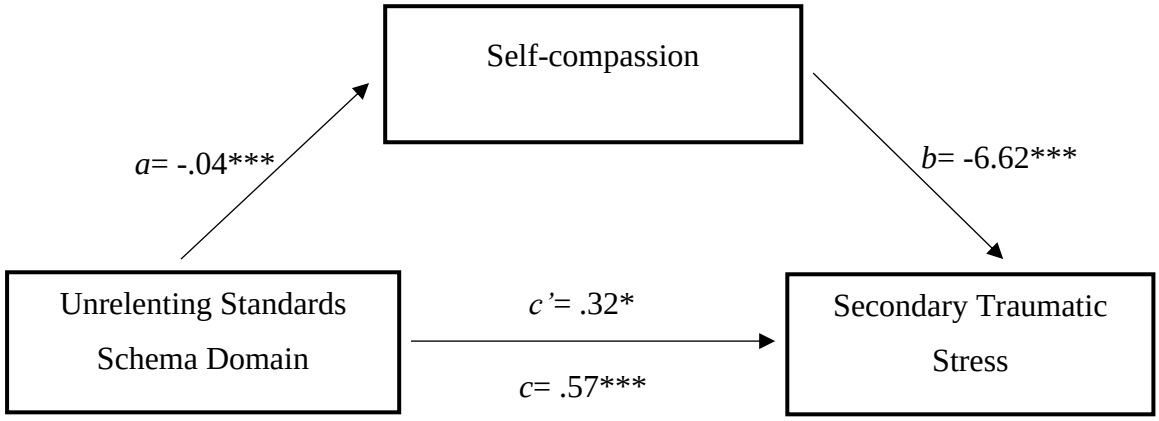


Note. *p < .05, **p < .01, ***p < .001; Non-standardized beta coefficients were used.

Figure 5. The mediation role of self-compassion on the relationship between the other-directedness domain and secondary traumatic stress.

3.4.5. The mediating role of self-compassion in the relationship between unrelenting standards schema domain and secondary traumatic stress

In Model 5, whether there was a mediating role of self-compassion on the relationship between "unrelenting standards schema domain" and STS was tested. After statistically controlling for covariates (gender and working experience), according to direct paths for mediation model 5, firstly, it was revealed that unrelenting standards predicted self-compassion significantly and negatively (B= -.037, 95%CI [-.0487, -.0254], t= -6.302, p<.001). Secondly, it was found that self-compassion predicted STS significantly and negatively (B= -6.624, 95%CI [-10.2589, -2.9885], t= -3.611, p<.001). Thirdly, it was discovered that unrelenting standards predicted STS significantly and positively (B= .567, 95%CI [.2822, .8525], t= 3.942, p<.001). Finally, accordingly indirect effect on Model 5, it was found that there was a mediating role of self-compassion in the relationship between "unrelenting standards schema domain" and STS [(b=.246, 95%BCA CI (.1031, .3830)]. Completely standardized indirect effect (K^2) was found as .168. Thus, it can be stated that the effect of mediation in Model 5 is close to the medium value (see Table 9). This result of the mediation analysis supported the sixth hypothesis that was related to the "unrelenting standards schema domain". It was also discovered that the total model is significant [F (3,112) = 7.44, p<.001], and it is seen that it explains 21% of STS (R^2=.21). Mediation Model 4 is represented in Figure 6.



Note. *p < .05, **p < .01, ***p < .001; Non-standardized beta coefficients were used.

Figure 6. The mediation role of self-compassion on the relationship between unrelenting standards domain and secondary traumatic stress.

In addition to all findings that were reported in the result section, coefficients and confidence intervals that were related to all mediation models are presented in Table 10.

Table 10

Related Values for Mediating Role of Self-compassion on the Relationship between Early Maladaptive Schema Domains and Secondary Traumatic Stress

Mediation Models	Coefficients		%95 BCA Confidence Interval	
	B	SE	Low	High
Disconnection and Rejection ⟶ Self-compassion⟶Secondary Traumatic Stress	.13	.04	.0049	.2199
Impaired Autonomy and Performance ⟶ Self-compassion ⟶Secondary Traumatic Stress	.09	.04	.0221	.1672
Impaired Limit ⟶Self-compassion ⟶ Secondary Traumatic Stress	.15	.10	-.0294	.3519
Other-directedness ⟶ Self-compassion ⟶ Secondary Traumatic Stress	.25	.07	.1117	.3997
Unrelenting Standards⟶ Self-compassion⟶Secondary Traumatic Stress	.25	.07	.1031	.3830

Note. B= Non-standardized beta coefficient, SE= Standard error, BCA= Bias corrected and accelerated

CHAPTER IV
DISCUSSION

In this study, data were collected from refugee aid workers whose age range was between 23 and 64 in order to test relationships between early maladaptive schema domains, self-compassion, and STS. To be more precise, whether experiencing secondary traumatic stress was predicted by one of the EMS domains via self-compassion was examined. Therefore, in the current chapter, firstly, findings of analyses between secondary traumatic stress and demographic variables were discussed. Secondly, relationships between variables that are EMS domains, STS, and self-compassion were mentioned. Thirdly, results that were obtained from testing the relationship between EMS domains and STS via the mediation role of self-compassion were discussed. Finally, the results of the current study, clinical implications, limitations, and further recommendations were highlighted.

4. 1. Correlation Coefficients between Groups of Variables

In the current part, results that were acquired from Pearson's correlation analyses between early maladaptive schema domains, self-compassion, and STS were argued in the light of the related literature.

In terms of the relationship between schema domains and self-compassion, correlation coefficients range from -.19 to -.63. In other words, "Impaired autonomy and performance schema domain" had the highest correlation coefficient among all schema domains, and "Impaired limits schema domain" had the lowest correlation coefficient among all others. In reference to these findings, it was interpreted that participants who were higher levels in EMS domains were more likely to have a lower level of self-compassion. Therefore, it can be said that early toxic experiences that are argued as a source of EMS (Young, 1990; 1999) pose danger for the existence of self-compassion. When examining the studies which are related to EMS and self-compassion variables, it is seen that the current findings were supported by them (Thimm, 2017; Yakın, 2015; Fırıncı, 2019). Fırıncı (2019) found that there was a significant and negative correlation between total schema scores and self-compassion. Yakın (2015) discovered that "Impaired autonomy and performance / other-directedness", "Impaired limits/ exaggerated standards", "Disconnection, and rejection schema domains" were significantly and negatively correlated with self-compassion. In

these two studies, the version of YSQ-SF Turkish form that was adapted by Sarıtaş and Gençöz (2011) was used. It is important to explain that there are three schema domains ("Impaired Limits/Exaggerated Standards, Disconnection/Rejection, and Impaired Autonomy and performance /Other Directedness") instead of five schema domains. Thus, schemas were also grouped differently. "Entitlement", "approval-seeking", "unrelenting standards", "pessimism", "insufficient self-control", and "punitiveness schemas" are under the "Impaired Limits/Exaggerated Standards schema domain". "Emotional deprivation", "social isolation", "defectiveness/shame", "emotional inhibition", "mistrust/abuse", and "failure" schemas are under the "Disconnection/Rejection schema domain". "Subjugation", "dependency/incompetence", "enmeshment", "vulnerability to harm", "abandonment/instability", and "self-sacrifice" schemas are under the "Impaired Autonomy and performance /Other Directedness schema domain" (Sarıtaş & Gençöz, 2011). Thimm (2017) also found significant relationships between EMS and self-compassion. Specifically, it was obtained that except for "enmeshment", "entitlement", and "self-sacrifice" schemas, all schemas were correlated significantly with self-compassion. Besides, for schema domains, significant correlation coefficients were between -.29 and -.56. Early maladaptive schemas are mostly driven by experienced abandonment, abuse, neglect, or reject (Young, Klosko, & Weishaar, 2003). Therefore, it can be said that EMS in origin is opposed to self-compassion. Self-compassion is defined in relation with compassion (Neff, 2003a) and compassion includes some components that are "being touched by the suffering of others", "opening one's awareness to others' pain and not avoiding or disconnecting from it so that feelings of kindness toward others", and "the desire to alleviate their suffering emerge" (Wispe, 1991). It is seen that people who have early maladaptive schemas did not have compassionate parents therefore they might not learn to represent compassion toward themselves.

In terms of the relationship between schema domains and STS, not all of the correlation coefficients were found significant. Except for Impaired limits schema domain, all of the schema domains were correlated significantly and positively with STS. Significant correlation coefficients range from .35 to .49. Specifically, "Impaired autonomy and performance" schema domains had the highest correlation coefficient among them. Although several studies examined the relationship between EMS or its domains and symptoms of psychopathology (Yakın, 2015), well-being (Gök, 2012), psychological distress (Thimm, 2017), depression (Roelofs, Lee, Ruijten, & Lobbestael, 2011), the topic of STS has not been examined in terms of EMS or its domains. It is possible to find studies

that are about the effectiveness of EMS therapy on PSTD. For instance, Cockram, Drummond, and Lee (2010) explored whether early maladaptive schemas were beneficial for comprehending and treating post-traumatic stress disorder. In this study, data were collected from Vietnam war veterans. It was discovered that all of the EMS scores were higher in participants who were in the PTSD group than the non-PSTD group. Especially, vulnerability to harm and emotional inhibition schemas were found significantly higher among veterans with PTSD. In addition to this finding, it was revealed that veterans with PTSD who were treated with schema therapy were showed significantly more improvement in terms of PTSD and anxiety than the veterans with PTSD who were just treated with manualized cognitive-behavioral therapy (Cockram, Drummond, & Lee, 2010). Ahmadian, Mirzaee, Omidbeygi, Holsboer-Trachsler, and Brand (2015) conducted research about differences in maladaptive schemas between people who had chronic, acute PTSD, and healthy ones. At the end of their study, it was understood that participants who had acute PTSD and participants who had chronic PTSD got higher scores for all EMS than healthy ones. Moreover, "self-control", "social isolation", and "vulnerability to harm and illness" schemas were reported higher among chronic PSTD sufferers (Ahmadian, Mirzaee, Omidbeygi, Holsboer-Trachsler, & Brand, 2015). Similarities between PTSD and STS are taken into consideration, it can be stated that the significant findings between STS and EMS are supported by other studies. When looking into the recent findings, the highest correlation coefficient is between "Impaired autonomy and performance schema domain" and STS. Young, Klosko, & Weishaar (2003) remarked that when people who have "impaired autonomy and performance schema domain" find it hard to separate their own identity from their parent figures and also build their own life. It was also highlighted that these people might stay children when they became adults. Thus, it can be interpreted that because their autonomy was impaired when they were children, they still have trouble separating themselves from others and they may be easily affected by other traumatic memories.

The correlation coefficient related to the relationship between self-compassion and STS was found significant. The current finding indicates that as self-compassion increases, STS decreases. There are some studies which were about self-compassion and STS or burnout. For instance, Richardson, Jaber, Chan, Jesse, Kaur, Sangha (2016), examined the relationship between all of the sub-dimensions of self-compassion and STS in medical training. At the end of their analysis, self-kindness and mindfulness were found significantly and negatively correlated with STS whereas "self-judgment", "isolation", and "over-identification" were significantly and positively correlated with STS. All of these correlation

coefficients were small degrees. Yip, Mak, Chio, and Law (2017) conducted a study about whether positive and negative components of self-compassion predict burnout and STS. In their study, sub-dimensions of self-compassion were divided into two groups in accordance with the positive and negative direction of its sub-dimensions. Positive sub-dimensions were named as "self-warmth" whereas negative sub-dimensions were named as "self-coldness". Findings in this study indicated that "self-coldness" which included "over-identification", "isolation", and "self-judgment" sub-dimensions and "self-warmth" which included "mindfulness", "common humanity", and "self-kindness" were associated with STS. The correlation coefficient between "self-warmth" and STS was found -.33 and "self-coldness" and STS was found .52. Considering these two studies, it can be said that finding self-compassion and STS is supported by the existing literature. It is possible to explain the reason why self-compassion is found negatively and significantly correlated with STS. Neff and Costigan (2014) remarked that self-compassion has a role in differences in reacting to negative events. In parallel, negative emotions and extreme reactions were decreased with high self-compassion and accepting thoughts, taking perspective for own problems were increased with high self-compassion (Leary, Tate, Adams, Allen, & Hancock, 2007).

4. 2. Secondary Traumatic Stress and Demographic Variables

In this part, findings that were obtained from the analyses between STS and demographic variables were discussed on the basis of current literature.

Under the analysis between STS and gender, it was revealed that there was no significant difference between females and males in terms of experiencing STS. Some studies support this finding whereas others do not. In parallel with the current finding, Creamer and Liddle (2005) conducted a study to examine the relationships between STS and some demographic variables such as caseload, gender, age, and experience level with 81 disaster mental health workers who were overcome with attacks of September 11. In terms of gender variables, differences between genders were not found on the level of STS. There are also other studies that support this finding (MacEachern, Dennis, Jackson, & Jindal-Snape, 2019; Meldrum, King, & Spooner, 2002; Pearlman & Mac Ian, 1995; Kahil & Palabiyikoglu, 2018; Gündüz, 2020). On the other hand, Ivicic and Motta (2017) examined variables that are related to secondary traumatization with 88 mental health professionals. Concerning the gender variable, it was found that females were higher on STS than males. This finding is also supported by other studies (Kassam-Adams, 1999; Meyers & Cornille,

2002). Nevertheless, other studies revealed that male participants had a higher level of STS than females (Sprang, Craig, & Clark, 2011; Wee & Myers, 2002).

Results about the analysis between STS and receiving in-service training revealed that receiving in-service training about working with traumatized groups/ refugees was effective in decreasing participants' STS levels. This finding is supported by other studies in the literature (Pearlman & Mac Ian, 1995; Erdener, 2019; Slattery & Goodman, 2009). For instance, a study that was conducted by Slattery and Goodman (2009) highlighted that secondary traumatic stress was seen as less likely among professionals who received supervision. Erdener (2019) performed a study that focused on psychological resistance and secondary traumatic stress of professionals who worked in disaster areas. In parallel with the previous study, it was discovered that the STS level of professionals who received in-service training was lower than the others who did not receive it.

About the analysis between STS and age, it was discovered that there were no differences between different age groups in terms of STS. In the literature, some of the studies support this finding (Adams, Figley, & Boscarino, 2008; Gürdil, 2014; Kranda, 2019). To be illustrated, a study that was performed by Adams, Figley, and Boscarino (2008) focused on the differences between STS and burnout and the contribution of secondary trauma to psychological distress via collecting data from 236 social work practitioners. Findings showed that there were no significant differences among different age groups' STS levels. In this study, the average age in this study was higher than the current study. On the contrary, some of the studies in the literature revealed significant age differences in secondary traumatic stress (Creamer & Liddle, 2005; Ghahramanlou & Brodbeck, 2000). For instance, Creamer and Liddle (2005) found that younger people who were working with traumatized groups were associated with higher STS. In their study, participants' age range between 21 and 65.

The findings of the role of education level in STS remarked that there were no significant differences among distinct education level in terms of secondary traumatic stress. In other words, there was no significant difference among participants with a "bachelor's degree", "master's degree", or "doctorate's degree". When viewing the related literature, research that represented consistent findings with the current study is seen (Kahil & Palabıyıkoğlu, 2018; Creamer & Liddle, 2005; Ghahramanlou & Brodbeck, 2000; Erdener, 2019; Kranda, 2019). To give an example, Erdener (2019) conducted a study about psychological resistance and STS level of professionals working in the disaster area. The education level in this study varied from primary school graduates to have a doctorate

degree. The results of this study remarked that STS did not differ in terms of distinct education levels. On the other hand, it is clearly seen that there are conflicting findings on the role of education level in STS. To be illustrated, Baird and Jenkins (2003) investigated vicarious traumatization, STS, and burnout levels of 101 professionals who were working with victims of sexual assault and domestic violence. In this study, the minimum education level was high school, and the maximum was a doctorate degree. It was discovered that participants who were more educated than others presented less STS.

In reference to the finding of the analyses between the feeling sense of competence and STS, it was seen that there were no significant differences among participants who felt more competent than others. This finding was not supported by the studies in the literature. Adams, Figley, and Boscarino (2008) discovered that a sense of mastery was correlated negatively with secondary trauma. Similarly, Choi (2017) revealed that higher levels of psychological empowerment which is seen to be related to the sense of competency are a protective factor against STS.

According to the results of analyses between experience and STS, it was stated that there were also no significant differences between STS scores of participants who differed from each other's experience level. Various studies support the current finding in the literature (Meldrum, King, & Spooner, 2002; Kranda, 2019). For instance, Meldrum, King, and Spooner (2002) performed a study that was related to STS in case managers. In their study, there were 300 participants who provide mental health services and their year of experience was between 6 to 51. As a result of their analyses, it was discovered that there was no significant effect of year of experience on scores of STS. Contrary to these findings (Meldrum, King, & Spooner, 2002; Kranda, 2019), in some studies, it was discovered that year of experience had a significant effect on STS (Cunningham, 2003; Creamer & Liddle, 2005; Bride, 2012; Kahil & Palabıyıkoğlu, 2018). Cunningham (2003) researched the effect of working with traumatized groups on social work clinicians whose experiences. In this study, it was found that there was a significant but negative correlation between years of experience and STS. This negative correlation between years of experience and STS is explained by Bride (2012). It was stated that when experts are exposed to work with the traumatic groups, they begin to develop coping skills against these difficult working conditions.

4. 3. The Mediating Role of Self-Compassion in the Relationship between Early Maladaptive Schema Domains and Secondary Traumatic Stress

In this part, findings of analysis that were conducted to investigate the mediating role of self-compassion in the relationship between EMS domains and STS were discussed. Five model analyses were conducted for each schema domain one by one, thus findings were represented separately for each schema domain. Since other studies that examined the current model were not found in the literature, findings of mediating analysis were discussed with highlighting studies about self-compassion, EMS or its domains, and STS.

When examining findings related to the "disconnection and rejection schema domain", it is seen that increasing scores in this domain decreases the level of self-compassion, increases in self-compassion decrease the severity of STS, and increasing scores in this schema domain increases the severity of STS. Moreover, it is revealed that the relationship between "disconnection and rejection schema domain" was mediated by self-compassion.

In "disconnection and rejection schema domain", "emotional deprivation", "emotional inhibition", "social isolation/mistrust", and "defectiveness" take part (Soygül et al., 2009). "Disconnection and rejection schema domain" is associated with a lack of stable, safe, love, nurturance, and belonging. People with this schema domain have traumatic childhood memories and they tend to have devastating relationships or escape from close relationships (Young, Klosko, & Weishaar, 2003). Moreover, people believe that their need for empathic relationships, sharing of feelings, being accepted by others, and getting respect from others will not be met predictably (Young, Klosko, & Weishaar, 2003). Considering characteristics of "disconnection and rejection schema domain", it may be thought that because people with "disconnection and rejection schema domain" did not learn empathy, compassion, acceptance from their parents during their childhood, they do not have compassion for themselves. Therefore, it can be thought that the "disconnection and rejection schema domain" predicts a low level of self-compassion.

Results about "impaired autonomy and performance schema domain" highlighted that increasing scores in "impaired autonomy and performance schema domain" decreases self-compassion, increasing self-compassion decreases STS and increasing scores in "impaired autonomy and performance schema domain" increase STS. Besides, the relationship between "impaired autonomy and performance schema domain" and STS was mediated by self-compassion.

In “impaired autonomy and performance schema domain”, “enmeshment/dependency”, “abandonment”, “failure”, “pessimism”, and “vulnerability to harm” take part (Soygüt et al., 2009). “Impaired autonomy and performance schema domain” is associated with having difficulties in differentiating themselves from their parent figures and behaving independently. In the past, people with “impaired autonomy and performance schema domain” could be overprotected or neglected when they were children (Young, Klosko, & Weishaar, 2003). In STS, professionals are influenced by their clients’ traumatic experiences. As it is mentioned earlier, because people with “impaired autonomy and performance schema domain” have difficulties in differentiating themselves from their parent figure, they may have difficulties in separating themselves from their clients’ experiences. So, they may tend to suffer from STS.

Findings related to “impaired limits schema domain” were not significant for all variables. It is only found that increasing self-compassion scores decrease the STS level. On the other hand, self-compassion and STS were not significantly predicted by “impaired limits schema domain”. Moreover, the mediating role of self-compassion in the relationship between impaired limits and STS were also not significant.

In “impaired limits schema domain”, there is just one schema which is “insufficient self-control/ self-discipline” (Soygüt et al., 2009). People with “impaired limits schema domains” were exposed to extremely permissive and indulgent parents when they were children. Their characteristic features are stated difficulties in creating adequate internal limits for reciprocity or self-discipline, respecting the rights of others, or performing long-dated goals. Selfishness, pertness, dutifulness, and narcissism are commonly seen in them (Young, Klosko, & Weishaar, 2003). Because of these features, it may not be found significant predictions among self-compassion, impaired limits, and STS.

Results about the “other-directedness schema domain” revealed that increasing in “other-directedness schema domain” reduces the self-compassion level. Increasing in self-compassion level decreases STS levels. Increasing in “other-directedness schema domain” increases the STS level. Additionally, it was found that the relationship between the “other-directedness schema domain” and STS was mediated by self-compassion.

In the “other-directedness schema domain”, there are “self-sacrifice” and “punitiveness” schemas (Soygüt et al., 2009). Striking features in this domain is seeing the needs of others more important than one’s own needs to gain approval, continue the emotional connection, or avoid to revenge. So, as they focus excessively on others’ needs, their self-awareness about their anger and choices decreases (Young, Klosko, & Weishaar,

2003). During their childhood, people with this schema domain were exposed to conditional love from their parents. In childhood, people who have schemas from this domain are not free to pursue their natural disposition. In adulthood, they are oriented externally and therefore they conform to other's desires (Young, Klosko, & Weishaar, 2019). Because they learned to focus on others' needs more in the past, they may continue to represent this behavior to gain approval from even their clients. Therefore, it may be thought that these people may be more inclined to develop STS after exposing clients' trauma.

Findings related to the "unrelenting standards schema domain" expressed that rising in the score of "unrelenting standards schema domain" decreases the self-compassion level. Increasing self-compassion scores reduces the STS level. Increases in the "unrelenting standards schema domain" increase STS levels. Furthermore, the relationship between "unrelenting standards schema domain" and STS was mediated by self-compassion.

In the "unrelenting standards schema domain", there are "unrelenting standards" and "approval seeking" schemas (Soygüt et al., 2009). People who have high scores in this schema domain tend to try to reach their extremely high internalized standards to prevent experiencing disapproval or feeling shame. Feeling under pressure and behaving hypercritically toward themselves are common in this domain (Young, Klosko, & Weishaar, 2003). Moreover, people with "unrelenting standards schema domain" try to gain approval from others rather than forming a secure and genuine sense of self (Young, Klosko, & Weishaar, 2003, pp. 20). There are seen also impairments in feeling pleasure, relieving, wellness, self-esteem, sense of achievement, or being satisfied in relationships (Young, Klosko, & Weishaar, 2003). Because of this reason, professionals with having high scores in "unrelenting standards schema domain" may be inclined to have a lack of self-compassion and more STS levels.

When reviewing these results about EMS domains and STS, it is seen that people who have high in early maladaptive schema domains show more severe secondary traumatic stress. Young, Klosko, and Weishaar (2003) emphasized that early maladaptive schemas do not only develop during childhood but also, they continue to be detailed throughout life. Therefore, it can be inferred that being exposed to others' traumatic experiences because of occupational reasons might also develop their early maladaptive schema domains.

Although it was stated that early maladaptive schemas contribute to some psychopathological problems such as personality disorders and disorders that are listed in Axis I, each individual has certain level of schemas (Young, 1990,1999). It may be thought that every schema does not lead to experience psychopathological symptoms. Therefore, it

is highlighted that schema therapy should also be discussed in terms of positive psychology perspective (Yakın, 2015). For instance, it is argued that negative emotions due to early maladaptive schemas can be changed into more positive ones with the help of mindfulness (Yalçın, Kavaklı, Kesici, & Ak, 2017). Although the nature of early maladaptive schemas above has been discussed in terms of psychopathology, it should not be forgotten that early maladaptive schemas are also approached in terms of positive psychology.

As it is seen, self-compassion took a mediation role in the relationship between all schema domains except for "impaired limits schema domain" and STS. In schema therapy, focusing childhood experiences is evaluated crucial because lower levels of self-compassion and developing EMS are seen related to toxic childhood experiences and maltreatment (Young, 1990;1999; Vettese et al., 2011). Moreover, it is highlighted that exercises that are related to developing self-compassion are used to build up healthy adult mode in schema therapy (Vreeswijk, Broersen, & Nadort, 2012). In short, it is seen that self-compassion has a crucial role in EMS. Because of that, in the current study, professionals' STS and EMS domains except for impaired limits might be mediated by self-compassion.

In the literature, it is hard to find a study that examined a similar model with the current study. However, there was found research that support partially our findings. Yakın (2015) examined the mediating role of self-compassion with emotion-regulation in the relationship between EMS domains and psychological well-being. It was found that the relationship between "disconnection/ rejection schema domain", "impaired autonomy and performance", and "other-directedness" and psychopathological symptoms was mediated by emotion regulation and self-compassion. When considering STS is related to psychological well-being, it may be thought that the current findings are supported by this study (Yakın, 2015). In another study, it was discovered that the positive dimension of self-compassion has a mediation role in the relationship between childhood traumas and the "disconnection/rejection schema domain" in individuals who have substance addiction (Konuş, 2019). Furthermore, Thimm (2017) found that the relationship between EMS and psychological distress was mediated by self-compassion and mindfulness.

4.4. Clinical Implication

There are several studies that highlight the importance of psychological well-being or secondary traumatic stress in refugee aid workers (Çırakoğlu, 2018; Turgut, 2014; Şahin, 2019; Hasdemir, 2018). However, it is seen that studying secondary traumatic stress with

early maladaptive schema domains and self-compassion variables is relatively new for the literature. In parallel with the contributions of the study for the literature, there are also substantial implications for the clinical area.

It is stated that self-compassion has an important role in psychological health (Neff & Costigan, 2014; Finlay-Jones, Rees, & Kane, 2015; MacBeth & Gumley, 2012). When this role of self-compassion on well-being is considered, it is thought to be important that providing training related to self-compassion exercises for the professionals worked with the traumatic sample. This training can include psychoeducation that shows the importance and necessity of self-compassion. Because components of self-compassion, mindfulness training may be provided as well. For instance, guided meditations and exercises like self-compassion break, supportive touch, or self-compassion journal (Neff, 2020) may be taught to professionals worked with refugees.

Moreover, self-compassion is important in schema therapy. Vreeswijk, Broersen, and Nadort, (2012) stated that exercises that are related to developing self-compassion are used to build up healthy adult mode in schema therapy. In schema therapy, focusing childhood experiences is evaluated crucial because lower levels of self-compassion and developing EMS are seen related to toxic childhood experiences and maltreatment (Young, 1990;1999; Vettese et al., 2011). According to the study that was conducted by Thimm (2017), the importance of EMS on psychological distress is emphasized. Therefore, for refugee aid workers who get high scores in EMS domains, schema therapy can be consulted when they suffer from STS.

4.5. Limitation and Future Suggestions

Although the current study contributes to the literature with significant findings, there were certain limitations. To correct the limitations, several suggestions were given.

Firstly, the sample comprised of 116 participants. This target sample consisted of a specific group and the sample size was small. Because of the small sample size, it is thought that some of the variables which were gender and in-service training were not distributed normally and non-parametric analysis was performed. Furthermore, it is thought that due to non-normally distributed gender variables, findings might be influenced negatively. Also, it is thought that the small sample size in this study could not reflect the population and this might create a problem with generalizability. Therefore, it is recommended that the sample

size should be increased. However, it should be noted that professionals who worked with refugees did not volunteer to participate in their own.

Secondly, self-report inventories were used in the current study. Hence, participants might not express their own emotions and thoughts and they might have shown themselves as they want. Also, feedback about inventory was received. It was reported that inventory in the current study was too long. It is thought that nearly half of them did not continue to answer items in this inventory due to its length. Thus, it is suggested that the inventory should be prepared shorter to prevent dropouts.

Thirdly, some features of the inventory were not convenient for professionals who work with refugees. For instance, some translators could not participate in the current study because of the language barrier. In other words, although they knew to speak Turkish, they did not know reading in Turkish so they could not answer the items by reading. In addition, the lowest option in the question about education level was to be a university graduate. Due to this reason, several professionals could not attend to this study. In accordance with these problems, it is offered that inventory should be translated for other language options which are prevalent among these professionals, and education level should be started with primary school options.

4.6. Conclusion

In this study, firstly, the effects of some demographic variables on STS were examined. Then, the relationships among EMS domains, STS, and self-compassion were analyzed. Finally, whether the relationship between EMS domains and STS was mediated by self-compassion was examined.

First of all, when the analysis findings related to the role of some demographic variables on STS are examined, refugee aid workers who receive in-service training tend to experience less STS than the others who do not receive this training. On the other hand, the roles of gender, age, education level, feeling a sense of competence, and working experience on STS was not found to be significant.

Secondly, when examining the findings of relationships, it was seen that “Disconnection and Rejection”, “Impaired Autonomy and Performance”, “Impaired Limits”, “Other-directedness”, and “Unrelenting Standard” schema domains were negatively and significantly associated with self-compassion. Moreover, “Disconnection and Rejection”, “Impaired Autonomy and Performance”, “Other-directedness”, and

“Unrelenting Standard” schema domains were positively and significantly correlated with STS. On the other hand, the relationship between Impaired Limits and STS was not found significant. The relationship between self-compassion and STS was found to be significant and negative.

Finally, when reviewing mediation model analyses, it was found that “Disconnection and Rejection”, “Impaired Autonomy and Performance”, “Other-directedness”, and “Unrelenting Standards” predicted STS through self-compassion. On the other hand, it was discovered that the relationship between Impaired Limits and STS was not mediated by self-compassion.

When evaluating all findings, receiving in-service training is found very effective to prevent STS among refugee-aid workers. The level of compassion that refugee aid workers will show for themselves is related to their high scores in EMS domains and STS in refugee aid workers is related to all EMS domains except for Impaired Limits. STS level among refugee aid workers who get high scores in “Disconnection and Rejection”, “Impaired Autonomy and Performance”, “Other-directedness”, and/or “Unrelenting Standards” is decreased with self-compassion.

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APPENDICES

APPENDIX 1: BİLGİLENDİRİLMİŞ ONAM FORMU

Değerli Katılımcı,

Bu çalışma Doç. Dr. Okan Cem Çırakoğlu danışmanlığında Başkent Üniversitesi Klinik Psikoloji Yüksek Lisans programı öğrencisi Ayça Güzey tarafından yürütülen bir tez çalışmasıdır. Çalışmanın amacı, erken dönem uyum bozucu şemaların ve öz-şefkatin, ikincil travmatik stres ile ilişkisini incelemektir. Bu çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Bununla birlikte, sizden herhangi bir kimlik bilgisi talep edilmemektedir ve cevaplarınız gizli tutulacaktır. Verdiğiniz cevaplar toplu olarak değerlendirilecek ve sadece araştırmacı tarafından bilimsel çalışmalarda kullanılacaktır. Bu sebeple, araştırma sonuçlarından sağlıklı bilgiler edinilebilmesi için size yöneltilen soruların samimi biçimde cevaplanması ve boş bırakılmaması önem teşkil etmektedir. Araştırmaya katılım herhangi bir risk taşımamaktadır. Ölçekler genel olarak kişisel rahatsızlık yaratacak sorular içermemektedir fakat araştırma sırasında herhangi bir nedenden ötürü rahatsızlık yaşarsanız, katılımınızı sonlandırabilirsiniz.

Çalışma sırasında, verilen ölçekleri boş madde bırakmamaya özen göstererek ve samimi bir şekilde doldurmanız sizden istenmektedir. Çalışmaya katılım yaklaşık 10-15 dakika sürecektir. Çalışma hakkında daha detaylı bilgi almak için Ayça Güzey'e (e-mail: aycaguzey87@gmail.com) ulaşabilirsiniz.

Katılımınız için şimdiden teşekkür ederiz.

Ayça Güzey

Başkent Üniversitesi

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

İmza:_____

Tarih:_____

APPENDIX 2: DEMOGRAFİK BİLGİ FORMU

1. **Cinsiyetiniz:** Kadın [ ] Erkek [ ]
2. **Doğum yılınız:**_____
3. **Eğitim durumunuz:** Lisans [ ] Yüksek Lisans [ ] Doktora [ ]
4. **Mezun olduğunuz bölüm (Lütfen olabildiğince açık yazınız. Kısaltma kullanmayınız):**

   _____
5. **Çalıştığınız kurum:** Sivil Toplum Örgütü [ ] Devlet Kuruluşu [ ]
6. **Çalıştığınız kurumdaki göreviniz:**

   _____
7. **Çalışma ortamınız:** Ofis [ ] Saha [ ]
8. **Travmatik gruplarla çalışma süreniz:** _____ ay
9. **Travmatik gruplara maruz kalma süreniz:** Günde _____ saat

   Haftada _____ saat
10. **Travmatik gruplarla çalışırken herhangi bir hizmet içi eğitim aldınız mı?**

    Evet [ ] Hayır [ ]
11. **Travmatik gruplarla çalışırken kendinizi ne derecede yetkin hissediyorsunuz?**

1	2	3	4	5
Tamamıyla yetersiz		Ne yeterli ne yetersiz		Tamamıyla yeterli

APPENDIX 3: ÖZ-DUYARLIK ÖLÇEĞİ

Sizden istenilen bu ifadeleri okuduktan sonra kendinizi değerlendirmeniz ve sizin için en uygun seçeneğin karşısına çarpı (X) işareti koymanızdır. Lütfen her ifadeye mutlaka TEK yanıt veriniz ve kesinlikle BOŞ bırakmayınız.

1	2	3	4	5
Hiçbir zaman	Nadiren	Sık sık	Genellikle	Her zaman

1. Bir yetersizlik hissettiğimde, kendime bu yetersizlik duygusunun insanların birçoğu tarafından paylaşıldığını hatırlatmaya çalışırım.	1	2	3	4	5
2. Kişiliğimin beğenmediğim yönlerine ilişkin anlayışlı ve sabırlı olmaya çalışırım.	1	2	3	4	5
3. Bir şey beni üzdüğünde, duygularıma kapılıp giderim.	1	2	3	4	5
4. Hoşlanmadığım yönlerimi fark ettiğimde kendimi suçlarım.	1	2	3	4	5
5. Benim için önemli olan bir şeyde başarısız olduğumda, kendimi bu başarısızlıkta yalnız hissederim.	1	2	3	4	5
6. Zor zamanlarımda ihtiyaç duyduğum özen ve şefkati kendime gösteririm.	1	2	3	4	5
7. Gerçekten güç durumlarla karşılaştığımda kendime kaba davranırım.	1	2	3	4	5
8. Başarısızlıklarımı insanlık halinin bir parçası olarak görmeye çalışırım.	1	2	3	4	5
9. Bir şey beni üzdüğünde duygularımı dengede tutmaya çalışırım.	1	2	3	4	5
10. Kendimi kötü hissettiğimde kötü olan her şeye kafamı takar ve onunla meşgul olurum.	1	2	3	4	5
11. Yetersizliklerim hakkında düşündüğümde, bu kendimi yalnız hissetmeme ve dünyayla bağlantımı koparmama neden olur.	1	2	3	4	5
12. Kendimi çok kötü hissettiğim durumlarda, dünyadaki birçok insanın benzer duygular yaşadığını hatırlamaya çalışırım.	1	2	3	4	5
13. Acı veren olaylar yaşadığımda kendime kibar davranırım.	1	2	3	4	5
14. Kendimi kötü hissettiğimde duygularıma ilgi ve açıklıkla yaklaşmaya çalışırım.	1	2	3	4	5
15. Sıkıntı çektiğim durumlarda kendime karşı biraz acımasız olabilirim.	1	2	3	4	5
16. Sıkıntı veren bir olay olduğunda olayı mantıksız biçimde abartırım.	1	2	3	4	5
17. Hata ve yetersizliklerimi anlayışla karşılarım.	1	2	3	4	5
18. Acı veren bir şeyler yaşadığımda bu duruma dengeli bir bakış açısıyla yaklaşmaya çalışırım.	1	2	3	4	5
19. Kendimi üzgün hissettiğimde, diğer insanların çoğunun belki de benden daha mutlu olduklarını düşünürüm.	1	2	3	4	5
20. Hata ve yetersizliklerime karşı kınayıcı ve yargılayıcı bir tavır takınırım.	1	2	3	4	5
21. Duygusal anlamda acı çektiğim durumlarda kendime sevgiyle yaklaşırım.	1	2	3	4	5

1	2	3	4	5
Hiçbir zaman	Nadiren	Sık sık	Genellikle	Her zaman

22. Benim için bir şeyler kötüye gittiğinde, bu durumun herkesin yaşayabileceğini ve yaşamın bir parçası olduğunu düşünürüm.	1	2	3	4	5
23. Bir şeyde başarısızlık yaşadığımda objektif bir bakış açısı takınmaya çalışırım.	1	2	3	4	5
24. Benim için önemli olan bir şeyde başarısız olduğumda, yetersizlik duygularıyla kendimi harap ederim.	1	2	3	4	5
25. Zor durumlarla mücadele ettiğimde, diğer insanların daha rahat bir durumda olduklarını düşünürüm.	1	2	3	4	5
26. Kişiliğimin beğenmediğim yönlerine karşı sabırlı ve hoşgörülü değilimdir.	1	2	3	4	5

APPENDIX 4: İKİNCİL TRAVMATİK STRES ÖLÇEĞİ

Aşağıdaki listede travmatize olmuş danışanlarla çalışmaktan etkilenen bazı yardım gruplarının duygusal yaşantılarına ilişkin ifadeler yer almaktadır. Lütfen her ifadeyi okuyunuz ve son yedi (7) gün içerisinde durumu ne sıklıkta yaşadığınızı ilgili sayıyı yuvarlak içine alarak belirtiniz.

NOT: "Danışan" kelimesi bir yardım ilişkisinde bulunduğunuz kişiyi betimlemektedir. Örn: Müşteri, hasta veya yardım alan kişi gibi.

1	2	3	4	5
Hiçbir zaman	Çok az	Bazen	Sık sık	Çok sık

1. Kendimi duygusal olarak uyuşmuş hissettim.	1	2	3	4	5
2. Danışanlarımla olan görüşmelerimi düşündüğümde kalbim hızla çarpmaya başladı.	1	2	3	4	5
3. Danışan(lar)ım tarafından yaşanmış travma(lar)yı sanki yeniden yaşıyormuş hissine kapıldım.	1	2	3	4	5
4. Uyumakta güçlük yaşadım.	1	2	3	4	5
5. Gelecek hakkında ümitsizliğe kapıldım.	1	2	3	4	5
6. Danışanlarımla olan görüşmelerimi aklıma getiren hatırlatıcılar beni üzdü.	1	2	3	4	5
7. Başkalarıyla sosyal ortamlarda birlikte olma isteğim azdı.	1	2	3	4	5
8. Kendimi tedirgin hissettim.	1	2	3	4	5
9. Her zaman olduğumdan daha az aktiftim.	1	2	3	4	5
10. Amaçlamadığım halde danışanlarımla olan görüşmelerimi ister istemez düşündüm.	1	2	3	4	5
11. Odaklanmakta güçlük yaşadım.	1	2	3	4	5
12. Bana danışanlarımla yaptığım görüşmeleri hatırlatan kişi, yer veya şeylerden kaçındım.	1	2	3	4	5
13. Danışanlarımla olan görüşmelerim hakkında rahatsız edici rüyalar gördüm.	1	2	3	4	5
14. Bazen danışanlarımla çalışmaktan uzak durmak istedim.	1	2	3	4	5
15. Çabuk bunaldım.	1	2	3	4	5
16. Kötü bir şey olacakmış beklentisindeydim.	1	2	3	4	5
17. Danışanlarımla olan görüşmelerim ile ilgili belleğimde boşluklar olduğunu fark ettim.	1	2	3	4	5

APPENDIX 5: YOUNG ŞEMA ÖLÇEĞİ (YSQ-SF3)

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

1'den 6'ya kadar olan seçeneklerden sizi tanımlayan en yüksek şıkkı işaretleyin.

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

1. Bana bakan, benimle zaman geçiren, başıma gelen olaylarla gerçekten ilgilenen kimsem olmadı.	1	2	3	4	5	6
2. Beni terk edeceklerinden korktuğum için yakın olduğum insanların peşini bırakmam.	1	2	3	4	5	6
3. İnsanların beni kullandıklarını hissediyorum.	1	2	3	4	5	6
4. Uyumsuzum.	1	2	3	4	5	6
5. Beğendiğim hiçbir erkek/kadın, kusurlarımı görürse beni sevmez.	1	2	3	4	5	6
6. İş (veya okul) hayatımda neredeyse hiçbir şeyi diğer insanlar kadar iyi yapamıyorum.	1	2	3	4	5	6
7. Günlük yaşamımı tek başıma idare edebilme becerisine sahip olduğumu hissetmiyorum.	1	2	3	4	5	6
8. Kötü bir şey olacağı duygusundan kurtulamıyorum.	1	2	3	4	5	6
9. Anne babamdan ayrılmayı, bağımsız hareket edebilmeyi, yaşıtlarım kadar başaramadım.	1	2	3	4	5	6
10. Eğer istediğimi yaparsam, başımı derde sokarım diye düşünürüm.	1	2	3	4	5	6
11. Genellikle yakınlarıma ilgi gösteren ve bakan ben olurum.	1	2	3	4	5	6
12. Olumlu duygularımı diğerlerine göstermekten utanırım (sevdiğimi, önemsediğimi göstermek gibi).	1	2	3	4	5	6
13. Yaptığım çoğu şeyde en iyi olmalıyım; ikinci olmayı kabullenemem.	1	2	3	4	5	6
14. Diğer insanlardan bir şeyler istediğimde bana "hayır" denilmesini çok zor kabullenirim.	1	2	3	4	5	6
15. Kendimi sıradan ve sıkıcı işleri yapmaya zorlayamam.	1	2	3	4	5	6

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

16. Paramın olması ve önemli insanlar tanıyor olmak beni değerli yapar.	1	2	3	4	5	6
17. Her şey yolunda gidiyor görünse bile, bunun bozulacağını hissederim.	1	2	3	4	5	6
18. Eğer bir yanlış yaparsam, cezalandırılmayı hak ederim.	1	2	3	4	5	6
19. Çevremde bana sıcaklık, koruma ve duygusal yakınlık gösteren kimsem yok.	1	2	3	4	5	6
20. Diğer insanlara o kadar muhtacım ki onları kaybedeceğim diye çok endişeleniyorum.	1	2	3	4	5	6
21. İnsanlara karşı tedbiri elden bırakamam yoksa bana kasıtlı olarak zarar vereceklerini hissederim.	1	2	3	4	5	6
22. Temel olarak diğer insanlardan farklıyım.	1	2	3	4	5	6
23. Gerçek beni tanırlarsa beğendiğim hiç kimse bana yakın olmak istemez.	1	2	3	4	5	6
24. İşleri halletmede son derece yetersizim.	1	2	3	4	5	6
25. Gündelik işlerde kendimi başkalarına bağımlı biri olarak görüyorum.	1	2	3	4	5	6
26. Her an bir felaket (doğal, adli, mali veya tıbbi) olabilir diye hissediyorum.	1	2	3	4	5	6
27. Annem, babam ve ben birbirimizin hayatı ve sorunlarıyla aşırı ilgili olmaya eğilimliyiz.	1	2	3	4	5	6
28. Diğer insanların isteklerine uymaktan başka yolum yokmuş gibi hissediyorum; eğer böyle yapmazsam bir şekilde beni reddederler veya intikam alırlar.	1	2	3	4	5	6
29. Başkalarını kendimden daha fazla düşündüğüm için ben iyi bir insanım.	1	2	3	4	5	6
30. Duygularımı diğerlerine açmayı utanç verici bulurum.	1	2	3	4	5	6
31. En iyisini yapmalıyım, "yeterince iyi" ile yetinemem.	1	2	3	4	5	6
32. Ben özel biriyim ve diğer insanlar için konulmuş olan kısıtlamaları veya sınırları kabul etmek zorunda değilim.	1	2	3	4	5	6
33. Eğer hedefime ulaşmazsam kolaylıkla yılgınlığa düşer ve vazgeçerim.	1	2	3	4	5	6
34. Başkalarının da farkında olduğu başarılar benim için en değerlisidir.	1	2	3	4	5	6

1	2	3	4	5	6
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35. İyi bir şey olursa, bunu kötü bir şeyin izleyeceğinden endişe ederim.	1	2	3	4	5	6
36. Eğer yanlış yaparsam, bunun özrü yoktur.	1	2	3	4	5	6
37. Birisi için özel olduğumu hiç hissetmedim.	1	2	3	4	5	6
38. Yakınlarımın beni terk edeceği ya da ayrılacağından endişe duyarım.	1	2	3	4	5	6
39. Herhangi bir anda birileri beni aldatmaya kalkışabilir.	1	2	3	4	5	6
40. Bir yere ait değilim, yalnızım.	1	2	3	4	5	6
41. Başkalarının sevgisine, ilgisine ve saygısına değer bir insan değilim.	1	2	3	4	5	6
42. İş ve başarı alanlarında birçok insan benden daha yeterli.	1	2	3	4	5	6
43. Doğru ile yanlışı birbirinden ayırmakta zorlanırım.	1	2	3	4	5	6
44. Fiziksel bir saldırıya uğramaktan endişe duyarım.	1	2	3	4	5	6
45. Annem, babam ve ben özel hayatımızı birbirimizden saklarsak, birbirimizi aldatmış hisseder veya suçluluk duyarız.	1	2	3	4	5	6
46. İlişkilerimde, diğer kişinin yönlendirici olmasına izin veririm.	1	2	3	4	5	6
47. Yakınlarımla o kadar meşgulüm ki kendime çok az zaman kalıyor.	1	2	3	4	5	6
48. İnsanlarla beraberken içten ve cana yakın olmak benim için zordur.	1	2	3	4	5	6
49. Tüm sorumluluklarımı yerine getirmek zorundayım.	1	2	3	4	5	6
50. İstediğimi yapmaktan alıkonulmaktan veya kısıtlanmaktan nefret ederim.	1	2	3	4	5	6
51. Uzun vadeli amaçlara ulaşabilmek için şu andaki zevklerimden fedakârlık etmekte zorlanırım.	1	2	3	4	5	6
52. Başkalarından yoğun bir ilgi görmezsem kendimi daha az önemli hissederim.	1	2	3	4	5	6
53. Yeterince dikkatli olmazsanız, neredeyse her zaman bir şeyler ters gider.	1	2	3	4	5	6

1	2	3	4	5	6
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54. Eğer işimi doğru yapmazsam sonuçlara katlanmam gerekir.	1	2	3	4	5	6
55. Beni gerçekten dinleyen, anlayan veya benim gerçek ihtiyaçlarım ve duygularımı önemseyen kimsem olmadı.	1	2	3	4	5	6
56. Önem verdiğim birisinin benden uzaklaştığını sezersem çok kötü hissederim.	1	2	3	4	5	6
57. Diğer insanların niyetleriyle ilgili oldukça şüpheciyimdir.	1	2	3	4	5	6
58. Kendimi diğer insanlara uzak veya kopmuş hissediyorum.	1	2	3	4	5	6
59. Kendimi sevilebilecek biri gibi hissetmiyorum.	1	2	3	4	5	6
60. İş (okul) hayatımda diğer insanlar kadar yetenekli değilim.	1	2	3	4	5	6
61. Gündelik işler için benim kararlarıma güvenilemez.	1	2	3	4	5	6
62. Tüm paramı kaybedip çok fakir veya zavallı duruma düşmekten endişe duyarım.	1	2	3	4	5	6
63. Çoğunlukla annem ve babamın benimle iç içe yaşadığını hissediyorum- Benim kendime ait bir hayatım yok.	1	2	3	4	5	6
64. Kendim için ne istediğimi bilmediğim için daima benim adıma diğer insanların karar vermesine izin veririm.	1	2	3	4	5	6
65. Ben hep başkalarının sorunlarını dinleyen kişi oldum.	1	2	3	4	5	6
66. Kendimi o kadar kontrol ederim ki insanlar beni duygusuz veya hissiz bulurlar.	1	2	3	4	5	6
67. Başarmak ve bir şeyler yapmak için sürekli bir baskı altındayım.	1	2	3	4	5	6
68. Diğer insanların uyduğu kurallara ve geleneklere uymak zorunda olmadığımı hissediyorum.	1	2	3	4	5	6
69. Benim yararıma olduğunu bilsem bile hoşuma gitmeyen şeyleri yapmaya kendimi zorlayamam.	1	2	3	4	5	6
70. Bir toplantıda fikrimi söylediğimde veya bir topluluğa tanıtıldığımda onaylanılmayı ve takdir görmeyi isterim.	1	2	3	4	5	6
71. Ne kadar çok çalışırsam çalışayım, maddi olarak iflas edeceğimden ve neredeyse her şeyimi kaybedeceğimden endişe ederim.	1	2	3	4	5	6
72. Neden yanlış yaptığımın önemi yoktur; eğer hata yaptıysam sonucuna da katlanmam gerekir.	1	2	3	4	5	6

1	2	3	4	5	6
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73. *Hayatımda ne yapacağımı bilmediğim zamanlarda uygun bir öneride bulunacak veya beni yönlendirecek kimsem olmadı.*	1	2	3	4	5	6
74. *İnsanların beni terk edeceği endişesiyle bazen onları kendimden uzaklaştırırım.*	1	2	3	4	5	6
75. *Genellikle insanların asıl veya art niyetlerini araştırırım.*	1	2	3	4	5	6
76. *Kendimi hep grupların dışında hissederim.*	1	2	3	4	5	6
77. *Kabul edilemeyecek pek çok özelliğim yüzünden insanlara kendimi açamıyorum veya beni tam olarak tanımalarına izin vermiyorum.*	1	2	3	4	5	6
78. *İş (okul) hayatımda diğer insanlar kadar zeki değilim.*	1	2	3	4	5	6
79. *Ortaya çıkan gündelik sorunları çözebilme konusunda kendime güvenmiyorum.*	1	2	3	4	5	6
80. *Bir doktor tarafından herhangi bir ciddi hastalık bulunmamasına rağmen bende ciddi bir hastalığın gelişmekte olduğu endişesine kapılıyorum.*	1	2	3	4	5	6
81. *Sık sık annemden babamdan ya da eşimden ayrı bir kimliğimin olmadığını hissediyorum.*	1	2	3	4	5	6
82. *Haklarıma saygı duyulmasını ve duygularımın hesaba katılmasını istemekte çok zorlanıyorum.*	1	2	3	4	5	6
83. *Başkaları beni, diğerleri için çok, kendim için az şey yapan biri olarak görüyorlar.*	1	2	3	4	5	6
84. *Diğerleri beni duygusal olarak soğuk bulurlar.*	1	2	3	4	5	6
85. *Kendimi sorumluluktan kolayca sıyıramıyorum veya hatalarım için gerekçe bulamıyorum.*	1	2	3	4	5	6
86. *Benim yaptıklarımın, diğer insanların katkılarından daha önemli olduğunu hissediyorum.*	1	2	3	4	5	6
87. *Kararlarıma nadiren sadık kalabilirim.*	1	2	3	4	5	6
88. *Bir dolu övgü ve iltifat almam kendimi değerli birisi olarak hissetmemi sağlar.*	1	2	3	4	5	6
89. *Yanlış bir kararın bir felakete yol açabileceğinden endişe ederim.*	1	2	3	4	5	6
90. *Ben cezalandırılmayı hak eden kötü bir insanım.*	1	2	3	4	5	6