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

THE MEDIATING ROLE OF SELF-COMPASSION IN THE RELATIONSHIP BETWEEN SCHEMA MODES AND POSTTRAUMATIC GROWTH IN INDIVIDUALS WITH TRAUMATIC EXPERIENCES

BY

HİLAL ÜNSALDI

MASTER'S THESIS

THESIS ADVISOR

ASSOC. PROF. BURÇİN AKIN SARI

ANKARA - 2024

BAŞKENT ÜNİVERSİTESİ

SOSYAL BİLİMLER ENSTİTÜSÜ

YÜKSEK LİSANS TEZ ÇALIŞMASI ORİJİNALLİK RAPORU

Tarih: 23/08/2024

Öğrencinin Adı, Soyadı: Hilal Ünsaldı

Öğrencinin Numarası: 22110051

Anabilim Dalı: Psikoloji Anabilim Dalı

Programı: Klinik Psikoloji Tezli Yüksek Lisans Programı

Danışmanın Unvanı/Adı, Soyadı: Doç. Dr. Burçin Akın Sarı

Tez Başlığı: The Mediating Role of Self-compassion in the Relationship Between Schema Modes and Posttraumatic Growth in Individuals with Traumatic Experiences

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TEŞEKKÜR

Öncelikle, Şema Terapiyle olan tanışıklığımın yüksek lisans sürecim boyunca derinleşmesine alan açan, tez sürecim boyunca rehberliği ve destekleyici duruşu ile yoluma ışık tutan değerli tez danışmanım Doç. Dr. Burçin Akın Sarı'ya emekleri için çok teşekkür ederim.

Yüksek lisans sürecimin en başından beri karşılaştığım zorluklarda her zaman kapısını çalabildiğim, mizahıyla harmanladığı bilgeliğini benden esirgemeyen değerli hocam Prof. Dr. Okan Cem Çırakoğlu'ya minnettarım. Psikoterapistlik yolculuğumda en zorlu ve en keyifli deneyimleri birer birer tecrübe ettiğim süpervizyon sürecinde şefkatli yol göstericim olması bir yana, hayatımın en zor deneyimleriyle baş etmeye çalıştığım bir yıl geçirirken benim için her zaman orada olan, alan tutan sevgili hocam Tuğba Uyar Suiçmez'e içtenlikle teşekkür ederim, yolum sizlerle kesiştiği için şükran doluyum.

Sonsuz desteklerini ve sevgilerini her zaman hissettiğim, eğitimim ve mutluluğum için her zaman ellerinden geleni yapan ve bana inançlarını hep sürdüren, hayat amaçlarımı destekleyen canım ailem, en büyük şansımsınız. İlk öğretmenim, kanatları gölgesinde uçmaktan keyif aldığım canım babam, sevgisi ve desteğiyle sarıp sarmalayan güzel kalpli annem, ne zaman ihtiyacım olsa benim için orada olduğunu bildiğim canım ablam ve artık yetişkin olsa da benim için hep küçük kalacak olan düşünceli canım kardeşim, emekleriniz için çok teşekkür ederim.

Yıllardır olduğu gibi bu maceramda da elimi hiç bırakmayan, her zaman yapabileceklerim için beni yüreklendiren, derin sevgisini, desteğini, şefkatli eşliğini her zaman hissettiğim oyun arkadaşım, akademik buddyim, güvenli limanım, biricik eşim Fuat Çıkan'a çok teşekkür ederim.

Yüksek lisans dönemecini birlikte yürüdüğümüz sevgili yol arkadaşlarım Nil Alara Okyay, Onur Karaduman ve Gülce Özcan'a tez sürecimi daha tolere edilebilir hale getiren destekleri ve dayanışmaları için; İlayda Kaya, Merve Deniz, Rabia Akbulut, Deniz Köroğlu, Melis Gizem Halli'ye ise süpervizyon ve yüksek lisans sürecim boyunca bana eşlikleri için çok teşekkürler.

Son olarak bilime ve eğitimin gücüne inanan, başarılarımı hep içtenlikle kutlamış, merhum canım büyükbabama teşekkür ederim. Umarım başardıklarımı görüp o her zamanki gururlu halinle gülümsüyorsundur.

ÖZET

ÜNSALDI, Hilal, Travmatik Yaşantısı Olan Bireylerde Şema Modları ve Travma Sonrası Gelişim Arasındaki İlişkide Öz-şefkatin Aracı Rolü, Başkent Üniversitesi, Sosyal Bilimler Enstitüsü, Klinik Psikoloji Tezli Yüksek Lisans Programı, 2024.

Her ne kadar travma ve sonrası süreçler olumsuz doğurgularla eşleştirilse de, travmatik yaşantılardan sonra kişiler olumlu değişiklikler de deneyimleyebilirler. Travma sonrası gelişim kavramı, travmatik deneyimlerden sonra kişinin yaşadığı pozitif değişimleri temsil etmektedir. Şema Terapi yaklaşımından köken alan Şema modu kavramı ise kişinin yaşadığı bu olumlu değişimleri belirlemede önemi olan etmenlerden biri olarak değerlendirilebilir. Şema modları kişilerin duygu, düşünce ve davranışlarında anlık olarak baskın olan belirli içsel tarafları temsil eder. İşlevsel ve işlevsiz olarak iki gruba ayrılan bu modların travma sonrası gelişim sürecini şekillendirmede rolü olabileceği düşünülmektedir. Bu sürece etki edebileceği düşünülen bir diğer kavram ise öz-şefkattir. Kişinin kendine gösterdiği şefkati temsil eden bu kavramın özellikle travma sonrası süreçlerde işlevli ve işlevsiz modların aktive olduğu durumlardaki etkisi merak uyandırmaktadır. Bu bağlamda, araştırma kapsamında şema modları ve travma sonrası gelişim arasındaki ilişkide öz-şefkatin aracı rolünün incelenmesi amaçlanmıştır. Araştırma örneklemi en az 3 aydan en fazla 15 yıl öncesine kadar herhangi bir travmatik olay yaşamış veya bir yakınının başına gelen herhangi bir travmatik olaya tanık olmuş, 18-65 yaş arasında, Türkçe bilen 358 katılımcıdan oluşmaktadır. Katılımcılara Demografik Bilgi Formu, Kısa Şema Modu Envanteri, Öz-şefkat Ölçeği, Travma Sonrası Gelişim Envanteri (PTGI-X) sunulmuştur. Demografik değişkenler ve araştırmanın temel değişkenleri arasındaki ilişkileri incelemek amacıyla korelasyon, t-test ve ANOVA analizleri yürütülmüştür. Daha sonra hipotezleri test etmek amacıyla Yapısal Eşitlik Modeli kapsamında analizler yürütülmüştür. Elde edilen bulgulara göre işlevsel şema modları (Sağlıklı Yetişkin ve Mutlu Çocuk) ile travma sonrası gelişim arasındaki ilişkide öz-şefkatin pozitif şekilde aracılık ettiği gözlenirken, bazı işlevsiz şema modları (İncinmiş Çocuk, Disiplinsiz Çocuk ve Talepkar Ebeveyn) ile travma sonrası gelişim arasındaki ilişkide öz-şefkatin negatif şekilde aracılık ettiği saptanmıştır. Bunun yanı sıra öz-şefkat aracılığında Kopuk Korungan işlevsiz şema modunun beklenmedik bir şekilde travma sonrası gelişimi olumlu şekilde yordadığı görülmüştür. Son olarak, araştırmanın sonuçları ilgili alanyazın çerçevesinde tartışılıp araştırmaya ilişkin klinik çıkarımlar ve sınırlılıklara yer verilmiştir.

Anahtar Kelimeler: Travma Sonrası Gelişim, İşlevsel Şema Modları, İşlevsiz Şema Modları, Öz-şefkat, Şema Terapi

ABSTRACT

ÜNSALDI, Hilal, The Mediating Role of Self-compassion in the Relationship Between Schema Modes and Posttraumatic Growth in Individuals with Traumatic Experiences, Başkent University, Institute of Social Sciences, Clinical Psychology Master's Program with Thesis, 2024.

Although trauma and its aftermath are associated with negative consequences, people can also experience positive changes after traumatic experiences. The concept posttraumatic growth represents the positive changes experienced by a person after traumatic experiences. The concept of schema modes, which originates from the Schema Therapy approach, can be considered one of the important factors in determining these positive changes experienced by the person. Schema modes represent certain internal aspects that are momentarily dominant in people's emotions, thoughts, and behaviors. It is thought that these modes, which are divided into two groups as adaptive and maladaptive, may have a role in shaping the posttraumatic growth process. Another concept that is thought to affect this process is self-compassion. The effect of this notion, which represents the compassion one has for oneself, arouses curiosity, especially in posttraumatic processes when adaptive and maladaptive modes are activated. In this context, the research aimed to examine the mediating role of self-compassion in the relationship between schema modes and posttraumatic growth. The research sample consists of 358 participants between the ages of 18 and 65, who speak Turkish, who have experienced any traumatic event or have witnessed any traumatic event that happened to a relative from at least 3 months to a maximum of 15 years ago. Demographic Information Form, Brief Schema Mode Inventory, Self-Compassion Scale, and Posttraumatic Growth Inventory (PTGI-X) were presented to the participants. Correlation, t-test, and ANOVA analyzes were conducted to examine the relationships between demographic variables and the main variables of the study. Then, analyzes were conducted within the scope of the Structural Equation Model to test the hypotheses. According to the findings, it was observed that self-compassion positively mediated the relationship between adaptive schema modes (Healthy Adult and Happy Child) and posttraumatic growth, while the relationship between certain maladaptive schema modes (Vulnerable Child, Undisciplined Child, and Demanding Parent) and posttraumatic growth was observed to be negatively mediated. Additionally, findings showed that self-compassion unexpectedly positively mediated the relationship between Detached Protector mode and posttraumatic growth. Finally, the results of the research are discussed within the framework

of the relevant literature, and clinical implications and limitations of the research are presented.

Keywords: Posttraumatic Growth, Adaptive Schema Modes, Maladaptive Schema Modes, Self-compassion, Schema Therapy

TABLE OF CONTENTS

TEŞEKKÜR ..... **i**

ÖZET ..... **ii**

ABSTRACT ..... **iv**

LIST OF TABLES ..... **ix**

LIST OF FIGURES ..... **x**

I. INTRODUCTION **1**

1.1. Trauma **2**

1.2. Posttraumatic Growth **3**

1.2.1. Models explaining posttraumatic growth **4**

1.2.1.1. Life crises and personal growth model **4**

1.2.1.2. Affective–cognitive processing model **5**

1.2.1.3. Functional descriptive model **5**

1.2.2. Domains of posttraumatic growth **8**

1.2.3. Factors related with posttraumatic growth **8**

1.3. Schema Therapy Model **11**

1.3.1. Early maladaptive schemas **11**

1.3.2. Schema modes **12**

1.3.2.1. List of schema modes **13**

1.4. Schema Modes and Posttraumatic Growth **17**

1.5. Self-compassion **18**

1.5.1. Elements of self-compassion **19**

1.6. Schema Modes and Self-compassion **21**

1.7. Self-compassion and Posttraumatic Growth **21**

1.8. The Purpose and the Importance of Current Research **23**

1.9. Research Questions and Research Hypotheses **25**

2. METHODS **28**

2.1. Participants **28**

2.2. Measurements **32**

2.2.1. Demographic information form **32**

2.2.2. Short schema mode inventory (SMI) **32**

2.2.3. Posttraumatic growth inventory (PTGI-X) **32**

2.2.4. Self-compassion scale **33**

2.3. Procedure **33**

2.4. Analyzes **34**

3. RESULTS **35**

3.1. Overview **35**

3.2. Data Screening and Cleaning **35**

3.3. Descriptive Statistics **36**

3.4. Correlations Between the Study Variables **38**

3.5. Control Variable Analyses **41**

3.6. Mediation Analysis and Hypothesis Testing **42**

4. DISCUSSION **50**

4.1. Discussing of the Findings Regarding the Main Variables of Research and Demographic Variables **50**

4.2. Discussion of the Findings Regarding the Determination of Schema Modes Predicting Posttraumatic Growth **52**

4.3. Discussion of Findings Regarding the Mediating Role of Self-Compassion in the Relationship Between Schema Modes and PTG **56**

4.4. Clinical Implications **60**

4.5. Limitations and Recommendations **61**

REFERENCES **63**

APPENDICES

Appendix 1: Informed Consent Form

Appendix 2: Demographic Information Form

Appendix 3: Brief Schema Mode Inventory

Appendix 4: Posttraumatic Growth Inventory (PTGI-X)

Appendix 5: Self-Compassion Scale

Appendix 6: Ethics Committee Approval

LIST OF TABLES

Pages

Table 2.1. Demographic Charachteristics of Sample 29
Table 2.2. Statistics Related to Traumatic Experiences. 31
Table 3.1. Descriptive Statistics and Reliability Values of the Study Variables..... 37
Table 3.2. Bivariate Correlations Between the Study Variables. 39
Table 3.3. Summary Table of the Hypotheses and the Results 45
Table 3.4. Unstandardized and Standardized Regression Coefficients and Standard Errors of the Analyzed Paths between the Variables. 49

LIST OF FIGURES

Pages

Figure 1.1. Functional Descriptive Model..... 7
Figure 1.2. The Hypothesized Mediation Model..... 27
Figure 3.1. The Hypothesized Mediation Model and Results of the Path Analysis..... 48

I. INTRODUCTION

After facing a traumatic event such as a natural disaster, fatal disease, loss of a loved one or torture, some individuals experience posttraumatic growth (PTG). PTG defined as positive psychological changes are brought about by the process of coping with life events that create serious difficulties in a person's life (Tedeschi & Calhoun, 1995). According to the Functional Descriptive Model intended to explain PTG, the process includes shattering the existing assumption world, confronting traumatic distress, ruminating, creating a new belief and assumption system, altering life narrative, and eventually gaining wisdom (Calhoun & Tedeschi, 2013; Tedeschi & Calhoun 2004). During this challenging process, individuals' entire world of meaning and relationships can change and transform. Thus, people are at risk for many psychological disorders in this sensitive period following trauma.

Personality traits and coping styles are some of the important factors that predict PTG (Schaefer & Moos, 1992; Tedeschi & Calhoun, 2004). It is known that early maladaptive schemas and schema modes developed based on these concepts (Young, 1990). Schema modes can be briefly defined as instantaneous reflections of personality traits and mood changes in a person's life (Lobbestael et al., 2010; Young et al., 2003). Schema modes that are already present in the person most of which are maladaptive, can be quite active in the person, especially during the PTG process. This can leave the person vulnerable and unsupported during a critical period. Although maladaptive schema modes are positively related to trauma (Lian & Mathialagan, 2024) and Posttraumatic Stress Disorder (PTSD) (Zaman et al., 2021), however, some factors are thought to exist to reduce its effects. As an important positive psychology concept, self-compassion which briefly means treating oneself kindly (Neff, 2003), is hypothesized to be one of these factors. As a form of self-relating (Finlay-Jones, 2017), self-compassion is positively related to PTG (Gökmen & Deniz, 2020; Wong & Yeung, 2017) and can have a protective and mediating role on PTG in the presence of schema modes. Furthermore, Schema Therapy aims to improve the person's quality of life by strengthening adaptive schema modes as well as working on maladaptive schema modes. In this context, contrary to the mainstream trend, investigating the strengthening and protective role of self-compassion is related to the interpretation of schema modes and PTG from a positive psychological perspective. This study aims to focus on the effect the self-compassion in PTG even in the presence of schema modes. This innovative perspective also reflects the therapist's concept of compassion-focused reparenting and the goal of strengthening adaptive modes in Schema Therapy. For this

reason, it is thought that the findings of this research are considered quite valuable, especially in developing Schema Therapy methods and techniques**.**

1.1. Trauma

The word "trauma" is derived from the Ancient Greek word for "wound" (Jones & Cureton, 2014). Trauma is defined as events that threaten and/or damage individuals' physical and psychological integrity, shake or destroy their assumptions about the world and/or others, significantly disrupt their ability to cope with events or situations and normal physical, emotional, and cognitive functionality (Herman, 2016). Not every stressful event is defined as traumatic, and definition of trauma has been expanding over the years in the psychology literature. According to the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) trauma defined as "Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event(s); witnessing, in person, the traumatic event(s) as it occurred to others; learning that the traumatic event(s) occurred to a close family member or close friend (in case of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental); or experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" (American Psychological Association [APA], 2013, p. 271). Events such as natural disasters, accidents, sexual or nonsexual physical assaults, imprisonment, torture, war, fatal diseases, and loss of a loved one are considered traumatic events. Traumatic events are divided into different categories according to their types such as naturally-caused and human-caused traumas or primary (individuals' experiences themselves) and secondary (individuals' witness others' traumatic experience) traumas (Aker, 2012). In a study investigating the prevalence of traumatic events in 24 countries, approximately 70.4% of the participants reported that they had experienced at least one traumatic event throughout their lifetime (Kessler et al., 2017). In Türkiye, the frequency of encountering a traumatic event was found to be 84.2% in a study conducted with 1055 participants in 3 provinces (Karancı et al., 2009). Additionally, the prevalence of experiencing various traumatic events throughout life was found to be 44.9% (Karancı et al., 2012). In another study, 67.3% of 740 adults reported they had experienced at least one traumatic experience (Gül, 2014). Moreover, Dursun and colleagues (2014) revealed the rate of encountering at least one traumatic experience was found to be 99.8% in the university student sample.

1.2. Posttraumatic Growth

"I am more vulnerable than I thought, but much stronger than I ever imagined"

(Calhoun & Tedeschi, 2006)

Traumatic experiences have negative consequences such as anxiety, depression, and PTSD (Beaglehole et al., 2018; Santiago et al., 2013; Yi & Syrjala, 2017), however some people may also experience positive psychological changes after traumatic events (Tedeschi & Calhoun, 1996; Zoellner & Maercker, 2006). Although it can vary depending on cultural differences (Exenberger et al., 2019), the understanding about suffering and experiencing pain will subsequently create beneficial and positive changes in a person is considered timeless and universal (Weiss & Berger, 2010; Xu et al., 2021). The concept of posttraumatic development has found its place in historical, religious, philosophical, and literary texts for thousands of years, even though it had various names throughout time and across cultures (Tedeschi & Calhoun, 2004). In this respect, Buddhism considers development as an outcome of attempting to cope with suffering. According to Islamic belief, the difficulties that people experience serve as a test for them (Tedeschi et al., 2018). Important name of existentialism, Frankl (1963) stated that pain will ease when the meaning is found in the consequences of pain. German philosopher Nietzsche's well-known dictum "what doesn't kill me makes me stronger" has reached from the 19th century to the present day and turned into a universal narrative in the manner of posttraumatic development (Nietzsche, 1888/2010). Therefore, asserting that PTG is as old as human history would not be inaccurate.

Over the years, many different terms have been used in the accumulated literature to define posttraumatic positive psychological alteration such as "perceived benefits" (McMillen & Fisher, 1998; Tennen et al., 1992), "stress-related growth" (Park et al., 1996), "positive changes in outlook" (Joseph et al., 1993), "positive psychological changes" (Yalom & Lieberman, 1991), "benefit finding" (Tomich & Helgeson, 2004) or "thriving" (Abraido-Lanza et al., 1998). However, the "posttraumatic growth" term become commonly used in research and clinical practice areas.

Tedeschi and Calhoun (1995) first conceptualized PTG as positive psychological changes that occur as a result of the process of coping with highly challenging life events. They suggested that negative experiences such as losing a loved one, experiencing natural disasters, being diagnosed with a terminal illness, etc. may have the power to permanently

alter people in positive ways across physiological, behavioral, psychological, and emotional areas. Authors stated that the process of development is a byproduct of ways discovered in attempts to cope with pain (Tedeschi et al., 2018). The distress caused by traumatic experiences positively contribute to individuals' well-being and ways of making sense of the outside world and themselves (Tedeschi & Calhoun, 2004). Thus, a painful encounter can set the stage for a person's growth. PTG represents a person's transition to a better state and functionality compared to before the traumatic event. It should be highlighted that, in contrast to going back to one's former self, progress in this context involves developing new beliefs as a result of confronting one's vulnerability. Due to these dynamic and development-focused features, this concept differs from related concepts in positive psychology such as resilience and hardiness which state the focus on invulnerability, better management and coping (Tedeschi & Calhoun, 1995). In addition, although the healing process seems it follows a certain order, it is cyclical and interactive. Posttraumatic growth is both a process and a result, and it develops as a subjective and complex experience for everyone (Dursun & Soylemez, 2020; Tedeschi et al., 2018). Regarding experiencing PTG, researchers found that positive changes range from 30% to 70% in those who have gone through highly stressful events (Weiss & Berger, 2010). Additionally, a recent meta-analysis showed moderate-to-high PTG ratio varies from 10% to 77.3% in 31 studies without restricting the type of trauma (Wu et al., 2019).

1.2.1. Models explaining posttraumatic growth

There are several models describing PTG. Life Crises and Personal Growth Model (Schaefer & Moos, 1992), Affective–Cognitive Processing Model (Joseph et al., 2012), and Functional Descriptive Model (Tedeschi & Calhoun, 2004) were explained below.

1.2.1.1. Life crises and personal growth model

Schaefer and Moos's (1992) Life Crises and Personal Growth model highlights the role of personal, environmental, and event-related factors in the process of PTG. These factors affect the event-related features and the process that emerged afterward. Subsequently, they collectively influence the coping strategies developed after the traumatic event and finally determine the PTG process. All these specific areas are referred to as "panels" and it is argued that they shape the PTG process bi-directionally.

In detail, Panel I and II; environmental system (social support, interpersonal relationship, cultural context, and financial resources) and personal system (demographic

and dispositional factors such as age, hope, pre-trauma factors etc.) influence the crisis experience and its aftermath. Panel III represents the event-related factors such as duration, severity, and the impact of the traumatic event. These factors shape the cognitive evaluation and coping mechanisms associated with the event (Panel IV). These coping styles have been defined as "approach coping", which includes attempts to solve the problem, or "avoidance coping" which tries to minimize or deny the problems with an emphasis on the unsolvability of the problem. Finally, the PTG course is determined by the combined impact of these processes (Schaefer & Moos, 1992; 1998).

1.2.1.2. Affective–cognitive processing model

Both this and the next model will be mentioned are developed upon Janoff-Bulman's (1992) theory of shattered assumptions and both suggest that posttraumatic growth results from an individual's cognitive battle to untangle the challenged assumptive world by traumatic event. Modifying on their previous Organismic Valuing Theory (Joseph & Linley, 2005), Joseph and colleagues (2012) argued in their proposed Affective–Cognitive Processing Model, that individuals have intrinsic motivation and proneness to grow aftermath of a traumatic experience. They suggest that ruminative brooding triggers cognition appraisal activities which leads to questioning preexisted assumptions and changing in negative or positive emotional state. Thus, individuals embark on different coping strategies based on their emotional states such as problem-focused and emotion-focused strategies or avoidance. At the end of this affective-cognitive cycle, the person either engages in the assimilative process by maintaining prior assumptions and not experiencing change after trauma or engages in accommodative processes by establishing congruence with the updated trauma-related information in their assumptive world.

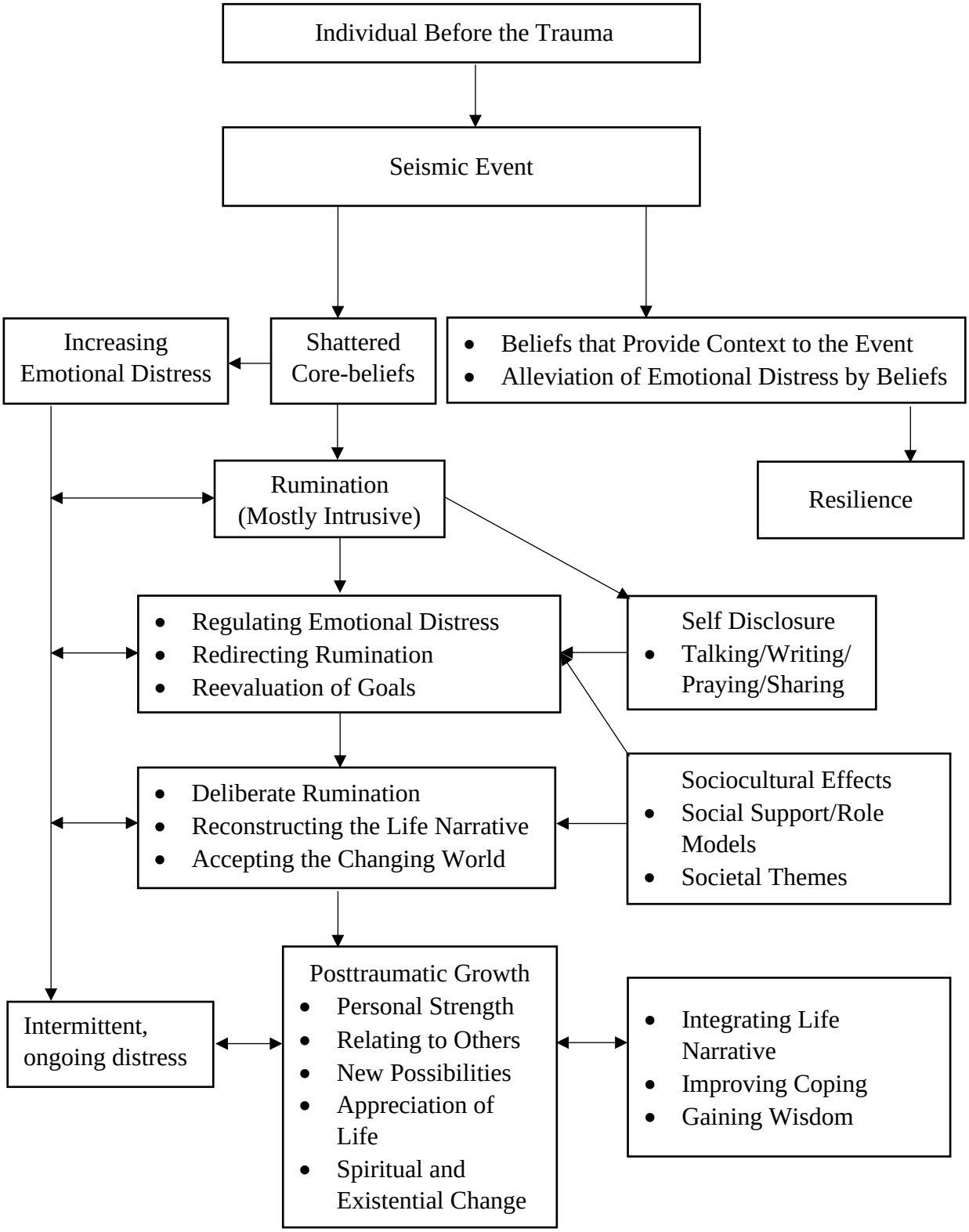
1.2.1.3. Functional descriptive model

As mentioned in the present research multiple times, the most notable model in the related study and clinical practices is undoubtedly the Functional Descriptive Model of Tedeschi and Calhoun (2004). Authors metaphorize the PTG process by expressing the similarities with an earthquake (Calhoun & Tedeschi, 2013). They claim that a “seismic event” must happen unexpectedly like an earthquake, that shakes and destroys the person's core belief system (about the justice and meaningfulness of the world, others and themselves) built throughout life. Therefore, this traumatic event creates enormous stress, and the person has insufficient resources to cope with the event, which is a crucial factor for

experiencing the struggle and starting the cognitive reconstruction process after the collapse. When the beliefs that give the world its predictability and reliability are invalidated, similar to rebuilding process following an earthquake, the person creates a new universe of assumptions including the posttraumatic reality of their new life course. In the process of reinterpreting the trauma, the person often becomes preoccupied with intrusive thoughts about the traumatic event. Intrusive ruminations and subsequent deliberate ruminations enable the person to process new information, adapt to changing conditions, and manage emotional distress. Alongside these factors, self-disclosure and social support also contribute substantially to the reformation of the person's life narrative. Thus, although the distress continues intermittently, individuals accept the changing world, create new assumptions, and have a different understanding than before the trauma. Thereby, manifestations of PTG seem in five domains such as developing personal strength, increasing appreciation of life, profound relationship with others, being aware of new possibilities, and having spiritual and existential change (Tedeschi & Calhoun, 1996). Consequently, this process brings integrity to the person's life narrative before and after the trauma, provides skills to manage future life crises, and helps gain wisdom to the person as it encourages them to explore existential issues. The proposed PTG process was summarized via Figure 1.

Figure 1.1.

Functional Descriptive Model



1.2.2. Domains of posttraumatic growth

According to Functional Descriptive Model, for posttraumatic development to occur, the traumatic event must create great stress for the person and the person must have insufficient resources to cope with the event. Accordingly, a necessary development and growth must occur in the five areas: personal strength, new possibilities, appreciation of life, relating to others, and spiritual-existential change (Tedeschi & Calhoun, 1996). To develop PTG, it is not obligatory to observe change in all the mentioned areas, changes in one or more of these areas can lead to PTG. Firstly, “personal strength” domain refers to the perception of transformation from the victim narrative to the survivor narrative for the individual. It carries the meaning of being aware of vulnerabilities yet increasing strength and self-reliance and being able to overcome struggles in the future (Calhoun & Tedeschi, 2006). As second domain, “relating to others” represents attitudes and behaviors aimed at establishing more positive relationships with others. Expressing feelings, getting help from others, and ending relationships that are no longer useful are examples of this subdomain (Tedeschi & Calhoun, 2004). The area of “new possibilities” is about the individual's ability to create new opportunities for themselves and choose progress on different paths. In this regard, people may acquire new interests and habits, prioritize their dreams, or change careers (Shakespeare-Finch & Barrington, 2012). As another domain, “appreciation of life” refers to realizing the importance of little things, being more grateful to the people around them, appreciating what life has to offer, and taking "second chances" after difficult experiences. Lastly, the field of “spiritual and existential change” is related to spiritual or religious beliefs, which can change depending on the existential development of the person and geographical-cultural contexts (Weiss & Berger, 2010). Questioning one's goals, one's place in the universe, and the meaning of one's experiences involves the reorganization of spiritual and existential systems.

1.2.3. Factors related with posttraumatic growth

Numerous concepts related to PTG have been addressed in the literature. Many studies investigating the link between PTG and age have yielded contradictory results. According to various findings, young people report PTG at a higher rate than the elderly (Gül & Karancı 2017; Güven, 2019; Helgeson et al., 2006; Linley & Joseph, 2004; Sharp et al., 2018; Tomita et al., 2017), while some studies have not found a significant relationship between PTG and age (Bartone & Bowles, 2020; Baş, 2016; Hirooka et al., 2016).

The gender variable has also been linked in the literature to inconsistent results. Some studies show that women report more PTG than men (Greene & McGovern, 2017; Helgeson, et al., 2006; Jeon, et al., 2017; Linley & Joseph, 2004; Nakayama et al., 2017; Sawyer & Brewster, 2018; Sharp et al., 2018; Vishnevsky et al., 2010; Yılmaz & Zara, 2016), while others have not found a significant difference between genders (Altınsoy & Aypay, 2021; Hirooka et al., 2016; Seidmahmoodi et al., 2011; Şakiroğlu, 2019).

Personality is also among the pre-traumatic factors associated with PTG. It was found that extraversion, optimism, openness to experience and responsibility (Gül & Karancı 2017) are positively related with PTG; in contrary, neuroticism is negatively related (Linley & Joseph, 2004). Conscientiousness, agreeableness, and emotional stability are other personality traits that are favorably correlated with PTG (Xie & Kim, 2022). In addition, studies have confirmed that PTG correlated with creativity (Orkibi & Ram-Vlasov, 2019; Zeng et al., 2021), alturism, gratitude, religiosity (Tsai et al., 2016), coping skills, hope and social support (Dong et al., 2017; Teixeira & Pereira, 2013).

It has been emphasized that different traumatic event types can determine the variation of PTG and its five domains (Lowe et al., 2022; Meyerson et al., 2011). Some authors claim that notable PTG is more associated with natural causes (natural disasters or diseases) than with human interactions such as sexual violence (Ickovics et al., 2006). Conversely, some authors suggest that sexual violence is more likely to trigger PTG because of the altering survivors' sense of self with their relationship with others (Ulloa et al., 2016). Shakespeare-Finch and Armstrong (2010) compared PTG in three groups of people those who have survived sexual assault, motor vehicle accidents, and experienced unexpected loss. In particular, the PTG domains of "appreciation of life" and "relating to others" showed greater perceived progress in the unexpected loss group than in the sexual assault group, although the PTG domain of "personal strength" showed equivalent increase in all three groups. Karancı and colleagues (2012) investigated PTG after bereavements, accidents, and disasters. Similarly, she stated that these experiences are associated with two subdimensions of PTG: “relating to others” and “appreciation of life”, but not with other subdimensions (i.e., “new possibilities”, “personal strength”, or “spiritual-existential change”). Linley and Joseph (2004) found that experiencing a sudden loss of a loved one results in higher PTG compared to other traumatic experience types.

Concerning the other aspects of traumatic event type, some researchers suggest that single and secondary traumas tend to induce PTG, however, chronic traumas tend to prevent

PTG (Shuwiekh et al., 2018). Also, it is reported that those who experienced the trauma by themselves reported higher PTG levels than those who witnessed someone else's traumatic experience (Altınsoy & Aypay, 2021; Kamibeppu et al., 2010; Wu et al., 2019).

Impact of the traumatic event is another factor that affects PTG. Yalom and Lieberman (1991) suggest that subjective pain and growth can coexist. Calhoun and Tedeschi (2013) state that to start the cognitive reconstruction processes and eventually growth, the individual must face struggles of the stressful traumatic event. Since very low levels of stress will not cause differentiation in the person's belief system, and very high levels of stress may be quite damaging to cope with, it reduces the possibility of PTG (Danhauer et al., 2013; Shuwiekh et al., 2018). Certain research indicates that the highest levels of PTG are linked to moderate posttraumatic stress symptoms, thus there is an inverted U-shaped curvilinear relationship defined between posttraumatic stress and PTG (Kangaslampi et al., 2022; Klosky et al., 2014; Michélsen et al., 2017; Na et al., 2021; Shakespeare-Finch & Lurie-Beck, 2014) as well as the association between grief intensity and PTG (Yılmaz & Zara, 2016). Besides, notions such as stressfulness of the event (Kesimci et al., 2005), traumatic perception level (Yilmaz & Zara, 2016), and higher event severity (Helgeson et al., 2006) were suggested to be linked with PTG in the literature.

Research examining the relationship between time since trauma and PTG reported different results. Liu and colleagues (2017) argued that the longer the time passed since the traumatic event, the higher PTG reported even within 2 years. Consistently, some studies indicate that PTG is more prone to develop as time elapses after the trauma (Akın, 2019; Ülbe & Kartal, 2019). However, others imply that PTG is more prone if the time is shorter (Kalpakjian et al., 2014). Researchers proposed that methodological restraints are partially responsible for these discrepancies (Dekel et al., 2012). In addition, a meta-analysis posits that PTG levels were found higher for people experiencing PTG in less than 6 months after a traumatic event than for those experiencing PTG in more than 6 months after the traumatic event (Wu et al., 2019). Nevertheless, authors hypothesize an inverse U-shaped association between time since trauma and PTG as a result of the contradictory findings in the literature mentioned thereinafter. Some studies showed that PTG levels peaked in 4-5 months (Kelly et al., 2017), and 12th months compared to the 6th and 24th months after the trauma (Husson et al., 2017).

It should be noted that all the above-mentioned factors which affect PTG, have an impact on one another. Therefore, conflicting research results should be considered inevitable due to the unique and complex nature of these relationships. Methodological differences and limitations are also critical factors shaping the outcomes.

1.3. Schema Therapy Model

Young (1990) developed Schema Therapy model for "difficult to treat" clients for whom Cognitive Behavioral Therapy (CBT) techniques were inadequate, who had difficulty adapting to therapy, and whose problems had become chronic and entrenched. Schema Therapy is an integrative and comprehensive theory that harmonizes the rich insights of different approaches such as CBT, Psychoanalysis, and Gestalt (Edwards & Arntz, 2012; Roediger et al., 2018). It includes implementations of cognitive, behavioral, and experiential techniques. It aims to build a bridge between the person's current problems and the early period of life, by helping the client identify their core unmet emotional needs and equipping them with healthy tools to meet and manage these needs with various techniques. In detail, the approach intends to reduce the severity of maladaptive schemas, modes, and coping strategies making them less active while expanding the effect of adaptive modes and increasing their activity (Young et al., 2003). Furthermore, the therapist-client relationship is quite important for the functioning of the treatment. The therapist actively contributes to the client's growing awareness and development by using two therapeutic stances: limited reparenting and empathic confrontation. While limited reparenting refers to meeting the client's needs within reasonable boundaries similar to a parent raising child, empathic confrontation highlights the necessity of change for healing and progress by conducting reality testing for the client in a safe and accepting environment (Young et al., 2003).

1.3.1. Early maladaptive schemas

According to Young (1990), early maladaptive schemas (EMSs) are self-defeating emotional and cognitive structures rooted in negative toxic childhood experiences and create a frame for one's beliefs about oneself, others, and the world. They consist of memories, emotions, cognitive and bodily sensations. They arise simply from the most basic universal needs such as attachment, autonomy, freedom to express emotions, spontaneity, and realistic limits not met during childhood or adolescence. In addition, early destructive experiences such as traumatization and selectively modeling the parents, and the emotional temperament of the child is also important factors in the formation of schemas (Young & Klosko, 1994;

Young et al., 2003). Schemas elaborate through the life span and become a pervasive and dysfunctional theme in one's life.

Young and colleagues (2003) defined five schema domains encompassing 18 EMSs based on their clinical experience. First is the *disconnection and rejection* schema domain which includes abandonment, mistrust/abuse, emotional deprivation, defectiveness/shame, and social isolation schemas. Second is *impaired autonomy and performance* schema domain which consists of dependence/incompetence, vulnerability to harm or illness, enmeshment/undeveloped self, and failure schemas. As third, *impaired limits* schema domain consists of entitlement/grandiosity and insufficient self-control/self-discipline schemas. The fourth is the *other-directedness* schema domain, which involves subjugation, self-sacrifice, and approval-seeking/recognition-seeking schemas. Finally, the *overvigilance and inhibition* schema domain comprises negativity/pessimism, emotional inhibition, unrelenting standards/hypercriticalness, and punitiveness schemas.

To cope with their schemas, people adopt three different maladaptive coping styles: overcompensation, avoidance, and surrender. These strategies overlap with the basic adaptation responses of "fight, flight, and freeze" in the face of a life threat for organisms (Porges, 2001). People may try to overcompensate for the schema by taking actions as if the opposite of the schema were true. With avoidance coping style, they can avoid situations in which they possibly feel the schema. Finally, they can surrender to the schema and live in a way that confirms and validates the schema (Young et al., 2003).

1.3.2. Schema modes

While Schema Therapy is effective for most clients, a more advanced element, Mode Work has been developed primarily for narcissistic and borderline personality disorders. However, not only has it been useful for the treatment of personality disorders, but it has also become an integrative and complementary part of Schema Therapy Model by treating a wide range of disorders such as PTSD (Cockram et al., 2010), depression (Arendt et al., 2024), complex obsessive compulsive disorders (Thiel et al., 2016), eating disorders (Joshua et al., 2023) and other disorders (Taylor et al., 2016).

The term "Schema Modes" has been proposed because the more transient symptoms and changing states of individuals are not well explained by EMSs which are relatively stable traits (Lobbestael, 2008). Schema modes are described as “the moment-to-moment emotional states and coping responses—adaptive and maladaptive—that we all experience”

by Young and colleagues (2003). They are often described as a temporary aspect of the person that is prioritized and active in the present (Lobbestael et al., 2010; Rafaeli et al., 2011). Schema modes are the combination of currently active schemas or adaptive-maladaptive schema functioning for the individual (Roediger et al., 2018). People can switch to different schema modes in response to events and situations, and different schemas and coping responses may be activated in these transitions. The fundamental goal of the Mode Work is to organize and quiet down the maladaptive modes while enhancing the Healthy Adult and Happy Child modes (Lobbestael et al., 2007; Young et al., 2003).

Schema modes are classified into four basic subdimensions: Child modes, Maladaptive Parent modes, Maladaptive Coping modes, and the Healthy Adult mode (Young et al., 2003). According to the theory of Young and colleagues (2003), four child modes were identified as the Vulnerable Child, the Angry Child, the Impulsive/Undisciplined Child, and the Happy Child modes. Maladaptive Coping modes comprise three modes: the Compliant Surrenderer, the Detached Protector, and the Overcompensator. Maladaptive Parent modes involve the Punitive Parent and the Demanding Parent. The last category is the Healthy Adult mode itself. Healthy Adult mode and Happy Child mode are adaptive schema modes, and they are not linked to maladaptive schemas.

The general categorization of modes under the titles of Child modes, Parent modes, Coping modes, and Healthy Adult is widely agreed upon. However, as interest and research on this subject increases, it has been reported that more than eighty modes continue to be defined under these four broad classifications (Edwards, 2022). In addition to the original schema modes mentioned above, Enraged Child Mode, Bully and Attack Mode, Self-Aggrandiser Mode, and Detached Self Soother Mode (Arntz & Jacob, 2017; Edwards, 2022) will be examined considering the 14-factor model of the Short Schema Mode Inventory (Aytaç et al., 2020; Lobbestael et al., 2010). The following provides a detailed explanation of each schema mode included in the present study.

1.3.2.1. List of schema modes

Child Modes

Child modes refer to childlike parts within the adult and it represent experienced raw emotional reactions just like in childhood (Arntz & Jacob, 2017; Roediger, 2020). These modes point to unmet needs and provide clues about them (Roediger, 2020). Young and

colleagues (2003) suggest that Child modes are universal, and every person has the capacity to experience these modes innately. They are characterized by display of intense emotions that are disproportionate to the situation and the person has difficulty in controlling these emotions and reactions (Jacob et al., 2014). Following, five child modes will be examined: Vulnerable Child, Angry Child, Enraged Child, Undisciplined Child, Impulsive Child and Happy Child.

In *Vulnerable Child* mode, people experience emotions such as sadness, loneliness, helplessness, and emptiness. To survive, the person constantly seeks the care and love that was mostly unmet in the past. Young and colleagues (2003) argued that the majority of schemas, including Abandonment, Mistrust/Abuse, Emotional Deprivation, Defectiveness, Social Isolation, and Dependence/Incompetence, are associated with the Vulnerable Child mode. For this reason, this schema is considered the core mode in therapeutic work. Secondly, people in the *Angry Child* mode mostly feel infuriated and frustrated. They express anger directly in response to perceived unmet needs or injustice and maltreatment, they can be rebellious and make demands (Arntz & Jacob, 2017; Young et al., 2003). This mode is mostly related to Abandonment, Mistrust/Abuse, Emotional Deprivation, and Subjugation schemas. Compared to the Angry Child, *Enraged Child* expresses more intense and uncontrollable fury. In this mode, people may get furious, show extreme rage and uncontrolled aggression, lash out verbally, and harm people or objects (Arntz & Jacob, 2017). As fourth, when in *Undisciplined Child* mode, the person finds it difficult to complete boring tasks and is unable to focus and maintain works that require dedication. Insufficient Self-control/Self-discipline is an example of associated schemas. Although there are some overlapping similarities, the Impulsive Child mode differs from the Undisciplined Child mode in some features. *Impulsive Child* acts recklessly to meet their needs without knowing any limits and have trouble delaying gratification. Young and colleagues (2003) defined this mode as an "uncivilized" child behaving impatient, spoiled, and uncontrolled. It may derive its origin from the Entitlement schema. Lastly, unlike the modes mentioned above, *Happy Child* mode reflects the sense of love, understanding, togetherness, pleasance, nurturance, fulfillment, joy, spontaneity, and peace because the current needs were met. This mod is not linked with any EMS and schema activation and is considered an adaptive mode (Arntz & Jacob, 2017; Young et al., 2003).

Maladaptive / Dysfunctional Parent Modes

Schema Therapy suggests Maladaptive Parent modes are internalizations of attitudes and behaviors of parent figures (Jacob et al., 2014). When in Parent modes, people embark on negative emotions and attitudes towards themselves such as self-criticism, self-hate, self-rejection, and high pressure (Arntz & Jacob, 2017). They engage in self-talk with the "voices" of their caregivers, similar to what their caregivers have talked in the past (Rafaeli et al., 2011). In *Punitive/Critical Parent* mode, people deeply exploit, criticize, punish, and restrict themselves, indeed the vulnerable child within them. This mode is more distinct in people who have severe depression or borderline personality disorder, and Punitiveness and Defectiveness schemas are the most commonly linked schemas (Young et al., 2003). On the other hand, *Demanding Parent* mode is the side that puts demands on the person that are almost impossible to fulfill such as high achievements or emotional investment and effort. It is characterized by trying to meet unrealistic high expectations, perfectionist standards, and take on brutal pressure (Rafaeli et al., 2011). Unrelenting Standards and Self-Sacrifice are frequently linked schemas to this mode.

Maladaptive / Dysfunctional Coping Modes

People develop three coping modes to help them adjust to a harmful environment and deal with the unpleasant feelings produced by the child and parent modes. Coping modes may feel less intense than other modes. Besides, they have been adaptive and useful survival strategies in the past, however, they are often dysfunctional in adulthood (Arntz & Jacob, 2017; Young et al., 2003). Resembling the previously described coping strategies surrender, avoidance, and overcompensation, these modes are originally defined as the Compliant Surrenderer, the Detached Protector, and the Overcompensator (Young et al., 2003). These headings have been expanded with newly defined modes to be more inclusive, and Arntz and Jacob (2017) have named them with minor changes. Below they are used interchangeably.

In surrendering coping mode named *Compliant Surrenderer*, individuals entirely subjugate to the demands and desires of others. They fear rejection and behave in a passive, dependent, obedient, submissive, and reassurance-seeking manner (Arntz & Jacob, 2017; Young et al., 2003). Even though they feel unhappy and reluctant, they exhibit behavior consistent with the demands of parent modes (Jacob et al., 2014).

In *Avoidance Coping* modes, people distance themselves from the outer world and they pay the price of being isolated from difficulties with deprivation of fulfilling feelings and social experiences. Disconnection and isolation represent psychological withdrawal from people, social interactions, and stressful situations to protect from possible harm and distress. *Detached Protector* mode guards the vulnerable modes by cutting off contact with emotions through behaviors such as alcohol and substance use and thereby people feel numbness and emptiness (Arntz & Jacob, 2017; Young et al., 2003). On the other hand, *Detached Self-Soother* mode shuts off their emotions by soothing, distracting, or stimulating behaviors such as bingeing, computer games, and workaholism (Arntz & Jacob, 2017).

Overcompensating modes behave as if the adverse of the child and parent modes were true. They try to cope with their helplessness and the dominance of others by overcompensating (Jacob et al., 2014). *Self-aggrandizer* mode is characterized by acting self-centered, grandiose, entitled, boastful, and abusive. Displays superiority over others and demands to be respected and treated special. Disobeys rules and shows a lack of empathy (Arntz & Jacob, 2017; Lobbestael et al., 2007) and some show passive-aggressive or obsessive behaviors (Young et al., 2003). When *Bully and Attack* mode gets active, the person deliberately targets and endeavors to damage others physically and verbally, strategically humiliating and degrading them. Utilize threats, violence, and intimidation to obtain what they want or defend themselves against perceived or actual harm (Edwards, 2022; Lobbestael et al., 2007).

Healthy Adult mode

This mode carries out suitable adult functions and enjoyable adult activities. *Healthy Adult* can be in control, aware of responsibility, establish a balance between their and the needs of others and can meet their needs from appropriate sources within appropriate limits. This mode could evaluate situations, conflicts, and relationships realistically. The Healthy Adult aids meet the child modes unmet emotional needs by nurturing, protecting, and limiting by adopting a self-compassionate approach. It also controls and manages the dysfunctional modes. In therapy, the therapist models the Healthy Adult to the client through limited reparenting by employing a compassionate stance. The main objective of mode work is to develop and strengthen the patient's Healthy Adult so that it can interact with the other modes more effectively (Jacob et al., 2014; Lobbestael, 2008; Rafaeli et al.,2011; Roediger et al., 2018; Yakın & Arntz, 2023; Young et al., 2003).

1.4. Schema Modes and Posttraumatic Growth

As mentioned earlier, personality traits and coping styles are some of the important factors that predict posttraumatic growth (Schaefer & Moos, 1992; Tedeschi & Calhoun, 2004). It is known that Schema Modes consisted of schema operations, including EMSs and schema coping styles developed based on these concepts (Young, 1990). Although limited number of studies are known to have investigated the relationship between PTG and Schema Modes or EMSs, it will be valuable to present the research findings related to these notions.

Previous research found that EMSs are linked with interpersonal problems (Janovsky et al., 2020), parental rearing style (Basso et al., 2019), depression (Harris & Curtin, 2002), anxiety, stress (Yu et al., 2017) and PTSD (Testa, 2008). Bär and colleagues (2023) revealed the association of schemas and schema modes in several clinical disorders such as mood disorders, eating disorders, attention deficit hyperactivity disorder (ADHD), and schizophrenia in their review study.

Lian and colleagues (2023) examined EMSs in traumatized population by reviewing published studies between 1990 and 2022. They concluded that traumatized people commonly displayed nine EMSs from the domains of Impaired Autonomy/Performance and Disconnection/Rejection. Delcea and colleagues (2023) investigated the effects of EMSs, psychological distress and PTG on people involved in traffic accidents. It was suggested that EMSs cause difficulties in the PTG process and increase the emotional and cognitive burdens of trauma. Moreover, authors stressed that EMSs are one of the important elements of pre-trauma factors. In another study, it was determined that EMSs are negatively related to PTG in women with breast cancer. Furthermore, they found that emotion regulation reduced the detrimental effects of EMSs on PTG (Karimzadeh et al., 2021).

In a systematic review that included 12 studies investigating schema modes and suicide risk, it was found that Vulnerable Child, Angry Child, Detached Protector, and Compliant Surrenderer modes are related to suicidal risk. Additionally, researchers stated that Healthy Adult and Happy Child modes have protective effects on suicide (Grażka & Strzelecki, 2023). Zaman and colleagues (2021) investigated the relationship between PTSD and schema modes in trauma survivors. They established that PTSD severity is higher in the group that has maladaptive schema modes and PTSD symptoms are mild to moderate in the group that has adaptive schema modes. In their narrative review, Lian and Mathialagan (2024) aimed to identify schema modes linked with traumatic experiences from 2003 to 2023

studies. They concluded Vulnerable Child, Angry Child, Punitive Parent, and Detached Protector modes are significantly associated with traumatic experiences. Relating to that, Lian and Bono (2023) postulated that Schema Therapy is suitable for traumatized populations and developed a trauma-focused Schema Therapy intervention by modifying experiential techniques such as imagery rescripting and chair work which including to work with schema modes. Subsequently, Lian and Bono (2024) presented an object relations integrated Schema Therapy case study to treat complex trauma and they reported the PTG manifestations.

Studies in the field of intervention demonstrate concordance with theoretical findings. In comparison to the control group of war veterans who attended CBT, Cockram and colleagues (2010) investigated the efficacy of Schema Therapy with veterans of war who demonstrated PTSD symptoms. They concluded that the Schema Therapy group had seen a noticeably greater improvement in both PTSD and anxiety symptoms and after receiving Schema Therapy, all EMSs, PTSD, anxiety, and depression symptoms had considerably decreased. Later, consistent findings provided about the effectiveness of Schema Therapy in traumatized populations (Moosaviassl & Moosavi, 2014; Naderi et al., 2015).

1.5. Self-compassion

The word compassion is of Latin origin and means "suffer with" (Germer, 2009). According to Goetz and colleagues (2010), compassion is the emotion that appears when one sees another's suffering and prompts a subsequent desire to help the other. In this respect, self-compassion can be understood as the self-directed version of this experience. Self-compassion is characterized by treating oneself with a kind and understanding attitude, providing space for emotions or thoughts and accompanying them to come and go while decreasing the intensity of the pain, and being aware of all these processes in an accepting manner, as opposed to over-integrating with the difficulty or pain experienced (Neff, 2003a). Although some researchers consider self-compassion as a form of emotion regulation (Diedrich et al., 2014), others argue that these concepts regard to be complementary (Neff et al., 2007). Congruently, self-compassion is defined as “a state of mind”, “a way of relating to the ever-changing experiences” (Neff, 2023), and “a form of adaptive self-relating” (Finlay-Jones, 2017). As mentioned by Neff (2003a), although the notion of self-compassion

has been present for centuries in the East, especially in Buddhist philosophy, it is still a relatively young concept in Western psychology.

While clarifying the self-compassion, it is also necessary to mention the concept of self-esteem, which is often confused with it. Self-esteem represents the judgment of self-worth through standards, comparison with others and demands superiority (Harter, 1999). However, self-compassion doesn't require appraisals, it relies on unconditional acceptance (Neff, 2023). Furthermore, there is no significant association between narcissism and self-compassion, in contrast to self-esteem (Demirci et al., 2019; Neff 2011). In this context, other misgivings about self-compassion are that it may cause weakness, self-centeredness, and diminished motivation (Robinson et al., 2016). However, while self-compassion takes a strong and fierce form in times of protecting oneself and taking care of one's needs, it can take a nurturing and gentle form when it aims at self-acceptance and soothing emotions (Neff, 2021). In addition, findings from the literature falsify the mentioned concerns. In contrast to the mentioned negative concepts, self-compassion is associated with resilience (Hamrick & Owens, 2018; Yuhan et al., 2021), adaptive coping strategies (Ewert et al., 2021), health-promoting behaviors (Wong et al., 2020), and enhanced interpersonal connections (Lathren et al., 2021). According to Germer (2009), self-compassion is the foundation for understanding others. When people struggle without self-compassion, they often overlook their environment and are unable to demonstrate empathy to others.

Moreover, self-compassion is negatively related to fear of failure (Neely et al., 2009), maladaptive perfectionism (Dundas et al., 2017), and self-handicapping behaviors (Sirois et al., 2019). Although self-compassion helps to alleviate negativity, it's crucial to highlight that it doesn't completely remove or push away unpleasant feelings. Indeed, compared to those who lack self-compassion, self-compassionate people are less likely to repress undesirable feelings and thoughts (Neff, 2003b). Further, they are also more likely to recognize and appreciate the value of their positive or negative emotions (Leary et al., 2007; Neff et al., 2007; Neff & Costigan, 2014). Consistent with these findings, Westphal and colleagues (2016) demonstrated the inverse relationship between self-compassion and emotional invalidation.

1.5.1. Elements of self-compassion

According to Neff (2003a) as a multifaceted construct, self-compassion has three bipolar components: “self-kindness versus self-judgment”, “a sense of common humanity

versus isolation", and "mindfulness versus overidentification". In times of adversity, these elements interact dynamically to create responses that ranging from uncompassionate self-responding to compassionate self-responding (Neff, 2022).

While one end of the "self-kindness versus self-judgment" continuum represents approaching oneself with an understanding, gentle and supportive attitude, unlike this stance the other end involves being harsh, critical, and punishing towards oneself when faced with difficulties. Self-kindness means being open and accepting of one's unsuccessfulness and mistakes just like a warm attitude shown to a friend in the same situation, being available to face emotions and being able to calm oneself (Biber & Ellis, 2017; Germer, 2009; Neff 2011; Neff, 2023).

The sense of "common humanity", the second component of self-compassion, is characterized by recognizing failures as common human experiences rather than isolated to the individual. It reflects the tendency to acknowledge the similarity and universality of shared negative experiences by all people. It eases to feel connected with others in the context of being human and imperfect (Brown, 2015; Neff, 2003). Conversely on the isolation tip of the continuum, when people fail or suffer, it is possible to fall into the fallacy of being the only one who fails on challenges and feel loneliness, guilt, and disconnection. (Germer, 2009; Neff 2011; Neff, 2023).

Lastly, "mindfulness versus over-identification" can be said to reflect finding the balanced distance of one's own experience by stepping outside from oneself and recognizing emotions and thoughts in an accepting way. Mindfulness is identified as a balanced awareness of the distress experienced in the present moment (Shapiro et al., 2006). In addition, Neff (2023) posits that the prerequisite for showing self-compassion is to recognize the situation primarily. Mindfulness helps to acknowledge without minimizing or maximizing the effect of the present experience and readiness the take up the challenge as it is (Brown & Ryan, 2003). In contrast to this realistic attitude of mindfulness, overly identifying with negative thoughts and feelings and confirming them could narrow their perspective and mislead people's attributions about themselves and the outside world (Neff & Pommier, 2013). Therefore, it is interpreted that there is no room for self-compassion because of the disrupted reality and self.

1.6. Schema Modes and Self-compassion

It was determined that self-compassion affects mental health positively (Muris & Petrocchi, 2017) and it is negatively related to anxiety, depression, stress (Ferrari et al., 2019; Neff & Costigan, 2014), ruminations, and emotion regulation problems (Neff et al., 2005). Regarding EMSs, Thimm (2017) found with the exception of enmeshment and entitlement schemas, other EMSs had a negative relationship with self-compassion. More importantly, he revealed that self-compassion and mindfulness individually mediated the relationship between EMSs and psychological distress. Yakın and colleagues (2019) investigated the relationship between EMSs and symptoms of psychopathology and life satisfaction considering mediating roles of self-compassion and negative emotion regulation. They found self-compassion and negative emotion regulation mediated the relationship between EMSs and psychopathology symptoms and satisfaction with life. Additionally, Fırıncı (2019) examined the relationship between EMSs and breakup adjustment with the mediation of self-compassion and she found that self-compassion significantly mediated the mentioned relationship.

Consistently, self-compassion is found positively related to adaptive schema modes and negatively related to maladaptive schema modes in various personality disorders (Salgó et al., 2021). Moreover, the study showed that adaptive schema modes are associated with adaptive emotion regulation strategies and maladaptive schema modes are associated with non-adaptive emotion regulation strategies. In another research, Yakın and Arntz (2023) conducted interviews to deeply investigate the Healthy Adult mode and they revealed three superordinate themes which are bond, balancing, and battle. Bond refers to the ability of the Healthy Adult to take care of the Vulnerable Child's needs and it comprises compassion and nurturance with emotional attunement. Balance presents the Healthy Adult's capacity to place restrictions on Angry and Impulsive Child while allowing space for the Vulnerable Child's requirements. Lastly Battle represents the moderation of maladaptive modes while welcoming challenges with hope.

1.7. Self-compassion and Posttraumatic Growth

Previous meta-analyses indicated that there is a significant correlation between self-compassion and decreased psychopathology (MacBeth & Gumley, 2012) and improved cognitive and psychological well-being (Zessin et al., 2015). It is possible that self-compassion has a big part in enhancing important aspects of PTG. After traumatic events,

people experience shame and self-criticism (Cromer & Smyth, 2010) and establishing a self-compassionate attitude is linked to reduced feelings of shame and self-judgment (Hoffart et al., 2015).

As mentioned earlier, people adopt different coping strategies in the process of PTG (Schaefer & Moos, 1998; Tedeschi et al., 2018). In this regard, it is known that self-compassion is associated with adaptive coping strategies (Seligowski et al., 2015) such that, increased self-compassion is linked to less avoidance and less cognitive suppression of unpleasant thoughts (Neff et al., 2007). Related with necessary intrusive /deliberate ruminations (Tedeschi & Calhoun, 2004) although self-compassion associated with less rumination (Leary et al., 2007; Svendsen et al., 2017) other results indicate that people with higher levels of self-compassion might be more open to dealing with their trauma-related memories without passing judgment on themselves (Thompson & Waltz, 2008). Self-compassion might help the traumatized people to perceive the event related memories from a self-distanced standpoint (Kross & Ayduk, 2011).

Wong and Yeung (2017) determined the significant relationship between self-compassion and PTG mediated by adaptive cognitive processes such as positive reframing and the presence of meaning in the university student population. Hence, they propose that self-compassion may be considered protective in the manner of adaptation to trauma. Supportingly, a recent study investigated the association between self-compassion, emotion and problem-focused coping, and PTG in emerging adult trauma survivors (Munroe et al., 2022). Results indicated that coping styles which are active coping, instrumental support, and positive reframing mediated the relationship between self-compassion and PTG.

As shown by empirical research, self-compassion was linked to fewer symptoms of posttraumatic stress in veterans (Dahm et al., 2015) as well as other trauma-exposed populations such as people who have experienced sexual assault, physical abuse, and natural disasters (Seligowski et al., 2015; Thompson & Waltz 2008; Zeller et al., 2015). Raiche (2017) discovered that self-compassion has a moderating role in the relationship between war exposure and PTG. The results showed that following severe traumatic events, soldiers with high levels of self-compassion displayed significant levels of PTG. Similar results are also found in the family context. In a study conducted with parents who lost their children at most 2 years ago, researchers reported that self-compassion positively related to PTG and has a mediating role between the level of traumatic grief and PTG (Khursheed & Shahnawaz,

2020). Chan and colleagues (2019) explored the relationship between self-compassion and PTG among caregivers of children with autism in China. They identified a positive relationship between variables by stating that self-compassion can have a protective function in mental health. Moreover, an up-to-date study investigated parental well-being during COVID-19 and findings illustrated that parents who reported more self-compassionate behavior were also likely to report higher pandemic-related PTG (Deitz, 2024). Another study examined the association between self-compassion and complex grief symptoms in adults who lost a loved one. It was found and negative significant relationship between the level of self-compassion and complex grief symptoms. Researchers concluded that low self-compassion levels can be a risk factor for displaying complex grief symptoms (Vara & Thimm, 2019).

Studies conducted in Türkiye demonstrate consistency with foreign literature. Tekcan (2018) argued that self-compassion has a moderating role in the relationship between posttraumatic stress symptoms and PTG. Confirmatively, Arıcı-Özcan (2019) found that posttraumatic stress and self-compassion were found to significantly and positively predict PTG in adults. Çolakoğlu (2013) reported a significant relationship between subdomains of self-compassion and PTG in individuals who had heart attack. According to Gökmen and Deniz (2020), self-compassion and forgiveness levels were found to be favorable predictors of PTG scores in adults. In another study, it has been found that the self-compassion level of women diagnosed with breast cancer positively predicts posttraumatic growth (Kaplan, 2022).

1.8. The Purpose and the Importance of Current Research

With criticism from the positive psychology perspective, investigating individuals' strengths rather than weaknesses has become a focal point in recent years (Seligman, 2011) and the focus of research has steadily turned from the detrimental to the positive effects of trauma (Teixeira & Pereira, 2013). Emerging literature suggests that self-compassion is likely to have an important role in understanding growth from trauma (Scoglio, 2018).

From the perspective of Schema Therapy, it has been argued that schema modes provide information about one's personality traits and coping styles in the face of difficulties (Lian & Mathialagan, 2024). In this context, investigating the relationship between schema modes and PTG will undoubtedly increase the existing knowledge. Supporting this idea, Lian and colleagues (2023) indicated the suitability of Schema Therapy as a trauma-focused

treatment. Subsequently, researchers integrated trauma-focused approach into Schema Therapy through experiential techniques (Lian and Bono, 2023). However, to the best of the author's knowledge, the relationship between schema modes and PTG has not been examined in the literature.

In parallel, researchers have stated that Schema Therapy research mostly focused on the outcomes in recent years and neglected the mechanisms of change in treatment (Gibbons et al., 2009; Yakın et al., 2020). It has also been stated that there is insufficient evidence regarding the role of schema modes and experiential techniques in change processes (Yakın et al., 2020). Tschacher and friends (2012) discovered that enabling the change in Schema-Focused treatment requires insight and clarification. Lian and Bono (2023) emphasized the importance of having an empathetic, client-centered approach and adopting sensitivity to the client's emotional readiness while conducting Schema Therapy for traumatized populations. It can be postulated that these concepts intersect quite well with the components of the self-compassion. Furthermore, modeling and internalizing the therapist's compassionate attitude is crucial for the client in the manner of establishing a therapeutic alliance and strengthening the Healthy Adult mode through experiential techniques. Confirmatively, Yakın and colleagues (2019) proposed that integrating elements of Schema Therapy with modern positive psychology principles such as self-compassion has intriguing clinical potential. Therefore, investigating the role and effect of self-compassion in Schema Mode Work can be quite inspiring in the clinical implication field of Schema Therapy.

Based on the theoretical framework, the aim of this study is to examine the underlying mechanism of the relationship between adaptive and maladaptive schema modes, self-compassion, and PTG. To the best of the author's knowledge, the relationship between schema modes, self-compassion and PTG has not been examined in international research area. In line with the shifting paradigm of contemporary psychology, the present study intends to draw attention to the crucial role of a positive psychology concept of self-compassion in Schema Mode Work and further explore this relationship's function in the PTG process. It is thought that this research will shed light on this very current path by considering the change mechanism in the Schema Therapy approach from a trauma-focused positive psychological perspective. Figure 1.2. shows the hypothesized research model of the current study.

1.9. Research Questions and Research Hypotheses

1. Do adaptive schema modes positively predict posttraumatic growth?
2. Do maladaptive schema modes negatively predict posttraumatic growth?
3. Does self-compassion positively mediate the relationship between adaptive schema modes and posttraumatic growth?
4. Does self-compassion negatively mediate the relationship between maladaptive schema modes and posttraumatic growth?
5. Do PTG scores differ according to gender, age, distress level of traumatic event, time since the occurrence of the traumatic event, type of trauma, and psychological treatment?

Hypothesis 1. Self-compassion is expected to positively predict posttraumatic growth.

Hypothesis 2. Adaptive schema modes which are *Happy Child* **(2a)** and *Healthy Adult* **(2b)** expected to positively predict posttraumatic growth.

Hypothesis 3. Maladaptive Child Modes which are *Vulnerable Child* **(3a)**, *Angry Child* **(3b)**, *Enraged Child* **(3c)**, *Undisciplined Child* **(3d)** and *Impulsive Child* **(3e)** expected to negatively predict posttraumatic growth.

Hypothesis 4. Maladaptive Parent Modes which are *Punitive/Critical Parent* **(4a)** and *Demanding Parent* **(4b)** expected to negatively predict posttraumatic growth.

Hypothesis 5. Maladaptive Coping Modes which are *Compliant Surrenderer* **(5a)**, *Detached Protector* **(5b)**, *Detached Self-Soother* **(5c)**, *Self-aggrandizer* **(5d)** and *Bully and Attack* **(5e)** expected to negatively predict posttraumatic growth.

Hypothesis 6. Self-compassion is expected to mediate the positive relationship between adaptive schema modes which are *Happy Child* **(6a)** and *Healthy Adult* **(6b)** and posttraumatic growth.

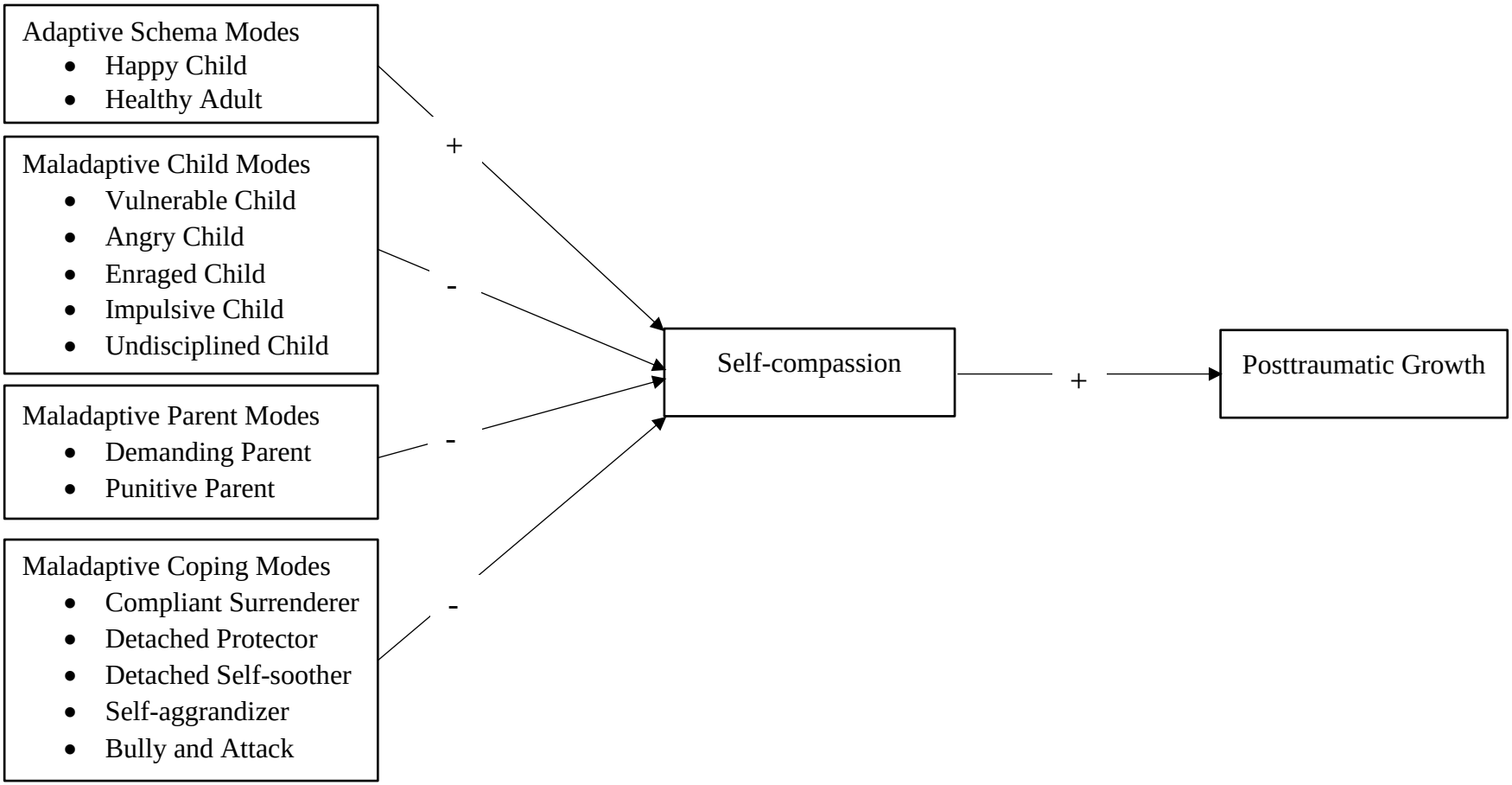
Hypothesis 7. Self-compassion is expected to mediate the negative relationship between Maladaptive Child Modes which are *Vulnerable Child* **(7a)**, *Angry Child* **(7b)**, *Enraged Child* **(7c)**, *Undisciplined Child* **(7d)** and *Impulsive Child* **(7e)** and posttraumatic growth.

Hypothesis 8. Self-compassion is expected to mediate the negative relationship between Maladaptive Parent Modes which are *Demanding Parent* **(8a)** and *Punitive/Critical Parent* **(8b)** and posttraumatic growth.

Hypothesis 9. Self-compassion is expected to mediate the negative relationship between Maladaptive Coping Modes which are *Compliant Surrenderer* **(9a)**, *Detached Protector* **(9b)**, *Detached Self-Soother* **(9c)**, *Self-aggrandizer* **(9d)** and *Bully and Attack* **(9e)** and posttraumatic growth.

Figure 1.2.

The Hypothesized Mediation Model



2. METHODS

2.1. Participants

The sample included Turkish speaking individuals aged between 18-65 who have experienced traumatic events from 3 months to 15 years ago. It has been stated that the PTG can occur within weeks or months (Linley & Joseph, 2004). In various studies, measurements of PTG have been made at different times after the traumatic event such as 3 months (Currier et al., 2013; Kösoğlu, 2020), 4 to 5 months (Kelly et al., 2018), 6 months (Wu et al., 2019), and 1 year (Amiri, 2021). Therefore, individuals who have experienced a traumatic event at least 3 months ago are included in the study. Participants who have been exposed to any traumatic event that will affect their life sooner than the last three months or more than 15 years ago or who are under the age of 18 were not eligible to participate to the research.

In total, 595 participants were reached within the scope of this study. However at the end of the data cleaning process after excluding noneligible participants and outliers, the final data set included 358 participants who were included in the main analysis. Table 2.1. displays the demographic characteristics of the sample. Out of 358 participants, 275 were females (76.8%) and 83 were males (23.2%). On average, participants were 29.80 (*SD* = 10.54) years of age. Regarding the education level, 53.1% of the participants had a Bachelor's or postgraduate degree. The majority of the sample included single participants (69.8%) compared to married ones (30.2%). Most of the respondents reported that they spend most of their life time in a town (27.1%) or a metropolis (56.4%). Participants were asked to report if they have a psychiatric diagnosis or if they are using a psychiatric medication since these conditions may effect the PTG process. Out of 358 respondents, 52 (14.5%) had a psychiatric diagnosis and 37 (10.3%) reported using a psychiatric medicine.

Table 2.1.

Demographic Characteristics of the Sample

Variables	*F*	*%*
Gender		
Male	83	23.2 %
Female	275	76.8 %
Education		
Primary School Graduate	1	0.3%
Secondary School Graduate	2	0.6%
High School Graduate	165	46.1%
Bachelor's Degree	128	35.8%
Postgraduate Degree	62	17.3%
Marital Status		
Married	108	30.2%
Single	250	69.8%
Work Status		
Employed	148	41.3%
Unemployed	177	49.4%
Student and Employed	33	9.2%
Socioeconomic Status		
Very Low	6	1.7%
Low	31	8.75%
Medium	250	69.8%
High	67	18.7%
Very High	4	1.1%
Mostly Lived Place		
Village	16	4.5%
District	43	12%
Town	97	27.1%
Metropolis	202	56.4%
Have you received or are you currently receiving any psychological/psychiatric treatment?		
No	198	55.3%
Not currently but previously received	102	28.5%
Receiving psychiatric treatment	15	4.2%
Receiving psychotherapy	34	9.5%
Receiving psychiatric treatment and psychotherapy	9	2.5%
Do you have psychiatric diagnosis?		
Yes	52	14.5%
No	306	85.5%
Are you using a psychiatric medication?		
Yes	37	10.3%
No	321	89.7%
Total N	358	

Participants were also asked to report details related to their traumatic experiences since these factors can be related to PTG, and potentially be used as control variables. Table 2.2. summarizes the details and statistics related to participants' traumatic experiences. The majority of the participants (36.6%) reported that they had only experienced one of the traumatic events listed in the questionnaire, and 117 (32.7%) respondents experienced two traumatic events. The majority of the participants (37.7%) indicated that the traumatic experience of an unexpected death of a loved one or a close acquaintance (bereavement), affected them most. Out of 358 participants, 255 (71.2%) of them indicated that they had experienced the traumatic event (primary trauma). Lastly, the majority of the sample (32.4%) stated that it has been 1-3 years since the traumatic event.

Table 2.2.

Statistics Related to Traumatic Experiences

Variables	*F*	*%*
Number of Traumatic Event Experienced		
1	131	36.6 %
2	117	32.7 %
3	74	20.7%
4	30	8.4%
5	2	0.6%
6	2	0.6%
8	2	0.6%
Total	358	
Among these traumatic events, which one do you think affected you the most?		
Serious Accident/Explosion/Fire	36	10.1%
Natural disaster	78	21.8%
Sexual assault	22	6.1%
Non-sexual assault	12	3.4%
War/Military confrontation	4	1.1%
Sexual abuse as a child	10	2.8%
Imprisonment	4	1.1%
Being exposed to torture	2	0.6%%
Serious illness	25	7%
Bereavement	135	37.7%
Other	30	8.4%
Total	358	
Who experienced this traumatic event?		
Me	255	71.2%
My acquaintance	103	28.8%
Total	358	
How long has it been since this traumatic event?		
3-6 Months	23	6.4%
6-9 Months	14	3.9%
9-12 Months	37	10.3%
1-3 Years	116	32.4%
3-5 Years	58	16.2%
5-15 Years	110	30.7%
Total	358	

2.2. Measurements

2.2.1. Demographic information form

The Demographic Information Form implicated questions related to participants' age, gender, educational background, psychiatric diagnosis. Questions related to experienced traumatic events were also included since these details have a potential to effect PTG and serve as control variables in the analysis. Thus, the number of the experienced traumatic events, the most influential event, the time since the occurrence of the traumatic event, and the negative impact severity of the traumatic event were also asked to the participants (see Appendix B).

2.2.2. Short schema mode inventory (SMI)

The original form of the scale contains 270 items developed by Young (2007) to assess 16 schema modes by self-report. Based on this initial long scale, Lobbestael and colleagues (2010) developed the Short Schema Mode Inventory (SMI) which contained 118 items and 14 subdimensions. The scale's Cronbach's alpha reliability coefficients ranged between .79 to .96 for 14 factors (Lobbestael et al., 2010). In this study, Short Schema Mode Inventory was used, which was adapted to Turkish by Aytaç and colleagues (2020). The scale consists of 113 items and 14 factors. The factors are Vulnerable Child mode, Angry Child mode, Enraged Child mode, Undisciplined Child mode, Impulsive Child mode, Happy Child mode, Punitive/Critical Parent mode, Demanding Parent mode, Compliant Surrenderer mode, Detached Protector mode, Detached Self-Soother mode, Self-aggrandizer mode, Bully and Attack mode, and Healthy Adult mode. The scoring of the scale is a 6-point Likert ranging from 1 (never) to 6 (always). Higher scores obtained from the scale reflect higher endorsement of schema modes of individuals. The Turkish adaptation and validity-reliability study of the scale was carried out by Aytaç and colleagues (2020) with clinical and nonclinical samples. The scale's Cronbach's alpha reliability coefficients ranged between .67 to .92 for 14 factors and .96 for the total scale (Aytaç et al., 2020). Consistent results were found in the current data which indicates data the reliabilities ranged between .64 and .92 (see Appendix C).

2.2.3. Posttraumatic growth inventory (PTGI-X)

The Posttraumatic Growth Inventory was developed by Tedeschi & Calhoun (1996) and revised as PTGI-X by Tedeschi and colleagues (2017). PTGI-X differs from the original

scale with 4 items which were added to the Spiritual and Existential Change factor. The scale aims to measure individuals' posttraumatic positive changes. It consists of 25 items and 5 subscales: Personal Strength, Relating to Others, New Possibilities, Appreciation of Life, and Spiritual and Existential Change. The scale has a 5-point Likert type scoring ranging from 0 (I have never experienced) to 5 (I have experienced too much). The total score that can be obtained from the scale varies between 0-125. Higher scores on the scale indicate that people have higher levels of posttraumatic growth. In the current study, the Turkish version of the scale was used which was validated by Tedeschi and colleagues (2017). The authors reported the Cronbach's alpha reliability coefficient as .96 for the total scale in their validation study. The reliabilities of the subscales varied between .81 to .90. In the current study the total score of the scale was used in the analysis, and the reliability coefficient of the scale was found as .94 (see Appendix D).

2.2.4. Self-compassion scale

The Self-Compassion Scale was developed by Neff (2003b), and it aims to measure individuals' compassion toward themselves. The scale consists of 26 items and 3 subdomains. These are self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus overidentification. It has 5 points Likert type scoring ranging from 1 (never) to 5 (always). The Cronbach alpha coefficient of the scale was reported as .92. The Turkish adaptation and validity-reliability studies of the scale were carried out by several researchers (Akın et al., 2007; Deniz et al., 2008), however inconsistencies were observed in the Turkish translation of the scale and the factor structures. Therefore, researchers suggested that validity-reliability should be tested again in the Turkish sample. Kantaş (2013) re-adapted the scale and the Cronbach alpha coefficient for the entire scale was reported as .94. High scores obtained from the scale indicate higher levels of self-compassion (Kantaş, 2013). Items numbered 3, 4, 6, 9, 10, 11, 15, 16, 17, 20, 21, 22, and 26 are the reverse coded items of the scale. In the current study, the Cronbach's alpha reliability coefficient of the total scale was found as .94 (see Appendix E).

2.3. Procedure

Prior to data collection, a power analysis was conducted to determine the required sample size to test the proposed model, which includes a maximum of fourteen predictors and a mediator by using G*Power software (Faul et al., 2009). According to the results, 316

individuals are required to capture a small indirect effect size (f^2 = .025) with a power of .80 at α =.05.

The data collection process started after obtaining ethical approval from the Başkent University Ethics Committee. The data was collected via online survey software Qualtrics by using convenient sampling methods. The link to the survey was shared on online platforms such as WhatsApp, Instagram, Linkedin, and Facebook groups. First, an informed consent form (see Appendix A) including the purpose of the study, the conditions of participation, the contact information of the researchers, and confidentiality presented to the participants. Participants were also informed that they could leave the study at any time. Then the demographic information form and scales are presented to the participants who voluntarily agreed to participate in the research.

2.4. Analyzes

The analyzes were conducted by using Statistical Package for Social Science (SPSS V. 26.0) and AMOS 23.0 (Arbuckle, 2014). First, by using SPSS, the reverse coded items were recoded, missing data points were checked, multivariate outlier cases were detected and the multivariate normality assumptions were tested. The internal consistency reliabilities of the measures were tested by calculating the Cronbach's alpha values using SPSS. The Pearson Product Moment Correlation coefficients and the descriptive statistics of the main variables were analyzed. The main hypotheses which include testing the mediation and indirect effects between the schema modes and PTG through self-compassion were tested by conducting path analysis with AMOS. Since there were multiple indirect effects, AMOS was preferred to test all regression paths together at once in order to minimize the error rate.

3. RESULTS

3.1. Overview

The results are presented in the four sections below. First, the data cleaning and screening procedure was explained in detail. Next, descriptive statistics and detailed reliability results were presented. The bivariate correlations between the study variables were presented in the third section. The fourth section includes mediation analysis and hypothesis testing results. Descriptive statistics, reliability and correlation analysis results were obtained by using SPSS (V. 26.0) and the Structural Equation Modeling, which comprises path analysis technique, was used to test the mediation model by using AMOS 23.0 (Arbuckle, 2014).

3.2. Data Screening and Cleaning

In the initial step, 595 participants were reached within the scope of this study. Out of 595 participants, 167 participants did not complete at least one scale of the survey. 56 participants were not eligible to participate in the study since they reported that more than 15 years had passed since they experienced the traumatic event. Moreover, 6 participants were detected who completed the survey under unrealistic durations or responded to all items with the same score. Thus, in the first phase, 229 participants were eliminated from the data set.

With the remaining 366 participants, the data set was examined for the missing values. However, the data showed that participants answered all of the items and there was not any missing value detected. Therefore, data screening was continued by conducting outlier analysis. In order to detect multivariate outliers, Mahalanobis distance statistical measure was used. As recommended by Tabachnick and Fidell (2013), a conservative probability estimate ($p < .001$) was specified for the X^2 value to determine whether a case was an outlier according to the Mahalanobis distance. According to the results, 8 cases were found to be multivariate ($p < .001$) and univariate outliers. Thus, those 8 cases were deleted, and the analyses were conducted with the remaining 358 participants.

Since only one data collection method was used (self-reporting) in the current study, the data was checked for the common method bias. The Harman's single-factor test was conducted to see whether the common method variance posed a risk for the results. All variables that were included in the hypothesis testing model were loaded onto one factor,

and exploratory factor analysis was conducted with none rotation (Podsakoff et al., 2003). The results indicated that, one factor explained only 38.7% of the variance. Based on these findings, common method bias does not seem to pose a risk that affects the relationships between variables since it is below the agreed cut-off score of 50%.

3.3. Descriptive Statistics

The descriptive statistics including the minimum and the maximum values, means, standard deviations, and detailed reliability results of the study variables were presented in the Table 3.1. As shown in the Table 3.1., the skewness and kurtosis values were between the range of -1.5 and +1.5, indicating that the data meets the normal distribution assumption (Tabachnick & Fidell, 2013). Based on the results, all variables showed high reliability values. The lowest reliability value was obtained for Undisciplined Child mode which was measured with only 4 items.

Table 3.1.

Descriptive Statistics and Reliability Values of the Study Variables

Variable	Mean	*SD*	Min.	Max.	Skewness	Kurtosis	Cronbach's α
Age	29.81	10.54	18.00	65.00	1.40	1.28	-
Education	3.69	0.77	1.00	5.00	0.36	-0.65	-
Number of Experienced Trauma	2.08	1.12	1.00	8.00	1.39	3.79	-
Impact of the Trauma	6.23	1.03	2.00	7.00	-1.30	1.14	-
Time Past Since the Trauma	4.40	1.44	1.00	6.00	-0.71	-0.09	-
Posttraumatic Growth	69.05	22.90	7.00	122.00	-0.34	-0.32	0.94
Self-compassion	3.04	0.63	1.35	4.73	0.04	-0.29	0.94
Bully and Attack mode	2.27	0.78	1.00	4.75	0.56	-0.15	0.76
Happy Child mode	3.71	0.85	1.22	5.89	-0.09	-0.50	0.87
Punitive Parent mode	1.93	0.79	1.00	4.80	1.16	0.89	0.88
Vulnerable Child mode	2.45	0.96	1.00	5.70	0.63	-0.05	0.92
Demanding Parent mode	3.07	0.91	1.00	5.71	0.31	-0.05	0.80
Compliant Surrenderer mode	2.43	0.78	1.00	5.57	0.59	0.49	0.78
Self-aggrandizer mode	2.78	0.77	1.00	5.56	0.29	0.04	0.79
Impulsive Child mode	2.13	0.82	1.00	5.50	0.87	0.54	0.87
Undisciplined Child mode	2.80	0.89	1.00	5.75	0.48	0.11	0.64
Enraged Child mode	1.82	0.82	1.00	4.56	1.16	0.65	0.91
Healthy Adult mode	4.24	0.79	1.11	6.00	-0.56	0.35	0.82
Angry Child mode	2.78	0.87	1.00	5.50	0.44	0.03	0.84
Detached Protector mode	2.49	0.92	1.00	5.44	0.43	0.13	0.90
Detached Self-soother mode	3.10	0.95	1.00	6.00	0.19	0.12	0.72

Note. N = 358. Education, the number of experienced trauma and the time past since the traumatic event was measured via ordinal scale items. Schema modes were measured on a 6-point likert type scale. Self-compassion was measured on a 5-point likert type scale. Posttraumatic growth was measured on a 6-point likert type scale and the total scale points were used for analysis.

3.4. Correlations Between the Study Variables

After the descriptive analysis and assumption checks, Pearson Product Moment Correlation Analysis was conducted to test the relationship between the study variables. Table 3.2. shows the correlations for the study variables. According to the results, socioeconomic status was positively related to posttraumatic growth (r = .11, p < .05). Moreover, self-compassion was also positively related with participants' age (r = .21, p < .01). Since these variables were significantly associated with self-compassion and posttraumatic growth, which are the outcome variables of the hypothesized model, they were decided to be added to the main analysis as the control variables.

Regarding the correlations between the predictors and outcomes, as hypothesized self-compassion showed a significant positive correlation (r = .28, p < .01) with posttraumatic growth. Furthermore, adaptive schema modes which are Happy Child and Healthy Adult modes were significantly and positively correlated with self-compassion (r = .56, p < .01; r = .41, p < .01; respectively) and posttraumatic growth (r = .32, p < .01; r = .11, p < .05; respectively). Considering the maladaptive schema modes, posttraumatic growth showed negative relationships with Undisciplined Child (r = -.16, p < .05), Vulnerable Child (r = -.18, p < .01), Demanding Parent (r = -.11, p < .05), and Detached Protector (r = -.24, p < .01) modes. In line with the hypotheses, self-compassion showed significantly negative relationships with all of the maladaptive schema modes. Vulnerable Child (r = -.59, p < .01) and Demanding Parent (r = -.51, p < .01) modes showed the highest correlation with self-compassion, whereas Detached Self-soother (r = -.27, p < .01) and Enraged Child (r = -.29, p < .01) modes showed the lowest correlations among the schema modes. Please see Table 3.2. to review other significant correlations.

Table 3.2.

Bivariate Correlations Between the Study Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Age	-													
2. SES	.10	-												
3. Education level	.38*	.12*	-											
4. Number of experienced trauma	.04	-.03	.04	-										
5. Impact of the trauma	.08	-.02	.08	.10	-									
6. Time past since the trauma	.05	.03	.04	.07	.05	-								
7. Happy Child mode	.14**	.18**	.09	-.07	-.01	.04	-							
8. Healthy Adult mode	.23**	.13*	.16**	.06	.18**	.08	.67**	-						
9. Angry Child mode	-.12*	-.03	-.09	.21**	.13*	.01	-.40**	-.17**	-					
10. Enraged Child mode	-.15**	-.09	-.17**	.03	-.05	-.05	-.32**	-.39**	.56**	-				
11. Impulsive Child mode	-.20**	-.06	-.19**	.07	-.05	-.03	-.40**	-.46**	.58**	.76**	-			
12. Undisciplined Child mode	-.22**	-.06	-.09	.04	.08	.07	-.37**	-.30**	.49**	.40**	.54**	-		
13. Vulnerable Child mode	-.20**	-.15**	-.05	.14**	.07	.00	-.62**	-.42**	.73**	.50**	.59**	.55**	-	
14. Demanding Parent mode	-.01	-.01	.17**	.19**	.12*	.05	-.28**	-.02	.53**	.22**	.26**	.24**	.52**	-
15. Punitive Parent mode	-.13*	-.12*	-.09	.02	-.05	-.05	-.44**	-.51**	.55**	.68**	.68**	.44**	.71**	.42**
16. Bully and Attack mode	-.14**	.00	-.12*	.15**	.03	-.06	-.29**	-.20**	.61**	.63**	.60**	.40**	.48**	.39**
17. Compliant Surrenderer	-.10	.00	.08	.13*	-.03	-.06	-.27**	-.26**	.43**	.35**	.39**	.40**	.55**	.49**
18. Detached Protector mode	-.13*	-.17**	-.03	.13*	.12*	-.01	-.56**	-.32**	.64**	.46**	.56**	.50**	.79**	.44**
19. Detached Self-soother mode	-.03	-.02	.01	.14**	.15**	-.09	-.15**	.06	.47**	.20**	.26**	.23**	.33**	.50**
20. Self-aggrandizer mode	-.08	.04	-.08	.10	-.01	-.01	-.11*	-.09	.51**	.48**	.53**	.36**	.34**	.45**
21. Self-compassion	.21**	.09	.06	-.08	-.05	.01	.56**	.41**	-.46**	-.29**	-.42**	-.44**	-.59**	-.51**
22. Posttraumatic growth	.07	.11*	-.09	-.10	.04	-.01	.32**	.11*	-.06	.02	-.03	-.16*	-.18**	-.11*

Table 3.2.

Continued

	15	16	17	18	19	20	21	22
15. Punitive Parent mode	-							
16. Bully and Attack mode	.55**	-						
17. Compliant Surrenderer	.62**	.42**	-					
18. Detached Protector mode	.63**	.50**	.41**	-				
19. Detached Self-soother mode	.22**	.30**	.27**	.29**	-			
20. Self-aggrandizer mode	.44**	.69**	.39**	.33**	.38**	-		
21. Self-compassion	-.41**	-.34**	-.33**	-.44**	-.27**	-.31**	-	
22. Posttraumatic growth	.01	-.06	-.02	-.24**	.08	.08	.28*	-

Note. $N = 358$. * $p < .05$. ** $p < .01$. SES = Socioeconomic status. SES was measured on a 5-point likert type scale, “1” refers to “too low” and “5” refers to “very high”. Impact of the trauma was measured on a 7-point likert type scale, where “1” refers to “it was not stressful at all”and “7” refers to “the traumatic event was extremely stressful”. The time past since the traumatic event was measured on 7 time points, where “1” refers to “3-6 months” and “7” refers to “15 years ago”.

3.5. Control Variable Analyses

Prior to hypothesis testing, several ANOVA and t-test analyses were conducted to check the effects of the potential control variables and to answer *Research Question 5*. First, two independent t-test analyses were conducted to test the PTG and self-compassion differences based on gender. According to the results, there was a non-significant difference ($t(356) = .465$, $p = .642$) between the male ($N = 83$, $M = 68.02$, $SD = 25.21$) and female ($N = 275$, $M = 69.36$, $SD = 22.19$) participants based on their PTG scores. However, the results also showed that male participants ($N = 83$, $M = 3.17$, $SD = .59$) had significantly higher self-compassion scores compared to females ($N = 275$, $M = 3.00$, $SD = .64$); $t(356) = -2.11$, $p = .035$.

Secondly, the effect of having a psychiatric diagnosis was tested on the outcome variables which are self-compassion and PTG. The t-test results showed that participants who have a psychiatric diagnosis ($N = 52$, $M = 2.82$, $SD = .66$) had significantly lower self-compassion scores compared to those who do not have a diagnosis ($N = 306$, $M = 3.08$, $SD = .62$); $t(356) = -2.73$, $p = .007$. However, the PTG scores of the diagnosed ($N = 52$, $M = 68.73$, $SD = 24.24$) and non-diagnosed ($N = 306$, $M = 69.10$, $SD = 22.70$) participants did not differ significantly; $t(356) = -0.11$, $p = .914$. In addition to the effect of the psychiatric diagnosis, the effect of using psychiatric medicine on the outcome variables was also tested. The results were similar, participants who use psychiatric medication ($N = 37$, $M = 2.84$, $SD = .69$) displayed lower levels of self-compasion compared to the participants who do not use psychiatric medication ($N = 321$, $M = 3.06$, $SD = .62$); $t(356) = -1.99$, $p = .048$. There was a non-significant difference between the medication using group ($N = 37$, $M = 73.11$, $SD = 24.31$) and others ($N = 321$, $M = 68.58$, $SD = 22.72$) in terms of their PTG scores; $t(356) = 1.14$, $p = .255$.

Lastly, the effect of the trauma type was tested on PTG and self-compassion. The groups were identified as participants who have experienced the traumatic event themselves (primary trauma group) and individuals who witnessed others' traumatic experiences (secondary trauma group). The results indicated that the primary ($N = 255$; $M = 67.84$, $SD = 23.27$) and secondary traumatic groups ($N = 103$; $M = 72.04$, $SD = 21.75$) did not significantly differ from each other based on their PTG scores ($t(356) = -1.57$, $p = .117$). The results also showed that the self-compassion scores of the primary trauma ($N = 255$; $M =$

3.08, *SD* = .65) and secondary trauma groups (*N* = 103; *M* = 2.95, *SD* = .59) did not significantly differ from each other ($t(356) = 1.77$, $p = .078$).

Based on these results, gender, psychiatric diagnosis status, and psychiatric medication use status were decided to be included in the main analysis as control variables since they showed significant relationships with self-compassion, which is the mediator. Moreover, since age and SES showed significant correlations with self-compassion and PTG, respectively, they were also decided to be added as control variables to the main analysis.

3.6. Mediation Analysis and Hypothesis Testing

The main purpose of this research was to test the mediating effect of self-compassion between the schema modes and posttraumatic growth. The Structural Equation Modeling method was conducted to perform path analysis and test the hypothesized mediation model by using AMOS. In the first step, all of the schema modes are entered into the model as predictors and they are allowed to correlate with each other. This step has resulted in a just-identified model since degrees of freedom were equal to zero. Therefore, schema modes that were non-significant in predicting self-compassion and posttraumatic growth were removed from the model. Thus, in this step, Impulsive, Enraged, Angry Child modes and Bully and Attack mode were removed from the model. Moreover, non-significant paths from schema modes to PTG were deleted to obtain degrees of freedom. The control variables which are age, gender, SES, having a psychiatric diagnosis and psychiatric medication use were added to the final model. According to the results, the hypothesized model provided a good fit to the data ($\chi^2(46) = 85.13$, $p < .001$, $\chi^2/df = 1.85$, NFI = .967, TLI = .953, CFI = .984, RMSEA = .05, 90% CI = .03, .06). The standardized and unstandardized path coefficients were presented at Table 3.4.

The analyses revealed that Hypothesis 1 which indicated that self-compassion will positively predict PTG was supported ($\beta = .23$, $p < .001$). Results showed that the link between the Happy Child mode and PTG was also significant ($\beta = .19$, $p < .01$), which supports Hypothesis 2a. However, the direct link between Healthy Adult mode and PTG was not significant, thus Hypothesis 2b was not supported.

Regarding the maladaptive child modes, none of them was significant to directly predict PTG. Therefore, Hypothesis 3 was not supported. Among the maladaptive parent modes, Punitive Parent ($\beta = .31$, $p < .001$) was able to significantly predict PTG however the

direction of the relationship was positive. Thus, Hypothesis 4a was not supported because the direction of the relationship was opposite to what was expected. Unlike Punitive Parent, Demanding Parent mode was non-significant to predict PTG, thus, Hypothesis 4b was not supported. Lastly, the direct effects of the maladaptive coping modes on PTG were examined, and based on the results Detached Protector mode significantly and negatively predicted PTG (β = -.29, p < .001). Detached Self-soother mode also significantly predicted PTG however the direction of the link was positive (β = .16, p < .01) contrary to expectations. Based on the results, Compliant Surrenderer, Self-aggrandizer, and Bully and Attack modes were unable to predict PTG. Thus, Hypothesis 5b was supported however, Hypothesis 5a, 5c, 5d, and 5e were not supported.

In the next step of the analyses, the relationships between the schema modes and self-compassion were examined, and the indirect effects of the schema modes through self-compassion were investigated. By using the bootstrapping method, the indirect effects were computed and their significance was tested for each of 2,000 bootstrapped samples. As hypothesized, both of the adaptive schema modes, which are Happy Child (β = .25, p < .001) and Healthy Adult (β = .17, p < .001) significantly predicted self-compassion. Based on these results, self-compassion partially mediated the relationship between Happy Child mode and PTG, and fully mediated the relationship between Healthy Adult mode and PTG. The bootstrapping results indicate that the standardized indirect effect of Happy Child mode on PTG through self-compassion was β = .06 (p = .001, SE = .02, 95% CI [.02, .12]), and the standardized indirect effect of Healthy Adult mode on PTG was β = .04 (p = .01, SE = .02, 95% CI [.01, .09]). These results provide evidence for Hypothesis 6, which indicated that self-compassion will mediate the relationships between the adaptive schema modes and PTG.

According to the results, Vulnerable Child (β = -.29, p < .001) and Undisciplined Child (β = -.17, p < .001) modes significantly and negatively predicted self-compassion. These results show that self-compassion fully mediated the relationships between Vulnerable Child and Undisciplined Child modes and PTG. The results provide evidence for Hypothesis 7a and 7d. However, the links between self-compassion and Angry Child, Enraged Child and Impulsive Child modes were not significant. Therefore, Hypotheses 7b, 7c and 7e were not supported. The mediation results indicate that the standardized indirect effect of Vulnerable Child mode on PTG through self-compassion was β = -.07 (p = .001,

SE = .02, 95% CI [-.14, -.02]) , and the standardized indirect effect of Undisciplined Child on PTG was β = -.04 (*p* = .002, *SE* = .03, 95% CI [-.08, -.01]).

Concerning the maladaptive parent modes, Demanding Parent mode significantly and negatively predicted self-compassion (β = -.39, $p < .001$). Thus, this result provides evidence for Hypothesis 8a, since self-compassion fully mediated the relationship between Demanding Parent mode and PTG. However the path between Punitive Parent mode and self-compassion was not significant, thus Hypothesis 8b was not supported, since self-compassion failed to mediate the relationship between Punitive Parent mode and PTG. The results showed that the standardized indirect effect of Demanding Parent mode on PTG through self-compassion was β = -.09 (*p* = .001, *SE* = .03, 95% CI [-.15, -.04]).

Lastly, the relationships between the maladaptive coping modes and self-compassion were investigated. Among the coping modes, only Detached Protector mode significantly predicted self-compassion (β = .17, $p < .01$). Thus, self-compassion partially mediated the relationship between Detached Protector mode and PTG. The standardized indirect effect of Detached Protector mode on PTG through self-compassion was β = .04 (*p* = .001, *SE* = .03, 95% CI [-.15, -.04]). However, the direction of the relationship was positive, thus Hypothesis 9b is not supported. In contrast to Detached Protector mode, Detached Self-soother, Compliant Surrenderer, Self-aggrandizer and Bully and Attack modes were unable to predict self-compassion in the presence of the other predictors. Therefore, Hypothesis 9a, 9b, 9c, 9d, and 9e were not supported. The tested mediation model is depicted in Figure 3.1. In sum, the hypothesized mediation model explained 52% variance in self-compassion and 22% in PTG.

Table 3.3.

Summary Table of the Hypotheses and the Results

Hypotheses	**Results**
1. Self-compassion is expected to positively predict posttraumatic growth.	S
2a. Happy Child mode expected to positively predict posttraumatic growth.	NS
2b. Healthy Adult mode expected to positively predict posttraumatic growth.	NS
3a. Vulnerable Child mode expected to negatively predict posttraumatic growth.	NS
3b. Angry Child mode expected to negatively predict posttraumatic growth.	NS
3c. Enraged Child mode expected to negatively predict posttraumatic growth.	NS
3d. Undisciplined Child mode expected to negatively predict posttraumatic growth.	NS
3e. Impulsive Child mode expected to negatively predict posttraumatic growth.	NS
4a. Punitive/Critical Parent mode expected to negatively predict posttraumatic growth.	NS (OCTE)
4b. Demanding Parent mode expected to negatively predict posttraumatic growth.	NS
5a. Compliant Surrenderer mode expected to negatively predict posttraumatic growth.	NS
5b. Detached Protector mode expected to negatively predict posttraumatic growth.	S
5c. Detached Self-Soother mode expected to negatively predict posttraumatic growth.	NS (OCTE)
5d. Self-aggrandizer mode expected to negatively predict posttraumatic growth.	NS
5e. Bully and Attack mode expected to negatively predict posttraumatic growth.	NS
6a. Self-compassion is expected to mediate the positive relationship between Happy Child mode and posttraumatic growth.	S
6b. Self-compassion is expected to mediate the positive relationship between Healthy Adult mode and posttraumatic growth.	S (FM)
7a. Self-compassion is expected to mediate the negative relationship between Vulnerable Child mode and posttraumatic growth.	S (FM)
7b. Self-compassion is expected to mediate the negative relationship between Angry Child mode and posttraumatic growth.	NS
7c. Self-compassion is expected to mediate the negative relationship between Enraged Child mode and posttraumatic growth.	NS

7d. Self-compassion is expected to mediate the negative relationship between Undisciplined Child mode and posttraumatic growth.	S (FM)
7e. Self-compassion is expected to mediate the negative relationship between Impulsive Child mode and posttraumatic growth.	NS
8a. Self-compassion is expected to mediate the negative relationship Demanding Parent mode and posttraumatic growth.	S (FM)
8b. Self-compassion is expected to mediate the negative relationship Punitive/Critical Parent mode and posttraumatic growth.	NS
9a. Self-compassion is expected to mediate the negative relationship between Compliant Surrenderer mode and posttraumatic growth.	NS
9b. Self-compassion is expected to mediate the negative relationship between Detached Protector mode and posttraumatic growth.	NS (OCTE)
9c. Self-compassion is expected to mediate the negative relationship between Detached Self-Soother mode and posttraumatic growth.	NS
9d. Self-compassion is expected to mediate the negative relationship between Detached Self-aggrandizer mode and posttraumatic growth.	NS
9e. Self-compassion is expected to mediate the negative relationship between Bully and Attack mode and posttraumatic growth.	NS

Note. S = Supported, NS = Not Supported, OCTE = Opposite correlation than expected, FM = Full Mediation.

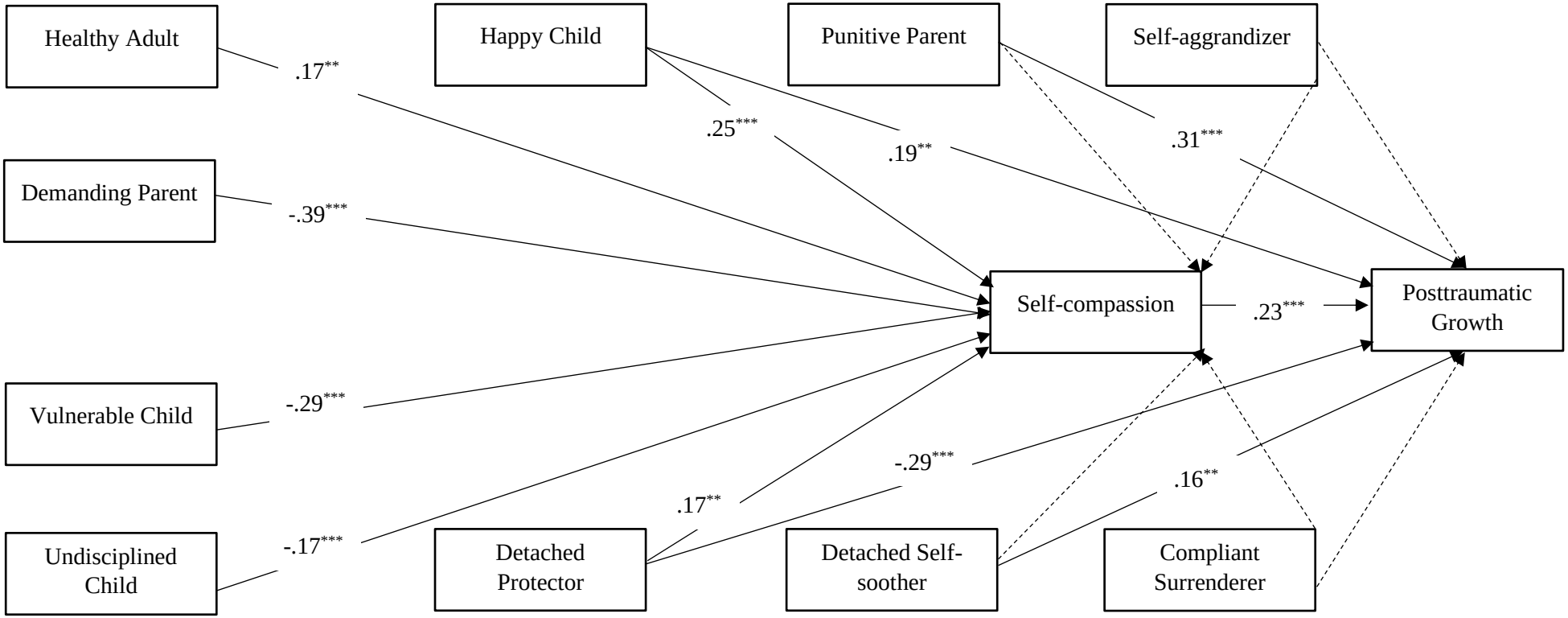
The tested mediation model also included some control variables that were significantly correlated with self-compassion and PTG. These variables were gender, age, SES, the psychiatric diagnosis and the psychiatric medication use status of the participants. As Table 3.4 shows, none of these control variables significantly predicted self-compassion or PTG in the presence of the main predictors. Since the effects of these variables were non-significant, they were not added to Figure 3.1. Moreover, in light of the literature, it was hypothesized that the impact of the traumatic event, the type of the trauma (primary or secondary) and the time past since the traumatic event would be related to PTG. However, since these variables showed non-significant correlations with PTG they were not included in the main analysis.

Finally, the effect of receiving psychological treatment on PTG was tested through conducting one-way ANOVA. The participants were divided into five groups as follows,

participants who did not receive any psychological treatment (N = 198, M = 69.05, SD = 22.36), who previously received psychiatric treatment or psychotherapy (N = 102, M = 69.68, SD = 24.08), who currently receive only psychiatric medication treatment (N = 15, M = 68.87, SD = 25.25), who currently receive only psychotherapy (N = 34, M = 65.76, SD = 22.44), and who currently receive both psychiatric treatment and psychotherapy (N = 9, M = 74.56, SD = 22.01). As the results indicate groups were not evenly distributed based on their sample sizes. Even though participants who currently receive both treatment types had the highest mean in PTG scores, based on the results there was not a significant difference between the groups, $F(4, 353) = 0.322$, $p = .454$.

Figure 3.1.

The Hypothesized Mediation Model and Results of the Path Analysis



Note. N = 358. Dashed lines represent non-significant paths. All the coefficients are standardized estimates obtained from AMOS.

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

Table 3.4.

Unstandardized and Standardized Regression Coefficients and Standard Errors of the Analyzed Paths between the Variables

Variable	Unstandardized Estimate	S.E.	Standardized Estimates
Age → Self-compassion	.004	.002	.07
Gender → Self-compassion	.047	.058	.03
Psychiatric Diagnosis → Self-compassion	.016	.084	.01
Psychiatric Medication Use → Self-compassion	-.033	.095	-.02
Happy Child mode→ Self-compassion	.183	.046	.25***
Healthy Adult mode→ Self-compassion	.136	.047	.17**
Demanding Parent mode → Self-compassion	-.265	.036	-.39***
Punitive Parent mode → Self-compassion	.075	.052	.10
Vulnerable Child mode → Self-compassion	-.190	.051	-.29***
Undisciplined Child mode → Self-compassion	-.120	.033	-.17***
Compliant Surrenderer mode → Self-compassion	.073	.041	.092
Detached Protector mode → Self-compassion	.118	.044	.17**
Detached Self-soother mode → Self-compassion	.014	.029	.02
Self-aggrandizer mode → Self-compassion	-.061	.038	-.08
Self-compassion → Posttraumatic growth	.339	.087	.23***
Happy Child mode → Posttraumatic growth	.202	.068	.19**
Punitive Parent mode → Posttraumatic growth	.363	.075	.31***
Detached Protector mode → Posttraumatic growth	-.293	.067	-.29***
Detached Self-soother mode → Posttraumatic growth	.156	.050	.16**
Self-aggrandizer mode → Posttraumatic growth	.078	.068	.07
SES → Posttraumatic growth	.068	.071	.05

Note. N = 358. SES = Socioeconomic status. SE = Standard errors. ** $p < .01$, *** $p < .001$.

4. DISCUSSION

This section of the study presents the findings from the analyses regarding the research questions and hypotheses within the context of the information in the literature. This study aims to present and test a mediating model that explains posttraumatic growth by examining the mediating role of self-compassion between schema modes and posttraumatic growth. Firstly, relationships between demographic variables and the main variables of the research were evaluated. Subsequently, the relationships between the main variables of the research were discussed. In the next stage, the findings of the mediator model analysis, which examined the mediating role of self-compassion in the relationship between schema modes and PTG, were discussed. Finally, the clinical implications and limitations of the current study are included and recommendations are presented for further research. No research has been found in the literature in which the current working model was tested with the variables in question. However, the revealed results were evaluated based on relevant literature.

4.1. Discussing of the Findings Regarding the Main Variables of Research and Demographic Variables

Findings obtained from the Pearson Product Moment Correlation Analysis revealed positive and negative significant relationships between main variables (schema modes, self-compassion and PTG) and some of the demographic variables. Among the demographic variables, socioeconomic status (SES) is the only variable that shows a positive significant correlation with PTG. This finding is supported by foreign and Turkish literature. Increased SES was found to be associated with increased PTG in Türkiye (Gökmen & Deniz, 2020). Consistently, Lau and friends (2021) revealed that higher monthly household income corresponds to higher PTG. Wang and colleagues (2014) proposed that women with higher SES can have more likely to experience PTG as they may be less likely to deal with economic problems like others. According to Heidarzadeh and colleagues (2018), there was a positive correlation between the total PTG score and income status, particularly in the domains of "new opportunities" and "appreciation of life". Considering these findings, it can be speculated that those with high welfare status are more likely to access and receive support after trauma.

In respect to gender, it was found a significant gender difference in self-compassion, as males reported higher levels of self-compassion than females. The literature provides various information on this subject. Some studies report no significant relationship between

gender and self-compassion (İskender, 2009; Neff, Rude, et al., 2007), while some studies report higher self-compassion in women than men (Vishnevsky et al., 2010; Sebuktekin, 2018). However, in line with the findings of the current study, some studies report that men display higher levels of self-compassion (Neff 2003b; Neff & McGehee, 2010; Raes, 2011; Thabet et al., 2015; Yarnell et al., 2015). In the society, women are frequently assigned as nurturing and self-sacrificing caregivers to others (Ruble & Martin, 1998). Researchers state that women often have to be socialized with the norm of self-sacrifice, putting the needs of others before their own, which can affect their ability to show compassion to themselves (Raffaelli & Ontai, 2004). Further, it was emphasized that women are being more critical of themselves and conduct negative self-talk (DeVore, 2013). Given this data, it can be argued that gender role norms play a part in explaining why men exhibit higher levels of self-compassion whereas women do not. This proposition is thought to be quite valid for Turkish culture as well. Supporting this, in a meta-analysis study conducted in Türkiye, although the results were not significant, it was found that males' self-compassion average scores were higher than females (Bacanlı & Çarkıt, 2020).

According to findings, age shows a positive correlation with self-compassion and this finding is consistent with the literature (Neff & Pommier 2013; Neff & Vonk 2009). Researchers suggest that age-related increasing life satisfaction, self-acceptance and wisdom are likely to be correlated with a bi-directional relationship between age and self-compassion (Ardelt 1997; Neff, 2023). Moreover, Lee and colleagues (2021) discovered that self-compassion peaks around age 77. These findings support that the wisdom gained from maturity and experience enables a person to engage with life's challenges and face them with acceptance, recognize the common nature of suffering, and adopt a more balanced stance toward oneself (Neff, 2023).

Lastly, participants with psychiatric diagnosis and takes under psychiatric medication treatment reported lower levels of self-compassion. Since psychiatric diagnosis and treatment are related to negative mental health outcomes, and self-compassion is negatively related to the mentioned factors, these negative correlations can be expected. In parallel with the current research findings, meta-analysis studies supported the inverse correlation between self-compassion and anxiety, stress, depression, suicidal thoughts and broad psychopathology (Braun et al., 2016; Hughes et al., 2021; MacBeth & Gumley, 2012; Muris & Petrocchi, 2016; Suh & Chong, 2022). In their systematic review, Athanasakou and colleagues (2020) determined a negative association between self-compassion in clinical

populations with diagnoses of depression, anxiety disorders, PTSD, bipolar disorder, borderline personality disorder, and schizophrenia. Therefore, since psychopathology is likely to be associated with negative self-talk, overidentification with diagnosis, and loneliness and detachment from others, it can be thought that people with a diagnosis have low self-compassion due to their diagnosis.

4.2. Discussion of the Findings Regarding the Determination of Schema Modes Predicting Posttraumatic Growth

As postulated in the first hypothesis, self-compassion positively predicted PTG. This finding of the study aligns with previous research findings in the literature (Arıcı-Özcan, 2019; Chan et al., 2019; Çolakoğlu, 2013; Deitz, 2024; Gökmen & Deniz, 2020; Kaplan, 2022; Khursheed & Shahnawaz, 2020; Munroe et al., 2022; Wong & Yeung, 2017). It can be postulated that self-compassion contributes to the PTG process by helping the person take a healthy distance from the trauma, cultivate a kind attitude toward oneself that is devoid of self-judgment and self-criticism, improving relationships with others to reach support, emphasizing shared humanity experiences of trauma, and facilitating the implementation of adaptive coping strategies in posttraumatic process. Therefore, as Seligman (2011) stated for the aims of positive psychology, self-compassion facilitates not only repairing what is destroyed but also building new qualities.

Confirming the Hypothesis 2a, results showed that Happy Child mode will positively predict PTG as expected. Happy Child is sensitive to the need for entertainment and rest, turns to resources from which individuals can enjoy life, connects with others, able to be spontaneous, calm and peaceful because the needs are met. It is consistent with the information in the literature, that positive characteristics are related to PTG (Dong et al., 2017; Gül & Karancı 2017; Orkibi & Ram-Vlasov, 2019). Therefore, aforementioned qualities of Happy Child possibly have a link with the features of PTG such as appreciation of life, connecting to others, prioritizing own goals, and increased psychological resilience (Tedeschi et al., 2018). On the other hand, results showed that there is no significant relationship between Healthy Adult mode and PTG. Although this finding contradicts the Hypothesis 2b, it should be evaluated together with the results that self-compassion shows full mediation between Healthy Adult mode and PTG.

In terms of the relationship between Maladaptive Child modes and PTG, contrary to Hypothesis 3, it was noted that there is no significant relationship between Vulnerable Child,

Angry Child, Enraged Child, Undisciplined Child and Impulsive Child modes and PTG. It is speculated that since child modes evoke raw emotional reactions in similar childhood experiences, usually it is not anticipated to go through a logical thinking process. It is of course possible for these modes to be seen in posttraumatic processes, but unless the intense emotions triggered by the modes are adequately processed, they cannot be expected to be effective in the formation of the PTG process. These reasons are believed to contribute to the lack of a significant relationship between child modes and PTG. It should also be noted that a wide range of factors can contribute to the path between child modes and PTG. Hence, despite the nonsignificant link between child modes and PTG, when self-compassion takes part in the model as a mediator, the results differ for the Vulnerable Child and Undisciplined Child modes.

Examining the Maladaptive Parent modes in Hypothesis 4, no significant relationship was found between Demanding Parent and PTG. It is conceivable that other mechanisms acting between these two variables can be observed associated with Demanding Parent mode such as concepts of perfectionism, fear of failure, or self-sacrifice. On the other hand, it is thought that concepts such as resilience, optimism, and hope regarding PTG also be effective in the aforementioned relationship. Regarding Punitive Parent, an unexpected positive significant relationship was found between this mode and PTG. It is important to note that prior findings posit that posttraumatic growth and posttraumatic depreciation and distress are usually experienced at the same time (Baker et al., 2008; Day & Wadey, 2016; Tedeschi et al., 2018; Zięba et al., 2019). Harman and Lee (2010) stated that people who experiences higher PTSD symptoms reports higher self-criticising. Also, these informations can be interpreted through the lens of Schema Therapy Model. From Schema Mode perspective, it has been stated that Punitive Parent and Vulnerable Child are two of the most common schema modes among traumatised people (Lian & Mathialagan, 2024). Further, these modes usually refer to each other and have a dyadic relationship (Edwards, 2019; Lian & Mathialagan, 2024). Supportively, according to Dadomo and colleagues (2016), Punitive Parent and the Vulnerable Child coexist in a victim-abuser relationship. Considering these information, as a part of the PTG processes, where ruminations related to the traumatic event are dominant and existing assumptions are questioned, the person may choose to take responsibility for the traumatic event, and therefore take the "blame" of the trauma, on himself/herself to create a feeling of controllability and predictability about the traumatic event. More detailed, Punitive Parent's self-abusiveness can be explained by the "turning-

against-self" defense mechanism in line with the Psychoanalytic Theory (Gangi et al., 2009). If it is not possible to address someone or something responsible, traumatised people might direct their anger toward themselves instead of externalizing it. Therefore, it can be speculated that during posttraumatic coping, Punitive Parent mode activates in this process and triggers the Vulnerable Child, thus person feel worthless and hate towards themselves. The person could blame herself /himself for the trauma and think that she/he deserves what happened to her/him because she/he is a "bad" person and doesn't deserve to have “good” things. Regarding dyadic relationship of Vulnerable Child and Punitive Parent modes, these experiences can match with the "voice" of the Punitive Parent mode (Jacob et al., 2014). Considering this information, since these mentioned features can be seen in parallel with the phases in the formation of PTG, including the processes of confronting the traumatic pain and rumination, it seems reasonable the Punitive Parent mode to predict PTG.

Lastly in prediction variables, in terms of Maladaptive Coping modes, Hypothesis 5 is confirmed only for the Detached Protector mode thus, this mode was found to predict PTG negatively. As one of the unexpected findings, Detached Self-Soother mode positively predicted PTG. However, no significant relationship was found between Compliant Surrenderer, Self-aggrandizer, Bully and Attack mode and PTG. These modes are surrendering and overcompensating coping modes. It can be thought that surrendering after trauma and adopting a passive stance does not contribute to developing PTG. As for overcompensatory modes, it is thought that they refer to responding immediately with a "fight" response in the posttraumatic period without confronting the pain and distress of the trauma. Therefore, it can be expected to be a nonsignificant relationship. In terms of Detached Protector was found to predict PTG negatively, this finding is consistent with the literature on traumatized people (Johnston et al., 2009; Pust et al., 2021). Moreover, researchers indicated that Detached Protector is the most common mode among traumatized people (Lian & Mathialagan, 2024). Detached Protector is one of the avoidance coping mode. From the PTG perspective, this mode refers to shutting down the system to get away and protect from the harmful emotions and thoughts caused by the trauma. In this mode, people cut off communication with both their own emotions and thoughts or with others, isolate themselves emotionally and physically, refuse help from others, and spend time with activities that will keep them busy and away from the effects of the traumatic event (Young et al., 2003). This numbness protects them from the detrimental effects of trauma, but they cannot fully engage in life and relationships (Lian & Bono, 2024). Regarding PTG,

traumatized people often feel more secure in dissociation because it protects them from triggers of traumatic event (Naifeh et al., 2012). However, while avoiding from reality, the person cannot experience the required distress for PTG in the first place and cannot sustain processing the trauma through ruminations or questioning of assumptions. Therefore, it can be postulated that Detached Protector mode prevents people from developing PTG.

Detached Self-soother, another avoidance coping mode, has been shown to positively predict PTG contrary to the expected. Unlike Detached Protector's avoidance, Detached Self-soother avoids by occupying themselves with soothing, stimulating, or distracting activities such as excessive working, binge eating, overly engaging in sexual activities and overindulgence in computer games and television, etc. (Arntz & Jacob, 2017; Edwards, 2022; Young et al., 2003). As interpreted earlier, detaching is not contributed to the PTG process, and even has the potential to hinder the PTG process. In this context, the fact that the Detached Self-soother is positively associated with PTG could be related to the controversial concept of illusory PTG (Jayawickreme & Blackie, 2014; Maercker & Zoellner, 2004). The term "illusory PTG" refers to merely perceived growth that is experienced after a traumatic event and does not exist in reality (Boals, 2023). The author claims that self-report PTG should be considered perceived PTG and that perceived PTG can consist of genuine and/or illusory PTG in varying ratios. Detached Self-soother displays seemingly adaptive behaviors such as overworking in occupational or domestic contexts. In addition, since Detached Self-soother avoids distress, they are not experiencing or displaying negative emotions and behaviors, it may seem and feel functional. These experiences possibly give the impression that the person continues to function when viewed superficially. But deep down, the person engages in these behaviors to disconnect from their feelings. Supporting this, according to Boals (2023), people can overreport PTG because of the emotional biases that help maintain positive illusions amid distress as a coping strategy. Thus, this coping strategy can create an illusory perception of PTG, apart from or in addition to the genuine PTG. Promoting this proposition, self-reports of PTG show a favorable correlation with denial coping and avoidance coping (Boals & Schuler, 2018; Henson et al., 2021). This notion can be interpreted as supporting the effect of illusory PTG since Detached Self-soother is a coping mode.

4.3. Discussion of Findings Regarding the Mediating Role of Self-Compassion in the Relationship Between Schema Modes and PTG

Confirming the sixth hypothesis of the research, self-compassion mediated the positive relationship between adaptive schema modes (Happy Child and Healthy Adult) and PTG. Link between Happy Child mode and PTG is partially mediated by self-compassion. In addition to what was previously mentioned about Happy Child mode and PTG association in the previous heading, current study contributed to the existing literature by exploring the mediating role of self-compassion. For PTG to occur, the person must have resources that will meet their needs, have a responsive and supportive environment where they can freely express themselves within safe boundaries, and thus learn skills for managing their emotional distress (Tedeschi et al., 2018). It can be said that these requirements are just like those of a growing child whose basic needs are met such as attunement, safety, care and love. Self-compassion possibly has a role in facilitating to reach of these features by establishing curious awareness and evaluation about trauma, self, and the outer world. In terms of Happy Child mode, self-compassion can help to explore authentic inner strength and acknowledge the situation as a common human experience to feel connected with others and ask for help to reexperience the safety, unity, joy, spontaneity, imperfect happiness, and balance (Neff, 2011). From the positive psychology perspective, it refers to the positive emotions and engagement factors of the PERMA Model, which is defined by Seligman to represent the five facets of well-being: **P**ositive emotions-seeking out for positive affects, **E**ngagement-pursuing own rewarding and flow-created activities, (positive) **R**elationships-connecting with others, **M**eaning-creating a meaningful and purposeful life, and **A**ccomplishment- pursuing achievements intrinsically for its own sake (Seligman, 2011). Happy Child mode fosters actively seeking for positive emotions and enjoying and engaging yourself by developing skills and hobbies with passion.

As mentioned before, Healthy Adult mode did not predict PTG. However, over and above as expected in the Hypothesis 6b, self-compassion presented full mediation between the Healthy Adult mode and PTG. A full mediation relationship illustrates that self-compassion is an indispensable aspect of the Healthy Adult mode for developing PTG. These results align with the information presented in the literature suggesting that Healthy Adult possesses self-compassion (Roediger et al., 2018; Yakın & Arntz, 2023). It is claimed that Healthy Adult is the key mode to the change mechanism in Schema Therapy (Fassbinder et al., 2016; Yakın et al., 2020). This mode displays reparative parenting to the child modes by

specifically nurturing and protecting the Vulnerable Child, limiting the other Child modes, and managing the Dysfunctional Parent and Coping modes. Healthy Adult mode is characterized by "functional dealing with reality" and claimed that it creates a new framework for interacting with other schema modes to establish and maintain equilibrium (Yakın & Arntz, 2023). In terms of positive psychology, it is thought that Healthy Adult enables to reach “eudaimonia” which is meaningful happiness and well-being rather than quick pleasures through revealing one's potential and realizing oneself (Vázquez et al., 2009). Since self-compassion is defined as a form of adaptive self-relating (Finlay-Jones, 2017), its importance as a functional component of the Healthy Adult on the road to the PTG can be well understood. From the angle of Healthy Adult mode, self-compassion skill helps people to mindfully acknowledge the trauma and its effects from a safe distance without overidentification with the negativities. It enables one to analyze and identify the needs afterward trauma and take personal initiative, demanding care from others. Also, it aids in experiencing required emotional distress without being overly harsh on oneself, reduces the detrimental effects and maladaptive modes activity in an empathic way, and provides mindful insight. Therefore, it can be postulated that self-compassion affects the PTG processes such as intrusive ruminations transition to deliberate ruminations and rebuilding assumptions in PTG. Subsequently, it might facilitate managing emotional distress, reaching social support, developing a changing life narrative after trauma, and fostering flourishing. In terms of PERMA Model, this mode refers to all factors which are Positive emotions, Engagement, (positive) Relationships, Meaning and Accomplishment.

Concerning Maladaptive Child Modes, it was stated none of the child modes predicted PTG earlier in the study. However, in the mediation model, self-compassion fully mediated the negative individual relationship between Vulnerable Child and Undisciplined Child modes and PTG. Therefore, Hypothesis 7 is partially confirmed. Similar to the Healthy Adult's importance in change within Schema Therapy, findings demonstrated the centrality of the Vulnerable Child mode theoretically (Young et al., 2003) and empirically (Aalbers et al., 2021). Vulnerable Child mode is one of the most prevalent schema modes among traumatised populations and defined as a "victimized self-schema" according to Lian and Mathialagan (2024). Masterson (2013) posited that following a traumatic event, victims often experience severe feelings of despair, helplessness, and hopelessness, as well as guilt, emptiness, and void. Since Vulnerable Child feels sad, lonely, dissociated, abused, and victimised (Johnston et al., 2009; Young et al., 2003), these statements support the notion

that this mode can be quite active throughout the posttraumatic process. Regarding self-compassion, these experiences are consistent with the negative tips of its three bidirectional continuums which are self-judgment, overidentification, and isolation (Neff, 2003). This result draws attention to the effect of self-compassion in the context of relationship between schema modes and PTG. We may infer from this information that the PTG process is hindered by a lack of self-compassion for those who scored higher in Vulnerable Child mode.

Similar with the Vulnerable Child, self-compassion fully mediated the negative relationship between Undisciplined Child and PTG. Undisciplined Child mode dislikes having to complete routine or ordinary tasks and they get easily frustrated, give up and display impatience (Young et al., 2003). PTG is a challenging process, so it requires confronting the pain, being able to stay with it, making sense of it, and experiencing the transformative nature of the pain. This experience can be processed with patience, fortitude, and the ability to manage and tolerate distress (Tedeschi & Calhoun, 2004). Since Undisciplined Child has the opposite of these features it is expected to negatively relate with PTG. Moreover, in the Schema Mode Inventory, this mode was measured with 4 items and the statement "I am lazy" is one of the items. It is speculated that if this item was evaluated by the participants without being objective themselves, it may reflect a self-judgmental bias. Therefore, this can be one of the reasons mediating the relationship between self-compassion and PTG.

Regarding Maladaptive Parent Modes, as expected, self-compassion mediated the negative relationship between Demanding Parent and PTG regarding Hypothesis 8a. Moreover, it is a full mediation between the variables. Demanding Parent mode refers to high expectations, intense pressure, a perfect order, the necessity of being effective and not wasting time (Roediger et al., 2018). It asks for unachievable, emotionally charged, and achievement-focused requests and sacrifices (Rafaeli et al., 2011). On the other hand, trauma creates a chaos in person’s life and mind, it manifests as an "earthquake" that destroys nearly everything in the intellectual world of the person. Afterward trauma, people seek comfort and safety. They need time to respectively see and feel the pain, grieve, learn from pain, and transform it into an understanding. If this mode is active, it may command rapid recovery and growth by not letting the person walk the thorny road of PTG. It forces them to return to work quickly, functionally carry on with daily life, restore the pre-trauma order and "be well". This attitude is far from positive psychological features such as self-kindness, giving

oneself space and time for healing. The mindfulness component of self-compassion facilitates facing and acknowledging the pain and grief. Also, the knowledge that every person needs time for recovery is emphasized by the common humanity aspect of self-compassion. Therefore, it can be said that self-compassion has a supportive and protective companion role and interferes with the Demanding Parent mode and PTG association.

It was previously stated that a positive significant relationship was found between Punitive Parent and PTG. Considering the abusive and judgmental nature of the Punitive Parent, a significant relationship was expected between this mode and self-compassion. However, the proposed mediation of self-compassion between Punitive Parent mode and PTG was not found to be significant in Hypothesis 8b. Lian and Mathialagan (2024) emphasized two angles of Punitive Parent mode within the object relations model. In the first one, the Punitive Parent usually triggers the vulnerable child and victimizes themselves by showing self-destructive behaviors through using “turning-against-self” defense mechanism concerning trauma (Gangi et al., 2009) and it resonates with self-compassion’s “self-kindness versus self-judgment” component. In the second manifestation of Punitive Parent, in contrast to self-directed punitiveness, the individual directs abusive and punitive stances toward others. Ferenczi's (1933) concept of "identification with the aggressor" provides support for this notion. From this perspective, it seems reasonable that self-compassion did not mediate this relationship because since abusiveness is directed to others, this stance of Punitive Parent does not represent “self-kindness versus self-judgment” component of self-compassion.

In the previous section, it has been stated that Detached Protector was found to predict PTG negatively. However, in the mediation model, self-compassion partially mediated the positive relationship between Detached Protector and PTG. Therefore, Hypothesis 9b is not supported. The direction of the relationship between the Detached Protector and PTG has changed by self-compassion mediation. This result is thought to be approached from two different perspectives. First, self-compassion can allow people to avoid from trauma related issues. This avoidance can be healthy and considered a process in which the people prepare themselves until they confront the distress of the trauma. In fact, sometimes it can be thought of as the denial coping mechanism protecting the person. The person may be mindfully aware of her/his avoidance in the presence of self-compassion. It can overlap the Detached Protector mode but more permeable. Basically, it is believed that it can be conceptualized as an allowed detachment. For instance, the person avoids the

triggers of the traumatic event, but they might be aware of their avoidance and act in this way to cope and tolerate. Therefore, when the person feels ready to face the pain, they can confront the suffering necessary for PTG. It can be interpreted here that self-compassion has a preserving quality for the person to be ready to develop PTG. On the other hand, another possibility is that when a person is self-compassionate, he/she stays on the side that overly approves and reinforces the avoidance behavior and sees this as a nonexistent improvement, earlier mentioned as illusory PTG. The difference from the first mentioned perspective is that the person attributes his avoidance to preparation before recovery, but to the recovery itself. Consequently, from a biased standpoint, avoidance is seen to be confused with recovery and growth regarding PTG.

4.4. Clinical Implications

Given that majority of the people experience trauma of varying severities throughout their life (Dursun et al., 2014; Karancı et al., 2012; Kessler et al., 2017), it can be said that posttraumatic processes are inescapable for all people. The findings of the present study are proposed to contribute to the existing literature by shedding light on the role of self-compassion between schema modes and PTG. Especially in Schema Therapy, working on traumatic content through cognitive, experiential, and behavioral aspects is of critical importance. It has been reported that in the presence of self-compassion, PTG can occur even if people's maladaptive schema mode scores are higher. Even more, there are relationships between schema modes and PTG that are fully mediated by self-compassion. It is believed that such information will have a crucial role in shaping future research and interventions in Schema Mode Work. It is believed that incorporating self-compassion understanding and practices into treatment processes will have a major positive impact on the patient's well-being, particularly when working with schema modes in posttraumatic processes. For this reason, it seems very fundamental that self-compassion and/as well as other positive psychology interventions such as hope, optimism, and gratitude are integrated into Schema Mode Work as a complementary to interventions in the clinical context and the Trauma-Focused Schema Therapy approach, which is a new focus in the field of research (Lian & Bono 2023). It has been proposed that identifying the links between schema modes and PTG can enable the implementation of promising influential intervention and training techniques. New practices and techniques, including guided meditations and exercises, mindfulness practices, group and individual therapy integrations and psychoeducation content focused on self-compassion can be developed for therapy settings. Moreover, since

self-compassion is thought to have a crucial role in the change mechanism in Schema Therapy, it is recommended that the central integration of self-compassion will be effective not only in posttraumatic processes but also in other psychopathologies where Schema Therapy Mode Work is conducted. Since traumatic experiences are diverse and frequent in Türkiye (Dursun et al., 2014; Gül, 2014; Karancı et al., 2009; Karancı et al., 2012), self-compassion focused preventive social interventions can be carried out with the policies to be implemented by public health decision-makers to be protective in posttraumatic processes.

4.5. Limitations and Recommendations

The study has some limitations that should be taken into consideration. In terms of sample characteristics, the fact that majority of the participants were women, single, with bachelor's or postgraduate degrees, and SES not evenly distributed poses a limitation in terms of the generalizability of the findings. In future studies, it is recommended that the sample be distributed evenly across the specified variables and that a sample consisting of a larger number of participants be used for the generalizability of the findings. Secondly, self-report inventories are employed in the current study. Therefore, participants might not have expressed their feelings and thoughts and might have presented themselves in a way that pleased them. Hence, the social desirability factor may interfere with the scores. Also, in estimating own PTG, it should be noted that illusory PTG can be another factor that affects the participants' perception of PTG. For future research, it is recommended to develop and use sophisticated measurement tools, methods, and notifications to differentiate the genuine and illusory PTG in self-reports. For instance, multiple measurements from family members can be utilized or semi-structured interviews conducted by the clinician. Another limitation could be the research design of the study. The use of a cross-sectional method in this research created an obstacle to determining the cause-effect relationship. It is thought that especially measuring PTG longitudinally can provide more reliable results to make cause-effect inferences. Lastly, it is believed that the large number of items in the data collection instruments utilized in the study contributed to the participants' fatigue and distraction as they were answering the scales. Moreover, because of the lengthy nature of the measures, it is believed that most of the participants didn't complete the survey. To avoid dropouts, it is advised that the inventory be prepared shorter.

Best of the author's knowledge, this is the first study examining schema modes and the PTG process, it is recommended that further research be conducted investigating the relationships between these two concepts. This study's findings revealed certain relationships between the main variables. However, the modes associated with PTG, the relationships of particular modes with self-compassion, the links of the modes with each other in the context of trauma, and other effective mechanisms in this relationship should also be investigated in more depth. The results of this study indicated that self-compassion could play a part in the change mechanism of Schema Therapy. It is also recommended to investigate other factors that influence the mechanism of change and may or may not be related to self-compassion. Additionally, these results are believed to have potential benefits for future study on the trauma-focused Schema Therapy approach. Qualitative and intervention studies might obtain further profound information regarding all mentioned associations.

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APPENDICES

Appendix 1: Informed Consent Form

Değerli katılımcı, bu tez çalışması Başkent Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Hilal Ünsaldı tarafından Dr. Öğr. Üyesi Burçin Akın Sarı danışmanlığında yürütülmektedir. Araştırmada travmatik yaşantılara sahip bireylerde travma sonrası büyüme sürecinin incelenmesi amaçlanmaktadır. Travma sonrası büyüme kavramı, travmatik bir olay yaşadıktan sonra deneyimlenen pozitif değişimleri temsil etmektedir. Çalışmaya katılmak için herhangi bir travmatik olay yaşamış veya tanık olmuş olmanız gerekmektedir (doğal afet, bir yakınınızın kaybı, ölümcül bir hastalık tanısı, kaza vb.) ve başınızdan geçen bu travmatik olayın üstünden en az 3 ay geçmiş olması ve en fazla 15 yıl önce gerçekleşmiş olması gerekmektedir. Araştırmada size sunulan değerlendirme araçlarını eksiksiz doldurmanız beklenmektedir ve bu süreç tahminen 20 dakika sürecektir. Araştırma sorularının genel geçer doğru ve yanlış cevapları yoktur. Araştırmanın doğru sonuçlar verebilmesi için cevaplanması gereken soruları size doğru gelen biçimde ve içten bir şekilde yanıtlamanız büyük önem taşımaktadır.

Bu çalışmaya katılım tamamen gönüllülük esasına dayanmaktadır ve sizden herhangi bir kimlik bilgisi alınmayacaktır. Sizden alınan her türlü bilgi ise tamamen gizli tutulacaktır ve araştırmadan elde edilecek bilgiler ve araştırmanın sonuçları yalnızca bilimsel amaçlarla kullanılacaktır. Bu araştırma psikolojik veya fizyolojik herhangi bir risk taşımamaktadır. Ancak herhangi bir rahatsızlık duyduğunuz anda anketi sonlandırabilirsiniz. Araştırmaya katıldığınız için şimdiden teşekkür ederiz. Bu çalışma hakkında daha fazla bilgi almak için Psikolog Hilal Ünsaldı ile e-posta adresi üzerinden iletişim kurabilirsiniz.

☐ Araştırma hakkında ayrıntılı olarak bilgilendirildim. Bu çalışmaya gönüllü olarak katılmayı kendi rızamla kabul ediyorum ve istediğim zaman çalışmayı sonlandırabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayınlarda kullanılmasını kabul ediyorum.

Appendix 2: Demographic Information Form

1. **Cinsiyetiniz:** ☐ K ☐ E ☐ Diğer:…….. ☐ Belirtmek istemiyorum
2. **Doğum Yılınız: .....**
3. **Yaşadığınız ülke:** ☐Türkiye ☐Diğer: .....
4. **Medeni Durumunuz:** ☐Evli ☐Bekar
5. **Çalışma Durumunuz:** ☐ Çalışıyorum ☐ Çalışmıyorum ☐ Öğrenciyim ve aynı zamanda çalışıyorum
6. **Sosyoekonomik durumunuzu nasıl değerlendiriyorsunuz?**

☐ Çok Düşük ☐ Düşük ☐ Orta ☐ Yüksek ☐ Çok Yüksek

7. **Son mezun olduğunuz okul nedir?**

☐ Okuma-yazma biliyorum ☐ İlkokul mezunuyum ☐ Ortaokul mezunuyum ☐ Lise mezunuyum ☐ Üniversite/lisans mezunuyum ☐ Lisansüstü mezunuyum

8. **Yaşamınızın büyük bölümünü aşağıdakilerden hangisinde geçirdiniz?**

☐ Büyükşehir ☐ Şehir

☐ İlçe ☐ Köy / Belde

9. **Herhangi bir psikolojik/psikiyatrik tanınız var mı? Evet ise lütfen belirtiniz.**

☐ Evet (Lütfen belirtiniz): _____ ☐ Hayır

10. **Herhangi bir psikiyatrik ilaç kullanıyor musunuz?**

☐ Evet (Lütfen belirtiniz): _____ ☐ Hayır

11. **Herhangi bir psikolojik / psikiyatrik destek aldınız mı veya halihazırda alıyor musunuz?**

☐ Hayır

☐ Daha önce aldım

☐ Psikiyatrik tedavi görüyorum

☐ Psikoterapi alıyorum

☐ Hem psikoterapi hem psikiyatrik destek alıyorum

12. Eğer destek almış ya da halen alıyor iseniz, yukarıda belirtmiş olduğunuz desteği ne kadar süre boyunca aldınız / ne kadar süredir almaktasınız? (Lütfen ay olarak belirtiniz)

_____

13. Birçok kişinin başından, hayatının herhangi bir döneminde, oldukça stresli ve travmatik bir olay geçmiş ya da böyle bir olaya tanık olmuştur. Aşağıda belirtilen olaylar içinde, başınızdan geçen ya da tanık olduğunuz olayların HEPSİNİ yanındaki kutuyu işaretleyerek belirtiniz.

- ☐ **1.** Ciddi bir kaza, yangın ya da patlama olayı (örneğin trafik kazası, iş kazası, çiftlik kazası, araba, uçak ya da tekne kazası vb.)
- ☐ **2.** Doğal afet (örneğin, deprem, kasırga, sel baskını vb.)
- ☐ **3.** Tanıdığınız veya tanımadığınız bir kişi tarafından cinsel bir saldırıya maruz kalma (örneğin teşhirciliğe veya istenmeyen dokunuşlar, maruz kalma tecavüz ya da tecavüze teşebbüs vb.)
- ☐ **4.**Tanıdığınız veya tanımadığınız bir kişi tarafından cinsel olmayan bir saldırıya maruz kalma (örneğin saldırıya uğrayıp soyulma, fiziksel bir saldırıya maruz kalma, silahlı saldırı, bıçaklanma ya da silahla rehin alınma vb.)
- ☐ **5.** Askeri bir çarpışma ya da savaş alanında bulunma
- ☐ **6.** 18 yaşından daha küçük olduğunuz bir dönemde kendinizden 5 ya da daha büyük yaşta biriyle cinsel temas
- ☐ **7.** Hapsedilme (örneğin cezaevine düşme, savaş esiri olma, rehin alınma vb.)

- **8.** İşkenceye maruz kalma
- **9.** Hayatı tehdit eden bir hastalık
- **10.** Sevilen ya da yakın birinin beklenmedik ölümü
- **11.** Bunların dışında bir olay: .....

14. Bu olaylar arasında sizi en fazla etkilediğini düşündüğünüz hangisidir? (Madde numarasını lütfen belirtiniz): _____

15. Beni en çok etkileyen bu olay;

☐ **Benim başıma geldi.** ☐**Bir yakınımın başına geldi.**

16. Yaşadığınız bu olayın üstünden ne kadar zaman geçti?

☐3-6 ay arası ☐6 ay –9 ay arası ☐9 ay-1 yıl arası ☐1 yıl- 3 yıl arası ☐3-5 yıl arası ☐5-15 yıl arası ☐15 yıldan daha fazla

17. Bu olay sizin için ne kadar stres vericiydi? Size en uygun seçeneği işaretleyiniz. (1= Hiç stres verici değildi, 7= Aşırı düzeyde stres vericiydi)

(Hiç stres verici değildi) (Aşırı düzeyde stres vericiydi)

1 2 3 4 5 6 7

Appendix 3: Brief Schema Mode Inventory

Aşağıda, insanların kendilerini tanımlarken kullanabileceği ifadeler yer almaktadır. Lütfen her bir maddeyi **genellikle** bunları **hangi sıklıkta** hissettiğiniz ya da bunlara hangi sıklıkta inandığınız üzerinden derecelendiriniz.

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

Sıklık	**Genellikle**
	1. Sevildiğimi ve kabul edildiğimi hissediyorum.
	2. Kendimden zevk alacak şeyleri esirgiyorum çünkü hak etmiyorum.
	3. Oldum olası yetersiz, kusurlu veya eksik hissediyorum.
	4. Kendimi cezalandırmaya yönelik bedenime/kendime zarar verme eğilimlerim var (örn., kendimi kesmek).
	5. Kaybolmuş hissediyorum.
	6. Kendime karşı çok katıyım.
	7. Çatışmak, terslenmek veya dışlanmak istemediğim için diğer insanları memnun etmeye çok uğraşırım.
	8. Kendimi affedemiyorum.
	9. İlginin benim üstünde olmasını sağlayacak şeyler yaparım.
	10. İnsanlar dediğimi yapmadıkları zaman sinirlenirim.
	11. Kendimi kontrol etmekte zorlanıyorum.
	12. Eğer amacıma ulaşamazsam, kolayca hayal kırıklığına uğrar ve vazgeçerim.
	13. Şiddet içeren patlamalarım oluyor.

	14. Başımı derde sokacak veya insanları kıracak şekilde dürtüsel davranırım veya duygularımı ifade ederim.
	15. Kötü bir şey olursa benim hatamdır.
	16. Kendimi hoşnut ve rahat hissediyorum.
	17. Beraber olduğum insanlara göre kendimi değiştiririm, böylece benden hoşlanırlar veya beni onaylarlar.
	18. Diğer insanlarla aramda bir bağ olduğunu hissediyorum.
	19. Mücadele etmezsem insanlar beni ya istismar eder/kullanır ya da ihmal ederler.
	20. Kendisi ile dalga geçilmesine izin veren kişi bir hiçtir.
	21. Beni kızdıran insanlara fiziksel olarak saldırıda bulunurum.
	22. Bir kez sinirlenmeye başlarsam, genellikle kızgınlığımı kontrol edemem ve kendimi kaybederim.
	23. Benim için Bir Numara olmak önemlidir (örn. en popüler, en başarılı, en varlıklı, en güçlü).
	24. Kayıtsız / duygusuz hissediyorum.
	25. Duygularımın beni etkilemesine izin vermeden sorunları mantıksal bir şekilde çözebiliyorum.
	26. İkinci sırada olmakla yetinmem.
	27. Saldırı en iyi savunmadır.
	28. Diğer insanlara karşı soğuk hissediyorum.
	29. Kendimi kopmuş hissediyorum (kendimle, duygularımla veya diğer insanlarla aramda bir bağ yok).
	30. Duygularımı körlemesine izlerim.
	31. Çaresiz hissediyorum.
	32. Başka insanların beni eleştirmesine veya aşağılamasına izin veririm.
	33. İlişkilerimde, diğer kişinin daha üstte /hakimiyeti ele almasına olmasına izin veririm.

	34. Diğer insanlardan uzak hissediyorum.
	35. Düşünmeden konuşurum ve bu nedenle ya başımı derde sokarım ya da başkalarını incitirim.
	36. Rahatsız edici duygularımı düşünmemi engelleyecek kadar kendimi aşırı düzeyde çalışmaya veririm veya spor yaparım.
	37. Özgürlüğümü veya bağımsızlığımı engelleyen insanlara kızgınım.
	38. Hiçbir şey hissetmiyorum.
	39. Diğer insanların ihtiyaçlarına ve duygularına aldırmaksızın ne istersem onu yaparım.
	40. Yapmam gerekenleri bitirmedikçe dinlenmeme veya eğlenmeme izin vermem.
	41. Sinirlendiğimde etrafta ne varsa fırlatırım.
	42. Birisine öfkelenmiş hissediyorum.
	43. Diğer insanlarla uyum içinde olduğumu hissediyorum.
	44. İçimde boşaltmak istediğim yoğun bir öfke var.
	45. Yalnız hissediyorum.
	46. Duygularımdan kaçınmak için beni uyaran veya sakinleştiren şeyler yapmayı severim (örn. çalışmak, kumar oynamak, yemek, alışveriş, cinsel etkinlikler, TV seyretmek).
	47. Eşitlik diye bir şey yoktur, bu nedenle en iyisi diğerlerinden üstte olmaktır.
	48. Sinirlendiğimde kendimi kaybederim ve diğer insanları tehdit ederim.
	49. Kendi isteklerimi söylemektense, diğer insanların istediklerini yapmasına izin veririm.
	50. Birisi benim yanımda değilse bana karşıdır.
	51. Canımı sıkan düşünceler veya duygularım beni rahatsız etmesin diye kendimi hep bir işle meşgul ederim.
	52. Başkalarına sinirlenirsem ben kötü bir insanımdır.
	53. İnsanlarla bir arada olmak istemiyorum.

	54. Hayatımda tam bir istikrar, denge ve emniyet/güven olduğunu hissediyorum.
	55. Duygularımı ne zaman açıp ne zaman açmayacağımı bilirim.
	56. Beni yalnız bıraktığı veya terk ettiği için birisine kızgınım.
	57. Diğer insanlarla aramda bir bağ olduğunu hissetmiyorum.
	58. Benim yararıma olduğunu bilsem bile, sıkıcı işleri yapmak için kendimi zorlayamam.
	59. Kuralları çiğnerim ve sonra bundan pişman olurum.
	60. Aşağılanmış hissediyorum.
	61. Önce yapar sonra düşünürüm.
	62. Kolay sıkılırım ve ilgim çabuk kaybolur.
	63. Çevremde insanlar varken bile kendimi yalnız hissederim.
	64. Başka insanların yaptığı zevk veren/ hoşa giden şeyleri yapmak için kendime izin vermiyorum çünkü ben kötüyüm.
	65. Aşırıya kaçmadan ihtiyaçlarımın karşılanmasını sağlarım.
	66. Pek çok insandan daha değerli ve daha iyiyim.
	67. Hiçbir şeyi önemsemiyorum, benim için ne olsa fark etmez.
	68. Birisi, nasıl hissetmem veya davranmam gerektiğini söylerse sinirlenirim.
	69. Diğer insanları yönetmezsen, sen yönetilirsin.
	70. Sonuçlarını düşünmeden, ne hissedersem söylerim veya dürtülerimle / düşünmeden / içimden nasıl gelirse öyle davranırım.
	71. Bana yaptıklarından dolayı insanları azarlayasım; bana yaptıklarını yüzlerine vurasım geliyor.
	72. Kendime bakabilirim.
	73. Başkalarına karşı oldukça eleştirelimdir.
	74. Başarmak ve işleri bitirmek için sürekli bir baskı altındayım.
	75. Hata yapmamaya çalışırım, aksi halde moralim bozulur, çökerim.

	76. Cezalandırılmayı hak ediyorum.
	77. Öğrenebilirim, olgunlaşabilirim ve değişebilirim.
	78. Üzücü düşünceler ve duygulardan kurtulmak için dikkatimi başka şeylere veririm.
	79. Kendime kızgınım.
	80. Tek düze / donuk hissediyorum.
	81. Yaptığım her şeyde en iyi olmalıyım.
	82. Standartlarımı tutturmak için zevkten, sağlıktan veya mutluluktan vazgeçiyorum.
	83. İnsanlara karşı talepkarımdır.
	84. Sinirlenirsem insanları kıracak kadar kontrolden çıkarım.
	85. Kimse bana dokunamaz.
	86. Ben kötü bir insanım.
	87. Kendimi güvende hissediyorum.
	88. Dinlenildiğimi, anlaşıldığımı, değer verildiğimi hissediyorum.
	89. Dürtülerimi kontrol etmek benim için imkânsızdır.
	90. Sinirlendiğimde bir şeyler kırarım.
	91. Başkalarına hükmettiğiniz sürece size bir şey olmaz.
	92. İşler istediğim gibi olmasa bile sesim çıkmaz, geride dururum
	93. Kızgınlığımın kontrolden çıktığı olur.
	94. Başkaları ile dalga geçerim.
	95. Bana yaptıklarından dolayı, birisine vuracak veya zarar verecek gibi hissediyorum.
	96. İşleri yapmak için bir doğru ve bir de yanlış yol olduğunu biliyorum; ben, yaptıklarımı doğru şekilde yapmak için çok çalışırım yoksa kendimi eleştirmeye başlarım.

	97. Çoğu zaman kendimi dünyada yapayalnız hissederim.
	98. Güçsüz ve aciz hissediyorum.
	99. Tembelim.
	100. Benim için önemli olan insanlarla ilgili her şeyi kabullenmem gerekir.
	101. Kandırıldım veya bana dürüst davranılmadı.
	102. Kenara atılmış veya dışlanmış hissediyorum.
	103. Başkalarını küçümserim.
	104. İyimser hissediyorum.
	105. Çoğu insandan daha fazla sorumluluk sahibi olmaya kendimi zorluyorum.
	106. Haksız bir şekilde eleştirildiğimde, tacize uğradığımda veya kullanıldığımda kendimi savunabilirim.
	107. Bana kötü bir şey olduğunda anlayışı hak etmiyorum.
	108. Kimsenin beni sevmediğini hissediyorum.
	109. Özünde iyi bir insan olduğumu hissediyorum.
	110. Değer verdiğim şeylere ulaşmak için, gerektiğinde, sıkıcı ve rutin işleri tamamlamaya tahammülüm vardır.
	111. Kendimi doğal ve neşeli hissediyorum.
	112. Birisini öldürebilecek kadar sinirlenebiliyorum.
	113. Kim olduğumu ve kendimi mutlu etmek için ne yapmam gerektiğini bilirim.

Appendix 4: Posttraumatic Growth Inventory (PTGI-X)

Aşağıda, sizi en fazla etkileyen yaşamsal krizin bir sonucu olarak ortaya çıkmış olabilecek değişiklikleri belirten ifadeler verilmiştir. Bu değişikliklerin yaşamınızda ne dereceye kadar yer aldığını verilen ölçek üzerinde işaretleyiniz.

Yaşadığım yaşamsal kriz sonucu…

0= Hiç yaşamadım

1= Çok az yaşadım

2= Biraz yaşadım

3= Orta düzeyde yaşadım

4= Oldukça fazla yaşadım

5= Çok fazla yaşadım

	1. Hayatımda neyin önemli olduğu ile ilgili önceliklerimi değiştirdim.
	2. Hayatımın değerini daha çok takdir ediyorum.
	3. Yeni ilgi alanları geliştirdim.
	4. Kendime daha çok güvenim var.
	5. Manevi konuları daha iyi anlıyorum.
	6. Zor durumda kaldığımda insanlara güvenebileceğimi daha iyi anladım.
	7. Hayatıma yeni bir yön verdim.
	8. Diğer insanlara daha çok yakınlık hissediyorum.
	9. Duygularımı ifade etmeye daha istekliyim.
	10. Zorluklarla başa çıkabileceğimi daha iyi anladım.
	11. Hayatımda daha iyi şeyler yapabilirim.
	12. Olayları olduğu gibi kabullenmekte daha iyiyim.
	13. Her günün değerini daha iyi anlıyorum.
	14. Hayatta gerçekleşmesi mümkün olmayacak yeni fırsatlar çıktı karşıma.
	15. Diğer insanlara daha çok şefkatliyim.

	16. İlişkilerim için daha çok emek harcıyorum.
	17. Değişmesi gereken şeyleri değiştirmeyi denemeye daha istekliyim.
	18. Daha güçlü bir dini inancım var.
	19. Düşündüğümden daha güçlü olduğumu gördüm.
	20. İnsanların ne kadar harika olduğuyla ilgili çok şey öğrendim.
	21. Başkalarına ihtiyaç duymak artık benim için daha kabul edilebilir.
	22. Dünya ile aramdaki uyum daha anlamlı gelmeye başladı.
	23. Varoluşun bütünü ile olan bağım artık daha kuvvetli.
	24. Yaşam ve ölüm hakkındaki sorularla daha iyi yüzleşebiliyorum.
	25. Hayatın anlamı hakkında daha netim.

Appendix 5: Self-Compassion Scale

Değerli katılımcı, aşağıdaki cümleler zor durumlar karşısında kendinize genel olarak nasıl davrandığınızla ilgilidir. Ne sıklıkla aşağıda belirtildiği şekilde davranma eğiliminde olduğunuzu ilgili puanlamayı yaparak derecelendiriniz.

1= Neredeyse hiçbir zaman
2= Nadiren
3= Ara sıra
4= Çoğu zaman
5= Neredeyse her zaman

	1. Kişiliğimin beğenmediğim yanlarına karşı anlayışlı ve sabırlı olmaya çalışırım.
	2. Kendimi bir şekilde yetersiz hissettiğimde, çoğu insanın da böylesi yetersizlik duyguları yaşayabileceğini kendime hatırlatmaya çalışırım.
	3. Kendimi üzgün hissettiğimde, yanlış giden her şeyi kafama takma ve kurma eğilimindeyimdir.
	4. Ben zorluklarla mücadele ederken, başka insanların yaşam koşullarının benimkinden daha kolay olduğunu hissetme eğilimi gösteririm.
	5. Acı veren bir şey olduğunda, durumu belirli bir zihinsel mesafeden, dengeli bir bakış açısıyla görmeye çalışırım.
	6. Sıkıntı çektiğim dönemlerimde, kendime karşı biraz katı yürekli olabilirim.
	7. Kendimi üzgün ve her şeyden kopmuş hissettiğimde, dünyada benim gibi hisseden daha pek çok insan olduğunu kendime hatırlatırım.
	8. Duygusal olarak acı çektiğim zamanlarda kendime karşı sevecen olmaya çalışırım.
	9. Yetersizliklerimi düşünmek, kendimi daha yalnız ve dünyadan kopuk gibi hissetmeme neden olur.
	10. Kişiliğimin beğenmediğim yanlarına karşı hoşgörüsüz ve sabırsızımdır.
	11. Benim için önemli olan bir şeyde başarısız olduğumda, yetersizlik hisleriyle kendimi tüketirim.
	12. Kendi hatalarıma ve yetersizliklerime karşı hoşgörülüyümdür.

	13. Benim için önemli olan bir şeyde başarısız olduğumda, bu konudaki duygularımı bastırmak veya abartmak yerine durumu olduğu gibi açık yüreklilikle anlayıp kabullenmeye çalışırım.
	14. Sıkıntılı dönemlerimde kendime karşı şefkatliyimdir.
	15. Benim için önemli bir şeyde başarısız olduğumda, bu başarısızlığın yalnız benim başıma geldiğini hissetme eğiliminde olurum.
	16. Hatalarıma ve yetersizliklerime karşı kınayıcı ve yargılayıcıyımdır.
	17. Beğenmediğim yanlarımı gördüğümde kendime yüklenir, moralimi bozarım.
	18. Kendimi üzgün hissettiğimde, duygularımı merakla ve açık yüreklilikle anlamaya çalışırım.
	19. İşler benim için kötü gittiğinde, bu zorlukların, yaşamın bir parçası olarak, herkesin başına gelebileceğini düşünürüm.
	20. Acı veren bir şey olduğunda, olayı gereğinden fazla büyütme eğilimi gösteririm.
	21. Kendimi üzgün hissettiğimde, diğer insanların çoğunun benden daha mutlu olduğunu düşünme eğilimi gösteririm.
	22. Bir şey beni üzdüğünde, kendimi duygularıma kaptırır giderim.
	23. Çok zor bir dönemden geçerken kendime ihtiyacım olan duyarlılık ve sevecenliği gösteririm.
	24. Başarısızlıklarımı insanlık halinin bir parçası olarak görmeye çalışırım.
	25. 25. Herhangi bir şey beni üzdüğünde, duygularımı bir denge içerisinde tutmaya çalışırım.
	26. Gerçekten zor zamanlarda, kendime karşı sert ve acımasız olma eğilimindeyim.

Appendix 6: Ethics Committee Approval

Evrak Tarih ve Sayısı: 19.02.2024-316617

T.C.
BAŞKENT ÜNİVERSİTESİ REKTÖRLÜĞÜ
Akademik Değerlendirme Koordinatörlüğü

Sayı : E-62310886-605-316617
Konu : Hilal Ünsaldı'nın Etik Onayı Hk.

19.02.2024

SOSYAL BİLİMLER ENSTİTÜSÜ MÜDÜRLÜĞÜNE

İlgi : 19.01.2024 tarih ve 305027 sayılı yazınız.

Enstitünüz Psikoloji Ana Bilim Dalı öğretim üyesi, Dr. Öğretim Üyesi Burçin Akın Sarı danışmanlığında, Klinik Psikoloji (Tezli) Yüksek Lisans programı öğrencisi Hilal Ünsaldı tarafından yürütülecek olan, "The moderating role of selfcompassion in the relationship between schema modes and posttraumatic growth in individuals with traumatic experiences" adlı tez çalışması değerlendirilmiş ve bilgilerinize ekte sunulmuştur.

Prof. Dr. Sadegül AKBABA ALTUN
Kurul Başkanı

Ek: Değerlendirme Formu

Evrak Tarih ve Sayısı: 19.02.2024-316617

Sayı : 17162298.600-29 5 Şubat 2024
Konu : Tez Çalışması

İlgili Makama

Üniversitemiz Sosyal Bilimler Enstitüsü Psikoloji Ana Bilim Dalı öğretim üyesi, Dr. Öğretim Üyesi Burçin Akın Sarı danışmanlığında, Klinik Psikoloji (Tezli) Yüksek Lisans programı öğrencisi Hilal Ünsaldı tarafından yürütülecek olan, "The moderating role of selfcompassion in the relationship between schema modes and posttraumatic growth in individuals with traumatic experiences" adlı tez çalışması değerlendirilmiş ve yapılmasında bir sakınca olmadığı tespit edilmiştir.
Bilgilerinize saygılarımızla sunarız.

Başkent Üniversitesi Sosyal ve Beşeri Bilimler ve Sanat Alan Araştırma Kurulu

Ad, Soyad	Değerlendirme	İmza
Prof. Dr. Gözen Güner Aktaş	Olumlu/~~Olumsuz~~	
Prof. Dr. Sadegül Akbaba Altun	Olumlu/~~Olumsuz~~	
Prof. Dr. Fatih Çetin	Olumlu/~~Olumsuz~~	
Prof. Dr. Hasan Tahsin Fendoğlu	Olumlu/~~Olumsuz~~	
Prof. Dr. Filiz Kalelioğlu	Olumlu/~~Olumsuz~~	
Prof. Dr. Hidayet Hale Künüçen	Olumlu/~~Olumsuz~~	
Prof. Dr. Özcan Yağcı	Olumlu/~~Olumsuz~~	