LOOMING VULNERABILITY AND PERFECTIONISM AS MEDIATING FACTORS AMONG PARENTAL BONDING, SOCIAL ANXIETY AND DEPRESSION

A THESIS SUBMITTED TO
THE GRADUATE SCHOOL OF SOCIAL SCIENCES
OF
MIDDLE EAST TECHNICAL UNIVERSITY

BY

AYŞE ALTAN ATALAY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR
THE DEGREE OF / DOCTOR OF PHILOSOPHY
IN
PSYCHOLOGY

JANUARY 2011

Approval of the Graduate School of (Name of the Graduate School)

Prof.Dr. Meliha Altunışık
Director

I certify that this thesis satisfies all the requirements as a thesis for the degree of Doctor of Philosophy.

Prof. Dr. Nebi Sümer
Head of Department

This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Doctor of Philosophy.

Prof. Dr. Hürol Fışıloğlu
Co-Supervisor

Assoc. Prof. Belgin Ayvaşık
Supervisor

Examining Committee Members

Prof. Dr. Tülin Gençöz	(METU,PSY)	
Assoc. Prof. Belgin Ayvaşık	(METU, PSY)	
Prof. Dr. Elif Barışkın (Kabakçı)	(HU, PSYCH)	
Prof. Dr. Hürol Fışıloğlu	(METU, PSY)	
Assoc. Prof. Şennur Tutarel-Kışlak	(AU, PSY)	

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last name : Ayşe, Altan Atalay

Signature :

ABSTRACT

LOOMING VULNERABILITY AND PERFECTIONISM AS MEDIATING FACTORS AMONG PARENTAL BONDING, SOCIAL ANXIETY AND DEPRESSION

Altan Atalay, Ayşe

Ph.D., Department of Psychology

Supervisor : Assoc. Prof. Belgin Ayvaşık

Co-Supervisor: Prof. Dr. Hürol Fışıloğlu

January 2011, 242 pages

Looming Maladaptive Style (LMS) was proposed to be an anxiety specific cognitive vulnerability factor. Perfectionism also acts as a vulnerability to both anxiety disorders and depression. Parenting is another factor associated with both anxiety and depression, with a majority of studies focusing on care and overprotection dimensions of parenting. These parenting dimensions have been reported to be associated with vulnerabilities to psychological disorders. The present study, aims to investigate the parental characteristics associated with LMS and perfectionism as well as testing the mediator roles of these constructs in the relationship of parental bonding to social anxiety and depression. To fulfill this aim, data was gathered from 389 university students all of whom were

administered a questionnaire package composed of Looming Maladaptive Style Questionnaire- Revised (LMSQ-R), Parental Bonding Inventory (PBI), Liebowitz Social Anxiety Scale (LSAS), Brief Fear of Negative Evaluation (BFNE) and Beck Depression Inventory (BDI). In order to obtain psychometric characteristics of LMSQ-R, the scale was administered to a group of 176 university students prior to the main study. Results revealed that both social looming and maladaptive perfectionism were associated with dimensions of parenting. Although perfectionism was associated with both social anxiety and depression, LMS was much more closely associated with social anxiety. Maladaptive perfectionism had a significant mediator role between all dimensions of PBI and depression. Perfectionism also mediated the relationship between maternal care and social anxiety. LMS was not found to have any mediator role. These results were discussed under the light of relevant literature.

Keywords: Looming Maladaptive Style, Perfectionism, Parenting, Social Anxiety, Depression

ÖZ

ANNE-BABA BAĞLANMASININ SOSYAL ANKSİYETE VE DEPRESYONLA İLİŞKİSİNDE ZİHİNSEL ABARTMA VE MÜKEMMELİYETÇİLİĞİN ARACI DEĞİŞKENLER OLARAK ROLLERİ

Altan Atalay, Ayşe

Doktora, Psikoloji Bölümü

Tez Yöneticisi : Doç. Dr. Belgin Ayvaşık

Ortak Tez Yöneticisi: Prof. Dr. Hürol Fışıloğlu

Ocak 2011, 242 sayfa

Zihinsel Abartma Tarzı (ZAT) anksiyeteye özgün olarak önerilen bir bilişsel hassasiyet tarzıdır. Mükemmeliyetçilik de hem anksiyete hem de depresyonla ilişkili olduğu öne sürülen bir diğer tarzdır. Depresyon ve anskiyete ile ilişkili olarak en sıklıkla çalışılan diğer bir değişken grubu da ebeveynlik tarzıdır. Bu alanda yapılan pek çok çalışma özellikle ilgi ve aşırı koruma boyutlarına odaklamıştır. Bu çalışma ZAT ve mükemmeliyetçilikle ilgili ebeveyn özellikleriyle birlikte, bu değişkenlerin ebeveynlik tarzının sosyal anksiyete ve depresyonla ilişkisinde aracı değişken olarak rolünü test etmeyi amaçlamaktadır. Bu amacı gerçekleştirmek için 389 üniversite öğrencisinden demografik bilgi

formu, Zihinsel Abartma Tarzı Ölçeği (ZATÖ), ABBÖ, Çok Boyutlu Mükemmeliyetçilik Ölçeği (ÇBMÖ), Liebowitz Sosyal Anksiyete Skalası (LSAS), Kısa Olumsuz Değerlendirilme Korkusu (KODK) ölçeği ve Beck Depresyon Envanterinden (BDE) oluşan bir batarya doldurmaları istenmiştir. Ana çalışma öncesi, ZATÖ' nün Türkçe formunu psikometrik özelliklerinin belirlenmesi için bu ölçek 176 kişilik bir örnekleme dağıtılmış ve yeterli sonuçlar alınmıştır. Sonuçlar hem sosyal büyütmenin hem de uyumsuz mükemmeliyetçiliğin hem sosyal anksiyete hem de depresyonla ilişkili olduğunu göstermiştir. Mükemmeliyetçilik hem depresyon hem sosyal anksiyete ile ilişkiliyken, ZAT sosyal anksiyete ile daha yakın ilişkili bulunmuştur. Uyumsuz mükemmeliyetçiliğin ebeveynlik değişkenlerinin tüm boyutlarıyla depresyon arasındaki ilişkide ve anne ilgisiyle sosyal kaygı arasındaki ilişkide aracı değişken olarak rolü olduğu bulunmuştur. ZAT'nin aracı değişken olarak rolü bulunmamıştır. Bu sonuçlar var olan bilgiler ve daha önce yapılmış çalışmalar ışığında tartışılmıştır.

Anahtar Kelimeler: Zihinsel Abartma Tarzı, Mükemmelliyetçilik, Ebeveynlik Tarzı, Sosyal Anksiyete, Depresyon

To My Beloved Father Hayat Altan

ACKNOWLEDGMENTS

First of all, I would like to thank my dear supervisor Assoc. Prof. Belgin Ayvaşık for her valuable comments and support during this process. I must express my gratitude for her guidance, advice, criticism, encouragements and insight throughout the research.

I also wish to express my deepest gratitude to the two major members of the jury Prof. Dr. Tülin Gençöz and Prof. Dr. Elif Kabakçı for their carefully attending to my research subject, constructive criticism, encouragements and patience for my last minute requests throughout this period. It was a pleasure for me to work with them.

I would also like to thank my co-supervisor Prof. Dr. Hürol Fışıloğlu and Assoc. Prof. Dr. Şennur Tutarel Kışlak for their constructive suggestions and valuable comments.

I would like to thank Prof. Dr. Hamit Fişek for allowing me to follow his classes on AMOS at Boğaziçi University.

I would also like to thank Nil Esra Başaran, Özlem Hesapçı Sanaktekin, Özge Orbay, Müjgan Altın, Elif Göçek, Serdar Altok, and Aydın Karaçanta for letting me collect data from their classes.

I wish to express my gratitude to Dr. Nur Yeniçeri, she was like my academic mentor during whole this period and she was the person who was always listening to my whining about the whole process.

My equiry Pınar Tosun. She was with me throughout my adacemic life. Without her support (both emotional and instrumental) life in Ankara would have been much more difficult form me.

My “Wonderwoman” Mehin Akhun, I owe her a lot for her last minute suggestions and providing me support whenever I needed. Especially the period following the defense would have been much more difficult without her.

My Ankara buddy, Dilek Sarıtaş. She was the first person that I met in METU. She was there with me during the first class hour in METU and she was also there listening to me while I was presenting my dissertation to the jury at the end. She much more than just a friend from graduate school for me.

I am grateful to Nuran “Nunu” Cansız. Without her support in taking care of Yamaç and all the housework, it would be impossible for me to graduate.

I should ask for forgiveness from my son, Yamaç “Yamaçiko” Atalay. I know that it is very difficult to have a mother who is not emotionally available all the time, especially around June and December. I can never make up for those days, but I promise to be an almost full-time emotionally available mother in future days.

Last but not least, to my dear husband Arda. I can never forget his “bittersweet” response when I informed him about my acceptance to the program. Although he did not travel from İstanbul to Ankara and back every week, he was with me all the time. Besides his unlimited patience for a wife who is absent for 2-3 days a week, I am grateful to him for always giving me the support and courage that I needed and also handling my emotional ups and downs efficiently. I know

that this period was not easy for both of us. Words are inadequate to express my gratitude to him.

TABLE OF CONTENTS

LIST OF TABLES

TABLES

LIST OF FIGURES

FIGURES

LIST OF ABBREVIATIONS

GAD: Generalized Anxiety Disorder

OCD: Obsessive-Compulsive Disorder

PTSD: Post Traumatic Stress Disorder

SAD: Social Anxiety Disorder

G-SAD: Generalized Social Anxiety Disorder

S-SAD: Specific Social Anxiety Disorder

APD: Avoidant Personality Disorder

PBI: Parental Bonding Instrument

BI: Behavioral Inhibition

IDS: Involuntary Defeat Strategy

LVM: Looming Vulnerability Model

LMS: Looming Maladaptive Style

LMSQ-R: Looming Maldaptive Style Questionnaire-Revised

MPS-H: Multidimensional Perfectionism Scale-Hewitt

MPS-F: Multidimensional Perfectionism Scale-Frost

SOP: Self Oriented Perfectionism

SPP: Socially Prescribed Perfectionism

OOP: Other Oriented Perfectionism

CM: Concern over Mistakes

DA: Doubt about Actions

PE: Parental Expectations

PC: Parental Criticism

PS: Personal Standards

O: Organization

MEC: Maladaptive Evaluative Concerns

CBT: Cognitive Behavioral Therapy

BAI: Beck Anxiety Inventory

LSAS: Liebowitz Social Anxiety Scale

BFNE: Brief Fear of Negative Evaluation Scale

BDI: Beck Depression Inventory

STAI-T: State-Trait Anxiety Inventory-Trait Version

SES: Socioeconomic Status

CCSH: Cognitive Content Specificity Hypothesis

AS: Anxiety Sensitivity

CHAPTER I

INTRODUCTION

1. 1. Anxiety

Anxiety can be defined as experience of being apprehensive of threatening aspects of the environment and has originally a protective value. It is usually characterized by autonomic responses and defensive behavior that prepares the body to fight with the treat or escape from the situation (Gordon & Hen, 2004); therefore, it originally has a protective value. Liddell (1949) suggested that anxiety resembles a price that human being paid in return for the ability to think in a sophisticated manner, which can be defined as a capacity to adapt to new circumstances and make plans for the future.

Fear and anxiety evolutionally designed as the “first line of defense” of the human being. It gives the individual the ability to sense dangerous situations and cope with them through fight or flight (Kim & Gorman, 2005). Normal fear is considered as healthy since it protects human from the threatening stimuli that comes from the environment. Although originally anxiety has a function of protecting the individual from environmental threat, in extreme cases it can be problematic and cause extreme disability by interfering with functioning and thus inhibiting performance (Beck, Emery, & Greenberg, 1985). According to Barlow

(2000), what lies underneath anxiety is a sense of uncontrollability, a state of helplessness and a readiness or hypervigilance for possible threat that developed in order to cope with helplessness. He suggested the term “anxious apprehension” to define anxiety. Although anxiety is a natural and necessary part of human life, which is innate and survival oriented, experiencing excessive amounts of this emotion can be quite disabling for the individuals. Barlow (2000) emphasized the importance of chronicity rather than intensity to differentiate normal anxiety from clinical anxiety. It was suggested that chronic anxiety resulted in increases in the central nervous system (CNS) tension, autonomic inflexibility and functional brain asymmetry (Heller, Nitschke, Etienne, & Miller, 1997) as well as worry, avoidance behaviors, superstitions, and disruptions in concentration and performance (Barlow, 2000).

One of the key issues in this area is the distinction between anxiety and fear. Both anxiety and fear are evolutionarily derived defensive functions and they are important for survival (Barlow, 2002; Lang, Cuthbert, & Bradley, 1998). Fear is usually defined as a concept that is momentary and usually ties to a single specific stimuli. It involves the fight or flight response that individual gives when faced with a stressful stimuli. On the other hand, anxiety is more diffuse, general and linked to a situation or environment rather than specific stimuli (Emery & Tracy, 1987). Barlow (2002) especially emphasized the helplessness and uncontrollability that the individual experiences after the thought of being exposed to a stressful situation (chance of future threat). In other words, anxiety entails a feeling of terror and hypervigilance regarding the future, and keeps the individual in a constant phase of preparation for the future threatening events.

This preparation and readiness to cope presents itself in the form of obsessions, worry or behavioral avoidance (Barlow, 2000). Moreover, anxiety disorders form one of the most common and financially costly categories of psychological disorders in the world (Williams, Reardon, Murray, & Cole, 2005). Among the DSM-IV anxiety disorders, generalized anxiety disorder (GAD) and Obsessive-Compulsive Disorder (OCD) can be conceptualized as disorders of anxiety whereas specific phobia, Post-Traumatic Stress Disorder (PTSD), and Social Anxiety Disorder (SAD) can be categorized under the heading of disorders of fear (Gordon & Hen, 2004).

Many different studies identify family aggregation as one of the main reasons for anxiety disorders; also there are other studies that significantly imply the effect of environment on anxiety disorders (Hettema, Neale, & Kendler, 2001). In recent years, several studies were conducted the location of “anxiety” in the brain. Neuroimaging techniques were utilized to assess the brain parts that are activated during exposure to anxiety related phenomenon. Not surprisingly, amygdala which is responsible for fear memory, and center of fear circuit and limbic system, appeared to be of extreme importance in this system. In subjects with impairment in this region of the brain, threshold for startle reflex appeared to be very low, and the subject showed hyperactive anxiety states (Grillon, 2002). Amygdala is connected to the other parts of the brain that are related to anxiety, such as, hippocampus, prefrontal, insular and mesotemporal cortex and anterior cingulate gyrus. The activation in amygdala and basal nucleus of the stria terminalis (BNST) activate the neuroendocrine and sympathetic systems in the brain and body through activation of hypothalamus. Among these neuroendocrine

systems, HPA (hypothalamic- pituitary-adrenal) axis is of significant importance. Activation of this axis results in release of neurotransmitters such as norepinephrine and in turn release of glucocorticoid that is responsible for adverse effects of stress (i.e. memory problems, cardiovascular disease, immune system problems and somatic problems). GABA, serotonin, glutamate and dopamine are known to play role in neuropsychology of anxiety (Kim & Gorman, 2005).

In terms of origins of anxiety, many different theorists proposed different diathesis-stress models. Nearly all consider the interplay between genetic factors, developmental context, and environmental stressors as very important (Cicchetti & Cohen, 1995; Ingram & Price, 2001). Barlow's (2000) model is one of the most advanced models. He suggested three sets of vulnerabilities that interact with each other and lead to development of anxiety and other emotional disorders. Firstly, he emphasizes the influence of a generalized biological vulnerability that refers to genetic and temperamental factors such as anxiety sensitivity, neuroticism, and behavioral inhibition. Second set, which is composed of early life experiences, helplessness, sense of control, and information processing biases, is called generalized psychological vulnerability. Lastly, specific psychological vulnerabilities involve factors that are specific to each disorder. For instance, in case of panic disorder, this vulnerability stems from the individual's experiences with parents that emphasize the importance of somatic symptoms and physical sensations in signaling dangerous situations (Anthony & Barlow, 2002).

Regarding the origins of anxiety, in his early works, Freud suggested that anxiety was a derivative of unsatisfied libidinal urges. He thought that when sexual tension is not released, the individual starts to present anxious symptoms.

Later, he modified his views on anxiety and on his book “Inhibitions, Symptoms, and Anxiety” (1926), he concluded that anxiety shows itself when classical defenses are inadequate or misused. According to behaviorist perspective anxiety was a state that was acquired through classical Pavlovian conditioning. Later, Mowrer (1960) proposed the two-factor theory, which became the basis for many cognitive-behavioral therapies. He suggested that the fear response has been classically conditioned and that avoidance positively reinforces and maintains that fear. Although, psychoanalytic and behaviorist perspective became basis for competitive approaches, they are unable to explain some of the differences observed between experimental studies and therapy (Emery & Tracy, 1987). Lang (1971) revised conceptualization of anxiety and introduced three systems model of anxiety. According to this model, anxiety is composed of three components that are loosely connected with each other. These components are (1) somatic: physical arousal symptoms and physiological changes that occur in response to threatening stimuli, (2) behavioral: anxiety related actions such as avoidance, repetitious checking; and (3) cognitive: appraisals, interpretations, existing beliefs about self and world. This model formed the basis of many models of anxiety disorders and treatment techniques were aimed at working on all three components of anxiety (Power & Dalgleish, 1997). The emphasis on cognitive aspect of anxiety opened the way for cognitive models of anxiety. Both, Beck and Ellis, who are the pioneers of cognitive perspective, focused on the future orientation aspect of these cognitions. The other idea that they both emphasized was the tendency of the anxious individual to overgeneralize the meaning of the stimuli. In summary, the cognitive behavioral perspective views anxiety as a

physiological/behavioral/cognitive response given to threatening stimuli and directly related to irrational beliefs, faulty, maladaptive cognitions, and core beliefs (Beck & Emery, 1985; Ellis & Dryden, 1997).

1. 2. Social Anxiety

Social anxiety can be defined as ‘‘marked and persistent fear of one or more performance or social situations in which the person is exposed to unfamiliar people or to possible scrutiny by others’’ (APA, 1994). Individuals high in social anxiety experience excessive fears in situations where they might be evaluated or judged by others. In those situations, cognitions involving concerns about being humiliated or embarrassed are activated. These cognitions may still be present despite the individuals’ awareness of the illogicality of their thoughts. Because of the intense anxiety triggered by these cognitions, they either try to avoid those situations or endure them with marked distress. As a result of the avoidance and safety behaviors, the individual may experience impairment in daily functioning (occupational, educational arena, social functioning and intimate relationships etc.). SAD has mainly two subtypes as Generalized SAD (G-SAD) and Specific SAD (S-SAD) (Berman & Schneier, 2004; Mourtier & Stein, 1999) with the generalized subtype being the more severe and serious form of the disorder. In G-SAD, the individual experiences fear in most social situations, daily functioning is more impaired and there are often other comorbid diagnoses. In addition to these, most of these people have an extensive family history of SAD. In contrast, in S-SAD, number of feared situations is limited and easily identifiable.

SAD had been included as an Axis I disorder into DSM in (American Psychiatric Association [APA], 2000) together with an Axis II disorder called "Avoidant Personality Disorder" (APD) which is also associated with experiencing severe anxiety in social situations. APD is usually seen as a more severe and restrictive form of SAD especially G-SAD. In order to make clear the overlap between two conditions (SAD and APD), several researchers proposed a spectrum view of APD (Muller, Koen, & Stein, 2004) where on one end stands shyness which creates minimal functional impairment, followed by S-SAD and G-SAD in the middle. Chronic APD is located on the most severe end of the continuum. In accordance with the spectrum model, Scheider, Blanco, Antio, and Liebowitz (2002) proposed that SAD is a concept that is perfectly fitting to the spectrum concept, because of its trait like qualities and early onset of symptoms. They further suggested that all shyness, avoidant personality disorder and selective mutism can be conceptualized under this title of social anxiety spectrum disorders.

SAD is a common disorder that has an earlier age of onset when compared with other psychological disturbances and affects a wide range of age groups (Wittchen, Stein, & Kessler, 1999). Results of a recent epidemiological study by Stinson, Dawson, Chou, Smith, Goldstein, Ruan, & Grant (2007) suggested the mean age of onset for SAD symptoms as 9.7, with cases that present first symptoms as early as age 5. Furthermore, cases of later onset are relatively rare and usually emerge as secondary diagnoses. Results of most epidemiological studies set the first emergence of SAD symptoms between ages 13 and 16.6 (Fehm, Pelissolo, Furmark, & Wittchen, 2005), which may be indicative of the

important genetic and familial background as well as temperamental factors in development of SAD (Wittchen & Fehm, 2003)

Results from different epidemiological studies vary regarding its prevalence rates in the general population (between 1 and 16 %), which may be due to vagueness and inconsistencies in the diagnostic criteria and symptoms that seem to overlap with other psychological disorders with greatest variations between studies that used DSM-III, DSM-IIIR and DSM-IV as source for diagnostic criteria as well as some other methodological differences (Wittchen & Fehm, 2003). For example results of a wide scale United States national comorbidity study reveal the lifetime prevalence rate of SAD as 7.9 % placing it as the third most common psychological disorder in USA following depression and alcohol abuse (Kessler, McGonagle, Zhao, Nelson, Hughes, Eschlema, Wittchen, & Kendler, 1994). Briefly, prevalence estimates vary widely, with various epidemiological surveys reporting that between 7 % and % 13 of the population have suffered from social phobia at some point in their lifetime (Brook & Schmidt, 2008).

Different from other types of phobias, in social phobia avoidance isn't always possible. Despite the inability to avoid all stressful social encounters, the intense anxiety felt at those situations is still present. In order to understand the role of avoidance or lack of avoidance in maintenance of SAD, many cognitive models of social anxiety had been proposed (Clark, 2001). According to the model of Clark and Wells (1995), when an individual with social phobia enters a social situation, increases in levels of anxiety take place, as a consequence of activation of certain assumptions. These assumptions can be categorized into three

types. First group is composed of unconditional beliefs about the self (the belief that one is unacceptable, incompetent, different etc), the second involves high standard concerning social performance (the individual has to perform in a perfect and flawless way in order to be socially successful), and last group is dominated by some conditional beliefs concerning the consequences of certain behaviors (beliefs that if the individual acts in a certain way, it will have bad influence on others and rejection would be inevitable). Presence of these assumptions directs the individual to evaluate the social situations as dangerous, and see a greater likelihood of performing in an unacceptable way. In addition to this, such a condition, often leads these individuals to interpret ambiguous situations as sign of disapproval and rejection. All these processes lead to generation and maintenance of anxiety.

As a result of the increases in anxiety levels, a shift in attentional processing takes place, which is characterized by a detailed monitoring of the self, and creating the impression of oneself as a social object. At the same time, increases in anxiety levels lead to an increase in physiological sensations related to anxiety, which are interpreted as a cue to begin self focused attention.

A direct result of this shift in attention is the usage of internally generated information to construct an impression of the self as a social object, or as an impression of the self as it is observed by the outsiders. Here the individual has started to operate in a closed system where she/he does not get any information from the outside (like real feedback from the audience), but focuses on some internal cues (increased heart rate, blushing, shaking hands, previous unpleasant experiences etc.). This closed system in its nature is designed to confirm

previously held assumptions that revolve around the idea that the individual is a social disaster, and all the internal physical sensations are interpreted as evidence that the individual is behaving poorly, in an unacceptable way. An important part of Clark and Wells' model is their suggestion that these negative impressions of the self are sometimes experienced as some vivid images of the self. These images, like seeing the self performing poorly in a social situation, are often quite convincing and are believed to excerbate social anxiety, making the individual get the impression that the feared outcome (failure, rejection etc.) are more likely and imminent.

Another problem that is caused by increased self-focus, is the lack of enough attentional resources to focus on the task, which in turn leads to omitting the positive feedback from the audience, and in turn enhances the previously held negative assumptions.

This sense of being perceived in a negative way makes the individual engage in a series of compensatory behavior, which are also called safety behaviors. These safety behaviors that are related to internal sensations or cognitive images that are mentioned before are originally aimed at making the negative event more unlikely. On the other hand, they usually function in a way that makes the feared consequence more likely. For instance, an individual who thinks that his hands are shaking during a social event grabs a glass tightly, thinking that this will camouflage his shaking hands. On the contrary, holding something tightly has the effect of increased shaking in hands.

According to Clark and Wells (1995), this cycle had influence on the socially anxious individuals' life far beyond social situations, most of the time in

the form of post event processing or doing a “post-mortem” of the situation. Like its name implies, post-event processing includes repeated analysis and potential reenactment of one’s own performance following the social situation. However, self-focused attention is still active in this process, and this further strengthens the negative assumptions held about oneself, in a way that maintains the disorder. Also, at the end of the post-mortem, the analyzed interaction is added into the list of failures and kept, in order to be used in future social situations.

What happens prior to the social situation is also of great importance. Before the social situation, the socially anxious individual has a tendency to form different images or scenarios concerning what might happen. Once this process is initiated, the individual starts to feel anxious. As a result of this, all recollections of similar events that took place in the past, memories of past failures and negative images of themselves during the event, start dominating the cognitive processes. In conclusion, the individual has now only two options; to avoid the situation completely or to participate in an already self focused mode, with the expectation of experiencing a failure again.

1. 2. 1. Factors in Development of Social Anxiety as a Cognitive Style

1. 2. 1. 1. Family Characteristics

Family characteristics are one of the most extensively studied variables in the area of etiology of anxiety disorders. Parental child-rearing practices, family functioning, and infant-parent attachment are the major three elements that are found to be most influential in anxious symptomatology (Bögels & Brechman-Toussaint, 2006).

1. 2. 1. 1. 1. Parenting Styles and Behaviors*:* One of the important familial elements that is considered to be important in the etiology of anxiety and particularly social anxiety is two dimensions of parenting, namely; overprotection (control, intrusiveness) and emotional warmth (sensitivity, acceptance). Parker (1983) developed Parental Bonding Instrument (PBI) to assess this characteristic of families. PBI is one of the instruments that are most widely used across cultures (Chorpita & Barlow, 1998). Parker (1983) defined "overprotection" as excessive involvement and intrusions of parents in controlling the child's world in order to minimize threat and dangerous stimuli. Such a stance usually impedes child's autonomy and keeps him or her from being exposed to daily rituals of modern life and thus preventing him or her from developing social and coping skills that will be used later in life (Nathason, 1992). Besides leaving the child unable to cope with life events, overprotective parenting is believed to be not adequately limiting child's exposure to unpleasant and dangerous situations (Parker, 1983).

The other dimension, emotional warmth can be defined as the responsiveness and availability (both psychological and physical) of the parent. Such a family environment is believed to influence child's beliefs and expectations about the world and thus effect child's anxiety. Continuous criticism and hostility directed at the child in the household may lead the child to perceive oneself as incompetent, worthless and the world as hostile and dangerous (Bögels, Brechman-Toussant, 2006). Parker (1993) introduced the term "affectionless control". A term used to describe a family environment that is high in

overprotection and low in emotional warmth. Affectionless control is believed to be an antecedent for both depression and anxiety in adulthood (Parker, 1983). This notion is supported by empirical data. Silove, Parker, Hadzi-Pavlovic, Manicavasagar, and Blaszcynski (1991) worked with a large group of adult anxiety patients and controls and asked them to recall the parenting that they received as a child. They rated their parents on both emotional warmth and overprotection dimensions. The results showed that low warmth and high protection was the style that was most associated with anxiety disorders in later life. This result is further supported by Muris and Merckelbach (1998) in their study with anxiety disordered patients. They found that both maternal and paternal control and warmth were related to anxiety disorders, particularly social anxiety disorder and generalized anxiety disorder. In partial contrast with this, Muris, Merckelbach, and Damsma (2000) and Brown and Whiteside (2008) both offered that increase in anxiety symptoms was related to lack of emotional warmth (or parental rejection), rather than overprotection. This kind of inconsistencies are said to be a consequence of not using a single operational definition for these concepts (emotional warmth and overprotection) (Masia & Morris, 1998).

Further support came from studies conducted with non-clinical subjects. Similar to anxiety patients, in nearly all non-clinical groups greater anxiety appeared to be more closely related with lower warmth and higher overprotection (Arrindell, Kwee, Methorst, Van der Ende, Pol, & Moritz, 1989). Likewise, Eastburg and Johnson (1990) found that shyness and social isolation was associated with higher protection and lower warmth among female university students. More recent support came from Bögels, Van Oosten, Muris and

Smulders (2001), in which children and adolescents were investigated. They found that overprotection and especially maternal overprotection was associated with higher levels of social anxiety. Although there are great number of studies supporting this finding (Bögels & Brechman-Toussaint, 2006), studies examining maternal and paternal influences separately yield contradictory results. For instance, Brakel, Muris, Bögels and Thomassen (2006) found paternal style to be more related to anxiety rather than maternal child-rearing practices. Likewise, Connell and Goodman (2002) on their meta-analytic study found that paternal childrearing was more related to anxiety at middle childhood years rather than early childhood years.

1. 2. 1. 1. 2. Parental Modeling: An important finding in the area of anxiety disorders is the high overlap between parental and child anxiety disorders. This may be due to genetic factors which will be discussed in the proceeding sections or children's' exposure to behavior of anxious parents (Muris, Steerneman, Merckelbach, & Meesters, 1996). Children who had chance to observe their parent's anxious behavior show a greater tendency to assign a comparable fear to the similar events in the future and thus they will be more likely to become anxious. Also, observing anxious parents may exacerbate development of threat perception biases and a limited sense of personal control (Bögels & Brechman-Toussaint, 2006). In the case of social anxiety, besides exposure to anxious behavior of parents, parents' friendship styles (having a close, dependable friend), their affiliation with formal organizations, and having a dependable social network play an important role in child's social skills

development (Bruch & Heimberg, 1994; Homel, Burns, & Goodnow, 1987). According to Bruch, Gosky, Collins, and Berger (1989), parents' own concern about other peoples' evaluation, lack of sociability and social isolation of the family are the factors that are highly correlated with social anxiety. Empirical support or this view comes from Bögels, van Oosten, Muris and Smulders (2001) who found that both family sociability and mother's level of social anxiety are significantly related to level of social anxiety in adolescents and children.

1. 2. 1. 1. 3. Attachment: Ainsworth and Wittig (1969) were the first to emphasis the effect of infant-caretaker quality on the later life psychopathology, and they are central to understanding anxiety. Infant's tendency to seek protection or comfort from caregiver at those situations automatically increased his chance for survival. The anxiety and the angry protest had the function of ensuring the mother's return. Of course responsiveness of the caregiver made a considerable difference in the quality of attachment. In infant-caregiver dyads, the caregiver is used as a "secure base" from which they explore and to whom they can return later when they are distressed. In adulthood, these individuals consider themselves worthy, and they hold an image of others as available, responsive and reliable. Their relationships with others are characterized by intimacy and thrust (Hazan and Shaver, 1987).

In cases where the infant had not developed certainty about the caregiver's availability, he will be more likely to depend on others for emotion regulation and thus will have less capacity for self-regulation. In this kind of dyads, the attachment relationship is said to be anxious-ambivalent. In the future,

these children consider themselves as unlovable and in their intimate relationships they are in a constant fear of abandonment, which in turn make them appear as jealous and clingy (Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987).

If a caregiver rejects the infant consistently, the child starts perceiving her as unresponsive and he or she will be more likely to prefer more physical and emotional distance in his or her relationships with others. These children are considered to have an anxious-avoidant style. As adults, these children tend to ignore their own needs for close relationships and they see others as not dependable and irresponsive. As a result they avoid close relationships (Bartholomew and Horowitz, 1991).

In the recent years, researchers working in the area of social anxiety started focusing on this aspect of social anxiety. They found that social anxiety was negatively related to secure attachment and was most closely linked to anxious-avoidant style (Michaelson, Kessler, & Shaver, 1997). This view supports the hypothesis that socially anxious people experience difficulties in the area of trust, self-esteem, depending on others and participating in intimate relationships.

1. 2. 1. 2. Temperamental Factors

The term temperament refers to “early dispositional differences that are associated with emotional reactivity” (Stein, 1998). According to Alport (1937), temperament can be defined as the way an individual experiences emotions. This includes vulnerability to emotional stimulation, strength, reaction time and mood intensity. Temperament is believed to influence the individual’s personality and also studies indicate that it has a genetic basis (Digman, 1994).

The component of temperament that is most closely related to social phobia is behavioral inhibition. Behavioral inhibition (BI) can be defined as a personality characteristic that presents itself in the form of withdrawal, wariness, harm avoidance and shyness, in addition to sympathetic hyperactivity, and emotional arousal in situations that are novel to the individual (Cloniger, 1986; Reznick, Kagan, Snidman, Gersten, Baak, & Rosenberg, 1985). It is perceived as a relatively stable personality feature that starts to present itself during early childhood. Behaviorally inhibited babes are observed to be more reactive, easily aroused and distressed. As toddlers, they present a fearful and shy personality. During the childhood years, most are seen as shy, introverted and overly cautious individuals (Pollack, Marrs, Miller, & Biederman, 1995). Assessment of behavioral inhibition is more problematic in later years of life because of other developmental influences (Hirshfeldt-Becker, Micco, Henin, Bloomfield, Biederman, & Rosenbaum, 2008), but there is a consensus that behaviorally inhibited children appear to be more guarded, self-disciplined, anxious during their interactions with others, more introvert and more lonely (lack of a large social network) as adults (Caspi, Harrington, Milne, Amell, Theodore, & Moffit, 2003).

Behavioral inhibition is known to be one of the vulnerability factors for internalizing disorders such as anxiety and depressive disorders (Biederman, Rosenbaum, Bolduc-Murphy, Faraone, Chalof, Hirshfeld, and Kagan, 1993). Schofield, Coles and Gibb (2009) emphasized two different components of behavioral inhibition; namely, Social BI and Non-Social BI. The social component is defined as a restraint in interacting with strangers. On the other

hand, non-social component deals with novelty and unfamiliarity in non-human situations or surroundings. Regarding the relationship between behavioral inhibition and SAD, many studies indicate that behavioral inhibition acts as a forerunner to expression of social withdrawal in many cases (Kagan, Reznick, Snidman, Gibbons, & Johnson, 1988). Also, Schofield, Coles and Gibb (2009) concluded that SAD was particularly related to social BI rather than non-social BI and social BI was connected to SAD more than any other anxiety or depressive disorder. Retrospective studies with adults are also in line with these studies (Coles, Schofield, & Pietrefesa, 2006; Gladstone, Parker, Mitchell, Wilhelm, & Mali, 2005; Neal, Edelman, & Glachan, 2002). For example, in their study with a clinical sample composed of participants diagnosed with different anxiety disorders, Mick and Telch (1998) found that behavioral inhibition was specifically linked to adult social anxiety disorder rather than other disorders such as GAD. In summary, there is a consensus in the literature that behavioral inhibition is exclusively associated with social anxiety disorder in childhood and early adolescence and it can be identified earlier in life as a vulnerability to SAD and thus can be utilized as a tool for prevention of social anxiety disorder (Biederman, Hirschfeld-Becker, Rosenbaum, Herod, Friedman, Sniedman et al., 2001).

1. 2. 1. 3. Genetic Factors

Genetic factors and family aggregation are known to be important factors that are related to etiology of SAD. Several studies that are conducted on twins and families of social phobic individuals to assess this subject concluded that first degree relatives of patients with social phobia were much likely to show

symptoms or at least present with inhibited personality characteristics (Fyer, Mannuzza, Chapman, Liebowitz, & Klein, 1993; Kendler, Myers, Prescott, Martin, & Klein, 2001). Furthermore, a meta-analytic study of research with twins concluded a heritability estimate of .65 for social anxiety (Beatty, Heisel, Hall, Levine, & La France, 2002). In addition to these, genetic studies done on constructs closely linked to SAD such as behavioral inhibition, shyness, and fear of negative evaluation give similar results (Kendler, Myers, Prescott, & Neale, 2001; Stein et al. 1998). All these studies provide support for the view that SAD has genetic predisposition.

Studies aimed to answer the question of "what is inherited?" Firstly found a common genetic component responsible for multiple disorders (bulimia nervosa, substance abuse disorders, depression, etc.) as well as SAD (Andrews, 1996; Eley, 1999; Nelson, et al., 2000). Another study done with a sample that is composed of more than 5000 twins, found two genetic factors related to anxiety. Results from twins with SAD showed that SAD group had both of these factors (Hettema, Prescott, Myers, Neale, Kendler, 2005). A more recent study by Mosing et al. (2010) also signaled common genetic factors between depression, social anxiety, GAD, and panic disorder. Although these studies did not answer questions specific to SAD, they were able to provide some explanation for the problem of comorbidity (Rapee & Spence, 2004).

Several studies that focused of possible mechanisms of action responsible for anxiety concluded that anxiety disorder proneness was related to a variation in the gene encoding serotonin transporter. Anxiety proneness was related to a single s allele found in these individuals (Caspi, 2003; Frisch, Michaelovsky, Rockon,

Amir, & Hermesh, 2000; Gordon & Hen, 2004; Gustavsonn, Nothen, Jonsson, Niedt, & Forslund, 1999; Jorm, Henderson, Jacomb, Christensen, & Korten, 1998). Moreover, Caspi (2003) also found a relationship between the s allele and anxiety disorder proneness, but he concluded anxiety symptoms to be a byproduct of interaction between environmental and genetic factors. If an individual has the s allele and experienced traumatic life events starting from childhood or had a family environment that was likely to perpetuate anxiety symptoms, this individual has an increased risk for anxiety disorders (Caspi, 2003; Gordon & Hen, 2004). Although, researchers have started to investigate possible mechanisms of action (Arbelle, et al. 2003; Rowe, et al, 2000; Stein, Chartier, Kozak, King, & Kennedy, 1998), results can be contradictory and the area needs further studies (Rapee & Spence, 2004).

1. 2. 1. 4. Evolutionary Factors

From an evolutionary perspective, Sloman (2006) proposed the Involuntary Defeat Strategy (IDS) as the differentiating feature between normal and pathological anxiety. According to the IDS, the organism has a system for automatically giving up certain aspirations in case of failure, as a result of which the energy and resources are invested in another aspect of life, where a better outcome is expected. The main feature of IDS is feelings of helplessness, hopelessness, inferiority and psychomotor retardation. Sloman (2008) suggests that IDS is a perfectly adaptive system but in some cases it can lead to maladaptive consequences such as depression and anxiety. In individuals with anxiety disorders, there is a disruption in the IDS, and the system becomes too

intense and persistent. Sloman (2006) proposed that IDS has a unique way of operating for each disorder. He argued that the risk of making the others angry triggers the IDS in a social phobic. As a result of this, he acts in a more submissive manner to give the message that he is harmless and not threatening to the others. By doing so, the social phobic avoids or minimizes the feelings of discomfort and distress. This view is also in accordance with Gilbert and Trower (2001) that offered the view that social phobia is adaptive under certain circumstances because it is a way for the individual to avoid conflict and aggression.

1. 2. 1. 5. Cognitive Factors Associated with Social Anxiety

Cognitive factors especially cognitive biases are known to be influential in the etiology and maintenance of many behavioral disorders such as depression (Beck, 1987; Gotlib & Krasnoperova, 1998; Gotlib, Krasnoperova, Neuberger, Joorman, 2004), eating disorders (Dobson & Dozois, 2004; Lee & Shafran, 2004), obsessive compulsive disorder (Radomsky & Rachman, 1999; Summerfeldt & Endler, 1998), and social anxiety disorder (Foa, Franklin, Perry, & Herbert, 1996). Some recent studies also supported this theory concluding that cognitive biases increase the individual's tendency to interpret ambiguous situations as threatening especially in socially anxious individuals (Amir & Foa, 2001; Foa, Franklin, & Kozak, 2001; Huppert & Foa, 2004). The cognitive factors that play a role in development and maintenance of social anxiety disorder are mainly studied under three headings: (1) attentional biases, (2) memory biases, and (3) judgment and interpretation biases (Ledley, Fresco, & Heimberg, 2006).

1. 2. 1. 5. 1. Attentional Biases

People with social phobia have a particularly higher tendency to notice stimuli (behavior of themselves or behavior of others) which could be interpreted as signs of actual or impending criticism. This process is called attentional bias to threat. According to the model of social anxiety proposed by Beck, Emery, & Greenberg (1985), attentional biases are one of factors that maintain the disorder. Although there is a consensus regarding the role of attentional bias as a maintaining factor of SAD, there are two competing views regarding the nature of this bias. The first view has its origins in Rapee and Heimberg's (1997) model of Social Anxiety Disorder. They suggest that attentional bias in social anxiety takes place in the form of an approach behavior. Studies showed that the patients are vigilant for threatening information from the environment (Amir & Foa, 2001; Gilboa-Schechtman, Foa, and Amir, 1999). According to Ledley, Fresco, and Heimberg (2006), this bias can be related to the view that a social catastrophe is waiting around the corner, which is very common in socially anxious people. This bias acts as cause, consequence and maintaining factor for social anxiety disorder (Ledley, Fresco, & Heimberg, 1996). Consistent with cognitive models, empirical studies also found that socially anxious individuals show a selective attention for socially threatening cues (Amir, McNally, Riemann, Burns, Lorenz, & Mullen, 1996; Asmundson & Stein, 1994).

The other argument is that the social anxiety patients demonstrate another attentional bias, which is avoidance of threat cues. This view has its origins in social anxiety disorder model of Clark and Wells (1995). As indicated above,

Clark and Wells (1995) argue that in case of a threat, a socially anxious individual reduces processing of external cues and becomes self- focused. Instead of scanning outside, they turn inwards and make unrealistic judgments about what others think of them. Support for this view came from Mansell, Clark, Ehlers and Chen (1999). They found that when socially anxious individuals were induced an anxious mood, they tend to avoid threat cues. Their results were replicated by Chen, Ehlers, Clark and Mansell (2002) in a clinical sample and found similar results. More recently, Sposari and Rapee (2007) replicated the same study with clinical subjects. Although the procedure was the same with Mansell et al. (1999), they found a preferential attention towards social threat cues rather than avoidance.

A third view concerning attentional biases in social phobia assumes that during earlier phase of exposure to threatening stimuli, bias is in the form of hypervigilance, which is followed by strategic avoidance of threat. This view is called "hypervigilance –avoidance hypothesis" (Mogg, Bradley, Miles, & Dixon, 2004). In line with this, Garner, Mogg, and Bradley (2006), found a bias towards threat cues in high social anxiety individuals. Their results showed that although subjects showed a vigilant bias in both conditions, their response speed decreased in the anxiety induced trials. Although a lot of progress had been made, this area needs further investigation.

1. 2. 1. 4. 2. Memory Biases

One of the characteristics of anxiety disorders is the heightened accessibility of threatening information, especially negative and anxiety

provoking memories. In nearly all anxiety disorders, there is a memory bias for threatening information, that is, these memories are recalled and retrieved more easily than others. In social phobia, patients' recounting of the vivid details of their self-perceived public humiliation can be an example for memory bias (Coles & Heimberg, 2002). Memory biases are investigated under two headings: explicit memory (information is stored in explicit memory as a result of a conscious and effortful process) and implicit memory (stores as a result of learning that takes place automatically and effortless in the course of everyday life) (Ledley, Fresco, & Heimberg, 2006). Earliest studies done using classical explicit memory paradigms failed to find evidence to support a general explicit memory bias for threatening information in social phobic individuals (Amir, Foa, & Cloes, 2000; Cloitre, CNCİENNE, Heimberg, Holt, & Liebowitz, 1995; Lundh & Öst, 1997; Rapee, McCallum, Melvillei Ravenscroft, & Rodney, 1994). More recent studies that used different methods such as face recognition and directed forgetting found some promising results for further studies (Amir, Coles, Watlington, & Foa, 2000; Lundh & Öst, 1996). Despite a bunch of studies that failed to find memory bias in social anxiety, there are a few studies that demonstrated a significant memory bias for threat related material in social anxiety (Mansell & Clark, 1999; Mellings & Alden, 2000). Furthermore, in their study Hertel et al, (2008) compared generalized social anxiety disordered participants with non-anxious controls and asked them to generate endings for social and non-social scenarios. Later, they were asked to retrieve them. The results again showed a memory bias. They concluded that their significant results were due to control of source monitoring

errors (confusion about whether the remembered event really happened or is it just imagined).

1. 2. 1. 4. 3. Judgment and Interpretation Biases

These kinds of biases are seen as a major factor for maintenance of the disorder by preventing schema change and enhancing avoidance behavior (Ledley, Fresco, & Heimberg, 2006). According to Foa et al. (1996), mainly two types of judgmental biases occur in anxiety disorder patients: exaggerated estimates for the occurrence of negative events and exaggerated cost associated with such events. The nature of the event that the individual is biased for depends on the type of the anxiety disorder he has. In other words, anxiety disorder patients present a content-specific judgmental bias (Foa et al., 1996). Lucock and Salkovskis (1988) proposed the presence of content-specific judgmental biases in social phobia and their study provides support for this view. In their study, they compared individuals with untreated social phobia with non-clinical controls. Results showed that social phobic individuals overestimated the occurrence of negative outcomes in social situations when compared to controls, but no difference emerges in non-social events. This theory is further supported by Foa et al. (1996), which showed that when socially anxious patients are presented with Probability/Cost Questionnaire (PCQ), they tend to have higher cost and probability estimates for social situation when compared to non-social ones.

Besides probability and risk estimates, socially anxious individuals are also more likely to rate their own social performance as poorer than actual. In the classical study by Stopa and Clark (1993), participants' own rating of their social

performance was compared with ratings of assessors. The results indicate that socially anxious individuals rated their performance during a regular conversation more negatively than control subjects and the assessors. Besides conversation abilities, Mulkens, de Jong, Dobbelaar and Bögels (1999) hypothesized that socially anxious individuals are also likely to focus on some discreet symptoms (blushing, shaking and sweating) and tend to overestimate the degree of those symptoms. To test this hypothesis, they studied with individuals who are low and high in fear of blushing. They compared subjective ratings of blushing with some objective measure of blushing (like skin temperature and coloration). In line with the results of studies that test performance underestimation, they found that high fear of blushing subjects overestimated the degree of their blushing. In sum, it can be concluded that people with social phobia are likely to perceive their social performance worse than the objective measures and observers perceive.

Another type of interpretation commonly seen in socially anxious individuals is negative interpretation of socially ambiguous cues. Usually in social situations, people have to draw inferences concerning the thought, feelings and intentions of others. In people with social phobia, these inferences are more likely to have a negative tone, containing scenarios of rejection, failure, dislike etc. Amir, Foa and Coles (1998) and Stopa and Clark (2000) used similar techniques to assess how socially ambiguous information is interpreted by individuals with social anxiety. They presented participants a series of ambiguous scenarios about social and nonsocial situations. Each scenario had three alternative explanations and participants were asked to mark the explanation which is most likely to come to mind. Socially anxious individuals rate the socially negative explanations as

"most" likely to come to mind. Similarly when Stopa and Clark (2000) asked the participants to write down possible explanations for these scenarios, they found that socially anxious participants were more likely to generate explanations with a negative content (most of the time containing rejection, being unable to compete with others socially, and being incompetent). Findings of these studies were extended by Woncken et al, (2004) who found that the interpretation bias is specific to social information in high social anxiety participants. A more recent study done with socially anxious adolescents seem to replicate the findings of previous studies in terms of interpretation bias and its content specificity. When compared with their non-anxious counterparts, socially anxious adolescents made more negative interpretations of social situations. Also, in accordance with previous research they did not appear to be making more negative interpretations in non-social situations (Miers, Blöte, Bögels, & Westenberg, 2008). All these findings fit well in today's understanding of social anxiety disorder. They provide evidence for the roles of judgment and interpretation biases in both preeminent models of SAD (Clark & Wells, 1995; Rapee & Heimberg, 1997).

1. 3. Cognitive Vulnerability to Anxiety: Diathesis-Stress Models

Cognitive vulnerability refers to stable and relatively enduring cognitive structures that are acquired during the early years of life and lead to a liability to emotional disorders (Riskind, & Alloy, 2006). These cognitive structures, which are also called as schemas or core beliefs, may remain inactive and do not influence functioning of the individual until s/he is faced with a stressful life event

or a period, which will inevitably trigger and activate the preexisting schemas (Oliver, Klocek, & Wells, 1995).

Cognitive vulnerability models are useful in conceptualization and understanding of psychological disorders, because they shed light to the proximal and distal risk factors and protective factors. According to many models of psychological disorders, both predisposing factors and precipitating factors play a role in the development of psychological disorders such as depression, anxiety disorders and even eating disorders. This perspective explains the fact, why only some people develop psychological disorders even though many other people are also exposed to stressful life events. According to these models, only people who have cognitive vulnerability to these disorders show symptoms. In other words, cognitive vulnerability leads to an increase in liability to certain disorders (Riskind & Alloy, 2006).

Cognitive vulnerability also covers the concept of cognitive style, which can be defined as the way an individual deals with information that is around him/her. This concept includes the way that the individual searches for, acquires, categorizes, interprets and retrieves information (Sheeny & O'Connor, 2002). It is also suggested that cognitive vulnerability is a trait like construct that starts to form during childhood years, and becomes stable when the individual is about 12 years old (Gibb, 2002). Cognitive vulnerability also includes information processing biases that are highly associated with psychological disorders (Riskind & Alloy, 2006). Thus, cognitive style may act as a risk factor for many psychological disorders including depression, suicide (Sheeny, O'Connor, 2002),

generalized anxiety disorder (Wells & Carter, 2001), and obsessive compulsive disorder (Coles & Horng, 2006).

Up to date, most of the cognitive vulnerability models focused on depression and although some of the models like Cognitive Content Specificity (CCS) model aimed at differentiating vulnerability to anxiety from vulnerability to depression, many studies failed to differentiate anxiety from depression (Jolly, 1994; Beck & Perkins, 2001). All those studies raise questions concerning conceptualization of anxiety and some further suggest that these results could lead one to infer that anxiety is interchangeable with depression (Barlow 1991).

However, Riskind (1997) suggested that one can make inferences regarding the difference between anxiety and depression, just looking at the definition of these concepts. As indicated before, anxiety is characterized by a "mobilization" response to threatening stimuli, which is expected and can be avoided. However, in depression "demobilization" is more obvious, because the situation had already happen and can no longer be avoided. Based on this common sense distinction between depression and anxiety, Riskind (1997) suggested that the main distinction between anxiety and depression should be related concepts of time and rate of change (looming).

1. 3. 1. Looming Maladaptive Style (LMS): As a Vulnerability to all Anxiety Disorders

According to evolutionary models, living creatures have to attend to threats and in order to survive; they have to differentiate the ones that involve features that are rapidly rising in risk from the ones that are static. This ability to

differentiate between dynamic and static risks is seen among many species including primates and humans and necessary for survival (Riskind, 1997). Despite these benefits, this ability in some circumstances may lead to anxiety, which limits the individuals' daily functioning.

The Looming Vulnerability Model (LVM) (Riskind, 1997) includes the individuals' perception of the threat movement in the classical cognitive models of anxiety. Riskind (1997) suggested that the "mobile" quality of perceived threat increases anxiety because movement of the feared stimulus is interpreted as it is approaching and the danger is coming closer to the self. Such an increase in anxiety is not experienced if the threat is perceived as static or immobile. Riskind (1997) refers to the sense that dangers are mobile and dynamic as "looming vulnerability" and emphasizes its importance in generation and maintenance of anxiety. LVM explains the connection between looming vulnerability and anxiety as follows; an individual, who has a high sense of looming vulnerability, perceives threats and risks as rising rapidly through time and space. Such a way of perceiving the environment leads to the appraisal that threats and dangers are getting closer, larger, and more agonizing every passing minute and thus, increases the perceived likelihood of harm and makes the individual more hypervigilant to threat cues. Riskind (1997) further suggested that such a perception can be evoked through imagination even in the absence of an actual threat cue.

The model further assumes that the main difference between anxious and non-anxious people is the level their looming vulnerability. According to LVM, information processing biases of anxiety patients originate from the nature of their

mental representations of threat that is called the Looming Maladaptive Style (LMS). It is a pervasive cognitive pattern which involves mental representations of dynamically intensifying danger and rapidly rising risk. These mental scenarios include real or hypothetical events include rehearsals of potential life events and fantasies about the future. It is believed to function as a danger schema and in turn lead to biases in information processing.

According to Riskind and Williams (2005), LMS model goes beyond the traditional cognitive model of anxiety that perceives threat perceptions of anxiety patients as static like a snap-shot photograph. The novelty of the model is its emphasis on the importance of dynamic danger content, for it can foster many maladaptive coping strategies such as avoidance and sensitization (Riskind, 1997). In other words, looming vulnerability elicits anxiety, sensitizes the individual to signs of movement and threat, biases cognitive processing, and impedes habituation to threat stimuli, which can be interpreted as a vicious cycle that maintains the anxious condition (Riskind & Williams, 2005).

According to Riskind, Joiner, and Williams (2006), LMS originates from early life experiences and act as a distal factor in development of anxiety disorders. This cognitive style leads to information processing biases and as a result of that; individual starts interpreting environmental cues in a certain manner. In other words, LMS operates as a danger schema and individual becomes more likely to interpret information as threatening, by internally generating scenarios of threat that are increasing in terms of danger. This catastrophic interpretation leads to increased alertness and vigilance and

individual becomes more sensitive to detect threat cues. In patients with anxiety disorders, this cycle can be triggered even in the absence of threat cues.

As indicated before, the nature of threat (how it is interpreted) is of great importance in LVM. According to LMS model, if the threat is perceived as static and is not expected to expand in time, looming cycle is not fully activated, and anxiety is reduced in time as a result of exposure to the stimuli. However, in the case of exposure to a threatening stimulus that is perceived as having dynamic features, individual will be more likely to engage in self-protective behaviors and will be unlikely to habituate. These self-protective behaviors occur automatically and they immediately reduce anxiety.

Although they operate efficiently in reducing anxiety in a relatively short period, these self-protective methods such as behavioral or cognitive avoidance or worry, in the long term will lead to coping rigidity, which also limits the ability to see different choices of coping (Riskind & Williams, 2005). This system maintains the faulty mental representations of the patient and also the symptoms. According to Riskind and Williams (2005a), there are 3 potential pathways through which LMS works and makes individuals vulnerable to anxiety disorders. Firstly, presence of a rigid, and avoidance based coping style such as worrying, thought suppression or behavioral avoidance. Secondly, presence of an emotion regulation deficit; and lastly, limited resources left for adaptive cognitive styles since LMS occupies a large percentage of cognitive capacity for dealing with threatening stimuli.

A uniqueness of the LMS perspective is specificity in its relationship to anxiety disorders as a vulnerability model. Up to date, many vulnerability models

are aimed to explain the cognitive background of anxiety. For example, Cognitive-Content-Specificity model postulated by Beck, Brown, Steer, Eidelson, and Riskind (1987) suggested that despite high rates of co-occurrence, depression and anxiety can be differentiated from one another based on the dominant maladaptive thought content and unique cognitive profiles. Despite a high number of studies supported the cognitive content hypothesis, a meta-analytic study by Beck and Perkins (2001) suggested that cognitive content specificity hypothesis was only supported for depression, not for anxiety. In other words, they concluded that the themes involved in anxious cognitive content are shared cognitive variables, thus failing to differentiate anxiety from depression. Likewise, Uhlenhuth, McCarty, Paine, and Warner (1999) proposed presence of a predisposition to anxiety disorders under the name of "general anxiety-prone cognitive style" that concerns tendencies towards catastrophic appraisals, and intense negative thoughts. Although their model at first attempted to investigate a cognitive style specific to anxiety, further studies showed that this cognitive style is a shared component between anxiety and depression (Uhlenhuth, Starcevic, Warner, Matuzas, McCarty, Robets, & Jenkusky, 2002). On the other hand, LMS is found to be specific to anxiety (Riskind et al, 2000) and many studies confirmed this view (Reardon & Williams 2006; Riskind & Williams, 2005). For example when a group of GAD patients were compared with non-clinical controls, and patients with major depression in terms of looming, results showed that GAD group showed significantly higher amount of LMS when compared with others (Riskind & Williams, 2005). Likewise, Riskind and Rector (2007)

also showed strong associations between looming and OCD, but such an association was not present for depression.

Although, LMS is highly correlated with anxiety, and a common feature of all anxiety disorders, it is at the same time conceptually distinct from anxiety. Up to date, some studies on LMS aimed at investigating its divergent validity. These studies utilized Confirmatory Factor Analysis to see whether LMS and trait anxiety are highly correlated, but not identical concepts, and their measurement characteristics clearly make a distinction between them. Results of both studies show correlation with different measures of anxiety like trait anxiety, worry (Riskind et al, 2000), fear of negative evaluation, catastrophising and interpretive biases (Williams et al, 2005). In other words, they provide evidence for the prediction that looming is not a proxy for trait anxiety or anxious symptoms.

All these studies concerning divergent validity of LMS point out to a more distal role in development of anxiety disorders. This style is present even prior to emergence of anxious states, making a way to development of anxiety related symptoms. Indeed, studies have shown that LMS is able to predict even very short term changes in worry and OCD symptoms in very short intervals (Riskind, Tzur, Williams, Mann, & Shahar, 2007). Also, LMS was found to predict increases in anxiety in 4 and 7-month intervals (Black, Balaban, & Riskind; Williams, 2002, cited in, Riskind, Tzur, Williams, Mann, & Shahar, 2007).

Numerous empirical studies show that LMS is a part of many conditions like fear of spiders, fear of contamination, fear of acquiring HIV and many kinds of anxiety disorders (Reardon & Williams, 2007; Riskind, Abreu, Strauss, & Holt, 1997; Riskind & Maddux, 1994; Riskind & Rector, 2007; Riskind, Tzur,

Williams, Mann, & Shahar, 2007; Riskind & Williams,2005), and people higher in LMS show greater amount of trait anxiety (Riskind et al, 2000). In their study, Williams, Shahar, Riskind, and Joiner (2005) investigated the power of LMS on anxiety disorders and found that LMS was able to predict shared variance in a latent factor composed of measures of five distinct anxiety disorders (SAD, OCD, PTSD, GAD, and specific phobia). Similar findings were also found by Reardon and Williams (2006).

Riskind and Williams (2006) proposes the presence of three possible pathways from LMS to GAD. Firstly, LMS may activate certain responses that are serving for self-protective purposes like generating scenarios of incoming catastrophic events even in the presence of minor stress cues. Secondly, since LMS has capacity to absorb attentional control resources of these individuals, they may be lacking enough resources for coping with daily stresses. So, they may feel more vulnerable to sources of possible danger and thus be more likely to feel anxious and worry. Lastly, and connected with the previous route, LMS may lead these individuals to engage in more avoidant ways of coping and emotion regulation, which may present itself as worrying or rumination. In order to test the validity of LMS in GAD, Riskind and Williams (2005) conducted a series of studies investigating the presence of LMS in GAD. With the hypothesis that individuals that are appraising danger as impending and in the process of unfolding would be more likely to experience worry, anxiety, and would engage in self-protective strategies more. In other words, it was thought that high LMS would be one of the characteristics of GAD. In their research on undergraduate students with probable GAD and no GAD, Riskind and Williams (2005) found

that LMS was able to differentiate between two groups. Likewise, in a clinical sample, LMS was better than measures of static threat appraisals in differentiating GAD from both unipolar depression and non-clinical controls. The study also validates the role of LMS in acquisition and maintenance of GAD.

One of the first studies on LMS was conducted with subclinical OCD individuals and the findings showed that participants high on fear of contamination, engaged in more looming behavior (Riskind, Abreu, Strauss, & Holt, 1997). Although there are still not too many studies on the subject, Riskind and Williams (2006) proposed that like GAD, OCD is also highly likely to occur among individuals high in LMS. Firstly, high LMS people would be more inclined to initiate in scenarios of being contaminated or losing control over impulses as a result of their tendency to view dangers as dynamic. High intensity of these scenarios would in turn magnify the perceived importance of intrusive thoughts (Riskind, Williams, & Kyrios, 2002). Also, as in the case with GAD, presences of these scenarios interrupt mental control processes by occupying a large portion of available cognitive resources.

LMS in panic disorder is one of the least studied areas and there is nearly no published research. Riskind and Chambles, (1999, cited in Riskind and Williams, 2006) suggested that in the individuals who have stimulus specific forms of looming vulnerability, LMS to be operating as a catalyst for panic reactions. Like in other anxiety disorders, imagery quality of LMS makes it easier for this people to engage in catastrophising even in the presence of ambiguous somatic stimuli (Riskind & Williams, 2006).

Regarding the relationship between LMS and PTSD, Elwood, Hahn, Olatunji, and Williams (2009) suggested that trauma victims who are high in LMS are more likely than others to view ambiguous situations as more threatening, dangerous, more severe and more catastrophic as a result of their cognitively biased perspective. Thus, more severe post-traumatic reactions are expected from these people. Although not tested properly their assumptions were based on a former study by Elwood, Williams, Olatunji, and Lohr (2007) that found a high correlation between LMS like cognitive style and severity of PTSD symptoms. Recently, Taylor (2009) investigated the applicability of LMS model to PTSD and concluded that although LMS can explain certain features of PTSD, it is unable to account for all aspects of this disorder.

LMS also has some implications regarding treatment of anxiety disorders. The earliest studies that used looming paradigm (i.e. freezing of looming images and thereby blocking the process of looming) as a means of treatment of subclinical OCD in a group of university students found that freezing images was significantly effective in reducing anxiety related to obsessions (Riskind, Wheeler, & Picerno, 1997). In a very recent study McDonald, O'Brien, Farr, and Haaga (2010) conducted a study that aimed at cessation of smoking by creating a sense of looming. They induced a sense of dynamic appraisal of danger of smoking (not only the perceived likelihood) and made the participants perceive the threat related to smoking as changing and escalating every minute. Their preliminary results showed a significant decrease in rates of smoking as a result of the procedure. All these studies show that work on LMS will have important implications in treatment of anxiety disorders.

1. 3. 1. 1. Parental Factors Associated with Development of LMS

Literature concerning vulnerability to emotional disorders has also been interested in developmental antecedents of these vulnerability factors. One of the most popular theories regarding developmental background of cognitive vulnerability involves childhood experiences with parents and friends. In line with this, recent research provides empirical support for this notion by showing significant relationship between cognitive vulnerabilities and peer rejection, (Gibb, Abramson, & Alloy, 2004), parental verbal abuse (Sachs-Ericsson, Verona, Joiner, & Preacher, 2006), maternal anger expression and negative maternal feedback (Mezulis, Hyde, & Abramson, 2006). Most of these studies focus on development of cognitive vulnerability to depression; but, developmental origins of cognitive vulnerability to anxiety disorders seems to be neglected area in this line of research. Until recently, research on this domain mostly investigated the relationship between developmental variables and anxiety symptoms, rather than mediating variables.

Riskind, Williams, and Joiner (2006) suggest that just like all types of anxiety, early experiences and developmental problems are essential in generation of LMS. Maladaptive attachment patterns, unresolved childhood fears, and modeling and problems in parenting may have lead to development of LMS in certain individuals. Riskind, Williams, and Joiner (2006) further suggest that in childhood memories of individuals with anxiety disorder, examples of looming were evident. Also overprotective parenting, modeling of anxious parents, and temperamental factor like behavioral inhibition were hypothesized to be origins of LMS. There are only a limited number of studies concerning the developmental

antecedents of LMS. Riskind, Williams, Altman, Black, Balaban and Gessner (2004), suggested that LMS and vulnerability to anxiety is especially common among individuals who received either maternal overprotection or maternal underprotection. Also they suggested that LMS is more common among people who were insecurely attached to their caregivers during infancy. These disruptions in early life may have negative influence of the child's newly developing cognitive-affective schemas, and thus making him/her more vulnerable to develop pathology.

Results of research on origins of anxiety and depression seem to be very similar, both of which show abuse, maltreatment, and insecure attachment as origins of psychopathology. According to Riskind, Williams, and Joiner (2006) the feature that defines whether the child grows up into depressive or anxious style lies in the way the child interprets these disruptions. In line with this, results of Williams and Riskind (2004) that investigated the adult attachment patterns in romantic relationships found out that avoidant dimension of attachment is more dominant in depression; however, individuals high in LMS were also high in anxiety dimension of attachment.

On the basis of these studies, Riskind, et al. (1992, cited in Riskind, Williams, Gessner, Chrosniak, & Cortina, 2000) developed the Looming Cognitive Style Questionnaire (LMSQ) that measure expectations of dynamically increasing risk in the threatening situations. High scorers on LMSQ appear to be more anxious than low scorers and they are thought to be more vulnerable to anxiety disorders (Riskind, Williams, Gessner, Chrosniak, & Cortina, 2000).

1. 3.1.2. LMS and Social Anxiety

Clark and Wells (1995) model of SAD refers to post-event processing and nature of this process as one of the important maintaining elements of the disorder. This tendency to view oneself in a social situation from an observers' perspective is known to have increasing effects on the anxiety levels of socially anxious individuals by leading to increases in overall self-awareness, public self-awareness, frequency and belief in negative thoughts. Likewise, Hackmann, Surawy, and Clark (1998) emphasized the importance of negative mental images in SAD. They found that when compared with non-anxious counterparts, people with SAD are more likely to report spontaneous images or impressions. Furthermore, these images almost always tend to be more negative with respect to images of non-anxious individuals (Hinrichsen & Clark, 2003). It is believed that these images play an important role in maintenance of social phobia (Hackman, Clark, & McManus, 2002; Vassilopoulos, 2005). In accordance with results of experimental studies that focus on presence and nature of negative mental imagery, consistent with cognitive model of SAD by Clark and Wells (1995), Riskind and Williams (2006) also suggested the role of negative imagery in maintenance of SAD. Furthermore, they hypothesized that SAD is maintained by LMS via frightful dynamic images of swiftly progressing and escalating danger of being criticized and negatively evaluated. Further support for this view was provided by a recent study which investigated the role of anticipatory processing (Brown & Stopa, 2008a) on social performance in socially anxious and non-anxious university students. Although the study was not directly aimed at studying LMS, researchers realized the tendency of socially anxious participants

to use dynamic terms to describe their post event processing images. In other words, post-event processing was explained as a dynamic phenomenon rather than static and immobile by the socially anxious participants (Brown & Stopa, 2008a, 2008b). Most studies look at just one dimension of cognitions, which is static and more verbal and nearly all cognitive models of social anxiety are in that line (Clark & Wells, 1995; Rapee & Heimberg, 1997), so LVM adds specificity to the cognitive models of social anxiety (Brown & Stopa, 2008b).

Riskind and Williams (2006) emphasized the similarity between GAD and SAD in terms of origins. More specifically, it was suggested that in the case of SAD, impact of LMS develops during the early life of the individual that were dominated by experiences that revolve around gaining acceptance and worth in return for perfect performance. Such early experiences in turn lead to generation of mental scenarios of social catastrophe in social and performance situations, where the individual is unable to attain those standards of perfection. When those scenarios or images of intensifying danger and catastrophe are initiated, these individuals become unable to dismiss them as a result of impaired mental control and become trapped in the cycle with danger getting closer and bigger every passing minute (Riskind, Williams, & Joiner, 2006).

Like with other disorders, the research regarding the role of LMS in SAD is quite limited. Williams, Shahar, Risking and Joiner (2005) found that all kinds of anxiety were related to LMS on both social and physical looming dimensions, but there was a specific link between fear of negative evaluation and social looming. Also, these two variables were more strongly correlated with each other

with respect to other variables. More recent studies also showed a specific link between social looming and social phobia (Reardon & Williams, 2007).

When compared with other anxiety disorders, SAD seems to have a distinct profile, presenting a higher association with social looming and a lower association with physical looming (Brown & Stopa, 2008b). Also, another result of the same study that examined the relationship between LMS and three different measures of social anxiety, by a series of regression analyses, indicated that depression, not social looming appeared to be the larger predictor of social anxiety. Although this finding might be interpreted as a similarity in self-schematic content between social phobia and depression (Dozois & Frewen, 2006) that make differential diagnosis difficult (Mineka, Watson, & Clark, 1998), the specific pattern between looming (especially social looming) and social phobia is not seen between looming and depression (Reardon & Williams, 2007). In line with this, consistent with results of other studies (Williams et al, 2005) social looming did not predict variance in depression. Despite the proposed similarity between two conditions (depression and social anxiety), this result can be accounted for the different time orientation of these two concepts. Although depression is more focused on the past experiences and involves the cognitive content of loss and personal failure, social anxiety and social looming is more future oriented (Riskind, 1997). In sum, although social anxiety and depression are highly correlated and share a common denominator, social looming appears to have a characteristically distinct relationship with social anxiety but not with depression.

1. 4. Depression

Like fear, sadness is another major human emotion. It is a part of everyday life and is a natural reaction to loss (Power & Dalgleish, 2007). Based on Lazarus's (1991) criteria for human emotions, sadness includes an appraisal of loss or failure, and it does not have to be permanent. It can be mild and last a few seconds, or minutes or it can last a lifetime like in case for the loss of a loved one (Power & Dalgleish, 2007). The term "depression" or depressive is used to refer to temporary periods of low mood, on the other hand depression as disorder has some other differentiation features (Hähnel, 2008).

Regarding the prevalence rate of depressive disorders, particularly major depression, expectancies are high. For instance, NIMH (2007) study estimated that about 9.5 % of American population suffered from a depressive illness in the preceding year. Results of epidemiological studies yield more accurate results. Ohayon (2007) study done on a sample composed of 6694 American adults found that 1 month prevalence of a depressive disorder was 5.2%. Similarly, Cairney, Veldhuizen, Wade, Kurdyak, and Streiner (2007) also suggest a prevalence estimate of 4.8 %. Epidemiological research of depression in countries outside USA also give high prevalence rates, that range from 11.2 (King, Nazareth, Levy, Walker, Morris, Weich, et al., 2008) to 3.3 % (Olsen, Moretensen, & Bech, 2003) with highest rates in UK (King, Nazareth, Levy, Walker, Morris, Weich, et al., 2008).

The term melancholia goes as far as 5th century BC to the writings of Hippocrates. The modern definition of depression based of DSM-IV and ICD-10. Depression is characterized by depressed mood, insomnia or hypersomnia, low

self-esteem, feelings of worthlessness, guilt, loss of pleasure and interest in activities that were formerly interesting and pleasurable, psychomotor agitation, significant weight loss or gain, decrease in the ability to concentrate on tasks and thoughts of death or suicidal gestures (DSM IV, 1994). Many clinicians differentiated between two types of depression, mainly; anaclitic and introjective (Blatt, 1995). These two kinds of depression can be differentiated on the basis of major symptoms, developmental origins, and predisposing personality features. Anaclitic depression presents itself by feelings of loneliness, weakness and helplessness. The major themes revolve around fear of abandonment, separation from others and deep longings to be loved and cared for. On the other hand, an individual with introjective depression suffers from intensive self-criticism, which is accompanied by feelings of worthlessness, inferiority and guilt. A focus on self-critical or dependency motives in turn results in emergence of dysfunctional attitudes which are known to be a vulnerability to depression.

A conceptually similar classification was proposed by Beck et al. (1983). Their classification of depressions was based on cognitive vulnerability factor. Beck suggested that a person who is high on the dimension of sociotrophy (a need for positive interaction with other people) is highly susceptible to themes of disapproval from others, and loss of attachment figures and their symptoms are associated with “neurotic/ reactive depression. The other dimension which is characterized by the individual’s need for independence and attainment of goals is called autonomy. The depression in highly autonomous people is called “endogenomorphic" depression, revolving around the main theme of defeat. Both Blatt (1974) and Beck (1983) emphasis the underlying personality and schema

features in defining how the stressors will be appraised and interpreted. If a match exist between the individual's personality (sociotrophic or autonomous) and the nature of the stressor (stressor related to an interpersonal loss or failure to meet certain standards), the individual is more likely to get depressed than vice versa.

Recently, research started to be extensively more focused on exploring the key psychological processes that may be concerned with development of depressive symptoms. Brown and Harris (1978) were one of the first to point to chronic stressors as one of the factors that may lead to depression. Factors such as poverty, medical disabilities, marital dysfunctions etc are examples of chronic stressors (Bruce & Hoff, 1994, Dohrenwend, Levav, Shrout, Scwartz, Naveh, Link, Skodol, & Stueve, 1992; Swindle, Cronkite, & Moos, 1989). They defined chronic stressor as "ongoing difficulties lasting at least 4 weeks" and concluded that in most cases a chronic stressor was present prior to or at the onset of depressive symptoms. Their results were supported by other studies (Hammen, Davila, Brown, Ellicott, & Gitlin, 1992; Hammen, Shih, & Brennan, 2004). Regarding how chronic stressors create depression; Hammen (2005) suggested that these individuals all had an underlying vulnerability to depression that may be in the form of dysfunctional attitudes, schemas etc., and it is the chronic stressors or life events that trigger and activate these vulnerabilities (Goodman, 2002).

1. 4. 1. Developmental and Temperamental Factor Associated with Depression

Another factor that is believed to contribute to depression in adolescence and adulthood are the stressful childhood experiences. There is a large amount of

research on the effects of adverse childhood events such as parental death, divorce and marital discord, parental mental illness and substance abuse, exposure to family violence, neglect, and sexual and physical abuse (Hammen, 2005). In line with this, a study that compared the role of distal (events that happened up to 15 years ago) and proximal (happened the prior year) life events concluded that distal events were as influential as proximal events in terms of their direct predictive effects on depressive symptoms (Ensek & Lin, 1996). Impact of early life experiences is also supported by the studies on attachment, parental bonding and cognitive working models (Cicchetti & Toth 2005; Goodman 2002; Meyer, Pilknos, Proletti et al. 2001).

Since the early days, consistent results are obtained regarding the role of parental bonding in depression. Parker Tupling, and Brown (1979) who did the pioneering study in this area, found that lower levels of parental care and higher levels of parental overprotection were associated with higher levels of depression in a group of patients diagnosed with depression. According to Hall, Peden, Rayens, and Beebe (2004), lack of parental care may be associated with depression since it may lead to development of low self-esteem, negative view of self and eventually depressive states. On the other hand, parental overprotection may bring about depression via discouraging independence and constraining development of self-esteem (Parker, Tupling, & Brown, 1979). These findings also gained support from Ingram and Ritter (2000) in a study that assessed type of parental bonding and information processing biases. Their results showed that participants, who had histories of poor parental bonding, were more likely to

direct their attention to negatively valenced stimuli, when they are induced negative mood.

Also supporting preliminary findings of Parker, Tupling, and Brown (1979), MacKinnon, Henderson, and Andrews (1993) found low maternal care and high maternal overprotection to be associated with the risk of developing a depressive disorder, with putting a greater emphasis on the role of maternal care rather than overprotection dimension. This perspective gained support from Rey (1995), Mackinnon, Henderson, and Andrews (2009), and Oakley-Browne, Joyce, Wells, Bushnell, and Hornblow (1995). In their review, paper Hudson and Rapee (1997) also draw attention to the relatively low importance of parental overprotection in depression. They concluded that this care dimension was able to explain greater degrees of variance in depression than overprotection dimension. Although low overprotection and high care is operationalized as "optimal parenting", maternal and paternal bonding are proposed to have differential effects on depression. According to Rey (1995), both maternal care and overprotection are more effective in depression, compared to paternal care and overprotection.

Attachment style is much investigated as a vulnerability factor for depression as well as other psychological disturbances. Up to date most research in the area came up with an association between insecure attachment patterns and depression (Abela, Hankin, Haigh, Adams, Vinokuroff, & Trayhern, 2005; Bifulco, Moran, & Bernazzani, 2002; Carnelley, Pietromonaco, & Jaffe, 1994; Gerlsma & Luteijn, 2000; Haaga, Yarmus, Hubbard, Brody, Solomon, Kirk et al, 2002; Priel & Shamai, 1995; Roberts, Gotlib, & Kassel, 1996). Results of these studies show fearful and preoccupied attachment styles as highly associated with

depressive symptoms (Murphy & Bates, 1997; Carnelley, Pietromonaco & Jaffe, 1994).

Although there is a bunch of research on developmental bases of depression, many researchers focused on psychological factors on depression over the years. Research in this area focused on the personality traits of low self-esteem, neuroticism, hopelessness and perfectionism. A strong relationship between self-esteem and depression had been estimated since the early days of research on depression and even the earliest theories included self-esteem as one of the important vulnerability factors for depression. Even more, low self esteem is one of the diagnostic criteria for depression (Roberts, 2006). A number of theorists thought that this relationship was related to the fact that depressed or depression prone individuals were more dependent on external sources (i.e. opinions of others or praise from others) of self-esteem and that played an important role on maintenance of self-esteem and positive mood (Abramson, Alloy, Metalsky, 1989; Barnett & Gotlib, 1988; Crocker, Karpinsky, Qinn, & Chase, 2003; Kuiper, Olinger & MacDonald, 1988; Roberts and Kassel; 1997).

Trait neuroticism is also a factor that causes a vulnerability to depression. Watson and Clark (1984) defined this trait as a sensitivity to detect aversive stimulus, which in turn increases the tendency to experience negative emotions, such as fear, sadness, guilt, and worry (Costa & McCrae, 1992). As indicated earlier, Clark, Watson and Mineka (1994) in their classical paper hypothesized that neuroticism is a potential diathesis for both depression and anxiety and their tripartite model gained much empirical support.

Martin (1985) suggested that neuroticism influenced cognitive processing of emotional stimuli in a way that leads to depressogenic cognitions, which in turn play an important role in development and maintenance of depressive conditions. Martin (1985) also suggested that individuals high in this dimension are more likely to recall negatively valenced material which in turn may cause an inclination for information processing errors. Over the years, many studies done on the relationship between depression and neuroticism reached a consensus regarding the negative influence of neuroticism on the chronicity, remission and prognosis of depression (Andrew, Hawton, Fagg, & Westbrook, 1993; Hirschfeld, Klerman, Andreasen, Clayton, & Keller, 1986; Farmer, Redman, Harris, Mahmood, Sadler, Pickering, & McGuffin, 2002; O'Leary & Costello, 2001; Scott, Mark, Williams, Brittlebank, & Ferrier, 1995). According to Akiskal, Hirschfeld, and Yerevanian (1983), neuroticism acts as a vulnerability factor for depression through moderation of the effect of other variables and lead to development of psychological symptoms. Regarding trait like features of neuroticism, Van Os & Jones (1999) suggested that individuals who were high on neuroticism dimension as children were more vulnerable to be influenced by stressful life events and get depressed.

Attributional style is another factor that is closely connected to depression. Especially a negative attributional style that is characterized by a tendency to attribute negative life events to stable, internal and general caused, is believed make an individual prone to depressive conditions. Abramson, Alloy, and Metalsky (1989) proposed the "hopelessness" model of depression that revolves around negative attributional style. Their model offers that these people are more

vulnerable to depression because when this style is dominant, an individual is more likely to feel hopeless when confronted with stressors. In the long run, this hopelessness evolves into depression (Hankin & Abramson, 2002). It is also important to note the influence of negative life events since people with negative attributional style are not more likely to feel depressed than other people in absence of negative life events (Abramson, et al., 1989). The model is also a diathesis-stress model that tries to explain a cognitive vulnerability factor for depression and it is believed that this cognitive style begins to form during childhood years and becomes quite stable by the end of this period (Abramson, Alloy & Metalsky, 1989). Empirical research also highlighted this hypothesis finding a connection between depressive cognitive style and early parental bonding experiences (Ingram and Ritter, 2000).

As indicated earlier, perfectionism is another extremely important factor in diathesis-stress models of depression (Blatt, 1995), and had been studied extensively in the recent decades (Enns & Cox, 1997; Frost et al. 1991). Relationship between perfectionism and depression will be discussed in detail later.

Besides these psychological models of depression recent research highlight neuropsychological aspects of this condition. Similar to anxiety disorders, abnormalities in the hypothalamic pituitary adrenal (HPA) axis are also believed to be responsible for depressive conditions. This internal system is speculated to have an important role on development, persistence and recurrence of depressive symptoms (Holsboer & Barden, 1996; Plotsky, 1991; Thase et al. 2002))

1. 5. Perfectionism

Perfectionism is a complex phenomenon that can be both associated with psychopathology and normal adaptive behavior (Stöber & Otto, 2006). Perfectionism is defined by Horney (1950) as “tyranny of the shoulds”. Generally individuals who are high in perfectionism set high standards for themselves, and they are extremely sensitive about their failures and try to avoid mistakes. They are nearly never pleased with their own performance and always demand more than they had done. As a result of this, they rarely feel satisfied with themselves, and they are overly concerned with their performance (Shafran, Cooper, & Fairburn, 2002). They are most of the time overwhelmed with feelings of inadequacy, procrastination, and they are not satisfied with their own performance (Blatt, 1995). Shafran et al. (2002) also emphasized the role of fear of failure besides a relentless pursuit of success.

Hamachek (1978) was the first to differentiate normal perfectionism from neurotic perfectionism. According to him, normal perfectionism is the healthy form of perfectionism. Normal perfectionist individuals focus on the pleasurable aspects of striving for perfection. They have more reasonable expectations from themselves. They are able to see and accept both environmental and personal obstacles toward reaching perfection. They do not feel devalued as a result of failure and maintain a healthy balance of self-esteem. On the other hand, neurotic perfectionist individuals are never satisfied with their performance. They have expectations from themselves that are most of the time exceeding their resources. They are extremely vulnerable to failure and seek constant approval and success in order to feel valuable and maintain their self-esteem. In line with Hamachek’s

(1978) conceptualization, Slade and Owens (1998) proposed the dual process model of perfectionism and introduced two distinct types of perfectionism namely; positive and negative. Although these two styles may appear similar on the behavioral level, Slade and Owens (1998) argues that the main difference is the feeling of satisfaction or dissatisfaction. For negative perfectionists never feel satisfied with themselves, whereas positive perfectionist are much likely to experience satisfaction, pleasure and even euphoria as a consequence of success. That is, positive perfectionism is linked to positive reinforcement in which attention is directed to achievement of goals and other positive consequences such as getting closer to ideal self. Underlying motive behind positive perfectionists is the 'approach' behavior. Positive perfectionism is a similar concept to Hamachek's concept of normal perfectionism that it also acts as a motivating force for enhancing performance. Individuals who are high in positive perfectionism have high standards for themselves but different from negative perfectionism, they tend to focus on reinforcing aspects of their experiences and their motivation for success is high.

On the other hand, negative perfectionism is the form of perfectionism that is associated with many forms of psychopathology such as eating disorders, depression and many forms of anxiety disorders (Slade & Owens, 1998). Negative perfectionists also have high standards for themselves but, their high standards operate in a way that alters their performance. Unlike positive perfectionists, these people tend to focus on negatively reinforcing aspects of the experience, and main motivating force is the fear of failure, that in turn leads to anxiety, avoidance, and

procrastination. Their main motive is avoidance of negative outcomes, failure, punishment and disapproval from others.

Hewitt and Flett (1991) suggested that perfectionism has 3 different dimensions, namely, self oriented perfectionism (SOP), other oriented perfectionism (OOP) and socially prescribed perfectionism (SPP). Self- oriented perfectionism is defined as the type of perfectionism which is characterized by the individual setting unrealistically high standards for himself and criticizing the self for not being able to attain the standards. Other oriented perfectionists, on the other hand, set high standards for the people around them. They harshly criticize others and behave in a hostile and blaming manner. Lastly, an individual high in socially prescribed perfectionism (SPP) believes that society has unrealistic expectations from them. They feel that they will be harshly evaluated and criticized by others. This type of perfectionism is high in people who suffer from psychological disturbances related to self-presentational concerns (Shafran, & Mansell, 2001).

Also, at the beginning of 1990's another model of perfectionism was proposed by Frost, Marten, Lahart and Rosenblate (1990), which is more focused on specific aspects of perfectionism that are associated with negative self-evaluative tendencies. They suggested that perfectionism is composed to 6 different domains as, "Personal standards," "Doubt about Actions," "Parental Expectations,", "Organization", "Concern over Mistakes" and "Parental Criticism" and developed a scale by the name of "Multidimensional Perfectionism Scale- Frost" (MPS-F). According to Frost et al. (1990), the Concern over Mistakes (CM) subscale refers to being overly self-critical and self-evaluative.

CM is suggested to be the central to the construct of perfectionism. This domain provided the highest factor loading in the factor analytic study. The Doubt about Actions (DA) subscale reflects the uncertainty that the individual feels about the correctness of his/her decisions or behavior. The Personal Standards (PS) domain refers to high standards that individuals set regarding their performance. Because growing up with parents who are highly critical or have high expectations is believed to contribute to perfectionism, the MPS-F includes subscales to measure parental expectations (PE) and parental criticism (PC). Finally, the Organization (O) domain refers to being overly orderly, organized, and tidy. Among these 6 dimensions O was perceived as the one that is not related to any kind of psychopathology and was not included into analyses in more recent studies (Kawamura, Hunt, Frost, & Di Bartolo, 2001, Schumaker & Rodebaugh, 2009).

When all these dimensions are investigated separately, CM and DA emerge as the ones that are most strongly correlated with both anxiety and depression (Frost et al., 1993; Kawamura, Hunt, Frost, & DiBartolo, 2001). In contrast with positive relationship between dimensions of perfectionism and psychopathology, PS emerges as the dimension that is more closely related to positive affectivity (Stroeber & Otto, 2006). This distinction within MPS-F is well documented by a factor analytic study (Frost et al, 1993) that showed that CM, DA, PC and PE loaded on the maladaptive factor, whereas PS and O loaded on the adaptive factor. Later these two factors are named as “Maladaptive Evaluation Concerns-MEC” and “Personal Standards-PS” respectively. This two-factor model, besides being in accordance with Slade and Owen’s (1998) perception of perfectionism, gained empirical support from studies of Bieling,

Israeli, and Anthony (2004), Cox, Enns, Clara (2002a), Rice and Mizradeh (2000) and Stumpf and Parker (2000) that found two orthogonal higher-order MPS factors differing in their relationships with different personality constructs. The concept of MEC as a manifestation of negative perfectionism gained support from different groups of researchers. All of which found MEC to be significantly and positively correlated with both anxiety and depression (Bieling, Israeli, & Smith, 2003; Dunkley, Blankstein, Masheb, & Grilo, 2006; Kawamura, Frost, Hunt, DiBartolo, 2001; Schumaker & Rodebaugh, 2009). Moreover, MEC was found to be mediating the relationship between certain parental variables (like parental control, parental bonding, and attachment) with psychopathology (Kenny-Benson & Pomerantz, 2005; Soenens, Luyckx, Vaansteenkiste, Luyten, Duriez, & Goosens, 2008)

Besides results of factor analytic studies, correlational studies also provided evidence, showing that PS was negatively correlated with different measures of psychological distress (Alden, Ryder, & Mellings, 2002; Blankstein & Dunkley, 2002; Enns, & Cox, 1999; Schumaker & Rodebaugh, 2009). These results lead to the emergence of a view of high PS as an adaptive personality characteristic (DiBartolo, Frost, Chang, LaSota, & Grillsl, 2004) associated with more healthy mental health outcomes (DiBartolo, Li, & Frost, 2008) and personality characteristics such as positive affect (Frost et al., 1993), and efficacy (Frost et al., 1990).

Although, this two dimensional model of perfectionism (especially the concept of positive perfectionism) was highly criticized by different groups of researchers (Flett & Hewitt, 2002; Shafran, Cooper, &Fairburn, 2002), Stöber and

Otto (2006) concluded that there was a dual process regarding the effect of adaptive and maladaptive perfectionism on the individuals' well-being. They basically made a distinction between perfectionistic strivings (identical to PS of MPS-F, characterized by high expectations from the self) and perfectionistic concerns (identical to MEC), hypothesized as two distinct continuums rather than opposite end of a single continuum. They concluded that presence of perfectionistic concerns has basically adverse effects on the individual, and perfectionistic strivings encourage the individual to seek for the better in tasks that s/he encounters, thus has a positive effect. But, the individuals who suffer the most were hypothesized to be the ones that are high in both dimensions. Although further studies in this are needed, Stöber and Yang (2010) found that interaction of these two dimensions lead to the hypothesized negative outcome in university students.

1. 5.1. Parental Factors Associated with Development of Perfectionism

In terms of origins of perfectionism, many studies associated perfectionism with parental failure such as excessive authority, control, criticism, and disapproval (Blatt, 1995). Blatt (1995) hypothesized that perfectionism was most severe in children who were approved by their parents only as a result of meeting high expectations of the parents. Likewise, Burns (1980) suggested that roots of perfectionism lie in a household context dominated by perfectionist parents. The message that "less than perfect is unacceptable" is communicated both directly and or in form of excessive criticism (Blatt, 1995). This is supported by an empirical study by Vieth and Trull (1999) that investigated perfectionist

characteristics of both collage students and their parents. Their study showed that parental perfectionism (especially maternal) is highly correlated with perfectionism in the offspring. Also, high socially prescribed perfectionism (SPP) in parents is highly correlated with perfectionism in the individual. People that were brought up in this kind of families most of the time overvalue disapproval from others. Their sense of self is heavily dependent not on their own internal standards or values, but on the reactions and messages that they will receive from people around them. They perceive "being perfect" as the only chance to reduce the chance of disapproval from others (Sorotzkin, 1998). More specifically, Barrow and Moore (1983), suggest that any of the following four conditions during early childhood years may lead to perfectionist patterns in the future. The conditions are (1) high criticism and high expectations towards the child by parents, (2) learning perfectionist style by modeling perfectionist parents, (3) implications of criticism in parental expectations and standards, and (4) absence of standard rules and consistency. Consistent with this, Rothstein (1991) suggested that this non-approving, over critical and demanding patterns of the parents lead to the development of a feeling of inferiority in the child, that can only be overcame by feelings of a grandiosity and perfection. In families, where parents are rarely or never attuned to the emotional needs of their children, children eventually learn to focus on their performances at the expense of neglecting own emotions and they learn to keep their emotions under control.

Frost et al. (1991) also investigated the antecedents of perfectionism and found a strong association of maladaptive perfectionism with maternal harshness and perceived harshness of the parents by the child rather than parents self-

reported harshness. In sum, they concluded that, child's perfectionism is a result of harsh parental standards. This finding of Frost et.al (1991) is also in accordance with psychoanalytic views on the antecedents of perfectionism that perceives perfectionist fantasies as a way of coping with harsh and punitive early environment. Supporting this hypothesis, Flett, Hewitt and Singer (1995) also concluded that, restrictive, punitive and authoritative parenting is closely associated with perfectionism, especially the dimension of socially prescribed perfectionism. In line with this, Enns, Cox and Larsen (2000) who investigated the relationship between parenting practices and different dimensions of perfectionism proposed that parental lack of care was highly correlated with both SPP and CM.

1. 5. 2. Perfectionism and Social Anxiety

Since the early days, cognitive theories of social anxiety emphasis socially anxious individuals' preoccupation with how he/she is perceived socially and his/her doubt about own ability to convey a desired impression on other people (Clark & Wells, 1995; Rapee & Heimberg, 1997). This quality of social anxiety disorder is interpreted as an evidence for existence of a strong connection between social anxiety and perfectionism (Saboonchi, Lundh, & Öst, 1999) but there are only a limited number of studies on this area. As mentioned earlier, according to Heimberg (1995), a socially anxious individual holds high expectations from themselves which are unlikely to be met. This results in certain maladaptive consequences such as an inevitable frustration with own performance, higher levels of self-criticism, fear of failure and avoidance of social situations (Hill,

Zrull, & Turlington, 1997). In line with the models proposed about the relationship between two concepts, Alden, Bieling, and Wallace (1994) found a significant relationship between perfectionism and social anxiety in a group of women. The most striking part of their results was the fact that social anxiety was correlated with only one component of perfectionism, which is the socially prescribed perfectionism. The following studies done with samples composed of both males and females also resulted in similar conclusions (Arthur & Hayward, 1997; Bieling & Alden, 1997). Alden, Ryder, and Melling (2002) suggested that the main difference between socially anxious and socially non-anxious individuals was the perceptions they hold about people around them. In particular, Alden et al., (2002) put forward the view that the belief that others exert pressure on the individual to be perfect was a very distinctive characteristic of social anxiety. Unreasonable expectations of others lead to greater levels of negative evaluation in the individual with high SPP, which in turn leads to increase in levels of anxiety (Laurenti, Bruch, & Haase, 2008). Although results of studies on the relationship between anxiety and perfectionism as conceptualized by Hewitt and Flett (1990) seem to provide consistent results in children; SOP as well as SPP appeared to be related to social anxiety. This difference between adult and children samples was interpreted as a difference between adults and children in terms of pattern of perfectionism (Hewitt, Caelian, Flett, Sherry, Collins, & Flynn, 2002).

Saboonchi et al. (1999) compared social phobic individuals with panic disorder patients, normal controls in terms of dimensions of perfectionisms. It appeared that social phobic individuals are more concerned with their mistakes

and are more doubtful about their actions. These results are in accordance with findings of Juster, et al. (1996), who conducted one of the pioneering studies in this area. They highlighted important aspects of the relationship between these two concepts. The study that assessed perfectionism among 61 patients with SAD and 39 community volunteers using MPS-F, gave important results regarding the possible role of perfectionism in the etiology of social anxiety disorder as a vulnerability or exacerbating factor. When compared with nonclinical controls, SAD patients obtained higher scores on DA, CM, and PC dimensions of MPS-F. Secondly, they were one of the first to suggest and provide empirical evidence for the view that individuals high in social anxiety hold on to high standards for performance in social settings, and any performance less than this perfect standard is interpreted as a disaster or failure.

In line with these findings, Anthony Purdon, Huta, and Swinson (1998) investigated the profiles of perfectionism that are specific to each anxiety disorder, and thus compared anxiety disordered patients with non-clinical controls. The results revealed that SAD patients were distinguishable from other anxiety patents on the parameters of CM, DA, and PC. Additionally, the level of overall perfectionism was higher in the subjects with social phobia when compared to the other anxiety disorder groups. Rosser, Issakidis, and Peters (2003) also found results consistent with Anthony et al., (1998) regarding the important role of CM and DA in social anxiety. They found that both CM and DA were associated with symptom severity of social anxiety disorder in a group of patients. As mentioned before, CM is found to be the most important and distress related dimension of perfectionism (Frost et al., 1990). It is particularly important

in social anxiety disorder because of these individuals sensitivity about making mistakes (Shafran & Mansell, 2001) and distorted perceptions about the importance and the consequences of their own mistakes (Stopa & Clark, 1993). In a very recent study, Shumaker and Rodebaugh (2009) tested the relationship of both state and trait social anxiety with dimensions of MPS. Quite contrary to previous studies, they found that CM and DA were only able to predict trait social anxiety. On the other hand, MEC subscale of perfectionism (CM, DA, PC, and PE) was able to predict both state and trait social anxiety. A similar finding was also reported by Villiers (2009) concerning the relationship between social anxiety and perfectionism.

Another controversial dimension of MPS-F in relation to social anxiety is the PS dimension. Some aspects of perfectionism fail to relate to social anxiety (Shumaker & Rodebaugh, 2009). Frost et al., (1990) showed that the relation between PS and psychopathology may be present only in people who are also high in CM.

Another line of evidence regarding the relationship between social anxiety and perfectionism comes from studies investigating treatment outcomes. Lundh and Öst (2001) studied perfectionism in a group of social phobic individuals. Participants received either group Cognitive Behavioral Therapy (CBT), individual CBT, or a self-help treatment. Results showed a decrease in all dimensions of MPS-F post-treatment scores except for O dimension. A similar study by Rosser et al., (2003) conducted on 61 individuals with social anxiety, though indicate a decrease in general perfectionism as a result of group CBT, failed to show a significant effect of CM in prediction of changes after treatment.

Since CM is proposed to be the core dimension of perfectionism, it was expected that participants higher on CM would show poorer prognosis in response to treatment. More recently, Ashbaugh, et al. (2007) replicated previous studies with 102 social anxiety patients, exploring whether changes in perfectionism (especially CM and DA dimensions) influenced treatment outcome for SAD. The patients who received 12-week –long group CBT showed significant changes on CM and DA, but consistent with Rosser, et al. (2003), CM failed to predict response to treatment. This might be indicative of different mechanism behind SAD and CBT treatment of SAD. Although severity of SAD is related to CM, small improvements on this dimension did not reduce the overall level of SAD (Ashbaugh, et al, 2007). Schumaker and Rodebaugh (2009) who assessed the association between maladaptive aspects of perfectionism (composed of CM, DA, PC, and PE) also obtained significant results. In sum, although the presence of a significant relationship between perfectionism (especially maladaptive aspects) and SAD had been shown in many studies, how it operates on SAD is not fully understood and further research is needed in this area.

1. 5. 3. Perfectionism and Depression

To summarize the relationship between depression and perfectionism, Rice, Bair, Castro, Cohen, and Hood (2003) suggested that it is the perfectionists'' rigid self-expectations, stringent self-evaluations, and very high standards limit their confidence in their ability to bring about desired outcomes. They tend to focus on worst scenarios and their belief in the realization of the worst scenario is higher than usual. They believe that these high standards should be attained but at

the same time, they see own efforts as useless. Later, this results in self-blame and depressed mood. Although there are many studies that suggest the importance of perfectionism in the diathesis-stress model of depression (Blankstein & Dunkley, 2002; Enns & Cox, 1997; Enns & Cox, 1999; Hewitt & Flett, 1991a; 1991b; Hewitt, Flett; & Ediger, 1996), it is still uncertain whether it really acts as a vulnerability factor or a correlate of consequence of depression (Viliers, 2009).

There are also studies that perceive perfectionism as a factor that leads to a vulnerability to depression, as a result of the perfectionists' tendency to overvalue their perceived failures, which is a direct consequence of holding high personal standards (Enns & Cox, 1997). In his three stage depression vulnerability model, Beck (1967) had also mentioned perfectionism as part of dysfunctional beliefs that in turn leads to vulnerability for depression. Likewise, Blatt (1995) emphasized the role of perfectionism in etiology of depression. He argued that especially in the self-critical type of depression, high standards result in harsh self-scrutiny which is also a consequence of a pursuit of perfection and achievement. When these individuals face with a failure of any degree, depressive symptoms emerge. Despite supporting the significant relationship between depressive symptomatology and perfectionism, Minarik and Ahrens (1996) failed to find high standards for interpersonal performance among depressed individuals. Moreover, results of their study, in addition to results of some other previous studies (Ahrens, Zeiss, & Kanfer, 1988), suggested that depressed people set lower standards, which may be representative of a different but unrecognized subtype of depression.

In terms of the relationship between different types of perfectionism and depression, there is a consensus among different groups of researchers (Enns, Cox, & Clara, 2002b; Randolph & Dykman, 1998) that maladaptive perfectionist pattern rather than an adaptive pattern lies beneath depressive disorders of any kind (Blatt, 2004). Especially Enns, Cox, and Clara (2002b) argued that the main difference between these two patterns of perfectionism is presence of a harsh parenting attitude while the individual is brought up.

Besides these, the two models of perfectionism both of which are measured with Multidimensional Perfectionism Scale (MPS-F and MPS-H), show significant correlations with depressive symptoms in both clinical and non-clinical samples (Enns & Cox, 1999; Flett et al., 1995; Flett et al., 1991a,b; Frost et al., 1993; Minarik & Ahrens, 1996; Preusser, Rice, & Ashby, 1994; Saddler & Buckland, 1995; Saddler & Sacks, 1993). Firstly, MPS-F (Frost et al., 1990) was shown to be correlated with depression in a number of studies. Nearly all studies showed that especially CM and DA domains were highly correlated with depression (Adkins & Parker, 1996; Enns & Cox, 1999; Frost et al., 1993; Minarek & Ahrens, 1996;), which is followed by PC and PE both of which have relatively weakly but significantly correlated with depressive symptoms (BDI, Hamilton Depression Inventory scores) (Minarik & Ahrens, 1996; Enns & Cox, 1999). In addition, Minarik and Ahrens (1996) found PS as significantly but inversely correlated with depression in a sample composed of university students. Moreover, in a series of studies that investigate perfectionist features in major depressive disorder, depressive personality disorder and dysthymia in both non-clinical subjects and primary–care patients, Huprich, Porcerelli, Keaschuk,

Binienda, and Engle (2008) found that self-report measures obtained from both groups were highly significantly correlated with CM, DA, and PC domains of perfectionism.

More recently, Kawamura et al, (2001) used 5 subscales of MPS-F to measure two factors of perfectionism based on Frost et al, (1993). The two factors namely Maladaptive Evaluative Concerns (CM, DA, PS, and PC) and adaptive (Personal Standards- PS) perfectionism both were related to depression aside from the influence of anxiety. What was novel in the results of this study was the finding that, though weak and negative, adaptive perfectionism, as well as maladaptive perfectionism was related to depression. This relationship is thought to be related to positive achievement striving in depression (PAS) (Frost et al, 1993). Based on the same conceptualization of perfectionism, DiBartolo, Li, and Frost (2008) found that although maladaptive evaluative concerns (MEC) were strongly related to nearly all kinds of psychopathology, personal standards (PS) were more related to positive features of mental health.

Hewitt and Flett (1991a, 1991b) concluded that both SPP and SOP were highly correlated with depression but SPP was the strongest predictor of depression in depressed patients. In another study with depressed patients, anxious patients, and controls, it was also found that depressed patients were high in SPP but this dimension was high also in anxious patients. So, they concluded that although SPP is related to many different kinds of psychopathology, but SOP acted as a vulnerability factor specific to depression (Hewitt & Flett, 1993). This finding was replicated by Flett and Hewitt (1991a, Fleet, Hewitt, & Blankstein, 1991; Hewitt, Flett, & Ediger, 1996) in a number of different studies and all

confirmed that SOP acts a vulnerability to depression especially when it interacted with achievement related stress.

Hewitt et al (1998) also found differences between SOP and SPP in terms of their relationships with depression. They concluded that although both SPP and SOP were correlated with depression, it was only SOP that is related to chronic (trait based) measures of depression. This finding also acts as an evidence for Flett & Hewitt's (1991) initial model of vulnerability to depression. In fact, these two dimensions of perfectionism (both SPP and SOP) were found to be related to depressive symptoms even in children between ages 10 to 15 (Hewitt et al, 2002, McCreary, Joiner, Schmidt, & Ialango, 2004).

Enns and Cox (1999) formed their own concept of "maladaptive perfectionism" combining different dimensions of MPS-F and MPS-H. Their concept is composed to concern over mistakes (CM) and doubt about actions (DA) dimensions of Frost (1990) and socially prescribed perfectionism (SPP) dimension of Flett and Hewitt (1991) and they are consistent with other two-dimensional views of perfectionism that were mentioned before.

Besides these, Dunkley, Zuroff, & Blankstein (2003) also based of the two MPS scales came up with the concept of self-critical perfectionism that is a combination of SPP, CM, PE and PC components of these two scales. Different from SOP, self-critical perfectionism has a very punitive and demeaning element in addition to high standards and hypersensitivity to criticism. In their study, Powers, Zuroff, & Topciu (2004) found that self-critical perfectionism rather than SOP is more likely to predict depressive symptoms and would be highly positively correlated with depression in a group of undergraduate students.

Another explanation for the link between depression and perfectionism was proposed by Molnar, Reker, Culp, Sadava, & DeCourville (2006). They suggested that it was self-worth that mediated the relationship between depression and perfectionism. In a more recent study, Sturman, Flett, Hewitt, and Randolph (2008) used the CM and DA dimensions of MPS-F and SPP dimension of MPS-H as a single latent to test the possibility that a sense of contingent self-worth mediates the relationship between perfectionism and depression. Their results were supporting findings of Molnar et al (2006) and they explained this phenomenon to be as the result of perfectionists' tendency to base their self-worth conditionally on being highly successful and actively working to reach high standards. Furthermore, Sturman et al (2008) suggested that this tendency results in a vulnerability to feelings of worthlessness and depression. Sturman et al (2008) also found out that this relationship was specific only to subtype of perfectionisms that was a combination of SPP, CM and DA and was conceptualized by Blankstein and Dunkley (2002) as "Evaluative Concerns Perfectionism" (EC) factor. They suggest that this type of perfectionism can be summarized as a set of beliefs revolving around the standards and judgments of others. These people are believed to perceive pressure from other to be perfect. They strongly believe that they need to be perfect to be loved and appreciated by others. Also, in accordance with Hamachek's (1978) view of negative perfectionists, individuals high in EC generally focus on negative aspects of their own performance and most of the time they overrule success and as a result they forget to reinforce themselves (Dunkley, Blankstein, Halsall, Williams, &

Winkworth, 2000; Wu & Wei, 2008). In accordance with other studies, EC factor was found to be highly positively correlated with depression.

To sum up, it can be stated that there is a consensus in the literature regarding the relationship between depression and perfectionism, regardless of the position of perfectionism as a vulnerability factor or a correlate or byproduct. Also, more recent studies consistently showed relationship of depression significantly with certain domains of perfectionism.

1. 5. 4. Perfectionism as a Means of Differentiating Anxiety from Depression

From another perspective, Frost, Heimberg, Holt, Mattia, & Neubauer (1993) introduced perfectionism as a variable that may be useful in the area of differentiating anxiety and depression. They emphasize that among the different dimensions of perfectionism that are conceptualized in MPS-F (Frost, et al., 1990) CM and DA are the ones that are most successfully representing pathological perfectionism. Likewise, these two concepts which had always been found to be highly correlated with many kinds of psychopathology were found to present a pattern more similar to anxiety rather than depression. In their study with university students, Frost, et al., (1993) checked the correlation of different dimensions of perfectionism with negative affectivity (NA) and positive affectivity (PA) dimensions of PANAS. The result showed that both CM and DA were significantly positively correlated with NA, rather than PA, which is a characteristic of anxiety. In other words, in their study Frost, et al. (1993) proposed that these two concepts may be reflective of anxiety rather than depression. Up to date, there are limited number of studies that investigate

whether the significant relationship between anxiety and perfectionism is an artifact of the strong relationship between depression and perfectionism. Juster et al (1996) in their study with university students high in social anxiety, found a significant relationship between anxiety and perfectionism (particularly CM and DA) apart from the effect of depression. Likewise, Ströber and Joorman (2001) in their research on worry came out with a similar result indicating a significant relationship between worry and CM and DA when depression is controlled. In a more recent study, Kawamura, Hunt, Frost, and DiBartolo (2001) found that maladaptive perfectionism, independent of the effect of depression, was significantly related to a subtype of anxiety dominated by trait anxiety, worry, and social anxiety. The same study at the same time found that a similar relationship between perfectionism and depression (when anxiety measures are controlled) is present.

Minarek and Ahrens (1996) who aimed at replicating these results on the other hand found that Beck Anxiety Inventory (BAI) scores which seemed to be correlated with both CM and DA, failed to demonstrate such a significant relationship when depression is controlled. This result can be due to the use of BAI, which is an inventory that is more focused on somatic component of anxiety rather than the cognitive or affective component, as a tool for assessment of anxiety. So, the lack of a significant relationship between BAI and perfectionism may be implying that perfectionism is more closely linked to cognitive and affective components of anxiety rather than the somatic component (Enns & Cox, 1999; Kawamura, et al., 2001). Results of these studies are signaling that there may be separate aspects of perfectionism that may be related to depression and

anxiety separately (Kawamura, et al., 2001) and thus perfectionism can be used as a parameter to differentiate depression from anxiety.

1. 6. Aims of the Present Study

The general purpose of the present study was to test the effects of LMS and perfectionism on depression and especially social anxiety. Among different types of anxiety disorders, SAD is shown to be the type of anxiety that is most closely associated with perfectionism (Juster, 1996). It was also hypothesized to be associated with a subtype of clinical depression (Blatt, 1995), thus, it is perceived as a vulnerability factor for both conditions. On the other hand, LMS was found to be associated to only anxiety states. Moreover, it is proposed to be the only vulnerability factor that is specific to anxiety (Riskind, et al., 2000), and related studies indicated a lack of association between LMS and depression. In the present study, perfectionism is expected to be associated with both depression and social anxiety, whereas LMS will be associated only with social anxiety. Moreover, up to date, research indicated social looming to be more closely associated with social anxiety compared to physical looming (Brown & Stopa, 2008), thus it is expected that measures of social anxiety will be more associated with social looming rather than physical looming.

As indicated above, one of the major debates in the research arena on perfectionism is the view that perfectionism is composed of mainly two forms, namely, maladaptive and adaptive. Arguments against this bi-dimensional structure (Flett & Hewitt, 2002) are also aimed to be addressed in the present study. Contrary to arguments proposed by Flett and Hewitt (2005), maladaptive

and adaptive forms of perfectionism are expected to differ in terms of their relationships with variables concerning perceived parenting, and positive perfectionism variable is expected not to be associated with measures of depression or social anxiety.

The present study also aims to address an argument in the literature concerning the relationship between anxiety and perfectionism. Despite the contrary evidence provided by Frost, et al (1993) and Kawamura, Hunt, and Frost (2001), Minarik and Ahrens (1996) attributed the relationship between perfectionism and anxiety to high levels of comorbidity between anxiety and depression thus; perfectionism is more related to depression than anxiety. In the light of these studies, perfectionism is expected to be related to social anxiety, independent of depression. Likewise, it is expected that perfectionism will be related to depression independent of anxiety.

Another major aim was to investigate the effects of perceived parental bonding on different variables. Parental bonding, as indicated before is known to be one of the most investigated risk factors for psychopathology especially in the Western cultures. Especially, low maternal care and high overprotection had been associated with anxiety and depression (Carter, Sbroco, Lewis, & Friedman, 2001; MacKinnon, Henderson, & Andrews, 1993; Parker, 1979). Moreover, some studies indicate the negative effect of high overprotection to be more than low care (Rapee, 1997). In sum, most studies emphasize the view that adults who had been raised in an overprotective family environment tend to be more anxious and depressed. Although there is extensive work regarding the relationship between psychological disturbances and parental bonding, up to date the research

concerning this relationship in Turkish culture is quite limited. Thus, one of the major aims of this study is to explore the relationship of social anxiety and depression with domains of parental bonding. To be more specific, it is expected that, measures of depression and social anxiety would be associated with lower levels of care and higher levels of overprotection. Especially, depression is expected to be more associated with care dimensions of parental bonding, whereas, measures social anxiety and fear of being negatively evaluated are expected to be more associated with overprotection dimension.

Likewise, previous studies highlight the influence of parenting attitudes characterized by lack of care and high overprotection, in development of maladaptive perfectionist patterns (Blatt, 1995; Enns, Cox, & Clara, 2002b; Hamachek, 1978; Sorotzkin, 1998). Therefore, another expectation is to find an association between maladaptive perfectionism and low parental care and high overprotection. On the other hand, such a relationship is not expected to be present in the relationship between parenting style and more adaptive forms of perfectionism.

Up to date only one study addressing the effect of parental variables on LMS was published. As indicated earlier, this study has some interesting results stating that a higher level of LMS is observed in individuals who received lower levels of parental overprotection. Besides being in contradiction with the literature on parental bonding and anxiety, further studies are needed in this area. Therefore, another aim of the present study is to replicate Riskind, Williams, Altman, Black, Balaban, & Gessner (2004) study and see the association between LMS and perceived parenting in Turkish culture.

Lastly, studies done on both perfectionism and LMS, place these concepts as distal vulnerability factors (Enns, Cox, & Clara, 2002a; Riskind, Joiner, & Williams, 2006; Soenens, Vansteenkiste, Luyten, Duriez, & Goossens, 2005), that may be mediating the relationship between developmental experiences and psychological disturbances. So, mediator roles of LMS and maladaptive perfectionism in the relationship between familial variables and psychological symptoms are of concern.

Thus, the hypotheses of the present study are;

1. It was hypothesized that disrupted parental bonding would be associated with the development of LMS.

2. It was hypothesized that disrupted parental bonding would be associated also with perfectionism. Besides, it is expected to differ between adaptive and maladaptive versions of perfectionism (Maladaptive Evaluative Concerns and Personal Standards).

3. It is expected that social anxiety would be associated with dimensions of looming, as well as parental variables. It is also expected that social looming would be more strongly associated with measures of social anxiety with respect to physical looming.

4. It is expected that although parental variables would be associated with depression, dimensions of looming would be weakly or not significantly associated with depression.

5. It was hypothesized that disrupted parental bonding and perfectionism would be associated with social anxiety.

6. It was hypothesized that dimensions of parental bonding and perfectionism would be associated with depression.

7. It was hypothesized the relationship of LMS with social anxiety and depression would be different from one another.

a. It was hypothesized that LMS would still be associated with social anxiety when depression is controlled.

b. It was hypothesized that LMS will not be associated depression when anxiety is controlled.

8. It was hypothesized that perfectionism would be associated with both depression and social anxiety, apart from each others' influences on the other.

9. Maladaptive perfectionism was expected to mediate the relationship of parental variables and social anxiety and depression.

10. Looming maladaptive style, especially social looming was expected to mediate the relationship between parental variables and social anxiety.

CHAPTER II

METHOD

2. 1. Participants

Participants were 389 university students (278 females and 111 males) from Boğaziçi University and Middle East Technical University. Although the ages ranged from 17 to 31 (M= 20.73, SD= 1.84), the majority of the population was between 19-21 years old (76 %). The demographic characteristics of the participants are displayed on Table 1.

Table 1. *Demographic Characteristics of the participants*

Demographic Variable	Type	n	%
Sex	Male	111	28.5
	Female	278	71.5
Marital Status	Single	384	98,7
	Married	5	1,3
Current Residence	With both parents	76	19,5
	With mother only	9	2,3
	With father only	7	1,8
	With relatives	8	2,1
	With friends	81	20,8
	Dormitory	192	49,4
	Other	16	4,1

Table 1. C*ontinued*

Demographic Variable	Type	n	%
Number of siblings	0	27	7,2
	1	191	50,9
	2	92	24,5
	3	32	8,5
	More than 3	33	8,8
Place of birth	Village	28	7,2
	Town	8	2,1
	County	29	7,5
	City	161	41,4
	Big city	163	41,9
Place of residence until age 17	Village	17	4,4
	Town	4	1,0
	County	28	7,2
	City	153	39,3
	Big city	187	48,1
Mothers Education	Illiterate	13	3,3
	Literate-no degree	10	2,6
	Primary School	123	31,6
	Junior high school	24	6,2
	High school	104	26,7
	Left University	10	2,6
	University	90	23,1
	MA	8	2,1
	PhD	6	1,5
Father's education	Literate-no degree	3	,8
	Primary School	66	17,0
	Junior high school	35	9,0
	High school	92	23,7
	Left University	14	3,6
	University	153	39,3
	MA	16	4,1
	PhD	9	2,3
Parents' marital Status	Married	348	96,1
	Divorced	12	3,3
	Separated	2	,6

2. 2. Measures

2. 2. 1. Demographic information form

The first part of the questionnaire was composed of questions that assess demographic information. This form was prepared in order to get information concerning age, gender, hometown, current residence, number of siblings, parents' education, occupation, income and status (married / divorced / deceased) (See Appendix A).

2. 2. 2. The Multidimensional Perfectionism Scale (MPS)

It is a 35-item questionnaire developed by Frost et. al (1990) based on what has been theorized about perfectionism. It measures six dimensions of perfectionism: Concern over Mistakes (CM; e.g., ‘‘People will probably think less of me if I make a mistake’’), Personal Standards (PS; e.g., ‘"If I do not set the highest standards for myself, I am likely to end up a second-rate person), Parental Expectations (PE; e.g., ‘‘My parents have expected excellence from me’’), Parental Criticism (PC; e.g., ‘‘I never felt like I could meet my parent's standards’’), Doubts about Actions (DA; e.g., ‘‘Even when I do something very carefully, I often feel that it is not quite right’’), and Organization (O; e.g., ‘‘Neatness is important to me’’). Respondents are asked to rate items on a 5-likert-type scale from 1 (strongly disagree) to 5 (strongly agree). Psychometric qualities tested with two all female samples (n=232) and (n= 178). Internal consistency for the whole scale appeared to be .91 with scores for subscales ranging from .77 to .93 (Frost et al., 1993).)

In a more recent study done on both sexes (Parker & Adkins, 1995), internal consistencies came out to be between .57 (PC) and .95 (O). Stöber (1998) replicated the factor analytic study on 243 university students. Although, initial principal components analysis (PCA) indicated a 6-factor solution like the original study by Frost et al (1990), the number of factors dropped to 4 when varimax rotation was used. The new factorial structure was composed of separate PS and O domains, and two other domains, one combining CM and DA and referred to as CMD, and the other combining PE and PC, named PEC. Ströber (1998) further suggested that a 4 factor structure will provide greater parsimony in the presentation and interpretation of results. Besides, it will be more selective in differentiating different psychopathological conditions from one another, which was seen as a major weakness of 6 factor versions of MPS (Frost & Steketee, 1997; Ströber, 1998).

The scale was translated and adapted into Turkish by Özbay and Mısırlı-Taşdemir (2003) on a student sample composed of 489 high school students (Presented in Appendix B). The scale showed adequate levels of reliability and validity with a Cronbach's alpha of .83 for the whole scale and .87, .77, .61, .71, .65, and .63, for O, CM, DA, PE, PC, and PS respectively. Also, the scale has a split-half reliability of .80. Exploratory factor analysis, as the original English version yielded a 6 factor solution explaining 48% of the total variance.

For the present study, perfectionism was measured based on only two scores derived from MPS. One is Personal Standards (PS) score which is composed of items that are tapping under PS dimension. The other score named as Maladaptive Evaluative Concerns (MEC) was a composite score that was derived as a result of

computation of a mean of other subscales (CM, DA, PE, and PC) as suggested by (Frost et al. 1993; Kawamura et al. 2001; Kawamura and Frost 2004; Shumaker & Rodebaugh, 2009).

2. 2. 3. Parental Bonding Instrument (PBI)

The PBI is composed of 25 Likert-type questions that range from 0 to 3 that assess the quality of the child-parent relationship from the child's perspective. As mother and father are rated separately by the subjects, the PBI has four scores: maternal care, paternal care, maternal overprotection, and paternal overprotection. It was developed by Parker, Tupling and Brown (1979). The original standardization was done using a sample consisting of 53 (26 female) participants. The factor analysis yielded a two-factor solution with 13 items assessing "Care", 12 items assessing "Overprotection". Care is the level of affection, emotional warmth, empathy, and closeness provided by the parent (as reported by the adult) as opposed to emotional coldness, indifference, and neglect. Overprotection is the level of control, overprotection, intrusion, excessive contact, and prevention of independent behavior provided by the parent (as reported by the adult) as opposed to the allowance of independence and autonomy. The scale has a test-retest reliability of .76 and .63 over a period of three weeks for care and overprotection respectively. Coefficient alphas have been reported as .92 for the Care subscale and .78 for the Overprotection subscale. Parker, Tupling, and Brown (1979) also demonstrated PBI's convergent validity, as both care and overprotection scales correlate with interviewers' ratings, .78 and .50, respectively. More recently, Parker (1990) published a review paper that focused on usage of PBI in various

populations during the last decade, which again showed strong internal consistency, reliability and validity.

It was adapted to Turkish by Kapçı and Küçüker (2006) (See Appendix C). Different from the original version, in the Turkish version, all the items were scored in the same direction leading to differences in the interpretation of total scores from care and overprotection dimensions. In the original English form, high scores on care dimension and low scores of overprotection dimension are considered as indicators of healthier parenting. With the modifications made in the scoring of the Turkish version, higher scores on both subscales represent more positive perceived parenting. In sum, higher scores on overprotection dimension indicate less overprotection and high scores on care dimension indicate high care. Factor structure of the Turkish version of the scale was different from the original version in terms of items loading under care and overprotection dimensions. In the original version, overprotection dimension includes items associated with parental control as well as items aimed at assessing parental overprotection. In contrast, results from the Turkish sample indicated that, the items measuring parental control loaded under parental care factor. In sum, these analyses showed that parental care in Turkish society is considered as an entity containing care, affection, love from the parents and parental control.

Also, the Turkish version has satisfactory levels of internal validity, .87 and .89 for mother total score and father's total score respectively. Results of exploratory factor analysis revealed a two factor solution but different from the original English version, some of the items (control items) loaded on the Care

factor, rather than the Overprotection factor. This finding was interpreted as a result of cultural differences.

2. 2. 4. Beck Depression Inventory (BDI)

It was developed by Beck, Rush, Shaw, and Emery (1979) and it is composed of 21 clinically derived items each represent a symptom category of depression. For each item, subjects are expected to select the statement that best describes their mood state in the past week, including the day of testing, to get a sense of their current level of depression. These self-evaluative statements are ranked in varying degrees of severity from 0 to 3, and subjects are allowed to select more than one statement in each symptom category if necessary. In order to get a total BDI score, scores across the items would be summed up, with higher scores reflecting more severe levels of depression. BDI has a concurrent validity of .65, based on clinician ratings. Also, it has adequate levels of split half (.90) and test-retest reliability (.75).

The BDI was adapted into Turkish by Hisli (1988) (See Appendix D). The split half reliability and internal consistency of the Turkish version were found to be. 74 and .86, respectively. It has test-retest reliability scores ranging from .76 to .84. It is a valid and reliable measure that can be used in Turkish populations (Savaşır & Şahin, 1997).

2. 2. 5. Liebowitz Social Anxiety Scale (LSAS)

The Liebowitz Social Anxiety Scale consists of 24 items rated on a 3-point Likert type scale for both “fear of anxiety” and “avoidance behavior”. It is

developed by Liebowitz (1987) to assess difficulties that social phobic individuals experience in certain social situations.

Turkish version of the scale is established by Soykan, Özgüven, and Gençöz (2004), and they reported psychometric properties of the scale as sufficient. In the present study the whole scale score was used, and the Cronbach's alpha coefficient for this scale was found as .93 (see Appendix E).

2. 2. 6. Brief Fear of Negative Evaluation Scale (BFNE)

BFNE is a scale that was developed to measure apprehension about negative evaluation by Leary (1983). It is the short version of the original Fear of Negative Evaluation (FNE) scale developed by Watson and Friend (1969). It contains 12-items that were chosen from the original scale, to which respondents' rate the degree to which each statement. The items are scored on a 5-point likert-type scale ranging from 5 "extremely characteristic" to 1 "not at all". Total scores range from 12 to 60, with higher scores representing greater fear of negative evaluation. The scale has high internal consistency and adequate levels of test-retest reliability over a 4 week period, .90 and .75, respectively. It was also reported to have high correlations with the original FNE scale (r=.96). Adaptation of the scale to Turkish was done by Koydemir and Demir (2007) (see Appendix F). The BFNE scale had good internal consistency (α = .94) and criterion validity (positive correlations with Revised Cheek and Buss Shyness Scale (RCBS) (r=.33) and Rosenberg's Self-Esteem Scale (r=-.21). In a more recent study, the BFNE yielded a Chronbach's alpha score of .78 (Koydemir & Demir, 2008).

2. 2. 7. Looming Maladaptive Style Questionnaire-Revised (LMSQ-R)

LMSQ-R (Riskind, et. al, 2000) is composed of six vignettes three of which are concerned with looming content related to social threat (scenarios 2, 4, 5) and the rest three associated with looming content related to physical threat (scenarios 1, 3, 6) (see Appendix G). There are four 5-likert type questions that assess anxiety felt, perceived risk, and degree of looming and vividness of visualization concerning each vignette. The questions included: "How anxious do you feel imagining yourself in this situation?", ''In this scene are the chances of your having difficulty decreasing or expanding with each moment? ", "Is the level of threat in the encounter staying fairly constant or is it growing rapidly larger with each passing moment?", "How much do you visualize your problem as in the act of becoming progressively worse?''. The last three questions for each vignette are summed up and average the items for the social threat vignettes together to calculate a "social looming" score, and do the same for other scenarios for a "physical looming threat." Scores from the two looming scales are averaged for a total measure for the LMSQ.

In terms of reliability and validity, different studies provided results all seem to be in the acceptable range. Riskind, et al. (2000) study which is one of the first published papers using LMSQ-R, provide a Cronbach coefficient alpha that suggests a high level of internal consistency ($\alpha = .91$). Also on a more recent study by Adler and Strunk (2009), the scale's internal consistency also appeared to be adequate ($r = .83$). The scale has excellent test-retest reliability over a 4-month period (Williams & Riskind, 2000) and 7-month period ($r = .72$) (Black, Balaban, & Riskind, 2002). LMSQ-R also appears to be a valid scale with higher

scores related to higher levels of anxiety as measured by Beck Anxiety Inventory, Spielberger's Trait Anxiety Scale, Anxious Thoughts Inventory and Beck Depression Inventory (r= .39, .44, .53, and .24 respectively). LMSQ-R is also known to have adequate discriminant validity, thus it can differentiate between anxiety and depression. Although the scale seemed to be significantly correlated with BDI as well, the correlation coefficient was reduced to non-significant levels (r=.14) when anxiety measures were partialled out (Riskind, et al., 2000).

The permission to translate the scale into Turkish was obtained from the author. One psychology professor and two graduate students in psychology, which were all fluent in English, translated the vignettes and items of the scale into Turkish independently. These three translations were compared and questions from these three different versions were administered to a group of university students to be reviewed. Corrections were made on the basis of feedback received from these reviewers and a common translated version emerged (see Appendix H). In a preliminary study, Turkish translation was pilot tested.

2. 2.7.1. Participants

Participants were 176 university students (104 female and 72 male), who agreed to participate in the study. The mean age of the participants was 20.55 (SD = 1.84). The age range of the participants was between 19 and 30.

2. 2. 7.2. Instruments

2. 2. 7. 2. 1. Demographic Information Form

It is composed of questions concerning the participants' age, and gender.

2. 2. 7. 2. 2. Looming Maladaptive Style Questionnaire-Revised (LMSQ-R)

LMSQ-R (Riskind, et. al, 2000) as introduced in the previous section.

2. 2. 7. 2. 3. Liebowtz Social Anxiety Scale (LSAS)

As introduced in the previous section.

2. 2. 7. 2. 4. Brief Fear of Negative Evaluation (BFNE)

As introduced in the previous section.

2. 2. 7. 2. 5. State-Trait Anxiety Inventory-Trait Version (STAI-T)

Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) is a self-report scale that measures chronic levels of anxiety and it is composed of 20 items. Participants are asked to answer 20 items about how they generally feel, on a four-point scale (from "1 = almost never" to "4 = almost always"). High scores indicate more severe trait anxiety. The scale was shown to have strong psychometric properties in over 3000 studies (Bieling, Antony, & Swinson, 1998). Turkish version of the scale is established by Öner and Le Compte (1975) it has internal consistency scores between .83 ve .87 (see Appendix I).

2. 2. 7. 2. 6. Beck Depression Inventory (BDI)

As introduced in the previous section.

2. 2. 7. 2. 7. Beck Anxiety Inventory (BAI)

It is a scale developed by Beck, Epstein, Brown, and Steer (1988) that consists of 21, Likert type items, assessing how the subject has been experiencing in the past week on a 4 point scale. Each item is descriptive of somatic, panic-like or subjective levels of anxiety. The scores range from 0 to 63. The scale has a Cronbach's alpha of .97 and a test-retest reliability of .75 in a one week period. In terms of validity, BAI's correlation with BDI, Hamilton Psychiatric Rating Scale

for Anxiety (HARS-R) and Hamilton Psychiatric Rating Scale for Depression (HRSD-R) were .48, .51, and .25, respectively. It was translated into Turkish by Ulusoy, Şahin, and Erkmen (1996). The Turkish version has adequate levels of reliability and validity (Appendix J).

2. 2. 7. 3. Procedure

The participants all volunteered to participate in the study without any incentives. They were given a packet that included all the questionnaires, a demographic information sheet, and an informed consent form. The questionnaire was administered during class hour and it took approximately 25 minutes for participants to complete the questions.

2. 2. 7. 4. Results

Prior to analysis, the data were examined through SPSS program for accuracy of data entry, missing values and fit between their distributions and assumptions for multivariate analysis. The data set did not have any problems with normality, linearity and homoscedasticity. Also Mahalanobis distance was used to detect multivariate outliers. No outliers were found and the analyses were performed on a sample of 176 university students.

2. 2. 7. 4. 1. Means, Standard Deviations, and Alpha Reliabilities for Measures

Internal consistencies (Cronbach's alpha) were calculated for the composite LMSQ-R score and the two subscales; social and physical looming. Table 2 shows the means, standard deviations, and alpha reliabilities for the

measures that were used in the present study. LMSQ-R also has adequate Guttman split-half reliability (.85).

Table 2. *Means, Standard Deviations and Reliabilities for study measures.*

Measures	N	M	SD	α
LMSQ-R	176	58.80	13.06	.87
Social loom	176	29.61	7.47	.88
Physical loom	176	29.19	7.58	.85
LSAS	173	89.23	20.23	.87
BAI	173	24.96	13.53	.89
BDI	173	13.19	7.50	.78
BFNE	172	33.54	8.81	.75
STAI-T	175	44.33	8.65	.82

Note: LMSO-R = Looming Maladaptive Style Questionnaire Revised, LSAS = Liebowitz Social Anxiety Scale, BAI = Beck Anxiety Inventory, BDI = Beck Depression Inventory, BFNE = Brief Fear of Negative Evaluation, STAI-T= State Trait Anxiety Inventory-Trait version

Also a series of t-tests were conducted to see if gender makes a difference. Results revealed that female participants had significantly higher scores than males on LMSQ-R (t (172) = 2.05, $p < .05$), social looming (t (172) = 2.13, $p < .05$) and Trait anxiety (t (171) = 2.76, $p < .05$).

2. 2. 7. 4. 2. Convergent and Divergent Validity

Table 3 displays the results for Pearson correlation coefficients among study variables. Social looming had a positive significant correlation with all scales, which indicates that individuals high in looming vulnerability also tend to show greater levels of anxiety and depression in different measures. Contrary to the expectations, although not highly correlated, BDI appeared to be correlated with all three looming scores.

Table 3. *Correlation coefficients.*

	1	2	3	4	5	6	7	8
1. Social Looming	-							
2. Physical Looming	.51**	-						
3. LMSQ-R	.87**	.87**						
4. LSAS	.42**	.27**	.40**					
5. BAI	.22**	.26**	.28**	.19*				
6. BDI	.26**	.24**	.29**	.29**	.30**			
7. BFNE	.42**	.23**	.38**	.45**	.25**	.28**		
8. STAI-T	.42**	.31**	.42**	.32**	.34**	.59**	.46**	

*p<.05, **p<.01, Note*:* LMSO-R = Looming Maladaptive Style Questionnaire-Revised, LSAS = Liebowitz Social Anxiety Scale, BAI = Beck Anxiety Inventory, BDI = Beck Depression Inventory, BFNE = Brief Fear of Negative Evaluation, STAI-T= State Trait Anxiety Inventory-Trait version.

2. 3. Procedure

Students taking introductory psychology and social psychology courses were invited to participate in the study in return for course credit. The data was gathered in a period of one month, in a number of sessions arranged in different days and times. A battery of questionnaires, arranged in counter balanced form, in order to control the order effects, was distributed to the participants in groups of about 50 people. During data gathering, an informed consent form was also presented to the participant informing them about the purpose of the study and that they were free to withdraw from the study at any time (see Appendix K). Besides complete confidentiality, any anonymity was maintained in gathering and processing data. In general, it took about 25-30 minutes to complete the entire questionnaire battery.

CHAPTER III

RESULTS

3.1. Data Cleaning

Before starting the analyses, all variables (N = 389) were examined for the presence of errors in data entry, missing values, univariate outliers, skewness, kurtosis, linearity, normality, and multivariate outliers using various SPSS programs. Two cases with missing values on more than 5% of the responses were deleted. The single missing values on MPS and BFNE scores were replaced by the mean for all cases. Preliminary analyses indicated that there were 7 univariate outliers on the scores of LSAS, BDI, Social and Physical Looming, all of which were deleted from the data (Tabachnick & Fidell, 2007). Distribution form all the variables were assessed for normality, which revealed moderate skewness on the total scores of LSAS and BDI. Given that these departures were only slight and the impact of departure from zero skewness is reduced as sample size increases (Tabachnick & Fidell, 2007), the results of the untransformed data are reported. Using Mahalonobis distance with $p < .001$, five cases were identified as multivariate outliers, and thus were also deleted. As a result of data cleaning procedure, 375 cases were examined for the further analyses.

3. 2. Descriptive Statistics

Means, standard deviations, minimum and maximum scores for variables are presented on Table 4.

Table 4. *Descriptive statistics for the measures of the study.*

	N	Mean	SD	Min.	Max.
LMSQ-R	375	59.93	13.20	18	88
Social looming	375	29.87	7.33	9	45
Physical looming	375	30.06	7.62	9	45
LSAS	375	88.59	21.47	50	159
BFNE	374	35.04	9.22	15	58
BDI	375	9.47	6.66	0	33
MPS					
PS	374	20.18	3.43	9	29
MEC	374	9.79	2.39	4.42	17.62
PBI					
Maternal Care	375	19.55	4.66	9	35
Paternal Care	375	22.77	5.93	11	44
Maternal Overprotection	375	13.50	4.10	1	21
Paternal Overprotection	375	14.97	4.30	3	21

Note: LMSQ-R = Looming Maladaptive Style Questionnaire-Revised, LSAS= Liebowitz Social Anxiety Scale, BFNE= Brief Fear of Negative Evaluation Scale, BDI= Beck Depression Inventory, PS = Personal Standards, MEC= Maladaptive Evaluative Concerns.

3.3. T-tests for Gender Difference:

A series of t-tests were performed to see the gender differences in terms of all the variables, results of which indicate presence of differences in MEC, personal standards maternal and paternal overprotection variables. Males tend to have higher levels of MEC (t (372) = -5.54, $p < .001$) and personal standards (t (372) = -2.10, p< .05) with respect to females, on the other hand, females reported having received healthier levels of both maternal (t (373) = 4.44, $p < .001$) and paternal overprotection (t (373) = 2.72, $p < .01$) than males. In other words males

perceived both their mothers and fathers as more overprotective than females do. Means and standard deviations are presented on Table 5.

Table 5. *Means and Standard Deviations of all variables with respect to Gender.*

	Female (N=263)		Male (N= 104)		Group Difference
	Mean	SD	Mean	SD	T
LMSQ-R	60.25	13.33	59.15	12.91	.73
Physical Looming	30.40	7.49	29.22	7.88	1.36
Social Looming	29.85	7.36	29.93	7.28	-.09
LSAS	89.11	21.88	87.31	20.49	.74
BFNE	35.08	9.31	34.94	9.02	.14
BDI	9.09	6.49	10.39	6.99	-1.73
MEC	9.37	2.30	10.82	2.30	-5.54***
PS	19.94	3.42	20.76	3.40	-2.10*
Maternal Care	42.12	8.78	42.14	7.23	-.01
Paternal Care	39.03	9.88	37.25	9.19	1.62
Maternal Overprotection	14.09	4.16	12.06	3.58	4.44***
Paternal Overprotection	15.32	4.05	14.02	4.55	2.72**

*p < .05; **p < .01
Note: LMSQ-R = Looming Maladaptive Style Questionnaire-Revised, LSAS= Liebowitz Social Anxiety Scale, BFNE= Brief Fear of Negative Evaluation Scale, BDI= Beck Depression Inventory, PS = Personal Standards, MEC= Maladaptive Evaluative Concerns.

3. 4. Pearson Correlation Coefficients

As can be seen in the Table 6, age of the participants was negatively and significantly correlated with LMSQ-R score (r = -.13, p <.01) and its two sub scores (social looming (r = -.12, p < .01); and physical looming (r = -.11, p < .01). So, it can be stated that a reduction is observed in anxiety levels of the participants as age increased. On the other hand gender appeared to be correlated with all of the perfectionism variables (r = .28, p < .01 for MEC and r = .11, p < .01 for PS)

indicating that males have a greater tendency to become perfectionists. Gender was also significantly correlated with maternal (r = -.22, p < .01) and paternal (r = -.14, p< .01) overprotection Both mothers' and fathers' education and SES were correlated with LMSQ-R, LSAS, maternal care, and paternal care (r's ranging between .11 and .21).

LMSQ-R score as an overarching cognitive vulnerability to anxiety, was significantly correlated with LSAS (r = .44, p < .01), BFNE (r = .39, p < .01), maternal (r = -17, p < .01), and paternal (r = -.20, p < .01) overprotection. Keeping in mind that higher scores on overprotection dimension of PBI indicates in fact less overprotection, it can be stated that individuals higher in LMS report their both parents as more overprotective. Also among dimensions of MPS, LMSQ-R was significantly correlated with MEC (r = .25, p < .01)]. Though not expected to be associated with depression, LMSQ-R also appeared to be associated with BDI scores (r = .17, p < .01).

LSAS, which measures levels of social anxiety, appeared to be significantly correlated with, BFNE (r = .51, p < .01), BDI (r = .37, p < .01), MEC (r = .31, p < .01) and PS (r = -.11, p < .01), and all dimensions of PBI maternal care (r = -.24, p < .01), paternal care (r = -.18, p < .01), maternal (r = -.19, p < .01) and paternal overprotection (r = -.17, p < .01). These results indicate that high scores on LSAS was associated with more negative levels of perceived parenting.

When the correlation of BFNE with other variables was investigated, it appeared that has a significant relationship with BDI (r = .32, p < .01), MEC (r =

.32, $p < .01$), and maternal ($r = -.17$, $p < .01$) and paternal overprotection ($r = -.12$, $p < .05$) dimensions of parental bonding.

BDI, a measure of severity of depression, also showed highly significant correlations with MEC ($r = .41$, $p < .01$). Regarding its relationship to parental variables, it can be said that BDI significantly correlated with Maternal Care ($r = .31$, $p < .01$), Paternal care ($r = -.21$, $p < .01$), Maternal Overprotection ($r = -.34$, $p < .01$), and Paternal Overprotection ($r = -.29$, $p < .01$). Again, as expected Higher BDI scores were found to be associated with more negative levels of perceived parenting.

MEC, which is a measure of more negative aspects of perfectionism has significant correlations with PS ($r = .31$, $p < .01$) MEC was also correlated with all dimensions of PBI, maternal care ($r = -.35$, $p < .01$); paternal care ($r = -.30$, $p < .01$); maternal overprotection ($r = -.40$, $p < .01$); and paternal overprotection ($r = -.34$, $p < .01$); indicating that MEC increases as the quality of parenting decreases. On the other hand, PS which is thought to be measuring positive aspects of perfectionism was significantly correlated only with paternal overprotection ($r = -.12$, $p < .01$) among the dimensions of PBI.

Table 6. *Intercorrelations among study variables.*

		1	2	3	4	5	6	7	8	9	10	11	12
1	Age												
2	Gender	.02											
3	Mothers' education	.04	-.04										
4	Fathers' education	-.01	-.03	.58**									
5	SES	-.02	-.05	.41**	.45**								
6	LMSQ-R	-.13*	-.04	-.18**	-.21**	-.18**							
7	Physical looming	-.11*	-.07	-.16**	-.18**	-.14**	.89**						
8	Social looming	-.12*	.00	-.16**	-.19**	-.19**	.88**	.56**					
9	LSAS	-.09	-.04	-.16**	-.21**	-.11*	.44**	.33**	.45**				
10	BFNE	.00	-.01	-.06	-.10	-.07	.39**	.26**	.43**	.51**			
11	BDI	.07	.09	-.01	-.09	-.06	.17**	.10	.20**	.37**	.32**		
12	MEC	.07	.28**	-.09	-.09	-.05	.25**	.19**	.26**	.29**	.31**	.41**	
13	PS	.01	.11*	.00	.02	.10	-.01	.00	-.02	-.11*	.09	-.06	.31**
14	M Care	-.08	.00	.12*	.13*	.10	-.03	.01	-.06	-.24**	-.12*	-.31**	-.35**
15	P Care	-.03	-.08	.06	.15**	.15**	-.04	-.01	-.05	-.18**	-.10	-.21**	-.30**
16	M Overprotection	-.01	-.22**	.06	.05	-.02	-.17**	-.13*	-.18**	-.19**	-.17**	-.34**	-.40**
17	P Overprotection	.03	-.14**	.09	.11*	-.04	-.20**	-.15**	-.20**	-.17**	-.12*	-.29**	-.34**

Note: ** p < .01, * p < .05, LMSQ-R = Looming Maladaptive Style Questionnaire-Revised, LSAS= Liebowitz Social Anxiety Scale, BFNE= Brief Fear of Negative Evaluation Scale, BDI= Beck Depression Inventory, PS = Personal Standards, MEC= Maladaptive Evaluative Concerns.

Table 6. *Continued.*

		13	14	15	16
1	Age				
2	Gender				
3	Mothers' education				
4	Fathers' education				
5	SES				
6	LMSQ-R				
7	Physical looming				
8	Social looming				
9	LSAS				
10	BFNE				
11	BDI				
12	MEC				
13	PS				
14	M Care	.02			
15	P Care	.04	.48**		
16	M Overprotection	-.03	.37**	.24**	
17	P Overprotection	-.12*	.24**	.25**	.51**

Note: ** p < .01, * p < .05, LMSQ-R = Looming Maladaptive Style Questionnaire-Revised, LSAS= Liebowitz Social Anxiety Scale, BFNE= Brief Fear of Negative Evaluation Scale, BDI= Beck Depression Inventory, PS = Personal Standards, MEC= Maladaptive Evaluative Concerns.

3. 5. Parental Variables and Looming Vulnerability

Hypothesis 1: It was hypothesized that disrupted parental bonding would be associated with the development of looming maladaptive style.

In order to test hypothesis 1 proposing that parental care and parental overprotection are associated with the LMS scores (for social and physical looming separately), a hierarchical multiple regression analysis was utilized. In the first step demographic variables such as age, gender, perceived SES, mothers' and fathers' education scores were entered into the equation. On the second step, all four variables of the PBI were entered (maternal care, paternal care, maternal overprotection and paternal overprotection).

When all scores were regressed on social looming, as shown in Table 7, the results indicated demographic variables explained 8 % of the total variance. F (5, 364) = 6.55, $p < .01$; and among the demographic variables, age (β = -.18, t (364) = -3.46, $p < .001$) and fathers' educational level (β = -.11, t (364) = -2.14, $p < .05$) appeared to be significantly associated with LMS. The parental variables entered in Step 2 predicted an additional 4 % of the variance in LMS scores (an increase to 13 % in the total variance predicted) beyond the effects of demographic variables, F (9, 360) = 5.76, $p < .01$ (F_{change} (4, 360) = 4.46, p <.01). Among the parental scores, both maternal (β = -.13, t (360) = -2.08, $p < .05$) and paternal overprotection (β = -.13, t (360) = -2.27, $p < .05$) were able to predict LMS scores. Although parental care variables were not significantly predicting changes taking place in social looming, lower maternal and paternal overprotection scores were associated with higher social looming scores, meaning

that individuals high in social looming perceive both their mothers and fathers as more overprotective.

With physical looming scores serving as the dependent variable, the demographic variables entered in the first step explained 7 % of the total variance and F (5, 364) = 5.40, $p < .001$, with only age appearing to be significantly associated with physical looming (β = -.16, t (364) = -3.09, $p < .01$). Although inclusion of parental variables in the second step led to a 3% increase in the variation explained F (9, 360) = 4.64, $p < .01$ (R^2= .1. F_{Change} (4, 360) = 3.52, $p <$ .01), none of the parental variables significantly contributed to the prediction of physical looming. Results can be seen in Table 7 in more detail.

Table 7. *Demographic variables and Parental Bonding Inventory subscores predicting Social and Physical Looming.*

	Social Looming			
Predictor variables	ΔR^2	R_{Change}	β	T
Step 1	.08***			
Age			-.17	-3.46**
Gender			-.01	-.094
Mothers' Educ.			-.03	-.443
Fathers' Educ.			-.14	-2.14*
SES			-.11	-2.04
Step 2	.12**	.04**		
Maternal Care			.02	.37
Paternal Care			.04	.64
Maternal OP			-.13	-2.08*
Paternal OP			-.13	-2.27*

Table 7. *Continued*

	Physical Looming			
Predictor variables	ΔR^2	R_{Change}	β	t
Step 1	.07***			
Age			-.16	-3.09**
Gender			-.07	-1.49
Mothers' Educ.			-.06	-.96
Fathers' Educ.			-.12	-1.87
SES			-.07	-1.18
Step 2	.10*	.03**		
Maternal Care			.09	Oca.50
Paternal Care			.02	.313
Maternal OP			-.12	-2.01
Paternal OP			-.11	-1.89

Note: SES= Socioeconomic Status
*p<.05. **p<.01. ***p<.001

3. 6. Parental Variables and Perfectionism

Hypothesis 2: It was hypothesized that disrupted parental bonding would be associated also with perfectionism. Besides, it was expected to differ between adaptive and maladaptive versions of perfectionism (Maladaptive Evaluative Concerns and Personal Standards).

A hierarchical multiple regression analysis was performed with the Maladaptive Evaluative Concerns score (composite score of CM, DA, PE and PC dimensions of MPS) as the dependent variable, in order to test hypothesis 2. On the first step, demographic variables were entered, which is followed by the second step, where the four PBI scores (maternal care, paternal care, maternal overprotection, and paternal overprotection) were introduced as independent

variables. In Table 8, results of the regression analysis are presented. The first step explained 8 % of the total variance F (5, 363) = 6.70, p <.001, and among the demographic variables only gender appeared to be significantly associated with MEC, indicating that males report significantly higher scores of maladaptive evaluative concerns when compared with females, β = .27, t (363) = 5.38, p < .01.

R for regression was significantly different from zero for the second step, F (9, 359) = 13.47, p <.001, explaining 25 % of the total variance (R^2_{Change} = .17, F_{Change} (4, 359) = 20.17, p <.001), with all independent variables significantly associated with perfectionism. The size and direction of the analyses indicate that higher amounts of perfectionism was present among participants who scored higher in maternal care (β = -.15, t (359) = -2.77, p < .01), paternal care (β = -.11, t (359) = -2.01, p < .05), maternal (β = -.18, t (359) = -3.25, p < .01) and paternal overprotection (β = -.14, t (359) = -2.51, p < .05). Considering that higher scores in both care and overprotection dimensions of PBI indicate positive perceived parenting, these results show that high MEC was associated with low care and high overprotection from both mother and father.

Table 8. *Demographic variables and Parental Bonding Inventory subscores predicting Maladaptive Evaluative Concerns.*

	MEC			
Predictor variables	ΔR²	R^2_{Change}	B	T
Step 1	.08***			
Age			.03	.56
Gender			.27	5.38***
Mothers' Education			-.04	-.60
Fathers' Education			-.06	-.99
SES			.00	.03

Table 8. *Continued*

Step 2	.25***	.17***		
Maternal Care			-.15	-2.77**
Paternal Care			-.11	-2.01*
Maternal OP			-.18	-3.25**
Paternal OP			-.14	-2.51*

Note: MEC= Maladaptive Evaluative Concerns, SES= Socioeconomic Status.
*p<.05. **p<.01. ***p<.001

In order to see whether any difference exists between adaptive and maladaptive domains of perfectionism, the same regression analyses were performed on Personal Standards (PS) scores. The demographic variables entered in the first step altogether explained 3 % of the variance, F (5, 363) = 1.92, p >.05, and none the predictors, appeared to be significantly associated with Personal Standards (PS). Likewise, none of the variables entered in the second step appeared to be associated with PS, thus not leading to any significant changes in the variance explained (R^2 = .04, F (9, 359) = 1.72, p > .05. Results of this analysis indicated differences behind two types of perfectionism. Results can be seen in Table 9. In sum, results of the analyses seem to confirm hypothesis 2, by showing the significant association of parental variables with perfectionism. Moreover, the hypothesis was further supported with the lack of a powerful significant association between parental variables and adaptive perfectionism (PS).

Table 9. *Demographic variables and Parental Bonding Inventory subscores predicting PS.*

	PS			
Predictor variables	ΔR^2	R^2_{Change}	β	T
Step 1	.03*			
Age			.02	.43
Gender			.12	2.30
Mothers' Education			-.04	-.64
Fathers' Education			.00	.04
SES			.12	2.03
Step 2	.04	.01		
Maternal Care			-.01	-.13
Paternal Care			.06	.96
Maternal OP			.06	.89
Paternal OP			-.14	-2.33

Note: PS= Personal Standards. SES= Socioeconomic Status.
*p<.05. **p<.01. ***p<.001

3. 7. 1. Parental Variables, Physical Looming, Social Looming and Perfectionism as Predictors of Social Anxiety

Hypothesis 3: It was expected that social anxiety would be associated with both dimensions of looming, as well as parental variables. It is also expected that social looming would be more strongly associated with measures of social anxiety with respect to physical looming.

Hypothesis 5: It was hypothesized that perfectionism would be associated also with social anxiety.

Hypothesis 7: It was hypothesized that LMS would still be associated with social anxiety when depression is controlled.

Hypothesis 8: It was hypothesized that perfectionism would be associated with both depression and social anxiety, apart from each others' influences on the other.

To assess the association of social anxiety with demographic variables, parental variables, dimensions of looming, and perfectionism a hierarchical regression analysis was utilized with demographic variables on the first step, parental variables on the second, two looming scores (social and physical) on the third step, and two dimensions of perfectionism entered on the fourth step. All variables were regressed on LSAS scores. A fifth step was included to check the relationship of these variables with LSAS when the effect of BDI scores is controlled in order to test hypothesis number 8. The first step explained 6 % of the total variance and F (5, 364) = 4.79, $p < .001$, among the demographic variables age (β = -.12, t (364) = -2.45, p< .05) and fathers' education (β = -.17, t (364)= -2.66, $p <$ .01) were significant. In the second step after the inclusion of parental variables, the variance explained was increased to 13 %, F (4, 360) = 6.02, $p <$ .001. ($R^2_{\text{Change}} = .05$, F_{Change} (4, 360) = 7.14, $p < .001$) Only, maternal care (β = -.14, t (360) = 2.38, $p < .05$) significantly contributed to the prediction of changes in LSAS, indicating that individuals with higher scores on LSAS, significantly reported having received lower care from their mothers. The third step made an addition of 15 % (F_{Change} (2, 358) = 37.01, p < .001) to the variance explained F (11, 358) = 12.64, $p < .001$, with only social looming (β = .36, t (360) = 6.48, $p <$ .001) significantly predicting changes in LSAS. As expected, results showed that amount of social anxiety increased when level of social looming increases. The

next step where perfectionism dimensions were included into analyses explained and additional 4 % (F_{Change} (2, 355) = 10.37, $p < .001$) of the variance and variance explained increased to 32 % F (13, 355) = 12.86, $p < .001$. on this step, MEC (β = .22, t (355) = 3.85, $p < .001$) was positively significantly associated with LSAS scores but PS (β = -.17, t (355) = -3.60, $p < .001$) was significantly associated with LSAS scores in a negative way. The last step, where the BDI scores was introduced into the equation increased the variance explained to 36 % [F (14, 354) = 14.15, $p < .001$] with leading to a 4 % increase in the variance explained (F_{Change} (1, 354) = 21.33, $p < .001$) .As expected, BDI scores appeared to be significantly associated with LSAS scores (β = .23, t (354) = 4.62, $p < .001$). In addition to that, results of this step of the regression analysis appeared to be confirming hypotheses 7 a and 8 showing that both social looming (β = .32, t (354) = 5.92, $p < .001$), MEC (β = .14, t (354) = 2.47, $p < .05$), and PS (β = -.13, t (354) = -2.83, $p < .01$) remained significantly associated with LSAS, when the effects of BDI were controlled. Results of the regression analysis are summarized in Table 10.

Table 10. *Demographic Variables, Parental Bonding Inventory Subscores, Domains of LMS, and Dimensions of Perfectionism in predicting LSAS scores.*

	LSAS			
Predictor variables	ΔR^2	R^2_{Change}	B	T
Step 1	.06**			
Age			-.12	-2.45*
Gender			-.04	-.87
Mothers' education			-.06	-.90
Fathers' education			-.17	-2.66*
SES			-.01	-.17

Table 10. *Continued.*

Step 2	.13***	.07***		
Maternal Care			-.14	-2.38*
Paternal Care			-.06	-1.02
Maternal OP			-.10	-1.65
Paternal OP			-.06	-1.09
Step 3	.28***	.15***		
Physical Looming			.08	1.51
Social Looming			.36	6.48***
Step 4	.32***	.04***		
MEC			.22	3.85***
PS			-.17	-3.60***
Step 5	.36***	.04***		
Physical Looming			.07	1.39
Social Looming			.32	5.92***
MEC			.14	2.47*
PS			-.13	-2.83**
BDI			.23	4.62***

*p<.05. **p<.01. ***p<.001, *Note:* SES= Socioeconomic Status. LSAS= Liebowitz Social Anxiety Scale, BDI= Beck Depression Inventory, PS = Personal Standards, MEC= Maladaptive Evaluative Concerns.

As can be seen in Table 11, the same regression analysis was performed with BFNE, which is another measure of social anxiety, as the dependent variable. The demographic variables entered in the first step explained 2 % of the total variance F (5, 363) = 1.16, $p > .05$, with none of the variables making a significant contribution to the prediction of BFNE. The parental variables on the second level however, were able to account for an additional 3 % (F_{Change} (4, 359) = 3.03, $p < .05$) of the variance, increasing the variance explained to 5 % , F (9, 359) = 1.98, $p < .05$ and among the variables, only maternal overprotection (β = -.14, t (359) = -2.2. $p < .05$) was significantly associated with BFNE. The

direction of the relationship between two variables indicates that individuals who have higher BFNE scores significantly scored lower on maternal overprotection. This can be interpreted as these individuals have a tendency to perceive their mothers parenting style as more overprotective in the first 16 years of their lives. The third level with the inclusion of looming explained an additional 15 % (F_{Change} (2, 357) = 33.46, $p < .001$), thus increasing the total variance explained to 20 %, F (11, 357) = 7.99, $p < .001$, but only social looming ($\beta = .40$, t (357) = 6.73, $p < .001$) appeared to be significantly associated with fear of being negatively evaluated, confirming hypothesis 3. The fourth step that was included into the equation with the aim of testing hypothesis 5, increased the variance explained to 23 % by leading to a 3 % increase in the total variance explained (F_{Change} (2, 354) = 7.85, p < .001, F (13, 354) = 8.25, $p < .001$). In this step, only MEC came out to be significantly predicting changes in BFNE ($\beta = .20$, t (354) = 3.31, $p < .01$). The fifth step was included with the aim of testing hypothesis 7a and 8 for BFNE aspect of social anxiety. This step explained 27 % of the variance F (14, 353) = 9.24, $p < .001$. ($R^2_{Change} = .04$, F_{Change} (1, 353) = 17.18, $p < .001$). BDI, that was entered as the predictor variable on this step was associated with BFNE ($\beta = .22$, t (353) = 4.14, $p < .01$). Confirming hypothesis 7a, although BDI scores were controlled, social looming was still able to significantly predicting changes taking place in BFNE ($\beta = .35$, t (353) = 6.13, $p < .001$). As a result of obtaining a significant association of MEC ($\beta = .13$, t (353) = 2.06, $p < .05$) with BFNE in this step, Hypothesis 8 was also confirmed by showing that nature of the relationship between BFNE and perfectionism did not change even after controlling for the effect of BDI.

Table 11. *Demographic Variables, Parental Bonding Inventory Subscores, Domains of LMS, Dimensions of Perfectionism in Predicting BFNE scores.*

	BFNE			
Predictor variables	ΔR^2	R^2_{Change}	B	T
Step 1	.02			
Age			-.06	-1.11
Gender			-.01	-.11
Mothers' education			.02	.25
Fathers' education			-.10	-1.56
SES			-.03	-.49
Step 2	.05*	.03*		
Maternal Care			-.04	-.64
Paternal Care			-.03	-.45
Maternal OP			-.14	-2.20*
Paternal OP			-.02	-.36
Step 3	.20***	.15***		
Physical Looming			.03	.50
Social Looming			.40	6.73***
Step 4	.23***	.03***		
MEC			.20	3.31**
PS			.05	.91
Step 5	.27***	.03***		
Physical Looming			.02	.31
Social Looming			.35	6.13***
MEC			.13	2.06*
PS			.08	1.65
BDI			.22	4.14***

Note: SES= Socioeconomic Status, BFNE= Brief Fear of Negative Evaluation Scale, BDI= Beck Depression Inventory, PS = Personal Standards, MEC= Maladaptive Evaluative Concerns..
*p<.05. **p<.01. ***p<.001

3. 7. 2. Parental Variables, Physical Looming, Social Looming and Perfectionism as Predictors of Depression

Hypothesis 4: It was expected that although parental variables would be associated with depression, dimensions of looming would be weakly or not significantly associated with depression.

Hypothesis 6: It was hypothesized that dimensions of perfectionism will be associated with depression.

Hypothesis 7b: It was hypothesized that LMS would not be associated with depression when social anxiety is controlled.

Hypothesis 8: It was hypothesized that perfectionism would be associated with both depression and social anxiety, apart from each others' influences on the other.

In order to test for the hypotheses 4, 6, 7b, and 8, a five- level- hierarchical regression analysis with BDI scores as the dependent variable was performed including demographic variables in the first step, and parental variables and looming on the second and third steps respectively, which was followed by dimensions of perfectionism (MEC and PS) entered on the fourth step and two measures of social anxiety (LSAS and BFNE) entered on the fifth. The first level explained 2 % of the variance in depression scores F (5, 364) = 1.56, p>.05 showing that none of the demographic scores were associated with changes in depression. Parental variables on the other hand made a significant contribution [R^2 = .17, F (9, 360)= 8.45, p < .001] leading to a 15 % increase in the variance explained (F_{Change} (4, 360) = 16.83, p < .001), with maternal care (β = -.19, t (360) = -3.33, p < .01), maternal overprotection (β = -.18, t (360) = -2.97, p < .01), and

paternal overprotection (β = -.14, t (360) = -2.54, $p < .05$) appearing as significantly predicting depression. These results indicated that both low levels of maternal care and high levels of overprotection from both parents (as indicated by lower scores on the Turkish version of PBI) were associated with higher levels of depression. The third level, where two looming scores were entered increased the variance explained to 19 %, F (2, 358) = 2.88, $p < .05$ (R^2_{Change}= .02, F_{Change} (2, 358) = 3.26, $p < .05$), showing that only social looming was able to predict changes in depression (β = .13, t (358) = 2.22, $p < .05$). These two steps were confirming hypothesis 4 showing that dimensions of parental bonding were associated with levels of depression and among the domains of LMS, only social looming was significantly but weakly predicting the changes in depression. The fourth level in which MEC and PS were entered into the equation, explained an additional 7 % of the variance, F_{Change} (2, 354) = 17.01, $p < .001$, thus the total variance explained increased to 27 %, F (13, 354) = 9.79, $p < .001$. Confirming hypothesis 6 both MEC and PS appeared to be significantly predicting changes in BDI scores. But, although association of MEC (β = .33, t (354) = 5.62, $p < .001$). with BDI appeared in the positive direction, PS (β = -.17, t (354) = -3.39, $p < .01$), was negatively associated with BDI. With the inclusion of LSAS and BFNE on the last step the regression equation explained 32 % of the total variance, F (15, 352) = 11.61, $p < .001$ (R^2_{Change} = .05, F_{Change} (2, 352) = 14.15, $p < .001$,). Both measures of social anxiety (LSAS β = .19, t (352) = 3.26, $p < .01$ and BFNE β = .14, t (352) = 2.59, $p < .05$) were positively associated with BDI scores. In fact, this step of the regression analysis was confirming both hypotheses 7b and 8 by indicating a nonsignificant association of social looming and still significant

associations of MEC (β = .26, *t* (352) = 4.49, *p* < .001). and PS (β = -.14, *t* (352) = -2.89, *p* < .01), with BDI scores, when the measures of social anxiety are controlled. Results are presented on Table 12.

Table 12. *Demographic Variables, Parental Bonding Inventory Subscores, Domains of LMS, and Dimensions of Perfectionism in Predicting BDI scores.*

	BDI			
Predictor variables	ΔR^2	R^2_{Change}	β	t
Step 1	.02			
Age			.01	.11
Gender			.09	1.66
Mothers' education			.09	1.33
Fathers' education			-.13	-1.89
SES			-.03	-.54
Step 2	.17***	.15***		
Maternal Care			-.19	-3.33***
Paternal Care			-.02	-.32
Maternal OP			-.18	-2.97**
Paternal OP			-.14	-2.54*
Step 3	.19***	.02*		
Physical Looming			-.00	-.07
Social Looming			.13	2.22*
Step 4	.27***	.08***		
MEC			.33	5.62***
PS			-.17	-3.32**
Step 5	.32***	.05***		
Physical Looming			-.05	-.89
Social Looming			-.03	-.50
MEC			.26	4.49***
PS			-.14	-2.89**
LSAS			.19	3.26**
BFNE			.14	2.59*

Note: SES= Socioeconomic Status, LSAS= Liebowitz Social Anxiety Scale, BFNE= Brief Fear of Negative Evaluation Scale, BDI= Beck Depression Inventory, PS = Personal Standards, MEC= Maladaptive

Evaluative Concerns.
*p<.05. **p<.01. ***p<.001

3. 8. Mediation Analyses

To investigate the possibility that MEC and LMS underlies the link between parental care-parental overprotection and individuals' level of depression, social anxiety, and fear of negative evaluation, mediation analyses were performed. Following the recommendations of Preacher and Hayes (2004), mediation was assessed by using two methods. Firstly, Baron and Kenny's (1986) guidelines for performing mediation analyses were followed. According to these guidelines, there are four requirements for mediation. Firstly, there must be a significant relationship between the independent variable and the mediator variable. Secondly, the mediator variable and the dependent variable should be related. And lastly, there must be significant relationship between independent and dependent variable, which should be reduced when the effect of mediator variable is controlled. In other words, the relationship between dependent variable and independent variable should no longer be significant or should significantly decrease its strength, after controlling the effect of mediator variable. So potential mediator roles of MEC and LMS were tested, for the relationship between each parental bonding score (maternal care, paternal care, maternal overprotection, and paternal overprotection) and each depression and social anxiety measure (LSAS and BFNE). Variables that are to be included in mediation analyses were selected considering the zero-order correlations (see Table 6). The relationships with an r score above .20 were considered to be suitable for mediation analyses. Thus a

total of 6 mediation analyses were conducted. Secondly, Sobel test was used to assess whether the indirect effect (relationship between independent and dependent variables through changes in the mediator) is statistically significant, in cases where Baron and Kenny's (1986) requirements are met.

3. 8. 1. The Mediator role of Maladaptive Evaluative Concerns between PBI Variables and Measures of Depression and Social Anxiety

Regarding the mediator role of MEC in the relationship between parental variables and measures of depression and social anxiety, only five mediation analyses were performed. Since zero-order correlation analyses indicated strong correlations between only maternal care and LSAS scores, the mediation analysis aimed at testing the role of MEC as a mediator in the relationship between parental variables and LSAS will only be composed of testing the role of maternal care as the independent variable. Since the correlation of LSAS with other parental variables is below a certain level of significance, further analyses were not performed.

Secondly, BFNE did not indicate correlations higher than r = .20, thus, no mediation analyses were done with BFNE serving as the independent variable. Lastly, BDI appeared to be adequately associated with all the parental variables as well as MEC, thus, mediator role of MEC was tested for the relationship of all dimensions of parental bonding with BDI scores.

In order to check whether four assumptions of Baron and Kenny (1986) are satisfied, two regressions were performed for each mediation analysis.

First, the mediating variable (MEC) was regressed on the independent variables (PBI dimensions) to check the significance of the association between them.

Secondly, a hierarchical regression was performed with the dependent variables (LSAS and BDI) serving as the outcome variables, and the independent variables (PBI dimensions) and the mediator variable (MEC) entered on the first and second steps respectively.

3. 8. 1. 1. The Mediator Role of Maladaptive Evaluative Concerns (MEC) between Maternal Care and Measures of Social Anxiety and Depression

It was hypothesized that MEC would mediate the relationship between maternal care and measures of social anxiety and depression. Two mediation analyses were conducted to examine the mediator role of MEC on the relationship between maternal care/control and LSAS and BDI scores.

In the first mediation analysis, mediator role of MEC was tested with LSAS serving as the dependent variable. To establish that MEC acts as a mediator between maternal care and social anxiety:

- Maternal care scores must be significantly associated with LSAS.
- Changes in the maternal care must be able to significantly predict changes in MEC.
- Changes in maternal care must also significantly account for the changes in LSAS.

- Lastly, the strength of the relationship between maternal care and LSAS should be reduced, when the effect of MEC on LSAS is controlled for

To test whether these conditions are satisfied, two regression analyses were done. Firstly, regression analysis was performed in order to test the remaining assumptions, with MEC serving as the dependent variable and maternal care were entered on first and second steps respectively. The regression equation explained 4% of the variance F (1, 372) = 50.95, $p < .001$), and showed that lower levels of maternal care was associated with higher levels of MEC ($\beta = -.35$, t (372) = -7.14, $p < .001$).

Secondly, a hierarchical regression analysis, in which LSAS served as the dependent variable, was conducted. The first step that introduced maternal care as the independent variable, explained only 6% of the total variance (F (1, 372) = 22.01, $p < .001$), with a significant association with maternal care ($\beta = -.24$, t (372) = - 4.69, $p < .05$). On the second step MEC was entered into the equation and the explained variance increased to 11 % (F (2, 371) = 21.97, $p < .001$, $R^2_{\text{Change}} = .05$, $F_{\text{Change}}(1,371) = 20.76$, $p < .001$), and MEC had a significant association with LSAS ($\beta = .24$, t (371) = 4.56, $p < .001$). After controlling for MEC Maternal care again revealed a significant but reduced association with LSAS, $\beta = -.15$, t (371) = -2.93, $p > .01$. These two analyses indicate the partial mediator role of MEC between Maternal care and LSAS. Results of regression analyses are summarized in Table 13.

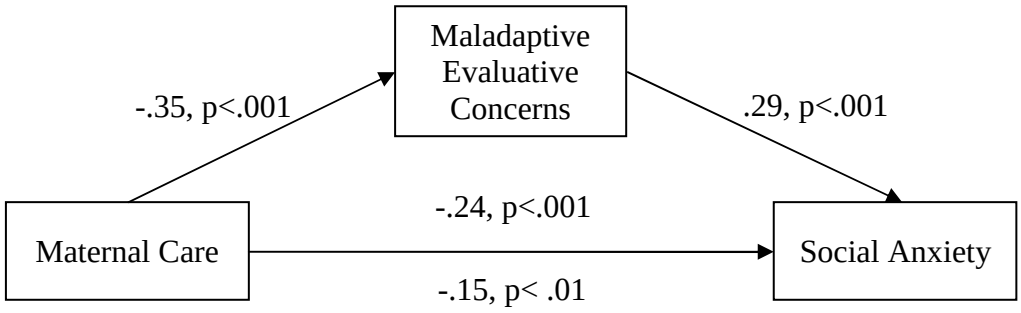
Table 13. *Summary of Regression Models Testing for MEC as Mediator between Maternal Care and Social Anxiety.*

Model: Independent variable	Dependent variable	R^2	F	β	t
Maternal Care	MEC	.12	50.95***	-.35	-7.14***
Mediator: MEC	LSAS				
1.Maternal Care		.06	22.01***	-.24	-4.69*
2.MEC		.11	21.97***	.24	5.71***
(Maternal Care)				-.15	-2.93

Note: *** p < .001, ** p < .01, * p < .05, LSAS = Liebowitz Social anxiety Scale, MEC = Maladaptive Evaluative Concerns

In order to provide further support for the mediator effect of MEC, a Sobel test was conducted (z = -3.84, p < .001). Additional analyses showed that 35.15 % of the maternal care- social anxiety path was accounted for by the maladaptive evaluative concerns. All these results confirm the role of MEC as a mediator between these variables, which is depicted in Figure 1.

Figure 1. *Mediator role of MEC between Perceived Maternal Care and Social Anxiety*



It was also hypothesized that MEC would mediate the relationship between maternal care and depression. In order to test this, following assumptions should be met:

- Maternal care scores must be significantly associated with BDI scores.
- Changes in the maternal care must be able to significantly predict changes in MEC.
- Changes in maternal care must also significantly account for the changes in BDI.
- Lastly, the strength of the relationship between maternal care and BDI should be reduced, when the effect of MEC on BDI is controlled for.

Considering the mediator role of MEC between maternal care and Depression, again two different regression analyses were performed. As can be seen in Table 14 and indicate above, the first regression analysis with MEC serving as the dependent variable and maternal care as the independent variable indicated a significant relationship between these two variables.

In the second regression analysis, where BDI scores are placed as the dependent variable, first step, where maternal care was entered as the independent variable explained 9 % of the variance , (F (1, 372) = 38.43, $p < .001$), with maternal care significantly associated with depression (β= -.31, t (372) = -6.20, $p < .001$). The inclusion of MEC in the second step explained an additional 10 % of the variance (F_{Change} (1, 371) = 47.53, $p < .001$), thus increasing the total variance explained to 19 % F (2, 371) = 45.38, $p < .001$), indicating a significant

association of MEC with depression (β = .34, t (371) = 6.89, $p < .001$) but no significant reduction took place in the association of maternal care with depression when the effect of MEC controlled (β = .19, t (371) = -3.77, $p < .05$). Thus, the analysis showed that MEC failed to fully mediate the relationship between maternal care and depression (Table 14).

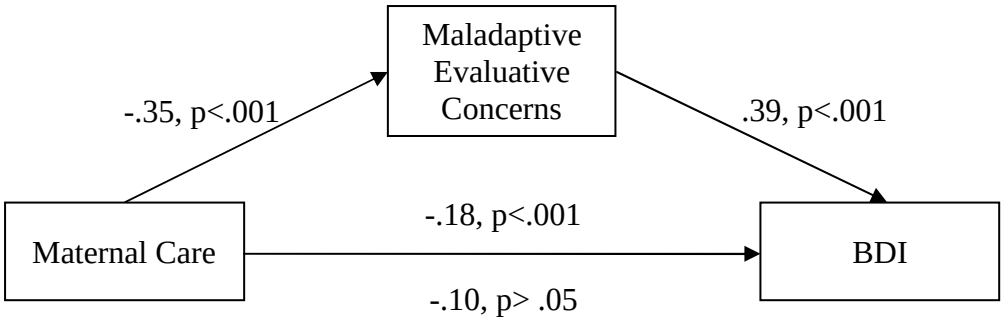
Table 14. *Summary of Regression Models Testing for MEC as Mediator between Maternal Care and Depression.*

Model: Independent variable	Dependent variable	R^2	F	β	t
Maternal Care	MEC	.12	50.95***	-.35	-7.14***
Mediator: MEC	BDI				
1.Maternal Care		.03	38.43***	.18	-6.20***
2.MEC		.18	45.38***	.39	6.89***
(Maternal Care)				.10	-3.77***

Note: *** p < .001, ** p < .01, * p < .05, BDI = Beck Depression Inventory, MEC = Maladaptive Evaluative Concerns

Further analyses were conducted to check the role of MEC as a partial mediator in the relationship between maternal care and depression (see Figure 2). Results of the Sobel test revealed that the changes taking place in the strength of the association between maternal care and BDI, when MEC was controlled is significant (z = -4.96, $p < .001$), together with additional calculations, it was shown that maladaptive perfectionism partially mediates 39.02 % of the relationship between maternal care and depression.

Figure 2. *Mediator role of MEC between Perceived Maternal Care and BDI.*



3. 8. 1. 2. The Mediator Role of Maladaptive Evaluative Concerns (MEC) between Paternal Care and Depression

It was also hypothesized that MEC would mediate the relationship between paternal care and depression. In order for this mediation to be significant, the following assumptions should be satisfied.

- Paternal care must be significantly associated with BDI scores.
- Variations in paternal care must significantly account for the variations in MEC scores.
- MEC should be significantly predicting changes taking place in BDI scores.
- When the effect of the MEC on BDI scores is controlled for, the strength of the previously significant relation between paternal care and depression should significantly decrease.

The first regression equation analysis that was done to test the mediator role of MEC between paternal care and depression, checked the association between parental care and MEC with a regression analysis in which MEC scores

were regressed on MEC scores. The regression equation, explained 9 % of the variance in MEC, F (1, 372) = 37.45, $p < .001$, with paternal care significantly associated with MEC (β= -.30, t (372) = -6.12, $p < .001$).

Next, a hierarchical regression was conducted with paternal care variable entered on the first step explained only 4 % of the variance (F (1, 372) = 16.90, $p < .001$) with paternal care appearing as significantly associated with depression (β= -.21, t (372) = -4.11, $p < .001$). But the second step of the equation explained an additional 13 % (F_{Change} (1, 371) = 58.49, $p < .001$) increasing the variance explained to 17 % (F (2, 371) = 39.00, $p < .001$), showing the significant contribution of MEC to prediction of depression (β= .38 t (371) = 7.56, $p < .001$) and the predictive effect of paternal care on depression appeared not to be significant when influence of MEC is controlled (β= -.09, t (371) = -1.90, $p > .05$). As summarized in Table 15, these results signal the role of MEC as a mediator between paternal care and depression.

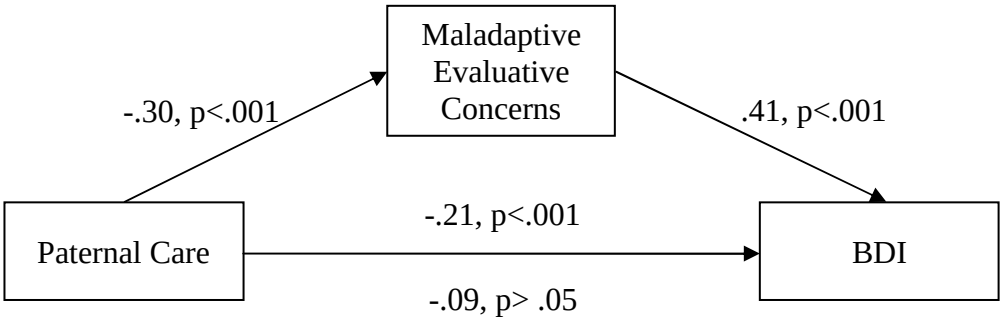
Table 15. *Summary of Regression Models Testing for MEC as Mediator between Paternal Care and Depression.*

Model: Independent variable	Dependent variable	R^2	F	B	t
Paternal Care	MEC	.09	37.45***	-.30	-6.12***
Mediator: MEC	BDI				
1.Paternal Care		.04	16.90***	-.21	-4.11***
2.MEC		.17	65.31***	.38	7.56***
(Paternal Care)				-.09	-1.90

Note: *** p < .001, ** p < .01, * p < .05, BDI = Beck Depression Inventory, MEC = Maladaptive Evaluative Concerns

In order to test the significance of mediation analysis, a Sobel test was performed, which showed that maladaptive perfectionism fully mediates the relationship between paternal care and depression (z = -4.83, p < .001) and the mediator explains 55.23 % of the relationship between dependent and independent variables. This relationship is depicted in Figure 3.

Figure 3. *Mediator role of MEC between Perceived Paternal Care and BDI*



3. 8. 1. 3. The Mediator Role of Maladaptive Evaluative Concerns (MEC) between Maternal Overprotection and Depression

Another hypothesis was concerning the mediator role of MEC in the relationship between maternal overprotection and depression. The following assumptions should be satisfied:

- Maternal overprotection should be significantly associated with depression.
- Maternal overprotection should be able to significantly predict the variations in MEC.
- Variations in MEC must significantly account for the variations in BDI

- When the effect of MEC on BDI scores is controlled for, the strength of the previously significant relation between maternal overprotection and depression should significantly decrease.

Considering the role of MEC as a mediator between maternal overprotection and depression, a regression analysis was performed with maternal overprotectiveness entered as the predictor variable, with MEC serving as the dependent variable. Results revealed that the regression explained 16 % of the MEC, F (1, 372) = 70.58, $p < .001$, and maternal overprotectiveness was significantly predicting MEC (β = -.40, t (372) = -8.37, $p < .001$).

Secondly, a hierarchical regression analysis where BDI is introduced as the dependent variable was conducted. Maternal overprotection entered on the first step, explained 11% of the variance (F(1, 372) = 46.82, $p < .001$), with maternal protection significantly predicting changes in depression (β = -.33, t (372) = -6.84, $p < .001$). The second step in which MEC was entered as the independent variable explained 20 % of the variance in depression F (1, 371) = 46.66, $p < .001$; R^2_{Change}= .09, F_{Change} (1, 371) = 41.41, $p < .001$). In this step both MEC (β = .33, t (371) = 6.43, $p < .001$) and maternal overprotection (when MEC is controlled) (β = -.20, t (371) = - 4.05, $p < .001$) appeared to be still significantly associated with depression. Results are summarized in Table 16.

In order to test whether the reduction in the association between maternal overprotection and BDI scores is significant, a Sobel test was conducted. Results revealed that mediation effect is partial but significant (z = -5.08, p < .001) and the 38.78 % percent of the relationship is mediated by MEC. As also depicted in

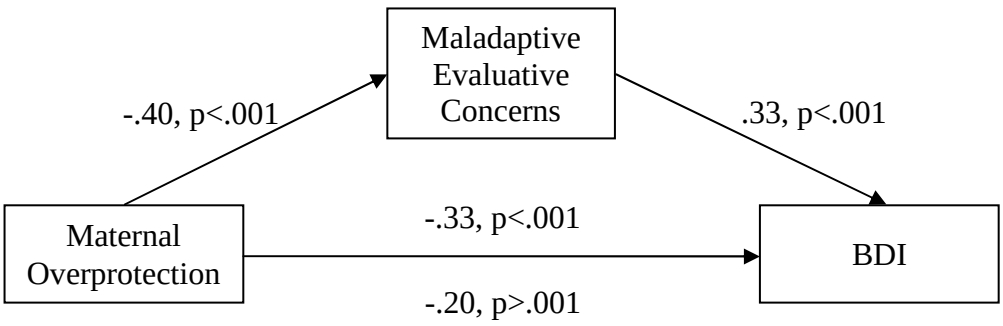
Figure 4, these analyses showed the role of maladaptive perfectionism as a partial mediator in the relationship between maternal overprotection and depression.

Table 16. *Summary of Regression Models Testing for MEC as Mediator between Maternal Overprotection and Depression*

Model: Independent variable	Dependent variable	R^2	F	β	t
Maternal Overprotection	MEC	.16	70.58***	-.40	-8.37***
Mediator: MEC	BDI				
1.Maternal Overprotection		.11	46.82*	-.33	-6.84***
2.MEC		.20	46.66***	.33	6.43***
(Maternal Overprotection)				-.20	-4.05***

Note: *** p < .001, ** p < .01, * p < .05, BDI = Beck Depression Inventory, MEC = Maladaptive Evaluative Concerns

Figure 4: *Mediator role of MEC between Perceived Maternal Overprotection and Depression*



3. 8. 1. 4. The Mediator Role of Maladaptive Evaluative Concerns (MEC) between Paternal Overprotection and Depression

Another hypothesis was concerning the role of MEC as a mediator between paternal overprotection and depression. In order to verify this hypothesis, following assumptions should be met:

- Paternal overprotection should be significantly associated with depression.
- Paternal overprotection should be able to significantly predict the variations in MEC.
- Variations in MEC must significantly account for the variations in BDI
- When the effect of MEC on BDI scores is controlled for, the strength of the previously significant relation between paternal overprotection and depression should significantly decrease.

In order to test whether MEC mediates the relationship between paternal overprotection and depression, a regression analysis where MEC was regressed on paternal overprotection was conducted. This regression equation explained 12 % of the total variance F (1, 371) = 49.11, $p < .001$, with paternal overprotection appearing as significantly predicting MEC (β= -.34, t (361) = -7.01, $p < .001$).

In order to test whether the other assumptions are met, a hierarchical regression analysis was done to predict BDI scores, with the aim of testing the role of MEC in the relationship between paternal overprotection and BDI scores. The first step explained 8 % of the total variance F (1, 372) = 33.82, $p < .001$, by paternal overprotection appearing as significantly associated with BDI scores (β= -.29, t (372) = -5.81, $p < .001$). The third step explained an additional 11 %,

(F_{Change} (1, 370)= 49.41, $p < .001$) increasing the total variance explained to 19 % (F (2, 371) = 43.81, $p < .001$) with both MEC (β= .35, t (371) = 7.03, $p< .001$) and paternal overprotection when effect of MEC is controlled (β= -.17, t (371) = -3.41, $p < .01$) were contributing significantly to prediction of BDI. Lack of reduction in the significance levels of the association between BDI and paternal overprotection, when effect for MEC was controlled, showed that MEC does not fully mediate the relationship between paternal overprotection and depression. A summary of the results of regression analyses can be seen on Table 17.

Table 17. *Summary of Regression Models Testing for MEC as Mediator between Paternal Overprotection and Depression*

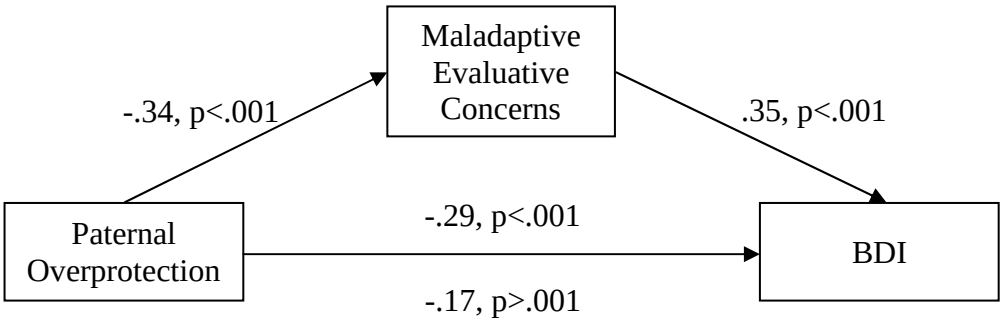
Model: Independent variable	Dependent variable	R^2	F	β	T
Paternal Overprotection	MEC	.12	49.11***	-.34	-7.01***
Mediator: MEC	BDI				
1.Paternal Overprotection		.08	33.82***	-.29	-5.81***
2.MEC		.19	43.81***	.35	7.03***
(Paternal Overprotection)				-.17	-3.41***

Note: *** p < .001, ** p < .01, * p < .05, BDI = Beck Depression Inventory, MEC = Maladaptive Evaluative Concerns,

Next, a Sobel test was conducted to see whether the change taking place in the association between paternal overprotection and BDI when MEC was controlled is significant. Results of the Sobel test indicate that the reduction is significant (z = -4.92, p < .001) and the MEC as a partial mediator, mediates 41.79

% of the relationship between paternal overprotection and depression. The mediator role of maladaptive perfectionism in the relationship between paternal overprotection and depression is depicted in Figure 5.

Figure 5: *Mediator role of MEC between Perceived Maternal Overprotection and Depression*



3. 8. 2. The Mediator Role of Looming Maladaptive Style (LMS) between PBI Variables and measures of Depression and Social Anxiety

Prior to mediation analyses, results of zero-order correlations were analyzed to decide the variables suitable for mediation analyses (see Table 6). The results indicated nonsignificant or weakly significant ($r < .20$) correlations between physical looming and all dimensions of parental bonding. Also, correlations of parental care and maternal overprotection with social looming were also weak with r's again below .20. Taking all these into account, mediation analyses testing the mediator role of looming (both social and physical) were not performed for the relationship of BDI, LSAS, and BFNE with parental variables except for paternal overprotection.

Also, when the zero-order correlations of paternal overprotection with dependent variables were analyzed, it was seen that the relationship of paternal overprotection with LSAS and BFNE were also below .20. Thus, the mediation analyses aiming at testing the role of LMS as a mediator between parental variables and measures of social anxiety and depression were restricted to testing the mediator role of social looming only for the relationship between paternal overprotection and BDI scores.

3. 8. 2. 1. The Mediator Role of Looming Maladaptive Style (LMS) between Paternal Overprotection and Depression

It was also hypothesized that social looming will mediate the relationship between paternal overprotection and depression. For this hypothesis to be confirmed, following assumptions should be met:

- Paternal overprotection should be significantly associated with depression.
- Paternal overprotection should be able to significantly account for the changes in social looming.
- Variations in social looming must significantly predict the variations in BDI
- When the effect of social looming on BDI scores is controlled for, the strength of the previously significant relation between paternal overprotection and depression should significantly decrease.

To test the model involving social looming as the mediating variable between paternal overprotection and depression, a regression analysis was performed to see the relationship between the mediator variable social looming

and the independent variable (paternal overprotection). This regression analysis showed that paternal overprotection explained 4 % of the variance F (1, 372) = 15.23, $p < .001$ in social looming and it was significantly contributing to the prediction of social looming (β= - .20, t (372) = -3.90, $p < .001$).

Next, a hierarchical regression analysis where BDI served as the dependent variable was performed. As shown in Table 18, the first step where the independent variable (paternal overprotection) was included into the analysis explained 8 % F (1, 373) = 34.32, $p < .001$ showing a significant association between paternal overprotection and depression (β = -.29, t (373) = -5.86, $p < .001$). Social looming entered on the second step were also explaining an additional 2 % (F_{Change} (1, 372) = 8.30, $p < .01$) of the variation increasing the total variance explained to 10% F (2, 372) = 21.65, $p < .001$, social looming was significantly associated with depression (β = .14, t (372) = 2.88, $p< .01$). Besides, the level of significance of the relationship between paternal overprotection and depression did not change even when the effect of LMS scores is controlled (β = -.26, t (360) = -5.23, $p < .001$).

In sum, the regression analyses showed that social looming did not have the effect of fully mediating in the relationship between paternal overprotection and depression (Table 18). In order to test the possibility of social looming acting as a partial mediator, a Sobel test was conducted that indicated that the change in the strength of the association between paternal overprotection and depression was not significant (z = 2, $p > .05$)

Table 18. *Summary of regression models testing for social and physical Looming as mediators between paternal overprotection and depression*

Model: Independent variable	Dependent variable	R^2	F	R^2_{Change}	β	t
Paternal Overprotection	Social Looming	.04	15.23***		-.20	-3.90***
Mediator: LMS	BDI					
1.Paternal Overprotection		.08	34.32***		-.29	-5.86***
2.Social Looming		.10	21.65***	.02	.14	2.88**
(Paternal Overprotection)					-.26	-5.23***

Note: *** p < .001, ** p < .01, * p < .05 BDI = Beck Depression Inventory, LMS = Looming Maladaptive Style

3. 9. Summary of the Results

Hypothesis 1: *It was hypothesized that disrupted parental bonding would be associated with the development of LMS (social and physical).*

Among the parental variables, maternal and paternal overprotection appeared to be associated with social looming. None of the variables were associated with physical looming.

Hypothesis 2: *It was hypothesized that disrupted parental bonding would be associated also with perfectionism. Parental bonding was also expected to differ between adaptive and maladaptive versions of perfectionism (MEC and PS).*

Results indicate that all dimensions of parental bonding, especially maternal care and overprotection were significantly associated with MEC (maladaptive perfectionism).

On the contrary, PS (adaptive perfectionism) was not associated with any of the parental variables measured in the present study.

Hypothesis 3: *It was expected that social anxiety would be associated with dimensions of looming, as well as parental variables. It was also expected that social looming would be more strongly associated with measures of social anxiety with respect to physical looming.*

Among the parental variables, social anxiety (as measured by LSAS) was significantly associated with only maternal care.

As expected, social anxiety was highly, significantly associated with social looming, and whereas physical looming did not appear to be associated with social anxiety as measured by LSAS.

Results show that BFNE was associated with only maternal overprotection among the parental variables.

BFNE was also associated with social looming, but not with physical looming.

Hypothesis 4: *It is expected that although parental variables would be associated with depression, dimensions of looming would be weakly or not significantly associated with depression.*

As expected, all dimensions of parental bonding except for paternal care were associated with BDI scores

Social looming was only weakly significantly associated with BDI.

Hypothesis 5: *It was hypothesized that disrupted parental bonding and perfectionism would be associated with social anxiety.*

Both adaptive and maladaptive forms of perfectionism appeared to be associated with LSAS scores.

Direction of association is different for adaptive and maladaptive forms. BFNE appeared to be significantly associated with only MEC, but not PS.

Hypothesis 6: *It was hypothesized that disrupted parental bonding and perfectionism would be associated with depression.*

Depression scores appeared to be associated with both MEC and PS. Similar to LSAS, the direction of the relationship was different for MEC and PS.

Hypothesis 7a: *It was hypothesized that LMS will still be associated with measures of social anxiety when measures of depression are controlled.*

Association between social looming and both LSAS and BFNE remained significant when the effect of BDI was controlled for.

Hypothesis 7b: *LMS will not be associated with depression when social anxiety is controlled.*

As expected, the association between looming (especially social) and BDI scores decreased below significance level, when LSAS and BFNE scores were controlled for.

Hypothesis 8: *It was hypothesized that perfectionism would be associated with both depression and social anxiety, apart from each others' influences on the other.*

BDI appeared to be still significantly associated with both MEC and PS, when measures of social anxiety were controlled.

Association between adaptive and maladaptive perfectionism with measures of social anxiety did not change when BDI scores were controlled.

Mediation hypotheses

Hypothesis 9: *Maladaptive perfectionism is expected to mediate the relationship of parental variables and social anxiety and depression.*

Maladaptive perfectionism fully mediated the relationship between maternal care and social anxiety.

It was also found to be fully mediating the relationship between paternal care and depression.

Maladaptive perfectionism was also found to be partially mediating the relationships of maternal care, maternal overprotection and paternal overprotection to depression.

Hypothesis 10: *Looming maladaptive style, especially social looming is expected to mediate the relationship between parental variables and social anxiety but not depression.*

Contrary to the hypotheses, nor social, neither physical looming was found to have mediator roles in the association between parental variables and measures of social anxiety and depression.

CHAPTER IV

DISCUSSION

4. 1. Overview

The present study examines the relationship of social anxiety (two aspects of social anxiety are of concern, namely fear of being negatively evaluated, social interaction anxiety and avoidance), and depression with maladaptive perfectionism and looming maladaptive style (LMS) (is composed of two different components, social and physical). Secondly, parental variables associated with both social anxiety, depression and psychological vulnerability (conceptualized as LMS and maladaptive perfectionism for the present study) are of concern. Also the mediating roles of LMS and maladaptive perfectionism in the relationship between parental bonding and social anxiety and depression are investigated.

4. 2. LMS and its association with Social Anxiety and Depression

One of the major goals of the study was to examine the hypothesis that LMS would predict social anxiety. Results obtained from the main study, indicate that LMS successfully predicts variance in anxiety disorders especially the social anxiety disorder. Consistent with the prediction, looming predicted 15 % of both social anxiety and fear of being negatively evaluated and 2 % of the variation in depression.

Results were consistent with the main hypothesis that suggests the differential association of LMS with social anxiety and depression. It was hypothesized that LMS would be more related with measures of social anxiety than measures of depression. As expected, results revealed more significant correlations of LMS with social anxiety than depression. Moreover, results of regression analyses showed that the significant association between LMS and depression was due to the overlap between social anxiety and depression. This results supports the basic premise of LMS, which is its specificity to anxiety rather than both anxiety and depression. Starting from the earliest studies on LMS, it was argued that the major and most important characteristic of LMS was its specificity to anxiety (Riskind, et al, 2000), and this specificity had been shown numerous times in different clinical (Riskind & Rector, 2007; Riskind, Wheeler, & Picerno, 1997) and non-clinical groups (Riskind & Williams, 2006; Riskind et al, 2000; Riskind et al, 2007; Williams et al, 2005).

In fact this result, besides confirming one of the main hypotheses of the present study, has important implications in the research arena that aims to investigate the differentiation between anxiety and depression. Up to date, different models were proposed with the aim of indentifying a cognitive vulnerability variable specific for anxiety. One of these models is Cognitive Content Specificity Hypothesis (CCSH) assumes that the main difference between anxiety and depression lies in the timeline that they are concerned with. CCSH proposes that although depression is a form of perseveration regarding the past, anxiety on the other hand is more directed to future, appearing to be more concerned with threats or disasters that are likely to take place in the future

(Greenberg & Beck, 1989). Previous efforts for testing the significance of CCSH were not fruitful, since CCSH was either unable to distinguish anxiety from depression solely based on cognitive content. CCSH studies were found to fall short in differentiating depression and anxiety. Anxiety related cognitions as postulated by CCSH did not appear to be specific to anxiety but rather appeared as one of the main characteristics shared with depression.

Although the notion of looming vulnerability is consistent with CCSH in terms of conceptualizing anxiety related cognitions as focusing on future events, in line with results of previous studies, result of the current study showed that it is a cognitive vulnerability specific to anxiety disorders. According to Riskind (1997), LMS takes into account the nature of the imagery experienced in states of intense anxiety, which is characterized by dynamic, movie-like content. This forms the main distinction between LMS and other models like CCSH, in which imagery is explained in terms of motionless, snapshot like images.

This finding gained further support by results of additional analyses in the present study. As noted earlier, without effect of social anxiety controlled, LMS is able to predict about 2 % of the variance in depression. Although, effect is statistically significant, it is reduced to levels of non-significance when effect of social anxiety and fear of being negatively evaluated are controlled for. On the other hand, LMS (when both social and physical looming are taken into account), is able to account for 15 % of the variance in both measures. And when effect of depression is controlled, variance explained by LMS remains in significant limits (12 and 13 % for LSAS and BFNE, respectively). This result once again shows that LMS is a cognitive style that is specific to anxiety, not depression.

Aside from CCSH, differentiating anxiety from depression in terms of underlying cognitive processes had been the major concern of many researchers especially in the last two decades (Starcevic & Berle, 2006).One example comes from the studies done using Anxious Thoughts and Tendencies (AT&T) scale (Uhlenhuth, McCarthy, Paine, & Warner, 1999), which measures the vulnerability for anxiety disorders in terms of some of cognitive distortions such as catastrophising, selective abstraction and intrusive thoughts which were proposed by Beck et al. (1985). This model failed to account for certain kinds of anxiety disorders such as specific social anxiety disorder and panic disorder without agoraphobia (Uhlenhuth, Starcevic, Warner, Matuzas, McCarthy, Roberts, & Jenkusky, 2002). Moreover, most recent studies showed that it is a concept that is associated more with depression rather than anxiety disorders (Starcevic & Berle, 2006).

Another line of research concerning the differentiating cognitive processes between anxiety and depression came from research on anxiety sensitivity. Anxiety sensitivity was in fact one of the first concepts that was proposed to be an underlying cognitive factor specific to anxiety, especially panic disorder, later research showed that it is able to predict variance in both anxiety and depression. Moreover, in their review paper, Cox, Fuentes, Borger, and Taylor (2001) suggested that AS was more closely related to depression than to anxiety, and that a specific link (fear of cognitive dyscontrol) existed between AS and depressive states (Cox, Taylor, & Enns, 1999). Likewise, other cognitive construct such as intolerance of uncertainty, pathological worry and though-action fusion, which at first emerged as cognitive vulnerability factor specific to anxiety disorders, were

later found to be significantly predictive of depressive states, as well as anxiety (Starcevic & Berle, 2006).

All these studies highlight the absence of a vulnerability factor specific to anxiety, and mostly argue about common vulnerabilities for anxiety and depression. Perhaps the greatest contribution of LMS to the literature is to propose a more robust model of cognitive vulnerability specific to anxiety. Thus, results of the present study, together with and as a part of research regarding LMS, provide evidence for the presence of a cognitive style specific to anxiety, also supporting Beck, Brown, Steer, Eidelson, & Riskind's (1987) view regarding future orientation of the cognitive content in anxiety states.

Results show that LMS is significantly able to differentiate social anxiety from depression, also showing that LMS is related specifically to social anxiety, not to depression. This result has important implications in the literature that becomes fuzzier and less coherent when it comes to the differentiation between depression and social anxiety. Although, in the area of emotions and positive and negative affectivity, especially the tripartite model of Watson and Clark (1991) made great contributions to differentiation of anxiety and depression. They proposed that high negative affect was the underlying characteristic of both anxiety and depression, but low positive affect was specific to depression. Although, this hypothesis had been replicated numerous times, a specific type of anxiety disorder which is called social anxiety disorder presented a profile that is quite distinct from other types of anxiety disorders, presenting low levels of positive affect (which is said to be the distinguishing characteristic of depression).

Thus, it can be said that different from other anxiety disorders, social anxiety has a different status, regarding its relationship with depression.

Besides, many of the epidemiological studies that had been conducted up to today highlighted SAD as the type of anxiety disorder having the higher rates of comorbidity with depression. These studies form another line of evidence regarding this special relationship between SAD and depression, making the differential diagnosis even more complicated. In other words, because of low levels of positive affect and high levels of comorbidity with depression, some consider it as a subtype of depression (Feldman, 1993, Hodges, 1990). This resemblance is so intense that even the cognitive model of social anxiety as proposed by Clark &Wells (1995) took into account the cooccurance of depression in social anxiety, stating that presence of intense negative view of self leads to high comorbidity.

Since its main focus is on social anxiety, results of the current study also tap into these arguments. Specificity of LMS to anxiety, especially social anxiety in the present study, is at the same time demonstrating the differentiation between social anxiety and depression. Also, the weak but significant association between depression and LMS can be perceived as a result of the high comorbidity between depression and social anxiety. As stated earlier, the present study, also indicate a highly significant association between social anxiety and depression.

Although, not under the scope of the present study, prolonged SAD in the long run may contribute to development of depressive complaints. Since the individuals with social anxiety are more prone to avoid stressful situations and social contact to prevent the possible negative affect, they are more likely to lead

restricted lives, without social interaction and adequate amounts of social support. In the long run, this isolated lifestyle may lead to a feeling of loneliness and since they cannot utilize from social support properly, they may be more vulnerable to experience depressive affect as a response to negative life events. Lack of social support and life is more restricted (Brown, Chorpita, & Barlow, 1998; Musa, Lepine, Clark, Mansell, & Ehlers (1993).

Consistent with the hypotheses, social looming, but not physical looming, was found to predict all measures of social anxiety (LSAS and BFNE). These results are in accordance with findings of Williams et al. (2005) and Stopa and Brown (2008), who found that a specific link between social looming and fear of being negatively evaluated exists. Also this association persisted even after the effect of depression was controlled. An extension for this finding may be the argument that social looming is a cognitive vulnerability specific to social anxiety disorder, and lack of an association between social anxiety symptoms (as measured by both LSAS and BFNE) indicate that a cognitive style that is characterized by high social looming may be specific to social anxiety. To our knowledge, no study investigating the LMS profiles of different anxiety disorders had been conducted yet. Instead, studies on LMS have focused on differentiating between anxiety and depression. Secondly, it can be stated that individuals who report high levels of social looming are more prone to develop symptoms of social anxiety disorder when environmental triggers pass a certain threshold. In other words, although they do not report state social anxiety, when they are faced with environmental stressors or a triggering event they are more likely to suffer from SAD, than individuals with low social looming. This argument is also in line with

Brown, Chorpita, and Barlow (1998) who suggested that each anxiety disorder has a cognitive structure specific to itself.

4. 2. 1. Perceived Parenting and LMS

Gibb (2002) in her review article pointed to significant importance of childhood events, especially parental bonding in generation of negative cognitive styles and cognitive vulnerability to anxiety and depression. In line with this, one of the novelties of the present study is its focus on parenting variables associated with development of LMS. Although this cognitive style had been shown to be linked with many different types of anxiety disorders, only one study investigated the parental variables that are associated with LMS. The most striking result of Riskind, Williams, Altman, Black, Balaban, & Gessner (2004) was the difference between the effects of maternal and paternal parenting. They found that while parental care was not associated with LMS, both overprotective parenting from fathers, as well as independence nurturing parenting from mothers were associated with development of a vulnerability for anxiety disorders. Present results were partially consistent with results of Riskind et al (2004). Like Riskind et al (2004), current result did not confirm a significant association of maternal or paternal care with social or physical looming, but, a significant association was present between both maternal and paternal overprotection and social looming. To be more specific, results showed that higher degrees of social looming were present in individuals who perceived their both parents as overprotective.

In fact these results are in line with the model of Chorpita and Barlow (1998) that highlighted the pivotal role of parental overprotection in generation of

anxiety in children. They argued that such a parenting style, leads to development of a belief system involving the view that the outside world is full of dangers and one is unable to control it (Davis & Phares, 1969). In other words, children of overprotective parents perceive the likelihood of threat in a magnified manner. This explanation for the relationship between parental overprotection and higher levels of social anxiety in the child gained support from many different authors (Hudson & Rapee, 2000; Taylor & Alden, 2006). In addition to this, Rapee (1997) also proposed that such a parenting style limits the child's chance to observe and acquire certain skills, thus preventing them from developing realistic expectations from themselves and the world. Living with the feeling that danger (or threat) is around the corner, these individuals feel anxious in almost all situations and thus, may exhibit a greater vulnerability to suffer from anxiety disorders.

To sum up, overprotective parenting, either by giving the message to the child that the world is full of dangers, or by preventing him/her from acquiring adequate social skills, may be resulting in a cognitive style that is characterized by dynamic mental scenarios of escalating vulnerability to danger, which is getting more and more serious and threatening every passing minute. The study indicates that this cognitive style may be one of the possible mechanisms responsible for such a relationship between parental overprotection and social anxiety. In line with Chorpita and Barlow (1998), a parent-child interaction governed by an atmosphere of overprotection is likely to give the child the message that the world is full of ambiguity and lots of danger that is intensifying every minute, which in turn may lead to development of a cognitive style that requires generating mental images of rapidly rising risk. Having a tendency to form such images or scenarios

concerning especially the social issues, will in turn lead to a vulnerability for development of social anxiety in later life.

One significant difference between the results of Riskind et al (2004) and the present study was the difference between maternal and paternal overprotection in terms of their association with LMS. Unlike the original study, present results indicate that influence of both mothers and fathers are in the same direction. In fact the finding of a negative association between maternal overprotection and LMS in Riskind et al (2004) was quite surprising and also in contradiction with previous literature investigating the relationship between cognitive vulnerability and psychopathology.

One other important detail regarding the association between parental variables and LMS is the variance explained by parental care and overprotection. Inclusion of parental variables explained only an additional 5 % of the variance in social looming and 4% in physical looming, although still statistically significant, this result may also be interpreted as a sign for presence of different factors other than parental bonding in development of a cognitive style characterized by looming. Features of family other than maternal and paternal care and overprotection (like interparental relationships, psychological control, and relationship with siblings, etc.) may be more critical in development of LMS.

4. 3. Association of Perceived Parenting with Social Anxiety and Depression

As expected, dimensions of parenting were found to predict measures of social anxiety and depression. These results are in line with results of previous studies that indicate presence of a significant relationship between dimensions of

parenting and psychopathology (Enns, Cox, & Clara, 2002b; Ingram, Overbey, & Forher, 2001; McGinn, Cuker, & Sanderson, 2005).

In line with most of the previous studies, lower levels of care and higher levels of overprotection, especially from mothers, was associated with higher levels of depression. In fact such a parenting style was referred to as “affectionless control” by Parker (1979, 1984). Affectionless control was found to contribute to development of a depressogenic cognitive style in children (Alloy, Abramson, Tashman, et al, 2001). According to Rapee (1997) and Wood et al (2003) similar parenting style that was termed as “authoritarian parenting” by Baumrind (1971) was also found to be the parenting style associated with highest levels of psychopathology.

4. 3. 1. Association of Parental Care with Social Anxiety and Depression

Regarding the influence of low parental caring, which is a component of affectionless control, preliminary studies point to the association of low levels of parental care with increased levels of depression (Parker, 1983). Kenny and Rice (1995) based on studies about child-parent attachment, concluded that individuals who received low-care parenting, tend to see themselves as not good enough to be loved, and others as emotionally unresponsive and unavailable. When a child feels that he/she cannot receive optimum levels of care, the image of “loving parent” is distorted and the child does not feel loved, appreciated and valued. This leads to development of representation of a social world full of people who are judgmental and easily dissatisfied as a result of mistakes. This in turn leads to insecure types of attachment, where the child believes that he/she is worthless and easily

expandable by the people around him/her. Such a belief was found to lead to development of depressogenic cognitive styles and eventually to depression (Garber & Flynn, 2001; Gibb et al, 2001; Parker, 1993).

According to Parker et al, (1995), although it was first thought to be specific to depressive disorders, low care from parents was linked with an increased chance of psychopathology, including anxiety disorders. Besides depression, maternal care also appeared to be one of the significant predictors of social anxiety. This result shows that the individuals, who received lower levels care from their mothers in the first 16 years of their lives, were more inclined to be socially anxious as young adults. This result is in line with the results of previous studies that found lower levels of emotional warmth in the parents of social phobic individuals Arrindell, Kwee, Methorst, van der Ende, Pol, and Moritz (1989) Arrindell, Emmelkamp, Monsma, & Brilman, 1983; Parker, 1979). Regarding the specificity of the effect of maternal care, a similar result was provided in a study conducted with a Portuguese sample of adolescents suffering from SAD (Cunha, Soares, & Pinto-Gouveia, 2008). Bögels, van Oosten, Muris, and Smulders, (2001) also shown that socially anxious children perceive their parent s a less caring when compared with non-clinical controls. According to Kimbrel, Cobb, Hundt, and Nelson-Gray (2008) this association is due to the fact that lower levels of maternal care is most commonly characterized by maternal criticism and rejection. In children with such parents, a sensitivity for making mistakes and being evaluated is present. Since these children are most of the time hypersensitive to criticism and negative evaluation from others, they also try to avoid these kinds of situations by avoiding social interactions.

The association between parental care (especially maternal) and psychopathology is also supportive of Bowlby's (1969, 1973) theory of attachment. He hypothesized that when compared with the securely attached children, insecurely attached children are more prone to be drowning by the feelings of anxiety since they perceive themselves under a constant threat of being rejected by the parent. The uncertainties they feel regarding the availability of their parents lead them to respond in an anxious and terrorized way, since they are not confident that the caretaker will respond (Bowlby, 1973). In fact, there is plenty of studies that support the link between insecure attachment patterns and anxiety starting from childhood years (Bosquet & Egeland, 2006; Roelofs, Meester, Huurne, Bamelis, & Muris, 2006; Shamir-Essakow, Ungerer, & Rapee, 2005). In sum, lower levels of parental care appear to be associated with higher levels of both depression and social anxiety. This might be related to the fact that these children form a representation of a social world as full of people who are judgmental and easily dissatisfied with any performance that is less than perfect. Biases in cognitive processing (in the form of memory or attentional biases for example) may have additive effect on this. Focusing mainly on negative aspects of interpersonal relationships, they will end up developing social interpretation biases which will eventually lead to higher levels of social anxiety.

4. 3. 2. Association of Parental Overprotection with Social Anxiety and Depression

The other component of affectionless control, which is high parental overprotection, also appeared to be associated with depression and fear of being

negatively evaluated in the present study. Results of the present study indicate that children of both overprotective mothers and fathers reported having higher levels of depression in their adult years. Although many previous studies indicate parental care rather than parental overprotection as the variable more closely associated with development of adult depressive disorders (Heider et al, 2006), current results point to the influence of high parental overprotection as one of the factors associated with depression. This finding is consistent with Heider (2008) which indicate the effect of maternal overprotection in vulnerability to depression. Likewise, Shah and Waller (2003) also documented the association between high levels of overprotection and development of some core beliefs associated with vulnerability to depression. In line with that, Blatt and Homann (1992) speculated that parental overprotection and especially high levels of parental control led to a personality style that is governed by intense self-criticism and in fact self-criticism may be a factor that mediates the relationship between parental overprotection and depression. This parenting style leads to development of a negative self-image, which in turn ends up in a vulnerability for depressive disorders (Campos, Besser, & Blatt, 2010). Besides self-criticism, literature provide evidence for the mediator role of many variables in the relationship between parental overprotection and depression such as self-esteem (Restifo, Akse, Guzman, Benjamins, & Dick, 2009; Rice, Ashby, & Slaney, 1998), negative inferential styles (Gibb, 2007), coping (Dunkley & Blankstein, 2000) and cognitive vulnerability to depression (Alloy, Abramson, Smith, Gibb, & Nereen, 2006)

Although, parental overprotection was expected to be especially associated with social anxiety, the current results failed to support this hypothesis. Parental overprotection was shown to be associated with development of social anxiety in Western cultures numerous times (Rapee, 1997; Taylor & Alden, 2006). Current results, besides being in contradiction with findings from Western societies, may be considered quite appropriate when characteristics of the Turkish culture are considered. Few studies done on Turkish culture investigating the association of parental bonding with psychopathology showed presence of an association between measures of psychopathology and only parental (both maternal and paternal) care (Anlı & Karslı, 2010; Akyıl, 2000). These results are also in line with works of Kağıtçıbaşı (1977, 2000, 2010) all of which indicate that parental overprotection, unlike in the Western cultures, is perceived as a positive parenting quality and may be a part of emotional warmth (Anlı & Karslı, 2010), through which the child receives extra attention and guidance to cope with difficult situations (Bögels et al, 2001). Despite efforts toward acceptance of Western values, in the present day Turkey, child-rearing practices still reflect traditional values (Fişek, 1993).

One other surprising finding of the present study was the difference between behavioral/emotional and cognitive components (as measured by LSAS and BFNE respectively) of social anxiety in terms of familial correlates. In other words, current results yielded a significant association between maternal overprotection and fear of negative evaluation. In fact, this result is in accordance with Otani et al (2009), who also found increased levels of maternal overprotection to be associated with higher levels of interpersonal sensitivity.

Although concept of “interpersonal sensitivity” is not identical to fear of being negatively evaluated; they are both concerned with being overly sensitive to criticism (perceived or actual) from others. Although the results of the present study did not yield a significant association between maternal overprotection and behavioral component of social anxiety, its significant association with fear of being negatively evaluated is supportive of the results of Heider et al, (2008), Taylor and Alden (2006) and Greco and Morris (2002), suggesting a significant relationship between higher levels of overprotection and higher social anxiety.

In fact, the differentiation between cognitive and behavioral/emotional dimensions of SAD may be responsible for the inconsistencies in the results of studies done in Turkish culture. As different from studies mentioned earlier (Anlı & Karslı, 2010), some studies indicate the adverse effects of overprotective parenting highlighting the positive association between parental overprotection and anxiety. For example, Soygüt and Çakır (2009) found a positive correlation between overprotective/anxious parenting and anxiety/depression symptoms. Also, Koydemir-Özden and Demir (2009) in a group of Turkish university students found that individuals who had mothers that failed to create a sense of safety and security were more fearful of being negatively evaluated. One other major difference between these two lines of studies is the nature of materials used in assessing anxiety/ or social anxiety. In both Koydemir-Özden and Demir (2009) and Soygüt and Çakır (2009), measures that assess anxiety were more focused on the cognitive components of anxiety. On the other hand, Anlı & Karslı (2010) assessed behavioral component of anxiety. One possibility is that the lack of association between parental overprotection and social anxiety is due

to the measures used and dimensions of parental bonding may be differentially associated with different dimensions of anxiety/ social anxiety.

In other words, cognitive components of social anxiety may be more susceptible to parental overprotection. The child who was brought up by parents who are restrictive and controlling may not be avoiding social situations or experience intense fear in those situations, but may be concerned with how they are perceived by others. In fact, another finding of the present study seems to be supporting this argument. As indicated above, LMS, which is a robust measure of a cognitive style that is specific to anxiety, had been found to be associated with only overprotective parenting. Thus, it can be argued that an overprotective parenting style operates in a way that makes the child more vulnerable to the perspective and evaluations of others, since they have at least one figure in their lives that makes such judgments about how they behave and possible consequences of their actions, which is the overprotective parent.

A doubt regarding the sensitivity of the PBI to cross-cultural differences is another explanation for the diversity of the findings in the studies done on Turkish samples. Regarding the reflections of cross-cultural differences on PBI scores, Heider et al (2006) study with a large sample from 6 different countries in Europe concluded that the pattern of the association between parenting and mood disorders did not differ among different countries, and thus no cultural difference is present with respect to this. On the contrary, Sato et al (1999) highlighted the importance of considering cultural differences when using PBI, since meanings of the items in the scale may not be the same across cultures especially on the overprotection dimension, as also suggested by Kağıtçıbaşı (1972). In accordance

with these, findings from factor analytic examination of PBI in French culture (Morh, Preisig, Fenton, & Ferrero, 1999), Pakistani (Qadir, et al, 2005), and Japanese culture (Sato, Narita, Hirano, 1999) indicate possible cross-cultural differences. In fact all of these studies, offered a 3-factor model, composed of one care and two overprotection scores. Also in the Turkish version of the scale, some of the items that originally tap under the overprotection dimension, that are thought to measure control, were included into care dimension. As discussed by Kapçı and Küçüker (2006) this may also be due to cultural differences. In Turkish families, the normative parenting style is characterized by a combination of both care and control, and parental control is perceived as an extension of a caring parenting pattern rather than an overprotective parenting pattern.

4. 4. Association of Perfectionism with Measures of Social Anxiety and Depression

Results of the present study indicate significant associations of both adaptive and maladaptive perfectionism with social anxiety and depression. On the other hand, fear of being negatively evaluated was associated only with maladaptive perfectionism. To be more specific, results indicated that, higher levels of maladaptive perfectionism was consistently associated with higher levels of social anxiety, fear of being negatively evaluated and depression. On the other hand, increases in adaptive perfectionism were associated with lower levels of social anxiety and depression. This result is in accordance with results of other studies indicating high degrees of perfectionism among depressed individuals in

both clinical and non-clinical samples (Castro & Rice, 2003; Enns, Cox, 1999; Frost, et al., 1990; Minarik & Ahrens, 1996; Slaney, 1995).

As indicated earlier, the significant relationship of maladaptive perfectionism with depression and social anxiety had been shown numerous times. In fact, Habke and Flyn (2001) proposed a model that explains the relationship of perfectionism with both depression and social anxiety. According to Habke & Flynn (2001) this relationship is due to overimportance of own flaws that is a characteristic of perfectionism. Since they are afraid of being negatively evaluated, perfectionist individuals have a tendency to hide their flaws. These attempts at hiding possible defects lead to and are consequences of a disclosure phobia, which at the same time leads to social withdrawal. Eventually, being cautious about own flaws and a tendency to hide them lead to a significant decrease in social contact. The decrement in the level of social contact reduces the level of both social support received and behavioral repertoire of the perfectionist individual. These lead to strong feelings of anxiety and depression, coupled by a negative view of self. This turns into a feedback loop where as the individual avoids social contact more, perceives himself as more imperfect and eventually feels more anxious and depressed (Hill, Zrull, & Turlington, 1997). Perfectionist individuals' tendency to avoid relationships because of this fear of rejection and disapproval was also documented by Blatt (1995).

4. 4. 1. Perceived Parenting and Perfectionism

One of the main aims of the present study was to investigate the parental variables associated with perfectionism. In order to investigate this, positive and negative dimensions of perfectionism were analyzed separately in order to

differentiate the parental variables associated with each dimension. Analyses showed that Maladaptive Evaluative Concerns (MEC) which is a manifestation of negative perfectionism was associated with a parenting style that was characterized by low caring and higher overprotection from both mother and father. A family environment not being able to provide adequate levels of caring (both maternal and paternal) was found to be associated with higher levels of negative perfectionism. Likewise, overprotection from both mother and father was found to be associated with higher levels of negative perfectionism. This finding in fact was an expected finding because previous studies had also highlighted the relationship between parenting variables and perfectionism. For instance, Enns, Cox and Clara (2002a) found a significant association between maladaptive perfectionism and a parenting style named as "Harsh parenting" which is characterized by extreme criticalness, overprotection, and lack of care and extreme expectations. Another line of support comes from studies conducted using Flett-MPS, which also found a significant association between perfectionism and authoritarian parenting. Authoritarian parenting that is presented by especially the mother was associated with higher amounts SPP, which is known to be the dimension of perfectionism that is most closely associated with internalizing disorders (Flett, Hewitt, & Singer, 1995; Kenney-Benson, & Pomerantz, 2005).

Besides empirical studies, findings of the current study are also supportive of theoretical works of Nemechek (1978), Sorotzkin (1998) and Blatt (1995), all of which point to a link between perfectionism and dysfunctional parenting forms. To be more specific, current findings support the view that in a family in which

parents do not provide care, the child may feel not loved and not accepted. Likewise, being brought up overprotective parents may lead underdevelopment of a knowledge regarding ones true capacity. The child will feel incapable, inferior, unaccepted, and unloved. In most cases, these feelings of being inferior and worthless are compensated by feelings of grandiosity and perfectionism. With the expectation of gaining love and acceptance, the individual starts living in a pursuit of perfection.

Another important finding was regarding the parental variables associated with adaptive perfectionism, in other words Personal Standards (PS). In contrast to MEC, which is a manifestation of maladaptive perfectionism, PS was found to be associated any of the parenting variables assessed in the present study. Since, only few studies investigated early experiences associated with development of maladaptive perfectionism, not much is known about this subject. Regarding this argument, an early empirical study reported a lack of difference between parenting patterns received by maladaptive and adaptive perfectionism in terms of parental care and overprotection (Rice, Ashby, & Pressuer, 1996). In contrast with this, Enns, Cox and Clara (2002a) found that although both adaptive and maladaptive perfectionism were associated with parenting perfectionism, harsh parenting appeared to be the familial variable that was able to differentiate between these two kinds of perfectionism. It is possible that other parenting characteristics such as parenting perfectionism and secure attachment patterns are associated with this type of perfectionism and there are evidence from the literature regarding the association of these parenting characteristics with adaptive

perfectionism (Enns, Cox, & Clara, 2002a; Rice & Mizradeh, 2000; Rice, Lopez, & Vergara, 2005).

4. 4. 2. Perfectionism and Personal Standards

Having mentioned the difference between MEC and PS in terms of associated parental variables, it is important to point out another important finding regarding personal standards. Since the earliest publications on Frost's model of multidimensional perfectionism, there has been a confusing mixture of findings regarding the dimension of personal standards. The earliest studies conducted on non-clinical samples indicate low but significant associations between PS and measures of anxiety and depression (Frost et al., 1990; Stöber et al., 1998). Later studies on the other hand almost consistently provided results regarding the negative correlations between perfectionism and measures of anxiety and depression (DiBartolo, Li, & Frost, 2008; Kawamura, Hunt & Frost, 2001). Also results of studies done with clinical samples did not indicate any significant difference between depressed, anxious individuals and non-clinical controls (Antony, Purdon, Huta, & Swinson, 1998; Enns & Cox, 1999; Juster et al., 1996; Saboonchi, Lundh, & Öst, 1999). In line with the results of all these studies mentioned, personal standards appeared as a significant predictor of both depression and social anxiety. Although not significant, its association with fear of being negatively evaluated was also negative. Different from MEC which appeared to be positively associated with different measures of psychopathology, results indicated that people with higher Personal Standards tended to have lower levels of depression and social anxiety. Although earlier studies including some of

the publications of Frost indicate an additive effect of PS in psychopathology (Frost et al., 1990), suggesting the role of PS as a factor that increases vulnerability to especially depression and anxiety disorders, more recent studies show quite the opposite. These studies question the role of PS as a boosting element in diathesis-stress models of psychological disorders. In fact, they argue about the role of high personal standards as the adaptive dimension of perfectionism (Blankstein & Dunkley, 2002; DiBartolo et al., 2004). They support that setting higher personal goals, are associated with lower levels of psychopathology and higher levels of some positive personality traits such as conscientiousness and extraversion (Parker & Stumpf, 1995; 2000).

4. 4. 3. Negative and Positive Perfectionism

These results concerning differences between MEC and PS also address the argument regarding the presence of the concept of positive perfectionism. Since the early 2000's, there is an ongoing debate regarding the presence of a concept called positive perfectionism. Although two-dimensional models of perfectionism has been suggested starting from 70's (Hamachek, 1978), first objections to this view came from Shafran and Mansell (2001) who rejected the concept of a two dimensional perfectionism, defending that dimensions of perfectionism other than personal standards are not related to the concept of perfectionism, thus, lead to misunderstandings in the concept. They also stated that although perfectionism begins as a positive and rewarding quality, it becomes excessive, negative and destructive if the individual fails to reach the high standards that they set, when they are unaware of the negative impact of

perfectionism and through fatigue and lack of concentration. In other words, they suggested that all types of perfectionism are maladaptive since they can lead to negative consequences eventually. Moreover, another line of objection came from Flett and Hewitt (2006), who rejected the term of adaptive or positive perfectionism, suggesting that "positive perfectionism" in most circumstances was not adequate in differentiating perfectionism from conscientiousness. Although most researchers consider Hewit and Flett's (1990) concept of Self Oriented Perfectionism (SOP) as a form of adaptive perfectionism and provide evidence supporting this notion (Enns & Cox, 2002; Frost et al., 1993; Hill, McIntire, & Bacharach, 1997; Stöber & Otto, 2006), they argue that SOP by itself has many negative and maladaptive features (Flett & Hewitt, 2006) and in is indeed a vulnerability factor in dealing with negative life experiences, especially failure (Besser, Flett, Hewitt, 2004).

Results of the present study are supportive of the alternative arguments that were postulated by Stöber and Otto (2006), who made the distinction between perfectionistic striving (PS) and perfectionistic concerns (PC). According to their formulation, the critical characteristic that differentiates between perfectionists and non-perfectionists is the perfectionist striving dimension, which is composed of high personal standards and found to be associated with many positive qualities or adjustment outcomes similar to the concept of personal standards measured in the present study. The other dimension, namely perfectionist concern, which also includes MEC, was proposed to the element that differentiates adaptive and maladaptive forms of perfectionism. Like its name implies, it is associated with concern over mistakes, doubting about actions and socially prescribed

perfectionism. Contrary to suggestions of Shafran, et al (2002) concerning the view that PS is the dimension of perfectionism that is most close to clinical perfectionism, since setting high standards by itself brings destruction, results of the present study are regarding the increased levels of PS have associations with decreases in social anxiety and depression in line with Stöber and Otto (2006) that postulated that PS by itself is not pathological. Kawamura, Hunt and Frost (2001) results showing a negative association between PS and depression are in line with the present study as well as providing support for adaptive-maladaptive perfectionism distinction. The perspective and explanation postulated by Stöber and Otto (2006) gained empirical support from Blankstein, Dunkley, and Wilson (2008) who found that it was MEC, not personal standards that was able to mediate the relationship between depression and self-esteem mediation. Also a bunch of earlier studies found perfectionistic concerns (or MEC) to be more directly and consistently associated with different types of psychopathology including depression, social anxiety and eating disorders (Frost, et al, 1993; Bieling, Israeli, Anthony, 2003; Bieling, Israeli, Smith, 2003; Shumaher & Rodebaugh, 2009). In areas of psychology that are not related to psychopathology, Stöber and Kersting (2007), showed that unlike perfectionist concern, students high on perfectionist striving had more successful results from aptitude tests. In addition to that, Stoll, Lau, and Stöber (2008) once again found the performance enhancing influence of perfectionistic strivings or high personal standards. Additional evidence for the adaptive-maladaptive perfectionism distinction is provided a more recent study by Ulu and Tezer (2010) conducted on Turkish university students who found that adaptive perfectionism is associated with more

positive personality characteristics, on the other hand maladaptive perfectionism appeared to be mainly associated with neuroticism. Although they used Almost Perfect Scale-Revised rather than MPS, they reached a consensus regarding the dual nature of this concept.

Another result of the present study that was mentioned earlier provides further partial support for the argument regarding the presence of an adaptive dimension of perfectionism. In contrast to Maladaptive Evaluative Concerns (maladaptive form of perfectionism), that appeared to be related to both parental care and overprotection, personal standards (adaptive form of perfectionism) were not associated with parental variables that were assessed in the present study. Although the results do not indicate anything regarding the antecedents of adaptive perfectionism, results are able to successfully differentiate between two forms of perfectionism. In fact, this result is also in accordance with results of Enns, Cox, and Clara (2002a) that found a lack of relationship between parental harshness variables and adaptive perfectionism. Lack of significant results regarding the familial variables related to adaptive perfectionism, in fact may make way to investigate regarding hypothetical models proposed by Hamachek (1978) and Sorotzkin (1998). It may be that harsh parenting attitudes (overprotection lack of care) provided by parents of maladaptive perfectionist individuals, through lowering of self-esteem and limiting development of self-concept, lead to self-conscious emotions and eventually psychopathological states (Rice, Kubal, & Preusser, 2004).

4. 4. 4. Perfectionism and Gender

There are contradictory finding in the literature regarding gender differences in perfectionism, moreover, most of the publications in the area do not report gender differences (Blankstein, Dunkley, & Wilson, 2008). Results of the present study indicated that males scored significantly higher than females in terms of nearly all measures of maladaptive perfectionism. This finding is in line with results of Arslan, Hamarta, Üre, and Özyeşil (2010) that also utilized MPS-Frost and assessed Turkish university students. Camadan (2010) utilized MPS-Frost also find gender differences in the association between parents' and adolescents' perfectionism. This finding is also in line with Çağlar, Bilgili, Karaca, Ayaz, and Aşçı (2010) that indicated higher levels of SPP in males when compared with females. In addition to that, researches from Western societies also indicate gender difference in perfectionism (Flett, Hewitt, & Singer, 1995; Slaney & Ashby, 1996; Stöber & Stöber, 2009). Dunkley, Blankstein, and Wilson (2008) also reported gender differences in relationship between different components of perfectionism, consistent with the models aiming at making a distinction between maladaptive and adaptive forms of perfectionism. In fact, consistent with the results of present study, they concluded that there was a gender difference in MEC with males having higher levels of maladaptive perfectionism, but such a difference was not present in personal standards perfectionism. In addition to these, some studies indicate presence of changes with respect to gender in the association between perfectionism and depression (Blankstein et al., 2007; Preusser et al., 1994). According to Flett, Hewitt, & Singer (1995) the higher levels of perfectionism in males is due to differential parenting practices provided

by parents towards males and females. More specifically, males are encouraged to develop agenetic traits, since they are expected to be more competitive and achievement striving with respect to females.

Higher levels of maladaptive perfectionism in males may also be a result of culture and gender socialization in Turkish society. According to Özkan and Lajunen (2005) differences in gender roles start to build up in Turkish society, even before the child is born. This early distinction between to sexes may be an extension of the differences between two genders in terms of their values in the family. Especially in traditional Turkish families, boys are considered as more valuable since they are expected to carry on the family name, besides making greater financial and practical contribution to the welfare of the family. In contrast, females are not faced with such expectations while they are growing up (Kagitcibasi, 1982). An important implication of those high expectations from males may be experiencing higher levels of sensitivity for making mistakes, being more doubtful about the consequences and accurateness of their actions, as well as considering evaluations from parents as more important. Although the general tendency of preferring sons over daughters has started changing especially Westernized- modern Turkish families (Ataca & Sunar, 1999; Kagitcibasi & Ataca, 2005), sample of the present study were mostly composed of university students coming from lower SES families living outside metropolitan areas of Turkey.

4. 5. Results of Mediation Analyses

Another aim of the present study was to examine the roles of maladaptive perfectionism and LMS as mediators between parental variables and measures of depression and social anxiety. Since such an approach can identify the mechanisms between parental variables and measures of psychopathology, it can be quiet beneficial in explaining the background and possible pathways between adverse childhood experiences and psychopathology in adult years. According to the mediation hypotheses, parental care and overprotection are expected to reveal significant associations with measures of social anxiety and depression in participants. It is also expected that maladaptive perfectionism as a known vulnerability factor will reveal significant associations with depression and social anxiety. A similar role of looming maladaptivity is expected to be present in the relationship between parental variables and social anxiety, but not depression. Moreover, parental care and overprotection are expected to be associated with both maladaptive perfectionism and looming maladaptivity. Based on these associations, mediation analyses were conducted in order to see whether maladaptive perfectionism and looming vulnerability play a mediator role between parental variables and measures of social anxiety and depression. In other words, their relationship between parental care variables and measures of social anxiety and depression will be reduced or disappear after controlling for maladaptive perfectionism or looming vulnerability.

Chorpita and Barlow (1998) were one of the first to suggest the possible mediator model to explain the relationship between parental overprotection and anxiety. They proposed that overprotective parenting at the same time caused both

development of anxiety, and vulnerability factors for anxiety. Disruptions in the bonding with the parents, which is a consequence of painful childhood experiences, were found to lead to dysfunctional schemata regarding self, others and the world. These schemata may act as vulnerability factors for development of later psychopathology (Ingram et al, 1998; Kendall, 1992; Segal, 1988). Up to date, many studies were conducted investigating the role of sense of control (Ballash, Pemble, Usui, Buckley, & Woodruf-Borden, 2006; Chorpita, Brown, & Barlow, 1998) intolerance of uncertainty (Zlomke & Young, 2009) and early maladaptive schemas (Soygüt & Çakır, 2009) as mediators.

4. 5. 1. Mediator Role of Maladaptive Perfectionism in the Relationship of Parental Variables with Social Anxiety and Depression

One of the novel findings of the present study was to investigate the mediator role of MEC in the relationship between parental variables and different domains of social anxiety. To our knowledge, there are no studies investigating the role of maladaptive perfectionism as a mediator between parental variables and social anxiety. However, role of many maladaptive cognitive structures had been investigated thoroughly (Muris, Meesters, Merckelbach, & Hulsenbeck, 2000).

Partially fulfilling the expectations from mediation analyses, in the present study, maternal lack of care appeared to be associated with adulthood levels of social anxiety through the development of MEC. In other words, a family environment governed by a mother who is not providing adequate levels of affection, interest and responsiveness to the child's needs, may lead to

development of dysfunctional beliefs (in the present study maladaptive evaluative concerns or maladaptive perfectionism) (Gallagher & Cartwright-Hatton, 2008). These dysfunctional beliefs revolve around the idea that one is inadequate, may be lacking in important aspects of competence. Thus, these concerns in turn lead to development of negative outcomes such as social anxiety. In fact, the association between parental lack of care and social anxiety had been documented several times. According to Bögels, van Oosten, Muris, & Smulders (2001) parental lack of care that can also be experiences in the form of negative evaluation, and inadequate positive reinforcement from parents is also related to development of a socially anxious style. This result, which is also in line with Taylor & Alden (2005), provides a possible explanation for how maladaptive perfectionism mediates the relationship between maternal lack of care and social anxiety. A child who is exposed to harsh criticism, hostility and inadequate levels of affection may be in feelings of constant shame about which s/he is and develops schemas about him/her as worthless, inadequate. Knowing that all his/her actions, decision, and behaviors are inadequate and full of mistakes, he starts assuming that a major way of overcoming this feelings of worthlessness is becoming flawless or perfect. In order to minimize his/her failures he starts focusing his/her possible mistakes and such a hypervigilance regarding mistakes, leads the overestimation of perceived chance of making mistakes. This perception leads to development of more negative images of the self that is seen in social anxiety (Clark & Wells, 1995). Constantly feeling that one is unable to perform appropriately especially in social situations leads to feelings of discomfort in presence of other, which is coupled with intense avoidance of social situations in

the long run. Another possible explanation for this result was proposed by Blatt and Homann (1992). They have speculated that lack of maternal responsiveness and affection involvement leads to development of negative internal working models regarding the social world as uncaring (Blatt & Homann, 1992) in turn ends up in poor social functioning and elevated levels of anxiety regarding the possibility of being evaluated.

One of the most recent and precise studies regarding the role of MEC as a mediator between parenting style and psychopathology was Enns, Cox and Clara (2002a), who found that maladaptive perfectionism mediated the relationship between harsh parenting (can be operatonalized as lack of care, overprotection and excessive expectations. In addition to this, Soenens, Vansteenkiste, Luyten, Duriez and Goossens (2005) also found that a maladaptive perfectionism variable that is composed of a composite score of CM and DA acted as a significant mediator in the relationship between parental psychological control and depression. Despite the consensus in the literature on this issue, MEC was found to have a full mediator role only between paternal care and depression in the present study. In other words, paternal lack of care leads to development of schemata (or dysfunctional beliefs), which in turn acts as vulnerability to depression.

Although the current results show that mediating effect of MEC on the relationship between parental overprotection and depression is only partial, whereas, its effect as a mediator is more precise for the relationship between parental care variables and depression, it seems to be confirming the model proposed by Ingram, Miranda, and Segal (1998) speculating that early

maladaptive experiences with harsh, punitive parents give way to the development of negative cognitive schema. In line with this, another study signaled the significance of maternal care in development of vulnerability to depression, finding that participants who received lower levels of maternal care reported higher frequency of negative statements, which in turn led to a vulnerability to experiencing more severe depressive episodes (Ingram, Overbey, & Fortier, 2001; Ingram & Ritter, 2000). In short, the finding regarding the significance of maternal care confirm both psychoanalytic (Blatt, 1995; Blatt & Homann, 1992) and cognitive behavioral theories of depression, showing that adverse early experiences with parents especially mother (mother as uncaring, undependable, harsh and critical), are internalized by the child and lead to the development of negative internal working models (or schemas) about the self as weak, vulnerable and inefficient. This leads to development of a feeling of inadequacy and helplessness, and maladaptive perfectionism in those cases may be utilized as a defense against these feelings of helplessness and hopelessness (Flett & Besser, 2005). In addition to this, Alloy, Abramson, Tashman, et al. (2001) also mentioned indirect acquisition of vulnerability to depression from negative parenting practices. They concluded that maladaptive parenting leads to development of a hypercritical way of evaluating the self, which is likely to act as vulnerability for future depressive episodes.

Moreover, Blatt and Homann (1992) also strongly emphasized that both parental overprotection and maladaptive perfectionism were associated with only introjective depression, which is characterized by extreme self-criticalness. On the other hand, a parenting style characterized by a lack of nurturance and affection

was more strongly related to both types of depression (Blatt, Wein, Chevron & Quinlan, 1979).

In fact, the results failed to support hypotheses regarding the strength of mediator role of MEC in the relationship between social anxiety and parental overprotection. Although, it had not been studied before, results of previous correlational studies designed to investigate the relationship between parental overprotection, social anxiety and perfectionism, were indicating the possible role of MEC (as well as other vulnerability factors) as a mediator role between especially parental overprotection and social anxiety (Chorpita & Barlow, 1998; Hudson & Rapee, 2000; Taylor & Alden, 2006). Lack of support for these hypotheses may be related to the way some of the variables were measured.

Overall, results of mediation analyses are in line with research that investigates the link between perceived parental attitudes and different types of psychopathology. A parenting style that is characterized by harshness, intrusiveness, unresponsiveness and control had been in most studies found to be linked to development of maladaptive evaluative concerns (Kawamura et al, 2002;) in other words maladaptive perfectionism, which in turn acts as a mediator between negative parental representations and different types of distress (Enns, et al, 2002a; Soenens et al, 2005).

4. 5. 2. Mediator Role of LMS in the relationship of Parental Variables with Social Anxiety and Depression

Another aim of the present study was to investigate whether LMS accounts for the relationship between different dimensions of parental bonding and

measures of depression and social anxiety. Contrary to the expectations, none of the dimensions of LMS were able to mediate the relationship between any of the parental variables with social anxiety or depression. Besides failing to confirm some of the most important hypotheses of the current study, lack of mediating effect of especially social looming, in the relationship between parenting and especially social anxiety, may be due to the measures used to test parental variables in the present study.

4. 6. General Discussion and Clinical implications

The major aim of the present study was to provide evidence for the Looming Vulnerability Model (LVM), that suggest that LMS is specific to anxiety and predicts unique variance in anxiety measures when the effect of depression is controlled. Given all the arguments on the high correlation and comorbidity of depression and anxiety (especially social anxiety), the specificity of LMS will be quite useful in the area that addresses the high levels of comorbidity between two conditions and aims to differentiate these two conditions.

The present study has the greatest contributions to stress-vulnerability models of psychopathology. As indicated by Riskind, Alloy and Iacoviello (2010) one major benefit of the vulnerability models is the explanation they provide regarding the background for different psychological problems and identification of common and specific risk factors for the development of these disorders. Thus, results of the present study indicate that maladaptive perfectionism is a common risk factor in the diatheses of both depression and social anxiety, whereas looming maladaptive style (LMS) stands out as a specific risk factor for anxiety disorders

(specifically social anxiety regarding the design of the present study). These findings regarding shared consequences of maladaptive perfectionism and specific consequences of LMS are supportive of the previous studies that identify both of these characteristic as risk factors (Kawamura, Hunt, Frost, 2002; Riskind et al 2000, Riskind and Williams etc;). In fact, one should consider the difference between these two concepts in their roles as risk factors. LMS is a distal factor, but MEC acts more like a proximal factor in anxiety. Besides, these two factors tend to differ in terms of their mechanisms and content. As Riskind et al (2000) had indicated, MEC is more like the classical general vulnerability factors which are more verbal based and static in nature. This may be accounting for the differences in the roles that they play in diathesis-stress models of anxiety disorders.

Although the present study failed to replicate and extend the findings of Kawamura, Hunt, and Frost (2002) regarding the differential presentations of dimensions of perfectionism in anxiety and depression, they still can be interpreted as an indication of important role of maladaptive perfectionism in social anxiety. This finding becomes more obvious when results of the mediation analyses are taken into account. In great contrast with Minarik and Ahrens (1996), who suggested that no relationship between anxiety and perfectionism exist aside from the variance explained by depression, the present study once again verifies the importance and significance of the relationship between social anxiety and especially maladaptive perfectionism, in addition to the role it plays in the relationship between parenting and social anxiety.

As indicated above, the present study once again emphasized the important role of perfectionism in certain types of psychopathology such as depression and social anxiety. Treatment interventions may focus of perfectionistic tendencies and thus reduce the chance of relapse in those disorders following successful treatment. Examples of the treatment interventions that are aimed at reducing perfectionistic concerns had be published several times (Anthony & Swinson, 2009; Ashbaugh, et al, 2007; Riley, Lee, Cooper, Fairburn, & Shafran, 2007). Although those studies give contradicting results regarding the significant effectiveness of those interventions (Rosser, Issakidis, & Peters, 2003), results seem promising. Moreover, the present study has important implications regarding personal standards perfectionism and its significance as a manifestation of adaptive forms of perfectionism. This construct may have critical importance in the destructiveness of more maladaptive forms of perfectionism and its role in developing possible treatment interventions may be of great importance.

Finally, the present study also has important implications regarding the treatment of anxiety disorders, aiming the reduction of LMS in individuals with the cognitive style. Although several authors have mentioned possible treatment strategies aimed at dealing with LMS (Elwood, Riskind, & Olatunji, 2009; Riskind & Williams, 1999), there are yet no studies investigating the effectiveness of those LMS oriented interventions. All previous studies on LMS as well as the current study indicate the importance of LMS as a risk factor for anxiety disorders and treatment programs aimed at particularly this cognitive style may be beneficial in treatment and may be prevention of anxiety disorders.

4. 7. Limitations and Further Studies

Parental factors as measured by PBI were able to measure only a very limited amount of the variability in depression, social anxiety, adaptive perfectionism, and social looming. Also, none of the dimensions of PBI appeared to be associated with physical looming. This requires the need to focus on other family characteristics that may be associated with vulnerability to depression, social anxiety and especially LMS. So, further studies may investigate the role of other family variables such as psychological control, parental perfectionism, parental anxiety, parental depression, relationships with siblings as possible indicators of psychopathology and especially LMS.

Besides, PBI as a measure of parenting styles in Turkish culture has not been well documented. Although, the scale had been widely used in many different cultures and languages including Germany, Australia, Pakistan, France, Taiwan and Japan (Heider, 2008; Morh, et al, 1999; Murphy, 1997; Otani et al, 2008; Qadir, et al, 2005; Sato et al, 1999;) all of which indicate adequate levels of reliability and validity for the scale. Moreover, the scale was reported to show satisfactory amount of sensitivity to cultural factors. The present study is the first study that used the Turkish version of PBI in its relationship to different dimensions of psychopathology namely, depression and social anxiety. Despite the consistent findings regarding the association of high levels of overprotection and low levels of care with depression and social anxiety, that had been verified in many different cultures, the present study failed to demonstrate such a relationship. This may be due to cultural factors specific to Turkish culture as indicate earlier. But, insensitivity of the Turkish version of PBI may be another

reason that is responsible for obtaining such a result. Thus, the results could have been more precise if another measure of parental care and overprotection (like EMBU) had been administered as well as PBI.

Secondly, especially in the past two decades, interaction of temperamental with parental characteristics gained importance in vulnerability literature. Rather than indicating the association between parental characteristics such as overprotection with anxiety of depression, recent research focused also on how the child's temperament influenced the way his or her parents take care of him or her. Particularly, research investigating the roots of childhood anxiety disorders focus on the combination of these two factors (parenting and temperaments) by gathering data from parents about both their parenting styles and baseline characteristics of their offspring. A study using those techniques is Taylor and Alden (2006) concluding that behaviorally inhibited children by default are more likely to trigger the tendency to be an overprotective parent; thus the relationship between high levels of anxiety and parental overprotection is due to this interaction. Although Riskind et al (2004) speculated about the role both temperamental and parental qualities in emergence of LMS, up to now, no studies had been conducted to investigate the role of temperament on LMS as well as the interaction of these two very important factors. So, future studies may investigate the role temperament plays in development of LMS.

One of the main characteristic of the present study was its focus on potential vulnerabilities that may lead to development of anxiety and depression. Although, perceived parenting style had been hypothesized to be one of the most influential factors underneath anxiety, depression, and LMS results failed to show

such an association. So, one possibility would be to focus on the factors that had possibly operated in such ways that would lead to elimination of the influence of these vulnerability factors. Measuring the impact of these elements, that can also be referred to as resilience factors can be the main aim of some further studies. In other words, further studies, may investigate the roles of variables such as peer support, intelligence, hardiness etc as buffers against maladaptive parenting styles.

Another important issue that the present study failed to answer was the parental variables behind adaptive perfectionism. So far, similar to the results of current study, many previous studies were able to address the parental variables behind maladaptive perfectionism. But, none of them, including the present study was successful in demonstrating a significant relationship between adaptive perfectionism and a particular parenting variable. So, future studies may aim to find the familial processes that may be responsible for development of more healthy forms of perfectionism.

As indicate earlier, social looming appeared to be only dimension of LMS to be associated with social anxiety in contrast, physical looming did not appear to be associated with any of the outcome variables. Moreover, we do not know different anxiety disorders have different LMS profiles specific to each. Such a paradigm had been followed by the researchers working in the area of Tripartite model of anxiety and depression (Watson, Clark, & Mineka, 1998), indicating differential affective styles of different anxiety disorders. Moreover, such a stance had also been taken in the literature on perfectionism, with Juster, et al., (1996) arguing different perfectionism profiles specific to different anxiety disorders.

Thus, further studies may also look at LMS and search for distinct cognitive patterns for different anxiety disorders.

Some of the research on LMS conducted in Western cultures was concerned with temporal stability of LMS. Such studies have important implications in conceptualization of LMS as a distal vulnerability factor and they provide a chance to see whether LMS is able to predict onset of anxiety disorders in the future. So far, temporal stability of LMS was well documented in Western cultures (Gravel, 2009; Riskind, Tzur, Williams, Mann, & Shahar, 2007) and it was shown to be related to emergence of anxiety symptoms (i.e. test anxiety) or at least a tendency to become extremely anxious in times of stress. In the light of these previous studies, it can be stated that examination of temporal stability of LMS may be under the scope of the future studies.

Although investigated, gender differences were beyond the scope of the present study, and were not aimed to be investigated thoroughly; results indicate significant difference in MEC showing that males are more prone to negative effects of perfectionism than females. Thus, one other interest of the future studies can be the investigation of gender differences in perfectionism, taking into account the influence of culture as well.

REFERENCES

Abela, J. R. Z., Hankin, B. L., Haigh, E. A. P., Adams, P., Vinokuroff, T., & Trayhern, L. (2005). Interpersonal vulnerability to depressive episodes in high-risk children: The role of insecure attachment and reassurance seeking. *Journal of Clinical Child and Adolescent Psychology, 34,* 182–192.

Abramson, L. Y., Alloy, L. B., & Metalsky, G. I. (1989). Hopelessness depression: a theory-based subtype of depression. *Psychological Review,* 96, 358– 72.

Adkins, K. K. & Parker, W. (1996). Perfectionism and suicidal preoccupation. *Journal of Personality, 64,* 529 - 543

Ahrens, A. H., Zeiss, A. M., & Kanfer, R. (1988). Dysphoric deficits in interpersonal standards, self-efficacy, and social comparison. *Cognitive Therapy and Research, 12,* 53–67.

Alden, L. E., Bieling, P. J., & Wallace, S. T. (1994). Perfectionism in an interpersonal context: A self-regulation analysis of dysphoria and social anxiety. *Cognitive Therapy and Research, 18,* 297- 316.

Alden, L. E., Ryder, A. G., & Mellings, T. M. B. (2002). Perfectionism in the context of social fears: Towards a two-component model. In G. L. Flett, & P. L. Hewitt (Eds.), *Perfectionism: Theory, research and treatment* (pp. 373–391). Washington, DC: American Psychological Association.

Akiskal, H.S., Hirschfeld, R.M., & Yerevanian, B.I. (1983). The relationship of Personality to affective disorders: a critical review. *Archives of General Psychiatry, 40,* 801-810.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed. – text revision). Washington, DC: Author.

Amir, N., & Foa, E. B. (2001). Cognitive biases in social phobia. In S. G. Hofmann, & P. M. DiBartolo (Eds.), *From social anxiety to social phobia: Multiple perspectives* (pp. 254–267). Needham Height, MA: Allyn & Bacon.

Amir, N., Foa, E. B., & Coles, M. E. (1998). Negative interpretation bias in social phobia. *Behaviour Research and Therapy, 36,* 945–957.

Amir, N., Foa, E. B., & Coles, M. E. (2000). Implicit memory bias for threat-relevant information in generalized social phobia. *Journal of Abnormal Psychology, 109,* 713–720.

Amir, N., McNally, R. J., Riemann, B. C., Burns, J., Lorenz, M., & Mullen, J. T. (1996). Suppression of the emotional Stroop effect by increased anxiety in patients with social phobia. *Behaviour Research and Therapy, 34*, 945–948.

Andrew, B., Hawton, K., Fagg, F., & Westbrook, D. (1993). Do psychosocial factors influence outcome in severely depressed female psychiatric in-patients? *British Journal of Psychiatry, 163*, 747-754.

Andrews, G. (1996). Comorbidity in neurotic disorders: The similarities are more important than the differences. In R. M. Rapee (Ed.), *Current controversies in the anxiety disorders* (pp. 3–20). New York: Guilford Press.

Anhalt, K., & Morris, T. L. (2008). Parenting characteristics associated with anxiety and depression: A multivariate approach. *Journal of Early and Intensive Behavior Intervention,* 122-137.

Anlı, İ, & Karslı, T. A. (2010). Perceived parenting style depression and anxiety levels in Turkish late-adolescent population. *Procedia-Social and Behavioral Sciences, 2*, 1234-1236.

Antony, M. M., & Barlow, D. H. (2002). Specific phobias. In D. H. Barlow (Ed.), *Anxiety and its disorders* (2nd edition, pp. 380-417). New York: Guilford.

Antony, M. M., & Swinson, R. P. (2009). *When perfect isn't good enough: Strategies for coping with perfectionism*. Oakland, CA: New Harbinger Publications.

Arrindell, W. A., Kwee, M. G. T., Methorst, G. J., van der Ende, J., Pol, E., & Moritz, B. J. M. (1989). Perceived parental rearing styles of agoraphobic and socially phobic in-patients. *British Journal of Psychiatry, 155*, 526–535.

Arthur, N., & Hayward, L. (1997). The relationships between perfectionism, achievement, and emotional distress in postsecondary students. *Journal of College Student Development, 38,* 622–632.

Ashbaugh, A., Antony, M. M., Liss, A., Summerfeldt, L. J., McCabe, R. E., & Swinson, R. P. (2007). Changes in perfectionism following cognitive-behavioral treatment for social phobia. *Depression and Anxiety, 24*, 169–177.

Ashbaugh, A. R., Antony, M. M., McCabe, R. E., Schmidt, L. A., & Swinson, R. P. (2005). Self-evaluative biases in social anxiety. *Cognitive Therapy and Research, 29*, 387–398.

Asmundson, G. J. G., & Stein, M. B. (1994). Selective processing of social threat in patients with generalized social phobia: Evaluation using a dot-probe paradigm. *Journal of Anxiety Disorders, 8*, 107–117.

Ataca, B., & Sunar, D.G. (1999). Continuity and change in Turkish urban family life. *Psychology and Developing Societies.* 11. 77-90.

Ballash , N. , Leyfer , O. , Buckley , A. F. , & Woodruff-Borden , J. (2006) . Parental control in the etiology of anxiety. *Clinical Child and Family Psychology Review , 9* , 113 – 133.

Ballash, N. G., Pemble, M. K., Usui, W. M., Buckley, A. F., and Woodruff-Borden, J. (2006). Family functioning, perceived control, and anxiety: A meditational model. *Journal of Anxiety Disorders, 20*, 486–497.

Barber , B. K. , Stolz , H. E. , & Olsen , J. A. (2005) . *Parental support, psychological control, and behavioral control: Assessing relevance across time, culture, and method* . New York : Wiley .

Barlow, D. H. (2000). Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory. *American Psychologist, 55,* 1247-1263.

Barlow, D.H. (2002). True alarms, false alarms, and learned anxiety. In D.H. Barlow (Ed.), *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed.) (pp. 219- 251). New York: Guilford Press.

Barnett, P. A., & Gotlib, I. H. (1988). Psychosocial functioning and depression: Distinguishing among antecedents, concomitants, and consequences. *Psychological Bulletin, 104,* 97–126.

Baron, R. M. & Kenny, D. A. (1986). The moderator-mediator distinction in social psychological research: conceptual, strategic and statistical considerations. *Journal of Personality and Social Psychology,51,* 1173-82.

Barrow, J. C., & Moore, C. A. (1983). Group interventions with perfectionistic thinking. *Personnel and Guidance Journal, 61,* 612-615.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61,* 226–244.

Baumrind , D. (1971) . Current patterns of parental authority . *Developmental Psychology Monographs , 4* , 1 – 103 .

Beck, A. T. (1983). Cognitive therapy of depression: New perspectives. In P. J. Clayton & J. E. Barrett (Eds.), *Treatment of depression: Old controversies and new approaches* (pp. 265-290). New York: Raven.

Beck, A. T., Brown, G., Steer, R. A., Eidelson, J. I., & Riskind, J. H. (1987). Differentiating anxiety and depression: a test of the cognitive content specificity hypothesis. *Journal of Abnormal Psychology, 96,* 179–183.

Beck, A. T., Epstein, N., Brown, G. (1988) An inventory for measuring clinical anxiety: psychometric properties. *Journal of Consulting and Clinical Psychology, 56,* 893-897.

Beck, R. & Perkins, T. S. (2001). Cognitive content-specificity for anxiety and depression: a meta-analysis. *Cognitive Therapy and Research, 25,* 829–838.

Beck, A. T., Emery, G., & Greenberg, R. I. (1985). *Anxiety disorders and phobias: A cognitive perspective.* New York: Basic Books.

Berman, R. M., & Schneier, F. R. (2004). Symptomatology and diagnosis of social anxiety disorder. In B. Bandelow & D. J. Stein (Eds.), *Social anxiety disorder.* New York: Marcel Dekker. p 1–18.

Besser, A., Flett, G. L., & Hewitt, P. L. (2004). Perfectionism, cognition, and affect in response to performance failure vs. success. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 22,* 301- 328.

Biederman, J., Hirshfeld Becker, D. R., Rosenbaum, J. F., Herot, C., Friedman, D., Snidman, N., et al. (2001). Further evidence of association between behavioral inhibition and social anxiety in children. *American Journal of Psychiatry, 158(10),* 1673–1679.

Bieling, P. J., Israeli, A. L., & Antony, M. M. (2004). Is perfectionism good, bad, or both? Examining models of the perfectionism construct. *Personality and Individual Differences, 36,* 1373- 1385.

Bieling, P. J., Israeli, A. L., Smith, J., & Antony, M. M. (2003). Making the grade: The behavioral consequences of perfectionism in the classroom. *Personality and Individual Differences, 35,* 163- 178.

Bifulco, A, Moran, P. M., Ball, C., & Bernazzani, O. (2002). Adult Attachment Style: I. Its relationship to clinical depression. *Social Psychiatry and Psychiatric Epidemiology, 37,* 50-59.

Blankstein, K. R., & Dunkley, D. M. (2002). Evaluative concerns, self-critical, and personal standards perfectionism: A structural equation modeling strategy. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 285- 315). Washington, DC: American Psychological Association.

Blatt, S. J. (1974). Levels of objective representation in anaclitic and introjective depression. *The Psychoanalytic Study of the Child, 24,* 107-157.

Blatt, S. J. (1995). The destructiveness of perfectionism. *American Psychologist, 50(12),* 1003-1020.

Blatt, S. J. (2004). *Experiences of depression: Theoretical, research and clinical perspectives.* Washington, DC: American Psychological Association.

Blatt, S. J., & Homann, E. (1992). Parent–child interaction in the etiology of dependent and self-critical depression. *Clinical Psychology Review, 12*, 47–91.

Bosquet, M., & Egeland, B. (2006). The development and maintenance of anxiety symptoms from infancy through adolescence in a longitudinal sample. *Development and Psychopathology, 18*, 517–550.

Bögels, S. M., & Brechman-Toussaint, M. (2006). Family issues in child anxiety: Attachment, family functioning, parental rearing and beliefs. *Clinical Psychology Review, 7*, 834−856.

Bögels, S. M., van Oosten, A., Muris, P., & Smulders, P. (2001). Familial correlates of social anxiety in children and adolescents. *Behaviour Research and Therapy, 39*, 273−287.

Brakel, A. M. L., van Muris, P., Bögels, S. M., & Thomassen, C. (2006).A multifactorial model for the aetiology of anxiety in non-clinical adolescents: Main and interactive effects of behavioural inhibition, attachment, and parental rearing. *Journal of Child and Family Studies, 15,* 568−578.

Brown, G. W, & Harris, T. (1978). Social origins of depression. London: Tavistock.

Brown, A. M., & Whiteside, S. P. (2008). Relations among perceived parental rearing behaviors, attachment style, and worry in anxious children. *Anxiety Disorders,* 22, 263-272.

Bruch, M. A., Gorsky, J. A., Collins, T. M., & Berger, P. A. (1989). Shyness and sociability reexamined: A multicomponent analysis. *Journal of Personality and Social Psychology, 57,* 904–915.

Bruch, M. A., & Heimberg, R. G. (1994). Differences in perceptions of parental and personal characteristics between generalized and nongeneralized social phobics. *Journal of Anxiety Disorders, 8,* 155–168.

Burns, D. D. (1980, November). The perfectionist's script for self-defeat. *Psychology Today*, 34-52.

Cairney, J., Veldhuizen, S., Wade, T. J., Kurdyak, P, & Streiner, D. L. (2007). Evaluation of 2 measures of psychological distress as screeners for depression in the general population. *Canadian Journal of Psychiatry*, 52(2), 111- 120.

Camadan, F. (2010). Predicting the students' perfectionism from their parents' perfectionism. *Procedia-Social and Behavioral Sciences, 2*, 4260- 4265.

Campos, R. C., Besser, A., & Blatt, S. J. (2010). The mediating role of self criticism and dependency in the association between perceptions of maternal caring and depressive symptoms. *Depression and Anxiety, 0,* 1-9.

Carnelley, K., Pietromonaco, P. & Jaffe, K. (1994) Depression, working models of others and relationship functioning. *Journal of Personality and Social Psychology*, **66**, 127–140.

Carter, M. M., Sbrocco, T., Lewis, E. L., & Friedman, E. K. (2001). Parental bonding and anxiety: Differences between African American and European American college students. *Anxiety Disorders, 15*, 555-569.

Caspi, A., Harrington, H., Milne, B., Amell, J. W., Theodore, R. F., & Moffitt, T. E.(2003). Children's behavioral styles at age 3 are linked to theiradult personality traits at age 26. *Journal of Personality, 71*, 495–513

Chorpita , B. F. , & Barlow , D. H. (1998) . The development of anxiety: The role of control in the early environment. *Psychological Bulletin , 124* , 3 – 21 .

Chorpita, B. F., Brown, T. A., and Barlow, D. H. (1998). Perceived control as a mediator of family environment in etiological models of childhood anxiety. *Behavior Therapy 29,* 457–476.

Cicchetti, D. & Cohen, D. J. (1995). *Manual of Developmental Psychopathology.* New York: Wiley.

Cicchetti, D., & Toth, S. (2005). Child maltreatment. *Annual Review of Clinical Psychology, 1*, 409– 438.

Clark, D. M. (2001). A cognitive perspective on social phobia. In R. Crozier, & L. E. Alden (Eds.). *International handbook of social anxiety: Concepts, research and interventions relating to the self and shyness* (pp. 405–430). Kingdom Chichester, UK: Wiley.

Clark, L. A., Watson, D., & Mineka, S. (1994). Temperament, personality, and the mood and anxiety disorders. *Journal of Abnormal Psychology, 103*, 103–116.

Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. In R. Heimberg, M. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: Diagnosis, assessment and treatment*. New York: Guilford.

Cloitre, M., Cancienne, J., Heimberg, R. G., Holt, C. S., & Liebowitz, M. R. (1995). Memory bias does not generalize across anxiety disorders. *Behaviour Research and Therapy, 33,* 305–307.

Cloniger, C. R. (1986). Unified biosocial theory of personality and its rolein the development of anxiety states. *Psychiatric Development, 3*, 167- 26.

Coles, M. E., & Horng, B. (2006). A prospective test of cognitive vulnerability to obsessive–compulsive disorder. *Cognitive Therapy and Research, 30,* 723–734.

Coles, M. E., Schofield, C. A., & Pietrefesa, A. S. (2006). Behavioral inhibition and obsessive-compulsive disorder. *Journal of Anxiety Disorders, 20,* 1118–1132.

Cox, B. J., Enns, M. W., & Clara, I. P. (2002a). The multidimensional structure of perfectionism in clinically distressed and college student samples. *Psychological Assessment, 14,* 365- 373.

Cox, B.J., Fuentes, K., Borger, S.C., & Taylor, S. (2001). Psychopathological correlates of anxiety sensitivity: Evidence from clinical interviews and self-report measures. *Journal of Anxiety Disorders, 14,* 317-332.

Cox, B. J., Enns, M. W., & Taylor, S. (2001). The effect of rumination as a mediator of elevated anxiety sensitivity in major depression. *Cognitive Therapy and Research, 25*(5), 525–534.

Crocker, J., Karpinski, A., Quinn, D. M., & Chase, S. K. (2003). When grades determine self-worth: Consequences of contingent self-worth for male and female engineering and psychology majors. *Journal of Personality and Social Psychology, 85,* 507--516.

Connell, A. M., & Goodman, S. H. (2002). The association between psychopathology in fathers versus mothers and children internalizing and externalizing behavior problems: A meta-analysis. *Psychological Bulletin, 128,* 746−773.

Costa, P. T., Jr., & McCrae, R. R. (1992). *Revised NEO Personality Inventory (NEO-PI-R) and NEO Five-Factor Inventory (NEO-FFI) professional manual.* Odessa, FL: Psychological Assessment Resources.

Cunha, M., Soares, I. y Pinto-Gouveia, J. (2008). The role of individual temperament, family and peers in social anxiety disorder: A controlled study. *International Journal of Clinical and Health Psychology, 8,* 631-655.

Çağlar, E., Bilgili, N., Karaca, A., Ayaz, S., & Aşçı, H. (2010). The psychological characteristics and health related behaviour of adolescents: The possible roles of social physique anxiety and gender. *Spanish Journal of Psychology, 13, 741-* 750.

DiBartolo, P. M., Frost, R. O., Chang, P., LaSota, M., & Grills, A. E. (2004). Shedding light on the relationship between personal standards and psychopathology: The case for contingent self-worth. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 22,* 241-254.

DiBartolo, P. M., Li, C. Y., & Frost, R. O. (2008). How do the dimensions of perfectionism relate to mental health? *Cognitive Therapy and Research, 32*, 401-417.

Dohrenwend, B.P., Levav, I., Shrout, P.E., Schwartz, S., Naveh, G., Link, B.G., Skodol, A.E., & Stueve, A. (1992). Socioeconomic status and psychiatric disorders: the causation-selection issue. *Science, 255,* 946–952.

Dozois, D. J. A.,& Frewen, P. A. (2006). Specificity of cognitive structure in depression and social phobia: A comparison of interpersonal and achievement content. *Journal of Affective Disorders, 90,* 101–109.

Dunkley, D. M., Blankstein, K. R., Masheb, R. M., & Grilo, C. M. (2006). Personal standards and evaluative concerns dimensions of „clinical" perfectionism: A reply to Shafran et al. (2002, 2003) and Hewitt et al. (2003). *Behaviour Research and Therapy, 44,* 63-84.

Dunkley, D.M., Blankstein, K.R., Halsall, J., Williams, M., & Winkworth, G. (2000). The relation between perfectionism and distress: Hassles, coping and perceived social support as mediators and moderators. *Journal of Counseling Psychology, 47*,437-453.

Dunkley, D. M., Zuroff, D. C., & Blankstein, K. R. (2003). Self-critical perfectionism and daily affect: Dispositional and situational influences on stress and coping. *Journal of Personality and Social Psychology, 84,* 234-252.

Dunkley, D. M., Zuroff, D. C., & Blankstein, K. R. (2006). Specific perfectionism components versus self-criticism in predicting maladjustment. *Personality and Individual Differences, 40,* 665- 676.

Eastburg, M., & Johnson, W. B. (1990). Shyness and perceptions of parental behavior. *Psychological Reports, 66,* 915–921.

Ellis, A., & Dryden, W. (1997). *The practice of rational emotive behavior therapy (2nd Ed.).* New York: Springer.

Elwood, L. S., Williams, N. L., Olatunji, B. O., & Lohr, J. M. (2007). Interpretation biases in victims and non-victims and their relation to symptom development. *Journal of Anxiety Disorders, 21,* 554−567.

Emery, G., & Tracy, N. L. (1987). Theoretical issues in the cognitive-behavioral treatment of anxiety disorders. In L. Michelson & L. M. Ascher (Eds.), *Anxiety and Stress Disorders: Cognitive-Behavioral Assessment and Treatment*. New York: The Guildford Press.

Enns, M. W., & Cox, B. J. (1997). Personality dimensions and depression: Review and commentary. *Canadian Journal of Psychiatry, 42,* 274-284.

Enns, M. W., & Cox, B. J. (1999). Perfectionism and depression symptom severity in major depressive disorder. *Behaviour Research and Therapy, 37,* 783–794.

Enns, M. W., & Cox, B. J. (2002). The nature and assessment of perfectionism: A critical analysis. In G. L. Flett, & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 33-62).Washington, DC: American Psychological Association.

Enns, M. W., Cox, B. J., & Clara, I. (2002a). Parental bonding and adult psychopathology: Results from the U.S. National Comorbidity Survey. *Psychological Medicine, 32,* 997-1008.

Enns, M. W., Cox, B., & Clara, I. (2002b). Adaptive and maladaptive perfectionism: Developmental origins and association with depression proneness. *Personality and Individual Differences, 33,* 921–935.

Enns, M. W., Cox, B. J., & Larsen, D. K. (2000). Perceptions of parental bonding and symptom severity in adults with depression: mediation by personality dimensions. *Canadian Journal of Psychiatry, 45,* 263–268.

Farmer, A., Redman, K., Harris, T., Mahmood, A., Sadler, S., Pickering, A. & McGuffin, P. (2002). Neuroticicm, extraversion, life events and depression. The Cardiff Depression Study. *British Journal of Psychiatry 181*, 118–122.

Fehm, L., Pelissolo, A., Furmark, T., & Wittchen, H. U. (2005) Size and burden of social phobia in Europe. *European Neuropsychopharmacology, 15,* 453–462

Feldman LA. (1993). Distinguishing depression and anxiety in self-report: evidence from confirmatory factor analysis on nonclinical and clinical samples. *Journal of Consuling and Clinical Psychology,* 61, 631.38

Fişek, G. (1993).

Flett, G. L., & Hewitt, P. L. (2002). Perfectionism and maladjustment: An overview of theoretical, definitional, and treatment issues. In G. L. Flett, & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 5-13). Washington, DC: American Psychological Association.

Flett, G. L., Hewitt, P. L., & Singer, A. (1995). Perfectionism and parental authority styles. *Individual Psychology, 51,* 50-60.

Foa, E. B., Franklin, M. E., Perry, K. J., & Herbert, J. D. (1996). Cognitive biases in generalized social phobia. *Journal of Abnormal Psychology*, **105**, 433-439.

Frost, R. O., Heimberg, R. G., Holt, C. S., Mattia, J. I., & Neubauer, A. L. (1993). A comparison of two measures of perfectionism. *Personality and Individual Differences, 14,* 119-126.

Frost, R. O., Marten, P., Lahart, C., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy and Research, 14,* 449-468.

Fyer, A. J., Mannuzza, S., Chapman, T. F., Liebowitz, M. R., & Klein, D. F. (1993). A direct interview family study of social phobia. *Archives of General Psychiatry 50,* 286- 293.

Gallagher , B. , & Cartwright-Hatton , S. (2008) . The relationship between parenting factors and trait anxiety: Mediating role of cognitive errors and metacognition . *Journal of Anxiety Disorders , 22* , 722 – 733.

Garber, J., & Flynn, C. (2001). Predictors of depressive cognitions in young adolescents. *Cognitive Therapy and Research, 25,* 353–376.

Gencoz, T., Soykan, C., Özguven, H. D. (2003) Liebowitz social anxiety scale: The Turkish version. *Psychological Reports, 93,* 1059-1069.

Gerlsma, C. & Luteijn, F. (2000). Attachment style in the context of clinical and health psychology: a proposal for the assessment of valence, incongruence, and accessibility of attachment representations in various working models. *Brtish Journal of Medical Psychology, 73,* 15–34

Gilboa–Schechtman, E., Foa, E. B., & Amir, N. (1999). Attentional biases for facial expressions in social phobia: The face–in–the–crowd paradigm. *Cognition and Emotion, 13,*305–318.

Gladstone, G. L., Parker, G. B., Mitchell, P. B.,Wilhelm, K. A., & Malhi, G. S. (2005). Relationship between selfreported childhood behavioral inhibition and lifetime anxiety disorders in a clinical sample. Depression and Anxiety, 22, 103–113.

Gordon, J.A. & Hen, R. (2004). Genetic approaches to the study of anxiety. *Annual Review of Neuroscience, 27,* 193-222.

Gotlib, I. H., & Krasnoperova, E. (1998). Biased information processing as a vulnerability factor for depression. *Behavior Therapy, 29,* 603–617.

Gotlib, I. H., Krasnoperova, E., Neubauer Yue, D., & Joorman, J. (2004). Attentional biases for negative interpersonal stimuli in clinical depression. *Journal of Abnormal Psychology 113,* 127–35

Gravel, K. L. (2009). The relationship between looming vulnerability and performance: The role of test anxiety. California State University, Unpublished manuscript.

Greco, L. A., and Morris, T. L. (2002). Paternal child-rearing style and child social anxiety: Investigation of child perceptions and actual father behavior. *Journal of Psychopathology and Behavioral Assessment, 24*, 259–267.

Grillon, C. (2002). Startle reactivity and anxiety disorders: aversive conditioning, context, and neurobiology. *Biological Psychiatry 15*, 958–975.

Haaga, D.A., Yarmus, M., Hubbard, S., Brody, C., Solomon, A., Kirk, L., et al. (2002). Mood dependency of self-rated attachment style. *Cognitive Therapy and Research, 26*(1), 57-71.

Habke, A. M., & Flynn, C. A. (2002). Interpersonal aspects of trait perfectionism. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 151-180). Washington, DC : APA.

Hackmann, A., Surawy, C., & Clark, D. M. (1998). Seeing yourself through others' eyes: A study of spontaneously occurring images in social phobia. *Behavioural and Cognitive Psychotherapy, 26*, 3–12.

Hackmann, A., Clark, D. M., & McManus, F. (2000). Recurrent images and early memories in social phobia. *Behaviour Research and Therapy, 38*, 601–610.

Hall, L. A., Peden, A. R., Rayens, M. K., & Beebe, L. H. (2004). Parental bonding: A key factor for mental health of college women. *Issues in Mental Health Nursing, 25*, 277-291.

Hamachek, D. E. (1978). Psychodynamics of normal and neurotic perfectionism. *Psychology, 15*, 27-33.

Hammen C. 2005. Stress and depression. *Annual Review of Clinical Psychoogy, 1*, 293–318.

Hammen, C., Davila, J., Brown, G., Ellicott, A., & Gitlin, M. (1992). Psychiatric history and stress: predictors of severity of unipolar depression. *Journal of Abnormal Psychology,* 101, 45–52.

Hammen, C., Shih, J. H., & Brennan, P. A. (2004). Intergenerational transmission of depression: test of an interpersonal stress model in a community sample. *Journal of Consulting and Clinical Psychology,* 72, 511–22.

Hankin, B. L., & Abramson, L. Y. (2002). Measuring cognitive vulnerability to depression in adolescence: Reliability, validity, and gender differences. *Journal of Clinical Child and Adolescent Psychology, 31,* 491–504.

Hazan, C, & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, 52, 511-524.

Heider, D., Matschinger, H., Bernert, S., Alonso, J., Brugha, T. S., Bruffaerts, R., de Girolamo, Giovanni, et al. (2008). Adverse parenting as a risk factor in the occurrence of anxiety disorders. *Social Psychiatry and Psychiatric Epidemiology, 43*, 266-272.

Heller, W., Nitschke, J. B., Etienne, M. A., & Miller, G. A. (1997). Patterns of regional brain activity differentiate types of anxiety. *Journal of Abnormal Psychology, 106*, 376–385.

Hettema, J. M., Neale, M. S., & Kendler, K. S. (2001). A review and metaanalysis of the genetic epidemiology of anxiety disorders. *American Journal of Psychiatry*, *158*, 1568–1578.

Hettema, J. M., Prescott, C. A., Myers, J. M., Neale, M. C., & Kendler, K. S. (2005). The structure of genetic and environmental risk factors for anxiety disorders in men and women. *Archives of General Psychiatry, 62*, 182–189.

Hewitt, P. L., Caelian, C. F., Flett, G. L., Sherry, S. B., Collins, L., & Flynn, C. A. (2002). Perfectionism in children: Associations with depression, anxiety, and anger. *Personality and Individual Differences, 32*, 1049–1061.

Hewitt, P. L., & Flett, G. L. (1990). Perfectionisnn and depression: A multidimensional analysis J*ournal of Social Behavior and Personality,* 5, 423-428.

Hewitt, P. L., & Flett, G. L. (1991a). Perfectionism in the self and social contexts: Conceptualization, assessment, and association with psychopathology. *Journal of Personality and Social Psychology, 60*, 456-470.

Hewitt, P. L., & Flett, G. L. (1991b). Dimensions of perfectionism in unipolar depression. *Journal of Abnormal Psychology, 100*, 98-101.

Hewitt, P. L., & Flett, G. L. (1993a). Dimensions of perfectionism, daily stress, and depression: A test of the specific vulnerability hypothesis. *Journal of Abnormal Psychology, 102*, 58-65.

Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: Conception, assessment, and association with psychopathology. *Journal of Personality and Social Psychology, 60*, 456-470.

Hewitt, P. L., Flett, G. L., & Ediger, E. (1996). Perfectionism and depression: Longitudinal assessment of a specific vulnerability hypothesis. *Journal of Abnormal Psychology, 105*, 276–280.

Hill, R. W., Zrull, M. C., & Turlington, S. (1997). Perfectionism and interpersonal problems. *Journal of Personality Assessment, 69*(1), 81–103.

Hirschfeld, R.M., Klerman, G.L., Andreasen, N.C., Clayton, P.J., & Keller, M.B. (1986). Psycho-social predictors of chronicity in depressed patients. *British Journal of Psychiatry, 148,* 648-654.

Hisli, N. (1988). A study on the validity of Beck Depression Inventory. *Psikoloji Dergisi, 6,* 118–122.

Hisli, N. (1989). Reliability and validity of Beck Depression Inventory for university students. *Psikoloji Dergisi, 7,* 3–13.

Hodges, K. (1990). Depression and anxiety in children: a comparison of self-report questionnaires to clinical interview. *Psychological Assesment,* 2, 376.81

Holsboer, F. & Barden, N. (1996). Antidepressants and hypothalamic– pituitary–adrenocortical regulation. *Endocrine Reviews, 17,* 187–205.

Homel. R., Burns, A., & Goodnow, J. **(**1987). Parental social networks and child development. J*ournal of Social and Personal Relationships, 4,* 159-177.

Horney, K. (1991). Neurosis and human growth: The struggle towards self-realization. New York: Norton. (Original work published 1950).

Hudson, J. L., & Rapee, R. M. (2000). The origins of social phobia. *Behaviour Modification, 24(1),* 102– 129.

Huprich, S. K., Porcerelli, J. P., Keaschuk, R., Binienda, J., & Engle, B. (2008). Depressive personality disorder, dysthymia, and their relationship to perfectionism. *Depression and Anxiety, 25,* 207–217.

Ingram, R.E., Overbey, T., & Fortier, M. (2001). Individual differences in dysfunctional automatic thinking and parental bonding: specificity of maternal care. *Personality and Individual Differences, 30,* 401-412.

Ingram, R. E., & Price, J. M. (Eds.). (2001). *Vulnerability to psychopathology: Risk across the lifespan.* New York: Guilford Press.

Ingram, R. E., & Ritter, J. (2000). Vulnerability to depression: Cognitive reactivity and parental bonding in high-risk individuals. *Journal of Abnormal Psychology, 109,* 588–596.

Jorm, A. F., Christensen, H., Henderson, A. S., Jacomb, P. A., Korten, A. E., & Rodgers, B. (2000). Predicting anxiety and depression from personality: Is there a synergistic effect of neuroticism and extraversion? *Journal of Abnormal Psychology, 109,* 145–149.

Juster, H. R., Heimberg, R. G., Holt, C. S., & Frost, R. O. (1996). Social phobia and perfectionism. *Personality and Individual Differences, 21,* 403–410.

Kagan, J., Reznick, J. S., Snidman, N., Gibbons, J., & Johnson, M. O. (1988). Childhood derivatives of inhibition and lack of inhibition to the unfamiliar. *Child Development, 59,* 1580−1589.

Kagitcibasi, Ç. (2010). *Aile, Benlik ve İnsan Gelişimi: Kültürel Psikoloji,* Koç Üniversitesi Yayınevi, Turkey.

Kagitçibasi, C., & Ataca, B. (2005). Value of children and family change: A three-decade portrait from Turkey. *Applied Psychology: An International Review, 54,* 317–337.

Kapçı, G. E., & Küçüker, S. (2006). Ana Babaya Bağlanma Ölçeği: Türk üniversite öğrencilerinde psikometrik özelliklerinin değerlendirilmesi. *Türk Psikiyatri Dergisi, 17,* 286- 295.

Kawamura, K. Y., Hunt, S. L., Frost, R. O., & DiBartolo, P. M. (2001). Perfectionism, anxiety, and depression: Are the relationships independent?. *Cognitive Therapy and Research 25,* 291–301.

Kendler, K.S., Prescott, C.A., Myers., J., & Neale, M.C. (2003). The structure of genetic and environmental risk factors for common psychiatric and substance use disorders in men and women. *Archives of General Psychiatry, 60(9),* 929- 937.

Kenney-Benson, G. A., & Pomerantz, E. M. (2005). The role of mothers' use of control in children's perfectionism: Implications for the development of depressive symptoms. *Journal of Personality, 73,* 23–46.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month prevalence of DSM-II-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51,* 8–19.

Kim, J. & Gorman, J. (2005). The psychobiology of anxiety. *Clinical Neuroscience Research, 4,* :335-347.

Kimbrel, N. A., Cobb, A. R., Mitchell, J. T., Hundt, N. E., & Nelson-Gray, R. O. (2008). Sensitivity to punishment and low maternal care account for the link between bulimic and social anxiety symptomology. *Eating Behaviors, 9,* 210 – 217.

Koydemir, S., & Demir, A. (2007). Psychometric properties of the brief version of the Fear of Negative Evaluation Scale. *Psychological Reports, 100,* 883–893.

Koydemir, S., & Demir, A. (2008). Shyness and cognitions: An examination of Turkish university students. *The Journal of Psychology, 142*(6), 633–644.

Koydemir-Özden, S., & Demir, A. (2009). The relationship between perceived parental attitude and shyness among Turkish youth: The fear of negative evaluation and self-esteem as mediator. *Current Psychology, 28,* 169- 180.

Kuiper, N. A., Olinger, L. J., & MacDonald, M. R. (1988). Vulnerability and episodic cognitions in a self-worth contingency model of depression. In L. B. Alloy (Ed.), *Cognitive processes in depression* (pp. 289–309). New York: Guilford Press.

Lang, P. J., Bradley, M. M., & Cuthbert, B. N. (1998). Emotion, motivation, and anxiety: Brain mechanisms and psychophysiololgy. *Biological Psychiatry, 44,* 1248–1263.

Laurenti, H. J., Bruch, M. A., & Haase, R. F. (2008). Social anxiety and socially prescribed perfectionism: Unique and interactive relationships with maladaptive appraisal of interpersonal situations. *Personality and Individual Differences, 45,* 55-61.

LeCompte, W. A., & Öner, N. (1976). Development of the Turkish edition of the-trait anxiety inventory. In C. D. Spielberger and D. Guerrero (Eds.) *Cross cultural anxiety* (pp.51-68). Washington D.C.: Hemisphere Pub. Corp.

Leary, M. R. (1983). A brief version of the Fear of Negative Evaluation Scale. *Personality and Social Psychology Bulletin, 9,* 371–376.

Ledley, D. R., Fresco, D. M., & Heimberg, R. G. (2006). Cognitive vulnerability to social anxiety disorder. In L. B. Alloy, & J. H. Riskind (Eds.), *Cognitive vulnerability to emotional disorders.* London: Lawrence Erlbaum Associates, Inc.

Lucock, M. P., & Salkovskis, P. M. (1988). Cognitive factors in social anxiety and its treatment. *Behaviour Research and Therapy, 26,* 297–302.

Lundh, L. G., & Öst, L. G. (1997). Explicit and implicit memory bias in social phobia: The role of subdiagnostic type. *Behaviour Research and Therapy, 35,* 305–317.

Lundh L.G. & Öst L.G. (2000). Attentional bias, self-consciousness and perfectionism in social phobia before and after cognitive-behaviour therapy. *Scandinavian Journal of Behaviour Therapy 200,* 30, 4–16.

Mackinnon, A. J., Henderson, A. S., & Andrews, G. (1993). Parental 'affectionless control' as an antecedent to adult depression: a risk factor defined. *Psychological Medicine, 23,* 135–141.

Mansell, W., & Clark, D. M. (1999). How do I appear to others? Social anxiety and processing of the observable self. *Behaviour Research and Therapy, 37*, 419–434.

Mansell, W., Clark, D. M., Ehlers, A., & Chen, Y. P. (1999). Social anxiety and attention away from emotional faces. *Cognition & Emotion, 13*, 673–690.

Martin, M. (1985). Neuroticism as predisposition toward depression: A cognitive mechanism. *Personality and Individual Differences, 6*, 353–365.

Masia, C. L., & Morris, T. L. (1998). Parental factors associated with social anxiety: Methodological limitations and suggestions for integrated behavioral research. *Clinical Psychology: Science and Practice, 5*, 211–228.

McCreary, B. T., Joiner, T. E., Schmidt, N. B., & Ialango, N. S. (2004). The structure and correlates of perfectionism in African American children. *Journal of Clinical Child and Adolescent Psychology, 33*(2), 313-324.

Mellings, T. M. B., & Alden, L. E. (2000). Cognitive processes in social anxiety: The effects of self-focus, rumination and anticipatory processing. *Behaviour Research and Therapy, 38*, 243–257.

Meyer, S., Pilknos, P., Proletti, J., *et al* (2001) Attachment styles and personality disorders as predictors of symptom course. *Journal of Personality Disorders*, **15**, 371–389.

Mezulis, A. H., Hyde, J. S., & Abramson, L. Y. (2006). The developmental origins of cognitive vulnerability to depression: Temperament, parenting, and negative life events. *Developmental Psychology, 42*, 1012– 1025.

Michelson, K., Kessler, R., and Shaver, P. (1997). Adult attachment in a nationality representative sample. *Journal of Personality and Social Psychology, 73*, 1092-1106.

Mick, M. A., & Telch, M. J. (1998). Social anxiety and history of behavioral inhibition in young adults. *Journal of Anxiety Disorders, 12*, 1–20.

Minarik, M.L.,&Ahrens, A.H. (1996). Relations of eating and symptoms of depression and anxiety to the dimensions of perfectionism among undergraduate women. *Cognitive Therapy and Research, 20*, 155-169.

Mineka, S.,Watson, D., & Clark, L. A. (1998). Comorbidity of anxiety and unipolar mood disorders. *Annual Review of Psychology, 49*, 377–412.

Molnar, D. S., Reker, D. L., Culp, N. A., Sadava, S. W., & DeCourville, N. H. (2006). A mediated model of perfectionism, affect, and physical health. *Journal of Research in Personality, 40*, 482-500.

Mowrer, O., (1960). *Learning Theory and Behavior.* Wiley, New York.

Mulkens, S., de Jong, P. J., Dobbelaar, A., & Bögels, S. M. (1999). Fear of blushing: fearful preoccupation irrespective of facial coloration. *Behaviour Research and Therapy, 37,* 1119–1128.

Muller, J. E., Koen, L., & Stein, D. J. (2004). The spectrum of social anxiety disorders. In: B. Bandelow & D. J. Stein (Eds.). *Social anxiety disorder.* New York: Marcel Dekker. p 19–34.

Muris, P., & Merckelbach, H. (1998). Specific phobias. In A. S. Bellack & M. Hersen (Eds.), *Comprehensive clinical psychology* (pp. 461±474). Oxford: Pergamon Press.

Muris, P., Merckelbach, H., & Damsma, E. (2000). Threat perception bias in nonreferred, socially anxious children. *Journal of Clinical Child Psychology, 29,* 348–359.

Muris, P., Steerneman, P., Merckelbach, H., & Meesters, C. (1996). Parental modelling and fearfulness in middle childhood. *Behaviour Research and Therapy, 34,* 265–268.

Murphy, B., & Bates, G.W. (1997). Adult attachment style and vulnerability to depression. *Personal and Individual Differences, 22*(6), 835-944.

Musa, C., Lepine, J-P., Clark, D. M., Mansell, W., & Ehlers, A. (2003). Selective attention in social phobia and the moderating effect of a concurrent depressive disorder. *Behaviour Research & Therapy, 41,* 1043–1054.

Nathason, D. L. (1992). *Shame and pride: affect, sex, and the birth of the self.* New York: Norton.

Neal, J. A., & Edelmann, R. J. (2003). The etiology of social phobia: Toward a developmental profile. *Clinical Psychology Review, 23(6),* 761–786.

Newcomb, K., Mineka, S., Zinbarg, R., & Griffith, J. (2007). Perceived family environment and symptoms of emotional disorders: The role of perceived control, attributional style, and attachment. *Cognitive Therapy and Research, 31,* 419–437.

Oakley-Browne, M. A., Joyce, P. R., Wells, J. E., Bushnell, J. A., & Hornblow, A. R. (1995). Adverse parenting and other childhood experience as risk factors for depression in women aged 18–44 years. *Journal of Affective Disorders, 34*(1), 13–23.

Ohayon, M. M. (2007) Epidemiology of depression and its treatment in the general population. *Journal of Psychiatric Research, 41,* 207–213.

O'Leary, D. & Costello, F. (2001) Personality and outcome in depression: an 18-month prospective follow-up study. *Journal of Affective Disorders, 63,* 67-78.

Oliver, J.M., Klocek, J., & Wells, A. (1995). Depressed and anxious moods mediate relations Among perceived socialization, self-focused attention, and dysfunctional attitudes. *Journal of Clinical Psychology, 51(6),* 726-739.

Özbay, Y. & Taşdemir M. Ö. (2003). Çok Boyutlu Mükemmeliyetçilik Ölçeği: Geçerlik ve Güvenirlik Çalışması. *VII. Ulasal Psikolojik Danışma ve Rehberlik Kongresi,* 9-11 Temmuz. Malatya.

Özkan, T., & Lajunen, T. (2005) Masculinity, Femininity and Bem Sex Role Inventory in Turkey. *Sex Roles, 52,* 103-110.

Parker, G. (1983a). Parental 'affectionless control' as an antecedent to adult depression - a risk factor delineated. *Archives of General Psychiatry 40,* 956-960.

Parker, G. (1983b). *Parental Overprotection: A Risk Factor in Psychosocial Development.* Grune and Stratton, New York.

Parker, G., Tupling, H., & Brown, L. (1979). A parental bonding instrument. *British Journal of Medical Psychology, 52*(1), 1-10.

Plotsky, P. M. (1991). Pathways to the secretion of adrenocorticotropin: a view from the portal. *Journal of Neuroendocrinology,3,* 1–9.

Pollock, R., Rosenbaum, J., Marrs, A., Miller, B., & Biederman, J. (1995). Anxiety disorders of childhood: Implications for adult psychopathology. In M.H. Pollack & M.W. Otto (Eds.), *Psychiatric Clinics of North America* (pp. 745-766). Philadelphia: W.B. Saunders Co.

Powers, T. A., Zuroff, D. C., & Topciu, R. A. (2004). Covert and overt expressions of self-criticism and perfectionism and their relation to depression. *European Journal of Personality, 18,* 61–72.

Preusser, K. J., Rice, K. G., & Ashby, J. S. (1994). The role of self-esteem in mediating the perfectionism-depression connection. *Journal of College Student Development, 35,* 88-93.

Priel, B. & Shamai, D. (1995). Attachment style and perceived social support: Effects of affectregulation. *Personality and Individual Differences, 19,* 235–241.

Radomsky, A. S., & Rachman, S. (1999). Memory bias in obsessive–compulsive disorder (OCD). *Behaviour Research and Therapy, 37,* 605–618.

Randolph, J. J., & Dykman, B. M. (1998). Perceptions of parenting and depression-proneness in the offspring: Dysfunctional attitudes as a mediating mechanism. *Cognitive Therapy and Research, 22*, 377–400.

Rapee , R. M. (1997) . Potential role of childrearing practices in the development of anxiety and depression. *Clinical Psychology Review , 17* , 47 – 67 .

Rapee, R. M., & Heimberg, R. G. (1997). A cognitive-behavioral model of anxiety in social phobia. *Behaviour Research and Therapy, 35,* 741–756.

Rapee, R. M., McCallum, S. L., Melville, L. F., Ravenscroft, H., & Rodney, J. M. (1994). Memory bias in social phobia. *Behaviour Research and Therapy, 32*, 89–99.

Rapee, R. M., & Spence, S. H. (2004). The aetiology of social phobia: Empirical evidence and an initial model. *Clinical Psychology Review, 24(7),* 737–767.

Reardon, J. M., & Williams, N. L. (2007). The specificity of cognitive vulnerabilities to emotional disorders: anxiety sensitivity, looming vulnerability and explanatory style. *Journal of Anxiety Disorders, 21*, 625–643.

Restifo, K., Akse, J., Guzman, N. V., Benjamins, C., & Dick, K. (2009). A pilot study of self-esteem as a mediator between family factors and depressive symptoms in young adult university students. *Journal of Nervous and Mental Disease 197,* 166 –171.

Rey, J. M. (1995). Perceptions of poor maternal care are associated with adolescent depression. *Journal of Affective Disorders*, *34*(2), 95–100.

Reznick, J. S., Kagan, J., Snidman, N., Gersten, M., Baak, K., & Rosenberg, A. (1986). Inhibited and uninhibited behavior: A follow-up study. *Child Development, 57,* 660-680.

Rice, K. G., Ashby, J. S, & Preusser, K. J. (1996). Perfectionism, relationships with parents, and self-esteem. *Individual Psychology, 52,* 247-260.

Rice, K. G., Ashby, J. S., & Slaney, R. B. (1998). Self-esteem as a mediator between perfectionism and depression: A structural equation analysis. *Journal of Counseling Psychology, 45*, 304-314.

Rice, K. G., Bair, C. J., Castro, J. R., Cohen, B. N., & Hood, C. A. (2003). Meanings of perfectionism: A quantitative and qualitative analysis. *Journal of Cognitive Psychotherapy, 17*, 39-58.

Rice, K. G., Lopez, F. G., & Vergara, D. (2005). Parental/social influences on perfectionism and adult attachment orientations. *Journal of Social and Clinical Psychology, 24*, 580-605.

Rice, K. G., & Mirzadeh, S. A. (2000). Perfectionism, attachment, and adjustment. *Journal of Counseling Psychology, 47,* 238-250.

Rice, K. G., & Preusser, K. J. (2002). The Adaptive/Maladaptive Perfectionism Scale. *Measurement and Evaluation in Counseling and Development, 34,* 210-222.

Rice, K.G. & Slaney, R.B. (2002). Clusters of perfectionists: Two studies of emotional adjustment and academic achievement. *Measurement and Evaluation in Counselling and Development, 35,* 35-48.

Rice, K.G., Kubal, A.E. & Preusser, K.J. (2004). Perfectionism and children's self-concept: Further validation of the Adaptive/Maladaptive Perfectionism Scale. *Psychology in the Schools*. *41*(3), 279-290.

Riley, C., Lee, M., Cooper, Z., Fairburn, C. G., & Shafran, R. (2007). A randomised controlled trial of cognitive-behaviour therapy for clinical perfectionism: A preliminary study. *Behaviour Research and Therapy, 45,* 2221-2231.

Riskind, J. (1997). Looming vulnerability to threat: A cognitive paradigm for anxiety. *Behaviour Research and Therapy*, *35*(8), 685-702.

Riskind, J., Abreu, K., Strauss, M., & Holt, R. (1997). Looming vulnerability to spreading contamination in subclinical OCD. *Behaviour Research and Therapy, 35*(5), 405-414.

Riskind, J. H., & Alloy, L. B. (2006). Cognitive vulnerability to emotional disorders: Theory, design, and methods. In L. B. Alloy & J. H. Riskind (Eds.), *Cognitive vulnerability to emotional disorders*. Hillsdale, NJ: Erlbaum.

Riskind, J. H. & Chambless, D. L. (1999). Exploring cognitive antecedents of panic: Effects of looming vulnerability, perceived control, and causal attributions. Unpublished manuscript.

Riskind, J., & Rector, N. (2007). Beyond belief: Incremental prediction of obsessive-compulsive disorder by looming vulnerability illusions. *Journal of Cognitive Psychotherapy, 21*(3), 243-256.

Riskind, J. H., Tzur, D., Williams, N. L., Mann, B., & Shahar, G. (2007). Short-term predictive effects of the looming cognitive style on anxiety disorder symptoms under restrictive methodological conditions. *Behaviour Research and Therapy, 45,* 1765–1777.

Riskind, J., & Wahl, O. (1992). Moving makes it worse: The role of rapid movement in fear of psychiatric patients. *Journal of Social & Clinical Psychology, 11*(4), 349-364.

Riskind, J., Wheeler, D., & Picerno, M. (1997). Using mental imagery with subclinical OCD to 'freeze' contamination in its place: Evidence for looming vulnerability theory. *Behaviour Research and Therapy, 35*(8), 757-768.

Riskind, J., & Williams, N. (1999). Specific cognitive content of anxiety and catastrophizing: Looming vulnerability and the looming maladaptive style. *Journal of Cognitive Psychotherapy, 13*(1), 41-54.

Riskind, J., & Williams, N. (2005). The Looming Cognitive Style and Generalized Anxiety Disorder: Distinctive Danger Schemas and Cognitive Phenomenology. *Cognitive Therapy and Research, 29*(1), 7-27.

Riskind, J., Williams, N., Altman, M., Black, D., Balaban, M., & Gessner, T. (2004). Developmental Antecedents of the Looming Maladaptive Style: Parental Bonding and Parental Attachment Insecurity. *Journal of Cognitive Psychotherapy, 18*(1), 43-52.

Riskind, J., Williams, N., Gessner, T., Chrosniak, L., & Cortina, J. (2000). The looming Social and Physiological maladaptive style: Anxiety, danger, and schematic processing. *Journal of Personality and Social Psychology, 79*(5), 837-852.

Riskind, J., Williams, N., & Joiner, T. (2006). The looming cognitive style: A cognitive vulnerability for anxiety disorders. *Journal of Social & Clinical Psychology, 25*(7), 779- 801.

Riskind, J. H., Williams, N. L., & Kyrios, M. (2002). Experimental methods for studying cognition. In R. O. Frost & G. Steketee (Eds.), *Cognitive approaches to obsessions and compulsions: Theory, assessment, and treatment*. Oxford: Elsevier Press.

Roberts, J. E., Gotlib, I. H., & Kassel, J. D. (1996). Adult attachment security and symptoms of depression: The mediating roles of dysfunctional attitudes and low self-esteem. *Journal of Personality and Social Psychology, 70*, 310–320.

Roberts, J.E., & Kassel, J.D. (1997). Labile self-esteem, stressful life events, and depressive symptoms: Prospective data testing a model of vulnerability. *Cognitive Therapy and Research, 21*, 569-589.

Roelofs, J., Meesters, C., Huurne, M., Bamelis, L., & Muris, P. (2006). On the links between attachment style, parental rearing behaviors, and internalizing and externalizing problems in non-clinical children. *Journal of Child and family Studies, 15*, 331-344.

Rosenbaum, J. F., Biederman, J., Hirshfeld, D. R., Bolduc, E. A., Faraone, S. V., Kagan, J., Snidman, N., & Reznick, J. S. (1991). Further evidence of an

association between behavioral inhibition and anxiety disorders: Results from a family study of children from a non-clinical sample. *Journal of Psychiatric Research, 25*, 49–65.

Rosser, S., Issakidis, C., & Peters, L. (2003). Perfectionism and social phobia: Relationship between the constructs and impact on cognitive behavior therapy. *Cognitive Therapy & Research*, *27*, 143-151.

Rothstein, A. (1991). On some realtionship of fantasies of perfection to the calamities of childhood. *International Journal of Psycho-Analysis*, 72, 313-323.

Saboonchi, F., Lundh, L. G., & Öst, L. G. (1999). Perfectionism and self-consciousness in social phobia and panic disorder with agoraphobia. *Behaviour Research and Therapy*, *37*, 799–808.

Saddler, D. & Buckland, R. (1995). The Multidimensional Perfectionism Scale: Correlations with Depression in College Students with Learning Disabilities. *Psychological Reports, 77(2),* 483-490.

Saddler, C. D., & Sacks, L. (1993). Multidimensional perfectionism and academic procrastination: relationship with depression in university students. *Psychological Reports*, *73*, 863-871.

Safford, S. M., Alloy, L. B., Crossfield, A. G., Morocco, A. M., & Wang, J. C. (2004). The relationship of cognitive style and attachment style to depression and anxiety in young adults. *Journal of Cognitive Psychotherapy, 18(1*), 25–41.

Sagar, S. S., & Stoeber, J. (2009). Perfectionism, fear of failure, and affective responses to success and failure: The central role of fear of experiencing shame and embarrassment. *Journal of Sport & Exercise Psychology, 31*(5), 602-627.

Schofield, C. A., Coles, M. E., & Gibb, B. E. (2009). Retrospective reports of behavioral inhibition and young adults' current symptoms of social anxiety, depression, and anxious arousal. *Journal of Anxiety Disorders*, *23*, 884–890.

Schneider, F. R., Blanco, C., Antia, S. X., & Liebowitz, M. R. (2002). The social anxiety spectrum. *Psychiatric Clinics of North America*, *25*, 757–774.

Scott, J., Williams, J. M. G., Brittlebank, A.,& Ferrier, I. N. (1995). The relationship between premorbid neuroticism, cognitive dysfunction and persistence of depression. *Journal of Affective Disorders, 33,* 167-172.

Shafran, R., Cooper, Z., & Fairburn, C. G. (2002). Clinical perfectionism: A cognitive–behavioural analysis. *Behaviour Research and Therapy, 40,* 773–791.

Shafran, R., & Mansell,W. (2001). Perfectionism and psychopathology: A review of research and treatment. *Clinical Psychology Review*, *21,* 879–906.

Shah, R. & Waller, G. (2001). Parental style and the vulnerability to depression: The role of core beliefs. *Journal of Nervous and Mental Disease, 188,* 295-321.

Shamir-Essakow, G., Ungerer, J. A., & Rapee, R. M. (2005). Attachment, behavioral inhibition, and anxiety in preschool children. *Journal of Abnormal Child Psychology, 33,* 131-143.

Shumaker, E. A. & Rodebaugh, T. L. (2009). Perfectionism and social anxiety: Rethinking the role of high standards. *Journal of Behavior Therapy and Experimental Psychiatry,.40,* 423-33.

Silove, D., Parker, G., Hadzi-Pavlovic, D., & Manicavasagar, V. (1991). Parental representations of patients with panic disorder and generalized anxiety disorder. *British Journal of Psychiatry*, *159*, 835-841.

Slade, P. D., & Owens, R. G. (1998). A dual process model of perfectionism based on reinforcement theory. *Behavior Modification*, *22,* 372–390.

Slaney, R. B., & Ashby, J. S. (1996). Perfectionists: Study of a criterion group. *Journal of Counseling and Development, 74*, 393-398.

Slaney, R. B., Rice, K. G., Mobley, M., Trippi, J., & Ashby, J. S. (2001). The revised Almost Perfect Scale. *Measurement and Evaluation in Counseling and Development, 34*, 130-145.

Soenens, B., Luyckx, K., Vansteenkiste, M., Luyten, P., Duriez, B., & Goossens, L. (2008). Maladaptive perfectionism as an intervening variable between psychological control and adolescent depressive symptoms: A three-wave longitudinal study. *Journal of Family Psychology*, *22*(3), 465-474.

Soenens, B., Vansteenkiste, M., Luyten, P., Duriez, B., and Goossens, L. (2005). Maladaptive perfectionistic self-representations: The mediational link between psychological control and adjustment. *Personality and Individual Differences,* 38, 487–498.

Soygüt, G., & Çakır, Z. (2009). The mediating role od interpersonal schemas between parenting styles and psychological symptoms: A schema focused view. *Turkish Journal of Psychiatry, 20,* 144- 152.

Spielberger, C. D., Gorsuch, R. L., & Lushene, R. E. (1970). Manual for the state-trait anxiety inventory. Polo Alto, CA: Consulting Psychologist Press.

Spokas, M., & Heimberg, R. G. (2009). Overprotective parenting, social anxiety and locus of control: Cross sectional and longitudinal relationships. *Cognitive Therapy and Research, 33,* 543- 551.

Starcevic, V., Berle, D., Milicevic, D., Hannan, A., Lamplugh, C., & Eslick, G. D. (2007). Pathological worry, anxiety disorders and the impact of co-occurrence with depressive and other anxiety disorders. *Journal of Anxiety Disorders, 21*, 1016–1027.

Stein, M. B., Chartier, M. J., Hazen, A. L., Kozak, M. V., Tancer, M. E., Lander, R. N., Furer, P., Chubaty, D. & Walker, J. R. (1998). A direct-interview family study of generalized social phobia. *American Journal of Psychiatry, 155*, 90-96.

Stinson, F. S., Dawson, D. A., Chou, S. P., Smith, S., Goldstein, R. B, Ruan, W. & Grant, B. F. (2007). The epidemiology of DSM-IV specific phobia in the USA: results from the National Epidemiology Survey on Alcohol and Related Conditions. *Psychological Medicine, 37*, 1047–1059.

Stoll, O., Lau, A., & Stoeber, J. (2008). Perfectionism and performance in a new basketball training task: Does striving for perfection enhance or undermine performance? *Psychology of Sport and Exercise, 9*, 620-629.

Stopa, L.,&Clark, D.M. (1993). Cognitive processes in social phobia. *Behaviour Research and Therapy, 31*, 255–267.

Stopa, L. & Clark, D. M. (2000). Social phobia and interpretation of social events. *Behaviour Research and Therapy, 38*, 273–283.

Stöber, J. (1998). The Frost Multidimensional Perfectionism Scale: More perfect with four (instead of six) dimensions. *Personality and Individual Differences, 24*, 481-491.

Stöber, J., & Joormann, J. (2001). Worry, procrastination, and perfectionism: Differentiating amount of worry, pathological worry, anxiety, and depression. *Cognitive Therapy and Research, 25*, 49-60.

Stoeber, J., & Kersting, M. (2007). Perfectionism and aptitude test performance: Testees who strive for perfection achieve better test results. *Personality and Individual Differences, 42*, 1093-1103.

Stoeber, J., & Otto, K. (2006). Positive conceptions of perfectionism: Approaches, evidence, challenges. *Personality and Social Psychology Review, 10*, 295-319.

Stoeber, J., & Stoeber, F. S. (2009). Domains of perfectionism: Prevalence and relationships with perfectionism, gender, age, and satisfaction with life. *Personality and Individual Differences, 46*, 530- 535.

Stöber, J. & Yang (2010). Perfectionism and emotional reactions to perfect and flawed achievements: Satisfaction and pride only when perfect. *Personality and Individual Difference,* in press.

Stumpf, H., & Parker, W. D. (2000). A hierarchical structural analysis of perfectionism and its relation to other personality characteristics. *Personality and Individual Differences, 28,* 837-852.

Sturman, E. D., Flett, G. L., Hewitt, P. L., & Randolph, S. G. (2008). Dimensions of perfectionism and self-worth contingencies in derpression. *Journal of Rational Emotive Cognitive Behavioral Therapy, 27,* 213- 231.

Summerfeldt, L. J., & Endler, N. S. (1998). Examining the evidence for anxiety-related cognitive biases in obsessive– compulsive disorder. *Journal of Anxiety Disorders, 12,* 579–598.

Swindle, R. W., Cronkite, R. C., & Moos, R. H. (1989). Life stressors, social resources, coping, and the 4-year course of unipolar depression. *Journal of Abnormal Psychology,* 98, 468–77.

Terry-Short, L. A., Owens, R. G., Slade, P. D., & Dewey, M. E. (1995). Positive and negativeperfectionism. *Personality and Individual Differences, 18,* 663-668.

Ulusoy, M., Sahin, N. & Erkmen, H. (1998). Turkish version of the Beck Anxiety Inventory: psychometric properties. *Journal of Cognitive Psychotherapy,* 12(2), 21‑28.

Uhlenhuth, E. H., McCarty, T., Paine, S., & Warner, T. (1999). The revised Anxious Thoughts and Tendencies (AT&T) scale: A general measure of anxiety-prone cognitive style. *Journal of Affective Disorders, 52,* 51–58.

Uhlenhuth, E. H., Starcevic, V., Warner, T. D., Matuzas, W., McCarty, T., Roberts, B., & Jenkusky, S. (2002). A general anxiety-prone cognitive style in anxiety disorders. *Journal of Affective Disorders, 70,* 241–249.

Ulu, I. P. & Tezer, E. (2010). Adaptive and maladaptive perfectionism, adult attachment, and Big Five personality traits. *Journal of Psycholölgy, 144,* 327- 340.

Villiers, D. P. (2009). Perfectionism and social anxiety among collage students. Unpublished dissertation.

Van Os, J., & Jones, P. B. (1999). Early risk factors and adult person environment relationships in affective disorder. *Psychological Medicine. 29,* 1055-1067.

Vassilopoulos, S. (2005). Social anxiety and the effects of engaging in mental imagery. *Cognitive Therapy and Research, 29,* 261–277.

Vieth, A. Z., & Trull, T. J. (1999). Family patterns of perfectionism: An examination of college students and their parents. *Journal of Personality Assessment, 72*, 49-67.

Watson, D. and Clark, L.A. (1984). Negative affectivity: The disposition to experience aversive emotional states. *Psychological Bulletin , 96,* 465- 490.

Wells, A., & Carter, K. (2001). Further test of a cognitive model of GAD: metacognitions and worry in GAD, panic disorder, social phobia, depression and non-patients. *Behavior Therapy,* 32, 85–102

Williams, N. L., Reardon, J. M., Murray, K. T., & Cole, T. M. (2005a). Anxiety disorders: a developmental vulnerability stress perspective. In: B. L. Hankin, & J. R. Z. Abela (Eds.), *Development of psychopathology: a vulnerability-stress perspective*. Sage Publications.

Williams, N., & Riskind, J. (2004). Adult Romantic Attachment and Cognitive Vulnerabilities to Anxiety and Depression: Examining the Interpersonal Basis of Vulnerability Models. *Journal of Cognitive Psychotherapy, 18*(1), 7-24.

Wittchen, H. U. & Fehm, L. (2003). Epidemiology and natural course of social fears and social phobia. *Acta Psychiatrica Scandinavica, 108,* 4–18.

Wittchen, H. U., Stein, M. B., & Kessler, R. C. (1999). Social fears and social phobia in a community sample of adolescents and young adults: prevalence, risk factors and co-morbidity. *Psycholgical Medicine, 29,* 309–323

Wood , J. J. , McLeod , B. D. , Sigman , M. , Hwang , W. C. , & Chu , B. C. (2003) .Parenting and childhood anxiety: Theory, empirical findings, and future directions . *Journal of Child Psychology and Psychiatry , 44* , 134 – 151 .

Wu, T., & Wei, M. (2008). Perfectionism and negative mood: The mediating roles of validation from others versus self. *Journal of Counseling Psychology, 55,* 276- 288.

APPENDICES

APPENDIX A: DEMOGRAPHIC INFORMATION FORM

1. Yaşınız : _____

2. Cinsiyetiniz: € Kadın € Erkek

3. Medeni durumunuz:

€ Bekar

€ Evli

€ Boşanmış

€ Dul

€ Diğer____

4. Şu anda kiminle yaşıyorsunuz?

€ Anne ve babanızla € Evde tek başına

€ Annenizle € Evde arkadaşlarla

€ Babanızla € Yurtta

€ Akrabaların yanında € Diğer (lütfen açıklayın**)**

_____

5. Ailenizin kaçıncı çocuğusunuz? _____

6. Varsa kız kardeşlerinizin sayısı: _____

7. Varsa erkek kardeşlerinizin sayısı: _____

8. Kardeşleriniz arasında kendiniz de dahil olmak üzere üveylik var mı?

☐ Evet ☐ Hayır

9. Doğduğunuz yerleşim birimi:

€ Köy

€ Bucak

€ Kasaba

€ Şehir

€ Büyük şehir

10. En uzun süreli yaşadığınız yerleşim birimi (yaklaşık hayatınızın ilk 17 yıllı):

€ Köy

€ Bucak

€ Kasaba

€ Şehir

€ Büyük şehir

11. Annenizin eğitim durumu:

€ Okur-yazar değil

€ Okur-yazar fakat herhangi bir okul bitirmemiş € Üniversite terk

€ İlkokul mezunu € Üniversite mezunu

€ Ortaokul mezunu € Yüksek lisans mezunu

€ Lise mezunu € Doktora mezunu

12. Babanızın eğitim durumu:

€ Okur-yazar değil

€ Okur-yazar fakat herhangi bir okul bitirmemiş € Üniversite terk

€ İlkokul mezunu € Üniversite mezunu

€ Ortaokul mezunu € Yüksek lisans mezunu

€ Lise mezunu € Doktora mezunu

13. Annenizin mesleği: _____

14. Babanızın mesleği: _____

15. Anneniz: Sağ _____ Sağ değil _____

Öz _____ Öz değil _____

16. Babanız: Sağ _____ Sağ değil _____

Öz _____ Öz değil _____

17. Anne ve babanız:

€ Evli € Boşanmış € Ayrı yaşıyorlar

18. Ailenizin ortalama aylık geliri: _____

19. Ekonomik olarak ailenizi hangi seviyede görüyorsunuz?

€ Alt

€ Alt-Orta

€ Orta

€ Üst-Orta

€ Üst

APPENDIX B: MULTIDIMENSIONAL PERFECTIONISM SCALE (MPS)

Yönerge

Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 5 aralıklı ölçek üzerinde, ilgili rakam üzerine çarpı (X) koyarak gösteriniz.

Examples of the items.

	Kesinlikle katılmıyorum	**Katılmıyorum**	**Kararsızım**	**Katılıyorum**	**Kesinlikle katılıyorum**
1- Ebeveynlerim benim için çok yüksek standartlar belirler.	( )	( )	( )	( )	( )
2- Düzen (plan) benim için çok önemlidir.	( )	( )	( )	( )	( )
3- Çocukken, bir şeyi mükemmel olarak gerçekleştirmediğimde cezalandırıldım.	( )	( )	( )	( )	( )
4- Kendim için en yüksek standartları belirlemezsem, muhtemelen ikinci sınıf bir insan olurum.	( )	( )	( )	( )	( )
5- Ebeveynlerim hatalarımı asla anlamaya çalışmadılar.	( )	( )	( )	( )	( )

APPENDIX C: PARENTAL BONDING INVENTORY (PBI)

Yönerge

Aşağıda, ana-babanızın çeşitli tutum ve davranışlarına ilişkin ifadeler yer almaktadır. 16 yaşınıza kadar olan dönemde **annenizi/ babanızı** hatırlamaya çalışarak, her bir ifadede en uygun seçeneğin karşısındaki paranteze X işareti koyunuz.

Examples of the items.

	Tamamen böyleydi	**Kısmen böyleydi**	**Pek böyle değildi**	**Hiç böyle değildi**
1.Benimle yumuşak ve arkadaşça bir tarzda konuşurdu.	( )	( )	( )	( )
2.İhtiyaç duyduğum kadar yardım etmezdi.	( )	( )	( )	( )
3. Hoşlandığım şeyleri yapmama izin verirdi.	( )	( )	( )	( )
4.Duygusal olarak bana karşı soğuk görünürdü.	( )	( )	( )	( )
5. Sorunlarımı ve endişelerimi anlıyor görünürdü.	( )	( )	( )	( )

APPENDIX D: BECK DEPRESSION INVENTORY (BDI)

Yönerge

Aşağıda, kişilerin ruh durumlarini ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde, bir çesit ruh durumunu anlatmaktadır. Her madde için o ruh durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatle okuyunuz. Son bir hafta içindeki (şu an dahil) kendi ruh durumunuzu göz önünde bulundurarak, size en uygun olan ifadeyi bulunuz. Daha sonra, o maddenin yanındaki harfin üzerine (x) işareti koyunuz.

Examples of the items.

1. (a) Kendimi üzgün hissetmiyorum.
   (b) Kendimi üzgün hissediyorum.
   (c) Her zaman için üzgünüm ve kendimi bu duygudan kurtaramıyorum.
   (d) Öylesine üzgün ve mutsuzum ki dayanamıyorum.

2. (a) Gelecekten umutsuz değilim.
   (b) Geleceğe biraz umutsuz bakıyorum.
   (c) Gelecekten beklediğim hiçbir şey yok.
   (d) Benim için bir gelecek yok ve bu durum düzelmeyecek.

3. (a) Kendimi başarısız görmüyorum.
   (b) Çevremdeki bir çok kişiden daha fazla başarısızlıklarım oldu sayılır.
   (c) Geriye dönüp baktığımda, çok fazla başarısızlığımın olduğunu görüyorum.
   (d) Kendimi tümüyle başarısız bir insan olarak görüyorum.

4. (a) Herşeyden eskisi kadar zevk alabiliyorum.
   (b) Herşeyden eskisi kadar zevk alamıyorum.
   (c) Artık hiçbir şeyden gerçek bir zevk alamıyorum.
   (d) Bana zevk veren hiçbirşey yok. Herşey çok sıkıcı.

APPENDIX E: LIEBOWITZ SOCIAL ANXIETY SCALE (LSAS)

Yönerge

Aşağıdaki tüm seçeneklere geçen haftayı düşünerek-bugün de dahil olacak şekilde- puan veriniz. Eğer durumlardan biri geçen hafta içerisinde oluşmadıysa, durumla karşılaştığınızda göstereceğinizi düşündüğünüz tepkiyi puanlayınız. Her bir durum için (yaşanmış olan ya da yaşanmış olduğu varsayılan) **hem korku ya da anksiyetenin derecesini hem de kaçınma sıklığını puanlayınız.**

Examples of the items.

	Korku ya da anksiyete				**Kaçınma**			
	Yok	**Hafif**	**Orta**	**Şiddetli**	**Asla**	**Arasıra**	**Sıkça**	**Genellikle**
1. Topluluk içerisinde telefon etmek	( )	( )	( )	( )	( )	( )	( )	( )
2. Küçük bir grupla beraber bir aktiviteye katılmak	( )	( )	( )	( )	( )	( )	( )	( )
3. Toplulukta yemek yemek	( )	( )	( )	( )	( )	( )	( )	( )
4. Toplulukta içecek içmek	( )	( )	( )	( )	( )	( )	( )	( )
5. Yönetici konumundaki biri ile konuşmak	( )	( )	( )	( )	( )	( )	( )	( )
6. Seyirci önünde rol yapmak, oynamak ya da konuşmak	( )	( )	( )	( )	( )	( )	( )	( )

APPENDIX F: BRIEF FEAR OF NEGATIVE EVALUATION (BFNE)

Yönerge

Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 5 aralıklı ölçek üzerinde, ilgili rakam üzerine çarpı (X) koyarak gösteriniz.

Examples of the items.

	Beni hiç yansıtmıyor	**Beni biraz yansıtıyor**	**Beni orta derecede yansıtıyor**	**Beni çok yansıtıyor**	**Beni tamamıyla yansıtıyor**
1- . Bir değişiklik yaratmayacağını bilsem bile, insanların hakkımda ne düşüneceği beni kaygılandırır.	( )	( )	( )	( )	( )
2- Insanların hakkımda kötü br izlenim edindiklerini bilsem bile buna aldırış etmem.	( )	( )	( )	( )	( )
3- Diğer insanların, eksikliklerimin farkına varmasından sıklıkla korkarım.	( )	( )	( )	( )	( )
4- Birinin üzerinde nasıl bir izlenim yarattığım konusunda nadiren kaygılanırım.	( )	( )	( )	( )	( )
5- Başkalarının beni onaylamayacak olmasından korkarım.	( )	( )	( )	( )	( )

APPENDIX G: LOOMING MALADAPTIVE STYLE QUESTIONNAIRE-REVISED (LMSQ-R)- ORIGINAL FORM

Instructions

In these questions, we are interested in your immediate thoughts and reactions to a number of different scenes. Put down whatever comes to mind in response to each of these scenes immediately, rather than thinking about your answer for a long time.

After you read each scene, try to **vividly** imagine it. What comes to mind as you bring that scene to mind and think about it? Concentrate on it and imagine it in as much vivid detail as possible.

After you have finished concentrating on the scene, answer the questions about what you were imagining was happening. Please do not leave out any questions if possible.

To summarize;

1) Vividly imagine yourself in each scene.
2) Answer all the questions about your own immediate thoughts and feelings.

Examples of the items.

Suppose that you were to hear a strange engine noise from your car as you were driving on the expressway in heavy rush hour traffic. There are rushing cars and trucks on both sides of you and your car sounds as if it the engine could be cracking or the engine is developing a serious problem.

1. How worried or anxious does your imagining this scene make you feel?
   Not at all 1 2 3 4 5 Very Much

2. In this scene, are the chances of your having a difficulty with the car's engine decreasing, or increasing and expanding with each moment?
   Chances are
   decreasing with time 1 2 3 4 5 Chances are expanding

3. Is the level of threat to you from the car's engine staying fairly constant, or is it growing rapidly larger with each passing moment?
   Threat is staying Threat is growing
   fairly constant 1 2 3 4 5 rapidly larger

4. How much do you visualize your car's engine as in the act of progressively worsening?
   Not at all 1 2 3 4 5 Very Much

APPENDIX H: LOOMING MALADAPTIVE STYLE QUESTIONNAIRE-REVISED (LMSQ-R)- TURKISH FORM

Yönerge

Aşağıda bazı senaryolar sunulmuştur. Sizden istenen bu senaryoları okuduktan sonar aklınıza gelen ilk düşünceyi ya da tepkiyi yazmanızdır. Cevabınız üzerinde uzun sure düşünmeden, senaryoyla ilgili aklınıza gelenleri hemen yazınız. Her senaryoyu okuduktan sonra, senaryoyu açık ve net bir şekilde zihninizde canlandırmaya çalışın. Bu sahneyi zihninizde canlandırdığınızda ve düşündüğünüzde aklınıza ne geliyor? Senaryoya dikkatli bir şekilde odaklanın ve mümkün olduğunca açık ve net ya da canlı bir şekilde hayal etmeye çalışın. Senaryoya odaklanmayı bitirdikten sonra, zihninizde canlandırdığınız zaman neler olduğuyla ilgili soruları cevaplayınız. Lütfen mümkün olduğunca hiç bir soruyu boş bırakmayınız.

Özetle;

1. Her bir sahneyi açık ve net bir şekilde ya da canlı bir şekilde hayal edin.
2. Aklınıza gelen düşünce ve duygularla ilgili tüm soruları cevaplayınız.

Examples of the items.

Farzedin ki trafiğin çok yoğun olduğu bir saate çevreyolunda giderken arabanızın motorundan garip bir ses geldiğini duydunuz. Her iki yanınızdan da arabalar ve kamyonlar hızla geçiyor ve arabanızın motorundan her an motor bozulacakmış ya da ciddi bir problem varmış gibi sesler geliyor.

Bu sahneyi zihninizde canlandırmak sizi ne kadar endişelendirdi ya da kaygılandırdı?

Hiç değil 1 2 3 4 5 Çok fazla

Bu sahneyi zihninizde canlandırırken, arabanızın motoruyla ilgili bir sorunun olma olasılığı azalıyor mu yoksa her geçen dakika artıyor ve daha da güçleniyor mu?

Olasılıklar zamanla azalıyor 1 2 3 4 5 Olasılıklar zamanla fazlalaşıyor

Arabanızın motoru ile ilgili sorunun oluşturduğu tehdit oldukça sabit mi kalıyor, yoksa her geçen dakika hızla artıyor mu?

Tehdit sabit kalıyor 1 2 3 4 5 Tehdit hızla büyüyor.

Arabanızın motorundaki sorunun gittikçe daha da kötüleştiğini gözünüzde ne kadar canlandırıyorsunuz?

Hiç 1 2 3 4 5 Çok fazla

APPENDIX I: STATE TRAIT ANXIETY INVENTORY- TRAIT FORM (STAI-T)

YÖNERGE:Aşağıda kişilerin kendilerine ait duygularını anlatmada kullandıkları bir takım ifadeler verilmiştir. Her ifadeyi okuyun, sonra da o anda nasıl hissettiğinizi ifadelerin sağ tarafındaki parantezlerden uygun olanını işaretlemek suretiyle belirtin. Doğru ya da yanlış cevap yoktur. Herhangi bir ifadenin üzerinde fazla zaman sarfetmeksizin **anında** nasıl hissettiğinizi gösteren cevabı işaretleyin.

Examples of the items.

		Hemen hemen hiçbir zaman	**Bazen**	**Çok zaman**	**Hemen her zaman**
1	Genellikle keyfim yerindedir	(1)	(2)	(3)	(4)
2	Genellikle çabuk yorulurum	(1)	(2)	(3)	(4)
3	Genellikle kolay ağlarım	(1)	(2)	(3)	(4)
4	Başkaları kadar mutlu olmak isterim	(1)	(2)	(3)	(4)
5	Çabuk karar veremediğim için fırsatları kaçırırım	(1)	(2)	(3)	(4)

APPENDIX J: BECK ANXIETY INVENTORY (BAI)

Aşağıda insanların kaygılı yada endişeli oldukları zamanlarda yaşadıkları bazı belirtiler verilmiştir.Lütfen her maddeyi dikkatle okuyunuz.Daha sonra,her maddedeki belirtinin bugün dahil son bir haftadır sizi ne kadar rahatsız ettiğini aşağıdaki ölçekten yararlanarak maddenin yanındaki uygun yere (X) işareti koyarak belirleyiniz.

Examples of the items

0 = HİÇ 2 = ORTA DERECEDE

1 = HAFİF DERECEDE 3 = CİDDİ DERECEDE

Sizi ne kadar rahatsız etti?

1.Bedeninizin herhangi bir yerinde uyuşma veya karıncalanma	(0) (1) (2) (3)
2.Sıcak/ateş basmaları	(0) (1) (2) (3)
3.Bacaklarda halsizlik titreme	(0) (1) (2) (3)
4.Gevşeyememe	(0) (1) (2) (3)
5.Çok kötü şeyler olacak korkusu	(0) (1) (2) (3)

APPENDIX K: INFORMED CONSENT FORM

Degerli Katılımcı,

Bu araştırma Orta Doğu Teknik Üniversitesi Psikoloji Bölümü bünyesinde sürmekte olan doktora tezinin bir parçasıdır. Bu araştırmaya katıldığınız için teşşekkür ederiz. Araştırmanın amacı, sosyal kaygıya zemin hazırlayan bilişsel ve ailesel faktörleri incelemektedir. Anketlerde size sosyal kaygı yaşama düzeyiniz, aile geçmişiniz ve bilişsel tarzınızı anlamaya yönelik sorular yer almaktadır.

Araştırmanın sonuçları açısından sağlıklı bilgiler edinilmesi için yönergelerin dikkatlice okunması, verilen cevaplarda samimi olunması ve cevaplandırılmamış soru bırakılmaması son derece önemlidir. Bu anket kısa süreli de olsa olumsuz duyguları tetikleyebilir. Bu nedenle istenildiği takdirde araştırmacıya başvurabilirsiniz. Katılım sırasında sorulardan ya da herhangi bir başka nedenden ötürü kendinizi rahatsız hissederseniz cevaplama işini yarıda bırakmakta serbestsiniz. Böyle bir durumda anketi uygulayan kişiye, anketi tamamlamadığınızı söylemeniz yeterli olacaktır. Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz. Şimdi lütfen, aşağıdaki formu doldurup imzalayarak uygulayıcıya geri veriniz.

Ayşe Altan Atalay, e-posta: ayse.altan@gmail.com

Uzm. Psk. Ayşe Altan Atalay

ODTÜ Psikoloji Bölümü

Tez Danışmanı:

Doc. Dr. Belgin Ayvaşık

ODTU Psikoloji Bölümü

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip bırakabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı olarak kullanılmasını kabul ediyorum.

Ad ve Soyadı:

Tarih:

İmza:

APPENDIX K

TURKISH SUMMARY OF THE RESEARCH (TÜRKÇE ÖZET)

Bu çalışmanın amacı, ZAT ve mükemmeliyetçiliğin sosyal kaygı ve depresyon üzerindeki etkilerinin ve ebeveynlik tutumlarıyla ilişkilerindeki aracı görevlerinin araştırılmasıdır. Sosyal kaygı, karşılaşılma sıklığı en yüksek olan psikolojik bozukluklardan biri olarak öne çıkmaktadır (Brook ve Schmidt, 2008).

Bu güne kadar sosyal kaygı bozukluğuna yol açan etmenler olarak pek çok farklı değişkenden bahsedilmektedir. Bunlar arasında en öne çıkanlardan biri ailesel özelliklerdir. Bu güne kadar yapılan araştırmalarda, sosyal kaygı ile ilgili olarak en çok öne çıkan ailesel özellikler ailenin ebeveynlik tutumu, ailenin işlevselliği ve çocuk-ebeveyn arasındaki bağlanma öne çıkmaktadır (Bögels ve Brechman-Toussaint, 2006). Ebeveynlik tarzlarının sosyal kaygı ile ilişkisi konusunda en sıklılıkla değinilen ebeveynlik özellikleri ilgi ve koruma/kontrol olarak ortaya çıkmaktadır. Parker ve ark. (1979) ebeveynliğin bu boyutlarını incelemek için Ana-Babaya Bağlanma Ölçeğini geliştirmiştir. Bu ölçekte ilgi, duygusal sıcaklık, çocuğu kabul etme, gereksinimlerini karşılama ve bakım verme olarak tanımlanırken, kontrol, aşırı koruma, bağımsızlığı engelleme ve çocuğun kendi dünyasına aşırı derecede müdahale etme olarak kavramsallaştırılmıştır. Her iki boyut da sosyal kaygı ile oldukça yakından ilişkili kavramlar olarak öne çıkmıştır. Parker (1992) özellikle “duygusuz kontrol” olarak adlandırdığı ve düşük ilgi- yüksek korumacılık olarak beliren ebeveynlik tarzını sosyal anksiyeteye zemin hazırladığını öne sürmüştür. Bu önerme birçok farklı araştırmacı tarafından desteklenmiştir. Diğer yandan daha yakın tarihli çalışmalar kaygı

bozukluklarında- özellikle sosyal kaygı bozukluğunda- ilgi boyutundansa aşırı koruma/kontrol boyutunun daha etkili olduğuna işaret etmektedir (Bögels, van Oosten, Muris, ve Smulders, 2001).

Sosyal kaygı ile ilgili olarak öne çıkan bir diğer aile değişken ise ebeveyni örnek almadır. Bu alanda kalıtımsal özelliklerin etkisinden de çok bahsedilse de çocuğun ebeveyn tarafından sergilenen kaygılı davranışlara maruz kalmasının, benzer olaylara kaygı yüklemesine ve böylelikle daha kaygılı bireyler olmaya eğilimli olmasına yok açtığı düşünülmektedir (Bögels ve Brechman-Toussaint, 2006). Diğer taraftan sosyal kaygısı yüksek olan ebeveynlerin çocuklarına sosyal davranış için örnek olamamasını ve beceri geliştirmeleri için olanak sağlayamamalarının da çocuktaki sosyal kaygının yüksek olmasıyla ilişkili olduğu düşünülmektedir (Bruch ve Heimberg, 1994). Sosyal kaygı ve aile ilişkisinde öne çıkan bir diğer kavram da bağlanmadır. Yapılan çalışmalar, oldukça tutarlı bir şekilde, sosyal kaygı ve güvenli bağlanma çeşitleri arasında olumsuz bir ilişkiye işaret etmektedir. Özellikle kaygılı-kaçınan bağlanma şekli sosyal kaygı ile ilişkilendirilmektedir (Michaelson, Kessler ve Shaver, 1997).

Diğer Etkenler

Sosyal kaygıya hassasiyetle ilgili olduğu düşünülen bir diğer kavram da mizaçtır. İçe kapanıklık, yeniye zor alışma, ve çekingenlik ile kendini belli eden davranışsal ketleme, sosyal kaygıya zemin hazırlayan mizaç türü olarak belirmektedir (Caspi, Harrington, Milne, Amell, Theodore, ve Moffit, 2003). Buna ek olarak Schofield, Coles ve Gibb (2009) davranışsal ketlemenin sosyal ve sosyal olmayan davranışsal ketlenme olarak iki farklı boyutundan bahsetmektedir.

Sosyal kaygı bozukluğu bu iki mizaç alt türünden sosyal davranışsal ketleme ile diğer kaygı ve depresif bozukluk türlerine göre daha yakından bağlantılıdır.

Sosyal kaygıya eğilim konusunda öne en çok çıkan ve en fazla çalışılan etkenlerden bir de kalıtımsal değişkenlerdir. Sosyal fobik bireylerin birinci derece akrabalarıyla yapılan çalışmalar, bu akrabalar klinik anlamda sosyal anksiyete bozukluğu tanısı alamasalar da oldukça ketlenmiş kişilik özellikleri göstermektedirler (Kendler, Myers, Presscott, Martin ve Klein, 2001). Diğer taraftan, sosyal kaygıdan sorumlu olan geni bulma amacıyla yapılan çalışmalar sadece sosyal kaygı ile ilişkilendirilebilecek bir gen yerine birçok kaygı bozukluğu ve depresyonla bağlantılı genetik faktörlerden bahsetmektedir ki bu sonuçlar sosyal anksiyetenin diğer kaygı bozuklukları ve depresyonla olan yüksek komorbidite oranları düşünüldüğünde oldukça anlamlıdır (Mosing ve ark., 2010; Rapee ve Spence, 2004).

Evrimsel açıdan sosyal kaygı bozukluğunu inceleyen çalışmalar, sosyal kaygının uyumlu bir yönü olduğunu öne sürmüşlerdir. Sloman (2006) tarafından öne sürülen İstemsiz Yenilme Stratejisi (İYS) sosyal kaygını oldukça uyumlu ve hayatta kalabilme açısından kritik bir işlevinden bahsetmektedir. Buna göre, sosyal kaygıya sahip bireyin boyun eğici davranış şekli çevredeki bireylere tehdit oluşturmadığı ve diğerlerini rekabete sürüklemediği için kaygılı birey rekabetle ilgili olumsuz duygulardan kaçabilmektedir.

Bilişsel Etkenler

Tüm bu etkenler dışında bir de sosyal anksiyetede etkin bilişsel faktörlerden söz edilmektedir. Bilişsel faktörler diğer pek çok psikolojik bozuklukta olduğu

gibi sosyal anksiyete bozukluğunda da oldukça etkindir (Amir ve Foa, 2001). Bunun yanında Fresco, Ledley ve Haimberg'e (2006) göre, sosyal kaygının bilişsel altyapısına odaklanan çalışmalar özellikle dikkat yanlılığı, bellek yanlılığı, yargılama ve yorumlama yanlılığı üzerinde durmuşlardır. Özellikle yargılama ve yorumlama yanlılığı, sosyal anksiyete bozukluğunda tutarlı bir seyir izlemektedir.

Anksiyete Bozukluklarında Bilişsel Hassasiyet

Bu çalışmanın temel odaklarından biri de anksiyete bozukluklarına karşı bilişsel yatkınlığın incelenmesidir. Bilişsel yatkınlık, özellikle hayatın erken dönemlerinde oluşan ve duygusal bozukluklara bir yatkınlığa yol açan, oldukça kalıcı ve sürekli bilişsel yapıları kapsamaktadır (Riskind & Alloy, 2006). Aynı zamanda temel inançlar, ya da şemalar olarak da adlandırılan bu bilişsel yapılar, birey herhangi bir stresöre maruz kalmadığında aktif halde olmazlar. Birey, altta yatan bu yapıları tetikleyen bir dışsal uyarana maruz kalıncaya kadar gündelik hayat üzerinde etkin olmazlar (Oliver, Klocek, ve Wells, 1995). Bilişsel yatkınlığı inceleyen pek yok çalışma olmasına karşın, bu çalışmaların büyük çoğunluğu depresyona karşı bilişsel yatkınlığı incelemektedir (Riskind ve Alloy, 2006). Anksiyeteye odaklanan Bilişsel İçerik Özgüllüğü Hipotezimodeli (Beck, Brown, Steer, Eidelson, ve Riskind, 1987) ve Genel kaygı eğilimli bilişsel tarz (Uhlenhuth, McCarthy, Paine, ve Warner, 1999) gibi bazı modeller öne sürülmüş olmasına karşın bunlar oldukça yetersiz kalmış (Beck & Perkins, 2001) ve bilişsel yapılar açısından anksiyeteyi özellikle depresyondan ayırt edebilmeyi başaramamışlardır (Barlow, 1991).

Zihinsel Abartma Tarzı Modeli

Riskind'in (1997) öne sürdüğü Zihinsel Abartma Tarzı Modeli (ZATM) özellikle anksiyete bozukluklarının altında yatan bilişsel yapılara odaklanmakla kalmayıp aynı zamanda anksiyete bozukluğu olan bireylerdeki kaygı algısının diğer bireylerden farklı olduğundan da bahsetmektedir. Riskind'e göre yüksek kaygılı bireylerde algılanan tehdit diğer modellerde kavramsallaştırılandan farklı olarak statik değil hareketlidir. Şöyle ki, yüksek kaygılı bir birey bir tehditle karşılaştığında tehlikeyi gitgide artan, büyüyen, kötüleşen ve yaklaşan bir tehlike olarak algılar. Bunun sonucunda çevredeki tehlikeleri gerçekte olduklarından daha şiddetli olarak algılar ve çevreden gelecek olan tehdit işaretlerine karşı sürekli tetikte olur. Bu tetiktelik zaman zaman kaygı döngüsünün etrafta gerçek bir tehdit olmadan bile uyarılmasına neden olur. Riskind'e göre bu algılayış tarzı anksiyetenin hem ortaya çıkmasında hem de sürdürülmesinde oldukça etkilidir.

Riskind'in (1997) modeline göre kaygılı ve kaygı düzeyin düşük bireyler arasındaki başlıca farklılık zihinsel abartmaya karşı eğilim düzeyleridir. Yüksek looming'i olan kişiler, kendi yaşam olayları ve gelecekte olabilecek olaylarla ilgili potansiyel tehdidin gittikçe arttığı, kötüleştiği ve yaklaştığı zihinsel senaryolar oluştururlar. Riskind, Joiner ve Williams'a (2006) göre, ZAT, erken yaşam olaylarının bir sonucu olarak oluşur ve kaygı bozukluklarına karşı uzak bir risk faktörü olarak etki eder. Bu tarz, bilgi işlemleme yanlılığına yola açar ve birey çevreden gelen işaretleri data katastrofik şekilde algılar.

Yapılan çalışmalar, ZAT'ın kaygı bozuklukları ve kaygı içeren birçok durumla ilişkili olduğunu göstermektedir (Reardon ve Williams, 2007; Riskind,

Abreu, Strauss, ve Holt, 1997; Riskind ve ark, 2007; Riskind ve Williams, 2005). ZAT, kaygı ile oldukça yakından ilişkili olmasına ve tüm anksiyete bozukluklarında ortak olarak görülen bir durum olmasına karşın, yapılan çalışmalar ZAT'ın kavramsal olarak anksiyeteden farklı olduğunu göstermektedir (Riskind ve ark., 2000; Williams ve ark., 2005). Anksiyete ve depresyon arasındaki yüksek korelasyonlara karşın yapılan tüm araştırmalarda ZAT, anksiyete ile yüksek korelasyon göstermesine karşın, depresyonla ilişkisi oldukça sınırlı hatta bazı çalışmalarda anlamlılık düzeyinin altındadır (Brown ve Stopa, 2008; Riskind ve ark., 2000; Riskind, Tzur, Williams, ve Mann, 2007). Ayrıca, ZAT çalışmalarının kaygı bozukluklarının sağaltımı konusunda da faydaları olabileceği tartışılmaktadır. Bu alanda ZAT bağlantılı tekniklerin OKB (Riskind, Wheeler, ve Picerno, 1997) ve sigara bağımlılığı (McDonald, O'Brien, Farr, ve Haaga, 2010) gibi durumlarda kullanıldığına ilişkin yayınlar mevcuttur.

Riskind, Williams ve Joiner'a (2006) göre, tüm diğer anksiyete bozukluklarında olduğu gibi, erken yaşam dönemindeki deneyimler ve gelişimsel problemler ZAT ile ilgili olabilir. Risking ve ark (2006) aşırı korumacı ebeveynlik tarzlarının, kaygılı ebeveynleri model almanın ve davranışsal ketlenme ZAT'ın oluşumunda etkili olabileceğini ileri sürmüşlerdir. ZAT ile ilgili ebeveyn özellikleri ve gelişimsel etkenlerle ilgili çalışma sayısı oldukça kısıtlıdır. ZAT'nin ilişkili olduğu bağlanma şekillerini ve bu tür bir yatkınlığa yok açabilecek ebeveynlik tarzını inceleyen Riskind, Williams, Altman, Black, Balaban, ve Gessner'e (2004) göre, ZAT ve anksiyeteye yatkınlık, özellikle baba tarafından aşırı korumaya maruz kalan bireylerde ve kaçıngan-kaygılı bağlanma tarzına sahip kişilerde daha yoğunlukla görülmektedir.

Sosyal anksiyetenin özellikle Clark ve Wells (1995) tarafından öne sürülen bilişsel modeli, bu bozuklukta özellikle olay sonrası işlemleme durumundan ve bu zihinsel sürecin bozukluğun sürdürülmesindeki etkisini vurgulamaktadır. Bunu dışında sosyal anksiyete bozukluğunda olumsuz zihinsel imgelerin önemi birçok farklı modelde ve çalışmada vurgulanmıştır (Hackman, Surawy, ve Clark, 1998; Hinrichsen ve Clark, 2003). Tüm bu bulgular ve önermeler, ZAT'ın sosyal anksiyetedeki önemini destekler niteliktedir. Bu alandaki çalışma sayısı kısıtlı olmakla birlikte, bulgular genel olarak tutarlıdır. Riskind ve Williams's (2006) göre, ZAT, sosyal anksiyetede gitgide artan eleştirilme ve kabul edilmeme riski içeren imgeler yoluyla etki eder. Yine Riskind ve Williams (2006), sosyal anksiyetede görülen ZAT'ın yaşamın erken dönemlerinde, sosyal anlamda kabul görme ve mükemmel performans karşılığı değer verilme türü deneyimlerle ilişkili olabileceğini ileri sürmüştür. Bu tür deneyimler sonraki dönemlerde sosyal performans gerektiren durumlarla ilgili felaket senaryolarının oluşmasında rol oynamaktadır. Sosyal kaygıya yatkın birey gitgide şiddetlenen sosyal felaket senaryoları başlayınca kendisini bu zihinsel süreçten kopartamamakta ve tehlikeyi gittikçe daha olumsuz ve daha yakın olarak algılamaya başlamaktadır (Riskind, Williams, ve Joiner, 2006). Buna ek olarak, sosyal anksiyete bozukluğu diğer anksiyete bozukluklarından farklı bir ZAT profili göstermektedir (Williams, Shahar, Riskind, ve Joiner, 2005). Brown ve Stopa (2008) tarafından da desteklenen bu profile göre, sosyal anksiyete ZAT'ın fiziksel boyutundan ziyade, sosyal boyutuyla daha yakından ilişkilidir. Bu profil aynı zamanda sosyal anksiyetenin depresyondan ayırıcı tanısı konusundaki tartışmalar düşünüldüğünde de oldukça anlamlıdır.

Bu araştırmada incelenen bir diğer değişken de depresyondur. Karşılaşılma sıklığı oldukça fazla olan bu bozukluk farklı teorisyenler tarafından iki kategoriye ayrılmıştır (Beck ve ark. 1983; Blatt, 1995). Beck ve ark'a (1983) göre sosyotropik ve endogenomorfik depresyon alt türleri arasındaki ayrım özellikle bu iki tür depresyonla ilişkilendirilen farklı yatkınlık faktörleri göz önünde bulundurularak yapılmıştır. Sosyotropik depresyonda diğerleri tarafından onaylanma, çevredeki insanlarla olumlu ilişkiler önemliyken, endogenomorphic depresyonda bağımsızlık, amaçlara ulaşmak ve özerklik öne çıkan temalardır. Eğer bireylerin bilişsel tarzları ve maruz kaldıkları stresörler uyumlu haldeyse bu bireylerin depresif belirtiler gösterme olasılığı yükselir (Beck ve ark., 1983; Blatt, 1974).

Son yıllarda yapılan araştırmalar depresif belirtilerin ortaya çıkmasıyla ilişkili olabilecek psikolojik süreçlere odaklanmaktadır. Bu alanda en çok öne çıkan perspektif, Brown ve Harris (1978) tarafından öne sürülen kronik stresör hipotezidir. Hammen'e (2005) göre, depresif bireylerde, depresyona yatkınlığa yol açan bilişsel yapılar uzun süreli olarak stresöre maruz kalma sonucu tetiklenmektedir ve bunun sonucu olarak kişi depresif belirtilerden şikayet etmeye başlamaktadır.

Depresyonla ilişkili ailesel faktörler söz konusu olduğunda bugüne kadar yapılan çalışmalar, sosyal anksiyetede olduğu gibi depresyonda da ebeveynle bağlanmanın önemini vurgulamaktadır. Parker ve ark. (1979) tarafından ortaya konmuş "duygusuz kontrol" tazı ebeveynlik depresif şikayetlerle de ilişkilidir. Hall, Peden, Reyes ve Beebe'ye (2004) göre, özellikle ebeveynin ilgi eksikliği,

düşük benlik değeri ve olumsuz kendilik imgesine yol açma ihtimali olduğu için depresyonla ilişki olabilir. Diğer taraftan ebeveynin aşırı korumacılığı, benlik değeri gelişimini engelleyeceği ve çocuğun özerkliğini ketleyeceği için depresyonla ilişkili olabilir (Parker ve ark., 1979).

Bağlanma tarzı da depresyonla ilişkili değişkenlerden biri olarak öne çıkmaktadır. Güvensiz bağlanma şekilleri ve depresyon arasındaki ilişki pek çok araştırmada vurgulanmıştır (Abela, Hankin, Haigh, Adams, Vinokuroff, ve Trayhern, 2005).

Depresyonla ilişkili olan psikolojik değişkenler de oldukça yoğun bir şekilde incelenmiştir ve araştırmalar özellikle düşük benlik değeri, nevrotiklik, umutsuzluk ve mükemmeliyetçilik gibi kişilik özelliklerini işaret etmektedir (Abramson, Alloy ve Metalsky, 1989; Blatt, 1995; Clark, Watson, ve Mineka, 1994; Roberts, 2006).

Mükemmeliyetçilik

Mükemmeliyetçilik hem psikolojik bozukluklar hem de normal, uyumlu insan davranışıyla ilişkilendirilen bir kavramdır (Stöber & Otto, 2006). Horney (1950) tarafından "gerekliliklerin hükümranlığı" olarak tanımlanmıştır. Genel olarak mükemmeliyetçi bireyler kendilerine daha yüksek standartlar koyan, kendi başarısızlıkları konusunda oldukça duyarlı ve hata yapmaktan kaçınan kişilerdir. Bu özellikleri nedeniyle kendi performanslarından nadiren tatmin olurlar (Shafran, Cooper, & Fairburn, 2002).

Mükemmeliyetçiliğin farklı boyutlarına dikkat çeken ve normal-nörotik mükemmeliyetçilik arasında ayrım yapan ilk Hamachek (1978) olmuştur. Normal

mükemmeliyetçiliği sağlıklı mükemmeliyetçilik olarak da adlandıran Hamachek, nörotik mükemmeliyetçilerin kendi performanslarıyla asla tatmin olmadıklarını, kendilerinden yüksek beklentileri olduğunu, başarısızlığa karşı oldukça duyarlı olmakla birlilikte benlik değerlerini korunabilmek için sürekli olarak övgüye ve çevre tarafından onaylanmaya ihtiyaç duyduklarını ifade etmiştir. Bununla uyumlu olarak, Slade ve Owens (1998) pozitif ve negatif mükemmeliyetçilik kavramlarını ortaya atmıştır. Özellikle negatif mükemmeliyetçilik başta yeme bozuklukları olma üzere pek çok psikolojik bozuklukla ilişkilendirilmektedir (Slade ve Owens, 1998).

Bunlara ek olarak Hewit ve Flett (1991) faklı ve çok boyutlu bir mükemmeliyetçilik modeli öne sürerek, başlıca üç çeşit mükemmeliyetçilik olduğunu öne sürmüştür. "kendine yönelik", "başkalarına yönelik", ve "toplumsal beklentiye dayalı" mükemmeliyetçilik olarak üç boyutta açıklamıştır.

Yine aynı dönemde aynı isimle, farklı bir mükemmeliyetçilik modeli de Frost, Marten, Lahart, ve Rosenblate (1990) tarafından öne sürülmüştür. Bu modele göre, mükemmeliyetçilik, "Düzen/Tertip", "Davranışlardan Şüphe", "Ebeveynsel Eleştiri", "Hatalara Aşırı İlgi", "Aile Beklentileri" ve "Kişisel standartlar" olarak altı alt boyuttan oluşmaktadır. Fost ve ark. (1990) Hatalara aşırı ilgi boyutunu mükemmeliyetçiliğin merkezine yerleştirir. Bu 6 boyuttan Düzen/tertip, hiçbir tür psikolojik bozuklukla ilişkilendirilemediği için daha yeni çalışmalarda toplam mükemmeliyetçilik puanlarına dahil edilmemeye başlanmıştır (Kawamura, Hunt, Frost, ve DiBartolo, 2001).

Frost'ün çok boyutlu mükemmeliyetçilik ölçeği detaylı incelendiğinde, "Davranışlardan şüphe" ve "Hatalara aşırı ilgi" boyutlarının kaygı ve depresyonla

en yakından ilgili boyutlar olduğu ortaya çıkmaktadır. Buna karşın psikolojik bozukluklarla ilgili bir diğer boyut da "kişisel standartlar" boyutudur ancak bu boyut, diğerlerinin aksine psikolojik bozukluklarla negatif korelasyona sahiptir (Frost ve ark., 1993; Kawamura ve ark., 2001). Bu bulgular daha önce de bahsedilmiş olan olumlu mükemmeliyetçilik kavramını destekler niteliktedir. Bu kavramsallaştırmaya bir diğer destek de Frost ve ark.'dan (1993) gelmektedir. Bu çalışmada mükemmeliyetçilik başlıca iki faktör halinde incelenmiştir. İlk faktör olan UDE olumsuz mükemmeliyetçiliğe yakındır ve hem anksiyete hem de depresyonla pozitif korelasyon göstermektedir (Bieling, Israeli ve Smith, 2003; Kawamura ve ark., 2001). Diğer taraftan "kişisel standartlar" kendi başına bir faktör olarak ortaya çıkmıştır ve psikopatoloji ölçekleriyle gösterdiği negatif korelasyon, mükemmeliyetçiliğin olumlu boyutunu desteklemektedir (Alden, Ryder, ve Mellings, 2002; Blankstein ve Dunkley, 2002).

Mükemmeliyetçiliğin kökeniyle ilgili bugüne kadar çıkan yayınlar tutarlı bir şekilde olumsuz ebeveynlik tutumlar, kontrol, aşırı eleştiri, ve onaylamamayı bu kavramın oluşmasıyla en yakından ilgili faktörler olarak öne çıkarmaktadır. Örneğin Blatt (1995) ebeveynleri tarafından sadece yüksek beklentileri karşıladıklarında onaylanan çocuklarda mükemmeliyetçiliğin en yoğun örneklerine rastlanabileceğini öne sürer. Buna uygun olarak, Burns'de (1980) mükemmeliyetçi ebeveynleri, çocukta bu özelliklerin gelişmesiyle ilişkilendirir. Mükemmeliyetçilikle ilgili ailesel değişkenler üzerine oldukça fazla yayın olmasına karşın, bu yayınların çoğunluğu spekülatif düzeydedir ve bu alandaki görgül araştırma sayısı oldukça azdır. Bu çalışmalar da özetle ebeveyndeki mükemmeliyetçiliğin (Vieth ve Trull, 1999), ebeveynin katı tutumlarının (Frost ve

ark., 1991) ve ilginin az olduğu yetkeci ebeveynlik tarzlarının (Enns, Cox, ve Larsen, 2000; Flett, Hewitt, ve Singer, 1995) özellikle olumsuz mükemmeliyetçilikle ilişkili olduğu üzerinedir.

Tüm kaygı bozukklukları içinde, sosyal kaygı bozukluğu, mükemmeliyetçilikle en yakından ilişkili olan bozukluk olarak belirir (Juster, 1999). Heimberg'e (1995) göre, sosyal anksiyeteli bireylerin kendilerinden karşılanması oldukça güç olan yüksek beklentileri vardır. Bu durumun kendi performansından memnun olmama, kendini eleştirme, başarısızlıktan korkma ve son olarak da sosyal ortamlardan kaçınma gibi birtakım sonuçları vardır (Hill, Zrull, ve Turlington, 1997). Bu konuda yapılan araştırmalarda en yaygın olarak çıkan sonuçlardan biri, sosyal açıdan anksiyetesi yüksek olan bireyleri diğerlerinden ayıran en temel mükemmeliyetçilik boyutunun, diğer kişilerle ilgili algıları olduğu görülmektedir. Bu algı nedeniyle sürekli dış çevre tarafından olumsuz şekilde yargılanma kaygısı yaşamaktadırlar (Alden, Ryder, ve Mellings, 2002; Arthur ve Hayward, 1997; Laurenti, Bruch, ve Haase, 2008). Bazı diğer araştırmalar ise, sosyal anksiyetenin özellikle "Davranışlardan Şüphe", "Ebeveynsel Eleştiri", ve "Hatalara Aşırı İlgi",boyutlarıyla ilişkili olduğunu bulmuştur (Anthony, Purdon, Huta, ve Swinson, 1998; Saboonchi ve ark., 1999). Daha yakın tarihli araştırmalar ise UDE boyutunun sosyal anksiyete ile ilgili olduğunu öne sürmektedir (Shumaker ve Rodebaugh, 2009).

Depresyon da mükemmeliyetçilikle oldukça yakından ilişkili kavramlardan biridir. Hatta mükemmeliyetçilik depresyona yatkınlığa neden olan etkenlerden biri olarak sıklıkla öne sürülmüştür (Blankstien ve Dunkley, 2002; Enns ve Cox, 1999; Rice, Bair, Castro, Cohen, ve Hood, 2003). Blatt'a göre özellikle kendini

eleştiren tip depresyonlarda, mükemmeliyetçiliğin neden olduğu yüksek standartlar, kendini inceleme durumuna yok açmakta ve bu kişiler koydukları yüksek standartlara erişemediklerinde depresif belirtiler yaşamaktadırlar. Depresyon ve mükemmeliyetçilik arasındaki ilişki hem klinik hem de klinik olmayan örneklemlerde pek çok kez gösterilmiştir (Enns ve Cox, 1999; Minarik ve Ahrens, 1996; Preusser, Rice, Ashby, 1994). Frost ölçeği kullanılarak yapılan araştırmalarda, yine sosyal anksiyetede olduğu gibi "Davranışlardan Şüphe" ve "Hatalara Aşırı İlgi",boyutları depresyonla en yakından ilgili boyutlar olarak öne çıkmıştır (Adkins ve Parker, 1996; Minarik ve Ahrens, 1996; Huprich, Porcerelli, Keaschuk, Binienda, ve Engle, 2008). Yine sosyal anksiyetede olduğu gibi UDE depresyonla da yüksek olumlu korelasyona sahip bulunmuştur (BiBartolo, Li ve Frost, 2008).

Tüm bu bilgilerin ışığında bu çalışmanın hipotezleri şunlardır:

1. Ebeveyne bağlanmadaki sorunlar, ZAT'ın oluşumuyla ilişkili olacaktır

2. Ebeveynle bağlanma sorunları mükemmeliyetçilikle ilişkili olacaktır ve uyumlu ve uyumsuz mükemmeliyetçiliği yordayan ebeveyn özellikleri farklılık gösterecektir.

3. Sosyal anksiyete, abartma boyutlarıyla ilişkili olacaktır. Bunu yanında sosyal abartmanın, fiziksel abartmaya göre sosyal anksiyete ile daha yakından ilişkili olması beklenmektedir.

4. Depresyon'un abartma ile ilişkisi istatistiksel açıdan anlamlılık düzeyinin altında ya da oldukça zayıf biçimde anlamlılık düzeyinde olacaktır.

5. Sosyal anksiyetenin algılanan ebeveynlik tutumlarıyla ve mükemmeliyetçilikle ilişkili olması beklenmektedir

6. Depresyonun algılanan ebeveynlik tutumlarıyla ve mükemmeliyetçilikle ilişkili olması beklenmektedir

7. ZAM'nin sosyal anksiyete değişkenleri kontrol edildiğinde depresyonla anlamlı düzeyde ilişkili olmaması beklenmektedir.

8. Mükemmeliyetçiliğin, sırasıyla sosyal anksiyete değişkenleri ve depresyon kontrol edildiğinde halen depresyon ve sosyal anksiyete ile anlamlı derecede ilişkili olması beklenmektedir.

9. Uyumsuz mükemmeliyetçiliğin algılanan ebeveynli tarzı değişkenleriyle depresyon ve sosyal anksiyete arasındaki ilişkide aracı değişken rolü olması beklenmektedir.

10. ZAT'ın algılanan ebeveynli tarzı değişkenleriyle depresyon ve sosyal anksiyete arasındaki ilişkide aracı değişken rolü olması beklenmektedir.

YÖNTEM

Katılımcılar: Yaşları 17 ile 46 arasında değişen 389 ODTÜ ve Boğaziçi Üniversitesi lisans öğrencisi araştırmaya katılmıştır.

Ölçüm:

Demografik Bilgi Formu:

Bu kısım, katılımcıların cinsiyeti, yaşı, doğum yerleri, ailelerinin yaşadığı yer, kardeş sayısı, anne baba eğitim ve iş durumu gibi demografik değişkenler konusunda bilgi alan sorulardan oluşmaktadır.

Çok Boyutlu Mükemmeliyetçilik Ölçeği (ÇBMÖ):

35 sorudan oluşan bu ölçek, Frost ve ark. (1990) tarafından geliştirilmiştir. Mükemmeliyetçiliği Düzen/Tertip", "Davranışlardan Şüphe", "Ebeveynsel Eleştiri", "Hatalara Aşırı İlgi", "Aile Beklentileri" ve "Kişisel standartlar" olarak boyutta değerlendiren bu ölçek Türkçe'ye Özbay ve Mısırlı-Taşdemir (2003) tarafından çevrilmiştir.

Ana-Babaya Bağlanma Ölçeği (ABBÖ):

25 adet Likert-tipi sorudan oluşan ölçek, Parke ve ark. (1979) tarafından geliştirilmiştir ve ebeveynlik tarzını ilgi ve aşırı korumacılık boyutlarından incelemektedir. Katılımcıdan hem annesini hem de babasını değerlendirmesi istenmektedir. Türkçe versiyonu Kapçı ve Küçüker (2006) tarafından geliştirilmiştir ve yeterli psikometrik özelliklere sahiptir.

Beck Depresyon Envanteri (BDE):

Beck, ve ark tarafından geliştirilen ölçek, 21 sorudan oluşmaktadır ve kişiden kendisini son bir haftadaki durumunu baz alarak değerlendirmesi istenir. Türkçeye Hisli (1988) tarafından çevrilmiştir ve güvenirlik ve in tutarlılık değerleri oldukça yeterlidir.

Liebowittz Sosyal Anskiyete Skalası (LSAS):

Kaçınma davranışı ve kaygı/korku için ayrı 24'er sorudan oluşan ölçek Liebowitz (1987) tarafından geliştirilmiştir. Türkçe standardizasyon çalışması Soykan, Özgüven ve Gençöz (2004) tarafından yapılmıştır.

Kısa Olumsuz Değerlendirilme Ölçeği (KODÖ):

Olumsuz değerlendirilme olasılığından duyulan kaygıyı ölçen KODÖ, Olumsuz Değerlendirilme Ölçeği'nin (ODÖ) kısa formu olarak Leary (1983) tarafından geliştirilmiştir. 12 sorudan oluşan ölçeğin Türkçeleştirilme çalışması Koydemir ve Özden (2007) tarafından yapılmış ve Türkçe formu yeterli psikometrik özelliklere sahiptir.

Zihinsel Abartma Tarzı Ölçeği (ZATÖ)

Riskind ve Ark. (2000) tarafından geliştirilen ZATÖ,bireylerin tehdit içeren uyaranları hareketli ve oldukça olumsuz sonuçlara gidecek şekilde algılama potansiyelini ölçme amacıyla geliştirilmiştir. Tehdit içeren durumları içeren altı vinyetten oluşan ölçek sosyal ve fiziksel looming olarak iki bölümden oluşmaktadır. Ölçeğin çeviri işlemlerine başlamadan önce yazardan çeviri için izin alınmıştır. Ardından ölçek üç kişi tarafından İngilizceden Türkçeye bağımsız olarak çevrilmiş ve bu üç çeviri birbiriyle karşılaştırılmıştır. Ardından bu üç versiyon değerlendirilmeleri amacıyla bir grup üniversite öğrencisine dağıtılmıştır. Öğrencilerden gelen geribildirim çerçevesinde düzeltmeler yapılıp, ölçeğin son formu oluşturulmuştur. Ana çalışma öncesi, ölçeğin psikometrik değerlendirilmesinin yapılması için bir ön çalışma gerçekleştirilmiştir.

Bu ön çalışmaya 176 üniversite öğrencisi (104 kız, 72 erkek) katılmıştır. ZATÖ dışında katılımcılara demografik bilgi formu, Liebowitz Sosyal anksiyete skalası, Kısa Olmusuz Değerlendirilme Ölçeği, Durumluk-Sürekli Kaygı Ölçeği, Beck Anksiyete Ölçeği ve Beck Depresyon Ölçeği verilmiştir.

Yapılan analizler sonucunda, Ölçeğin yeterli güvenirlik değerine (.85- .88 arası) sahip olduğu görülmüştür. Bunun dışında diğer ölçeklerle anlamlı seviyede

korelasyon katsayılarına sahip olması ölçeği yeterli geçerliğe sahip olduğuna işaret etmektedir. Sonuçlar ZATÖ'nün Türkçe formunun kullanılabilir özelliklerine sahip olduğunu göstermektedir.

İşlem

Çalışma öncesinde Orta Doğu Teknik Üniversitesi Etik Kurulu'ndan onay alınmış, psikolojiye giriş ders notunda 1 kredi yükselmesi karşılığında çalışmaya katılan üniversite öğrencilerinden bilgilendirilmiş onam formunu imzalamaları istenmiştir. Öğrencilerin dersleriyle çakışmayan bir saatte ayrı bir sınıfta 50 kişilik gruplar haline ölçekleri doldurmaları istenmiştir. Tüm kitapçığın doldurulması yaklaşık 30 dakika sürmektedir.

BULGULAR

Analizler öncesi çok değişkenli aşırı puanlar taranmış ve 14 tane vaka araştırmadan çıkarılmıştır. Analizlere kalan 375 kişi ile devam edilmiştir. Verilen ölçeklerde cinsiyet farklarını görmek için yapılan t-testler cinsiyet farklarının UDE, kişisel standartlar, anne ve baba aşırı korumacılığı alanlarında olduğunu göstermiştir. Buna göre erkekler mükemmeliyetçiliğin her iki boyutunda da kızlardan daha yüksek puanlar almaktadırlar. Bunun dışında erkekler hem anne hem de babalarını kızların algıladığından daha aşırı koruması olarak algılamaktadırlar. Hipotezleri doğrulayacak şekilde, ebeveyn bağlanması looming'i anlamlı şekilde yordamaktadır. Ancak regresyon sonuçlarına göre ABBÖ boyutlarının açıkladığı varyans oldukça düşüktür. Diğer taraftan ABBÖ'nün sadece aşırı korumacılık boyutlarının sadece sosyal looming'i

yordadığı görülmüştür. Ebeveynlik tutumlarıyla ilgili hiçbir değişken fiziksel loomingle ilişkili değildir. ABBÖ'nün aynı zamanda mükemmeliyetçilikle de ilişkisi araştırılmıştır ve uyumsuz mükemmeliyetçiliğin bir göstergesi olan UDE'in ABBÖ'nün tüm boyutlarıyla ilişkili olduğu görülmüştür. Diğer taraftan kişisel standartlar hiçbir anne- baba değişkeni tarafından yordanmamaktadır.

Yapılan hiyerarşik regresyonlar, kullanılan her iki sosyal anksiyete ölçeğinin de hipotezlerde öngörüldüğü gibi hem ABBÖ değişkenleri hem de sosyal looming tarafından yordandığını göstermektedir. Ancak LSAS, ABBÖ boyutlarından sadece anne ilgisi ile anlamlı derecede ilgili iken KODÖ ise anne aşırı korumacılığı ile ilişkili bulunmuştur. Her iki ölçek de sosyal looming ve UDE ile anlamlı derecede ilişkili iken kişisel standartların sadece LSAS'ı anlamlı düzeyde yordadığı görülmüştür.

Aynı değişkenleri BDE ile ilişkisine gelince, beklendiği gibi ABBÖ, BDE'deki varyansın % 15'lik kesimini açıklamaktadır ve baba ilgisi dışında tüm ABBÖ boyutları BDE ile ilişkilidir. Bununla birlikte sosyal abartma, UDE ve kişisel standartların da BDE'yi anlamlı derecede yordadığı bulgular arasındadır.

Bu araştırmada test edilen bir diğer hipotez de sosyal anksiyete ve depresyon ölçeklerinin mükemmeliyetçilikle ilişkisi üzerinedir. Bu hipoteze göre, diğer değişkenler kontrol edildiğinde sosyal anksiyete de depresyon da mükemmeliyetçilikle halen anlamlı derecede ilişkili olacaktır. Yapılan regresyon analizleri bu hipotezleri doğrulamaktadır. Her iki sosyal anksiyete ölçeğinin de depresyon skorları kontrol edildiğinde mükemmeliyetçilik tarafından aynı şekilde anlamlı derecede yordandığı bulunmuştur. Aynı şekilde her iki sosyal anksiyete ölçeği de kontrol edildiğinde depresyonun, mükemmeliyetçiliğin hem kişisel

standartlar hem de UDE alt ölçekleriyle anlamlı şekilde ilişkili olduğu bulunmuştur.

Aynı analizler depresyon ve sosyal anksiyetenin birbirini etkisinden bağımsız olarak LMS ile iliişkisi üzerinde tekrarlandığında, beklendiği gibi, LMS'nin depresyonun ektisi kontrol edildiğinde dahi sosyal anksiyete ile ilişkili olduğunu gösterirken, Benzer bir ilişkinin LMS'nin yordayıcısı olarak test edildiğinde bulunamamıştır. Buna göre LMS ve depresyon arasındaki ilişki sosyal anskiyete değişkenleri kontrol edildiğinde anlamlılığını yitirmektedir.

UDE ve LMS'nin anne-baba değişkenlerinin sosyal anksiyete ve depresyon ölçekleriyle ilişkisinde aracı değişken olarak rolünü incelmek için 6 adet aracıdeğişken analizi yapılmıştır. Analizler öncesi korelasyonlar incelenmiş ve korelasyon katsayısı (r) .20'nin altında olan değişkenlerle analiz yapılmamıştır. Buna göre UDE'in anne ilgili ve sosyal anksiyete arasındaki ve depresyonun tüm anne-baba değişkenleriyle arasındaki ilişkideki aracı değişken görevi ve sosyal looming'in baba aşırı korumacılığı ve depresyon arasındaki ilişkisindeki aracı değişken rolünü test etmek amacıyla analizler yapılmasına karar verilmiştir. Baron ve Kenny'nin (1986) kriterlerine göre her bir aracı değişken analizi için iki adet regresyon analizi yapılmıştır. Birinci regresyon analizinde, sosyal kaygı ya da depresyon skorları bağımlı değişken olarak alınmış, Bağımsız değişkenler iki adımda analize katılmıştır. İlk adımda anne-baba değişkenleri, ikinci adımda ise UDE, analize dahil edilmiştir. İkinci regresyon analizinde UDE bağımlı değişken olarak, anne-baba değişkenleri bağımsız değişken olarak yer almaktadır. Beta değerleri arasındaki düşüşün anlamlılığı ölçmek için her bir analiz sonrası Sobel testi uygulanmıştır. Her bir aracı değişken analizi için aynı yol takip edilmiştir.

Yapılan analizlerin sonuçlarına göre, UDE anne ilgisi ve sosyal anksiyete arasındaki ilişkide ve baba ilgisiyle depresyon arasındaki ilişkide tam aracı değişken olarak görev yaptığı bulunmuştur. Buna ek olarak UDE'in depresyonun anne ilgisi, anne ve baba aşırı korumacılığı ile ilişkilerinde kısmi aracı değişken olarak rolü olduğu bulunmuştur. Sonuçlar Sobel testleriyle desteklenmiştir. Buna karşın ZAT'ın (sosyal abartma) anlamlı olarak tam ya da kısmi ara değişken rolü bulunamamıştır.

TARTIŞMA

Bu araştırmada sosyal anksiyete ve depresyonun olumsuz mükemmeliyetçilik ve ZAT ile ilişkisi araştırılmıştır. İkinci olarak anne-baba değişkenlerinin sosyal anksiyete, depresyon,ve psikolojik bozukluklara yatkınlıkla (Mükemmeliyetçilik ve ZAT olarak) ilişkisi araştırılmıştır. Son olarak ZAT ve olumsuz mükemmeliyetçiliğin anne-baba değişkenleriyle psikopatoloji ölçütleri arasındaki ilişkide aracı değişken olarak rolü araştırılmıştır.

Zihinsel Abartmanın'in Sosyal Anksiyete ve Depresyonla İlişkisi

Ana çalışmadan elde edilen bulgular, ZAT'ın özellikle de sosyal abartmanın sosyal anksiyetedeki varyansın bir bölümünü anlamlı derecede yordayabildiğini göstermektedir. Bu sonuçlar çalışmanın ana hipotezini desteklemektedir. Diğer taraftan yapılan analizler, depresyonun sosyal abartma ile olan ilişkisinin sosyal anksiyete değişkenleri kontrol edildiğinde anlamlılık düzeyinin altına indiğini göstermiştir. Bu sonuç, abartma ile ilgili yurt dışında yapılmış çalışmaların sonuçlarıyla uyum içinde olmakla beraber, zihinsel abartmanın en önemli

özelliğini de vurgulamaktadır. Riskind ve ark. (2000) zihinsel abartma tarzının daha önce öne sürülmüş diğer bilişsel tarzlardan farklı olarak sadece kaygı bozukluklarına ait olduğunu öne sürmektedir. Anksiyete bozukluklarına bilişsel hassasiyetle ilgili bugüne kadar birçok farklı hipotez ve model öne sürülmüştür. Bunlardan biri anskiyete duyarlılığıdır. Anksiyete duyarlılığı ilk başlarda anksiyete ile ilgili bir kavram olarak öne sürülmüşken daha sonra yapılan araştırmalar, bu kavramın aynı zamanda depresyonla da ilişkili olduğunu göstermiştir (Starcevic ve Berle, 2006). Buna bir diğer örnek de Bilişsel İçerik Spesifikliği Hipotezidir (Beck ve ark (1987). Bu model de depresyon ve anksiyeteyi bilişsel içerik açısında ayrıt edip depresyon ve anksiyetenin birbirinden ayrı iki kavram olduğunu göstermeye çalışsa de yapılan çalışmalar bu bakış açısının anksiyetenin depresyondan bağımsız yönün açıklamakta yetersiz kaldığı görüşün desteklemektedir (Beck & Perkins, 2001). Zihinsel abartma modeli bu anlamda bir ilki oluşturmakta ve kaygının depresyondan bağımsız bir yönünü ortaya koymaktadır.

Bu sonuçlar depresyonla hem eştanı hem de bilişsel içerik açısından en fazla benzerlik gösteren anksiyete bozukluğu olan sosyal anksiyete bozukluğu (Watson & Clark, 1991) için de bulunmuştur. Bu sonuçlar sosyal anksiyetenin depresyondan ayırıcı tanısı açısından da önemlidir. Bugüne kadar yapılan bazı çalışmalar, sosyal anksiyetenin eşlik eden değersizlik duygusu (Clark ve Wells, 1995) ve pozitif duygu durumundaki düşüklük nedeniyle emosyonel profil olarak anksiyete bozukluklarındansa depresyona daha yakın oluğunu ve bu yüzden daha çok depresyonun bir alt kolu olarak kategorize edilmesi gerektiğini öne sürmektedir (Feldman, 1993; Hodges, 2000). Bu çalışma bu öngörüleri

yanlışlamakta ve sosyal anksiyetenin depresyondan ayrı ve diğer anksiyete bozukluklarıyla ortak bir yönü olduğunu bulmuştur.

Sosyal anksiyetenin zihinsel abartmayla birebir ilişkisine gelecek olursak, beklendiği gibi sosyal anksiyetenin sadece sosyal abartmayla anlamlı bir ilişkisi olduğu bulunmuştur. Bu durum literatürle de uyum içindedir (Stopa ve Brown, 2008b; Williams, ve ark, 2005) ve sosyal anksiyete'nin diğer anksiyete bozukluklarından farklı olarak Zihinsel abartma boyutlarında sosyal abartmayla ilişkili olarak farklı bir profil ortaya koyduğu söylenebilir.

Anne-Babalık Tarzı ve ZAT

Beklenenden farklı olarak zihinsel abartmanın sadece sosyal boyutu test edilen anne-babalık tarzlarıyla ilişkili bulunmuştur. Buna göre sosyal zihinsel abartma anne-babalık değişkenlerinden sadece anne ve baba aşırı korumacılığı boyutlarıyla ilişkilidir. Daha önce yapılan çalışmalar (Riskind ve ark., 2004) ve anksiyete bozukluklarının ailevi geçmişi göz önünde bulundurulduğunda bu sonuçlar oldukça anlamlıdır. Chorpita ve Barlow'a (1998) göre, ebeveyn aşırı korumacılığı anksiyete bozukluklarının geçmişinde oldukça önemli bir rol oynamaktadır. Onlara göre, bu ebeveynlik tarzı çocuğa dış dünyanın tehlikelerle dolu olduğuna ve keşinin bunları kontrol etmekte yetersiz olduğuna ilişkin bir mesaj vermektedir. Bu tip ebeveynlerin çocukları çevreden gelecek potansiyel tehlikeleri gerçekte olduğunu birkaç katıl olarak algılamaktadırlar. Sonuç olarak da kaygı yaşamaya daha elverişli bireyler olarak yetişmektedirler.

Aynı ilişkiyi farklı şekilde açıklayan Hudson ve Rapee (2000) aşırı korumacı ebeveynlerin çocuklarına beceri geliştirmelerine fırsat verecek alan

tanımadıklarını ileri sürmektedir. Sürekli anne-babanın denetiminde ve koruması altında yaşayan çocuk uzun vadede dış dünya ile baş etmesini sağlayacak gerekli becerilere sahip olamamakta ve bunun sonucunda kendisini dış dünyadan gelen tehditler karşısında daha savunmasız hissetmektedir. Bu durum da daha fazla kaygı yaşamasına yol açmaktadır.

Bu araştırmada anne-babalık tarzları ve zihinsel abartma arasında anlamlı bir ilişki bulunmasına karşın ölçülen ebeveynli değişkenlerinin fiziksel zihinsel abartmayı açıklayamıyor olması, ve sosyal zihinsel abartmadaki varyansın oldukça az bir bölümün açıklayabiliyor olması, bu alanda daha fazla çalışmaya ihtiyaç olduğunu ve ebeveynliğin farklı boyutlarına da odaklanılması gerekliliğini düşündürmektedir.

Anne-Babalık Tarzının Sosyal Anksiyete ve Depresyona İlişkisi

Ölçülen anne-babalık değişkenlerinden hepsi depresyonla ilişkili çıkmıştır. Buna göre hem anne hem de babalarından düşük düzeyde ilgi ve yüksek miktarda aşırı korumaya maruz kalan birey daha yoğun depresif belirtiler yaşamaktadırlar. Bu bulgular Parker (1979; 1983) ve Kenny ve Rice'ın (1995) sonuçlarıyla oldukça uyumludur. Buna göre çocuk, yeterli miktarda ilgi alamadığında çocuk kendini sevilmez hisseder ve dünya ile ilgili olumsuz şemalar edinimiyle sonuçlanır.

Parker ve ark. (1995) tarafından yapılan ilk çalışmalarda bu ebeveynlik tarzı depresyona özgü bir tarz olarak öne sürülse de sonradan yapılan çalışmalar, anksiyete bozuklukları da dahil pek çok psikolojik bozuklukla ilişkili bulunmuştur. Bununla ilişkili olarak batılı ülkelerde yapılan pek çok çalışmada düşük ilgi ve yüksek aşırı koruma olarak tanımlanabilecek ebeveynlik tarzı sosyal

anksiyete ile de ilişkili bulunmuştur (Arrindell ve ark., 1989; Bögels ve ark., 2001; Cunha ve ark., 2008). Tüm bunların ışığında bu çalışmada da bu tarzın sosyal anksiyete ile ilişkili olması beklenmiştir. Ancak beklenenin aksine, sosyal anksiyete ebeveynlik değişkenlerinden sadece anne ilgisi ile ilişkili bulunmuştur. Kimbrel ve ark'a (2008) göre bu bulgu oldukça anlamlıdır. Şöyle ki, anne ilgisinin az olduğu durumlara çoğunlukla anne tarafından aşırı eleştiri ve ret eşlik etmektedir. Böyle bir tutuma maruz kalan çocuk kendi hatalarına ve eleştirilmeye karşı aşırı bir hassasiyet geliştirir. Sosyal çevre ile ilgili imgesi genel olarak eleştiren ve yargılayan şeklinde olduğundan eleştiriyi engellemenin tek yolu olarak sosyal etkileşimden kaçmayı kullanır. Sosyal anksiyete ölçeği ile aşırı koruma boyutları arasında anlamlı bir ilişki bulunmayışı Türk kültürünün özellikleri düşünüldüğünde oldukça anlamlıdır. Türk kültüründe çocuğu aşırı korumanın olumlu bir ebeveynlik özelliği olarak görüldüğü ve olumsuz sonuçlara yol açmadığı pek çok araştırmada çıkmıştır (Anlı ve Karslı, 2010; Kagitcibasi, 1977; 2000; 2010)

Bu çalışmada kullanılan sosyal anksiyete ölçeklerinden biriyle anne-baba aşırı koruması arasında ilişki bulunamamışken, sosyal anksiyetenin olumsuz değerlendirilme kaygısı boyutu özellikle anneden algılanan aşırı koruma ile ilişkili bulunmuştur. Bu durum bir öncesi argümanla çelişkili olsa da literatürde anne-baba aşırı korumasının sosyal anksiyete üzerindeki olumsuz etkilerine işaret eden çalışmalar da bulunmaktadır (Koydemir-Özden ve Demir, 2009; Soygüt ve Çakır, 2009). Diğer bir deyişle bu çelişki bir anlamda kullanılan sosyal anksiyete ölçeklerinin bu kavramın farklı boyutlarını ölçmesiyle ilişkili olabilir. LSAS, sosyal anksiyetenin duygusal ve davranışsal boyutunu ölçerken KODÖ, daha fazla

bilişsel boyutuna odaklanmaktadır. Özetle sosyal anksiyetenin bilişsel boyutunu anneden algılanan aşırı korumacılıkla ilişkili olduğu söylenebilir.

Mükemmeliyetçiğin Sosyal Anksiyete ve Depresyon Ölçekleriyle İlişkisi

Çalışmanın sonuçları, hem depresyon hem de sosyal anksiyetenin mükemmeliyetçiliğin hem uyumlu hem de uyumsuz mükemmeliyetçilikle ilişkili olduğunu göstermiştir. Ancak her iki kavramında uyumlu ve uyumsuz mükemmeliyetçilikle ilişkileri birbirinden farklıdır. Çalışma sonuçlarına göre uyumsuz mükemmeliyetçilik sosyal anksiyete de depresyonla birlikte artışa geçerken, Uyumlu mükemmeliyetçiliğin yükseldiği durumlarda depresyon ve sosyal anksiyetede düşüşler olmaktadır. Bu sonuçlar literatürle de uyum içindedir (Enns ve Cox, 1999; Frost ve ark., 1990; Minarik ve Ahrens, 1996). Hill Zrull ve Turlington'a (1997) göre de bu sonuçlar oldukça anlamlıdır. İki mükemmeliyetçilik boyutunun psikopatoloji ölçekleriyle farklı yünde ilişkide olması, mükemmeliyetçiliğin olumlu ve olumsuz boyutları olduğuna ilişkin argümanı desteklemektedir (Stöber ve Otto, 2006).

Algılanan Ebeveynlik tarzı ve Mükemmeliyetçilik

Bu çalışmanın bir diğer amacı da mükemmeliyetçilikle ilişkili ebeveynlik tarzlarının araştırılmasıdır. Bu alandan pek çok yayın olmasına karşın görgül araştırma sayısı oldukça sınırlıdır. Uyumlu ve uyumsuz mükemmeliyetçiliğin anne-baba değişkenleriyle ilişkisine ayrı ayrı bakılmıştır. Sonuçlar uyumsuz mükemmeliyetçiliğin tüm ebeveynlik değişkenlikleriyle ilişkili olduğunu göstermektedir. Buna göre, uyumsuz mükemmeliyetçilik boyutunda yüksek puan

alan bireyler, hem anne hem de babalarını daha az ilgili ve daha korumacı olarak tanımlamaktadırlar. Bu bulgular daha önce yapılmış ve mükemmeliyetçi bireylerin ebeveynlerinin daha sert, eleştiren ve korumacı olduğunu öne süren araştırmaların sonuçlarıyla ve daha teorik görüşlerle uyum içindedir (Enns, Cox, ve Clara, 2002a; Flett, Hewitt, ve Singer, 1995; Nemechek, 1978; Sorotzkin, 1998). Bu çalışmada göze çarpan bir diğer fark da kişisel standartlar olarak da adlandırılan uyumlu mükemmeliyetçilik boyutunu hiçbir anne-baba değişkeniyle ilişkili bulunmamış olmasıdır. Şimdiye kadar bu konuda çok çalışmama olmamasına karşın, bu çalışmanın sonuçları diğerleriyle oldukça tutarlıdır (Enns, Cox, ve Clara, 2002a). Bu sonuçlar hem mükemmeliyetçiliğin farklı anne-baba özellikleriyle alakalı ve birbirinden görece bağımsız gelişen iki boyutu olduğu konusundaki görüşü desteklemekte (Frost ve ark., 1993; Nemechek, 1978), hem de uyumlu mükemmeliyetçilikle ilgili çalışma eksikliğini vurgulamaktadır.

Uyumsuz Mükemmeliyetçiğin Aracı Değişken Olarak Rolü

Bu çalışmanın bir diğer amacı da uyumsuz mükemmeliyetçiğin algılanan ebeveynlik tarzı değişkenleriyle sosyal anksiyete ve depresyon değişkenleri arasındaki ilişkide aracı değişken olarak rolünün araştırılmasıdır. Yapılan analizler, uyumsuz değerlendirilme endişesinin anne ilgisi ve sosyal anksiyete arasındaki ilişkide aracı değişken olarak anlamlı şekilde etkisi olduğunu göstermiştir. Buna göre anneden algılanan düşük ilgi, çocukta uyumsuz mükemmeliyetçiliğin gelişmesine ve sonuçta daha yoğun sosyal kaygı yaşamasına neden olmaktadır.

Uyumsuz mükemmeliyetçiliğin anne baba değişkenleriyle depresyon arasında da anlamlı aracı değişken rolü olduğu da bulunmuştur. Buna göre hem anne hem de babadan algılanan düşük ilgi ve yüksek aşırı koruma uyumsuz mükemmeliyetçiliği yükseltmek suretiyle depresyonun da yükselmesine yol açmaktadır. Bu bulgular daha önce yapılan çalışmalarla uyum içindedir (Soenens, ve ark., 2005; Soygüt ve Çakır, 2009). Buna göre olumsuz ebeveynlik tarzları negatif şemaların gelişmesine yol açmakta ve bu da uzun vadede bu kişilerde psikolojik bozukluklara karşı bir yatkınlık oluşturmaktadır.

Çalışmanın Katkıları

Bu çalışmanın ZAT ile ilgili sonuçları literatürde uzun dönemden bu yana süregelmekte olan anksiyete ve depresyonun birbirinden ayırt edilmesi alanında yapılmış olan çalışmalara katkıda bulunmaktadır. Diğer taraftan mükemmeliyetçiliğin özellikle depresyon ve sosyal anksiyetede ki önemini bir kere daha vurgulamıştır. Mükemmeliyetçiliğin psikolojik bozukluklarda iki yönlü etkisini de destekleyen bu çalışma, uyumsuz mükemmeliyetçiliğin psikolojik bozuklukların tedavisinde hedef alınması gerekliliği görüşünü destekler niteliktedir. Uyumsuz mükemmeliyetçiliğe odaklanan terapi yaklaşımları uzun vadede bozukluğu tekrar nüksetmesini engelleyecek nitelikte olabilir.

Bir diğer sonuç ise özellikle anksiyete bozukluklarının sağaltımıyla ilgilidir. Daha önce de belirtildiği gibi ZAT'ın, bireylerde anksiyete bozukluğu belirtilerinin ortaya çıkmasından çok önce var olan bir tarzdır ve anksiyete bozukluklarına bir yatkınlığa neden olmaktadır. Bu yönüyle risk grubundaki bireylerin ZAT açısından değerlendirilip bu bilişsel tarzlarının değiştirilmesi

yönünde müdahelelerin yapılması, anksiyete bozukluklarının önlenmesinde oldukça yardımcı olabilir. Şimdiye kadar ZAT kaynaklı yöntemler sistemik bir şekilde anksiyete bozukluklarının tedavisinde kullanılıyor olmasa da, bu alanda yapılan çalışmalar oldukça olumlu sonuçlar vermektedir (Elwood, Riskind, ve Olatunji, 2009; Riskind ve Williams, 1999).

Sınırlılıklar ve Sonraki Çalışmalar

ABBÖ ile ölçülen anne-babalık tarzları, çalışmada hem sosyal anksiyete hem de depresyondaki varyansın oldukça kısıtlı bir bölümünü açıklayabilmiştir. Ayrıca uyumlu mükemmeliyetçilik ve fiziksel loomingle ilgili bulunmamışlardır. Bu yüzden ileriki çalışmalar, ebeveyn ilgisi ve aşırı koruması dışındaki aile değişkenleri ve diğer gelişimsel değişkenlere odaklanmalıdır.

İkinci olarak, ebeveynlik tarzları ve mizaç, genel olarak psikolojik bozukluklara eğilimi inceleyen literatürde oldukça bahsi geçen kavramlardır. ZAT ile ilgili olarak da Riskind ve ark (2004) mizacın olası önemli rolünü vurgulamaktadır. Bu alanda henüz yapılan bir çalışma yoktur ancak ileride yapılacak çalışmalar, ZAT'da mizaç'ın yeri ve ebeveynlik tarzları ve mizaç arasındaki etkileşime de odaklanabilir.

Bu çalışmanın odağında olmamasına karşın özellikle mükemmeliyetçilikle ilgili anlamlı cinsiyet farklılıklarından bahsedilebilir. Bu sonuçlar göz önünde bulundurulduğunda, ileriki çalışmalar Türk toplumunun özelliklerini de dikkate alarak mükemmeliyetçilikte cinsiyet farklılıklarına odaklanabilir.

CURRICULUM VITAE

PERSONAL INFORMATION

Surname, Name: Altan Atalay, Ayşe
Nationality: Turkish (TC)
Date and Place of Birth: 28 October 1977, Istanbul
Marital Status: Married
Phone: +90 212 342 40 67
Fax: +90 212 287 24 81
email: ayse.altan@gmail.com

EDUCATION

Degree	Institution	Year of Graduation
MS	Boğaziçi University- Clinical Psychology	2001
BS	Boğaziçi University- Psychology	1999
High School	Kemal Atatürk Lisesi	1995

WORK EXPERIENCE

Year	Place	Enrollment
2010- Present	Yeditepe University, Department of Psychology	Part-time Lecturer
2000- Present	Boğaziçi University Center for Psychological Services	Clinical Psychologist
2001-2004 January	Boğaziçi University Department of Psychology	Research Assistant

FOREIGN LANGUAGES

Turkish (Native)
English (Fluent)

PUBLICATIONS

Topçuoğlu, V., Biçer, D., Altan, A., Köksal, F., ve Yöney, H. (2003). Obsesif kompulsif bozukluk hastalarında ilaç tedavisine yanıtın dört sistem endişe envanteriyle değerlendirilmesi. *3P Dergisi; 11(3),* 207-212.

Altan-Atalay, A., & Gençöz, T. (2008). Critical Factors of social physique anxiety: Exercising and body image satisfaction. *Behaviour Change, 25,* 178-188.

HOBBIES

Reading, Photograpy, Hiking