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Self-Esteem and Symptom Severity in General Anxiety Disorder and Major Depressive Disorder: A Serial Mediation Model of Experiential Avoidance and Psychological Resilience

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ABSTRACT

Introduction: Generalized Anxiety Disorder (GAD) and Major Depressive Disorder (MDD) are prevalent mental health conditions, and low self-esteem is considered a vulnerability factor for psychological distress. However, the relationship between self-esteem and symptom severity remains unclear, as evidence regarding the nature of this association is still insufficient. On the other hand, experiential avoidance is recognized as a transdiagnostic variable closely linked to clinical outcomes and individual characteristics, while also being associated with psychological resilience. This study investigates the serial mediating roles of experiential avoidance and psychological resilience in the relationship between self-esteem and the severity of anxiety and depressive symptoms in individuals diagnosed with GAD and MDD.

Methods: The study was conducted with 201 voluntary participants aged between 18 and 65 who had been diagnosed with either GAD (n = 90) or MDD (n = 111) and were being monitored accordingly. Participants were assessed using a sociodemographic and clinical data form prepared by the interviewer, along with the Hamilton Anxiety Rating Scale, Hamilton Depression Rating Scale, Psychological Resilience Scale, Rosenberg Self-Esteem Scale, and the Multidimensional Experiential Avoidance Questionnaire.

Results: The results indicate an indirect relationship between self-esteem and anxiety and depressive symptoms, mediated by experiential avoidance and psychological resilience. This mediation effect was found to be complete for anxiety and partial for depression. Sensitivity analysis confirmed the robustness of the mediation findings.

Conclusion: The findings suggest that individuals diagnosed with GAD and MDD tend to adopt more experiential avoidance strategies in relation to low self-esteem, which in turn leads to a decrease in psychological resilience and an increase in symptom severity. Accordingly, interventions targeting experiential avoidance in the context of self-esteem may contribute to symptom reduction by enhancing psychological resilience.

Keywords: Experiential avoidance, generalized anxiety disorder, major depressive disorder, psychological resilience, self-esteem

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INTRODUCTION

Psychological resilience is a concept that enhances individuals' ability to cope with life events and plays an effective role in managing stress. It has been defined in various ways. Some definitions characterize it as the ability to adapt successfully and cope with adversity when faced with challenging and threatening situations (1), while others describe it as the capacity to maintain psychological strength despite adverse conditions (2). Strong psychological resilience can protect individuals from psychological distress. Numerous studies have reported a negative relationship between levels of depression and psychological resilience.

Self-esteem refers to a favorable attitude that arises from the individual's approval of the self-concept formed through self-evaluation. It reflects a positive emotional state in which the person is content with themselves without perceiving themselves as inferior or superior, and considers themselves to be valuable, lovable, and trustworthy (3). Rosenberg (4) defined self-esteem as an individual's positive or negative attitude toward themselves. If an individual holds a positive attitude in their self-evaluation, they are considered to have high self-esteem; conversely, a negative attitude indicates low self-esteem.

Highlights

- **Self-esteem is associated with anxiety and depression through mediational mechanisms.**
- **Experiential avoidance fully mediates anxiety and partially mediates depression.**
- **Enhancing resilience and reducing experiential avoidance may lessen symptoms.**

Depression and anxiety are clinical conditions that can affect self-esteem. A positive association has been found between depression and low self-esteem. Reduced self-esteem may lead to increased anxiety and contribute to more perfectionistic and anxiety-driven approaches in social relationships (5).

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In the model used in this study, the second predictor variable is experiential avoidance. Experiential avoidance is defined as an individual's attempt to modify the form or frequency of certain experiences they are unwilling to maintain, as well as the contexts that give rise to them. These experiences may include bodily sensations, emotions, thoughts, memories, and behavioral tendencies (6). The pathways of experiential avoidance have been categorized as emotional avoidance, thought suppression and distraction, procrastination, repression, and denial (7). A study found that even when controlling for anxiety levels, depression was positively associated with emotional, behavioral, and experiential avoidance (8). Emotional avoidance is recognized as a short-term adaptive emotion regulation strategy aimed at avoiding unwanted internal experiences (6). An individual may attempt to avoid thinking about a traumatic experience in an effort to prevent the distress it causes and the potential emergence of dysfunctional behaviors. This avoidance often leads to thought suppression. However, the act of suppressing a thought tends to increase its intrusiveness, resulting in greater psychological discomfort. Thought suppression can thus become a confusing and time-consuming process (9). Among the pathways of experiential avoidance, suppression involves actively inhibiting a specific thought, whereas distraction aims to replace the unwanted thought with an alternative one. Procrastination is defined as the unnecessary delay of tasks that need to be completed in a timely manner, a tendency to postpone tasks until the last minute, and the inability to prioritize them effectively (10).

While suppression is a commonly employed defense mechanism, its frequent use can hinder the ability to derive satisfaction and learn new adaptive strategies. Suppression was first conceptualized by Freud as the process of pushing impulses, emotions, memories, or experiences into the unconscious. This framework provided an explanation for previously inexplicable psychological symptoms and disorders. When repressed experiences are brought to conscious awareness, they are often perceived as threats and can trigger symptoms of anxiety (11). Denial, on the other hand, involves ignoring or dismissing a situation perceived as threatening or anxiety-inducing by pushing it into the unconscious and treating it as if it had never occurred. Although suppression and denial may appear similar, a key distinction lies in their outcomes: while repressed experiences can be accepted once they reach conscious awareness, denied experiences are replaced with alternative thoughts and beliefs (11). A thesis study found that experiential avoidance increases anxiety and reduces self-efficacy (12). Experiential avoidance involves a general tendency to evade negative emotions. Regulating negative emotions through experiential avoidance prevents positive corrective experiences and, consequently, the development of self-efficacy (12). Similarly, another study found that self-esteem mediates the relationship between perfectionism and depressive symptoms (13). The same study also revealed that when self-esteem is controlled, experiential avoidance mediates the relationship between perfectionism and depressive symptoms (13).

The present study examines the serial mediating role of experiential avoidance and psychological resilience in the relationship between self-esteem and symptoms of anxiety and depression. Self-esteem is associated with anxiety and depressive symptoms both directly and indirectly, with experiential avoidance and psychological resilience serving as sequential mediators in this relationship. According to this hypothesis, low self-esteem is linked to higher levels of experiential avoidance, which in turn diminishes psychological resilience, thereby contributing to increased levels of anxiety and depressive symptoms. Examining these variables through a serial mediation model offers a more comprehensive understanding of how low self-esteem may contribute to psychopathology. From a clinical perspective, these findings underscore the potential value of intervention programs aimed at reducing experiential avoidance and enhancing psychological resilience in alleviating symptoms of anxiety and depression.

METHODS

Sample

The sample of the study consisted of a total of 201 participants, including 136 women and 65 men, aged between 18 and 65 years (Mean [M] = 36.094, Standard deviation [SD] = 13.233), who were literate and either received outpatient care at the Psychiatry Outpatient Clinic or inpatient treatment at the Psychiatry Department of İzmir City Hospital between March 30, 2024, and September 30, 2024. Participants met the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnostic criteria for Generalized Anxiety Disorder (GAD) or MDD and voluntarily agreed to participate after being informed about the study. Ethical approval for the study was obtained in writing from the Ethics Committee on March 13, 2024, with decision number 2024/11. Individuals who met the DSM-5 criteria for psychotic disorders or depression with psychotic features, those with known acute or chronic neurological conditions, a history of head trauma or central nervous system infections, or those lacking decision-making capacity or suffering from comorbid conditions that might impair accurate reporting (*e.g.*, delirium, dementia, or intellectual disability) were excluded from the study. A cross-sectional correlational design and purposive sampling method were employed in this research.

Each participant was informed about the purpose of the study before completing the sociodemographic and clinical data form. Subsequently, the Multidimensional Experiential Avoidance Questionnaire (MEAQ), the Psychological Resilience Scale, the Rosenberg Self-Esteem Scale (RSES), the Hamilton Depression Rating Scale (HDRS), and the Hamilton Anxiety Rating Scale (HARS) were administered in printed format. To control for potential confounding effects related to the order of administration, the sequence of scales was randomly determined for the first participant, and a counterbalancing method was applied for subsequent participants.

Data Collection Instruments

Sociodemographic and Clinical Data Form

This form was developed by the researchers to assess the sociodemographic and clinical characteristics of the sample group. It was completed by the researcher during interviews with the participants. The form includes data on participants' gender, educational status, marital status, living arrangements (whether they live alone or with others), employment status, history of psychiatric consultations, current psychiatric treatments, presence of mental illness in the family, history of suicide attempts, history of psychiatric hospitalization (if applicable, the number of hospitalization days), and the age of onset of the disorder.

Multidimensional Experiential Avoidance Questionnaire (MEAQ)

The MEAQ, originally developed by Gámez et al. (2011) and adapted into Turkish by Yıldırım and Bahtiyar (2020), is a six-point Likert-type scale consisting of 59 items (14). The scale comprises five subscales: Avoidance, Distraction and Suppression, Distress Endurance, Procrastination, and Repression and Denial. The Avoidance subscale includes items 1, 5, 6, 12, 17, 18, 23, 24, 29, 31, 35, 36, 41, 42, 47, 48, 51, 52, 55, 56, and 58. The Distraction and Suppression subscale consists of items 2, 7, 11, 13, 20, 25, 30, and 37. The Distress Endurance subscale includes items 4, 10, 16, 22, 27, 34, 40, 45, 50, 54, and 59. The Procrastination subscale comprises items 3, 9, 15, 28, 33, 39, and 44. The Repression and Denial subscale consists of items 8, 14, 19, 21, 26, 32, 38, 43, 46, 49, 53, and 57. Items 21 and 28 are reverse-scored. In addition to the subscale scores, a total score is calculated using the formula: Avoidance + Distraction and Suppression + Procrastination + Repression and Denial + (77 - Distress Endurance). The Cronbach's alpha coefficient for the total score was found to be 0.93, while the internal consistency coefficients for the subscales were as follows: 0.91 for Avoidance, 0.87 for Distraction and Suppression, 0.87 for Distress Endurance, 0.85 for

Procrastination, and 0.84 for Repression and Denial. Regarding split-half reliability, the Cronbach's alpha value was 0.85 for the first half (30 items) and 0.89 for the second half (29 items). Additionally, the Guttman split-half reliability coefficient was reported as 0.89 (15).

In the original study of the MEAQ (15), it was determined that the Distress Endurance subscale exhibited weak correlations with the other MEAQ subscales and had low factor loadings. This finding suggests that the Distress Endurance subscale may be a less central component of the broader Experiential Avoidance (EA) construct. Additionally, since Distress Endurance represents a positive factor, whereas the other subscales reflect negative components, it was excluded from the total experiential avoidance score in this study. The Cronbach's alpha coefficients calculated for the MEAQ subscales in the present study are as follows: Behavioral Avoidance: 0.851, Distress Avoidance: 0.883, Procrastination: 0.741, Distraction/Suppression: 0.824, Repression/Denial: 0.749.

Rosenberg Self-Esteem Scale (RSES)

The Rosenberg Self-Esteem Scale (RSES), originally developed by Rosenberg (1965), is a self-report measure designed to assess self-esteem. The original scale consists of 63 items across 12 subscales. However, the Self-Esteem subscale, which is most commonly used in research, includes 10 items rated on a four-point Likert scale. Higher scores on this subscale indicate higher levels of self-esteem. The adaptation of the scale developed by Rosenberg (1965) to the Turkish population was carried out by Çuhadaroğlu (1986) (16). In the present study, only the self-esteem subscale was used, and the internal consistency coefficient (Cronbach's alpha) calculated for this subscale was found to be 0.842.

Psychological Resilience Scale (PRS)

The scale was developed by Friborg et al. (2003) and comprises five dimensions: 'personal competence,' 'structured style,' 'social competence,' 'family cohesion,' and 'social resources' (17). In a subsequent study, Friborg et al. (2005) demonstrated that the six-dimensional structure of the scale provided a better explanation of the psychological resilience model. In this revised structure, the 'personal competence' dimension was divided into two subcomponents: 'self-perception' and 'perception of the future,' resulting in a total of six dimensions. The Psychological Resilience Scale (PRS) was adapted into Turkish by Basım and Çetin (2011). In the criterion-related validity study, correlations ranged between 0.168 and 0.453 with the Social Comparison Scale and between –0.138 and –0.242 with the Locus of Control Scale. The Cronbach's alpha coefficients for the subscales ranged from 0.66 to 0.81 (18). In the present study, the total Cronbach's alpha coefficient of the scale was calculated as 0.858, and the alpha coefficients for the subscales ranged from 0.689 to 0.810.

Hamilton Depression Rating Scale (HDRS)

The Hamilton Depression Rating Scale (HDRS), originally developed by Hamilton (1960), is a 17-item clinician-administered scale used to assess the severity of depressive symptoms (19). The Turkish adaptation, including validity and reliability studies, was conducted by Akdemir et al. (1996) (20). In the internal consistency analysis, the scale demonstrated a Cronbach's alpha coefficient of 0.75 and a reliability coefficient of 0.76, indicating acceptable internal reliability. The HDRS scoring system includes items rated on 0–4 and 0–2 point scales. Items that measure symptoms of quantifiable severity are scored on a 0–4 scale, with 4 indicating the most severe symptom intensity. The maximum possible total score is 53. The cut-off points for the HDRS are as follows: ≥23: Very severe depression, 19–22: Severe depression, 14–18: Moderate depression, 8–13: Mild depression, ≤7: Normal. In the present study, the HDRS exhibited high internal consistency, with a Cronbach's alpha coefficient of 0.90, confirming its reliability in assessing depressive symptoms.

Hamilton Anxiety Rating Scale (HARS)

The Hamilton Anxiety Rating Scale (HARS) was developed by Hamilton (1959) to assess the level, distribution, and severity of anxiety symptoms (21). The Turkish adaptation and validation study was conducted by Yazıcı et al. (1998) (22). The scale comprises 14 items that evaluate both psychological and somatic symptoms of anxiety. Specifically eight items constitute the somatic subscale, assessing physical manifestations of anxiety. Six items form the psychic subscale, measuring cognitive and emotional aspects of anxiety. The total score is derived by summing these two subscores. Each item is rated on a 5-point Likert scale (0 = not present to 4 = severe), with a maximum possible score of 56. The severity classification based on total scores is as follows: ≤17: Mild anxiety, 18–24: Moderate anxiety, ≥25: Severe anxiety. In the present study, the HARS exhibited satisfactory internal consistency, with a Cronbach's alpha coefficient of 0.83, confirming its reliability in measuring anxiety symptoms.

Statistical Analysis

The data were analyzed using the JASP software (Version 0.18.3; JASP Team, 2023). To examine differences in anxiety and depression scores between groups, an independent samples t-test was conducted. The chi-square (χ^2) test was employed to evaluate relationships between categorical variables. Additionally, Pearson correlation analysis was performed to investigate the relationships among the variables included in the study.

Path analysis was conducted to examine the sequential mediating effects of experiential avoidance and psychological resilience in the relationship between self-esteem and symptoms of anxiety and depression. The GAD and MDD samples were analyzed within a single model to investigate the relationships between common variables and processes shared by both disorders.

Model fit was evaluated using several goodness-of-fit indices, including the Comparative Fit Index (CFI), Goodness-of-Fit Index (GFI), Normed Fit Index (NFI), Standardized Root Mean Square Residual (SRMR), Root Mean Square Error of Approximation (RMSEA), chi-square/degrees of freedom ratio (χ^2/df), and confidence interval (CI) indices. These indices were used to assess the adequacy of the proposed structural model.

A CFI, GFI, and NFI value of ≥ 0.95 indicates a good model fit, while values ≥ 0.90 suggest an acceptable fit. Similarly, SRMR and RMSEA values of ≤ 0.05 signify a good fit, whereas RMSEA values between 0.05 and 0.10 and SRMR values between 0.05 and 0.08 indicate an acceptable fit (23). Furthermore, the 95% CI not containing zero indicates the presence of a statistically significant difference.

RESULTS

The GAD group consisted of 90 voluntary participants aged between 18 and 65 years (M = 36.855, SD = 13.647), of whom 29 were male (32.2%) and 61 were female (67.8%). The MDD group included 111 voluntary participants aged between 18 and 64 years (M = 35.478, SD = 12.917), comprising 36 males (32.4%) and 75 females (67.6%). The two groups were found to be statistically equivalent in terms of age [t(199) = 0.733, p = 0.464], gender distribution (χ^2 = 0.001, p = 0.975), years of education [t(199) = -1.141, p = 0.255], relationship status (χ^2 = 0.045, p = 0.832), and employment status (χ^2 = 2.273, p = 0.518).

A significant relationship was found between history of hospitalization and diagnosis (χ^2 = 6.458, p = 0.011). Individuals diagnosed with MDD were more likely to have a history of hospitalization compared to those diagnosed with GAD. However, the effect size indicated a small relationship (φ = 0.179). Additionally, the two groups were found to

be equivalent in terms of history of psychiatric treatment (χ^2 = 0.603, p=0.438), past suicide attempts (χ^2 = 1.267, p=0.260), and reported age of illness onset [t(199) = 0.595, p=0.553].

No significant differences were found between the GAD and MDD groups in terms of experiential avoidance [t(199) = -0.142, p = 0.887], self-esteem [t(199) = 1.829, p = 0.069], or psychological resilience [t(199) = 1.489, p = 0.138]. However, a significant difference was observed between the groups regarding anxiety symptoms [t(199) = 7.032, p<0.001] and depressive symptoms [t(199) = -7.301, p<0.001]. Specifically, the GAD group exhibited higher anxiety scores, whereas the MDD group demonstrated higher depression scores. The effect size calculated for symptom differences between the groups was found to be large for both anxiety (d=0.98) and depression (d=1.01). These findings indicate that both screening measures appropriately distinguish between anxiety and depressive symptoms.

Table 1 presents the descriptive statistics for the variables included in the study, along with the Pearson correlation coefficients between them. Statistically significant positive and negative correlations were observed among all variables.

Path Analysis

A path analysis was conducted to examine the mediating role of experiential avoidance and psychological resilience, respectively, in the relationship between self-esteem and anxiety and depressive symptoms. The model fit indices were within the range of good fit to acceptable fit: χ^2= 11. 770, *df* = 4, χ^2/df = 2.942, *RMSEA* = 0.098 (90% CI: 0.040, 0.161), *SRMR* = 0.060, *GFI* =0.973, *CFI* = 0.929.

Table 2 presented the results of the path analysis. Self-esteem was directly linked to experiential avoidance, experiential avoidance was negatively associated with psychological resilience, and psychological resilience had a direct negative association with anxiety and depressive symptoms. Self-esteem was indirectly related to anxiety and depression through the serial mediation of experiential avoidance and psychological resilience. Notably, this mediation was full for anxiety but partial for depression (Table 2).

Sensitivity Analysis

The sensitivity analysis results are shown in Table 3. The sensitivity analysis confirmed the robustness of the indirect pathways, indicating that the mediating variables remained stable while the direct effects of self-esteem showed some variability. The direct relationship between self-esteem and anxiety was found to be non-stable and dependent on model assumptions- conditions. Path and sensitivity analyses support a full mediation effect, as the direct effect of self-esteem on anxiety remained statistically insignificant (p = 0.354) and did not yield a stable result under different assumptions. On the other hand, the direct effect of self-esteem on depression remained statistically significant (p = 0.002), but it showed slight fluctuations in the sensitivity analysis.

This supports the findings of partial mediation (rather than full mediation) in the relationship between self-esteem and depression. Notably, the indirect effects of self-esteem on anxiety and depressive symptoms—through experiential avoidance (β = -0.338, p<0.001) and psychological resilience (β = -0.415, p<0.001)—remained stable and demonstrated robustness across variations in model assumptions. This further confirms the mediating role of the relevant variables.

These findings indicate that self-esteem shows both direct and indirect associations with depressive symptoms, while its link to anxiety is entirely mediated by other factors.

Table 1. Descriptive statistics and correlations among study variables

Variables	GAD Group Mean±SD (n=90)	MDB Mean±SD (n=111)	Total Mean±SD (n=201)	1	2	3	4
1. SE	23.956±4.726	22.694±4.974	23.259±4.893	-			
2. EA	MDD Group	110.045±24.324	109.826±24.189	-0.338***	-		
3. PR	84.267±22.508	79.748±20.450	81.771±21.460	0.267***	-0.415***	-	
4. Anxiety	Total	23.657±6.787	27.099±8.589	-0.147*	0.302***	-0.337***	
5. Depression	24.577±6.459	33.333±10.401	29.413±9.855	-0.274***	0.225***	-0.355***	0.372**

N= 211. EA: Experiential Avoidance, GAD: Generalized Anxiety Disorder, MDD: Major Depressive Disorder, PR: Psychological Resilience, SD: Standard Deviation, SE: Self-esteem.
***p < .001, **p < .01, * p < .05

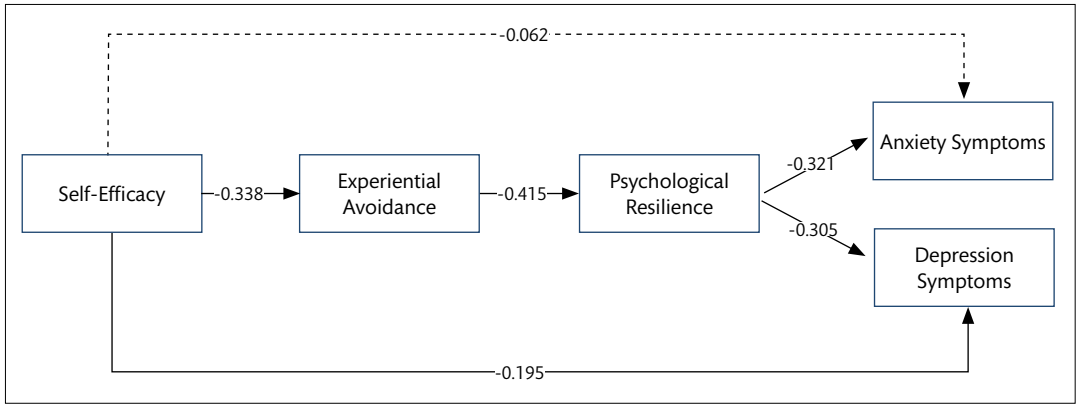

Figure 1. Mediation path analysis. Solid lines represent significant paths, while dashed lines indicate nonsignificant paths.

Table 2. The indirect effects of self-esteem on anxiety and depression through experiential avoidance and psychological resilience

Predictor	Outcome	B	β	SE	z	p
Self-Esteem	Experiential Avoidance	-1.669	-0.338	0.059	-5.700	<0.001
Experiential Avoidance	Psychological Resilience	-0.368	-0.415	0.056	-7.462	<0.001
Psychological Resilience	Anxiety symptoms	-0.128	-0.321	0.065	-4.978	<0.001
	Depression symptoms	-0.139	-0.305	0.072	-4.267	<0.001
Self-Esteem	Anxiety symptoms	-0.109	-0.062	0.067	-0.924	0.353
	Depression symptoms	-0.389	-0.195	0.083	-2.336	0.019

Table 3. Summary of sensitivity analysis

Path	Original Model (β)	P	Sensitivity Model (Mean β)	Min β	Max β
SE → EA	-0.338	<0.001	-0.345	-0.346	-0.337
EA → PR	-0.415	<0.001	-0.417	-0.418	-0.416
PR → Anxiety	-0.321	<0.001	-0.328	-0.329	-0.323
SE → Anxiety	-0.062	0.354	-0.038	-0.055	-0.037
PR → Depression	-0.305	<0.001	-0.300	-0.305	-0.300
SE → Depression	-0.195	0.02	-0.216	-0.217	-0.199

EA: Experiential Avoidance, PR: Psychological Resilience, SE: Self-esteem.

DISCUSSION

In this study, path analysis was conducted to examine the relationship between self-esteem, anxiety, and depressive symptoms through the mediating roles of experiential avoidance and psychological resilience in a randomly selected clinical sample. The findings indicate that psychological resilience and experiential avoidance partially mediate the relationship between self-esteem and depression. Additionally, a direct relationship between self-esteem and depressive symptoms was also observed in our analysis. A review of the literature suggests that low self-esteem is associated with increased symptoms of depression and anxiety (24). Individuals with low self-esteem are more likely to develop depression. The feelings of worthlessness and inadequacy experienced by individuals with depression may lead to distorted interpretations of life events, contributing to hopelessness. This, in turn, may reinforce negative self-perceptions related to worthlessness, failure, and inadequacy, further diminishing self-esteem. Such a reciprocal interaction may exacerbate the severity of depression. To support self-esteem, it may be effective to activate social support systems that help individuals enhance their sense of achievement and positive self-perception. Additionally, Cognitive-Behavioral Therapy (CBT), along with compassion-focused and acceptance-based psychotherapeutic interventions, may serve as beneficial strategies in promoting psychological resilience and reducing depressive symptoms.

In our study, an examination of the psychiatric treatment histories of individuals in the anxiety and depression patient groups revealed no significant differences between the two groups. Similarly, in a related study in the literature that investigated the impact of CBT on changes in anxiety and the role of experiential avoidance in this process, no significant differences were found in participants' psychiatric treatment histories within the study design (6).

The relationship between self-esteem and anxiety in our study was found to be fully mediated by experiential avoidance and psychological resilience. In anxiety disorders, a commonly employed strategy to alleviate anxiety is experiential avoidance, which involves avoiding distress through physical or cognitive means.

Contrary to the belief that experiential avoidance is beneficial, research has demonstrated that experiential avoidance exacerbates anxiety symptoms rather than alleviating them (25). Consistent with this evidence, our study found that self-esteem is indirectly related to anxiety and depressive symptoms through the sequential mediation of experiential avoidance and psychological resilience. A study examining the relationships between perfectionism, self-esteem, experiential avoidance, and depressive symptoms using structural equation modeling found that even after controlling for the effects of low self-esteem, experiential avoidance independently mediated the relationship between perfectionism and depressive symptoms (26). Similarly, in our study, self-esteem was directly associated with experiential avoidance, aligning with findings in the literature. Furthermore, self-esteem was indirectly related to anxiety and depressive symptoms through the sequential mediation of experiential avoidance and psychological resilience. Findings in the existing literature suggest that experiential avoidance is not primarily used as a direct strategy to regulate low self-esteem (26). However, contrary to this assertion, our study identified a linear relationship between self-esteem and engagement in experiential avoidance strategies. Research has shown that the chronic use of experiential avoidance is an ineffective coping mechanism in the long term and may even be potentially harmful, as it is associated with more severe depressive symptoms. These findings support the notion that "what we resist, persists", highlighting the paradoxical effects of avoidance-based coping strategies (27).

Experiential avoidance is a psychological process that refers to an individual's tendency to consciously suppress or avoid distressing thoughts, emotions, or memories (28). While this strategy may provide short-term relief from emotional discomfort, in the long term, it can weaken psychological flexibility and adaptive capacity, leading to negative mental health outcomes. In contrast, psychological resilience refers to an individual's ability to adapt, recover, and even grow in response to stress, trauma, or adverse life events (29). Research suggests

that experiential avoidance and psychological resilience are inversely related. Frequent reliance on experiential avoidance strategies may hinder an individual's ability to directly confront and process emotionally challenging experiences, thereby negatively affecting the development of psychological resilience. Our study also found that patients who engaged more frequently in experiential avoidance exhibited lower levels of psychological resilience. Furthermore, we identified a negative correlation between psychological resilience and levels of anxiety and depression. Individuals with higher psychological resilience are thought to reframe negative and stressful life events in a way that benefits them, turning these experiences into an advantage in both professional and personal life (30). Although some theories suggest that psychological resilience is an innate trait, others argue that it can be cultivated and strengthened over time through exposure to adversity. The ability to extract positive meaning from crises and integrate these experiences into one's personal growth may serve as a protective factor against depression (30). Individuals with high psychological resilience tend to accept rather than avoid challenging life events, enabling them to process and make sense of these experiences, thereby enhancing their adaptive capacity (29). In this context, acceptance- and mindfulness-based interventions are considered effective strategies for reducing reliance on experiential avoidance while simultaneously enhancing psychological resilience (30).

In conclusion, our study found that in the relationship between self-esteem, anxiety, and depression, experiential avoidance and psychological resilience serve as mediators, with the relationship between self-esteem and anxiety being fully mediated by these factors. This suggests that self-esteem does not directly influence anxiety symptoms but rather exerts its effects through experiential avoidance and psychological resilience. We propose that greater emphasis should be placed on intervention strategies aimed at enhancing self-esteem, as increased psychological resilience may lead to reduced reliance on experiential avoidance strategies, thereby indirectly contributing to the improvement of self-esteem. To gain a more comprehensive understanding of the mediating roles of these variables, further in-depth studies are needed. Such research would provide valuable insights into the mechanisms underlying the interplay between self-esteem, psychological resilience, and experiential avoidance, ultimately contributing to more effective clinical interventions.

This study has several limitations that should be acknowledged. First, the use of a cross-sectional design prevents causal interpretations regarding the relationships among self-esteem, experiential avoidance, psychological resilience, and symptom severity. Second, the reliance on self-report measures may introduce common method bias and social desirability effects. Third, the study sample was limited to patients diagnosed with GAD or MDD from a single clinical center, which may reduce the generalizability of the findings to broader or non-clinical populations. Additionally, the exclusion of individuals with psychotic features, neurological disorders, or cognitive impairments—although necessary for methodological rigor—may limit the applicability of the results to more complex clinical presentations. Lastly, the operational exclusion of the "distress endurance" subscale from the total experiential avoidance score, based on its divergent structure, may have influenced the comprehensiveness of the construct assessment. In our study, no significant differences were observed between the anxiety and depression groups in terms of years of education and employment status, suggesting that both groups were comparable in terms of socioeconomic background. Accordingly, the lack of variation in sociocultural level between the clinical groups limited our ability to examine the potential influence of socioeconomic status on self-esteem, experiential avoidance, and psychological resilience, representing another limitation of the present study.

Ethics Approval: Ethical approval was granted by the Scientific Research Ethics Committee of İzmir City Hospital on 13 March 2024, with decision number 2024/11.

Informed Consent: Participants were informed about the purpose of the study and their written consent was obtained.

Peer-review: Externally peer-reviewed.

Conflict of Interest: The authors declare that they have no competing interests.

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