TESTING THE CAREGIVER STRESS MODEL WITH THE PRIMARY CAREGIVERS OF SCHIZOPHRENIC PATIENTS

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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 Master of Science.

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ABSTRACT

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The aim of this study was to examine the relationship between the stressors of caregiving for a schizophrenic patient and related outcomes. The Caregiver Stress Model was used as the conceptual framework for the current study. The sample of the study was composed of 98 Turkish caregivers of schizophrenic patients who were treated at psychiatry clinics of hospitals in Ankara. Twelve mediation models were tested using marital satisfaction and social support as mediators. The models contained primary stressor (basic needs), secondary stressor (activities of living), and intrapsychic strain (parental efficacy) as independent variables; and depression and general psychological health as dependent variables. The results suggested both social support and marital satisfaction as significant mediators of the relationships of both primary and secondary stressors with the outcome variables; however, social support and marital satisfaction were not significant mediators of the relationships between parental efficacy and outcome variables. The significant implications and limitations of the study were also discussed.

Keywords: Caregiver stress model, schizophrenia, general psychological health, depression

ÖZ

ŞİZOFRENİ HASTALARININ BAKICILARINDA BAKICI STRES MODELİNİN TEST EDİLMESİ

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Bu çalışmanın amacı şizofreni hastalarının birincil bakıcılarında strese sebep olan faktörler ve bakıcıların tecrübe ettiği depresyon ve genel sağlık durumları arasındaki ilişkiyi incelemektir. Çalışmanın teorik çerçevesini Bakıcı Stres Modeli oluşturmaktadır. Örneklemi oluşturan 98 bakıcının hastaları, Ankara hastanelerinin çeşitli psikiyatrik kliniklerinde tedavi gören şizofreni hastalarıdır. Sosyal destek ve evlilik aracı değişkenler olmak üzere 12 aracılık modeli test edilmiştir. Strese sebep olan birincil faktörler (temel ihtiyaçlar) ve ikincil faktörler (günlük aktiviteleri yerine getirme ve ebeveyn olma yeterliliği) bağımsız değişkenler olarak; depresyon ve genel psikolojik sağlık ise bağımlı değişkenler olarak incelenmiştir. Elde edilen bulgulara göre, sosyal destek ve evlilik doyumu birincil ve ikincil faktörler ile depresyon ve sağlık sonuçları arasında anlamlı aracı değişkenlerdir. Bununla birlikte, ebeveyn olma yeterliliği ile depresyon ve genel psikolojik sağlık sonuçları arasındaki ilişkilerde, sosyal destek ve evlilik doyumunun anlamlı aracı değişkenler olmadıkları bulunmuştur. Son olarak ise, çalışmanın çıkarımları ve sınırlılıkları tartışılmıştır.

Anahtar Kelimeler: Bakıcı stres modeli, şizofreni, genel psikolojik sağlık, depresyon

To My Family and Özlem Bozo

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“Hoşgeldin rengârenk sanrım. Sanırım hiç vazgeçmeyeceksin. Ben de alışıyorum ve bağlanıyorum aslında sana. Seninle beraber gelen fısıltılara ve haykırışlara… Beynimin içinde olup bitenleri izlerken yaşa seslerini duyuyorum. Ben mi diyorum? Ben mi yaşamalıyım? Başımı duvara vurma isteğini gerçekleştirebilsem her şey sonlanacak. Kolay…
Küfretsem, çığlık atsam daha doğrusu yaşamın içine akıtsam kızgınlığımı… Yapamıyorum. Güler yüzlü olduğumu söyleyenler ve aklı başında olduğuma inanlar var. Onlarla beraber yaşayamadığımın farkındayım. Hoş geldin sanrım…” (From a part of her writings)

One day, I met a girl called Yasemin, a patient with schizophrenia. I was a student of last year at university. I was not a psychologist yet, and I was just one of the students working voluntarily at the association of the patients and caregivers. She changed my whole perception and my knowledge about schizophrenia. Besides, among all the people helped me in this thesis process, she was special. I’d like to express my special thanks to her.

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To my family: “Without you, I’m nothing.”

To Özlem Bozo: “Without you, this thesis would be never ended.”

To Başak Safrancı: “Without you, I would never be graduated.”

To Öznur Öncül: “you are the Master of Science!”

And lastly, I want to dedicate my thesis to all sufferers of the schizophrenia and their relatives. There is always more to do, though you think there is nothing left.

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CHAPTER I

INTRODUCTION

After the mid 1950s, impacts of living with a mentally ill family member have been begun to be investiged by the researchers (Clausen & Yarrow, 1955). Sainsbury and Grad (1962) introduced the term of “the family burden” after the growing trend of brief hospitalizations of the patients and shift to the community care (as cited in Saunders, 1999, p.95). In the 1970s, the movement of de-institutionalization of the mentally ill patients was accepted by developed countries also, and family-based caring approach was recognized instead of hospital care. According to the declaration of National Board of Welfare (1999), community–based care, which was supported by the family environment, normalizes the patients’ world. This social policy was generally accepted and contributed to the movement of de-instutualization of the mentally ill patients all over the world (as cited in Pejlert, 2001, p.194).

Schizophrenia is a chronic, severe mental illness that is characterized by positive and negative symptoms. Positive symptoms are delusions, hallucinations, disorganized speech, grossly disorganized, and catatonic behavior; and negative symptoms are lack of pleasure in daily life, lack of ability to start and sustain planned activities. Moreover, schizophrenia is a disorder that includes social and occupational impairment, and also patients of which must have duration of this disturbance at least six months with at least one month of active phase. Life time prevalence of schizophrenia is about 1% (DSM-IV-TR, 2000). According to Hatfield (1990), there was a mentally ill patient in one out of four families (as cited in Saunders, 1999, p.96). According to National Institute of Mental Health, more than 48 million Americans in a year suffered from various mental disorders (1993). More specifically, according to National Alliance for the Mentally Ill (2007) over 2 million Americans suffered from schizophrenia. Although there is relatively less research on schizophrenia and its prevalence in Turkey, Doğan et al. (1995) found the prevalence of schizophrenia as 0.5% (as cited in Arıhan, 1998, p.72). Arslantaş and Adana asserted that there are 29 millions schizophrenic patients all over the world and at least 20 millions of these patients lived in developing countries. In Turkey, there are approximately 700.000 people having the diagnosis of schizophrenia and other psychotic disorders, which imply that there are at least 700.000 family members that are affected by these mental disorders (2011). Although it was asserted that caregivers of patients with schizophrenia seen as the key element of the treatment process, their needs have been studied by researchers rarely (Lefley & Johnson, 1990).

As mentioned above, schizophrenia, a chronic and severe mental disorder, creates psychological stress not only in patients themselves but also in their caregivers and other family members. Plentiful studies have illustrated that family functioning, and all family relationships and roles are affected by a patient with severe mental illness, and this led to inevitable changes in finances, employment, social life, physical health, marital and family relationships, and daily household activities (Marsh, 1992). Physical and emotional problems, restrictions in social life, tense relationships in the household were also reported by caregivers as common negative consequences of having a schizophrenia patient in the family (Provencher, 1996).

1.1. Caregiver Burden and Comparative Studies

1.1.1. Caregiver burden

There were abundant studies that investigated the effect of being a caregiver of schizophrenia patient. The most widespread definition and classification of burden was introduced by Hoenig and Hamilton (1966). According to these researchers two kinds of burden exist: objective and subjective. The objective burden was defined as practical and observable problems such as financial difficulties, disruptions in leisure and work activities. The subjective burden was defined as psychological reactions such as depression, anxiety, and feeling of loss.

There are lots of studies that investigated the subjective and objective burden in the literature. Nevertheless, Braitwaite (1992) asserted that using the term burden as an outcome measure of caring process is misleading since the burden is composed of both subjective and objective qualities and there is no distinct lines between them (as cited in Argimon, Limon, Vila, & Cabezas, 2004, p. 454).

The study demonstrated how caregiver burden affected and was affected by the caregivers of schizophrenic patients. The burden of caregiving was found even at the first episode of the illness; caregivers had psychological stress and had to cope with the relatives' problems, because negative symptoms and behavioral problems of the patients were important stressors (Tennakoon et al, 2000). Furthermore, parental caregiving was perceived as continuous, endless effort; therefore, grief, chronic sorrow and constant worry were experienced by these caregivers (Pejlert, 2001). The sense of grief was mentioned in other studies, too. Loss of idealized child, loss of future plans, and change of the healthy child to a disadvantaged child led parents to experience grief (Tuck, Mont, Evans, & Shupe, 1997). Moreover, the caregivers were worried about the future of their patients especially about the time they would no longer be able to help them and these concerns led to increments in the caregiver burden (Foldemo, Gullberg, & Ek, 2005).

As mentioned before, not only primary caregivers of the schizophrenic patients were affected from caring process, but also all family units were affected negatively from having a mentally ill patient at home. For instance, adolescences were also affected negatively due to having a mentally ill member at home, even more if the mentally ill family members are parents and siblings. Moreover, Valiakalayil, Paulson, and Tibbo showed that adolescents had difficulties about dealing with positive and negative symptoms of schizophrenia if they were uninformed about the illness, and if they had to cope with additional household activities (2004).

Besides, Karla, Nischal, Trivedi, Dalal, and Sinha (2009) found that siblings experienced more burden as compared to spouses of the patients of schizophrenia. For siblings, it was demonstrated that negative symptoms, the probability of the violent behavior of patients, fear of abuse, and social isolation of the patient were sources of psychological stress (Friedrich, Lively, & Buckwalter, 1999). On the contrary, Rammohan, Rao, and Subbakrishna, showed that spouses encountered greater burden than parents and siblings (2002). It was stated that while objective burden was equally experienced by spouses and parents, spouses experienced more emotional burden (Rammohan, Rao, & Subbakrishna, 2002).

To understand the experiences of caregivers better, the researchers did also comparative studies.

1.1.2. Comparative Studies

There were several studies which compared the burdens of schizophrenia and physical/mental disorders to caregivers. Chakrabarti, Raj, Kulhara, Avasthi, and Verma did a study with 78 caregivers of affective disorders (bipolar-manic, bipolar depressed, major depression) and 60 caregivers of schizophrenic patients and they showed that overall burden was significantly higher in caregivers of schizophrenia patients than caregivers of affective disorders (1995). More interestingly, Pariento and Carpiniello did a comparative research and demonstrated that caregivers of schizophrenia have relatively more burden than caregivers of mental retardation (1996).

The comparative study of the burden of caregivers of patients with schizophrenia and end stage renal disease (ESDR) patients as a physical disorder showed that although the members of two groups had similar economic burden, caregivers of schizophrenia patients had more objective and subjective burden than caregivers of ESDR patients (Afgheh, Ardeshirzadeh, Firouzeh, Mahmoudrad, &

Sadeghinezhad, 2008). Magliano and et al. did another comparative study and investigated the difference between physical disorders namely, lung, brain, kidney, heart diseases, diabetes and schizophrenia in terms of long term family burden (2005). It was found that caregivers in all categories reported restrains in social activities, negative impacts on the entire family, and a sense of loss. Moreover, while the caregivers of the patients with brain diseases reported higher levels of objective burden than other groups, subjective burden was stated as higher by the caregivers of schizophrenia and brain disease patients.

These studies showed that caring for a schizophrenia patient was more burdensome than caring for a patient with other disorders. Besides these comparative studies, there are also studies to understand and explain the predictors of the burden more deeply.

There are many studies that established age, gender, education level, socioeconomic status of the caregiver, the duration of caregiving, current behavioral problems, symptom severity, number of people living at home, number of caregivers, number of the other people the caregiver takes care except for the ill person as the predictors of burden. The following paragraphs will present the findings on the predictors of caregiver burden.

1.2. Sociodemographic Variables and Their Effects on Caregiver Burden

It was illustrated that women/mothers are more likely to be the primary caregivers of schizophrenic patients (Kuipers, 1993), and women caregivers experience higher levels of psychological distress, even though patient is at the first episode of schizophrenia (Tennakoon et al., 2000).

Fathers are also affected by the burden of having a schizophrenic child negatively. Wiens and Daniluk illustrated that fathers reported self-blame and guilt. Furthermore, because of not being able to access help for their children and their concerns about possible genetic links in the development of the disorder provoked the frustration in these fathers related to their self-blame and guilt (2009).

Marital status of the caregiver was also effectual on caregiver burden; seperated/divorced caregivers reported more financial strains and difficulties in caring their mentally ill patients compare to married caregivers (Ohaeri, 2001).

Age of the caregivers is also effective on the caregiver burden. Lefley demonstrated that older parents experienced burden more because of their worry about death and the ambiguous future of their mentally ill children (1987). On the contrary, Reinhard and Horwitz demonstrated that younger parents showed more burden when the symptom severity of the cared patients were high and needed more emotional and active assistance (1995).

Gender of the patient is another predictor of caregiver burden. Male patients caused more objective family burden in the areas of daily life than female patients; and as the patients' age gets older, higher levels of family burden was experienced (Ochoa et al., 2008). Likewise, Schumacher, Dodd, and Paul (1993) demonstrated that caregivers of male patients described higher levels of strain and got lower scores on life quality scale (cited in Lim & Zebrack, 2004, p.52).

The caregivers who are unemployed and having low educational level reported significantly more burden (Caqueo-Urizar & Gutierrez-Maldonado, 2006). It was asserted that employment of the caregivers led to day-off and created relief for them although it was a limited time in a day (Maldonado, Caqueo-Urizar, & Kavanagh, 2005). Moreover, employed caregivers had lower financial strains compared to unemployed caregivers (Ohaeri, 2001).

The duration of caregiving and the number of hours spent with the patient are also important. Number of contact was found as a strong predictor for caregiving burden (Schene, Wijngaarden, & Koeter, 1998). Furthermore, Roick, Heider, Toumi, and Angermeyer (2006) found that co residence with schizophrenic patients and the longer amount of time spent with the patients reasoned more burden (as cited in Parabiaghi, & et. al, 2007). As a contradictory finding, it was asserted that co residence does not affect the distress levels of caregivers (Reinhard & Horwitz, 1995; LaidLaw, Coverdale, Falloon, & Kydd, 2002). However, it was known that the caregivers whose patients had more serious symptoms and needed more help reported significantly more burden (Reinhard & Horwitz, 1995). This result demonstrated that the amount of caregiving responsibilities and the number of the patients' needs determined the level of burden regardless of whether the patient lives together with the caregiver or not.

Besides the factors mentioned above, current behavioral symptoms of the patient and symptom severity are also important factors in predicting caregiver burden. Saunders (1999) did a study with 58 caregivers of schizophrenic patients and found that positive and negative symptoms are the best predictors of family functioning and psychological distress of a caregiver. Similarly, Jungbauer, Mory and Angermeyer did a study with 51 parents and 52 spouses of patients of schizophrenia and illustrated that the severity of current behavioral problems is significant in predicting caregivers' future psychosomatic complaints (2002). Moreover, unpredictability, violence, and bizarre ideas in the acute phase of the illness were found to be correlated with caregiver distress (Gibbons, Horn, Powell, & Gibbons, 1984). Karla, Nischal, Trivedi, Dalal, and Sinha did also find similar results; overall family burden is correlated with patients functioning level and and severity of the illness positively (2009).

As compared to normal population, schizophrenia patients were found to be more likely to have medical comorbidity, such as hypothyroidism, chronic obstructive pulmonary disease, diabetes with complications, hepatitis C, fluid/electrolyte disorder (Carney, Jones, & Woolson, 2006) and disorders related to nicotine dependence (Brown, Inskip, & Barraclough, 2009). In a similar way, Dixon, Postrado, Delahanty, Fischer and Lehman did a study with 719 patients with schizophrenia to investigate the prevalence of medical comorbities of schizophrenia patients. It was found that at least one medical condition was stated by majority of schizophrenic patients related to problems of sight, teeth, and high blood pressure (1999).

Moreover, these physical problems were found to be negatively related to perceived physical status, psychosis, depression, and suicide attempt (Dixon, Postrado, Delahanty, Fischer, & Lehman, 1999). It was found that psychosis was worsened and negatively affected by medical comorbidity (Hall, Gardner, Popkin, Lecann, & Stickney, 1981). That is, medical comorbidities seem to increase the caregiver burden.

Besides sociodemographic variables, caregiver health, efficacy and mastery over the situation, social support, and marital satisfaction have also been important variables in caregiver studies.

1.3. Other Predictors of Caregiver Burden and the Outcome Variables

Grandon, Jenaro and Lemos did a study to examine the predictor variables of burden in caregivers of schizophrenic patients and they demonstrated that higher rates of relapses, positive symptoms' severity, level of dependence to the caregivers, lower sense of control related to patient, social strains, and less emotional support are predictors of burden in caregivers of schizophrenia (2008). In their cross-sectional study, Chien, Chan, and Morrissey examined 203 caregivers of schizophrenic patients in China, and they demonstrated that worse health status, less satisfaction with social support, older age, lower financial status, and the number of family members living with the patient are the factors that are significantly associated with the burden of the caregivers (2007).

Moreover, a positive correlation between the number of patient's needs and the levels of family burden in daily life activities, disrupted behavior, and disruptions in caregiver's daily routine was indicated by Ochoa et al. (2008). The study of Ochoa and colleagues with 196 caregivers of schizophrenia demonstrated that the amount of needs of the patients such as daytime activities, poorer self-care, and presence need in food lead to higher levels of caregiver burden. In the same way, Grafström, Fratiglioni, and Winblad illustrated that longer duration of the illness and decreased activities of daily life capacities of the caregivers were the primary stressors of greater burden of caregivers (1994). Caregivers reported inactivity, slowness, lack of personal hygiene and doing household tasks as the most burdensome sides of schizophrenic patients (Gopinath & Chaturvedi, 1992). Veltro, Magliano, Lobrace , Morosini, and Maj (1994) stated that schizophrenic patient's functional decline and dependence, which is consistent over time, were assumed as most stressful aspect of caring (as cited in Tang, Leung, & Lam, 2008, p.724). In another study, Jones, Roth, and Jones showed that caregivers reported more burden related to their day-to-day tasks than patients' problematic behaviors (1995). The caregivers whose children were hospitalized for longer periods, and who reported higher number of patients' unmet needs experienced more burden (Cook, Heller, & Pickett-Schenk, 1999). Parabiaghi et al. (2007) obtained similar results; lower patient's symptomatology, lower number of needs of patients in daily life, and higher functioning of patients and patients' better life quality were associated to lower levels of overall burden of caregivers.

1.3.1. Parental Efficacy

Bandura introduced the concept of self efficacy, which refers to the belief in one's capabilities to perform a serial of actions to achieve a goal (1977). The term of parental efficacy as a different form of Bandura's self efficacy is defined as the parental belief that they are able to influence and control the environment in which their child grows (Shumow & Lomax, 2002). According to Bandura, the expectation about one’s own efficacy determines how much effort people spend and how long they hold on in the face of difficulties and unpleasant experiences (1977). Moreover, Bandura asserted that parental efficacy has influence on both parent and child, on the emotional adjustment between them, and also on child behavioral problems (1997).

Mastery, which involves a sense of control and efficacy over the situation, was found to be associated with mental functioning and burden of the caregivers (Bibou-Nakou, Dikaiou, & Bairactaris, 1997). According to Noh and Turner (1987), personal resources, mastery, and self efficacy are the factors that are negatively correlated with a family member’s ability to handle the distress related to caregiving role. Moreover, Halpern and McLean (1997) demonstrated that parental efficacy has a negative relationship with maternal depression; and mothers who had lower levels of parental efficacy beliefs reported higher levels of distress than mothers who had higher parental efficacy beliefs. In a similar vein, a negative correlation between parental efficacy and maternal depression was found by Neil, Wilson, Shaw, and Dishion (2009). In terms of caregiver burden, Solomon and Draine (1995) showed that higher scores on general measures of coping, especially on self-efficacy and mastery over problems scale, were found to be significantly associated to lower levels of subjective burden in families with mentally ill member (cited in Saunders, 2003, p.179). Moreover, it was shown that mastery over the continuing situation of the ill relative mediated the relationship between stress and burden (Noh & Turner, 1987).

Even though the term of parental efficacy was generally used for parents and their infants or adolescent children in the literature, to the researcher’ knowledge, this was the first time to use this term for parents of older children. In the current study, it was aimed to investigate the possible association between parental efficacy and depressive symptoms/general psychological health of the caregivers; and the mediator role of social support and marital satisfaction in these relationships.

1.3.2. Social Support

The concept "social support" has been defined differently in the literature by different researchers, and there have been different approaches to define this term. Nevertheless, there was a common point that the support had to be beneficial for the receiver, and led to good outcome (Hammer, 1981). That is to say, besides all the variables that increased caregiver burden and stress, social support seems to be a positive factor.

It was illustrated that appropriate support from the other family members had positive impact on caregiver's psychological irritation and emotional upset. Social support did also lead to the lower levels of burden of caregivers (Winefield & Harvey, 1993). Magliano et al. did a study with 709 caregivers of schizophrenic patients. The results showed that professional support and support from social networks had a positive impact on burden of these families (2002).

Moreover, Song, Biegel, and Milligan found that the possibility of having depressive symptomatology is low if they had higher family and agency support. Also, overall social support was found to be the best predictor of the depressive symptomatology of the caregivers of schizophrenic patients in this study (1997). Similarly, Schulz and Williamson illustrated that there is a negative relationship between the same variables, which was maintained for a long time (1991). Moreover, Schumacher, Dodd, and Paul (1993) asserted that depression of the caregivers was predicted by the social support they received (cited in Lim & Zebrack, 2004, p.55). Furthermore, current behavioral problems, lower levels of social support from other family members and health professionals led to more depressive symptoms and burden in caregivers (Song, Biegel, & Milligan, 1997). Struening et al. (1995) found that support networks and quality of the relationships with health professionals were negatively related with depressive symptoms (cited in Song, Biegel, & Milligan, 1997). As mentioned before, Chien, Chan, and Morrissey (2007) did a study examining the effects of sociodemographic variables and social support on caregiver burden; and found that social support is the best predictor of it (2007).

Since the frequency of unmarried or divorced schizophrenic patients is high, caring for schizophrenic patients is more likely to be a responsibility of parents and siblings (Karla, Nischal, Trivedi, Dalal, & Sinha, 2009). Relatedly, it was found that social support provided from the siblings is also important when the parental availability ended; the brothers and sisters had to take the responsibility of their ill brothers or sisters. Even in the presence of parents, spouses, or several siblings, the amount of support provision by siblings decreases (Horwitz, 1993).

Social support was appraised as function of a set of social interactions by some researchers and was constituted by “the social network” (Hammer, 1981). Potasnzik and Nelson found that the caregivers’ of relatives with mentally ill stated lower levels of burden when their social networks are small and dense, and when their satisfaction with their network is high (1984). Furthermore, the size of social support network and satisfaction with social support network were found to be positively correlated with life satisfaction and health of the caregivers (Haley et al., 1987).

Being a member of a support group was also influential on the burden and depression of caregivers. Choua, Liub, and Chuc found lower levels of burden and depressive symptoms among the caregivers of schizophrenic patients who attend to a support group as compared to control groups at one month follow up (2002). Furthermore, receiving inadequate support from mental health professionals created suffer for the caregivers of family members with severe mental illness (Saunders, 2003). In Cook, Heller, and Pickett-Schenk (1999) study, it was found that the caregivers whose children were hospitilazed for longer periods, and who reported higher number of patients' unmet needs experienced more burden and depressive feelings. However, among these caregivers who had participated in support groups, the burden was found to be significantly lower as compared to their counterparts who did not attend to a support group

Social support seems to be an important factor in predicting burden of the caregivers of patients with schizophrenia, and in the current study it was examined as a mediator between the stressors and outcome variables.

1.3.3. Marital satisfaction

According to Burgess and Locke (1945, p. 439) marital "satisfaction appears to be a resultant of the correspondence between the actual and the expected or a comparison of the actual relationship with the alternative, if the present relationships were terminated." (as cited in Rollins & Cannon, 1974, p.271). It was well documented that marital satisfaction and adjustment are affected by the burden of caregiving a mentally ill member of the family. In a study, marital satisfaction of 131 parents of adult offspring with severe mental illness was examined and it was found that the participants experience psychological distress and reduced marital quality (Cook, Hoffschmidt, Cohler, & Pickett, 1992). In another study, in 27 Canadian parents of schizophrenic patients, living at the same home with their schizophrenic children, decrement in the quality and intimacy in their relationship with their partners was observed (Klinck & Waring, 1988). In some studies, dyadic adjustment was used interchangeably with marital satisfaction. Dyadic adjustment was lower in the couples who had schizophrenic child and these couples reported low consensus and cohesion in their relationship as compared to control group (Espina, Ortego, Alda, & Gonzalez, 2003). Moreover, Potasnzik and Nelson showed that if spouses involved in caring of the patients, burden was relatively lower for the other spouse, the primary caregiver (1984).

Marital adjustment or satisfaction is also an important factor for spouse caregivers of schizophrenic patients. Angermeyer did a study with 45 spouses of schizophrenic patients, 49 spouses of depressive patients, and 39 spouses of patients with anxiety disorders, and surprisingly found that, the reported life quality by spouses of schizophrenic patients did not vary from that of spouses of depressive or anxious patients. However, the quality of life of the spouses especially in the psychological well-being and social relationship areas was lower than the normal population; the functional state of the patients determined the life quality of spouses

(2006). Moreover, Beach, Winters, and Weintraub did a study with 145 married couples that was consisted of 37 depressive, 37 bipolar, 21 schizophrenic patients, and 49 people as control participants. It was shown that all groups showed decline in marital adjustment scores, and the divorce rate was increased among three disorder groups compared to control group between first and after 3 years measurements (1986). Similarly, taking all responsibility of the household, decreased sexual relations, and decreased overall quality of the marital relationships caused more burden of spouses of the patients (Rammohan, Rao, & Subbakrishna, 2002). These findings demonstrated that marital satisfaction of caregivers is influential on their burden; the presence of high marital satisfaction is protective for caregivers. Although the predictors mentioned above were examined separately, in the literature there are also theoretical models that try to explore and explain the relationships between distress created by the caregiving process and the related outcomes.

1.3.4. Caregiver Health

Caregiving process does also have negative impact on psychological health of the caregivers. It was well documented that the level of burden was found to be associated with health problems among the caregivers of people with schizophrenia. High level of burden led to low levels of well-being and general health perception of primary caregivers of schizophrenia over time (Maldonado, Urízar, & Kavanagh, 2005).

The prevalence of psychiatric disorders such as depression and anxiety was twice higher in caregivers of schizophrenic patients, and also physical illness and disability had higher prevalence rates as compared to non caregivers (Cochrane, Goering, & Rogers, 1997). In another research done with 200 caregivers of the patients of schizoaffective, schizophrenia, and bipolar disorder patients showed that % 35 of the caregivers reported symptoms of various mental illnesses (Hosseini, Sheylhmounesi, & Shahmohammadi, 2010). Similarly, LaidLaw, Coverdale, Falloon, and Kydd (2002) showed that likelihood of having a mental disorder was more than 25 %. For example, caregiver workload was positively associated with anxiety of the caregiver (Winslow, 1997). Moreover, the lower scores of activities of daily living were found to be correlated with higher depression scores of caregivers (Haley, Levine, Brown, & Bartolucci, 1987).

In some studies, gender differences were observed in terms of depression, which is also an outcome measure in the current study. Schulz and Williamson (1991) demonstrated that male caregivers reported lower depressive symptoms than female caregivers (as cited in Song, Biegel, & Milligan, 1997, p. 272). As a contradictory finding, Jones and Peter (1992) asserted that there were no gender differences in caregiver depression (as cited in Song, Biegel, & Milligan, 1997, p. 272). However, it was found that perception of health was found to be lower among female caregivers (Maldonado, Urizar, & Kavanagh, 2005). Mothers reported lower scores than fathers in terms of functional state, well-being, and general health (Maldonado, Urizar, & Kavanagh, 2005). Psychological well-being of the caregivers was found to be associated with stigma, other problems within the family, dependency and behavioral symptoms of the patients, and perception of loss (Martens & Addington, 2001).

Sisk (2000) found a negative association between health promoting behaviors and perceived burden of caregivers. The rate of health related activities was lower for the caregivers who had more burden. Consequently, it was asserted that these problems led to increments in the use of health services among these caregivers, (Cochrane, Goering, & Rogers, 1997). Similarly, Potasznik and Nelson stated that some caregivers of schizophrenic patients have to seek psychiatric help for them to deal with the guilt, perpetual worry, strained marital and family relationships, insomnia, fatigue, and depression; and most of them use psychiatric medications (1984). To sum up, the literature indicated that the caregivers of schizophrenia patients experience more physical and psychological health problems nas compared to control groups.

1.4. Caregiver Studies in Turkey

There are few studies on the Turkish caregivers (e.g. Karancı, 1995; Karlıkaya, Yükse, Varlibaş, & Tireli, 2005; Yeşilbalkan & Okgün, 2009; Demirtepe-Saygılı & Bozo, 2011), to our knowledge, the only study on the caregivers of schizophrenia patients in Turkish psychology literature was conducted by Karancı (1995). In her study, she reported that the caregivers experience limitations in social life, tension and conflict in family relationships, feelings of grief, and worry about future of the patients, financial costs, and negative effects of the longer duration of illness.

1.5. Caregiver Stress Models

In the literature, there are four main models that try to explain caregiver stress They are the Family Stress Theory (McCubbin & McCubbin, 1993), Transactional Stress Model (Lazarus & Folkman, 1984), The Resource Deterioration Model (Ensel & Lin, 1991), and Caregiving Stress Model (Pearlin, Mullan, Semple, & Skaff, 1990).

In their Family Stress Theory (1989), McCubbin and McCubbin suggested that during transitions and changes, families have power and competence to improve the growth of the members of family and to prevent the family from critical disruption and destruction (as cited in Saunders, 1999, p. 97) The second model, Resource Deterioration Model (Ensel & Lin, 1991), presumes that stressors and outcomes are mediated by coping and support resources. According to this model, when a vulnerable group is exposed to a stressor, the stressor increases the distress by reducing the level of inadequate coping and support both directly and indirectly. The third model, the Transactional stress model (Folkman & Lazarus, 1984), suggested that the interaction between demands of situation and individual's coping capacity determines the level of stress. The last model, the Caregiver Stress model (Pearlin et al., 1990) including the interaction of stressors and mediators, will be explained in the following section in detail.

1.5.1. The Caregiver Stress Model

The Caregiver Stress Model was developed by Pearlin, Mullan, Semple, and Skaff in 1990. The caregivers of a family member with a chronic illness were examined by the combination of both positive and negative factors in this model (see Figure 1). The model views the caregiver stress as a result of a process that comprises a number of interrelated conditions, involving the socioeconomic characteristics, resources of caregivers, and the primary and secondary stressors they are faced with (Pearlin, Mullan, Semple, & Skaff, 1990). In this model, four main domains are mentioned: The background and context of stress, the stressors, stress mediators, and the outcomes. Primary stressors (the problems and difficulties experienced directly in caregiving, daily needs), the secondary stressors (the strains of role and activities outside of caregiving, and intrapsychic strains such as diminishment of self concept), the socioeconomic characteristics and resources of caregivers, and also stress mediators (coping and social support) are all taken into account in the model.

Primary stressors are related to the caregiving tasks and the daily needs. The secondary stressors are role strains and intrapsychic strains. While role strains involve difficulties in other tasks independent from caregiving like employment and social needs; intrapsychic strains are about the self concept. Self concept involves self-esteem and mastery, loss of self, role captivity, competence, and gains. Moreover, it is presumed that the relationship between intrapsychic strain and primary and secondary stressors is bidirectional.

Intrapsychic strains are come up from primary and secondary stressors and their effects on both the primary and secondary stressors.

Coping and social support are accepted as mediators between stressors and outcome variables; and it is presumed that the effect of them diminishes their relationship or extinguishes it completely.

Eventually, outcome variables of these stressors are physical and psychological well-being of the caregivers, which is compromised by the relationship of all the variables (Pearlin et al., 1990).

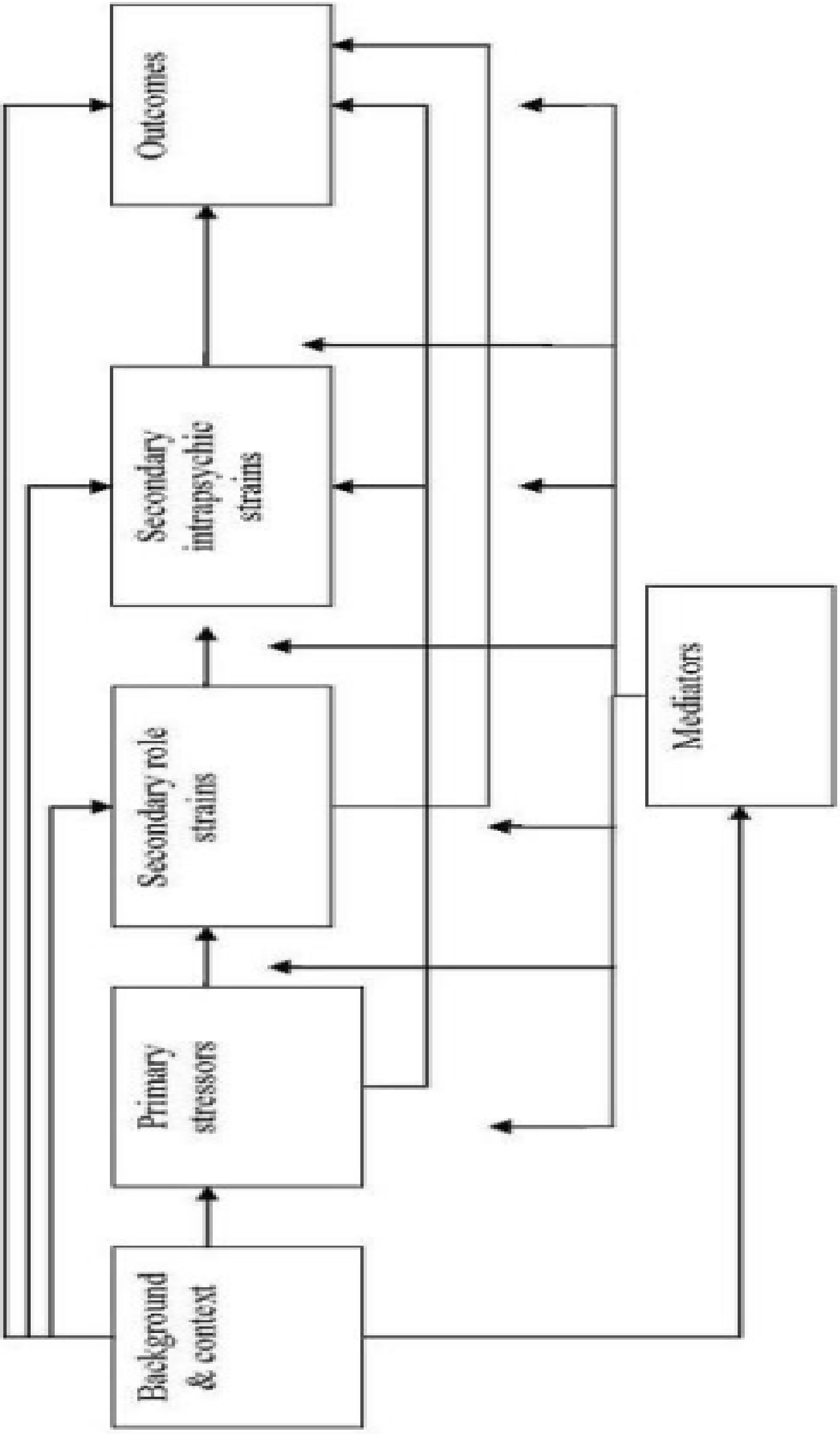


Figure 1. Caregiver Stress Model

Source: Pearlin et al, 1990

After the National Consensus Develeopment Conference in 2006, the Family Caregiver Alliance printed a report that supports the Caregiver Stress Model and its efficacy in explaining the variables related to caregiving process and suggests the Pearlin model as valuable tool for both practice and research (as cited in Hilgeman, et al., 2009, p. 248).

The original work of Caregiver Stress Model (Pearlin et al., 1990) was evolved from the studies on caregivers of Alzheimer patients. Furthermore, it was well documented that the model was applicable to the caregivers of other samples, such as dementia (Colin & Reid, 2002), leukemia (Demirtepe-Saygılı & Bozo, 2011), and frail elderly veterans (Dofman, Holmes, & Berlin, 1996). The model was also proved to be applicaple in other cultures. Lee, Kim, and Kim (2006) tested the model with some extensions and found comparable results to the studies in the American culture. Moreover, the model was tested in Turkish caregivers of children with leukemia, and it was found that the satisfaction level of the basic needs and role strain were the predictors of the depressive symptoms in Turkish caregivers (Demirtepe-Saygılı & Bozo, 2011). Thus, the caregiver stress model (Pearlin et al., 1990) was found to be valid for Turkish culture, too.

1.5.2. The Extensions and Omissions of the Original Model

Understanding and finding possible solutions for caregivers have been the most important aim of the caregiver studies, and the Caregiver Stress Model was thought to be useful in reaching these aims. The Caregiver Stress Model was used in caregivers of schizophrenia for the first time. The original work of Caregiver Stress Model (Pearlin et al., 1990) was evolved of the studies on caregivers of Alzheimer patients. The current sample was different from the sample of the original model. Therefore, it was essential to make some extensions and omissions in the model. For instance, since marital satisfaction has been an important variable in studies on the caregivers of patients with schizophrenia, it was added to the current study.

The primary stressors were basic needs, and the secondary stressors were role strains, which are the activities of living of the caregiver herself/himself. Parental efficacy was included in current study as intrapsychic strains. The mediators were social support and marital satisfaction, instead of coping. And lastly, depression and general psychological health were the outcome variables. The models tested in current study were shown in Figure 2a and Figure 2b.

1.6. Aims of the Current Study

Within the framework of The Caregiver Stress Model (Pearlin et al., 1990) and in the light of the studies mentioned above, the aim of the current study was to investigate the relationships among dissatisfaction with day-time activities (basic needs), daily routines (activities of living), and perceived parental efficacy (intrapsychic strain) of primary caregivers' of schizophrenic patients and their depressive symptomatology and general health by controlling for the effects of gender, time since diagnosis, current client behavioral problems, and caregivers' reported socioeconomic status; and the mediator role of social support and marital satisfaction in these relationships. Accordingly, twelve mediation models, including marital satisfaction and social support as mediators, were tested separately. The hypotheses of the current are mentioned below.

The hypotheses regarding the first model are, (1) the primary caregivers of schizophrenic patients who are dissatisfied with their basic needs would show higher level of depressive symptomatology; (2) the primary caregivers of schizophrenic patients, who can carry out their daily routines, would show less depressive symptomatology; and (3) the primary caregivers of schizophrenic patients, who have higher level of perceived parental efficacy, would have lower level of depressive symptomatology; and (4) all three relationships would be mediated by (a) perceived social support and (b) marital satisfaction of these caregivers.

The hypotheses regarding the second model are, (1) the primary caregivers of schizophrenic patients who are dissatisfied with their basic needs would have worse general psychological health than those who are not; (2) the primary caregivers of schizophrenic patients, who can carry out daily routines, would have better general psychological health than who cannot; (3) the primary caregivers of schizophrenic patients who have higher level of perceived parental efficacy would have better general psychological health than who does not, and 4) all three relationships will be mediated by (a) perceived social support and (b) marital satisfaction of these caregivers.

The hypothesized mediation models of the current study can be seen in Figure 2a and Figure 2b.

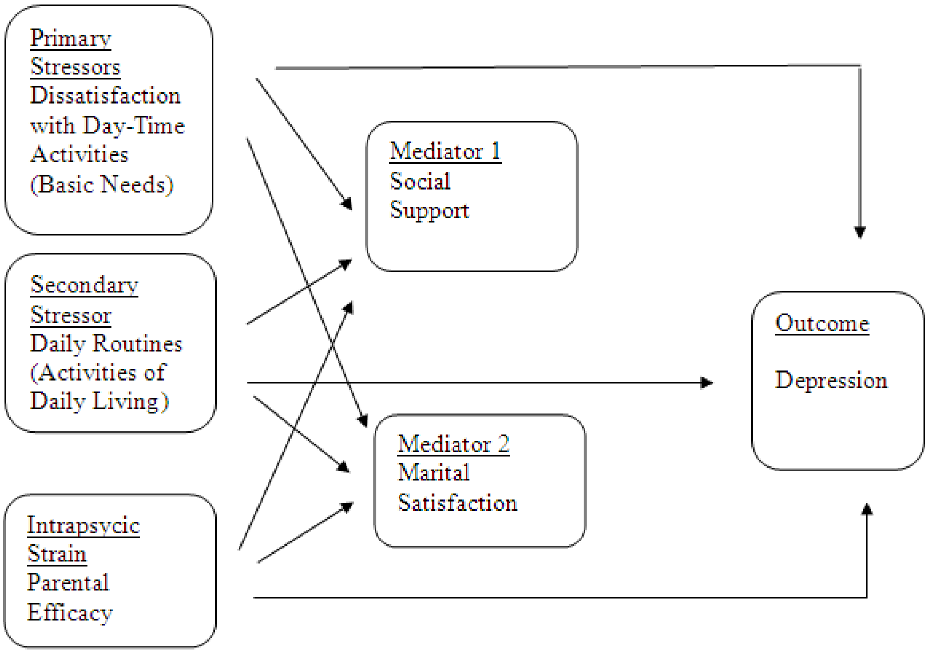


Figure 2a. The Mediation Model for Depression

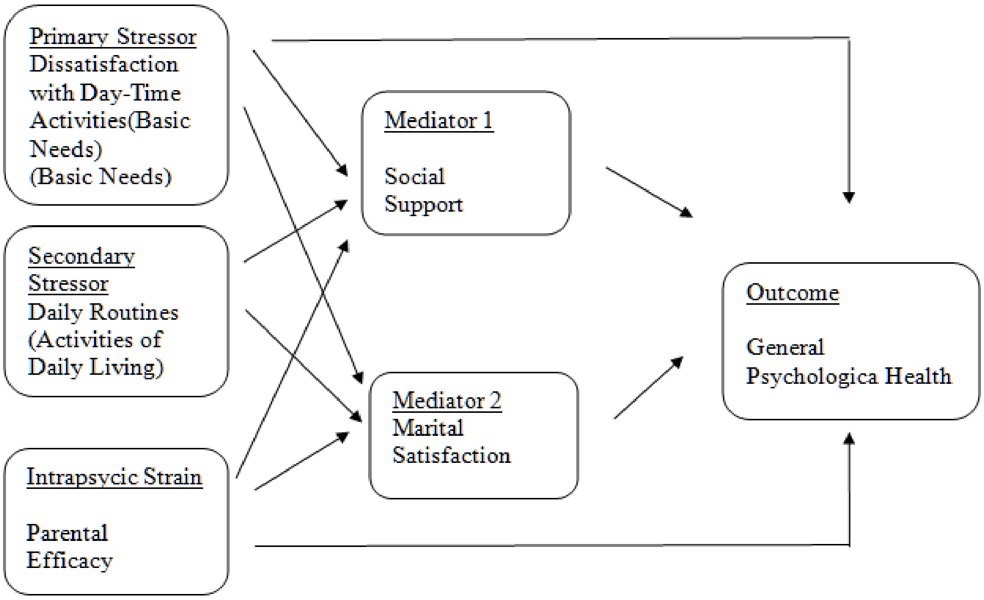


Figure 2b. The Mediation Model for General Psychological Health

CHAPTER II

METHOD

2.1. Participants

The present study was conducted with 98 caregivers of schizophrenia patients who were being followed at Ankara Üniversitesi Tıp Fakültesi, Şizofreni Yakınları ve Dayanışma Derneği, or other clinics in Ankara. There were several inclusion criteria. The patient that is given care by the participants need to a) have a primary diagnosis of schizophrenia according to DSM-IV criteria, b) be diagnosed with schizophrenia for at least 1 year, and c) live with his/her caregiver for at least 1 year.

The age of the participants ranged between 34 and 74 with a mean of 53.5 (SD = 9.17). Mothers made up of 46.9 % of the sample (n = 46), and the rest of the participants were fathers (n = 31), sisters (n = 13), and close relatives (n = 8). Perceived family income was categorized into three as lower, middle, and upper. People who defined themselves as belonging to middle income group constituted 90.8 % (n = 89) of the sample; and the remaining participants perceived themselves as a member of either lower income group (6.1 %, n = 6) or upper income group (3.1 %, n = 3). Education levels of the participants were as follows: 38.8 % primary school (n = 38), 32.7 % high school (n = 32), and 28.6 % university and above (n = 28). The participants who did not have a job currently consisted 30.6% of the sample (n = 30). All of the participants received help from another person. While 64.3 % (n = 63) of them had a helper, and the remaining 35.7 % (n=35) received help from caregiers' siblings. Male patients constitutes the majority sample (57.1 %, n = 56). The time passed after the first symptoms of schizophrenia ranged between 1 year and 32 years with a mean of 10.97 years (SD = 7.94). While 25.5% of the participants had a physical disorder (n = 25), only 8.2 % (n=8) of the participants reported a psychological disorder. And finally, % 30.6 of the participants reported themselves as being a member of a support group (n = 30).

Table 1. Demographic Characteristics of the Sample

	M	SD	%
Caregiver's age	53.5	9.17	
Marital status			
Married			98
Divorced			2
Closeness to the patient			
Mother			46.9
Father			31.6
Siblings			13.3
Relative			8.2
Family income			
Low			6.1
Middle			90.8
High			3.1
Education			
Primary school			38.8
High School			32.7
University and above			28.6
Occupation			
Employee			41.9
Unemployed			32.3
Retired			25.8

Table 1 (continued)

	M	SD	%
Patient's age	32.32	9.01	
Patient's gender			
Male			42.9
Female			57.1
Time of diagnosis	10.97	7.94	
Caregiver physical disorder			25.5
Caregiver psychological disorder			8.2
Support group membership			30.6

2.2. Measures

The questionnaire set used in the current study included demographics and caregiving history form, The Caregiver Well-Being Scale (Berg-Weger, Rubio, & Tebb, 2000), The Parenting Sense of Competence (Gibaud-Wallston & Wandersman, 1978), Dyadic Adjustment Scale (Spanier, 1976)., Multidimensional Scale of Perceived Social Support (MSPPS) (Zimet, Dahlem, Zimet, & Farley, 1988), Brief Symptom Inventory (Deragotis & Meliseratos,1983), and Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979).

2.2.1. Demographics and Caregiving History Form

This form, prepared for the caregivers of schizophrenic patients, consisted of demographic questions about both the caregiver' and patient' age, gender, education, and socioeconomic status of caregiver. Moreover, it consisted of questions about the disorder and the caregiving history, such as the duration of caregiving, the closeness to the patient, the number of people living at home, number of caregivers, number of people to take care for except for the ill child, the presence of physical and psychological illness, whether they receive any treatment, and membership to an illness related organization or support group (See Appendix A).

2.2.2. The Caregiver Well-Being Scale

This scale was developed by Berg-Weger, Rubio, and Tebb (2000) to assess the basic needs and daily activity needs of the caregivers (See Appendix B). It includes two subscales, namely; basic needs and activities of living. The basic needs subscale assesses not only the physical needs such as sleep and nutrition but also some other needs like expression of feelings, relaxation, and personal growth. Activities of living subscale assesses the daily activities of the caregivers and some additional activities that can be regarded as leisure activities, such as spending time with friends. Both subscales consist of 22 items and the person rates himself/herself on a 5-point scale ranging between 1(very strongly disagree) and 5 (very strongly agree). It was adapted to Turkish culture by Demirtepe and Bozo (2009). Cronbach alpha coefficient was .93 for basic needs subscale and. 89 for activities of living subscale. In the present study, the internal consistency coefficients were found to be .92 for the activities of living subscale and .93 for basic need subscale.

2.2.3. The Parenting Sense of Competence (PSOC)

This scale was developed by Gibaud-Wallston and Wandersman (1978) to assess satisfaction with the parental role, parenting efficacy, and interest in parenting.

It consists of 16 items and was adapted to Turkish culture by Seçer, Çeliköz and Yaşa (2008) with the Cronbach alpha coefficient .84. The person rates himself/herself on a 5-point scale ranging between 1(very strongly disagree) and 5 (very strongly agree). Higher scores illustrate higher level of parental sense of competence (See Appendix C). In the current study, internal consistency coefficient of this scale was found to be .68.

2.2.4. Multidimensional Scale of Perceived Social Support (MSPSS)

For assessing perceived social support Multidimensional Scale of Perceived Social Support was used. It was developed by Zimet, Dahlem, Zimet, and Farley (1988), and adapted to Turkish by Eker and Arkar (1995) with a Cronbach alpha coefficient between .80 and .95 (Eker, Akar, &Yaldız, 2001). It consists of 12 items and the person rates himself/herself on a 7-point scale ranging between 1 (very strongly disagree) and 7 (very strongly agree). The MSPPS provides information about 3 sources of social support, namely family, friends and significant other (See Appendix D). In the current study, the internal consistency coefficient for the total MSPSS score was found to be .97.

2.2.5. Dyadic Adjustment Scale (DAS)

This scale consists of 32 items that aimed at assessing the quality of the relationship as perceived by married or cohabiting couples (Spanier, 1976). The scale consists of 32 items and provides 5 dimensions, namely, dyadic consensus, dyadic satisfaction, affectional expression, dyadic cohesion, and dyadic adjustment as total score. The administration of the scale takes only 5 to 10 minutes. It was adapted to Turkish by Fışıloğlu and Demir (2000) with the Cronbach alpha coefficient .92. In the current study, the internal consistency coefficient for the total DAS score was found to be .97.

2.2.6. Beck Depression Inventory

This scale was developed by Beck, Rush, Shaw, and Emery (1979), and adapted to Turkish by Hisli (Hisli, 1988: cited in Savaşır & Şahin, 1997) with Cronbach alpha coefficient .80. It consisted of 21 multiple choice questions about how the patient feels among the last week. Somatic, cognitive, motivational, and emotional symptoms were assessed. The person rates himself/herself on a 4 point scale ranging between 0 and 3. The higher scores are attributed to the higher depression levels. For the present sample, the internal consistency coefficient for the total BDI score was found to be .81.

2.2.7. Brief Symptom Inventory (BSI)

For evaluating the general psychological health, Brief Symptom Inventory was used. The BSI instrument was developed by Deragotis and Meliseratos (1983). The BSI was the short form of the instrument, the SCL-90-R, and it was shown that the correlations between the BSI and SCL-R-90 were. 92 to .99 (Derogatis, 1993). It was adapted to Turkish by Sahin and Durak (1994) with Cronbach alpha coefficient .94. It consists of 53 items and the person rates himself/herself on a 4-point scale ranging between 0 and 4. It aims to identify psychological symptoms and it can be used in the people over the age of 13. It is composed of 9 primary symptom dimensions namely, somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic, paranoid ideation, and psychoticism with 3 global indices, namely, global severity index (GSI), positive symptom distress index (PSDI), and positive symptom total (PST). Higher scores on this inventory mean higher problems in these areas. In the present study, the internal consistency coefficient for the total BSI score was found to be .98.

2.3. Procedure

The necessary permissions were received from Middle East Technical University Research Center for Applied Ethics, Ankara Provincial Directorate of Health, the head of the psychiatry department of Ankara University, and the head of special outpatient clinics. Written consent was sought by all participants, with the explanation of the purpose of the study, and confidentiality of the personal identity and the data was assured.

The participants were contacted at hospital stays of their patients, and at appointments in outpatient polyclinics of Ankara University. The participants applied to special outpatient clinics were contacted by the physician's referral. The aims of the study were told to all participants and inform consent form was given. Only volunteers were included in the study. The questionnaires were distributed and asked participants to fill them at their homes. However, some participants had low level of education and the questionnaires were administered to them orally and the answers were coded. Filling out the questionnaire sets took approximately 45-60 minutes. For association members, the questionnaires were distributed and collected via their patients.

2.4. Statistical Analysis

The Statistical Package for the Social Sciences (SPSS) was used for data analysis in the current study. Participants who had more than 20 % missing items in at least one of the questionnaires were excluded from the study. Consequently, 26 of the cases were excluded due to missing scores.

For each scale used in the current study, reliability analyses were run. Two t-tests were conducted in order to see the possible caregivers' and patients' gender differences in terms of study variables, and two separate one-way Analysis of Variances (ANOVAs) were conducted to reveal the effects of education and closeness to the patients on the study variables. Prior to the main analyses, to investigate the relationship among the study variables, a zero order Pearson correlation analysis was run. Finally, to test the mediation models, 12 separate mediation analyses were run.

CHAPTER III

RESULTS

3.1. Preliminary Analyses

Descriptive information about The Caregiver Well-Being Scale (Activities of Living (AL) and Basic Needs (BN)), The Parenting Sense of Competence (PE), Dyadic Adjustment Scale (DAS), Multidimensional Scale of Perceived Social Support (MSPSS), Brief Symptom Inventory (BSI), and Beck Depression Inventory (BDI) were presented; and the reliability analyses showed that all measures used in the study had satisfactory internal consistencies (See Table 2).

Table 2. Descriptive Information Regarding the Measures of the Study

Measures	Alpha Coefficient	Mean	Std. Deviation	Min-Max
PE	.68	50,80	9,04	40-76
MSPSS	.97	54,89	22,4	13-84
BDI	.81	12,77	10,8	1-46
BSI	.98	35,08	44,1	0-149
AL	.92	68,72	18,3	34-96
BN	.93	75,35	16,2	37-102
DAS	.97	96,25	31,6	0-136

3.2. Group Comparisons

To examine the group differences on variables, two separate independent samples t-tests were conducted in which gender of both the caregiver and the patient were used as the independent variables.

There was a significant difference between female and male caregivers on depression (t(96) = 1.68, p < .05) and parental efficacy (t(96) = 2.09, p <.05) The female caregivers got significantly higher scores on depression (m = 14.59, sd =12.69) than male caregivers (m = 9.91, sd = 5.71). Similarly, parental efficacy scores of the female caregivers (m = 52.30, sd = 8.95) were significantly higher than the male caregivers (m = 48.45, sd = 8.78). There were no significant gender differences on the remaining variables (See Table 3).

Table 3. Descriptive Statistics and T-Test Results for Female and Male Caregivers

		n	m	sd	t(96)	p
General Psychological Health	Female	60	40,97	49,54	1.68	.97
	Male	38	25,80	32,27	1.68	.97
Depression	Female	60	14,59	12,69	2.14	.05
	Male	38	9,91	5,71	2.14	.05
Activities of Living	Female	60	71,27	17,33	1.74	.09
	Male	38	64,72	19,33	1.74	.09
Basic Needs	Female	60	74,31	18,80	-.796	.43
	Male	38	76,99	11,09	-.796	.43
Parental Efficacy	Female	60	52,30	8,95	2.09	.04
	Male	38	48,45	8,78	2.09	.04

Table 3. (continued)

		n	m	sd	t(96)	p
Marital Satisfaction	Female	60	92,99	35,69	-1.28	.20
	Male	38	101,40	23,46	-1.28	.20
Social Support	Female	60	55,18	23,67	.16	.88
	Male	38	54,45	20,49	.16	.88

There were significant differences between the caregivers of female patients and male patients on the variables activities of living, basic needs, depression, and general psychological health. For activities of living, there was a significant difference between the caregivers of female patients and the caregivers of male patients (t(96) = 1.97, p < .05). The caregivers of female patients had significantly higher scores on activities of living (m = 72.87, sd = 20.7) than the caregivers of male patients (m = 65.62, sd = 15.79). That is, the caregivers of female patients were more satisfied with their daily routine activities than the caregivers of male patients.

For basic needs, there was a significant difference between the caregivers of female patients and the caregivers of male patients (t(96) = 3.02, p < .05). The caregivers of female patients had higher scores than (m =80.85, sd = 13.16) the caregivers of male patients (m = 71.23, sd = 17.19) on basic needs. That is, the caregivers of female patients were more satisafied with their basic needs than the caregivers of male patients. Moreover, there were significant differences between the caregivers of female patients and the ones with male patients in terms of the level of depressive symptoms (t(96) = -3.80, p < .001) and general psychological health (t(96) = -2.40, p < .001). The caregivers of male patients had significantly higher scores on depression (m = 16.12, sd = 12.48) than the ones of female patients (m = 8.31, sd = 5.38) which suggested that the caregivers of male patients reported significantly more depressive symptoms than the ones of male patients. Similarly, the caregivers of male patients had significantly higher scores on general psychological health (m = 44.11, sd = 53.68) than the ones of female patients (m = 23.05, sd = 21.78), which means that they reported more symptoms on BSI. There were no significant differences between the caregivers of male and female patients on the remaining variables (See Table 4).

Table 4. Descriptive Statistics and T-Test Results for the Caregivers Who Had Female and Male Patients

		n	m	sd	t(96)	p
Psychologial General Health	Female	42	23.05	21.78	-2.40	.05
	Male	56	44.11	53.68	-2.40	.05
Depression	Female	42	8.31	5.38	-.3.80	.001
	Male	56	16.12	12.48	-.3.80	.001
Activities of Living	Female	42	72.87	20.70	1.97	.05
	Male	56	65.62	15.79	1.97	.05
Basic Needs	Female	42	80.85	13.16	3.02	.05
	Male	56	71.23	17.19	3.02	.05

Table 4. (continued)

		n	m	sd	t(96)	p
Parental Efficacy	Female	42	50.01	9.02	-.75	.46
	Male	56	51.40	9.08	-.75	.46
Marital Satisfaction	Female	42	92.87	24.39	-.91	.36
	Male	56	98.79	36.16	-.91	.36
Social Support	Female	42	50.14	19.75	-1.85	.07
	Male	56	58.46	23.72	-1.85	.07

To reveal the effects of education and closeness to the parents on the study variables, two separate one-way Analysis of Variances (ANOVAs) were conducted. The results showed that the effect of education on depression was significant ($F(2, 95) = 7.11$, $p < .001$). When the differences between the primary school, high school and university and above groups were examined with Tukey HSD test, it was found that university and above group had significantly lower depression ($m = 7.39$, $sd = 5.12$) than the primary school group ($m =16.9$, $sd = 14.69$). That is, primary school group had more depressive symptoms than university and above group. Moreover, the difference between people having high school and university and above education was not significant. Similar results were obtained for general psychological health.

The effect of education on general psychological health was significant (F(2. 95) = 6.71. p < .05). When the differences between the primary school, higher school, and university and above groups were examined with Tukey HSD test, it was found that university and above group had significantly lower scores (m = 14.04. sd = 22.09) from BSI, which assessed general psychological health status of the caregivers, than the primary school group (m =51.99, sd = 58.92), indicating that primary school graduates reported higher symptoms. The difference between people having primary school and high school was not significant.

The result did also show that the effect of education on activities on living (F(2, 95) = 15.55, p < .001) and basic needs (F(2, 95) = 18.25, p < .001) were significant. When the differences between the primary school, high school, and university and above groups were examined with Tukey HSD test, it was found that university and above group had significantly higher scores on activities of living (m = 62.26, sd = 6.33) than the primary school group (m =66.49, sd =19.01). This suggested that university and above group satisfied with their basic needs than primary group. Moreover, it was found that university and above group had significantly higher scores on basid needs (m = 88.32, sd = 7.82) than primary school group (m = 67.69, sd = 19.09). That is, university and above group carried out their their day time activities than primary school group. However, the difference between people having primary school and high school education was not significant (See Table 5).

Table 5. Descriptive Statistics, Analysis of Variance and Tukey HSD Test for Education in terms of Study Variables

	Primary School		High School		University and Above			One-Way ANOVA	
	m	sd	m	sd	M	sd	df	F(2.95)	p
BDI	16.9_a	14.69	12.58_{ab}	5.85	7.39_b	5.12	2	7.11	.001
BSI	51.99_a	58.92	33.41_{ab}	32.21	14.04_b	22.09	2	6.71	.05
AL	66.49_a	19.01	59.53_a	17.29	62.26_b	6.33	2	15.55	.001
BN	67.69_a	19.09	73.09_a	17.38	88.32_b	7.82	2	18.25	.001

Note. The mean scores that do not share the same subscript on the same row significantly different from each other at .05 alpha level of Tukey's HSD test.

When the effects of closeness to the patients were examined, it was found that the closeness to the patients varied significantly in only depression and activities of living scores of the caregivers. The results showed that the effect of closeness to the patient on depression was significant (F(3, 94) = 3.23, p < .05). When the differences between the mothers, fathers, siblings, and relatives groups were examined with Tukey HSD test, it was found that mothers have significantly higher depressive symptoms (m = 14.81, sd = 14.26) than fathers (m =8.45, sd = 2.81). The differences between other groups were not significant.

Similarly, the effect of closeness to the patient on activities of living was significant (F(3, 94) = 2.76, p < .05). When the differences between the mothers, fathers, siblings, and relatives groups were examined with Tukey HSD test, it was found that mothers had significantly higher activities of living scores (m = 74.06, sd = 18.11) than fathers (m = 62.53, sd = 20.42), which suggested that mother satisfied with their day time activities than fathers. And again, the differences between other groups were not significant (See Table 6).

Table 6. *Descriptive Statistics, Analysis of Variance and Tukey HSD Test for the scales for Closeness to the Patient*

	Mothers		Fathers		Siblings		Relatives			One-Way ANOVA	
	m	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*	*df*	*F*(3.94)	*p*
BDI	14.81_a	14.26	8.45_b	2.81	17.11_{ab}	7.67	10.75_{ab}	3.10	3	3.23	.05
AL	74.06_a	18.11	62.53_b	20.42	66.00_{ab}	13.51	66.50_{ab}	8.05	3	2.76	.05

Note. The mean scores that do not share the same subscript on the same row significantly different from each other at .05 alpha level of Tukey's HSD test.

3.3. Pearson's Correlations among Variables

Zero order correlation coefficients among the measures were examined in order to investigate the relationships among sociodemographic variables, primary stressors, secondary stressors, Mediators, and outcome variables (See Table 7). The demographic variables were highly correlated with each other. Moreover, among these variables, physical illness was significantly correlated with depression (r =. 38, p < .01) and with general psychological health (r =. 39, p < .01). There were also significant correlations among primary stressor, secondary stressors, and outcome variables except for the parental efficacy. As shown in Table 7, basic needs was found to be correlated with activities of daily living (r=.77, p<.01), social support was significantly correlated with marital satisfaction (r=.54, p<.01). For outcome variables the correlation coefficient between depression and general psychological health was (r =. 85, p < .01). However, parental efficacy, one of the secondary stressors, was only correlated with one of demographic variables, the number of caring other (r= -.30, p<.01). And, parental efficacy had no relationship with the primary, secondary stressors and outcome variables.

Table Correlation Coefficients among Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Caregiver Age	1													
2. Patient Age	.544**	1												
3. Number of Living at home	-.372**	-.559**	1											
4. Time of diagnosis	.473**	.903**	-.494**	1										
5. Number of Caring others	-.090	-.127	.216*	-.117	1									
6. Physical Illness	-.450**	-.235**	.082	.262**	-.360**	1								
7. Physchological Illness	.123	.135	-.166	.066	-.385**	.338**	1							
8. General Psychological Health	-.107	-.117	-.061	-.091	.126	- .391**	-.131	1						
9. Depression	-.058	-.098	.008	-.166	.031	-.376**	-.166	.846**	1					
10. Activities of Living	.151	.166	-.160	.146	-.557**	.146	.146	-.657**	-.612**	1				
11. Basic Needs	.188	.273**	-.199*	.282**	-.255*	.282**	.282**	-.769**	-.842**	.772**	1			
12. Parental Efficacy	.050	.183	-.221*	.145	-.300**	.145	.145	-.074	-.015	.216*	.128	1		
13. Marital Satisfaction	.189	.157	-.050	.048	-.105	.048	.048	-.622**	-.471**	.374**	.386**	.093	1	
14. Social Support	-.012	-.185	.344**	-.212*	-.305**	-.212*	-.212*	-.591**	-.371**	.380**	.259*	.142	.544**	1

Note. For all correlations. N=98 * p <.05; **p <.01; ***p <.001

3.4. Model Testing

In order to test the main hypotheses of the study, 12 mediation models were tested. Using social support and marital satisfaction as mediators, the models included primary stressors (basic needs) and secondary stressors (activities of living and parental efficacy) as independent variables; and depression and general psychological health as the dependent variables. According to Baron and Kenny (1986), there were four conditions necessary for the mediation analysis; the independent variable has to be significantly relatedto the outcome, the independent variable has to be related to the mediator significantly, mediator has to be related to the outcome variable significantly, and lastly the effects of independent variable on the outcome variable after controlling for mediator has to be lessened or disappeared entirely.

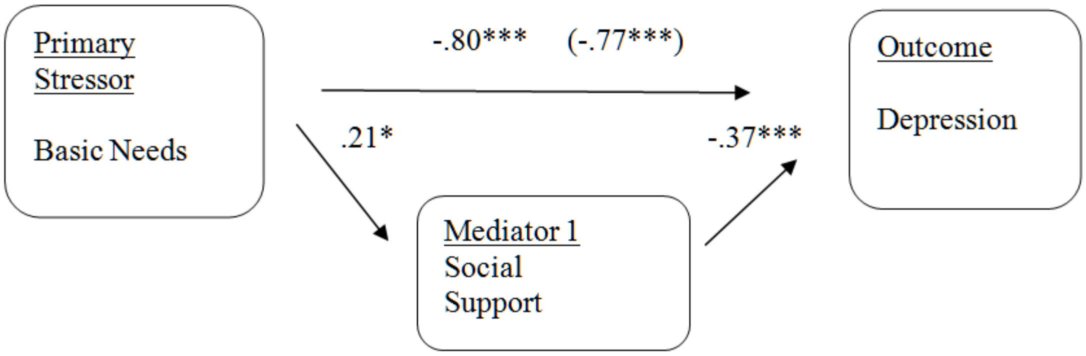
By using standard multiple regression analysis, three separate regression analyses were conducted for each model. Moreover, Sobel test was performed to test the significance of the indirect effects.

3.4.1. Mediation Models for Depression

For depression as the dependent variable, six mediation models were conducted. Primary stressors (basic needs) and secondary stressors (activities of daily living and parental efficacy) were the independent variables. The mediators were social support and marital satisfaction.

3.4.1.1. Social Support as Mediator

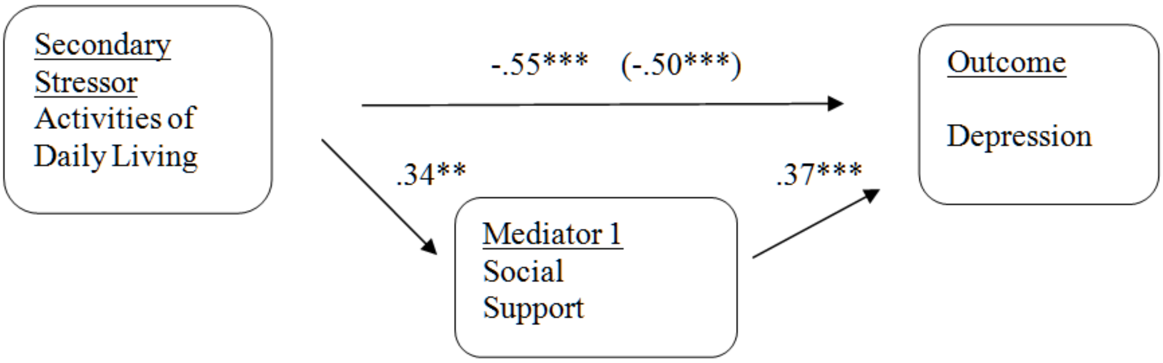
The relationship between basic needs (primary stressor) and depression was mediated by social support. Basic needs was a significant predictor of depression (β = - .80, p < .001) and social support (β = -.21, p < .05), and after controlling for basic needs, social support was a significant predictor of depression (β =.-37, p < .001). The final condition of mediation was also met: The standardized regression coefficient between basic needs and depression decreased significantly when controlling for social support (from β = - .80, p < .001 to β = -.77, p < .001). The mediating role of social support between basic needs and depression was confirmed by Sobel test (Sobel z = -.38, p = .352, one-tailed). Therefore, social support mediated the relationship between basic needs and depression (See Figure 3).



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

Figure 3. The Relationship between Primary Stressor and Depression having Social Support as the Mediator

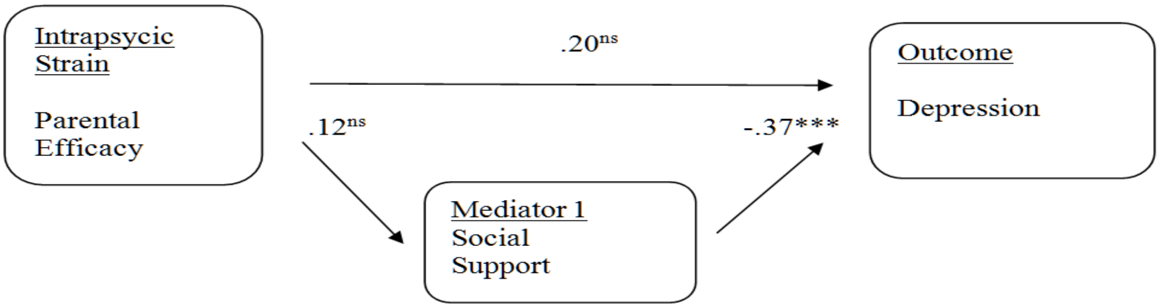
The relationship between activities of living (secondary stressor) and depression was mediated by social support. Activities of living was a significant predictor of depression (β = - .55, p < .001) and social support (β = .34, p < .05), and after controlling for activities of living social support was a significant predictor of depression (β =-.37, p < .001). The final condition of mediation was also met: The standardized regression coefficient between activities of living and depression decreased significantly when controlling for social support (from β = - .55, p < .001 to β = -.50, p < .001). The mediating role of social support between activities of living and depression was confirmed by Sobel test (Sobel z = -.38, p < .05, one-tailed). Therefore, social support mediated the relationship between activities of living and depression (See Figure 4).



Note. * *p* < .05; ** *p* <.01; *** *p* <.001

Figure 4. The Relationship between Secondary Stressor and Depression Having Social Support as the Mediator

Parental efficacy (intrapsychic strain) was not a predictor of social support significantly (β = .12, p < .23). Moreover, it was not a significant predictor of depression (β = .02, p = .85). The relationship between parental efficacy (intrapsychic strain) and depression was not mediated social support since the conditions of mediation were not fulfilled (See Figure 5).



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

Figure 5. The Relationship between Intrapsychic Strain and Depression having Social Support as the Mediator

3.4.1.2. Marital satisfaction as mediator

The relationship between basic needs (primary stressor) and depression was mediated by marital satisfaction. Basic needs was a significant predictor of depression (β = - .80. p < .001) and marital satisfaction (β = .37. p < .001), and after controlling for basic needs, marital satisfaction was a significant predictor of depression (β =.-47. p < .001). The final condition of mediation was also met: The standardized regression coefficient between basic needs and depression decreased significantly when controlling for marital satisfaction (from β = - .80, p < .001 to β = -.74, p < .001). The mediating role of social support between basic needs and depression was confirmed by Sobel test (Sobel z = -3.05. p =.001). Therefore, marital satisfaction mediated the relationship between basic needs and depression (See Figure 6).

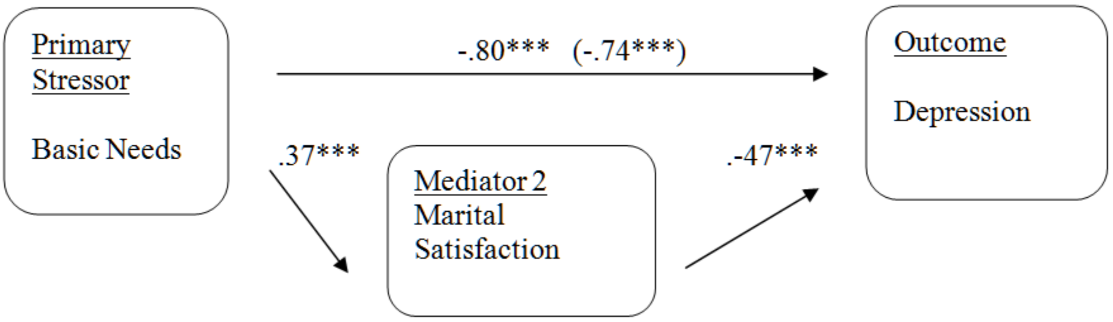


Figure 6. The Relationship between Primary Stressor and Depression having Marital Satisfaction as the Mediator

The relationship between activities of living (secondary stressor) and depression was mediated by marital satisfaction. Activities of living was a significant predictor of depression (β = - .55. p < .001) and marital satisfaction (β = .38. p < .001), and after controlling for activities of living, marital satisfaction was a significant predictor of depression (β =.-47. p < .001). The final condition of mediation was also met: The standardized regression coefficient between activities of living and depression decreased significantly when controlling for marital satisfaction ((from β = - .55 p < .001 to β = -.-48. p < .001). The mediating role of marital satisfaction between activities of living and depression was confirmed by Sobel test (Sobel z = -2.93. p =.001). Therefore, marital satisfaction mediated the relationship between activities of living and depression (See Figure 7).

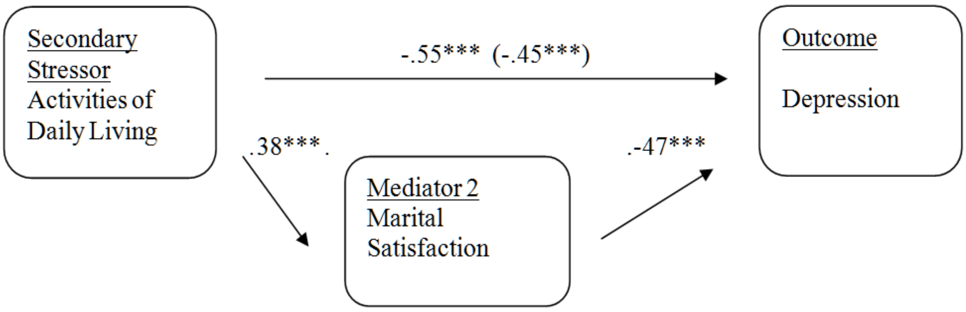


Figure 7. The Relationship between Secondary Stressor and Depression having Marital Satisfaction as the Mediator

Parental efficacy (intrapsychic strain) was not a predictor of marital satisfaction significantly (β = .079. p < .44). Moreover, it was not a significant predictor of depression (β = .02. p = .85). The relationship between parental efficacy (intrapsychic strain) and depression was not mediated marital satisfaction since the conditions of mediation were not fulfilled (See Figure 8).

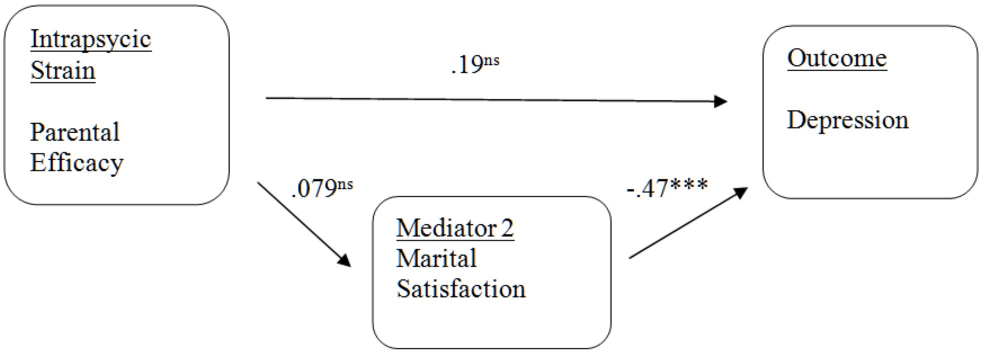


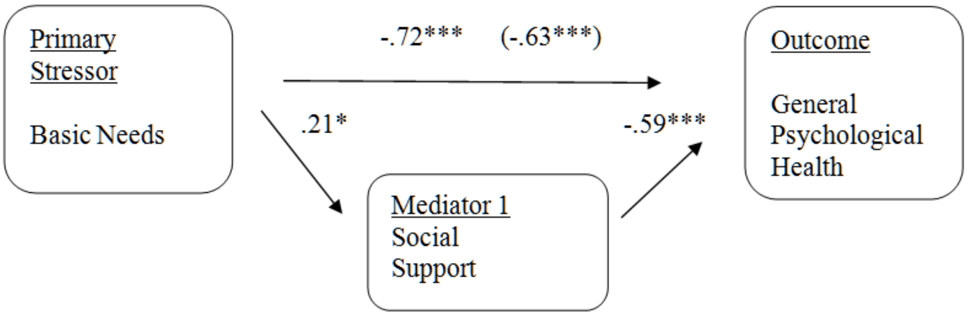
Figure 8. The Relationship between Intrapsychic Strain and Depression having Marital Satisfaction as the Mediator

3.4.2. Mediation Models for General Psychological Health

For general psychological health as the dependent variable, six mediation models were conducted. Primary stressors (basic needs) and secondary stressors (activities of living and parental efficacy) were the independent variables. The mediators were social support and marital satisfaction.

3.4.2.1. Social Support as Mediator

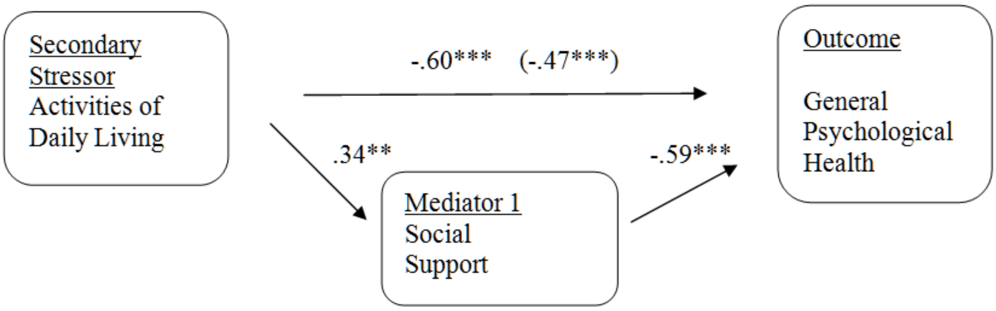
The relationship between basic needs (primary stressor) and general psychological health was mediated by social support. Basic needs was a significant predictor of general psychological health (β = - .72, p < .001) and social support (β = -.21, p < .05), and after controlling for basic needs, social support was a significant predictor of general psychological health (β =-.59, p < .001). The final condition of mediation was also met: The standardized regression coefficient between basic needs and depression decreased significantly when controlling for social support (from β = -.72, p < .001 to β = -.63, p < .001). The mediating role of social support between basic needs and general psychological health was confirmed by Sobel test (Sobel z = -1.99, p =.05). Therefore, social support mediated the relationship between basic needs and general psychological health (See Figure 9).



Note. * *p* < .05; ** *p* <.01; *** *p* <.001

Figure 9. The Relationship between Primary Stressor and General Psychological Health having Social Support as the Mediator

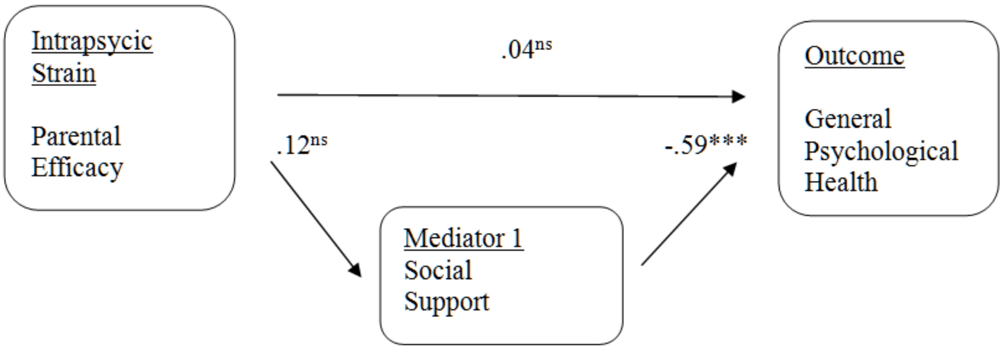
The relationship between activities of living (secondary stressor) and general psychological health was mediated by social support. Activities of living was a significant predictor of general psychological health (β = - .60, p < .001) and social support (β = .34, p < .05), and after controlling for activities of living social support was a significant predictor of general psychological health (β = -.59, p < .001). The final condition of mediation was also met: The standardized regression coefficient between activities of living and general psychological health decreased significantly when controlling for social support (from β = - .60, p < .001 to β = -.47, p < .001). The mediating role of social support between activities of living and general psychological health was confirmed by Sobel test (Sobel z = -2.93, p <.01). Therefore, social support mediated the relationship between activities of living and general psychological health (See Figure 10).



Note. * p < .05; ** p <.01; *** p <.001

Figure 10. The Relationship between Secondary Stressor and General Psychological Health Having Social Support as the Mediator

Parental efficacy (intrapsychic strain) was not a predictor of social support significantly (β = .12, p < .23). Moreover, it was not a significant predictor of general psychological health (β = -.39, p < .68). The relationship between parental efficacy (intrapsychic strain) and general psychological health was not mediated social support since the conditions of mediationwere not fulfilled (See Figure 11).



Note. * p < .05; ** p <.01; *** p <.001

Figure 11. The Relationship between Intrapsychic Strain and General Psychological Health having Social Support as the Mediator

3.4.2.2. Marital satisfaction as mediator

The relationship between basic needs (primary stressor) and general psychological health was mediated by marital satisfaction. Basic needs was a significant predictor of general psychological health (β = - .72, p < .001) and marital satisfaction (β = .37, p < .001, and after controlling for basic needs, marital satisfaction was a significant predictor of general psychological health (β =- .62, p < .001). The final condition of mediation was also met: The standardized regression coefficient between basic needs and general psychological health decreased significantly (from β = - .72, p < .001 to β = -.58, p < .001). The mediating role of social support between basic needs and general psychological health was confirmed by Sobel test (Sobel z = -3.39, p =.001). Therefore, marital satisfaction mediated the relationship between basic needs and general psychological health (See Figure 12).

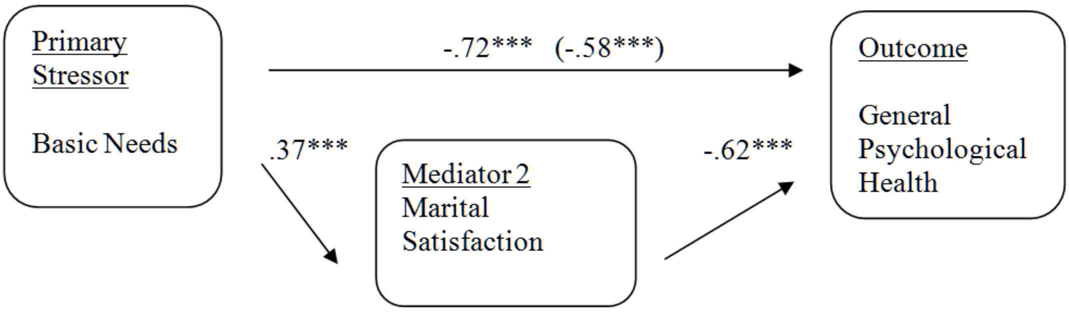


Figure 12. The Relationship between Primary Stressor and General Psychological Health having Marital Satisfaction as the Mediator

The relationship between activities of living (secondary stressor) and general psychological health was mediated marital satisfaction. Activities of living was a significant predictor of general psychological health (β = - .60, p < .001) and marital satisfaction (β = .38, p < .001), and after controlling for activities of living, marital satisfaction was a significant predictor of general psychological health (β = -.62, p < .001). The final condition of mediation was also met: The standardized regression coefficient between basic needs and general psychological health decreased significantly (from β = - .60, p < .001 to β = -.44, p < .001). The mediating role of social support between basic needs and general psychological health was confirmed by Sobel test (Sobel z = -3.24, p =.001). Therefore, marital satisfaction mediated the relationship between activities of living and general psychological health (see Figure 13).

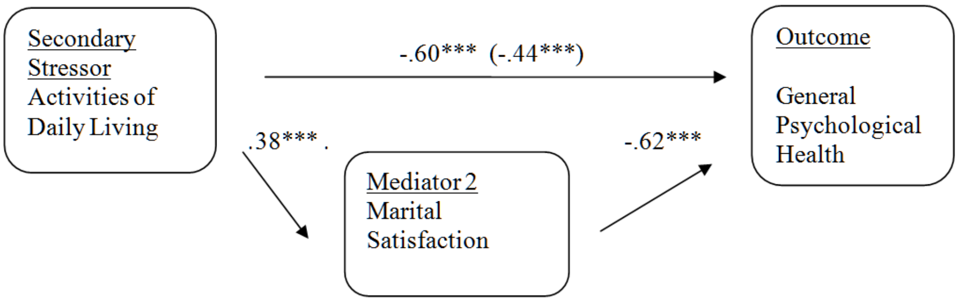


Figure 13. The Relationship between Secondary Stressor and General Psychological Health having Marital Satisfaction as the Mediator

Parental efficacy (intrapsychic strain) was not a predictor of marital satisfaction significantly (β = .079, p < .44). Moreover, it was not a significant predictor of general psychological health (β = -.039, p = .68). The relationship between parental efficacy (intrapsychic strain) and general psychological health was not mediated marital satisfaction since the conditions of mediation were not fulfilled (See Figure 14).

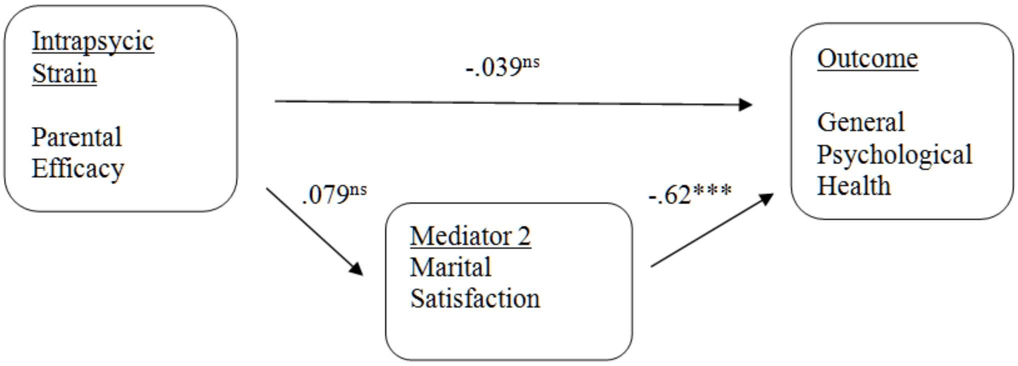


Figure 14. The Relationship between Intrapsychic Strain and General Psychological Health having Marital Satisfaction as the Mediator

The summary for the mediation models tested with the primary stressor (basic needs), secondary stressor (activities of living) , secondary intrapsychic strain (parental efficacy) and outcomes (depression and general psychological health) having social support and marital satisfaction as the mediators are presented in Table 8.

Table 8. The Summary of Mediation Models

IV	Mediator	DV	Mediation	Sobel
Basic Needs	Social Support	Depression	Yes	Significant
Basic Needs	Marital Satisfaction	Depression	Yes	Significant
Activities of Living	Social Support	Depression	Yes	Significant
Activities of Living	Marital Satisfaction	Depression	Yes	Significant

Table 8. (continued)

IV	Mediator	DV	Mediation	Sobel
Parental Efficacy	Social Support	Depression	No	
Parental Efficacy	Marital Satisfaction	Depression	No	
Basic Needs	Social Support	General Psychological Health	Yes	Significant
Basic Needs	Marital Satisfaction	General Psychological Health	Yes	Significant
Activities of Living	Social Support	General Psychological Health	Yes	Significant
Activities of Living	Marital Satisfaction	General Psychological Health	Yes	Significant
Parental Efficacy	Social Support	General Psychological Health	No	
Parental Efficacy	Marital Satisfaction	General Psychological Health	No	

CHAPTER 4

DISCUSSION

Identifying the factors that affect the caregiving process negatively or positively is the most important part of the caregiver studies. For this purpose, several models were developed by researchers. The Caregiver Stress Model (Pearlin et al., 1990) is one of these models; and the current study was conducted in the theoretical framework of this model. The summaries of the models that were applied to caregivers of schizophrenia patients, the results of the study, clinical implications, the limitations of the current study, and lastly, the recommendations for the further research were discussed in following sections.

4.1. The Summary of the Mediation Models

As hypothesized, the caregivers, who satisfied their basic needs reported higher levels of social support and as a result, lower levels of depression and higher levels of general psychological health. Moreover, the caregivers, who satisfied their basic needs reported higher levels of marital satisfaction and consequently, lower levels of depression and higher levels of general psychological health.

In addition, the caregivers who could carry out their daily routines, experienced higher levels of social support and as a result, they reported lower levels of depression and higher levels of general psychological health. Moreover, the caregivers, who could carry out their daily routines, reported higher levels of marital satisfaction and consequently, lower levels of depression and higher levels of general psychological health.

However, parental efficacy was not a predictor of any of the mediators. Consequently, neither social support nor marital satisfaction was mediator between parental efficacy and outcome variables, i.e., depressive symptoms and general psychological health.

4.2. Results of the Study

Maldonado, Caqueo-Urizar, and Kavanagh reported that families complain about having no time for themselves, patient's symptoms, difficulties related to caregiving process, isolation, and restrictions in social life, leisure and self-care activities; all of which increase their burden and lead to poor health and functioning(2005). Similar to this finding, current study showed that the caregivers, who could not satisfy their basic needs and perform daily routines, reported higher level of depressive symptomatology and lower levels of general psychological health.

It was emphasized that the parents, distressed by the marital and daily problems and tired of caregiving responsibilities, have difficulties in applying effective parenting strategies and this may lead to increments in the behavioral problems of the child with schizophrenia (Espina, Ortego, Alda, & Gonzalez, 2003). However, parental efficacy was not a significant predictor of marital satisfaction. As mentioned before, the term of parental efficacy was used generally for infant-mother relationships in the literature. To our knowledge, the current study was the first study in which the term used for older children. Nevertheless, parental efficacy did not appear as a significant predictor of depressive symptoms and general psychological health of people giving care to schizophrenia patients. Moreover, as shown in the Table 2, the reliability of the Parental Sense of Competence Scale, a scale assessing the relationship between younger children and mother, was relatively low. Therefore, the results related to the relationship between parental efficacy and outcome variables should be interpreted with caution.

It was asserted that there is a strong relation between caring a schizophrenia patient and reduced quality of life. Caregivers, mostly women, especially mothers, had poorer states of perceived health, because they took all the responsibilities of caring in most of the cases (Alonso, Prieto, & Anto, 1995). The current study demonstrated similar results with this study. Women caregivers constituted the majority of the sample; and the same pattern was also observed in these caregivers.

While female caregivers were found to have higher depressive symptomatology than male caregivers in the current study, Jones and Peter (1992) asserted that there were no gender differences on caregiver depression (as citied in Song, Biegel, & Milligan, 1997). Nevertheless, the number of the male caregivers in the current study was not enough to make accurate comparisons.

In another study, it was shown that gender of patient and educational level of the caregiver was associated with the caregiver burden (Papastavrou, Charalambous, Tsangari, & Karayiannis, 2010). In a parallel way, the current study showed that the caregivers, who had higher levels of education, had lower scores on depression and higher scores on general psychological health. Moreover, the results demonstrated that the caregivers having male patients had higher levels of depression and lower levels of general psychological health.

4.3. Clinical Implications

It was asserted that caregiver tasks and psychological distress of the caregivers may be lessened by improving the functional state of the patients, decreasing the number of hours spent with the patients, and enhancing the coping capacities of the caregivers (Schene, Wijngaarden, & Koeter, 1998). Karancı did also show that medical treatment, support given to the caregiver and hospitalization of the patient are perceived as helpful and the support of professionals and health care institutions were crucial for these caregivers (1995). However, due to the present health system and the movement of family-based care approach all over the world, the hospitalization of the patients for a long duration is not possible. Yet, also shown in several studies, the current study showed the importance of interventions for improving the conditions of the caregivers.

Psychoeducation is one of the interventions having significant impact on caregiver burden and related health outcomes. Pakenham and Dadds demonstrated that supportive/educational intervention in which information related to illness was given and experiences shared by the caregivers were effective. Moreover, this intervention led to reduction in distress, anxiety, and depression (1987). In a similar way, information about schizophrenia and the quilt of being the cause of schizophrenia were associated with the psychiatric morbidity and life quality of the caregivers. Information about the disorder led to relief of the guilt related to possibility of being cause for schizophrenia and should be definitely addressed in the interventions (Chen et al., 2004).

It was also asserted that structured psychoeducational intervention was shown to be more effective than routine out-patient care in terms of psychopathology, disability, burden, support, and satisfaction of the caregivers (Kulhara, Chakrabarti, Avasthi, Sharma, & Sharma, 2009). Throughtout the data collection of the current study, the lack of knowledge about schizophrenia was also observed among the Turkish caregivers. That is, the current study also showed the importance of the development of psychoeducation programmes for Turkish caregivers together with routine out-patient care.

4.4. Limitations and Recommendations for Further Research

The current study has several limitations. Firstly, the current study was a cross sectional study and causal conclusions cannot be made. Secondly, the detailed symptom assessment of these patients was absent in the current study. As mentioned above, there were lots of studies illustrating that current behavioral symptoms of schizophrenic patients was an important factor that generate burden to the caregivers. Moreover, It is known that schizophrenia is classified into 4 subtypes, namely, paranoid, catatonic, disorganized, and undifferentiated (DSM-IV-TR, 2000), and these subtypes have different prognosis and symptoms. Therefore, the differences between the subtypes may lead to different pathways and different types of burdens.

However, the current study did not control for the effects of different types of schizophrenia.

Moreover, medical or physical comorbidity of these patients was an important factor that may affect the course of the illness. It was found that psychosis is worsened and negatively affected by medical comorbidity (Hall, Gardner, Popkin, Lecann, & Stickney, (1981). In the current study, however, medical comorbidity was not taken in consideration. Futhermore, the whole data set was obtained from Ankara, the capital city of Turkey. Even though there were no studies examining the differences between urban and rural areas in terms of caregiving process, there may be some differences in different regions of Turkey due to cultural, economical, and educational differences.

Hilgeman et al. (2009) suggested that each race or ethnicity has different advantages and disadvantages in terms of dealing with burden created by caregiving process. As mentioned above, it is important to develope different interventions targeting different facets of the stressing process for caregivers from different ethnic or cultural backgrounds. Depending on this finding it can be suggested that there may be some differences stemmed from the cultural features of Turkish society, and this issue needs to be studied further. The perception of stigmatization was found to be a significant predictor of mother’s physical health, when controlled for the effects of mother’s age, educational and marital status, living with ill children, other daily stressors, the age of ill child, and symptom severity (Greenberg, Greenley, Mckee, Brown, & Griffin-Francell, 1993). This finding illustrated that families worried about the future of ill children and current stigmatization of the environment are vital issues to be considered.

4.5. Conclusion

Pearlin (1983) demonstrated that dementia which is also a chronic and progressive disorder led to unintentional changes in their caregivers' daily lives (as citied in Lee, Kim, & Kim, 2006, p. 784). This pattern was also valid for the caregivers of schizophrenia. In addition, caring a schizophrenia patient was burdensome in many aspects. The lives of the caregivers were altered immediately and eternally.

In conclusion, the results of the study proposed that the caregiver stress model (Pearlin et al., 1990) is an appropriate tool for the researchers studying and practicing with the caregivers of schizophrenia.

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APPENDICES

APPENDIX A: Informed Consent

Bu tez çalışması. Yard. Doç. Özlem Bozo danışmanlığında. Orta Doğu Teknik Üniversitesi Klinik Psikoloji Yüksek Lisans Öğrencisi Özlem Konağ tarafından yürütülmektedir. Çalışmanın amacı. şizofreni hastalarının ilk bakıcılarının. bakıcılık sürecinin neden olduğu stres faktörlerleri ve genel ve psikolojik sağlıkları arasındaki ilişkiyi anlamak üzere bilgi toplamaktır. Çalışmaya katılım gönüllülük esasına dayanmaktadır. Cevaplarınız tamimiyle gizli tutulacak ve sadece araştırmacılar tarafından değerlendirilecektir; elde edilecek bilgiler bilimsel yayımlarda kullanılacaktır.

Anket. genel olarak kişisel rahatsızlık verecek soruları içermemektedir. Ancak. katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz katılımı yarıda bırakmakta serbestsiniz. Böyle bir durumda anketi uygulayan kişiye. anketi tamamlamadığınızı söylemeniz yeterli olacaktır. Anket sonunda. bu çalışmayla ilgili sorularınız cevaplanacaktır. Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz. Çalışma hakkında daha fazla bilgi almak için Özlem Konağ (Tel: 0312 2872210; e1372333@metu.edu.tr) ile iletişim kurabilirsiniz.

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda bırakıp çıkabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum. (Formu doldurup imzaladıktan sonra uygulayıcıya geri veriniz).

İsim Soyad Tarih İmza
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APPENDIX B: Demographics and Caregiving History Form

1. Yaşınız:__________

2. Cinsiyetiniz: ____ Kadın ____ Erkek

3. Eğitim Durumunuz: ____ İlkokul ____Ortaokul ____Lise

____ Üniversite ____Üniversite üstü

4. Mesleğiniz:_____________

5. Şu anki evlilik durumunuz: _____ Bekar _____ Evli

_____ Boşanmış _____Eşi vefat etmiş

6. Aylık gelir miktarınız: _____ Düşük _____ Orta _____ Yüksek

7. Hastanızın yaşı:__________

8. Hastanızın cinsiyeti: ____ Kadın ____ Erkek

9. Hastanın nesi oluyorsunuz?______________

11. Evinizde siz dahil kaç kişi
yaşıyor?____-______

12. Hastanızın tanısı ne zaman
kondu?____

13. Hastanızın bakımını üstlenen başka biri var mı? (varsa kim olduğunu

belirtiniz) ____

14. Sizin bakımını üstlendiğiniz kaç kişi var? (kimler olduğunu belirtiniz)

____

15. Herhangi bir fiziksel rahatsızlığınız var mı? (varsa belirtiniz)

____

16. Herhangi bir psikolojik rahatsızlığınız var mı? (varsa belirtiniz)

____

17. Fiziksel ya da psikolojik tedavi görüyor musunuz? / Yardım alıyor musunuz?

(varsa tedavi şeklini belirtiniz)

____

18. Hastalıkla ilgili bir dernek ya da kuruluşa üye misiniz? (varsa belirtiniz)____

APPENDIX C: The Caregiver Well-Being Scale

Activities of Living Subscale

Aşağıda herbirimizin yaptığı ya da birilerinin bizim için yaptığı bazı yaşamsal faaliyetler sıralanmıştır. Her bir faaliyet için yaşamınızın son 3 ayını düşünün. Bu süre içinde. her bir faaliyetin ne derecede karşılandığını düşünüyorsunuz? Aşağıda bulunan ölçeği kullanarak sizin için uygun sayıyı yuvarlak içine alınız.

1 hiçbir zaman 2 nadiren 3 ara sıra 4 sık sık 5 her zaman

1. Yiyecek satın almak	1	2	3	4	5
2. Yemek hazırlamak	1	2	3	4	5
3. Evi temizlemek	1	2	3	4	5
4. Evin çekip çevirilmesiyle ilgilenmek	1	2	3	4	5
5. Ulaşım kolaylığına sahip olmak	1	2	3	4	5
6. Kıyafet alış verişi yapmak	1	2	3	4	5
7. Kıyafetleri yıkamak ve giydiklerine özen göstermek	1	2	3	4	5
8. Gevşemek/ rahatlamak	1	2	3	4	5
9. Egzersiz/spor yapmak	1	2	3	4	5
10. Bir hobiden keyif almak	1	2	3	4	5
11. Yeni bir ilgi alanı ya da hobi edinmek	1	2	3	4	5
12. Sosyal etkinliklere katılmak	1	2	3	4	5
13. Herhangi bir konu hakkında derinlemesine düşünmek için zaman ayırmak	1	2	3	4	5
14. Manevi ve ilham verici faaliyetlere zaman ayırmak	1	2	3	4	5
15. Çevredenizdeki güzelliklerinin	1	2	3	4	5

farkına varmak					
16. Arkadaşlar ya da aileden destek istemek	1	2	3	4	5
17. Arkadaşlar ya da aileden destek almak	1	2	3	4	5
18. Gülmek/ kahkaha atmak	1	2	3	4	5
19. Kendinize iyi davranmak veya kendinizi ödüllendirmek	1	2	3	4	5
20. Kariyerinize/ işinize devam etmek	1	2	3	4	5
21. Kişisel temizlik ve dış görünüşünüze zaman ayırmak	1	2	3	4	5
22. Aile ya da arkadaşlarla hoşça vakit geçirmek için zaman ayırmak	1	2	3	4	5

Basic Needs Subscale

Aşağıda bazı temel ihtiyaçlar sıralanmıştır. Her bir ihtiyaç için hayatınızın son 3 ayını düşünün. Bu süre içinde her bir ihtiyacın ne ölçüde karşılandığını belirtiniz. Aşağıda bulunan ölçeği kullanarak sizin için uygun sayıyı yuvarlak içine alınız.

1 hiçbir zaman 2 nadiren 3 ara sıra 4 sık sık 5 her zaman

1. Yeterli paraya sahip olmak	1	2	3	4	5
2.Dengeli beslenmek	1	2	3	4	5
3. Yeterince uyumak	1	2	3	4	5
4. Fiziksel sağlığınıza dikkat etmek	1	2	3	4	5
(doktora. diş hekimine gitmek vs.)					
5. Kendinize vakit ayırmak	1	2	3	4	5
6. Sevildiğini hissetmek	1	2	3	4	5
7. Sevginizi ifade etmek	1	2	3	4	5
8. Öfkenizi ifade etmek	1	2	3	4	5
9. Neşenizi ve keyfinizi ifade etmek	1	2	3	4	5

10. Üzüntünüzü ifade etmek	1	2	3	4	5
11. Cinsellikten keyif almak	1	2	3	4	5
12. Yeni beceriler öğrenmek	1	2	3	4	5
13. Kendini değerli hissetmek	1	2	3	4	5
14. Başkaları tarafından takdir edildiğini hissetmek	1	2	3	4	5
15. Ailenizden hoşnut olmak	1	2	3	4	5
16. Kendinizden hoşnut olmak	1	2	3	4	5
17. Gelecekle ilgili kendinizi güvende hissetmek	1	2	3	4	5
18. Yakın arkadaşlara sahip olmak	1	2	3	4	5
19. Bir eve sahip olmak	1	2	3	4	5
20. Gelecekle ilgili planlar yapmak	1	2	3	4	5
21. Sizi düşünen birilerinin olması	1	2	3	4	5
22. Hayatınızın bir anlamı olması	1	2	3	4	5

APPENDIX D: The Parenting Sense of Competence

Mother Form

Bu ölçek. sizin çocuk bakımına yönelik tutumunuzu ölçmek amacıyla hazırlanmıştır. Her cümle ile ilgili tutumlar. kişiden kişiye değişebilir. Bunun için vereceğiniz cevaplar yalnızca sizin kendi tutumunuzu yansıtmaktadır. Her cümlenin sizi ilgilendirdiğini düşünerek. cümlede belirtilen tutumun. size ne derece uygun olduğuna karar veriniz. Cümlede belirtilen tutum ifadesine tamamen katılıyorsanız 5 seçeneğini. katılıyorsanız 4 seçeneğini. kararsız iseniz 3 seçeneğini. katılmıyorsanız 2 seçeneğini. hiç katılmıyorsanız 1 seçeneğini işaretleyiniz. Bütün soruları mutlaka cevaplayınız. Her cümle için sadece bir seçeneği işaretleyiniz ve adınızı. soyadınızı yazmayınız. Katılımız ve ölçeği doldurmadaki samimiyetiniz için şimdiden teşekkür ederiz.

I.KİŞİSEL BİLGİLER:

Bir işte çalışıyor musunuz: Evet ( ) Hayır ( )

Mesleğiniz Memur ( ) İşçi ( ) Esnaf ( ) Diğer ( )

Eğitim Durumunuz İlköğretim ( ) Ortaöğretim ( ) Yükseköğretim ( ) Lisans Üstü ( )

Sosyo-ekonomik düzeyiniz Düşük ( ) Orta ( ) Yüksek ( )

Kaç çocuğunuz var 1 ( ) 2 ( ) 3 ( ) 4 ve Daha Fazla ( )

	Hiç Katılmıyorum	Katılmıyorum	Emin Değilim	Katılıyorum	Tamamen Katılıyorum

1. Sergilediğim davranışların çocuğumu nasıl etkilediğini biliyor olmam. çocuk bakımı konusundaki problemlerimin çözümünü kolaylaştırıyor	1	2	3	4	5
2. Çocuk bakımı konusunda yeterli düzeyde bilgi ve beceriye sahibim	1	2	3	4	5
3. Çocuğa doğru mu. yanlış mı davranıldığını bilmemek. iyi bir ebeveyn olmayı engellemez	1	2	3	4	5
4. Yeni bir annenin iyi bir ebeveyn olmak için gerekli davranışları öğrenebileceği. örnek bir model olabileceğime inanıyorum	1	2	3	4	5
5. Ebeveyn olmak hoş bir duygu olmasına rağmen. çocuğumun küçük olması benim bu duyguyu yaşamama engel oluyor	1	2	3	4	5
6. Neden bilmem ama. çocuğumun kontrolü bende olması gerekirken. bazen sanki yönetilen benmişim gibi hissediyorum	1	2	3	4	5
7. Annemin benden daha iyi bir anne olduğunu düşünüyorum	1	2	3	4	5
8. İyi bir ebeveyn olmanın zor olmadığını düşünüyorum	1	2	3	4	5
9. Bazen. iyi bir ebeveynle kendimi karşılaştırdığımda. hiçbir şeyin üstesinden gelemediğim duygusuna kapılıyorum	1	2	3	4	5
10. Çocuğumun derdinden en iyi	1	2	3	4	5

ben anlarım					
11. Anne olduğum süreyi göz önüne alınca. bu role tam olarak alıştığıma inanıyorum	1	2	3	4	5
12. Gerek sabah kalktığımda. gerekse akşam yatağa girdiğimde hep çocuğum konusunda hiçbir şey başaramadığım duygusuna kapılıyorum	1	2	3	4	5
13. İyi bir anne olmak. başlı başına bir ödüldür	1	2	3	4	5
14. Yetenek ve ilgilimin. iyi bir ebeveyn olma konusunda değil. başka alanlarda olduğunu düşünüyorum	1	2	3	4	5
15. Küçük bir çocuk annesi olmak benim için biraz daha ilginç olsaydı. çocuğuma daha iyi davranma konusunda kendimi daha fazla motive edebilirdim	1	2	3	4	5
16. Ebeveyn olmak beni gergin ve endişeli kılıyor	1	2	3	4	5

Father Form

Bu ölçek. sizin çocuk bakımına yönelik tutumunuzu ölçmek amacıyla hazırlanmıştır. Her cümle ile ilgili tutumlar. kişiden kişiye değişebilir. Bunun için vereceğiniz cevaplar yalnızca sizin kendi tutumunuzu yansıtmaktadır. Her cümlenin sizi ilgilendirdiğini düşünerek. cümlede belirtilen tutumun. size ne derece uygun olduğuna karar veriniz. Cümlede belirtilen tutum ifadesine tamamen katılıyorsanız 5 seçeneğini. katılıyorsanız 4 seçeneğini. kararsız iseniz 3 seçeneğini. katılmıyorsanız 2 seçeneğini. hiç katılmıyorsanız 1 seçeneğini işaretleyiniz. Bütün soruları mutlaka cevaplayınız. Her cümle için sadece bir seçeneği işaretleyiniz ve adınızı. soyadınızı yazmayınız. Katılımız ve ölçeği doldurmadaki samimiyetiniz için şimdiden teşekkür ederiz.

I.KİŞİSEL BİLGİLER:

Bir işte çalışıyor musunuz: Evet ( ) Hayır ( )

Mesleğiniz Memur ( ) İşçi ( ) Esnaf ( ) Diğer ( )

Eğitim Durumunuz İlköğretim ( ) Ortaöğretim ( ) Yükseköğretim ( ) Lisans Üstü ( )

Sosyo-ekonomik düzeyiniz Düşük ( ) Orta ( ) Yüksek ( )

Kaç çocuğunuz var 1 ( ) 2 ( ) 3 ( ) 4 ve Daha Fazla ( )

	Hiç Katılmıyorum	Katılmıyorum	Emin Değilim	Katılıyorum	Tamamen Katılıyorum

Sergilediğim davranışların çocuğumu nasıl etkilediğini biliyor olmam. çocuk bakımı konusundaki problemlerimin çözümünü kolaylaştırıyor	1	2	3	4	5
Çocuk bakımı konusunda yeterli düzeyde bilgi ve beceriye sahibim	1	2	3	4	5
Çocuğa doğru mu. yanlış mı davranıldığını bilmemek. iyi bir ebeveyn olmayı engellemez	1	2	3	4	5
Yeni bir babanın. iyi bir ebeveyn olmak için gerekli davranışları öğrenebileceği. örnek bir model olabileceğime inanıyorum	1	2	3	4	5
Ebeveyn olmak hoş bir duygu olmasına rağmen. çocuğumun küçük olması benim bu duyguyu yaşamama engel oluyor	1	2	3	4	5
Neden bilmem ama. çocuğumun kontrolü bende olması gerekirken. bazen sanki yönetilen benmişim gibi hissediyorum	1	2	3	4	5
Babamın benden daha iyi bir baba olduğunu düşünüyorum	1	2	3	4	5
İyi bir ebeveyn olmanın zor olmadığını düşünüyorum	1	2	3	4	5
Bazen. iyi bir ebeveynle kendimi karşılaştırdığımda. hiçbir şeyin üstesinden gelemediğim duygusuna kapılıyorum	1	2	3	4	5
Çocuğumun derdinden en iyi ben anlarım	1	2	3	4	5
Baba olduğum süreyi göz önüne alınca. bu role tam olarak alıştığıma inanıyorum	1	2	3	4	5

Gerek sabah kalktığımda. gerekse akşam yatağa girdiğimde hep çocuğum konusunda hiçbir şey başaramadığım duygusuna kapılıyorum	1	2	3	4	5
İyi bir baba olmak. başlı başına bir ödüldür	1	2	3	4	5
Yetenek ve ilgilimin. iyi bir ebeveyn olma konusunda değil. başka alanlarda olduğunu düşünüyorum	1	2	3	4	5
Küçük bir çocuk babası olmak benim için biraz daha ilginç olsaydı. çocuğuma daha iyi davranma konusunda kendimi daha fazla motive edebilirdim	1	2	3	4	5
Ebeveyn olmak beni gergin ve endişeli kılıyor	1	2	3	4	5

APPENDIX E: Multidimensional Scale of Perceived Social Support (MSPPS)

Aşağıda 12 cümle ve her birinde de cevaplarınızı işaretlemeniz için 1 den 7ye kadar rakamlar verilmiştir.Her cümlede söyleneni sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini daire içine alarak işaretleyiniz. Bu şekilde 12 cümlenin her birinde bir işaret koyarak cevaplarınızı veriniz.

1. İhtiyacım olduğunda yanımda olan özel bir insan var.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

2.Sevinç ve kederimi paylaşabileceğim özel bir insan var.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

3.Ailem bana gerçekten yardımcı olmaya çalışır.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

4.İhtiyacım olan duygusal yardımı ve desteği ailemden alırım.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

5.Beni gerçekten rahatlatan özel bir insan var.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

6.Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

7.İşler kötü gittiğinde arkadaşlarıma güvenebilirim.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

8.Sorunlarımı ailemle konuşabilirim.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

9.Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

10.Yaşamımda duygularıma önem veren özel bir insan var.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

11.Kararlarımı vermede ailem bana yardımcı olmaya isteklidir.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

12.Sorunlarımı arkadaşlarımla konuşabilirim.

Kesinlikle hayır	1	2	3	4	5	6	7	Kesinlikle evet

APPENDIX F: Brief Symptom Inventory

Aşağıda. insanların bazen yaşadıkları belirtilerin ve yakınmaların bir listesi verilmiştir. Listedeki her bir maddeyi lütfen dikkatle okuyun. Daha sonra o belirtilerin SİZDE BUGÜN DAHİL. SON BİR HAFTADIR NE KADAR VAROLDUĞUNU yandaki bölmede uygun olan yerde işaretleyin. Her belirti için sadece bir yeri işaretlemeyi ve hiçbir maddeyi atlamamaya özen gösterin. Yanıtlarınızı kurşun kalemle işaretleyin. Eğer fikir değiştiriseniz ilk yanıtınızı silin.

Yanıtlarınızı aşağıdaki ölçeğe göre değerlendiriniz:

Bu belirtiler sizde ne kadar var?

0-Hiç yok 1-Biraz var 2-Orta derecede var 3-Epey var 4-Çok fazla var

1. İçinizdeki sinirlilik ve titreme hali	0	1	2	3	4
2. Baygınlık. baş dönmesi	0	1	2	3	4
3. Bir başka kişinin sizin düşüncelerinizi kontrol edeceği fikri	0	1	2	3	4
4. Başınıza gelen sıkıntılardan dolayı başkalarının suçlu olduğu duygusu	0	1	2	3	4
5. Olayları hatırlamada güçlük	0	1	2	3	4
6. Çok kolayca kızıp öfkelenme	0	1	2	3	4
7. Göğüs (kalp) bölgesinde ağrılar	0	1	2	3	4
8. Meydanlık (açık) yerlerden korkma duygusu	0	1	2	3	4
9. Yaşamınıza son verme düşünceleri	0	1	2	3	4
10. İnsanların çoğuna güvenilmeyeceği hissi	0	1	2	3	4
11. İştahta bozukluklar	0	1	2	3	4
12. Hiçbir nedeni olmayan ani korkular	0	1	2	3	4
13. Kontrol edemediğiniz duygu patlamaları	0	1	2	3	4
14. Başka insanlarla beraberken bile yalnızlık hissetmek	0	1	2	3	4
15. İşleri bitirme konusunda kendini engellenmiş hissetmek	0	1	2	3	4
16. Yalnız hissetmek	0	1	2	3	4

17. Hüzünlü. kederli hissetmek	0	1	2	3	4
18. Hiçbir şeye ilgi duymamak	0	1	2	3	4
19. Ağlamaklı hissetmek	0	1	2	3	4
20. Kolayca incinebilme. kırılmak	0	1	2	3	4
21. Kendini diğerlerinden daha aşağı görme	0	1	2	3	4
22. Mide bozukluğu. bulantı	0	1	2	3	4
23. Diğerlerinin sizi gözlediği ya da hakkınızda konuştuğu duygusu	0	1	2	3	4
24. Uykuya dalmada güçlükler	0	1	2	3	4
25. Yaptığınız şeyleri tekrar tekrar doğru mu diye kontrol etmek	0	1	2	3	4
26. Karar vermede güçlükler	0	1	2	3	4
27. Otobüs. tren. metro gibi umumi vasıtalarla seyahatlerden korkmak	0	1	2	3	4
28. Nefes darlığı. nefessiz kalmak	0	1	2	3	4
29. Sıcak soğuk basmaları	0	1	2	3	4
30. Sizi korkuttuğu için bazı eşya. yer ya da etkinliklerden uzak kalmaya 31. çalışmak	0	1	2	3	4
32. Kafanızın 'bomboş' kalması	0	1	2	3	4
33. Bedeninizin bazı bölgelerinde uyuşmalar. karıncalanmalar	0	1	2	3	4
34. Günahlarınız için cezalandırılmanız gerektiği	0	1	2	3	4
35. Gelecekle ilgili umutsuzluk duyguları	0	1	2	3	4
36. Konsantrasyonda (dikkati birşey üzerinde toplama) güçlük/zorlanmak	0	1	2	3	4
37. Bedeninizin bazı bölgelerinde zayıflılık. güçsüzlük hissi	0	1	2	3	4
38. Kendini gergin ve tedirgin hissetmek	0	1	2	3	4
39. Ölme ve ölüm üzerine düşünceler	0	1	2	3	4
40. Birini dövme. ona zarar verme. yaralama isteği	0	1	2	3	4
41. Birşeyleri kırma dökme isteği	0	1	2	3	4
42. Diğerlerinin yanındayken yanlış birşeyler yapmamaya çalışmak	0	1	2	3	4

43. Kalabalıklarda rahatsızlık duymak	0	1	2	3	4
44. Başka bir insana hiç yakınlık duymamak	0	1	2	3	4
45. Dehşet ve panik nöbetleri	0	1	2	3	4
46. Sık sık tartışmaya girmek	0	1	2	3	4
47. Yalnız bırakıldığında/ kalındığında sinirlilik hissetmek	0	1	2	3	4
48. Başarılarınız için diğerlerinden yeterince takdir görmemek	0	1	2	3	4
49. Yerinde duramayacak kadar tedirgin hissetmek	0	1	2	3	4
50. Kendini yetersiz görmek/ değersizlik duyguları	0	1	2	3	4
51. Eğer izin verirseniz insanların sizi sömüreceği duygusu	0	1	2	3	4
52. Suçluluk duyguları	0	1	2	3	4
53. Aklınızda bir bozukluk olduğu fikri	0	1	2	3	4

APPENDIX G: Beck Depression Inventory

Aşağıda gruplar halinde bazı sorular yazılıdır. Her gruptaki cümleleri dikkatle okuyunuz. Bugün dahil. geçen hafta içinde kandinizi nasıl hissettiğinizi en iyi anlatan cümleyi seçiniz. Seçmiş olduğunuz cümlenin yanındaki numaranın üzerine (X) işareti koyunuz.

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 birçok kişiden daha fazla başarısızlıklarım oldu sayılır.

(c)Geriye dönüp baktığımda. çok fazla başarısızlığımın olduğunu görüyorum.

(d)Kendimi tümüyle başarısız bir insan olarak görüyorum.

4. (a)Her şeyden eskisi kadar zevk alabiliyorum.

(b)Her şeyden eskisi kadar zevk alamıyorum.

(c)Artık hiçbir şeyden gerçek bir zevk alamıyorum.

(d)Bana zevk veren hiçbir şey yok. Her şey çok sıkıcı.

5. (a)Kendimi suçlu hissetmiyorum.

(b)Arada bir kendimi suçlu hissettiğim oluyor.

(c)Kendimi çoğunlukla suçlu hissediyorum.

(d)Kendimi her an için suçlu hissediyorum.

6. (a)Cezalandırıldığımı düşünmüyorum.

(b)Bazı şeyler için cezalandırılabileceğimi hissediyorum.

(c)Cezalandırılmayı bekliyorum.

(d)Cezalandırıldığımı hissediyorum.

7. (a)Kendimden hoşnudum.

(b)Kendimden pek hoşnut değilim.

(c)Kendimden hiç hoşlanmıyorum.

(d)Kendimden nefret ediyorum.

8. (a)Kendimi diğer insanlardan daha kötü görmüyorum.

(b)Kendimi zayıflıklarım ve hatalarım için eleştiriyorum.

(c)Kendimi hatalarım için çoğu zaman suçluyorum.

(d)Her kötü olayda kendimi suçluyorum.

9. (a)Kendimi öldürmek gibi düşüncelerim yok.

(b)Bazen kendimi öldürmeyi düşünüyorum. fakat bunu yapmam.

(c)Kendimi öldürebilmeyi isterdim.

(d) Bir fırsatını bulsam kendimi öldürürdüm.

10.(a)Her zamankinden daha fazla ağladığımı sanmıyorum.

(b)Eskisine göre şu sıralarda daha fazla ağlıyorum.

(c)Şu sıralarda her an ağlıyorum.

(d)Eskiden ağlayabilirdim. ama şu sıralarda istesem de ağlayamıyorum.

11.(a)Her zamankinden daha sinirli değilim.

(b)Her zamankinden daha kolayca sinirleniyor ve kızıyorum.

(c)Çoğu zaman sinirliyim.

(d)Eskiden sinirlendiğim şeylere bile artık sinirlenemiyorum.

12.(a)Diğer insanlara karşı ilgimi kaybetmedim.

(b)Eskisine göre insanlarla daha az ilgiliyim.

(c)Diğer insanlara karşı ilgimin çoğunu kaybettim.

(d)Diğer insanlara karşı hiç ilgim kalmadı.

13.(a)Kararlarımı eskisi kadar kolay ve rahat verebiliyorum.

(b)Şu sıralarda kararlarımı vermeyi erteliyorum.

(c)Kararlarımı vermekte oldukça güçlük çekiyorum.

(d)Artık hiç karar veremiyorum.

14.(a)Dış görünüşümün eskisinden daha kötü olduğunu sanmıyorum.

(b)Yaşlandığımı ve çekiciliğimi kaybettiğimi düşünüyor ve üzülüyorum.

(c)Dış görünüşümde artık değiştirilmesi mümkün olmayan olumsuz değişiklikler olduğunu hissediyorum.

(d)Çok çirkin olduğumu düşünüyorum.

15.(a)Eskisi kadar iyi çalışabiliyorum.

(b)Bir işe başlayabilmek için eskisine göre kendimi daha fazla zorlamam gerekiyor.

(c)Hangi iş olursa olsun. yapabilmek için kendimi çok zorluyorum.

(d)Hiçbir iş yapamıyorum.

16 (a)Eskisi kadar rahat uyuyabiliyorum.

(b)Şu sıralarda eskisi kadar rahat uyuyamıyorum.

(c)Eskisine göre 1 veya 2 saat erken uyanıyor ve tekrar uyumakta zorluk çekiyorum.

(d)Eskisine göre çok erken uyanıyor ve tekrar uyuyamıyorum.

17.(a)Eskisine kıyasla daha çabuk yorulduğumu sanmıyorum.

(b)Eskisinden daha çabuk yoruluyorum.

(c)Şu sıralarda neredeyse her şey beni yoruyor.

(d)Öyle yorgunum ki hiç bir şey yapamıyorum.

18.(a)İştahım eskisinden pek farklı değil.

(b)İştahım eskisi kadar iyi değil.

(c)Şu sıralarda iştahım epey kötü.

(d)Artık hiç iştahım yok.

19.(a)Son zamanlarda pek fazla kilo kaybettiğimi sanmıyorum.

(b)Son zamanlarda istemediğim halde üç kilodan fazla kaybettim.

(c)Son zamanlarda istemediğim halde beş kilodan fazla kaybettim.

(d)Son zamanlarda istemediğim halde yedi kilodan fazla kaybettim.

Daha az yemeye çalışarak kilo kaybetmeye çalışıyorum. Evet ( ) Hayır ( )

20.(a)Sağlığım beni pek endişelendirmiyor.

(b)Son zamanlarda ağrı. sızı. mide bozukluğu. kabızlık gibi sorunlarım var.

(c)Ağrı. sızı gibi bu sıkıntılarım beni epey endişelendirdiği için başka şeyleri düşünmek zor geliyor.

(d)Bu tür sıkıntılar beni öylesine endişelendiriyor ki. artık başka hiçbir şey düşünemiyorum.

21.(a)Son zamanlarda cinsel yaşantımda dikkatimi çeken bir şey yok.

(b)Eskisine oranla cinsel konularla daha az ilgileniyorum.

(c)Şu sıralarda cinsellikle pek ilgili değilim.

(d)Artık. cinsellikle hiçbir ilgim kalmadı.