THE PREDICTIVE ROLES OF PERCEIVED SOCIAL SUPPORT, EARLY MALADAPTIVE SCHEMAS, PARENTING STYLES, AND SCHEMA COPING PROCESSES IN WELL-BEING AND BURNOUT LEVELS OF PRIMARY CAREGIVERS OF DEMENTIA PATIENTS

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ABSTRACT

THE PREDICTIVE ROLES OF PERCEIVED SOCIAL SUPPORT, EARLY MALADAPTIVE SCHEMAS, PARENTING STYLES, AND SCHEMA COPING PROCESSES IN WELL-BEING AND BURNOUT LEVELS OF PRIMARY CAREGIVERS OF DEMENTIA PATIENTS

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The main purpose of the current study was to investigate the predictive roles of perceived social support, early maladaptive schemas, parenting styles, and schema coping processes in well-being and burnout levels of primary caregivers of dementia patients.Ninety-nine adult children as the primary caregivers of dementia patients completed the measures of Young Schema Questionnaires (YSQ), Young Parenting Inventory (YPI), Young Compensation Inventory (YCI), Young Rygh Avoidance Inventory (YRAI), Maslach Burnout Inventory (MBI), Caregiver Well-Being Scale, Beck Depression Inventory (BDI), and Perceived Social Support (PSS). Results indicated the mediator role of early maladaptive schemas between parenting styles and caregiver well-being-basic needs, depression, and burnout relations. However, the results did not support the mediator role of early maladaptive schemas on the association of parenting styles with caregiver well-being activity of living relation. In addition, the moderator role of perceived social support and perceived social support

from significant others were found in the relation between early maladaptive schemas and caregiver well-being basic needs. Schema coping processes, namely, schema coping processes of avoidance and compensation, did not moderate any of the relations tested. Findings highlighted the buffering role of perceived social support especially from significant others in the caregiving processes. Strengths, limitations, and the findings of the current study were discussed in the light of the related literature; and suggestions for future studies, as well as the clinical implications of the findings, were presented.

Keywords: Caregiving, Early Maladaptive Schemas, Parenting Styles, Perceived Social Support, Caregiver Well-Being.

ÖZ

DEMANS HASTASINA TEMEL BAKIM VEREN BİREYLERDE ALGILANAN SOSYAL DESTEĞİN, ERKEN DÖNEM UYUMSUZ ŞEMALARIN, EBEVEYNLİK STİLLERİNİN VE ŞEMA BAŞ ETME BİÇİMLERİNİN İYİLİK HALİ VE TÜKENMİŞLİK SEVİYELERİ ÜZERİNDEKİ YORDAYICI ROLÜ

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Bu araştırmanın temel amacı demans hastasina temel bakım veren bireylerde algılanan sosyal desteğin, erken dönem uyumsuz şemaların, ebeveynlik stillerinin ve şema baş etme biçimlerinin iyilik hali ve tükenmişlik seviyeleri üzerindeki yordayıcı rolünü incelemektir. Doksan-dokuz demans hastasına temel bakım veren yetişkin çocuklarına Young Şema Ölçeği, Young Ebeveynlik Ölçeği, Young Telafi Ölçeği, Young Kaçınma Ölçeği, Maslach Tükenmişlik Ölçeği, Bakıcı İyilik Ölçeği, Beck Depresyon Envanteri ve Çok Yönlü Algılanan Sosyal Destek Envanteri uygulanmıştır. Sonuçlar erken dönem uyumsuz şemaların, ebeveynlik stilleri ve bakıcı iyilik hali-temel ihtiyaçlar, depresyon ve tükenmişlik ilişkisinde aracı role sahip olduğunu göstermiştir. Fakat bu aracı rol, bakıcı iyilik hali-yaşamsal faaliyetler alt ölçeği için desteklenmemiştir. Buna ek olarak, algılanan sosyal desteğin ve özel kişiden algılanan sosyal desteğin, erken dönem uyumsuz şemaları ve bakıcı iyilik

hali-temel ihtiyaçlar ilişkisinde moderator rolünün olduğu görülmüştür. Şema baş etme biçimlerinin, yani telafi ve kaçınma şema baş etme biçimlerinin test edilen herhangi bir ilişkide moderatör rolü bulunamamıştır. Bulgular, bakım verme sürecinde algılanan sosyal desteğin, özellikle de özel kişiden algılanan sosyal desteğin koruyucu rolünü vurgulamıştır. Araştırmanın güçlü yanları, sınırlılıkları ve bulguları ilgili literature ışığında tartışılmıştır. Bunlarla beraber araştırmanın klinik göstergeleri ve gelecek çalışmalar için öneriler de sunulmuştur.

Anahtar Kelimeler: Bakım vermek, Erken Dönem Uyumsuz Şemaları, Ebeveynlik Stilleri, Algılanan Sosyal Destek, Bakıcı İyilik Hali.

To My Grandfathers

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INTRODUCTION

The proportion of the population older than 65 years of age is growing rapidly and this growth will accelerate over the next 25 yearsin the USA (Older Americans 2000: Key Indicators of Well-Being, 2000). The number of dementia patients also increase as a result of changing demographic profile. According to World Alzheimer Report (2010), 36 million people have dementia, and this number is assumed to rise to 115.4 million by 2050 (as cited in Boots, de Vugt, van Knippenberg, Kempen, & Verhey, 2014). In other words, a large proportion of aging population worldwide is affected by dementia (World Health Organization, 2012). Dementia is a syndrome that arises from a brain disease, has a progressive and chronic nature, and disturbs multiple higher cortical functions such as memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgment. These disturbances accompany disturbances in emotional control, social behavior, or motivation according to the ICD-10 Classification of Mental and Behavioral Disorders (World Health Organization, 1992). According to *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV), in order to receive the diagnosis of dementia , a person must experience a decline in memory and also a decline in at least one of the following cognitive abilities: " ability to generate coherent speech or understand spoken or written language", "ability to recognize or identify objects, assuming intact sensory function", " ability to execute motor activities, assuming intact motor abilities, sensory function, and comprehension of the required task", and "ability to think abstractly, make sound judgments, and plan and carry out complex tasks" (APA, 2000). After DSM-IV, DSM-V was released (APA, 2013b). In DSM-V, the DSM-IV diagnoses of dementia and amnestic disorder were categorized under major neurocognitive disorder (NCD) (APA, 2013c) instead of separate diagnosis of dementia and amnestic disorder . For this reason, DSM-IV criteria were used to explain characteristics of dementia. In

addition to the criteria mentioned above, another criterion of dementia in DSM-IV is that the decline in these cognitive abilities should interfere with daily life of the person (APA, 2000). Because of the interference with daily life, 69% (Rosa et al., 2010) to 72% (Diehl-Schmid et al., 2013) of the dementia patients live with a caregiver. According to Zarit and Edwards (1999), caregiving is "interactions in which one family member is helping another on a regular basis with tasks that are necessary for independent living" (as cited in Oyebode, 2003). Caregivers of dementia patients were spouses (61%) (Heru & Ryan, 2006), children (29%), or other relatives and friends (Heru, Ryan, & Iqbal, 2004). Therefore, not only patients, but also their families and friends were affected on personal, emotional, financial, and social levels by dementia (Wimo & Prince, 2010). Ballard (1989) explained dementia as the "funeral that never ends", because caregivers face many losses over the course of the illness instead of one final loss (as cited in Perren, Schmid, Herrmann, & Wettstein, 2007). This supported the claim that dementia caregivers are affected more negatively than other patients' caregivers (Pinquart & Sorensen, 2003b).

Caregivers provide their patients undemanding and demanding services, which vary between driving the person to an appointment, bathing, and dressing (Rosa et al., 2010). According to Ricci, Tolve, Bonati, Pinelli, and Neri (2003), dementia caregivers spend 75% of their daytime for responding to the patients' needs; the amount of time increases as the illness worsens (as cited in Di Mattei, Prunas, Novella, Cappa, & Sarno, 2008). Another study found that, at least 46 hours per week are spent by half of the caregivers for activities of daily living. Because of the care providing activities, half of the caregivers end or reduce employment (Schulz et al., 2003). After looking at the tasks carried out by the caregivers and time spend for these activities, it is not surprising that caregivers experience burden (Wang, Xiao, He, & De Bellis, 2014). According to George and Gwyther (1986), caregiver burden is "the physical, psychological or emotional, social, and financial problems that can be experienced by family members caring for impaired older adults." (as cited in McCurry, Logsdon, Teri, & Vitiello, 2007). "Burden" and "strain" terms are used interchangeably in caregiving literature (Donaldson, Tarrier, & Burns, 1997). Both burden and strain are associated with care-related issues, such

as physical impairment (Kim, Chang, Rose, & Kim, 2012; Schulz et al., 2003), patient behavioral problems (Coen, Swanwick, O'Boyle, & Coakley, 1997; Schulz et al., 2003; Uei, Sung, & Yang, 2013), and the need for supervision and care (Kim, Chang, Rose, & Kim, 2012; Schulz et al., 2003; Uei, Sung, & Yang, 2013), which are all related to psychological well-being of the caregiver (Diehl-Schmid et al., 2013; Gallant & Connell, 1997;Lawton, Moss, Kleban, Glicksman, & Rovine, 1991).

In addition to the caregiver burden and strain, caregivers of dementia patients also reported higher levels of stress (Andrén & Elmstahl, 2007; Bertrand, Fredman, & Saczynski, 2006; Le´vesque, Ducharme, & Lachance, 1999; Pinquard & Sörensen, 2003; Vedhara et al., 1999). For spouses, sources of stress were being older and physical or financial problems of caregiver as a result of being older, while conflicting responsibilities were sources of stress for adult children (Oyebode, 2003). The relationship among distress, stress and caregiver physical and psychological health was investigated in many studies. For example, Alzheimer disease's caregivers reported chronic stress which turned to distress, and then distress turned to metabolic syndrome, an ultimate predictor of coronary heart disease. In other words, level of psychological distress mediated the relationship between caregiving stress and physical health problems (Vitaliano et al., 2002). Due tochronic exposure to stress, caregivers of dementia patients have negative health outcomes (Di Mattei et al., 2008; Mausbach et al., 2012; Mausbach, Patterson, Rabinowitz, Grant, & Schulz, 2007), such as coronary heart disease (Vitaliano et al., 2002), cardiovascular disease (Mausbach et al., 2010), hypertension (Shaw et al., 2003), blood pressure (Shaw et al., 1999), impaired immune functioning (Kiecolt-Glaser, Glaser, Gravenstein, Malarkey, & Sheridan, 1996; Mills et al., 1997; Mills et al., 2004; Mills, Yu, Ziegler,Patterson, & Grant, 1999), anxiety (Coope et al., 1995), and depression (Coope et al., 1995; Fauth & Gibbons, 2014; Leggett, Zarit, Kim, Almeida, & Klein, 2014;Simpson, & Carter, 2013).

Brodaty and Donkin (2009) asserted that caregivers were "the invisible second patient" (as cited in Boots, Vugt, Knippenberg, Kempen, & Verhey, 2014). This was supported by the finding that caregivers of dementia patients reported higher levels of physical and emotional morbidity (Takai et al., 2009; Ulstein, Wyller, & Engedal, 2007). According to a study by Schulz, O'Brien, Bookwala, and

Fleissner (1995), physical morbidity was related to patient problem behaviors and cognitive impairment, perceived social support, and caregiver's depression and anxiety, whereas psychiatric morbidity in caregivers was associated with patient problem behaviors, income, self-rated health, perceived stress, life satisfaction, caregiver depression, anxiety, perceived social support, and cognitive deterioration.

By using brief self-administered sociodemographic questionnaire, suffering from some emotional morbidity was found in more than half of the dementia caregivers and the most reported emotional symptom was anxiety, followed by depression (Covinsky et al., 2003; Mahoney, Regan, Katona, & Livingston, 2005). As reasons for the anxiety and depression; caregivers' poor health, poor relationship between caregiver and care-receiver, and care-receiver irritability contributed depression, whereas deterioration of care-receiver daily activities, living with the care-receiver, having poor relationship between caregiver and care receiver, poor health reported by the caregiver predicted anxiety disorder (Mahoney, Regan, Katona, & Livingston, 2005). Alzheimer caregivers reported higher levels of depressive symptoms (Diehl-Schmid et al., 2013; Kiecolt-Glaser, Dura, Speicher, Trask, & Glaser, 1991; Mausbach, Patterson, & Grant, 2008; Papastavrou, Kalokerinou, Papacostas, Tsangari, & Sourtzi, 2007) as compared to non-caregiver spouses (Beeson, 2003; Cuijpers, 2005; Fuller-Jonap & Haley, 1995; Mahoney, Regan, Katona, & Livingston, 2005), and non-dementia caregivers such as Parkinson's disease (Hooker, Monahan, Bowman, Frazier, & Shifren, 1998). As expected, nearly 23% of the caregivers mentioned the use of psychotropic drug, especially benzodiazepines (48.8%), antidepressants (32.6%), herbal supplements (14%), and mood stabilizers (4.6%) (Truzzi et al., 2012). In terms of physical morbidity, caregiving increased the risk of physical health problems, such as lower response levels for antibodies, higher levels of stress hormones (Vitaliano, Zhang, & Scanlan, 2003), impaired cardiovascular health (Lee, Colditz, Berkman, & Kawachi, 2003; Mausbach, Patterson, Rabinowitz, Grant, & Schulz, 2007; von Kanel et al., 2008), hyperlipidemia (Vitaliano, Russo, & Niaura, 1995), hyperglycemia and hyperinsulinemia (Vitaliano, Scanlan, Krenz, & Fujimoto, 1996), poorer immune functioning (Kiecolt-Glaser, Dura, Speicher, Trask, & Glaser, 1991), and hypertension (Grant et al., 2002; Roepke et al., 2011; Shaw et al., 1999; von Kanel et

al., 2008). Physical and psychological healths of the caregivers were also found to be associated. Elevated depressive symptoms were associated with increased negative health outcomes (Piercy et al., 2013), especially cardiovascular disease (Mausbach, Patterson, Rabinowitz, Grant, & Schulz, 2007). In short, caregiving affects both psychological and physical health of the caregivers dramatically.

Caregivers do not have enough time to do positive health activities, such as adherence to proper nutritional regimen, doing routine exercise, and getting sufficient sleep (Gallant & Connell, 1997). Caregivers of Alzheimer's disease patients reported more sleep problem and less sleep time (Simpson & Carter, 2013), which resulted in more functional impairment than non-caregivers (McKibbin et al., 2005). Sleep deficiency was highlighted to be associated with obesity and diabetes (Knutson, Spiegel, Penev, & van Cauter, 2007), increased cardiovascular risk (Mills et al., 2009), increased mortality (Grandner, Hale, Moore, & Patel, 2010), increased level of depression (Simpson, & Carter, 2013; Wilcox, & King, 1998), and stress (Wilcox, & King, 1998), all of which were indicators of decreased well-being. According to Lawton, Moss, Kleban, Glicksman, and Rovine (1991), psychological well-being is defined as "a subjective state that results from many long-standing factors as well as situation specific stressors related to caregiving, and it is an important outcome measure" (as cited in Lawrance, Tennstedt, & Assman, 1998). Accordingly, well-being was used as an outcome measure in this study.

The strongest predictors of caregiver well-being were related to patients' cognitive and functional impairment (Ornstein et al., 2013), and behavioral problems (Hooker et al., 2002; Pinquart & Sorensen, 2003a) such as apathy, forgetfulness, restlessness or agitation, incontinence, aimlessness, lack of cooperation, aggressiveness, and inappropriate sexual behaviors (Uei, Sung, & Yang, 2013) of the patients. More specifically, caregiver's depressive symptoms were related to patient's agitation/aggression (Ornstein et al., 2013; Diehl-Schmid et al., 2013), egocentric behavior, and reduced sleep (Diehl-Schmid et al., 2013).

According to Mace and Robins (1999), caring for a person with Alzheimer's disease is living a 36-hour day, and this leads to physical, emotional, and mental exhaustion. To put it differently, caregivers of dementia patients have a tendency to burnout. Burnout can be defined as extreme physical and mental fatigue, emotional

exhaustion, decreased work motivation, and lack of empathy towards others (Maslach, 1982). Emotional exhaustion (EE), depersonalization (DP), and reduced personal accomplishment (RPA) are three symptoms of burnout. EE means lack of energy and enthusiasm, and the draining of one's emotional resources. The development of an indifferent, impersonal or cynical attitude between oneself and the service recipient refers to DP. Finally, RPA refers to a tendency to perceive one's work negatively or as ineffective (Maslach, Schaufeli, & Leiter, 2001). Studies in different countries and with different samples suggested that these three dimensions are separate but clearly related (Mäkikangas, Hätinen, Kinnunen, & Pekkonen, 2011;Schutte, Toppinen, Kalimo, & Schaufeli, 2000; Taris, Schreurs, & Schaufeli, 1999). For example, among these three dimensions of burnout, the highest correlation was asserted to be between emotional exhaustion and depersonalization, which shows that these three dimensions are not dependent (Truzzi et al., 2012).

Although early burnout studies were conducted with workers in services related to social and healthcare occupations, there are also few studies related to burnout among familial caregivers of patients with dementia. The view that dementia patients' familial caregivers may suffer from burnout was supported by a growing body of data (Almberg, Grafstrom, & Winblad, 1997; Takai et al., 2009; Truzzi et al., 2008). Strong predictors of burnout are limitations in one's social life, poor health indicators, and lack of a positive outlook in caregiving (Almberg, Grofstrom, & Winblad, 1997).

As one of the dimensions of burnout, 42.1% of the caregivers reported emotional exhaustion (Truzzi et al., 2012). In other words, familial caregivers of dementia patients have higher levels of emotional exhaustion (Matsuda, 2001), and having higher levels of emotional exhaustion was closely associated with functional level of the care recipient (Yılmaz, Turan, & Gundogar, 2009), caregivers' psychological well-being such as anxiety (Truzzi et al., 2012; Yılmaz, Turan, &Gundogar, 2009), depression (Takai et al., 2009; Truzzi et al., 2012), and "wish to die" thoughts (Truzzi et al., 2012). Moreover, caregivers having physical and emotional symptoms such as sadness, anxiety, insomnia, irritability, and fatigue reported higher emotional exhaustion scores than caregivers who do not have any physical symptoms (Truzzi et al., 2012). In addition to emotional exhaustion, other

dimensions of burnout were also examined in relation to several factors. Thirty-eight percent of the caregivers of dementia patients reported reduced personal accomplishment (Truzzi et. al., 2012), which was associated with caregivers' lower level of education and caring for a male patient (Yılmaz, Turan, & Gundogar, 2009). In addition, reduced personal accomplishment was related to sadness, insomnia, and fatique (Truzzi et. al., 2012). Depersonalization was found to be present in 22.8% of the caregivers (Truzzi et. al., 2012), and related to caregiver depression (Yılmaz, Turan, & Gundogar, 2009). Thus, although there are only limited number of studies on caregiver burnout, they all indicated negative outcomes .High burnout was also associated with poor physical health (Melamed, Shirom, Toker, Berliner, & Shapira, 2006). Similarly, high burnout was found to increase the risk of psychiatric morbidity (Willcock, Daly, Tennant, & Allard, 2004); such as depression (Thomas, 2004; Truzzi et al., 2008), anxiety symptoms (Truzzi et al., 2008), and somatic complaints (Melamed, Kushnir, & Shirom, 1992), stress (Koeske & Koeske, 1991; Watson, Deary, Thompson, & Li, 2008).

As mentioned above, caregiving affects both psychological and physical well-being of the caregiver. One of the psychological variables in this process can be early childhood experiences. Because, early childhood experiences with significant others determine organized thoughts, and feelings about self, others, and the world, they shape individual's perception and response to new experiences (Segal, 1988). These organized thoughts, behaviors, and feelings are schemas. Early maladaptive schemas (EMS) are defined as "a broad pervasive theme or pattern; comprised of memories, emotions, cognitions, and bodily sensations; regarding one's self and one's relationship with others; developed during childhood or adolescence; elaborated through one's life time; dysfunctional to some degree" (Young, Kolosko, & Weishaar, 2003, p. 7). EMSs, which are self-defeating emotional and cognitive patterns, are evident in community samples (Reeves & Taylor, 2007).Everyone has at least one of EMSs which are beginning in early development and repeats throughout life. In adulthood, life events trigger schemas, in which these events are perceived unconsciously as similar to the traumatic experiences of their childhood. When one of those schemas is triggered, experiencing a strong negative emotion, such as grief, shame, fear, or rage occurs. Though not all schemas have trauma at

their origin, all EMSsare destructive, and most schemas are caused by noxious experiences that are repeated on a regular basis throughout childhood and adolescence. These experiences are cumulative and they cause emergence of a full-blown schema regarded as a priori truths, so that these schemas influence the processing of later experiences as well (Young, Kolosko, & Weishaar, 2003). Schemas develop as a result of unmet core emotional needs in childhood, which are secure attachment to others including safety, stability, nurturance, and acceptance; autonomy, competence, and a sense of identity; freedom to express valid needs and emotions; spontaneity and play; and lastly, realistic limits and self-control. These needs are believed to be universal and some individuals have stronger needs than others (Young, Kolosko, & Weishaar, 2003).

Toxic childhood experiences are considered primary origin of early maladaptive schemas. These schemas develop earliest and are strongest, and typically originate in the nuclear family (Young, Kolosko, & Weishaar, 2003). Acquisitions of schemas are fostered by four types of early life experiences. The first one is toxic frustration of needs, which occurs when the child experiences too little of a good thing and this results in schemas such as emotional deprivation or abandonment through deficits in the early environment. These deficits can be stability, understanding, or love. The second acquisition is traumatization or victimization. The child who is harmed or victimized may develop schemas such as mistrust/abuse, defectiveness/shame, or vulnerability to harm. In the third type, the child experiences too much of a good thing, is coddled or indulged, develops schemas such as dependence/incompetence or entitlement/grandiosity. Autonomy and realistic limits, which are child's core emotional needs, are not met. Therefore, parents may overprotect a child, or may be overly involved in the life of the child, or may give the child an excessive degree of freedom and autonomy without any limits. The last type is selective internalization or identification with significant others. The child selectively identifies with and internalizes the parent's thoughts, feelings, experiences, and behaviors. Children do not identify with or internalize everything their parents do; rather, they selectively identify with and internalize certain aspects of significant others. Some of these identifications and internalizations become

schemas, and some become coping styles or modes (Young, Kolosko, & Weishaar, 2003).

Table 1.1.

Early Maladaptive Schemas with Associated Schema Domains

Schema Domain	Disconnection & Rejection	Impaired Autonomy & Performance	Impaired Limits	Other Directedness	Overvigilance & Inhibition
Early Maladaptive Schemas	Abandonment/ Instability	Dependence Incompetence	Entitlement/ Grandiosity	Subjugation	Negativity/ Pessimism
	Mistrust/ Abuse	Vulnerability to Harm or Illness	Insufficient Self-Control/ Self-Discipline	Self-Sacrifice	Emotional Inhibition
	Emotional Deprivation	Enmeshment/ Undeveloped Self		Approval Seeking/ Recogniti-on Seeking	Unrelenting Standards/ Hypercritical-ness
	Defectiveness/ Shame	Failure			Punitiveness
	Social Isolation/ Alienation				

Adapted from Young, Weishaar, and Kolosko (2003)

According to Young, Kolosko, and Weishaar (2003), there are 18 different EMSs under five broad categories of unmet emotional needs. These categories are called schema domains; namely, “disconnection and rejection” , “impaired autonomy and performance”, “impaired limits”, “other directedness”, and “overvigilance and inhibition” (See Table 1.1).

People with disconnection and rejection domain are more likely to feel insecure about others, and believe that they are not expected to be meet their needs for stability, safety, nurturance, love, and belonging. Unstable (abandonment/instability), abusive (mistrust/abuse), cold (emotional deprivation), rejecting (defectiveness/shame), or isolated from the outside world (social isolation/alienation) are typical families of origin. Disconnection and rejection domain schemas refer to people who are the most hurt. People with abandonment/instability schema have sense that their connection to significant others are unstable. People with this schema believe that important others will be absent because of their unpredictability, they will die, they will abandon the patient for someone better, or they are only present erratically. People with mistrust/abuse schema believe that other people will take advantage on them for their own selfish reasons if they have opportunity. The emotional deprivation schema is the expectation that one's emotional connection desire will not be met adequately. These deprivations are related to affection or caring, listening or understanding, and guidance from others. Feelings that one is worthless and inferior, unlovable, and being ashamed of one's perceived defects refer to the defectiveness/shame schema. Finally, the social isolation/alienation schema is about the feeling of being different from others and larger social world and related isolation from any group or community (Young, Kolosko, & Weishaar, 2003).

The second domain is impaired autonomy and performance. This domain indicates the characteristics of people who are less likely to function independently, to differentiate themselves from parent figures, to form their own identity and to live their own life. Their parents had overprotective behaviors and did everything for them without allowing their children to finish things by themselves; or, at the opposite extreme, not interested in their children when they were in need. As a result, they do not have specific goals or skills. In terms of competence, for instance, they stay with their children even when they became adults. In this domain, there are four schemas. The first one is dependence/incompetence schema, which is based on characteristics of people who have feeling that one is incapable of completing their everyday responsibilities without the help of someone else. The second one is vulnerability to harm or illness schema. People with this schema have fear of

medical catastrophes such as heart attacks, AIDS; emotional catastrophes like going crazy, losing control; and external catastrophes such as accidents, crime, and natural disasters. It is believed that these can happen any moment and one will not be able to prevent them because of inefficient coping skills. The third schema in this domain is enmeshment/undeveloped self. Overly involving in one or more significant others (often parents) at the cost of individuation and social development is the feature of this schema. The last one is the failure schema, which is the conviction that one will fail and is inadequate in the areas of achievement compared to one's peers (Young, Kolosko, & Weishaar, 2003).

The third domain is impaired limits, in which schemas are related to inadequate internal limits in terms of reciprocity or self-discipline. They have difficulties including respecting the rights of others, cooperation, keeping commitments, or fulfilling long-term goals. As children, they typically grew up in overly permissive and indulgent families and they did not need to follow general rules or limits associated with others' rights and their self-control. In their adulthood, they have no ability to postpone fulfillment and control their impulses for future benefits. Assuming that one is superior to others and therefore merit special rights and privileges without caring the rights of others refer to the entitlement/grandiosity schema. People with the insufficient self-control/self-discipline schema cannot or will not practice sufficient self-control and tolerate frustration while achieving their personal goals. In addition, they do not put good order of the emotional expression and their impulses (Young, Kolosko, & Weishaar, 2003).

The fourth domain is other-directedness, which is related to disregarding one's own needs and focusing on fulfilling the needs of others to be approved by, and connected emotionally with others. They have a tendency to concentrate on responses of the other person rather than on their own needs when communicating with others. In other words, they are directed externally, give importance to desires of others, and also they are not aware of their own anger and preferences. As children, their parents gave importance to social appearances or their own emotional needs more than that of child's, and give conditional acceptance; that is to say, child must keep in check the important aspects of themselves for obtaining love or approval. In this domain, there are three schemas. The subjugation schema is

exaggerated comply with others to avoid anger, retaliation, or abandonment, and conviction that their needs and emotions are unimportant or invalid. Thus, needs and emotions are subjugated. Subjugation causes maladaptive anger manifestation, such as behaving in a passive-aggressive way, uncontrolled tempter outbursts, or psychosomatic symptoms. People with the self-sacrifice schema have a tendency to fulfill the needs of others rather than their own to have self-esteem, avoid guilt and be connected with them. Other schema in this domain is approval-seeking/recognition-seeking related to obtaining approval or recognition from others, whose reactions are more important determinants of self-esteem, at the expense of developing a secure and genuine sense of self (Young, Kolosko, & Weishaar, 2003).

The fifth and last schema domain is overvigilance and inhibition, which refers to suppressing spontaneity and making an effort for meeting rigid, internalized rules about their own performance in the cost of being happy, expressing oneself, having close relationships, or being healthy. In their childhood, they were encouraged to be in self-control and self-denial over spontaneity and joy. The first schema in this domain is negativity/pessimism. People with this schema expect that everything goes wrong in a wide range of situation and they ignore positive aspects of situation with focusing on negative aspects of life. People with emotional inhibition schema restrict their spontaneous emotions (e.g., anger), communication, and actions for not being criticized or losing their impulse control. It is difficult for them to express vulnerability, so they focus on rationality while ignoring their emotions. The unrelenting standards/hypercriticalness schema is related to the belief that one must make effort to fulfill very high internalized standards to be approved. They are hypercritical, perfectionist, have rigid rules, and are preoccupied with time and efficiency. The final schema in this domain is punitiveness, which is based on the belief that people should be harshly punished for making mistakes. They do not have tolerance for not fulfilling standards, and in this case, they tend to be angry (Young, Kolosko, & Weishaar, 2003). The summary of the 18 early maladaptive schemas was presented in Table 1.2.

Table 1. 2.

18 Early Maladaptive Schemas

Early Maladaptive Schemas	Brief Description
1. Abandonment	The belief that important others will leave
2. Mistrust/ Abuse	The belief that other people will take advantage on them
3. Emotional Deprivation	The expectation that one's emotional support is not adequate
4. Defectiveness/Shame	The feeling that one is worthless or inferior
5. Social Isolation/Alienation	The feeling of being different from others
6. Dependence/Incompetence	The feeling that one is incapable of taking care of oneself
7. Vulnerability to Harm or Illness	The belief that catastrophes can happen any time
8. Enmeshment/Undeveloped Self	The involving of oneself with significant other
9. Failure	The conviction that one is inadequate compared to others
10. Entitlement/Grandiosity	The assumption that one is superior to others
11. Insufficient Self-Control/ Self-Discipline	The belief that one cannot control emotions or impulses
12. Subjugation	The conviction that one's needs and emotions are unimportant
13. Self-Sacrifice	The priority is fulfilling the needs of others
14. Approval Seeking/Recognition Seeking	The heightened need for approval/recognition from others
15. Negativity/Pessimism	The expectation that everything goes wrong
16. Emotional Inhibition	The restriction of one's own spontaneous emotions
17. Unrelenting Standards/Hypercriticalness	The belief that one must fulfill very high internalized and approved standards
18. Punitiveness	The belief that mistakes should be harshly punished

Adapted from Young, Kolosko, and Weishaar, (2003)

According to Young and his colleagues' framework, as given above, there were 18 Early Maladaptive Schemas under 5 schema domains (Young, Kolosko, & Weishaar, 2003). However, the number and the name of schemas are different in different studies with clinical and community samples. For example, presence of all 15 schemas which are assessed by Young Schema Questionnaire Long Form was supported in clinical sample (Lee, Taylor, & Dunn, 1999). On the contrary, not all schemas have been supported in each study. In Baranoff, Oei, Cho, and Kwon's (2006) study with students, there were 13 schemas excluding the subjugation and the

dependence/incompetence schemas. According to Sarıtaş and Gençöz's study (2011), there are three schema domains namely, impaired limits/exaggerated standards schema domain including EMSs of entitlement, approval seeking, unrelenting standards, pessimism, insufficient self-control, punitiveness; disconnection/rejection schema domain containing EMSs of emotional deprivation, social isolation, defectiveness/shame, emotional inhibition, mistrust/abuse, failure; impaired autonomy/other directedness schema domain including EMSs of subjugation, dependency/incompetence, enmeshment, vulnerability to harm, abandonment/instability, and self-sacrifice. According to Soygüt, Karaosmanoğlu, and Çakır's (2009) adaptation of Young Schema Questionnaire Short Form-3, there are 14 early maladaptive schemas under 5 different schema domains. In the present study, Soygüt, Karaosmanoğlu, and Çakır's (2009) questionnaire was used. Therefore, suggested schema domains by Soygüt, Karaosmanoğlu, and Çakır (2009) were used (See Table 1. 3.).

Table 1. 3.

Listing of Early Maladaptive Schemas

Schema Domain	Impaired Autonomy	Disconnection	Unrelenting Standards	Impaired Limits	Other-Directedness
	Enmeshment/ Dependence	Emotional Deprivation	Unrelenting Standards	Entitlement/ Insufficient Self-Control	Self-Sacrifice
	Abandonment	Emotional Inhibition	Approval-Seeking		Punitiveness
	Failure	Social Isolation/ Mistrust			
	Pessimism	Defectiveness			
	Vulnerability to Harm				

Adapted from Soygüt, Karaosmanoğlu, and Çakır (2003)

After giving brief information onEMSs, now the relationship between EMSs and psychological symptoms will be addressed. In general, early maladaptive schemas are important in the development and maintenance of psychiatric symptoms (Welburn, Coristine, Dagg, Pontefract, & Jordan, 2002). More specifically, psychological symptoms were predicted by early maladaptive schemas of emotional isolation, impaired limits, insufficiency, and fair-responsible-anxious (Kapçı & Hamamcı, 2010), defectiveness and failure schema, emotional deprivation, abandonment, dependence, enmeshment, self-sacrifice, entitlement, and insufficient self-control (Bidadian, Bahramizadeh, & Poursharifi, 2011). However, different schemas can result in the same Axis I diagnosis in different individuals. Thus, almost all the schemas can be manifested in depression, anxiety, substance abuse, psychosomatic symptoms, or sexual dysfunction (Young, Kolosko, & Weishaar, 2003).

The relationship between early maladaptive schemas and psychological well-being has been investigated by many researchers. Some studies have found a relationship between a certain psychopathology and certain EMSs. Although in this introduction it was stated that there is an association between schemas and well-being, specific schemas were not mentioned. In the following paragraphs a brief literature about this relation will be given.

EMSs were closely associated with mood disorders. There are several studies that found a relationship between early maladaptive schemas and depression (Calvete, Orue, & Hankin, 2013; Halvorsen, Wang, Eisemann, & Waterloo, 2010; Harris & Curtin, 2002; Muris, 2006; Renner, Lobbestael, Peeters, Arntz, & Huibers, 2012; Roelofs, Lee, Ruijten, & Lobbastael, 2011). Although studies related to the relationship between bipolar disorder and early maladaptive schemas were not ample, bipolar disorder was highligted to be associated with early maladaptive schemas (Hawke & Provencher, 2012; Hawke, Provencher, & Arntz, 2011).

There were also studies investigating the association of EMSs with anxiety disorders (e.g., Muris, 2006).In this line, panic and obsessive-compulsive disorders (Kim, Lee, & Lee, 2014; Pinto-Gouveia, Castillo, Galhardo, & Cunha, 2006), social phobia (Calvete, Orue, & Hankin, 2013; Diez, Zurnalde, & Sola, 2012;Kim, Lee, &

Lee, 2014) and posttraumatic stress disorder (Cockram, Drummond, & Lee, 2010) were closely associated with EMSs.

Like depressive disorders and anxiety disorders, patients with eating disorders have more EMSs than healthy controls in general(Waller, Ohanian, Meyer, & Osman, 2000). Eating problems (Muris, 2006), such as bulimia nervosa disorder and binge eating disorder were found to be related to early maladaptive schemas (Waller, Ohanian, Meyer, & Osman, 2000).In addition, sexual dysfunction disorder (Oliveira & Nobre, 2013), schizophrenia (Bortolon, Capdevielle, Boulenger, Gely-Nargeot, & Raffard, 2013), chronic pain disorder (Saariaho, Saariaho, Karila, & Joukamaa, 2010), alcohol dependence (Brotchie, Meyer, Copello, Kidney, & Waller, 2004; Roper, Dickson, Tinwell, Booth, & McGuire, 2010; Young, Kolosko, & Weishaar, 2003), opiate dependence, combined alcohol and opiate dependence (Brotchie, Meyer, Copello, Kidney, & Waller, 2004), substance abuse disorder (Muris, 2006; Shorey, Stuart, & Anderson, 2013), psychological distress (Schmidt, Joiner, Young, & Telch, 1995), and personality disorder symptoms (Lawrance, Allen, & Chanen, 2011; Lee, Taylor, & Dunn, 1999;Schmidt, Joiner, Young, & Telch, 1995; Young, Kolosko, & Weishaar, 2003) were related to early maladaptive schemas. Based on the literature above, it can be suggested that there is a relationship between Early Maladaptive Schemas and well-being. However, there was no study investigating the association between early maladaptive schemas and caregiver well-being.

For adapting schemas' intense and overwhelming emotions, people develop certain coping strategies in their early childhood. These strategies can be adaptive at the early years of life, but then it becomes maladaptive by generalizing them to other people and events. So, these are labeled as "maladaptive coping styles" which prevent people from intense, overwhelming emotions related to schemas, and help to avoid a schema; however, they also block change, and do not heal the schema (Young, 1999; Young, Kolosko, & Weishaar, 2003). The majority of coping responses are behavioral, cognitive, and emotive. Schema and coping styles are different from each other, because everyone uses different coping styles in different situations at different stages of their lives for coping with the same schema. Schema remains stable for an individual over time, whereas the coping styles for a given schema do not (Young, Kolosko, & Weishaar, 2003).

There are three schema coping styles; namely, overcompensation, avoidance, and surrender (Young, Kolosko, & Weishaar, 2003). Schema surrender is acting in a way that schemas are accurate. By this way, people repeat schema-driven patterns, so they experience the childhood experiences that create the current schema again (Young, Kolosko, & Weishaar, 2003). Schema avoidance is related to avoiding situations, and suppressing feelings associated with those schemas. Therefore, the schema is never activated (Young, Kolosko, & Weishaar, 2003). There were few research related to the relationship between psychopathology and schema avoidance. For example, schema coping style of avoidance was related to psychopathological symptoms (Gök, 2012), such as alcohol abuse (Brotchie, Hanes, Wendon, & Waller, 2006), bulimia (Spranger, Waller, & Bryant-Waugh, 2001), and social anxiety (Diez, Zurnalde, & Sola, 2012). Additionally, in terms of the relationship between schema coping and schema domain, it was highlighted that avoidance schema coping style was associated with disconnection/rejection and impaired limits/exaggerated standards schema domains (Gök, 2012). Schema overcompensation means fighting with the schema by thinking, feeling, behaving, and relating as if the opposite of the schema were true. They behave as different as possible from the time when the schema was acquired. By this way, the schema is perpetuated rather than healed. They typically engaged in counterattacking; behave in an excessive, insensitive, or unproductive way (Young, Kolosko, & Weishaar, 2003). Compensation coping style was related to impaired limits/exaggerated standards and impaired autonomy/other directedness schema domains (Gök, 2012). In terms of the association with psychopathology, schema compensation mediated the association between eating pathology and perceptions of parenting (Sheffield, Waller, Emanuelli, Murray, &Meyer, 2009), and moderated the relationship between emotional deprivation schema and social anxiety (Diez, Zumalde, & Sola, 2012).

Early maladaptive schemas were related to early experiences with parents. More specifically, it was highlighted that perceptions of parenting were associated with the EMSs of defectiveness/shame, insufficient self-control, vulnerability, and incompetence/inferiority (Harris & Curtin, 2002). Similarly, higher levels of schema domains were related to negative parenting experiences with both parents (Gök, 2012), such as high levels of rejection, control and anxious rearing, and low levels of

emotional warmth (Muris, 2006). Thus, parenting styles were associated with early maladaptive schemas, which are also related to psychopathology. According to these relationships, it can be stated that early maladaptive schemas mediate the relationship between parenting styles and psychopathology (Gök, 2012; Young, Kolosko, & Weishaar, 2003). For example, it was found that early maladaptive schemas mediated the association between recalled parental rearing behaviors and symptoms of personality disorder (Thimm, 2010). In addition, disconnection-rejection schema domain mediated the relationship between maternal rejection and psychological distress (Sarıtaş, 2007). Similarly, in a non-clinical sample, there was a significant relationship between avoidant personality disorder and abandonment, subjugation, and emotional inhibition schemas. These schemas, in turn, mediated the association between retrospectively reported childhood experiences and avoidant personality disorder symptoms (Carr & Francis, 2010). Moreover, it was asserted that only the emotional isolation subscale of the Young Schema Questionnaire served as a mediator variable between the family dysfunction and psychological symptomatology (Kapçı & Hamamcı, 2010). In terms of eating disorders, it has been found that eating psychopathology predicted paternal rejection and overprotection. In addition, father-daughter relationship and eating symptomatology relationship was mediated by early maladaptive schemas of abandonment, defectiveness/shame, and vulnerability to harm (Jones, Leung, & Harris, 2006). What is more, the association between parental bonding and eating disorder symptoms was mediated by defectiveness/shame, and dependence/incompetence schemas (Turner, Rose, & Cooper, 2005). For depression, on the other hand, abusive and neglectful parenting was found to be associated with depression and this association was mediated by early maladaptive schemas (McGinn, Cukor, & Sanderson, 2005). Parental perceptions and depressive symptomatology association was mediated by defectiveness/shame, insufficient self-control, vulnerability, and incompetence/inferiority schemas (Harris & Curtin, 2002). So, according to these examples, it can be stated that early maladaptive schemas mediated the relationship between parenting styles and psychopathology.

Negative parenting styles were associated with psychopathology such as depression (Anlı & Karslı, 2010; Fentz, Arendt, O'Toole, Rosenberg, & Hougaard,

2011; Oakley-Browne, Joyce, Wells, Bushnell, & Hornblow, 1995; Rapee, 1997), suicidality (Heider et al., 2007; Sheffield, Waller, Emanuelli, & Murray, 2006), anxiety disorder (Alonso et al., 2004; Anlı & Karslı, 2010; Bögels, Oosten, Muris, & Smulders, 2001; Cockram, Drummond, & Lee, 2010; Duchesne, Larose, Vitaro, & Tremblay, 2010;Gastel, Legerstee, & Ferdinand, 2009; Grüner, Muris, & Merckelbach, 1999; Hale, Engels, & Meeus, 2006; Hummel & Gross, 2001; McLeod, Wood, & Weisz, 2007; Rapee, 1997;Spokas & Heimberg, 2009), eating disorder (Enten & Golan, 2009; Haycraft & Blissett, 2010; Leung, Thomas, & Waller, 2000; Sheffield, Waller, Emanuelli, Murray, & Meyer, 2009), alcohol addiction (Cheng, Anthony, & Huang, 2010; de Rick & Vanheule, 2006), drug addiction (Benchaya, Bisch, Moreira, Ferigolo, & Barros, 2011), somatization (Janssens, Oldehinkel, & Rosmalen, 2009; Sheffield, Waller, Emanuelli, & Murray, 2006), and even schizophrenia (Wu, Li, Zhu, & Zheng, 2005).

This pattern between negative parenting and psychopathology can be decreased in severity by social support. Social support is defined as "information leading the subject to believe that he (or she) is cared for and loved, esteemed, and a member of a network of mutual obligations." (Cobb, 1976, p. 300). In addition to this definition, according to Cohen and McKay, social support means that interpersonal relationship buffers one against stressful environment (1984). As an example, support from family members buffers one against burnout (Baruch-Feldman, Brondolo, Ben-Dayan, & Schwarz, 2002). According to stress-buffer hypothesis, psychosocial stress does negatively affect physical and/or psychological well-being of a person with little or no social support. However, strong social support decreases or eliminates this effect (Cohen & Willis, 1985). As an example, social support was found to be associated with psychological well-being (Ownsworth, Henderson, & Chambers, 2010), such as less depressive symptoms (Lu, 2011), and reduced risk of mortality after 20 years (Shirom, Toker, Alkaly, Jacobson, & Balicer, 2011). In terms of the dementia caregivers, effective social support was considered as stress modifier, which in turn related to better caregiver health and more positive caregiver health outcomes over time (Goode, Haley, Roth, & Ford, 1998). As a main effect, informal social support is also strongly correlated with psychological well-being of

dementia caregivers(Au et al., 2009). Thus, social support has both direct and indirect effects on psychological well-being of dementia caregivers.

According to Lahey and Cohen (2000), there are two types of social support: received social support and perceived social support. Received social support was suggested that the real amount and frequency of social support received by others, while perceived social support was based on individuals' perceptions about available social support from social environment (as cited in Mackinnon, 2012, p.4). Most researchers used perceived social support rather than received social support as a target of the investigation (Thoits, 1995), because, in terms of prediction about adjustment to life stress, perceived support is more important than received support (Wethington & Kessler, 1986). Accordingly, perceived social support was used in this study.

There are many studies investigating the relationship between perceived social support and psychological and physical well-being. In investigations with cancer patients indicated that lower degrees of feelings of loneliness and hopelessness are related to higher perceived social support from family members (Pehlivan, Ovayolu, Ovayolu, Sevinç, & Camcı, 2012). Similarly, it was highlighted that a higher level of perceived social support was associated with lower psychological distress as compared to cancer patients who perceived less social support (Özpolat, Ayaz, Konağ, & Özkan, 2014). In terms of the caregivers, perceived social support was highlighted to be negatively related to depression in caregivers of mentally ill patients (Yen & Lundeen, 2006), caregivers of cancer patients (Kuscu et al., 2009), mothers of deaf children (Sipal & Sayın, 2013), and caregivers of leukemia children (Bozo, Anahar, Ateş, & Etel, 2010). Moreover, perceived social support was also found to be related to caregiver strain in caregivers of children with Tourette's Disorder (Schoeder & Remer, 2007).

According to the relationship between dementia caregiver well-being and perceived social support, psychological well-being (Chappell & Reid, 2002) and physical morbidity (Schulz, O'Brien, Bookwala, & Fleissner, 1995) of dementia caregivers were found to be strongly correlated with perceived social support. However, giving care to a patient with dementia takes enormous amount of time, which decreases the available time for social interaction of those caregivers.

Accordingly, having less time for social interaction and progressive loss of a loved one worsen perceptions of social support (Bergman-Evans, 1994). Hence, caregiving worsened the perceptions of social support (Brummett et al., 2006).

In addition to the relationship between caregiver well-being and perceived social support, perceived social support has been found to have a moderator role in other studies. Moderator variable affects the direction and strength of a relationship between independent and dependent variables, as a third variable (Baron & Kenny, 1986). For example, according to the study with caregivers of children with leukemia, it was stated that caregivers who perceive higher levels of social support report lower levels of psychological symptoms if they fulfill their own needs and continue their daily activities (Demirtepe-Saygılı & Bozo, 2011). Similarly, in a study using a sample of Alzheimer patients' caregivers, perceived social support moderated the relation between stress and resilience (Wilks & Croom, 2008). In conclusion, social support is crucial for physical and psychological well-being of caregivers.

As it is suggested in the literature, negative parenting styles are related to psychopathology with the mediator role of early maladaptive schemas in this relationship. In addition, caring dementia patients, using maladaptive schema coping processes, and having lower levels of perceived social support increase the risk of having psychological problems. Caring dementia patients does also increase the likelihood of experiencing burnout. However, there is no study examining the association of negative parenting styles with well-being and burnout with the mediator role of early maladaptive schemas in the sample of caregivers of dementia patients, along with the effects of schema coping processes, and the moderator role of perceived social support in this relationship. Therefore, the aims of the current study are:

1. To investigate gender, marital status, having child or not, having a physical illness or not, working status, level of education, and having psychological disorder or not differences in terms of the measures of the study (i.e., caregiver well-being, parenting styles, perceived social support, depression, schema coping strategies, burnout, early maladaptive schemas).

2. To investigate the discrepancies in different levels of dementia in terms of the measures of the study (i.e., caregiver well-being, parenting styles, perceived social support, depression, schema coping strategies, burnout, early maladaptive schemas).
3. To determine interrelationships among the measures of the study.
4. To examine the mediator role of early maladaptive schemas in the relationship of parenting styles with caregiver well-being, burnout, and depression.
5. To determine the moderator role of perceived social support in the relationship of early maladaptive schemas with caregiver well-being, depression, and burnout.
6. To investigate the moderator role of schema coping processes of avoidance on the relationship between early maladaptive schemas and caregiver well-being, depression, and burnout.
7. To examine the moderator role of schema coping processes of compensation on the relationship between early maladaptive schemas and caregiver well-being, depression, and burnout.

Hence, hypotheses of the current study are as follows:

1. Early maladaptive schemas will mediate the the relationship between parenting styles and outcome variables:
    I. Early maladaptive schemas will mediate the the relationship between parenting styles and caregiver well-being.
    II. Early maladaptive schemas will mediate the the relationship between parenting styles and depression.
    III. Early maladaptive schemas will mediate the the relationship between parenting styles and burnout.
2. Perceived social support will moderate the relationship between early maladaptive schemas and outcome variables:
    I. Perceived social support will moderate the relationship between early maladaptive schemas and caregiver well-being.

II. Perceived social support will moderate the relationship between early maladaptive schemas and depression.
III. Perceived social support will moderate the relationship between early maladaptive schemas and burnout.

3. Schema coping processes (avoidance and compensation) will moderate the association between early maladaptive schemas and outcome variables:

I. Schema coping processes of avoidance will moderate the association between early maladaptive schemas and caregiver well-being.
II. Schema coping processes of avoidance will moderate the association between early maladaptive schemas and depression.
III. Schema coping processes of avoidance will moderate the association between early maladaptive schemas and burnout.
IV. Schema coping processes of compensation will moderate the association between early maladaptive schemas and caregiver well-being.
V. Schema coping processes of compensation will moderate the association between early maladaptive schemas and depression.
VI. Schema coping processes of compensation will moderate the association between early maladaptive schemas and burnout.

CHAPTER 2

METHOD

2.1. Participants

Ninety-nine adult children as the primary caregivers of the dementia patients, 78 (78.8%) of which were female, and 21 (21.2%) of which were male, participated in this study. The inclusion criterion, being the primary caregiver of an dementia patient, can be defined as the person responsible for helping the patient in his/her daily needs and providing supervision to the person in need.

The participants were between the ages of 25 and 64 (*M = 51.20, SD = 7.57*). In terms of their marital status, 67 (67.7%) participants were married, 12 (12.1%) were single, 14 (14.1%)were divorced, and 6 (6.1%) were widowed. Out of 99 participants, 21 (21.2%)participants' highest degree was primary school, and 29 (29.3%) of them were high school graduates. On the other hand, 39(% 39.4) of them graduated from university, while 10 (10.1%) of them had either master's ordoctoral degree. While the majority of the participants were not working at the time of data collection 63.6% (*n* = 63), the rest of them were working36.4% (*n = 36)*. Only 17 (17%) participants did not have a child; while, 24 (24.2%) of them had one child, 53 (53.5%) of them had two children, and the remaining 5 (5.1%) participants had three children.

According to place they spend most of their life, 83 (83.8%) of them spent most of their life in a metropolis, 12 (12.1%) of them in a city, 3 (3%) of them in a town, and 1 (1%) of them in a village. As for the socioeconomic status, 9 (9.1%) participants defined their economic status as low, 86 (86.9%) of them middle, and 4 (4%) of them high. Participants' having a physical or psychological disorder scattered as follows; 17 (17.2%) participants had a psychological disorder, while 29 (29.3%) of them had a physical illness. In addition, 18 (18.2%) of them were received psychological treatment, whereas 26 (26.3%) of them received physical treatment.

Table 2.1.

Demographic Characteristics of Participants

Variables	*N*	%	*M*	*SD*
Gender				
Female	78	78.8		
Male	21	21.2		
Age			51.20	7.57
Marital Status				
Single	12	12.1		
Married	67	67.7		
Divorced	14	14.1		
Widowed	6	6.1		
Education Level				
Primary School	21	21.2		
High School	29	29.3		
University	39	39.4		
Master's/Doctorate	10	10.1		
Working				
Yes	36	36.4		
No	63	63.6		
Number of Children				
0	17	17.2		
1	24	24.2		
2	53	53.5		
3	5	5.1		
Residence				
Metropolis	83	83.8		
City	12	12.1		
Town	3	3		
Village	1	1		
Economic Status				
Low	9	9.1		
Middle	86	86.9		
High	4	4		
Psychological Disorder				
Yes	17	17.2		
No	82	82.8		
Physical Disorder				
Yes	29	29.3		
No	70	70.7		
Psychological Treatment				
Yes	18	18.2		
No	81	81.8		
Physical Treatment				
Yes	26	26.3		
No	73	73.7		
Level of the Dementia of the care-receiver				
Mild	24	24.2		
Moderate	50	50.5		
Severe	25	25.3		

Lastly, 24 (24.2%) participants were giving care to mildly demented patients, 50 (50.5%) of them to moderately demented patients, and 25 (25.3%) of them to severelydemented patients (See Table 2.1. for details).

2.2. Measures

At first, demographic information form was given to the participants to gather demographic information of the participants. It was formed by the researcher, and included questions about age, sex, marital status, educational level of the participants, workingstatus, job, number of children, the place they spend most of their life, economic status, the existence of psychological and physical disorders and their treatment history, and finally the dementia level of the patients (see Appendix B). The dementia levels of the patients were taken from patients' medical report. In other words, data on the dementia level in this study based on the objective criteria.In addition to the demographic information form, the questionnaire set included Young Schema Questionnaire (see Appendix C) to evaluate participants' early maladaptive schemas, Young Parenting Inventory (see Appendix D) to evaluate parenting styles of the participants' demented parents, Young Compensation Inventory (see Appendix E) and Young Avoidance Inventory (see Appendix F) in order to evaluate participants' schema coping processes, Beck Depression Inventory (see Appendix G), Caregiver Well-Being Scale (see Appendix H), and Maslach Burnout Inventory (see Appendix I) to examine caregiver well-being, and Multidimensional Scale of Perceived Social Support (see Appendix J) in order to examine participants' perception about the social support by family, friends, and a significant other.

2.2.1. Young Schema Questionnaire-Short Form 3 (YSQ-SF3):

Young Schema Questionnaire Long Form was developed for investigating the presence and the degree of 16 primary schemas with 205 items. It is a self-report questionnaire rated on a 6-point Likert type scale (Young & Brown, 1990, 2001). This form was found to be reliable and valid (Schmidt, Joiner, Young, & Telch, 1995). After that, Young (1998) developed 75-item short form of the questionnaire (as cited in Wellburn, Coristine, Dagg, Pontefract, & Jordan, 2002). This form also measured 15 early maladaptive schemas, namely,emotional deprivation, abandonment, mistrust/ abuse, social alienation, defectiveness, ıncompetence, dependency, vulnerability to harm, enmeshment, subjugation of needs, self-sacrifice,

emotional ınhibition, unrelenting standards, entitlement, and ınsufficient self-control (Schmidt, Joiner, Young, & Telch, 1995; Welburn, Coristine, Dagg, Pontefract, & Jordan, 2002). These two versions of the Young Schema Questionnaire had similar psychometric proporties (Waller, Meyer, & Ohanian, 2001). Lastly, Young Schema Questionnaire-Short Form 3 was developed to evaluate early maladaptive schemas with 90 items measuring 18 different maladaptive schemas on five domains: disconnection/rejection, impaired autonomy and performance, impaired limits, other-directedness, and overvigilance and inhibition (Young, 2006). This form is also a 6-point Likert-type scale (1 = *completely untrue of me*; 2 = *mostly untrue of me*; 3 = *slightly more true than untrue*; 4 = *moderately true of me*; 5 = *mostly true of me*; 6 = *describes me perfectly*), and higher scores on the schemas indicates a greater possibility of the presence of the schema (Young, 2006). Soygüt, Karaosmanoğlu, and Çakır (2009) adapted the questionnaire to Turkish. It has acceptable reliability and validity values. The study showed 14 different schemas on 5 schema domains. These schema domains are impaired autonomy, disconnection, unrelenting standards, other-directedness, and impaired limits.The first domain included enmeshment/dependence, abandonment, failure, pessimism, and vulnerability to harm, the second included emotional deprivation, emotional inhibition, social/isolation/mistrust, and defectiveness, the third one included unrelenting standards, and approval-seeking, the third domain included entitlement/insufficient self control, whereas the last one included self-sacrifice, and punitiveness. Turkish version of the scale was found to be reliable and valid. Reliability analyses was done via test-retest and internal consistency, while validity was confirmed via convergent validity and discriminant validity(Soygüt, Karaosmanoğlu, & Çakır, 2009). The internal consistency reliability of the inventory for the present sample was.93.

2.2.2. Young Parenting Inventory (YPI):

The Young Parenting Inventory was developed to measure parenting styles that underly EMSs. It is a 72-item inventory, and has two forms (one for mothers, and one for fathers). It is rated on a 6-point Likert type scale indicating how well the items reflect participants' mother or father. Higher scores on this inventory mean negative parenting styles that may result in EMSs (Young, 1994). The scale has acceptable levels of reliability and validity for both total scale and 9 different

parenting styles: emotionally depriving, oveprotective, belittling, perfectionist, pessimistic/fearful, controlling, emotionally inhibited, punitive, and conditional/narcissistic (Sheffield, Waller, Emanuelli, Murray, & Meyer, 2005). Turkish adaptation of the inventory was made by Soygüt, Çakır, and Karaosmanoğlu (2008). Adequate levels of reliability and validity of Turkish version was confirmed via test-retest reliability, internal consistency analysis, convergent validity, and discriminant validity. This adaptation was similar to the original form with the addition of overpermissive/boundless and exploitative/abusive parenting but with the removal of perfectionist parenting (Soygüt, Çakır, & Karaosmanoğlu, 2008). The internal consistency reliability of the inventory for the present sample was .94.

2.2.3. Young Compensation Inventory (YCI):

Young Compensation Inventory is a 48-item self-report questionnaire developed to assess compensation coping styles in schema coping processes. The inventory is rated on a 6-point Likert type scale. Higher scores indicate general pattern of compensation schema coping(Young, 1995). Karaosmanoğlu, Soygüt, and Kabul (2013) adapted Young Compensation Inventory in Turkish. The scale had seven dimensions including status seeking, control, rebellion, counterdependency, manipulation, intolerance to criticism, and egocentrism. Cronbach's alpha coefficients of the subscales ranged from .60 to .81, and split half reliability of overall inventory was .88, which indicates acceptable levels of internal consistency. In addition, the scale has good convergent validity with depression, anxiety, obsessive-compulsive symptomatology, and Young Schema Questionnaire (correlation coefficients ranging between r = .12 - .60, p< .05) (Karaosmanoğlu, Soygüt, & Kabul, 2013). The internal consistency reliability of the inventory for the present sample was .88.

2.2.4. Young Rygh Avoidance Inventory (YRAI):

Young Avoidance Inventory (YRAI) measures the presence and degree of avoidance strategies. It is a self report inventory and has 40 items related to emotional, cognitive, behavioral, and somatic avoidance. The Inventory is 6-point Likert type scale, and higher scores indicate more use of avoidance coping strategies (Young & Rygh, 1994). It has an acceptable level of internal consistency for the two subscales (behavioral/somatic avoidance (α =.65), and cognitive/emotional

avoidance (α =.78), and for total inventory (α = .79) (Spranger, Waller, & Bryant-Waugh, 2001). YRAI is being adapted to Turkish by Karaosmanoğlu, Soygüt, Tuncer, Derinöz, and Yeroham (in progress, as cited in Karaosmanoğlu, Soygüt, Tuncer, Derinöz, & Yeroham, 2005). Turkish version of the inventory was found to have six dimensions. The psychometric investigation of the scale was done by Soygüt (2007) and scale was found reliable via internal consistency and split half reliability analyses. In addition, validity was confirmed by convergent validity. The internal consistency reliability of the inventory for the present sample was .74.

2.2.5. Maslach Burnout Inventory (MBI):

Maslach Burnout Inventory (MBI) was developed to measure burnout with 22-items. The inventory has three subscales, namely, emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Jackson, 1981). Emotional exhaustion is measured with 9 items, whereas depersonalization - an unfeeling and impersonal response toward recipients of one's care or service- is measured with 5 items (Maslach & Jackson, 1981, p. 3). Higher scores on these subscales mean higher burnout. On the other hand, personal accomplishment subscale evaluates "feelings of competence and successful achievement in one's work with people" with 8 items (Maslach & Jackson, 1981, p. 3). However, in this scale, lower scores means higher burnout. The inventory was found to be reliable and valid (Maslach & Jackson, 1981). Ergin (1992) adapted scale in Turkish with the same three subscales and 22 items measured on a 5-point Likert type scale. This scale was originally developed for a large spectrum of human service workers (Maslach & Jackson, 1981). However, in this study, participants were caregivers of the dementia patients. Therefore, the scale was adapted for the caregivers. For the present sample, the internal consistency reliabilities of the total inventory and emotional exhaustion, reduced personal accomplishment, and depersonalization subscales were .85, .87, .84, .60, respectively.

2.2.6. Caregiver Well-Being Scale:

The Caregiver Well-Being Scale was developed by Tebb (1995), and it had two subscales that are basic needs and activity of living. These subscales measure how much the caregivers meet their basic needs and the level of their satisfaction with activities of daily living from a strengths based perspective.In addition to

physical needs such as sleep and nutrition, basic needs subscale measures expression of emotions, relaxation, and personal growth.However, activity of living subscale measures activities done in everyday life and spare time activities, such as enjoying a hobby. The scale was found to be valid and reliable via internal consistency reliability, construct validity, and criterion related validity (Berg-Weger, Rubio, & Tebb, 2000). The internal consistency reliability of these subscales are 0.91, and 0.81, respectively (Berg-Weger, Rubio, & Tebb, 2000). Demirtepe and Bozo (2009) adapted scale to Turkish culture with satisfactory reliability and validity. Reliability and validity were determined through internal consistency reliability, test-retest reliability, discriminantvalidity, and convergent validity analyses. For the present sample, the internal consistency reliability coefficients were found as .89 for basic needs subscale and .85 for activity of living subscale.

2.2.7. Beck Depression Inventory (BDI):

Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979) is a self report measure to assess the severity of depressive symptomatology in terms of cognitive, behavioural, affective, and somatic components of depression with 21 items. The items are measured on a 4-point scale ranging between 0 and 3, and rated according to the severity of the symptom mentioned in the item. The total score is obtained by summing the all of the responses, and higher scores mean more severe depression. In terms of the psychometric proporties of the scale, BDI was found reliable and valid (Beck, Steer, & Carbin, 1988). Reliability was confirmed through split-half reliability and item-total correlation analyses. Moreover, BDI scores of the participants were found to be highly correlated with another measure of depression, which indicated high validity of the scale (Beck, Steer, & Brown, 1996). Hisli (1988) adapted scale in Turkish with strong psychometric properties (Hisli, 1988; 1989). The internal consistency reliability of the inventory for the present sample was .84.

2.2.8. Multidimensional Scale of Perceived Social Support (MSPSS):

The Multidimensional Scale of Perceived Social Support (MSPSS) was developed to measure perceived social support from three different sources, family, friends, and significant other. MSPSS is a 12-item, 7-point Likert-type scale (1 = *very strongly disagree*, 7 = *very strongly agree*). Higher scores on this scale means higher levels of perceived social support. The scale indicated good internal and test-

retest reliability and moderate construct validity. High levels of perceived social support were found to be related to low levels of the symptoms of depression and anxiety (Zimet, Dahlem, Zimet, & Farley, 1988). Turkish version of the scale was adapted to Turkish by Eker and Arkar (1995). After adaptation, the form was revisited. The Cronbach's alpha reliability of the Turkish revised version ranged between .80 and .95, and it had construct validity (Eker, Arkar, & Yaldız, 2001). According to this study, internal reliability coefficients were found as .87 for perceived social support from family, .92 for perceived social support from friends, .93 for perceived social support from significant others, and .90 for the total scale.

2.3. Procedure

The data was collected from Neurology Departments of hospitals in İzmir and Ankara, and the Alzheimer Association. Ethical approvals were obtained from ethical committees of Middle East Technical University, hospitals, from the head of Neurology Departments, and Alzheimer Associations before the data collection. After the aim of the study was explained to the participants, informed consent form (see Appendix A) was obtained. Afterwards, the questionnaire sets were administered to the participants orally. It took the researcher approximately 1 hour on average to administer a questionnaire.

2.4. Design & Statistical Analysis

Statistical Package for Social Sciences (SPSS), version 20 for Windows, was used in the current study for statistical analyses. At first, descriptive statistics of the measures of the study and demographic variables were conducted. For investigating demographic differences in terms of the measures of the study, seperate t-tests analyses were conducted. In addition, for investigating the effect of the level of dementia of the care-receiver on the measures of the study, Analysis of Variance (ANOVA) was conducted. By this way, it was determined whether dementia level will be controlled or not in further analyses. After that, zero-order correlations were conducted to investigate intercorrelations among all of the measures of the study. Later, the mediator role of early maladaptive schemas between parenting styles and caregiver well-being, burnout, and depression were investigated via regression analyses. Finally, 15 hierarchical regression analyses were performed. In the first 4 regression analyses the moderator role of perceived social support on the relationship

between early maladaptive schemas and caregiver well-being, burnout, and depression were investigated. In the second fourth regression analyses, the moderator role of schema coping processes of avoidance on the relationship between early maladaptive schemas and caregiver well-being, burnout, and depression were investigated. And in the third 4 regression analyses, the moderator role of schema coping processes of compensation on the relationship between early maladaptive schemas and caregiver well-being, burnout, and depression were investigated. Lastly, in 3 hierarchical regression analyses, the moderator role of perceived social support from family, perceived social support from friends and perceived social support from significant others on the association between early maladaptive schemas and caregiver well-being were examined.

CHAPTER 3

RESULTS

I. Preliminary Analyses

3. 1. Descriptive Statistics for the Measures of the Study

In order to see descriptive characteristics of the measures of the study, means, standard deviations, minimum-maximum score ranges, and Cronbach's alpha coefficients for internal consistency were computed for Young Schema Questionnaire (YSQ); schema domains of the Young Schema Questionnaire, namely, impaired autonomy (IA), disconnection (D), unrelenting standards (US), impaired limits (IL), other-directedness (OD); Young Parenting Inventory (YPI); Young Compensation Inventory (YCI); Young-Rygh Avoidance Inventory (YRAI); Multidimensional Scale of Perceived Social Support (MSPSS); sources of the perceived social support, specifically, perceived social support from family (PSSFA), perceived social support from friends (PSSFR), perceived social support from significant others (PSSSO); Beck Depression Inventory (BDI); two subscales of the Caregiver Well-Being Scale (CWBS), basic needs (BN), and activity of living (AL); and Maslach Burnout Inventory (MBI); dimensions of Maslach Burnout Inventory, including emotional exhaustion (EE), reduced personal accomplishment (RPA), depersonalization (DP). Results of the descriptive analyses are presented in Table 3.1.

3.2. Differences among the levels of Demographic Variables on the Measures of the Study

Separate t-tests and analysis of variance (ANOVA) were conducted to examine the differences among the levels of demographic variables on the measures (i.e., Well-Being, Parenting Styles, Schema Coping Strategies, Perceived Social Support, and Burnout) of the study. Demographic variables were categorized into different groups. These categorizations are shown in Table 3.2. For these t-test analyses, only significant differences were reported.

Table 3.1.

Descriptive Characteristics of the Measures

Measures	*N*	Mean	*SD*	Range (Min-Max)	Cronbach's alpha
Young Schema Questionnaire					
YSQ total	99	211.95	44.38	111-327	.93
IA	99	57.08	17.39	30-120	.88
D	99	40.90	12.71	23-78	.84
US	99	28.23	7.64	13-47	.75
IL	99	21.24	6.36	7-39	.65
OD	99	40.35	9.02	21-63	.74
Young Parenting Inventory					
YPI total	99	174.09	46.80	102-308	.94
Schema Coping Strategies					
YCI	99	151.60	26.24	79-210	.88
YRAI	99	127.74	17.41	88-163	.74
Perceived Social Support					
MSPSS total	99	65.08	16.03	30-84	.90
PSSFA	99	24.68	4.72	4-28	.87
PSSFR	99	21.40	7.21	4-28	.92
PSSSO	99	19.00	8.24	4-28	.93
Caregiver Well-Being					
BN	99	81.94	13.49	42-107	.89
AL	99	77.17	13.24	47-101	.85
BDI total	99	10.81	7.32	0-31	.84
Maslach Burnout Inventory					
MBI total	99	50.30	11.14	26-82	.85
EE	99	22.87	6.91	11-41	.87
RPA	99	19.53	5.90	8-37	.84
DP	99	7.90	2.75	5-17	.60

Note. YSQ = Young Schema Questionnaire, IA = Impaired Autonomy, D = Disconnection, US = Unrelenting Standards, IL = Impaired Limits, OD = Other-Directedness, YPI = Young Parenting Inventory, YCI = Young Compensation Inventory, YRAI = Young Rygh Avoidance Inventory, MSPSS = Multidimensional Scale of Perceived Social Support, PSSFA = Perceived Social Support from Family, PSSFR = Perceived Social Support from Friends, PSSSO = Perceived Social Support from Significant Others, BN = Caregiver Well-Being Scale-Basic Needs, AL = Caregiver Well-Being Scale- Activity of Living, BDI = Beck Depression Inventory, MBI = Maslach Burnout Inventory, EE = Emotional Exhaustion, RPA = Reduced Personal Accomplishment, DP = Depersonalization.

Table 3.2.

Categorization of the Demographic Variables

Variables	*n*	%
Gender		
Female	78	78.8
Male	21	21.2
Marital Status		
Married	67	67.7
Unmarried	32	32.3
Education		
At most highschool degree	50	50.5
At least university degree	49	49.5
Working Status		
Working	36	36.4
Not working	63	63.6
Having Children or not		
Having children	82	82.8
Childless	17	17.2
Having a Physical Illness or not		
Yes	29	29.3
No	70	70.7
Having a Psychological Disorder or not		
Yes	17	17.2
No	82	82.8
Level of the Dementia of the Care-Receiver		
Mild	24	24.2
Moderate	50	50.5
Severe	25	25.3

3.2.1. Differences among the levels of Demographic Variables on Caregiver Well-Being

To investigate possible differences of these categorized demographic variables on Caregiver Well-Being (i.e., basic needs, and activity of living), separate *t*-tests were conducted with basic needs, and activity of living subscales of the Caregiver Well-Being Scale as the dependent variables.

3.2.1.1. Gender Differences on Caregiver Well-Being

In order to investigate possible gender differences on caregiver well-being-activity of living, *t*-test was conducted with caregiver well-being-activity of living as the dependent variable. There was a significant difference between females (*m* =

78.94, *sd* = 12.98), and males [*m* = 70.63, *sd* = 12.41; *t*(97) = 2.63, *p*< .05]. In other words, women scored higher on caregiver well-being-activity of living than men.

Table 3.3.

Gender Differences on Caregiver Well-Being

	Males		Females		
	m	*sd*	*m*	*sd*	*t*(97)
Caregiver Well-Being					
Activity of Living	70.63	12.41	78.94	12.98	2.63*

Note. *p< . 05

3.2.1.2. Differences between the levels of Marital Status on Caregiver Well-Being

A *t*-test was conducted with caregiver well-being-basic needsas dependent variables, to compare married and unmarried participants on the measures of caregiver well-being-basic needs.The results indicated that marital status has a significant effect on the caregiver well-being-basic needs [*t*(97) = - 3.57, *p* < .01]. In other words, there was a significant difference in the scores of married (*m* = 85.10, *sd* = 11.56), and unmarried (*m* = 75.31, *sd* = 14.96) participants. This result suggested that married participants had higher level of well-being than unmarried participants in terms of meeting their basic needs.

Table 3.4.

Differences between the levels of Marital Status on Caregiver Well-Being

	Married		Unmarried		
	m	*sd*	*m*	*sd*	*t*(97)
Caregiver Well-Being					
Basic Needs	85.10	11.56	75.31	14.96	-3.57**

Note. **$p < .01$

3.2.1.3. Differences due to Having Children or not on Caregiver Well-Being-Basic Needs

The effects of having children on the measures of caregiver well-being-basic needs were investigated through *t*-test with caregiver well-being-basic needs as dependent variable. There was a significant difference in the scores for participants with children ($m = 83.19$, $sd = 12.82$), and without children [$m = 75.88$, $sd = 15.36$; $t(97) = -2.07$, $p < .05$]. Participants who have children were found to have higher scores on caregiver well-being-basic needs than participants without children.

Table 3.5.

Differences due to Having Children or not on Caregiver Well-Being-Basic Needs

	Having Children		Childless		
	m	*sd*	*m*	*sd*	*t*(97)
Caregiver Well-Being					
Basic Needs	83.19	12.82	75.88	15.36	-2.07*

Note. *$p < .05$

3.2.2. Differences among the levels of Demographic Variables on Parenting Styles

In order to investigate the possible differences among the levels of demographic variables on Parenting Styles, separate *t*-tests were conducted with Parenting Styles as the dependent variables.

3.2.2.1. Gender Differences on Parenting Styles

A*t*-test was conducted to examine gender differences on the parenting styles. The results yielded significant results for gender [$t(97) = 2.03$, $p < .05$]. Specifically, female participants ($m = 178.96$, $sd = 49.27$) were found to be exposed to worse parenting styles than male participants ($m = 155.99$, $sd = 30.82$).

Table 3.6.

Gender Differences in terms of Parenting Styles

	Female		Male		
	m	*sd*	*m*	*sd*	*t*(97)
Parenting Styles	178.96	49.27	155.99	30.82	2.03*

Note. *$p < .05$

3.2.2.2. Differences between the levels of Having a Physical Illness or not in terms of Parenting Styles

A*t*-test was conducted to compare parenting styles of participants who had physical illness, and participants who had no physical illness. There was a significant difference in the scores of participants with physical illness ($m = 192.21$, $sd = 54.38$), and without a physical illness ($m = 166.59$, $sd = 41.42$); $t(97) = -2.55$, $p < .05$.Accordingly, participants with physical illness had higher scores on Young Parenting Inventory than participants without physical illness. In other words,

participants with physical illness were found to be exposed to worse parenting style than participants without physical illness.

Table 3.7.

Differences of Having a Physical Illness or not on Parenting Styles

	Having a Physical Illness		No Illness		
	m	*sd*	*m*	*sd*	*t* (97)
Parenting Styles	192.21	54.38	166.59	41.42	-2.55*

Note. *$p < .05$.

3.2.2.3. Differences between the levels of Working Status in terms of Parenting Styles

A *t*-test was conducted to investigate whether there was a difference between the levels of working status in terms of parenting style.The result of the analysis was significant [$t(97) = 2.51$, $p < .05$]. In other words, the scores of parenting style were lower for working participants ($m = 158.88$, $sd = 43.99$) than participants not working ($m = 182.78$, $sd = 46.45$).

Table 3.8.

Differences between the levels of Working Status in terms of Parenting Styles

	Working		Not Working		
	m	*sd*	*m*	*sd*	*t* (97)
Parenting Style	158.88	43.99	182.78	46.45	2.51*

Note. *$p < .05$

3.2.3. Differences among the levels of Demographic Variables on Perceived Social Support

Demographic variables were categorized as can be seen from Table 3.2. To investigate possible differences among these categorized demographic variables on Perceived Social Support (i.e., total perceived social support, perceived social support from family, friends, and significant others), separate *t*-test analyses were conducted.

3.2.3.1. Differences of Marital Status on Perceived Social Support

To investigate the possible differences between the levels of marital status in terms of perceived social support, separate *t*-test analyses were conducted with the total score of perceived social support, perceived social support from family, perceived social support from friends, and perceived social support from significant others as the dependent variables. There was a significant differences between married (m = 68.17, sd = 14.69) and unmarried (m = 58.62, sd = 17.00) participants; [$t(97) = -2.87$, $p<.05$] in terms of total perceived social support.

Table 3.9.

Differences between the levels of Marital Status on Perceived Social Support

	Married		Unmarried		
	m	*sd*	*m*	*sd*	*t* (97)
Perceived Social Support					
PSS-Total	68.17	14.69	58.62	17.00	-2.87*
PSS-Family	25.72	3.21	22.50	6.43	-3.33**
PSS- Significant Others	20.31	7.91	16.28	8.36	-2.33*

Note. *$p< .05$,**$p< .01$

There was a significant differences between married (m = 25.72, sd = 3.21), and unmarried (m = 22.50, sd = 6.43) participants; [$t(97) = -3.33$, $p< .01$] in terms of perceived social support from family, too. Married (m = 20.31, sd = 7.91), and

unmarried (*m* = 16.28, *sd* = 8.36) participants were also significantly different from each other in terms ofperceived social support from significant others [*t*(97) = -2.33, *p*< .05]. Results indicated that married participants perceived higher levels of total social support, social support from family, and from significant other single participants.

3.2.3.2. Differences between the levels of having Children or not on Perceived Social Support

Separate *t*-tests analyses were conducted to compare levels of having children on perceived social support. There was a significant difference between participantswho have children (*m* = 66.57, *sd* = 15.31) and who do not have children (*m* = 57.93, *sd* = 17.92)[*t*(97) = -2.06, *p*< .05] in terms of total perceived social support. There was also a significant difference between people who have children (*m* = 25.23, *sd* = 3.98) and who do not have children (*m* = 22.00, *sd* = 6.87)[*t*(97) = -2.65, *p*< .01] in terms of perceived social support from family. Participants who have children had higher total perceived social support and perceived social support from family scores than participants who do not have children.

Table 3.10.

Differences between Having Children or not in terms of Perceived Social Support

	Having Children		Childless		
	m	*sd*	*m*	*sd*	*t* (97)
Perceived Social Support					
PSS-total	66.57	15.31	57.93	17.92	-2.06*
PSS-Family	25.23	3.98	22.00	6.87	-2.65**

Note. *p< .05,**p< .01

3.2.3.3. Differences between Having a Physical Illness or not in terms of Perceived Social Support

A *t*-test was conducted with perceived social support from friends as dependent variables to investigate the differences between participants having physical illness and participants with no illness on the measure of perceived social support from friends. The result showed that there was a significant difference between participants with physical illness (m = 19.10, sd = 7.63), and without physical illness (m = 22.35, sd = 6.87) [$t(97) = 2.07$, $p < .05$] on the measure of perceived social support from friends.In other words, participants who have physical illness perceived friends' social support lower than participants who have no physical illness.

Table 3.11.

Differences between Having a Physical Illness or not in terms of Perceived Social Support from Friends

	Having a Physical Illnesss		Having No Physical Illness		
	m	*sd*	*m*	*sd*	*t* (97)
Perceived Social Support					
PSS-friends	19.10	7.63	22.35	6.87	2.07*

Note. *$p < .05$

3.2.4. Differences between the levels of Demographic Variables in terms of Depression

In order to investigate possible differences between the levels of demographic variables on depression, separate *t*-test analyses were conducted with depression as the dependent variable.

3.2.4.1. Differences between the levels of Education in terms of Depression

In order to find out the level of education differences on the measure of depression, a *t*-test was conducted with depression as the dependent variable. There

was a significant difference between people graduated at most from high school (m = 12.34, sd = 7.60) and at least from university (m = 9.24, sd = 6.74)[$t(97) = 2.15$, $p < .05$] in terms of depression. The result suggested that participants with higher education reported lower scores on depression than low educated participants.

Table 3.12.

Differences between the levels of Education in terms of Depression

	At most High School Degree		At least University Degree		
	m	*sd*	*m*	*sd*	*t* (97)
Depression	12.34	7.60	9.24	6.74	2.15*

Note. *$p < .05$

3.2.4.2. Differences between the levels of Working Status in terms of Depression

The differences between the levels of working status on depression were examined via *t*-test. There was a significant difference in the scores for working people (m = 8.14, sd = 6.73) and people who were not working (m = 12.34, sd = 7.25) [$t(97) = 2.84$, $p < .01$]. Accordingly, working participants had lower scores on depression than participants who were not working.

Table 3.13.

Differences between the levels of Working Status in terms of Depression

	Working		Not Working		
	m	*sd*	*m*	*sd*	*t* (97)
Depression	8.14	6.73	12.34	7.25	2.84**

Note. **$p < .01$

3.2.4.3. Differences between Having a Psychological Disorder or not in terms of Depression

A *t*-test was conducted to compare participants with psychological disorder and without psychological disorder on the measure of depression. There was a significant differencebetween participant with psychological disorder (*m* = 15.29, *sd* = 9.16), and without psychological disorder (*m* = 9.88, *sd* = 6.57)[*t*(97) = -2.88, *p*< .01] in terms of depression. In other words, participants with psychological disorder had higher scores on depression than participants without psychological disorder.

Table 3.14.

Differences between Having a Psychological Disorder or not in terms of Depression

	Having a Psychological Disorder		Not Havinga Psychological Disorder		
	m	*sd*	*m*	*sd*	*t* (97)
Depression	15.29	9.16	9.88	6.57	-2.88**

Note. **p< .01

3.2.5. Differences between the levels of Demographic Variables in terms of Schema Coping Strategies

The differences between the levels of demographic variables were examined through separate t-tests with schema coping strategies as the dependent variable. Significant results of these analyses are presented below.

3.2.5.1. Differences between the levels of Working Status on Schema Coping Strategies of Avoidance

In order to investigate differences between the levels of working status on the schema coping strategies of avoidance, a *t*-test was conducted with schema coping strategies of avoidance as the dependent variable. There was a significant difference in the scores for working participants (*m* = 122.92, *sd* = 16.37) and participants who were not working (*m* = 130.50, *sd* = 17.51)[*t*(97) = 2.17, *p*< .05]. Working participants had higher scores on avoidance than participants not working.

Table 3.15.

Differences between the levels of Working Status in terms of Schema Coping Strategies of Avoidance

	Working		Not Working		
	m	*sd*	*m*	*sd*	*t* (97)
Schema Coping Processes					
Avoidance	122.92	16.37	130.50	17.51	2.17*

Note. *$p < .05$

3.2.6. Differences between the levels of Demographic Variables on Burnout

The differences between the levels of demographic variables were examined through separate *t*-tests with burnout as the dependent variable. Significant results of these analyses are presented below.

3.2.6.1. Differences between the levels of WorkingStatus in terms of Burnout

A *t*-test was conducted to compare the levels of working status on burnout. There was a significant difference in the scores of working participants($m = 47.14$, $sd = 9.60$) and participants who were not working [$m = 52.11$, $sd = 11.62$; $t(97) = 2.17$, $p < .05$]. The result yielded that working participants had lower scores on burnout than participants not working.

Table 3.16.

Differences between the levels of Working Status in terms of Burnout

	Working		Not Working		
	m	*sd*	*m*	*sd*	*t* (97)
Burnout-total	47.14	9.60	52.11	11.62	2.17*

Note. *$p < .05$

3.2.7. Differences among the Levels of Dementia on Schema Coping Strategies, Burnout, Perceived Social Support, and Caregiver Well-Being

In order to explore how three levels of dementia (mild, moderate, and severe) differ on the measures of the study (i.e., schema coping strategies of avoidance, schema coping strategies of compensation, total perceived social support, perceived social support from family, perceived social support from friends, perceived social support from significant others, caregiver well-being-basic needs, caregiver well-being-activity of living, depression, and burnout), 10 separate analyses of variance (ANOVA) were conducted. However, results of the ANOVA analysis showed that there were no significant differences among the levels of dementia in terms of the measures of the study. Therefore, the level of dementia was not controlled throughout the analyses.

3.3. Intercorrelations among the Measures of the Study

In order to reveal the associations among the measures of the study, Pearson's correlation coefficients were calculated for early maladaptive schemas, parenting styles, depression, and for other measures of the study, namely caregiver well-being, perceived social support, schema coping strategies, and burnout. The results of these analyses are presented in the Table 3.17, and only the strong correlation coefficients greater than .25 were presented.

Results yielded that early maladaptive schemas were significantly and positively correlated with depression (r = .48, p< .01), indicating that higher schema scores was related to higher level of depression. However, early maladaptive schemas were significantly and negatively correlated with basic needs subscale of Caregiver Well-Being scale (r = -.28, p< .01), which refers higher schema scores were related to meeting the basic needs less.In addition, early maladaptive schemas were negatively related to total perceived social support (r = -.25, p<.05), and more specifically perceived social support from friends (r = -.25, p<.05), which means that participants having higher schema scores tend to perceive lower total social support and social support from friends. Furthermore, early maladaptive schemas had correlations with schema coping strategies of compensation (r = .52, p< .01) and avoidance (r = .32, p< .01), indicating that participants with higher schema scores tended to used more schema coping strategies. In addition, early maladaptive

schemas were significantly and positively correlated with parenting styles (r = .45, p< .01), indicating more negative parenting styles were related to higher schema scores; burnout (r = .28, p< .01), indicating that participants with higher schema scores had higher levels of burnout.

Depression was negatively correlated with caregiver well-being in terms of meeting of basic needs (r = -.50, p< .01), and performing activities (r = -.36, p<.01), total perceived social support (r = -.28, p< .01), perceived social support from friends (r = -.29, p< .01), indicating that participants with higher depression scores had lower scores on caregiver well-being and perceived social support. Additionally, depression had positive correlations with schema coping strategies of avoidance (r = .33, p< .01), burnout (r = .33, p< .01), and parenting styles (r = .33, p< .01), which means higher levels of depression was associated with higher levels of schema coping strategies of avoidance, higher levels of burnout, and worse parenting styles.

Regarding caregiver well-being-basic needs, significant results were yielded with caregiver well-being-activity of living (r = .67, p< .01), indicating that higher meeting basic needs more was related to higher performance on activities of living; total perceived social support (r = .49, p< .01), perceived social support from significant other (r = .36, p< .01), perceived social support from family (r = .42, p< .01), perceived social support from friends (r= .41, p< .01), meaning that participants meeting their basic needs more perceived more social support, including from significant other, family, and friend and experienced less burnout (r = -.27, p< .01).

Caregiver well-being-activity of living was found to be associated with total perceived social support (r = .34, p< .01), perceived social support from significant other (r = .25, p< .05), perceived social support from family (r = .26, p< .05), and perceived social support from friends (r = .30, p< .01), indicating that higher performance on activities of living was associated with higher levels of perceived social support.

Total perceived social support had significant associations with perceived social support from significant other (r = .90, p< .01), perceived social support from family (r = .53, p< .01), perceived social support from friends (r = .85, p< .01), indicating that higher total perceived social support was related to higher scores on the different sources of perceived social support; burnout (r = -.32, p< .01), which

means that participants who perceived higher social support experienced less burnout; and parenting styles (r = -.25, p< .05), meaning that participants who perceived higher social support exposed to better parenting styles.

Table 3.17.

Pearson's Correlations among the Measures of the Study

Variables	YSQ	BDI	BN	AL	MSPSS	PSSFA	PSSFR	PSSSO	YCI	YRAI	YPI	MBI
YSQ	1											
BDI	.48**	1										
BN	-.28**	-.50**	1									
AL	-.18	-.36**	.67**	1								
MSPSS	-.25*	-.28**	49**	.34**	1							
PSSFA	-.18	-.22*	.42**	.26*	.53**	1						
PSSFR	-.25*	-.29**.	41**	.30**	.85**	.21*	1					
PSSSO	-.16	-.17	.36**	.25*	.90**	.28**	.67**	1				
YCI	.52**	.11	.06	.01	-.07	.06	-.05	-.12	1			
YRAI	.32**	.33**	-.17	-.15	-.14	-.09	-.09	-.13	.34**	1		
YPI	.45**	.33**	.22*	-.13	-.25*	-.16	-.28**	-.15	.23*	.24*	1	
MBI	.28**	.33**	-.27**	-.20*	-.32**	-.23*	-.32**	-.21*	.26*	.07	.44**	1

Note 1. *p< .05,**p< .01

Note 2. YSQ = Young Schema Questionnaire, BDI = Beck Depression Inventory, BN = Caregiver Well-Being Scale-Basic Needs, AL = Caregiver Well-Being Scale- Activity of Living, MSPSS = Multidimensional Scale of Perceived Social Support, PSSFA = Perceived Social Support from Family, PSSFR = Perceived Social Support from Friends, PSSSO = Perceived Social Support from Significant Others, YCI = Young Compensation Inventory, YRAI = Young Rygh Avoidance Inventory, YPI = Young Parenting Inventory, MBI = Maslach Burnout Inventory.

In addition, perceived social support from significant others was found to be associated with perceived social support from family (r = .28, p< .01); and perceived social support from friends (r = .67, p< .01). Perceived social support from

friends,also had a significant association with parenting styles (r = -.28, p< .01), indicating higher levels of perceived social support from friends were related to lower negative parenting styles.

Regarding burnout, significant results were revealed with perceived social support from friends (r = -.32, p < .01), indicating that higher levels of burnout were associated with lower perception of social support from friends; schema coping strategies-compensation (r = .26, p< .01), meaning that participants reported higher levels of burnout were more likely to use schema coping strategies-compensation; and parenting styles (r = .44, p< .01), indicating higher levels of burnout were related to worse parenting styles.

Finally, schema coping strategies-compensation was found to be associated with schema coping strategies-avoidance (r = .35, p<.01), which means that higher levels of compensation were associated with higher levels of avoidance.

II. Analyses for Testing the Hypotheses

3.4. Mediation Analyses

In order to examine the mediating factors between parenting styles as predictor variable, and respectively caregiver well-being-basic needs, caregiver well-being-activity of living, burnout, and depression as outcome variables; four separate mediation analyses were conducted by following the steps proposed by Baron and Kenny (1986). As for the first mediation analysis; the mediator role of early maladaptive schemas on the relationship between parenting styles and caregiver well-being-basic needs was examined. As for the second mediation analysis; the mediator role of early maladaptive schemas on the relationship between parenting styles and caregiver well-being-activity of living was investigated. In the third model; the mediator role of early maladaptive schemas on the relationship between parenting styles and burnout was examined. Finally, the mediator role of early maladaptive schemas on the relationship between parenting styles and depression was investigated.

Before the analyses, zero-order correlations among the predictor, mediator, and outcome variables were examined (see Table 3.17). Following conditions should be satisfied to call a variable a “mediator” according to “causal steps” approach. First, predictor variable should significantly predict the outcome variable. Second,

the mediator variable should significantly predict the outcome variableafter controlling for the predictor. In addition, the association between the predictor variable and outcome variable should become non-significant or decrease significantly when the mediator effect is controlled. In addition, predictor variable should significantly predict the mediator variable (Baron & Kenny, 1986).

3.4.1. The Mediator Role of Early Maladaptive Schemas between Parenting Styles and Caregiver Well-Being-Basic Needs Relation

In order to test the mediator role of early maladaptive schemas between parenting styles and caregiver well-being-basic needs, separate regression analyses were performed. Correspondingly, in the first step of the first analysis, parenting styles was entered into the regression equation as the predictor of caregiver well-being-basic needs [pr = -.22, β = -.22, $t(97)$ = -2.18, p< .05] and it explained 5% of the variance [$F(1, 97)$ = 4.73, p< .05]. After that, as the second step, early maladaptive schemas was entered into the regression as the predictor of caregiver well-being-basic needs [pr = -.28, β = -.28, $t(97)$ = -2.84, p< .01] and it explained 8% of the variance [$F(1, 97)$ = 8.09, p< .01]. After controlling for early maladaptive schemas, previously observed relationship between parenting styles and caregiver well-being-basic needs decreased its strength [pr = -.22, β = -.11, $t(96)$ = -1.04, p=.30] and the observed decrease was confirmed to be significant by the Sobel test (z = -2.44, p< .05).

Finally, in order to complete the mediation analysis, parenting styles should have a significant relationship with early maladaptive schemas. For this reason, another regression analysis was conducted to investigate the association of parenting styles with early maladaptive schemas. Parenting styles was entered into equation [pr = .45, β = .45, t (97) = 4.96, p< .001] and it explained 20% of variance in early maladaptive schemas [$F(1, 97)$ = 24.61, p< .001].

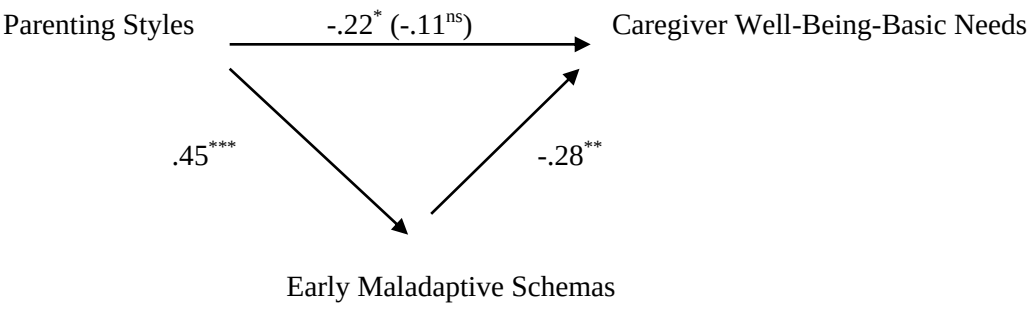
The two regression analyses with further support of Sobel test showed that early maladaptive schemas mediated the relationship between parenting styles and caregiver well-being-basic needs.

Table 3.18.

The Summary of the Mediation Analysis for Parenting Styles and Caregiver Well-Being-Basic Needs

Outcome Variable	Predictor	*β*	*t*	*df*	*F*	*pr*	
Basic Needs	1. Parenting Styles	-.22	-2.18*	1,97	4.73*	-.22	.05
	2. Early Maladaptive Schemas	-.28	-.2.84**	1,97	8.09**	-.28	.08
	(Parenting Styles)	-.11	-1.04	-	-	-.22	-
EMS	1.Parenting Styles	.45	4.96***	1,97	24.61***	.45	.20

Note. $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$



Note. ^{ns}=non-significant, $^{*}p<.05$, $^{**}p <. 01$, $^{***}p < .001$

Figure 3.1.

The Mediator Role of Early Maladaptive Schemas between Parenting Styles and Caregiver Well-Being-Basic Needs

3.4.2. The Mediator Role of Early Maladaptive Schemas between Parenting Styles and Caregiver Well-Being-Activity of Living Relation

In order to test the mediator role of early maladaptive schemas between parenting styles and caregiver well-being activity of living, separate regression analyses were run. Correspondingly, in the first step of the first analysis, parenting styles was entered into the regression equation as the predictor of caregiver well-being activity of living [*pr* = -.13, *β* = -.13, *t*(97) = -1.25, *p*=.21] and it explained 2% of the variance [*F*(1, 97) = 1.57, *p*=.21]. After that as the second step, early maladaptive schemas was entered into the regression as the predictor of caregiver well-being activity of living [*pr* = -.18, *β* = -.18, *t*(97) = -1.76, *p=.08*] and it explained 3% of the variance [*F*(1, 97) = 3.08, *p*=.08]. After controlling for early maladaptive schemas, previously observed relationship between parenting styles and caregiver well-being did not decrease its strength [*pr* = -.18, *β* = -.15, *t*(96) = -1.33, *p=.19*]. Therefore, the Sobel test was not run.

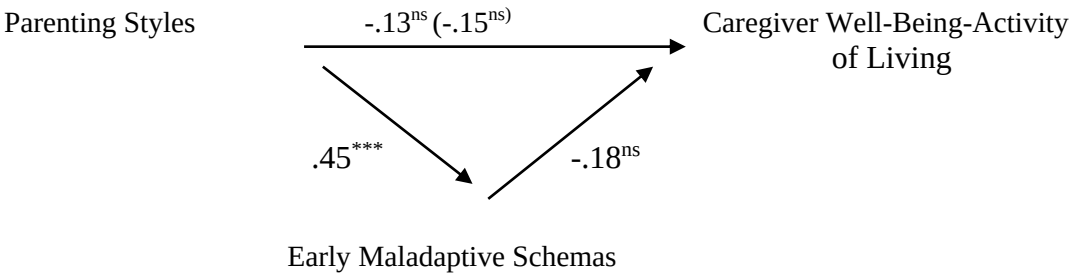
Table 3.19.

The Summary of the Mediation Analysis for Parenting Styles and Caregiver Well-Being-Activity of Living

Outcome Variable	Predictor	*β*	*t*	*df*	*F*	*pr*	
Activity of Living	1. Parenting Styles	-.13	-1.25^{ns}	1,97	1.57^{ns}	-.13	.02
	2. EMS	-.18	-1.76^{ns}	1,97	3.08^{ns}	-.18	.03
	(Parenting Styles)	-.15	-1.33^{ns}	-	-	-.18	-
EMS	1. Parenting Styles	.45	4.96***	1,97	24.61***	.45	.20

Note 1.^{ns}=non-significant,****p*< .001

Note 2. EMS = Early Maladaptive Schemas



Note. ns=non-significant, ***p< .001

Figure 3.2.

The Mediator Role of Early Maladaptive Schemas between Parenting Styles and Caregiver Well-Being-Activity of Living

For mediation, parenting styles should have a significant association with early maladaptive schemas. Therefore, another regression analysis was conducted to examine the relationship between parenting styles and early maladaptive schemas. Parenting styles was entered into the equation [pr=.45, β=.45, t(97) = 4.96, p<.001] and it explained 20% of variance in early maladaptive schemas [F(1, 97) =24.61, p< .001]. The analysis was not suitable for Baron and Kenny's (1986) "casual steps" approach in testing mediation. Therefore, it can be said that early maladaptive schemas did not mediate the relation between parenting styles and caregiver well-being-activity of living.

3.4.3. The Mediator Role of Early Maladaptive Schemas between Parenting Styles and Burnout Relation

In order to test the mediator role of early maladaptive schemas between parenting styles and burnout, separate regression analyses were performed.

Correspondingly, in the first step of the first analysis, total parenting styles score was entered into the regression equation as the predictor of burnout [pr = .44, β = .44, t(97) = 4.84, p< .001] and it explained 20% of the variance [F(1, 97) = 23.45, p< .001]. As the second step, early maladaptive schemas were entered into the

regression equation as the predictor of burnout [*pr* = .28, *β* = .28, *t*(97) = 2.84, *p*< .01] and it explained 8% of the variance [*F*(1, 97) = 8.08, *p*< .01]. After controlling for early maladaptive schemas, previously observed relation between parenting styles and burnout decreased [*pr* = .44, *β* = .40, *t*(97) = 3.89, *p*< .001] and the observed decrease was significant according to the Sobel test (*z* = 2.52, *p*< .05). To complete the mediation analysis, there should be a relationship between parenting stylesand early maladaptive schemas. For this reason, another regression analysis was conducted to investigate the association between parenting styles and early maladaptive schemas. Parenting styles was entered into equation [*pr* = .45, *β* = .45, *t*(96) = 4.96, *p*< .001] and it explained 20% of variance in early maladaptive schemas [*F*(1, 97) = 24.61, *p*< .001].These two regression analyses supported by Sobel test showed that early maladaptive schemas mediated the relationship between parenting styles and burnout. In addition, early maladaptive schemas accounted for 20% of the variance in the relation between parenting styles and burnout.

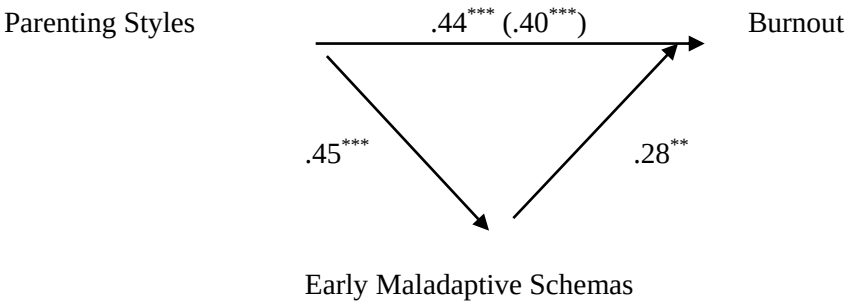
Table 3.20.

The Summary of the Mediation Analysis for Parenting Styles and Burnout

Outcome Variable	Predictor	*β*	*t*	*df*	*F*	*pr*	
Burnout	1. Parenting Styles	.44	4.84***	1,97	23.45***	.44	.20
	2. EMS	.28	2.84**	1,97	8.08**	.28	.08
	(Parenting Styles)	.40	3.89***	-	-	.44	-
EMS	1.Parenting Styles	.45	4.96***	1,97	24.61***	.45	.20

Note 1. **p <.01,***p< .001

Note 2. EMS = Early Maladaptive Schemas



Note. $^{**}p<.01$, $^{***}p< .001$

Figure 3.3.

The Mediator Role of Early Maladaptive Schemas between Parenting Styles and Burnout

3.4.4. The Mediator Role of Early Maladaptive Schemas between Parenting Styles and Depression Relation

In order to test the mediator role of early maladaptive schemas between parenting styles and depression, separate regression analyses were conducted.Accordingly, in the first step of the first analysis, parenting styles was entered into the regression equation as the predictor of depression [pr = .33, β = .33, $t(97) = 3.43$, $p< .01$] and it explained 11% of the variance [$F(1, 97) = 11.76$, $p< .01$]. Then, early maladaptive schemas was entered into the regression equation as the predictor of depression [pr = .48, β = .48, $t(97) = 5.36$, $p< .001$] and it explained 23% of the variance [$F(1, 97) = 28.70$, $p< .001$]. After controlling for early maladaptive schemas, previously observed relationship between parenting styles and depressiondecreased [pr = .33, β = .14, $t(96) = 1.44$, p=.15] and the observed decrease was significant as illustrated by the Sobel test ($z = 3.61$, $p< .001$).

Table 3.21.

The Summary of the Mediation Analysis for Parenting Styles and Depression

Outcome Variable	Predictor	*β*	*t*	*df*	*F*	*pr*	
Depression	1. Parenting Styles	.33	3.43^{**}	1,97	11.76^{**}	.33	.11
	2. EMS	.48	5.36^{***}	1,97	28.70^{***}	.48	.23
	(Parenting Styles)	.14	1.44^{ns}	-	-	.33	-
EMS	1. Parenting Styles	.45	4.96^{***}	1,97	24.61^{***}	.45	.20

Note 1.^{ns}=non-significant, $^{**}p$<.01, $^{***}p$< .001

Note 2. EMS = Early Maladaptive Schemas

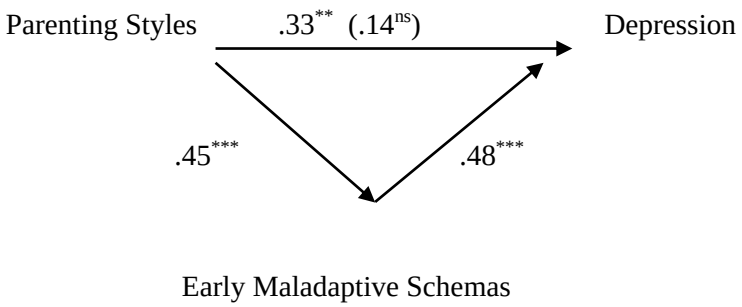


Figure 3.4.

The Mediator Role of Early Maladaptive Schemas between Parenting Styles and Depression

To complete the mediation analysis, parenting styles should have a significant association with early maladaptive schemas. Therefore, another regression analysis was also conducted to examine the relationship between parenting styles and early

maladaptive schemas. Parenting styles was entered into equation [pr = .45, β = .45, $t(97) = 4.96$, $p < .001$] and it explained 20% of variance in early maladaptive schemas [$F(1, 97) = 24.61$, $p < .001$].

These two regression analyses that were supported by the Sobel test showed that early maladaptive schemas mediated the relationship between parenting styles and depression.

Table 3.22.

The Results of the Mediation Analyses

IV	Mediator	DV	Mediation	Sobel
Parenting Styles	EMS	Basic Needs	Yes	Significant
Parenting Styles	EMS	Activity of Living	No	---
Parenting Styles	EMS	Burnout	Yes	Significant
Parenting Styles	EMS	Depression	Yes	Significant

Note. EMS = Early Maladaptive Schemas

3.5. Moderation Analyses

Before running the regression analyses, the predictors were linearly transformed by subtracting the respective sample mean from each predictor in order to center the variables. Then, as Aiken and West (1991) suggested, variableswere multiplied for the interaction term. After the examination of zero-order correlations,4 sets of moderation analyses were conducted. In the first three sets, moderating roles of perceived social support, schema coping process of avoidance, and schema coping processes of compensation were investigated. In each of these sets, there were 4 moderation analyses regressing on caregiver well-being basic needs, caregiver well-being activity of living, depression, and burnout were conducted. The moderating role of perceived social support, schema coping processes of avoidance, and schema coping processes of compensation on the association between early maladaptive schemas and caregiver well-being-basic needs, caregiver well-being activity of

living, depression, and burnout were examined. On the other hand, in the fourth set of moderation analyses, the moderating role of perceived social support from family, perceived social support from friends, and perceived social support from significant others were investigated. The moderating role of these different sources of perceived social support on the relationship between early maladaptive schemas and caregiver well-being-basic needs were examined.

Table 3.23.

The Summary of the Set of Moderation Analyses

Predictor	Moderator	Outcome	Moderation	Significant
1st Moderation	EMS	PSS	BN	Yes
2nd Moderation	EMS	PSS	AL	No
3rd Moderation	EMS	PSS	Depression	No
4th Moderation	EMS	PSS	Burnout	No
1st Moderation	EMS	Avoidance	BN	No
2nd Moderation	EMS	Avoidance	AL	No
3rd Moderation	EMS	Avoidance	Depression	No
4th Moderation	EMS	Avoidance	Burnout	No
1st Moderation	EMS	Compensation	BN	No
2nd Moderation	EMS	Compensation	AL	No
3rd Moderation	EMS	Compensation	Depression	No
4th Moderation	EMS	Compensation	Burnout	No
1st Moderation	EMS	PSS-from Family	BN	No
2nd Moderation	EMS	PSS-from Friends	BN	No
3rd Moderation	EMS	PSS-from S.O.	BN	Yes

Note. EMS=Early Maladaptive Schemas, PSS=Perceived Social Support, PSS-from S.O.=Perceived Social Support from Significant Others, AL=Caregiver Well-Being-Activity of Living, BN=Caregiver Well-Being-Basic Needs.

3.5.1. Moderating Role of Perceived Social Support

In this set of analyses, the moderating role of perceived social support was examined with four hierarchical regression analyses. Caregiver well-being-basic needs, caregiver well-being-activity of living, depression, and burnout were sequentially used as the dependent variables in the regression equations. After the examination of zero-order correlations, hierarchical multiple regression analysis regressing the caregiver well-being basic needs, caregiver well-being activity of living, depression, and burnout to perceived social support and early maladaptive schemas was conducted. As Aiken and West (1991) suggested, before running the regression analyses, all variables were centered.

3.5.1.1. Moderating Role of Perceived Social Support on the Relationship between Early Maladaptive Schemas and Caregiver Well-Being-Basic Needs

In order to test the moderating role of perceived social support between caregiver well-being-basic needs and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and perceived social support were entered in the first step and in the second step, the interaction terms was entered.

According to the result of hierarchical multiple regression analysis presented in Table 3.24, there were main effects of early maladaptive schemas (β = -.18, t(96)= -2.04, p< .05), and perceived social support (β =.41, t(96)= 4.52, p< .001). That is, early maladaptive schemas and perceived social support were significantly associated with the caregiver well-being-basic needs (F(2,96) = 17.64, p< .001). In the second step, the interaction of perceived social support and early maladaptive schemas did also reveal a significant relationship with caregiver well-being-basic needs (β = .18, t(95)=2.06, p< .05, ΔR^2= .03), (F_{change}(1,95) = 4.25, p< .05) that is, perceived social support moderated the relationship between early maladaptive schemas and caregiver well-being-basic needs. The corresponding B, Standard Error of B, β, R^2change and F change values; and d.f. values for the F change scores are presented in Table 3.24.

Table 3.24.

Regression Models Predicting Caregiver Well-Being-Basic Needs with Early Maladaptive Schemas and Perceived Social Support

	Caregiver Well-Being-Basic Needs						
Variable	B	SEB	β	t	ΔR^2	ΔF	df
Step 1					.27	17.64^{***}	2,96
EMS	-.06	.03	$-.18^{*}$	-2.04^{*}			96
PSS	.35	.08	$.41^{***}$	4.52^{***}			96
Step 2					.03	4.25^{*}	1,95
PSS X EMS	.00	.00	$.18^{*}$	2.06^{*}			95

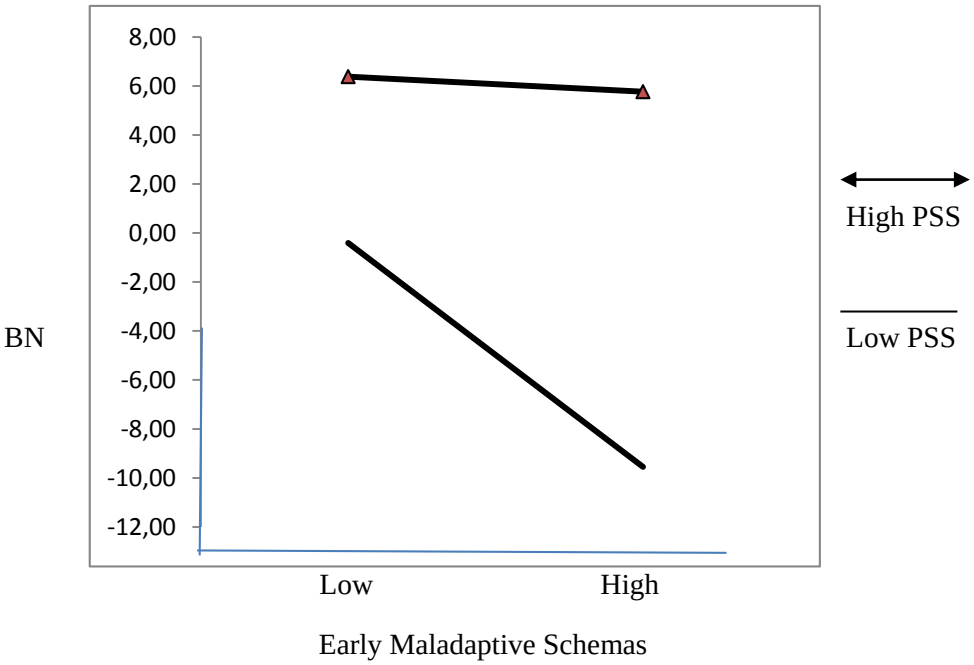
Note 1. $^{*}p < .05$, $^{***}p < .001$

Note 2. PSS = Perceived Social Support, EMS = Early Maladaptive Schemas

Figure 3.5. shows the interaction effect of perceived social support and early maladaptive schemas on caregiver well-being-basic needs. Using procedures recommended by Cohen, Cohen, West, and Aiken (2002), the simple regression of caregiver well-being-basic needs on early maladaptive schemas was computed for high (16.03) and low (–16.03) levels of perceived social support (i.e., M + SD). Next, the slope of each regression line was tested in order to see whether they were statistically significant (Aiken & West, 1991). This analysis revealed that the positive regression of caregiver well-being-basic needs on early maladaptive schemas occurred when perceived social support is low (β = -.35, $t(95)$ = -2.78, $p < .01$) but not when perceived social support is high (β = -.02, $t(95)$ = -.14, p = .89).

Accordingly, when perceived social support is high, there was no significant difference between high and low early maladaptive schemas when predicting caregiver well-being-basic needs. In other words, if caregivers of dementia patients perceived higher levels of social support, having high or low schema scores did not make a difference in terms of caregiver well-being. However, when perceived social

support is low, there was a difference between high and low early maladaptive schemas when predicting caregiver well-being basic needs. That is, caregivers of dementia patients who had high schema scores had lower caregiver well-being as compared to caregivers with low schema scores if they perceived low social support. Thus, perceived social support can be a protective factor for caregivers of dementia patients with higher schema scores in terms of caregiver well-being.



Note. PSS=Perceived Social Support, BN=Caregiver Well-Being-Basic Needs

Figure 3.5.

Interaction effect of perceived social support and early maladaptive schemas

3.5.1.2. Moderating Role of Perceived Social Support on the Relationship between Early Maladaptive Schema and Caregiver Well-Being-Activity of Living

In order to test the moderating role of perceived social support between caregiver well-being-activity of living and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and

Kenny (1986). In the first regression analysis, early maladaptive schemas and perceived social support were entered in the first step and in the second step, the interaction terms was entered.

Table 3.25.

Regression Models Predicting Caregiver Well-Being-Activity of Living with Early Maladaptive Schemas and Perceived Social Support

	Caregiver Well-Being-Activity of Living						
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.12	6.76^{**}	2,96
EMS	-.03	.03	$-.10^{ns}$	-1.02^{ns}			96
PSS	.25	.08	$.31^{**}$	3.01^{**}			96
Step 2					.00	$.13^{ns}$	1,95
PSS X EMS	.00	.00	$.04^{ns}$	$.36^{ns}$			95

Note 1. ^{ns}= non-significant, $^{**}p< .01$

Note 2. PSS = Perceived Social Support, EMS = Early Maladaptive Schemas

According to the results of hierarchical multiple regression analysis presented in Table 3.25, early maladaptive schemas was not significantly associated with caregiver well-being-activity of living (β = -.10, $t(96)$ = -1.02, p = .31), ($F(2,96)$ = 6.76, $p< .01$). On the other hand, perceived social support was significantly and positively associated with caregiver well-being-activity of living (β = .31, $t(96)$=3.01, $p< .01$). The interaction of perceived social support and early maladaptive schemas revealed no significant association with caregiver well-being-activity of living (β=.04, $t(95)$=.36, p= .72, ΔR^2= .00), ($F_{change}(1,95)$=.13, p=.72). In other words, perceived social support did not moderate the relationship between early maladaptive schemas and caregiver well-being-activity of living. The corresponding B, Standard Error of B, β, R^2 change and F change values; and d.f. values for the F change scores are presented in Table 3.25.

3.5.1.3. Moderating Role of Perceived Social Support on the Relationship between Early Maladaptive Schemas and Depression

In order to test the moderating role of perceived social support between depression and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and perceived social support were entered in the first step and in the second step, the interaction terms was entered. According to the result of hierarchical multiple regression analysis presented in Table 3.26, early maladaptive schemas was significantly and positively associated with depression (β = .44, t(96)=4.88, p< .001), (F(2,96) = 16.66, p< .001). On the other hand, perceived social support was not significantly associated with depression (β = -.15, t(96) = -1.64, p = .10). The interaction of perceived social support and early maladaptive schemas was also not significant (β = -.11, t(95) = -1.18, p = .24, ΔR^2= .01), (F_{change}(1,95) = 1.40, p = .24). In other words, perceived social support did not moderate the relationship between early maladaptive schemas and depression. The corresponding B, Standard Error of B, β, R^2 change and F change values; and d.f. values for the F change scores are presented in Table 3.26.

Table 3.26.

Regression Models Predicting Depression with Early Maladaptive Schemas and Perceived Social Support

	Depression						
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.26	16.66^{***}	2,96
EMS	.07	.02	$.44^{***}$	4.88^{***}			96
PSS	-.07	.04	$-.15^{ns}$	-1.64^{ns}			96
Step 2					.01	1.40^{ns}	1,95
PSS X EMS	-.00	.00	$-.11^{ns}$	-1.18^{ns}			95

Note 1. ^{ns}= *nonsignificant* ***p < .001

Note 2. PSS = Perceived Social Support, EMS = Early Maladaptive Schemas

3.5.1.4. Moderating Role of Perceived Social Support on the Relationship between Early Maladaptive Schemas and Burnout

In order to test the moderating role of perceived social support between burnout and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and perceived social support were entered in the first step and in the second step, the interaction terms was entered. According to the result of hierarchical multiple regression analysis presented in Table 3.27, there were main effects early maladaptive schemas (β = .21, t(96)=2.12, p < .05) and perceived social support (β = -.27, t(96) = -2.73, p< .01). That is, early maladaptive schemas and perceived social support were significantly related to burnout (F(2,96) = 7.90, p< .01). On the contrary, the interaction of perceived social support and early maladaptive schemas was not significant in predicting burnout (β = .05, t(95) = .55, p = .59, ΔR^2 = .00), (F_{change}(1,95) = .30, p = .59). In other words, perceived social support did not moderate the relationship between early maladaptive schemas and burnout. The corresponding B, Standard Error of B, β, R^2change and F change values; and d.f. values for the F change scores are presented in Table 3.27.

Table 3.27.

Regression Models Predicting Burnout with Early Maladaptive Schemas and Perceived Social Support

					Burnout		
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.14	7.90^{**}	2,96
EMS.05	.03	$.21^{*}$	2.12^{*}				96
PSS	-.19	.07	$-.27^{**}$	-2.73^{**}			96
Step 2					.00	$.30^{ns}$	1,95
PSS X EMS	.00	.00	$.05^{ns}$	$.55^{ns}$			95

Note 1. ^{ns}=non-significant, $^{*}p$< .05, $^{**}p$< .01

Note 2. PSS = Perceived Social Support, EMS = Early Maladaptive Schemas

3.5.2. Moderating Role of Schema Coping Processes of Avoidance

In this set of analyses, moderating role of schema coping processes of avoidance was examined with four hierarchical regression analyses. Caregiver well-being-basic needs, caregiver well-being-activity of living, depression, and burnout were sequentially used as dependent variables in the regression equations. After examination of the zero-order correlations, hierarchical multiple regression analysis regressing the caregiver well-being-basic needs, caregiver well-being activity of living, depression, and burnout to schema coping processes of avoidance and early maladaptive schemas was conducted. As Aiken and West (1991) suggested, before running the regression analyses, all variables were centered.

3.5.2.1. Moderating Role of Schema Coping Processes of Avoidance on the Relationship between Early Maladaptive Schemas and Caregiver Well-Being Basic Needs

In order to test the moderating role of schema coping processes of avoidance between caregiver well-being-basic needs and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and schema coping processes of avoidance were entered in the first step and in the second step, the interaction terms was entered.

According to the result of hierarchical multiple regression analysis presented in Table 3.28, early maladaptive schemas was significantly and negatively associated with caregiver well-being-basic needs (β = -.26, t(96)= -2.43, p< .05), (F(2,96) = 4.46, p< .05). On the other hand, schema coping processes of avoidance was not significantly associated with caregiver well-being-basic needs (β = -.09, t(96) = -.84, p = .41). The interaction of schema coping processes of avoidance and early maladaptive schemas was also not significant (β = .05, t(95) = .50, p = .62, ΔR^2 = .00), (F_{change}(1,95) = .25, p = .62). That is, schema coping processes of avoidance did not moderate the relationship between early maladaptive schemas and caregiver well-being-basic needs. The corresponding B, Standard Error of B, β, R^2change and F change values; and d.f. values for the Fchange scores are presented in Table 3.28.

Table 3.28.

Regression Models Predicting Caregiver Well-Being-Basic Needs with Early Maladaptive Schemas and Schema Coping Processes of Avoidance

	Caregiver Well-Being-Basic Needs						
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.09	4.46^{*}	2,96
EMS	-.08	.03	$-.26^{*}$	-2.43^{*}			96
Avoidance	-.07	.08	$-.09^{ns}$	$-.84^{ns}$			96
Step 2					.00	$.25^{ns}$	1,95
Avoidance X EMS	.00	.00	$.05^{ns}$	$.50^{ns}$			95

Note 1. ^{ns}=non-significant, $^{*}p < .05$

Note 2. EMS = Early Maladaptive Schemas

3.5.2.2. Moderating Role of Schema Coping Processes of Avoidance on the Relationship between Early Maladaptive Schemas and Caregiver Well-Being-Activity of Living

In order to test the moderating role of schema coping processes of avoidance between caregiver well-being-activity of living and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and schema coping processes of avoidance were entered in the first step and in the second step, the interaction terms was entered. According to the result of hierarchical multiple regression analysis presented in Table 3.29, early maladaptive schemas was not revealed a significant association with caregiver well-being-activity of living (β = -.14, $t(96) = -1.35$, $p = .18$), ($F(2,96) = 2.08$, $p = .13$). In addition, schema coping processes of avoidance was not significantly associated with caregiver well-being-activity of living (β = -.11, $t(96) = -.99$, $p = .33$). The interaction of schema coping processes of avoidance and early maladaptive schemas was also not significant (β =

.02, $t(95) = .24$, $p = .81$, $\Delta R^2 = .00$), ($F_{change}(1,95) = .06$, $p = .81$), that is, schema coping processes of avoidance did not moderate the relationship between early maladaptive schemas and caregiver well-being-activity of living. The corresponding B, Standard Error of B, β, R^2change and F change values; and d.f. values for the F change scores are presented in Table 3.29.

Table 3.29.

Regression Models Predicting Caregiver Well-Being-Activity of Living with Early Maladaptive Schemas and Schema Coping Processes of Avoidance

	Caregiver Well-Being-Activity of Living						
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.04	2.08^{ns}	2,96
EMS	-.04	.03	$-.14^{ns}$	-1.35^{ns}			96
Avoidance	-.08	.08	$-.11^{ns}$	$-.99^{ns}$			96
Step 2					.00	$.06^{ns}$	1,95
Avoidance X EMS	.00	.00	$.02^{ns}$	$.24^{ns}$			95

Note 1. ^{ns}=non-significant

Note 2. EMS = Early Maladaptive Schemas

3.5.2.3. Moderating Role ofSchema Coping Processes of Avoidance on the Relationship between Early Maladaptive Schemas and Depression

In order to test the moderating role of schema coping processes of avoidance between depression and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and schema coping processes of avoidance were entered in the first step and in the second step, the interaction terms was entered. According to the results of hierarchical multiple regression analysis

presented in Table 3.30, there were main effects of early maladaptive schemas (β = .40, $t(96) = 4.25$, $p < .001$) and schema coping processes of avoidance (β = .22, $t(96) = 2.34$, $p < .05$). That is, early maladaptive schemas and schema coping processes of avoidance were significantly associated with depression ($F(2,96) = 17.29$, $p < .001$). However, the interaction of schema coping processes of avoidance and early maladaptive schemas was not significant (β = .11, $t(95) = 1.24$, p = .22, ΔR^2= .01), ($F_{change}(1,95) = 1.54$, p = .22), that is, schema coping processes of avoidance did not moderate the relationship between early maladaptive schemas and depression. The corresponding B, Standard Error of B, β, R^2change and F change values; and d.f. values for the F change scores are presented in Table 3.30.

Table 3.30.

Regression Models Predicting Depression with Early Maladaptive Schemas and Schema Coping Processes of Avoidance

			Depression				
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.27	17.29^{***}	2,96
EMS	.07	.02	$.40^{***}$	4.25^{***}			96
Avoidance	.09	.04	$.22^{*}$	2.34^{*}			96
Step 2					.01	1.54^{ns}	1,95
Avoidance X EMS	.00	.00	$.11^{ns}$	1.24^{ns}			95

Note 1. ^{ns}=nonsignificant, $^{*}p < .05$, $^{***}p < .001$

Note 2. EMS = Early Maladaptive Schemas

3.5.2.4. Moderating Role of *Sc*hema Coping Processes of Avoidance on the Relationship between Early Maladaptive Schemas and Burnout

In order to test the moderating role of schema coping processes of avoidance between burnout and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and schema coping processes of avoidance were entered in the first step and in the second step, the interaction terms was entered.

Table 3.31.

Regression Models Predicting Burnout with Early Maladaptive Schemas and Schema Coping Processes of Avoidance

				Burnout			
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.08	4.02*	2,96
EMS	.08	.03	.31**	3.00**			96
Avoidance	-.03	.07	-.05ns	.05ns			96
Step 2					.03	3 .09ns	1,95
Avoidance X EMS	-.00	.00	-.17ns	-1.76ns			95

Note 1. ns=non-significant, *p< .05, **p< .01

Note 2. EMS = Early Maladaptive Schemas

According to the result of hierarchical multiple regression analysis presented in Table 3.31, early maladaptive schemas was significantly associated with burnout (β = .31, t(96) = 3.00, p< .01), (F(2,96) = 4.02, p< .05). However, schema coping processes of avoidance was not significantly associated with burnout (β = -.05, t(96) = -.05, p = .66). In addition, the interaction of schema coping processes of avoidance and early maladaptive schemas was not significant (β = -.17, t(95) = -1.76, p = .08,

ΔR^2 = .03), (F_{change}(1,95) = 3.09, p = .08), that is, schema coping processes of avoidance did not moderate the relationship between early maladaptive schemas and burnout. The corresponding B, Standard Error of B, β, R^2change and F change values; and d.f. values for the F change scores are presented in Table 3.31.

3.5.3. Moderating Role of Schema Coping Processes of Compensation

In this set of analyses, moderating role of schema coping processes of compensation was examined with four hierarchical regression analyses. Caregiver well-being-basic needs, caregiver well-being-activity of living, depression, and burnout were sequentially used as dependent variables in the regression equations. After examination of the zero-order correlations, hierarchical multiple regression analysis regressing the caregiver well-being-basic needs, caregiver well-being-activity of living, depression, and burnout to schema coping processes of compensation and early maladaptive schemas was conducted. As Aiken and West (1991) suggested, before running the regression analyses, all variables were centered.

3.5.3.1. Moderating Role of Schema Coping Processes of Compensation on the Relationship between Early Maladaptive Schemas and Caregiver Well-Being-Basic Needs

In order to test the moderating role of schema coping processes of compensation between caregiver well-being-basic needs and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and schema coping processes of compensation were entered in the first step and in the second step, the interaction terms was entered. According to the result of hierarchical multiple regression analysis presented in Table 3.32, early maladaptive schemas was significantly associated with caregiver well-being-basic needs (β = -.45, t(96) = -3.97, p< .001), (F(2,96) = 7.40, p< .01). Schema coping processes of compensation was also significantly associated with caregiver well-being-basic needs (β = .29, t(96) = 2.63, p< .05). However, the interaction of schema coping processes of compensation and early maladaptive schemas was not significant (β = .12, t(95) = 1.22, p = .23, ΔR^2 = .01), (F_{change}(1,95) = 1.49, p = .23), that is,

schema coping processes of compensation did not moderate the relationship between early maladaptive schemas and caregiver well-being-basic needs. The corresponding B, Standard Error of B, *β, R2*change and *F* change values; and d.f. values for the *F* change scores are presented in Table 3.32.

Table 3.32.

Regression Models Predicting Caregiver Well-Being-Basic Needs with Early Maladaptive Schemas and Schema Coping Processes of Compensation

	Caregiver Well-Being-Basic Needs						
Variable	B	SE B	*β*	*t*	ΔR^2	ΔF	df
Step 1					.13	7.40^{**}	2,96
EMS	-.14	.03	$-.45^{***}$	-3.97^{***}			96
Compensation	.15	.06	$.29^{*}$	2.63^{*}			96
Step 2				.01	1.49^{ns}	1,95	
Compensation X EMS	.00	.00	$.12^{ns}$	1.22^{ns}			95

Note 1. ^{ns}=non-significant, $^{*}p< .05$, $^{**}p< .01$, $^{***}p< .001$

Note 2. EMS = Early Maladaptive Schemas

3.5.3.2. Moderating Role of Schema Coping Processes of Compensation on the Relationship between Early Maladaptive Schemas and Caregiver Well-Being-Activity of Living

In order to test the moderating role of schema coping processes of compensation between caregiver well-being-activity of living and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and schema coping processes of compensation were entered in the first step and in the second step, the interaction terms was entered.According to

the results of hierarchical multiple regression analysis presented in Table 3.33, early maladaptive schemas was significantly associated with caregiver well-being-activity of living (β = -.27, t(96) = -2.31, p< .05), (F(2,96) = 2.19, p = .12). However, schema coping processes of compensation was not significantly associated with caregiver well-being-activity of living (β = -.15, t(96) = 1.26, p = .21). The interaction of schema coping processes of compensation and early maladaptive schemas was also not significant (β = .12, t(95) = 1.21, p = .23, ΔR^2= .02), (F_{change}(1,95) = 1.46, p = .23), that is, schema coping processes of compensation did not moderate the relationship between early maladaptive schemas and caregiver well-being-activity of living. The corresponding B, Standard Error of B, β, R^2change and F change values; and d.f. values for the F change scores are presented in Table 3.33.

Table 3.33.

Regression Models Predicting Caregiver Well-Being-Activity of Living with Early Maladaptive Schemas and Schema Coping Processes of Compensation

	Caregiver Well-Being-Activity of Living						
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.04	2.19^{ns}	2,96
EMS	-.08	.03	$-.27^{*}$	-2.31^{*}			96
Compensation	.07	.06	$.15^{ns}$	1.26^{ns}			96
Step 2					.02	1.46^{ns}	1,95
Compensation X EMS	.00	.00	$.12^{ns}$	1.21^{ns}			95

Note 1. ^{ns}=non-significant, $^{*}p$< .05

Note 2. EMS = Early Maladaptive Schemas

3.5.3.3. Moderating Role of Schema Coping Processes of Compensation on the Relationship between Early Maladaptive Schemas and Depression

In order to test the moderating role of schema coping processes of compensation between depression and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and schema coping processes of compensation were entered in the first step and in the second step, the interaction terms was entered.

Table 3.34.

Regression Models Predicting Depression with Early Maladaptive Schemas and Schema Coping Processes of Compensation

	Depression						
Variable	B	SE B	*β*	*t*	ΔR^2	ΔF	*df*
Step 1					.25	16.31^{***}	2,96
EMS	.10	.02	$.59^{***}$	5.57^{***}			96
Compensation	-.05	.03	$-.19^{ns}$	-1.86^{ns}			96
Step 2					.00	$.44^{ns}$	1,95
Compensation X EMS	.00	.00	$-.06^{ns}$	$.66^{ns}$			95

Note 1. ^{ns}=non-significant, $^{***}p< .001$

Note 2. EMS = Early Maladaptive Schemas

According to the results of hierarchical multiple regression analysis presented in Table 3.34, early maladaptive schemas was significantly associated with depression ($\beta = .59$, $t(96) = 5.57$, $p< .001$), ($F(2,96) = 16.31$, $p< .001$). On the contrary, schema coping processes of compensation was not significantly associated with depression ($\beta = -.19$, $t(96) = -1.86$, $p = .07$). The interaction of schema coping processes of compensation and early maladaptive schemas was also not significant (β

= -.06, $t(95) = -.66$, $p = .51$, $\Delta R^2 = .00$), ($F_{change}(1,95) = .44$, $p = .51$), that is, schema coping processes of compensation did not moderate the relationship between early maladaptive schemas and depression. The corresponding B, Standard Error of B, β, R^2 change and F change values, and d.f. values for the F change scores are presented in Table 3.34.

3.5.3.4. Moderating Role of Schema Coping Processes of Compensation on the Relationship between Early Maladaptive Schemas and Burnout

In order to test the moderating role of schema coping processes of compensation between burnout and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and schema coping processes of compensation were entered in the first step and in the second step, the interaction terms was entered.

Table 3.35.

Regression Models Predicting Burnout with Early Maladaptive Schemas and Schema Coping Processes of Compensation

			Burnout				
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.10	5.05^{**}	2,96
EMS	.05	.03	$.21^{ns}$	1.80^{ns}			96
Compensation	.06	.05	$.15^{ns}$	1.32^{ns}			96
Step 2					.00	$.32^{ns}$	1,95
Compensation X EMS	-.00	.00	$-.06^{ns}$	$-.56^{ns}$			95

Note 1. ^{ns}=non-significant, $^{**}p < .01$

Note 2. EMS = Early Maladaptive Schemas

According to the results of hierarchical multiple regression analysis presented in Table 3.35, there were no main effects of early maladaptive schemas (β = .21, $t(96) = 1.80$, p = .07) and schema coping processes of compensation (β = .15, $t(96) = 1.32$, p = 19) on burnout. In other words, early maladaptive schemas and schema coping processes of compensation were not significantly associated with burnout ($F(2,96) = 5.05$, $p < .01$). Similarly, the interaction of schema coping processes of compensation and early maladaptive schema was not significant (β = -.06, $t(95) = -.56$, p = .57, ΔR^2 = .00), ($F_{change}(1,95) = .32$, p = .57), that is, schema coping processes of compensation did not moderate the relationship between early maladaptive schemas and burnout. The corresponding B, Standard Error of B, β, R^2change and F change values; and d.f. values for the F change scores are presented in Table 3.35.

3.5.4. Moderating Role of Perceived Social Support from Family, Perceived Social Support from Friends, and Perceived Social Support from Significant Others on the Relationship between Early Maladaptive Schemas and Caregiver Well-Being-Basic Needs

In this set of analyses, moderating role of perceived social support from family, perceived social support from friends, and perceived social support from significant others were examined with three hierarchical regression analyses.Caregiver well-being-basic needs was used as the dependent variable throughout the analyses. Because only the moderator role of perceived social support on the association between early maladaptive schemas and caregiver well-being–basic needs was confirmed by the analyses, the analyses were repeated for different sources of social support to determine which one really buffers for the negative effects of early maladaptive schemas. After examination of the zero-order correlations, hierarchical multiple regression analysis regressing the caregiver well-being-basic needs to perceived social support from family, perceived social support from friends, and perceived social support from significant others and early maladaptive schemas was conducted. As Aiken and West (1991) suggested, before running the regression analyses, all variables were centered.

3.5.4.1. Moderating Role of Perceived Social Support from Family on the Relationship between Early Maladaptive Schemas and Caregiver Well-Being-Basic Needs

In order to test the moderating role of perceived social support from family between caregiver well-being-basic needs and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and perceived social support from family were entered in the first step and in the second step, the interaction terms was entered.

Table 3.36.

Regression Models Predicting Caregiver Well-Being-Basic Needs with Early Maladaptive Schemas and Perceived Social Supportfrom Family

	Caregiver Well-Being-Basic Needs						
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.22	13.20^{***}	2,96
EMS	-.06	.03	$-.21^{*}$	-2.21^{*}			96
PSSFA	1.10	.28	$.39^{***}$	3.93^{***}			96
Step 2					.00	$.04^{ns}$	1,95
PSSFA X EMS	-.00	.00	$-.02^{ns}$	$-.19^{ns}$			95

Note 1. ^{ns}=non-significant, $^{*}p< .05$, $^{***}p< .001$

Note 2. PSSFA = Perceived Social Support from Family, EMS = Early Maladaptive Schemas

According to the result of hierarchical multiple regression analysis presented in Table 3.36, early maladaptive schemas was significantly and negatively associated with caregiver well-being-basic needs (β = -.21, $t(96)$ = -2.21, $p< .05$), ($F(2,96)$ = 13.20, $p< .001$). Perceived social support from family revealed a significant relationship with caregiver well-being-basic needs (β = .39, $t(96)$ = 3.93, $p< .001$),

too. However, the interaction of perceived social support from family and early maladaptive schemas was not significant (β = -.02, t(95) = -.19, p = .85, ΔR^2 = .00), (F_{change}(1,95) = .04, p = .85), that is, perceived social support from family did not moderate the relationship between early maladaptive schemas and caregiver well-being-basic needs. The corresponding B, Standard Error of B, β, R^2change and F change values; and d.f. values for the F change scores are presented in Table 3.36.

3.5.4.2. Moderating Role of Perceived Social Support from Friends on the Relationship between Early Maladaptive Schemas and Caregiver Well-Being-Basic Needs

In order to test the moderating role of perceived social support from friends between caregiver well-being-basic needs and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986).

Table 3.37.

Regression Models Predicting Caregiver Well-Being-Basic Needs with Early Maladaptive Schemas and Perceived Social Support from Friends

	Caregiver Well-Being-Basic Needs						
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.20	11.96^{***}	2,96
EMS	-.06	.03	$-.19^{*}$	-2.01^{*}			96
PSSFR	.59	.18	$.32^{**}$	3.29^{**}			96
Step 2					.03	3.70^{ns}	1,95
PSSFR X EMS	.01	.00	$.18^{ns}$	1.92^{ns}			95

Note 1. ^{ns}=non-significant, *p< .05, **p< .01, ***p< .001

Note 2. PSSFR = Perceived Social Support from Friends, EMS = Early Maladaptive Schemas

In the first regression analysis, early maladaptive schemas and perceived social support from friends were entered in the first step and in the second step, the interaction terms was entered. According to the results of hierarchical multiple regression analysis presented in Table 3.37, there were main effects of early maladaptive schemas (β = -.19, t(96)= -2.01, p< .05), (F(2,96) = 11.97, p< .001) and perceived social support from friends (β = .32, t(96) = 3.29, p< .01). That is, early maladaptive schemas, and perceived social support from friends were significantly associated with caregiver well-being-basic needs. However, there was no significant moderation effect of perceived social support from friends (β = .18, t(95) = 1.92, p = .06, ΔR^2 = .03), (F_{change}(1,95) = 3.70, p = .06) on the relationship between early maladaptive schemas and caregiver well-being-basic needs. The corresponding B, Standard Error of B, β, R^2 change and F change values; and d.f. values for the F change scores are presented in Table 3.37.

3.5.4.3. Moderating Role of Perceived Social Support from Significant Others on the Relationship between Early Maladaptive Schemas and Caregiver Well-Being-Basic Needs

In order to test the moderating role of perceived social support from significant others between caregiver well-being-basic needs and early maladaptive schemas, two steps of multiple regressions were generated using the procedure suggested by Baron and Kenny (1986). In the first regression analysis, early maladaptive schemas and perceived social support from significant others were entered in the first step and in the second step, the interaction terms was entered. According to the result of hierarchical multiple regression analysis presented in Table 3.38, early maladaptive schemas was significantly and negatively associated with caregiver well-being-basic needs (β = -.24, t(96) = -2.70, p< .01), (F(2,96) = 10.63, p< .001). On the other hand, perceived social support from significant others was significantly and positively associated with caregiver well-being-basic needs (β = .32, t(96) = 3.51, p< .01). In addition, the interaction of perceived social support from significant others and early maladaptive schemas was significant (β = .26, t(95) = 2.88, p< .01, ΔR^2 = .07), (F_{change}(1,95) = 8.29, p < .01), that is, perceived social support from significant others did moderate the relationship between early maladaptive schemas and caregiver well-being-basic needs. The corresponding B,

Standard Error of B, β, R^2change and F change values; and d.f. values for the F change scores are presented in Table 3.38.

Table 3.38.

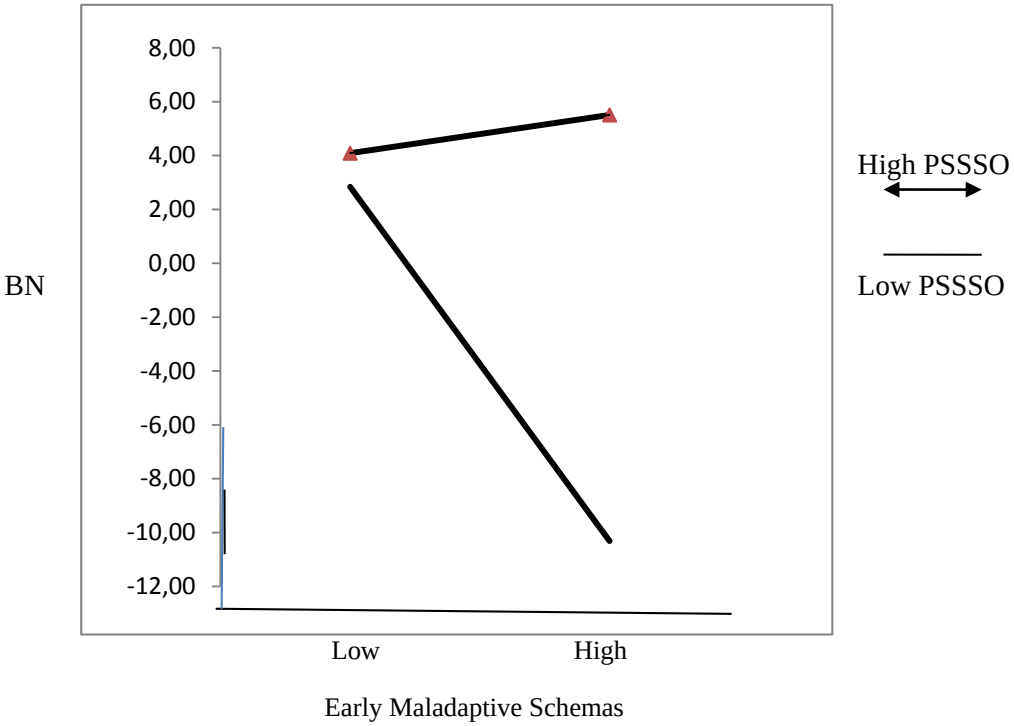
Regression Models Predicting Caregiver Well-Being-Basic Needs with Early Maladaptive Schemas and Perceived Social Supportfrom Significant Others

			Caregiver Well-Being-Basic Needs				
Variable	B	SE B	β	t	ΔR^2	ΔF	df
Step 1					.18	10.63***	2,96
EMS	-.07	.03	-.24**	-2.70**			96
PSSSO	.52	.15	.32 **	3.51**			96
Step 2					.07	8.29**	1,95
PSSSO X EMS	.01	.00	.26**	2.88**			95

Note 1. **p< .01, ***p< .001

Note 2. PSSSO = Perceived Social Support from Significant Others, EMS = Early Maladaptive Schemas

Figure 3.6. shows the interaction effect of perceived social support from significant others and early maladaptive schemas on caregiver well-being-basic needs. Using procedures recommended by Cohen, Cohen, West, and Aiken (2002), the simple regression of caregiver well-being-basic needs on early maladaptive schemas was computed for high (8.24) and low (–8.24) levels of perceived social support from significant others (i.e., M $\pm$ SD). Next, the slope of each regression line was tested in order to see whether they were statistically significant (Aiken & West, 1991).



Note. BN=Caregiver Well-Being-Basic Needs, PSSSO= Perceived Social Support from Significant Others

Figure 3.6.

Interaction effect of perceived social support from significant others and early maladaptive schemas

This analysis revealed that the positive regression of caregiver well-being-basic needs on early maladaptive schemas occurred when perceived social support from significant others is low (β = -.50, t(95) = -3.82, p< .001) but not when perceived social support is high (β = .01, t(95) = .09, p = .93).

Accordingly, when perceived social support from significant other was high, there was no significant difference between high and low early maladaptive schemas when predicting caregiver well-being-basic needs. In other words, if caregivers of dementia patients perceived higher levels of social support from significant others, having higher or lower schema scores did not make a difference in terms of caregiver well-being. However, when perceived social support from significant other was low,

there was a difference between high and low early maladaptive schemas when predicting caregiver well-being basic needs. That is, caregivers of dementia patients who had higher schema scores was expected to have lower caregiver well-being as compared to caregivers with lower schema scores if they perceived low social support from significant others. Thus, perceived social support from significant others can be a protective factor for caregivers of dementia patients with higher schema scores in terms of caregiver well-being.

CHAPTER 4

DISCUSSION

To the purposes of the present study, initially, to investigate the differences among the levels of demographic variables on the measures of the study (i.e., caregiver well-being, depression, and burnout) were examined. Secondly, intercorrelations among all the measures of the study were calculated. Lastly, mediating and moderating factors were determined through several different sets of hierarchical regression analyses. In this chapter, the results of these analyses were discussed in the light of the related literature. After that, strenghts and limitations of the present study were addressed. At last, clinical implications of the present study and recommendations for future research were presented.

4.1. Findings Related to Differences among the Levels of Demographic Variables on the Measures of the Study

One of the main aims of the present study was to investigate differences among the levels of demographic variables on the measures of the study. In this part, differences among the levels of demographic variables namely gender, marital status, having children or not, having a physical illness or not, working status, level of education, having psychological disorder or not on all of the measures of the study (i.e., caregiver well-being, parenting styles, perceived social support, depression, schema coping strategies, and burnout) were discussed.

4.1.1. Findings Related to Differences among the levels of Demographic Variables on Caregiver Well-Being

The results of the present study showed that levels of demographic variables significantly differentiated on caregiver well-being (i.e., activity of living and basic needs). In this part, results related to differences among the levels of demographic variables on caregiver well-being were discussed. These demographic variables were gender, marital status, and having children or not. In other words, gender, marital

status, and having children or not had brought out significant differences on caregiver well-being.

Firstly, regarding to gender, females had higher scores on satisfaction with performing activity of living than males. This finding seems to be inconsistent with the previous studies indicating that female caregivers were found to have lower well-being scores than male caregivers (Larson et al., 2008; Ruppanner & Bostean, 2014). However, this inconsistency can be because of the items in caregiver well-being activity of living subscale. Items like " buying food", "preparing meals", and "cleaning house" might be seen as tasks for female in Turkish culture. Therefore, females may give higher points to these items, and thus, the score of females can be higher than males.

Secondly, the result of the analysis regarding marital status, differences on basic needs subscale of caregiver well-being revealed that unmarried participants had lower scores on meeting their basic needs as compared to those who were married. This finding is comparable to the results of the previous studies showing that married participants highlighted to have higher psychological well-being than single participants (Reneflot & Mamelund, 2012; Stack & Eshleman, 1998; Verbakel, 2012). The reason why married participants scored higher on this dimension might be because of having higher social and physical support in their marriage. This might give married participants the opportunity to live their daily life just as before caregiver role. In studies, the benefit of social support from marital relationship was supported (e.g., Jackson, 1992). Social support explanation can also be valid for the result that having children posed significant differences in basic needs subscale of caregiver well-being. Participants who have children were found to have higher scores on meeting their basic needs than participants without children, parallel to the literature. For instance, the study referring to the relationship between having children and well-being showed a similar finding (Deaton & Stone, 2014).

4.1.2. Findings Related to Differences among the levels of Demographic Variables on Parenting Styles

According to the results of the present study, demographic variables (i.e., gender, having a physical illness or not, and working status) revealed significant differences on parenting styles. In this part, these results were discussed.

First of all, regarding to gender, females reported higher scores on parenting styles than males. In other words, females reported to be exposed to have worse parenting styles than males when they were asked to retrospectively recall their early childhood experiences with their parents. One explanation to this finding can be that females gave more importance to interpersonal interactions as compared to males (Wagner & Compas, 1990). Another explanation can be related to emotion expression, and the type of emotion. In recent studies, it was found that females expressed their emotions more freely than males (Fabes & Martin, 1991; Kring & Gordon, 1998). In addition, emotions, such as sadness, considered to be the characteristics of females more than males (Kelly & Hutson-Comeaux, 1999). And, females reported more negative events as compared to males (Eaton & Bradley, 2008). By these, it may be comprehensible that females expressed negative parenting styles more freely than males.

Secondly, the levels of having a physical illness differed in parenting styles. Participants with physical illness reported to be exposed worse parenting practices as compared to participants without physical illness. This finding is reasonable in the light of the finding indicating that parent-child relationship was asserted to be less positive if a child had a chronic physical illness (Pinquart, 2013). Another explanation to this finding can be that those who were exposed to worse parenting may also become more vulnerable to illness. Therefore, it is not surprising that participants with physical illnesses reported to be exposed to have a worse parenting styles than participants without physical illness.

Thirdly, working participants reported to be raised with better parenting practices than participants who were not working. Working status can be associated with higher school achievement, which might be related to parenting styles indirectly. In other words, this difference can be the result of the negative association between school achievement and parenting styles (Stright & Yeo, 2014).

4.1.3. Findings Related to Differences among the levels of Demographic Variables on Perceived Social Support

In this part, results related to differences among the levels of demographic variables on perceived social support (i.e., total perceived social support, perceived social support from family, friends, and significant others) were discussed. In this

respect, marital status, having children or not, and having a physical illness or not had brought out significant differences on perceived social support.

Firstly, marital status posed significant differences in perceived social support. In other words, married participants perceived higher levels of total social support, social support from family, and from significant others as compared to unmarried participants. This finding is consistent with previous studies indicating that marital status was found as predictors of perceived social support (Cunningham & Knoester, 2007; Forouzan et al., 2013; Rambod& Rafihii, 2010). Secondly, participants having children reported higher total perceived social support, and perceived social support from family than participants without children. One possible explanation for this finding would be that being married and having children might increase people's social network, and this also may increase the level of perceived social support. In the literature, similar to this finding, involuntary childless women reported more dissatisfaction with the social support they receive as compared to women in general population (Lechner, Bolman, & van Dalen, 2007).

Thirdly, having a physical illness or not differed in terms of perceived social support, that is, participants who had physical illness perceived friends' social support lower than the ones without physical illness.The relationship between social support and physical illness has been well established in several studies (Cohen & Wills, 1985; Danhauer, Crawford, Farmer, & Avis, 2009; Rambod, & Rafihii, 2010).

4.1.4. Findings Related to Differences between the levels of Demographic Variables in terms of Depression

The results of the present study, which indicated that the level of education, working status, and having a psychological disorder or not, have revealed significant differences on depression. In this respect, the results related to differences between the levels of demographic variables on depression were discussed in this part.

First of all, regarding to the level of education, it was found that participants with higher education level had lower scores on depression as compared to low educated participants,which is parallel to the literature (Kuscu et al., 2009; Yadav et al., 2013). In addition, working status differentiated on depression. That is, working participants reported lower scores on depression than participants who were not working. This finding was also found to be consistent with the literature (Burr,

Rauch, Rose, Tisch, & Tophoven, 2014; Castillo, Archuleta, & van Landingham, 2006; Demirtepe, 2008; Lorant et al., 2007; Pacheco, Page, & Webber, 2014). The level of education and working status were discussed together, because of their relationship with each other. One reason for this finding is psychological distress. Psychological distress was found to be higher for the unemployed as compared with the employed ones (Jackson, Stafford, Banks, & Warr, 1983). And distress was highlighted to be associated with depression (Coope et al., 1995; Fauth & Gibbons, 2014; Leggett, Zarit, Kim, Almeida, & Klein, 2014; Simpson, & Carter, 2013). Another reason why working status differentiated on depression is that working status can be considered as a protective factor, because it increases persons' resources (Kim, Baker, Spillers, & Wellisch, 2006).

In the literature, whether depression is cause or effect is still unclear (Olesen, Butterworth, Leach, Kelaher, & Pirkis, 2013). For example, depressed people reported more new unemployment circumstances. In other words, depression was found as a cause of unemployment (Bültmann et al., 2006; Lerner et al., 2004). On the other hand, depression was seen most commonly among unemployed people (Yadav et al., 2013). In this case, depression is an effect of unemployment. Although being cause or effect is unclear in the literature, it is obvious that working status and depression areclosely associated.

Thirdly, the levels of having a psychological disorder differentiated significantlyon depression. In other words, participants with a psychological disorder had higher scores on depression than participants without psychological disorder. The reason of this difference might be that 20% of the population had mental disorder at one time or another in their lives, and depression is one of the most common mental disorders (The British Psychological Society [BPS], 2013). And, this similar finding regarding the commonality of depression was seen in dementia caregivers (Covinsky et al., 2003; Mahoney, Regan, Katona, & Livingston, 2005).

4.1.5. Findings Related to Differences between the levels of Demographic Variables in terms of Schema Coping Strategies

In this part, results related to differences between the levels of demographic variables on schema coping strategies (i.e., schema coping strategies of avoidance and schema coping strategies of compensation) were discussed. The levels of

working status revealed significant differences in schema coping strategies of avoidance.

Only schema coping strategies that differed with working status was schema coping strategies of avoidance, with higher scores of unemployed participants. This can be explained through the relationship between working status and psychopathology (Burr, Rauch, Rose, Tisch, & Tophoven, 2014; Castillo, Archuleta, & van Landingham, 2006; Lorant et al., 2007; Milner, Spittal, Page, LaMontagne, 2014; Olesen, Butterworth, Leach, Kelaher, & Pirkis, 2013; Pacheco, Page, & Webber, 2014;), which is, in turn, associated with schema coping strategies of avoidance (Brotchie, Hanes, Wendon, & Waller, 2006; Diez, Zurnalde, & Sola, 2012; Gök, 2012; Spranger, Waller, & Bryant-Waugh, 2000;). From this relationship, it can be inferred that the relationship between working status and schema coping strategies might have occurred through psychopathology.

4.1.6. Findings Related to Differences between the levels of Demographic Variables on Burnout

According to the results of the study, only the levels of working status brought out significant differences on burnout. In this part, results related to differences between the levels of demographic variables on burnout were discussed.

In the present study, it was found that working participantshad lower scores on burnout than participants not working. In other words, employed participants have lower tendency to experience burnout as compared to unemployed participants. This finding is surprising because caregiving affects the work life of the caregiver who spends at least 15 hours per week for caregiving(Mendes, 2011). As a result of this, caregiving may lead to work-life imbalance. Work life imbalance is defined as “the dilemma of managing work obligations and personal/family responsibilities” (Lockwood, 2003, p. 3), and related to burnout (Hammig, Brauchli, & Bauer, 2012; Wilkinson, 2008), which may result in ending or reducing employment because of care providing activities (Schulz et al., 2003). In other words, the finding of this study can be explained that burnout can cause unemployment. Another explanation to this finding can be that lower responsibility should be given to working participants by sharing responsibility in family itself. This can also help decrease burnout level of working caregiver. In addition, if it is accepted that working people

are highly educated, these people can have the advantage of searching information about diseases, by which they can accept dementia and this might bring understanding of the patient, and may result in lower burnout. Moreover, highly educated people can support more and cope with the situation better (Gage-Bouchard, Devine, & Heckler, 2013) to avoid burnout. On the contrary, this finding can be understood with the explanation that those who are not working are probably working at home. That's probably why those who are working have lower burnout.

4.1.7. Findings Related to Differences among the Levels of Dementia on Schema Coping Strategies, Burnout, Perceived Social Support, Depression, and Caregiver Well-Being

In this part, results related to differences among the levels of dementia on the measures of the study (i.e., schema coping strategies of avoidance, schema coping strategies of compensation, total perceived social support, perceived social support from family, perceived social support from friends, perceived social support from significant others, caregiver well-being basic needs, caregiver well-being activity of living, depression, and burnout) were discussed. As for the level of the dementia differences on the measures of the study, the result of the study revealed that there were no significant differences among the levels of dementia on the measures of the study. In other words, it may be summarized that the scores of participants on the measures of the study were not affected by level of dementia. Although this result seems to be inconsistent with the fact that as the illness progress, patients require greater level of care, and depend on caregiver more for their daily living (Alzheimer Association, 2014). On the other hand, it is highly possible that every level has some difficulties. For example, in the first level, caregivers might have some difficulties in accepting the diagnosis, and they may accuse patients because of their new behavioral pattern due to dementia. On the contrary, as the illness progresses, caregivers' knowledge on disease and specifically progression of the disease may increase. And this increases caregivers' preparation for the future challenges, reduces the level of the frustration of the caregiver and the expectations from patients (Robinson, Wayne, & Segal, 2014). In addition, in a severe dementia case, caregiver may receive more help for caregiving activities (Alzheimer Association, 2014). These facts might have a considerable effect on the finding that care giving to

patients with different levels of the dementia did not make a difference on the measures of the study.

4.2. Findings Related to Intercorrelations amongthe Measures of the Study

Correlation analyses among all measures of the present study (i.e., early maladaptive schemas, parenting styles, depression, caregiver well-being, perceived social support, schema coping strategies, and burnout) indicated several significant results. In this part, these correlation analyses were discussed.

As for the relationship with early maladaptive schemas (EMSs), all the relationships found between EMSs and other measures of the study were consistent with the previous studies. Firstly, it was figured out that EMSs were positively correlated with depression. This finding is consistent with the previous studies in which a relationship between early maladaptive schemas and depression was found (Calvete, Orue, & Hankin, 2013; Halvorsen, Wang, Eisemann, & Waterloo, 2010; Harris & Curtin, 2002; Muris, 2006; Renner, Lobbestael, Peeters, Arntz, & Huibers, 2012; Roelofs, Lee, Ruijten, & Lobbastael, 2011). The association might be the result of the importance of schemas in the development and maintenance of psychiatric symptoms (Welburn, Coristine, Dagg, Pontefract, & Jordan, 2002). Similarly, EMSs were found to be negatively correlated with basic needs subscale of caregiver well-being, parallel to the relationship between EMSs and well-being found in the literature (Bidadian, Bahramizadeh, & Poursharifi, 2011; Kapçı & Hamamcı, 2010; Muris, 2006; Welburn, Coristine, Dagg, Pontefract, & Jordan, 2002). Besides the relationship between EMSs and caregiver well-being, correlation analyses revealed significant positive association of EMSs with burnout as it was the case in the previous studies (Bamber, & McMahon, 2008; Grebot, Berjot, Lesage, & Dovero, 2011). Moreover, negative correlations were found between EMSs and total perceived social support, and perceived social support from friends, as similar to Ünal's study (2012). This relationship is not surprising. Since EMSs can be considered as people's perception and response to world, they might change people's perception related to social support. On the contrary, a positive correlation between EMSs and schema coping strategies namely schema coping strategies of compensation, and avoidance was found parallel to other findings (Gök, 2012). Lastly, since EMSs develop during childhood or adolescence, the importance of

parenting styles seems to be certain. In the present study, EMSs revealed significant and positive correlation with parenting styles as in other studies (Gök, 2012; Muris, 2006; Ünal, 2012).

Besides the relationship between EMSs and measures of the study, correlation analyses revealed significant associations of depression with the measures of the study as well. According to the results, individuals who scored higher on depression were more likely to have lower scores on caregiver well-being basic need, and caregiver well-being activity of living. The same association was also found in the adaptation of Caregiver Well-Being scale to Turkish (Demirtepe & Bozo, 2009), and other studies (Grant, Guille, & Sen, 2013). This finding is in line with expectation, because depression is used as a measure of well-being (van Hemert, van de Vijver, &Poortinga, 2002). In fact, WHO Wellbeing Index was supported to be used using in the depression research (Krieger et al., 2014). Furthermore, depression was found to be negatively associated with total perceived social support, and perceived social support from friends as expected based on the relevant literature (Erdem & Apay, 2014; Ferrajao, & Oliveira, 2014; Greco et al., 2014; Sipal & Sayin, 2013; Stewart, Umar, Tomenson, & Creed, 2014; Zhou, Zhu, Zhang, Cai, 2013). The relationship between depression and perceived social support was supported with the claim that social support is important in terms of development, maintenance, and treatment of depression (Au et al., 2009; Lu, 2011). On the other hand, participants who have higher levels of depression were more likely to use schema coping strategies of avoidance. This finding was supported by a study indicating that schema coping strategies of avoidance is associated with psychopathological symptoms, which in turn, was found to be related with depressive symptomatology (Gök, 2012). In other words, this finding might be reasonable through the psychopathology pathway. In addition, depression was positively associated with burnout as it was the case in previous studies (Chang et al., 2013; Shin, Noh, Jang, Park, & Lee, 2013). Lastly, there was a positive correlation between parenting styles and depression. This finding is comparable to the results of previous studies showing that negative parenting styles were highlighted to be associated with depression (Anlı & Karslı, 2010; Fentz, Arendt, O'Toole, Rosenberg, & Hougaard, 2011; Oakley-Browne, Joyce, Wells, Bushnell, & Hornblow, 1995; Rapee, 1997).

There was found significant association between caregiver well-being basic needs and other measures of the study. According to the relationship with caregiver well-being basic needs, it was figured out that caregiver well-being basic needs was positively correlated with caregiver well-being activity of living. This correlation (Berg-Weger, Rubio, & Tebb, 2000) is not surprising because they are two subscales of the same scale. The similar association was found between schema coping strategies of compensation, and schema coping strategies of avoidance with the same reason, they are also two strategies of schema coping. This finding was also supported by research (Gök, 2012). In addition, total perceived social support, perceived social support from significant other, perceived social support from family, and perceived social support from friend were found to be positively correlated with basic needs subscale of caregiver well-being, indicating that higher perception of support by caregivers was associated with meeting their basic needs more. This finding was also supported by the Chappell and Reid's study (2002). On the contrary, in terms of the relationship between caregiver well-being basic needs and burnout, correlation analyses revealed significant negative association, as it was the case in the literature (Melamed, Kushnir, & Shirom, 1992; Takai et al., 2009; Thomas, 2004; Truzzi et al., 2008;Truzzi et al., 2012; Willcock, Daly, Tennant, & Allard, 2004; Yılmaz, Turan, & Gundogar, 2009).

Regarding total perceived social support, total perceived social support showed significant negative association with burnout. The level of burnout symptoms was highlighted to be related to perceived social support parallel to the literature (Ariapooran, 2014; Boren, 2014; Fradelos et al., 2014; Rzeszutek & Schier, 2014; Tuna & Olgun, 2010). The reason of this association might be that participants with higher burnout level, most probably have higher responsibility in terms of caring. Higher responsibility may be the reason of not having support from others and this may result in lower perception of social support from others. Another finding regarding total perceived social support was that participants who scored higher on parenting styles were more likely to report lower total perceived social support. This finding is consistent with previous studies (Lagace-Sequin & DeLeavey, 2011). One possible explanation for this finding would be that early childhood experiences with significant others determined organized thoughts, and

feelings about self, others, and the world which shaped individual's perception and response to new experiences (Segal, 1988). Therefore, early childhood experiences might affect individual's perception of social support, as well.

4.3. Findings Related to Mediation Analyses

In this part, the mediator role of early maladaptive schemas (EMSs) in the relationships between parenting styles and caregiver well-being basic needs, caregiver well-being activity of living, depression, and burnout were discussed.

4.3.1. Findings Related to the Mediator Role of Early Maladaptive Schemas between Parenting Styles and Caregiver Well-Being-Basic Needs, Caregiver Well-Being-Activity of Living, Depression, and Burnout

The effects of parenting styles on caregiver well-being basic needs and depression were mediated by early maladaptive schemas. That is, the increment in negative parenting caused an increase in schema scores, which resulted in decrease in caregiver well-being basic needs and increase in depression. The outcome variables, caregiver well-being and depression were different but interrelated. For example, depression is used as a measure of well-being (van Hemert, van de Vijver, & Poortinga, 2002). In addition, researchers were encouraged to use WHO Wellbeing Index as a measure of depression (Krieger et al., 2014). Actually, the mediator role of EMSs between parenting styles and well-being, and depression has been well established in several studies (Gök, 2012; Harris & Curtin, 2002; Kapçı & Hamamcı, 2010; McGinn, Cukor, & Sanderson, 2005;Sarıtaş, 2007;Young, Kolosko, & Weishaar, 2003). This association might seem plausible according to the explanation that parenting styles were associated with early maladaptive schemas (Gök, 2012; Harris, & Curtin, 2002; Muris, 2006), which is also related to psychopathology (Anlı & Karslı, 2010; Fentz, Arendt, O'Toole, Rosenberg, & Hougaard, 2011; Oakley-Browne, Joyce, Wells, Bushnell, & Hornblow, 1995; Rapee, 1997). In addition, the relationship between parenting styles and burnout was mediated by early maladaptive schemas. Increment in negative parenting caused higher early maladaptive schemas scores, a condition which resulted in an increased burnout. This finding can be plausible with the explanation that caregivers who were raised with negative parenting styles were obliged to take care of their parents, this leads to more burden as compared to caregivers exposed to better parenting styles; and this

condition is associated with lower well-being (Diehl-Schmid et al., 2013; Gallant & Connell, 1997;Lawton, Moss, Kleban, Glicksman, & Rovine, 1991). The explanation related to mediator role of EMSs in the relationship between parenting styles and depression can also be valid for burnout, because burnout was positively associated with depression in previous studies (Chang et al., 2013; Shin, Noh, Jang, Park, & Lee, 2013). In other words, the mediator role of EMSs in the relationship between parenting styles and burnout can be explained through psychopathology pathway; in literature, there was no study found to investigate the mediator role of EMSs on the relationship between parenting styles and burnout. Therefore, to our knowledge, the present study is the first one to investigate this subject. Thus, this study provided empirical confirmation for caregiver studies having early maladaptive schemas as a mediator between parenting styles and outcome variables (i.e., caregiver well-being basic needs, depression, and burnout).

The mediator role of early maladaptive schemas on the association between parenting styles and caregiver well-being activity of living was not verified by the analyses. It is surprising in the light of findings indicating that a caregiver well-being basic need was positively correlated with caregiver well-being activity of living (Berg-Weger, Rubio, & Tebb, 2000). In addition, caregiver well-being activity of living was found to be correlated with depression and general well-being. This finding can be the reason of the fact that the concept of activity of living might be more than absence of psychopathology. For example, caregiver well-being activity of living was found to have 4 factors, namely time for self and leisure activities, household maintenance, support, and self-care (Demirtepe & Bozo, 2009).

4.4. Findings Related to Moderation Analyses

In this part, the moderator role of perceived social support, schema coping strategies of avoidance, schema coping strategies of compensation, and different sources of perceived social support were discussed.

4.4.1. Findings Related to Moderating Role of Perceived Social Support

In this part, the moderating role of perceived social support on the relationship of early maladaptive schemas with other measures of the study (i.e., caregiver well-being basic needs, caregiver well-being activity of living, depression, and burnout) was discussed. The moderator role of perceived social support on the

relationship between early maladaptive schemas and other measures of the study was only supported for caregiver well-being basic needs. That is, perceived social support did not moderate the early maladaptive schemas-caregiver well-being activity of living, depression, and burnout relations in adult child caregivers of dementia patients. As Baron and Kenny stated, moderator variable affects the direction and strength of a relationship between independent and dependent variables as a third variable (1986). In other words, the strength of the relationship between early maladaptive schemas and caregiver well-being-basic needs was affected by the degree of social support perceived by the caregivers. Accordingly, when perceived social support was high, but not when it was low, a higher schema scores was associated with better caregiver well-being. Thus, perceived social support can be a protective factor for caregivers of dementia patients with higher schema scores in terms of caregiver well-being. This finding is parallel to the stress-buffering hypothesis of Cohen and Willis (1985). In terms of the dementia caregivers, effective social support was considered as a stress modifier, which is, in turn, related to better caregiver health and more positive caregiver health outcomes over time (Goode, Haley, Roth, & Ford, 1998). Only one source of perceived social support, namely, perceived social support from significant other, moderated the early maladaptive schemas-caregiver well-being basic needs relation. Similar to total perceived social support, when perceived social support from significant other was high, but not when it was low, a higher schema scores was associated with better caregiver well-being. That is to say, high perceived social support buffered the negative effects of high schema scores, and caregivers had higher well-being. This might be explained by spousal support for the caregivers of the dementia patients. The reason of the importance of spousal support in caregiver well-being can be explained by Bowlby (1988), who asserted that people have a tendency to seek and enjoy closeness in times of need. Parallel to this, when people face with a threat, their partners can be considered as a primary source of comfort and safety. As other studies in the literature (Giese-Davis, Hermanson, Koopman, Weibel, & Spiegel, 2000; Jackson, 1992; Manne et al., 2004b) suggested, spousal support is particularly important for psychological well-being. Thus, it can be stated that some behaviors are perceived as

supportive when they come from a particular source but not from others. In other words, support does partially depend on the source (Dakof & Taylor, 1990).

The moderating role of perceived social support on the early maladaptive schemas and caregiver well-being activity of living, depression, and burnout relationships was not supported. This was surprising, because in earlier studies activity of living, depression, and burnout were significantly associatedcaregiver well-being (Demirtepe & Bozo, 2009; Grant, Guille, & Sen, 2013; Melamed, Kushnir, & Shirom, 1992;Takai et al., 2009; Thomas, 2004; Truzzi et al., 2008; Truzzi et al., 2012;Willcock, Daly, Tennant, & Allard, 2004; Yılmaz, Turan, & Gundogar, 2009). In addition, perceived social support was found to be associated with depression (Bozo, Anahar, Ateş, & Etel, 2010; Erdem & Apay, 2014;Ferrajao, & Oliveira, 2014; Greco et al., 2014;Kuscu et al., 2009; Sipal & Sayin, 2013; Stewart, Umar, Tomenson, & Creed, 2014; Yen & Lundeen, 2006;Zhou, Zhu, Zhang, & Cai, 2013), and burnout (Ariapooran, 2014; Boren, 2014; Fradelos et al., 2014; Rzeszutek & Schier, 2014; Tuna & Olgun, 2010). According to caregiver well-being activity of living, the finding is surprising and difficult to interpret,because this scale is also subscale of caregiver well-being. In addition, the items in this scale seem to be related to social support more than basic needs subscale. For example, the items like attending social events, allocating time for activities done with family or friends to have good time, asking for support from family or friends, and getting support from family or friends. In addition, in the literature, as opposed to the finding of the present study, there was a study which supported moderating role of perceived social support on caregiver well-being activity of living and psychological symptom relation (Demirtepe-Saygılı & Bozo, 2011).

4.4.2. Finding Related to Moderating Role of Schema Coping Strategies

In this part, the moderating role of schema coping strategies, namely avoidance and compensation in the relationships between early maladaptive schemas and other measures of the study (i.e., caregiver well-being basic needs, caregiver well-being activity of living, depression, and burnout) were discussed.

Schema coping strategies, both avoidance and compensation did not moderate the relationship between early maladaptive schemas and caregiver well-being-basic needs, caregiver well-being activity of living, depression, and burnout. In other

words, schema coping strategies did not have any buffering (positive or negative) effect on these relations. This finding is also surprising, in the light of the explanation that coping strategies develop as a result of adapting schemas' intense and overwhelming emotions. The schema coping processes might affect expression of early maladaptive schemas and relationship of the early maladaptive schemas with other measures. For example, in the Diez, Zurnalde, and Sola's study (2012), schema coping processes of compensation was found to be as a moderator on the relationship between emotional deprivation of schema and social anxiety. However, this was not supported in the present study. This finding is difficult to interpret; one reason can be that schema coping processes can be related to self-awareness, or easy to cover. Therefore, participants could hide or was unaware of their schema coping strategies.

4.5. Strengths of the Study

Despite the growth of informal caregiver population in the world, almost nothing is known about the effect of early maladaptive schemas, schema coping processes, and parenting styles on caregiving processes. To address this gap in the literature, this study focused on the association of early maladaptive schemas and parenting styles with caregiver's well-being and burnout experience, and the moderating role of perceived social support, and schema coping processes on these associations. In other words, this study addressed a subject about which, to the best of our knowledge, nothing has been published.

Studies related to early maladaptive schemas are increasing; however, studies related to schema coping processes are very scarce. According to Karaosmanoğlu, Soygüt, and Kabul, understanding schema coping processes was important for better understanding of psychopathology (2013). However, current study is the first study, in terms of investigating schema coping processes and caregiver well-being. In addition, present study expands the knowledge that early maladaptive schemas' mediator role on the association between parenting styles and well-being to the caregiver population. In addition, this study examined other associated factors, such as perceived social support.

In Turkey, formal care is limited, and informal caregiving is much more burdensome and stressful than expected. Therefore, studying in this area, and applying research to clinical settings can be beneficial.

4.6. Limitations of the Study

The present study has several limitations. Firstly, gender distribution of the sample was unequal; the number of male participants was unproportionately low. Thus, this might led to problems in terms of the evaluation of gender differences on the measures of the study. The reason of this problem was that the participants who brought their parents to the appointments with physicians or to Alzheimer Association were mostly daughters. Although some patients came to the hospital with their sons, these male caregivers reported their sisters as the primary caregivers. However, when the caregiver literature stating that caregivers are mostly women (Heru & Ryan, 2006; Heru, Ryan, & Iqbal, 2004) is taken into account, the unequal gender ratio in the present study may not be considered as a limitation.

It is difficult to find dementia caregivers to fill out the questionnaires, this may be because of their higher responsibility, or higher level of distress related to caregiving. This is a common problem in caregiver studies (e.g., Barrera et al., 2004; Coope et al., 1995; de Vugt et al., 2003; Kazak et al., 1997). Therefore, the present study revealed the results of the caregivers who are eager to take part in the research and have time to participate in the study.

In the current study, all measures relied on self-reports of the participants. For example, parenting styles scale relied on retrospective recall, and schemas may be covered by avoidance and overcompensation (Young, Kolosko, & Weishaar, 2003). Individuals might report lower levels of schemas than they actually have. As a result, parenting styles and schemas cannot be detected by self-reports. These inventories are generally used in therapies for awareness. Therefore, other data collecting techniques such as interviews can be used for more accurate results.

In the present study, sample size was small, so it limits generalizability and statistical power of the results. This sample is heterogeneous in terms of caregivers' demographic characteristics (i.e., gender, age, marital status, educational status). Moreover, the current study is cross-sectional, and thus, it is impossible to draw cause-effect relationship and observe the changes on measures in a time course.

Current study did not examine the variables related to dementia patients; only level of the disorder was taken into account. However, the characteristics of the patients and the level of the disease interferring with caregivers' life were not

considered. In addition, whether caregivers ask and get help from others or not, and how many hours they spend as a caregiver should be taken into account.

Although the present study has some limitations, the study related to caregivers of dementia patients are scarce;and parenting styles, early maladaptive schemas, and schema coping processes have not been studied before. This research is one of the earliest studies related to dementia caregivers' early maladaptive schemas, parenting styles, and schema coping processes.

4.7. Clinical Implications and Future Directions

In Schema Therapy, understanding parenting experiences takes high importance in terms of its associations with early maladaptive schemas and psychopathology (Young et al., 2003). In a similar manner, the results of the current study supported the important role of parenting styles on early maladaptive schemas and psychopathology for dementia caregivers. Overall, as for clinical implications, the findings of this study may help to understand the importance of early experiences on the caregiving processes. Therefore, including early experiences with parents and early maladaptive schemas to the treatment related to psychological problems of dementia caregivers might be important for better outcome. This notion may be a support for those applications in Schema Therapy.

Perceived social support, especially perceived social support from significant others moderated the relationship between early maladaptive schemas and caregiver well-being. The results of this study revealed that perceived social support can be important as a protective factor for caregivers even after experiencing negative parenting as cause of EMSs. Therefore, the results of this study provides suggestions about dealing with maladaptive cognitions might not be sufficient to increase well-being but it is also important to help individuals seek and get higher levels of social support, especially from significant others Briefly, intervention programs that aim to increase individuals' perceived social support may be helpful for caregivers' well-being and this benefit can be more than expected because many caregivers do not ask for support (Burton, Haley, & Small, 2006).

In terms of the clinical implications of the present study, the most important one was to develop intervention programs related to negative parenting, early maladaptive schemas, and perceived social support to increase well-being of the

caregivers. The difficulties related to caregiving a stressful (Andrén & Elmstahl, 2007; Bertrand, Fredman, & Saczynski, 2006; Le´vesque, Ducharme, & Lachance, 1999; Pinquard & Sörensen, 2003; Vedhara et al., 1999) and demanding (Rosa et al., 2010) condition may increase the necessities and benefits of the intervention programs.

In this study, the importance of parenting styles on EMSs was supported. In the future studies, some longitudinal studies can be done for better understanding of the association between early maladaptive schemas and parenting styles. With the help of these longitudinal studies, some prevention strategies can be done in adolescence and young adults for early maladaptive schemas before they become more stable and permanent.

As suggestions for future researchers; the gender difference and sameness between care receiver and caregiver can be searched. The effect of this on well-being, parenting styles, and depression can be examined. This and the whole study can be compared with samples other than caregivers or samples from different cultures. In addition, in this study, total early maladaptive schemas, parenting, and schema coping scores were used. In future studies, factors of these measures can be handled to see the bigger picture with more detail. Moreover, in future studies, to obtain more accurate results, and eliminate limitations related to self-report questionnaires, different data collection techniques such as interviews can be used.

There are a lot of studies related to early maladaptive schemas, however, the role of schema coping strategies for better understanding of psychopathology has been neglected (Karaosmanoğlu, Soygüt, & Kabul, 2013). In this study, schema coping strategies are taken into account. However, there was found no moderator role of schema coping strategies on the association between early maladaptive schemas and caregiver well-being, depression, and burnout. In future studies, studies related to the importance of schema coping strategies can be replicated both in community and clinical samples.

The scales (i.e., Young Parenting Inventory, Young Schema Questionnaire, Young Compensation Inventory, and Young Rygh Avoidance Inventory) used in the present study comes from the same theoretical background, which gives opportunity for model testing with structural equation model. In future studies, model testing can

be performedon bigger samples to determine risk and protective factors caregiver well-being.

4.8. Conclusion

The current study aimed attesting the predictive roles of perceived social support, early maladaptive schemas, parenting styles, and schema coping processes in well-being and burnout levels of primary caregivers of dementia patients. For this purpose, 99 adult children of dementia patients participated in the study. The current study sought to extend the previous work to caregiver population by providing a clearer picture of the relationships amongperceived social support, early maladaptive schemas, parenting styles, and schema coping processes in well-being and burnout levels. It was found that early maladaptive schemas mediated the relationship between parenting styles and caregiver well-being basic needs, depression, and burnout. However, the mediator role of early maladaptive schemas on the association between parenting styles and caregiver well-being activity of living was not supported. That is, the increment in negative parenting caused an increase in schema scores, which resulted in decrease in caregiver well-being basic needs and increase in depression and burnout. Actually, the mediator role of EMSs between parenting styles and well-being and depression has been well established in several studies (Gök, 2012; Harris & Curtin, 2002; Kapçı & Hamamcı, 2010; McGinn, Cukor, & Sanderson, 2005; Sarıtaş, 2007; Young, Kolosko, & Weishaar, 2003). In terms of burnout, caregivers who were raised with negative parenting styles were obliged to take care of their parents, and this might led to more burden as compared to caregivers raised with better parenting styles. According to caregiver well-being activity of living, this finding seems to be suprising. However, this finding can be the reason of the fact that the concept of activity of living might be more than absence of psychopathology (Demirtepe & Bozo, 2009). In addition to the mediation analyses, several regression analyses investigating the moderator role of perceived social supportand schema coping processes in early maladaptive schemas and caregiver well-being/burnout relations were investigated. The moderator role of perceived social support, especially perceived social support from significant others, on the relationship between early maladaptive schemas and caregiver well-being basic needs was supported. Thus, perceived social support (from significant other, in

particular) can be a protective factor for caregivers of dementia patients with higher schema scores in terms of caregiver well-being basic needs. This finding is parallel to the stress-buffering hypothesis of Cohen and Wills (1985). The significant finding related to perceived social support from significant others indicated the importance of spousal support on the stressful situation (Bowlby, 1988; Giese-Davis, Hermanson, Koopman, Weibel, & Spiegel, 2000; Jackson, 1992; Manne et al., 2004b). However, the moderator role of schema coping processes was not supported. This finding is difficult to interpret; one reason can be that schema coping processes can be related to self-awareness, or easy to cover.

The present study is first in the literature examining the early maladaptive schemas, parenting styles, and schema coping processes on the caregiving processes. However, the sample represents only the participants who are eager to take part in the research and have time to participate in the study. Moreover, the collected data relied on self-report instruments. These factors and small sample size limitedthe generalizability of the findings.

In terms of the clinical implications, intervention programs related to negative parenting, early maladaptive schemas, and perceived social support to increase caregivers' well-being can be developed. In future researches, longitudinal and comparative data collected from bigger samples and analyzed with model testing can provide a better insight in the well-being of dementia caregivers.

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APPENDICES

APPENDIX A. Informed Consent Form

(Gönüllü Katılım Formu)

Sayın Katılımcı;

Bu çalışma Doç. Dr. Özlem Bozo danışmanlığında, ODTÜ Klinik Psikoloji Yüksek Lisans Programı öğrencisi Elçin Ayrancı tarafından, demans hastalarına bakım veren çocukların erken dönem yaşantıları ve şimdiki psikolojik durumları arasındaki ilişkiyi saptamak amacıyla, yüksek lisans tezi kapsamında yürütülmektedir.

Bu çalışma kapsamında vereceğiniz tüm bilgiler tamamen gizli kalacaktır. Çalışmanın hiçbir bölümünde isminiz ve kimliğinizi ortaya çıkaran herhangi bir soru sorulmamaktadır. Çalışmanın objektif olması ve elde edilecek sonuçların güvenirliği bakımından anket uygulamalarında içtenlikle duygu ve düşüncelerinizi yansıtacak şekilde yanıtlar vermeniz önemlidir. Çalışmaya katılım tamamıyla gönüllülük esasına dayanmaktadır. Anketler 45 dakika sürmektedir ve genel olarak, kişisel rahatsızlık verecek sorular içermemektedir. Ancak, katılım sırasında herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, cevaplama işini istediğiniz anda bırakmakta serbestsiniz. Verdiğiniz bilgiler gizli tutulacak ve sadece araştırmacılar tarafından değerlendirilecektir; elde edilecek bilgiler bilimsel yayınlarda kullanılacaktır. Katılımınız için şimdiden teşekkür ederiz.

Çalışma hakkında daha fazla bilgi almak için ODTÜ Klinik Psikoloji Yüksek Lisans Programı öğrencisi Elçin Ayrancı (E-posta: elcinayranci@gmail.com) ile iletişim kurabilirsiniz.

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

Ad Soyad	Tarih	İmza
_____	----/----/-----	_____

APPENDIX B. Demographic Information Form

(Demografik Bilgi Formu)

Yaşınız:
Cinsiyet:
Medeni haliniz:

1. Bekar _____ 2. Evli _____
3. Boşanmış _____ 4. Dul _____

Eğitim durumunuz:

1. İlköğretim _____ 2. Lise _____
3. Üniversite _____ 4. Yüksek Lisans/ Doktora _____

Çalışıyor musunuz?: _____ Evet _____ Hayır
Evet ise mesleğiniz: _____
Çocuğunuz var mı?: _____ Evet _____ Hayır
Evet ise kaç tane? _____
Yaşamınızın çoğunun geçtiği yer:
1. Metropol (İstanbul, Ankara, İzmir) 2. Şehir
3. Kasaba 4. Köy
Ekonomik durumunuzu en iyi hangi seçenek yansıtıyor?
Düşük _____
Orta _____
Yüksek _____
Herhangi bir fiziksel hastalığınız var mı?
Varsa nedir?
Şu anda herhangi bir tedavi görüyor musunuz? _____ Evet _____ Hayır
Evet ise nedir?
Herhangi bir psikolojik hastalığınız var mı?
Varsa nedir?
Şu anda herhangi bir tedavi görüyor musunuz? _____ Evet _____ Hayır
Evet ise nedir?
Bakım verdiğiniz hastanızın demans düzeyi:
Hafif _____
Orta _____
Ağır _____

APPENDIX C. Young Schema Questionnaire Short Form

(Young Şema Ölçeği)

Yönerge: Aşağıda, kişilerin kendilerini tanımlarken kullandıkları ifadeler sıralanmıştır. Lütfen her bir ifadeyi okuyun ve sizi ne kadar iyi tanımladığına karar verin. Emin olamadığınız sorularda neyin doğru olabileceğinden çok, sizin **duygusal olarak** ne hissettiğinize dayanarak cevap verin.

Bir kaç soru, anne babanızla ilişkiniz hakkındadır. Eğer biri veya her ikisi şu anda yaşamıyorlarsa, bu soruları o veya onlar hayatta iken ilişkinizi göz önüne alarak cevaplandırın.

1 den 6'ya kadar olan seçeneklerden sizi tanımlayan en yüksek şıkkı seçerek her sorudan önce yer alan boşluğa yazın.

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

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

19. _____ Çevremde bana sıcaklık, koruma ve duygusal yakınlık gösteren kimsem yok.
20. _____ Diğer insanlara o kadar muhtacım ki onları kaybedeceğim diye çok endişeleniyorum.
21. _____ İnsanlara karşı tedbiri elden bırakamam yoksa bana kasıtlı olarak zarar vereceklerini hissederim.
22. _____ Temel olarak diğer insanlardan farklıyım.
23. _____ Gerçek beni tanırlarsa beğendiğim hiç kimse bana yakın olmak istemez.
24. _____ İşleri halletmede son derece yetersizim.
25. _____ Gündelik işlerde kendimi başkalarına bağımlı biri olarak görüyorum.
26. _____ Her an bir felaket (doğal, adli, mali veya tıbbi) olabilir diye hissediyorum.
27. _____ Annem, babam ve ben birbirimizin hayatı ve sorunlarıyla aşırı ilgili olmaya eğilimliyiz.
28. _____ Diğer insanların isteklerine uymaktan başka yolum yokmuş gibi hissediyorum; eğer böyle yapmazsam bir şekilde beni reddederler veya intikam alırlar.
29. _____ Başkalarını kendimden daha fazla düşündüğüm için ben iyi bir insanım.
30. _____ Duygularımı diğerlerine açmayı utanç verici bulurum.
31. _____ En iyisini yapmalıyım, "yeterince iyi" ile yetinemem.
32. _____ Ben özel biriyim ve diğer insanlar için konulmuş olan kısıtlamaları veya sınırları kabul etmek zorunda değilim.
33. _____ Eğerhedefime ulaşamazsam kolaylıkla yılgınlığa düşer ve vazgeçerim.
34. _____ Başkalarının da farkında olduğu başarılar benim için en değerlisidir.
35. _____ İyi bir şey olursa, bunu kötü bir şeyin izleyeceğinden endişe ederim.
36. _____ Eğer yanlış yaparsam, bunun özrü yoktur.
37. _____ Birisi için özel olduğumu hiç hissetmedim.
38. _____ Yakınlarımın beni terk edeceği ya da ayrılacağından endişe duyarım
39. _____ Herhangi bir anda birileri beni aldatmaya kalkışabilir.
40. _____ Bir yere ait değilim, yalnızım.
41. _____ Başkalarının sevgisine, ilgisine ve saygısına değer bir insan değilim.
42. _____ İş ve başarı alanlarında birçok insan benden daha yeterli.
43. _____ Doğru ile yanlışı birbirinden ayırmakta zorlanırım.
44. _____ Fiziksel bir saldırıya uğramaktan endişe duyarım.
45. _____ Annem, babam ve ben özel hayatımız birbirimizden saklarsak, birbirimizi aldatmış hisseder veya suçluluk duyarız
46. _____ İlişkilerimde, diğer kişinin yönlendirici olmasına izin veririm.
47. _____ Yakınlarımla o kadar meşgulüm ki kendime çok az zaman kalıyor.
48. _____ İnsanlarla beraberken içten ve cana yakın olmak benim için zordur.
49. _____ Tüm sorumluluklarımı yerine getirmek zorundayım.
50. _____ İstediğimi yapmaktan alıkonulmaktan veya kısıtlanmaktan nefret ederim.
51. _____ Uzun vadeli amaçlara ulaşabilmek için şu andaki zevklerimden fedakârlık etmekte zorlanırım
52. _____ Başkalarından yoğun bir ilgi görmezsem kendimi daha az önemli hissederim.
53. _____ Yeterince dikkatli olmazsanız, neredeyse her zaman bir şeyler ters gider.
54. _____ Eğer işimi doğru yapmazsam sonuçlara katlanmam gerekir.
55. _____ Beni gerçekten dinleyen, anlayan veya benim gerçek ihtiyaçlarım ve duygularımı önemseyen kimsem olmadı.

56. _____ Önem verdiğim birisinin benden uzaklaştığını sezersem çok kötü hissederim.
57. _____ Diğer insanların niyetleriyle ilgili oldukça şüpheciyimdir.
58. _____ Kendimi diğer insanlara uzak veya kopmuş hissediyorum.
59. _____ Kendimi sevilebilecek biri gibi hissetmiyorum.
60. _____ İş (okul) hayatımda diğer insanlar kadar yetenekli değilim.
61. _____ Gündelik işler için benim kararlarıma güvenilemez.
62. _____ Tüm paramı kaybedip çok fakir veya zavallı duruma düşmekten endişe duyarım.
63. _____ Çoğunlukla annem ve babamın benimle iç içe yaşadığını hissediyorum- Benim kendime ait bir hayatım yok.
64. _____ Kendim için ne istediğimi bilmediğim için daima benim adıma diğer insanların karar vermesine izin veririm.
65. _____ Ben hep başkalarının sorunlarını dinleyen kişi oldum.
66. _____ Kendimi o kadar kontrol ederim ki insanlar beni duygusuz veya hissiz bulurlar.
67. _____ Başarmak ve bir şeyler yapmak için sürekli bir baskı altındayım.
68. _____ Diğer insanların uyduğu kurallara ve geleneklere uymak zorunda olmadığımı hissediyorum.
69. _____ Benim yararıma olduğunu bilsem bile hoşuma gitmeyen şeyleri yapmaya kendimi zorlayamam.
70. _____ Bir toplantıda fikrimi söylediğimde veya bir topluluğa tanıtıldığımda onaylanmayı ve takdir görmeyi isterim.
71. _____ Ne kadar çok çalışırsam çalışayım, maddi olarak iflas edeceğimden ve neredeyse her şeyimi kaybedeceğimden endişe ederim.
72. _____ Neden yanlış yaptığımın önemi yoktur; eğer hata yaptıysam sonucuna da katlanmam gerekir.
73. _____ Hayatımda ne yapacağımı bilmediğim zamanlarda uygun bir öneride bulunacak veya beni yönlendirecek kimsem olmadı.
74. _____ İnsanların beni terk edeceği endişesiyle bazen onları kendimden uzaklaştırırım.
75. _____ Genellikle insanların asıl veya art niyetlerini araştırırım.
76. _____ Kendimi hep grupların dışında hissederim.
77. _____ Kabul edilemeyecek pek çok özelliğim yüzünden insanlara kendimi açamıyorum veya beni tam olarak tanımalarına izin vermiyorum.
78. _____ İş (okul) hayatımda diğer insanlar kadar zeki değilim.
79. _____ Ortaya çıkan gündelik sorunları çözebilme konusunda kendime güvenmiyorum.
80. _____ Bir doktor tarafından herhangi bir ciddi hastalık bulunmamasına rağmen bende ciddi bir hastalığın gelişmekte olduğu endişesine kapılıyorum.
81. _____ Sık sık annemden babamdan ya da eşimden ayrı bir kimliğimin olmadığını hissediyorum.
82. _____ Haklarıma saygı duyulmasını ve duygularımın hesaba katılmasını istemekte çok zorlanıyorum.
83. _____ Başkaları beni, diğerleri için çok, kendim için az şey yapan biri olarak görüyorlar.
84. _____ Diğerleri beni duygusal olarak soğuk bulurlar.

85. _____ Kendimi sorumluluktan kolayca sıyıramıyorum veya hatalarım için gerekçe bulamıyorum.
86. _____ Benim yaptıklarımın, diğer insanların katkılarından daha önemli olduğunu hissediyorum.
87. _____ Kararlarıma nadiren sadık kalabilirim.
88. _____ Bir dolu övgü ve iltifat almam kendimi değerli birisi olarak hissetmemi sağlar.
89. _____ Yanlış bir kararın bir felakete yol açabileceğinden endişe ederim.
90. _____ Ben cezalandırılmayı hakeden kötü bir insanım.

APPENDIX D. Young Parenting Inventory

(Young Ebeveynlik Ölçeği)

Aşağıda anne ve babanızı tarif etmekte kullanabileceğiniz tanımlamalar verilmiştir. Lütfen her tanımlamayı dikkatle okuyun ve ebeveynlerinize ne kadar uyduğuna karar verin. 1 ile 6 arasında, çocukluğunuz sırasında annenizi ve babanızı tanımlayan en yüksek dereceyi seçin. Eğer sizi anne veya babanız yerine başka insanlar büyüttü ise onları da aynı şekilde derecelendirin. Eğer anne veya babanızdan biri hiç olmadı ise o sütunu boş bırakın.

1 - Tamamı ile yanlış
2 - Çoğunlukla yanlış
3 - Uyan tarafı daha fazla
4 - Orta derecede doğru
5 - Çoğunlukla doğru
6 - Ona tamamı ile uyuyor.

	Anne	**Baba**	
1.	_____	_____	Beni sevdi ve bana özel birisi gibi davrandı.
2.	_____	_____	Bana vaktini ayırdı ve özen gösterdi.
3.	_____	_____	Bana yol gösterdi ve olumlu yönlendirdi.
4.	_____	_____	Beni dinledi, anladı ve duygularımızı karşılıklı paylaştık.
5.	_____	_____	Bana karşı sıcaktı ve fiziksel olarak şefkatliydi.
6.	_____	_____	Ben çocukken öldü veya evi terk etti.
7.	_____	_____	Dengesizdi, ne yapacağı belli olmazdı veya alkolikti.
8.	_____	_____	Kardeş(ler)imi bana tercih etti.
9.	_____	_____	Uzun süreler boyunca beni terk etti veya yalnız bıraktı.
10.	_____	_____	Bana yalan söyledi, beni kandırdı veya bana ihanet etti.
11.	_____	_____	Beni dövdü, duygusal veya cinsel olarak taciz etti.
12.	_____	_____	Beni kendi amaçları için kullandı.
13.	_____	_____	İnsanların canını yakmaktan hoşlanırdı.
14.	_____	____	Bir yerimi inciteceğim diye çok endişelenirdi.
15.	_____	_____	Hasta olacağım diye çok endişelenirdi.
16.	_____	_____	Evhamlı veya fobik/korkak bir insandı.
17.	_____	_____	Beni aşırı korurdu.
18.	_____	_____	Kendi kararlarıma veya yargılarıma güvenememe neden oldu
19.	_____	_____	İşleri kendi başıma yapmama fırsat vermeden çoğu işimi o yaptı.
20.	_____	_____	Bana hep daha çocukmuşum gibi davrandı.
21.	_____	_____	Beni çok eleştirirdi.
22.	_____	_____	Bana kendimi sevilmeye layık olmayan veya dışlanmış bir gibi hissettirdi.
23.	_____	_____	Bana hep bende yanlış bir şey varmış gibi davrandı.
24.	_____	_____	Önemli konularda kendimden utanmama neden oldu.
25.	_____	_____	Okulda başarılı olmam için gereken disiplini banakazandırmadı.
26.	_____	_____	Bana salakmışım veya beceriksizmişim gibi davrandı.
27.	_____	_____	Başarılı olmamı gerçekten istemedi.

28. ____ ____ Hayatta başarısız olacağıma inandı.
29. ____ ____ Benim fikrim veya isteklerim önemsizmiş gibi davrandı.
30. ____ ____ Benim ihtiyaçlarımı gözetmeden kendisi ne isterse onu yaptı.
31. ____ ____ Hayatımı o kadar çok kontrol altında tuttu ki çok az seçme özgürlüğüm oldu.
32. ____ ____ Her şey onun kurallarına uymalıydı.
33. ____ ____ Aile için kendi isteklerini feda etti.
34. ___ ____ Günlük sorumluluklarının pek çoğunu yerine getiremiyordu ve ben her zaman kendi payıma düşenden fazlasını yapmak zorunda kaldım.
35. ____ ____ Hep mutsuzdu; destek ve anlayış için hep bana dayandı.
36. ____ ____ Bana güçlü olduğumu ve diğer insanlara yardım etmem gerektiğini hissettirdi.
37. ____ ____ Kendisinden beklentisi hep çok yüksekti ve bunlar için kendini çok zorlardı.
38. ____ ____ Benden her zaman en iyisini yapmamı bekledi.
39. ____ ____ Pek çok alanda mükemmeliyetçiydi; ona göre her şey olması gerektiği gibi olmalıydı.
40. ____ ____ Yaptığım hiçbir şeyin yeterli olmadığını hissetmeme sebep oldu.
41. ____ ____ Neyin doğru neyin yanlış olduğu hakkında kesin ve katı kuralları vardı.
42. ____ ____ Eğer işler düzgün ve yeterince hızlı yapılmazsa sabırsızlanırdı.
43. ____ ____ İşlerin tam ve iyi olarak yapılmasına, eğlenme veya dinlenmekten daha fazla önem verdi.
44. ____ ____ Beni pek çok konuda şımarttı veya aşırı hoşgörülü davrandı.
45. ____ ____ Diğer insanlardan daha önemli ve daha iyi olduğumu hissettirdi.
46. ____ ____ Çok talepkârdı; her şeyin onun istediği gibi olmasını isterdi.
47. ____ ____ Diğer insanlara karşı sorumluluklarımın olduğunu bana öğretmedi.
48. ____ ____ Bana çok az disiplin veya terbiye verdi.
49. ____ ____ Bana çok az kural koydu veya sorumluluk verdi.
50. ____ ____ Aşırı sinirlenmeme veya kontrolümü kaybetmeme izin verirdi.
51. ____ ____ Disiplinsiz bir insandı.
52. __ __ ____ Birbirimizi çok iyi anlayacak kadar yakındık.
53. ____ ____ Ondan tam olarak ayrı bir birey olduğumu hissedemedim veya bireyselliğimi yeterince yaşayamadım.
54. ____ ____ Onun çok güçlü bir insan olmasından dolayı büyürken kendi yönümü belirleyemiyordum.
55. ____ __ __ İçimizden birinin uzağa gitmesi durumunda, birbirimizi üzebileceğimizi hissederdim.
56. _____ ____ Ailemizin ekonomik sorunları ile ilgili çok endişeli idi.
57. ____ ____ Küçük bir hata bile yapsam kötü sonuçların ortaya çıkacağını hissettirirdi.
58. ____ ____ Kötümser bir bakışı açısı vardı, hep en kötüsünü beklerdi.
59. ____ ____ Hayatın kötü yanları veya kötü giden şeyler üzerine odaklanırdı.
60. ____ ____ Her şey onun kontrolü altında olmalıydı.
61. ____ ____ Duygularını ifade etmekten rahatsız olurdu.
62. ____ ____ Hep düzenli ve tertipliydi; değişiklik yerine bilineni tercih ederdi.

63. ____ ____ Kızgınlığını çok nadir belli ederdi.
64. ____ ____ Kapalı birisiydi; duygularını çok nadir açardı.
65. ____ ____ Yanlış bir şey yaptığımda kızardı veya sert bir şekilde eleştirdiği olurdu.
66. ____ ____ Yanlış bir şey yaptığımda beni cezalandırdığı olurdu.
67. ____ ____ Yanlış yaptığımda bana aptal veya salak gibi kelimelerle hitap ettiği olurdu.
68. ____ ____ İşler kötü gittiğinde başkalarını suçlardı.
69. ____ ____ Sosyal statü ve görünüme önem verirdi.
70. ____ ____ Başarı ve rekabete çok önem verirdi.
71. ____ ____ Başkalarının gözünde benim davranışlarımın onu ne duruma düşüreceği ile çok ilgiliydi.
72. ___ ____ Başarılı olduğum zaman beni daha çok sever veya bana daha çok özen gösterirdi.

APPENDIX E. Young Compensation Inventory

(Young Telafi Ölçeği)

Aşağıda kişilerin kendilerini tanımlarken kullandıkları ifadeler sıralanmıştır. Lütfen her bir ifadeyi okuyun ve sizi ne kadar iyi tanımladığına karar verin. Daha sonra 1 den 6 ya kadar olan seçeneklerden sizi tanımlayan en yüksek dereceyi seçerek her sorudan önce yer alan boşluğa yazın.

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

1. ___ Kırıldığımı çevremdeki insanlara belli ederim.
2. ___ İşler kötü gittiğinde sıklıkla başkalarını suçlarım.
3. ___ İnsanlar beni hayal kırıklığına uğrattığında veya ihanet ettiğinde çok fazla öfkelenir ve bunu gösteririm.
4. ___ İntikam almadan öfkem dinmez.
5. ___ Eleştirildiğimde savunmaya geçerim.
6. ___ Başarılarımı veya galibiyetimi başkalarının taktir etmesi önemlidir.
7. ___ Pahalı araba, elbiseler, ev gibi başarının görünür ifadeleri benim için önemlidir.
8. ___ En iyi ve en başarılı olmak için çok çalışırım.
9. ___ Tanınmış olmak benim için önemlidir.
10. ___ Başarı, ün, zenginlik, güç veya popülarite kazanma ile ilgili hayaller kurarım.
11. ___ İlgi odağı olmak hoşuma gider.
12. ___ Diğer insanlardan daha cilveli / baştan çıkarıcı bir insanımdır.
13. ___ Hayatımda düzen olmasına çok önem veririm (Organizasyon, düzenlilik, planlama, gündelik işler).
14. ___ İşler kötü gitmesin diye çok çaba harcarım.
15. ___ Hata yapmamak için karar verirken kılı kırk yararım.
16. ___ Çevremdeki insanların yaptıklarını fazlasıyla kontrol ederim.
17. ___ Çevremdeki insanlar üzerinde denetim veya otorite sahibi olabildiğim ortamlardan hoşlanırım.
18. ___ Hayatımla ilgili bir şey söyleyen, bana karışan insanlardan hoşlanmam.
19. ___ Uzlaşmakta veya kabullenmekte çok zorlanırım.
20. ___ Kimseye bağımlı olmak istemem.
21. ___ Kendi kararlarımı almak ve kendime yeterli olmak benim için hayati önem taşır.
22. ___ Bir insana bağlı kalmakta veya yerleşik bir düzen kurmakta güçlük çekerim.
23. ___ İstediğimi yapma özgürlüğüm olması için "bağımsız biri" olmayı tercih ederim.

24. ___ Kendimi sadece bir iş veya kariyerle sınırlamakta zorlanırım, hep başka seçeneklerim olmalıdır.
25. ___ Genellikle kendi ihtiyaçlarımı başkalarınınkinden önde tutarım.
26. ___İnsanlara sık sık ne yapmaları gerektiğini söylerim. Her şeyin doğru bir şekilde yapılmasını isterim.
27. ___ Diğer insanlar gibi önce kendimi düşünürüm.
28. ___ Bulunduğum ortamın rahat olması benim için çok önemlidir (örn: ısı, ışık, mobilya).
29. ___ Kendimi asi biri olarak görürüm ve genellikle otoriteye karşı koyarım.
30. ___ Kurallardan hoşlanmam ve onları çiğnemekten mutlu olurum.
31. ___ Hoş karşılanmasa veya bana uymasa da alışılmışın dışında olmayı severim.
32. ___ Toplumun standartlarında başarılı olmak için uğraşmam.
33. ___ Çevremdekilerden hep farklı oldum.
34. ___ Kendimden bahsetmeyi sevmem ve insanların özel yaşamımı veya hislerimi bilmelerinden hoşlanmam.
35. ___ Kendimden emin olmasam da veya kendimi kırılmış hissetsem de başkalarına hep güçlü görünmeye çalışırım.
36. ___ Değer verdiğim insana yakın dururum ve sahiplenirim.
37. ___ Hedeflerime ulaşmak için sık sık çıkarlarım doğrultusunda yönlendirici davranışlarda bulunurum.
38. ___ İstediğimi elde etmek için açıkça söylemektense dolaylı yollara başvururum
39. ___ İnsanlarla aramda mesafe bırakırım; bu sayede benim izin verdiğim kadar beni tanırlar.
40. ___ Çok eleştiririm.
41. ___ Standartlarımı korumak ve sorumluluklarımı yerine getirmek için kendimi yoğun bir baskı altında hissederim.
42. ___ Kendimi ifade ederken sıklıkla patavatsız veya duyarsızımdır.
43. ___ Hep iyimser olmaya çalışırım; olumsuzluklara odaklanmama izin vermem.
44. ___ Ne hissettiğime aldırmadan çevremdekilere güler yüz göstermem gerektiğine inanırım.
45. ___ Başkaları benden daha başarılı veya daha fazla ilgi odağı olduğunda kıskanırım veya kötü hissederim.
46. ___ Hakkım olanı aldığımdan ve aldatılmadığımdan emin olmak için çok ileri gidebilirim.
47. ___ İnsanları gerektiğinde şaşırtıp alt edebilmek için yollar ararım, dolayısı ile benden faydalanamazlar veya bana kötülük yapamazlar.
48. ___ İnsanların benden hoşlanması için nasıl davranacağımı veya ne söyleyeceğimi bilirim.

APPENDIX F. Young- Rygh Avoidance Inventory

(Young Kaçınma Ölçeği)

Aşağıda kişilerin kendilerini tanımlarken kullandıkları ifadeler sıralanmıştır. Lütfen her bir ifadeyi okuyun ve sizi ne kadar iyi tanımladığına karar verin. Daha sonra 1 den 6 ya kadar olan seçeneklerden sizi tanımlayan en yüksek dereceyi seçerek her sorudan önce yer alan boşluğa yazın.

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

1. ___ Beni üzen konular hakkında düşünmemeye çalışırım.
2. ___ Sakinleşmek için alkol alırım.
3. ___ Çoğu zaman mutluyumdur.
4. ___ Çok nadiren üzgün veya hüzünlü hissederim.
5. ___ Aklı duygulara üstün tutarım.
6. ___ Hoşlanmadığım insanlara bile kızmamam gerektiğine inanırım.
7. ___ İyi hissetmek için uyuşturucu kullanırım.
8. ___ Çocukluğumu hatırladığımda pek bir şey hissetmem.
9. ___ Sıkıldığımda sigara içerim.
10. ___ Sindirim sistemim ile ilgili şikâyetlerim var (Örn: hazımsızlık, ülser, bağırsak bozulması).
11. ___ Kendimi uyuşmuş hissederim.
12. ___ Sık sık baş başım ağrır.
13. ___ Kızgınken insanlardan uzak dururum.
14. ___ Yaşıtlarım kadar enerjim yok.
15. ___ Kas ağrısı şikâyetlerim var.
16. ___ Yalnızken oldukça fazla TV seyrederim.
17. ___ İnsanın duygularını kontrol altında tutmak için aklını kullanması gerektiğine inanırım.
18. ___ Hiç kimseden aşırı nefret edemem.
19. ___ Bir şeyler ters gittiğindeki felsefem, olanları bir an önce geride bırakıp yola devam etmektir.
20. ___ Kırıldığım zaman insanların yanından uzaklaşırım.
21. ___ Çocukluk yıllarımı pek hatırlamam.
22. ___ Gün içinde sık sık şekerleme yaparım veya uyurum.
23. ___ Dolaşırken veya yolculuk yaparken çok mutlu olurum.
24. ___ Kendimi önümdeki işe vererek sıkıntı hissetmekten kurtulurum.
25. ___ Zamanımın çoğunu hayal kurarak geçiririm.
26. ___ Sıkıntılı olduğumda iyi hissetmek için bir şeyler yerim.
27. ___ Geçmişimle ilgili sıkıntılı anıları düşünmemeye çalışırım.

28. ___ Kendimi sürekli bir şeylerle meşgul edip düşünmeye zaman ayırmazsam daha iyi hissederim.
29. ___ Çok mutlu bir çocukluğum oldu.
30. ___ Üzgünken insanlardan uzak dururum.
31. ___ İnsanlar kafamı sürekli kuma gömdüğümü söylerler;başka bir deyişle, hoş olmayan düşünceleri görmezden gelirim.
32. ___ Hayal kırıklıkları ve kayıplar üzerine fazla düşünmemeye eğilimliyim.
33. ___ Çoğu zaman, içinde bulunduğum durum güçlü duygular hissetmemi gerektirse de bir şey hissetmem.
34. ___ Böylesine iyi ana-babam olduğu için çok şanslıyım.
35. ___ Çoğu zaman duygusal olarak tarafsız/ nötr kalmaya çalışırım.
36. ___ İyi hissetmek için, kendimi ihtiyacım olmayan şeyler alırken bulurum.
37. ___ Beni zorlayacak veya rahatımı kaçıracak durumlara girmemeye çalışırım.
38. ___ İşler benim için iyi gitmiyorsa hastalanırım.
39. ___ İnsanlar beni terk ederse veya ölürse çok fazla üzülmem.
40. ___ Başkalarının benim hakkımda ne düşündükleri beni ilgilendirmez.

APPENDIX G. Beck Depression Inventory

(Beck Depresyon Envanteri)

Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde, bir çeşit ruh durumunu anlatmaktadır. Her maddede o duygu durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatlice okuyunuz. Son bir hafta içindeki (şu an dahil) kendi duygu durumunuzu göz önünde bulundurarak, size uygun olan ifadeyi bulunuz. Daha sonra, o madde numarasının karşısında, size uygun ifadeye karşılık gelen seçeneği bulup işaretleyiniz.

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 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 hoşnutum.
   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 her zaman suçluyorum.
d) Her kötü olayda kendimi suçluyorum.

9. a) Kendimi öldürmek gibi düşüncelerim yok.
b) Bazen kendimi öldürmeyi düşünüyorum fakat bunu yapamam.
c) Kendimi öldürebilmeyi isterdim.
d) Bir fırsatını bulursam kendimi öldürürdüm.

10. a) Her zamankinden daha fazla ağladığımı sanmıyorum.
b) Eskisine gore şu sıralarda daha fazla ağlıyorum.
c) Şu sıralar 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 gore insanlarla daha az ilgiliyim.
c) Diğer insanlara karşı ilgimin çoğunu kaybettim.
d) Diğer insanlara karşı hiç ilgim kalmadı.

13. a) Kararlarımı eskisi kadar 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 gore 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 sıralar eskisi kadar rahat uyuyamıyorum.
c) Eskisine gore 1 veya 2 saat erken uyanıyor ve tekrar uyumakta

zorluk çekiyorum.
d) Eskisine gore 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 hiçbir şey yapamıyorum.

18. a) İştahım eskisinden pek farklı değil.
b) İştahım eskisi kadar iyi değil.
c) Şu sıralar iştahım epey kötü.
d) Artık hiç iştahım yok.

19. a) Son zamanlarda pek fazla kilo kaybettiğimisanmıyorum.
b) Son zamanlarda istemediğim halde üç kilodan fazla kaybettim.
c) Son zamanlarda beş kilodan fazla kaybettim.
d) Son zamanlarda yedi kilodan fazla kaybettim.

- Daha az yiyerek kilo kaybetmeye çalışıyorum. EVET ( ) HAYIR ( )

20. a) Sağlığım beni pek endişelendirmiyor.
b) Son zamanlarda ağrı, size, mide bozukluğu, kabızlık gibi sorunlarım var.
c) Ağrı, size gibi bu sıkıntılarım beni epey endişelendirdiği için başka şeyleri düşünmek zor geliyor.
d) Bu tür sıkıntılar beni öylesine endişelendiriyor ki, artık başka bir şey düşünemiyorum.

21. a) Son zamanlarda cinsel yaşantımda dikkatimi çeken bir şey yok.
b) Eskisine gore cinsel konularla daha az ilgileniyorum.
c) Şu sıralarda cinsellikle pek ilgili değilim.
d) Artık, cinsellikle hiçbir ilgim kalmadı.

APPENDIX H. Caregiver Well-Being Scale

(Bakıcı İyilik Ölçeği)

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 (doktora, diş hekimine gitmek vs.)	1	2	3	4	5
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

Aşağıda her birimizin 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 ölçüde 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 çevrilmesiyle ilgilenmek	1	2	3	4	5
5. Ulaşım kolaylığına sahip olmak	1	2	3	4	5
6. Kıyafet alışverişi 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. Çevrenizdeki güzelliklerin farkına varmak	1	2	3	4	5
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

APPENDIX I. Maslach Burnout Inventory

(Maslach Tükenmişlik Ölçeği)

Aşağıda 22 cümle ve her bir cümle yanında da cevaplarınızı işaretlemeniz için 0'dan 4'e kadar rakamlar verilmiştir. Her cümlede söylenen ifadeye ne kadar katıldığınızı ya da katılmadığınızı belirtmek için rakamlardan yalnız bir tanesini daire içine alarak işaretleyiniz.

0 Kesinlikle katılmıyorum
1 Katılmıyorum
2 Ne katılıyorum ne de katılmıyorum
3 Katılıyorum
4 Tamamen katılıyorum

1. Hasta bakımından soğuduğumu hissediyorum.	0	1	2	3	4
2. Hasta baktığım günün sonunda kendimi ruhen tükenmiş hissediyorum.	0	1	2	3	4
3. Sabah kalktığımda bir gün daha hasta bakımını kaldıramayacağımı düşünüyorum.	0	1	2	3	4
4. Baktığım hastanın ne hissettiğini hemen anlarım.	0	1	2	3	4
5. Baktığım hastaya o sanki insan değilmiş gibi davrandığımı hissediyorum.	0	1	2	3	4
6. Bütün gün hasta bakmak benim için gerçekten yıpratıcı	0	1	2	3	4
7. Baktığım hastanın sorunlarına en uygun çözüm yollarını bulurum.	0	1	2	3	4
8. Hasta bakmaktan tükendiğimi hissediyorum.	0	1	2	3	4
9. Hasta bakarak insanların yaşamına katkıda bulunduğuma inanıyorum.	0	1	2	3	4
10. Hasta bakmaya başladığımdan beri insanlara karşı sertleştim.	0	1	2	3	4
11. Hasta bakmanın beni giderek katılaştırmasından korkuyorum.	0	1	2	3	4
12. Çok şeyler yapabilecek güçteyim.	0	1	2	3	4
13. Hasta bakmanın beni kısıtladığını hissediyorum.	0	1	2	3	4
14. Hasta bakma konusunda çok fazla çalıştığımı hissediyorum.	0	1	2	3	4
15. Baktığım hastaya ne olduğu umrumda değil.	0	1	2	3	4
16. Doğrudan doğruya bir hastayla ilgilenmek bende çok fazla stress yaratıyor.	0	1	2	3	4
17. Baktığım hastayla aramda rahat bir hava yaratırım.	0	1	2	3	4
18. Baktığım hastayla ilgilendikten sonra kendimi canlanmış hissederim.	0	1	2	3	4
19. Hasta bakımı konusunda başarılıyımdır.	0	1	2	3	4
20. Yolun sonuna geldiğimi hissediyorum.	0	1	2	3	4

21. Hasta bakımındaki duygusal sorunlara serinkanlılıkla yaklaşırım.	0	1	2	3	4
22. Baktığım hastanın bazı problemlerini sanki benyaratmışım gibi davrandığını hissediyorum.	0	1	2	3	4

APPENDIX J. Multidimensional Scale of Perceived Social Support

(Çok Yönlü Algılanan Sosyal Destek Envanteri)

Aşağıda 12 cümle ve her bir cümle altında da cevaplarınızı işaretlemeniz için 1'den 7'ye kadar rakamlar verilmiştir. Her cümlede söylenenin 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 birine bir işaret koyarak cevaplarınızı veriniz. Lütfen hiçbir cümleyi cevapsız bırakmayınız. Sizce doğruya en yakın olan rakamı işaretleyiniz.

1. Ailem ve arkadaşlarım dışında olan ve ihtiyacım olduğunda yanımda olan bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.
Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
2. Ailem ve arkadaşlarım dışında olan ve sevinç ve kederlerimi paylaşabileceğim bir insan (örneğin, flört, nişanlı,sözlü, akraba, komşu, doktor) var.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
3. Ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana gerçekten yardımcı olmaya çalışır.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
4. İhtiyacım olan duygusal yardımı ve desteği ailemden (örneğin, annemden, babamdan, eşimden, çocuklarımdan, kardeşlerimden) alırım.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
5. Ailem ve arkadaşlarım dışında olan ve beni gerçekten rahatlatan bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) 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 (örneğin, annemle, babamla, eşimle, çocuklarımla, kardeşlerimle) 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. Ailem ve arkadaşlarım dışında olan ve duygularıma önem veren bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
11. Kararlarımı vermede ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) 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 K: Turkish Summary

(Tezin Türkçe Özeti)

GİRİŞ

Altmış beş yaş üzeri nüfusun oranı hızlı bir şekilde artmaktadır (Older Americans 2000: Key Indicators of Well-Being, 2000). Değişen bu nüfus oranı demans hastalarının da artmasına neden olmaktadır. Dünya Alzheimer Raporu'na göre 36 milyon kişi demans hastasıdır ve bu sayının 2050'de 115 milyona ulaşması beklenmektedir (akt. Boots, de Vugt, van Knippenberg, Kempen, ve Verhey, 2014). DSM IV 'de demans için bazı kriterler belirlenmiştir. Bu kriterlere ek olarak bir kişinin demans hastası sayılabilmesi için bilişsel becerilerdeki düşüşün kişinin günlük hayatını engellemesi de gerekmektedir (APA, 2000). Günlük hayatları engellendiği için demans hastalarının büyük bir kısmı bakım veren kişiyle beraber yaşamaktadırlar (örn: Rosa ve ark., 2010; Diehl-Schmid ve ark., 2013). Zarit ve Edwards'a (1999) göre bakım vermek "bir aile üyesinin diğerine bağımsız yaşaması için gerekli olan işlerde düzenli olarak yardım etmesi sonucunda oluşan etkileşim" dir (akt. Oyebode, 2003). Demans hastalarına bakım verenler, eşler (%61) (Heru ve Ryan, 2006), çocuklar (%29) ya da başka akrabalar veya arkadaşlardır (Heru, Ryan, ve Iqbal, 2004). Bu sebeple, demanstan sadece hasta değil, aileleri ve arkadaşları da kişisel, duygusal, ekonomik ve sosyal açıdan etkilenmektedirler (Wimo ve Prince, 2010).

Brodaty ve Donkin (2009) bakım verenleri "görünmeyen ikinci hastalar" olarak tanımlamıştır (akt. Boots, Vugt, Knippenberg, Kempen, ve Verhey, 2014). Bu tanım, demans hastalarına bakım verenlerde görülen yüksek psikolojik ve fiziksel hastalık durumlarını destekler niteliktedir (Ulstein, Wyller, ve Engedal, 2007; Takai ve ark., 2009; Schulz, O'Brien, Bookwala, ve Fleissner, 1995). Demans hastalarına bakım veren kişilerde koroner kalp rahatsızlıkları (Vitaliano ve ark., 2002),

kardiyovasküler rahatsızlıklar (Mausbach ve ark., 2010), yüksek tansiyon (Shaw ve ark., 2003; Shaw ve ark., 1999; Grant ve ark., 2002; Roepke ve ark., 2011; von Kanel ve ark., 2008), bağışıklık sisteminin zayıflaması (Kiecolt-Glaser, Glaser, Gravenstein, Malarkey, ve Sheridan, 1996; Mills ve ark., 2004; Mills, Yu, Ziegler,Patterson, ve Grant, 1999; Mills ve ark., 1997; Kiecolt-Glaser, Dura, Speicher, Trask, ve Glaser, 1991) gibi fiziksel rahatsızlıklar görülmektedir.

Fiziksel rahatsızlıkların yanı sıra, demans hastalarına bakım veren kişiler yüksek stres seviyeleri (Bertrand, Fredman, ve Saczynski, 2006; Le´vesque, Ducharme, ve Lachance, 1999; Pinquard ve Sörensen, 2003; Andrén ve Elmstahl, 2007; Vedhara ve ark., 1999; Vitaliano, Zhang, ve Scanlan, 2003), yüksek seviyede depresyon (Mausbach, Patterson, ve Grant, 2008; Kiecolt-Glaser, Dura, Speicher, Trask, ve Glaser, 1991; Papastavrou, Kalokerinou, Papacostas, Tsangari, ve Sourtzi, 2007; Diehl-Schmid ve ark., 2013; Beeson, 2003; Fuller-Jonap ve Haley, 1995; Cuijpers, 2005; Mahoney, Regan, Katona, ve Livingston, 2005; Simpson, ve Carter, 2013; Coope ve ark., 1995; Fauth ve Gibbons, 2014; Leggett, Zarit, Kim, Almeida, ve Klein, 2014) ve anksiyete (Covinsky ve ark., 2003; Mahoney, Regan, Katona, ve Livingston, 2005; Coope ve ark., 1995) rapor etmişlerdir. Yani, kısaca bakım vermek, bakım veren kişinin psikolojik ve fiziksel sağlığını etkilemektedir.

Mace ve Robins (1999) Alzheimer hastasına bakım vermenin günü 36 saat olarak yaşamak olduğunu, bu durumun fiziksel, duygusal ve zihinsel tükenmeye neden olduğunu belirtmiştir. Bir başka deyişle, demans hastalarına bakım verenlerin tükenmişlik yaşamaya yatkınlıkları vardır. Tükenmişlik fiziksel ve zihinsel olarak aşırı yorgunluk, duygusal tükenmişlik, düşük iş motivasyonu ve başkalarına karşı empati eksikliği olarak tanımlanmaktadır (Maslach, 1982). Tükenmişliğin üç semptomu, duygusal tükenme, duyarsızlaşma ve düşük kişisel başarıdır (Maslach, Schaufeli, ve Leiter, 2001). Demans hastalarına bakım veren aile üyelerinin tükenmişlik yaşadıkları bir çok çalışma tarafından desteklenmiştir (örn. Almberg, Grafstrom, ve Winblad, 1997; Truzzi ve ark., 2008; Takai ve ark., 2009; Truzzi ve ark., 2012; Matsuda, 2001). Tükenmişliğin belirleyicileri ise, bireyin sosyal hayatının kısıtlanması, kötü sağlık ve bakım vermeyi olumlu bir durum olarak görmemektir (Almberg, Grofstrom, ve Winblad, 1997).

Bakım vermek, bakım verenin hem psikolojik hem de fiziksel iyilik halini etkilemektedir. Bu süreçte, bakım verenin iyilik haline etki eden bir diğer değişken erken dönem çocukluk yaşantıları olabilir, çünkü erken dönemde önemli kişilerle yaşanan deneyimler organize düşünceleri, kendiliği, dünya ve başkaları hakkındaki duyguları belirlemekte, bireyin yeni deneyimleri algılamasını ve verdiği tepkiyi şekillendirmektedir (Segal, 1988). Bu belirlemeyi ve şekillendirmeyi yapan organize düşünceler, davranışlar ve duygular şemalardır. Erken dönem uyumsuz şemaları, "kişinin çocukluk ve ergenlik döneminde kendiliğe ve diğerlerine dair geliştirdiği, uzun vadede ise bireyin psikolojik uyumunu bozan genel yaygın bilişsel temalardır. Bununla birlikte, bu şemalar sadece bilişsel düzeyde gelişmekle kalmayıp; anılar, duygular ve bedensel duyumlardan da oluşur. Kişinin yaşamı boyunca gittikçe karmaşıklaşır ve önemli bir dereceye kadar işlev bozucudur " (Young, Klosko ve Weishaar, 2003).

Şema terapi, çocukluk döneminde karşılanması gereken temel duygusal ihtiyaçların karşılanmaması, engellenmesi ya da aşırı karşılanması gibi durumlarda erken dönem uyum bozucu şemaların geliştiğini belirtmektedir. Bu ihtiyaçlar başkalarına güvenli bağlanma (güvenlik, istikrar, bakım ve benimsenme), özerklik, yetenek ve olumlu kimlik algısı; duygu ve ihtiyaçları ifade etme özgürlüğü; kendiliğindelik ve oyun; gerçekçi sınırlar ve özdenetim olarak tanımlanmıştır. Şemaların kazanılması dört şekilde olmaktadır. Bunlar, ihtiyaçların karşılanmaması, travmatize edilme ya da kurbanlaştırılma, ihtiyaçların gerektiğinden fazla karşılanmaya çalışılması ve seçici içselleştirme/önemli diğeriyle özdeşleşmedir (Young ve ark., 2003).

Şema Terapi modelinde 18 erken dönem uyumsuz şema vardır ve bu şemalar beş şema alanı altında toplanmıştır. Bu şema alanları ayrılma/reddedilme, zedelenmiş özerklik ve performans, zedelenmiş sınırlar, başkalarına yönelimlik ve aşırı tetikte olma ve baskılamadır. Ayrılma ve reddedilme alanından şemalara sahip olan kişilerin genellikle diğerlerine güvenli bağlanma konusunda sorunları vardır ve genellikle istismarcı, tutarsız, reddedici, duygusal açıdan soğuk, dış dünyadan yalıtılmış aileleri olduğu ifade edilmektedir. Bu şema alanında yer alan şemalar ise terkedilme/istikrarsızlık, güvensizlik/suistimal edilme, duygusal yoksunluk, kusurluluk/utanç ve sosyal izolasyon/yabancılaşmadır. İkinci alan olan zedelenmiş

özerklik ve performans dört farklı şemayı içermektedir. Bağımlılık/yetersizlik, hastalıklar-tehditler karşısında dayanıksızlık, iç içe geçme/gelişmemiş benlik, başarısızlık bu alanda yer alan şemalardır. Bu alandaki şemaya sahip kişiler, bağımsız hareket edebilme, kendilerini ebeveyn figürlerinden farklılaştırma, kendi kimliklerini oluşturma ve kendi hayatlarını yaşama konusunda sorun yaşarlar. Bu kişilerin ebeveynlerinin aşırı koruyucu davranışları olduğu, çocuklarının bir şeyleri kendi başlarına bitirmelerine izin vermeden çocukları için her şeyi yaptıkları, ya da bunun tam tersi çocuklarının ihtiyaçları olduğunda çocuklarıyla ilgilenmedikleri belirtilmiştir. Zedelenmiş sınırlar alanı, karşılıklılık ve öz disiplinle ilgili içsel sınırlardan yoksun olmakla ilgili olan üçüncü şema alanıdır. Bu alandaki şemalar ise hak görme/büyüklük ve yetersiz özdenetimdir. Bu alanda şemaları olanlar diğerlerinin haklarına saygı duymakta, işbirliği yapmakta, sözünde durmakta ya da uzun vadeli planlara uymakta zorluk çekerler. Bu şema alanından şemalara sahip olanların yetiştirilme tarzlarına bakıldığında aşırı izin verici ve yönlendirici olmayan ebeveynlik tarzları ile karşılaşılmıştır. Dördüncü şema alanı ise öteki yönelimliliktir. Bu şema alanındaki şemalar boyun eğicilik, kendini feda, onay arayıcılıktır. Bu şema alanındaki kişiler, onaylanma ve bağ kurma ihtiyacındadırlar ve bu sebeple kendi ihtiyaçları yerine başka insanların ihtiyaçlarını karşılamak adına aşırı çaba harcarlar. Bu kişilerin ebeveynleri kendi duygusal ihtiyaçlarına ve sosyal görünümlerine odaklıdırlar ve çocukların şartlı kabul gördüğü aile ortamlarında yetişmişlerdir. Beşinci ve son şema alanı ise aşırı tetikte olma ve bastırılmışlık alanıdır. Bu alanda karamsarlık, duyguları bastırma, yüksek standartlar/aşırı eleştiricilik ve cezalandırılma şemaları vardır. Bu alandaki şemalar bireyin duygu ve dürtülerini ifade etmeyip bastırmasına neden olur. Bu bireyler, çocukluk yıllarında oyun ve mutluluğun peşinden gitmesi yerine, kontrollü olmaları teşvik edilir. Tipik olarak kuralcı ve sert olan, özdenetim ve özverinin kendiliğindenlik ve memnuniyetten üstün tutulduğu ebeveynlik çocuğun bu alandan şemalar geliştirmesine zemin hazırlar (Young ve ark., 2003).

Young, Kolosko ve Weishaar (2003), beş şema alanı altında 18 şema belirlemişlerdir. Fakat, şemaların sayıları ve isimleri çalışmadan çalışmaya değişmektedir (Lee, Taylor, ve Dunn, 1999; Baranoff, Oei, Cho, ve Kwon, 2006; Sarıtaş ve Gençöz, 2011). Bu çalışmada kullanılan ölçeğin adaptasyonunun Soygüt,

Karaosmanoğlu ve Çakır (2009) tarafından yapılmasından dolayı, Soygüt, Karaosmanoğlu ve Çakır'ın (2009) şema alanları ve şema sayıları kullanılmıştır. Yani, bu çalışmada beş şema alanının altında 14 erken dönem uyumsuz şemasının olduğu bilgisinden yararlanılmıştır.

Erken dönem uyumsuz şemalar, psikiyatrik semptomların başlamasında ve devam etmesinde önemlidirler (Welburn, Coristine, Dagg, Pontefract, ve Jordan, 2002). Şemaların psikopatoloji ile ilişkisi literatürde önemli bir yere sahiptir. Örneğin, depresyon (Roelofs, Lee, Ruijten, ve Lobbastael, 2011; Harris ve Curtin, 2002; Calvete, Orue, ve Hankin, 2013; Muris, 2006; Renner, Lobbestael, Peeters, Arntz, ve Huibers, 2012; Halvorsen, Wang, Eisemann, ve Waterloo, 2010), anksiyete (Muris, 2006; Pinto-Gouveia, Castillo, Galhardo, ve Cunha, 2006; Kim, Lee, ve Lee, 2014; Diez, Zurnalde, ve Sola, 2012; Calvete, Orue, ve Hankin, 2013; Cockram, Drummond, ve Lee, 2010), yeme bozuklukları (Muris, 2006; Waller, Ohanian, Meyer, ve Osman, 2000) gibi pek çok psikolojik rahatsızlık ile şema ilişkisi bulunmuştur. Fakat yazarın bildiği kadarıyla, bakım verenin iyilik hali ve şema arasındaki ilişkiyi inceleyen bir çalışma yoktur.

Şemaların ortaya çıkardığı yoğun duygulara uyum sağlamak için, bireyler çocukluk dönemlerinde başa çıkma stratejileri geliştirirler. Bu stratejiler erken dönemde uyumlu olabilir, fakat diğer olaylara ve kişilere genellendiğinde uyumsuz olurlar. Şemaya teslim olma, şema kaçınması ve şema aşırı telafisi üç uyumsuz şema baş etme biçimidir. Bireyler şemaya teslim olduklarında şemanın doğru olduğunu kabul ederler. Şema kaçınması ise, durumdan kaçınma ve şema ile ilişkili hissedilenleri bastırmakla alakalıdır. Bu sebeple şema hiç aktive olmamaktadır (Young ve ark., 2003). Şema kaçınması ve psikopatoloji ilişkisini inceleyen bir çok çalışma vardır (Gök, 2012; Brotchie, Hanes, Wendon, ve Waller, 2006; Spranger, Waller, ve Bryant-Waugh, 2001; Diez, Zurnalde, ve Sola, 2012). Şema aşırı telafisinde ise, birey şema ile şemanın zıttı doğruymuş gibi düşünerek, hissederek ve hareket ederek şema ile savaşır. Bu durum da şemanın düzelmesi yerine tekrar etmesine yol açar (Young ve ark., 2003). Şema aşırı telafi baş etme biçiminin de psikopatoloji ile ilişkili olduğu sonucuna ulaşan çalışmalar vardır (Sheffield, Waller, Emanuelli, Murray, ve Meyer, 2009; Diez, Zumalde, ve Sola, 2012).

Erken dönem uyumsuz şemaları ebeveynlik stilleri ile ilişkili bulunmuştur (Harris ve Curtin, 2002, Gök, 2012; Muris, 2006). Ebeveynlik stilleri erken dönem uyumsuz şemaları ile ilişkili, erken dönem uyumsuz şemaları da psikopatoloji ile ilişkilidir. Bu ilişkiye bakılarak, erken dönem uyumsuz şemaların ebeveynlik stilleri ve psikopatoloji arasında aracı rolü olduğu söylenebilir (Young ve ark., 2003; Gök, 2012). Bu ilişki farklı psikopatolojiler ile de bulunmuştur (Thimm, 2010; Sarıtaş, 2007; Carr ve Francis, 2010; Kapçı ve Hamamcı, 2010; Jones, Leung, ve Harris, 2006; Turner, Rose, ve Cooper, 2005; McGinn, Cukor, ve Sanderson, 2005).

Olumsuz ebeveynlik stilleri ve psikolojik rahatsızlıklar arasında da ilişki bulunmuştur. Bu psikolojik rahatsızlıklara da depresyon (Fentz, Arendt, O'Toole, Rosenberg, ve Hougaard, 2011; Oakley-Browne, Joyce, Wells, Bushnell, ve Hornblow, 1995; Anlı ve Karslı, 2010; Rapee, 1997), anksiyete (Grüner, Muris, ve Merckelbach, 1999; McLeod, Wood, ve Weisz, 2007; Gastel, Legerstee, ve Ferdinand, 2009; Grüner, Muris, ve Merckelbach, 1999; Duchesne, Larose, Vitaro, ve Tremblay, 2010; Bögels, Oosten, Muris, ve Smulders, 2001; Spokas ve Heimberg, 2009; Hummel ve Gross, 2001; Alonso ve ark., 2004; Cockram, Drummond, ve Lee, 2010; Hale, Engels, ve Meeus, 2006; Anlı ve Karslı, 2010; Rapee, 1997), yeme bozuklukları (Enten ve Golan, 2009; Haycraft ve Blissett, 2010; Sheffield, Waller, Emanuelli, Murray, ve Meyer, 2009; Leung, Thomas, ve Waller, 2000) ve alkol ve madde bağımlılıkları (de Rick ve Vanheule, 2006; Cheng, Anthony, ve Huang, 2010; Benchaya, Bisch, Moreira, Ferigolo, ve Barros, 2011) örnek verilebilir.

Olumsuz ebeveynlik ve psikopatoloji arasındaki ilişkinin şiddeti sosyal destekle azaltılabilir. Cohen ve McKay'in 1984 yılında yaptığı tanıma göre sosyal destek kişiyi stresli durumlar karşısında koruyan kişiler arası ilişkidir. Stres-tampon hipotezine göre, psikososyal stres, az ya da hiç sosyal desteği olmayan bireyin fiziksel ve psikolojik iyilik halini olumsuz etkilerken, güçlü sosyal destek bu etkiyi azaltmakta ya da ortadan kaldırmaktadır (Cohen ve Willis, 1985).

Algılanan sosyal destek ve fiziksel ve psikolojik iyilik hali ile yapılan çalışmalar, algılanan sosyal desteğin olumlu rolüne işaret etmektedir (Pehlivan, Ovayolu, Ovayolu, Sevinç, ve Camcı, 2012; Özpolat, Ayaz, Konağ, ve Özkan, 2014; Yen ve Lundeen, 2006; Kuscu ve ark., 2009; Sipal ve Sayın, 2013; Bozo, Anahar, Ateş, ve Etel, 2010; Schoeder ve Remer, 2007; Chappell ve Reid, 2002; Schulz,

O'Brien, Bookwala, ve Fleissner, 1995). Algılanan sosyal desteğin bakım veren kişinin iyilik halindeki olumlu rolünün yanı sıra, algılanan sosyal destek başka çalışmalarda moderatör rolü üstlenmiştir (Demirtepe-Saygılı ve Bozo, 2011; Wilks ve Croom, 2008).

Yukarıda bahsedilen literatür bulguları doğrultusunda çalışmanın amaçları:

1. Cinsiyet, medeni hal, çocuğa sahibi olup olmamak, fiziksel ya da psikolojik bir rahatsızlığın olması, iş durumu, eğitim düzeyi gibi demografik değişkenlerin araştırmanın değişkenleri (örn: bakıcı iyilik hali, ebeveynlik stilleri, algılanan sosyal destek, depresyon, şema baş etme stilleri, tükenmişlik ve erken dönem uyumsuz şemaları) açısından farklarını incelemek
2. Demans seviyesinin (hafif, orta, ağır) araştırmanın değişkenleri açısından farklarını incelemek
3. Çalışmanın değişkenleri arasındaki ilişkileri incelemek
4. Erken dönem uyumsuz şemalarının, ebeveynlik stilleri ile bakım verenin iyilik hali, depresyon ve tükenmişlik arasındaki ilişkide aracı rolünü incelemek
5. Algılanan sosyal desteğin, erken dönem uyumsuz şemaları ile bakım verenin iyilik hali, depresyon ve tükenmişlik arasındaki ilişkide biçimleyici rolünü incelemek
6. Kaçınma şema baş etme stratejisinin, erken dönem uyumsuz şemaları ile bakım veren iyilik hali, depresyon ve tükenmişlik arasındaki ilişkide biçimleyici rolünü incelemek
7. Aşırı telafi şema baş etme stratejisinin, erken dönem uyumsuz şemaları ile bakım veren iyilik hali, depresyon ve tükenmişlik arasındaki ilişkide biçimleyici rolünü incelemek

Sonuç olarak, bu çalışmanın hipotezleri:

1. Erken dönem uyumsuz şemaları, ebeveynlik stilleri ve araştırmanın değişkenleri arasındaki ilişkide aracı role sahiptir.
    I. Erken dönem uyumsuz şemaları, ebeveynlik stilleri ve bakıcı iyilik hali arasındaki ilişkide aracı role sahiptir.
    II. Erken dönem uyumsuz şemaları, ebeveynlik stilleri ve depresyon arasındaki ilişkide aracı role sahiptir.
    III. Erken dönem uyumsuz şemaları, ebeveynlik stilleri ve tükenmişlik arasındaki ilişkide aracı role sahiptir.

2. Algılanan sosyal destek, erken dönem uyumsuz şemaları ve araştırmanın değişkenleri arasındaki ilişkide biçimleyici role sahiptir.
    I. Algılanan sosyal destek, erken dönem uyumsuz şemaları ve bakıcı iyilik hali arasındaki ilişkide biçimleyici role sahiptir.
    II. Algılanan sosyal destek, erken dönem uyumsuz şemaları ve depresyon arasındaki ilişkide biçimleyici role sahiptir.
    III. Algılanan sosyal destek, erken dönem uyumsuz şemaları ve tükenmişlik arasındaki ilişkide biçimleyici role sahiptir.

3. Kaçınma ve aşırı telafi şema baş etme stilleri,erken dönem uyumsuz şemaları ve araştırmanın değişkenleri arasındaki ilişkide biçimleyici role sahiptir.
    I. Kaçınma şema baş etme stili, erken dönem uyumsuz şemaları ve bakıcı iyilik hali arasındaki ilişkide biçimleyici role sahiptir.
    II. Kaçınma şema baş etme stili, erken dönem uyumsuz şemaları ve depresyon arasındaki ilişkide biçimleyici role sahiptir.
    III. Kaçınma şema baş etme stili, erken dönem uyumsuz şemaları ve tükenmişlik arasındaki ilişkide biçimleyici role sahiptir.
    IV. Aşırı telafi şema baş etme stili, erken dönem uyumsuz şemaları ve bakıcı iyilik hali arasındaki ilişkide biçimleyici role sahiptir.
    V. Aşırı telafi şema baş etme stili, erken dönem uyumsuz şemaları ve depresyon arasındaki ilişkide biçimleyici role sahiptir.
    VI. Telafi şema baş etme stili erken dönem uyumsuz şemaları ve tükenmişlik arasındaki ilişkide biçimleyici role sahiptir.

YÖNTEM

Katılımcılar

Çalışmaya 25 ve 64 yaşları arasında olan demans hastalarına birincil bakım veren 99 yetişkin evlat katılmıştır. Bu katılımcıların 78'i kadın iken (%78.8), 21'i erkektir (%21.2). Demans hastasının birincil bakım vereni olma kriteri olarak, hastaya günlük ihtiyaçlarında yardım etmek ve ihtiyacı olduğu durumlarda gözetim ve denetim sağlamak alınmıştır. Katılımcıların demografik özellikleri Tablo 2.1'de gösterilmiştir.

Veri Toplama Araçları

Araştırmada veri toplama araçları olarak, araştırmacı tarafından geliştirilen, katılımcıların yaş, cinsiyet, medeni hali, eğitim durumları gibi demografik özelliklerini belirlemek amacıyla demografik bilgi formu kullanılmıştır. Bu forma ek olarak, katılımcıların erken dönem uyumsuz şemalarını belirlemek amacıyla 90 maddeden oluşan Young Şema Ölçeği (Young, 2006), ebeveynlik stillerini belirlemek amacıyla 72 maddeden oluşan Young Ebeveynlik Ölçeği (Young, 1994), şema baş etme biçimlerini belirlemek amacıyla 48 maddeden oluşan Young Telafi Ölçeği (Young, 1995) ve 40 maddelik Young Kaçınma Ölçeği (Young & Rygh, 1994) kullanılmıştır. Bu ölçekler 6'lı Likert tipi ölçeklerdir. Tükenmişliği ölçmek amacıyla 5'li Likert tipi olan 22 maddelik Maslach Tükenmişlik Envanteri (Maslach ve Jackson, 1981) kullanılmıştır. Bakım verenlerin iyilik hallerini tespit etmek amacıyla 5'li Likert tipi 44 maddelik Bakıcı İyilik Ölçeği (Tebb, 1995), algıladıkları sosyal desteği belirlemek amacıyla 7'li Likert tipi 12 maddelik Çok Yönlü Algılanan Sosyal Destek Envanteri (Zimet, Dahlem, Zimet, ve Farley, 1988) ve depresif semptomların seviyesini belirlemek amacıyla 21 maddelik Beck Depresyon Envanteri (Beck, Rush, Shaw, ve Emery, 1979) kullanılmıştır.

Prosedür

ODTÜ Uygulamalı Etik Araştırma Merkezi'nden, hastanelerden, nöroloji bölüm başkanlıklarından ve Alzheimer Derneği'nden alınan izinlerden sonra, İzmir ve Ankara'daki hastanelerin nöroloji bölümlerinden ve Alzheimer Derneği'nden katılımcılara ulaşılmıştır. Katılımcılara araştırmanın amacı anlatıldıktan sonra, çalışmaya gönüllü olarak katıldıklarının onayını almak amacıyla gönüllü katılım formu verilmiştir. Daha sonra ölçekler araştırmacı tarafından katılımcılara okunmuş ve cevapları kaydedilmiştir. Anketlerin doldurulması yaklaşık 1 saat sürmüştür.

İstatistiksel Analizler

Araştırmadan elde edilen verilerin analizi için SPSS 20.0 paket programı kullanılmıştır. İlk olarak, demografik değişkenlerin farklı seviyelerinin çalışmanın değişkenleri açısından nasıl farklılaştığını ölçmek amacıyla bağımsız t-test tek yönlü ANOVA analizleri yapılmıştır. Daha sonra ana değişkenlerin birbirleri ile olan ilişkilerini belirlemek için Pearson korelasyon analizleri uygulanmıştır. Korelasyon

analizlerinden sonra araştırmanın amaçlarında yer alan aracı ve biçimleyici rolleri araştırmak amacıyla bir dizi regresyon analizi yapılmıştır.

BULGULAR

Regresyon Analizleri

Erken dönem uyumsuz şemalarının ebeveynlik stilleri ve araştırmanın sonuç değişkenleri ilişkisindeki aracı rolünü belirlemek amacıyla dört regresyon analizi yapılmıştır. Bu analizlerin sonuçlarına göre, erken dönem uyumsuz şemalar, ebeveynlik stilleri ile bakıcı iyilik ölçeğinin alt ölçeği olan temel ihtiyaçların karşılanması, depresyon ve tükenmişlik arasındaki ilişkide aracı role sahiptir. Bakıcı iyilik hali ölçeğinde alt ölçek olarak yer alan yaşamsal faaliyetler alt ölçeğinin ise ebeveynlik stilleri ile olan ilişkisinde erken dönem uyumsuz şemalarının aracı rolünü desteklememektedir.

Aracı rolü tespit etmek için yapılan analizlerin yanında, algılanan sosyal desteğin ve şema baş etme biçimlerinin biçimleyici rolü dört farklı set regresyon analizi ile araştırılmıştır. Birinci sette, algılanan sosyal desteğin, erken dönem uyumsuz şemaları ve çalışmanın sonuç değişkenleri arasındaki ilişkilerinde biçimleyici rolüne bakılmıştır. Algılanan sosyal desteğin sadece erken dönem uyumsuz şemalar ve bakıcı iyilik hali-temel ihtiyaçların karşılanması ilişkisinde biçimleyici role sahip olduğu bulunmuştur. Bu nedenle bu ilişkide algılanan sosyal desteğin farklı kaynakları da ikinci sette incelenmiştir. Sonuçlara göre sadece özel kişiden alınan sosyal destek erken dönem uyumsuz şemaları ve bakıcı iyilik hali-temel ihtiyaçların karşılanması ilişkisinde biçimleyici role sahiptir. Bunlara ek olarak, şema baş etme biçimlerinden hem kaçınmanın hem de telafinin yapılan iki set regresyon analizinde, erken dönem uyumsuz şemaları ve çalışmanın sonuç değişkenleri ilişkisinde biçimleyici rolleri olmadığı bulunmuştur.

TARTIŞMA

Regresyon Analizleri

Bu araştırmada demans hastalarının birincil bakım veren yetişkin evlatlarında algılanan sosyal desteğin, erken dönem uyumsuz şemaların, ebeveynlik stillerinin ve şema baş etme biçimlerinin iyilik hali ve tükenmişlik seviyeleri üzerindeki yordayıcı rolü incelenmiştir.

Aracı rol analizlerine bakıldığında, erken dönem uyumsuz şemalarının, ebeveynlik stilleri ile temel ihtiyaçların karşılanması ve depresyon ilişkilerinde aracı rolünün olduğu bulunmuştur. Bulgulara göre negatif ebeveynlik stillerinin artması, erken dönem uyumsuz şemalarında bir artışa, o da temel ihtiyaçların karşılanmasında bir düşüşe ve depresyon seviyesinin de artmasına neden olmaktadır. Bu bulgu literatürle (Young ve ark., 2003; Gök, 2012; Sarıtaş, 2007; Kapçı ve Hamamcı, 2010; McGinn, Cukor, ve Sanderson, 2005; Harris ve Curtin, 2002) ve iyilik hali ve depresyon ilişkisi (van Hemert, van de Vijver, ve Poortinga, 2002) ile uyumludur. Bunlara ek olarak, erken dönem uyumsuz şemalarının, ebeveynlik stilleri ve tükenmişlik ilişkisinde de aracı role sahip olduğu bulunmuştur. Başka bir deyişle, negatif ebeveynlik stillerine maruz kalmak erken dönem uyumsuz şemaların artmasına, bu durum da tükenmişliğin artmasına neden olduğu sonucuna ulaşılmıştır. Bu çalışma, bakım veren çalışmalarında, erken dönem uyumsuz şemalarının ebeveynlik stilleri ile temel ihtiyaçların karşılanması, depresyon ve tükenmişlik ilişkilerindeki aracı rolünü destekler niteliktedir. Fakat aynı sonuca yaşamsal faaliyetlerin karşılanması açısından ulaşılamamıştır. Yani erken dönem uyumsuz şemaları, ebeveynlik stilleri ile yaşamsal faaliyetlerin ilişkisinde aracı role sahip değildir. Bu bulgu erken dönem uyumsuz şemalarının ebeveynlik stilleri ile temel ihtiyaçlar ilişkisinde aracı role sahipken, yaşamsal faaliyetler ilişkisinde aracı rolünün olmaması yaşamsal faaliyetler ile temel ihtiyaçların karşılanması ilişkisine de ters düşmektedir (Berg-Weger, Rubio, ve Tebb, 2000).

Biçimleyici rol analizlerine bakıldığında, algılanan sosyal destek, erken dönem uyumsuz şemaları ve temel ihtiyaçların karşılanması ilişkisinde biçimleyici role sahiptir. Yüksek erken dönem uyumsuz şemalarına sahip katılımcıların eğer algıladıkları sosyal destekleri yüksekse algıladıkları sosyal desteği düşük olanlara göre temel ihtiyaçlarını daha fazla karşıladıkları bulunmuştur. Bu durum algılanan sosyal desteğin yüksek erken dönem uyumsuz şemalara sahip demans hastasına bakım veren bireyler için koruyucu role sahip olduğunu göstermektedir. Bu bulgu stres-tampon hipotezi (Cohen ve Wills, 1985) ile uyumludur. Yüksek sosyal desteğin demans hastasına bakım veren bireyler için stres düzenleyici rolü olduğu ve bu rolün zaman içerisinde bakım veren kişinin sağlığı açısından daha olumlu sonuçları olduğu başka araştırmalarca da desteklenmiştir (Goode, Haley, Roth, ve Ford, 1998).

Algılanan sosyal desteğin bu ilişkideki biçimleyici rolünün bulunmasının ardından, bu ilişki algılanan sosyal desteğin kaynakları açısından da incelenmiştir. Aile, arkadaş ve özel kişiden algılanan sosyal desteğin erken dönem uyumsuz şemaları ve temel ihtiyaçların karşılanması ilişkisindeki biçimleyici rolünün incelenmesi sonucunda, sadece özel kişiden algılanan sosyal desteğin bu ilişkideki biçimleyici rolü bulunmuştur. Özel kişiden algılanan sosyal destek de yüksek erken dönem uyumsuz şemaları olan demans hastalarına bakım veren bireyler için koruyucu role sahiptir. Bu bulgu Bowlby'nin (1988) ihtiyaç durumlarında kişilerin yakınlık istedikleri ve bu yakınlıktan keyif aldıkları, bir tehdit ile karşılaşıldığında partnerlerin bu anlamdaki temel kaynak olduğunu ifade ettiği açıklaması ile uyumludur. Eşlerden alınan desteğin psikolojik iyilik halinde önemli olduğu literatür tarafından desteklenmektedir (Giese-Davis, Hermanson, Koopman, Weibel, ve Spiegel, 2000; Manne ve ark., 2004b; Jackson, 1992). Bu bulgu da bazı davranışların belirli bir kaynaktan geldiğinde destekleyici olarak algılanmasını, yani desteğin gelen kaynağa bağlı olduğunu akla getirmektedir (Dakof ve Taylor, 1990). Çalışmanın diğer değişkenleri açısından algılanan sosyal desteğin biçimleyici rolünün bulunmaması çalışmanın değişkenlerinin birbirleri ile olan ilişkileri açısından beklenmedik bir durumdur. Algılanan sosyal desteğin biçimleyici rolüne ek olarak, şema baş etme biçimlerinin de erken dönem uyumsuz şemaları ile çalışmanın değişkenleri arasındaki ilişkideki biçimleyici rolü incelenmiştir. Fakat şema baş etme stilleri açısından biçimleyici rol bulunamamıştır. Bu durum şema baş etme biçimlerinin, şemaların yarattığı yoğun duygularla baş etmek için geliştirildiği (Young ve ark., 2003) bilgisi ile çelişmektedir.

Çalışmanın Güçlü Yönleri

Resmi olmayan bakım verenlerin dünyadaki sayıları artmasına rağmen, bu alanda erken dönem uyumsuz şemaların, şema baş etme biçimlerinin ve ebeveynlik stillerinin bakım verme sürecindeki etkilerine dair neredeyse hiçbir şey bilinmemektedir. Literatürdeki bu boşluğu doldurmak için bu çalışma neredeyse hiçbir şeyin yayınlanmadığı bu konulara odaklanmıştır.

Erken dönem uyumsuz şemaları ile yapılan çalışmaların artmasına rağmen şema baş etme biçimleri ile ilgili çalışmalar çok azdır. Karaosmanoğlu, Soygüt ve Kabul (2013)'e göre şema baş etme biçimlerini anlamak psikopatolojiyi daha iyi

anlamak açısından önemlidir. Bu çalışma bakım verenlerin iyilik hali ve şema baş etme biçimlerini inceleyen ilk çalışmadır. Aynı zamanda erken dönem uyumsuz şemalarının ebeveynlik biçimleri ve iyilik hali ilişkisindeki aracı rolünün bakım veren popülasyonuna genellenebilirliği açısından da önemlidir. Bunlara ek olarak, bu çalışma algılanan sosyal desteği de incelemiştir.

Türkiye'de resmi bakım vermenin sınırlı olması, resmi olmayan bakım vermenin beklenenden daha zahmetli ve daha stresli olmasına neden olmaktadır. Bu nedenle bu alanda çalışmak, araştırmaları klinik alana uyarlamak yararlı olabilir.

Çalışmanın Sınırlılıkları

Araştırmadaki cinsiyet dağılımının eşit olmaması analiz açısından bir sınırlılık gibi görünse de bakım veren evreninin de bu şekilde dağılıyor olması bu durumu sınırlılık kategorisinden çıkarabilir.

Demans hastasına bakım veren yetişkin çocuklara ulaşmak, diğer bakım veren çalışmalarında olduğu gibi (Kazak ve ark., 1997; Barrera ve ark., 2004; de Vugt ve ark., 2003; Coope ve ark., 1995) kolay olmamıştır. Bu nedenle, örneklem çalışmaya katılmaya istekli ve zamanı olan kişileri kapsamaktadır.

Bu çalışmada kullanılan bütün ölçekler katılımcıların beyanına dayalıdır. İleriki çalışmalarda daha farklı veri toplama teknikleri, örneğin mülakat tekniği kullanılabilir. Buna ek olarak, örneklemin küçük olması, çalışmanın genellenebilirliğini ve istatistiksel gücünü sınırlandırmaktadır. Ayrıca bu çalışmanın kesitsel çalışma olması neden-sonuç ilişkisinden bahsetmeyi imkânsız hale getirmektedir. Bu çalışmada bakım verenin özellikleri alınması rağmen, bakım alan demans hastası ile ilgili demansının seviyesi haricinde bir bilgi alınmamıştır. Bu sınırlılıklara rağmen, bakım verenle ilgili çalışmalar azdır ve erken dönem uyumsuz şemalar, şema baş etme biçimleri ve ebeveynlik stilleri daha önce çalışılmamıştır. Bu çalışma bakım verenlerin erken dönem uyumsuz şemalarını, ebeveynlik stillerini ve şema baş etme stillerini inceleyen ilk çalışmadır.

Çalışmanın Katkıları ve Gelecek Çalışmalar için Öneriler

Bu çalışma Şema Terapi'de olduğu gibi erken dönem yaşantıların önemini bakım veren evreninde göstermektedir. Demans hastalarına bakım verenlerin psikolojik problemlerinin tedavi edilmesinde ebeveynleriyle olan erken dönem

yaşantılarının ve şemalarının tedaviye dâhil edilmesi daha iyi sonuçlar almak için önemlidir.

Bu araştırmada algılanan sosyal desteğin koruyucu rolü gösterilmiştir. Algılanan sosyal desteğin arttırılmasına yönelik yapılacak müdahale programları bakım verenlerin iyilik halleri açısından yararlı olabilir.

Gelecek çalışmalarda neden-sonuç ilişkilerini ortaya koymak için boylamsal çalışmalar yapılabilir. Bakım veren ve bakım alan kişinin cinsiyetinin aynı olması ya da farklı olması çalışmanın sonuç değişkenleri açısından incelenebilir. Bu inceleme ve bu çalışmanın tümü farklı örneklemlerle veya farklı kültürlerle de yapılabilir. Buna ek olarak, bu çalışmada erken dönem uyumsuz şemaları, ebeveynlik stilleri ve şema baş etme biçimleri toplam puan olarak kullanılmıştır. İlerleyen çalışmalarda faktör yapılarının incelenmesi daha detaylı bir tablo verebilir. Detaylı bir tablonun yanında, mülakat gibi daha farklı ölçme tekniklerinin kullanılması daha net sonuçlar da sağlayabilir.

Bu çalışmada şema baş etme biçimlerinin herhangi bir biçimleyici rolü bulunmamıştır. Gelecek çalışmalarda bu biçimleyici rol daha farklı örneklemlerle araştırılabilir. Ayrıca, kullanılan ölçeklerin aynı kuramsal geçmişe sahip olması model test edebilme imkânı sağlamaktadır. Gelecek çalışmalarda daha kalabalık bir örneklem grubuyla model test edilip, önleme çalışmaları için risk ve koruyucu faktörler belirlenebilir.

Appendix L: Thesis Photocopying Permission Form

TEZ FOTOKOPİSİ İZİN FORMU

ENSTİTÜ

Fen Bilimleri Enstitüsü ☐

Sosyal Bilimler Enstitüsü ☒

Uygulamalı Matematik Enstitüsü ☐

Enformatik Enstitüsü ☐

Deniz Bilimleri Enstitüsü ☐

YAZARIN

Soyadı: AYRANCI

Adı : ELÇİN

Bölümü: PSİKOLOJİ

TEZİN ADI (İngilizce): The Predictive Roles of Perceived Social Support, Early Maladaptive Schemas, Parenting Styles, and Schema Coping Processes in Well-Being and Burnout Levels of Primary Caregivers of Dementia Patients

TEZİN TÜRÜ: Yüksek Lisans ☒ Doktora ☐

1. Tezimin tamamından kaynak gösterilmek şartıyla fotokopi alınabilir. ☒
2. Tezimin içindekiler sayfası, özet, indeks sayfalarından ve/veya bir bölümünden kaynak gösterilmek şartıyla fotokopi alınabilir. ☐
3. Tezimden bir bir (1) yıl süreyle fotokopi alınamaz. ☐

TEZİN KÜTÜPHANEYE TESLİM TARİHİ: