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 Algılanan SOSYAL Desteğin, ERKEN DÖNEM UYUMSUZ ŞEMALARIN, EBEVEYNLIK STİLLERİNİN VE ŞEMA BAŞ ETME BİÇİMLERİNİN İYİLİK HALİ VE TÜKENMİŞLİK SEVIYELERİ ÜZERİNDEKİ YORDAYICI ROLÜ

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Anahtar Kelimeler: Bakım vermek, Erken Dönem Uyumsuz Şemaları, Ebeveynlik Stilleri, Algılanan Sosyal Destek, Bakıcı İyilik Hali.
To My Grandfathers
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CHAPTER 1

INTRODUCTION

The proportion of the population older than 65 years of age is growing rapidly and this growth will accelerate over the next 25 years in 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 to chronic 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, Grafstrom, & 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 fatigue (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 EMSs are 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

<table>
<thead>
<tr>
<th>Schema Domain</th>
<th>Disconnection &amp; Rejection</th>
<th>Impaired Autonomy &amp; Performance</th>
<th>Impaired Limits</th>
<th>Other Directedness</th>
<th>Overvigilance &amp; Inhibition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandonment/ Instability</td>
<td>Dependence Incompetence</td>
<td>Entitlement/ Grandiosity</td>
<td>Subjugation</td>
<td>Negativity/ Pessimism</td>
<td></td>
</tr>
<tr>
<td>Mistrust/ Abuse</td>
<td>Vulnerability to Harm or Illness</td>
<td>Insufficient Self-Control/ Self-Discipline</td>
<td>Self-Sacrifice</td>
<td>Emotional Inhibition</td>
<td></td>
</tr>
<tr>
<td>Emotional Deprivation</td>
<td>Enmeshment/ Undeveloped Self</td>
<td>Approval Seeking/ Recognition Seeking</td>
<td>Unrelenting Standards/ Hypercriticalness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Maladaptive Schemas</td>
<td>Defectiveness/ Shame</td>
<td>Failure</td>
<td></td>
<td>Punitiveness</td>
<td></td>
</tr>
<tr>
<td>Social Isolation/ Alienation</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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 temper 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

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

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

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

Adapted from Soygüt, Karaosmanoğlu, and Çakır (2003)
After giving brief information on EMSs, 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 (Kaçıcı & 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 highlighted 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, Zunalde, & 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, Kołosko, & 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 (Saritas, 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 (Kapcì & Hamamci, 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,
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 relationship between parenting styles and outcome variables:
   I. Early maladaptive schemas will mediate the relationship between parenting styles and caregiver well-being.
   II. Early maladaptive schemas will mediate the relationship between parenting styles and depression.
   III. Early maladaptive schemas will mediate 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 or doctoral 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 working 36.4% ($n = 36$). 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

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<th>%</th>
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<tr>
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<td>25</td>
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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 severely demented 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, working status, 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, incompetence, dependency, vulnerability to harm, enmeshment, subjugation of needs, self-sacrifice,
emotional inhibition, unrelenting standards, entitlement, and insufficient self-control (Schmidt, Joiner, Young, & Telch, 1995; Welburn, Coristine, Dagg, Pontefract, & Jordan, 2002). These two versions of the Young Schema Questionnaire had similar psychometric properties (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 ($\alpha = .65$), and cognitive/emotional
avoidance ($\alpha = .78$), and for total inventory ($\alpha = .79$) (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, discriminant validity, 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 properties 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, separate 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

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

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*

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

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

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(m)</td>
<td>(sd)</td>
</tr>
<tr>
<td>Activity of Living</td>
<td>70.63</td>
<td>12.41</td>
</tr>
</tbody>
</table>

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 needs as 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*

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Caregiver Well-Being Basic Needs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>85.10 11.56</td>
<td>Unmarried</td>
</tr>
<tr>
<td>Unmarried</td>
<td>75.31 14.96</td>
<td>t(97)</td>
</tr>
</tbody>
</table>

**Note.**  **p< .01**

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

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*

<table>
<thead>
<tr>
<th>Having Children</th>
<th>Childless</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver Well-Being Basic Needs</td>
<td>83.19 12.82</td>
<td>75.88 15.36</td>
</tr>
</tbody>
</table>

**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*

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>t(97)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Styles</td>
<td>178.96</td>
<td>155.99</td>
<td>2.03*</td>
</tr>
<tr>
<td></td>
<td>49.27</td>
<td>30.82</td>
<td></td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th></th>
<th>Having a Physical Illness</th>
<th>No Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Styles</td>
<td>m = 192.21, sd = 54.38</td>
<td>m = 166.59, sd = 41.42</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Working</th>
<th>Not Working</th>
<th>t (97)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Style</td>
<td>m = 158.88, sd = 43.99</td>
<td>m = 182.78, sd = 46.45</td>
<td>2.51*</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Married</th>
<th>Unmarried</th>
<th>t (97)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>m</td>
<td>sd</td>
<td>m</td>
</tr>
<tr>
<td>Perceived Social Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSS-Total</td>
<td>68.17</td>
<td>14.69</td>
<td>58.62</td>
</tr>
<tr>
<td>PSS-Family</td>
<td>25.72</td>
<td>3.21</td>
<td>22.50</td>
</tr>
<tr>
<td>PSS- Significant Others</td>
<td>20.31</td>
<td>7.91</td>
<td>16.28</td>
</tr>
</tbody>
</table>

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 of perceived 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 participants who 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**

<table>
<thead>
<tr>
<th></th>
<th>Having Children</th>
<th>Childless</th>
<th>(t) (97)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(m)</td>
<td>(sd)</td>
<td>(m)</td>
</tr>
<tr>
<td>Perceived Social Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSS-total</td>
<td>66.57</td>
<td>15.31</td>
<td>57.93</td>
</tr>
<tr>
<td>PSS-Family</td>
<td>25.23</td>
<td>3.98</td>
<td>22.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th></th>
<th>Having a Physical Illness</th>
<th>Having No Physical Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Social Support</td>
<td>$m$  $sd$</td>
<td>$m$  $sd$  $t$ (97)</td>
</tr>
<tr>
<td>PSS-friends</td>
<td>19.10 7.63</td>
<td>22.35 6.87 2.07&quot;</td>
</tr>
</tbody>
</table>

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*

<table>
<thead>
<tr>
<th></th>
<th>At most High School Degree</th>
<th>At least University Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( m )</td>
<td>( sd )</td>
</tr>
<tr>
<td>Depression</td>
<td>12.34</td>
<td>7.60</td>
</tr>
</tbody>
</table>

*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*

<table>
<thead>
<tr>
<th></th>
<th>Working</th>
<th>Not Working</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( m )</td>
<td>( sd )</td>
</tr>
<tr>
<td>Depression</td>
<td>8.14</td>
<td>6.73</td>
</tr>
</tbody>
</table>

*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 difference between 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

<table>
<thead>
<tr>
<th></th>
<th>Having a Psychological Disorder</th>
<th>Not Having a Psychological Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(m)</td>
<td>(sd)</td>
</tr>
<tr>
<td>Depression</td>
<td>15.29</td>
<td>9.16</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th></th>
<th>Working</th>
<th>Not Working</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>m</td>
<td>sd</td>
</tr>
<tr>
<td>Schema Coping Processes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>122.92</td>
<td>16.37</td>
</tr>
</tbody>
</table>

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 Working Status 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

<table>
<thead>
<tr>
<th></th>
<th>Working</th>
<th>Not Working</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>m</td>
<td>sd</td>
</tr>
<tr>
<td>Burnout-total</td>
<td>47.14</td>
<td>9.60</td>
</tr>
</tbody>
</table>

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 \( (r = -0.25, p < 0.05) \), 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*

<table>
<thead>
<tr>
<th>Variables</th>
<th>YSQ</th>
<th>BDI</th>
<th>BN</th>
<th>AL</th>
<th>MSPSS</th>
<th>PSSFA</th>
<th>PSSFR</th>
<th>PSSSO</th>
<th>YCI</th>
<th>YRAI</th>
<th>YPI</th>
<th>MBI</th>
</tr>
</thead>
<tbody>
<tr>
<td>YSQ</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>BDI</td>
<td>.48**</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>BN</td>
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<td>-.50**</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AL</td>
<td>-.18</td>
<td>-.36**</td>
<td>.67**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSPSS</td>
<td>-.25</td>
<td>-.28**</td>
<td>.49**</td>
<td>.34**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSSFA</td>
<td>-.18</td>
<td>-.22**</td>
<td>.42**</td>
<td>.26**</td>
<td>.53**</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>PSSFR</td>
<td>-.25</td>
<td>-.29**</td>
<td>.41**</td>
<td>.30**</td>
<td>.85**</td>
<td>.21**</td>
<td>1</td>
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<td></td>
</tr>
<tr>
<td>PSSSO</td>
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<td>-.17</td>
<td>.36**</td>
<td>.25**</td>
<td>.90**</td>
<td>.28**</td>
<td>.67**</td>
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</tr>
<tr>
<td>YCI</td>
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<td>.06</td>
<td>.01</td>
<td>-.07</td>
<td>.06</td>
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<td>1</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>YRAI</td>
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<td>.33**</td>
<td>-.17</td>
<td>-.15</td>
<td>-.14</td>
<td>-.09</td>
<td>-.09</td>
<td>-.13</td>
<td>.34**</td>
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</tr>
<tr>
<td>YPI</td>
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<td>.22**</td>
<td>-.13</td>
<td>-.25**</td>
<td>-.16</td>
<td>-.28**</td>
<td>-.15</td>
<td>.23**</td>
<td>.24**</td>
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<td></td>
</tr>
<tr>
<td>MBI</td>
<td>.28**</td>
<td>.33**</td>
<td>-.27**</td>
<td>-.20**</td>
<td>-.32**</td>
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<td>-.32**</td>
<td>-.21**</td>
<td>.26**</td>
<td>.07</td>
<td>.44**</td>
<td>1</td>
</tr>
</tbody>
</table>

*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 \( (r = 0.28, p < 0.01) \); and perceived social support from friends \( (r = 0.67, p < 0.01) \). Perceived social support from
friends, also had a significant association with parenting styles ($r = -0.28, p < .01$), 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 ($r = -0.32, p < .01$), indicating that higher levels of burnout were associated with lower perception of social support from friends; schema coping strategies-compensation ($r = 0.26, p < .01$), meaning that participants reported higher levels of burnout were more likely to use schema coping strategies-compensation; and parenting styles ($r = 0.44, p < .01$), 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 ($r = 0.35, p < .01$), 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 variable after 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 \( pr = -.22, \beta = -.22, t(97) = -2.18, p < .05 \) 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 \( pr = -.28, \beta = -.28, t(97) = -2.84, p < .01 \) 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 \( pr = -.22, \beta = -.11, t(96) = -1.04, p = .30 \) 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 \( pr = .45, \beta = .45, t (97) = 4.96, p < .001 \) 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

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>Predictor</th>
<th>β</th>
<th>t</th>
<th>df</th>
<th>F</th>
<th>pr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Needs</td>
<td>1. Parenting</td>
<td>-.22</td>
<td>-2.18*</td>
<td>1.97</td>
<td>4.73*</td>
<td>-.22</td>
</tr>
<tr>
<td></td>
<td>2. Early</td>
<td>-.28</td>
<td>-2.84**</td>
<td>1.97</td>
<td>8.09**</td>
<td>-.28</td>
</tr>
<tr>
<td>Maladaptive</td>
<td>Schemas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Parenting Styles)</td>
<td>-.11</td>
<td>-1.04</td>
<td>-</td>
<td>-</td>
<td>-.22</td>
<td>-</td>
</tr>
<tr>
<td>EMS</td>
<td>1. Parenting</td>
<td>.45</td>
<td>4.96***</td>
<td>1.97</td>
<td>24.61***</td>
<td>.45</td>
</tr>
</tbody>
</table>

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 \([pr = -.13, \beta = -.13, t(97) = -1.25, p = .21]\) 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 \([pr = -.18, \beta = -.18, t(97) = -1.76, p = .08]\) 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 \([pr = -.18, \beta = -.15, t(96) = -1.33, p = .19]\). 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

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>Predictor</th>
<th>(\beta)</th>
<th>(t)</th>
<th>(df)</th>
<th>(F)</th>
<th>(pr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity of Living</td>
<td>1. Parenting</td>
<td>-.13</td>
<td>-1.25&lt;sup&gt;ns&lt;/sup&gt;</td>
<td>1.97</td>
<td>1.57&lt;sup&gt;ns&lt;/sup&gt;</td>
<td>-.13</td>
</tr>
<tr>
<td></td>
<td>2. EMS</td>
<td>-.18</td>
<td>-1.76&lt;sup&gt;ns&lt;/sup&gt;</td>
<td>1.97</td>
<td>3.08&lt;sup&gt;ns&lt;/sup&gt;</td>
<td>-.18</td>
</tr>
<tr>
<td>(Parenting Styles)</td>
<td></td>
<td>-.15</td>
<td>-1.33&lt;sup&gt;ns&lt;/sup&gt;</td>
<td>-</td>
<td>-</td>
<td>-.18</td>
</tr>
<tr>
<td>EMS</td>
<td>1. Parenting</td>
<td>.45</td>
<td>4.96***</td>
<td>1.97</td>
<td>24.61***</td>
<td>.45</td>
</tr>
</tbody>
</table>

Note 1. <sup>ns</sup>=non-significant, ***<sup>p</sup>&lt;.001

Note 2. EMS = Early Maladaptive Schemas
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 \[ pr = .45, \beta = .45, t(97) = 4.96, p < .001 \] 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 \[ pr = .44, \beta = .44, t(97) = 4.84, p < .001 \] 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 \[ pr = .28, \beta = .28, t(97) = 2.84, p < .01 \] 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 \[ pr = .44, \beta = .40, t(97) = 3.89, p < .001 \] 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 styles and 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 \[ pr = .45, \beta = .45, t(96) = 4.96, p < .001 \] 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*

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>Predictor</th>
<th>( \beta )</th>
<th>( t )</th>
<th>( df )</th>
<th>( F )</th>
<th>( pr )</th>
<th>( F )</th>
<th>( pr )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>1. Parenting</td>
<td>.44</td>
<td>4.84***</td>
<td>1.97</td>
<td>23.45***</td>
<td>.44</td>
<td>.20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Styles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. EMS</td>
<td>.28</td>
<td>2.84**</td>
<td>1.97</td>
<td>8.08**</td>
<td>.28</td>
<td>.08</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Parenting Styles)</td>
<td>.40</td>
<td>3.89***</td>
<td>-</td>
<td>-</td>
<td>.44</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>EMS</td>
<td>1. Parenting</td>
<td>.45</td>
<td>4.96***</td>
<td>1.97</td>
<td>24.61***</td>
<td>.45</td>
<td>.20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Styles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

*Note 2. EMS = Early Maladaptive Schemas*
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 \( [pr = .33, \beta = .33, t(97) = 3.43, p < .01] \) 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 \( [pr = .48, \beta = .48, t(97) = 5.36, p < .001] \) 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 depression decreased \( [pr = .33, \beta = .14, t(96) = 1.44, p = .15] \) 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

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>Predictor</th>
<th>β</th>
<th>t</th>
<th>df</th>
<th>F</th>
<th>pr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>1. Parenting Styles</td>
<td>.33</td>
<td>3.43**</td>
<td>1.97</td>
<td>11.76**</td>
<td>.33</td>
</tr>
<tr>
<td></td>
<td>2. EMS (Parenting Styles)</td>
<td>.48</td>
<td>5.48***</td>
<td>1.97</td>
<td>28.70***</td>
<td>.48</td>
</tr>
<tr>
<td>EMS</td>
<td>1. Parenting Styles</td>
<td>.45</td>
<td>4.96***</td>
<td>1.97</td>
<td>24.61***</td>
<td>.45</td>
</tr>
</tbody>
</table>

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 \( pr = .45, \beta = .45, t(97) = 4.96, p < .001 \) 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*

<table>
<thead>
<tr>
<th>IV</th>
<th>Mediator</th>
<th>DV</th>
<th>Mediation</th>
<th>Sobel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Styles</td>
<td>EMS</td>
<td>Basic Needs</td>
<td>Yes</td>
<td>Significant</td>
</tr>
<tr>
<td>Parenting Styles</td>
<td>EMS</td>
<td>Activity of Living</td>
<td>No</td>
<td>---</td>
</tr>
<tr>
<td>Parenting Styles</td>
<td>EMS</td>
<td>Burnout</td>
<td>Yes</td>
<td>Significant</td>
</tr>
<tr>
<td>Parenting Styles</td>
<td>EMS</td>
<td>Depression</td>
<td>Yes</td>
<td>Significant</td>
</tr>
</tbody>
</table>

*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, variables were 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

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Moderator</th>
<th>Outcome</th>
<th>Moderation</th>
<th>Significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Moderation</td>
<td>EMS</td>
<td>PSS</td>
<td>BN</td>
<td>Yes</td>
</tr>
<tr>
<td>2nd Moderation</td>
<td>EMS</td>
<td>PSS</td>
<td>AL</td>
<td>No</td>
</tr>
<tr>
<td>3rd Moderation</td>
<td>EMS</td>
<td>PSS</td>
<td>Depression</td>
<td>No</td>
</tr>
<tr>
<td>4th Moderation</td>
<td>EMS</td>
<td>PSS</td>
<td>Burnout</td>
<td>No</td>
</tr>
<tr>
<td>1st Moderation</td>
<td>EMS</td>
<td>Avoidance</td>
<td>BN</td>
<td>No</td>
</tr>
<tr>
<td>2nd Moderation</td>
<td>EMS</td>
<td>Avoidance</td>
<td>AL</td>
<td>No</td>
</tr>
<tr>
<td>3rd Moderation</td>
<td>EMS</td>
<td>Avoidance</td>
<td>Depression</td>
<td>No</td>
</tr>
<tr>
<td>4th Moderation</td>
<td>EMS</td>
<td>Avoidance</td>
<td>Burnout</td>
<td>No</td>
</tr>
<tr>
<td>1st Moderation</td>
<td>EMS</td>
<td>Compensation</td>
<td>BN</td>
<td>No</td>
</tr>
<tr>
<td>2nd Moderation</td>
<td>EMS</td>
<td>Compensation</td>
<td>AL</td>
<td>No</td>
</tr>
<tr>
<td>3rd Moderation</td>
<td>EMS</td>
<td>Compensation</td>
<td>Depression</td>
<td>No</td>
</tr>
<tr>
<td>4th Moderation</td>
<td>EMS</td>
<td>Compensation</td>
<td>Burnout</td>
<td>No</td>
</tr>
<tr>
<td>1st Moderation</td>
<td>EMS</td>
<td>PSS-from Family</td>
<td>BN</td>
<td>No</td>
</tr>
<tr>
<td>2nd Moderation</td>
<td>EMS</td>
<td>PSS-from Friends</td>
<td>BN</td>
<td>No</td>
</tr>
<tr>
<td>3rd Moderation</td>
<td>EMS</td>
<td>PSS-from S.O.</td>
<td>BN</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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 ($\beta = -.18$, $t(96)= -2.04$, $p < .05$), and perceived social support ($\beta = .41$, $t(96)= 4.52$, $p < .001$). 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 ($\beta = .18$, $t(95)=2.06$, $p < .05$, $AR^2= .03$), ($F_{change}(1,95) = 4.25$, $p < .05$) 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, $\beta$, $R^2$ change 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

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SEB</th>
<th>β</th>
<th>t</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>.27</td>
<td></td>
<td></td>
<td></td>
<td>17.64***</td>
<td>2.96</td>
<td></td>
</tr>
<tr>
<td>EMS</td>
<td>-.06</td>
<td>.03</td>
<td>-.18*</td>
<td>-2.04*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSS</td>
<td>.35</td>
<td>.08</td>
<td>.41***</td>
<td>4.52***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td>.03</td>
<td></td>
<td>.18*</td>
<td>2.06*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSS X EMS</td>
<td>.00</td>
<td>.00</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

**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 |
|---|---|---|---|---|---|---|
| Variable | B | SE B | β | t | ΔR² | ΔF | df |
| Step 1 | | | | | | | |
| EMS | -.03 | .03 | -.10ns | -1.02ns | ns | -1.02 | 96 |
| PSS | .25 | .08 | .31** | 3.01** | | | 96 |
| Step 2 | | | | | | | |
| PSS X EMS | .00 | .00 | .04ns | .36ns | ns | .36 | 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, ΔR²=.00), (Fchange(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, R² 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 ($\beta = .44, t(96)=4.88, p< .001$), ($F(2,96) = 16.66, p< .001$). On the other hand, perceived social support was not significantly associated with depression ($\beta = -.15, t(96) = -1.64, p = .10$). The interaction of perceived social support and early maladaptive schemas was also not significant ($\beta = -.11, t(95) = -1.18, p = .24$, $\Delta R^2= .01$), ($F_{\text{change}}(1,95) = 1.40, p = .24$). In other words, perceived social support did not moderate the relationship between early maladaptive schemas and depression. The corresponding B, Standard Error of B, $\beta$, $R^2$ 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

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$\Delta R^2$</th>
<th>$\Delta F$</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>.26</td>
<td></td>
<td></td>
<td></td>
<td>16.66***</td>
<td></td>
<td>2.96</td>
</tr>
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<td>EMS</td>
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<td>.02</td>
<td>.44***</td>
<td>4.88*</td>
<td></td>
<td></td>
<td>96</td>
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<td>PSS</td>
<td>-.07</td>
<td>.04</td>
<td>-.15ns</td>
<td>-1.64ns</td>
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<td></td>
<td>96</td>
</tr>
<tr>
<td>Step 2</td>
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<td></td>
<td></td>
<td>1.40ns</td>
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<td>1.95</td>
</tr>
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<td>.00</td>
<td>-.11ns</td>
<td>-1.18ns</td>
<td></td>
<td></td>
<td>95</td>
</tr>
</tbody>
</table>

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, ΔR² = .00), (Fchange(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, R² change 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

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.14</td>
<td>7.90**</td>
<td>2.96</td>
</tr>
<tr>
<td>EMS.05</td>
<td>.03</td>
<td>.03</td>
<td>.21</td>
<td>2.12*</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>PSS</td>
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<td>.07</td>
<td>-.27**</td>
<td>-2.73**</td>
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<td></td>
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</tr>
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<td></td>
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<td>.30ns</td>
<td>1.95</td>
</tr>
<tr>
<td>PSS X EMS</td>
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<td>.00</td>
<td>.05ns</td>
<td>.55ns</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ($\beta = -.26, t(96)= -2.43, p < .05), (F(2,96) = 4.46, p< .05)$. On the other hand, schema coping processes of avoidance was not significantly associated with caregiver well-being-basic needs ($\beta = -.09, t(96) = -.84, p = .41$). The interaction of schema coping processes of avoidance and early maladaptive schemas was also not significant ($\beta = .05, t(95) = .50, p = .62, \Delta R^2 = .00), (F_{change}(1,95) = .25, p = .62)$. 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, $\beta$, $R^2$ change and $F$ change values; and d.f. values for the $F_{change}$ 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

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>$\Delta R^2$</th>
<th>$\Delta F$</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
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<td>.09</td>
<td></td>
<td>4.46*</td>
<td>2.96</td>
<td></td>
</tr>
<tr>
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<td>.03</td>
<td>-.26*</td>
<td>-2.43*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
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<td>.08</td>
<td>-.09ns</td>
<td>-.84ns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
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<td></td>
<td>.00</td>
<td></td>
<td>.25ns</td>
<td>1.95</td>
<td></td>
</tr>
<tr>
<td>Avoidance X EMS</td>
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<td>.00</td>
<td>.05ns</td>
<td>.50ns</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ($\beta = -.14$, $t(96) = -1.35$, $p = .18$), ($F(2,96) = 2.08$, $p = .13$). In addition, schema coping processes of avoidance was not significantly associated with caregiver well-being-activity of living ($\beta = -.11$, $t(96) = -.99$, $p = .33$). The interaction of schema coping processes of avoidance and early maladaptive schemas was also not significant ($\beta =$
.02, t(95) = .24, p = .81, ΔR^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^2 change 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

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
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<th>β</th>
<th>t</th>
<th>ΔR^2</th>
<th>ΔF</th>
<th>df</th>
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<td></td>
</tr>
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<td>.03</td>
<td>-.14</td>
<td>-.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
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<td>.08</td>
<td>-.11</td>
<td>-.99</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
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<td></td>
<td>.00</td>
<td>.06</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Avoidance X EMS</td>
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<td>.00</td>
<td>.02</td>
<td>.24</td>
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</tbody>
</table>

Note 1. *ns* = non-significant

Note 2. EMS = Early Maladaptive Schemas

3.5.2.3. Moderating Role of Schema 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 ($\beta = .40, t(96) = 4.25, p < .001$) and schema coping processes of avoidance ($\beta = .22, t(96) = 2.34, p < .05$). 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 ($\beta = .11, t(95) = 1.24, p = .22, \Delta R^2 = .01$), ($F_{\text{change}}(1, 95) = 1.54, p = .22$), that is, schema coping processes of avoidance did not moderate the relationship between early maladaptive schemas and depression. The corresponding $B$, Standard Error of $B$, $\beta$, $R^2$, $\Delta R^2$ 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

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>SE $B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$\Delta R^2$</th>
<th>$\Delta F$</th>
<th>df</th>
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<td></td>
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<td>17.29***</td>
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<td>2,96</td>
</tr>
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<td>.02</td>
<td>.40***</td>
<td>4.25</td>
<td></td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>Avoidance</td>
<td>.09</td>
<td>.04</td>
<td>.22*</td>
<td>2.34</td>
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<td></td>
<td>96</td>
</tr>
<tr>
<td>Step 2</td>
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<td>1.54 ns</td>
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<td>1,95</td>
</tr>
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<td>.00</td>
<td>.11 ns</td>
<td>1.24</td>
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<td>95</td>
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</table>

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

Note 2. EMS = Early Maladaptive Schemas
3.5.2.4. Moderating Role of Schema 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

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df</th>
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</thead>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS</td>
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<td>.03</td>
<td>.31**</td>
<td>3.00**</td>
<td></td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>Avoidance</td>
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<td>.07</td>
<td>-.05ns</td>
<td>-.05ns</td>
<td></td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>Step 2</td>
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<td></td>
<td></td>
<td></td>
<td>.03</td>
<td>3.09ns</td>
<td>1.95</td>
</tr>
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<td>.00</td>
<td>-.17ns</td>
<td>-.17ns</td>
<td></td>
<td></td>
<td>95</td>
</tr>
</tbody>
</table>

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 ($\beta = .31$, $t(96) = 3.00$, $p<.01$), ($F(2,96) = 4.02$, $p<.05$). However, schema coping processes of avoidance was not significantly associated with burnout ($\beta = -.05$, $t(96) = -.05$, $p = .66$). In addition, the interaction of schema coping processes of avoidance and early maladaptive schemas was not significant ($\beta = -.17$, $t(95) = -1.76$, $p = .08$, $1.95$)
\[ \Delta R^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 \( B \), \( \beta \), \( R^2 \) change 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 \((\beta = -.45, t(96) = -3.97, p < .001), (F(2,96) = 7.40, p < .01) \). Schema coping processes of compensation was also significantly associated with caregiver well-being-basic needs \((\beta = .29, t(96) = 2.63, p < .05) \). However, the interaction of schema coping processes of compensation and early maladaptive schemas was not significant \((\beta = .12, t(95) = 1.22, p = .23, \Delta R^2 = .01), (F_{change}(1,95) = 1.49, p = .23) \), 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, $\beta$, $R^2$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*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>SE $B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$\Delta R^2$</th>
<th>$\Delta F$</th>
<th>df</th>
</tr>
</thead>
<tbody>
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<td>-3.97***</td>
<td></td>
<td></td>
<td>2.96</td>
</tr>
<tr>
<td>EMS</td>
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<td>.03</td>
<td>-.45***</td>
<td>-3.97***</td>
<td>96</td>
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<tr>
<td>Compensation</td>
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<td>.06</td>
<td>.29*</td>
<td>2.63*</td>
<td></td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>Step 2</td>
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<td>.12ns</td>
<td>1.22ns</td>
<td></td>
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<td>.00</td>
<td>.12ns</td>
<td>1.22ns</td>
<td></td>
<td></td>
<td>95</td>
</tr>
</tbody>
</table>

*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 \( (\beta = -.27, t(96) = -2.31, p < .05) \), \( (F(2, 96) = 2.19, p = .12) \). However, schema coping processes of compensation was not significantly associated with caregiver well-being-activity of living \( (\beta = -.15, t(96) = 1.26, p = .21) \). The interaction of schema coping processes of compensation and early maladaptive schemas was also not significant \( (\beta = .12, t(95) = 1.21, p = .23, \Delta R^2 = .02, (F_{change}(1, 95) = 1.46, p = .23) \), 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, \( \beta \), \( R^2 \) change 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*

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>( \beta )</th>
<th>( t )</th>
<th>( \Delta R^2 )</th>
<th>( \Delta F )</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS</td>
<td>-.08</td>
<td>.03</td>
<td>-.27*</td>
<td>-2.31*</td>
<td></td>
<td></td>
<td>96</td>
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<td>Compensation</td>
<td>.07</td>
<td>.06</td>
<td>.15ns</td>
<td>1.26ns</td>
<td></td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation X EMS</td>
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<td>.00</td>
<td>.12ns</td>
<td>1.21ns</td>
<td></td>
<td></td>
<td>95</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
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<td>.59</td>
<td>5.57</td>
<td>.59</td>
<td>5.57</td>
<td>96</td>
</tr>
<tr>
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<td>.03</td>
<td>-.19</td>
<td>-.19</td>
<td>-.19</td>
<td>-.19</td>
<td>96</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation X EMS</td>
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<td>.00</td>
<td>-.06</td>
<td>-.06</td>
<td>-.06</td>
<td>-.06</td>
<td>95</td>
</tr>
</tbody>
</table>

Note 1. *=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 (β = .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 (β = -.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, $\beta$, $R^2$ 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*

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$\Delta R^2$</th>
<th>$\Delta F$</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>.10</td>
<td>5.05</td>
<td><strong>2.96</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS</td>
<td>.05</td>
<td>.03</td>
<td>.21$^{**}$</td>
<td>1.80$^{**}$</td>
<td>96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation</td>
<td>.06</td>
<td>.05</td>
<td>.15$^{**}$</td>
<td>1.32$^{**}$</td>
<td>96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td>.00</td>
<td>.32$^{**}$</td>
<td>1.95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation X EMS</td>
<td>-.00</td>
<td>.00</td>
<td>-.06$^{**}$</td>
<td>-.56$^{**}$</td>
<td>95</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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 ($\beta = .21, t(96) = 1.80, p = .07$) and schema coping processes of compensation ($\beta = .15, t(96) = 1.32, p = .19$) 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 ($\beta = -.06, t(95) = -.56, p = .57, \Delta R^2 = .00$), ($F_{change}(1,95) = .32, p = .57$), that is, schema coping processes of compensation did not moderate the relationship between early maladaptive schemas and burnout. The corresponding $B$, Standard Error of $B$, $\beta$, $R^2$ change 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 Support from Family

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS</td>
<td>-.06</td>
<td>.03</td>
<td>-.21</td>
<td>-2.21</td>
<td></td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>PSSFA</td>
<td>1.10</td>
<td>.28</td>
<td>.39</td>
<td>3.93</td>
<td>***</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSSFA X EMS</td>
<td>-.00</td>
<td>.00</td>
<td>-.02</td>
<td>-.19</td>
<td></td>
<td></td>
<td>95</td>
</tr>
</tbody>
</table>

Note 1. **=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 ($\beta = -.21, t(96) = -2.21, p<.05$). ($F(2,96) = 13.20, p<.001$). Perceived social support from family revealed a significant relationship with caregiver well-being-basic needs ($\beta = .39, t(96) = 3.93, p<.001$),
too. However, the interaction of perceived social support from family and early maladaptive schemas was not significant ($\beta = -.02$, $t(95) = -.19$, $p = .85$, $\Delta R^2 = .00$), ($F_{change}(1,95) = .04$, $p = .85$), 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, $\beta$, $R^2$ change 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*

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$\Delta R^2$</th>
<th>$\Delta F$</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>.20</td>
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<td>2.96</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS</td>
<td>-.06</td>
<td>.03</td>
<td>-.19$^*$</td>
<td>-2.01$^*$</td>
<td>96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSSFR</td>
<td>.59</td>
<td>.18</td>
<td>.32**</td>
<td>3.29**</td>
<td>96</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Step 2       | .03 | 3.70
| PSSFR X EMS  | .01 | .00 | .18** | 1.92** | 95 |

*Note 1. *$^\text{ns}$=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 ($\beta = -0.19$, $t(96) = -2.01$, $p < 0.05$), ($F(2,96) = 11.97$, $p < 0.001$) and perceived social support from friends ($\beta = 0.32$, $t(96) = 3.29$, $p < 0.01$). 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 ($\beta = 0.18$, $t(95) = 1.92$, $p = 0.06$, $\Delta R^2 = 0.03$), ($F_{\text{change}}(1,95) = 3.70$, $p = 0.06$) on the relationship between early maladaptive schemas and caregiver well-being-basic needs. The corresponding $B$, Standard Error of $B$, $\beta$, $R^2$ 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 ($\beta = -0.24$, $t(96) = -2.70$, $p < 0.01$), ($F(2,96) = 10.63$, $p < 0.001$). On the other hand, perceived social support from significant others was significantly and positively associated with caregiver well-being-basic needs ($\beta = 0.32$, $t(96) = 3.51$, $p < 0.01$). In addition, the interaction of perceived social support from significant others and early maladaptive schemas was significant ($\beta = 0.26$, $t(95) = 2.88$, $p < 0.01$, $\Delta R^2 = 0.07$), ($F_{\text{change}}(1,95) = 8.29$, $p < 0.01$), 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, $\beta$, $R^2$ change 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 Support from Significant Others*

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>$\beta$</th>
<th>t</th>
<th>$\Delta R^2$</th>
<th>$\Delta F$</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>.18</td>
<td></td>
<td></td>
<td></td>
<td>10.63***</td>
<td>2.96</td>
<td></td>
</tr>
<tr>
<td>EMS</td>
<td>-.07</td>
<td>.03</td>
<td>-.24**</td>
<td>-2.70**</td>
<td></td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>PSSSO</td>
<td>.52</td>
<td>.15</td>
<td>.32**</td>
<td>3.51***</td>
<td></td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>Step 2</td>
<td>.07</td>
<td></td>
<td></td>
<td></td>
<td>8.29**</td>
<td>1.95</td>
<td></td>
</tr>
<tr>
<td>PSSSO X EMS</td>
<td>.01</td>
<td>.00</td>
<td>.26**</td>
<td>2.88**</td>
<td></td>
<td></td>
<td>95</td>
</tr>
</tbody>
</table>

*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 ± 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 from significant others is low ($\beta = -0.50$, $t(95) = -3.82$, $p < 0.001$) but not when perceived social support is high ($\beta = 0.01$, $t(95) = 0.09$, $p = 0.93$).

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, strengths 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 are closely associated.

Thirdly, the levels of having a psychological disorder differentiated significantly on 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 participants had 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 among the 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 & Karşı, 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

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 & Karśli, 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 associated with caregiver well-being (Demirtepe & Bozo, 2009; Grant, Guille, & Sen, 2013; Melamed, Kushner, & 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 interfering 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 performed on bigger samples to determine risk and protective factors caregiver well-being.

4.8. Conclusion

The current study aimed at testing 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 among perceived 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 lead 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 surprising. 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 support and 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 limited the 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.
REFERENCES


a measure of the severity of depression. *Journal of Affective Disorders, 156*, 240–244.


Tuna, M., & Olgun, N. (2010). The role of perceived social support on stroke patients’ caregivers who have the burnout syndrome. *Hacettepe University Faculty of Health Sciences Nursing Journal, 41–52.*


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APPENDICES

APPENDIX A. Informed Consent Form

(Gönüllü Katılım Formu)

Sayın Katılımcı;

Bu çalışmada 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.


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 yayınlarda kullanılmasını kabul ediyorum. (Formu doldurup imzaladıktan sonra uygulayıcıya geri veriniz).

Ad Soyad

Tarih

İmza

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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 __________

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 seçeneğin 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 hastalığı var mı?
Varsa nedir?

Şu anda herhangi bir tedavi görüyor musunuz? ______ Evet ______ Hayır

Evet ise nedir?

Bakım verdiğiınız hastanızın demans düzeyi:
Hafif _____
Orta _____
Ağır _____

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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 hissettüğünize dayanarak cevap verin.

Bir kaç soru, anne babanızla ilişkiniz hakkında. 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 şirki 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 geçirilen, 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) hayatında neredeyse hiçbir şeyi diğer insanlar kadar iyi yapamıyorum.
7. _____ Günlük yaşamımı tek başına idare edebilme becerisine sahip olduğumu hissetmiyorum.
8. _____ Kötü bir şey olacağı duygusundan Kurtulamıyorum.
9. _____ Anne babamdan ayrılmayı, bağımsız hareket edebilmeyi, yaşatlıklarım kadar, başaramadım.
10. _____ Eğer istediğimi yaparsam, başımı derde sokarım diye düşünürüm.
11. _____ Genellikle yakınlarına ilgi gösteren ve bakan ben olurum.
12. _____ Olumlu duygularımı diğerlerine göstermekten utanıyorum (sevdigimi, önmesedigimi göstermek gibi).
13. _____ Yaptığım çoğu şeyde en iyi olmuşum; ikinci olmayı kabul etmem.
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 görüşe bile, bunun bozulacağıını hissedirim.
18. _____ Eğer bir yanlış yaparsam, cezalandırılmayı hak ederim.
19. _____ Çevremde bana sıcaklık, koruma ve duygusal yakınluk gösteren kimsem yok.
20. _____ Diğer insanlara o kadar muhtacım ki onları kaybedecekim diye çok endişeleniyorum.
21. _____ İnsanlar karşı tedbiri elden bırakamam yoksa bana kasıtlı olarak zarar vereceklerini hissedermi.
22. _____ Temel olarak diğer insanlardan farklıım.
23. _____ Gerçek beni tanırlarsa beğenmiş olarıma, beni yakın olmak istemez.
24. _____ İşleri halletmede son derece yetersizim.
25. _____ Gündelik işlerde kendimi başkalarına bağlıyorsanız bire birden sorunlarla karşılaşırsanız.
26. _____ Her an bir felaket (doğal, adli, mali veya tıbbi) olabilir diye hissediyorum.
27. _____ Annem, babam ve ben birbirimizin hayatını ve sorunlarıyla aşırı ilgi olmaya eğilimliyiz.
28. _____ Diğer insanların isteklerine uymaktan başka yolum yokmuş gibi hissediyorum; eğer böyle yapmazsam bir çekilde beni reddedeler veya intikam alırlar.
29. _____ Başkalarınızı kendinden daha fazla düşündüğüm için ben iyi bir insanım.
30. _____ Duygularınızı diğerlerine açmayı utanç verici bulurum.
31. _____ En iyisini yapmalıyım, “yeterince iyi” ile yetinmem.
32. _____ Ben özel biriyim ve diğer insanlar için konulmuş olan kısıtlamaları veya sınırları kabul etmek zorunda değilim.
33. _____ Eğer hedefime ulaşamazsam kolaylıkla yılgınlığa düşer ve vazgeçerim.
34. _____ Başkalarının da farkında olduğu başarılar benim için en değerli.
35. _____ İyi bir şey olursa, bunu kötü bir şeyin izleyecekinden endişe ederim.
36. _____ Eğer yanlış yaparsam, bunun özü yoktur.
37. _____ Birisi için özel olduğumu hiç hissetmedim.
38. _____ Yakınlarınızın beni terk edeceğin ya da ayrılanırken endişe duyarım.
39. _____ Herhangi bir anda birleri 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 yanlış birbirinden ayırmakta zorlanırım.
44. _____ Fiziksel bir saldırmaktan endişe duyarım.
45. _____ Annem, babam ve ben özel hayatımızın birbirimizden ziyade saklısak birbirimizi aldattığımız hissederek veya suçluluk duyarız.
46. _____ İlişkilerimde, diğer kişinin yönlendirdiği olmasına hiç veririm.
47. _____ Yakınlarınızla o kadar meşgulüm ki kendime çok az zaman kalıyor.
48. _____ İnsanlarla beraberken içten ve cana yakın olmak benim için zordur.
49. _____ Tüm sorumluluklarınızı yerine getirmek zorundayım.
50. _____ İstediğimi yapmaktan alkonulmaktan veya kısıtlamaktan nefret ederim.
51. _____ Uzun vadeli amaçlara ulaşabilmek için şu andaki zevklerin öneminin de etkilemek zorlanırım.
52. _____ Başkalarından yoğun bir ilgi görmezsem kendimi daha az önemli hissederim.
53. _____ Yeterince dikkatli olmasanz, neredeyse her zaman bir şeyler ters gider.
54. _____ Eğer işimi doğru yapmazsam sonuçlara katlanmam gerekir.
55. _____ Beni gerçekten dinleyen, anlayan veya benim gerçek ihtiyaçlarını ve duygularını önemseyen kimsem olmadı.
56. _____ Önem verdiğim birisinin benden uzaklaştığını sezersem çok kötü hissederm.
57. _____ Diğer insanların niyetleriyle ilgili oldukça şüpheciyimdir.
58. _____ Kendimi diğer insanlara uzak veya kopmuş hissediyorum.
59. _____ Kendimi sevibilecek biri gibi hissetmiyorum.
60. _____ İş (okul) hayatında diğer insanlar kadar yetenekli değilim.
61. _____ Gündelik işler için benim kararlarımı güvenilemez.
62. _____ Tüm paramı kaybedip çok fakir veya zavallı duruma düşmekte 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 adına 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 bırakırlar.
67. _____ Başarmak ve bir şeyleri yapmaktan endişe duyarım.
68. _____ Diğer insanların uydurduğu kurallara ve geleneklere uymak zorunda olmadığını hissediyorum.
69. _____ Benim yararıma olduğunu bilsem bile hoşuma gitmeyen şeyler yapmaya kendimi zorlayanmam.
70. _____ Bir toplantında fikrimi söylediğimde veya bir topluluga tanıtıldığında onaylanmayı ve takdir görmeyi isterim.
71. _____ Ne kadar çok çalışırsem çalışayım, maddi olarak iflas edeceğimden ve neredeyse her şeyimi kaybedeceğimden endişe ederim.
72. _____ Neden yanlış yaptığım önemi yoktur; eğer hata yapıtsam sonucuna da katlanmam gereki.
73. _____ Hayatımda ne yapacağımı bilmediğim zamanlarda uygun bir öneri bulunacak veya beni yönlendirecek kimsem olmadı.
74. _____ İnsanların beni terk edeleceği endişesiyle bazı onları kendimden uzaklaştırm.
75. _____ Genellikle insanların asıl veya art niyetlerini araştırırım.
76. _____ Kendimi hep grupların dışında hissederim.
77. _____ Kabul edilemeyecek pek çok özellikim yüzünden insanlara kendimi açamıyorum ve beni tam olarak tanımlamalarına izin vermeyorum.
78. _____ İş (okul) hayatında diğer insanlar kadar zeki değilim.
79. _____ Ortaya çıkan gelenek sorunları çözüleme konusunda kendime güvenmiyorum.
80. _____ Bir doktor tarafından herhangi bir ciddi hastalık bulunmamasına rağmen bende ciddi bir hastalığın gelişmiş olduğu endişesiine kapılıyorum.
81. _____ Sık sık annemden babamdan ya da eşimden ayrı bir kimliğimin olmadığı hissediyorum.
82. _____ Haklarına saygı duyulmasını ve duygularını hesaba katılmayın istemekte çok zorlanıyorum.
83. _____ Başkaları beni, diğerleri için çok, kendim için az şey yapan biri olarak görürler.
84. _____ Diğerleri beni duygusal olarak soğuk bulurlar.
85. _____ Kendimi sorumluluktan kolayca sıyrıyorum veya hatalarım için gerekçe bulamıyorum.
86. _____ Benim yaptıklarımın, diğer insanların katkılarından daha önemli olduğunu hissediyorum.
87. _____ Kararlarına nadiren sadık kalabilirim.
88. _____ Bir dolu övgü ve iltifat almanın kendimi değerli birisi olarak hissetmemi sağlar.
89. _____ Yanlış bir kararın bir felakete yol açabileceğiinden endişe ederim.
90. _____ Ben cezalandırılmayı hakeden kötü bir insanım.
APPENDIX D. Young Parenting Inventory

(Young Ebeveynlik Ölçeği)


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

<table>
<thead>
<tr>
<th>Anne</th>
<th>Baba</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ____</td>
<td>____ Beni sevdi ve bana özel birisi gibi davranış.</td>
</tr>
<tr>
<td>2. ____</td>
<td>____ Bana vaktini ayırırdı ve özen gösterdi.</td>
</tr>
<tr>
<td>3. ____</td>
<td>____ Bana yol gösterdi ve olumlu yönlendirdi.</td>
</tr>
<tr>
<td>4. ____</td>
<td>____ Beni dinledi, anladı ve duygularımızı karşıtımlı paylaştı.</td>
</tr>
<tr>
<td>5. ____</td>
<td>____ Bana karşı sıcak ve fiziksel olarak şefkatliydi.</td>
</tr>
<tr>
<td>6. ____</td>
<td>____ Ben çocukken öldü veya evi terk etti.</td>
</tr>
<tr>
<td>7. ____</td>
<td>____ Dengesizdi, ne yapacağı belli olmayan veya alkolikti.</td>
</tr>
<tr>
<td>8. ____</td>
<td>____ Kardeş(ler)imi bana tercih etti.</td>
</tr>
<tr>
<td>9. ____</td>
<td>____ Uzun süreler boyunca beni terk etti veya yalnız bıraktı.</td>
</tr>
<tr>
<td>10. ____</td>
<td>____ Bana yalan söyledi, beni kandırdı veya bana ihanet etti.</td>
</tr>
<tr>
<td>11. ____</td>
<td>____ Beni dövdü, duygusal veya cinsel olarak taciz etti.</td>
</tr>
<tr>
<td>12. ____</td>
<td>____ Beni öyle amaçlara için kullandı.</td>
</tr>
<tr>
<td>13. ____</td>
<td>____ İnsanların canını yakmaktan hoşlanmadı.</td>
</tr>
<tr>
<td>14. ____</td>
<td>____ Bir yerimi inciteceğim diye çok endişelendi.</td>
</tr>
<tr>
<td>15. ____</td>
<td>____ Hasta olacağım diye çok endişelendi.</td>
</tr>
<tr>
<td>16. ____</td>
<td>____ Evhamlı veya fobik/korkak bir insandı.</td>
</tr>
<tr>
<td>17. ____</td>
<td>____ Beni aşırı korurdu.</td>
</tr>
<tr>
<td>18. ____</td>
<td>____ Kendi kararlarına veya yargılarmına güvenememe neden oldu</td>
</tr>
<tr>
<td>19. ____</td>
<td>____ İşleri kendi başına yapmama fırsat vermeden çoğu işimi o yaptı.</td>
</tr>
<tr>
<td>20. ____</td>
<td>____ Bana hep daha çocuksuzum gibi davranırdı.</td>
</tr>
<tr>
<td>21. ____</td>
<td>____ Beni çok eleştirdi.</td>
</tr>
<tr>
<td>22. ____</td>
<td>____ Bana kendimi sevilmeye layık olmaya veya dışlanmıştır bir gibi hissettirdi.</td>
</tr>
<tr>
<td>23. ____</td>
<td>____ Bana hep bende yanlış bir şey vurmuş gibi davranırdı.</td>
</tr>
<tr>
<td>24. ____</td>
<td>____ Önemli konularda kendimden utanmama neden oldu.</td>
</tr>
<tr>
<td>25. ____</td>
<td>____ Okulda başarılı olmam için gerekli disiplini bakarak zorlamadı.</td>
</tr>
<tr>
<td>26. ____</td>
<td>____ Bana salaklaşmayın veya beceriksiztim diye davranırdı.</td>
</tr>
<tr>
<td>27. ____</td>
<td>____ Başarılı olmamı gerçekten istemedi.</td>
</tr>
</tbody>
</table>
28. ____ ____ Hayatta başarısız olacağını inandı.
29. ____ ____ Benim fikrim veya isteklerim önemsizmiş gibi davranıldı.
30. ____ ____ Benim ihtiyaçlarını gözetmeden kendisi ne isterse onu yaptı.
31. ____ ____ Hayatımı o kadar çok kontrol altında tuttu ki çok az seçme özgürlüğüm oldu.
32. ____ ____ Her şey onun kurallara uymalıydı.
33. ____ ____ Aile için kendii isteklerini feda etti.
34. ____ ____ Günlük sorumluluklarının pek çoğunun yerine getiremiyordu ve ben her zaman kendii payına düşen fazlasını yapmak zorunda kaldım.
35. ____ ____ Hep mutsuzdu; destek ve anlayış için hep bana dayandı.
36. ____ ____ Bana güçlü olduğunu ve diğer insanlara yardım etmem gerektiğini hissettirdi.
37. ____ ____ Kendisinden beklentisi hep çok yüksekti ve bunlar için kendini çok zorladı.
38. ____ ____ Benden her zaman en iyisini yapmamı bekledi.
39. ____ ____ Pek çok alanda mükemmelyetçiydi; ona göre her şey olması gerektiğini gibi olmamalıydı.
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, eğlene veya dinlenmekten daha fazla önem verdi.
44. ____ ____ Beni çok konuda şımarttı veya aşırı hoşgörülü davranmıştı.
45. ____ ____ Diğer insanlardan daha önemli ve daha iyi olduğunu hissettirdi.
46. ____ ____ Çok talepkardı; her şeyin onun istediği gibi olması istendi.
47. ____ ____ Diğer insanlara karşı sorumluluklarını 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 için verirdi.
51. ____ ____ Disiplinsiz bir insandı.
52. ____ ____ Birbirimizde çok iyi anlayacak kadar yakındık.
53. ____ ____ Ondan tam olarak ayrı bir birey olduğunu hissedemedem ve bireyselliği yeterince yaşamadım.
54. ____ ____ Onun çok güçlü bir insan olmasıдан dolayı büyükken kendi yönümü belirleyemiyordum.
55. ____ ____ İçimden birinin uzaga gitmesi durumunda, birbirimizi üzereleseçimizi hissettirdi.
56. ____ ____ Ailemizin ekonomik sorunları ile ilgili çok endişeli idi.
57. ____ ____ Küçük bir hata bile yapmas kötülü sonuçların ortaya çıkacağını hissettirdi.
58. ____ ____ Kötümser bir bakışı açısı vardı, hep en kötüsünü bekledi.
59. ____ ____ Hayatın kötü yanlarını veya kötü giden şeyler üzerine odaklandı.
60. ____ ____ Her şey onun kontrolü altında olmamalıydı.
61. ____ ____ Duygularını ifade etmekten rahatsız ve başka bir sorun olmuyordu.
62. ____ ____ Hep düzenli ve tertipliydi; değişiklik yerine bilineni tercih ederdi.
Kızgınlığını çok nadir belli ederdi.
Kapalı birisiydi; duygularını çok nadir açardı.
Yanlış bir şey yaptığında kizardı veya sert bir şekilde eleştirdiği olurdu.
Yanlış bir şey yaptığında beni cezalandırdığı olurdu.
Yanlış yaptığında bana aptal veya salak gibi kelimelerle hitap ettiği olurdu.
İşler kötü gittiğinde başkalarını suçladı.
Sosyal statü ve görünüme önem verirdi.
Başarı ve rekabete çok önem verirdi.
Başkalarının gözünde benim davranışlarının onu ne duruma düşüreceği ile çok ilgiydi.
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 tanımladığını 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 çevremekle insanların 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. ___ Başarılarını veya galibiyetini başkalarının takтир etmesi önemlidir.
7. ___ Pahalı araba, elbiseler, ev gibi başarının görünür ifadeleri benim için önemlidir.
8. ___ En iyi ve en başarılı olmak içi çok çalışırım.
9. ___ Tanınmış olmak benim için önemlidir.
10. ___ Başarı, ün, zenginlik, güç veya popülerite kazanma ile ilgili hayaller kururam.
11. ___ Ilgi odağı olmak hoşuma gider.
12. ___ Diğer insanlardan daha cıvıltılı / baştan çıkarıcı bir insanım.
13. ___ Hayatında düzen olmasına çok önem veririm (Organizasyon, düzenlilik, planlama, gündelik işler).
14. ___ İşler kötü gittmesine diye çok çaba harcarım.
15. ___ Hata yapmamak için karar verirken kılı kırk kırarım.
16. ___ Çevremdeki insanların yaptıkları 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. ___ Ulaşmakta veya kabul edilmede çok zorlanırım.
20. ___ Kimseye bağlı olmam istemem.
21. ___ Kendi kararlarını almak ve kendime yeterli olmak benim için hayatı önem taşır.
22. ___ Bir insana bağlı kalmakta veya yerleşik bir düzen kurmakta güçlük çekirim.
23. ___ İstediğini 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 ihtiyaçlarını başkalarının kendinden önde tutarım.
26. ___ İnsanlara sık sık ne yapmaları gerektiğiğini söylerim. Her şeyin doğru bir şekilde yapılmasını isterim.
27. ___ Diğer insanlar gibi önce kendimi düşünürüm.
28. ___ Bulunduğum ortamin rahat olması benim için çok önemlidir (örn: ısı, ışık, mobilya).
29. ___ Kendimi öyle bir şekilde gösteririm ve genellikle onlara karşı koyarım.
30. ___ Kurallardan hoşlanmam ve onları çiğnemekten mutlu olurum.
31. ___ Hoş karşılanmama veya bana uyma arasında olmayı severim.
32. ___ Toplumun standartlarından başarılı olmak için uğraşmam.
33. ___ Çevremdekiilerden hef farklı durum.
34. ___ Kendimden bahsetmeyi sevmem ve insanların özel yaşamını veya hislerini bilmederinden hoşlanmam.
35. ___ Kendimden emin olmasa da veya kendimi kırılmış hissetsem de başkaları hep güçlü görünmeye çalışırım.
36. ___ Değer verdğim insana yakın dururma ve sahiplenirim.
37. ___ Hedeflerime ulaşmak için sık sık çıkarlarım doğrultusunda yönlendirici davranışlarda bulunurum.
38. ___ İstediğini elde etmek için açıkça söylemekten ve dolaylı yollara başvururum.
39. ___ İnsanlarla aramda mesafe bırakırım; bu sayede benim için bir karanlık oluşturur.
40. ___ Çok eleştiririm.
41. ___ Standartlarını korumak ve sorumluluklarını yerine getirmek için kendimi yoğun bir baskı altında hissedirim.
42. ___ Kendimi ifade ederken ilklikla patavatsız veya duyarsızım.
43. ___ Hepsine olayma çalışırım; olumsuzluklara odaklanmama izin vermem.
44. ___ Ne hissettüğime aldırmandan çevremdeki kareler yüz göstermem gerektiğiine inanırım.
45. ___ Başkaları benden daha başarılı veya daha fazla ilgi odağı olduğunda kıskanır ve kötü hissederim.
46. ___ Hakkım olanı aldırmandan ve aldatılmadığından emin olmak için çok ileri gidebilirim.
47. ___ İnsanları gerektğinde şaşırtıp alt edebilmek için yollara başvururum, dolayısı ile benim faydalanamazlar veya bana kötülük yapamazlar.
48. ___ İnsanların benenden hoşlanmaya rağmen nasıl davranacağını ve ne söyleyeceği 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 tanımladığını 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 uyaran 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. ___ Sakınleşmek için alkol alırım.
3. ___ Çoğu zaman mutluyum.
4. ___ Çok nadiren üzgün veya hızlınlı hissederim.
5. ___ Aklı duyguara üstün tutarım.
6. ___ Hoşlanmadığım insanlara bile kızmam gerekliğine inanırım.
7. ___ İyi hissetmek için uyuşturucu kullanırım.
8. ___ Çocukluğumda hatırladığında pek bir şey hissetmem.
9. ___ Sıkıldığında sigara içerir.
10. ___ Sıçradığında sistemim ile ilgili şikayetlerim var (Örn: hassımsızlık, ülser, dışarıya doğru yola devam etmektir.
11. ___ Kendimi uyuşmuş hissederim.
12. ___ Sık sık baş başım ağrır.
13. ___ Kızgınken insanlardan uzak dururum.
14. ___ Yaşatılmaları kadar enjim yol.
15. ___ Kas ağrısı şikayetlerim var.
16. ___ Yalnızken oldukça fazla TV seyrederim.
17. ___ İnsanın duyguarlarını kontrol altında tutmak için aklımı kullanması gerekliğine inanırım.
18. ___ Hiç kimse denemedi.
19. ___ Bir şeyler ters gittiğindeki felsefem, olanları bir an önce geride bırakıp yola devam etmek.
20. ___ Kırıldığım zaman insanların yanından uzaklaşım.
21. ___ Çocukluk yıllarımı pek hatırlamam.
22. ___ Gün içinde sık sık şekerleme yaparım veya uyurum.
23. ___ Dolaşırken veya yolculuk yaparken çok mutlu olurum.
24. ___ Kendimi önünde işe vererek şikâyetim pek hatırlamak.
25. ___ Zamanının çoğunun hayal kurarak geçirmem.
26. ___ Sıkıntıları olduğunda iyi hissetmek için bir şeyler yerim.
27. ___ Geçmişimle ilgili şikâyetleri anaklarını düşünmemeye çalışırım.

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28. Kendimi sürekli bir şeyle meşgul edip düşünmeye zaman ayırmasam 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 kırıkları ve kayıplar üzerine fazla düşünmemeye eğilimliyim.
33. çoğu zaman, içinde bulunduğu durum güçlü duygular hissetmemi gerektirse de bir şey hissetmem.
34. Böylesine iyi ana-babam olduğu için çok şanslıyım.
35. çoğu zaman duygusal olarak tarafı olmak/ nötr kalmaya çalışırım.
36. İyi hissetmek için, kendimi ihtiyacım olmayan şeyler almak daha bırakıyorum.
37. Beni zorlayacak veya rahatımı kaçıracak durumlara girmemeye çalışırım.
38. İşler benim için iyı gitmiyorsa hastalanırım.
39. İnsanlar beni terk ederse veya ölürse çok fazla üzülmem.
40. Başkalarının benim hakkında ne düşündükleri beni ilgilendirmez.
Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde, bir çeşit ruh durumunu anlatmaktadır. Her madde de o duygu durumunun derecesini belirleyen 4 seçenek vardır. Lütfen 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) Çevremden birço kişiden daha fazla başarısızlıklarım oldu sayıılır.  
    c) Geriye dönüp bakתığında, çok fazla başarısızlığın olduğunu görüyorum.  
    d) Kendimi türüyle 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 cezalandırılabileceğini 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 buyu yapamam.  
    c) Kendimi öldürebilmeyi isterdim.  
    d) Bir fırsatı bulursam kendimi öldürürüm.

10. a) Her zamankinden daha fazla ağladığımı sanmıyorum.  
     b) Eskisine göre şu sırалarda daha fazla ağlıyorum.  
     c) Şu sıralar her an ağlıyorum.  
     d) Eskiden ağlayabilirdim, ama şu sıralarda istesem de ağlayamıyorum.

11. a) Her zamankinden daha sınırlı değilim.  
      b) Her zamankinden daha kolayca sınırleniyor ve kızıyorum.  
      c) Çoğu zaman sınırlıyım.  
      d) Eskiden sınırlendikliğim şeylerle bile artık sınırlenemiyorum.

12. a) Diğer insanlara karşı ilgiyi kaybetmedim.  
      b) Eskisine göre insanlarla daha az ilgişiym.  
      c) Diğer insanlara karşı ilgiimin çoğunu kaybettim.  
      d) Diğer insanlara karşı hiç ilgi kalmadı.

13. a) Kararlarını eskisi kadar rahat verebiliyorum.  
      b) Şu sıralarda kararlarını veremeye erteliyorum.  
      c) Kararlarını vermekte oldukça güçlük çekiyorum.  
      d) Artık hiçbir karar veremiyorum.

14. a) Dış görünüşümün eskisinden daha kötü olduğunu sanmıyorum.  
     b) Yaşlandığımı ve çekiciliğimi kaybettigiimi düşünüyor ve üzülüyorum.  
     c) Dış görünüşümde artık değiştirilmesi mümkün olmayan olumsuz değişiklikler olduğunu hissediyorum.  
     d) Çok çirkin olduğunu düşünüyor.

15. a) Eskisi kadar iyi çalışabiliriyorum.  
     b) Bir işe başlayabilmek için eskisine göre kendimi daha fazla zorlamam gerekir.  
     c) Hangi iş olursa olsun, yapabilmek için kendimi çok zorluyorum.  
     d) Hiçbir iş yapamıyorum.

16. a) Eskisi kadar rahat uyuyabiliyorum.  
     b) Şu sralarda eskisi kadar rahat uyuyamıyorum.  
     c) Eskisine göre 1 veya 2 saat erken uyuyor ve tekrar uyumakta

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zorluk çekiyorum.
d) Eskisine göre çok erken uyanyor 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 istahım epey kötü.
d) Artık hiç istahım yok.

19. a) Son zamanlarda pek fazla kilo kaybettiğim sanmıyorum.
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 şeyler düşünmek zor geliyor.
d) Bu tür sıkıntılar beni öylesine endişelendirdiyo ki, artık başka bir şey düşünmemiyorum.

21. a) Son zamanlarda cinsel yaşamında dikkatimi çeken bir şey yok.
b) Eskisine göre 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 ihtiyaçın 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
2. Dengeli beslenmek
3. Yeterince uyumak
4. Fiziksel sağlığınıza dikkat etmek (doktora, diş hekimine gitmek vs.)
5. Kendinize vakit ayırınmak
6. Sevildiğini hissetmek
7. Sevginizi ifade etmek
8. Öfkenizi ifade etmek
9. Neşenizi ve keyfinizi ifade etmek
10. Üzüntünüüzü ifade etmek
11. Cinsellikten keyif almak
12. Yeni beceriler öğrenmek
13. Kendini değerli hissetmek
14. Başkaları tarafından takdir edildiğini hissetmek
15. Ailenizden hoşnut olmak
16. Kendinizden hoşnut olmak
17. Gelecekle ilgili kendinizi güvende hissetmek
18. Yakın arkadaşlara sahip olmak
19. Bir eve sahip olmak
20. Gelecekle ilgili planlar yapmak
21. Sizi düşünen birlerinin olması
22. Hayatınızın bir anlamı olması

Aşağıda her birimizin yaptığı ya da birlerinin bizim için yaptığı bazı yaşamsal faaliyetler sıralanmıştır. Her bir faaliyet için yaşamımızın 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

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<tr>
<th>No.</th>
<th>İşinin Tanımı</th>
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<td>Yemek hazırlamak</td>
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<td>4.</td>
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<td>17.</td>
<td>Arkadaşlar ya da aileden destek almak</td>
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<td>Gülmek/Kahkaha atmak</td>
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<td>21.</td>
<td>Kişisel temizlik ve dış görünüşünüzü zaman ayırımk</td>
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<td>22.</td>
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APPENDIX I. Maslach Burnout Inventory

(Maslach Tükenişlik Ölçeği)

Aşağıda 22 cümle ve her bir cümle yanında da cevaplarınızı işaretlemeniz için 0’dan 4’e kadar rakamları verilmiştir. Her cümlede söylediğiniz 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.
2. Hasta bakışım günün sonunda kendimi ruhen tükenmiş hissediyorum.
3. Sabah kalktığında bir gün daha hasta bakımı kaldıramayacağımı düşünüyorum.
4. Baktığım hastanın ne hissettüğünü hemen anlarım.
5. Baktığım hastaya o sanki insan değilmiş gibi davranladığı hissediyorum.
6. Bütün gün hasta bakım benim için gerçekte yıpratıcı
8. Hasta bakıktan tükenemi hissediyorum.
9. Hasta bakarak insanların yaşamına katkida bulunduğuma inanıyorum.
10. Hasta bakmaya başladığından beri insanlara karşı serületşim.
11. Hasta bakmanın beni giderek kısıtladığını hissediyorum.
12. Çok şeyler yapabilecek güçteyim.
13. Hasta bakmanın beni kısıtladığını hissediyorum.
15. Baktığım hastaya ne olduğu umrumda değil.
17. Baktığım hastaya aramda rahat bir hava yaratırım.
18. Baktığım hastaya ilgilendikten sonra kendimi canланmış hissederim.
20. Yolun sonuna geldiğimi hissediyorum.
22. Baktığım hastanın bazı problemlerini s Ankı benyaratmışım gibi davranışı görüyorum.
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 arkadaşlarınız dışında olan ve ihtiyacım olduğunda yanımda olan bir insan (örneğin, flört, nişanlı, sözü, arkadaş, komşu, doktor) var. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
2. Ailem ve arkadaşlarınız dışında olan ve sevinç ve kederlerimi paylaşabileceğim bir insan (örneğin, flört, nişanlı, sözü, arkadaş, komşu, doktor) var. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
3. Ailem (örneğin, annem, babam, eşim, cocuklarım, kardeşlerim) bana gerçekten yardımcı olmaya çalışır. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
4. İhtiyacım olan duygusal yardımcı ve desteği ailemden (örneğin, annemden, babamdan, eşimden, çocuklarından, kardeşlerimden) alırım. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
5. Ailem ve arkadaşlarınız dışında olan ve beni gerçekten rahatsızlan bir insan (örneğin, flört, nişanlı, sözü, arkadaş, komşu, doktor) var. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
6. Arkadaşlarınız bana gerçekten yardımcı olmaya çalışır. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
7. İşler kötü gittiğinde arkadaşlarınızla güvencebileşim. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
8. Sorunlarını ailemle (örneğin, annemle, babamla, eşimle, çocuklarınıyla, kardeşlerimle) konuşabilirsin. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
9. Sevinç ve kederleriim paylaşabileceğim arkadaşlarınız var. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
10. Ailem ve arkadaşlarınız dışında olan ve duygularına önem veren bir insan (örneğin, flört, nişanlı, sözü, arkadaş, komşu, doktor) var. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
11. Kararlarını vermede ailem (örneğin, annem, babam, eşim, çocuklarınız, kardeşlerim) bana yardımcı olmaya isteklidir. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
12. Sorunlarını arkadaşlarınızla konuşabilirsin. Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet
Appendix K: Turkish Summary

(Tezin Türkçe Özeti)

GİRİŞ


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), bağırsıklık 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.


Şema terapi, çocukluk döneminde karşılanması gereken temel duygusal ihtiyaçların karşılanmaması, engellenmesi ya da aşırı karşılanmaması gibi durumlarda erken dönem uyumsuz şemaların geliştirilmesini belirtmektedir. Bu ihtiyaçlar başkalarına güvenli bağlanma (güvenlik, istikrar, bakım ve benimsenme), özerklik, yetenek ve olumlu kimlik algısı; duygulu ve ihtiyaçlar ifade etme özgürlüğü; kendiliğindelik ve oyun; gerçekçi sınırlar ve özdenetim olarak tanımlanmıştır. Şemaların kazanılması dört şekilde olmaktadır. Bunlar, ihtiyaçların karşılanması, travmatize edilmeme ve özdenetim, kişiyi terk etme ve başkalarına yönelimlik ve aşırı tetikte olma ve baskılamadır. Ayrılmanın rednedilmiş önemlidir, sosyal izolasyon/yabancılaşmadır. İkinci alan ise terk edilmiş/istikrar kaybı, güvensizlik/suistimal edilme, duygusal atış, kuşulsuzluk/utanç ve sosyal izolasyon/yabancılaşmadır. İkinci alan olan zedelenmiş


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; Özmolat, Ayaz, Konağ, ve Özkan, 2014; Yen ve Lundeen, 2006; Kucu ve ark., 2009; Sipal ve Sayın, 2013; Bozo, Anahar, Ateş, ve Etel, 2010; Schoeder ve Remer, 2007; Chappell ve Reid, 2002; Schulz, 2002).

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, tüketmişlik ve erken dönem uyumsuz şemaları) açısından farklarını incelemek
2. Demans seviyesinin (hafif, orta, ağır) araştırmanın değişkenleri açısından farkların incelemek
3. Çalışmanın değişkenleri arasındaki ilişkileri incelemek
4. Erken dönem uyumsuz şemalarının, ebeveynlik stilleri ile bakım verenin iyilik hali, depresyon ve tüketmişlik arasındaki ilişki aracılığıyla rolünün incelemek
5. Algılanan sosyal desteği, erken dönem uyumsuz şemaları ile bakım verenin iyilik hali, depresyon ve tüketmişlik arasındaki ilişki aracılığıyla biçimleyici rolünün incelemek
6. Kaçınma şema baş etme stratejisinin, erken dönem uyumsuz şemaları ile bakım veren iyilik hali, depresyon ve tüketmişlik arasındaki ilişki aracılığıyla biçimleyici rolünün incelemek
7. Aşırı telafi şema baş etme stratejisinin, erken dönem uyumsuz şemaları ile bakım veren iyilik hali, depresyon ve tüketmişlik arasındaki ilişki aracılığıyla biçimleyici rolünün incelemek

Sonuç olarak, bu çalışmanın hipotezleri:

1. Erken dönem uyumsuz şemaları, ebeveynlik stilleri ve araştırmanın değişkenleri arasındaki ilişki aracılığıyla rol sahiptir.
   I. Erken dönem uyumsuz şemaları, ebeveynlik stilleri ve bakıcı iyilik hali arasındaki ilişki aracılığıyla rol sahiptir.
   II. Erken dönem uyumsuz şemaları, ebeveynlik stilleri ve depresyon arasındaki ilişki aracılığıyla rol sahiptir.
   III. Erken dönem uyumsuz şemaları, ebeveynlik stilleri ve tüketmişlik arasındaki ilişki aracılığıyla rol 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 tüketmişlik 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 tüketmişlik 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 tüketmişlik arasındaki ilişkide biçimleyici role sahiptir.

YÖNTEM

Katılmalar

Çalışmaya 25 ve 64 yaşları arasında olan demans hastalarına birincil bakım veren 99 yetişkin evlat katılmıştır. Bu katılmaların 78’i kadın iken (%78.8), 21’i erkek iken (%21.2). Demans hastasının birincil bakım veren kriteri olarak, hastaya günlük ihtiyaçlarında yardım etmek ve ihtiyaç olduğu durumlarda yönetim ve denetim sağlamak alınmıştır. Katılmaların demografik özellikleri Tablo 2.1’de gösterilmiştir.
Veri Toplama Araçları


Prosedür


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**


**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.


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 bilmememektedir. 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

Türkiye’de resmi bakım vermenin sınırlı olması, resmi olmayan bakım vermenin beklenenden daha zahmetli ve daha stresli olması neden olmaktadır. Bu nedenle bu alanda 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 çalışmalarda 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.


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

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

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


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. Tezim tamamından kaynak gösterilmek şartıyla fotokopi alınabilir. | ☒
2. Tezim içerisinde sayıfaları, 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:**

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