NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
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MASTER'S PROGRAMME

MASTER'S THESIS

ANALYSIS OF THE RELATIONSHIP BETWEEN SELF-ESTEEM OF SCHIZOPHRENIA PATIENTS AND THEIR FAMILIES' EXPRESSED EMOTION AND BURNOUT LEVEL

Timur LENK

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2016

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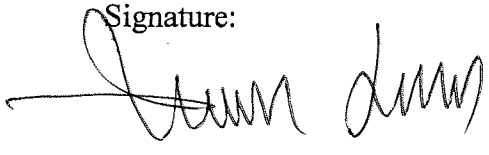

NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
Clinical Psychology Master Program
Thesis Defence

Analysis Of The Relationship Between Self-Esteem Of Schizophrenia Patients And Their Families' Expressed Emotion And Burnout Level

We certify the thesis is satisfactory for the award of degree of
Master of CLINICAL PSYCHOLOGY

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ABSTRACT

ANALYSIS OF THE RELATIONSHIP BETWEEN SELF-ESTEEM OF SCHIZOPHRENIA PATIENTS AND THEIR FAMILIES' EXPRESSED EMOTION AND BURNOUT LEVEL

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Master of Science, Department of Clinical Psychology

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The relationship between self-esteem of schizophrenia patients and their families' expressed emotion and burnout level is examined in this study. The research sample was 30 outpatients or inpatients of a psychiatry clinic in Bursa and 30 family members or caregivers who live with these patients for at least one year. Participants were retrieved by convenience sampling method. Sociodemographic Information Form, Rosenberg Self-Esteem Scale (RSES), Level of Expressed Emotion Scale (LEES) and Maslach Burnout Inventory (MBI) were used. No relation was found between self-esteem level of the patients and the level of burn-out and expressed emotion of their families but negative relationship between self-esteem and age of onset of the disease was found. There was a negative relationship between expressed emotion and emotional exhaustion which is a sub-dimension of burn out. New research with a larger sample and especially with patients at acute exacerbation may shed more light on this subject.

Keywords: schizophrenia, expressed emotion, self-esteem, burnout

ÖZ

ŞİZOFRENİ HASTALARININ BENLİK SAYGISI AİLELERİNİN DUYGU DIŞAVURUM VE TÜKENMİŞİLİK DÜZEYLERİ ARASINDAKİ İLİŞKİNİN İNCELENMESİ

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Bu araştırmada şizofreni hastalarının benlik saygısı, ailelerinin duygu dışavurum ve tükenmişlik düzeyleri arasındaki ilişki incelenmiştir. Çalışmanın örneklemini, Bursa ili sınırları içerisinde bulunan serviste yatarak tedavi gören ya da ayaktan tedavi için başvuran hastalar ve en az bir yıldır bu hastalarla beraber yaşayan yakınları ya da bakım verenleri olan 30 katılımcı oluşturmaktadır. Katılımcılara güdümlü yöntem kullanılarak ulaşılmıştır. Araştırmada, Sosyodemografik Veri Formu, Rosenberg Benlik Saygısı Ölçeği (RSES), Duygu Dışavurum Düzeyi Ölçeği (LEES), Maslach Tükenmişlik Ölçeği (MBI) ile ölçülmüştür. Korelasyon, İndependent sample T-test Frequency analizleri yapılmıştır..

Araştırma sonuçları RSES toplamı ve hastanın hastalık başlangıç yaşı, MBI alt ölçeği duygusal tükenme ve LEES aralarında negatif ilişki saptanmıştır. Hastaların medeni durumlarının değerlendirildiği çalışmada şizofreni hastalarının bekar kalma oranın yüksek olduğu saptanmıştır. Hastaların çalışma durumu ve MBI duygusal tükenme toplamı ile aralarında anlamlı bir fark bulanamadığı saptanmıştır.

Anahtar kelimeler: Şizofreni, Duygu Dışavurum, Benlik Saygısı, Tükenmişlik

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Timur Lenk
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LIST OF ABBREVIATIONS

RSES: Rosenberg Self-Esteem Scale

LEES: Level of Expressed Emotion Scale

MBI: Maslach Burnout Inventory

DT: Emotional Exhaustion

DU: Desensitization

KB: Personal Achievement

TÜİK: Türkiye İstatistik Kurumu

SPSS : Statistical Program for Social Sciences

WHO : Dünya Sağlık Örgütü

1.INTRODUCTION

Schizophrenia is a chronical disease and burthen for the families. This situation causes burnout in families. The interaction between family and patient is effective for the course of disease. Therefore, the purpose of this study is investigating the relationship between burnout and expressed emotion level of the families and self-esteem and demographic features of patients.

1.1.Schizophrenia

Schizophrenia is a severe mental disorder that has early onset and disease in thinking, sensations and behaviors and also patients lose touch with social relationships and reality and live in unique autistic world (Öztürk, 2015).

Schizophrenia is seen in every society without noticing socio-economic status or geographical position. It is asserted that 21 million people all around the world suffer from schizophrenia. Schizophrenia is widespread in Ethiopia, Guinea-Bissau, India, Iran, Pakistan and Tanzania. 12 million of females and 9 million of males had schizophrenia around the world (WHO, 2016).

According to data from World Health Organization, prevalence of schizophrenia in Asia and Europe is 0.85%. According to the report of World Health Organization (2001), 25% of the population had mental problems and the caregivers of these people experienced severe level of distress, fatigue and burden (Kokurcan, 2014).

Although the prevalence of schizophrenia is equal for males and females, the age of onset and the course of disease is different. The most common age of onset for males is 15-25, for females is 25-35. The course of disease for females is better than males. If the age of onset is after 45, it is defined as late-onset schizophrenia. The late-onset is more prevalent for female patients. Also, the late-onset patients have better vocational functioning, more favorable symptoms, better response to treatment, less destruction and better course of disease in comparison to early-onset patients (WHO, 2016).

The prevalence of schizophrenia is 0.9% and rate of incidence of lifelong is 1.5% in Turkey. The new schizophrenia cases who are more than six thousand occur every year in our country. Because of this reason, the families who are more than two hundred thousand are affected due to schizophrenia in a distressful way. Every year, the new schizophrenia cases who are more than 20 million occur all around the world (Doğan, 2002).

Schizophrenia is the most destructive and distressful disorder for individual, family and social environment in comparison to other chronic and mental disorders. Therefore, schizophrenia patients need to be healthy. The families and the caregivers have to be included in the treatment for the meeting of the need, care of patients and the treatment (Chien, 2003).

It is emphasized that the families have an important and complementary role for patients and the families are important part of treatment of patients. Also it is expected that the families and the caregivers take responsibility of patients and residential care, to support the patients at home after being discharge from hospital (Özütek, 2005).

1.2. Symptoms And Diagnostic Criteria For Schizophrenia

Symptoms of schizophrenia are divided into three subgroups which are hallucinations and delusions consisting of evaluating the fact, disorganization that includes bizarre behaviour and positive formal thought disorder and lastly lack of psychomotor ability that is related to negative symptoms. Therefore, symptoms of schizophrenia are divided into three parts (Köroğlu & Güleç, 2007). Positive symptoms include psychotic symptoms such as behaviour, delusion, disorganized speech and hallucinations. Negative symptoms involve poverty of speech, loss of interest and motivation and decrease in affectivity range. Cognitive symptoms include abstract thinking, lack of attention and operational functions and to become organized

Beginning of psychotic symptoms is seen suddenly and clearly in some of patients who have chronic illness like schizophrenia. Distinct psychotic symptoms do not exist but prodromal phase is observed in the majority of patients. The prodromal phase is similar to

obsession, compulsion, depression and anxiety which are slowly developing, to continue for weeks, months, years and nonspecific (Kırkpınar, 1998).

Active phase that has intensive psychotic symptoms is following prodromal phase. After the active phase, significant decrease in functionality and residual phase is seen. In other words, residual phase is not able to return former functionality. In residual phase, negative symptoms become distinct and the phase proceeds slowly (Nasrallah & Smeltzer, 2005).

1.3. Dsm-V Diagnostic Criteria

A. Two (or more) of the following, each present for a significant portion of time during a 1 month period (or less if successfully treated). At least one of these should include 1–3.

(1) Delusions

(2) Hallucinations

(3) Disorganized speech

(4) Grossly disorganized or catatonic behavior

(5) Negative symptoms (i.e., diminished emotional expression or avolition).

B. For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. The disturbance is not attributed to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

F. If there is a history of autism spectrum disorder or other communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least 1 month (or less if successfully treated) (APA, 2013).

1.4. Types Of Schizophrenia

1. Paranoid Schizophrenia: Younger age of onset is seen and progression is slow. There are some defects in contents of thought. The patients try to hide symptoms, do not accept the disorder, defend themselves because of delusions and move away from people. The most common delusions are grandiosity, persecution, suspicion, skepticism, irritability and contagion. Excessive sexual, philosophical and metaphysical pursuits are sometimes seen in patients and also they could devotee to religion. Paranoid schizophrenia is the most responsive subtype to treatment in clinical area (Öztürk & Uluşahin, 2008).
2. Disorganized Schizophrenia: Younger age of onset is seen. The subtype has more negative and positive symptoms than other subtypes. Patients are isolated from society, live their own world and also their behaviors are childish and primitive. In this subtype, stereotyped and repetitive speech, inconsistent delusions, short term fluctuations in emotional reactions, hallucinations, neologism, destruction in personality and deterioration of behavior and action in interpersonal relationships are occurred mostly (Şahin, 1999).
3. Catatonic Schizophrenia: The onset is suddenly and range of age is from 15 to 25. Movement defects dominate catatonic schizophrenia. In this subtype, patients

remain for a long time and their sleep and nutrition are affected. Patients do not respond to external reactions while remaining for a long time to stand against a point. Although they seem to break with external environment, they recognize, understand and record (Şahin, 1999).

4. Residual Schizophrenia: After one or more schizophrenia attack, residual schizophrenia onsets. Negative symptoms increase in consequences of attacks and chronic schizophrenia emerges. Disorder has been turned into personality and patients are unwilling to change. Negative symptoms that are not looking after oneself, breaking with environment, self-indulgence, blunted affect, deprivation and embodiment of thoughts are observed (Kaygusuz, 2015).
5. Undifferentiated Schizophrenia: In this sub-type, symptoms are intertwined for this reason, there are enough symptoms to get a diagnosis for schizophrenia but the subtype of schizophrenia is not decided (Kara,2014)
6. Simple Schizophrenia: The subtype has more negative symptoms. Schizophrenia onsets as an insidious, gradual and simple way(Kaplan & Sadock, 2004).

1.5. History Of Schizophrenia

Schizophrenia disorder was firstly described in the second half of the 1800s. Morel (1860; as cited in Ceylan & Çetin, 2005) termed schizophrenia as "dementia precoce" which means destruction of person along with adolescence. Kahlbaum (1874; as cited in Ceylan & Çetin, 2005) firstly defined catatonic symptoms. Moreover, Kahlbaum (1863; as cited in Ceylan & Çetin, 2005) used the term "praphrenia hebetica". Hecker (1871; as cited in Ceylan & Çetin, 2005) observed patients' bizarre behaviors thus he defined hebephrenia. In the middle age, psychotic symptoms of schizophrenia were related to supernatural powers and patients were considered to be cursed. Schizophrenia is known as a disease since ancient history but gaining recognition as a psychiatric disorder is fairly new (Ceylan & Çetin, 2005).

Eugen Bleuler added the term of schizophrenia in the literature instead of dementia precox in 1911. Bleuler criticized the definition of dementia precox because, he thought

that there is not only one type of disorder. He tried to indicate that the separation between behavior, thought and emotion occurs in schizophrenia. Morever, Bleuler brought cross-sectional approach for schizophrenia and he specified that there is no necessary for destructive progress and result of schizophrenia and also severe destruction is generally seen in severe cases (Ceylan & Çetin, 2005).

Subtypes of schizophrenia which are disorganized, catatonic, paranoid and simple and definition of dementia precox were integrated by Krapelin who had an important role in schizophrenia disorder. Krapelin tried to reveal the difference between precox which means early onset and dementia which means cognitive impairment. Krapelin indicated that the destruction continues with disorder and the most important symptoms are delusions and hallucinations. He differentiated manic depressive psychosis from schizophrenia and he said that there is normal functioning but exacerbations of disorder are seen in manic depressive psychosis. Furthermore, he specified that paranoid schizophrenia has different symptoms from manic depressive psychosis. Also he stated that the process of paranoid disorder with patients' persecution and persistent delusions is destructive and the symptoms are chronic (Ceylan & Çetin, 2005).

1.6. Etiology Of Schizophrenia

Pathogenesis of schizophrenia has a lot of causes which are biochemical factors, psychosocial factors, genetic causes, functional and structural defects in brain. Etiology is not based on only one cause so the situation makes treatment of schizophrenia difficult. Therefore, multidisciplinary approach has to be used for treatment of schizophrenia (Kneisl et.al., 2004).

The main idea about etiology of schizophrenia is developmental disease of brain. The most important reason of mental disorders was determined as environmental factors in the past researches about schizophrenia and other mental disorders. After that, genetic relations were detected in result of family and case-control studies. Therefore, genetic and environmental factors are related with each other (Kaplan & Sadock, 2015).

The factors in schizophrenia etiology which are changes in structure of brain, excessive dopamine in brain, genetic transfer, virus in brain, drugs that prevent the normal development of brain and traumas during childbirth could be reason of schizophrenia (Yalom, & Vınogradov, 2008).

1.7. Treatment Of Schizophrenia

Schizophrenia is a chronic disorder that is treatable. The treatment is important because of effects of disorder on society, cost for families, families' experiences about difficulties in the process of care. The purpose of treatment is primarily to soothe the symptoms and after that to cure the disease with treatment methods. The treatment methods could vary from people to people depending on nature and extent of disease. Firstly, the premorbid situation of individual is examined in treatment. Premorbid medical conditions, psychosocial stressors, personality, patient's attitude toward treatment before the disease and during the course of the disease and patient's compliance to treatment are evaluated to plan treatment method, medication selection and dose adjustment (Yıldız, 2005).

Nowadays, atypical and typical antipsychotics are widely used for the treatment of schizophrenia. The most important factor to use the antipsychotics is discovering chlorpromazine because when chlorpromazine is used in treatment, symptoms are soothed substantially. Regarding atypical psychotics, they provide less side effect and symptoms are soothed better. Medical treatment is used lifelong by patients but it is not enough to extinguish negative symptoms. Psychosocial skill trainings are applied to extinguish negative symptoms of patients. Medical treatment supports psychosocial skill trainings to overcome negative and positive symptoms. If the psychosocial development of patients is not supported with medical treatment, the disease could relapse, patient's life quality and caring of families could become difficult (Kaplan & Sadock, 2004).

Psychosocial rehabilitation, regular medication use, education for patients and families have important part of schizophrenia treatment. The purpose of treatment and rehabilitation is to strengthen coping skills of patients, to increase coping capacity of patients, to provide realistic and appropriate purposes for patient, to prevent or delay relapse, decrease the behaviors that is difficult to be accepted by the family and society or

to create family and society support to eliminate these behaviors completely, to make patients aware of personal characteristics and to provide taking advantages of personal functions in a highest level (Liberman & Kopelowicz, 1995).

1.8. Schizophrenia And Family

Chronical psychiatric disorders such as schizophrenia affect not only patients but also the family and the society. Treatment, medication use and hospitalizing have direct effects on the family and the society economically. Also, the conditions like loss of operational functions of patients, financial and inner problems of the families, the families' time that spend for disease, loss of job and productiveness of patients show that schizophrenia concern not only the patients but also the family and the society (Arslantaş et.al., 2011).

Although the relationship between family, culture and civilization seems complicated and varies among individuals, the concept of family has some common characteristics. Family is an important concept for individual to find out desire to live and identity. It is observed that family has significant contribution to development of schizophrenia. Mental disorders improve in a result of improper interpersonal relationships, erroneous communication in family or family psychopathology (Kumar, 2008).

Variance of individual because of schizophrenia is primarily realized by family members. Bizarre behaviors such as decreased self-care, social isolation, meaningless glances, suspicion, hostility and fear are observed by family members. Family members experience complex emotions and they may not know to do bewilderedly (Terschinsky, 2000).

Family members may feel anger, embarrassment or guilt to patient after a period of time. They might be intolerant towards some behaviors of patient and sometimes they may be angry to patient unintentionally. The conditions may affect mental health of family members. In the beginning, caregiving process is voluntarily for family members but when course of disease progresses, caregiving process would be compulsory. Expectations and hopes of families decreases towards patients. This situation accelerates hospitalizing

process of patients. After to be discharged from hospital, coming back to the family shows the importance of family for the course of disease (Kuşçu, 1998).

Misinterpretations of symptoms of schizophrenia by family members cause high expressed emotion. It is stated that high expressed emotion of families affects patients negatively, hospitalization and relapses are more frequently and family dynamics are affected negatively (Antai-Otong, 2008).

Psychoeducation is important because of the reasons which are families learn that the patient has real disease, behaviors of patients are affected by symptoms and patients do not have control because of medication treatment. Therefore, the family comply with schizophrenia and the treatment through psychoeducation (Doornbos, 2001).

1.9. Expressed Emotion

People feel a lot of emotions all day and enact after emotional experiences. The concept of expressed emotion is behavioral reactions and it is defined in different ways by various researchers. According to a definition, regardless of its value (negative or positive) or channel (gesture, mimics and verbal), expressed emotion is an apparent demonstration of emotion (Kring et.al., 1994). Gross and John (1995) states that expressed emotion is behavioral changes which are related to experiencing emotions like smiling, crying and frowning. According to one another description, expressed emotion is behaviors that are transmitting or symbolizing emotional experiences, observable, verbal and nonverbal (Kenndy-Moore & Watson, 1999).

Expressed emotion reflects the emotional atmosphere of patient's home or caring place. Expressed emotion is defined such as the presence or absence of family members' hostile attitude towards patient, siblings' excessive attention, intimacy, devotion or excessive interfering attitude, criticizing about someone at home, supposing that patient's inner world is like their own inner world and not differentiate those (Arslantaş et.al., 2009).

Hostility: It is not about acts and behaviors of patient; it is about patient's personality. Negative emotion transfer towards patient is prevalent. Also blaming directly about every subject, refusing and criticizing in any case are seen (Kocabıyık et.al., 2005).

Criticism: It involves that being intolerance towards acts of patient, thinking about patient as unlovable and feeling offended. Inappreciativeness towards patient, disliking what the patient does and disapproval to patient in any subject are the characteristics (Duman et. al., 2013).

Warmth and Positive Remarks: It includes the attitudes of family members towards the patient such as indulgent, positive, affectionate, respectful, approving, supportive and also they empathize with patient (Scazufca et. al., 1996).

Excessive Attention and Over-Protectiveness: It involves that concerning about patient, self-reproach of family members, behaving in such a manner that as if patient is a child or does not anything without help and being interested in patient in such a way that sacrificing themselves (Strachan et. al., 1989).

1.10 History Of Expressed Emotion

Expressed emotion is based on researches and studies of Medical Research Council about schizophrenia patients in United Kingdom in 1960s and 1970s. According to these studies, the emotionally importance of communication and interaction in family is understood. The studies become predictor about course of disease and emotional characteristics of patients (Tüzer et.al., 2003).

Firstly, expressed emotion is stated as a serious situation that affects patient, course of disease and lives of family or caregiver (Brown et.al., 1956; as cited in Çetin et.al., 2013). According to Brown and his colleagues (1956; as cited in Çetin et.al., 2013), expressed emotion includes all verbal or nonverbal behaviors, attitudes, emotions and thoughts from family members or caregivers towards patient, family members or caregivers (Brown, 1972)

1.11. Self And Self-Esteem

Adopting and approving concept of self and self-image constitute self-esteem. Self-esteem is an admiration which is consisting of evaluating oneself and approval of concept of self and also self-esteem is emotional side of self. One could find out deficiency about

oneself, criticize oneself but also admire oneself to find out all favorable characteristics about oneself. One does not need outstanding qualifications for liking and respecting oneself. Self-esteem does not mean to see oneself as inferior or superior, it means the situation that one can satisfy oneself. Finding out oneself as worthful, positive, lovable and likeable is self-esteem. Self-esteem is a positive mood which provides to accept and rely on self (Yörükoğlu & Atalay, 1986).

Self-esteem imports the favor, confidence and respect to oneself and it is described as knowing oneself and evaluating oneself realistically so accepting and adopting own abilities and power. Self-esteem has emotional, cognitive, social and physical elements. The factors which are feeling oneself worthful, revealing abilities, achieving, becoming admirable in society, becoming accepted and lovable, adopting own physical features are the foremost factors for occurrence and development of self-esteem (Çuhadaroğlu, 1986).

According to Rosenberg (1965), self-esteem is one's positive or negative attitude towards oneself. If the individual evaluates oneself with positive attitude, the self-esteem of the individual would be high. However, self-esteem of individual could be low if s/he evaluates oneself with negative attitude (Rosenberg, 1965).

1.12. Schizophrenia And Self-Esteem

The concept of self of schizophrenia patients is typically lower considering all population. Schizophrenia patients are affected socially because of the disease, medication use, hospitalizing and isolating from society. Also their interpersonal relationships and social relationships deteriorate (Borras et.al., 2009).

Schizophrenia patients are not able to work or not maintenance their job and this situation causes a decline in self-esteem. If defense mechanisms and ego strength of schizophrenia patients weaken, a decrease in self-esteem would be observed. The factors which are improvement of self-care and operational functions, not perceived high expressed emotions in family, productiveness of patients enhance self-esteem and social relationships. The factors that affect patients' lives negatively are loss of the ability to maintain a job, being unemployed, failures in social relationships and not being able to take care of

themselves. The negative effects decrease self-esteem. This situation causes emergence of depression and deterioration of life quality and balance (Blankertz, 2001).

1.13. Burnout

The concept of burnout was added the literature by Freudenberger in 1974. Burnout was mentioned as an occupational hazard in the article of Freudenberger. According to Maslach (2003), burnout is a psychological syndrome that occurs as a reaction towards stressors in work environment.

Burnout is stated as a consumption of mental and physical energy. Long-term effects of organizational stressors about job and organizational factors lead to burnout. The important reason of burnout is loss of the ability to extinguish stressors by the help of individual resources. The result of interactions in work environment differentiate stressors that causes burnout from others.

Maslach (2003); deals the subject of desensitization to extend the concept of burnout. Desensitization is seen in the employees who work for helping other individuals or have negative behaviors towards other employees (Maslach, 2003).

According to Duygun (2003), Maslach and Jackson mention about three criteria of burnout. These three criteria are desensitization which is negative attitudes and manners towards caregivers, loss of personal achievement which is evaluating themselves negatively and emotional burnout that is being incapable to concentrate on their works (Duygun, 2003).

Burnout is seen in caregivers of patients with all chronic psychiatric disorders. However, it is expected that burnout is seen frequently in caregivers of schizophrenia patients who have incapability to evaluate reality and deterioration in cognitive functions. Burnout in family members and caregivers is described as problems to live with patients, difficulties in daily activities and unfavorable events because of schizophrenia effects (Kokurcan, 2014).

Level of expressed emotion and expectations of families towards patients are related with burnout. If the expectations of families towards patients rise and the patients does not meet the expectations, family members' emotions such as disappointment, sadness and anger would increase. Expressed emotion of family members and caregivers increases more severely. Prognosis of schizophrenia is affected negatively because of severe expressed emotion consisted of family members' burnout (Kokurcan, 2014).

In conclusion, the aim of this study is examining relationship between self-esteem of patients who are diagnosed as schizophrenia and level of expressed emotion and burnout in families.

2. LITERATURE REVIEW

In the literature, Priebe and the others (1989) conducted 9-months follow-up study on 21 schizophrenia patients. Considering this follow-up study, patients who live with high expressed emotion relatives were monitored retrospectively (3 years before treatment) and prospectively (9 months). It was determined that patients who live with high expressed emotion relatives respond significantly poorer to treatment than patients who live with low expressed emotion relatives. Also it was detected that patients who live with low expressed emotion relatives could benefit from prophylactic treatment more than 2 years so social intervention in families could decrease expressed emotion of relatives and relapses of patients.

Researches and studies are examined globally in the literature and the study of Ben Smith and his colleagues (2006) about the relationship between persecutory delusions, auditory hallucinations and depression, 'self-esteem, negative beliefs, past traumatic experiences of 100 schizophrenia patients is examined. In a result of this study, patients who have low self-esteem and depressive have more auditory hallucinations. Also it was indicated that, this patients' past experiences were more traumatic and the control of hallucinations were more difficult. Auditory hallucinations were strongly related with self-esteem and depression but not related with negative beliefs.

Provencher and his colleagues (1997) had study about 70 schizophrenia patients and caregivers. It was found that negative symptoms increase burnout level significantly in comparison to positive symptoms. It was explained that positive symptoms are brought under control with medical treatment but negative symptoms respond medical treatment limited. Therefore, the effect of negative symptoms on burnout was more. Also, negative symptoms cause despair in caregivers and increase burnout.

The studies in literature were investigated and the study of Güçray (2001) about 511 high school students who are 276 females and 235 males was examined. The result of the study shows that self-esteem and problem-solving skills have significant contribution on decision making behaviors (Güçray, 2001). The findings show that high self-esteem is

related with effective decision making skills, decision making situations, coping with stress skills and self-confidence in decision making.

The studies were examined, Uyanık-Balat and Akman (2004) aimed to investigate the self-esteem scores of 482 high school students who have different socio-economic status. The result of this study shows that there is not a significant difference between gender and socio-economic status in scores and all participants have high self-esteem.

Kahriman (2005) have a study about self-esteem and assertiveness level in Karadeniz Technical University Trabzon Health Faculty with 441 students. The results of the study indicate that there is positive relationship between self-esteem and assertiveness level. In other words, assertiveness level increases when self-esteem level increases.

3. METHOD

3.1.Sample

This study is about the relationship between self-esteem of schizophrenia patients and their families' expressed emotion and burnout.

This study was conducted in "Psychosis Clinic" of Uludağ University Department of Psychiatry between March 7 and April 8, 2016. The research sample was made by using convenience sampling method. The research sample was chosen within outpatients or inpatient "Psychosis Clinic" of Uludağ University Department of Psychiatry and family members and caregivers who live with these patients for at least one year. The purpose of the study was explained to the patients and family members who participate this study. Also, the information about the study was given and written consent of participants was obtained.

It was explained that to participate in the study is on a volunteer basis, participants have rights to refuse participating or to terminate the interview at any point. Also, the personal information was not used in any way and it was guaranteed to keep private.

Participants are 30 patients who had diagnosed by diagnostic criteria of schizophrenia in DSM-V and 30 caregivers and family members. After consent form was signed by participants, sociodemographic information was examined. Level of Expressed Emotion Scale and Rosenberg Self-Esteem Scale were applied to schizophrenia patients and Maslach Burnout Inventory was applied to family members and caregivers.

3.2.Instruments

3.2.1. Sociodemographic Information Form

Sociodemographic characteristics and information of patients are evaluated by researchers. The questions are about gender, age, educational status and family information. The questions which are about emotional attitudes of family, self-esteem of patients and the

disease are evaluated. There are questions about personal information of family members or caregivers in sociodemographic questions.

3.2.2. Rosenberg Self-Esteem Scale (RSES)

The scale is applied to patients. RSES was developed by Rosenberg in 1965. The validity and reliability of the Turkish version were made by Çuhadaroğlu (1986). It was seen in the literature that RSES is a valid measurement tool for patients for psychiatric disorders. The validity coefficient of the scale is r=71. Also, test-retest reliability method is used to determine reliability coefficient that is r=75. The self-esteem subscale that reflects one's own opinion for self-respect and self-esteem is used. Ten items involve 5 negatives which are 3,5,8,9,10 and 5 positives which are 1,2,4,6,7 (Çuhadaroğlu, 1986).

According to Guttman technique, reproducibility coefficient is found out 0.92 in reliability examination of RSES. Silver and Tippet (1965, as cited in Robinson & Shaver, 1980; Rosenberg, 1979,1986) found out test-retest reliability coefficient that is 0.85 in a result of the study that is applied to 28 college students in two weeks apart.

3.2.3. Level of Expressed Emotion Scale (LEES)

It is a self-evaluation scale that aims to understand emotional atmosphere and relationship between the patient and the caregiver or one of family members. The scale investigates the attitudes of patient's relatives towards the patient. The scale is developed by Cole and Kazarian (1988).

The validity and reliability of the Turkish version were made by Berksun (1993). The scale which has 60 items and two options (yes or no) is filled by the patient. The patient marks the items as between 0-1 by taking into consideration the relationship with relatives or caregivers in last three months. The subscales which are attitude toward illness, expectation/tolerance, intrusiveness and emotional response consist of 15 items. The score is changed between 0-15 for subscales and between 0-60 in total. The more the scores increase, the more level of expressed emotion of family members or caregivers towards the patient (Berksun, 1993).

3.2.4. Maslach Burnout Inventory (MBI)

It is conducted to relatives of the patient. It was developed by Maslach and Jackson (1981). Turkish validity and reliability studies of this inventory are done by Ergin (1992) and Pine (1992). It consists of 22 items with Likert scale (from 0 to 4). In the inventory, one of the options (never, rarely, sometimes, mostly, always) need to be marked. Inventory has three subgroups that are emotional exhaustion (9 items), desensitization (6 items) and personal achievement (8 items).

Emotional exhaustion (DT): Emotional exhaustion states decrease in energy subgroup of life and stress that result from effects of psychological and emotional demands of person. This subgroup has eight items and item numbers of this subgroup are 1,2,3,6,8,13,16 and 20.

Desensitization (DU): Desensitization subgroup indicates that individuals behave emotionlessly unrelated to their caregivers or family members on their own without considering Behaviors. This subgroup has 6 items and their numbers are on 5,10,11,15,21 and 22. Personal achievement subgroup is defined as the sense of achievement and competence in business and private life while facing people.

Personal achievement (KB): Personal achievement subgroup specific items and item numbers are 4,7,912,14,17,18 8 and 19. Maximum and minimum scores of burnout inventory are from 0 to 20 in desensitization subgroup, from 0 to 32 in personal achievement subgroup and from 0 to 36 in emotional exhaustion subgroup separately. Although increase in scores of emotional exhaustion and desensitization shows that the person has increased burnout, the increased in scores of personal achievement indicates that the person has low level of burnout.

4. RESULTS

Table 1.

The disribution of the demographic variables of the patients.

Gender	n	(%)
Gender		
Male	20	(66.7)
Female	10	(33.3)
Total	30	(100.0)
Marital Status		
Maried	2	(6.7)
Single	27	(90.0)
Widow	1	(3.3)
Total	30	(100.0)
Educational Status		
Literate	1	(3.3)
Primary School (5 years)	2	(6.7)
Elemantary Education (8 years)	4	(13.3)
High School	13	(43.3)
Graduate School-University	10	(33.3)
Total	30	(100.0)

Considering gender of the patients in the study; 20 (66.7 %) patients were male, 10 (33.3 %) were female.. Considering marital status of the patients; 2 (6.7 %) patients were maried, 27 (90.0 %) single and 1 (3.3 %) patient widow. Considering educational status of the patients; 1 (3.3 %) patient was literate, 2 (6.7 %) patients graduated from primary school (5 years), 4 (13.3 %) patients graduated form elemantary school (8 years), 13 (43.3 %) patients graduated form high school and 10 (33.3 %) patients graduated from graduate school-university.

Table 2.

The disribution of the demographic variables of the families.

Gender of the patients' relatives	**n**	**(%)**
Gender		
Male	16	(53.3)
Female	14	(46.7)
Total	30	(100.0)
Marital Status		
Maried	22	(73.3)
Single	5	(16.7)
Widow	3	(10.0)
Total	30	(100.0)
Educational Stuatus		
Literate	1	(3.3)
Primary School (5 years)	11	(36.7)
Elemantary Education (8years)	3	(10.0)
High School	8	(26.7)
Graduate School-University	7	(23.3)
Total	30	(100.0)

Considering gender of the patients' relatives in the study; 16 (53.3 %) people were male, 14 (46.7%) people were female. Considering marital status of the patients; 22 (73.3 %) people were maried, 5 (16.7 %) people were single and 3 (10.0 %) people were widow. Considering educational status of the patients; 1 (3.3 %) person was literate, 11

(36.7 %) people graduated from primary school (5 years),3 (10.0 %) people graduated form elemantary school (8 years), 8 (26.7 %) people graduated from high school and 7 (23.3 %) people graduated from graduate school-university.

Table 3.

The Correlation of Self-Esteem level and demographic factors of schizophrenic patients with Burn-out and Expressed Emotion level of their families.

Variables	1	2	3	4	5	6	7	8	9
1.Rosenberg Self-esteem total	-	-.086 .650 30	-.097 .612 30	.070 .713 30	-.059 .759 30	-.024 .901 30	-.182 .335 30	-.376* .041 30	-.026 .893 30
2.Maslach emotional exhaustion total		-	.357 .053 30	-.158 .403 30	.764** .000 30	-.551** .002 30	.359 .051 30	.221 .241 30	.112 .554 30
3.Maslach depersonalization total			-	.020 .918 30	.618** .000 30	-.218 .247 30	-.132 .487 30	.099 .602 30	.272 .147 30
4.Maslach personal sucess total				-	.430* .018 30	.055 .772 30	-.019 .921 30	-.087 .648 30	.228 .225 30
5.Maslach burnout inventory total					-	-.446* .014 30	.204 .280 30	.148 .436 30	.299 .108 30
6. Emotion expression level totaal						-	-.062 .746 30	-.182 .337 30	.165 .385 30
7. Patient, how old are you?							-	.376* .041 30	.032 .868 30
8. Age of disease onset								-	.256 .172 30
9. How many times have you been hospitalized?									-

*p< .05 **p< .01

The correlations between the mean scores of Rosenberg self-esteem total, Maslach emotional exhaustion total, Maslach depersonalization total, Maslach personal sucess total, Maslach burnout inventory total, emotion expression level total, patient's age, patient's

age of disease onset and how many times have you been hospitalized were analyzed.

In Table 1, when the corelation between the variables are examined, there were significant negative correlation between Rosenberg 1 self-esteem scale total and the

patient's age of disease onset (r = -. 376 *), Maslach emotional exhaustion total, Maslach depersonalization total (r=-.551**), Maslach burnout inventory total, emotion expression level totaal (r=-.551**).

There was significant positive correlation between the variable of the participants which are Maslach depersonalization total and Maslach burnout inventory total (r=-.618**), , Maslach personal sucess total and Maslach burnout inventory total (r=.430*), patient's age and patient's age of disease onset.

Table 4.

The comparison of the mean scores of MBI-total according to occupation of the patients

The occupation status of the patient	*n*	$\bar{X}$	*S*	*sd*	*t*	*p*
Employed	6	84.50	5.85	28	-.442	.662
Nonemployed	24	86.16	8.69			

$p<0.5$

When the mean scores of MBI-total of the patients were compared according to their occupation status with t-test analysis, no significant difference was found, [t=-.442, p>05]. According to the patients' occupation status; employed patients were found ($\bar{X}$=84.50), nonemployed patients were found ($\bar{X}$=86.16).

Table 5.

The comparison mean* scores *of MBI total of families according to occupation status of patients.

The occupation status of the patient	*n*	$\bar{X}$	*S*	*sd*	*T*	*p*
Employed	6	33.33	3.93	28	.990	.331
Nonemployed	24	30.66	6.24			

$p<0.5$

When the mean scores of Maslach Emotional Exhaustion total of the patients were compared according to their occupation status with t-test analysis, no significant difference was found,[t=-.990, p>05]. According to the patients' occupation status; empolyed patients were found ($\bar{X}$=33.33), nonemployed patients were found ($\bar{X}$=30.66). According to the general results, there were no significant differences between Maslach emotional exhaustion total score and occupation status of patients.

Table 6.

The comparison of mean scores of MBI- depersanalization subscale of the families according to occupation status of patients.

The occupation status of the patient	*n*	$\bar{X}$	*S*	*sd*	*T*	*p*
Employed	6	23.50	3.01	28	-.829	.414
Nonemployed	24	24.58	2.82			

$p<0.5$

When the mean scores of Maslach Depersonalization of the patients were compared according to their occupation status with t-test analysis, no significant difference was found, [t=-.829, p>05]. According to the patients' occupation status; empolyed patients were found ($\bar{X}$=23.50), nonemployed patients were found ($\bar{X}$=24.58). According to the general results, there were no significant differences between Maslach depersonalization total score and occupation status of patients.

Table 7.

The comparison of mean scores of MBI-personal success subscale of the families according to occupation status of patients.

The occupation status of the patient	*n*	$\bar{X}$	*S*	*sd*	*T*	*p*
Employed	6	27.66	2.94	28	-1.676	.105
Nonemployed	24	30.91	4.48			

$p<0.5$

When the mean scores of Maslach Personal Success of the patients were compared according to their occupation status with t-test analysis, no significant difference was found, [t=-1.676, p>.05]. According to the patients' occupation status; empolyed patients were found ($\bar{X}$=27.66), nonemployed patients were found ($\bar{X}$=30.91). According to the general results, there were no significant differences between Maslach personal success total score and occupation status of patients.

Table 8.

The comparison of mean scores of LSES total of the families according to occupation status of patients.

The occupation status of the patient	*n*	$\bar{X}$	*S*	*sd*	*T*	*p*
Employed	6	25.83	12.1	28	1.061	.298
Nonemployed	24	20.75	10.1			

$p<0.5$

When the mean scores of Level Expressed Emotion of the patients were compared according to their occupation status with t-test analysis, no significant difference was found, [t=1.061, p>.05]. According to the patients' occupation status; empolyed patients were found ($\bar{X}$=25.83), nonemployed patients were found ($\bar{X}$=20.75) . According to the general results, there were no significant differences between emotion expression level total score and occupation status of patients.

Table 9.

The comparison of mean scores of RSES total according to occupation status of patients.

The occupation status of the patient	*n*	$\bar{X}$	*S*	*sd*	*T*	*p*
Employed	6	3.50	1.22	28	-.316	.754
Nonemployed	24	3.70	1.48			

$p<0.5$

When the mean scores of Rosenberg Self-Esteem Scale of the patients were compared according to their occupation status with t-test analysis, no significant difference was found, [t=-.316, p>.05]. According to the patients' occupation status; empolyed patients were found ($\bar{X}$=3.50), nonemployed patients were found ($\bar{X}$=3.70). According to the general results, there were no significant differences between Rosenberg self-esteem scale total score and occupation status of patients.

5.DISCUSSION

Schizophrenia patients and patients' relatives or caregivers participated in the study. Self-esteem of patients, expressed emotion and burnout of patients' relatives or caregivers were evaluated. The relation between the self-esteem of patients, burnout and expressed emotion of families, subscales of burnout (emotional exhaustion, desensitization, personal achievement), age of patients, age of onset and number of inpatient treatment were investigated. Also, sociodemographic information about gender, marital status, education status of patients and patients' relatives or caregivers were examined.

5.1. Discussion About Results of Sociodemographic Data Analysis

When patients are evaluated in terms of marital status, it is detected that number of married patients are 2 (6.7%), single patients are 27 (90%) and widowed patient is only one (3.3%). Some studies in the literature concluded that rate of being single is high for schizophrenia patients. The result of this study is supported by the literature. The nature of schizophrenia that causes withdrawal from relationships, specific introversion and losing touch with reality is compatible with the result (Öztürk, 2015).

The patients were evaluated with regard to working conditions. Number of employees are 6 (20%) and number of unemployed patients are 24 (84%). The high rate of unemployed patients is compatible with the literature. Schizophrenia is a disorder that reduces work rate, impairs socialization and functionality, decreases self-esteem depending on loss of job or not maintaining a job (Emiroğlu et.al., 2009).

Patients were evaluated in terms of education status; number of literate patient is only one (3.3%), primary school graduates (5 years) are 2 (6.7%), elementary school graduates (8 years) are 4 (13.3%), high school graduates are 13 (43.3%) and university graduates are 10 (33.3%). Education status of patients is considerably high in comparison to general population. According to Turkish Statistical Institute (2011), 50.4% of Turkey population are primary-secondary school graduates, 18.1% high school graduates and 7.5% university graduates (TÜİK, 2011). The high level of education among the patient group of

this study may be related with the hospital the sample was taken. The patients who apply to university hospitals are generally the people who have insurance and better socioeconomic status. The education level is higher in the west part of Turkey. If the sample was taken also from state hospital and especially from different parts of Turkey, the education level could be lower.

5.2. Discussion About Results of Correlation Analysis

The significant relationship between patients' level of self-esteem and relatives' burnout and expressed emotion level is not found. There is a negative relationship between patients' self-esteem and relatives' burnout and expressed emotion as expected but it is not significant statistically. The results could be affected because of medication use, treatment and limited number (30) of patients. Therefore, if data from patients and relatives is collected in acute exacerbation of schizophrenia and number of patients is increased, there could be a significant relationship between variables.

Correlation analysis is used for investigating the relationship between self-esteem of patients and age of onset. There is a negative significant relationship between self-esteem of patients and age of onset of schizohprenia. In other words, late age of onset is correlated with low self-esteem and early age of onset is correlated with high self-esteem. Lincoln et.al., (2007) mentions the relation of age of onset with insight.

Correlation analysis is used to compare the relationship between expressed emotion and burnout of patients' relatives and caregivers. There is a negative significant relationship between burnout and expressed emotion of relatives. Therefore, when the expressed emotion of families increases, burnout level decreases. Expressed emotion is defined in literature as family members' coping strategies with distress in home environment and interpersonal behaviours. High expressed emotion of family members involves severe emotional care, hostility or severe criticism. Burnout through caring patients and high expressed emotion lead to relapses and rehospitalisation (Berksun, 1992).

Correlation analysis is used for comparing the relationship between expressed emotion towards patients and emotional exhaustion which is a subscale of burnout. In a

result of analysis, the negative significant relationship between expressed emotion towards patients and emotional exhaustion is investigated. In other words, when expressed emotion of families is high, emotional exhaustion would be lower and also when expressed emotion of families is less, emotional exhaustion would be more.

Emotional exhaustion is mentioned in the literature as the most important determinant of burnout (Kaçmaz, 2005). The individuals in emotional exhaustion level think that they are less responsible, less adequate and less productive compared to the past (Ertürk & Keçioğlu, 2012). Families' expectations from patients and level of expressed emotion are related with each other. Failure of patients to meet expectations causes severe reactions of families which are sadness, criticism, boredom and anger. If the patient does not have cognitive ability, interest and desire to meet expectations because of the disease, expressed emotion of family members would be more severe. This situation causes emotional exhaustion and burnout related to care patients (Platt, 1985).

5.3. Discussion About Results of T-Test Analysis

T-test was used in this study on the purpose of specifying whether level of expressed emotion differs from on the working condition of patients. It is determined as a result of study that level of expressed emotion does not differ from on the working condition of patients. In other words; when patients who work at any job, expressed emotion of families does not differ from working condition.

T-test was used in this study in order to state whether total of Rosenberg self-esteem scale differs from on the working condition of patients. It is determined as a result of study that total of Rosenberg self-esteem scale does not differ from on the working condition of patients. In other words, there is no significant difference between self-esteem of patients who work at any job and working condition of patients.

6. CONCLUSION AND RECOMMENDATIONS

Sociodemographic information, self-esteem of patients, families' expressed emotion and burnout level is researched in this study with 30 caregivers and 30 schizophrenia patients of "Psychosis Clinic" of Uludağ University Department of Mental Health and Disease on between March 7 and April 8, 2016. The results of this study are listed below.

1. There is not a significant relationship between self-esteem of schizophrenia patients and their relatives' expressed emotion and burnout level.
2. Negative relationship between self-esteem of schizophrenia patients and age of onset is determined.
3. Negative relationship between families' expressed emotion and emotional exhaustion which is a subscale of Maslach Burnout Inventory is detected.
4. Negative relationship between expressed emotion and burnout of families is determined.

6.1. RECOMMANDATIONS

1. The study could be repeated with a large sample.
2. The relationship between variables could be evaluated more clearly with data collection in an acute exacerbation of schizophrenia.
3. It is found that early onset schizophrenia is relaled with low self-esteem. This should be taken into consideration in rehabilitation programs.

6.2. RESEARCH LIMITATIONS

Research results are not generalized to patients of other psychiatric disorders because of the reason that all participants of research are only schizophrenia patients.

Research results are not generalized to patients who live out of Bursa because research was carried out to schizophrenia patients who live in Bursa.

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APPENDICES

ARAŞTIRMA AMAÇLI ÇALIŞMA İÇİN AYDINLATILMIŞ ONAM FORMU

(Araştırmacının Açıklaması)

Evlilik uyumu ile ilgili yeni bir araştırma yapmaktayız. Araştırmanın ismi "Şizofreni Hastalarının Benlik Saygısı Ailelerinde Duygu Dışavurum ve Tükenmişlik Düzeylerinin İncelenmesi"dir.

Sizin de bu araştırmaya katılmanızı öneriyoruz. Bu araştırmaya katılıp katılmamakta serbestsiniz. Çalışmaya katılım gönüllülük esasına dayalıdır. Kararınızdan önce araştırma hakkında sizi bilgilendirmek istiyoruz. Bu bilgileri okuyup anladıktan sonra araştırmaya katılmak isterseniz formu imzalayınız.

Bu araştırmayı yapmak istememizin nedeni, evliliğin uyum ve bireyler arası ilişkilerinde ki önemidir. Yakın Doğu Üniversitesi Sosyal Bilimler Enstitüsü Uygulamalı (Klinik) Psikolojisi Anabilim Dalları'nın ortak katılımı ile gerçekleştirilecek bu çalışmaya katılımınız araştırmanın başarısı için önemlidir.

Eğer araştırmaya katılmayı kabul ederseniz doldurduğunuz formlar istatistiksel karşılaştırma amaçlı kullanılacaktır. Doldurduğunuz cevap formlarıyla, kişisel bilgileriniz ayrı zarflara konulacak ve gizlilik sağlanacaktır. Bu çalışmaya katılmanız için sizden herhangi bir ücret istenmeyecektir. Çalışmaya katıldığınız için size ek bir ödeme de yapılmayacaktır.

Bu çalışmaya katılmayı reddedebilirsiniz. Bu araştırmaya katılmak tamamen isteğe bağlıdır Yine çalışmanın herhangi bir aşamasında onayınızı çekmek hakkına da sahipsiniz.

ARAŞTIRMA AMAÇLI ÇALIŞMA İÇİN AYDINLATILMIŞ ONAM FORMU

(Katılımcının / Hastanın Beyanı)

Sayın Timur LENK ve Ebru Tansel ÇAKICI tarafından Psikoloji Anabilim Dalları'nda evlilik uyumu konusunda bir araştırma yapılacağı belirtilerek bu araştırma ile ilgili yukarıdaki bilgiler bana aktarıldı. Bu bilgilerden sonra böyle bir araştırmaya "katılımcı" olarak davet edildim.

Eğer bu araştırmaya katılırsam araştırmacı ile aramda kalması gereken bana ait bilgilerin gizliliğine bu araştırma sırasında da büyük özen ve saygı ile yaklaşılacağına inanıyorum. Araştırma sonuçlarının eğitim ve bilimsel amaçlarla kullanımı sırasında kişisel bilgilerimin ihtimamla korunacağı konusunda bana yeterli güvence verildi.

Projenin yürütülmesi sırasında herhangi bir sebep göstermeden araştırmadan çekilebilirim. (Ancak araştırmacıları zor durumda bırakmamak için araştırmadan çekileceğimi önceden bildirmemim uygun olacağının bilincindeyim)

Araştırma için yapılacak harcamalarla ilgili herhangi bir parasal sorumluluk altına girmiyorum. Bana da bir ödeme yapılmayacaktır.

Araştırma sırasında herhangi bir sırada sorun oluştuğunda istenilen saatte, araştırmacı Timur Lenk'i 0544 679 06 77 (cep) no'lu telefondan ve timurlenk.6516@gmail.com adresinden arayabileceğimi biliyorum Bu araştırmaya katılmak zorunda değilim ve katılmayabilirim. Araştırmaya katılmam konusunda zorlayıcı bir davranışla karşılaşmış değilim.

Bana yapılan tüm açıklamaları ayrıntılarıyla anlamış bulunmaktayım. Kendi başıma belli bir düşünme süresi sonunda adı geçen bu araştırma projesinde "katılımcı" olarak yer alma kararını aldım. Bu konuda yapılan daveti kabul ediyorum.

İmzalı bu form kâğıdının bir kopyası bana verilecektir.

Katılımcı	**Görüşme tanığı**	**Araştırmacı**
Adı, soyadı:	Adı, soyadı:	Adı, soyadı:
Adres:	Adres:	Adres:
Tel.	Tel:	Tel:
İmza:	İmza:	İmza:

SOSYODEMOGRAFİK VERİ FORMU

HASTANIN

1.Kaç yaşındasınız ?
.....

2.Cinsiyet
a)Erkek b)Kadın

3.Eğitim düzeyiniz?
a)Okur-yazar
b)ilkokul (5 yıl)
c)İlköğretim (8 yıl)
d) Lise
e) Yüksekokul-Üniversite

4.Medeni Durumunuz
a) Evli
b) Bekar
c) Boşanmış
d) Eşinden ayrı yaşıyor
e) Dul
f) Diğer

5.Meslek
a) Var (.....)
b) Yok(.....)

6.Çalışma Durumu
a) Çalışıyor
b) Çalışmıyor

7.Gelir düzeyiniz nedir?
a) 1.300 tl ve altı
b) 1.300-2.600 tl arası
c) 2.600-5.600 tl arası
d) 10.000 tl ve üzeri

8.Evinizde kimlerle yaşamaktasınız?
a) Yalnız
b) Sadece eşinizle
c) Eş ve çocuklar
d) Anne ve baba
e) Diğer (.....)

9. Kronik psikiyatrik bir hastalığınız var mı?
a) Evet ise lütfen belirtiniz.....

b) Hayır

10. Hastalık Başlangıç Yaşı_____

11.Bugüne kadar kaç defa psikiyatri servisinde yatarak tedavi gördünüz ?
.....

12.Son 1 yıl içinde kaç defa psikiyatrik servisinde yatarak tedavi gördünüz ?
.....

13. Alkol
a) Kullanıyor
b) Kullanmıyor

14. İlaç Kullanımı
a) Düzenli Kullanıyor
b) Düzensiz Kullanıyor

15. Sigara
a) Kullanıyor
b) Kullanmıyor

SOSYODEMOGRAFİK VERİ FORMU (HASTA YAKINI İÇİN)

Sayın Katılımcı,

Bu form psikiyatri tedavisi gören yakını olan aile bireyleri için hazırlanmıştır. En az 1 yıldır birlikte yaşadığınız ve 1 yıldan uzun zamandır psikiyatrik tedavisi süren aile bireyinizle ilgili aşağıdaki soruları cevaplamanızı rica ediyoruz.

1.Siz kaç yaşındasınız ?
.....

2.Cinsiyetiniz nedir?
a)erkek b)kadın

3.Eğitim düzeyiniz?
a)okur-yazar
b)ilkokul (5 yıl)
c) ilköğretim (8 yıl)
d)Lise
e)Yüksekokul/Üniversite
d) diğer (.....)

4.Medeni durumunuz nedir?
a) evli
b) bekar
c) boşanmış
d) eşinden ayrı yaşıyor
e) dul

5.Meslek
a) Var (.....)
b) Yok

6.Çalışma Durumu
a) Çalışıyor
b) Çalışmıyor

7.Gelir düzeyiniz nedir?
a) 1000 TL' nin altında
b) 1000-5000 TL arasında
c) 5000-10000 TL arası
d) 10000 TL ve üzeri

8.Evinizde kimlerle yaşamaktasınız?
a) sadece eşinizle
b) eş ve çocuklar
c) anne ve baba
d)diğer (.....)

9. Psikiyatrik tedavi gören akrabanız
a) Eşim
b) Annem veya Babam
c) Kardeşim
d) Diğer (.....)

10. Psikiyatrik tedavi gören yakınınız kaç yıldır tedavi görmektedir
(.....)

11. Psikiyatrik tedavi gören yakınınız kaç defa yatılı psikiyatrik tedavi görmüştür? (.....)

12. Psikiyatrik tedavi gören yakınınız son 1 yıl içinde kaç defa yatılı psikiyatrik tedavi görmüştür? (.....)

DUYGU DIŞAVURUM DÜZEYİ ÖLÇEĞİ (LEES)

AÇIKLAMA: Aşağıda birinin size karşı davranışlarını tanımlayan cümleler vardır. Lütfen birlikte yaşadığınız, sizin için önemli olan bir insanı düşünerek cümleleri okuyun ve tanımlanan biçimlerde davranıp davranmadığını Doğru (D), Yanlış (Y), şeklinde işaretleyin. Bunu yaparken son bir yılınızı düşünün.

1.Bazen konuşmak istemezsem eğer, beni anlar (zorlamaz) . (D) (Y)

2 Sinirlendiğimde o beni yatıştırır. (D) (Y)

3.Benim kendime ait kontrolümü o yitirdiğimi söyler. (D) (Y)

4.Beklentilerini doyuramadığım zamanlarda bile bana hoşgörülü davranır . (D) (Y)

5 Ben konuşurken müdahale etmez. (D) (Y)

6.Benim sinirlerimi bozmaz. (D) (Y)

7.İyi değilim dediğimde benim ilgi çekmek istediğimi söyler. (D) (Y)

8.Beklentilerini doyuramadığım zaman suçluluk duymama neden olur . (D) (Y)

9.Bana karşı aşırı bir koruyucu, kollayıcılığı yoktur. (D) (Y)

10.Kendimi iyi hissetmediğim zamanlar öfkelenir. (D) (Y)

11.Hasta veya keyifsiz olduğumda bana karşı anlayışlıdır . (D) (Y)

12.Benim olaylara bakış açımı anlayabilir. (D) (Y)

13.Her zaman müdahalecidir. (D) (Y)

14.Bir şeyler kötüye gitmeye başlayınca korku v heyecana kapılmaz. (D) (Y)

15.Kendimi kötü hissettiğimde bana dışarıdan yardım aramam için cesaret verir. (D) (Y)

16.Ona birçok sorun yarattığımı düşünmez. (D) (Y)

17.Bir şeyleri benimle yapmak konusunda ısrar etmez. (D) (Y)

18.İşler sarpa sarınca doğru dürüst düşünmez. (D) (Y)

19.Keyifsiz huzursuz olduğumda bana yardımcı olmaz. (D) (Y)

20. Benden umduğunu bulamazsa beni aşağılar. (D) (Y)

21. Yanımdan ayrılmamak sürekli benimle olmak gibi bir düşüncesi yoktur. (D) (Y)

22. Yolunda gitmeyen işler için beni suçlar. (D) (Y)

23. Benim bir insan olarak değerli olduğumu hissettirir. (D) (Y)

24.Keyifsiz huzursuz ya da kafam karışık olduğunda bu duruma tahammül göstermez. (D) (Y)

25.Beni çaresizliğim ve bunalımla öylece bir kenara bırakır. (D) (Y)

26. Kötü olduğum zamanlarda benim duygularımı nasıl ele alacağını bilmez . (D) (Y)

27.Sorunlarımı ondan öç almak için yarattığımı söyler. (D) (Y)

28. Benim özelliklerimi (özelliklerimin sınırlarını), neyi becerip beceremediğimi bilir. (D) (Y)

29. Ne yaptığımı bilmek içi beni sık sık kontrol eder. (D) (Y)
30. Zor durumlar karşısında soğukkanlılığını ve kendine hakimiyetini koruyabilir. (D) (Y)
31. Hasta olduğumda benim kendimi iyi hissetmem için uğraşır. (D) (Y)
32. Benim neyi becerip beceremeyeceğim konusunda gerçekçidir. (D) (Y)
33. Her zaman işlerime burnunu sokar. (D) (Y)
34. Söylediğim şeyleri sonuna kadar dinler. (D) (Y)
35. Uzman yardımı aramanın doğru olmayacağını söyler. (D) (Y)
36. İşler yolunda gitmediği zaman bana öfkelenir. (D) (Y)
37. Hakkımda her şeyi mutlaka öğrenmek ister. (D) (Y)
38. O yanımda olduğu zaman huzurlu ve rahat hissetmemi sağlar. (D) (Y)
39. İyi olmadığımı söylediğimde beni abartmakla suçlar. (D) (Y)
40. Bir şeyler yolunda gitmese bile bana karşı hep sabırlıdır. (D) (Y)
41. Gittiğim yeri mutlaka ısrarla öğrenmek ister. (D) (Y)
42. Bana sebepsiz yere öfkelenir. (D) (Y)
43. Hasta olduğum zaman ilgili biri olur. (D) (Y)
44. Desteğine ihtiyacım olduğum zaman esirgemez. (D) (Y)
45. Benim özel meselelerime karışır. (D) (Y)
46. Zor (stres yaratan) bir durumla kolayca başa çıkar. (D) (Y)
47. Kendimi iyi hissetmiyorsam, durumumu merak eder ve anlamak ister. (D) (Y)
48. Bir hata yaparsam anlayışla karşılar. (D) (Y)
49. Hayatıma burnunu sokmaz. (D) (Y)
50. İyi olmadığım zaman bana tahammülü yoktur. (D) (Y)
51. Kendimi kötü hissettiğimde bundan dolayı beni suçlamaz. (D) (Y)
52. Benden çok fazla şey bekler. (D) (Y)
53. Şahsıma ait çok özel konularda çok soru sormaz. (D) (Y)
54. İşler yolunda gitmediği zamanlar o işleri daha da kötüleştirir. (D) (Y)
55. Kendimi iyi hissetmediğim zaman, o bunları benim yarattığımı söyleyerek sık sık beni suçlar. (D) (Y)
56. Ben her şeyi beceremeyince zıvanadan çıkar çok öfkelenir. (D) (Y)
57. Geliş gidiş saatlerim konusunda onu haberdar etmesem huzursuz olur. (D) (Y)
58. İşler iyi gitmediği zamanlar huzursuz olur. (D) (Y)
59. Kendimi iyi hissetmediğim zamanlarda bana güven verir, destek olur. (D) (Y)
60. Kendimi iyi hissetmediğimde bile benden aynı gayreti bekler. (D) (Y)

MASLACH TÜKENMİŞLİK ÖLÇEĞİ (MBI)

Sizden istenen her bir ifadenin örneklediği durumu ne kadar sıklıkla yaşadığınızı uygun yanıt aralığına çarpı (X) işareti koyarak belirtmenizdir.

MADDELER:

1.Hastamdan soğuduğumu hissediyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

2.Gün sonunda kendimi ruhen tükenmiş hissediyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

3.Sabah kalktığımda bir gün daha bu işi kaldıramayacağımı hissediyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

4.Hastamın ne hissettiğini hemen anlarım.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

5.Hastama sanki insan değilmiş gibi davrandığımı fark ediyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

6.Bütün gün hastamla uğraşmak benim için gerçekten çok yıpratıcı.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

7.Hastamın sorunlarına en uygun çözüm yollarını bulurum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

8.Hastamın bakımına yönelik yaptığım işten yıldığımı hissediyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

9.Yaptığım şeylerle hastamın yaşamına katkıda bulunduğuma inanıyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

10.Hastamla birlikte olmaya başladığımdan beri insanlara karşı sertleştim.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

11.Hastamın bakımının beni giderek katılaştırmasından korkuyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

12.Çok şeyler yapabilecek güçteyim.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

13.Hastamın beni kısıtladığını düşünüyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

14.Hastamın bakımı konusunda çok fazla çalıştığımı hissediyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

15.Hastama ne olduğu umurumda değil.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

16.Doğrudan doğruya hastamla ilgilenmek bende çok fazla stres yaratıyor.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

17.Hastamla aramda rahat bir hava yaratırım.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

18.Hastamla birlikte olduktan sonra kendimi canlanmış hissederim.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

19.Hastamın bakımına yönelik birçok kayda değer başarı elde ettim.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

20.Yolun sonuna geldiğimi hissediyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

21.Hastamla ilgili duygusal sorunlara serinkanlılıkla yaklaşırım.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

22.Hastamın bazı problemlerini sanki ben yaratmışım gibi davrandığını hissediyorum.

Hiçbir zaman () Çok nadir () Bazen () Çoğu zaman () Her zaman ()

ROSENBERG BENLİK SAYGISI ÖLÇEĞİ (RSES)

1. Kendimi en az diğer insanlar kadar değerli buluyorum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

2. Bazı olumlu özelliklerim olduğunu düşünüyorum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

3. Genelde kendimi başarısız bir kişi olarak görme eğilimindeyim.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

4. Ben de diğer insanların birçoğunun yapabildiği kadar birşeyler yapabilirim.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

5. Kendimde gurur duyacak fazla birşey bulamıyorum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

6. Kendime karşı olumlu bir tutum içindeyim.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

7. Genel olarak kendimden memnunum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

8. Kendime karşı daha fazla saygı duyabilmeyi isterdim.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

9. Bazen kesinlikle kendimin bir işe yaramadığını düşünüyorum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

10. Bazen kendimin hiç de yeterli bir insan olmadığımı düşünüyorum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

CURRICULUM VITAE

PERSONAL INFORMATIONS

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EDUCATION STATUS

- 2014-2016 : Near East University, Institute of Social Science, Clinical Psychology Master Program
- 2009-2014 : Near East University, Faculty of Arts and Social Sciences, Psychology Undergraduate Program

WORK EXPERIENCES

- June-August, 2014: Çekirge Devlet Hatanesi, Internship of Clinical Psychology, Intern Psychologist.
- June-August, 2015: Uludağ Üniversitesi Tıp Fakültesi Hastanesi , Internship of Clinical Psychology, Intern Psychologist.
- September, 2015 : Şevket Yılmaz Eğitim Araştırma Hastanesi, Psychologist.
- February, 2015: Göloğlu Bursa Rehabilitasyon Merkezi, Internship of Clinical Psychology, Intern Psychologist.

FOREIGN LANGUAGES

- English (Reading, Writing, Speaking: Good Level)

TİMUR LENK – VAN

Doğum tarihi: 12/11/1988

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Askerlik Durumu: Tecilli (2016)

Kariyer Hedefim:
Lisans ve yüksek lisans eğitimim süresince edindiğim bilgi ve becerilerimi geliştirerek hizmet edeceğim kurumlara, edindiğim bilgi birikimi ile olumlu yönde katkılarda bulunup söz sahibi olabilmek.

Eğitim:

İlköğretim: İkinisan İlköğretim Okulu (1995/2003)

Lise: Atatürk lisesi(2003/2006)

Lisans: Yakın Doğu Üniversitesi Fen Edebiyat Fakültesi Psikoloji Bölümü (mezun-2009/14)

Yüksek lisans: Yakın Doğu Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji Programı(2014-16)

Katıldığım Eğitim ve Seminerler:
- Madde bağımlılığı konferansı (Kıbrıs Türk Tabipler birliği)
- Psikodrama sempozyumları (Doç. Dr. Ebru Çakıcı)
- Ruh sağlığı sempozyumları(KKTC)
- Psikolojik test eğitimleri (Uludağ üniversitesi) Bursa

İş/Staj Deneyimlerim:
- Çekirge devlet hastanesi(2012 stajyer) (3 ay)
  Klinik psikolog, Çocuk gelişimi stajyeri

- Uludağ üniversitesi tıp fakültesi hastanesi 2015/2016 (4 ay)
  Staj – Klinik psikolog, çocuk gelişimi, yatan hasta vizit kontrolleri, rapor hazırlama, test uygulama, yorumlama
  Bender-gestalt (çocuk), mmpı(kodlama yorumlama), kentgy,scl90, wısc-r, leiter(çocuklarda), vb. hepsini uygulama ve yorumlama rapor hazırlama ve hastaya sunma.

- Şevket yılmaz eğitim araştırma hastanesi 2015 (2 ay).

Projeler:
- Kıbrıs savaşının mücahitler üzerinde etkisi (Kıbrıs genelinde yüksek lisans bitirme tezi spss kodlamadlı).
- Kumar bağımlılığının kültürsüzleşme üzerindeki etkisi (Kıbrıs genelinde bitirme tezi spss kodlamalı, dil İngilizce olarak).

Yabancı Dil:
- İngilizce: Okuma: Çok iyi, Yazma: Çok iyi, Anlama: İyi

İlgi Alanlarım:
- Klinik ortamı
- Sosyoloji ve Psikoloji
- Kişisel Gelişim,

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