EMOTIONAL AND BEHAVIORAL PROBLEMS IN RELATION WITH THE ATTACHMENT SECURITIES OF ADOPTED VS. NON-ADOPTED CHILDREN AND THE CHILD REARING PRACTICES OF THEIR PARENTS

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Approval of the Graduate School of Social Sciences

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I certify that this thesis satisfies all the requirements as a thesis for the degree of Doctor of Philosophy.

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This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Doctor of Philosophy.

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ABSTRACT

EMOTIONAL AND BEHAVIORAL PROBLEMS IN RELATION WITH THE ATTACHMENT SECURITIES OF ADOPTED VS. NON-ADOPTED CHILDREN AND THE CHILD REARING PRACTICES OF THEIR PARENTS

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This study aimed to explore the emotional and behavioral problems of Turkish adoptees and compare them with non-adopted peers raised by their biological parents. To fulfill this aim, 61 adopted children aged between 6-18 were compared to 62 age and gender matched non-adopted children. A second classification was made in terms of being followed in a child psychiatry unit. Both parents were asked to rate their children's problem behaviors on "Child Behavior Check List / 6-18", temperament characteristics on "School Age Temperament Inventory", their own personality traits on "Basic Personality Traits Inventory" and own parenting styles on "Measure of Child Rearing Styles". Children were asked to rate both parents' availability and reliability as attachment figures on "Kerns Security Scale" and parenting styles on "Measure of Child Rearing Styles". Adolescents between ages 11-18, rated their own problem behaviors on "Youth Self Report". Group differences and correlations were analyzed. The results indicated non-significant differences between adopted and non-adopted groups in all of the measures. Children in clinical group unit displayed more problem behaviors, were less task persistent and had more activity than children in non-clinical group. Children under 10 years rated their mothers as being more available attachment

figure, being more accepting and responsive than their fathers. Contrary to the literature, age of the child at the time of adoption was not found to be related with problem behaviors or attachment relations. On the other hand, results indicated that the older the child learned about her/his adoption status, the more emotional and behavioral problems occurred. Findings of the study were discussed in the frame of relevant literature. Clinical and policy implications were offered.

Keywords: Adoption, Adopted Children, Problem Behaviors, Attachment, Parenting Style

ÖZ

EVLAT EDİNİLMİŞ VE BİYOLOJİK EBEVEYNLERİYLE YAŞAYAN ÇOCUKLARIN DAVRANIŞSAL VE DUYGUSAL SORUNLARI VE BAĞLANMA DÜZEYLERİ İLE ANNE BABALARININ ÇOCUK YETİŞTİRME STİLLERİNİN KARŞILAŞTIRMALI OLARAK DEĞERLENDİRİLMELERİ

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Bu çalışmanın amacı, evlat edinilmiş ve biyolojik ailesi yanında yaşayan çocukların davranışsal ve duygusal sorunlarını, çocukların bağlanma ilişkileri ve ebeveynlerinin çocuk yetiştirme stilleri kapsamında karşılaştırmalı olarak değerlendirmektir. Bu amaçla 6-18 yaşları arasındaki 61 evlat edinilmiş çocuk ve yaş/cinsiyet bakımından eşleştirilmiş biyolojik ailesi yanında yaşayan 62 çocuk ile bu çocukların ebeveynleri araştırmaya dahil edilmişlerdir. Evlat edinilip edinilmeme durumlarının yanısıra, herhangi bir çocuk ruh sağlığı biriminde izlenip izlenmeme durumları da dikkate alınarak bu çocuklar dört grupta değerlendirilmişlerdir. Çocukların duygusal ve davranışsal sorunlarını değerlendirmek üzere anne ve babalar ölçekler doldurmuşlar, ayrıca 11-18 yaş arasındaki ergenler kendilerini değerlendirmişlerdir. Anne-babalar ayrıca çocuklarının mizaç özelliklerini, kendi kişilik özelliklerini ve kendi ebeveynlik

stillerini değerlendirmişlerdir. Çocuklar, anne ve babalarının duyarlılık ve ulaşılabilirliklerine olan güvenlerini ve anne babalarının ebeveynlik stillerini değerlendirmek üzere ölçek doldurmuşlardır. Veri toplanmasının ardından grup farklılıkları ve korelasyonlar analiz edilmiştir. Sonuçlar evlat edinilmiş çocukların hiçbir ölçümde, biyolojik aileleriyle yaşayan akranlarından farklı olmadıklarını göstermiştir. Öte yandan, klinik gruptaki çocukların anneleri, diğer gruba göre daha fazla duygusal ve davranışsal sorunlar rapor etmiş, çocuklarının bir görevi sürdürmede daha az başarılı ve mizaç olarak daha hareketli olduklarını belirtmişlerdir. 10 yaşından küçük çocuklar, büyük çocuklara göre anne ve babalarını daha fazla duyarlı ve güvenilir olarak algılamış ve anne babalarını daha kabul edici ebeveynler olarak değerlendirmişlerdir. Alanyazınından farklı olarak, çocuğun evlat edinilme yaşı, sorun davranışı ile ya da anne babasına bağlanması ile ilişkili bulunmamıştır. Öte yandan, çocuğun evlat edinildiğini öğrenme yaşı ile sorun davranışları arasında anlamlı bir ilişki bulunmuş, çocuğun özel durumunu öğrenme yaşı geciktikçe sorun davranışlarının da arttığı gözlenmiştir. Bu sonuçlar ilgili alanyazını çerçevesinde tartışılmıştır. Ayrıca, klinik uygulama ve politika oluşturma ile ilgili öneriler tartışılmıştır.

Anahtar kelimeler: Evlat Edinme, Sorun Davranışı, Bağlanma, Çocuk Yetiştirme Stili

to my mother

and

to my beautiful princess & charming prince

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INTRODUCTION

"Family" is defined as the basic unit in society, traditionally consisting of two parents rearing their children (Merriam Webster Online Dictionary). The term "two parents rearing their children" used to mean a mother giving birth to children and rearing them together with her husband. Family structure has changed in the last century; in the first place, marriage is not essential anymore to form a family. The companion of a mother and a father together is not always necessary; there are single parents, and gay and lesbian parents. Also giving birth to a child is neither necessary nor sufficient to form a family. There are parents who cannot give birth to a child and there are children who are not raised within their birth families. Regardless of the type of the family (birth or not) or type of the parents (traditional, single or same-sex) being raised in a warm, loving and caring family is very important for physical, intellectual and emotional development of a child.

Pre-, peri- and post-natal difficulties, malnutrition, unhealthy home environment, psychiatric illness in the family and/or substance abuse by the biological parents place the children at biological and psychological risk for later problems. Neglect and abuse within the family in the early ages is a negative factor for the development of the children. In addition, economic problems and illegitimate children are the main reasons for child abandonment. According to the international child protection laws and policies, children have the rights to be raised in a healthy home environment with their families. When the children are abandoned or do not have healthy living conditions, the social system has to provide alternative solutions for them. Usually the first step is placing the child into residential care. However, the literature provides us with the information about the negative outcomes of residential care for the brain development of children under 5 years of age (Browne, 2008). When it is not possible to stay in their birth families,

alternative permanent placements rather than institutions should be provided, preferably through foster care or adoption.

If the reunion of the child and birth family is not possible or is not safe for various reasons, then adoption seems as a healthy solution. “Adoption” is placing a child permanently and legally within a family, other than her/his biological parents who are not able or willing to take care. This new family could be either relatives of the child (*kinship adoption*) or completely unrelated adults (*non-kinship adoption*) in the home country (*domestic adoption*) or even from a different country (*international adoption*). Adoption process involves mainly three parties: the adopted child (*adoptee*), the adoptive parents (*adopter*) and the biological parents (*birth parents*).

1.1 Adoption Studies

1.1.1 Overall adjustment, psychosocial problems

Studies on adopted children indicate that adopted children perform significantly better than their peers in residential care (Browne, 2008) and foster care, but have, although slightly, more emotional and behavioral problems than their peers raised by biological parents. Hodges (2005), reported that adopted children showed significantly less criminal/antisocial behaviors, had less psychiatric hospitalization and substance abuse when compared to their biological parents or biological siblings raised by their biological parents. However, same adopted children had higher scores of maladaptive behaviors than age and SES matched non-adopted children. In another study, it was found that, although no differences were observed between the IQ scores, adopted children had more learning problems, were less successful in school and received more special education services than their peers living with their biological parents (van IJzendoorn, Juffer, & Klein Poelhuis, 2005).

Through adoption, children get a better permanent life, relatively higher educated, loving, and nurturing parents. This leads to less behavior and emotional problems than non-adopted siblings or peers in residential or foster care (Johnson, 2002). It is also reported that adoption could reverse some of the deficits associated

with being in residential care in the early childhood. In a follow-up study (Rutter & The English and Romanian Adoptees Study Team, 1998), internationally adopted children from Romanian orphanages were behind their non-adopted peers living with their biological parents, in terms of cognitive and physical development at the time of adoption (59% were considered as retarded and 15% were mildly retarded). Results of the study showed that, at age 4, cognitive scores and the physical developmental levels of these children were within the normal range and were better than their peers still living in the Romanian orphanages.

Rosnati, Montirosso & Barni (2008), asked 186 adopted and 195 non-adopted Italian mothers and fathers to rate their children aged between 7-11 years. Adoptive parents reported more externalizing behaviors than non-adoptive parents. Adopted children had more attention deficits and aggressive behaviors than non-adopted peers.

In a Greek study (Vorria, Papaligoria, Sarafidou et al., 2006), 61 adopted children were compared to 39 children reared by their biological parents. Although the adopted children were not developmentally delayed for the age of 4, they scored poorer in cognitive assessments, they were less secure and had more difficulties in understanding emotions than the comparison group. In 1988, Tsitkas, Coulacoglou, Mitsotakis and Driva studied the development of adopted children who lived in a center for babies for 3-36 months (cited in Vorria et al., 2006, p.1247). Adopted children (aged between 5.6 and 6.6 years), whose physical development and health conditions were as good as their non-adopted peers, had more behavior problems, less social competence, and had more difficulties in practical reasoning, reading and writing than their classmates.

There are a great number of studies conducted between 70s and 90s reporting poorer social competence or more emotional, behavioral and educational problems of adoptees when compared to non-adopted peers (Simmel, Brooks, Barth, & Hinshaw, 2001; Xing Tan, 2006). Howe (1997), quoted studies reporting adopted children (who were adopted at an early age) as having better adaptations than children reared in single-parent families or illegitimate children. But at the same time, these children showed more externalizing problems, had more behavior

and peer relations problems, were more unhappy and anxious in adolescence than children raised by two biological parents.

These results bring the question "is adoption a risk factor or a protective factor?" in minds. It seems like, there is no exact answer for this question, and it depends on whom we compare the adopted children to? To the children raised by their biological parents? To the children who are in foster care? To the children still living in institutions? Or to their biological siblings, still living with their birth parents?

Van IJzendoorn and Juffer (2006), argued that comparing to "past peers" (peers left behind in the institution or biological siblings); adoption is a protective factor and curative intervention for the adopted children. On the other hand, comparing to the "current peers" (non-adopted peers living with their biological parents) adoption might be considered as a risk factor (p.1229). Van den Dries, Juffer, van IJzendoorn, and Bakermans-Kranenburg (2009) stated that adoption implies risks (e.g., deprivation before placement) as well as protection (e.g., receiving nurturing care and stimulation from alternative parent figures, p.411).

Many authors agreed on the fact that adopted children or adolescents are over represented in mental health services (Hodges, 2005; Howe, 1997; Groza & Ryan, 2002; Juffer & van IJzendoorn, 2005; Nickman, Rosenfeld, Fine, et al, 2005). Adopted children are referred for psychological evaluation 2-5 times more often than non-adopted peers (Wilson, 2004). Adoptive families sought more help from mental health services than non-adoptive parents even though their children show equal or less amount of problems when compared to children living with their birth parents. On the other hand, non-clinical studies reported minor adjustment differences between adopted and non-adopted groups. Although over-represented in clinical settings most of the adoptees do not experience clinically significant impairment.

Over-representation of adopted children/adolescents is not by itself sufficient to accept these children as more problematic. It is argued that (Wilson, 2004; Juffer & van IJzendoorn, 2005) adoptive parents were slightly more educated and had higher socio-economic status than non-adoptive parents. Besides, adoption procedures make them familiar with mental health services and they know how to

access those services. Hodges (2005), also stated that adoptive parents are more anxious and more vigilant than non-adoptive parents, and thus they may be more likely to perceive minor problems as more serious. On the other hand, teachers or school counseling services may report more problems when they are aware of the adoption (Juffer & van IJzendoorn, 2005). Additionally, mental health professionals might also be biased in responding to the adoptive parents and might perceive behaviors and symptoms of children as more serious in case of adoption (Hodges, 2005; Simmel et al., 2001).

1.1.2 Risk and protective factors

There are some genetic, biological, and environmental risk factors associated with later adjustment problems, psychosocial difficulties, or psychopathology.

Genetic factors include mental retardation, mental illnesses, and/or substance abuse of biological parents. There is some evidence that birth mothers of adopted children were impulsive (Simmel et al., 2001), where impulsivity might be a cause for parental substance abuse and a risk factor of Attention Deficit Hyperactivity Disorder (ADHD) for children. Young age of the birth mother is also associated with ADHD and Oppositional Defiant Disorder (ODD).

Biological factors include poor pre- and post-natal care (e.g., malnutrition or unhealthy living conditions due to poverty), birth complications, maternal age above 35 or below 20 at birth, low birth weight and/or gender of the child - where boys were reported to have more behavior problems than girls (Elmund, 2007; Howe, 1997; Simmel, 2007; Stams, Juffer, & van IJzendoorn, 2002).

Environmental risk factors would be neglect or abuse before adoption, abandonment, living in the institutions more than 3 months (Browne, 2008), having multiple foster care placements resulting with frequent changes of caregivers and leading to difficulties in forming healthy attachment relations. Age of the adoptee at the time of adoption is an important factor, the younger, the better! When searched for the later developed behavior problems of adopted children who were adopted as babies and received good care, the existence of a biological child of the adoptive parents were found to be related to behavior problems of the adopted children

(Nickman et al., 2005). If the biological child joins the family after the adoptee does, than the risk is tripled (Howe, 1997).

On the contrary, presence of another adopted sibling is found to be (although slightly) a protective factor. The other protective factors were listed as being female, having a good quality care before adoption and good parent-child relations in the adoptive family.

Most of the above mentioned factors are not only associated with later adjustment problems, but also they have short-term negative consequences. Adoption at older ages, gender (boys are less advantaged), child's pre-adoption history and/or existence of behavioral and emotional problems are strongly associated with disruption of the adoption, i.e., removing the child from the adoptive family at some point prior to the legalization of adoption (Simmel, 2007; Smith-Mc Keever, 2006). Elmund (2007), reported in her Swedish study that, the higher age of the child at adoption was among the strong predictors of out-of-home care after 10 years of age.

1.1.3 Age of the child at the time of adoption

Age of the children at adoption plays an important role in the adjustment of adoptees. Studies indicated that children adopted in infancy show normal range of family and school functioning whereas children adopted at an older age have greater risk for psychopathological symptoms. Post Traumatic Stress Disorder (PTSD) symptoms and/or difficulties in forming attachment are reported for children who were adopted after 6 months of age (Fensbo, 2004; Hodges, 2005, Howe, 1997). Howe (1997), declared that good-quality care before adoption and being female are found to be two protective factors for better adjustment of adoptees who were not adopted at an early age.

In a study conducted with adoptees from Romanian orphanages, children who were adopted in the first 3 months of their lives, did not show significant differences than the control group in terms of cognitive development. Children who stayed 8 to 24 months at the orphanage before adoption, had average intelligence scores, whereas older (after 24 months) adopted children were assessed as mildly retarded (Rutter et al, 1988).

Early adopted children have more stable homes and lives. On the other hand, older adopted children had most probably experienced neglect and abuse in their birth homes or had to move from one place to another, i.e., from residential care to foster care. In case the adoptees had chances to spend some time with their birth parents when they were very young, it is likely that they were taken care of by incompetent, neglectful, abusive, or rejecting parents (Howe, 1997).

The length of time the children spent in their new families was associated with better functioning (Van den Dries et al., 2009). Spending more time with caring and nurturing parents, they have more time and opportunity to recover from previous traumas. Results of a meta-analysis revealed that the children who spent more than 12 years with their adoptive parents showed a larger catch-up in terms of behavior problems than children who had spent shorter time with the new parents (Juffer & van IJzendoorn, 2005). Thus, there is a general agreement on that adopting a child as early as possible gives the child the opportunity to spend longer time with her/his adoptive parents.

Only one study, reporting no association between adopted children's problem behaviors and age at placement, was encountered (Rosnati et al., 2008).

Age of the child at the time of adoption, has been reported as a risk factor for the disruption of adoption. In 1997, Howe stated that 10% to 50% of older adoptions were terminated, rates were increasing as the child gets older at the time of adoption. A recent study also reported that only 3% of infant-placed adoptions were disrupted in UK in 1995, whereas 7-21% of older adoptions were disrupted (cited in Nickman et al., 2005, p.989). Dance and Rushton (2005), followed 99 children who were between 5-11 years of age when they were adopted. After 6 years, 23% of the adoptions were disrupted, 49% were continuing positively, and 28% were continuing with difficulties.

In summary, adopted children are reported as having more psychosocial problems or educational difficulties than children reared by their biological parents. These are slight differences, but differences between adopted children and children living in the institutions were quite clear in favor of adopted children. Among the risk factors, age at adoption is one of the important factors, the earlier the child is adopted, the better is her/his later adaptation.

1.1.4. Adoption in Turkey

1.1.4.1. Adoption services in Turkey

The first known Ottoman institution for the orphans was founded in 1863 (cited in Erol, Şimşek, & Üstüner, 2005, p.23). In 1886, Darülaceze was founded in İstanbul as a shelter for the homeless; 3 years later separate wards were built for the homeless infants and children (Darülaceze, 2009). After 1917, because of the World War I, a large number of children all over the country were placed in the orphanages. Because of the overload of the institutions, children were given to the families as adoptees or apprentices. Adoption was legally recognized after the establishment of the first Turkish Civil Law in 1926 (cited in Asma, 2008, p.124).

According to Turkish Civil Law, adoption is defined as a procedure to establish a legal parent-child connection between a child who is not able to grow within her/his birth family and an adult who is eligible to adopt. Eligibility conditions are provided in the official web site of The General Directorate of Social Services and Child Protection Agency (Sosyal Hizmetler ve Çocuk Esirgeme Kurumu Genel Müdürlüğü –SHÇEK).

Today, adoption services are executed according to the 305th to 320th articles of Turkish Civil Law (renewed in 2001). Adoption is possible either directly from the biological parent or from the legal guardian of the child or through The General Directorate of Social Services and Child Protection Agency (SHÇEK). Official website of SHÇEK reports that approximately 500 children are being adopted each year (SHÇEK, 2009a). Up to December 31 2008, SHÇEK organized the adoption of 9794 children (official letter from SHÇEK, e-mail dated February 3, 2009, see Appendix A).

Children whose biological parents had given consent for adoption in a court decision, or children for whom SHÇEK holds a court order for not asking biological parents' consent, are eligible for adoption. Biological parents' consent are not asked if the parents are unknown (or cannot be found), if the parent has a mental disorder, has no judicial mind (non compos mentis), or if the parent does not fulfill parental duties.

Special needs children (children who have birth anomalies, physical or mental disabilities or who need continuous medical care because of chronic health problems such as heart or kidney diseases etc.) are not eligible for adoption. Children above 4 years of age, are not very lucky in terms of adoption, generally, the candidate parents prefer infants or younger children. In addition, it is not easy to place sibling groups into adoption. Therefore, children with biological siblings and above age 4 are also considered as special needs children.

Hague Conventions on Children's Rights (item 21/b) declared that international adoption might be considered if the child cannot be given a good care or can not be adopted within her/his homeland. Turkish translation of the Conventions is available in the official website of SHÇEK (2009b). Turkey has signed the Conventions on September 14, 1990. As there is a long waiting list for adoption, since September 1, 2004 *children who are not eligible to be adopted in Turkey* are placed within Turkish families abroad, aliens residing in Turkey or for international adoption. Approximately 50 children were adopted by Turkish citizens residing abroad. Only five children were given for international adoption (official letter from SHÇEK, Appendix A).

In 2005, families within the adoption or foster care system and allied professionals (Childcare specialists, child psychiatrists, clinical psychologists, developmental psychologists, lawyers, pediatricians, social workers, special educators etc.) founded "*The Association for Foster Care and Adoption*" in Ankara, under the presidency of Prof. Dr. Neşe Erol. This association is not a mediating institution for foster care or adoption services, instead the main objective is to provide support for adoptive and foster or candidate families via family support groups, educational seminars, and clinical or legal consulting.

1.1.4.2. Adoption Studies in Turkish literature

The psychology of adopted children and their families received unfortunately insufficient attention in the Turkish literature. Because adoption services are organized by SHÇEK and family courts are the only authority, most of the time adoption is considered as a subject of social work and law. In the Turkish literature, the term "adoption" is mentioned only in medical articles, which compare

genetic and environmental factors (Turk Medline, 2009). Keyword search in YÖK Library (2009) indicates, 16 masters and one doctoral theses on adoption between 1986 and 2007. Thirteen out of seventeen studies are about adoption in Turkish Law, two are on adoption according to Islamic Law, and the remaining two are about social work area. As can be seen easily, psychology has not given much attention to the subject. However, besides these limitations, steps are taken to fill the gap with two recent publications.

Erol (2008) edited a book, which includes the written scripts of symposium presentations on Foster Care, Adoption Services and Mental Health. The book also contains contributions of foster and adopted children and their families. In the same year, Erol & Şimşek (2008), summarized the adoption literature and problems that may arise in different developmental stages in a chapter of a child psychiatry textbook.

1.2 Attachment Studies

1.2.1 Theoretical background for attachment

Mother-child bonding has always been a subject of interest for many authors. From the evolutionary theorists to psychoanalysts, from animal studies or behavioral studies to the theory of object-relations, many authors and researchers provided explanations on this area. Within the scope of this study, only the modern attachment theory and its contributors will be presented and discussed in the next sections.

1.2.1.1 John Bowlby

It is not misleading to consider John Bowlby as the "father" of the attachment theory. Although he was trained by the child psychoanalyst Melanie Klein, he was deeply interested in real-life relationships and scientific observations rather than children's inner fantasies.

According to Bowlby (1980), from the moment of birth, human beings have an innate psychobiological system to seek security for survival. This system motivates the humans to seek proximity to the people who will protect them in

times of danger or threat. These people (*attachment figures*) are usually the mothers of the babies, but some other primary caregivers might become attachment figures as well. In case of any perceived threat, the infant searches for security; the availability and responsiveness of the attachment figure makes the infant feel secure and develop a *secure attachment* relationship with the caregiver. If the infant does not receive a predictable and caring response from the caregiver in case of a perceived threat, then s/he feels insecure, develops *insecure attachment* and learns to cope with stress in her/his own way by organizing her/his behaviors (*attachment behaviors*) to increase the availability and responsiveness of the caregiver when needed.

Bowlby (1969), proposed two forms of attachment behaviors for the development of attachment between the child and the attachment figure. The first form of attachment behaviors is the "*signaling behaviors*", where these behaviors bring the mother to the child. Crying, smiling, babbling, being fussy etc. are the examples of signaling behaviors that the child displays to receive the attention of the mother. In addition to these behaviors, children also display "*approach behaviors*". Behaviors like seeking and following the mother, clinging, asking for cuddling etc. bring the child to the mother. Each child displays various forms of seeking and following behaviors depending on her/his level of motor development. Non-nutritional sucking or nipple grasping are also considered as approach behaviors. If the caregiver is responsive to those attention seeking behaviors in a consistent manner, then the child learns to deal with her/his anxiety and to cope with that threat. After the perceived threat is terminated by the attachment figure, the infant starts to explore the environment, which is essential for social and mental development. On the other hand, if the attachment figure is not dependable, consistent or predictable, the infant would feel anxious, display behaviors either to minimize the contact with the caregiver to avoid rejection, or to get maximum attention.

While developing attachment relationships with the caregivers, children also develop *internal representations (working models)* about themselves and the others from the likelihood of availability of the caregiver and receiving support in the existence of any perceived threat. Bowlby (1973), proposed two mental

representations about self and others, which will form basis for future relationships. Expectations of the infant / young child about the availability of the caregiver, about the likelihood of receiving support from that person when exposed to a stressful event, leads her/him to form positive or negative beliefs about the self and the others. Parents' attitudes toward their children play a great role in this formation. In the *positive model*, the child receives warm, communicative and open responses from the caregiver and feels that s/he is lovable, worth loving and caring and the others are available, supportive and dependable when needed. Therefore, the child learns to seek intimacy and support from others in times of distress. *Negative working model*, will more likely to occur when the caregiver is unavailable or unpredictable. The child feels that s/he is not lovable and not worth loving and caring. As a result, the child learns not to expect any support and intimacy from others and becomes dismissing or avoidant in social relations. Although these internal models influence the development of attachment relationships, according to Bowlby, they can be changed with new and corrective experiences in the first five years.

1.2.1.2 Mary Ainsworth

If Bowlby is the father of the attachment theory, then the psychologist Mary Ainsworth is definitely the "mother". With her systematic experimentation approach to identify children's different styles of attachment behaviors and later the classification of those behaviors, she made great contributions to Bowlby's attachment theory.

Ainsworth, observed mother-child relationships in Canada, England, Uganda, and United States, and she believed that physical caregiving was not sufficient for the development of secure attachments. It was the quality of the relation during caregiving and the mother's emotional well-being that made the difference (cited in Brandell & Ringel, 2007, p. 45)

Based on these observations, she developed an experimental observation technique, which she named "The Strange Situation" (Ainsworth, Blehar, Waters & Wall, 1978). In this 8-stage experiment, the child's behaviors are observed during the presence and non-presence of the mother with the inclusion of a stranger (the

observer) into the scene and child's responses at the time of reunion with mother upon her arrival after 3 minutes of absence. From these observations, three groups of children with different attachment styles were identified.

1. Secure attachment: Sixty-five percent of the children that were observed showed similar behavior patterns, which Ainsworth categorized them as Group B. During The Strange Situation experiment, these children played and explored when they were alone with their mothers but played less when the stranger was present. They cried shortly when the mother left the room and showed their happiness at the reunion. They started contact when the mother arrived, they were easily comforted and were ready to play again. When these children were distressed, they used their mothers as a "*secure base*" in order to feel secure and comforted, and to continue their exploring behaviors. In addition, the mothers of these children were consistently responsive to their children and exhibited harmonious and cooperative behaviors.

2. Insecure – avoidant attachment: Twenty percent of the children (Group A) were less concerned with the presence of the stranger and did not cry when the mother left the room, and were indifferent to her return. Reunion was not happy for both the mother and the child. They actively avoided returning mothers and resisted when the mother tried to approach. For Ainsworth, this behavior was associated with mother's rejecting behaviors, her anger at baby's demands, and lack of cuddling the baby. The rejecting attitude or unavailability of the mother would teach the baby to be on her/his own and even not to seek comfort in times of threat. These children are more likely to become anxious and as a result, avoid social interactions in order not to show their weaknesses or needs.

3. Insecure – ambivalent attachment: Fifteen percent of the children (Group C) were anxious, and they explored little even in the presence of the mother. Unlike avoidant children, these children were intensely preoccupied with their mothers. They cried a lot after mother's leave and did not easily calmed down with her return. During reunion, these children approached their mothers but pushed them away or resisted being picked up. They were hardly comforted when distressed. Ainsworth associated this behavior with mother's lack of or inconsistent responsiveness and mother's insensitivity to her baby's needs, usually seen in

withdrawn or depressed mothers. The child's demanding and rejecting behaviors can be considered as a way of obtaining mother's attention and proximity. These children are usually demanding but never satisfying children.

The above mentioned attachment styles that were offered by Ainsworth, formed a basis for future studies on attachment. After she introduced her observational experimentation technique, many researchers contributed to the attachment literature with objective and quantitative findings.

1.2.1.3 Mary Main

As a former student of Ainsworth, Mary Main contributed attachment literature with a fourth category of attachment style and her attachment studies with adults.

Together with her colleagues, in a longitudinal research project on middle class children's attachment styles, they found that about 79% of the time attachment styles remained constant from 18 months to 6 years of age (cited in Brandell & Ringel, 2007, p.81). They also observed a fourth group of children (about 5%) that did not fit into Ainsworth's classification of attachment styles, which they called "*disorganized/disoriented attachment*" (Main & Solomon, 1986, 1990).

Disorganized Attachment: These children seemed fearful and engaged in repetitive or aggressive behaviors. Their behaviors at reunion were unpredictable. They displayed contradictory behavior patterns such as approaching and then suddenly avoiding or exhibiting misdirected behavior patterns such as crying when the stranger leaves or stereotypical behaviors such as rocking, hair pulling or freezing. The mothers of these children were either depressed or had unresolved grief due to early loss of own parents (Main & Solomon, 1986).

In this type of attachment, there is no or very little organized strategy to cope with stress and to form an attachment relationship with the caregiver, because here, the attachment figure is the direct cause of distress or fear. An abusive, abandoned and frightening caregiver is the source of fear and the protector at the same time. The infant shows signs of distress and displays avoidant and inconsistent reactions in the presence of the caregiver (Bakermans-Kranenburg & van IJzendoorn, 2007; Stams et al, 2002).

Another contribution of Main to the attachment literature is a structured interview for adults about the relations with their parents (or other caregivers). The interview was initially developed by Main and her colleagues and later reported by Main & Goldwyn (1988). Interviewees were asked directly about their childhood experiences of rejection, being upset, ill, and hurt as well as loss, abuse, and separations; and were requested to remember memories about those experiences. In addition, they were asked to offer explanations for their parents' behaviours and to describe the current relationships with their parents.

Based on these responses, Main and Goldwyn (1984) classified four adult attachment styles, similar to Ainsworth's classification.

1. Secure-autonomous: These adults were able to discuss the unpleasant memories as well as the happy ones. They were able to view their parents objectively and accept them with their limitations and problems. It was reported that most of the children of these adults were securely attached.

2. Dismissive: These adults did not remember much about their childhood memories. They were reluctant to talk about their pasts. Although they described their parents as perfect, they displayed examples of the opposite. Most of these adults, had children who were avoidantly attached.

3. Preoccupied: These adults were still highly occupied with their pasts and were still full of hurt and anger. They had difficulties in separating emotionally from their parents and past memories. Their children were mostly ambivalently attached.

4. Unresolved-disorganized: This type of attachment was associated with loss and trauma. It is similar to the disorganized attachment style of children. These adults exhibited unresolved and disoriented mental state with irrational beliefs, extreme behaviors, denial of the loss or abuse, and inability to integrate the loss or trauma.

1.2.1.4 Cindy Hazan and Philip Shaver

These researchers studied adult attachment and argued that romantic love can be viewed as an attachment process; and early attachment experiences shaped the romantic relationship styles. Based on the self-report measures, Hazan and

Shaver (1987) identified 3 groups of adults whose attachment styles corresponded to the childhood attachment styles.

1. Secure: Adults in this group had positive attitudes towards their current romantic relations and their past relations with parents. Securely attached adults felt secure and intimate in their romantic relations.

2. Ambivalent: These adults were jealous, preoccupied with their partners and had frequent ups and downs related with their romantic relationships.

3. Avoidant: These adults felt insecure, had negative expectations about romantic relationships and had difficulties in forming intimate relationships.

1.2.1.5 Kim Bartholomew and Leonard Horowitz

These researchers combined Bowlby's positive and negative internal representations of self and others, and proposed a four-category model of adult attachment (Bartholomew & Horowitz, 1991). According to them, internal working models of self was associated with dependence on others for self-validation. An adult with a positive model about self, requires less external approval for self-validation but an adult with a negative model about self, depends highly on others' acceptance for self-validation. On the other hand, internal representations about others were associated with avoidance of intimacy. A positive model of others was associated with less need to avoid intimate relationships but negative internal working model of others was associated with high desire to avoid intimacy. The four-category model is based on the combination of these internal working models of self and others.

1. Secure: These adults had positive representations about theirselves and others. They had a sense of worthiness, felt they were lovable, and had a belief about others as being generally accepting and responsive.

2. Preoccupied: These adults had negative representations about their selves and positive representations about others. They needed the acceptance of others for self-acceptance therefore were preoccupied with the views of their partners.

3. Fearful-avoidant: These adults had negative representations about their selves and others. Therefore they avoided close relationships with others as a means of self-protection from rejection.

4. Dismissive-avoidant: These adults had positive representations about their selves and negative representations about others. They avoided close relationships and at the same time maintained a sense of independence and invulnerability.

Many researchers had attempts to explain the process of adult attachment. They offered different attachment styles, which were basically a repetition of Bowlby's theory and Ainsworth's classification system.

1.2.2 Empirical studies on attachment styles

Bowlby (1982), stated that all children form attachments regardless of the quality of care they experience. Early experiences of an infant define her/his attachment style, which in turn shape her/his future relationships. Having a healthy, secure attachment with a caregiver is essential for the social, cognitive, and personality development of the baby; and has a very important role for adaptive functioning over time and future mental health (Roberson, 2006; Stams et al., 2002; Verrissimo & Salvaterra, 2006). Securely attached children are expected to be more responsive to others, more able to cope with stress and to solve problems, and more likely to establish and maintain friendships than insecurely attached children. Mikulincer and Shaver (2005) reported that securely attached adults are more sensitive to the needs of others and give more social support than adults who have anxious or avoidant attachment styles.

A longitudinal study about attachment styles of 48 pre-school children whose attachment styles were previously assessed at 12 and 18 months, indicated that securely attached children performed better on all of the social and cognitive tasks that they were given (Sroufe, 1988). Those children developed more symbolic play, had better impulse controls, exhibited better social skills and displayed more positive emotions. Additionally, their mothers were more supportive and responsive than the mothers of children with avoidant and ambivalent attachment styles. In their longitudinal study, Sroufe, Egeland, and Kreutzer (1990) followed 267 pregnant low SES women and their babies for 20 years, and found that mother's personality and quality of mothering were more predictive than the child's temperament, personality, and genetic make-up for the development of the attachment style of the child.

Disorganized attachment is associated with later behavior problems or poor psychosocial adjustment. Insecure and disorganized child-mother attachments are associated with both internalizing and externalizing behaviors (see Bakermans-Kranenburg & van IJzendoorn, 2007, p.1160; Howe, 2006 ; Stams et al., 2002). Children with disorganized attachment styles are more likely to develop internal representations as helpless or dependent to others (Howe, 2006). The prevalence of disorganized attachment is reported as 15% in non-clinical and 80% in clinical samples (Carlson, Cicchetti, Barnett, & Braunwald, 1989).

1.2.3 Attachment and adoption

As mentioned earlier, children adopted in infancy show normal range of family and school functioning whereas children adopted at an older age have greater risk for the development of psychopathological symptoms. It is not simply the older age that is risky for later adaptation but rather it is the experiences that those children had until adoption. Abuse, neglect, and multiple numbers of placements (and caregivers) make it harder to develop healthy attachments. Stovall and Dozier (1998) stated that fostered and adopted children carry their attachment styles and internal working models that they developed in their early lives to their new lives and attach to their new caregivers accordingly. This means, older adopted children are less likely to develop secure attachments due to their pre-adoption experiences. The likelihood of developing insecure or disorganized attachments in these children is high.

Although attachment is a biologically based process such as mating and parenting in the animal world, it is now clear that attachment is formed through mutual love, care, and affection; and it does not suddenly occur during delivery. A reciprocal relationship between the infant and the caregiver helps to maintain the attachment and defines the style of attachment (secure vs. insecure attachment). In 1960's adoptive mothers were considered as substitute mothers and they were viewed as inferior because of their lack of maternal hormones that are biologically secreted. Those mothers were believed to have less strong and less consistent mothering responses. Bowlby (1969, p.306) opposed this view by arguing that the role of principal attachment figure might be effectively taken by others. In his work

published in 1952, Bowlby described the children in residential care. These children were deprived of parental care and did not have opportunities to develop stable and continuous attachment relationships despite the fact that they were receiving sufficient physical care (cited in van den Dries et al., 2009, 412). Instead of institutional care, he recommended foster care or adoption to provide substitute parents for developing healthy attachment relationships.

Van den Dries et al. (2009) conducted a meta-analysis on 39 publications. Samples were non-clinical adopted and foster children with whom parent-child attachment relationships were examined. According to self-report attachment assessments, no differences were found between adoptees and non-adopted peers. However, observational assessments of attachment relationships indicated some significant differences. Adopted children had more disorganized attachments than non-adopted peers, but less disorganized attachments than peers living at the institutions, and were not significantly different from the foster children. Age at adoption had significant effects on attachment styles of adopted children. Children who were adopted before they were 12 months old were found as securely attached as non-adopted children, whereas children adopted after 12 months had less secure attachments than the comparison group.

Howe (2001), examined the attachment relations of 336 adopted adults who had contacts with their adoptive and birth mothers. Adopted adults were grouped according to their age at adoption (0-6 months, 7-23 months, and after 24 months). Results showed that adoptees in the first group had secure attachments and had contacts with both mothers more frequently than the older adopted adoptees. Older adopted adults had insecure attachments with their adoptive mothers and had less contact with both mothers. Howe argued that securely attached individuals were better at coping with the emotional challenges that meeting with birth parents would bring. Therefore, they were more willing to have contacts with both mothers and even to make two mothers meet.

Stams et al., (2002) displayed the results of a longitudinal study on 146 international adoptees. Children who were originally from South Africa, Sri Lanka or Columbia were adopted before 6 months of age by Dutch families and were followed from infancy to 7 years of age. At 12 months, most of the children were

securely attached (76%), 22% had avoidant, and 2% had resistant attachment styles. At age 7, secure attachment was associated with better social and cognitive development.

It has been reported in a recent study that, children who were adopted within the first 3 months of their lives, develop organized secure attachments to their adoptive parents and older adoption was found to be related with disorganized attachment (Juffer, Bakermans-Kranenburg & van IJzendoorn, 2005).

Verissimo and Salvaterra (2006) examined the attachment relationships of 106 Portuguese adopted children and their mothers. Attachment security scores of the adopted children were not significantly different from non-adopted peers. Contrary to other findings, age of the child at the time of adoption and at the time of study was not significantly related to children's attachment security scores.

Despite the contrary findings of Verissimo and Salvaterra (2006), from the majority of the above mentioned results, it can easily be concluded that the earlier the adopted child joins the family, the more secure attachment relationship is formed. Moreover, secure attachment is associated with better adaptations. All these studies reveal that, secure or not, the adopted children form an attachment with their adoptive parents. This indicates that, attachment is not necessarily a biological system, it can develop between biologically unrelated children and parents with warm, caring, and loving relations.

1.3 Parenting Styles

1.3.1 Theoretical background for parenting

Many authors offered different classifications of child rearing styles. In the further sections most popular classifications which provided a basis for parenting literature will be summarized.

1.3.1.1 Diana Baumrind

Baumrind is the first author to categorize parenting styles qualitatively rather than a quantitative categorization of high vs. low. Baumrind (1968), argued that a parent's key role in rearing a child is to socialize the child to conform to the

demands of others and at the same time to help the child to maintain a sense of personal integrity. She referred this parental attempt as "parental control". The term control does not mean being strict or using punishment, instead, it refers to the parental attempts to integrate the child into the family and the society. She classified three groups of parents as, "authoritarian", "permissive", and "authoritative" according to the ways they use parental control, i.e., authority. Authority includes maturity demands, communication style, and nurturance. The characteristics of the parents in Baumrind's study were reported as follows:

1. Authoritarian parenting: These parents had absolute set of standards; they emphasized obedience, expected respect for authority and discouraged the verbal give-and-take between child and the parent.

2. Permissive parenting: These parents were tolerant and were accepting the child's demands, used as little punishment as possible, made few demands for mature behavior and allowed their children to regulate the parent.

3. Authoritative parenting: In this style of parenting, the rules and the standards were set clearly, mature behaviors were expected from the child, the independent behaviors and individuality of the child and verbal give-and-take were encouraged. These parents had open communications with their children and the rights of the parents and the children were recognized.

Baumrind considered parenting style as a characteristic of the parent not a subset of parent-child relationship. She believed that children were not only influenced by their parents, but they also influenced their parents and therefore contributed to their own development.

1.3.1.2 Eleanor E. Maccoby and John A. Martin

In 1983, Maccoby and Martin worked on Baumrind's model and built-up a measurable model. They defined parenting style in two dimensions: *responsiveness* (contingency of parental reinforcement) and *demandingness* (the number of types of demands made by parents). Later Baumrind used these terms to explain her model of parental control. She described responsiveness as the actions of parents to foster the child's individuality, self-regulation, and self-assertion by being supportive and responsive to the child's demands and needs. Additionally, she described

demandingness as the attempts of parents to make the child integrated into the family and society by supervision and disciplinary efforts (cited in Darling & Steinberg, 1993, p.489).

From the combinations of these two dimensions four categories have emerged. Maccoby & Martin (1983) examined Baumrind's "permissiveness" parenting style in two separate categories. As shown in Figure 1, parents who were high in both dimensions were labeled as "*authoritative parents*" (quadrant I), and parents who were low in both dimensions were labeled as "*neglecting parents*" (quadrant III). "*Authoritarian parents*" were high in demandingness but low in responsiveness (quadrant IV), whereas "*indulgent parents*" were high in responsiveness but low in demandingness (quadrant II).

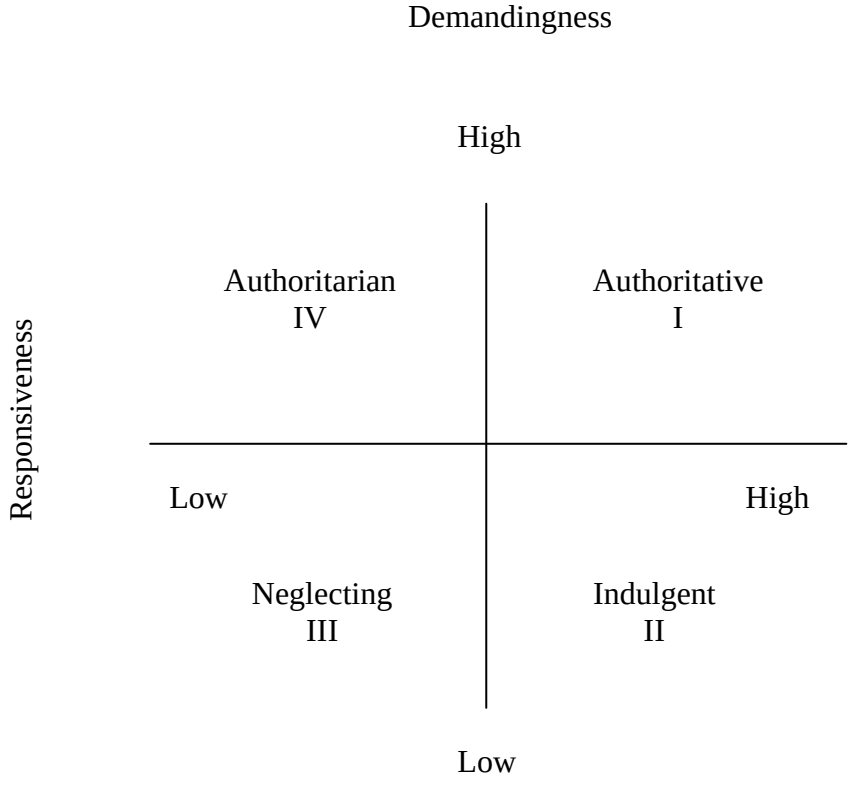

Figure 1. Categories of parenting styles offered by Maccoby and Martin (1983)

Authoritative parents (I), had set rules and standards clearly and expected their child to understand and follow them, showed emotional support, encouraged the child's independence and individuality, had open and two-way communication

with the child, and encouraged the child to express her/his ideas. The children of these parents developed a sense of responsible independence, had good communications with adults and peers, had psychosocial maturity and they had better academic success.

Permissive/indulgent parents (II) showed limitless tolerance and acceptance toward their children. Although they were warm and had high level of responsiveness, they lacked supervision and control, they allowed the child to regulate the parent and made few demands of mature behavior, used as little punishment as possible. Children of these parents were immature, slow in social and cognitive development, demanding and had difficulties in impulse control.

Permissive/neglecting parents (III) neither showed a good level of responsiveness to their children nor had a control over them. They usually avoided intimacy with their children and were insensitive to children's basic needs. Their children were reported to have poor adjustment and low scores of self-reliance.

Authoritarian parents (IV) had absolute sets of standard and rules, they expected complete obedience and respect for authority, they had one-way communication and did not approve child's expression of ideas. This type of parenting was associated with low levels of independence and social responsibility, and less academic achievement of children.

1.3.1.3 Nancy Darling and Lawrence Steinberg

These authors offered an integrative model to understand the processes of how the parenting style of the parent influences the development of the child. They described three aspects of parenting: the goals toward which the socialization is directed, the parenting practices of parents to help their children to reach those goals and the parenting style (or the emotional climate) within which socialization occurs (Darling & Steinberg, 1993; Steinberg, Lamborn, Darling, Mounts & Dornbusch, 1994).

Socializing the child by helping her/him to acquire specific social skills and behaviors and to develop a sense of integrity is the main goal of parenting. To achieve this goal, parents display specific goal directed behaviors such as feeding, talking to, playing with or even spanking the child as well as attending to child's

school activities (*parenting practices*) and non-goal directed behaviors such as gestures, change in tone of voice or expression of emotion.

In this contextual model of parenting styles, parenting goals for socializing the child influence the parenting style as well as the parenting practices of the parent. Parenting practices have a direct effect on the development of social behavior (ranging from table manners to academic performance) and personality characteristics (acquisition of values or self-esteem). On the other hand, parents with similar parenting styles may differ in their parenting practices. For instance, as it was mentioned in the previous section, authoritative parents explain the rationale of their rules, share their beliefs with their children and take the demands of their child into account. While one authoritative mother lets her child play outside before starting homework to make her/him start studying with a fresh mind, the other mother may not allow her child to engage in such activities before the homework is done, so that the child would have more free time. They both may have their reasons and explain them to their children. The parenting practices make the difference in displaying the styles.

1.3.2 Empirical studies on parenting

Dornbusch, Ritter, Leiderman, et al. (1987) examined the association between Baumrind's parenting styles and school performance of 7836 high school students. Results indicated positive correlations between authoritative parenting styles and grades, and negative correlations between authoritarian and permissive parenting and grades. Strongest relation was found between authoritarian style and grades. They also reported that as the level of parental education increased, the level of authoritative parenting increased, where authoritarian and permissive styles decreased.

Darling and Steinberg (1993), reported the results of Baumrind's study of 1972. Authoritarian parenting was associated with fearful behavior and behavioral compliance among European-American children, but was associated with assertiveness among African-American girls. Authoritative parenting was strongly associated with academic achievement among European-American adolescents but

was least effective for the academic achievement of Asian- and African-American peers.

Stormshak, Bierman, McMahan, and Lengua (2000), reported that high levels of psychological control (verbal punishment, withdrawal of attention or affection when child misbehaves) was associated with high levels of disruptive behavior in elementary school children. They also reported that elevated levels of externalizing behavior in children are associated with lack of structure in parenting where parents had inconsistent responses or overreactions.

Van Aken, Junger, Verhoeven et al (2007) examined the association between parenting and the externalizing behaviors of 122 three-year-old boys. They found that parental support (degree of responsiveness to child's needs) and positive discipline (reinforcing the good behavior) had positive effects on child's functioning. A positive association between parental psychological control (use of withdrawal of attention or affection as a disciplinary technique) and children's attention problems and aggressive behaviors was also reported.

Yahav (2006) examined the parenting styles perceived by 159 children and adolescents and their internal and external symptoms. Children with externalizing symptoms perceived both of their parents as more rejecting and over protective as compared with their non-symptomatic siblings and non-related symptomatic peers. Externalizing and internalizing children perceived their mothers as rejecting more than the other groups did.

A number of studies examined the mediating role of parental personality characteristics between parenting styles and problem behaviors of children. Parents who were extrovert, agreeable, conscientious, emotionally stable, and open to new experiences were more supportive, more responsive, less controlling and less rejecting parents; and they had low levels of lack of structure. High levels of neuroticism (less emotional stability) were related with low levels of parental support. Parents who were low on self-control and had impulsive actions were reported as using more psychological control and physical punishment (Kochanska, Friesenborg, Lange & Martel, 2004; Verhoeven, Junger, Van Aken et al., 2007)

Van Aken et al. (2007) reported that emotional stability of the parents was directly related to children's externalizing behaviors and attention problems,

indirectly related with the aggressive behaviors. Parents who were less emotionally stable provided less support to their children as they were less responsive and warm than more stable parents. In another study, high levels of parental neuroticism and lack of maternal conscientiousness were reported as risk factors for externalizing behaviors of children (Prinzie, Onghena, Hellinckx et al, 2004). Cooks and Kearney (2008) found that maternal perfectionism was related with sons' (aged 11-17 years) self-oriented perfectionism and was inversely related with their internalizing psychopathology.

1.4 Aims and the hypotheses of the study

This study aimed to explore the emotional and behavioral problems of Turkish adopted children and adolescents in comparison with non-adopted peers raised by their biological parents. To fulfill this aim, adopted children aged between 6-18 were compared with non-adopted children at the same age, in order to see if there were any differences between the emotional and behavioral problems, attachment security and temperament characteristics of both groups and personality characteristics and child rearing styles of their parents. Related with this objective and based on the adoption literature, it is hypothesized that adopted children would exhibit more behavioral and emotional problems than their non-adopted peers.

Reported relations between the parental personality and child rearing styles and the externalizing and internalizing behavior problems were summarized in section 1.3. The second aim of the study was to examine the relation between the personality characteristics and parenting styles of the parents and problem behaviors of the children. Therefore, it is hypothesized that parents with less emotional stability (or high neuroticism) would display less parental acceptance and more strict control. Additionally, adoptive parents are expected to display less strict control/supervision child rearing styles than non-adoptive parents.

Based on the literature on the relations between attachment and later psychological adjustment of adopted children, the third aim of this study was to investigate the relation between the attachment security and emotional and behavioral problems of the Turkish adopted and non-adopted children. Adopted

children are expected to have less secure attachments than non-adopted children and it is hypothesized that the attachment security level of the children would be negatively related with problem behaviors.

Another aim was to explore the possible risk and protective factors that might be related with problem behaviors of the children. Adopted boys and older adopted children were considered as having more risk for developing problem behaviors than adopted girls and children adopted before their first birthdays (Howe, 1997; Simmel, 2007; Stams, et al., 2002). Therefore it is hypothesized that, the younger adopted children would have less emotional and behavior problems than older adopted children. Additionally, boys are expected to display more emotional and behavioral problems than girls.

Although existence of any psychiatric disorder was not a main area of interest of this study, as many of the adopted children and their age and gender-matched non-adopted peers were followed in a child/adolescent psychiatry unit, the relation between the clinical status (being followed in a mental health unit or not) and the adoption status of the children was also examined.

A summary of aims and hypotheses of the study that were mentioned above is provided below:

- Aim 1: To explore the emotional and behavioral problems of Turkish adopted children and to compare them to non-adopted peers raised by their biological parents.
    - Hypothesis 1: Adopted children would exhibit more behavioral and emotional problems than their non-adopted peers.

- Aim 2: To examine the relation between the personality characteristics and parenting styles of the parents and problem behaviors of the children.
    - Hypothesis 2a: Parents with less emotional stability (or high neuroticism) would display less parental acceptance.
    - Hypothesis 2b: Parents with less emotional stability (or high neuroticism) would display more strict control.
    - Hypothesis 2c: Adoptive parents are expected to display less strict control/ supervision child rearing style than non-adoptive parents.

- Aim 3: To investigate the relation between the attachment security and emotional and behavioral problems of the Turkish adopted and non-adopted children.
    - Hypothesis 3a: Adopted children are expected to have less secure attachments than non-adopted children.
    - Hypothesis 3b: The attachment security level of the children would be negatively related with problem behaviors.

- Aim 4: To explore the possible risk and protective factors that might be related with problem behaviors of the children.
    - Hypothesis 4a: Younger adopted children would have less emotional and behavior problems than older adopted children.
    - Hypothesis 4b: Boys are expected to display more emotional and behavioral problems than girls.

1.5 The importance and implications of the study

All around the world, studies about different aspects, risk and protective factors of adoption and adoption services are published. The psychosocial functioning or mental health of adopted children and their families or adopted adults were reported. The literature on adoption is now directed at the comparison of traditional, single-parent or gay/lesbian adoptive families as well as international and/or transracial adoptions or at the comparison of adopted vs. artificially conceived children.

All these researchers agree on the conclusion that, adoption is a protective factor for future psychosocial functioning and the earlier it is, the better. However, Turkish adoption literature is far beyond these debates. In our country, adoption is studied mostly as a subject of Social Work and/or Civil Law and unfortunately is not under the scope of Psychology or Mental Health. A few numbers of recent publications (Erol, 2008; Erol & Şimşek, 2008) summarized the general adoption literature and discussed issues in Turkish adoption system. One study (Üstüner, Erol & Şimşek, 2005) reported emotional and behavioral problems among Turkish

children in foster family care system, but so far, any published empirical study about Turkish adopted children or families was not encountered. Therefore, this study will provide a significant contribution to Turkish adoption literature, since it is the first empirical study exploring the psychological processes within adoptive families.

Data was collected from both parents and children. Obtaining multi-informant data from a very specific population such as adoptive families makes the results of this study more reliable.

The results of this study will provide evidence for possible protective and risk factors for the psychological adjustment of Turkish adopted children and adolescents. Exploring the protective and risk factors would help to prevent future psychological problems of adopted children.

The results of this thesis might be enlightening for the establishment of future policies of adoption system.

CHAPTER 2

METHOD

2.1 Participants

Adopted and non-adopted children and their families constituted the participants of the study and comparison groups of this study. The term "non-adoptive" refers to the families where children and their parents are biologically related, the child is born into and raised by that family. The term "biological" is used to describe the birth parents or siblings of adoptive children. Through out the study, children and families are categorized as "adoptive and non-adoptive" in terms of their adoption status.

A second classification is made based on the "clinical status" of the children. If the child was currently being followed or had been treated in a child psychiatry unit, s/he was considered as a member of "clinical" group. Children who had never been referred to child psychiatry units, were recruited as the "non-clinical" groups.

"*Adopted/clinical*" status group included the adopted children who were followed in a child and adolescent mental health unit and their parents. "*Non-adopted/clinical*" group was formed by matching age and gender of non-adopted children followed in a mental health unit with those of adopted/clinical group. Adopted children who were not followed in a mental health unit were recruited to "*adopted/non-clinical*" group. Children in the "*non-adopted/non-clinical*" group were matched to adopted/non-clinical group in terms of their ages and genders. Detailed information about the recruitment of the participants is provided in the Procedure section (Section 2.3).

2.1.1 Adoption Status

Sixty-one adopted and 62 non-adopted children and their parents participated in the study. Among the adopted children 34 (55.73%) were girls and 27 (44.26%) were boys. In the non-adopted group, the number of the girls was 35 (56.45%) and boys were 27 (43.55%). Adopted and non-adopted children (adoption status group) were also sub grouped as clinical vs. non-clinical groups (clinical status group). The number of participants in each group is shown in Table.1.

Table 1. Number of participants

			Adopted	**Non – adopted**
Clinical	Female		22	21
	Male		18	16
		Sub total	(40)	(37)
Non - clinical	Female		12	14
	Male		9	11
		Sub total	(21)	(25)
Total			61	62

Information related to the ages of the children, mothers and fathers in adopted and non-adopted groups are displayed in Table 2. Age differences between adopted and non-adopted groups were tested. T-test results for mothers and fathers were significant [$t(118) = 9.48$, $p < .001$ and $t(112) = 8.32$, $p < .001$ respectively] where adoptive parents were older than non-adoptive parents. Mean ages of children for both groups were not found to be significantly different [$t(120) = -0.91$, *n.s.*].

Table 2. Mean ages for adoptive and non-adoptive families

	Adoptive				Non – adoptive			
	N	**M**	**Range**	**SD**	**N**	**M**	**Range**	**SD**
Children	61	125.30 mths (10.8 years)	67-223	42.22	62	131.81 mths (11.5 years)	71-211	37.03
Mothers	59	47.88 years	37-61	5.58	62	38.73 years	27-53	5.00
Fathers	54	51.17 years	36-75	6.39	61	41.92 years	34-58	5.48

Mean age of the children at the time of adoption was 16.13 months (1.4 years). The oldest age at the time of adoption was 96 months (8 years). Twenty four (40%) of them were adopted within the first 30 days of their lives. Table 3 shows the frequencies and the percentages of the ages of children at the time of adoption.

Table 3. Ages of children at the time of adoption

Age at the time of adoption	**N**	**%**
0 month (first 30 days)	24	40
1-3 months	8	13.3
6-18 months	9	15
24-48 months	14	23.3
54-96 months	5	8.4
Total	60	100

Thirteen (21.31%) adopted children were attending private schools whereas 48 (78.68%) were attending public schools. In the non-adopted group, 4 children (6.5%) were attending private schools and 58 children (93.5%) were public school students. For a distribution of grade levels, see Table 4.

Table 4. Grade levels of children

	Adopted		Non - adopted	
	N	%	N	%
Pre-school	1	1.7	1	1.6
$1^{st} – 5^{th}$ grades	35	56.66	36	58.07
$6^{th} – 12^{th}$ grades	23	38.32	25	40.33
University	2	3.32	0	0
Total	61	100	62	100

Data was collected mostly from families residing in Ankara. Twenty-one families from 11 other cities also participated in the study (see Table 5).

Table 5. Distribution of cities of residence

	Adoptive families		Non-adoptive families	
City	N	%	N	%
Ankara	40	65.5	58	93.5
Bursa	3	3.27	-	-
Çankırı	-	-	1	1.6
Çorum	-	-	1	1.6
Gaziantep	1	1.64	-	-
İstanbul	5	8.20	1	1.6
İzmir	5	8.20	-	-
Kayseri	4	6.50	-	-
Manisa	1	1.64	-	-
Mersin	1	1.64	-	-
Niğde	1	1.64	-	-
Tokat	-	-	1	1.6
Total	61	100	62	100

Most families were from high socio-economic status (SES). The SES levels of families from both groups are listed in Table 6. SES levels were determined in terms of parental education. Years of education of adoptive and non-adoptive parents and the levels of education that were completed are displayed in Tables 7 and 8.

Table 6. SES levels of families

	Adoptive		**Non-adoptive**	
	N	**%**	**N**	**%**
Low	7	11.47	7	11.3
Middle	22	36.07	29	46.8
High	32	52.46	26	41.9
Total	61	100	62	100

Table 7. Years of education parents received

	Adoptive				**Non-adoptive**			
	Mothers		**Fathers**		**Mothers**		**Fathers**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Under 8 years	17	27.6	11	20.4	15	24.2	12	19.7
Between 9 – 13 years	21	36.2	18	33.3	31	50.0	24	39.3
Over 14 years	21	36.2	25	46.3	16	25.8	25	41.0
Total	59	100	54	100	62	100	61	100

Under 8 years of parental education was considered as low SES; 9-13 years of education was considered as middle SES, and over 14 years of education was

considered as high SES. If the mother and father were from different education levels, higher education level was considered as a criteria for determining SES level.

Table 8: Highest education levels parents completed

	Adoptive				Non-adoptive			
	Mothers		Fathers		Mothers		Fathers	
	N	%	N	%	N	%	N	%
Primary school	12	20.33	7	12.96	8	12.90	5	8.19
Secondary school	5	8.47	4	7.41	7	11.29	7	11.48
High school	10	16.95	14	25.93	18	29.03	16	26.23
University for two years	11	18.64	4	7.41	13	20.97	8	13.11
University	17	28.82	22	40.74	13	20.97	17	27.87
Master's degree	4	6.79	3	5.55	3	4.84	6	9.84
Ph.D.	0	0	0	0	0	0	2	3.28
Total	59	100	54	100	62	100	61	100

About 40 percent of mothers in both groups were housewives. Majority of adoptive fathers were retired and of non-adoptive fathers were civil servants. The distribution of professions are displayed in Table 9 (continued next page).

Table 9. List of professions of adoptive and non-adoptive parents

	Adoptive				Non-adoptive			
	Mothers		Fathers		Mothers		Fathers	
	N	%	N	%	N	%	N	%
Artist / Musician	0	0	1	1.9	0	0	1	1.6
University Professor	0	0	0	0	0	0	2	3.2
Business	1	1.7	3	5.7	2	3.2	10	16.4
Civil servant	3	5.2	10	18.9	12	19.4	14	23.0
Driver	0	0	4	7.5	0	0	3	4.9
Economics/Banking	3	5.2	3	5.7	3	4.8	1	1.6
Engineer / Architect	1	1.7	8	15.1	2	3.2	9	14.8
Hair dresser	0	0	0	0	1	1.6	2	3.2
Health care	5	8.6	1	1.9	5	8.1	2	3.2
Housewife	24	39.7	-	-	26	41.9	-	-
Law professional	3	5.2	0	0	0	0	1	4.17
Police officer	0	0	0	0	1	1.6	2	3.2
Retired	15	25.9	16	28.3	4	6.5	4	6.6
Teacher	3	5.2	6	11.3	5	8.1	3	4.9
Technician	0	0	1	1.9	1	1.6	3	4.9
Worker	1	1.7	1	1.9	0	0	4	6.6
Total	59	100	54	100	62	100	61	100

Majority of children were living with both of their parents. There were single mothers, divorced or widowed parents as well. Family status of adoptive and non-adoptive groups can be viewed in Table 10.

Table 10. Family status of groups

	Adoptive		Non-adoptive	
	N	**%**	**N**	**%**
Parents live together	49	80	55	88.7
Single mother (never married)	4	6.7	0	0
Divorced – child lives with mother	2	3.3	4	6.5
Divorced – child lives with father	0	0	1	1.6
Father deceased – child lives with mother	3	5.0	0	0
Mother deceased– child lives with father	2	3.3	0	0
Separated - child lives with mother	1	1.7	2	3.2
Total	61	100	62	100

2.1.2 Clinical Status

Number and mean ages of the children, mothers and fathers in clinical and non-clinical groups regardless of adoption status are as follows (see Tables 11 & 12).

Table 11. Number of children grouped according to their clinical status

	Clinical N	**Non – clinical N**
Female	43	26
Male	34	30
Total	77	46

Table 12. Mean ages of the children and their parents in clinical vs. non-clinical groups regardless of their adoption status

	Clinical				Non – clinical			
	N	**M**	**Range**	**SD**	**N**	**M**	**Range**	**SD**
Children	77	129.47 mths (10.9 years)	67-223	38.71	46	127.13 mths (10.7 years)	67-206	41.60
Mothers	75	43.71 years	27-59	7.12	46	42.22 years	31-61	6.74
Fathers	72	47.33 years	34-75	7.81	43	44.31 years	34-61	6.59

Age differences of children and mothers in clinical and non-clinical groups were not significant [$t(120) = 0.31$, *n.s* for children and $t(118) = 1.13$, *n.s.* for mothers]. T-test results showed significant differences between fathers in clinical and non-clinical groups [$t(112) = 2.11$, $p < .05$] where fathers in clinical group were older than fathers of non-clinical children.

Mean age at first admission to a child psychiatry unit for adopted children was 6.64 years (range = 1-13 years, SD = 2.76), for non-adopted children was 7.79 years (range = 3-16 years, SD = 3.04). The difference between two groups was not found to be significant [$t(84) = 1.85$, *ns*]

Mean ages at the time of adoption of the children, mothers and fathers in the clinical and non – clinical groups are shown in Table 13. Age differences between clinical and non-clinical adoptive groups were not significant for children, mothers and fathers [$t(57) = 0.38$, *n.s.*; $t(57) = 0.46$, *n.s* and $t(53) = . 0.67$, *n.s.* respectively].

Table 13. Mean ages of the children and their parents at the time of adoption

	Clinical				Non – clinical			
	N	**M**	**Range**	**SD**	**N**	**M**	**Range**	**SD**
Children	40	16.62 mths (1.4 years)	0-78	22.63	21	14.20 mths (1.2 years)	0-96	24.71
Mothers	40	39.0 years	31-49	4.95	21	38.35 years	29-49	5.58
Fathers	37	42.41 years	33-51	5.04	18	41.39 years	34-55	5.82

In terms of the diagnoses that the children received, Attention Deficit Hyperactivity Disorder (ADHD) was the most common diagnosis for both adopted and non-adopted clinical groups. All of the children were referred to the researcher by various child psychiatrists or clinical psychologists, therefore they were already diagnosed. Distribution of diagnoses is displayed in Table 14.

Table 14. Diagnoses of the clinical children in adopted and non-adopted groups

	Adopted		Non-adopted	
Diagnosis	**N**	**%**	**N**	**%**
ADHD	19	47.5	14	37.84
ADHD + Conduct disorder	5	12.5	0	0
ADHD + Learning Disability	4	10	8	21.62
Anxiety Disorder	1	2.5	0	0
Depression	6	15	4	10.81
Enuresis	1	2.5	0	0
High Functioning Autism	0	0	1	2.70
Learning Disability	4	10	6	16.22
Mild mental retardation	0	0	2	5.41
School Rejection	0	0	1	2.70
Suicide attempt	0	0	1	2.70
Total	40	100	37	100

In the adopted group, six children were reported as having constipation, thyroid problems, epilepsy and asthma as well as their psychiatric problems. One child was Hepatitis B carrier. Three non-adopted children had epilepsy or asthma.

In terms of medical treatment, 23 adopted and 21 non-adopted children were using psychotropic medications. Table 15 shows the list of medication that the parents had reported.

Table 15. List of medication

	Adopted		Non – adopted	
Medication	**N**	**%**	**N**	**%**
Anti-convulsant (Carbamazepine)	2	8.70	1	4.76
Anti-convulsant + Risperidone	1	4.35	1	4.76
Anti-depressant (Fluoxetine)	0	0	1	4.76
Anti-depressant (SSRI)	2	8.70	1	4.76
Anti-depressant (Tri-cyclic)	3	13.04	1	4.76
Anti-psychotic (Risperidone)	1	4.35	1	4.76
Methylphenidate (MPH) Short acting	6	26.09	9	42.86
Methylphenidate (MPH) Time released	5	21.73	6	28.58
MPH Time released + Risperidone	3	13.04	0	0
Total	23	100	21	100

2.2 Measures

2.2.1 Adoption Information Questionnaire

This 85-item questionnaire is designed by the researcher, to obtain demographical information and to learn about the adoption history and the parental

views about adoption services and process. Either parent was accepted to complete the questionnaire, but both parents were requested to answer 10 open-ended questions on their representations about their children and personal ideas and feelings about the adoption process. Those ten questions were written in separate sheets for both parents (See Appendix B).

2.2.2 Family Information Questionnaire

This questionnaire is designed by the researcher and includes questions related to demographical information about the non-adoptive families. 3 open-ended questions on the parents' representations about their children and 10 open-ended questions about adoption are also included in the questionnaire, which both parents were asked to answer separately. Parents were asked to state, e.g., if they approve adoption, if they would have adopt, if they would have let their children have friends who were adopted etc. A copy of the questionnaire is provided in Appendix C.

2.2.3 Child Behavior Checklist (CBCL)

CBCL was first developed by Achenbach and Edelbrock (1983), for the assessment of problem behaviors of children and adolescents aged between 4-18. In 2001, previous version was revised for the age groups 6-18 by Achenbach and Rescorla. Parents or primary caregivers are asked to complete 20 semi structured or open ended items for "competency" and rate 118 likert-type items for "problem behaviors". Problem behaviors are rated as 0 (not true), 1 (somewhat or sometimes true) or 2 (very true or often true). Problem behavior items are grouped from the eight empirically based syndrome scales. High scores on the scales indicate clinical deviance. Three syndrome scales (*Anxious/Depressed, Withdrawn/Depressed* and *Somatic Complaints*) constitute "*Internalizing Problems*", whereas "*Externalizing Problems*" are formed by the sum of *Rule Breaking Behavior* and *Aggressive Behavior* scales. Remaining three scales (*Social Problems, Thought Problems, Attention Problems*) are not included in any subgroup but are used to compute "*Total Problems*" score.

Sample items for the 8 syndrome scales (in parenthesis) are as follows: Cries a lot(Anxious/Depressed), rather be alone (Withdrawn/Depressed), constipated (Somatic Complaints), doesn't get along (Social Problems), can't get mind off thoughts (Thought Problems), fails to finish (Attention Problems), breaks rules (Rule Breaking Behavior) and gets in fights (Aggressive Behavior). See Appendix D.

Six DSM (Diagnostic and Statistical Manual for Psychiatric Disorders) oriented problem scales (*Affective Problems, Anxiety Problems, Somatic Problems, Attention Deficit Hyperactivity Problems, Oppositional Defiant Problems* and *Conduct Problems*) are also computed for research purposes.

Turkish version of CBCL was introduced by Erol, Arslan and Akçakın in 1995. Validity and reliability studies of the Turkish sample indicated .84 test - retest reliability for 4488 children and adolescents. Internal consistency coefficient for internalizing problems was .82, for externalizing problems was .81 and was .88 for the total problems score (Erol & Şimşek, 1998).

In this study, mothers and fathers were asked to rate their children separately. In case of any missing parent, ratings of the care-giving parent were obtained. Internal consistency coefficients of our study were very similar to the standardization study. Coefficient alphas for Internalizing, Externalizing and Total Problems scales obtained from mothers were .85, .91 and .95 and from fathers were .85, .92 and .96 respectively.

2.2.4 School-Age Temperament Inventory (SATI)

The inventory is a parental report of the temperament of children and adolescents. The scale is originally developed for children between 8-11 years of age (Mc Clowry, 1995), later the validity and reliability of the scale with adolescent sample is reported (McClowry, Halverson & Sanson, 2003). Four temperament dimensions are measured from 38 items (12 are reverse coded): *Negative Reactivity* (intensity and frequency with which the child expresses negative affect), *Task Persistence* (the degree of self-direction that a child exhibits in fulfilling task and other responsibilities), *Approach/Withdrawal* (the child's initial response to new people and situations), and *Activity* (large motor activity). Parents are asked to rate

their children on a Likert-type scale from 1 (never) to 5 (always). Higher scores indicate that the child is high in negative reactivity, is task persistent, has a tendency to withdraw in new situations, and is highly active. See Appendix E.

Sample statements for each temperament dimensions are as follows: "When angry, yells or snaps at others" (Negative Reactivity), "Stays with homework until finished" (Task Persistence), "Bashful when meeting new children" (Approach/ Withdrawal) and "Runs when entering or leaving" (Activity).

The data for the Turkish standardization of the scale is obtained by Eremsoy (2007) from 336 primary school children. The internal consistency coefficients of the four dimensions ranged between .85 and .90 and test – retest correlations were between .80 and .89. In our study, alpha levels were found between .70 (Approach/ Withdrawal) and .88 (Negative Reactivity) from maternal reports. Alpha levels ranged between .71 (Approach/Withdrawal) and .85 (Negative Reactivity) in paternal reports.

2.2.5 Measure of Child Rearing Styles (MCRS)

This scale is developed by Sümer and Güngör (1999) to assess parenting styles based on Maccoby and Martin's (1983) dimensions. Two main parenting dimensions (*Acceptance/Involvement* vs. *Strict Control/Supervision*) are obtained from 22 items. By crossing the two dimensions, four parenting styles (*Authoritative*, *Permissive/Neglectful*, *Authoritarian* and *Permissive/Indulgent*) are obtained.

Turkish standardization study was completed with 279 university students, whom were asked to rate the child rearing styles of their mothers and fathers separately. Internal consistency coefficients for perceived parental acceptance from mothers and fathers were both .94 whereas for perceived strict control/supervision from mothers was .80 and from fathers was .70.

In this study both parents rated their child rearing styles, and children and adolescents rated perceived child rearing styles from both parents. Children and parent forms included the same statements with different wording, e.g., "We don't have a very close relationship with my child/mother/father" (reverse coded Parental Acceptance/Involvement item) or "I don't easily forgive my child when s/he disobeys my rules; My mother/father doesn't easily forgive me when I disobey

his/her rules" (Strict Control/Supervision). For the items of the scale, see Appendix F. In our study, internal consistency coefficients for perceived parental acceptance from mothers and fathers according to the children's ratings were .85 and .89 respectively, whereas for perceived strict control/supervision from mothers, it was .69 and from fathers it was .75. On the other hand, when parents rated their own parenting styles alpha levels for mothers' parental acceptance was .83 and strict control was .68. Fathers' internal consistency coefficients were as follows: .80 for parental acceptance and .65 for strict control.

2.2.6 Basic Personality Traits Inventory (BPTI)

This 45-item inventory is developed for the Turkish culture by Gençöz and Öncül (in progress) in order to assess six dimensions of personality (*Openness to experience, Conscientiousness, Extraversion, Agreeableness, Neuroticism,* and *Negative Valence*). Adults are asked to rate themselves on a 5-point likert scale where 1 indicates "not suitable at all" and 5 indicates "fully suitable". Eight items are reverse coded.

Sample items and internal consistency coefficients obtained from 474 university students in the original study for each personality trait (indicated in parentheses) are as follows: creative (Openness to experience; .80), hard working (Conscientiousness; .84), shy (Extraversion; .89), sensitive (Agreeableness; .85), inpatient (Neuroticism; .83), and artificial (Negative Valence; .71). For the items of BPTI, see Appendix G.

In this study, both parents were asked to complete BPTI for themselves. Cronbach alpha levels of the mothers ranged between .63 (Negative Valence) and .86 (Extroversion), where coefficients for the fathers were between .68 (Negative Valence) and .84 (Extroversion & Neuroticism).

2.2.7. Youth Self Report (YSR)

YSR is a self-report measure rated by the adolescents (age 11-18) to describe their own functioning. YSR is similar to CBCL, has 17 items for "competence" and 112 items for "problem behaviors". 89 items are the same as CBCL items with different wording. In YSR, the items are written as "I"

statements. The items are rated as 0 (not true), 1 (somewhat or sometimes true) or 2 (very true or often true). The syndrome scales and problem scales are the same as CBCL and computed similarly (See Appendix H).

The original YSR (Achenbach & Edelbrock, 1987, Achenbach & Rescorla, 2001) was adapted to Turkish by Erol and Şimşek in 1998. Internal consistency coefficients obtained from 2206 adolescents were .80 for internalizing problems, .81 for externalizing problems and .82 for total problems. Internal consistency coefficients of the scale in our study were .84, .86 and .92 for Internalizing, Externalizing and Total Problems respectively.

2.2.8 Kerns Security Scale (KSS)

This 15-item scale is developed by Kerns, Klepac and Cole (1996) to measure the child's perceptions of reliance on the attachment figure and perceptions on the availability of the attachment figure. Items are designed in a "Some kids… BUT Other kids…" format. Same statements are written in different wording for both parents in separate sheets (e.g. Some kids are sure their mom /dad will be there when needed; BUT Other kids are not sure their mom/dad will be there when needed). Children are asked to first indicate which statement is more like themselves and then to rate if that statement is really or somewhat true for them. Each item is scored from 1 to 4 and a total score is obtained from the sum of 15 items (7 items are reverse coded.). Higher scores reflect more secure parent-child attachment (greater reliance on or greater availability of attachment figures). For the items of the scale, see Appendix I.

The Turkish standardization study was conducted by Sümer and Anafarta (in press) with 194 fifth and sixth grade students. Internal consistency coefficients were .84 and .88 for mother and father forms, respectively. In our study according to the ratings of the children, alpha levels were .87 for mothers and .88 for fathers.

2.2.9 Questions asked during interview with mothers

Five open-ended questions were asked to adoptive and non-adoptive mothers, to understand the problems related to the children, the coping strategies, social support system, maternal representations about the child, life expectations of

the mother related to the child. Additional four questions were about being a mother, importance of a family for a child's life, key features for being a family (giving birth vs. raising a child). All the questions were structured by the researcher.

Sample questions are as follows: "Tell me 5 words describing your child's personality. Whom do you think these characteristics are similar?", "What is the most difficult problem behavior of your child that you have to cope? How do you cope? Whom do you get support?", "From where do these problems originate?" "How do you expect your child's future to be?", "What is the meaning of being a mother?", "Who do you think is the real mother? She, giving birth or she, raising the child?", "What is the difference between being a mother of a child that you gave birth and a child that some other woman gave birth?" For the questionnaire, see Appendix J.

2.3 Procedure

Prior to the study, approval from Middle East Technical University Ethical Committee was obtained. All the parents were informed about the rationale of the study, about the privacy of their identities and answers and about the questionnaires that they were asked to complete. Volunteer families were included to the study after signing the informed consent form (see Appendix K). Both parents and the children were expected to participate in the study, but in case of any family member who was not willing to participate, the ratings from the other members were also accepted. In case of divorced families, children were instructed to rate currently care-giving parent. If the child had contact with the other parent on a regular basis, s/he was asked to rate that parent as well, but that parent's participation was not expected. In case of re-marriages, children rated their step parents as they had spent more time of their lives, with them.

Volunteer adoptive families who had been referred to various child and adolescent psychiatry units in Ankara and 8 other cities (listed in Table 3) constituted the "*Adopted/Clinic*" group. Prior to data collection, permission to contact with adoptive families was asked from The General Directorate of Social Services and Child Protection Agency. Petition (see Appendix L) was sent through

Middle East Technical University Rectorate; unfortunately, the permission was not obtained (Appendix M). Therefore, *"Adopted/Non-clinic*" sample were recruited by snowball technique, by asking for the acquaintances of adoptive families, via flyers in Children's Hospitals and via announcements in e-mail groups. 9 parents refused to participate as soon as they were informed about the study. 4 of them requested a phone conversation with the researcher, they all stated their appreciation for the researcher on choosing this subject to study, but did not want to be a part of it. Main reason for not participating was their children being unaware of their special status. Additional 5 families who were willing to participate, changed their minds after seeing the questionnaires. They sent the envelopes back without completing the forms, as they found the questionnaires were too long and boring. 7 families did not send the questionnaires back or gave any feedback. Therefore 21 families (25.61%) out of 82 that were contacted, did not volunteer to participate, which lead to a response rate of 74.39%.

Non-adopted comparison groups were the children and adolescents living with their biological parents who were being treated in the child and adolescent psychiatry units (*Non-Adopted/Clinic group*) and children and adolescents who were never referred to a child and adolescent psychiatry unit (*Non-Adopted/Non-Clinic group*). Those participants were recruited via ad hoc (convenience) sampling, by putting specific emphasis on matching the age and gender characteristics of this group with those of the adopted group.

Non-clinical families residing out of Ankara received the questionnaires through courier companies and were requested to send the provided envelopes (on which the name and the address of the researcher was written) to the researcher as freight collect. For the clinical group, psychologists and/or psychiatrists working in the above mentioned cities asked their patients to participate and sent the forms to the researcher. Children, who were reported by their families as having a psychiatric diagnosis, were assigned the clinical groups even if they had quit the treatment. Adopted children, whose parents consulted to a mental health professional only at the time of disclosing the adoption information, were not considered "clinical" if there were no current psychiatric complaints.

The parents and adolescents were asked to complete the questionnaires themselves. The children between ages 6 - 8 and / or older children with attention deficits or reading disabilities received help from adults (For most of the cases in Ankara, it was the researcher. For others, colleagues, psychology students or for some cases, family members helped children reading the items). All the questionnaires were compiled together in a random order to avoid the ordering effect.

Apart from the questionnaires to be filled out, mothers were interviewed about their children and about their views on being a mother/family. At least two mothers (mother of a girl and mother of a boy) from each group (adopted/clinic, adopted/non-clinic, non-adopted/clinic, non-adopted/non-clinic) were randomly chosen. 12 mothers volunteered for the interview. Interviews were held by the researcher, preferably in her office. If that was not possible, then the mothers were interviewed at their home environment, without the presence of any family member.

2.4 Statistical Analyses

Statistical analyses were performed via computerized statistical program, SPSS. Differences between maternal and paternal ratings were analyzed separately by 2 (Group: adopted, non-adopted) X 2 (Group: clinical, non-clinical) between group MANCOVA design, where age and gender were included as the covariates. Children's ratings about their parents were again analyzed separately for each parent. Differences were analyzed separately by 2 (Group: adopted, non-adopted) X 2 (Group: clinical, non-clinical) between group MANCOVA design, where age and gender were included as the covariates for YSR and MCRS. For the analysis of KSS, 2 (Group: adopted, non-adopted) X 2 (Group: clinical, non-clinical) between group ANCOVA design was used where age and gender were included as the covariates. Additionally, to see the effects of gender and age on the dependent variables 2 (Gender) X 2 (Age) analyses were conducted separately for both parents on each measure. Pearson Product-Moment Correlation Coefficient was used to assess the degree of relationship between the measures of the study, and also the

relationship between the demographic variables related to adoption history and the measures of the study.

CHAPTER 3

RESULTS

3.1 Descriptive Statistics

3.1.1 Descriptive statistics for adoption history

Parents (either mothers or fathers) of 60 adopted children responded to The Adoption Information Questionnaire. 42 parents (70.0%) adopted their children through The General Directorate of Social Services and Child Protection Agency (SHÇEK), 16 (26.67%) parents had an indirect contact with biological parents through mutual acquaintances, and two couples (3.33%) adopted through kinship, i.e. father's nephew.

The average time spent between the official application to SHÇEK for adoption and uniting with the child was 1.7 years (range 3-60 months). 35 (59.3%) parents had a preference about the gender of their future child and 25 (71.43%) of them signed up for a girl. Additionally, 48 (81.4%) parents favored an age range, among them 43 (89.58%) parents signed up for babies between ages 0 – 2, only five (10.42%) parents wanted an older child. Mean age of the children when they were adopted was 15.80 months (1.3 years, range = 0 – 96 months, SD = 23.17). Average age of mothers and fathers at the time of adoption were 38.74 years (range = 29-49, SD = 5.14) and 42.07 years (range = 33-55, SD = 5.28) respectively.

Twenty-nine of the adopted children (49.2%) started their lives with a different name and after being adopted their names were altered. Parents of 13 (22.0%) children kept the original names and 18 (28.8%) children were named by their adoptive parents as they were newborns.

According to the parental responses, 45 (75.0%) of the adopted children knew that they were adopted. Mean age when they were informed was 5.95 years (range = 2-13 years, SD = 2.44). Parents of 12 children (20.0%) reported that they

were waiting for the right time to share the information whereas parents of three (5.0%) adopted children were determined not to disclose ever.

Information about biological parents were mostly missing. Only 6 families (9.84%) had contact with biological families, where the birth families of two adopted children were currently their relatives. Those children knew their adoption status, and did not feel uncomfortable about meeting biological parents and siblings. Remaining four (6.56%) children had contacts with their biological siblings who were adopted by other families, but none of the children knew that they were actually siblings although they had good friendships.

Three families (5.3%) preferred to keep the adoption information within the core family whereas 13 families (22.08%) shared this information only with family members and close friends. On the other hand, 41 (71.9%) families were open to share their adoption story with everyone they knew.

After adoption, only one family (1.7%) moved to a new environment to start a new life where nobody knew them. 9 families (15.54%) moved to a better environment to raise a child, but kept in touch with old neighbors. 10 families (17.2%) reported that they regret for not moving into non-familiar environments. 39 (68.50%) families kept on living in their current neighborhoods.

30 families (53.6%) kept in touch with other adoptive families. 4 families (7.14%) did not prefer to have any contact with other adoptive families. 22 families (39.3%) reported they would definitely had contact with other adoptive families if they had known any.

28 families (49.1%) shared adoption information with the teachers or school management; on the other hand, 22 families (38.6%) did not want to disclose to anybody at school.

3.1.2 Opinions of non-adoptive parents about adoption

Fifty-five non-adoptive mothers and 38 non-adoptive fathers responded to a questionnaire about adoption (Appendix C). The results are summarized in Table 16.

Table 16. Views of non-adoptive parents about adoption

	Mothers (N = 55)		Fathers (N = 38)	
	N	%	N	%
Knows an adoptive family	22	40	17	44.7
Thinks, parents having a biological child can also adopt	49	89.1	27	71.1
Thinks, adoption is to give a home to a homeless child	53	96.4	35	92.1
Thinks, adoption is to take care of somebody else's child	2	3.6	3	7.9
Thinks, adoption is recognized by religion	49	89.1	36	94.7
Would adopt, if didn't have a biological child	31	56.4	28	73.7
Might consider adoption although has a biological child	22	40	6	4.9
Would never adopt, thinks it is inconsiderable!	2	3.6	4	10.5
Would tell the child that s/he was adopted	50	90.9	30	78.9
Would never disclose adoption information to anyone	1	1.8	4	10.5
Would accept her/his biological child to have a friend who is adopted.	55	100	38	100

In general, non-adoptive parents expressed positive opinions about adoption. Most of them reported that they might have considered adoption if they did not have a biological child. However 2 mothers (3.6%) and 4 fathers (10.5%) would never think of adopting a child. Although majority of the parents thought that adoption is giving a home to a homeless child, 2 mothers (3.6%) and 3 fathers (7.9%) recognized adoption as taking care of someone else's child (who had failed to take care of his/her own child). Finally, none of the parents had any objections to their biological children having friends who were adopted.

3.1.3 Interview with mothers

Twelve mothers (7 adoptive and 5 non-adoptive) were interviewed. Half of them were mothers of children in the clinical group and the other half were mothers of non-clinical group (6 clinical and 6 non-clinical). They responded to open-ended questions (Appendix J).

When mothers were asked to find 5 words that describe their children, they had difficulties in describing their children with single words, they used phrases or sentences. All of the mothers, regardless of adoption or clinical status, declared more positive words/phrases than negative statements about their children. Examples for positive statements were: honest, happy, expresses him/herself very well, cute, social, responsible etc. Examples of negative statements were: asks for attention all the time, insists on her/his demands, hyperactive, angry, irresponsible etc).

Two adoptive mothers thought that those characteristics were unique to their children, whereas five mothers resembled their children's characteristics to adoptive family members (i.e., mother, father, maternal uncle and maternal grandmother). None of the mothers mentioned about biological families. All of the non-adoptive mothers found resemblance between their children and family members.

Fifty percent of the mothers expressed that "stubbornness" was the most difficult behavior of their children. They found it very difficult to cope when the children never give up demanding, until they get it. 40% of the mothers had trouble in coping with the anger outbursts. 35% had difficulties in making their children study, and watching TV too much was the main difficulty for one mother (5%).

Only two mothers (one adoptive and one non-adoptive) asked and received support from their spouses in order to cope with those difficult behaviors of their children. Remaining mothers received no support and tried to cope by themselves. Two adoptive mothers revealed that they could not cope when the children start being stubborn, they gave up most of the times and behaved according to their children's demands.

When the mothers were asked for the possible reasons for their children's problem behaviors, only one adoptive mother related those problems to the biological mother. She was 100% sure that those problems stemmed from the malnutrition of biological mother during pregnancy, although she did not know the birth mother. Other adoptive parents attributed personal characteristics, previous health problems or sibling jealousy as the source of behavior problems. Non-adoptive parents pointed out to not spending enough time with the child and sibling rivalry.

All of the mothers had concerns about their children's future lives. Most of them thought the behavior characteristics (being hyperactive, not willing to study, being irresponsible, displaying anger outbursts, acting impulsive etc.) of their children might lead to future academic or social difficulties. Adoptive mothers were also concerned about the biological families of their children. According to them, possible cultural differences with biological parents or siblings might be a problem in the future, if they happen to meet one day. All the adoptive mothers were worried about whether their children might wish to find their biological parents one day in the future. Although they were all willing to help finding the parents, they all agreed that this experience would upset the children. One mother hoped that her child's adoption status would not be a burden for his marriage when he is grown up.

Some examples from the mothers' definitions about the meaning of being a mother were as follows:

- Being a mother is sharing unconditional love. I would die for my child without any hesitation (adoptive mother).
- Not just giving birth. Being tolerant and warm all the time (adoptive mother).
- It is to apply for and than have the most pleasurable, most important, most difficult and most sensitive job in the world. Without getting the full responsibility of rearing a child, it is not possible to understand the value of being a mother (adoptive mother).
- It is self-sacrifice (adoptive mother).
- Being a mother requires self-sacrifice. You have to devote yourself, like being ready all the time to give your life away for someone else (adoptive mother).
- Spending a life time by thinking of someone else before your own self (non-adoptive mother).
- It is a very big responsibility, not every woman could do it (non-adoptive mother).
- Devotion, trust and commitment (non-adoptive mother).

- Parenthood means to give a full life to a child, to sit next to a sick child and pray God to take off from your life and add to your child's life (non-adoptive mother).

All the mothers agreed that the family who raise a child is the real family. It is not enough to give birth to be a parent.

All the adoptive mothers believed that there was no difference between being a mother of a child that they had given birth and being a mother of a child that some other woman gave birth. They stated that, they did not feel any different unless they meet such questions. One adoptive mother said, she would had more strict discipline, if she had given birth to her daughter, she would not be as tolerant as she was today.

Only one non-adoptive mother argued that it was not possible to feel like a full mother unless you carried the baby in your body. But she also believed that this feeling might be gained spending long time together. The rest of the non-adoptive mothers thought that raising a child and getting the full responsibility was more important than giving birth. One mother said "Giving your love to a child is more important than giving your genes".

3.2 Group Differences

3.2.1. Parental differences on the measures of the study

Initial analyses were done to compare parental ratings regardless of adoption or clinical status. Although 123 children participated in the study, number of children for whom both parents contributed to the study was somewhat smaller. Only 67 pairs of mothers and fathers rated Child Behavior Check List (CBCL) and 77 pairs rated School-Age Temperament Inventory (SATI) for their children. 79 couples responded to Measure of Child Rearing Styles (MCRS) and 78 couples responded to Basic Personality Traits Inventory (BPTI) among the whole group.

The multivariate tests did not indicate a significant parent effect between CBCL scores [$F(15,52) = 1,28$, *n.s.*] and 4 subscales of SATI [$F(4,73) = 0.49$, *n.s.*]. Mothers and fathers differed in MCRS [Multivariate $F(2,77) = 8.67$, $p < .001$, Wilks'$\Lambda = .82$, $eta^2 = .18$] and BPTI [Multivariate $F(6,72) = 3.48$, $p < .005$,

Wilks'Λ = .78, eta^2 = .23], indicating that although parents had some differences in child rearing styles and personality traits, in observing and rating the temperament and problem behaviors of their children they respond similarly.

According to the Bonferroni adjusted univariate analyses for MCRS, mothers showed more parental acceptance/involvement (*M* = 3.39, *SD* = .04) than fathers (*M* = 3.23, *SD* = .04) [Univariate *F(*1,78) = 8.81, *p* < .005, eta^2 = .10]. For these univariate analyses, considering the Bonferroni adjustment only the F scores that are significant at least at .025 alpha level were considered as significant.

Among the 6 subscales of BPTI, considering the Bonferroni adjustment only the F scores that are significant at least at .008 alpha level were considered as significant. As a result, significant differences between parents were observed only in openness subscale. Mothers were less open to new experiences (*M* = 3.71, *SD* = .07) and than fathers (*M* = 3.93, *SD* = .06) [Univariate *F(*1,77) = 8.28, *p* < .005, eta^2 = .10].

The above mentioned results related to CBCL, SATI, MCRS and BPTI of the whole group are summarized in Table 17.

Table 17: MANOVA table for the ratings of whole group mothers and fathers regardless of adoption or clinical status.

	Multi-variate F	df	Wilks Λ	Multivariate eta^2	Univariate F	Univariate eta^2
CBCL	1.28	15,52	.73	.27	-	-
SATI	0.49	4,73	.97	.03	-	-
MCRS	8.67***	2,77	.82	.18	-	-
Acceptance	-	1,78	-	-	8.81**	.10
Strict Control	-	1,78	-	-	4.59	.06
BPTI	3.48*	6,72	.78	.23	-	-
Openness	-	1,77	-	-	8.28**	.10
Conscientiousness	-	1,77	-	-	0.59	.01
Extraversion	-	1,77	-	-	0.69	.01
Agreeableness	-	1,77	-	-	5.26	.06
Neuroticism	-	1,77	-	-	0.17	.01
Negative Valence	-	1,77	-	-	1.11	.01

*** $p < .001$, **$p < .005$, *$p < .05$

CBCL - Child Behavior Check List; **SATI - School-Age Temperament Inventory**; MCRS - Measure of Child Rearing Styles; **BPTI - Basic Personality Traits Inventory**

Table 18 displays the mean scores of the mothers and fathers regardless of adoption and/or clinical status obtained from MCRS and BPTI. Means indicated with bold, are significantly different.

Table 18: Mean table of whole group mothers and fathers regardless of adoption or clinical status obtained from MCRS and BPTI.

	Mothers		Fathers	
	M	**SD**	**M**	**SD**
MCRS				
Acceptance/Involvement	**3.39**	**.04**	**3.23**	**.04**
Strict Control/Supervision	2.58	.04	2.48	.04
BPTI				
Openness	**3.71**	**.07**	**3.93**	**.06**
Conscientiousness	4.08	.08	4.02	.06
Extraversion/Introversion	3.93	.09	3.84	.08
Agreeableness	4.49	.05	4.36	.05
Neuroticism	2.61	.09	2.66	.10
Negative Valence	1.48	.06	1.56	.06

Based on these results, because of the similarity of parental responses, in order not to lose data, in the further analyses, mothers and fathers will be compared separately between adoption and clinical status groups; so it was not taken as the within group variable.

3.2.2. Group differences based on adoption and clinical status groups

To test the differences between groups 2 (Group: adopted, non-adopted) x 2 (Group: clinical, non-clinical) multivariate analysis were conducted separately for mothers, fathers and children for CBCL, SATI, MCRS, BPTI, YSR and KSS.

3.2.2.1 Group differences on Child Behavior Checklist (CBCL)

CBCL scores (3 problem behaviors, 8 syndrome scales and 6 DSM-oriented scales) were analyzed separately for mothers and fathers. Mean scores of the CBCL scales are displayed in Table 19.

3.2.2.1.1 Mothers' CBCL ratings

Gender and age were included into the analyses as covariates. Results of 2x2 MANCOVA revealed clinical status main effect [Multivariate $F(15,89) = 4.28$, $p < .001$, Wilks' $\Lambda = .58$, $eta^2 = .42$]. No significant adoption status main effect [Multivariate $F(15,89) = 1.32$, *n.s.*] or interaction effect [Multivariate $F(15,89) = 1.10$, *n.s*] were found.

For the pairwise comparisons, Bonferroni significance level of .003 was accepted. Considering the Bonferroni adjustment, 3 problem behavior scales, 6 out of eight syndrome scales and 5 out of six DSM-oriented scales were found significant. Results are summarized in Table 20.

According to these results, as expected, mothers of children who were followed in a child and adolescent mental health unit (clinical group) reported more internalizing, externalizing and total problems than mothers of children in the non-clinical group. Children in the clinical group were more withdrawn/depressed, had more social, thought and attention problems, had more rule breaking and aggressive behaviors than children in the non-clinical group based on their mothers' ratings. They also had more affective, anxiety, attention deficit hyperactivity, oppositional defiant and conduct problems (DSM-oriented scales) than non-clinical group. Mean scores of CBCL rated by mothers of clinical and non-clinical groups are shown in Table 21. Bold subscales indicate significant differences.

Table 19. Mean scores of CBCL scores rated by parents

	Adoptive								Non-adoptive							
	Clinical				Non-clinical				Clinical				Non-clinical			
	Mothers N = 34		Fathers N = 22		Mothers N = 17		Fathers N = 9		Mothers N = 35		Fathers N = 20		Mothers N = 23		Fathers N = 19	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
Internalizing Problems	13.79	7.95	11.45	7.14	10.59	7.28	7.78	5.59	14.37	8.37	13.05	9.16	7.87	5.36	7.26	4.89
Externalizing Problems	15.15	10.61	13.50	11.03	8.24	6.90	7.00	6.84	11.54	7.15	8.95	6.97	4.48	3.75	4.32	4.03
Total Problems	55.71	26.78	49.23	29.60	33.94	21.24	28.56	21.33	49.71	24.15	42.30	26.97	20.78	13.35	19.53	11.93
Syndrome Scales																
Anxiety/Depression	7.09	4.85	6.18	4.20	6.24	3.95	3.56	2.19	7.26	4.10	6.00	4.05	3.83	2.84	3.42	2.50
Withdrawal/Depression	3.47	2.51	2.64	2.66	2.41	2.53	3.00	2.83	4.71	3.28	4.95	3.87	2.22	1.78	2.47	2.12
Somatic Complaints	3.24	3.51	2.64	2.66	1.94	2.28	1.22	2.64	2.40	2.66	2.10	3.18	1.83	2.19	1.37	2.43
Social Problems	5.94	3.50	5.77	4.12	3.59	2.72	3.22	3.46	6.03	3.58	4.65	3.27	1.83	1.77	1.89	1.85
Thought Problems	4.53	3.37	4.50	3.64	2.65	2.09	2.11	1.36	3.69	3.27	4.00	4.32	1.09	1.35	1.05	1.68
Attention Problems	9.62	4.79	7.55	4.53	4.71	3.90	4.78	4.66	8.57	4.10	6.95	3.93	2.30	2.57	2.53	2.29
Rule Breaking Beh	4.38	3.63	3.73	3.43	1.59	1.94	1.44	2.07	2.43	2.38	2.15	2.43	1.17	1.40	0.68	1.20
Aggressive Behavior	10.76	7.65	9.77	8.09	6.65	5.24	5.56	5.15	9.11	5.28	6.80	5.05	3.30	2.75	3.63	3.39
DSM-Oriented Scales																
Affective Problems	4.35	2.90	3.91	3.18	3.12	2.64	2.67	1.73	4.46	3.19	4.75	3.89	1.96	1.69	1.79	1.69
Anxiety Problems	3.00	2.13	3.05	1.94	2.24	2.51	1.44	1.67	3.20	2.35	2.50	2.12	1.26	1.25	1.11	0.94
Somatic Problems	1.74	2.69	1.45	2.04	0.76	1.25	0.67	1.66	1.31	1.86	1.00	2.29	1.13	1.77	0.74	1.56
ADHD Problems	5.44	2.86	4.77	3.01	2.94	2.16	3.00	2.35	4.31	2.83	3.30	2.64	1.65	1.58	1.89	1.63
Oppositional Defiant P	3.85	2.63	3.32	2.82	2.18	1.91	1.89	1.69	3.54	1.92	2.60	2.19	1.39	1.37	1.42	1.46
Conduct Problems	4.74	4.31	4.36	4.78	1.29	1.76	1.22	1.72	2.80	3.08	2.15	2.46	0.74	1.14	0.47	1.02

Table 20: MANCOVA table for CBCL scores rated by mothers

	Multivariate F	df	Wilks Λ	Multivariate eta^2	Univariate F	Univariate eta^2
Covariates:						
GENDER	2.42***	15,89	.71	.29	-	-
AGE	1.56	15,89	.79	.21	-	-
Independent Variables:						
ADOPTION	1.32	15,89	.82	.18	-	-
CLINIC	4.28****	15,89	.58	.42	-	-
Int Pr.s	-	1,103	-	-	9.80***	.09
Ext Pr.s	-	1,103	-	-	19.72****	.16
Tot Pr.s	-	1,103	-	-	29.70****	.22
Anx/Dep	-	1,103	-	-	6.55	.06
Wdr/Dep	-	1,103	-	-	10.26***	.09
Som Com	-	1,103	-	-	2.54	.02
Soc Pr.s	-	1,103	-	-	28.92****	.22
Tho Pr.s	-	1,103	-	-	14.53****	.12
Att Pr.s	-	1,103	-	-	46.07****	.31
Rule Br Beh	-	1,103	-	-	14.84****	.13
Agg Beh	-	1,103	-	-	18.69****	.15
Aff Pr.s	-	1,103	-	-	10.86***	.10
Anx Pr.s	-	1,103	-	-	9.91***	.09
Som Pr.s	-	1,103	-	-	1.79	.02
ADHD Pr.s	-	1,103	-	-	26.34****	.20
Opp Def Pr.s	-	1,103	-	-	20.41****	.17
Cond Pr.s	-	1,103	-	-	20.52****	.17
ADP x CLN	1.10	15,89	.84	.16	-	-

**** $p < .001$, ***$p < .005$, **$p < .01$, *$p < .05$

Int Pr.s – Internalizing Problems, **Ext Pr.s – Externalizing Problems**, Tot Pr.s – Total Problems, **Anx/Dep - Anxious/Depressed**, Wdr/Dep - Withdrawn/Depressed, **Som Com - Somatic Complaints**, Soc Pr.s - Social Problems, **Tho Pr.s - Thought Problems**, Att Pr.s - Attention Problems, **Rule Br Beh - Rule Breaking Behavior**, Agg Beh - Aggressive Behavior, **Aff Pr.s - Affective Problems**, Anx Pr.s - Anxiety Problems, **Som Pr.s - Somatic Problems**, ADHD Pr.s - Attention Deficit Hyperactivity Problems, **Opp Def Pr.s - Oppositional Defiant Problems**, Con Pr.s – Conduct Problems

Table 21. Mean scores of CBCL scores rated by mothers of clinical and non-clinical groups

	Clinical N = 69		Non-clinical N = 40	
	M	**SD**	**M**	**SD**
Internalizing Problems	**14.04**	**0.91**	**9.31**	**1.21**
Externalizing Problems	**13.37**	**0.95**	**6.33**	**1.26**
Total Problems	**52.67**	**2.77**	**27.48**	**3.69**
Syndrome scales				
Anxiety/Depression	7.17	0.50	5.04	0.67
Withdrawal/Depression	**4.08**	**0.32**	**2.35**	**0.43**
Somatic Complaints	2.79	0.33	1.92	0.44
Social Problems	**6.01**	**0.38**	**2.64**	**0.50**
Thought Problems	**4.09**	**0.34**	**1.91**	**0.46**
Attention Problems	**9.07**	**0.49**	**3.58**	**0.65**
Rule-breaking Beh	**3.40**	**0.31**	**1.40**	**0.41**
Aggressive Behavior	**9.96**	**0.70**	**4.93**	**0.93**
DSM-oriented scales				
Affective Problems	**4.40**	**0.34**	**2.55**	**0.45**
Anxiety Problems	**3.10**	**0.26**	**1.74**	**0.34**
Somatic Problems	1.51	0.24	0.97	0.32
ADHD Problems	**4.88**	**0.30**	**2.31**	**0.40**
Oppositional Defiant P.	**3.70**	**0.25**	**1.79**	**0.34**
Conduct Problems	**3.79**	**0.37**	**0.99**	**0.49**

3.2.2.1.2 Fathers' CBCL ratings

2x2 MANCOVA analysis on fathers' ratings of CBCL, where gender and age were the covariates of the analysis, revealed no significant adoption status [Multivariate $F(15,50) = 0.63$, *n.s.*] or clinical status [Multivariate $F(15,50) = 1.84$,

n.s.] main effects or interaction effect [Multivariate $F(15,50) = 0.81$, *n.s.*] (See Table 22).

Table 22: MANCOVA table for CBCL scores rated by fathers

	Multivariate F	df	Wilks Λ	Multivariate eta^2	Univariate F	Univariate eta^2
Covariates:						
GENDER	1.62	15,50	.67	.33	-	-
AGE	1.30	15,50	.72	.28	-	-
Independent Variables						
ADOPTION	0.63	15,50	.81	.16	-	-
CLINIC	1.84	15,50	.64	.36	-	-
ADP x CLN	0.81	15,50	.81	.20	-	-

3.2.2.2 Group differences on School Age Temperament Inventory (SATI)

Mean scores of SATI scales obtained from parents are shown in Table 23.

3.2.2.2.1 Mothers' SATI ratings

When mothers' responses were analyzed via 2x2 MANCOVA where age and gender were the covariate variables, significant main effect was observed only in clinical status [Multivariate $F(4,106) = 8.74$, $p < .001$, Wilks' $\Lambda = .75$, $eta^2 = .25$]. No significant adoption status main effect [Multivariate $F(4,106) = 2.48$, *n.s.*] or interaction effect [Multivariate $F(4,106) = 2.04$, *n.s*] were found.

For these univariate analyses of clinical status main effect, considering the Bonferroni adjustment only the F scores that are significant at least at .013 alpha level were considered as significant. Results are summarized in Table 24.

Significant differences were observed in task persistence and activity subscales between the mothers' ratings of clinical and non-clinical groups [Univariate $F(1,109) = 32.87$, $p < .0001$, $eta^2 = .23$ and univariate $F(1,109) = 11.41$, $p < .01$, $eta^2 = .10$ respectively].

Table 23. Mean scores of SATI, MCRS and BPTI subscales rated by parents

	Adoptive								Non-adoptive							
	Clinical				Non-clinical				Clinical				Non-clinical			
	Mothers N = 36		Fathers N = 26		Mothers N = 20		Fathers N = 12		Mothers N = 35		Fathers N = 20		Mothers N = 24		Fathers N = 20	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
SATI																
Negative Reactivity	3.50	0.71	3.43	0.64	3.34	0.54	3.29	0.46	3.36	0.76	3.23	0.65	2.91	0.91	2.77	0.70
Task Persistence	2.60	0.75	2.80	0.71	3.16	0.81	2.94	0.77	2.71	0.65	2.75	0.59	3.69	0.68	3.61	0.61
Approach/Withdrawal	2.61	0.66	2.51	0.60	2.76	0.46	2.97	0.71	3.03	0.69	3.11	0.49	2.69	0.64	2.62	0.57
Activity	3.27	0.83	3.14	0.88	2.68	0.85	3.33	0.77	3.03	0.82	2.90	0.75	2.60	0.82	2.59	0.75
MCRS																
Acceptance/Involvement	3.38	0.40	3.18	0.32	3.42	0.40	3.40	0.34	3.24	0.37	3.12	0.45	3.46	0.29	3.24	0.37
Strict Control/Supervision	2.51	0.42	2.50	0.29	2.60	0.38	2.46	0.34	2.56	0.38	2.59	0.38	2.47	0.35	2.42	0.37
BPTI																
Openness	3.75	0.46	3.90	0.55	3.77	0.60	4.03	0.44	3.64	0.74	3.79	0.46	3.82	0.56	4.05	0.63
Conscientiousness	4.16	0.63	4.03	0.56	4.15	0.54	3.99	0.50	3.83	0.77	3.88	0.55	4.08	0.48	4.08	0.58
Extraversion/Introversion	4.06	0.64	3.67	0.79	3.95	0.83	4.11	0.70	3.81	0.95	3.56	0.62	4.03	0.62	4.14	0.65
Agreeableness	4.55	0.39	4.67	0.33	4.50	0.44	4.58	0.36	4.42	0.46	4.23	0.33	4.47	0.45	4.23	0.53
Neuroticism	2.66	0.70	2.59	0.86	2.67	0.77	2.88	0.86	2.75	0.82	2.72	0.86	2.44	0.75	2.52	0.75
Negative Valence	1.47	0.46	1.62	0.64	1.34	0.27	1.46	0.62	1.55	0.49	1.53	0.47	1.55	0.66	1.56	0.40

SATI - School-Age Temperament Inventory, **MCRS - Measure of Child Rearing Styles**, BPTI - Basic Personality Traits Inventory

Table 24: MANCOVA table for SATI scores of mothers

	Multivariate F	df	Wilks Λ	Multivariate eta^2	Univariate F	Univariate eta^2
Covariates:						
GENDER	3.27*	4,106	.89	.11	-	-
AGE	2.10	4,106	.93	.07	-	-
Independent Variables:						
ADOPTION	2.48	4,106	.91	.09	-	-
CLINIC	8.74***	4,106	.75	.25	-	-
Neg R	-	1,109	-	-	4.54	.04
Task P	-	1,109	-	-	32.87***	.23
Ap/Wd	-	1,109	-	-	0.83	.01
Actv	-	1,109	-	-	11.41**	.10
ADP x CLN	2.04	4,106	.93	.07	-	-

*** p < .001, **p < .005, *p < .05
Neg R – Negative Reactivity, **Task P – Task Persistence**, Ap /Wd – Approach/Withdrawal, **Actv - Activity**

Mean scores of SATI rated by mothers of clinical and non-clinical groups are shown in Table 25. Bold subscales indicate significant differences.

Table 25. Mean scores of SATI subscales rated by mothers of clinical and non-clinical groups

	Clinical N = 71		Non-clinical N = 44	
	M	SD	M	SD
Negative Reactivity	3.43	0.09	3.12	0.11
Task Persistence	**2.66**	**0.08**	**3.42**	**0.11**
Approach/Withdrawal	2.83	0.08	2.72	0.10
Activity	**3.16**	**0.10**	**2.63**	**0.12**

According to these results, mothers of the clinical group perceived their children as having less task persistence and higher activity levels as compared to the mothers of non-clinical group children.

3.2.2.2.2 Fathers' SATI ratings

2x2 MANCOVA for father responses on SATI where gender and age were the covariate variables, revealed significant adoption status main effect [Multivariate $F(4,70) = 3.09$, $p < .05$, Wilks' $\Lambda = .85$, $eta^2 = .15$], clinical status main effect [Multivariate $F(4,70) = 2.84$, $p < .05$, Wilks' $\Lambda = .86$, $eta^2 = .14$] and adoption X clinical status interaction [Multivariate $F(4,70) = 3.93$, $p < .05$, Wilks' $\Lambda = .82$, $eta^2 = .18$]. See Table 26.

Table 26: MANCOVA table for SATI scores of fathers

	Multivariate F	**df**	**Wilks Λ**	**Multivariate eta^2**	**Univariate F**	**Univariate eta^2**
Covariates:						
GENDER	3.16*	4,70	.85	.15	-	-
AGE	3.02*	4,70	.85	.15	-	-
Independent Variables:						
ADOPTION	3.09*	4,70	.85	.15	-	-
Neg R	-	1,73	-	-	5.72	.04
Task P	-	1,73	-	-	6.34	.23
Ap/Wd	-	1,73	-	-	0.84	.01
Actv	-	1,73	-	-	4.70	.10
CLINIC	2.84*	4,70	.86	.14	-	-
Neg R	-	1,73	-	-	3.55	.05
Task P	-	1,73	-	-	8.60***	.11
Ap/Wd	-	1,73	-	-	0.93	.01
Actv	-	1,73	-	-	0.10	.01
ADP x CLN	3.93**	4,70	.82	.18	-	-
Neg R	-	1,73	-	-	1.29	.02
Task P	-	1,73	-	-	7.59**	.09
Ap/Wd	-	1,73	-	-	11.267***	.13
Actv	-	1,73	-	-	1.773	.02

*** $p < .001$, ** $p < .01$, * $p < .05$
Neg R – Negative Reactivity, Task P – Task Persistence, **Ap/Wd – Approach/Withdrawal**, Actv - Activity

For the univariate analyses of adoption and clinical status main effects, and of the interaction effect, considering the Bonferroni adjustment only the F scores that are significant at least at .013 alpha level were considered as significant. Based on this criterion, significant adoption main effect was not observed on the subscales of SATI. On the other hand, for clinical status main effect, univariate analyses indicated significant difference in task persistence subscale [Univariate $F(1,73) = 8.60$, $p < .005$, $eta^2 = .11$].

Mean scores of SATI rated by fathers of clinical and non-clinical groups are shown in Table 27. Bold subscales indicate significant differences. According to these results fathers of the clinical group perceived their children as less task persistent than the fathers of non-clinical group children.

Table 27. Mean scores of SATI subscales rated by fathers of clinical and non-clinical groups

	Clinical N = 47		**Non – Clinical N = 32**	
	M	**SD**	**M**	**SD**
Negative Reactivity	3.33	0.09	3.04	0.12
Task Persistence	**2.79**	**0.09**	**3.24**	**0.12**
Approach/Withdrawal	2.82	0.09	2.78	0.11
Activity	3.02	0.11	2.96	0.14

Univariate analysis for the adoption status x clinical status interaction revealed significant differences in task persistence subscale [Univariate $F(1,73) = 7.59$, $p < .01$, $eta^2 = .09$] and approach/withdrawal subscale [Univariate $F(1,73) = 11.267$, $p < .001$, $eta^2 = .13$]. Mean scores of SATI rated by fathers in terms of

adoption and clinical status were already shown in Table 23. Below tables indicate mean differences of significant interaction effects.

Table 28. SATI Task Persistence subscale means rated by fathers

	Adoptive	Non-adoptive
Clinical	2.80 $_{a}$	2.75 $_{a}$
Non-clinical	2.94 $_{ab}$	3.61 $_{b}$

Note. The mean scores that do not share the same subscript on the same column or on the same raw indicate significant differences.

As can be seen in the above table, among the adopted group, fathers of the clinical and non-clinical group children did not differ on the task persistence subscale. On the other hand, for the non-adopted group, fathers of the non-clinical group reported more task persistence for their children than the fathers of clinical group. When the clinical status is examined, adoptive and non-adoptive fathers in the clinical and non-clinical groups did not have significant differences in rating their children's task persistence.

Table 29. SATI Approach/withdrawal subscale means rated by fathers

	Adoptive	Non-adoptive
Clinical	2.51 $_{a}$	3.11 $_{a}$
Non-clinical	2.97 $_{ab}$	2.62 $_{b}$

Note. The mean scores that do not share the same subscript on the same column or on the same raw indicate significant differences.

The results shown in Table 29 reveal that, among the adopted group, fathers of the clinical and non-clinical group children did not differ on the approach/withdrawal subscale. On the other hand, for the non-adopted group, fathers of the non-clinical group reported that their children were less prone to withdraw from new situations when compared to the fathers of children in the clinical group. In the clinical and non-clinical groups, adoptive and non-adoptive fathers did not differ in approach/withdrawal subscale.

3.2.2.3 Group differences on Measure of Child Rearing Styles (MCRS)

Mean scores of MCRS scales were already displayed in Table 23.

3.2.2.3.1. Mothers' MCRS ratings

According to the results of 2x2 MANCOVA analysis on mothers' MCRS ratings where gender and age were the covariate variables, there were no significant adoption status [Multivariate $F(2,108) = 0.24$, *n.s.*] or clinical status [Multivariate $F(2,108) = 1.45$, *n.s.*] main effects, or interaction effect [Multivariate $F(2,108) = 1.80$, *n.s.*] (See Table 30).

Table 30: MANCOVA table for MCRS scores rated by mothers

	Multivariate F	**df**	**Wilks Λ**	**Multivariate eta^2**	**Univariate F**	**Univariate eta^2**
Covariates:						
GENDER	0.19	2,108	.98	.01	-	-
AGE	1.61	2,108	.97	.03	-	-
Independent Variables						
ADOPTION	0.24	2,108	1.00	.01	-	-
CLINIC	1.45	2,108	.97	.03	-	-
ADP x CLN	1.80	2,108	.97	.03	-	-

3.2.2.3.2 Fathers' MCRS ratings

Similarly, for fathers' MCRS ratings, 2x2 MANCOVA analysis was computed where gender and age were the covariate variables. Adoption status [Multivariate $F(2,74) = 0.79$, *n.s.*] or clinical status [Multivariate $F(2,74) = 2.26$, *n.s.*] main effects, or interaction effect [Multivariate $F(2,74) = 0.52$, *n.s.*] were not found significant (See Table 31).

Table 31: MANCOVA table for MCRS scores rated by fathers

	Multivariate F	df	Wilks Λ	Multivariate eta^2	Univariate F	Univariate eta^2
Covariates:						
GENDER	0.54	2,74	.99	.01	-	-
AGE	0.40	2,74	.99	.01	-	-
Independent Variables:						
ADOPTION	0.79	2,74	.99	.02	-	-
CLINIC	2.26	2,74	.94	.06	-	-
ADP x CLN	.52	2,74	.99	.01	-	-

3.2.2.4 Group differences on Basic Personality Traits Inventory (BPTI)

Mean scores of BPTI scales were already displayed in Table 23.

3.2.2.4.1. Mothers' BPTI ratings

2x2 MANCOVA analysis on mothers' ratings of BPTI, where gender and age were the covariate variables, revealed no significant adoption status [Multivariate $F(6,103) = 0.88$, *n.s.*] or clinical status [Multivariate $F(6,103) = 0.40$, *n.s.*] main effects, or interaction effect [Multivariate $F(6,103) = 0.83$, *n.s.*] (See Table 32).

Table 32: MANCOVA table for BPTI scores of mothers

	Multivariate F	df	Wilks Λ	Multivariate eta^2	Univariate F	Univariate eta^2
Covariates:						
GENDER	0.43	6,103	.98	.02	-	-
AGE	0.80	6,103	.96	.04	-	-
Independent Variables:						
ADOPTION	0.88	6,103	.95	.05	-	-
CLINIC	0.40	6,103	.98	.02	-	-
ADP x CLN	0.83	6,103	.95	.05	-	-

3.2.2.4.2 Fathers' BPTI ratings

Results of 2x2 MANCOVA analysis on fathers' BPTI ratings, where gender and age were the covariates, revealed significant adoption status [Multivariate $F(6,69) = 2.25$, $p < .05$, Wilks' $\Lambda = .84$, eta$^2 = .16$] and clinical status [Multivariate $F(6,69) = 2.68$, $p < .05$, Wilks' $\Lambda = .81$, eta$^2 = .19$] main effects. Interaction effect [Multivariate $F(6,69) = 1.21$, *n.s.*] was not significant.

Univariate analyses indicated significant differences in agreeableness subscale for adopted group [Univariate $F(1,74) = 10.73$, $p < .005$, eta$^2 = .13$] and in extraversion/introversion subscale for clinical group, [Univariate $F(1,74) = 11.58$, $p < .001$, eta$^2 = .14$]. For these univariate analyses, considering the Bonferroni adjustment, only the F scores that are significant at least at .008 alpha level were considered as significant.

Those above mentioned results are summarized in Table 33.

Table 33: MANCOVA table for BPTI scores rated by fathers

	Multivariate F	df	Wilks Λ	Multivariate eta^2	Univariate F	Univariate eta^2
Covariates:						
GENDER	3.46**	6,69	.77	.23	-	-
AGE	0.48	6,69	.96	.04	-	-
Independent Variables:						
ADOPTION	2.25*	6,69	.84	.16	-	-
Open	-	1,74	-	-	0.20	.01
Cons	-	1,74	-	-	0.01	.01
Ext	-	1,74	-	-	0.19	.01
Agg	-	1,74	-	-	10.73**	.13
Neu	-	1,74	-	-	0.19	.01
NV	-	1,74	-	-	0.05	.01
CLINIC	2.68*	6,69	.81	.14	-	-
Open	-	1,74	-	-	2.84	.04
Cons	-	1,74	-	-	0.13	.01
Ext	-	1,74	-	-	11.58***	.14
Agg	-	1,74	-	-	0.46	.01
Neu	-	1,74	-	-	0.08	.01
NV	-	1,74	-	-	0.41	.01
ADP x CLN	1.21	6,69	.91	.10	-	-

*** p < .001, **p < .005, *p < .05
Open – Openness, Cons – Conscientiousness, **Ext – Extraversion/Introversion**, Agg – Agreeableness, **Neu – Neuroticism**, NV – Negative Valence

These results suggest that, adoptive fathers were more agreeable than non-adoptive fathers, and fathers of non-clinical group children were more extravert then the fathers of clinical group children.

Mean scores of BPTI rated by adoptive and non-adoptive fathers are shown in Table 34.

Table 34. Mean scores of BPTI subscales rated by adoptive and non-adoptive fathers

	Adoptive N = 38		Non-adoptive N =42	
	M	**SD**	**M**	**SD**
Openness	3.97	0.09	3.91	0.08
Conscientiousness	3.98	0.09	3.99	0.08
Extraversion/Introversion	3.91	0.12	3.84	0.11
Agreeableness	**4.53**	**0.07**	**4.22**	**0.06**
Neuroticism	2.71	0.15	2.64	0.13
Negative Valence	1.53	0.09	1.55	0.08

Table 35 displays the BPTI means scores obtained from the fathers of children in clinical and non-clinical children. Bold subscales indicate significant differences.

Table 35. Mean scores of BPTI subscales rated by fathers of clinical and non-clinical groups

	Clinical N = 46		Non-clinical N = 34	
	M	**SD**	**M**	**SD**
Openness	3.84	0.08	4.05	0.10
Conscientiousness	3.96	0.08	4.01	0.09
Extraversion/Introversion	**3.60**	**0.10**	**4.14**	**0.12**
Agreeableness	4.35	0.06	4.41	0.07
Neuroticism	2.65	0.12	2.71	0.15
Negative Valence	1.58	0.08	1.50	0.10

3.2.2.5 Group differences on Youth Self Report (YSR)

Children above age 11 rated their own functioning on YSR. Mean scores of YSR scores (3 problem behaviors, 8 syndrome scales and 6 DSM-oriented scales) are displayed in Table 36.

Table 36. Mean scores for Youth Self Report, rated by adolescents

	Adopted				**Non-Adopted**			
	Clinical N = 21		**Non-Clinical N = 8**		**Clinical N = 15**		**Non-Clinical N = 12**	
	M	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
Internalizing Problems	15.81	7.39	11.00	5.58	18.53	10.48	11.67	6.92
Externalizing Problems	15.76	8.46	9.00	3.02	14.00	9.55	9.17	5.36
Total Problems	65.38	19.22	46.13	15.24	64.47	28.98	46.92	17.05
Syndrome Scales								
Anxiety/Depression	8.19	4.34	5.75	3.92	8.47	4.55	4.92	3.63
Withdrawal/Depression	4.67	2.11	3.13	1.89	5.80	2.43	3.83	2.29
Somatic Complaints	2.95	2.82	2.13	1.36	4.27	4.80	2.92	2.71
Social Problems	5.33	3.86	4.63	2.56	5.73	3.67	2.92	2.27
Thought Problems	6.00	2.96	3.62	2.26	5.00	4.61	4.33	3.03
Attention Problems	8.48	3.04	4.75	4.13	8.40	3.14	5.33	2.15
Rule-breaking Beh	4.71	3.77	1.00	1.07	3.47	3.68	2.17	1.85
Aggressive Behavior	11.05	5.41	8.00	2.67	10.53	6.55	7.00	4.73
DSM-Oriented Scales								
Affective Problems	6.14	3.71	3.50	2.39	6.53	4.52	3.25	2.38
Anxiety Problems	3.57	2.31	2.50	2.14	4.13	2.47	2.08	1.78
Somatic Problems	1.29	1.95	1.25	1.04	2.40	3.31	1.50	1.38
ADHD Problems	5.00	2.53	3.25	2.25	3.93	2.19	3.00	1.41
Oppositional Defiant P.	5.19	2.64	4.50	1.51	4.73	2.69	3.08	1.73
Conduct Problems	4.95	3.56	0.88	1.46	3.67	3.52	1.67	1.37

For 2x2 MANCOVA, gender and age were included into the analyses as covariates. No significant adoption main effect [Multivariate $F(15,35) = 0.88$, *n.s.*] or interaction effect [Multivariate $F(15,35) = 1.08$, *n.s*] were found. Only clinical status main effect was observed [Multivariate $F(15,35) = 2.80$, $p < .01$, Wilks' $\Lambda = .45$, $eta^2 = .55$].

For the univariate analyses, Bonferroni significance level of .003 was accepted and only 2 out of 17 scores were found significant. Results are summarized in Table 37.

Adolescents in the clinical group, reported more attention and conduct problems for themselves in comparison to their non-clinical peers.

YSR mean scores obtained from adolescents in clinical and non-clinical groups are displayed in Table 38. Bold subscales indicate significant differences.

Table 37: MANCOVA table for YSR scores of adolescents

	Multivariate F	df	Wilks Λ	Multivariate eta^2	Univariate F	Univariate eta^2
Covariates:						
GENDER	1.85	15,36	.56	.44	-	-
AGE	0.67	15,36	.78	.22	-	-
Independent Variables:						
ADOPTION	0.80	15,36	.75	.25	-	-
CLINIC	2.72*	15,36	.47	.53	-	-
Int Pr.s	-	1,50	-	-	7.22	.13
Ext Pr.s	-	1,50	-	-	5.49	.10
Tot Pr.s	-	1,50	-	-	8.51	.15
Anx/Dep	-	1,50	-	-	6.28	.11
Wdr/Dep	-	1,50	-	-	9.12	.15
Som Com	-	1,50	-	-	1.36	.03
Soc Pr.s	-	1,50	-	-	3.62	.07
Tho Pr.s	-	1,50	-	-	1.89	.04
Att Pr.s	-	1,50	-	-	13.17***	.21
Rule Br Beh	-	1,50	-	-	6.15	.11
Agg Beh	-	1,50	-	-	3.62	.07
Aff Pr.s	-	1,50	-	-	9.26	.16
Anx Pr.s	-	1,50	-	-	5.54	.10
Som Pr.s	-	1,50	-	-	0.63	.01
ADHD Pr.s	-	1,50	-	-	3.75	.07
Opp Def Prs	-	1,50	-	-	2.04	.04
Cond Pr.s	-	1,50	-	-	10.71**	.18
ADP x CLN	1.08	15,36	.68	.32	-	-

*** $p < .001$, ** $p < .005$, * $p < .01$

Int Pr.s – Internalizing Problems, Ext Pr.s – Externalizing Problems, **Tot Pr.s – Total Problems**, Anx/Dep - Anxious/Depressed, **Wdr/Dep - Withdrawn/Depressed**, Som Com - Somatic Complaints, **Soc Pr.s - Social Problems,** Tho Pr.s - Thought Problems, **Att Pr.s - Attention Problems**, Rule Br Beh - Rule Breaking Behavior, **Agg Beh - Aggressive Behavior**, Aff Pr.s - Affective Problems, **Anx Pr.s - Anxiety Problems**, Som Pr.s - Somatic Problems, **ADHD Pr.s - Attention Deficit Hyperactivity Problems**, Opp Def Pr.s - Oppositional Defiant Problems, **Con Pr.s – Conduct Problems**

Table 38. Mean scores for YSR obtained from adolescents in clinical and non-clinical groups

	Clinical N = 36		Non-Clinical N = 20	
	M	**SD**	**M**	**SD**
Internalizing Problems	17.15	1.26	11.41	1.71
Externalizing Problems	14.65	1.28	9.55	1.74
Total Problems	64.67	3.56	47.06	4.83
Syndrome Scales				
Anxiety/Depression	8.32	0.69	5.37	0.94
Withdrawal/Depression	5.22	0.34	3.51	0.46
Somatic Complaints	3.61	0.54	2.54	0.74
Social Problems	5.57	0.57	3.72	0.78
Thought Problems	5.44	0.58	4.10	0.78
Attention Problems	**8.39**	**0.53**	**5.14**	**0.72**
Rule-breaking Behavior	3.99	0.53	1.77	0.72
DSM-Oriented Scales				
Aggressive Behavior	10.65	0.89	7.78	1.21
Affective Problems	6.36	0.59	3.34	0.80
Anxiety Problems	3.84	0.38	2.31	0.52
Somatic Problems	1.85	0.36	1.37	0.49
ADHD Problems	4.43	0.38	3.19	0.51
Oppositional Defiant P.	4.89	0.39	3.94	0.53
Conduct Problems	**4.21**	**0.49**	**1.47**	**0.67**

3.2.2.6 Group differences on Kerns Security Scale (KSS)

Perceived reliance of children to their attachment figures (i.e., mothers and fathers in this study) are measured by KSS. Mean scores of KSS are displayed in Table 39.

Table 39. Mean scores of KSS and MCRS subscales rated by children about their parents

	Adopted								Non – Adopted							
	Clinical				Non – Clinical				Clinical				Non – Clinical			
	Mothers N = 36		Fathers N = 26		Mothers N = 20		Fathers N = 12		Mothers N = 35		Fathers N = 20		Mothers N = 24		Fathers N = 20	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
KSS	50.65	9.62	49.83	9.68	53.00	4.99	46.00	10.57	46.88	9.75	45.29	10.15	51.14	7.19	48.60	9.10
MCRS																
Acc/Inv	3.51	0.58	3.28	0.67	3.58	0.34	3.16	0.66	3.28	0.59	3.01	0.77	3.47	0.35	3.17	0.67
St Ctrl	2.76	0.51	2.66	0.67	2.47	0.44	2.26	0.53	2.63	0.53	2.40	0.47	2.53	0.57	2.33	0.61

KSS – Kerns Security Scale. **MCRS – Measure of Child Rearing Styles,** Acc/Inv – Parental Acceptance/Involvement. **St Ctrl/Sup** – Strict Control/Supervision

3.2.2.6.1 Children's perceptions about their mothers on KSS

Children's perceptions about the reliability of their mothers as attachment figures were analyzed by 2x2 ANCOVA, where gender and age were included into the analyses as covariates. No significant adoption status [Univariate $F(1, 100) = 1.61$, *n.s.*] and clinical status [Univariate $F(1, 100) = 3.42$, *n.s*] main effects or interaction effect [Univariate $F(1,100) = 0.71$, *n.s*] were found. The only significant effect was found on covariate measure age [Univariate $F(1,100) = 8.02$, $p < .01$, $eta^2 = .01$] indicating an association between the age of children and their reliance on their mothers as the attachment figure (See Table 40).

Table 40. ANCOVA table for KSS results obtained from children about their mothers

	Univariate F	df	Univariate eta^2
Covariates:			
GENDER	0.51	1,100	.01
AGE	8.02**	1,100	.07
Independent Variables:			
ADOPTION	1.61	1,100	.02
CLINIC	3.42	1,100	.03
ADP x CLN	0.71	1,100	.01

**$p < .01$

3.2.2.6.2 Children's perceptions about their fathers on KSS

Children's perceptions about the reliability of their fathers as attachment figures were analyzed by 2x2 ANCOVA, where gender and age were included into the analyses as covariates. Similar results with mothers were obtained in children's perceptions of their fathers. The only significant effect was on age [Univariate $F(1,92) = 4.99$, $p < .05$, $eta^2 = .05$]. No significant adoption status [Univariate $F(1, 92) = 0.01$, *n.s.*] and clinical status [Univariate $F(1, 92) = 0.03$, *n.s*] main effects or

interaction effect [Univariate $F(1,92) = 3.48$, *n.s*] were found. Significance of age as the covariate measure indicates the association between the age of children and their perceived reliance on their fathers as attachment figures (See Table 41).

Table 41. ANCOVA table for KSS results obtained from children about their fathers

	Univariate F	Df	Univariate eta^2
Covariates:			
GENDER	0.01	1,92	.01
AGE	4.99*	1,92	.05
Independent Variables:			
ADOPTION	0.01	1,92	.01
CLINIC	0.03	1,92	.01
ADP x CLN	3.48	1,92	.04

*$p < .05$

3.2.2.7 Group differences on Measures of Child Rearing Styles (MCRS) rated by children

Child rearing styles of parents perceived by their children are measured by MCRS. Mean scores of MCRS were already displayed in Table 41.

3.2.2.7.1 Children's MCRS ratings about their mothers

When children's perceptions about their mothers' child rearing styles were analyzed by 2x2 MANCOVA with gender and age as covariates, no significant adoption status [Multivariate $F(2, 100) = 1.07$, *n.s.*] and clinical status [Multivariate $F(2, 100) = 2.18$, *n.s*] main effects or interaction effect [Multivariate $F(1,100) = 0.71$, *n.s*] were found. The only significant effect was on age, indicating an association between the ages of the children and their perceptions on child rearing

styles of their mother [Multivariate $F(1,100) = 8.02$, $p < .001$, Wilks' $\Lambda = .88$, $eta^2 = .13$]. See Table 42.

3.2.2.7.2 Children's MCRS ratings about their fathers

When children's perceptions about their mothers' child rearing styles were analyzed by 2x2 MANCOVA with gender and age as covariates, similar results were obtained. The only significant effect was found on age [Multivariate $F(2,92) = 6.39$, $p < .001$, Wilks' $\Lambda = .88$, $eta^2 = .12$], indicating an association between the ages of the children and their perceptions on child rearing styles of their fathers. No significant adoption status [Multivariate $F(2,92) = 0.30$, *n.s.*] and clinic [Multivariate $F(2,92) = 1.73$, *n.s*] main effects or interaction effect [Multivariate $F(2,92) = 1.45$, *n.s*] were found. See Table 43.

Table 42: MCRS scores rated by children about their mothers

	Multivariate F	**df**	**Wilks Λ**	**Multivariate eta^2**	**Univariate F**	**Univariate eta^2**
Covariates:						
GENDER	0.02	(2,100)	1.0	.01	-	-
AGE	7.17*	(2,100)	.88	.13	-	-
Independent Variables:						
ADOPTION	1.07	(2,100)	.98	.02	-	-
CLINIC	2.17	(2,100)	.96	.04	-	-
ADP x CLN	0.86	(2,100)	.98	.02	-	-

*$p < .001$

Table 43: MCRS scores rated by children about their fathers

	Multivariate F	df	Wilks Λ	Multivariate eta^2	Univariate F	Univariate eta^2
Covariates:						
GENDER	0.27	(2,92)	.99	.01	-	-
AGE	6.39***	(2,92)	.88	.12	-	-
Independent Variables:						
ADOPTION	0.30	(2,92)	.99	.01	-	-
CLINIC	1.73	(2,92)	.96	.04	-	-
ADP x CLN	1.45	(2,92)	.97	.03	-	-

*$p < .001$

3.2.3. Differences based on gender and ages of the children

Gender and age were not intended to be included into the analyses as independent variables, they both were included as covariates. However, in the children's ratings, age was the only significant variable, therefore the effects of gender and age on the dependent variables were also examined. For the 2 (Gender) X 2 (Age) analysis, age was categorized based on median split. Therefore, the children below 123 months (10 years 3 months) were considered as "younger" (N = 56) and children at or above 124 months were considered as "older" children (N = 53). Results are summarized separately for each measure. In order to avoid information overload, in this section, only the post hoc results of significant subscales were provided in the text.

3.2.3.1 Gender and age differences on CBCL

3.2.3.1.1 Mothers' CBCL ratings

Results of 2x2 MANOVA analysis indicated no significant age main effect [Multivariate $F(15,91) = 1.47$, *n.s.*] or interaction effect [Multivariate $F(15,91) = 0.61$, *n.s*]. On the other hand, gender main effect was observed [Multivariate $F(15,91) = 2.30$, $p < .01$, Wilks' $\Lambda = .73$, eta$^2 = .28$] on mothers' CBCL ratings.

For the univariate analyses, considering the Bonferroni adjustment only the F scores that are significant at least at .003 alpha level were considered as significant. Considering the Bonferroni adjustment, the only significant difference was found in somatic problems subscale [Univariate F(1,105) = 9.60, eta^2 = .08] out of 17 CBCL scores.

According to these results, mothers of girls reported more somatic problems (*M* = 1.83, *SD* = 0.25) than mothers of boys (*M* = 0.63, *SD* = 0.30).

3.2.3.1.2 Fathers' CBCL ratings

Results of 2x2 MANOVA analysis for CBCL ratings of the fathers revealed no significant gender [Multivariate *F*(15,52) = 1.41, *n.s.*] or age main effects [Multivariate *F*(15,52) = 0.81, *n.s.*] or interaction effect [Multivariate *F*(15,52) = 1.22, *n.s.*],

3.2.3.2 Gender and age differences on SATI

3.2.3.2.1 Mothers' SATI ratings

Differences between SATI ratings of mothers were analyzed by 2x2 MANOVA. No significant age main effect [Multivariate *F*(4,108) = 1.09, *n.s.*] or interaction effect [Multivariate *F*(4,108) = 0.70, *n.s*] were found. On the other hand, gender main effect was observed [Multivariate *F*(4,108) = 3.11, $p < .05$, Wilks' Λ = .90, eta^2 = .10] in SATI ratings of mothers.

For the univariate analyses, Bonferroni significance level of .013 was accepted. Considering the Bonferroni adjustment, a significant difference was found in task persistence subscale [Univariate F(1,111) = 7.82, $p < .01$, eta^2 = .07].

According to these results, mothers of girls reported more task persistence (*M* = 3.15, *SD* = 0.10) than mothers of boys (*M* = 2.73, *SD* = 0.11). Thus, girls were more task persistent in fulfilling tasks or responsibilities than boys according to their mothers.

3.2.3.2.2 Fathers' SATI ratings

Differences between SATI ratings of fathers were analyzed by 2x2 MANOVA. Significant gender [Multivariate $F(4,72) = 2.73$, $p < .05$, Wilks' $\Lambda = .87$, $eta^2 = .13$] and age [Multivariate $F(4,72) = 3.18$, $p < .05$, Wilks' $\Lambda = .85$, $eta^2 = .15$] main effects were observed in SATI ratings of fathers. On the other hand, no significant interaction effect [Multivariate $F(4,72) = 2.11$, *n.s*] was found.

For the univariate analyses, Bonferroni significance level of .013 was accepted. Considering the Bonferroni adjustment, significant differences were not observed between SATI subscales for gender main effect. However, for the age main effect, a significant difference was found in activity subscale [Univariate $F(1,75) = 6.56$, $p < .05$, $eta^2 = .08$].

Younger children were perceived as more active than ($M = 3.20$, $SD = 0.12$) than older children ($M = 2.76$, $SD = 0.13$) by their fathers according to SATI scales.

3.2.3.3 Gender and age differences on MCRS

3.2.3.3.1 Mothers' MCRS ratings

Differences between MCRS ratings of mothers were analyzed by 2x2 MANOVA. Among MCRS ratings of the mothers, significant gender [Multivariate $F(2,110) = 0.24$, *n.s.*] or age [Multivariate $F(2,110) = 1.51$, *n.s.*] main effects, or interaction effect [Multivariate $F(2,110) = 0.41$, *n.s.*] were not observed.

3.2.3.3.2 Fathers' MCRS ratings

Differences between MCRS ratings of fathers were analyzed by 2x2 MANOVA. Among MCRS ratings of the fathers, significant gender [Multivariate $F(2,76) = 1.11$, *n.s.*] or age [Multivariate $F(2,76) = 1.04$, *n.s.*] main effects, or interaction effect [Multivariate $F(2,76) = 1.99$, *n.s.*] were not observed.

3.2.3.4 Gender and age differences on BPTI

3.2.3.4.1 Mothers' BPTI ratings

Differences between BPTI ratings of mothers were analyzed by 2x2 MANOVA. Among BPTI ratings of the mothers, significant gender [Multivariate $F(6,115) = 0.41$, *n.s.*] or age [Multivariate $F(6,115) = 0.98$, *n.s.*] main effects, or interaction effect [Multivariate $F(6,115) = 0.60$, *n.s.*] were not observed.

3.2.3.4.2 Fathers' BPTI ratings

Differences between BPTI ratings of fathers were analyzed by 2x2 MANOVA. BPTI ratings of the fathers revealed significant gender [Multivariate $F(6,71) = 3.04$, $p < .05$, Wilks' $\Lambda = .80$, $eta^2 = .20$] main effect but significant age main effect [Multivariate $F(6,71) = 0.94$, *n.s.*], or interaction effect [Multivariate $F(6,71) = 0.75$, *n.s.*] were not observed.

For the univariate analyses of gender main effect, considering the Bonferroni adjustment, only the F scores that are significant at least at .008 alpha level were considered as significant. Univariate analyses indicated significant differences only in conscientiousness subscale [Univariate $F(1,76) = 9,11$ $p < .005$, $eta^2 = .11$].

These results indicate that the fathers of girls ($M = 4.16$, $SD = 0.8$) were more conscientious than the fathers of the boys ($M = 3.81$, $SD = 0.9$).

3.2.3.5 Gender and age differences on YSR

YSR is a measure for adolescents between 11-18 years (132-216 months) of age. Therefore, median split was done at 163.5 months in order to categorize the "age" variable. Adolescents younger than 163.5 months were considered as "younger adolescents" ($N = 24$) and the rest was considered as "older adolescents" ($N = 23$).

Differences for the 17 scores of YSR were analyzed by 2x2 MANOVA. Significant gender [Multivariate $F(15,29) = 1.36$, *n.s.*] or age [Multivariate $F(15,29) = 0.76$, *n.s.*] main effects, or interaction effect [Multivariate $F(15,29) = 0.60$, *n.s.*] were not observed.

3.2.3.6 Gender and age differences on KSS

3.2.3.6.1 Children's perceptions about their mothers on KSS

When perceived reliance of children to their attachment figures i.e. their mothers were analyzed by 2x2 ANOVA, no significant gender main effect [Univariate $F(1,102) = 0.41$, *n.s.*] or interaction effect [Univariate $F(1,102) = 0.06$, *n.s*] were found. On the other hand, age main effect was observed [Univariate $F(1,102) = 10.18$, $p < .005$].

Those results indicate that, younger children (under 123 months) perceive more reliance and security from their mothers than older children [$M = 52.84$, $SD = 1.28$ and $M = 47.39$, $SD = 1.13$ respectively].

3.2.3.6.2 Children's perceptions about their fathers on KSS

When perceived reliance of children to their fathers were analyzed by 2x2 ANOVA, no significant gender main effect [Univariate $F(1,94) = 0.14$, *n.s.*] was found. On the other hand, significant age main effect [Univariate $F(1,94) = 9.82$, $p < .005$] and gender X age interaction effect were observed [Univariate $F(1,94) = 3.95$, $p < .005$].

Pairwise comparisons for age main effect indicate that, younger children (under 123 months) perceive more reliance and security from their fathers than the children above 123 months [$M = 51.27$, $SD = 1.51$ and $M = 45.05$, $SD = 1.30$ respectively].

For the gender X age interaction effect of children's perceived reliance to their fathers, mean differences and significant interaction effects are summarized in Table 44.

Table 44. KSS ratings of children about their fathers

	Girls	Boys
Below 123 months	48.92 $_{a}$	53.63 $_{a}$
Above 124 months	46.65 $_{ab}$	43.46 $_{b}$

Note. The mean scores that do not share the same subscript on the same column or on the same raw indicate significant differences.

According to the results displayed in Table 44, younger girls and boys did not differ in their perceptions about secure child-father attachment; similarly, older girls perceive their child-father attachment not different than boys. On the other hand, younger boys perceive more secure child-father attachment than older boys, where younger and older girls did not have any significant differences on their child-father attachment perceptions.

3.2.3.7 Gender and age differences on MCRS

3.2.3.7.1 Children's perceptions about their mothers on MCRS

2x2 MANOVA analyses on child rearing styles of mothers perceived by their children revealed no significant gender main effect [Multivariate $F(2,102) = 0.08$, *n.s.*] or interaction effect [Multivariate $F(2,102) = 0.65$, *n.s*]. On the other hand, significant age main effect was observed [Multivariate $F(2,102) = 5.45$, $p < .05$, Wilks' $\Lambda = .90$, $eta^2 = .10$].

For these univariate analyses of age main effect, considering the Bonferroni adjustment, only the F scores that are significant at least at .025 alpha level were considered as significant. Univariate analyses indicated significant differences only in parental acceptance/involvement subscale [Univariate $F(1,103) = 10.61$, $p < .005$, $eta^2 = .09$].

Younger children reported receiving more parental acceptance and involvement from their mothers ($M = 3.62$, $SD = .07$) than older children ($M = 3.30$, $SD = .07$)

3.2.3.7.2 Children's perceptions about their fathers on MCRS

2x2 MANOVA analyses on child rearing styles of fathers perceived by their children revealed no significant gender main effect [Multivariate $F(2,94) = 0.29$, *n.s.*] or interaction effect [Multivariate $F(2,94) = 0.59$, *n.s*] but significant age main effect [Multivariate $F(2,94) = 4.69$, $p < .05$, Wilks' $\Lambda = .91$, $eta^2 = .09$].

For the univariate analyses of age main effect, considering the Bonferroni adjustment, only the F scores that are significant at least at .025 alpha level were considered as significant. Univariate analyses indicated significant differences only in parental acceptance/involvement subscale [Univariate $F(1,95) = 8.04$, $p < .01$, $eta^2 = .08$].

Younger children reported receiving more parental acceptance and involvement from their fathers ($M = 3.38$, $SD = .10$) than older children ($M = 2.98$, $SD = .09$).

3.2.4. Differences based on age at the time of adoption

Literature provides us with the information that earlier in life the child was adopted, the less is the possibility of developing mental problems in later life. Therefore the effects of the age at the time of adoption on the children's problem behaviors, temperaments, attachment securities and also child rearing styles of parents (reported by parents and children's perceptions about their parents) were analyzed. Parallel to the literature, age at adoption was coded as "early" (before 12 months) and "late" (after 12 months). 38 (62.3%) children were adopted before their first birthday, 22 (36.07%) children were adopted at an older age, data was missing for one child (1.63%).

MANOVA results for CBCL, SATI, MCRS, YSR and KSS indicated no significant effect of age at the time of adoption on behavior problems and temperaments of the children and their perceptions about parenting styles of their parents and about attachments securities. *F* values of the above mentioned scales are displayed in Table 45. BPTI was not included to the analyses this time, as personality traits of the parents are not related with the age of child at the time of adoption.

The behavior problems of children reported by their parents (CBCL) and by themselves (YSR), temperament styles of children reported by their parents and child-parent attachment securities perceived by the children were not significantly different between early adopted and late adopted children. Similarly, parents' child rearing styles reported by themselves and also by their children, did not have any significant differences between both groups.

Table 45. MANOVA results for the measures based on the age at the time of adoption

	Multivariate F	**df**	**Wilks Λ**	**Multivariate eta^2**	**Univariate F**	**Univariate eta^2**
Independent Variables:						
CBCL Mo	1.89	15,35	.55	.45	-	-
CBCL Fa	2.29	15,15	.30	.70	-	-
SATI Mo	1.04	4,51	.92	.08	-	-
SATI Fa	0.75	4,33	.92	.08	-	-
MCRS Mo	0.35	2,52	.99	.01	-	-
MCRS Fa	1.48	2,36	.92	.08	-	-
YSR Ad	0.72	15,12	.53	.47	-	-
KSS Ch-Mo	-	1,49	-	-	0.15	.01
KSS Ch-Fa	-	1,45	-	-	1.22	.03
MCRS Ch-Mo	1.71	2,47	.93	.01	-	-
MCRS Ch-Fa	0.33	2,43	.99	.08	-	-

CBCL Mo - CBCL rated by mothers; CBCL Fa – CBCL rated by fathers; **SATI Mo–SATI rated by mothers**; SATI Fa – SATI rated by fathers; **MCRS Mo – MCRS rated by mothers**; MCRS Fa – MCRS rated by fathers; **YSR Ad – YSR rated by adolescents**; KSS Ch-Mo: KSS rated by children about their mothers; **KSS Ch-Fa: KSS rated by children about their fathers**; MCRS Ch-Mo – MCRS rated by children about their mothers; **MCRS Ch-Fa – MCRS rated by children about their fathers**

3.2.5 Summary of the results

In order to remind the results related to group differences summary tables are formed. A summary table for the adoption and clinical status groups main effects and adoption status X clinical status interaction effect is provided in Table 46 (continued next page).

Table 46: Summary table for the findings related to adoption and clinical status

Measure	Adoption Status Main Effect	Clinical Status Main Effect	Interaction Effect
CBCL			
Maternal ratings			
Internalizing Problems	-	Cl > NCl	-
Externalizing Problems	-	Cl > NCl	-
Total Problems	-	Cl > NCl	-
Withdrawal/Depression	-	Cl > NCl	-
Social Problems	-	Cl > NCl	-
Thought Problems	-	Cl > NCl	-
Attention Problems	-	Cl > NCl	-
Rule Breaking Beh	-	Cl > NCl	-
Aggressive Behavior	-	Cl > NCl	-
Affective Problems	-	Cl > NCl	-
Anxiety Problems	-	Cl > NCl	-
ADHD Problems	-	Cl > NCl	-
Oppositional Defiant P	-	Cl > NCl	-
Conduct Problems	-	Cl > NCl	-
Paternal ratings			
All the scores	-	-	-
YSR			
Attention Problems	-	Cl > NCl	-
Conduct Problems	-	Cl > NCl	-
SATI			
Maternal ratings			
Task Persistence	-	Cl < NCl	-
Activity	-	Cl > NCl	-
Paternal ratings			
Task Persistence	-	Cl < NCl	NAd Cl < NAd NCl
Approach/Withdrawal	-	-	NAd Cl < NAd NCl
MCRS			-
Maternal ratings			
All of the subscales	-	-	-
Paternal ratings			
All of the subscales	-	-	-

Table 46: Summary table for the findings related to adoption and clinical status (cont.'d)

Measure	Adoption Status Main Effect	Clinical Status Main Effect	Interaction Effect
BPTI			
Maternal ratings			
All of the subscales	-	-	-
Paternal ratings			
Extraversion/Introversion	-	Cl < NCl	-
Agreeableness	Ad > NAd	-	-
KSS (children's ratings)			
For Mothers	-	-	-
For Fathers	-	-	-
MCRS (children's ratings)			
For Mothers	-	-	-
For Fathers	-	-	-

Ad – Adopted, NAd – Non-adopted, **Cl – Clinic**, NCl – Non-clinic, **NAd Cl – Non-adopted clinic**, NAd NCl - Non-adopted non-clinic, **CBCL – Child Behavior Check List**, YSR – Youth Self Report, **SATI – School Age Temperament Inventory**, MCRS – Measure of Child Rearing Styles, **BPTI – Basic Personaliy Traits Inventory**, KSS – Kerns Security Scale.

A summary table for the gender and age main effects and Gender x Age interaction effect is provided below.

Table 47: Summary table for the findings related to gender and age of the children

Measure	Gender Main Effect	Age Main Effect	Interaction Effect
CBCL			
Maternal ratings			
Somatic Problems	Girls > Boys	-	-
Paternal ratings			
All the scores	-	-	-
YSR			
All the scores	-	-	-
SATI			
Maternal ratings			
Task Persistence	Girls > Boys	-	-
Paternal ratings			
Activity	-	Younger > Older	-
MCRS			-
Maternal ratings			
All the subscales	-	-	-
Paternal ratings			
All the subscales	-	-	-
BPTI			
Maternal ratings			
All the subscales	-	-	-
Paternal ratings			
Conscientiousness	Girls > Boys	-	-
KSS (children's ratings)			
For Mothers	-	Younger > Older	-
For Fathers	-	Younger > Older	Younger Boys > Older Boys
MCRS (children's ratings)			
For Mothers			
Acceptance/Involvement	-	Younger > Older	-
For Fathers			
Acceptance/Involvement	-	Younger > Older	-

Younger – Children under 123 months (10 years 3 months), Older – Children at or above 124 months (10 years 4 months), **CBCL – Child Behavior Check List**, YSR – Youth Self Report, **SATI – School Age Temperament Inventory**, MCRS – Measure of Child Rearing Styles, **BPTI – Basic Personaliy Traits Inventory**, KSS – Kerns Security Scale.

A summary table for differences based on age at adoption is shown below. As can be seen from Table 48, age of the child at the time of adoption was not related

Table 48: Summary table for the findings related to the age of child at the time of adoption

Measure	Age at adoption*
CBCL	
Maternal ratings	
All the scores	-
Paternal ratings	
All the scores	-
YSR	
All the scores	-
SATI	
Maternal ratings	
All the subscales	-
Paternal ratings	
All the subscales	-
MCRS	
Maternal ratings	
All the subscales	-
Paternal ratings	
All the subscales	-
KSS (children's ratings)	
For Mothers	-
For Fathers	-
MCRS (children's ratings)	
For Mothers	
All the subscales	-
For Fathers	
All the subscales	-

*** Age at adoption: Early adoption – children adopted before 12 months,** Late adoption – children adopted after 12 months. C**BCL – Child Behavior Check List**, YSR – Youth Self Report, **SATI – School Age Temperament Inventory**, MCRS – Measure of Child Rearing Styles, **BPTI – Basic Personaliy Traits Inventory**, KSS – Kerns Security Scale.

3.3 Correlational Information

3.3.1 Correlations between measures

3.3.1.1 Correlations of CBCL and YSR scores rated by parents and adolescents

Correlational analyses revealed that, the correlations for CBCL ratings of both parents and self-reports of adolescents (YSR) ranged from moderate to high (.31 to .91). Correlations between CBCL scores of mothers, fathers and YSR scores are displayed in Table 49.

Table 49. Correlation coefficients of CBCL (mothers and fathers) and YSR scales (adolescents)

	M Int	**M Ext**	**M Tot**	**F Int**	**F Ext**	**F Tot**	**A Int**	**A Ext**	**A Tot**
M Int Pr.s	1.00								
M Ext Pr.s	.51**	1.00							
M Tot Pr.s	.81**	.87**	1.00						
F Int Pr.s	.67**	.50**	.61**	1.00					
F Ext Pr.s	.52**	.74**	.71**	.59**	1.00				
F Tot Pr.s	.64**	.73**	.78**	.82**	.91**	1.00			
A Int Pr.s	.45**	.06	.25	.50**	.18	.38*	1.00		
A Ext Pr.s	.35*	.48**	.50**	.33	.44*	.50**	.52**	1.00	
A Tot Pr.s	.51**	.34*	.49**	.41*	.29	.46*	.85**	.81**	1.00

** $p < .01$ * $p < .05$

M Int Pr.s - CBCL Internalizing Problems rated by mothers, M Ext Pr.s - CBCL Externalizing Problems rated by mothers, **M Tot Pr.s - CBCL Total Problems rated by mothers**, F Int Pr.s - CBCL Internalizing Problems rated by fathers, **F Ext Pr.s - CBCL Externalizing Problems rated by fathers**, F Tot Pr.s - CBCL Total Problems rated by fathers, **A Int Pr.s - YSR Internalizing Problems rated by adolescents**, A Ext Pr.s - YSR Externalizing Problems rated by adolescents**, A Tot Pr.s - YSR Total Problems rated by adolescents**

Parallel to the expectations, mothers and fathers were highly correlated in reporting problem behaviors of their children; however, both parents had moderate correlations with adolescents' self-reports.

3.3.1.2 Correlations of ratings of the mothers and their children

Correlations between the measures obtained from mothers and children (about their mothers) are summarized in Table 50.

As can be seen from the table, gender was negatively correlated with SATI Task Persistence scale (r = -.26, p < .01) and YSR Internalizing Problems (r = -.36, p < .01) but positively correlated with SATI Activity (r = .21, p < .05). Inferences can be made about girls having more task persistence (or boys having less task persistence), about girls reporting more internalizing problems, and about boys being more active (or girls being less active).

Age had moderate positive correlation with YSR Externalizing Problems (r = .29, p < .05) and negative correlations with KSS (r = -.27, p < .01) and MCRS Parental Acceptance ratings of children (r = -.22, p < .05). As the children grew older, their tendency to report externalizing problems increased, on the other hand, as they grew up, they reported less attachment security and less parental acceptance from their mothers.

The highest correlation between measures was observed between KSS and MCRS Parental Acceptance ratings of children (r =.67, p < .01). The more children perceived parental acceptance from their mothers, the more they reported attachment security.

A high correlation was also observed between BPTI Agreeableness subscale and MCRS Parental Acceptance subscale (r = .55, p < .01) from the self-reports of the mothers. As the agreeableness levels of the mothers increased their tendency to exhibit parental acceptance was also increased.

Table 50: Correlations among CBCL, SATI, MCRS, BPTI, YSR, and KSS scores of mothers and children

	1	2	3	4	5	6	7	8	9	10	11
1	1.00										
2	-.12	1.00									
3	-.13	.10	1.00								
4	.11	-.02	.51**	1.00							
5	.03	.05	.81**	.87**	1.00						
6	.02	-.03	.42**	.53**	.51**	1.00					
7	-.26**	.11	-.34**	-.51**	-.57**	-.48**	1.00				
8	-.08	-.13	.37**	.01	.18	.10	-.02	1.00			
9	.21*	-.19*	.32**	.52**	.51**	.55**	-.52**	-.01	1.00		
10	-.03	-.01	-.21*	-.19*	-.21*	-.15	.22*	-.08	-.17	1.00	
11	.06	-.17	.02	.17	.10	.21*	-.11	-.01	.28**	.12	1.00
12	-.03	.01	-.27**	-.07	-.14	-.12	.05	-.34**	-.13	.40**	-.06
13	.09	.01	-.22*	-.13	-.17	-.12	.14	-.09	-.09	.45**	.05
14	-.03	-.14	-.27**	-.07	-.16	-.11	.09	-.30**	-.19*	.39**	-.05
15	.01	-.02	-.07	-.01	-.02	-.05	.09	-.05	-.06	.55**	.10
16	.07	-.07	.32**	.30**	.34**	.49**	-.19*	.24*	.28**	-.18	.28**
17	-.04	.03	.19	.30**	.26**	.30**	-.15	-.07	.17	-.19*	.24*
18	-.36**	.23	.45**	.06	.25	.12	-.15	.11	.02	-.06	-.03
19	.01	.29*	.35*	.48**	.50**	.24	-.41**	-.19	.37**	-.26	.07
20	-.19	.23	.51**	.34*	.49**	.20	-.33*	.02	.26	-.12	-.04
21	.07	-.27**	-.18	-.12	-.17	-.06	.17	-.03	-.02	.05	-.11
22	.01	-.22*	-.11	.01	-.01	-.08	.13	-.04	-.08	.19	-.03
23	.02	-.25**	.20*	.24*	.28**	.06	-.26**	.17	.26**	-.07	.05

	12	13	14	15	16	17	18	19	20	21	22	23
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12	1.00											
13	.41**	1.00										
14	.60**	.28**	1.00									
15	.33**	.34**	.35**	1.00								
16	-.07	-.18	-.22*	-.05	1.00							
17	-.03	-.33**	-.13	-.40**	.38**	1.00						
18	-.11	-.28*	-.64	.08	-.07	.10	1.00					
19	-.10	-.05	.01	-.01	-.09	.03	.52**	1.00				
20	-.04	-.17	.06	.02	-.09	.07	.85**	.81**	1.00			
21	-.06	.01	.06	.08	-.06	-.08	-.36**	-.39**	-.36**	1.00		
22	.09	.05	.20*	.20*	-.06	-.05	-.28*	-.27*	-.26	.67**	1.00	
23	-.09	-.13	-.01	-.10	.11	.21*	.12	.04	.10	-.20*	-.08	1.00

** $p < .01$ * $p < .05$

1.Gender 2.Age **3.CBCL Internalizing Problems** 4.CBCL Externalizing Problems **5. CBCL Total Problems** 6. SATI Negative Reactivity **7.SATI Task Persistence** 8.SATI Approach/Withdrawal **9.SATI Activity** 10.MCRS Parental Acceptance/Responsiveness **11.MCRS Strict Control/Supervision** 12.BPTI Openness **13.BPTI Conscientiousness** 14.BPTI Extraversion **15.BPTI Agreeableness** 16 BPTI Neuroticism **17.BPTI Negative Valence** 18.YSR Internalizing Problems **19.YSR Externalizing Problems** 20.YSR Total Problems **21.KSS** 22.MCRS Parental Acceptance/Responsiveness children's ratings about their mothers **23. MCRS Strict Control/Supervision children's ratings about their mothers**

3.3.1.3 Correlations of ratings of the fathers and their children

Correlations between fathers' ratings and children's ratings about their fathers are displayed in Table 51.

Correlations between gender and other measures and also age and other measures were similar to the correlations explained above. Addition to those, a negative correlation was observed between gender and BPTI Conscientiousness subscale (r = -.32, p < .01), indicating that the fathers of the girls reported more conscientiousness.

The highest correlation between measures was observed between KSS and MCRS Parental Acceptance ratings of children (r = .75, p < .01). The more children perceived parental acceptance from their fathers, the more they reported attachment security.

CBCL Total Problems scale was negatively correlated with SATI Task Persistence subscale (r = .50, p < .01). The more total problems the children had, the less task persistent they were.

There was a positive correlation between BPTI Conscientiousness subscale and MCRS Parental Acceptance subscale (r = .49, p < .01). According the self-reports of the fathers, as their level of conscientiousness increased, their tendency to exhibit parental acceptance also increased.

Table 51: Correlations among CBCL, SATI, MCRS, BPTI, YSR, and KSS scores of fathers and children

	1	2	3	4	5	6	7	8	9	10	11
1	1.00										
2	-.12	1.00									
3	-.10	.13	1.00								
4	.02	-.12	.59**	1.00							
5	.02	-.03	.82**	.91**	1.00						
6	.06	-.05	.27*	.37**	.32*	1.00					
7	-.22*	-.06	-.29*	-.42**	-.50**	-.45**	1.00				
8	-.25*	.11	.38**	-.01	.12	.23*	-.16	1.00			
9	.14	-.31**	.17	.43**	.40**	.52**	-.42**	.10	1.00		
10	-.06	-.05	-.33*	-.21	-.30*	-.03	.31**	-.18	-.10	1.00	
11	.15	-.11	.03	.07	.08	.07	-.14	-.01	-.06	-.17	1.00
12	.14	-.03	-.18	-.04	-.11	.02	.21	-.16	.14	.34**	-.02
13	-.32**	-.03	-.11	-.16	-.21	-.01	.39**	-.06	-.08	.49**	-.16
14	.17	.01	-.42**	-.25*	-.33**	-.13	.08	-.29*	.11	.36**	-.20
15	-.07	.02	-.32*	-.19	-.26*	.05	.17	-.05	.02	.45**	-.12
16	.16	-.14	.33**	.12	.23	.08	-.11	.04	.15	-.29**	.18
17	-.04	-.07	.24	.14	.23	.01	-.01	-.10	-.12	-.28*	.29*
18	-.36**	.23	.50**	.18	.38*	.09	-.10	.24	-.29	.15	-.17
19	.01	.29*	.33	.44*	.50**	.03	-.28	-.06	.02	.03	-.03
20	-.19	.23	.41*	.29	.46*	.02	-.22	.06	-.18	.10	-.08
21	.01	-.22*	-.33**	-.15	-.25	.05	.24*	-.20	.16	.34**	-.27*
22	.04	-.28**	-.24	-.25	-.27*	-.04	.15	-.16	.11	.29*	-.07
23	-.05	-.23*	.27*	.27*	.32*	.06	-.16	.12	.17	-.23	.15

	12	13	14	15	16	17	18	19	20	21	22	23
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12	1.00											
13	.22*	1.00										
14	.33**	.01	1.00									
15	.39**	.25*	.43**	1.00								
16	.11	-.23*	-.29**	-.10	1.00							
17	.07	-.20	-.35**	-.18	.49**	1.00						
18	-.44**	.11	-.36*	-.05	-.14	-.03	1.00					
19	-.10	-.19	-.12	-.05	-.19	-.01	.52**	1.00				
20	-.29	-.07	-.17	-.05	-.25	-.04	.85**	.81**	1.00			
21	.17	.22	.34**	.24*	-.28*	-.15	-.18	-.17	-.13	1.00		
22	.15	.11	.35**	.22	-.26*	-.20	-.22	-.07	-.09	.75**	1.00	
23	-.17	.06	-.33**	-.07	.26*	.05	.09	-.14	.04	.10	.09	1.00

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

1.Gender 2.Age **3.CBCL Internalizing Problems** 4.CBCL Externalizing Problems **5. CBCL Total Problems** 6. SATI Negative Reactivity **7.SATI Task Persistence** 8.SATI Approach/Withdrawal **9.SATI Activity** 10.MCRS Parental Acceptance/Responsiveness **11.MCRS Strict Control/Supervision** 12.BPTI Openness **13.BPTI Conscientiousness** 14.BPTI Extraversion **15.BPTI Agreeableness** 16 BPTI Neuroticism **17.BPTI Negative Valence** 18.YSR Internalizing Problems **19.YSR Externalizing Problems** 20.YSR Total Problems **21.KSS** 22.MCRS Parental Acceptance/Responsiveness children's ratings about their fathers **23. MCRS Strict Control/Supervision children's ratings about their fathers**

3.3.2 Correlations between demographic variables related to adoption history and measures of the study

Correlations between the measures of the study and demographic variables related to adoption history (i.e., the age of child at the time of adoption, the age of the child at the time s/he has learned about adoption, the frequency of meeting biological family) are analyzed separately for mothers and fathers.

3.3.2.1 Maternal ratings

Correlations between demographic variables related to adoption history and the maternal ratings about the measures of the study are displayed in Table 52.

The correlation between the years of education that mothers had completed and children's perceptions about their mothers' strict controlled/supervising parenting style was -.31 ($p < .01$), indicating that the higher the mothers' education level, the less strict control/supervision is perceived by their children.

CBCL scores of mothers were related with the demographic variables (summarized in Table 53). Age of mother had positive low correlations ($r = .19 – .24$) with externalizing and total problems, with four syndrome scales such as, Somatic Complaints, Thought Problems, Attention Problems, Rule Breaking Behavior and two DSM-Oriented scales (ADHD Problems and Oppositional Defiance Problems).

A noteworthy relation was observed between the age of the child at the time of disclosing adoption information and CBCL scores. Maternal reports of Internalizing Behaviors ($r = .53$, $p < .01$), Externalizing Behaviors ($r = .47$, $p < .01$) and Total Behaviors ($r = .60$, $p < .01$) increased as the age of the child increased when s/he learned about her/his adoption status. All the other CBCL scores, with the exception of Somatic Complaints and Somatic Problems scores, also revealed moderate to high positive correlations ($r = .36 – .64$) with the age of child at the time of learning her/his adoption status.

Table 52. Correlation table for maternal ratings of measures and demographic variables

	Gender	Age	Maternal Age	Maternal Education	Paternal Age	Paternal Education	Age at adoption	Age at disclosure
NR	.02	-.03**	.14	.03	.17	.08	-.04	.20
TP	-.26**	.10	-.08	-,05	-.11	-.06	-.14	-.30
AW	-.08	-.13	-.12	-.05	-.10	.04	-.05	.03
Act	.21**	-.19	.08	-.07	.15	.04	-.16	.23
AR	-.03	-.09	-.04	.04	-.04	-.02	-.02	-.32
StC	.06	-.17	-.05	-.15	.04	-.14	-.06	-.03
O	-.03	.01	-.01	-.06	-.04	-.09	.07	.17
C	.09	.01	.12	-.02	.08	-.15	-.10	-.03
E	-.03	-.14	-.09	.09	-.09	-.05	.04	-.10
A	.01	-.02	-.03	-.03	-.05	-.15	.07	-.23
N	.07	-.07	-.03	-.07	.07	.06	-.02	.23
Nv	-.04	.03	-.10	-.17	.05	-.07	.04	.03
Int	-.36**	.23	.18	.01	.12	-.01	.16	.16
Ext	.01	.29*	.25	.11	.28*	.01	-.08	.36
Tot	-.19	.23	.23	.05	.19	.01	.13	.34
KS	-.08	-.27**	.05	.12	.04	.05	-.07	-.30
Acc	.01	-.22**	.03	.07	.03	-.05	.11	.06
Ctr	.03	-.26**	.01	-.31**	.08	-.14	.14	.06

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

NR - SATI Negative Reactivity, **TP - SATI Task Persistence,** AW - SATI Approach/Withdrawal, **Act - SATI Activity,** AR - MCRS Parental Acceptance/Responsiveness, StC - **MCRS Strict Control/Supervision,** O - BPTI Openness, **C - BPTI Conscientiousness,** E - BPTI Extraversion, **A - BPTI Agreeableness,** N - BPTI Neuroticism, **Nv - BPTI Negative Valence,** Int - YSR Internalizing Problems, **Ext - YSR Externalizing Problems,** Tot - YSR Total Problems, **KS – Kerns Security Scale,** Acc - MCRS Parental Acceptance/Responsiveness children's ratings about their mothers **Ctr - MCRS Strict Control/Supervision children's ratings about their mothers**

Table 53. Correlation table for maternal ratings of CBCL scores and demographic variables

	Gender	Age	Maternal Age	Maternal Education	Paternal Age	Paternal Education	Age at adoption	Age at disclosure
Int	-.13	.10	.11	-.14	.11	-.03	.02	.52**
Ext	.11	-.02	.20*	-.14	.27**	-.04	.02	.47**
Tot	.03	.05	.19*	-.14	.24*	-.03	.02	.60**
Syndrome Scales								
A/D	-.66	.02	.12	-.11	.13	.02	.07	.53**
W/D	.03	.10	-.11	-.18	-.07	-.16	-.21	.48**
SmC	-.27**	.16	.22*	-.04	.17	.06	.11	.22
Sc	-.05	-.11	.09	-.12	.12	-.13	.11	.40*
Th	.06	.11	.24*	-.08	.23*	.04	-.09	.50**
Att	.08	.12	.19*	-.03	.26**	.04	.07	.64**
RBB	.20*	.05	.24*	-.15	.33**	-.01	-.04	.49**
Agg	.05	-.04	.17	-.12	.23*	-.05	.05	.41*
DSM-oriented scales								
Aff	.01	.05	.15	-.20*	.19	-.07	-.15	.55**
Anx	.01	-.01	.06	-.15	.10	-.09	-.01	.39*
SmP	-.29**	.06	.17	-.01	.15	.07	.10	.22
adhd	.18	.02	.20*	-.02	.31**	.01	-.03	.47**
Opp	.01	.04	.19*	.01	.22*	.01	.07	.35*
Con	.18	-.04	.15	-.17	.23*	-.04	-.08	.36*

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

Int – Internalizing Problems, Ext – Externalizing Problems, **Tot – Total Problems**, A/D - Anxious/Depressed, **W/D- Withdrawn/Depressed**, SmC- Somatic Complaints, **Sc - Social Problems,** Th - Thought Problems, **Att - Attention Problems**, RBB - Rule Breaking Behavior, **Agg - Aggressive Behavior**, Aff - Affective Problems, **Anx - Anxiety Problems**, SmP - Somatic Problems, **adhd - Attention Deficit Hyperactivity Problems**, Opp - Oppositional Defiant Problems, **Con – Conduct Problems**

3.3.2.2 Paternal ratings

Correlations between demographic variables related to adoption history and the paternal ratings about the measures of the study are displayed in Tables 54 and 55.

Fathers' age was positively correlated with CBCL Somatic Complaints scale (r = .31, p < .01), CBCL Thought Problems scale (r = .26, p < .05), CBCL DSM-Oriented Somatic Problems scale (r = .34, p < .01) and BPTI Agreeableness personality trait (r = .22, p < .05). As the fathers got older, they rated more somatic and thought problems about their children and they were less agreeable.

Fathers' level of education was inversely correlated with Strict Control /Supervision parenting style (r = -.34, p < .01) and Agreeableness personality trait (r = -.36, p < .01).

The age of the child at the time of adoption was positively correlated with fathers ratings of CBCL attention problems score (r = .39, p < .05).

Contrary to the maternal ratings, the age of the child at the time of disclosing adoption information was not related with emotional and behavioral problems of the children as rated by their fathers. The only relation was the negative correlation with the BPTI Conscientiousness score of the fathers (r = -.46, p < .05).

Table 54. Correlation table for paternal ratings of measures and demographic variables

	Gender	Age	Maternal Age	Maternal Education	Paternal Age	Paternal Education	Age at adoption	Age at disclosure
NR	.06	-.05	.21	-.07	.18	.02	-.24	.29
TP	-.22*	-.06	-.20	-.11	-.15	-.21	-.04	-.39
AW	-.25*	.11	.02	-.01	-.05	.09	-.15	.23
Act	.14	-.31**	.19	.06	.22	.14	-.13	-.07
A/R	-.06	-.05	.05	.02	.13	-.10	-.22	-.05
StC	.15	-.11	-.13	-.39**	-.12	-.34**	-.10	.02
O	.14	-.03	.03	-.24*	.06	-.15	-.15	.13
C	-.32**	-.03	.06	-.08	.09	-.06	.05	-.46*
E	.17	.01	-.11	.05	-.04	-.12	-.10	.13
A	-.07	.02	.20	-.15	.22*	-.36**	.07	-.21
N	.16	-.14	.05	-.12	-.04	.01	.12	.09
Nv	-.04	-.07	-.04	-.28*	-.13	-.09	.03	-.03
Int	-.36**	.23	.18	.01	.12	-.01	.16	.16
Ext	.01	.29*	.25	.11	.28*	.01	-.08	.30
Tot	-.19	.23	.24	.05	.19	.01	.13	.34
KS	.01	-.22*	.04	.01	.11	-.01	-.10	-.32
Acc	.04	-.28*	.02	-.02	.06	-.01	-.03	-.01
Ctrl	-.06	-.23*	.14	-.04	.16	.05	.10	-.10

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

NR - SATI Negative Reactivity, **TP - SATI Task Persistence,** AW - SATI Approach/Withdrawal, **Act - SATI Activity,** A/R - MCRS Parental Acceptance/Responsiveness, StC - **MCRS Strict Control/Supervision,** O - BPTI Openness, **C - BPTI Conscientiousness,** E - BPTI Extraversion, **A - BPTI Agreeableness,** N - BPTI Neuroticism, **Nv - BPTI Negative Valence,** Int - YSR Internalizing Problems, **Ext - YSR Externalizing Problems,** Tot - YSR Total Problems, **KS – Kerns Security Scale,** Acc - MCRS Parental Acceptance/Responsiveness children's ratings about their fathers **Ctrl - MCRS Strict Control/Supervision children's ratings about their fathers**

Table 55. Correlation table for paternal ratings of CBCL scores and demographic variables

	Gender	Age	Maternal Age	Maternal Education	Paternal Age	Paternal Education	Age at adoption	Age at disclosure
Int	-.10	.13	.06	-.18	.05	.15	.18	-.04
Ext	.02	-.12	.10	-.27*	.14	.04	.23	-.18
Tot	.02	-.03	.14	-.23	.17	.17	.24	-.12
Syndrome Scales								
A/D	-.07	.01	.01	-.13	-.01	.16	.20	-.11
W/D	.07	.21	-.12	-.19	-.15	.07	.17	.07
SmC	-.25*	.10	.28*	-.09	.31**	.09	.01	.01
Sc	-.04	-.14	.09	-.21	.11	.03	.29	-.25
Th	.07	.02	.22	-.15	.26*	.07	.27	-.19
Att	.07	-.06	.09	-.08	.09	.10	.39*	-.07
RBB	.07	-.18	.19	-.27*	.17	.11	.06	-.18
Agg	.01	-.09	.05	-.25*	.12	.01	.28	-.17
DSM-oriented scales								
Aff	-.01	.18	.17	.21	.14	.05	.08	.30
Anx	-.05	-.08	.06	-.10	.08	.08	.22	-.29
SmP	-.24*	.07	.30*	.04	.34**	.13	.03	.09
adhd	.11	-.10	.10	-.18	.16	-.04	.20	-.06
Opp	.02	-.03	.05	-.24	.08	-.02	.18	-.06
Con	.10	-.21	.14	-.33**	.18	.03	.03	-.19

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

Int – Internalizing Problems, Ext – Externalizing Problems, **Tot – Total Problems**, A/D - Anxious/Depressed, **W/D- Withdrawn/Depressed**, SmC- Somatic Complaints, **Sc - Social Problems,** Th - Thought Problems, **Att - Attention Problems**, RBB - Rule Breaking Behavior, **Agg - Aggressive Behavior**, Aff - Affective Problems, **Anx - Anxiety Problems**, SmP - Somatic Problems, **adhd - Attention Deficit Hyperactivity Problems**, Opp - Oppositional Defiant Problems, **Con – Conduct Problems**

CHAPTER 4

DISCUSSION

This study examined the emotional and behavioral problems of adopted vs. non-adopted children and adolescents, in relation with their attachment relationships and child rearing styles of their parents. The first chapter of this thesis introduced the basic adoption literature in relation with theories of attachment and parenting styles. The second chapter introduced the participants, the measures, and the procedure of the study. In the third chapter, the results of the analyses were explained. In this chapter, results of the study will be discussed under the scope of the relevant literature; and limitations of the study, projections for future research, clinical and adoption policy implications will be provided.

4.1 Overview of the hypotheses

The first hypothesis of the study, that was expecting adopted children to exhibit more behavior problems than non-adopted peers, was not accepted.

The hypothesis 2a (i.e., parents with less emotional stability would display less parental acceptance) was rejected. The hypothesis 2b (i.e., parents with less emotional stability would display more strict control) was accepted. The hypothesis 2c (i.e., adoptive parents were expected to display less strict control/ supervision child rearing style than non-adoptive parents) was not accepted.

The first part of the third hypothesis, (i.e., adopted children were expected to have less secure attachments than non-adopted children) was rejected. The second part of the third hypothesis, (i.e., the attachment security level was expected to relate negatively with problem behaviors) was also rejected.

The hypothesis 4a (i.e., younger adopted children would have less emotional and behavior problems than older adopted children) was not accepted. The

hypothesis 4b (i.e., boys were expected to display more emotional and behavioral problems than girls) was rejected.

In the further sections discussions about the above and additional findings will be provided.

The initial analysis of the study examined the differences between the ratings of mothers and fathers in the whole group. The results indicated that, although mothers and fathers had some differences in personality traits and child rearing styles, in observing and rating the temperament characteristics and behavioral problems of their children, they responded similarly.

4.2 Findings concerning emotional and behavioral problems

Emotional and behavioral problems of the children were assessed by maternal and paternal reports (CBCL) and by self-reports of the adolescents (YSR). This multiple informant assessment revealed no adoption but some clinical status main effects. Children in the clinical group were rated by their both parents as having more problem behaviors than the children in non-clinical group. This expected result was confirmed in adolescent's self-reports as well.

The first hypothesis of the study that was expecting adopted children to exhibit more behavior problems than non-adopted peers, was not accepted based on the results related with the adoption status of the groups. In terms of adoption status, the findings of this study were not in line with the literature, where adopted children were reported as having poorer functioning than non-adopted peers (Hodges, 2005; Simmel et al., 2001; van IJzendoorn et al., 2005; Vorria et al., 2006; Xing Tan, 2006). On the other hand, although not significant, mothers reported slightly more emotional and behavioral problems for adopted children than non-adopted sample, where fathers of both groups reported similar problem behaviors. Furthermore, again non-significantly, adopted/clinical children scored highest in externalizing and total problems, in 4 syndrome scales (i.e., thought, attention and aggressive problems and rule breaking behavior) and in 3 DSM-Oriented scales (i.e., ADHD Problems, Oppositional Defiant Problems, and Conduct Problems) than children in adopted/non-clinical, non-adopted/clinical and non-adopted/non-clinical groups according to the ratings of both parents. These findings relate to Rosnati et al.'s

(2008) findings, where more externalizing and total problems with more aggressive and attention problems were reported for adopted children than their non-adopted peers.

CBCL mean scores of the adopted children in the current study were higher than the scores of Turkish children in foster (*N* = 31) or residential (*N* = 62) care as displayed in Üstüner et al.'s study (2005) and children (*N* = 28) whose biological parents were raised in institutions (Üstün, 2008). These two studies did not have separate groups for clinical children. If those children were not followed in a child psychiatry unit, then the comparison should be done only with non-clinical adopted sample (*N* = 17). In that case, mean scores of the *adopted group* rated by the mothers (Internalizing Problems: *M* = 10.59, *SD* = 7.28, Externalizing Problems: *M* = 8.24, *SD* = 6.90, Total Problems: *M* = 33.94, *SD* = 21.24) were slightly higher than the mean scores of *foster children* (Internalizing Problems: *M* = 8.20, *SD* = 6.50, Externalizing Problems: *M* = 8.70, *SD* = 8.20, Total Problems: *M* = 31.80, *SD* = 24.10). Although not tested statistically, an observable difference between adopted and *residential care* samples (Internalizing Problems: *M* = 6.52, *SD* = 5.80, Externalizing Problems: *M* = 10.9, *SD* = 9.60, Total Problems: *M* = 51.70, *SD* = 17.80) was clearly seen, where children in residential care had more externalizing and total problems than the adopted sample. Adopted children had higher internalizing problem scores than children in residential care. When compared to *children whose biological parents were raised in the institutions* (Internalizing Problems: *M* = 10.54, *SD* = 7.19, Externalizing Problems: *M* = 10.54, *SD* = 9.38, Total Problems: *M* = 37.11, *SD* = 23.43), adopted children had slightly lower scores in externalizing and total problems.

Adopted children scored highest in internalizing problems and lowest in externalizing problems in terms of maternal ratings when compared to other three groups. The adopted children had the highest Anxiety/Depression scores, which led a peak in internalizing problems. It is possible that these children felt more anxious because they were still working with identity and belongingness issues more than the other groups. And it is likely that, the adoptive mothers were more sensitive to anxiety related behaviors of their children and perceived them as more serious than the other mothers or caregivers. Also, it is most probably likely that, the anxiety,

depression, or withdrawal of the children in the residential settings are not recognized by the caregivers unless they exhibit externalizing behavior problems and interrupt with daily routines. The externalizing problems scores of adopted children in the present study and foster children in Üstüner et al.'s study (2005) were very close; both groups displayed less externalizing problems according to parental ratings. The reason why adopted and fostered children scored lowest in externalizing problems might be that, the adoptive and foster parents might have set more rules and limits than the other parents or caregivers.

In terms of self-reports of adolescents, with the same reasons mentioned above, results for the *non-clinical adopted* group of our sample (N = 8, Internalizing Problems: M = 11.00, SD = 5.58, Externalizing Problems: M = 9.00, SD = 3.02, Total Problems: M = 46.13, SD = 15.24) was compared to the results for the *adolescents in foster care* (N = 15, Internalizing Problems: M = 12.60, SD = 8.70, Externalizing Problems: M = 10.50, SD = 7.60, Total Problems: M = 39.40, SD = 25.60), *adolescents in residential care* (N = 30, Internalizing Problems: M = 26.50, SD = 10.20, Externalizing Problems: M = 18.10, SD = 10.10, Total Problems: M = 74.9, SD = 27.80) and *children of institutionally raised parents* (N = 11, Internalizing Problems: M = 13.00, SD = 11.09, Externalizing Problems: M = 8.55, SD = 5.85, Total Problems: M = 40.09, SD = 24.78). Adopted adolescents reported less internalizing and externalizing problems for themselves than all the other groups.

In terms of gender effect on problem behaviors, mothers of girls reported more somatic problems for their children than mothers of boys regardless of adoption and clinical status. This finding is parallel to the studies reporting more somatization disorders (Walker & Greene, 1991), more repeated or persistent pain (Eminson, Benjamin, & Shoretall, 1996; Garber, Walker, & Seman, 1991) in girls than boys. Girls also reported to suffer from conversion disorders 3 times more than boys in a Turkish sample (Pehlivantürk & Ünal, 2002).

4.3 Findings concerning child-rearing styles

Child rearing styles of parents measured by MCRS in adoption and clinical status groups were not significantly different. This is related with the second aim of

the study, which was examined by three hypotheses. Both parents in four groups (adopted/clinical, adopted/non-clinical, non-adopted/clinical and non-adopted/non-clinical) rated themselves and perceived by their children as accepting and involved parents. This shows the existence of good and warm parent-child relationships where adopted children perceived acceptance from their parents as much as non-adopted children. Positive moderate correlations were observed between the acceptance/ involvement parenting styles and open, conscientious, extrovert, and agreeable personality traits of mothers and fathers regardless of adoption status, indicating that being biologically related to a child is not necessary to accept the child.

Gender of the child was not related with child-rearing styles of parents. On the other hand, younger children perceived more acceptance and responsiveness from their both parents than older children. As the children grow older, they become more autonomous and display more disobedience to parental rules, therefore it is possible for them to feel less accepted by their parents as they face with more restrictions.

4.4 Findings concerning attachment security of children

The third aim of the study and related hypotheses were about attachment securities of the children. Attachment securities of children were assessed via KSS, with their self-reports. The non-significant differences observed between the attachment securities (perceiving the attachment figure as available and reliable) of adopted and non-adopted children in the present study, are consistent with the findings of only one study (Verissimo & Salvaterra, 2006). On the other hand, there are studies reporting poorer attachment related with the older age of the child at the time of adoption (Juffer et al., 2005; Stams et al., 2006; Stovall & Dozier, 1998; Van den Dries et al., 2009). About 53% of the adopted children in the present study were adopted within the first 3 months of their lives, this might be a positive factor in the establishment of attachment security in adopted children.

Improvements in the attachment securities of the children after adoption were reported (O'Connor, Bredenkamp, Rutter, et.al, 1999). Adopted children whose attachment relationships were assessed previously as being poor or

disordered, had no attachment problems or similar attachment securities than non-adopted controls after age of 4. Authors concluded that with good quality care, even severely deprived children could form healthy attachments. It is very likely possible that adopted children in the present study, had developed better attachment relations within time. If it would be possible to assess the attachment securities of these children at the time of adoption, significant differences might have been observed. The minimum time passed after joining the adoptive family was 30 months; a sufficient time to establish healthier attachment relations even for the older adopted children. The previous attachment problems might have disappeared with the existence of good, warm, and caring new parents.

When age main effect was examined, it was found that younger children perceived both of their parents as more available and reliable than older children, where Sümer and Anafarta (in press) reported a similar pattern in the Turkish standardization study of Kerns Security Scale. This is a consistent finding with the information that, as children grow up they start forming new attachments, particularly with their friends (Kerns, Tomich, & Kim, 2006). Bowlby (1969) stated that there might be a decline in the frequency and intensity of attachment behaviors as the children grow older. By the increase of their age, children learn to cope better with stress, making them less dependent to their caregivers.

4.5 Findings concerning personality traits of parents

Mothers of children in both adoption status and clinical status groups did not significantly differ in terms of personality traits, assessed by BPTI. Adoptive and non-adoptive mothers scored highest in agreeableness personality trait, which was strongly related with acceptance/responsiveness parenting style in the present study. Agreeable individuals are defined as trustworthy, tolerant, generous, helpful, altruistic, and open to communication (McCrae & Costa, 1987) which are the characteristics of an accepting parent.

The one and only significant adoption status main effect of the present study was observed in fathers' agreeableness score, where adoptive fathers rated themselves as more agreeable than non-adoptive fathers. Adoption is a critical subject where most of the times decision about adoption is hardly made. It is

possible that, women decide and accept adopting a child more easily than their husbands. On the other hand, most probably, the men who accept adopting a child are more tolerant, more self-sacrificing, and more openhearted individuals. In our study, it is possible that adoptive fathers were already agreeable and tolerant in nature, so that they became adoptive fathers.

Fathers of children in the clinical group scored higher than fathers of non-clinical children on extraversion scale, which indicates being more talkative, fun/excitement loving, active and passionate (Mc Crae & Costa, 1987). These features can be associated with ADHD, where fathers of children with ADHD mostly fit in the diagnostic criteria of adult ADHD (Faraone & Biederman, 2000). This finding is not surprising in a population where 70% of the children were diagnosed as ADHD.

Fathers of the girls rated themselves as more conscientious than the fathers of boys. People high on conscientiousness are well organized, hardworking, punctual, self-disciplined and preserving people (McCrae & Costa, 1987).

4.6 Findings concerning temperament characteristics of children

Temperament characteristics of children did not differ in adopted and non-adopted groups according to both parents' ratings of SATI. On the other hand, some differences were observed between children in clinical and non-clinical groups. Both parents of the clinical group rated their children as less task persistent, whereas mothers of clinical group rated their children as more active than non-clinical group. In addition to this, non-adopted children in the clinical group were less task persistent and had less tendency to withdraw in new situations than children in non-adopted/ non-clinical group.

Task persistence is associated with child's self-directedness in fulfilling a task. It is not unexpected for children in clinical group to have less task persistence, where at the same time they displayed more attention problems and DSM-oriented ADHD problems than non-clinical group children. These results were also confirmed by significant correlational relations between the temperament scales and internalizing, externalizing and total problems scores.

Activity score refers to the motor activity level of children. In the present study children in the clinical group were rated as more active by their mothers than children in non-clinical group. Activity scores had positive correlations with externalizing and total problems scores.

Not surprisingly, task persistence and activity scores were negatively related, indicating less activity in more task persistent children. To be able to persist on some task, one needs to stand still and concentrate for some time with a low activity level, which is almost impossible for the clinical group of this study where 70% of them were diagnosed as ADHD.

In terms of gender and age main effects, girls were more task persistent than boys, consistent with the findings of the original study of the measure (McClowry et al., 2003). Younger boys were reported by their fathers as more active than older boys, consistent with the information that level of ADHD decreases with the increase of age (Öner, Soykan-Aysev & Altınoğlu-Dikmeer, 2009).

4.7 Findings concerning age of the child at the time of adoption

An unexpected finding of the study was, the lack of relationship between the age of the children at the time of adoption and the problem behaviors based on parental and self-reports and also the attachment securities. Age of adoption was not significantly correlated with maternal ratings of CBCL or self-reports of adolescents on YSR, however a moderate relationship between the age of the child at the time of adoption and attention problems were observed from the ratings of fathers.

This finding is not consistent with adoption literature, where older age of the child at the time of adoption was reported among the risk factors for attachment problems, adjustment problems and later psychopathology (Elmund, 2007; Fensbo, 2004; Hodges, 2005; Howe, 1997; Nickman et al., 2005).

Contrary to the studies, which report that, the younger age at adoption is related with the attachment relations of adopted children, in the present study, no significant relation was observed between the attachment securities of the children toward their mothers and fathers and age at adoption. This finding is supported only by Verrissimo and Salvatera (2006). The length of time the children spent in their new families was associated with better functioning (Van den Dries et al., 2009). In

the present study, the range of time spent with the adoptive family was between 30 months (2 years 6 months) and 118 months (9 years 10 months) among the older adopted children which is a sufficient time to establish attachment relations. 21 children (34.43%) were adopted after their first birthdays. Among these older adopted children 15 of them (24% of the adopted sample) lived with their biological parents for a considerable amount of time (ranging from 2 months to 48 months) before they were placed at residential care or adoption. This seems to be a very important protective factor for the adaptive functioning of older adopted children, leading to non-significant differences from the early adopted children. Those children had formed a kind of attachment during that period. As Bowlby (1980) stated, even insecure attachments are better than unformed attachments.

4.8 Findings concerning the age of the child at the time of adoption information disclosure

High correlations were observed between the age of the child when s/he learned about her/his adoption status and maternal ratings of all CBCL but somatic problem scores. These results indicate that the earlier the child learned that s/he was an adopted child, the less problem behaviors occurred in older ages. The adopted child would have more time to deal with this new information before adolescence where identity formation is the main issue of that period. In the present study, the oldest age when the child learned about his adoption status was 13 years. He was referred to a child psychiatry unit with severe symptoms of depression, starting right after learning about the truth that was kept secret all through his life.

Brodinsky, Singer and Braff (1984) stated that although preschoolers were aware of their adoption status and talked about it comfortably, they did not consciously recognize the formation of biological and adoptive families. If the children learn about their adoption status as early as possible, while growing up they would internalize and neutralize this information and feel less distressed. Wilson (2004), reported that children express less positive feelings toward adoption as they grow older, due to greater ambivalence they feel about their adoption status and identities.

The age that the adopted child was informed, might also be a reflection of parents' attitudes toward and acceptance of the adoption. The delay in sharing the information might make the parents more tense, anxious, and alert with the fear of their child learning the truth from others. This tension and anxiety of the parents would negatively influence the well-being of their children.

4.9 Findings concerning adoption history and opinions of adoptive vs. non-adoptive parents

About 40% of the adoptive parents did not express a preference about the gender of the child during their adoption application. Another 40% of the adoptive families had signed up for a daughter, where 20% preferred a son. These numbers correspond to the gender distribution of participants, where the percentage of girls were more than boys (girls: 55% vs. boys: 45%). Verissimo and Salvatera (2006) reported similar patterns, where Portuguese adoptive families favored girls more than boys prior to adoption. During the conversations with adoptive parents for various reasons, many parents expressed their expectancies about their daughters taking care of them when the parents get older. This is a common wish of parents and an unspoken duty given to female children in most of the Turkish families. As a matter of fact, no matter how old they are, usually daughters get in charge in case of any health problems of parents. A birth mother cannot choose or determine the gender of the coming baby, but an adoptive mother can!

Articulating the expectancy of receiving care from their daughters in the elderly, might be related to the ages of the adoptive parents as well. Parallel to the other studies (Rosnati et.al, 2008; Vorria et al., 2006), the adoptive parents were older than non-adoptive parents in the present study. They had spent time in deciding, applying and waiting for the adoption so that their ages were increased.

Adoptive and non-adoptive mothers of clinical vs. non-clinical group of children were interviewed in order to explore their perceptions of problems in the family and possible outcomes. Responds to the interview questions, revealed a great similarity between the perceived problems or future expectations/worries of all mothers. They were all worried about behavior or attention problems of their children for the present time and negative outcomes of those problems in the future

such as a poor academic achievement or poor career opportunities. In addition to this, adoptive mothers were worried about the birth parents of their children. Although they were sure that their children would not prefer the birth families or abandon the adoptive families in the future, they all expressed fears about biological siblings or parents hurting their children. Again, this was not about adoption, it was about somebody that had the risk of hurting her child. This reflects that, in order to have fears, hopes, expectations or frustrations about their children mothers need not give birth to them. As quoted from Noy-Sharav (2002), the concern for the child's well being, and dread of losing her/him, the joy in her/his development, the need to find features and traits in which the child resembles either parent, the hope for personal continuity are all shared by biological and adoptive parents alike.

Non-adoptive parents filled a short questionnaire about their views on adoption. Non-adoptive mothers and fathers expressed positive attitudes about adoption. A very few number of parents considered adoption as taking care of a child that belongs to someone else who had failed to take care of her/his own child; and reported that they would have never adopted a child. On the other hand, most of the parents thought adoption was an honorable duty for humanity, where a homeless child is given an opportunity to be raised in a warm home environment by loving and caring parents. This is an important finding; these responses reflect the opinions of the society towards adoption as being accepted. In order to prevent prejudice and stigmatization in the society about adopted children, this acceptance from the non-adoptive parents is very encouraging.

4.10 Limitations of the study

The present study has some limitations. The first limitation is the sample size; with a larger number of participants, generalizing the findings would be easier and reliable.

Data was collected mostly from Ankara (65%) and from 11 other cities (35%). The present sample might not represent the adoptive population all through out Turkey.

The real number of the adoptions and the underlying reasons for adoptions can not be estimated precisely, as the Turkish Civil Law permits adopting a child

directly from the birth parents or legal guardians. Infertility of the parents seem to be the most frequent reason for adoptions. In our country it is not a secret that, some women get pregnant in order to give the child to her infertile relatives without getting paid. Or sometimes, the mother has multiple children and the family is not able to afford one more child, then with the help of other people, a couple having no child from a better economic status is found. These children directly become the child of those couples as if the adoptive mother had given birth; no adoption procedure is needed. Therefore, such arrangements do not appear in the adoption records. Another common type of adoption is that, sometimes relatives, particularly grandparents, adopt their grandchildren to provide health or special education services if the parents are unemployed or not able to take care of the child for various reasons. In such cases, usually the children are aware of adoption, and the adoptive parents already had biological children. Information about adoptions with different rationale, is missing in this study.

It was a big challenge to obtain participation of adoptive families in the study. Among all of the contacted adoptive parents, about 25% rejected to participate. In the remaining 75%, adoptive parents of children in the clinical group were very helpful and eager to complete the questionnaires. Among the non-clinical group, most of the families had some visits to child mental health professionals, before or after adoption in order to receive counseling about raising a child or disclosing adoption information, although there were no psychiatric problems within the family. Therefore, the participating parents might be experienced about filling questionnaires or being interviewed and might have a positive bias toward psychological services. Also, as indicated by the results of this study, these parents had agreeable personality traits, in other words, they were open to communication, helpful, tolerant and altruistic. As they were already open to any kind of communication about this subject, participating in this study did not discomfort them. On the other hand, information about the personality traits of the non-participating parents is unavailable. It is possible that, they had different personality traits or attitudes which led them to be non-open to such communication or to feel threatened.

Another limitation of the study is the lack of pre-adoption information. Very little information was available about the biological parents of the adopted children, therefore genetic or environmental characteristics of birth families and possible pre- or post-natal trauma, abuse or neglect histories could not be examined. The reasons for abandoning or voluntarily giving the child to adoption or institutional care remained mysterious.

Factors leading adoptive parents to consider adoption were not studied in the current study. In our country, usually, adoption is the last step for having a child, as a result of being unable to give birth to a biological child. So, it is possible for most of the adoptive parents who participated in the study, have gone through the stages of finding out that they will not be able to have biological children, searching for treatment options, deciding for alternative artificial fertilization techniques, having multiple unsuccessful attempts and finally deciding and applying for adoption. That process is a distressing process including emotional traumas and grief for the loss of unborn babies. Those unpleasant experiences might have an influence on the personality traits or parenting styles of the adoptive parents, which were not emphasized in this study.

Age of the adopted children was limited with the range of 6 to 18. If younger children would be included in the study, than it would be possible to gather information about children very shortly after they had joined the family. It would be possible to assess attachment relations or adjustment problems before any interventions were made.

Although the data about the children were gathered from multiple resources (mother, father and from the adolescent her/himself), lack of teacher report forms is another limitation. Mainly, parents in the non-clinical group hesitated asking teachers to complete the forms, as they found hard to explain the rationale of the study.

4.11 Future Directions

Adoption process, difficulties or strengths of adoptive families, different types of adoption etc. have been studied in the international literature intensively,

but it is relatively a new subject in our country and there is a great gap to fill in Turkish adoption literature.

Further studies with larger groups of adopted children and adoptive parents should be conducted. More information about the various features of Turkish adoptive families is needed.

There is definitely a great need for longitudinal studies on adopted children to be able to understand the vulnerabilities or strengths of adoptive families and the protective and risk factors for future psychological and social adjustment of adoptees. Studies should be arranged to assess the adopted children as early as possible after they had joined their new families.

Pre-adoption history of the children, including the abuse, neglect and trauma stories, should be examined. This issue highlights the necessity of good record keeping and opening those records to the adoptive families. Additionally, the previous losses and grieves of the adoptive parents should be studied.

4.12 Clinical Implications

As a general overview of the whole study; while being followed in a child psychiatry unit had observable effects on the emotional and behavioral problems or temperament characteristics of the children, *being adopted had almost no effect at all*.

Child and adolescent mental health professionals serve adopted children more and more each day. The most studied subjects in the psychotherapies of the adopted children and adolescents are reported as fear of abandonment, feelings of worthlessness, ambivalent feelings and thoughts about the roots or the family of origin and anger toward birth parents (Nickman et al., 2005). As well as being aware of international adoption literature, results of studies on Turkish adopted samples as well as children in foster care or institutions, will empower the interventions. Culture specific issues and vulnerabilities of adoptive families should be taken into account for any kind of intervention.

Perhaps the most important finding of the study indicated that, adopted children should be informed about their adoption status as early as possible. The older they learn about the truth, the more is the chance of displaying emotional and

behavioral problems. Adoption professionals and clinicians have full agreement on that, the adopted child should know her/his adoption story. But the debate is still continuing on when and how the adoption should be discussed. The results of this study, supports the view that favors disclosure as early as possible, preferably at preschool years.

Since no differences between adopted and non-adopted children was found in terms of emotional and behavioral problems or attachment securities, adoption should be promoted and encouraged among families.

4.13 Implications for Adoption Policies

Based on the findings of the present study and literature on adoption, possible arrangements for the establishment of adoption policies in Turkey are suggested.

Residential care is considered as the first option in order to protect homeless children. On the other hand, literature provides evidence for the negative outcomes of residential care on the physical, intellectual and social development of the children. Arrangements should be done to provide family-based placements for those children.

About 20 thousand children between ages 0-18 are residing in the institutions under the protection of Turkish Government. (Erol & Şimşek, 2008, p.760). Biological parents of most of those children are still alive and the major reason for those parents to leave their children in residential care is the poverty. In such cases, priority should be given to protect the union of the biological family by providing financial support, health care, and/or education services.

If the children are unable to return to their biological families for various reasons (loss of parents, abandonment, inability of the parent to take care of children, or abuse within the family etc.) alternative options of placements are arranged. Family-based care, such as foster care or adoption is considered. In both cases, relatives of the children who are able and willing to take care should be the first choice of placement. If there is no relative available, then unrelated but volunteer families should be considered. Literature on adopted children emphasizes

the positive and interventive aspects of adoption on the development of the children and for future adaptability.

In order a child to establish an attachment security with an attachment figure, a mutual, warm, caring relationship between the child and the caregiver should be formed as early as possible. If the child is eligible for adoption, s/he should be placed to her/his new home as quick as possible. Each day spent less in residential care is for the benefit of the child. Arrangements should be done to minimize the length of waiting period for adoption.

SHÇEK has a policy for not separating biological siblings as much as possible when considering adoptions. On the other hand, candidate adoptive parents mostly prefer to adopt a single child. Therefore, siblings have to wait for a longer period, additionally as they get older during this period, their chance to be adopted is weakening. Literature provides us with the information that having other adopted siblings (preferably biological siblings) is a protective factor for psychosocial adaptation of adoptees. Also, having a biological sibling within the family has additional benefits in case of any medical conditions. Therefore, candidate parents should be informed about this finding and adoption of the sibling groups together should be encouraged.

Although literature indicates that adopted children are over-represented in mental health settings, mental health professions in our country usually underestimate the importance of adoption status on emotional and/or behavioral problems of the children. Professionals should be more informed about the literature and guide adoptive parents accordingly. Training opportunities on adoption for the psychologists, childcare workers, social workers and other mental health professionals should be provided.

Almost all of the adoptive parents, who participated in the present study, stated their need about a training program before and after their children joined their family. Candidate adoptive parents should be trained before the adoption takes place. This training should include the psychological preparation of parents, issues such as discussing their decision with other family members, disclosing the adoption information as early as possible, or how to recognize and deal with possible problems related to the developmental stage of the child etc. These

programs should continue after the formation of the new family. Parents would benefit from additional training programs or periodical counseling sessions about child rearing after the adoption is completed. Raising a child has its own challenges at different stages of the psychosocial development of the child; raising an adopted child coming from a different background is more than a challenge. Parents should be supported and strengthened during this process.

Adoption is a multi-disciplinary frame of work and should be considered within teamwork. SHÇEK and non-governmental organizations related with adoption, foster care, child and adolescent mental health, social work etc should collaborate to organize training opportunities for professionals and families, and to organize campaigns for rising awareness on foster care and adoption. Reaching as many people as possible is important to familiarize the society and prevent stigmatization about these subjects.

Final words of the thesis are quoted from a father:

"*All the families deal with the same problems, the only difference is, in our case, we have an additional adjective before the word family*."

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APPENDICES

APPENDIX A

E-MAIL FROM THE GENERAL DIRECTORATE OF SOCIAL SERVICES AND CHILD PROTECTION AGENCY (SHÇEK) RECEIVED ON FEBRUARY 3rd 2009

T.C. Başbakanlık
Sosyal Hizmetler ve
Çocuk Esirgeme Kurumu

Bilgi Edinme Başvuru Bilgileriniz

Müracaat No:	500
Başvuru sahibinin ismi ve soyismi:	D. İlkiz Altınoğlu Dikmeer
Oturma yeri veya iş adresi:	Ankara Üniversitesi Tıp Fakültesi Cebeci Hastanesi Otistik Çocuklar Merkezi
Elektronik posta adresi:	ilkiz@superonline.com
İstenen bilgi veya belgeler:	Doktora tez çalışmasında kullanılmak üzere aşağıdaki bilgilerin tarafıma iletilmesini rica ederim. 1.2008 yıl sonu itibariyle evlat edindirilmiş çocuk sayısı (kız / erkek) 2.Evlat edindirilmiş yıllık ortalama çocuk sayısı (kız / erkek) 3.Yurt dışında yaşayan ailelere evlat edindirilmiş çocuk sayısı (kız / erkek) 4. Yabancılara evlat edindirilmiş Çocuk sayısı 5. Evlat edinilmiş olan çocukların hangi yaş aralığında oldukları

Bilgi Edinme Müracaatınızın Cevabı

Sayın:Deniz İlkiz ALTINOĞLU DİKMEER

Bilgi edinme talebiyle Kurumumuza yaptığınız başvuruya istinaden Çocuk Hizmetleri Daire Başkanlığımızın yazısı sonucunda edinilen bilgiler aşağıya çıkarılmıştır :

31.12.2008 tarihine kadar ülkemizde evlat edinme işlemi tamamlanmış çocuk sayısı:

Erkek:5139 Kız: 4655 Toplam:9794'tür.

Her yıl ortalama 500-600 arası çocuk evlat edindirilmek üzere aile yanına yerleştirilmektedir.

Yabancı ülklerde yaşayan Türk Vatandaşları tarafından evlat edinilen çocuk sayısı 2008 yılı dahil 50 civarındadır.

Yabancı ülke vatandaşları yanına yerleştirilen çocuk sayısı 5'dir.

Ülke içinde evlat edindirilen çocuklarımızın %90'a yakını 0-2 yaş grubundadır.

SHÇEK Genel Müdürlügü Basın va Halkla İlişkiler Müşavirliği
Anafartalar Cad. No: 70 Ulus / Ankara
Tel : 0312 310 24 60/1404 Fax : 0312 311 25 92

APPENDIX B

ADOPTION INFORMATION QUESTIONNAIRE

EVLAT EDİNME SORU FORMU

Ülkemizdeki evlat edinme hizmetinin gelişmesi amacıyla, evlat edinilmiş ve biyolojik aileleri yanında büyüyen çocuk ve ergenlerle ilgili bir çalışma planlanmıştır. Bu hizmeti çocuklara sunan siz değerli ailelerin deneyimlerinden yararlanmak ve görüşlerini almak istiyoruz.

Birden fazla çocuğunuz varsa, lütfen aşağıdaki soruları **evlat edindiğiniz çocuğunuz**u düşünerek cevaplayınız. **Birden fazla çocuk evlat edindiyseniz lütfen her çocuk için ayrı form doldurunuz**.

Sorulara ait tek bir doğru seçenek yoktur, birden fazla işaretleyebilirsiniz. Sunulan seçeneklere eklemek istediklerinizi ya da diğer tüm görüşlerinizi formun arkasındaki boşluklara yazmanız, çalışmamızı güçlendirecektir. Ailelerden gelen formların analizi sadece araştırmacı tarafından yapılacak, formlardaki cevaplar, kimlik ve iletişim bilgileri kesinlikle **gizli** tutulacaktır

Konu ile ilgili soruları yanıtladığınız ve katkılarınız için şimdiden teşekkür ediyoruz.

Prof. Dr. Neşe Erol Uzm. Psk. İlkiz Altınoğlu Dikmeer

Formu dolduran: □ Anne □ Baba
Tarih: …….

Anne baba hakkında bilgiler (tek ebeveynli aileler için: lütfen sadece çocuğun şu an birlikte yaşadığı ebeveynle ilgili soruları yanıtlayınız)

	Anne	**Baba**
İsim:		
Yaş:		
Meslek:		
Eğitim Durumu:	□ Okuryazar değil □ Okuryazar □ İlkokul mezunu □ Ortaokul mezunu □ Lise mezunu □ 2 yıllık üniversite mezunu □ 4 yıllık üniversite mezunu □ Yüksek Lisans □ Doktora ve üstü	□ Okuryazar değil □ Okuryazar □ İlkokul mezunu □ Ortaokul mezunu □ Lise mezunu □ 2 yıllık üniversite mezunu □ 4 yıllık üniversite mezunu □ Yüksek Lisans □ Doktora ve üstü
Medeni durumunuz:	□ Evliyim □ Bekârım □ Eşimle ayrı yaşıyoruz □ Boşandım □ Eşimi kaybettim	
Ailenizin toplam geliri:	□ Ortalamanın çok altında □ Ortalamanın biraz altında □ Ortalama düzeyde □ Ortalamanın biraz üstünde □ Ortalamanın çok üstünde	

Evlat edindiğiniz çocuk ile ilgili bilgiler

Çocuğunuzun adı soyadı:	
Çocuğunuzun cinsiyeti:	□ Kız □ Erkek
Çocuğunuzun şu andaki yaşı:	
Çocuğunuzun şu andaki eğitim durumu:	□ Özel okul □ Devlet okulu Sınıf:

Ailenin diğer bireyleri ile ilgili bilgiler
(Hakkında bu formu doldurduğunuz çocuğunuzdan başka çocuğunuz ya da evinizde anne baba ve çocuklar dışında sizinle birlikte yaşayan başka kimseler varsa lütfen belirtiniz)

Size yakınlığı (çocuk, büyükanne vs)	Yaşı	Cinsiyeti	Eğitimi	Mesleği

Çocuğunuzun biyolojik ailesi ile ilgili bilgiler:

Çocuğunuzun biyolojik annesi ile ilgili	□ Kim olduğu bilinmiyor □ Hayatta □ Hayatta değil □ Yaşayıp yaşamadığı bilinmiyor □ Sağlık sorunları var □ Bizim çocuğumuzu evlilik dışı dünyaya getirmiş □ Biyolojik baba ile birlikte yaşıyor □ Başka bir aile kurmuş □ Kurum bakımına verilen başka çocukları var □ Şu anda hapiste □ Diğer (Belirtiniz) .....
Çocuğunuzun biyolojik babası ile ilgili	□ Kim olduğu bilinmiyor □ Hayatta □ Hayatta değil □ Yaşayıp yaşamadığı bilinmiyor □ Sağlık sorunları var □ Biyolojik anne ile birlikte yaşıyor □ Başka bir aile kurmuş □ Kurum bakımına verilen başka çocukları var □ Şu anda hapiste □ Diğer (Belirtiniz) .....
Çocuğunuz biyolojik ebeveynleri ile görüşüyor mu?	□ Anne babası hayatta olmadığı için görüşmüyor □ Çocuğumuz görüşmek istemiyor □ Ailesi görüşmek istemiyor □ Biz uygun bulmuyoruz □ Sadece bizimle birlikte iken izin veriyoruz □ Anne baba dışında başka akrabaları ile görüşüyor (Belirtiniz) .....
Eğer görüşüyorlarsa, ne sıklıkta?	□ Nadiren (yılda 1 – 2 kez) □ Ara sıra (yılda 3 - 6 kez) □ Sık sık (yaklaşık her ay) □ Bayram ya da özel günlerde
Nerede görüşüyorlar?	□ Bizim evde □ Biyolojik ailenin evinde

	□ Dışarıda
Çocuğunuzun biyolojik kardeş(ler)i var mı?	□ Kardeşi yok □ … tane kardeşi var □ Bilgimiz yok
Varsa biyolojik kardeş(ler)i nerede yaşıyor?	□ Bilgimiz yok □ Biyolojik aile ile birlikte □ Yuvada/ yurtta □ Akraba yanında □ Koruyucu aile yanında □ Başka aile evlat edinmiş
Çocuğunuz biyolojik kardeşleri ile görüşüyor mu?	□ Çocuğumuz görüşmek istemiyor □ Biz uygun bulmuyoruz □ Sadece bizimle birlikte iken izin veriyoruz
Eğer görüşüyorlarsa, ne sıklıkta?	□ Nadiren (yılda 1 – 2 kez) □ Ara sıra (yılda 3 - 6 kez) □ Sık sık (yaklaşık her ay) □ Bayram ya da özel günlerde
Nerede görüşüyorlar?	□ Bizim evde □ Kardeşin yaşadığı yerde □ Dışarıda
Sizce çocuğunuzun biyolojik aile üyelerinden biriyle görüşmesi onu nasıl etkiliyor?	□ Mutlu oluyor □ Huzursuz oluyor □ Bize karşı tavırları değişiyor
Evlat edinme işlemi tamamlanmadan önce SHÇEK tarafından çocuğunuzun biyolojik ailesi hakkında ne tür bilgiler verildi?	□ Hiç bilgi verilmedi □ Kurum kayıtlarında biyolojik ailesi hakkında hiçbir bilgi olmadığı belirtildi □ Ailenin geçmiş öyküsü hakkında bilgi verildi □ Ailedeki tıbbi hastalıklar hakkında bilgi verildi □ Ailedeki psikiyatrik hastalıklar hakkında bilgi verildi □ Kurumda yaşayan diğer kardeşlerle tanıştırıldık □ Biyolojik anne babası ile / diğer akrabaları ile / diğer kardeşleri ile tanıştırıldık (Belirtiniz.....) □ Biyolojik ailesinin görüşme talebi olursa neler yapmamız gerektiği hakkında yasal ve psikolojik açılardan bilgi verildi □ Diğer (Belirtiniz) .....

Evlat edinme süreciyle ile ilgili bilgiler

Çocuğunuzu ne şekilde evlat edindiniz?	□ SHÇEK aracılığı ile □ Her iki ailenin ortak tanıdığı aracılığı ile □ Akrabalık bağımız sayesinde □ Diğer (Belirtiniz) .....
Evlat edinirken cinsiyet tercihi yaptınız mı?	□ Evet □ Hayır
Evet ise tercihiniz ne idi?	□ Kız □ Erkek
Evlat edinirken yaş tercihi yaptınız mı?	□ Evet □ Hayır
Evet ise tercihiniz ne idi?	□0-3 yaş □3-5 yaş □6-12 yaş □13-15 yaş □16-18 yaş
Evlat edindiğinizde çocuğunuz ve siz kaç yaşındaydınız?	□ Çocuğun yaşı……. □ Annenin yaşı……. □ Babanın yaşı …….
Evlat edinme konusunda ilk bilgilerinizi nasıl edindiniz?	□ Gazete haberlerinden □ TV / radyo programlarından □ Dizi ya da filmlerden

	□ İnternetten □ Doğrudan SHÇEK yetkililerinden □ Evlat edinmiş tanıdıklarımdan □ Avukatlardan / hukukçulardan □ Diğer (Belirtiniz) .....
Evlat edinmeye nasıl karar verdiniz?	□ Ben istiyordum □ Eşim istiyordu □ İkimiz de istiyorduk □ Aile büyükleri istiyordu □ Büyük çocuğum / çocuklarım istiyordu □ Diğer (Belirtiniz) .....
Evlat edinmeye ne zaman karar verdiniz?	□ Çocuklarım büyüdüğünde □ Çocuk sahibi olamayacağımızı öğrendiğimde □ Aile durumumuz düzeldiğinde □ Evlat edinme hizmeti konusunda bilgi sahibi olduğumda □ Diğer (Belirtiniz) .....
Evlat edinmenizin temel amacı neydi?	□ Çocuğumun olmaması □ Kız çocuğumun olmaması □ Erkek çocuğum olmaması □ Ölen öz çocuğumun yerini alması için □ Çocuk akrabam olduğu için □ Zor durumda olan bir çocuğa yardım etmek için □ Diğer (Belirtiniz) .....
Evlat edinme kararınızı kimlerle paylaştınız? (Belirtiniz)	□ Kesinleşene kadar kimseye söylemedim □ ..... ile paylaştım
Evlat edinme kararınız kesinleştikten sonra bu kararı kimler destekledi?	□ Kimse desteklemedi □ ..... destekledi
Kararınız kesinleştikten sonra sizi vazgeçirmeye çalışan oldu mu?	□ Evet (Belirtiniz) ..... □ Hayır
Başvurunuzdan ne kadar süre sonra evlat edinebildiniz?	
İlk tanıştırıldığınız çocuğu mu evlat edindiniz?	□ Evet □ Hayır (Çocuğunuzla karşılaşana kadar kaç çocuk gösterildi? ……)
Çocuğunuzla ilk karşılaşmanız nerede oldu?	
Çocuğunuz ile birlikte aynı evde yaşamaya başlamadan önce kaç kez bir araya geldiniz?	
İlk başvurunuzda size kurum tarafından ne tür bilgiler verildi?	□ Yasal süreçlerle ilgili bilgiler □ Bu hizmetten yararlanan çocukların özellikleri hakkında □ Bu hizmeti verebilecek ailelerin özellikleri hakkında □ Tahmini bekleme süresi hakkında □ Bugüne kadar yaşanan olumlu ve olumsuz örnekler hakk. □ Maddi konular hakkında □ Diğer (Belirtiniz) .....
Kurum tarafından evlat edinme	□ Hiç bilgi verilmedi

işlemi tamamlanmadan önce olası güçlükler hakkında ne tür bilgiler verildi?	□ Çocuğun zihinsel / psikolojik durumu hakkında □ Çocuğun tıbbi durumu (geçirdiği hastalıklar vb) hakkında □ Yaşadığı grup evindeki / yuvadaki alışkanlıkları hakkında □ Yeni bir ortama girmesiyle birlikte yaşayabileceği uyum sorunları hakkında □ Olası sorunlarla nasıl baş edebileceğimiz hakkında □ Diğer (Belirtiniz) .....

Çocuğunuzun sizinle yaşamaya başlamadan önceki yaşamı ile ilgili bilgiler:

Çocuğunuz sizinle birlikte yaşamaya başlamadan önce ne kadar süreyle nerede / kimin yanında yaşamış? Lütfen bilebildiğiniz kadarıyla doğumdan itibaren sırasıyla yazınız.	□ Biyolojik aile (süre:……) □ Akraba yanı (süre:……..) □ Yuva/ yurt (kaç tane ve süreleri:……..) □ Koruyucu aile (kaç tane ve süreleri:……..) □ Diğer (Belirtiniz) .....
Çocuğunuz sizinle yaşamak üzere evinize gelirken kendisine ait herhangi bir eşya getirdi mi?	□ Kendisine ait eşyası yoktu. □ Hiç bir eşya getirmedi. □ Evet, ... getirdi

Birlikte yaşam sonrası ilgili bilgiler:

Bakım: Çocuğunuzla birlikte olmaya başladıktan sonra çocuğunuzun bakımını nasıl sağladınız?	□ Ben baktım (Süre: .....) □ Eşim baktı (Süre: .....) □ Aile bireylerinden biri baktı (Belirtiniz.....) (Süre: .....) □ Bakıcı baktı (Süre: .....) □ Kreşe / etüde başladı □ Zaten kreşe / okula gidiyordu sorun olmadı □ Diğer (Belirtiniz) .....
İsim: Çocuğunuz sizinle yaşamaya başladıktan sonra ismini değiştirdiniz mi?	□ Evet, değiştirdik □ Hayır, böyle bir şeye gerek görmedik □ Hayır, ama keşke değiştirseydik □ Böyle bir hakkımız olduğunu bilmiyorduk □ Diğer (Belirtiniz) .....
İsim değişikliği yapmaya nasıl karar verdiniz?	□ İsmini beğenmedik □ İsmini kendisi de beğenmiyordu □ Geçmişiyle bağları kopsun diye □ Yeni bir hayata yeni isimle başlasın diye □ Diğer (Belirtiniz) .....
Şu andaki ismine nasıl karar verdiniz?	□ Kendi seçimiydi □ Benim önerdiğim bir isimdi □ Eşimin önerdiğim bir isimdi □ Evdeki diğer çocukların seçimiydi □ Aile büyüklerinden birinin ismi (Belirtiniz.....) □ Diğer (Belirtiniz) .....
Yeni ismine kolay uyum sağladı mı?	□ Evet, hiç zorlanmadı □ Bir türlü alışamadı □ Diğer (Belirtiniz) .....

Evlat edinilme bilgisi: Çocuğunuz evlat edinildiğini biliyor mu?	□ Evet, biliyor □ Hayır bilmiyor, zamanı gelince söyleyeceğiz □ Hayır bilmiyor, söylemeyi düşünmüyoruz
Eğer biliyorsa, kaç yaşında öğrendi?	
Evlat edinildiğini ne şekilde öğrendi?	□ Tesadüfen (Belirtiniz .....) □ Ben anlattım □ Eşim anlattı □ Anne baba birlikte anlattık □ Diğer aile bireyleri ile birlikte iken anlattık □ Uzman (psikolog, doktor, SHU vb) eşliğinde biz anlattık □ Uzman anlattı □ Diğer (Belirtiniz) .....
Öğrendiği anda nasıl karşıladı?	□ Sessiz kaldı □ İnanmadı □ Ağladı □ Bize kötü davrandı □ Bize sarıldı □ Hırçınlaştı □ Diğer (Belirtiniz) .....
Daha sonraki tepkileri nasıl oldu?	□ Bize daha yakın oldu □ Bizden uzaklaştı □ Daha hırçın / öfkeli oldu □ Daha duygusal oldu □ İçine kapandı □ Bize anne / baba demeyi kesti □ Biyolojik ailesiyle ilgili sorular sormaya başladı □ Diğer (Belirtiniz) .....
Önceki yaşamı ile bağlar: Çocuğunuz daha önce kurumda yaşadıysa, sizinle yaşamaya başladıktan sonra kurum ziyareti yapmak istedi mi?	□ Hayır, şu ana kadar hiç istemedi □ İstedi ama biz kabul etmedik □ İstedi ama henüz fırsat olmadı □ Düzenli olarak birlikte gidiyoruz □ Sadece bayram ve tatillerde gidiyoruz □ Diğer (Belirtiniz) .....
Çocuğunuz daha önce koruyucu aile yanında yaşadıysa, sizinle yaşamaya başladıktan sonra aileyi ziyaret etmek istedi mi?	□ Hayır, şu ana kadar hiç istemedi □ İstedi ama biz kabul etmedik □ İstedi ama henüz fırsat olmadı □ Düzenli olarak görüşüyor □ Sadece bayram ve tatillerde görüşüyor □ Diğer (Belirtiniz) .....
Çevre: Evlat edindiğinizi kimler biliyor? (Bu çalışmaya katılmayı kabul ettiğinizi göz önüne alarak "kimse bilmiyor" seçeneğini sunmadık)	□ Bizi tanıyan herkes biliyor □ Sadece ailemiz biliyor □ Sadece yakın çevremiz biliyor □ Diğer (Belirtiniz) .....
Evlat edinme nedeniyle çevre	□ Hayır, böyle bir şeye gerek görmedik

değiştirdiniz mi?	□ Hayır, ama keşke değiştirseydik □ Bizi kimsenin tanımadığı bir yerde yeni bir hayata başladık □ Çocuk yetiştirmek için daha uygun bir eve / çevreye taşındık ve eski komşularımızla görüşmeye devam ettik. □ Çocuk yetiştirmek için daha uygun bir eve / çevreye taşındık ve eski çevremizle ilişkimizi kestik. □ Diğer (Belirtiniz) .....
Evlat edinmiş başka ailelerle görüşüyor musunuz?	□ Evet, bazı ailelerle birbirimize destek oluyoruz □ Birçok ailenin biraraya geldiği düzenli toplantılarımız var □ Hayır, başka ailelerle birlikte olmak istemiyorum □ Evlat edinmiş başka aile tanımıyorum, tanısaydım görüşürdüm □ Evlat edinmiş başka aile tanımıyorum, tanısaydım da görüşmezdim □ Diğer (Belirtiniz) .....
Okul yaşamı: Çocuğunuz sizinle yaşamaya başladıktan ne kadar süre sonra kreşe / okula başladı?	□ Zaten gidiyordu, kendi kreşine / okuluna devam etti □ Hemen bizim seçtiğimiz yeni bir kreşe / okula başladı □ İlkokul yaşı gelene kadar evde bakıldı □ Diğer (Belirtiniz) .....
İlk kez sizin yanınızda kreşe / okula başladıysa, tepkileri nasıl oldu?	□ Hemen uyum sağladı □ Gitmek istemedi, çok direndi □ Evden çıkmak istemiyordu ama kreşe /okula gidince sorun kalmıyordu □ Arkadaşlarıyla geçinemedi ama sonra alıştı □ Hala uyum sağlayamadı □ Diğer (Belirtiniz) .....
Sizin yanınıza geldikten sonra okul değişikliği olduysa, bunu nasıl karşıladı?	□ Kendisiyle birlikte bu kararı verdiğimiz için sorun olmadı □ Eski arkadaşlarıyla görüşmek koşuluyla kabul etti □ Kesinlikle istemedi ama sonunda kabullendi □ Kesinlikle istemedi, hala uyum sağlamadı □ Kabullenmiş görünüyor ama uyum sorunları var □ Diğer (Belirtiniz) .....
Çocuğunuzun devam ettiği okula evlat edinme ile ilgili bilgi verdiniz mi?	□ Hayır, gerek görmedik □ Kendisi istemedi □ Sadece okul yönetimi ve öğretmeni biliyor □ Kendisi sadece yakın arkadaşlarına söyledi □ Okuldaki herkes biliyor □ Diğer (Belirtiniz) .....
Bu konuyla ilgili okulda herhangi bir sorun yaşandı mı / yaşanıyor mu?	□ Evet (Belirtiniz) ..... □ Hayır

Duygularınız:

Çocuğunuzun annesi / babası olarak neler hissediyorsunuz?	□ Kendimle gurur duyuyorum □ Zaman zaman "Hata mı yaptım acaba?" diye sorguluyorum □ Zaman zaman biyolojik annesi / babası olmadığım için üzülüyorum

	□ Zaman zaman biyolojik annesi / babası olmadığım için beni sevmediğini düşünüyorum □ Zaman zaman biyolojik annesi / babası olsaydım sevgim daha mı farklı olurdu diye düşünüyorum □ Zaman zaman biyolojik annesi / babası olsaydım dayanma gücüm daha mı farklı olurdu diye düşünüyorum □ Bu yaptığımın insanlık adına bir görev olduğunu düşünüyorum □ Diğer (Belirtiniz) .....

Çocuğunuzun özellikleri ile ilgili bilgiler:

Sizce çocuğunuz aile üyelerinden en çok kime yakındır?	1. 2. 3.
Çocuğunuzun 3 olumlu özelliğini yazınız. En çok beğendiğinizi lütfen daire içine alınız.	1. 2. 3.
Çocuğunuzun 3 olumsuz özelliğini yazınız. Sizi en çok rahatsız edeni daire içine alınız.	1. 2. 3.

Çocuğunuzun sağlık durumu ile ilgili bilgiler:

Çocuğunuz sizinle birlikte yaşamaya başladığında herhangi bir sağlık sorunu var mıydı?	□ Evet (Belirtiniz) ..... □ Hayır
Herhangi bir psikolojik sorunu var mıydı?	□ Evet (Belirtiniz) ..... □ Hayır
Herhangi bir fiziksel ya da zihinsel engeli var mıydı?	□ Evet (Belirtiniz) ..... □ Hayır
Şu anda herhangi bir süreğen hastalığı / engeli var mı?	□ Evet (Belirtiniz) ..... □ Hayır
Halen düzenli olarak kullandığı bir ilaç var mı?	□ Evet (Belirtiniz) ..... □ Hayır
Çocuğunuz sizinle birlikte yaşamaya başladıktan sonra Çocuk Ruh Sağlığı Uzmanına başvurdunuz mu? (Lütfen yaşını ve nedenini belirtiniz)	
Şu anda Çocuk Ruh Sağlığı tedavisi devam ediyor mu?	□ Evet (Belirtiniz) ..... □ Hayır
Uyum davranışları: Çocuğunuzda ilk zamanlarda yanda belirtilen tepkiler gözlendi mi? (Birden fazla seçenek işaretleyebilirsiniz)	□ Terk edilme korkusu (1) □ Kaybolma korkusu (2) □ Evden dışarı çıkmak istememe (3) □ Anne / babaya güvensizlik (4) □ Anne / babaya aşırı bağımlılık (5) □ Aşırı ilgi bekleme (6) □ İlgi çekmek için aşırı sevgi gösterme (7) □ İlgi çekmek için içine kapanma (8) □ İlgi çekmek için olumsuz davranışlar sergileme (9) □ Diğer aile bireylerini kıskanma (10)

	□ Yerine getirilmesi zor isteklerde bulunma (11) □ Evden kaçma / geldiği yere dönme ile tehdit etme (12) □ Kendine ait eşyaları saklama (13) □ Diğer (Belirtiniz) ..... (14)
Yukarıda belirtilen tepkilerden hala devam eden varsa lütfen numaralarını belirtiniz.	
Bu sorunlarla nasıl baş ettiniz? (Belirtiniz)	

Evlat edinme konusunda eğitim ile ilgili bilgiler:

Evlat edinme sürecinin ilk aşamalarında bu konuyla ilgili herhangi bir eğitim aldınız mı?	□ Hayır, almadık □ Aldık. Nereden / kimden? Süre: İçerik:
Eğitim aldıysanız, bu aldığınız eğitim yeterli miydi?	□ Evet, yeterliydi. □ Keşke bazı konularda biraz daha bilgi olsaydı. (Belirtiniz) .....
Şu anda herhangi bir eğitime ihtiyaç duyuyor musunuz?	□ Hayır, ihtiyacım yok □ Özellikle bazı konularda ihtiyaç hissediyorum. (Belirtiniz) .....
Geçmişe yönelik düşündüğünüzde evlat edinme sürecinin başında nasıl bir eğitim verilmesi yararlı olurdu? Bir eğitim programı hazırlansa hangi konuların yer alması sizce yararlı olurdu?	
Evlat edinme işlemi tamamlandıktan sonra kurum ne tür hizmetler sundu? Başka ne tür hizmetler olmasını isterdiniz?	
Evlat edinme sisteminde bir değişiklik yapılması söz konusu olsaydı, sizce nelerin değişmesi yararlı olurdu?	
Yeni aile adaylarına neler önerirsiniz?	

Sabrınız ve yardımınız için çok teşekkürler ☺

APPENDIX C

FAMILY INFORMATION QUESTIONNAIRE

AİLE BİLGİ FORMU

Ülkemizdeki evlat edinme hizmetinin gelişmesi amacıyla, evlat edinilmiş ve biyolojik aileleri yanında büyüyen çocuk ve ergenlerle ilgili bir çalışma planlanmıştır. Sizden kendi aileniz ile ilgili bilgilerin yanısıra **evlat edinme ile ilgili görüşlerinizi** de belirtmenizi istiyoruz.

Ailelerden gelen formların analizi sadece araştırmacı tarafından yapılacak, formlardaki cevaplar, kimlik ve iletişim bilgileri kesinlikle **gizli** tutulacaktır

Konu ile ilgili soruları yanıtladığınız ve katkılarınız için şimdiden teşekkür ediyoruz.

Uzm. Psk. İlkiz Altınoğlu Dikmeer

Formu dolduran: □ Anne □ Baba
Tarih: …….

Anne baba hakkında bilgiler (Tek ebeveynli aileler için: Lütfen sadece çocuğun şu an birlikte yaşadığı ebeveynle ilgili soruları yanıtlayınız)

	Anne	**Baba**
İsim:		
Yaş:		
Meslek:		
Eğitim Durumu:	□ Okuryazar değil □ Okuryazar □ İlkokul mezunu □ Ortaokul mezunu □ Lise mezunu □ 2 yıllık üniversite mezunu □ 4 yıllık üniversite mezunu □ Yüksek Lisans □ Doktora ve üstü	□ Okuryazar değil □ Okuryazar □ İlkokul mezunu □ Ortaokul mezunu □ Lise mezunu □ 2 yıllık üniversite mezunu □ 4 yıllık üniversite mezunu □ Yüksek Lisans □ Doktora ve üstü
Medeni durumunuz?	□ Evliyim □ Bekârım □ Eşimle ayrı yaşıyoruz □ Boşandım □ Eşimi kaybettim	
Ailenizin toplam geliri:	□ Ortalamanın çok altında □ Ortalamanın biraz altında □ Ortalama düzeyde □ Ortalamanın biraz üstünde □ Ortalamanın çok üstünde	

Hakkında form doldurduğunuz çocuğunuz ile ilgili bilgiler

Çocuğunuzun adı soyadı:	
Çocuğunuzun cinsiyeti:	□ Kız □ Erkek
Çocuğunuzun doğum tarihi:	
Çocuğunuzun şu andaki eğitim durumu:	□ Özel okul □ Devlet okulu Sınıf:
Çocuğunuzla ilgili olarak daha önce bir çocuk ruh sağlığı birimine başvurdunuz mu? Evet ise, ne zaman ve ne şikayetle başvurmuştunuz? Tedavisi devam ediyor mu?	□ Evet □ Hayır ....

Halen kullandığı bir ilaç varsa lütfen belirtiniz.	

Ailenin diğer bireyleri ile ilgili bilgiler
(Hakkında bu formu doldurduğunuz çocuğunuzdan başka çocuğunuz ya da evinizde anne baba ve çocuklar dışında sizinle birlikte yaşayan başka kimseler varsa lütfen belirtiniz)

Size yakınlığı (çocuk, büyükanne vs)	Yaşı	Cinsiyeti	Eğitimi	Mesleği

İki ebeveynli aileler için:
Aşağıdaki soruları yanıtlarken <u>Anne ve Baba'nın ayrı formlar</u> kullanmasını rica ediyoruz

ANNE FORMU

ÇOCUĞUNUZ İLE İLGİLİ GÖRÜŞLERİNİZ

Sizce çocuğunuz aile üyelerinden en çok kime yakındır?	1. 2. 3.
Çocuğunuzun 3 olumlu özelliğini yazınız. En çok beğendiğinizi lütfen daire içine alınız.	1. 2. 3.
Çocuğunuzun 3 olumsuz özelliğini yazınız. Sizi en çok rahatsız edeni daire içine alınız.	1. 2. 3.

EVLAT EDİNME İLE İLGİLİ GÖRÜŞLERİNİZ

1. Çevrenizde evlat edinmiş aileler var mı?	☐ Var ☐ Yok
2. Sizce kimler evlat edinebilir?	☐ Sadece çocuğu olmayanlar ☐ Biyolojik çocuğu olanlar da evlat edinebilir
3. Sizce biyolojik çocuğu olanların evlat edinmesi uygun mudur?	☐ Uygundur ☐ Uygun değildir
4. Sizce evlat edinmenin amacı nedir?	☐ Bir çocuğa yuva vermektir ☐ Başkasının bakmadığı çocuğuna bakmaktır
5. Sizce evlat edinmek dinen uygun mudur?	☐ Dinen uygundur ☐ Dinen uygun değildir
6. Siz bir çocuk evlat edinir miydiniz?	☐ Çocuğum olmasaydı düşünebilirdim ☐ Çocuğum olduğu halde düşünebilirim ☐ Böyle birşey asla söz konusu olamaz
7. Bir çocuk evlat edinmiş olsaydınız bunu çocuğunuza söyler miydiniz?	☐ Bunu çocuğumla paylaşırdım ☐ Bunu çocuğuma söylemez, saklardım
8. Bir çocuk evlat edinmiş olsaydınız bunu başkalarına söyler miydiniz?	☐ Bunu bizi tanıyan herkese söylerdim ☐ Bunu sadece yakınlarımıza söylerdim ☐ Bunu kimseyle paylaşmaz, gizlerdim
9. Şu anda çocuğunuzun evlat edinilmiş bir	☐ Onaylardım

arkadaşı olmasını onaylar mıydınız?	☐ Onaylamazdım
10. Bence evlat edinmek..... ……..….....	

İki ebeveynli aileler için:
Aşağıdaki soruları yanıtlarken <u>Anne ve Baba'nın ayrı formlar</u> kullanmasını rica ediyoruz

BABA FORMU

ÇOCUĞUNUZ İLE İLGİLİ GÖRÜŞLERİNİZ

Sizce çocuğunuz aile üyelerinden en çok kime yakındır?	1. 2. 3.
Çocuğunuzun 3 olumlu özelliğini yazınız. En çok beğendiğinizi lütfen daire içine alınız.	1. 2. 3.
Çocuğunuzun 3 olumsuz özelliğini yazınız. Sizi en çok rahatsız edeni daire içine alınız.	1. 2. 3.

EVLAT EDİNME İLE İLGİLİ GÖRÜŞLERİNİZ

1. Çevrenizde evlat edinmiş aileler var mı?	☐ Var ☐ Yok
2. Sizce kimler evlat edinebilir?	☐ Sadece çocuğu olmayanlar ☐ Biyolojik çocuğu olanlar da evlat edinebilir
3. Sizce biyolojik çocuğu olanların evlat edinmesi uygun mudur?	☐ Uygundur ☐ Uygun değildir
4. Sizce evlat edinmenin amacı nedir?	☐ Bir çocuğa yuva vermektir ☐ Başkasının bakmadığı çocuğuna bakmaktır
5. Sizce evlat edinmek dinen uygun mudur?	☐ Dinen uygundur ☐ Dinen uygun değildir
6. Siz bir çocuk evlat edinir miydiniz?	☐ Çocuğum olmasaydı düşünebilirdim ☐ Çocuğum olduğu halde düşünebilirim ☐ Böyle birşey asla söz konusu olamaz
7. Bir çocuk evlat edinmiş olsaydınız bunu çocuğunuza söyler miydiniz?	☐ Bunu çocuğumla paylaşırdım ☐ Bunu çocuğuma söylemez, saklardım
8. Bir çocuk evlat edinmiş olsaydınız bunu başkalarına söyler miydiniz?	☐ Bunu bizi tanıyan herkes bilirdi ☐ Bunu sadece yakınlarımıza söylerdim ☐ Bunu kimseyle paylaşmaz, gizlerdim
9. Şu anda çocuğunuzun evlat edinilmiş bir arkadaşı olmasını onaylar mıydınız?	☐ Onaylardım ☐ Onaylamazdım
10. Bence evlat edinmek.....	

APPENDIX D

CHILD BEHAVIOR CHECK LIST – CBCL / 6-18

6-18 YAŞ ÇOCUK VE GENÇLER İÇİN DAVRANIŞ DEĞERLENDİRME ÖLÇEĞİ

ID:

ÇOCUĞUN ADI, SOYADI	EV ADRESİNİZ VE TEL NO:	ANNE BABANIN İŞİ (Ayrıntılı biçimde yazınız, örneğin emekli ilkokul öğretmeni, şoför, oto tamircisi, avukat gibi.), EĞİTİMİ (Yıl olarak yazınız)
CİNSİYETİ: ⊔ ERKEK ⊔ KIZ	YAŞI:	BABANIN İŞİ:---------- TEL NO----------EĞİTİMİ:----------YAŞI-------
BUGUNUN TARIHI GÜN----AY------YIL------	ÇOCUĞUN DOĞUM TARİHİ AY------GÜN------YIL------	ANNENİN İŞİ:---------- TEL NO----------EĞİTİMİ:----------YAŞI:------ FORMU DOLDURAN: ⊔ ANNE---------- ⊔ BABA---------- ⊔ DİĞER----------Çocukla olan ilişkisi ----------
SINIFI:---------- OKULA DEVAM ETMİYOR ⊔		

I. Çocuğunuzun yapmaktan en çok hoşlandığı sporları sıralayınız Örnegin:Yüzme, futbol, basketbol, voleybol, atletizm, tekvando, jimnastik, bisiklete binme. güreş, balık tutma gibi.

⊔ Hiçbiri

	Çocuğunuz her birine ne kadar zaman ayırır ?				Çocuğunuz her birinde ne kadar başarılıdır?			
	Normalden az	**normal**	**Normalden fazla**	**bilmiyorum**	**Normalden az**	**normal**	**Normalden fazla**	**bilmiyorum**
a._____	⊔	⊔	⊔	⊔	⊔	⊔	⊔	⊔
b._____	⊔	⊔	⊔	⊔	⊔	⊔	⊔	⊔
c._____	⊔	⊔	⊔	⊔	⊔	⊔	⊔	⊔

II. Çocuğunuzun spor dışındaki ilgi alanları, uğraş, oyun ve aktivitelerini sıralayınız. Örneğin: Pul, bebek, araba, akvaryum, el işi, kitap, satranç, müzik aleti çalmak, şarkı söylemek, esim yapmak gibi (Radyo dinlemeyi ya da televizyon izlemeyi katmayınız)

⊔ Hiçbiri

	Çocuğunuz her birine ne kadar zaman ayırır ?				Çocuğunuz her birinde ne kadar başarılıdır?			
	Normalden az	**normal**	**Normalden fazla**	**bilmiyorum**	**Normalden az**	**normal**	**Normalden fazla**	**bilmiyorum**
a._____	⊔	⊔	⊔	⊔	⊔	⊔	⊔	⊔
b._____	⊔	⊔	⊔	⊔	⊔	⊔	⊔	⊔
c._____	⊔	⊔	⊔	⊔	⊔	⊔	⊔	⊔

III. Çocuğunuzun üyesi olduğu kuruluş, kulüp, takım ya da grupları sıralayınız. (Spor, müzik, lzcilik, folklor gibi.)

⊔ Hiçbiri

	Bilmiyorum	**Az Aktif**	**Normal**	**Çok Aktif**
	Çocuğunuz her birinde ne kadar aktiftir?			
a._____	⊔	⊔	⊔	⊔
b._____	⊔	⊔	⊔	⊔
c._____	⊔	⊔	⊔	⊔

****FULL COPY OF THE SCALE IS NOT PROVIDED HERE. FOR THE FULL COPY PLEASE CONTACT PROF. DR. NEŞE EROL AT ANKARA UNIVERSITY MEDICAL SCHOOL, DEPARTMENT OF CHILD PSYCHIATRY.****

Aşağıda çocukların özelliklerini tanımlayan bir dizi madde bulunmaktadır. Her bir madde **çocuğunuzun şu andaki ya da son 6 ay** içindeki durumunu belirtmektedir. Bir madde çocuğunuz **için çok ya da sıklıkla doğru ise 2, bazen ya da biraz doğru ise 1, hiç doğru değilse 0 s**ayılarını yuvarlak içine alınız. Lütfen tüm maddeleri işaretlemeye çalışınız.

0: Doğru Değil (Bildiğiniz kadarıyla) **1: Bazen ya da Biraz Doğru** **2: Çok ya da Sıklıkla Doğru**

0 1 2 1. Yaşından daha küçük gibi davranır

0 1 2 2. Büyüklerin izni olmadan içki içer

0 1 2 3. Çok tartışır

0 1 2 4. Başladığı işleri bitiremez

0 1 2 5. Çok az şeyden hoşlanır

0 1 2 6. Kakasını tuvaletten başka yerlere yapar

0 1 2 7. Övünür, yüksekten atar, hava yapar

0 1 2 8. Dikkatini uzun süre bir konu üzerinde toplayamaz ve sürdüremez

0 1 2 9. Bazı düşünceleri zihninden bir türlü atamaz (açıklayınız):

---

0 1 2 10.Yerinde rahat oturamaz, huzursuz ve çok hareketlidir

0 1 2 11. Yetişkinlerin dizinin dibinden ayrılmaz, onlara çok bağımlıdır

0 1 2 12. Yalnızlıktan yakınır

0 1 2 13. Kafası karmakarışıktır

0 1 2 14. Çok ağlar

0 1 2 15. Hayvanlara eziyet eder

0 1 2 16. Başkalarına eziyet eder, zalimce ve kötü davranır

0 1 2 17. Hayal kurar, düşüncelerinde kaybolur

0 1 2 18. İsteyerek kendine zarar verir ya da intihar girişiminde bulunur

0 1 2 19. Hep dikkat çekmek ister

0 1 2 20. Eşyalarına zarar verir

0 1 2 21. Ailesine ya da başkalarına ait eşyalara zarar verir

0 1 2 22. Evde söz dinlemez, evin kurallarına uymaz

0 1 2 23. Okulda söz dinlemez, okul kurallarına uymaz

0 1 2 24. İştahsızdır, az yemek yer

0 1 2 25.Diğer çocuklarla geçinemez

0 1 2 26. Hatalı davranışından dolayı suçluluk duymaz

0 1 2 27. Kolay kıskanır

0 1 2 28. Ev, okul ya da diğer yerlerde kuralları çiğner

0 1 2 29. Bazı hayvanlardan ve okul dışı ortamlardan ya da yerlerden korkar (açıklayınız): ----------

---

0 1 2 30. Okula gitmekten korkar

0 1 2 31. Kötü bir şey düşünmek ya da yapmaktan korkar

0 1 2 32. Mükemmel olmasının gerektiğine inanır

0 1 2 33.Kimsenin onu sevmediğini düşünür ve bundan yakınır

0 1 2 34. Başkalarının ona zarar vermeye, kötülük yapmaya çalıştığını düşünür

0 1 2 35. Kendini değersiz, yetersiz hisseder

0 1 2 36. Çok sık bir yerlerini incitir, başı kazadan kurtulmaz

0 1 2 37. Çok kavga, dövüş eder

0 1 2 38. Sıklıkla onunla alay edilir, dalga geçilir

0 1 2 39. Başı belada olan kişilerle dolaşır

0 1 2 40. Olmayan sesler ve konuşmalar işitir (açıklayınız):

---

0 1 2 41. Düşünmeden ya da aniden hareket eder (Aklına eseni yapar)

0 1 2 42. Başkaları ile birlikte olmaktansa yalnız kalmayı tercih eder

0 1 2 43. Yalan söyler ve hile yapar

0 1 2 44. Tırnaklarını yer

0 1 2 45. Sinirli ve gergindir

0 1 2 46. Kasları oynar, seğirir, tikleri vardır:

---

0 1 2 47. Gece kabusları, korkulu rüyalar görür

0 1 2 48. Diğer çocuklar tarafından sevilmez

0 1 2 49. Kabızlık çeker

0 1 2 50. Çok korkak ve kaygılıdır

0 1 2 51. Baş dönmesi vardır

0 1 2 52. Kendini çok suçlar

0 1 2 53. Aşırı yemek yer

0 1 2 54. Sebepsiz yere aşırı yorgundur

0 1 2 55. Çok kiloludur

56. Tıbbi nedeni bilinmeyen bedensel şikayetleri vardır:

0 1 2 a. Ağrılar, sızılar (baş ve karın ağrısı dışında)

0 1 2 b. Başağrıları

0 1 2 c. Bulantı, kusma hissi

0 1 2 d. Gözle ilgili yakınmalar (Görme bozukluğu dışında açıklayınız):

---

0 1 2 e. Döküntüler ya da başka cilt sorunları

0 1 2 f. Mide- karın ağrısı

0 1 2 g. Kusma

33. Hiç kimsenin onu sevmediğine inanır ve

0 1 2 h. Diğer (açıklayınız): ----------

APPENDIX E
SCHOOL AGE TEMPERAMENT INVENTORY (SATI)

OKUL ÇAĞI ÇOCUKLARI İÇİN MİZAÇ ÖLÇEĞİ

Lütfen aşağıdaki ölçeği kullanarak çocuğunuzun belirtilen davranışı ne sıklıkla yaptığını, her ifadenin karşısındaki uygun rakamı daire içine alarak belirtiniz.

HİÇBİR ZAMAN 1	NADİREN 2	ZAMAN ZAMAN 3	SIKLIKLA 4	HER ZAMAN 5

1.Evin içinde bir odadan diğerine giderken sessizce hareket eder.	**1**	**2**	**3**	**4**	**5**
2.Aradığı birşeyi bulamadığında sinirlenir.	**1**	**2**	**3**	**4**	**5**
3.Tanımasa bile kendi yaşındaki diğer çocuklara yaklaşır.	**1**	**2**	**3**	**4**	**5**
4.Başladığı bir işi bitirmeden diğerine geçer.	**1**	**2**	**3**	**4**	**5**
5.Aynı fikri paylaşmadığında bunu sessiz ve sakin bir tavırla idafe eder.	**1**	**2**	**3**	**4**	**5**
6.Arkadaşlarının araması veya gelmesi nedeniyle ara verdiği sorumluluklarına (ev ödevi, ev işi gibi), onlar gittikten sonra devam eder.	**1**	**2**	**3**	**4**	**5**
7. Evine gelen tanımadığı yetişkinlere karşı güleryüzlüdür.	**1**	**2**	**3**	**4**	**5**
8. Hatırlatılmadığı sürece ödevlerini tamamlamaz.	**1**	**2**	**3**	**4**	**5**
9. Tanımadığı yetişkinlerin yanında utangaç davranır.	**1**	**2**	**3**	**4**	**5**
10. Kendisine yapılan hafif bir eleştiri bile onu çok kızdırır.	**1**	**2**	**3**	**4**	**5**
11. Kendi başladığı işleri (resim, model, el işi gibi) bitirmeden yarım bırakır.	**1**	**2**	**3**	**4**	**5**
12. Yeni karşılaştığı durumlarda (akraba ziyareti, yeni oyun arkadaşları gibi) endişeli ve kaygılı görünür.	**1**	**2**	**3**	**4**	**5**
13. Eve girip çıkarken koşar.	**1**	**2**	**3**	**4**	**5**
14. Hayalkırıklığı veya başarısızlık yaşadığında şiddetli tepkiler gösterir (ağlar veya yüksek sesle şikayet eder).	**1**	**2**	**3**	**4**	**5**
15. Yaptığı bir iş ya da projede engellenmişlik yaşar, öfkelenir ve işi yarım bırakır.	**1**	**2**	**3**	**4**	**5**
16. Hatırlatmaya gerek kalmadan ödevlerini yapar.	**1**	**2**	**3**	**4**	**5**
17. Kendisiyle alay edildiğinde sinirlenir.	**1**	**2**	**3**	**4**	**5**
18. Kendi sorumluluğundaki günlük ev işlerini bitirmeden yarım bırakır.	**1**	**2**	**3**	**4**	**5**
19. Odaya gürültüyle, paldır küldür girer.	**1**	**2**	**3**	**4**	**5**
20. Bir hata yaptığında engellenmişlik yaşar ve öfkelenir.	**1**	**2**	**3**	**4**	**5**
21. Yeni tanıştığı çocuklara karşı çekingen davranır.	**1**	**2**	**3**	**4**	**5**

HİÇBİR ZAMAN 1	NADİREN 2	ZAMAN ZAMAN 3	SIKLIKLA 4	HER ZAMAN 5

22. Ödevleri ile bitirene kadar uğraşır.	**1**	**2**	**3**	**4**	**5**
23. Sinirlendiğinde karşısındakine bağırır veya kırıcı konuşur.	**1**	**2**	**3**	**4**	**5**
24. Merdivenleri koşarak veya zıplayarak iner cıkar.	**1**	**2**	**3**	**4**	**5**
25. Yapmakta olduğu iş (ev ödevi, ev işi gibi) bölünse bile tekrar geri döner.	**1**	**2**	**3**	**4**	**5**
26. Yanlış bir davranışının düzeltilmesinden hoşlanmaz.	**1**	**2**	**3**	**4**	**5**
27. Dükkan, sinema veya oyun salonu gibi yeni mekanlara çekinmeden girer.	**1**	**2**	**3**	**4**	**5**
28. Ulaşmak istediği yere koşarak gider.	**1**	**2**	**3**	**4**	**5**
29. Onay almadığı duurmlarda şiddetli tepkiler gösterir (bağırır, ağlar gibi)	**1**	**2**	**3**	**4**	**5**
30. Kendisine verilen işleri (ev ödevi, ev işi gibi) tamamlamakta zorlanır.	**1**	**2**	**3**	**4**	**5**
31. Yeni biri ile tanışmak yerine, tanıdığı biri ile oynamayı tercih eder.	**1**	**2**	**3**	**4**	**5**
32. Kızgın olduğunda yüksek sesler çıkarır (kapıları hızla çarpar, eşyalara vurur, bağırır gibi)	**1**	**2**	**3**	**4**	**5**
33. Daha önceden yapılmış olan planlarda bir değişiklik olduğunda sinirlenir.	**1**	**2**	**3**	**4**	**5**
34. Eve tanımadığı misafirler geldiğinde uzak durur, onlarla yakınlaşmaz ve konuşmaz.	**1**	**2**	**3**	**4**	**5**
35. Çoğu zaman sanki bir yere yetişecekmiş gibi oldukça telaşlı bir hali vardır.	**1**	**2**	**3**	**4**	**5**
36. Zor bir iş ile karşılaştığında kolaylıkla pes eder.	**1**	**2**	**3**	**4**	**5**
37. Aksi, mutsuz veya huysuz olduğu günleri vardır.	**1**	**2**	**3**	**4**	**5**
38. İlk kez gittiği bir evde kendini rahat hissetmiyormuş gibi görünür.	**1**	**2**	**3**	**4**	**5**

APPENDIX F

MEASURE OF CHILD REARING STYLES (MCRS)

ÇOCUK YETİŞTİRME STİLLERİ ÖLÇEĞİ

Aşağıda, kızınızla / oğlunuzla olan ilişkileriniz hakkında cümleler verilmiştir. Sizden istenen, **genel olarak çocuğunuzla ilişkinizi düşünerek** her bir cümlenin **sizin için** ne derece doğru olduğunu ilgili yeri işaretleyerek belirtmenizdir. Hiçbir maddenin doğru veya yanlış cevabı yoktur. Önemli olan kendi çocuğunuza uyguladığınız çocuk yetiştirme yöntemini dikkate alarak kendinizi doğru bir şekilde yansıtmanızdır.

Formu dolduran: ( ) Anne ( ) Baba

	hiç doğru değil (1)	doğru değil (2)	biraz doğru (3)	çok doğru (4)
1.Çocuğumla sık sık rahatlatıcı bir şekilde konuşurum				
2.Her davranışını sıkı sıkıya kontrol etmek isterim				
3.Çocuğuma nasıl davranacağı ya da ne yapacağı konusunda her zaman yararlı fikirler veririm				
4. Onun, benim istediğim hayatı yaşaması konusunda ısrarlıyım				
5. Çocuğuma, sorunları olduğunda onları daha açık bir şekilde görmesinde her zaman yardımcı olurum				
6.Arkadaşlarıyla ilişkilerine karışırım				
7.Sorunlarını çözmesinde çocuğuma destek olurum				
8.Benimkinden farklı bir görüşe sahip olmasına genellikle tahammül edemem				
9.Çocuğum sevgi ve yakınlığıma her zaman güvenir				
10.Kurallarıma aykırı davrandığında onu kolaylıkla affetmem				
11.Çocuğumla aramızda fazla yakın bir ilişkimiz yoktur				
12.Ne zaman, ne yapması gerektiği konusunda talimat veririm				
13.Bir problemi olduğunda bana anlatmaktansa, kendisine saklamayı tercih eder				
14. Geç saatlere kadar oturmasına izin vermem				
15. Çocuğumla birbirimize çok bağlıyız				
16. Arkadaşlarıyla geç saate kadar dışarıda kalmasına izin vermem				
17. Benim düşüncelerime ters gelen bir şey yaptığında onu suçlamam				
18. Boş zamanlarını nasıl değerlendireceğine karışırım				
19. Bir sorunu olduğunda bunu hemen anlarım				
20. Hangi saatte hangi arkadaşıyla buluşacağını bilmek isterim				
21. Onun ne hissettiği veya ne düşündüğü ile pek ilgilenmem				
22. Arkadaşlarıyla dışarı çıkmasına nadiren izin veririm				

ÇOCUK YETİŞTİRME STİLLERİ ÖLÇEĞİ

(ANNEM VE BEN)

Aşağıda, annen ile olan ilişkileriniz hakkında cümleler verilmiştir. Senden, **genel olarak annenle ilişkinizi düşünerek** her bir cümlenin **senin için** ne derece doğru olduğunu ilgili yeri işaretleyerek belirtmeni istiyoruz. Hiçbir maddenin doğru veya yanlış cevabı yoktur. Önemli olan her cümle ile ilgili olarak kendi durumunu doğru bir şekilde yansıtmandır.

	A N N E M			
	hiç doğru değil (1)	doğru değil (2)	biraz doğru (3)	çok doğru (4)
1. Annem, benimle sık sık rahatlatıcı bir şekilde konuşur				
2. Annem, her davranışımı sıkı sıkıya kontrol etmek ister				
3. Annem, nasıl davranacağım ya da ne yapacağım konusunda bana hep yararlı fikirler verir				
4. Annem, onun istediği hayatı yaşamam konusunda hep ısrarlı olur				
5. Annem, sorunlarım olduğunda onları daha açık bir şekilde görmemde hep yardımcı olur				
6. Annem, arkadaşlarımla ilişkilerime çok karışır				
7. Annem, sorunlarımı çözmemde destek olur				
8. Annem, onunkinden farklı bir görüşe sahip olmama genellikle dayanamaz				
9. Annemin sevgi ve yakınlığına her zaman güvenirim				
10. Annem, kurallarına aykırı davrandığımda beni kolaylıkla affetmez				
11. Annemle fazla yakın bir ilişkimiz yoktur				
12. Annem, ne zaman, ne yapmam gerektiği konusunda talimat verir				
13. Bir problemim olduğunda anneme anlatmaktansa, kendime saklamayı tercih ederim				
14. Annem, geç saatlere kadar oturmama izin vermez				
15. Annemle birbirimize çok bağlıyız				
16. Annem, arkadaşlarımla geç saate kadar dışarıda kalmama izin vermez				
17. Annem, Onun düşüncelerine ters gelen bir şey yaptığımda beni suçlamaz				
18. Annem, boş zamanlarımı nasıl değerlendireceğime karışır				
19. Bir sorunum olduğunda annem bunu hemen anlar				
20. Annem, hangi saatte hangi arkadaşımla buluşacağımı bilmek ister				
21. Annem, benim ne hissettiğimle veya ne düşündüğümle gerçekten ilgilenmez				
22. Annem, arkadaşlarımla dışarı çıkmama nadiren izin verir				

ÇOCUK YETİŞTİRME STİLLERİ ÖLÇEĞİ
(BABAM VE BEN)

Aşağıda, baban ile olan ilişkileriniz hakkında cümleler verilmiştir. Senden, **genel olarak babanla ilişkinizi düşünerek** her bir cümlenin **senin için** ne derece doğru olduğunu ilgili yeri işaretleyerek belirtmeni istiyoruz. Hiçbir maddenin doğru veya yanlış cevabı yoktur. Önemli olan her cümle ile ilgili olarak kendi durumunu doğru bir şekilde yansıtmandır.

	B A B A M			
	hiç doğru değil (1)	doğru değil (2)	biraz doğru (3)	çok doğru (4)
1. Babam, benimle sık sık rahatlatıcı bir şekilde konuşur				
2. Babam, her davranışımı sıkı sıkıya kontrol etmek ister				
3. Babam, nasıl davranacağım ya da ne yapacağım konusunda bana hep yararlı fikirler verir				
4. Babam, onun istediği hayatı yaşamam konusunda hep ısrarlı olur				
5. Babam, sorunlarım olduğunda onları daha açık bir şekilde görmemde hep yardımcı olur				
6. Babam, arkadaşlarımla ilişkilerime çok karışır				
7. Babam, sorunlarımı çözmemde destek olur				
8. Babam, onunkinden farklı bir görüşe sahip olmama genellikle dayanamaz				
9. Babamın sevgi ve yakınlığına her zaman güvenirim				
10. Babam, kurallarına aykırı davrandığımda beni kolaylıkla affetmez				
11. Babamla fazla yakın bir ilişkimiz yoktur				
12. Babam, ne zaman, ne yapmam gerektiği konusunda talimat verir				
13. Bir problemim olduğunda babama anlatmaktansa, kendime saklamayı tercih ederim				
14. Babam, geç saatlere kadar oturmama izin vermez				
15. Babamla birbirimize çok bağlıyız				
16. Babam, arkadaşlarımla geç saate kadar dışarıda kalmama izin vermez				
17. Babam, Onun düşüncelerine ters gelen bir şey yaptığımda beni suçlamaz				
18. Babam, boş zamanlarımı nasıl değerlendireceğime karışır				
19. Bir sorunum olduğunda babam bunu hemen anlar				
20. Babam, hangi saatte hangi arkadaşımla buluşacağımı bilmek ister				
21. Babam, benim ne hissettiğimle veya ne düşündüğümle gerçekten ilgilenmez				
22. Babam, arkadaşlarımla dışarı çıkmama nadiren izin verir				

APPENDIX G

BASIC PERSONALITY TRAITS INVENTORY (BPTI)

Formu Dolduran: ( ) Anne ( ) Baba

TÜRK KÜLTÜRÜNDE GELİŞTİRİLMİŞ TEMEL KİŞİLİK ÖZELLİKLERİ ÖLÇEĞİ

YÖNERGE: Aşağıda size uyan ya da uymayan pek çok kişilik özelliği bulunmaktadır. Bu özelliklerden her birinin sizin için ne kadar uygun olduğunu ilgili rakamı daire içine alarak belirtiniz.

Örneğin;
Kendimi ..... biri olarak görüyorum.

Hiç uygun değil	**Uygun değil**	**Kararsızım**	**Uygun**	**Çok uygun**
1	**2**	**3**	**(4)**	**5**

		Hiç uygun değil	Uygun değil	Kararsızım	Uygun	Çok uygun
1	Aceleci	1	2	3	4	5
2	Yapmacık	1	2	3	4	5
3	Duyarlı	1	2	3	4	5
4	Konuşkan	1	2	3	4	5
5	Kendine güvenen	1	2	3	4	5
6	Soğuk	1	2	3	4	5
7	Utangaç	1	2	3	4	5
8	Paylaşımcı	1	2	3	4	5
9	Geniş / rahat	1	2	3	4	5
10	Cesur	1	2	3	4	5
11	Agresif	1	2	3	4	5
12	Çalışkan	1	2	3	4	5
13	İçten pazarlıklı	1	2	3	4	5
14	Girişken	1	2	3	4	5
15	İyi niyetli	1	2	3	4	5
16	İçten	1	2	3	4	5
17	Kendinden emin	1	2	3	4	5
18	Huysuz	1	2	3	4	5
19	Yardımsever	1	2	3	4	5
20	Kabiliyetli	1	2	3	4	5
21	Üşengeç	1	2	3	4	5
22	Sorumsuz	1	2	3	4	5
23	Sevecen	1	2	3	4	5
24	Pasif	1	2	3	4	5
25	Disiplinli	1	2	3	4	5
26	Açgözlü	1	2	3	4	5
27	Sinirli	1	2	3	4	5
28	Cana yakın	1	2	3	4	5
29	Kızgın	1	2	3	4	5
30	Sabit fikirli	1	2	3	4	5
31	Görgüsüz	1	2	3	4	5
32	Durgun	1	2	3	4	5
33	Kaygılı	1	2	3	4	5
34	Terbiyesiz	1	2	3	4	5
35	Sabırsız	1	2	3	4	5
36	Yaratıcı	1	2	3	4	5
37	Kaprisli	1	2	3	4	5
38	İçine kapanık	1	2	3	4	5
39	Çekingen	1	2	3	4	5
40	Alıngan	1	2	3	4	5
41	Hoşgörülü	1	2	3	4	5
42	Düzenli	1	2	3	4	5
43	Titiz	1	2	3	4	5
44	Tedbirli	1	2	3	4	5
45	Azimli	1	2	3	4	5

APPENDIX H

YOUTH SELF REPORT (YSR)

11-18 YAŞ GENÇLER İÇİN KENDİNİ DEĞERLENDİRME ÖLÇEĞİ

ID:

ADINIZ, SOYADINIZ	**ADRESİNİZ :**	**ANNE BABANIZIN İŞİ (Ayrıntılı biçimde yazınız, örneğin emekli ilkokul öğretmeni, şoför, oto tamircisi, avukat gibi.), EĞİTİMİ (Yıl olarak yazınız)**
CİNSİYETİNİZ: **⊔ ERKEK ⊔ KIZ**	**YAŞINIZ:**	**BABA İŞ:---------- TEL NO----------EĞİTİM:----------YAŞ:---------** **ANNE İŞ:---------- TEL NO----------EĞİTİM:----------YAŞ:--------**
BUGUNUN TARIHI **GÜN----AY------YIL-----**	**DOĞUM TARİHİNİZ** AY------GÜN------YIL------	
OKULUNUZUN ADI :---------- **SINIFINIZ:----------** **OKULA DEVAM ETMİYORUM** **⊔**	**ÇALIŞIYORSANIZ, İŞİNİZİ BELİRTİNİZ.**	**Lütfen bu formu görüşlerinizi yansıtacak biçimde içinizden geldiği gibi doldurunuz. Her bir madde ile ilgili ek bilgi verebilir ve bunları 2. ve 4. sayfadaki boşluklara yazabilirsiniz.** **Teşekkürlerimizle.**

I. Yapmaktan en çok hoşlandığınız sporları sıralayınız.
Örnegin:Yüzme, futbol, basketbol, voleybol, atletizm, tekvando, jimnastik, bisiklete binme, güreş, balık tutma gibi.

⊔ Hiçbiri

	Herbirine ne kadar zaman ayırırsınız?			Herbirinde ne kadar başarılısınız?		
	Normalden az	**normal**	**Normalden fazla**	**Normalden az**	**normal**	**Nomalden fazla**
a._____	⊔	⊔	⊔	⊔	⊔	⊔
b._____	⊔	⊔	⊔	⊔	⊔	⊔
c._____	⊔	⊔	⊔	⊔	⊔	⊔

II. Spor dışı ilgi alanları, uğraş, oyun ve aktivitelerinizi sıralayınız. Örneğin: Kitap okumak, müzik aleti çalmak, şarkı söylemek, resim yapmak, arabalar ile uğraş, el sanatları gibi (Radyo dinlemeyi ya da televizyon izlemeyi katmayınız).

⊔ Hiçbiri

	Herbirine ne kadar zaman ayırırsınız?			Herbirinde ne kadar başarılısınız?		
	Normalden az	**normal**	**Normalden fazla**	**Normalden az**	**normal**	**Nomalden fazla**
a._____	⊔	⊔	⊔	⊔	⊔	⊔
b._____	⊔	⊔	⊔	⊔	⊔	⊔
c._____	⊔	⊔	⊔	⊔	⊔	⊔

III. Üyesi olduğunuz kuruluş, klüp, takım ya da grupları sıralayınız (Spor, müzik, izcilik, folklor gibi.)
Yaşıtlarınızla karşılaştırdığınızda her birinde ne kadar aktifsiniz?

⊔ Hiçbiri

	Az Aktif	**Normal**	**Çok Aktif**
a._____	⊔	⊔	⊔
b._____	⊔	⊔	⊔
c._____	⊔	⊔	⊔

Türkçe Çeviri ve Uyarlaması: Neşe Erol tarafından T.M. Achenbach'ın izniyle yapılmış ve basılmıştır (2002).
Ankara Üniversitesi Tıp Fakültesi Çocuk Ruh Sağlığı ve Hastalıkları Ana Bilim Dalı
6-1-01 Baskısı-501

****FULL COPY OF THE SCALE IS NOT PROVIDED HERE. FOR THE FULL COPY PLEASE CONTACT PROF. DR. NEŞE EROL AT ANKARA UNIVERSITY MEDICAL SCHOOL, DEPARTMENT OF CHILD PSYCHIATRY.****

Aşağıda gençleri tanımlayan bir dizi madde bulunmaktadır. Her bir madde sizin **şu andaki ya da son 6 ay içindeki** durumunuzu belirtmektedir. Bir madde sizin için **çok ya da sıklıkla doğru ise 2, bazen ya da biraz doğru ise 1, hiç doğru değilse 0** sayılarını yuvarlak içine alarak tüm maddeleri işaretlemeye çalışınız.

0: Doğru Değil (Bildiğiniz kadarıyla) **1: Bazen ya da Biraz Doğru** **2: Çok ya da Sıklıkla**

0 1 2 1. Yaşımdan daha küçük gibi davranırım

0 1 2 2. Büyüklerimin izni olmadan içki içerim

0 1 2 3. Çok tartışırım

0 1 2 4. Başladığım işleri bitiremem

0 1 2 5. Çok az şeyden hoşlanırım

0 1 2 6. Hayvanları severim

0 1 2 7. Yüksekten atar, övünürüm

0 1 2 8. Dikkatimi toplamakta ya da sürdürmekte güçlük çekerim

0 1 2 9. Bazı düşünceleri zihnimden bir türlü atamam (açıklayınız):

---

0 1 2 10.Yerimde oturmakta güçlük çekerim

0 1 2 11. Yetişkinlere çok bağımlıyımdır

0 1 2 12. Yalnızlık hissederim

0 1 2 13. Kafam karmakarışıktır

0 1 2 14. Çok ağlarım

0 1 2 15. Oldukça dürüstümdür

0 1 2 16. Başkalarına kötü davranırım

0 1 2 17. Çok fazla hayal kurarım

0 1 2 18. İsteyerek kendime zarar verir, kendimi öldürmeye çalışırım

0 1 2 19. Hep dikkat çekmek isterim

0 1 2 20. Eşyalarıma zarar veririm

0 1 2 21. Başkalarına ait eşyalara zarar veririm

0 1 2 22. Evde büyüklerimin sözünü dinlemem

0 1 2 23. Okulda söylenenleri yapmam

0 1 2 24. Yiyebileceğimden az yerim

0 1 2 25.Diğer çocuklarla geçinemem

0 1 2 26. Hatalı davrandığımda suçluluk duymam

0 1 2 27. Başkalarını kıskanırım

0 1 2 28. Ev, okul ya da diğer yerlerde kuralları çiğnerim

0 1 2 29. Bazı hayvanlardan ve okul dışı ortamlardan ya da yerlerden korkarım (açıklayınız):

---

0 1 2 30. Okula gitmekten korkarım

0 1 2 31. Kötü bir şey düşünmek ya da yapmaktan korkarım

0 1 2 32. Mükemmel olmam gerektiğine inanırım

0 1 2 33. Kimsenin beni sevmediğini düşünürüm

0 1 2 34. Başkalarının bana zarar vermeye, kötülük yapmaya çalıştığını düşünürüm

0 1 2 35. Kendimi değersiz ve yetersiz hissederim

0 1 2 36. Bir yerlerimi sık sık incitirim, başım kazadan kurtulmaz

0 1 2 37. Çok kavga, dövüş ederim

0 1 2 38. Benimle çok alay edilir, dalga geçilir

0 1 2 39. Başı belada olan kişilerle dolaşırım

0 1 2 40. Başkalarının işitmediği sesler ve konuşmalar işitirim (açıklayınız):

0 1 2 41. Düşünmeden hareket ederim

0 1 2 42. Başkaları ile birlikte olmaktansa yalnız kalmayı tercih ederim----------

0 1 2 43. Yalan söyler ve hile yaparım

0 1 2 44. Tırnaklarımı yerim

0 1 2 45. Sinirli ve gerginimdir

0 1 2 46. Bedenimin bazı kısımlarında kas seyirmeleri, oynamaları ve tikler vardır (göz tiki gibi):

-

0 1 2 47. Gece kabusları, korkulu rüyalar görürüm

0 1 2 48. Arkadaşlarım tarafından sevilmem

0 1 2 49. Bazı şeyleri pek çok çocuktan daha iyi yaparım

0 1 2 50. Çok korkak ve kaygılıyımdır

0 1 2 51. Başım döner

0 1 2 52. Kendimi çok suçlarım

0 1 2 53. Çok fazla yemek yerim

0 1 2 54. Sebepsiz yere yorgun hissederim

0 1 2 55. Aşırı kiloluyum

56. Tıbbi nedeni bilinmeyen bedensel yakınmalarım vardır. Örneğin :

0 1 2 a. Ağrılar, sızılar (başağrısı ve karın ağrısı dışında)

0 1 2 b. Başağrıları

0 1 2 c. Bulantı, kusma hissi

0 1 2 d. Gözle ilgili şikayetler (Görme bozukluğu dışında- açıklayınız):

--

0 1 2 e. Döküntüler ya da başka cilt sorunları

0 1 2 f. Mide- karın ağrısı

0 1 2 g. Kusma

0 1 2 h. Diğer (açıklayınız):

APPENDIX I

KERNS SECURITY SCALE (KSS)

Nasıl Biriyim? (Annem ve Ben)

Şimdi sana seninle ve annenle ilgili bazı sorular soracağız. Senin ve annenin nasıl insanlar olduğunuzu merak ediyoruz. Öncelikle sana bu soruların nasıl cevaplanacağını anlatayım. Her soru iki tür çocuktan söz ediyor ve bu çocuklardan hangisinin sana en çok benzediğini bilmek istiyoruz.

İşte bir örnek soru:

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **boş zamanlarında dışarıda oynamayı** tercih ederler	**AMA**	Bazı çocuklar da **televizyon seyretmeyi** tercih ederler	Bana biraz benziyor ☐	Bana çok benziyor ☐

Senden istediğim önce dışarıda oynamayı tercih eden sol taraftaki çocuklara mı yoksa televizyon seyretmeyi seven sağ taraftaki çocuklara mı daha çok benzediğine karar vermek. Henüz bir şeyleri işaretleme. Sadece hangi çocuğun sana daha çok benzediğine karar ver ve cümlenin o tarafına git. Şimdi de, seçtiğin çocuğun sana çok mu benzediğine yoksa sana biraz mı benzediğine karar ver ve bunun altındaki kutucuğu işaretle.

Her bir cümle için sadece bir tane kutucuğu işaretleyeceksin. O da senin hakkında en doğru olan ve senin en çok benzediğin ifade olacak.

(Eğer hem annen hem de üvey annen varsa, birlikte yaşadığın hangisiyse ona göre cevap ver.)

1.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **annelerine kolayca güvenirler**.	**AMA**	Bazı çocuklar da **annelerine güvenip güvenemeyecekleri konusunda emin değildirler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

2.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **yaptıkları her şeye annelerinin çok karıştıklarını** hisseder.	**AMA**	Bazı çocuklar da **annelerinin kendi başlarına bir şeyler yapmalarına izin verdiklerini** hissederler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

3.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocukların **annelerinin kendilerine yardım edeceklerine inanmaları** kolaydır.	**AMA**	Bazı çocuklar için ise **annelerine inanmak zordur.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

4.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **annelerinin onlarla yeterince zaman geçirdiklerini** düşünürler.	**AMA**	Bazı çocuklar da **annelerinin onlarla yeterince zaman geçirmediklerini** düşünürler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

5.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar annelerine ne düşündüklerini veya hissettiklerini **söylemekten pek hoşlanmazlar**.	**AMA**	Bazı çocuklar da annelerine ne düşündüklerini veya hissettiklerini **söylemekten hoşlanırlar.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

6.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar annelerine **çok fazla** ihtiyaç duymaz.	**AMA**	Bazı çocuklar da annelerine **çoğu şey için** ihtiyaç duyar.	Bana biraz benziyor ☐	Bana çok benziyor ☐

7.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **"Keşke anneme daha yakın olabilseydim"** derler.	**AMA**	Bazı çocuklar da **annelerine olan yakınlıklarıyla mutludurlar.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

8.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **annelerinin onları gerçekten sevmediklerinden** endişe duyarlar.	**AMA**	Bazı çocuklar da **annelerinin onları sevdiklerinden gerçekten emindirler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

9.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **annelerinin onları gerçekten anladıklarını** hissederler.	**AMA**	Bazı çocuklar da **annelerinin onları gerçekten anlamadıklarını** hissederler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

10.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **annelerinin onları terk etmeyeceklerinden gerçekten emindirler.**	**AMA**	Bazı çocuklar da bazen, **annelerinin onları terk edebileceğinden endişelenirler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

11.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **ihtiyaç duyduklarında annelerinin yanlarında olamayacaklarını düşünerek** endişelenirler.	**AMA**	Bazı çocuklar da **ihtiyaç duyduklarında annelerinin yanlarında olacaklarından** emindirler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

12.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar annelerinin **onları dinlemediklerini** düşünürler.	**AMA**	Bazı çocuklar da annelerinin **onları gerçekten dinlediklerini** düşünürler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

13.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **üzgün olduklarında annelerinin yanlarına giderler.**	**AMA**	Bazı çocuklar da **üzgün olduklarında annelerinin yanlarına gitmezler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

14.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **"Keşke annem sorunlarımla daha çok ilgilense"** derler.	**AMA**	Bazı çocuklar da **annelerinin onlara yeterince yardım ettiklerini** düşünürler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

15.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **anneleri etrafta olduklarında** kendilerini daha iyi hissederler.	**AMA**	Bazı çocuklar da **anneleri etrafta olduklarında kendilerini gerçekten daha iyi hissetmezler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

Nasıl Biriyim?
(Babam ve Ben)

Şimdi sana seninle ve babanla ilgili bazı sorular soracağız. Senin ve babanın nasıl insanlar olduğunuzu merak ediyoruz. Öncelikle sana bu soruların nasıl cevaplanacağını anlatayım. Her soru iki tür çocuktan söz ediyor ve bu çocuklardan hangisinin <u>sana</u> en çok benzediğini bilmek istiyoruz.

İşte bir örnek soru:

Örnek Cümle

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **boş zamanlarında dışarıda oynamayı** tercih ederler	**AMA**	Bazı çocuklar da **televizyon seyretmeyi** tercih ederler	Bana biraz benziyor ☐	Bana çok benziyor ☐

Senden istediğim önce dışarıda oynamayı tercih eden sol taraftaki çocuklara mı yoksa televizyon seyretmeyi seven sağ taraftaki çocuklara mı daha çok benzediğine karar vermek. Henüz bir şeyleri işaretleme. Sadece hangi çocuğun sana daha çok benzediğine karar ver ve cümlenin o tarafına git. Şimdi de, seçtiğin çocuğun <u>sana çok mu benzediğine</u> yoksa <u>sana biraz mı benzediğine</u> karar ver ve bunun altındaki kutucuğu işaretle.

Her bir cümle için sadece bir tane kutucuğu işaretleyeceksin. O da senin hakkında en doğru olan ve senin en çok benzediğin ifade olacak.

Şimdi sana seninle ve babanla ilgili bazı sorular soracağız.
(Eğer hem baban hem de üvey baban varsa, birlikte yaşadığın hangisiyse ona göre cevap ver.)

1.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **babalarına kolayca güvenirler**.	**AMA**	Bazı çocuklar da **babalarına güvenip güvenemeyecekleri konusunda emin değildirler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

2.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **yaptıkları her şeye babalarının çok karıştıklarını hisseder.**	**AMA**	Bazı çocuklar da **babalarının kendi başlarına bir şeyler yapmalarına izin verdiklerini hissederler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

3.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocukların **babalarının kendilerine yardım edeceklerine inanmaları** kolaydır.	**AMA**	Bazı çocuklar **için ise babalarına inanmak zordur.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

4.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **babalarının onlarla yeterince zaman geçirdiklerini** düşünürler.	**AMA**	Bazı çocuklar da **babalarının onlarla yeterince zaman geçirmediklerini** düşünürler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

5.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **babalarına ne düşündüklerini veya hissettiklerini** söylemekten pek hoşlanmazlar.	**AMA**	Bazı çocuklar da **babalarına ne düşündüklerini veya hissettiklerini** söylemekten hoşlanırlar.	Bana biraz benziyor ☐	Bana çok benziyor ☐

6.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar babalarına **çok fazla** ihtiyaç duymaz.	**AMA**	Bazı çocuklar da babalarına **çoğu şey için** ihtiyaç duyar.	Bana biraz benziyor ☐	Bana çok benziyor ☐

7.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **"Keşke babama daha yakın olabilseydim"** derler.	**AMA**	Bazı çocuklar da **babalarına olan yakınlıklarıyla mutludurlar.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

8.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **babalarının onları gerçekten sevmediklerinden** endişe duyarlar.	**AMA**	Bazı çocuklar da **babalarının onları sevdiklerinden gerçekten emindirler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

9.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **babalarının onları gerçekten anladıklarını** hissederler.	**AMA**	Bazı çocuklar da **babalarının onları gerçekten anlamadıklarını** hissederler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

10.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **babalarının onları terk etmeyeceklerinden gerçekten emindirler.**	**AMA**	Bazı çocuklar da bazen, **babalarının onları terk edebileceğinden endişelenirler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

11.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **ihtiyaç duyduklarında babalarının yanlarında olamayacaklarını düşünerek** endişelenirler.	**AMA**	Bazı çocuklar da **ihtiyaç duyduklarında babalarının yanlarında olacaklarından** emindirler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

12.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar babalarının **onları dinlemediklerini** düşünürler.	**AMA**	Bazı çocuklar da babalarının **onları gerçekten dinlediklerini** düşünürler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

13.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **üzgün olduklarında babalarının yanlarına giderler.**	**AMA**	Bazı çocuklar da **üzgün olduklarında babalarının yanlarına gitmezler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

14.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **"Keşke babam sorunlarımla daha çok ilgilense"** derler.	**AMA**	Bazı çocuklar da **babalarının onlara yeterince yardım ettiklerini** düşünürler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

15.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **babaları etrafta olduklarında** kendilerini daha iyi hissederler.	**AMA**	Bazı çocuklar da **babaları etrafta olduklarında kendilerini gerçekten daha iyi hissetmezler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

APPENDIX J

QUESTIONS ASKED DURING INTERVIEW WITH MOTHERS

ÇOCUK Yaş: Sınıf: Cinsiyet:
ANNE Yaş: Meslek:
GRUP 1.Adp / clin 2.Adp / non-cl 3.Non-adp / clin 4.Non-adp / non-cl

Çocuk ile ilgili sorular:

1. Çocuğunuzun kişiliğini tanımlayan 5 sözcük seçmenizi istyorum. Bu özellikleri size kimi hatırlatıyor? Bu benzerliği ne zaman farkettiniz?

2. Şu anda çocuğunuzun davranışlarının başedilmesi en zor yönü nedir? Bu problemlerle nasıl baş ediyorsunuz? Kimden yardım alıyorsunuz?

3. Çocuğunuzla ilgili yaşanan sorunlar sizce neden /nereden kaynaklanıyor? Sizce bunları engellemenin yolları nelerdir?

4. Şu an çocuğunuzla olan ilişkinizi nasıl tanımlarsınız? İleride nasıl olacağınızı tahmin ediyorsunuz?

5. Çocuğunuzun ileriki yaşamı ile ilgili sizi endişelendiren birşey var mı?

Genel sorular:

1. Sizce anne olmanın anlamı nedir?

2. Sizce aile ne demektir? Çocuk için önemi nedir?

3. Sizce gerçek aile kimdir? Doğuran / büyüten?

4. Sizce kendi doğurduğu bir çocuğun annesi olmakla, başkasının doğurduğu bir çocuğun annesi olmak arasında bir fark mıdır?

APPENDIX K
INFORMED CONSENT FORM

GÖNÜLLÜ KATILIM FORMU

Orta Doğu Teknik Üniversitesi (ODTÜ) Klinik Psikoloji Doktora Programı çerçevesinde Uzm. Psk. İlkiz Altınoğlu - Dikmeer tarafından yürütülen **"Evlat edinilmiş ve biyolojik ebeveynleriyle yaşayan çocuk ve ergenlerin davranışsal ve duygusal sorunları ile bu çocuk ve ergenler ile ailelerinin bağlanma ve çocuk yetiştirme biçimlerinin karşılaştırmalı olarak değerlendirilmeleri"** konulu tez çalışması hakkında bilgilendirildik.

Çalışmaya katılmayı kabul edersek,

- bizden (anne – baba ve çocuk) yukarıda söz edilen alanlarla ilgili bazı anket formlarını doldurmamız isteneceğini,
- verilen yanıtların bireysel olarak değerlendirilmeyeceğini, elde edilecek bilgilerin bilimsel yayımlarda kullanılacağını,
- kimlik bilgilerimizin kesinlikle gizli tutulacağını,
- çalışmaya katılımın gönüllülük temelli olduğunu, anketleri doldurmamız karşılığında bizden herhangi bir ücret talep edilmeyeceğini ya da bize bir ücret ödenmeyeceğini,
- anketleri doldururken sorulardan ya da herhangi başka bir nedenden ötürü rahatsızlık hissedersek yanıtlama işini yarıda bırakabileceğimizi, bunun herhangi bir yaptırımı olmadığını,
- çocuğumuzun bu çalışmaya katılmasına izin vermediğimiz durumda, kendisiyle hiçbir şekilde ilişkiye geçilmeyeceğini,
- çocuğumuzun ruh sağlığı ile ilgili bir hizmet almak için başvurduysak, çalışmaya katılmamaya karar vermemiz durumunda, alacağımız hizmetin kesinlikle değişmeyeceğini, bu çalışmanın çocuğumuzun sağlık durumundan bağımsız olduğunu,
- çalışma ile ilgili sorularımız olursa, anketleri doldurduktan sonra araştırmacı tarafından yanıtlanacağını,

- araştırmacıya (0312) 595-7915 ve (0312) 595-6654 no.lu telefonlardan ya da ilkiz@superonline.com e-posta adresinden ulaşabileceğimizi,
- çocuğumuzun çalışmaya katılımı ya da haklarının korunması ile ilgili sorularımız olduğunda ya da çocuğumuzun herhangi bir risk altında olabileceğine, strese maruz kalacağına inandığımız durumda Orta Doğu Teknik Üniversitesi Etik Kurulu'na (312) 210-37 29 no.lu telefondan ulaşabileceğimizi,

öğrenmiş bulunuyoruz. Yukarıda açıklaması yer alan çalışmaya katılım ile ilgili kararımız aşağıda imzalı olarak sunulmaktadır.

-

	ANNE (isim, imza, tarih)	BABA (isim, imza, tarih)	ÇOCUK (isim, imza, tarih)
Bu çalışmaya katılmayı KABUL EDİYORUM			
Bu çalışmaya katılmayı KABUL ETMİYORUM			
Çocuğumun katılmasına İZİN VERİYORUM			X
Çocuğumun katılmasına İZİN VERMİYORUM			X

APPENDIX L

LETTER OF PERMISSION SUBMITTED TO SHÇEK

T.C. Başbakanlık
Sosyal Hizmetler ve Çocuk Esirgeme Kurumu Genel Müdürlüğü
Eğitim Merkezi Başkanlığı'na,

Orta Doğu Teknik Üniversitesi Psikoloji Bölümü'nde Klinik Psikoloji Doktora Programı öğrencisiyim. Çalıştığım çocuk ruh sağlığı ve hastalıkları biriminde de sıklıkla karşılaştığım bir grup olan evlat edinilmiş 6-18 yaşları arasındaki çocuk ve ergenler ile ilgili bir tez çalışması yürütmeyi planlamaktayım. "Evlat edinilmiş ve biyolojik ebeveynleriyle yaşayan çocuk ve ergenlerin, davranışsal ve duygusal sorunları ile uyum düzeylerinin karşılaştırmalı olarak değerlendirilmeleri" konulu bu çalışma ile ilgili kuramsal çerçeve ve araştırma amaçları Ek 2'de, çalışma hakkında ailelere gönderilmesi planlanan mektup Ek 3'de ve araştırmada kullanılacak ölçekler Ek 4'de sunulmuştur.

Ailelerin kimlik bilgilerinin gizliliği konusunda Kurumunuzun gösterdiği hassasiyet göz önüne alınarak, ailelere gönderilmek üzere bir mektup hazırlanmıştır. Araştırma ile ilgili bilgilerin yer aldığı bu mektubun sonunda, araştırmaya katılmaya gönüllü olan ailelerin araştırmacı ile iletişime geçmeleri istenmiştir. Bu mektubun hazırlanması, zarflanması, postaya hazır hale getirilmesi gibi işlerin araştırmacı tarafından yürütülmesi ve masraflarının araştırmacı tarafından karşılanması planlanmaktadır.

Tez çalışmamı yürütebilmem için ve ailelere ulaşabilme yolu olan mektubun ailelere gönderilebilmesi için Kurumunuzdan izin alınması için gereğini saygılarımla arz ederim.

03.08.2007

Uzm.Psikolog İlkiz Altınoğlu-Dikmeer
ODTÜ Psikoloji Bölümü Doktora Öğrencisi

e-posta: ilkiz@superonline.com
cep telefon no: (0533)
(0506)
iş telefon no: (0312) 595-7046
iş adresi: Ank. Üniv. Tıp Fak. Çocuk Ruh Sağlığı ve Hastalıkları Anabilim Dalı

04.08.2007

Psikoloji Bölüm Başkanlığına:

İlkiz Altınoğlu-Dikmeer, Psikoloji Doktora Programı – Klinik Psikoloji Opsiyonu öğrencilerimizdendir. Öğrencimiz yeterlik sınavından başarıyla geçmiş olup halen doktara tez çalışmalarına, danışmanlığım altında devam etmektedir. Öğrencimizin doktora tezi "evlat edinilmiş ve biyolojik ebeveynleriyle yaşayan çocuk ve ergenlerin, davranışsal ve duygusal sorunları ile uyum düzeylerinin karşılaştırmalı olarak değerlendirilmeleri" konusundadır. Bu tez çalışması verilerinin toplanılabilmesi için Sosyal Hizmetler ve Çocuk Esirgeme Kurumu'nun (SHÇEK) desteğine ihtiyaç duyulmaktadır.

Öğrencimizin doktora tezi verilerini toplayabilmek için "evlat edinilmiş çocuk ve ergenlere, ayrıca bu grubun ailelerine" mektup ile ulaşımının sağlanabilmesi için SHÇEK Genel Müdürlüğü Eğitim Merkezi Başkanlığı'ndan izin alınması gerekmektedir. Çalışma ve kullanılacak ölçekler hakkında detaylı bilgi ekte sunulmaktadır.

SHÇEK Genel Müdürlüğü Eğitim Merkezi Başkanlığı'ndan gerekli izinin alınması için gereğini saygılarımla bilgi ve onaylarınıza sunarım.

Doç. Dr. Tülin Gençöz

EKLER:

Ek 1: Öğrenci Dilekçesi
Ek 2: Çalışma ile ilgili kuramsal çerçeve ve araştırma amaçları
Ek 3: Çalışma hakkında ailelere gönderilmesi planlanan mektup
Ek 4: Araştırmada kullanılacak ölçekler

APPENDIX M

LETTER OF REJECTION FROM SHÇEK

ÖĞRENCİ İŞLE
DA...

T.C.
BAŞBAKANLIK
SOSYAL HİZMETLER VE ÇOCUK ESİRGEME KURUMU
GENEL MÜDÜRLÜĞÜ

SAYI : B.02.1.SÇE.0.72.00.01/605.01-497 15 KASIM 2007
KONU : Araştırma

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
ÖĞRENCİ İŞLERİ DAİRE BAŞKANLIĞI
(Orta Doğu Yerleşkesi-Eskişehir Yolu/ANKARA)

İLGİ:17.09.2007 tarih ve 7013 sayılı yazınız.

İlgi yazı ile Orta Doğu Teknik Üniversitesi Psikoloji Anabilim Dalı Klinik Psikolojisi Doktora Programı öğrencisi İlkiz ALTINOĞLU DİKMEER'in "Evlat Edinilmiş ve Biyolojik Ebeveynleriyle Yaşayan Çocuk ve Ergenlerin, Davranışsal ve Duygusal Sorunları ile Uyum Düzeylerinin Karşılaştırılmalı Olarak Değerlendirilmesi" konulu tez çalışmasını Eylül 2007/ Haziran 2008 tarihlerinde yapabilme talebi bildirilmiştir.

Medeni Kanunun 314.Maddesi gereğince evlat edinme ile ilgili tüm bilgi ve belgeler gizlilik niteliği taşıdığından talebiniz değerlendirilememektedir.

Bilgilerinizi arz ederim.

H.Lütfi ÖZTÜRK
Genel Müdür a.
Eğitim Merkezi Başkanı

27.11.07 017733

Anafartalar Cad. 68/4 Ulus / ANKARA
Telefon: (0 312) 311 31 30 / 1233
e-posta: egitim@shcek.gov.tr

Ayrıntılı bilgi için irtibat : S.Ö.ÇETİN – Şb.Md.V.
Faks: (0 312) 311 89 98
Elektronik Ağ: www.shcek.gov.tr

APPENDIX N

PERMISSION TO USE CHILD BEHAVIOR CHECKLIST / 6-18 and YOUTH SELF REPORT

TÜRKİYE CUMHURİYETİ
ANKARA ÜNİVERSİTESİ TIP FAKÜLTESİ HASTANELERİ
Çocuk Ruh Sağlığı ve Hastalıkları Anabilim dalı

Ankara
17 / 02 / 2009

Sayı :

Konu : Ölçek kullanımı hk

Sayın İlkiz Altınoğlu Dikmeer,

Türkçe çeviri ve uyarlama çalışmaları ben ve çalışma arkadaşların tarafından yapılmış olan ve Türkçe formunun telif hakları şahsıma ait olan "*6-18 yaş Çocuk ve Gençler için Davranış Değerlendirme Ölçeği*" ile "*11-18 yaş Gençler için Kendini Değerlendirme Ölçeği*"ni "Evlat edinilmiş ve biyolojik ebeveynleriyle yaşayan çocuk ve ergenlerin, davranışsal ve duygusal sorunları ile uyum düzeylerinin karşılaştırmalı olarak değerlendirilmeleri" konulu doktora tez çalışmanızda kullanmanızda tarafımca bir sakınca bulunmamaktadır.

Prof. Dr. Neşe EROL
Klinik Psikolog

APPENDIX O

PERMISSION TO USE SCHOOL-AGE TEMPERAMENT INVENTORY

ilkiz altinoglu dikmeer

From: Sandee McClowry sandee.mcclowry@nyu.edu
To: d. ilkiz altinoglu dikmeer ilkiz@superonline.com
Sent: 18 Kasım 2007 Pazar 21:54
Attach: re-examination_of_the_validity.pdf; sandee.mcclowry.vcf
Subject: Re: Turkish version of SATI

> ----- Original Message -----

>From: Sandee McClowry < sandee.mcclowry@nyu.edu>
>To: ilkiz altinoglu dikmeer <ilkiz@superonline.com>
>CC: sm6@nyu.edu
>Sent: Friday, November 16, 2007 1:02 pm
>Subject: Re: Turkish version of SATI
> >
>
> >Hi!
> >You certainly are welcome to use the Turkish version of the SATI.
> I have > attached a manuscript that describes the reliability of the tool
> > for adolescents. I've also attached a manuscript describing the
> > efficacy of the intervention. You'll find out more information
> >about it at
> www.insightsintervention.com.
> >I would be very interested in learning about your results and
> those of Ekin Eremsoy.
> >Best wishes for a satisfying dissertation experience.
> >Sandee McClowry
> >
> >
> >
> > ----- Original Message -----
> >From: ilkiz altinoglu dikmeer <ilkiz@superonline.com>
> >Date: Thursday, November 15, 2007 3:53 pm
> >Subject: Turkish version of SATI
> >To: sm6@nyu.edu

APPENDIX P

PERMISSION TO USE MEASURE OF CHILD REARING STYLES and KERNS SECURITY SCALE

1956

Orta Doğu Teknik Üniversitesi
Middle East Technical University
Fen Edebiyat Fakültesi
Faculty of Arts and Sciences
Psikoloji Bölümü
Department of Psychology
06531 Ankara, Türkiye
Phone: +90 (312) 2103182
Fax: +90 (312) 2107975
www.psy.metu.edu.tr

17.02.2009

B.30.2.ODT.0.10.16.00/
Psy.

Sayın İlkiz Altınoğlu Dikmeer,

Türkçe uyarlama çalışması ben ve çalışma arkadaşlarım tarafından yapılan "Çocuk Yetiştirme Stilleri Ölçeği" ve "Kerns Güvenlik Algısı Ölçeği"ni "Evlat edinilmiş ve biyolojik ebeveynleriyle yaşayan çocuk ve ergenlerin, davranışsal ve duygusal sorunları ile uyum düzeylerinin karşılaştırmalı olarak değerlendirilmeleri" konulu tez çalışmanızda kullanmanızda tarafımca bir sakınca bulunmamaktadır. Saygılarımla

Prof. Dr. Nebi Sümer
Psikoloji Bölüm Başkanı

APPENDİX Q

PERMISSION TO USE BASIC PERSONALITY TRAITS INVENTORY

1956

Orta Doğu Teknik Üniversitesi
Middle East Technical University
Fen Edebiyat Fakültesi
Faculty of Arts and Sciences
Psikoloji Bölümü
Department of Psychology
06531 Ankara, Türkiye
Phone: +90 (312) 2103182
Fax: +90 (312) 2107975
www.psy.metu.edu.tr

17.02.2009

B.30.2.ODT.0.10.16.00/
Psy.

Sayın İlkiz Altınoğlu Dikmeer,

Ben ve çalışma arkadaşlarım tarafından geliştirilen "Temel Kişilik Özellikleri Ölçeği"ni "Evlat edinilmiş ve biyolojik ebeveynleriyle yaşayan çocuk ve ergenlerin, davranışsal ve duygusal sorunları ile uyum düzeylerinin karşılaştırmalı olarak değerlendirilmeleri" konulu tez çalışmanızda kullanmanızda tarafımca bir sakınca bulunmamaktadır.Saygılarımla

Prof. Dr. Tülin Gençöz

TURKISH SUMMARY

EVLAT EDİNİLMİŞ VE BİYOLOJİK EBEVEYNLERİYLE YAŞAYAN ÇOCUKLARIN DAVRANIŞSAL VE DUYGUSAL SORUNLARI VE BAĞLANMA DÜZEYLERİ İLE ANNE BABALARININ ÇOCUK YETİŞTİRME STİLLERİNİN KARŞILAŞTIRMALI OLARAK DEĞERLENDİRİLMELERİ

Evlat edinilmiş çocuk ve ergenlerin, biyolojik aileleri yanında yaşayan akranlarına göre daha şanslı oldukları; çünkü seçilmiş çocuklar oldukları, bir umutsuzluk döneminden sonra ailelerine umut ışığı oldukları oldukça yaygın bir görüştür. Öte yandan bu çocukların doğum öncesi ve doğum sırasında maruz kaldıkları kötü beslenme veya sağlıksız koşullar, aile içinde ve çevrede olumsuz yaşam koşulları, biyolojik aileden ayrılma, kurumda yaşama gibi deneyimler nedeniyle risk altında oldukları ve psikososyal uyum düzeylerinin biyolojik ailesiyle yaşayan akranlarının gerisinde oldukları da öne sürülmektedir (Howe, 1997; Rosnati, Montirosso & Barni, 2008; Simmel, Brooks, Barth, & Hinshaw, 2001; Van den Dries, Juffer, van IJzendoorn, and Bakermans-Kranenburg, 2009; Van IJzendoorn and Juffer, 2006; Xing Tan, 2006).

Evlat edinilen çocuk ve ergenlerle ilgili çalışmalar, bu çocukların psikolojik uyumlarının kurum bakımındaki akranlarından ve biyolojik aileleri yanında yetişmiş kendi biyolojik kardeşlerinden daha iyi olduğunu, okul başarılarının daha iyi olduğunu, daha az davranış sorunu gösterdiklerini, daha az madde kullandıklarını ve ruh sağlığı birimlerine daha az başvurduklarını (ya da gönderildiklerini) göstermektedir. Ancak aynı çocukların, çok az bir farkla da olsa, biyolojik aileleri yanında yetişen akranlarından daha fazla duygusal ve davranışsal sorunlar gösterdikleri de bildirilmektedir (Browne, 2007; Hodges, 2005; Johnson, 2002).

Evlat edinilen çocukların, diğer akranlarına göre çocuk ruh sağlığı birimlerine daha fazla getirildikleri de yurt dışında yapılan çalışmaların dikkat

çektiği ortak bir sonuçtur (Hodges, 2005; Howe, 1997; Groza & Ryan, 2002; Juffer & Van IJzendoorn, 2005; Nickman, Rosenfeld, Fine, et al, 2005, Wilson, 2004). Bu bilgi, ilk bakışta evlat edinilen çocukların, biyolojik aileleri ile yaşayan akranlarına göre daha fazla sorunlu oldukları izlenimini yaratmaktadır. Ancak araşırmacılar aynı zamanda, evlat edinen ailelerin, diğer ailelere göre daha kaygılı, daha endişeli ve yardım almaya daha açık aileler olduklarını da ortaya koymuşlardır (Hodges, 2005; Wilson, 2004; Juffer & Van IJzendoorn, 2005).

Araştırmalar, çocuğun evlat edinildiği yaşın önemini vurgulamaktadırlar. İlk 12 ay içinde evlat edinilen çocukların, okul başarılarının, aile içi uyumlarının daha büyük yaşta evlat edinilenlere göre daha iyi olduğu, 6 aydan daha büyük evlat edinilen çocukların ileride psikopatoloji geliştirme açısından ilk 6 ayda evlat edinilen çocuklara göre daha çok risk altında oldukları belirtilmektedir (Fensbo, 2004; Hodges, 2005, Howe, 1997). Benzer şekilde bebekken evlat edinilen çocukların daha geç yaşta evlat edinilen çocuklara oranla daha güvenli bağlanma geliştirdikleri (Van den Dries et al., 2009); geç yaşta evlat edinilen çocukların ise önceki yaşamlarında kurdukları bağlanma stillerini yeni yaşamlarına da taşıdıkları öne sürülmektedir (Stovall and Dozier, 1998).

Bu çalışmanın temel amacı şu anda 6-18 yaşları arasında olan evlat edinilmiş çocukların duygusal ve davranışsal sorunları ile bağlanma düzeylerini ve bu çocukların anne babalarının çocuk yetiştirme stillerini değerlendirmek ve evlat edinilmemiş akranları ve onların aileleri ile karşılaştırmaktır. Evlat edinme ile ilgili olabilecek risk ve koruyucu faktörlerin belirlenmesi de çalışmanın bir başka amacıdır. Ülkemiz alanyazınında evlat edinme, psikoloji ve ruh sağlığı alanlarında ihmal edilmiş bir konu olarak karşımıza çıkmaktadır. Evlat edinilmiş çocukların duygusal ve davranışlarının ele alındığı görgül bir çalışmaya rastlanılmamıştır. Bu nedenle bu çalışmanın alanda bir ilk olacağı ve bu konudaki boşluğu doldurmak adına bir adım atılmış olacağı düşünülmektedir.

Yöntem

Örneklem

Araştırmanın örneklemini evlat edinilmiş 61 çocuk ve ergen (34 kız, 27 erkek) ile, bu çocuklarla yaş ve cinsiyet açısından eşleştirilmiş biyolojik ailesiyle

yaşayan 62 çocuk ve ergen (35 kız, 27 erkek) ve bu çocukların ebeveynleri oluşturmaktadır. Çocukların yaşları 6-18 arasında değişmektedir, evlat edinilen çocukların yaş ortalaması 125 ay (10 yaş 8 ay; *SS* = 42.22) iken karşılaştırma grubundaki çockların yaş ortalaması 132 ay (11 yaş 5 ay) olarak (*SS* = 37.03) bulunmuşur. Evlat edinilen gruptaki çocukların % 65'i (*N* = 40) ve biyolojik ailesiyle yaşayan çocukların % 60'ı (*N* = 37) bir çocuk ruh sağlığı biriminde izlenmiş ya da halen izlenmektedir.

Veri Toplama Araçları

Evlat Edinme Soru Formu: 85 maddeden oluşan bu form ile aile ve çocuk hakkında demografik bilgi, çocuğun sağlık durumu, evlat edinme süreci, okul ve çevre ile ilişkiler ve anne babaların çocukları ile ilgili tasarımları hakkında bilgi toplamak amaçlanmıştır. Evlat edinen anne ya da babanın doldurması istenmiştir.

Aile Bilgi Formu: Bu formda demografik bilgiler, anne babaların çocukları ile ilgili tasarımları ve evlat edinme hakkındaki görüşleri sorulmuş ve karşılaştırma grubundaki anne ve babaların doldurması istenmiştir.

6-18 Yaş Çocuk ve Gençlerde Davranış Değerlendirme Ölçeği (Child Behavior Checklist - CBCL): Bu yaş grubundaki çocuk ve ergenlerin güçlü yönlerini ve sorun davranışlarını belirlemek üzere geliştirilmiş ve ülkemiz normları için geçerlik ve güvenirlik çalışması yapılmıştır (Achenbach ve Edelbrock, 1983; Erol, Arslan ve Akçakın, 1995). 20 uyum davranışı ve 118 duygusal ve davranışsal sorun davranışı maddelerinden oluşmaktadır. Bu maddelerin toplamlarından 3 davranış puanı, 8 sendrom puanı ve 6 DSM ölçütlerine dayalı tanı puanı elde edilmektedir. Çalışmaya katılan tüm anne ve babalardan çocukları ile ilgili bu maddeleri işaretlemeleri istenmiştir.

Okul Çağı Çocukları için Mizaç Ölçeği (School-Age Temperament Inventory - SATI): Çocuk ve ergenlerin mizaç özelliklerinin anne babaları tarafından değerlendirilmesi amacıyla geliştirilen (Mc Clowry, 1995:, Mc Clowry, Halverson & Sanson, 2003) bu ölçeğin Türkçe uyarlaması Eremsoy tarafından yapılmıştır (2007). Ölçekteki 38 maddeden 4 mizaç boyutu elde edilmektedir ve çalışmaya katılan tüm anne ve babalardan çocukları ile ilgili bu maddeleri işaretlemeleri istenmiştir.

Çocuk Yetiştirme Stilleri Ölçeği (Measure of Child Rearing Styles (MCRS): Bu ölçek, çocuk yetiştime stillerinin belirlenmesi amacıyla Sümer ve Güngör (1999) tarafından geliştirilmiştir. Ölçekte yer alan 22 maddeden iki boyut, ve bu iki boyutun çarprazlanması sonucunda da dört çocuk yetiştirme kategorisi elde edilmektedir. Çalışmaya katılan tüm anne ve babalardan kendi çocuk yetiştirme stillerini değerlendirmeleri istenmiştir. Ayrıca çalışmaya katılan tüm çocuklar, anne babalarının çocuk yetiştirme stilleri ile ilgili kendi algılarını da aynı ölçek üzerinde değerlendirmişlerdir.

Temel Kişilik Özellikleri Ölçeği (Basic Personality Traits Inventory - BPTI): Türk kültüründe geliştirilmiş (Gençöz ve Öncül, yayın aşamasında) olan bu ölçek 45 maddeden oluşmakta ve 6 kişilik özelliği boyutunu ölçmektedir. Çalışmaya katılan tüm anne ve babalardan kendi kişilik özelliklerini değerlendirmeleri istenmiştir.

11-18 Yaş Grubu Gençler için Kendini Değerlendirme Ölçeği* (*Youth Self Report - YSR): Ergenlerin kendilerini değerlendirdikleri bu ölçek, 17 uyum maddesinden ve 112 davranışsal ve duygusal sorun maddesinden oluşmaktadır. Üç davranış puanı, 8 sendrom puanı ve 6 DSM ölçütlerine dayalı tanı puanı elde edilmektedir. Özgün formu Achenbach ve Edelbrock (1987) tarafından geliştirilmiş, ve ülkemiz normları için geçerlik ve güvenirlik çalışması Erol ve Şimşek (1998) tarafından yapılmıştır. Çalışmaya katılan 11 yaş üzerindeki tüm ergenlerden bu ölçek üzerinde kendi güçlü yanlarını, duygusal ve davranışsal sorunlarını değerlendirmeleri istenmiştir.

Kerns Güvenli Bağlanma Ölçeği (Kerns Security Scale - KSS): 15 maddeden oluşan bu ölçek çocukların bağlanma figürlerinin duyarlı ve ulaşılabilir olacaklarına ne oranda güvendiklerini, stress altında iken bağlanma figürlerine güvenme eğilimlerini, ve bağlanma figürleri ile iletişim kurma isteklilik düzeylerini ölçmeyi amaçlamaktadır. Kerns, Klepac ve Cole (1996) tarafından geliştirilen ölçeğin Türkçe'ye uyarlanması Sümer ve Anafarta (basım aşamasında) tarafından yapılmıştır.

İşlem

Çalışma öncesinde Orta Doğu Teknik Üniversitesi Etik Kurulu'ndan onay alınmış, gönüllülük esasına dayanarak çalışmaya katılan tüm anne babalar çalışma

hakkında bilgilendirilmiş ve kendilerinden bilgilendirilmiş onam formunu imzalamaları istenmiştir. Evlat edinmiş ailelere ulaşmak üzere Başbakanlık Sosyal Hizmetler ve Çocuk Esirgeme Kurumu'na yapılan yazılı başvuru red edildiği için, ruh sağlığı birimlerine başvuran evlat edinmiş ailelerden gönüllü olanlar ve e-posta duyurularına olumlu yanıt veren evlat edinmiş ailelerin tümü araştırmaya dahil edilmişlerdir. Bu ailelerin tanıdığı diğer evlat edinmiş ailelere de ulaşılmış, gönüllü olanlar çalışmaya katılmışlardır. Karşılaştırma grubu ise ruh sağlığı birimlerine başvuran ve başvurmayan aileler arasından çocukların yaş ve cinsiyet bakımından eşleştirilmesi yoluyla belirlenmiştir.

Çalışmaya katılan çocuklar evlat edinilmiş olup olmamalarına (evlat edinme durumu) ve çocuk ruh sağlığı biriminde izlenmiş olup olmamalarına (klinik durum) bağlı olarak 4 ayrı gruba ayrılmışlardır. Anne ve babalardan çocuklarınının davranışsal ve duygusal sorunları ve mizaçları ile kendi kişilik özellikleri ve çocuk yetiştirme stillerini değerlendirmek üzere formlar doldurmaları istenmiştir. Çocuklar anne babalarının çocuk yetiştirme stilleri ile ilgili kendi algılarını ve anne babalarına bağlanma güvenlikleri ile algılarını doldurdukları ölçekler üzerinde değerlendirmişlerdir. Buna ek olarak 11 yaşından büyük çocuklar kendi duygusal ve davranışsal sorunlarını da değerlendirmişlerdir.

Gruplar arası farklılıklar çok yönlü varyans analizi ile değerlendirilmiş, evlat edinme özellikleri ile kullanılan ölçekler arasındaki ilişki Pearson çarpımlar-korelasyon yöntemiyle incelenmiştir. Araştırmaya katılan çocuk sayısı 123 olmasına karşın, hem annesinden hem de babasından ölçüm alınabilen çocuk sayısı 67'dir. 56 çocuğun ise sadece bir ebeveyni araştırmada yer almıştır. Başlangıç olarak araştırmaya katılan 67 çift anne babanın (evlat edinme ve kliniğe başvurma durumları göz önüne alınmadan) doldurdukları ölçeklerden elde edilen puanlar çok yönlü varyans analizi ile değerlendirilmiş ve hiç bir ölçekte anne baba ortalamaları arasında anlamlı bir fark bulunamamıştır. Buna dayanarak veri kaybını engellemek için araştırmaya katılan anne ve babalar her ölçek için birbirlerinden bağımsız olarak ayrı analizlerde değerlendirilmişlerdir.

Bulgular

Çocukların duygusal ve davranışsal sorunları, mizaç özellikleri, anne babaların kişilik özellikleri ve çocuk yetiştirme stilleri sadece anne ölçümleri ve sadece baba ölçümleri alınarak, 2 (grup: evlat edinilmiş, evlat edinilmemiş) X 2 (grup: kiniğe başvurusu olan ve olmayan) çok yönlü varyans analizi ile test edilmiştir. Çocukların ebeveynlerinin anne babalık stillerini ve 11 yaşından büyük çocukların kendi duygusal ve davranışsal sorunlarını değerlendirdikleri ölçümler arasındaki farklar yine 2 (grup: evlat edinilmiş, evlat edinilmemiş) X 2 (grup: kiniğe başvurusu olan ve olmayan) çok yönlü varyans analizi ile test edilmiştir. Çocukların bağlanma figürlerinin duyarlı ve ulaşılabilir olacaklarına ne oranda güvendikleri ise anneler ve babalar için ayrı varyans analizleri ile test edilmiştir. Buna göre, hiç bir ölçekte evlat edinilme durumunun temel etkisi ile, evlat edinilme x kliniğe başvurmuş olma ortak etkisi anlamlı bulunmamıştır. Buna karşılık annelerin değerlendirdiği CBCL sonuçları, ve bazı mizaç özellikleri için klinik durum temel etkisi anlamlı bulunmuştur. Buna göre, herhangi bir nedenle çocuk ruh sağlığı birimlerine başvuran çocuklar, hiç başvuru olmayan karşılaştırma grubuna göre daha fazla İçeyönelim, Dışayönelim ve Toplam Sorun davranışı göstermişlerdir. CBCL'nin 6 sendrom ve 6 DSM'ye dayalı tanı ölçeğinde de karşılaştırma grubuna göre daha fazla sorun davranışı rapor edilmiştir. Mizaç özellikleri açısından değerlendirildiklerinde ise, klinik gruptaki çocukların, klinik grupta olmayanlara göre bir görevi sürdürmede daha az başarılı oldukları ve daha hareketli oldukları bulunmuştur. Ayrıca, klinik gruptaki ergenler, klinik olmayan gruptaki ergenlere göre kendilerinde daha fazla dikkat ve davranım sorunu rapor etmişlerdir.

Evlat edinilme ve klinikte izlenme durumları göz ardı edilerek sadece yaş ve cinsiyet temel etkileri araştırıldığında ise, kız çocukların annelerinin erkek çocuk annelerine göre daha fazla somatik yakınma rapor ettikleri görülmüştür. Yine annelerin değerlendirmelerine göre bir görevi sürdürmede kızlar erkeklerden daha başarılı bulunmuştur. Öte yandan, 10 yaşından küçük çocuklar, büyük çocuklara göre anne ve babalarını daha fazla duyarlı ve güvenilir olarak algılamış ve anne babalarını daha kabul edici ebeveynler olarak değerlendirmişlerdir.

Evlat edinilme yaşının sorun davranışlarına, mizaç özelliklerine ve bağlanma davranışına olan etkisini sınamak için uygulanan varyans analizi

sonucunda evlat edinilme yaşı temel etkisi anlamlı düzeyde bulunmamıştır. Buna göre, yaşamlarının ilk bir yılı içinde evlat edinilen çocuklarla, daha sonraki dönemlerde evlat edinilen çocuklar arasında sorun davranışı ya da bağlanma açısından anlamlı bir fark yoktur.

Evlat edinme ile ilgili demografik özellikler ve ölçekler arasındaki korelasyonlar incelendiğinde, çocukların evlat edinildiklerini öğrenme yaşları ile annelerin CBCL değerlendirmeleri arasında anlamlı doğrusal bir ilişki olduğu gözlenmiştir. Buna göre, çocuğun evlat edinildiğini öğrenme yaşı arttıkça sorun davranışları da artmaktadır.

Tartışma

Çalışmanın sonuçları, evlat edinilmiş çocuk ve ergenlerin duygusal ve davranışsal sorunlar ve bağlanma düzeyleri açısından biyolojik aileleri yanında yaşayan akrankarından farklı olmadıklarını göstermiştir. Bu bulgu, evlat edinmenin koruyucu bir faktör olabileceğini göstermektedir. Ayrıca çalışmaya katılan çocukların evlat edinen aileleriyle geçirdikleri süre 2 yıl 6 ay ile 9 yıl 10 ay arasında değişmektedir. Bu süre başlangıçta uyum ya da bağlanma sorunu yaşamış bile olsalar, yeniden uyum yapabilme ve güvenli bir bağlanma geliştirebilme için yeterli bir süredir. Öte yandan daha geç evlat edinilen çocukların geçmiş öyküleri incelendiğinde, bir çoğunun kurum bakımına verilmeden önce biyolojik aileleriyle birlikte yaşadıkları (2 ay ile 48 ay arası) öğrenilmiştir. Çocuk için uygun olmayan ortamlarda bile yaşamış olsalar, bu çocukların bir çeşit bağlanma geliştirmiş olma olasılıkları çok yüksektir. Yeni ailelerinden gördükleri sevgi, ilgi ve iyi bakım sayesinde olumsuz bağlanma örüntüleri yerini daha sağlıklı ve olumlu örüntülere bırakmış olabilir.

Evlat edinen ve edinmeyen anne babalar kişilik özellikleri ve çocuk yetiştirme stilleri açısından farklılık göstermemişlerdir. Bu da, evlat edinilen çocukların, biyolojik aileleri ile yaşayan akranları ile benzer ortamlarda yetiştiklerini düşündürmektedir.

Korunmaya muhtaç çocukların, kurum bakımı yerine aile temelli bakım modellerinde yetişmelerinin olumlu sonuçları araştırmalarla ortaya konmaktadır. Ülkemizde de bu tip bakım modellerine geçilmesinin, evlat edinme sistemlerinin

topluma tanıtılıp farkındalık ve duyarlık geliştirilmesinin, bu alanda çalışan uzmanlara ve ailelere eğitim verilmesinin, daha çok çocuğun gerçek bir yuva ve aileye kavuşmasında önemli katkılar sağlayacağı düşünülmektedir.

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1997- Present	Ankara University Medical School Department of Child Psychiatry	Psychologist
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15. Altınoğlu, D.İ. (1994). Depresif bozukluklara kişilerarası yaklaşım. (çev) *3P Psikiyatri, Psikoloji ve Psikofarmakoloji Dergisi,* 2(4), 32-34. **[Interpersonal approach to depressive disorders. (translation to Turkish). *Journal of Psychiatry, Psychology and Psychopharmacology*].**

V. PUBLICATIONS IN PRESS

1. Altınoğlu-Dikmeer, D.İ. & Gençöz, T (in press). Özgül Öğrenme Güçlüğü belirtileri olan çocukların Wisconsin Kart Eşleme Testi ve Wechsler Çocuklar için Zeka Ölçeği Puanlarının incelenmesi. *Çocuk ve Ergen Ruh Sağlığı Dergisi.* **[Examination of Wisconsin Card Sorting Test and Wechsler Intelligence Scale for Children scores among children with and without symptoms of Learning Disability. *Turkish Journal of Child and Adolescent Psychiatry*.]**

2. Kerimoğlu, E. & Altınoğlu-Dikmeer, D.İ. (in press). Malignite Tanısı Alan Çocuk, Ergen ve Ailelerine Psikoterapötik Yaklaşım. *Turkish Journal of Pediatrics, Special Topics: Oncology*, **[Psychotherapeutic approaches to children and adolescents with malignancy and to their families]**.

VI. PRESENTATIONS SUBMITTED AT CONGRESSES AND SYMPOSIUMS

Below listed congresses and symposiums were held in Turkey and the papers were presented in Turkish language.

1. National Child & Adolescent Psychiatry Congress April 2009
   Oral Presentation: **A clinical model application for Specific Learning Disability**

2. National Child & Adolescent Psychiatry Congress April 2009
   Poster Presentation: **What is the ideal length of educational treatment groups for Specific Learning Disability?** (first author)

3. National Child & Adolescent Psychiatry Congress April 2009
   Poster Presentation: **Comparison of maternal child rearing styles of children with and without Specific Learning Disability.** (co-author)

4. National Congress of Graduate Psychology Students June 2008
   Oral Presentation: **What do we know about adoption?**

5. World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions May 2008
   Poster Presentation: **Factor structure of an executive function test battery of Turkish elementary and secondary school aged children** (co-author, presented in English)

6. World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions May 2008
   Poster Presentation: **Hyperlexia: Intellectual functioning of children with Pervasive Developmental Disorders** (co-author, presented in English)

7. National Psychology Congress September 2006
   Poster Presentation: **Examination of Wisconsin Card Sorting Test and Wechsler Intelligence Scale for Children scores among children with and without symptoms of Learning Disability** (first author)

8. National Child & Adolescent Psychiatry Congress April 2006
   Poster Presentation: **Turkish standardization and reliability study of Trail Making Test for school –aged children** (co - author)

9. National Child & Adolescent Psychiatry Congress April 2006
Poster Presentation: **Turkish standardization and reliability study of Wisconsin Card Sorting Test for school –aged children** (co - author)

10. National Child & Adolescent Psychiatry Congress April 2006
Poster Presentation: **Turkish standardization and reliability study of Word Association Test for school –aged children** (first author)

11. National Psychology Congress September 1996
Poster Presentation: **Standardization and adaptation of Neuropsychological Tests into Turkish Culture: A pilot study for depression and chronic alcoholism** (co-author)

12. National Psychiatry Congress June 1996
Poster Presentation: **Social factors in solvent substance abuse among adolescents** (co-author)

13. National Child & Adolescent Psychiatry Congress April 1995
Poster Presentation: **Biperiden abuse among adolescents** (co-author)

14. National Child & Adolescent Psychiatry Congress April 1994
Poster Presentation: **Inhalant substance abuse among adolescents** (co-author)

15. National Child & Adolescent Psychiatry Congress April 1992
Oral Presentation: **The effects of parental loss on the self-concepts of adolescents**

VII. CONTINUOUS EDUCATION IN USA (Between May 1998-February 1999)

1. Group Experience
Gestalt Institute of Cleveland (15 hours)

2. How to Talk So Kids Will Listen and Listen so Kids Will Talk
by Kimberly Langley,
Mandel School of Applied Social Sci.s, Case Western Reserve Uni (CWRU) (6 hours)

3. Introductory Gestalt Workshop
by Wesley Jackson, and Victoria Winbush
Gestalt Institute of Cleveland (15 hours)

4. Teaching Family Model
by Greg Smith
Catholic Charities Training Institute at Parmadale (24 hours)

5. Adolescent Domestic Violence
by David H. Larsen
Cuyahoga Community College (6 hours)

6. Treating Families Having a Member with Bipolar Disorder
by Angela Wilkes
Mandel School of Applied Social Sciences, CWRU (6 hours)

7. Anger Management
by Dennis O'Grady
Cuyahoga Community College (6 hours)

8. Child & Adolescent Psychopharmacology
by Stephen Grcevich
Catholic Charities Training Institute at Parmadale (3 hours)

9. Behavior Therapy
by Lori Sipes
Catholic Charities Training Institute at Parmadale (1.5 hours)

10. Play Therapy with Children Who Have Experienced Loss
by Lillian Schlachter
Mandel School of Applied Social Sciences, CWRU (6 hours)

11. Caring for the Caregiver: Lessons in the Prevention & Treatment of Professional Burnout & Stress Response
by Brooke Kroto
Mandel School of Applied Social Sciences, CWRU (6 hours)

12. Bowen Family Systems Theory
by Gerald Buckley
Mandel School of Applied Social Sciences, CWRU (6 hours)

13. Social Contagion of Youth Violence
by Jeffrey A. Fagan
Mandel School of Applied Social Sciences, CWRU (6 hours)

VII. CONTINUOUS EDUCATION IN TURKEY

1. Structural Equation Modeling: Applications of LISREL
by Nebi Sümer (4 hours)
2008

2. Mind-Body-Trauma: Coping with Stress
by Robert D. Macy from USA (6 hours)
1999

3. PTSD and its Treatment in Children
by Alan Steinberg and Armen Goenjiyan from USA (6 hours)
1999

4. Workshop on PTSD and its Treatment
by Danny Bromm, Juda Schacm and Schulamit Niv from Israel (6 hours)
1999

5. Neuropsychological Testing with Children and Adolescents
Turkish Psychological Association (16 hours)
1998

6. Genetic Component of Autism
by Sir Michael Rutter from England (3 hours)
1997

7. Diagnostic Interview for Autism
by Sir Michael Rutter from England (6 hours)
1997

8. Introduction to Family Systems
Turkish Psychological Association (20 hours)
1997

9. Interactional Group Psychotherapy
Turkish Psychological Association (72 hours)
1996-1997

10. Behavior and Cognitive Therapies
Turkish Psychological Association (36 hours)
1996

11.How to Manage Test Anxiety?
Turkish Psychological Association (20 hours)
1995

12. SPSS – Statistical Package for Social Sciences
Turkish Psychological Association (36 hours)
1995

13. Stress Management
Turkish Psychological Association (30 hours)
1995

14. Assessing Adolescent Psychopathology
by Thomas Achenbach from USA (12 hours)
1995

15. Addiction
Association of Psychiatrists and Psychiatry Residents (8 hours)
1994

16. Behavior & Cognitive Therapies
Association of Psychiatrists and Psychiatry Residents (8 hours)
1993

17. Psychodrama Training

Turkish Psychodrama Institute (100 hours)
1992-1994

18. Supervision on Group & Individual Psychotherapy

Ankara Group Psychotherapies Institute (200 hours)
1990-1994