ASSOCIATED FACTORS OF CHILD MALTREATMENT AND ITS CONSEQUENCES AMONG CHILDREN DIAGNOSED WITH AND WITHOUT ADHD: A COMPARATIVE STUDY

- WHEN TELLING IS NOT ENOUGH… -

A THESIS SUBMITTED TO
THE GRADUATE SCHOOL SOCIAL SCIENCES
OF
MIDDLE EAST TECHNICAL UNIVERSITY

BY

Ş. GÜLİN EVİNÇ

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY
IN
THE DEPARTMENT OF PSYCHOLOGY

JUNE 2011

Approval of the Graduate School of Social Sciences

_____

Prof. Dr. Meliha Altunışık
Director

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

_____

Prof. Dr. Nebi Sümer
Head of Department

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.

_____

Prof. Dr. Tülin Gençöz
Supervisor

Examining Committee Members

Prof. Dr. Ferhunde Öktem	(HU, CPSYCH)	_____
Prof. Dr. Tülin Gençöz	(METU, PSY)	_____
Prof. Dr. Elvan İşeri	(GU, CPSYCH)	_____
Prof. Dr. Bengi Öner-Özkan	(METU, PSY)	_____
Assist. Prof. Dr. Özlem Bozo	(METU, PSY)	_____

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Surname: Ş. Gülin Evinç

Signature:

ABSTRACT

ASSOCIATED FACTORS OF CHILD MALTREATMENT
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- *WHEN TELLING IS NOT ENOUGH…*-

Evinç, Şükran Gülin
Ph.D., Department of Psychology
Supervisor: Assoc. Prof. Dr. Tülin Gençöz

June 2011, 240 pages

Child maltreatment is one of the most severe problems that child mental health experts deal with. Limited studies on this field suggest risk of child maltreatment is higher for children with ADHD and disruptive behavior disorder. There is also great need for investigating child maltreatment and its risk factors in Turkish society. In the present study, with the aim of understanding maternal attitudes and actual practices of discipline styles, qualitative and quantitative analyses were run with 125 children and their mothers. Results indicated that mothers of children with ADHD combined type were more prone to approve physical and verbal punishment as discipline styles, consistently; children with ADHD combined type were more frequently and more severely exposed to both physical and verbal maltreatment. Maternal approval of verbal maltreatment as a discipline style predicted disruptive behaviors of children and disruptive behaviors of children predicted increased

maternal approval and practice of physical punishment as a discipline style. Maternal scores on perception of childhood sexual abuse, emotion focused coping style, personality characteristics, and psychopathologies were found to be predictive for maternal approval and actual practicing of abusive discipline styles. Maternal approval of physical punishment was predictor of child depressive symptoms and it was a mediator between oppositional behaviors and depressive symptoms.

Key Words: ADHD, Child Abuse, Child Maltreatment, Discipline Styles.

ÖZ

DEHB OLAN VE OLMAYAN ÇOCUKLARDA ÇOCUK İSTİSMARI VE SONUÇLARIYLA İLİŞKİLİ ETKENLER: KARŞILAŞTIRMALI BİR ÇALIŞMA

- SÖZÜN BİTTİĞİ YERDE…-

Evinç, Şükran Gülin
Doktora, Psikoloji Bölümü
Tez Yöneticisi: Doç. Dr. Tülin Gençöz

Haziran 2011, 240 sayfa

Çocuk istismarı çocuk ruh sağlığı alanında çalışan uzmanların karşılaştığı en ciddi problemlerden biridir. Bu alanda yapılan sınırlı sayıdaki çalışmalar istismara uğrama riskinin DEHB (Dikkat Eksikliği Hiperaktivite Bozukluğu) olan çocuklarda daha yüksek olduğunu göstermiştir. Çocuk istismarının ve bununla ilişkili etmenlerin Türk kültüründe araştırılmasına gereksinim duyulmaktadır. Bu çalışmada, annelerin disiplin tutum ve uygulamalarının anlaşılması amacıyla 125 çocuk ve annesinden bilgi toplanmış, nitel ve nicel analizler yürütülmüştür. Sonuçlar DEHB bileşik tip olan çocukların annelerinin istismar içeren sözel ve fiziksel cezayı disiplin stili olarak kabul etmeye daha eğilimli olduklarını, aynı şekilde, bu çocukların daha fazla sözel ve fiziksel istismara uğradıklarını göstermiştir. Annenin sözel istismarı disiplin stili olarak kabul etmesi çocuğun davranış sorunlarındaki artışı, çocuğun davranış sorunlarındaki artış annenin fiziksel istismara başvurma olasılığını, sıklığını, ve bu

istismar türünün şiddetini yordadağı bulunmuştur. Annenin, kendi çocukluk cinsel istismar öyküsünün, duygu odaklı başetme stilinin, kişilik özelliklerinin, istismar içeren ceza türlerini disiplin stili olarak kabul etmesini ve uygulamasını yordadığı sonucu elde edilmiştir. Bununla birlikte, bu çalışmanın sonuçlarına göre, annenin fiziksel cezayı disiplin stili olarak kabul etmesi çocuğun depresyon puanı üzerindeki artışı yordamış ve çocuğun davranış sorunları ve depresyon puanı arasında aracı değişken (mediator) işlevi görmüştür.

Anahtar Kelimeler: DEHB, Çocuk İstismarı, Disiplin Stilleri.

To my lovely mother Fatma Evinç

ACKNOWLEDGEMENTS

If I were to write valuable people I know, all of whom deserving great thanks even just for the contributions of their presence in my life, I had to forget about the rest of the thesis and focus only on this section. I would like to thank everyone smiling to me with good intentions. Because seeing a smiling person makes you smile and this is one of the greatest presents that one can give to the other. I know there are many people deserving much more than this and no matter which or how many, words I can use here will not be enough to tell how much I love them and how much I feel thankful to them. I just hope somehow they all know about my true feelings. However, I will try my chance to tell my gratitude for their presence and contributions during the process of this thesis.

One day a fox sees rabit writing on a computer in front of a cave. The fox asks the rabbit what she was writing. The rabbit says she was writing a thesis about how a rabbit can eat a fox. Fox laughs and asks how it can be possible. Rabbit takes the fox into the cave to show how it can be possible and comes out alone. Same dialogue is established between the rabbit and various predaceous animals like tiger, bear…etc. The whole day passes this way and then the rabbit finishes her work for the day, the bird wonders about what was happening, goes into the cave and sees the bones of all predaceous animals and a lion lying behind the bones and cleaning his teeth. A good supervisor is a lion carrying the thesis and standing behind. Both for my master and doctoral thesis I worked with Prof. Dr. Tülin Gençöz and if I had to write thesis five more times I would prefer working with her. She surely is more than a supervisor and helpful in every stage of the thesis by every means she can do. I am happy to know her as a teacher, as a supervisor, as a colleague, and as a person.

Another stable and consistent member of my thesis committee is Prof. Dr. Ferhunde Öktem. She is not stable only as a committee member; however, she is also stable as a highly valuable person in many domains of my life. I would like to thank her for her warm and supportive attitudes and also for each and every valuable contribution she made to my thesis and to my life. Assist. Prof. Özlem Bozo was also a perfect

member of my thesis committee. I would like to thank for her understanding and helpful attitudes and for all her contributions to my thesis. Prof. Dr. Bengi Öner-Özkan encouraged me for conducting a qualitative study and Prof. Dr. Elvan İşeri provided valuable suggestions. I feel thankful to both Prof. Dr. Bengi Öner-Özkan and Prof. Dr. Elvan İşeri for their warm attitudes and contributions in my thesis committee. I feel thankful to Assist. Prof. Elif Kuş Saillard for sparing her time and introducing MAX QDA to me. I would also like to thank Prof. Dr. Runa Uslu for her helpful attitudes about using and scoring REMS.

I am grateful to Prof. Dr. Faruk Gençöz for encouraging me about finishing the thesis, to Prof. Dr. Bahar Gökler for everything she taught to me and for supporting me about my doctoral education and her understanding attitudes in this process and also to Prof. Dr. Füsun Çuhadaroğlu Çetin for her supervisions, her understanding and helpful attitudes in my writing period.

There are also people helping me with gathering my data or with my analyses. I am thankful to Prof. Dr. Fatih Ünal, Ferda Karadağ; Ms, Dr. Dilşad Foto Özdemir, Dr. Devrim Akdemir, Dr. Özlem Sürücü for their contributions in gathering data. Among all I am indepted to three people especially. I would like to present my special thanks to Ferda Karadağ for helping and supporting me in every stage of the study; data gathering, contacting with families, copying the inventories, organizing the data, and encouraging me for completing and presenting the study. I also would like to show my special gratitude to Dr. Dilşad Foto Özdemir for her contributions in data gathering and for her supportive, sharing and helpful attitudes during the whole process of the study. Dr. Devrim Akdemir is my other colleague I specially want to thank for her contributions in data gathering and also for her helpful and encouraging attitudes about the completion of the thesis. I also would like to thank these people for their sincere friendship.

When studying with clinically diagnosed patients it is difficult to find subjects meeting the inclusion criteria and every contribution in this stage is valuable. For this reason I am thankful to all my colleagues directing patients to this study with special emphasis to Dr. Candan Şimşek and Dr. Oğuzhan Karcı. Among my colleagues, together with Sema Yurduşen who helped me in my mediation analysis, I would like

to thank Zeynep Tüzün, Dr. Dilek Ünal, Dr. Burcu Ersöz, Dr. Ece Uslu, and Dr. Özlem Can Uzun for their helpful attitudes and consistent help offers.

I also feel thankful to Okşan Önder for being my friend and for her sincere offers about helping me in this process. She is a person that one can depend on by all means. I also would like to thank Alper Erdem and Doğukan Gürkan for their friendship and helpful attitudes. I should also thank to Şaziye Kaplan who was substantially helpful about my preparations, her helps in transferring information and delivering forms made the process much easier. I would like to thank Mehmet Yıldız for making his support available for preparations (such as setting the computer, carrying the equipments) before my presentations.

I owe my deepest gratitude to my lovely family which is consisted of perfect members - just like me (!). I am incredibly lucky to have the best mother of the world, who easily could have been the best model as well. My mother, Fatma Evinç, is an altruistic hero covering my life with her great love and supporting me in all my life, for whatever and whenever I need. Before anything else, she taught me loving which is the most valuable thing I have learned. Another perfect member of my family is my father Ziya Evinç. I don't know if I could be a better psychologist than him. He is so good in comforting, cheering someone up even in the worst conditions. He is also good at knowing the things that no one does; just like google. He always made me feel special, important, and free to ask about anything making me confused or worried. I have a beautiful sister; Yeşim Evinç, whom I could be easily jealous of if I did not love this much. She is a perfect sister and a perfect friend. She supported me physically, psychologically, in any respect during my doctorate; just like she does on all domains of my life. When we lived in the same house she beared my stressful times, she helped me have the best physical conditions to study and with this aim she sacrificed from many things she wanted to do. When she lived in a different city she went on supporting me psychologically and she always made me feel she would be teleported whenever I needed. I have the best aunt and the best cousin. My aunt Ayşe Taşdemir has always been like a kind, cheerful, loving, beautiful elder sister to me. She has supported me in every stage of my life. It is said that an aunt is a half-mother; she surely is much more than that. I am also happy that she has married with Ahmet Taşdemir and gave me a cousin (Ceren Taşdemir) who is also like a sister to

me. When I am talking about the family I should not skip my grandmother. Whenever we needed, she has been a like a second mother to me and my sister. She always been an altruistic person and never hesitated in giving her love and support to her grandchildren. Serdar Kural is the recent member of my family. He is my brother in law and he fulfilled an absence of a good brother in my life. In short, I deeply and sincerely thank to my mother, father, sister, grandmother, my aunt and her family, and also my brother in law.

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INTRODUCTION

1.1. Attention Deficit and Hyperactivity Disorder

1.1.1 Definition of the attention deficit and hyperactivity disorder

Attention Deficit and Hyperactivity Disorder (ADHD) is one of the most prevalently diagnosed disorders in child mental health services (American Psychiatric Association; APA, 1994; Barkley, 1997). It is reported to be the most frequent reason of the referral to the child health services (Barkley, 1996). The high prevalence of the disorder brings about the increasing interest in its etiology and contributions. ADHD is a chronic, neurobehavioral disorder (Van Cleave & Leslie, 2008) and it is defined as having difficulty in giving attention to the homework or work, and in delaying the wish for doing something else while working on a task, as well as being overactive which cannot be considered normal at that developmental progress. Diagnostic and Statistical Manual of Mental Disorders (DSM – IV; APA, 1994) denominates this disorder as ADHD and International Statistical Classification of Disease and Related Health Problems (ICD 10, World Health Organization; WHO, 1993) names it as Hyperkinetic Disorder.

The diagnostic criteria for Hyperkinetic Disorder according to ICD 10 (WHO; 1993) are, having inattention, hyperactivity, impulsivity symptoms that was present before the age 7 and that have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level and also exhibiting the combination of inattention and hyperactivity in two or more settings. The diagnostic criteria for ADHD according to DSM–IV (APA, 1994) are, having either inattention or hyperactivity-impulsivity symptoms that was present before age 7 and that have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level and also exhibiting these symptoms in two or more settings.
According to American Psychiatric Association (APA, 1994), there are three subtypes of ADHD: ADHD Predominantly Inattentive Type, ADHD Predominantly

Hyperactive-Impulsive Type, and ADHD Predominantly Combined Type. If the child suffers from ADHD Predominantly Inattentive Type, the symptoms of attention deficit are dominant and enough to be diagnosed while the symptoms of hyperactivity do not exist or are not strong (notable) enough to make the diagnosis**.** When the child is diagnosed with ADHD Predominantly Hyperactive-Impulsive Type, symptoms of hyperactivity and impulsivity are dominant. Symptoms of attention deficit may exist but they are not diagnosed. ADHD Predominantly Combined Type is considered when symptoms of both hyperactivity and attention deficit exist and are diagnosed. Predominantly hyperactive-impulsive children, when compared to predominantly inattentive children, are recognized in younger ages such as preschool years, while majority of inattentive children are diagnosed in school years or never recognized (Blum & Mercugliano, 1997).

1.1.2. Prevalence and manifestation

According to the estimates of American Psychiatry Association (APA, 1994), 3 – 5% of the school age children suffer from ADHD. ADHD is diagnosed more frequently in boys than in girls (Singh, 2008).The estimated female – male ratio is approximately 1/ 4 (APA, 1994). Studies support this estimation by indicating that ADHD is more prevalent among boys (Öktem & Sonuvar, 1993). Kent and Cralddock (2003), reported the frequency of ADHD as 5 – 9% among school age children and indicated that it was seen among boys three times more than among girls. Öktem (1993) reported that the frequency of ADHD among the girls of age between 4 and 12 was 4%, and the same percentage among boys was 10%. The higher ratio observed in boys may derive from genetic factors either determining the existence of ADHD or determining the primarily exhibited, dominant symptom. Thus, girls may tend to exhibit inattentive symptoms primarily and may not be recognized easily. Wodushek (2003), in his study with 45 participants, could not find any relation between severity of ADHD symptoms and age or gender but reported that education was negatively correlated with ADHD.

Though ADHD was thought to be a childhood disorder which ends through adulthood, in recent years there is a growing consensus among the researchers and clinicians about the idea that individuals keep on suffering from ADHD in

adolescence and in adulthood as well (Manuzza, Klein, Bessler, Malloy, & La Padulla, 1998). Studies indicate that 80% of the children having ADHD still exhibit similar symptoms in adolescence, a period of particular stress and impairment (Weiss & Murray, 2003). Öktem (1996) has reported that the estimated prevalence of ADHD among adults is 2%, this means that while 50% of the adults leave their ADHD symptoms behind, other 50% continue suffering from this disorder and this prevalence also shows some differences between women and men (2%, and 5% for women and men respectively). Studies report that among the ones who have a childhood history of ADHD, 50 – 80% of the adolescents and 30 –50% of the adults keep on suffering from ADHD (Barkley, Dupaul, & McMurray, 1990). Based on these findings, the researchers try to find the answer of how ADHD is manifested in adulthood. Depending on the Utah adult ADHD research group's studies, Wender (2000) defines the adult ADHD characteristics as motor hyperactivity, attention deficits, affective lability, hot temper, explosive, short – lived outbursts, emotional over activity, disorganization, inability to complete tasks, and impulsivity associated symptoms (e.g., Academic problems – independent of IQ level, social problems, relationship problems, marital problems, alcohol - substance dependence).

1.1.3. Comorbidity

ADHD is shown to be related to many other disorders. Biederman (1997) indicates that at least 50% of children with ADHD exhibit one or more comorbid disorders in a life time period. A study conducted in ADHD Research and Education Center in Canada concerning 137 ADHD children aged between 3 – 18, indicated that 29% of ADHD children did not have any additional diagnosis, while 35% had one, 25.5% had 2, and 8% had 3 additional diagnosis (Erman, Turgay, Öncü, & Urdavic, 1999). Learning Disorders (10%; Biederman et al. 1991), Tourette's Syndrome (20-90%) anxiety disorders (25%), mood disorders (24%; Milberger, Biederman, Faraone, Murphy, & Tsuang, 1995) are some of the disorders reported to show comorbidity with ADHD. However ADHD shows the highest comorbidity with disruptive disorders, namely; Oppositional Defiant Disorder (ODD) and Conduct Disorder. The high prevalence of comorbidity observed in ADHD samples seems to be of importance (Burke et al., 2005; Dick et al., 2005; Volk et al., 2005).

The factors underlying this prevalence are not well understood. ‘‘What determines the development of a disorder comorbid to ADHD?’’ It may be the overlap of symptoms (i.e., inattention and over activity) between ADHD and such other disorders as mania and depression. This overlap may even cause misdiagnosis. Another possible factor is a probable predisposing role of ADHD in many ways (e.g., determining the relationship of the proband with environment, effecting the parent child interactions, causing the managing difficulties). There may also be some common factors underlying both ADHD and the comorbid disorders, such as psychosocial, physiological, genetic, or environmental vulnerabilities. All these ambiguities point to our lack of understanding of the etiology, which also affect the development of effective intervention programs.

1.1.4. Oppositional defiant disorder (ODD)

Oppositional Defiant Disorder (ODD) is defined as having negativistic, hostile, or defiant acts that hinder functioning in academic, occupational, or social domains (APA, 1994). 35% of children with ADHD exhibit comorbid ODD (Burke et al., 2005; Dick et al., 2005; Volk et al., 2005). The prevalence of comorbidity of ODD and Conduct Disorder (CD) was found to be around 35% (Anderson et al., 1987, Biederman et al., 1990, Faraone et al. 1991). According to some studies, oppositional behavior and substance abuse disorders are seen more prevalently among people with ADHD as compared to control group (Murphy & Barkley, 1996).

The ratio that ADHD overlaps with conduct disorder and oppositional defiant disorder is reported as 40 – 95% (Turgay et al., 1994; Faraone et al., 1995). The high prevalence of comorbid ODD and ADHD may derive from some common genetic factors, the characteristics of ADHD such as being a vulnerability factor for behavioral disorders because of the association with poor interpersonal relationships, or may derive from the characteristics of mothers of children with ADHD who have difficulty in catching the social cues.

1.1.5. Conduct disorder (CD)

Conduct Disorder (CD) is defined as having persistent antisocial acts in children and adolescents, which can be clustered in four areas: aggression to people and animals, destruction of property, deceitfulness and theft, and serious violations of rules. It has been indicated that the prevalence of CD among children with ADHD was 30 – 50% (Milberger et al. 1995), 54% (Şenol 1997).

1.1.6. Etiology

Despite the great concern for the etiology of ADHD, researchers indicate that there is no specific reason of ADHD, but there are many conditions observed to contribute to this disorder, for example; genetic, biological, brain related, and environmental contributions.

1.1.6.1. Genetics – biological – brain related factors

Researchers investigating the genetic factors contributing to ADHD focus on twin studies (e.g., Bradley & Golden, 2001). The monozygotic twins show 80% concordance, same sex dyzygotic twins show 30% concordance rate. Family studies give evidence to genetic factors underlying this disorder, by indicating that 10-35% of family members of children with ADHD exhibit the same disorder (Bradley & Golden, 2001). The role of dopaminergic neurotransmitter system has been extensively studied (e.g., Sagvolden & Sergeant, 1998; Swanson, et al., 2001) DAT1, DRD2, DRD3, DRD4 and DRD5 are the dopamine related genes which are thought to have an essential role in the core symptoms of ADHD (Kirley et al., 2002; Muglia et al., 2000; Sagvolden & Sergeant, 1998). Studies conducted to detect the brain dysfunctions report abnormalities in prefrontal, parietal, and temporal lobes, caudate nuclei, corpus collasum, cerebellum of ADHD children and reduction in volumes of either the whole brain or its specific areas (Sürücü, 2003; Tannock, 1998). Studies indicate an association between executive functions and ADHD independently from comorbid conditions (Nigg, Carte, Hinshaw, & Treuting, 1998). Barkley (1997) in his comprehensive review study reports that 4 executive neuropsychological functions are linked with inhibition: (a) working memory, (b) self-regulation of

affect–motivation–arousal, (c) internalization of speech, and (d) reconstitution (behavioral analysis and synthesis).

1.1.6.2. Psychosocial and environmental factors

Among environmental factors alcohol and tobacco smoke exposure during pregnancy and in very early life after birth are implicated to lead ADHD (Braun, Kahn, Froehlich, Auinger, Lanphear, 2006) A study made in Child Mental Health services of Hacettepe University, Turkey, revealed that 20% of the children with ADHD were premature babies (Öktem, 1996). The period of taking mother milk is indicated to be shorter in boys with ADD (approximately 5.5 months), and ADHD (approximately 1 – 2 months) compared to normal comparison group (Öktem & Sonuvar, 1993). The roles of feeding, vitamins, and dyes containing lead are being investigated in the etiology of ADHD. Foodstuffs are also thought to be associated with ADHD (Feingold, 1976). Some researchers suggest that children with ADHD have a tendency to allergic disorders (McGee et al., 1993).

Adverse family environment (e.g., low socio-economic status (SES), marital problems or mental disorder of parents, having a criminal parent etc.) has been shown to increase risks for child ADHD (Rutter & Quinton, 1977). Researchers also stated that there were different interactions between the ADHD children and their parents (Öktem, 1993) especially the interaction between hyperactive adolescents and their parents was even worse (Barkley et al., 1991). Results of some studies indicated that mothers of ADHD children were more controlling, autharitative and punishing (Cunningham & Barkley, 1979; Hechtman, 1981, 1996). These results may be interpreted either as low parenting skills leading to ADHD symptoms of children or as having ADHD children raising difficulties in parenting, or both. McClearly and Ridley (1999) stated that parent education program is one of the treatments used in order to reduce the negative sequella of ADHD. Researchers also indicated that parents who participated in their intervention programs reported improved parenting skills that help them in managing their children with ADHD. Biederman, Milberger et al. (1995) stated that the environmental factors predicted the poor prognosis of ADHD more than the disorder itself. However, results of the study conducted by Pekcanlar et al. (1999) did not reveal any dysfunction in family factors

in their sample consisting of different age groups, except for some communication and control problems they observed in the 9 – 14 age groups.

While the unshared environment can be shown as an underlying cause of HD, shared environment (Nigg & Hinshaw, 1998) was also shown as one of the underlying factors for antisocial behaviors and comorbid disorders of children with ADHD (Edelbrock, Rende, Plomin, & Thompson, 1995; Nigg & Goldsmith, 1998). In accordance with this, a great number of psychopathologies are shown to be more common among the relatives of ADHD children especially among parents compared to relatives of normal comparison samples (Biederman, Faraone, Keenan, & Tsuang, 1991; Biederman, Faraone, Keenan, Steingard, & Tsuang, 1991; Biederman, Faraone, Keenan, Knee, & Tsuang, 1990; Farone et al., 1991; Frick et al., 1991). The reason underlying the great number of psychopathology of either the ADHD proband or the relatives of ADHD proband is still an issue of debate. As parental characteristics, such as personality and psychopathology, are thought to play a great role on the psychosocial development of the child through many ways such as modeling, effecting the child parent interactions; thus, it seems as an important issue to understand. However in order to increase our understanding of this relationship, it seems useful to examine this issue under broader topics.

1.1.7. The possible negative outcomes of ADHD

ADHD has both short term and long term outcomes. In the short term children with ADHD exhibit difficulties in many domains during their childhood; externalizing difficulties (Hinshaw, 1987), internalizing problems (Jensen, Martin, & Cantwell, 1997), peer relationships (Hinshaw & Melnick, 1995), and academic performance (Hinshaw, 1992). Children experiencing problems in all these domains feel rejected and especially perception of peer rejection contributes to ongoing behavioral problems of ADHD (Parker & Asher, 1987). Related with these findings, ADHD is seen as a great risk for antisocial behaviors (Loeber, 1991). Manuzza et al. (1991) conducted a follow up study concerning 94 hyperactive boys selected among the patients who were evaluated in a no–cost psychiatric clinic between the years 1970 – 1977 and 78 normal controls. Their results revealed that participants who had an ongoing ADHD diagnosis were more likely to develop antisocial disorder, and

substance abuse (Manuzza et al., 1991). Studies indicate that the majority of criminal youth suffering from ADHD and hyperactivity is a strong criminogenic factor (Dalteg, Lindgren, & Levander, 1999). Dalteg and Levander (1998) have found hyperactivity to be an important predictor of poor outcome among juvenile delinquents.

Researchers have indicated that 80% of the children diagnosed with ADHD continue having symptoms in adulthood (Weiss & Murray, 2003), and childhood ADHD has also long term outcomes which occur in adulthood such as poor adult psychosocial life conditions (Dalteg, Lindgren, & Levander, 1999). Leaving the school, having problems in marriage, low social abilities, lack of attention in traffic, smoking habit, insufficiency at work, lower socio-economic status, poor planning skills, and higher risk of distress disorders are some of these possible negative outcomes (Barkley, Murphy, & Kwasnik, 1996; Borland & Heckman, 1996; Gittelman, 1985; Manuzza & Klein, 1999; Nigg et al., 2002;).

Results of these studies reveal various ways that adults manifest their symptoms: Among them there are adjustment and employment problems, relationship difficulties, car accidents, and other complications (Manuzza & Klein, 1999). It is suggested that even the individuals who do not carry on a diagnosable ADHD to adulthood, manifest subtreshold problems like inattention, impulsivity, mood disorders, and other adaptation or health problems (Nigg, John, Blaskey, Pullock, & Willcut, 2002).

1.2. Child Abuse and Neglect

1.2.1. Definition of child abuse and neglect

Physical, emotional or sexual maltreatment that hinders the optimal development of the child can be considered as child abuse or neglect. In 1961 Henry Kempe, described the “Battered Baby Syndrome” and since then professionals working with children drew more interest to this issue. Although the ratios about the prevalence of child abuse and neglect vary depending on the definitions of abuse and the sample studied on, in general it can be concluded that the prevalence of child abuse and

neglect are extremely striking. According to the world health organization, 40 million children aged between 1-14 years in all over the world are being neglected or abused (Johnson, 1996).

1.2.2. Child emotional neglect and abuse

It is the type of maltreatment that represses the psychological growth of the children. According to Barnett, Manly, and Cicchetti (1993) an emotionally maltreated child does not feel psychologically safe, accepted, and supported to develop autonomy required by his/her age in his/her environment.

Six main forms of emotional abuse are defined (Garbarino & Garbarino, 1994; Glaser, 2002); rejecting (refusing to acknowledge a person's presence, value or worth), degrading (insulting, ridiculing, name calling, imitating and infantilizing), terrorizing (inducing terror or extreme fear in a person; coercing by intimidation; placing or threatening to place a person in an unfit or dangerous environment), isolating (physical confinement; restricting normal contact with others; limiting freedom within a person's own environment), corrupting/ exploiting (socializing a person into accepting ideas or behavior which oppose legal standards), denying emotional responsiveness (failing to provide care in a sensitive and responsive manner). Though emotional and physical maltreatment (abuse and/or neglect) often occur together emotional abuse may also be observed without physical abuse (Korfmacher, 1998). Among 90% of physical abuse and neglect cases, emotional maltreatment is also reported (Claussen & Crittenden, 1991; Korfmacher 1998). Schneider (2005) indicates that emotional abuse threatens self confidence and autonomy and, in turn, this may lead to post traumatic stress disorder.

1.2.3. Child sexual abuse

Sexual abuse may be defined as any sexual activity that an adult or a substantially older child carries out with a child before the age of legal consent (Green, 1996). These activities may vary such as: oral-genital, genital-genital, genital-rectal, hand-genital, hand-rectal, or hand-breast contact; exposure of sexual anatomy; forced viewing of sexual anatomy; and showing pornography to a child or using a child in

the production of pornography. If these activities are perpetrated by another child, who is maximum 4 years older than the child exposed to these activities, they may be considered as sexual play. However in order to call these activities as sexual play there should not be force or coercion should not be included in to those activities (Johnson, 2001).

According to the definitions and data-gathering techniques the reported prevalence of child sexual abuse varies. Wurtele and Miller-Perrin (1992) maintained that the prevalence of child sexual abuse ranged from 7% to 62% for females and 3% to 16% for males. Kendall-Tackett and Marshall (1998) suggested that the rates of these problems vary not only according to the population surveyed, but also according to the definition of sexual abuse as operationalized by the investigator. Finkelhor (1994) surveyed the international rate of child sexual abuse based on research conducted among nonclinical populations in English speaking and Northern European countries, as well as in Costa Rica, the Dominican Republic, Spain, and Greece. Finkelhor's survey and analysis revealed similar international rates of child sexual abuse in the United States and Canada, ranging from 7% to 36% for women and 3% to 29% for men.

Child sexual abuse has both short and long term effects. Kendall-Tackett and Marshall (1998) indicated that the psychological and medical sequella of abuse can appear immediately or later. A study conducted in Palestinia university students indicated sexual abuse was associated with significantly higher levels of psychoticism, hostility, anxiety, somatization, phobic anxiety, paranoid ideation, depression, obsessive-compulsiveness, and psychological distress compared to their non-abused counterparts (Haj-Yahia & Tamish, 2001). Consistently, Paredes, Leifer, and Kilbane (2001) suggested that mothers who were sexually abused as children, and who had more problems in their family of origin had children showing poorer functioning and more behavioral symptomatology. However, results of the study conducted by Oates and colleagues (1998) did not support these findings. Oates and colleagues (1998) assessed the sexually abused children for self-esteem, depression and behavior at the time of diagnosis, after 18 months and after 5 years. Results of these researchers showed no difference in any of these measures at any of the three time intervals between those whose mothers had suffered child sexual abuse and

those whose mothers had not been abused. The study of Calam and colleagues (1998) may explain the contradiction between these findings. Calam and colleagues (1998) studied with 144 sexually abused children and they conducted three follow up sessions 4 weeks, 9 months, and 2 years post investigation. According to their results the abused children frequently complained about sleep disturbance, temper tantrums, and depression. Among these problems, depressive and anxious symptoms of the children decreased by time. Interestingly, Calam and colleagues (1998) found that as anxious and depressive symptoms decreased in their sample, suicide attempts, substance abuse, lack of interaction with peers and sexualized behavior increased. This finding raises a question whether anxious and depressive symptoms actually decrease or just change form in time. This is important because if the form of distress symptoms are changing form in time, rather than disappearing, examining the same symptoms in the determined time intervals may lead to bias and false negatives in the researches investigating the long term effects of child abuse. For this reason, it may be better to screen abused people for the whole psychopathology on the time intervals determined before.

1.2.4. Physical neglect and abuse

Physical neglect can be defined as causing physical problems on children by providing insufficient nutrition, clothing and hygiene (Kaplan, Pelcovitz, Labruna, 1999). Physical abuse is physical harm given to the children aged below 18 years. The perpetrators are generally the parents or another caregiver (Kaplan, 1996). The perpetrator intentionally gives the child a violent physical punishment or causes the child feel physical pain (Widom, 1989).

In general the physical neglect and abuse frequencies are high in most of the cultures (Hunter, Jain, Sadowski, 2000; Jones, & McCurdy, 1992; Samuda, 1988). However, the frequencies change according to many factors such as the definition of physical abuse, the cultural acceptance of physical punishment in the study sample, the age and the gender of the sample.

Jones and McCurdy (1992) studied in America where the laws are known as very strict about child abuse and found that 40% of children were victims of physical

neglect, 29% of children suffered from physical abuse and 17% were followed after a sexual abuse. However an Indian study indicated that the ratio of physical abuse in India was found to be much higher (42%) than the results of Jones and McCurdy (1992). Results of a study from Hong Kong suggested that the prevalence of physical abuse in that culture was 95%, however, in this study sample was consisted of University students, and they were asked to rate their childhood abuse history. In dependently from the culture it is shown that university students and the parents may differently define and rate the abuse (e.g., Orhon et al., 2006). Mostly, researches who investigate the parental attitudes about maltreatment types prefer studying with mothers (e.g., Ateah & Durrant, 2005; McElroy & Rodriguez, 2008; Schneider et al., 2005) rather than fathers, but still there are studies including fathers (e.g.; Francis & Wolfe, 2008) or both parents (e.g.; Park, 1996). The results of a study conducted by Park (1996) indicated that mothers in Seoul were more prone to use corporal punishment compared to fathers. This finding suggests that selection of parent is another factor determining the differences between the physical abuse prevalence found in different studies.

Turkish studies about physical abuse are very few. In one of these Turkish studies Oral and colleagues (2001) reported that discipline styles including physical violence were common among Turkish families and they indicated that in their sample consisting of 55 Turkish families, the offenders were only fathers in 38%, only mothers in 28%, and multiple in 34% of the cases. Another study suggested that children under the age of five are at increased risk for physical discipline and 36% of these children were exposed to physical abuse (Bilir, Ari, & Dönmez, 1986). Orhon et al., (2006) studied with 210 adults and asked them to complete a questionnaire about discipline practices. According to their results compared to parents, pediatric residents and medical students were more likely to accept abusive practices as discipline. Researchers also indicated that abusive discipline practices of pediatric residents and medical students were significantly associated with their childhood abuse experiences. This study was conducted by administering a questionnaire, thus differences between parents and other two groups, namely; pediatric residents and medical students may be related to parents biased responses to the questionnaire. More studies are needed to determine the physical neglect and abuse among Turkish

families, and also to determine professional groups' attitudes towards physical maltreatment.

1.2.5. Risk factors for child emotional and physical maltreatment

Defining risk factors is somewhat difficult and risky because it may lead to a wrong idea as 'there may be some factors that may cause child abuse or neglect'. When talking about the child abuse and neglect primarily it must be accepted that nothing may be an eligible and a valid reason for giving such kind of maltreatment. However, some conditions or characteristics of the environment, of the parent or children may predispose the maltreatment. In order to be able to conduct the most effective intervention we need to understand the underlying factors.

To better understand and clarify the data obtained about the characteristics of the abuser, abused child and the context that abuse occurred in, researchers made several categorizations. For example, Brown and colleagues (1998) categorized risk factors as child or adult characteristics (referring to the characteristics of the children and their parents), family functioning (referring to marital happiness or discord, income of the family and presence of a single parent or step-parent), community level (socio-economic status and neighborhood relations of the families), and the socio-cultural context (referring to cultural attitudes about child rearing). Similarly, Bronfenbrenner (1979), identified four levels of analysis: microsystems (the immediate setting), mesosystems (relations between settings), exosystems (broader social system settings), and macrosystems (overarching patterns of ideology and/or institutional organization). Microsystems, the immediate setting refers to the child, parents, family, and the conditions at individual or family level. Mesosystems, relations between settings, refer to the context that the microsystem settings (parents, family, and the conditions at individual or family level) occur and the relationship between them. Exosystems, broader social system settings, refer to the conditions and the social factors of the community. Macrosystems, refer to the overarching patterns of ideology and/or institutional organization, refer to the cultural factors and ideologies accepted, the social constitution. Belsky (1980) added another level, termed "ontogenic development" to the Bronfenbrenner's categorization. This category includes the factors about the past experiences that the parent has lived and at the

time s/he brings to the interaction. When, overviewed, it may be concluded that risk factors may be related to the children's characteristics, parents' characteristics (including their past and current experiences, familial characteristics and conditions), cultural factors and culturally approved discipline styles.

1.2.5.1. Child characteristics

Some characteristics of children may lead to higher vulnerability for being physically or emotionally abused (Ammerman, 1990). Younger children and male children are significantly more likely to be the victims of physical violence than older children and females (Berger, 2005; Ross, 1996; Straus, 1994). In addition to this, children having difficult temperament for example, children with behavioral problems are at higher risk of being abused (Frodi, 1981; O'Keefe, 1995). In a group of 532 Italian preadolescents, Baldry (2007) investigated whether aggressive and delinquent behaviors may be indicators of direct or indirect child maltreatment. Results of the study indicated that, compared to normative data, preadolescents with aggressive and delinquent behaviors were exposed to higher levels of direct and indirect family abuse. Children with developmental delays, disorders (Ammerman, Hersen, Van Hasselt, McGonigle, & Lubetsky, 1989), with physical disabilities (Goldson, 1998; Oates, 1996), or with chronic diseases were known to be particularly vulnerable (Sullivan & Knutson, 2000). The child related factors may be bidirectional. Such factors as, behavioral disorders, aggression, may precipitate child abuse but may also occure as a result of being abused. As Belsky noted (1980), "... characteristics of the child make sense as elicitors of maltreatment only when considered vis a` vis the caregiver's attributes" (p. 324).

1.2.5.2. Parental factors

Studies investigating the predictors of child abuse, suggest that parental characteristics have great importance on the likelihood of physical punishment and child abuse. Younger parental age (Lealman, Haigh, Phillips, Stone, & Ord-Smith, 1985; Olds et al., 1986; Straus, 1994; Wolfe, Edwards, Manion, & Koverola, 1988), low parental education (Bowker et al., 1988; Margolin & Larson, 1988; Zuravin & DiBlasio, 1992), low income (Bowker et al., 1988; Caliso & Milner, 1992; Cicchetti

& Rizley, 1981; Coohey, 2000; Gillham et al. 1998; Sedlak & Broadhurst, 1996; Straus & Smith, 1990), being a mother in adolescence (De Pa´Ul & Domenech, 2000), parental physical and mental health (Cicchetti & Rizley, 1981; Margolin & Larson, 1988), parent's ability to empathize and take the perspective of their child (McElroy & Rodriguez, 2008) are among the parental factors frequently indicated to be significant predictors of child maltreatment.

When studies are reviewed it may be concluded that higher parental anger and lower cognitive ability of empathizing are two factors associated with each other and with child maltreatment. Empathy is a cognitive-emotional process including; emotion recognition, perspective-taking, emotion replication, and response decision (Marshall, Hudson, Jones, & Fernandez 1995) and anger is an emotion indicated to provoke misinterpretation of the emotions and the intentions of others (Hall & Davidson, 1996; van Honk, Tuiten, de Haan, Van den Hout, & Stem, 2001; Wingrove & Bond, 2005). Abusive parents were shown to have expectations from their children which are unrealistic and incongruent with the child's developmental level (Azar, 1997; Azar & Siegel, 1990). It has been also reported that abusive parents cannot empathize with the child and misinterpret the situation when their expectations are not met, in turn, easily get angry (Hall & Davidson, 1996; Mash & Johnston, 1990). In conclusion, lower cognitive ability of empathizing (McElroy & Rodriguez, 2008) and higher parental anger was shown to be associated with higher likelihood of child maltreatment (Ateah & Durrant, 2005).

Though the cognitive difficulty of parents especially on empathizing was strongly associated with child maltreatment (Feshbach, 1964; Feshbach & Feshbach, 1969; Feshbach, Feshbach, Fauvre, & Ballard-Campbell, 1983; Mehrabian & Epstein, 1972) and fathers were shown to have greater difficulty on empathizing (Perez-Albeniz & Paul 2004), studies also indicated that mothers were more likely to show positive attitudes about using corporal punishment than fathers. In general mothers play a higher role on the education and discipline of the children, for this reason, they may be experiencing higher burn out (Park, 2000).

Familial characteristics such as type of the family and number of the children at home are also among the parent related factors determined as important predictors of

child maltreatment. Families with more children tend to engage in more physical violence (Berger, 2005). It is possible that when there are more children at home parenting stress increases and tolerance decreases. Marital status is another familial factor suggested to predict child maltreatment. Being a single parent family or two parent family may differentiate the likelihood of child maltreatment. It is reported that single working mothers have higher child maltreatment rates (Paxson & Waldfogel, 1999, 2002). This may be related to increased parenting stress and/or increased economical problems. Berger (2005) has found that income is a significant moderator between being single parent and exhibiting maltreatment. Specifically, Berger (2005) suggested there was a significant association between being a single parent and maltreatment among the families with low income but not among the ones with high income. However, Berger (2005) also indicated that compared to family type, depression, maternal alcohol consumption, and history of family violence were more important predictors of child maltreatment and their predictive roles were valid for both single and two parent families. Depending on the economical reasons or not, according to these results being a single parent family may be associated with higher parenting stress and child maltreatment. On the other hand, being a two parent family might also be considered as a stress and risk factor when there is violent or non-violent marital discord. According to the results of a study conducted by Edleson (1999) the co-occurrence of domestic violence and child maltreatment is between 30% and 60%.

Among the mental health problems of parents, depression (Whipple & Webster-Stratton, 1991), substance abuse and post-traumatic stress disorder (PTSD) were shown to be related to abusive parenting (Famularo, Kinscherff, & Fenton, 1992; Kelleher, Chaffin, Hollenberg, & Fischer, 1994; Murphy et al., 1991; Whipple & Webster-Stratton, 1991). Francis and Wolfe (2008) studied abusive attitudes and predictors of these attitudes and suggested that abusive fathers reported more mental health concerns (such as depression, hostility, and paranoid ideation), more stress in parenting, and significantly less empathy for their children. Lesnik-Oberstein et al. (1995) compared psychologically abusive Dutch mothers and non-abusive mothers on measures of psychiatric symptoms, aggression/ hostility, several dimensions of personality, social activity, verbal reasoning ability, and physical health. The

psychologically abusive mothers reported more dysthymic symptoms, neurotic symptoms, and aggression and hostility than did non-abusive mothers.

Perceived social support is suggested to play a stress buffering role and decrease the likelihood of children's being maltreated (Cicchetti & Rizley, 1981; O'Keefe, 1995; Straus & Smith, 1990). Consistently, compared to non-abusive, psychologically abusive mothers engaged in fewer social activities, scored lower on a measure of verbal reasoning, higher on social anxiety and lower on self-esteem (Lesnik-Oberstein et al., 1995).

1.2.5.3. Discipline and physical-emotional (verbal) abuse / maltreatment

1.2.5.3.1. The discrepancy between discipline and maltreatment

There are several rules people have to obey on all domains of real adult life, for example, not speaking loudly in a library, not making speed in traffic, not using others belongings without permission. Discipline is a process of learning and obeying the rules and this process is controlled first by the external sources (parents, teachers etc.), later by the internal sources (Hart, DeWolf, Wozniak, & Burts, 1992; Michels, Pianta, & Reeve, 1993; Smith & Brooks-Gunn, 1997; Strassberg, Dodge, Pettit, & Bates, 1994). The aim of discipline is helping the child gain self control and self discipline (Howard, 1991, p. 1352). These features are necessary for the child to socialize appropriately and adapt to the real world (Darling & Steinberg 1993, Rosen (1997).

Learning approach suggests (Skinner, 1938) that in behavior learning of organism reinforcement and punishment are important concepts. According to Skinner (1938) reinforcement, either positive or negative, aims to increase the likelihood of a behavior through something pleasant (Budak, 2003; Erden & Akman 1995). On the other hand, punishment, either positive or negative, aims to reduce the likelihood of a behavior through something unpleasant (Morgan, 1981). Punishment can only be effective when it occurs immediately after the behavior and when it consistently follows every instance of that behavior (Morgan, 1981). Punishment styles of some parents might include physical force. When the parents use physical force with the

intention of causing a child to experience pain, but not injury, for purposes of correction or control of the child's behavior, it is called corporal punishment, physical punishment, or physical maltreatment (American Academy of Pediatrics, Committee on Psychosocial Aspects on Child and Family Health, 1998; Holden, 2002; Straus, 2001).

Discipline is not solely reinforcement or punishment; indeed, it is a broader concept referring to the learning process. The purpose of an ideal discipline strategy is to teach a child how to behave and how to develop his/her moral character, rather than merely reducing a child's misbehavior (McCormick, 1992). Thorndike (1898) suggested that saying "wrong" had less effect than saying nothing, and the most effective response was saying "right" to the learner's responses. Consistently with Thorndike (1898), Vittrup and Holden (2010) suggested that punishment may not be effective in long term behavior changes. Researchers asked 6–10 years old children to watch videos depicting a child being disciplined and then asked them to rate each discipline method. Reasoning was rated as most fair, spanking as least fair method. Spanking was regarded most effective for immediate compliance but not for long-term behavior change (Vittrup & Holden, 2010).

The low long term effectiveness may be related to the aim and the fairness of the punishment given to a child, and to the extent of the association between the punishment and the behavior to be corrected. Park (1996) investigated the discipline strategies from the children's perspective and reported that severely or lightly 76.7% of children perceived to be physically punished in the last year and according to their data, regardless of the severity of the physical punishment 12% of children failed to associate the punishment with the actual reason. Parents' preferences of discipline strategy, sadly, are not made due to the effectiveness and quality. Ateah and Durrant (2003) suggested that not the goal of discipline but maternal anger following the child misbehavior predicted physical punishment use. Depending on these results one may conclude that when the parents, apart from their anger, aim to help their children learn the right behavior, the most effective way is to provide discipline in an empathic and supportive context.

1.2.5.3.2. Approval of physical discipline and intergenerational transmission from a cultural perspective

Discipline cannot be discussed ignoring the context it occurs in. In order to comprehend discipline, child related, parent related, and socio-cultural factors must be understood well. Collier and colleagues (1999) emphasized the importance of cultural differences when deciding whether an act is an abuse or not. Considering the cultural factors, the concepts of maltreatment and abuse may be distinguished from each other. An act may be considered as physical or verbal punishment, maltreatment or as an abuse depending on the parents' intent, severity and the cultural acceptance of the act (Elliott, Tong, & Tan 1997). All these styles are known to be inappropriate and it is difficult to distinguish one from the other in actual life, however, as Whipple and Richey (1997) suggested, among the maltreatment types, physical discipline, punishment, and abuse must be differentiated in order to understand the phenomena better.

Studies conducted in different cultures widely reported that parents believe in the effectiveness of physical discipline and approve using slight physical discipline (Collier & colleagues, 1999; Kağıtçıbaşı & colleagues, 2001; Orhon, Ulukol, Bingoler, Gulnar, 2006; Qasem, Mustafa, Kazem & Shah, 1998; Simons, Whitbeck, Conger, & Chyi-In, 1991; Whipple & Richey, 1997). A cultural study conducted in Turkey revealed that Turkish mothers of children receiving preschool education easily supported the children's appropriate behaviors, but experienced difficulty and felt less competent in decreasing inappropriate behaviors, in turn, exhibited inappropriate attitudes such as punishment, shouting, physically punishing, and threatening (Kircaali-Iftar, 2004). Orhon, Ulukol, Bingoler, Gulnar (2006) conducted a cross-sectional survey with 65 parents, 39 pediatric residents, and 106 medical students. Authors asked participants to complete a questionnaire (Survey of Standards for Discipline). According to their results life-threatening practices were accepted as discipline by none of the groups, but among the participants, 43.3% declared beating as acceptable. Among the medical students with an abusive childhood experience, 56.5% accepted beating as appropriate. Similarly Collier, and colleagues also (1999) reveled that in Palau physical punishment is considered culturally appropriate, unless it led severe injuries, and unless it is perpetrated

without the goal of discipline. Consistently, in their cross sectional interview Qasem, Mustafa, Kazem and Shah (1998) with 337 Kuwaiti parents indicated that 68% of parents approved physical punishment as an educational aspect especially when the misbehaviors of children were more serious. Yoon (1997) surveyed Korean public and professional groups (social workers, medical doctors and teachers) in order to investigate their perceptions about abuse and child maltreatment. The results of this study also revealed that while social workers and medical doctors name all types of maltreatments (emotional - physical discipline or punishment) as abuse, general public and teachers did not consider the maltreatment types as abuse unless there was a physical injury.

The results related to acceptance of physical punishment and categorization of abusive behaviors according to cultural factors must be interpreted with caution because even if the parent begins the physical punishment with the aim of discipline when the punishment does not work it may result in physical abuse (Hemenway, Solnick, & Carter, 1994). Research conducted about the discipline styles of the parents and the physical abuse demonstrated that the majority of substantiated cases of child physical abuse occurred in the context of punishment (Kadushin & Martin, 1981; Samuda, 1988; Trocm´e & Durrant, 2003).

It has been shown that approval of physical discipline is a great risk factor for child physical abuse. More specifically, it has been indicated that individuals who exhibit attitudes supporting physical punishment are more likely to abuse their children than those who oppose physical punishment (Jackson, Thompson, Christiansen, Colman, Wilcox, & Peterson, 1999; Qasem, Mustafa, Kazem & Shah, 1998; Vargas, Lopez, Perez, Zuniga, Toro, & Ciocca, 1995). Similarly, Whipple and Richey (1997) examined five articles from American literature and reported that approval of physical discipline attitudes like spanking predicts actual occurrence of abusive discipline and parents approving physical discipline spanked their children more often than did parents disapproving physical discipline. They concluded that parents disapproving physical discipline also used physical punishment but the frequency per day was lower. Therefore, a parent's attitudes towards child physical abuse seem to be an important predictor of child physical abuse.

Cultural approval and intergenerational transmission of child abuse seem to have a bidirectional relationship. As reported above, cultural approval of physical discipline increases the possibility of physical abuse. On the other hand, past experiences of childhood abuse and current domestic violence may lead to normalization of violence and a negative identification and in turn, may bring out and approval of its use (Bower-Russa, Knutson, & Winebarger, 2001; Durrant, Broberg & Rose-Krasnor, 1999; Holden et al. 1995; Jackson et al., 1999). A childhood history of abuse (Buntain-Ricklefs, Kemper, Bell, & Babonis, 1994; Graziano, Hamblen, & Plante, 1996; Holden & Zambarano, 1992; Jackson, et al., 1999; Rodriquez & Sutherland, 1999; Socolar & Stein, 1995; Straus, 1990), having witnessed violence in one's home of origin (Merrill, Hervig, & Milner, 1996; Ross, 1996; Straus & Smith, 1990) and having experienced corporal punishment (Straus, 1994) were regarded as risk factors for abusive parenting. Results of Kaufman and Zigler (1987), related to the association between childhood abuse history and abusive attitudes, are striking. Kaufman and Zigler (1987) suggested that 1/3 of parents with childhood abuse exhibited maladaptive and abusive attitudes to their children. The findings of Bower and Knutson (1996) also seem to strongly support such association between childhood abuse history and abusive attitudes. Bower and Knutson (1996) screened 1359 university undergraduates for childhood disciplinary histories and their perceptions of that history. Among the 1359 students the ones reporting to be physically punished were required to assess discipline attitudes. According to their results among the students having severely punitive histories, compared to those who labeled themselves abused, the ones who did not label themselves as abused were less likely to classify events physically abusive. Additionally, students who had experienced a specific form of physical discipline as a child were less likely to label that form of discipline abusive.

Rodriguez and Sutherland (1999) examined how childhood history of discipline predicted the 'maternal perception about how severe and typical punishments' were; and the use of discipline techniques. Ninety-nine parents were required to judge the severity of the disciplines depicted in the 12 physical discipline scenarios and reported the frequency of their childhood experience of such discipline and how often they had used them with their own children. Presence of such discipline in the parent's childhood was found to be related to the parent's use of that method, and the

parents judged techniques they used with their own children as less severe and more typical as methods of discipline.

Milnera and colleagues (2009) suggested that childhood physical abuse may be predicting perpetrating child physical abuse through trauma symptoms. In their study conducted with 5,394 participants (parents including both mothers and fathers and college students) they found that the association between a history of child physical abuse and adult child physical abuse risk was largely mediated by psychological trauma symptoms (Milnera et al. 2009).

Another possible explanation may be the transmission of impaired parenting (Egeland, Jacobvitz, & Sroufe, 1988; Simons, Whitbeck, Conger, & Wu, 1991). Parents learn parenting from their own parents and the ones grown up with harsh discipline practices normalize these attitudes (Bower-Russa, Knutson, & Winebarger, 2001; Durrant, Broberg & Rose-Krasnor, 1999; Holden et al., 1995; Jackson et al., 1999) and consider as acceptable disciplin styles (Bower-Russa, Knutson, & Winebarger, 2001; Kaufmann & Zigman, 1987). In addition to this higher revictimization is indicated among the adults having a history of childhood abuse (Yehuda, Spertus, & Golier, 2001). Women with history of childhood abuse, are suggested to be at higher risk for domestic violence (Yehuda, Spertus, & Golier, 2001) which may contribute to a mother's tendency to use corporal punishment (Claussen & Crittenden, 1991; Fantuzzo et al., 1991; Kolko, 1992; Salzinger, Feldman, Hammer, & Rosario, 1991). Intergenerational transmission of maltreatment may also be a result of the higher aggression (Sternberg, 2006), anger (Egeland, Sroufe, & Erikson 1983), distress disorders (Moeller, Bachmann & Moeller 1993; Yehuda, Spertus, & Golier, 2001), and social problems including having difficulty in intimate relationships (Colman & Widom, 2004; Haskett & Kistner, 1991; Mueller & Silverman, 1989) as consequences of childhood abuse.

Co-existence of wife abuse and child abuse is also frequently revealed in recent studies (Bowker, Arvitell, & McFerron, 1988; Dubowitz et al., 2001; Margolin & Gordis, 2003; Ross, 1996; Schechter & Edleson, 1994; Stark & Flitcraft, 1988; Straus & Smith, 1990). Mothers who are victims of domestic violence were reported to be more prone to the use of physical disciplinary tactics (Claussen ve Crittenden,

1991; Fantuzzo et al., 1991; Kolko 1992; Salzinger, Feldman, Hammer, & Rosario, 1991). Even when mothers did not have permissive attitudes about using corporal punishment, Oates (1998) suggested that mothers who experienced violence by husbands more often used corporal punishment of children than those who did not have such experiences. Interestingly compared to wife abuse, non-violent marital discord was a strong predictor for verbal child abuse (Tajima, 2000).

Studies indicate that child abuse can be observed in all cultures (American Academy of Pediatrics. Committee on Psychosocial Aspects on Child and Family Health, 1998; Hunter, 2000; Samuda, 1988). However, it has been reported that in a community, as the awareness about child rights and consequences of child abuse and the value given to an individual or to a child increases the frequency of physical abuse decreases (Earls, McGuire, & Shay, 1994; Hemenway, Solnick, & Carter; 1994; Korbin, 2002).

1.3. The Link Between ADHD and Maltreatment

1.3.1. Empirical evidence and possible explanations

Recently, physical abuse is more frequently associated with externalizing disorders (Margolin & Gordis, 2000) and sexual abuse is more frequently associated with internalizing disorders (Whiffen & MacIntosh, 2005). The frequency of ADHD is reported as 14-46% among abused children (Briscoe-Smith & Hinshaw, 1996; Endo et al., 2006; Glod & Teicher, 1996). Briscoe-Smith and Hinshaw (1996) studied with girls aged between 6-12 years and indicated that, compared to children without ADHD (4.5%), children with ADHD (14.3%) were more frequently and severely abused, in addition to this compared to girls with ADHD who are not abused, abused girls with ADHD exhibited higher externalization disorder. A retrospective study conducted in Turkey investigated the demographic and clinic features of the 54 emotionally, physically, sexually abused children and suggested that 22.2% of all abused children were diagnosed with ADHD (Çengel-Kültür, Çuhadaroğlu-Çetin, & Gökler, 2007).

Comorbidity of ADHD and disruptive behavior disorders is shown to increase the risk of abuse (Ford et al., 2000). Accordingly, Ford et al., (2000) indicated that the ratio of being abused among children diagnosed as pure ADHD was 25% for physical abuse and 11% for sexual abuse whereas when ODD is comorbid to ADHD, a notable increase can be observed on these ratios for physical abuse (%43-75) and a slight increase is shown on the ratios for sexual abuse (%18-31). Similar findings were reported by Urquiza (2002) who reported that the prevalence of emotional abuse was 90% among children with comorbid ADHD and ODD however; there was a significant decrease on these ratios when children had pure ADHD (remaining still high).

This co-occurrence of ADHD and abuse may be related to some common features of ADHD and abuse such as socio-economic status, parental characteristics, and parental psychopathologies. Parents of children with ADHD were frequently reported to have low socio-economic status (Rutter & Quinton, 1977) and low social support (Cunningham, Benness, & Siegel, 1988). These findings were linked to a variety of possible reasons such as; parental ADHD leading to inoccupation and being socially undesirable or poor environmental conditions precipitating ADHD of children. On the other hand discipline styles of parents having lower income are indicated to be harsher compared to ones having higher income (Pinderhughes, Dodge, & Bates, 2000; Portes, Dunham, & Williams, 1986). Low socio-economic status and low social support were also pointed to be significant predictors of child emotional and physical abuse (such as scolding, spanking, and hitting), probably, through a mediation effect of parental ADHD, or parental stress (Caliso & Milner 1992; Coohey, 2000; Gillham et al. 1998). Domestic violence and marital discord is also associated with increased risk of child emotional and physical abuse (Appel & Holden, 1998; Jouriles & LeCompte, 1991; Straus, 1994) and child behavior problems (Rutter & Quinton, 1977; Straus, 1994; Wender, 2000).

Parental mental health problems are known to be associated with both ADHD diagnosis of children and abuse potential of parents. According to studies investigating the clinical features among parents, prevalence of mental health problems is high in both groups, namely; parents of children with ADHD (Rutter & Quinton, 1977) and abusive parents (Whipple & Webster-Stratton, 1991). More

specifically depression (for ADHD: Biederman ve ark. 2004; Evinç, 2004; Milberger, Biederman, Faraone, Murphy, & Tsuang, 1995; for abusive parenting: Whipple & Webster-Stratton, 1991), bipolar disorder (for ADHD: Hirshfeld-Becker & colleagues, 2006; for abusive parenting: Çengel-Kültür et al., 2007), alcohol abuse (for ADHD: Milberger, Biederman, Faraone, Murphy, & Tsuang, 1995 for abusive parents: Merrill et al., 1996; Whipple & Richey 1997; Berger, 2005), antisocial or borderline personality disorders (Bland & Orn, 1986; Gordon et al., 1989; Susman, Trickett, Iannotti, Hollenbeck, & Zahn-Waxler, 1985; Whipple, Fitzgerald, & Zucker, 1995) were reported more frequently among parents of children with ADHD and among abusive parents.

Parental characteristics of children with ADHD are known to determine how well the mother handles the process and the problematic issues (Alizadeh, Applequist & Coolidge, 2007). Literature reveals that compared to mothers of healthy control children, mothers of children with ADHD scored higher on neuroticism, negative affect (Evinç, 2004; Nigg & Hinshaw, 1998), and passive aggression (Türkbay & colleagues, 2003). Similarly abusive parents were shown to have higher negative affect and feelings of anger (Francis & Wolfe, 2008; Mammen, Kolko, & Pilkonis, 2002; Rodriquez & Green, 1997). From the perspective of discipline attitudes, mothers of children with ADHD were shown to be more controlling, authoritarian, and punitive (Cunningham & Barkley, 1979; Hechtman, 1981, 1996). In addition to feelings of anger and negative affect, parental locus of control, and parental level of frustration tolerance were found to be significant predictors of abuse potential in a study conducted by McElroy and Rodriguez (2008) with seventy-three mothers of 5–12-year-old children identified as having an externalizing behavior problem. Parenting stress is one of the most important variables that is widely reported to be a significant predictor on parent-child relationship (Berger, 2005; Park 2001). Having a child with ADHD is a challenging situation for parenting. Controlling, protecting, directing are always a matter. Consequently, joy of parenting decreases and parental confidence is damaged; parents feel highly incompetent, blame themselves and experience higher parenting stress (Francis & Wolfe, 2008). In the long run, sometimes because of parents own psychopathologies, sometimes because of parents' depressive feelings and the increased difficulty of controlling children with ADHD outside the home parents become isolated and begin to receive lower social

support (Francis & Wolfe, 2008, Nigg & Hinshaw, 1998). All these may result in impaired parent-child relationships (Gershoff, 2002) and in turn parents experiencing, high parenting stress, low self confidence, less warmth and involvement with their children may exhibit abusive attitudes (Alizadeh, Kimberly, Applequist, & Coolidge, 2007; Park, 2001)

Behind all the common parental psychopathology and characteristics it should not be ignored that ADHD is shown to be a heritable and neurobiological, neurodevelopment disorder (Tannock, 1998). Accordingly it is widely indicated that parents of children with ADHD are likely to show impulse control and attention problems themselves (see review in Johnston & Mash, 2001), and impulsivity is a feature which has strong associations with aggressive behavior (Barratt, 1993, 1994; Hollander & Stein, 1995).

1.4. Consequences of Childhood Maltreatment

Maltreated children are at increased risk for a variety of emotional and behavioral problems. Consequences of maltreatment can appear in short or long term (Kendall-Tackett & Marshall, 1998). Child maltreatment is a highly distressing factor leading the children to be more vulnerable to a broad range of behavioral, psychological and physical problems that persist into adulthood. While some children are shown to be more vulnerable some children are suggested to be more resilient (Luthar et al., 2000). Having a supportive environment, a good parent child relationship in general, a strong attachment with the primary caregiver, and high levels of emotion regulation were indicated to be among the protective factors while the adverse conditions are listed in risk factors (Alink, Cicchetti, Kim, & Rogosoh, 2009; Cyr et al., 2009). Age and gender of the children were reported to be predicting the existence and the severity of the distress experienced following a traumatic event. More specifically younger children were suggested to show higher symptomatology as a result of sexual abuse (Wolfe et al., 1989), girls were reported to be more vulnerable to depression and anxiety symptoms whereas boys were more vulnerable for externalizing disorders (Sternberg, 2006).

1.4.1. Consequences on cognitive and psychological characteristics

Especially when prolonged, abused children are at increased risk of developing lower self esteem, learned helplessness, somatization, behavioral problems, posttraumatic stress disorder, externalizing and internalizing disorders, marital problems, eating disorders (Kent & Waller, 2000), and personality disorders (Moeller, Bachmann & Moeller, 1993; Yehuda, Spertus, & Golier, 2001). Vissing et al. (1991), in their nationally representative sample of 3346 families, found that child aggression (e.g., physical fights with other children), child delinquency (e.g., vandalism), and child interpersonal problems (e.g., trouble making friends) were significantly associated with the child being psychologically abused.

Child abuse is a traumatic event that may disrupt children's appraisals about themselves, others and the world, accordingly, impairs and weakens their coping ability (Ehlers, Mayou, & Bryant, 2003). The child may begin to perceive him/ herself as more worthless, helpless and incapable of coping in a stressful situation, the others as more angry and threatening, the world as more dangerous. Consistently, research indicated that when compared to non-abused controls abused children exhibit significantly lower self esteem, higher learned helplessness, depression and suicidality scores (Kazdin, 1985; Kent & Waller, 2000).

Mostly, parents are the primary caregivers of children and they are responsible to take care of the child, to protect him/her from the outside sources of threat, however, when the threat comes from the parent the child loses his/her shelter and the world seems more dangerous than ever. Abused children perceive their environment insecure, threatful (Ehlers, Mayou, & Bryant, 2003) social relationships as threatening and painful (Ornduff, 2000; Stovall & Craig, 1990), eventually experiences higher difficulty in his/her social relationships (Osofsky, 2003; Widom, 1997). Conflict and lack of intimacy are observed in their relationships often (Colman & Widom, 2004). Researchers suggest that limited close relationships of these children may be a result of continuous threat perception which leads to avoidance from social interactions (Haskett & Kistner, 1991; Mueller & Silverman, 1989), less intimacy (Colman & Widom, 2004) or their difficulty in interpreting the social cues and expressing their emotions (Azar, Ferraro, & Breton, 1998; Cicchetti

& Lynch, 1995), aggressive behaviors (Howing, Wodarski, Kurtz, Gaudin, & Herbst, 1990; Patterson, 1986), strong anger feelings (Egeland, Sroufe, & Erikson, 1983) may be causing these children to be less popular among their peers (Bolger et al., 1998; Salzinger et al., 1993; Sheilds, Ryan, & Cicchetti, 2001).

These children were indicated to have higher feelings of anger and exhibit more aggressive and hostile behaviors (Egeland, Sroufe, & Erikson, 1983). Studies conducted about the feeling of anger suggests that angry people experience great difficulty on interpreting the facial expressions objectively and they frequently interpret others as angry (Hall & Davidson, 1996; van Honk, Tuiten, de Haan, Van den Hout, & Stem, 2001; Wingrove & Bond, 2005). Depending on these results, one explanation of aggressive behavior of children may be the misperception of others feelings and intentions. On the other hand, given that a parent child relationship is a learning process of child which shapes the child's social interactions, aggressive behavior may be the only way that the child knows to interact with others.

1.4.2. Psychopathology related consequences

Cognitive educational problems are frequently observed in abused children (Egeland, Sroufe, & Erikson, 1983). These children suffer from inattention problems and low academic performance. Trauma is indicated to disrupt attention and other cognitive problems (Margolin & Gordis, 2000; Osofsky, 2003; Widom, 1997), and also it has been suggested that children having attention and cognitive problems are more vulnerable to experience traumatic life events (Ford et al., 2000). In addition to cognitive problems these children also are reported to have higher physical complaints, somatization (Felitti, 1991; Haj-Yahiaa & Tamish, 2001), lower obedience to school rules and higher school related problems (Hart & Brassard, 1991), which may all influence their academic achievement.

In the long term, together with all possible ongoing short term effects, childhood maltreatment was shown to be associated with poor body image, eating disorders, sexual dysfunction (regardless of the abuse type), personality disorders (Moeller, Bachmann, & Moeller, 1993; Yehuda, Spertus, & Golier, 2001) and problems in romantic relationships including marital discord (Kent & Waller, 2000). One of the

most tragic consequences of abuse is; having ongoing experiences of maltreatment in adulthood either as a victim or a perpetrator. Studies investigating adulthood effects of maltreatment suggest that adults reporting themselves maltreated in childhood were more likely to develop inappropriate identification (Bower-Russa, Knutson, & Winebarger, 2001; Durrant, Broberg, & Rose-Krasnor, 1999; Holden et al., 1995; Jackson et al., 1999), dependent or borderline personality, to experience difficulty in intimate relationships (Colman & Widom, 2004; Haskett & Kistner, 1991; Mueller & Silverman, 1989), to normalize the violence and in turn these women were more vulnerable to domestic violence (Yehuda, Spertus, & Golier, 2001). Similarly adults having an abusive childhood normalize physically and emotionally abusive attitudes and tend to accept these as appropriate discipline styles. This leads to intergenerational transmission of impaired parenting (Egeland, Jacobvitz, & Sroufe, 1988; Simons, Whitbeck, Conger, & Wu, 1991).

Interestingly the effects of sexual, physical abuse and emotional neglect or abuse were shown to be similar (Briere & Runtz, 1988; Johnson et al., 2001; Rich, Gingerich, & Rosen, 1997; Sackett & Saunders, 1999). Though researchers ignored effects of emotional neglect and abuse, recently it has been indicated that compared to sexual and physical abuse, emotional abuse has more negative consequences and sometimes even it is the core, the strongest predictor of these consequences (Hart & Brassard, 1987). Researchers suggest that the core problem predicting the psychological consequences may the damaged trust to the self, others and the world not the type of the abuse (Hart & Brassard, 1987).

1.4.3. The link between ADHD and PTSD following child abuse and the possible mediator role of dissociation

In addition to the demographic, etiological, and environmental factors, factors related to the parental characteristics and features of ADHD, the role of PTSD on the high co-occurrence of ADHD and child maltreatment has been recently an issue of a great debate. Symptoms related to the both disorders (ADHD and PTSD) frequently exist among abused children (Briscoe-Smith & Hinshaw, 1996; Endo et al., 2006; Glod & Teicher, 1996; Milnera et al., 2009). When the study results are reviewed there seems to be four possible ways to explain the high frequency of PTSD and ADHD among

abused children: 1- Depending on all reasons given above, children with ADHD may be more vulnerable to abuse and abused children may exhibit symptoms of PTSD. 2- Child abuse may exacerbate both ADHD and PTSD simultaneously and specific symptoms (e.g., difficulty with concentration, restlessness or irritability, and impulsivity) may be common to both disorders 3- Abused children may exhibit dissociation which can be seen in PTSD and mimic ADHD symptoms. 4- Overlapping symptoms may cause misdiagnose and PTSD may be skipped.

Common etiological, demographic, environmental, and parental factors were indicated to lead frequent diagnosis of ADHD among abused children (Appel & Holden, 1998; Caliso & Milner, 1992; Coohey 2000; Gillham et al. 1998; Jouriles & LeCompte, 1991; Rutter & Quinton, 1977; Straus, 1994; Wender, 2000). Ford et al. (2000) reported that traumatic experiences were more frequently observed among children with ODD and to a lesser extent among children with ADHD. An important feature of ADHD is impulsivity (WHO, 1993). Impulsive and riskful behaviors of children with ADHD are one possible explanation of increased abuse and higher exposure of traumatic events in this sample (Ford et al., 2000). Impulsivity is a feature which has strong associations with riskful behaviors and aggressive behavior (Barratt, 1993; Blank, 1994; Hollander & Stein, 1995). ADHD was reported to be associated with interpersonal and self regulatory problems and these problems were shown to increase the vulnerability for maltreatment (Angold & Costello, 1998; Cuffe, McCulag, & Pumaries, 1994). Children with ADHD were shown to be more distractible, hyperactive and sometimes more aggressive and defiant and all these characteristics were suggested to be more provocative for maltreatment (Patterson et al., 1998). ADHD is also frequently observed among the parents of children with ADHD and parental impulsivity was indicated to be in relation with parental aggression (Barrat, 1993; Hollander & Stein, 1995) and parental antisocial personality disorder (Faraone, Bieerman, & Milberger, 1995). For these reasons children with ADHD may be more vulnerable to traumatic experiences. As child abuse is a highly distressful and traumatic phenomena, it has been widely shown to cause symptoms related to PTSD, such as; anxiety, depression, somatization, dissociation (Çengel-Kültür, Çuhadaroğlu-Çetin, & Gökler, 2007; Endo & colleagues, 2006, Haj-Yahia & Tamish, 2001), higher avoidance from social

interactions and less intimacy in friendships (Haskett & Kistner, 1991; Mueller & Silverman, 1989; Parker & Herrera, 1996).

Child abuse may exacerbate both ADHD and PTSD simultaneously (Famularo, Fenton, Kinscherff, & Augustyn, 1996) and specific symptoms (e.g., difficulty with concentration, restlessness or irritability, and impulsivity) may be common to both disorders (Blank, 1994). Both ADHD (Briscoe-Smith & Hinshaw, 1996; Endo et al., 2006; Glod & Teicher, 1996) and PTSD are reported to be highly prevalent among abused children (Broman-Fulks et al., 2007). In addition to this both disorders are associated with interpersonal difficulties, aggressive and hostile behaviors (Margolin & Gordis, 2000; Parker & Herrera, 1996), poor academic functioning, cognitive problems (Margolin & Gordis, 2000; Osofsky, 2003; Widom, 1997). Studies indicated that maltreatment was a factor leading to inhibitory deficits which is also associated with ADHD (Comings, 1997). Etiological studies suggested that PTSD is strongly associated with a genetic predisposition toward psycho-physiological reactivity (True et al., 1993) and in turn, PTSD and ADHD frequently co-occur (Famulara, Teyton, Kinscherff, & Augustyn, 1996; Merry & Andrews, 1994).

Abused children may exhibit dissociation which can be evaluated as an important aspect of PTSD (Endo et al., 2006; Haj-Yahia & Tamish, 2001) and mimic ADHD symptoms. Approximately 19–73% of maltreated youths are suggested to exhibit dissociation. The studies investigating the consequences of child maltreatment report that among many interpersonal and psychological problems dissociation is commonly observed after child abuse regardless of the abuse type (Briere & Runtz, 1988; Narang & Contreras, 2000). Subjects with dissociative disorder are shown to meet the criteria for ADHD (DePrince et al., 2009; Endo et al., 2006)

Overlapping symptoms may cause misdiagnose and PTSD may be skipped. As maltreatment in childhood is a traumatic event, PTSD is one of the consequences of this type of traumatic experience (Milnera et al., 2009). Poor academic performance, poor cognitive functioning, high interpersonal difficulties, such as impulsivity, labile mood, dysphoria, and behavioral problems are shown to be trauma consequences highly associated with PTSD such as well (Ariga et al., 2008; Dixon et al., 2005; Ford et al., 2000; Haskett & Kistner, 1991; Titus et al., 2003; Weinstein et al., 2000).

Ford et al. (2000) re-analyzed the data of Wozniak et al. (1999) and suggested that when the overlapping symptoms of ADHD and PTSD were controlled the association between these disorders decreased. Results also indicated that these symptoms may begin after the abusive experiences (Endo & colleagues, 2006; Shonk & Cicchetti, 2001; Veltman & Browne, 2001). Neurobiological and neuro-imaging studies report that prolonged stress or prolonged exposure to trauma interrupts brain development and expose impairment on memory, learning, and the storing and processing of spatial information (Edwards, Harkins, Wright, & Menn, 1990; Sapolsky, 2000). Endo and colleagues (2006) also suggested that there were inheritance and etiological differences among the ADHD manifested before and after the abusive experiences.

1.5. The Aim and the Hypotheses of the Present Study

Present study will investigate the discipline attitudes of Turkish mothers. In general maternal characteristics, past experiences, psychopathological characteristics of children, namely ADHD diagnosis and symptom severity, scores of depression, self esteem, and social support will be examined in terms of their predictive roles on abusive discipline attitudes of mothers. Specifically the frequency of maternal abusive discipline attitudes in a sample diagnosed with ADHD and factors increasing the likelihood of physical discipline and emotional maltreatment are going to be studied. In addition children's self esteem, depression, and social support scores will be evaluated for their predictor role on maltreatment and the frequency of their occurrence as an outcome of maltreatment.

Though increasing, studies investigating maltreatment in a sample of children diagnosed with ADHD are still not enough. Among the few studies conducted to investigate the predictors of maltreatment used by mothers of children suffering from ADHD, most of them have assessed the attitudes solely with questionnaires (eg; Collier, McClure, Collier, Otto, & Polloi, 1999; McElroy & Rodriguez, 2008). In this study in order to prevent the effect of bias on questionnaires, qualitative methods were used in addition to questionnaires. Secondly, most of the researches were conducted with abused children investigating the psychopathology as a predictor and this does not exactly inform us about the ratio of maltreatment among the children

with ADHD. There are some studies conducted in samples of children with ADHD however, some of these studies used not the diagnosis but the subjects ADHD scores on a questionnaire and others were conducted with adults having ADHD and required them to report their perceptions about their childhood abuse. In this study children with ADHD were diagnosed with K-SADS which is a semi-structured interview and children in the control group were also regarded as healthy according to K-SADS.

Another important point is absence of studies conducted to investigate the maltreatment among Turkish children. There are few studies investigating the abusive attitudes of Turkish mothers, health care providers, and university students. Some of them investigated these attitudes in general population, some examined the psychopathology among abused children and others investigated psychopathology and perception of being abused in a non-clinical group.

This study has both content differences and methodological differences. In this study in addition to the frequency, a wide range of predictive factors and possible outcomes of abusive attitudes will be investigated among Turkish mothers both in a clinical and nonclinical population. Quantitative and qualitative assessments will be made through questionnaires and semi-structured interviews. Accordingly it is hypothesized that together with the ADHD symptoms, current maternal characteristics and maternal past experiences will contribute to abusive discipline attitudes. Depending on the cultural factors, to some extent, harsh discipline attitudes are hypothesized to be observed also in control group mothers. However, compared to control group, mothers of children with ADHD are hypothesized to score higher on all emotional and physical maltreatment types.

Briefly hypothesis of the present study are:

1. Mothers of children with ADHD would be more accepting the abusive discipline styles and in turn more prone to use these styles. In other terms; children diagnosed with ADHD would be more frequently and severely exposed to harsh/ abusive discipline. This relationship is hypothesized to differ among the subtypes of ADHD and particularly children with subtypes

including disruptive behaviors would be more vulnerable to maternal harsh/ abusive discipline styles.

2. Maternal past experiences and current characteristics would predict Conners ADHD and OD/CD Scores of children.
3. Maternal past experiences and current characteristics would predict maternal approval and actual practicing of harsh/ abusive discipline styles.
4. Conners ADHD and OD/CD scores of children would exhibit a bidirectional association with child maltreatment, pointing to the reciprocal relationship between them.
5. Exposure to harsh/ abusive discipline styles would predict self esteem and depression scores of children.

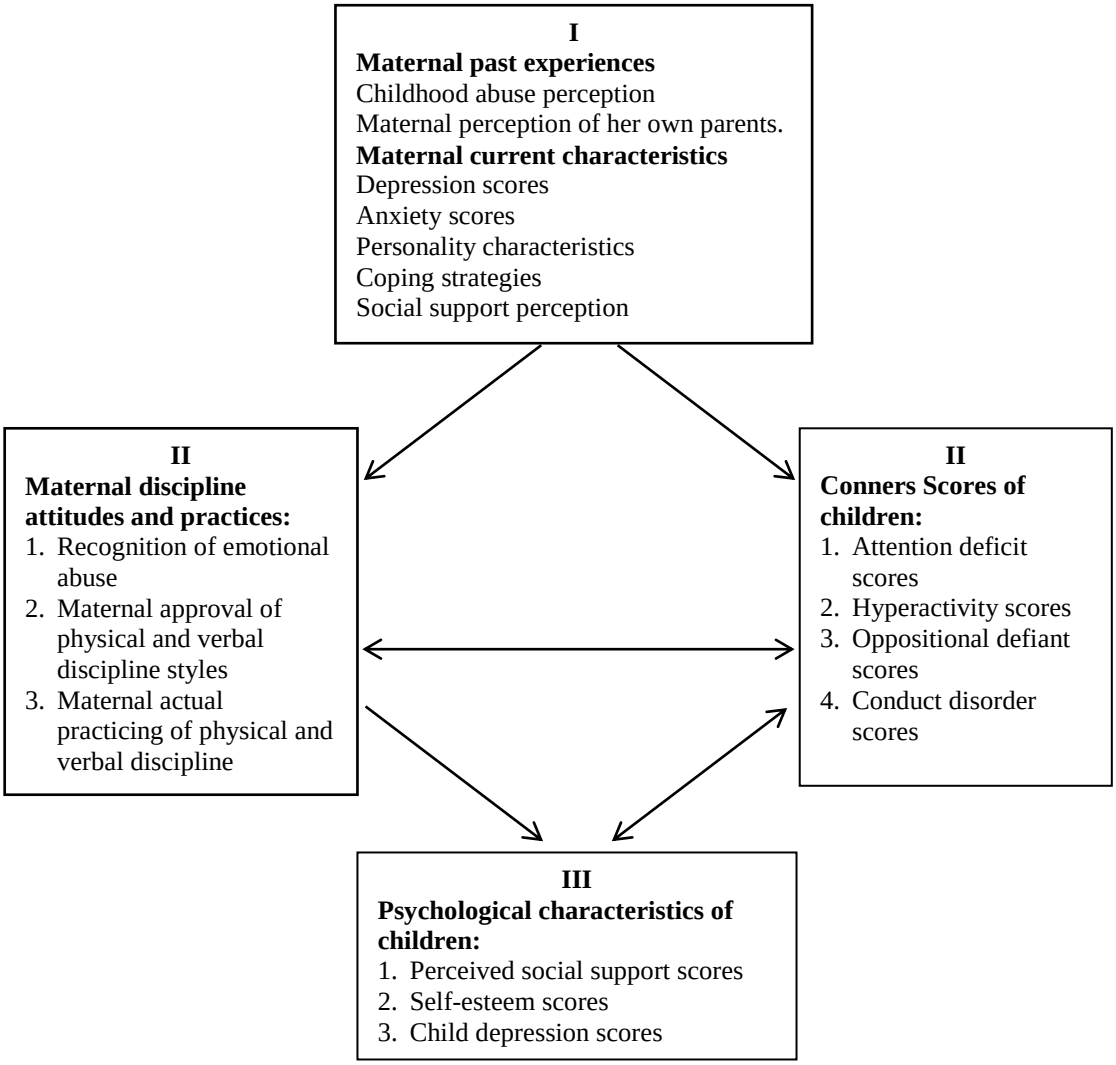

Figure 1. Hypothesis of the Study

CHAPTER II

METHOD

2.1. Subjects

There were two main groups of subjects namely study group and control group. Study group consisted of 100 children diagnosed with Attention Deficit and Hyperactivity Disorder (ADHD) and 100 mothers of children diagnosed with ADHD. Study group was also consisted from three groups, Attention Deficit Disorder Group (ADD Group; children with ADHD Predominantly Inattentive Type), Hyperactivity Disorder Group (HD Group; children with ADHD Predominantly hyperactivity Type), and Combined Group (Combined Group; children with ADHD Combined Type). Study group were taken among the applications to University of Hacettepe Child and Adolescent Psychiatry Polyclinic. Control group consisted of 25 children having no psychiatric diagnosis and 25 mothers of children having no psychiatric diagnosis. Study group were selected among the first applications to the child mental health services. In all groups the age ratio of children included to the study was between 72 and 107 months. The exclusion criterion was having neurological disorder and having scores below 80 on all Intelligence Quotient subtypes (Verbal IQ, Performance IQ, and Total IQ). 7 study group subjects participated to all clinical interviews, however; did not fulfill questionnaires, 5 study group subjects fulfilled questionnaires however; did not participate to the clinical interview consisting of open-ended questions related to the discipline styles of mother. In the quantitative analyses, where no qualitative data were used, all subjects fulfilling the questionnaires were included and subjects not fulfilling the questionnaires were excluded. In the qualitative analysis, where no quantitative data were used, all subjects participating clinical interviews were included and subjects not participating to the interview related to the discipline styles were excluded. In the analyses related with both qualitative and quantitative data, only the scores belonging to the subjects participating to both stages of the study were analyzed.

2.2. Instruments

The instruments used for the present study will be given under five categories; demographic form, structured and semi structured interviews, inventories administered to children, inventories administered to mothers and inventory administered to teacher. The first part contained questions about the socio-demographic characteristics the subjects (**See Appendix A**).The second category included the Schedule for Affective Disorders and Schizophrenia for School-Age Children: Present and Lifetime Version, Wechsler Intelligence Scale for Children Revised (WISC-R), Interviews made with open ended questions (**See Appendix B1 & Appendix B2**). The third category included Rosenberg's Self-Esteem Scale (**See Appendix C**), Child Depression Inventory (CDI; **See Appendix D**), and Social Support Appraisals Scale for Children (APP; **See Appendix E**). The fourth category included Recognition of Emotional Maltreatment Scale (REMS; **See Appendix F**), Adult ADD/ADHD DSM-IV based diagnostic screening and rating scale **(See Appendix G)**, Conners' Parent Rating Scale (CPRS; **See Appendix H**) Survey of Standards for Discipline **(See Appendix I)** State -Trait Anxiety Inventory **(See Appendix J-1 & Appendix J-2),** Beck Depression Inventory **(See Appendix K),**The Turkish Ways of Coping Inventory (TWCI; **See Appendix L**), Young Parenting Inventory (YPI; **See Appendix M**), Basic Personality Traits Inventory **(See Appendix N)**, Childhood Trauma Questionnaire **(See Appendix O),** Perceived Social Support Scale (PSS; **See Appendix P**). The fifth part included the Conners teacher rating form **(See Appendix R).**

2.2.1. Demographic information form

This is a form consisted of 12 questions among which there were both multiple choice type questions and fill in the blanks type questions. The form was prepared by the investigator with the aim of getting information about the demographic and family characteristics of the subjects **(See Appendix A)**.

2.2.2. Structured and semi structured interviews

2.2.2.1. Schedule for affective disorders and schizophrenia for school-age children: present and lifetime version

Schedule for Affective Disorders and Schizophrenia for School-Age Children: Present and Lifetime Version (K-SADS-PL) is a semi-structured instrument developed by Kaufman and colleagues (Kaufman, Birmaher, Brent, et al., 1997) to screen psychopathology in children and adolescents between ages 6-18 by gathering information from both parents and the offspring. Mood disorders, psychotic disorders, anxiety disorders, disruptive behavioral disorders, elimination disorders, eating disorders, tic disorders, and alcohol and other substance use disorders are the psychiatric conditions included in this instrument. Reliability and validity of KSADS- PL were determined in Turkey in 200 [Gökler, Ünal, Pehlivantürk, Kültür, Akdemir, Taner, 2004].

2.2.2.2. Wechsler intelligence scale for children revised (WISC-R)

The Wechsler Intelligence Scale for Children (WISC) was developed by Wechsler in 1949 to measure the intelligence of children aged between 5 and 15 years. The scale was revised in 1974 (WISC-R) and the age range expanded to 6-16 years. WISC-R was adapted to Turkish with a standardization study conducted by Savaşır and Şahin (1980), which included 1639 children from 11 different city centers. WISC-R includes 6 verbal (General Information, Similarities, Arithmetic, Judgment, Vocabulary, and Digit Span) and 6 performance (Picture Completion, Picture Arrangement, Block Design, Object Assembly, Digit Symbol, and Labyrinths) subtests. Both verbal and performance subtests have an extra subtest. In addition to the standard scores of these subtests, verbal intelligence scale, performance scale, and full-scale IQ coefficients are calculated. The mean value for all intelligence scales is 100 and the standard deviation is 15. The means of the standard scores for each subtest is 10 and the standard deviation is 3.

2.2.2.3. Interviews made with open ended questions

In order to obtain more detailed information about the actual discipline behaviors of the mothers, all children and mothers were interviewed with open ended questions. 6 standard open ended questions, regarding the length and the quality of time spent together, the source and the type of the children's problematic behavior, and how the problems are handled by the mother were prepared by the researcher and asked to all mothers and all children. In these answers, child neglect and abuse were particularly detected **(see Appendix B)**.

2.2.3. Inventories administrated to children

2.2.3.1. Rosenberg's self esteem scale

The Rosenberg Self-Esteem Scale which has been developed by Morris Rosenberg (1965) is a widely-used global self-esteem measure with a 10-item Likert scale, with items rated on a four point scale-ranging from strongly agree (4) to strongly disagree (1). The scores range from 10 to 40, with 40 indicating the highest score possible. A high score indicates a high level of self esteem. The scale generally has high reliability; test-retest correlations are typically in the range of .82 to .88, and Cronbach's alpha for various samples are in the range of .77 to .88. In the reliability study of Turkish version of the scale (Çuhadaroğlu, 1986), Cronbach alpha reliability coefficient was reported as .75 and validity of the scale was found as 71. The Cronbach alpha reliability coefficient in the present study was .83 (for the questionnaire, see Appendix C).

2.2.3.2. Child depression inventory (CDI)

The Children's Depression Inventory (CDI) for children aged 7 to 17 was devised by Kovacs (1981), based on the Beck Depression Inventory. The CDI (Kovacs, 1981) contains 27 items describing different symptoms of childhood depression and requires children to choose statements that best describe themselves during the previous two weeks. The statements are graded according to severity from 0 to 2. Approximately half of the items are reverse-scored and higher totals reflect more

severe depression. The CDI was adapted to Turkish culture by Öy (1991). The Turkish CDI's cut-off point was found to be 19. The scores on CDI range from 0 to 54. To examine the validity of the inventory the correlation between CDI and childhood depression inventory was investigated and the correlation coefficient was found to be .61. The internal consistency coefficient was .84 and reliability coefficient was .70 (for the questionnaire, see Appendix D).

2.2.3.3. Social support appraisals scale for children (APP)

The inventory was developed by Dubow and Ullman (1989) in order to evaluate child perception of social support from their families, friends, and teachers. The inventory was revised in 1991 by Dubow, Tisak, Causey, Hryshko and Reid (1991). It is consisted of items based on the definition of social support made by Cobb (1976). The items were rated on a five point likert type scale and the highest score that subjects can obtain is 205. Turkish adaptation was made by Gökler (2007). The criterion validity of the inventory was determined based on its correlation with child depression inventory and found to be satisfactory ($r = -.62$; $p<0.01$). Similarly, validity of the inventory was reported to be high based on the Cronbach alpha internal consistency coefficients (.93) and test-retest reliability coefficients (.49). For the questionnaire, see Appendix E.

2.2.4. Questinnaires administrated to mothers

2.2.4.1. Recognition of emotional maltreatment scale (REMS)

In this scale there are 30 short vignettes and in 25 of these vignettes, various forms of parental emotional maltreatment were described. Each vignette includes incidents that describe emotionally abusive or neglectful parental practices or interaction patterns. The initial form of the REMS consisted of 25 maltreating and 5 constructive parenting vignettes each of which was rated on a four-point scale ranging from 1 to 4. Parents were asked to rate each vignette from "1 = definitely inappropriate" to "4 = definitely appropriate". Vignettes describing constructive parenting were included in order to prevent response bias and therefore were not scored. According to the original calculation, the increase in scores indicated a lack of recognition of

emotionally maltreating parenting behavior. However, in this study in order to ease the evaluation of the results, the scoring was reversed by subtracting the mean from each subjects score. Uslu and colleagues (2010) examined the correlations between REMS, Child Abuse Potential Inventory (CAPI) and Parental Acceptance Rejection Questionnaire (PARQ). According to their results REMS showed significant correlations with CAPI and PARQ and the correlations were found as .40 and .44, respectively, thus suggested that convergent validity of REMS was supported. It is also reported that test-retest stability of REMS was .73 and internal consistency was .70 (for the questionnaire, see Appendix F).

2.2.4.2. Adult ADD/ADHD DSM-IV based diagnostic screening and rating scale

Adult ADD/ADHD DSM-IV based diagnostic screening and rating scale was developed by Turgay (1995). It is a five point likert type inventory assessing the ADHD symptoms in adulthood. The scale is composed of three dimensions; 9 items regarding symptoms of attention deficit according to DSM-IV, 9 items regarding hyperactivity-impulsivity based on DSM-IV and 30 items regarding problems related with ADHD. Validity and reliability studies of the Turkish version of the scale were conducted by Günay et al. (2006). Test-retest stability of the inventory was found to be .95 and internal consistency was indicated to be .95 as well (for the questionnaire, see Appendix G).

2.2.4.3. Conners Parent Rating Scale (CPRS)

Conners' Rating Scale was developed primarily to use in drug studies of children with hyperkinesias by Conners in 1969. After various revisions; "Conners' Rating Scales" aimed measure attention-deficit/hyperactivity disorder (ADHD) in children and adolescents through parents' and teachers' ratings of their behavioral problems as well as oppositional defiant disorder and conduct disorder. The scales correspond with symptoms used in the DSM-IV criteria for ADHD. It also contains an index for identifying children and adolescents at risk for a diagnosis of ADHD. This form includes 48 items, which aims to evaluate behavior of children assessed by their parents (Conners, 1997). The scale includes inattentiveness, hyperactivity, oppositional behavior and disruptive behavior domains. Turkish translation

(Dereboy, Şenol, Şener, & Dereboy, 2007) revealed good validity and reliability coefficients (.90). For the questionnaire, see Appendix G.

2.2.4.4. Survey of standards for discipline

This questionnaire was translated to Turkish by Orhon and colleagues (2006) from Morris and Johnson's questionnaire, the Survey of Standards for Discipline (Morris, Johnson, & Clasen, 1985). This questionnaire has been translated into Turkish. Authors modified some of the questions to provide clarity. The Turkish version of the questionnaire contains three parts: (1) socio-demographic characteristics, (2) the attitudes of participants toward child disciplinary practices, and (3) abusive childhood history. The first and the third parts do not exist in the original scale but were added to the questionnaire by Orhon et al. (2006). In this study only the second part of the questionnaire (namely; attitudes toward childhood discipline) was used. The questionnaire consists of 43 different disciplinary acts (27 physical and 16 verbal acts). Responses to these 43 different disciplinary acts in one of the following three categories: (a) acceptable as discipline; (b) unacceptable as discipline; and(c) unacceptable as discipline-would report to authorities as child abuse (for the questionnaire, see Appendix H). All items have different scores according to their content.

2.2.4.5. State-trait anxiety inventory

State-Trait Anxiety Inventory (STAI) scales were developed by Spielberger, Gorsuch, and Lushene (1970). State-Trait Anxiety Inventory-Trait Form (STAI-T; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) consists 20 items to measure individual's proneness to anxiety. The items are rated on a four-point Likert scale ranging from 1 "not at all" to 4 "very much so" according to how respondent generally feels about the statements. Internal consistency (with alphas ranged from .86 to .95) and test-retest reliability (with alphas ranged from .65 to .75) coefficients were very good (Spielberger et al., 1983). Oner and Le-Compte (1985) translated and adapted State-Trait Anxiety Inventory (STAI) into Turkish. In their study test-retest reliability for sample of both normal population and psychiatric patients for trait anxiety inventory was between .71 and .86. Internal consistency of this version

ranged between .83 and .87 (Oner, 1997). Furthermore, the correlation between Turkish version of STAI and Beck Depression Inventory was found to be .53. In terms of validity, STAI-T scores of clinical sample were found to be significantly higher than nonclinical control group (for the questionnaire, see Appendix Ia and Appendix Ib).

2.2.4.6. Beck depression inventory

The BDI is a 21 item four-point Likert type self-report inventory originally developed by Beck, Ward, Mendelson, Mock, and Erbaugh (1961). The inventory aims to assess the depressive symptomatology. The BDI demonstrates high internal consistency, with alpha coefficients of .86 and .81 for psychiatric and non-psychiatric populations, respectively (Beck et al., 1988). Tegin (1980) adapted the first version of the Beck Depression Inventory to Turkish in 1980. According to this study, the split-half reliability coefficient of BDI was .78 in a student sample whereas the test-retest reliability coefficient was .65. In addition, the 1979 BDI version was translated to Turkish by Hisli (1988). The split-half reliability of this version was .74 (Hisli, 1988). Scores for each item range from 0 to 3. The scores above 17 are considered as an indication of clinical depression (Hisli, 1989). For the questionnaire, see Appendix J.

2.2.4.7. The Turkish ways of coping inventory (TWCI)

WCI used in this study was originally developed in a yes – no response format by Folkman and Lazarus in 1980 and changed into a four point Likert Type Scale when revised by the same authors in 1985. The inventory aims to measure the cognitive and behavioral coping strategies that people use in stressful situations on a 4-point Likert Type Scale consisting of 74 items. Higher scores on each item imply a greater use of that coping strategy. The revised WCI consisted of 66 items and 8 subscales: problem focused coping, wishful thinking, distancing, emphasizing positive, self blame, tension reduction, self isolation, seeking social support. Studies conducted with WCI indicated that factors of WCI ranged from 4 to 8 (e.g., Bouchard, Sabaurin, Kussier, Wright & Richer, 1997; Jenkins, 1997). The adaptation of the scale into Turkish, was made by Siva (1991). Siva included 6 additional items

covering superstitious beliefs and fatalism. Results of Siva (1991) revealed a Cronbach alpha coefficient .90 and 7 factors. Gençöz, Gençöz and Bozo (2006) studied higher order dimensions of coping styles and found that TWCI was composed of 5 primary factors (Problem Focused Coping, Religious Coping, Seeking Social Support, Self–Blame/Helplessness, and Distancing) and three second order factors. As the second order factors, Distancing and Religious Coping grouped under the first higher order factor and named as 'Emotion Focused Coping'; Self–Blame/ Helplessness (with a negative loading) and Problem Focused Coping grouped under the second higher order factor, and named as 'Problem Focused Coping'; finally Seeking Social Support emerged under the third factor and named as '(Seeking Social Support): Indirect Coping Style'. In addition to the construct validity, Guttman split-half reliability and criterion validity of these three higher order factors revealed good reliability and validity outcomes. It was also emphasized that these 3 higher order factors constituted independent dimensions of coping styles (for the questionnaire, see Appendix K).

2.2.4.8. Young parenting inventory (YPI)

YPI, developed by Young (1994), consists of 72 item intended to identify the potential origins of 17 early maladaptive schemas. Each item concerns perceptions of maternal and paternal behaviors during childhood and is rated on a 6-point Likert-type scale (1 = entirely untrue of me, 6 = describes me perfectly). Preliminary evidence regarding the psychometric properties of the original form indicated that it had acceptable levels of validity and reliability (Sheffield et al., 2006). Psychometric study of the Turkish version of the scale conducted by Soygüt et al. (2008) revealed a 10-factor structure for both mother (the YPI-M) and father (the YPI-F) forms. These factors are: Emotionally depriving, overprotective/anxious, belittling/criticizing, pessimistic/worried, normative, restricted/emotionally inhibited, punitive, and conditional/ achievement focused, over permissive/boundless and exploitative/abusive parenting. Inter-correlation values for the factors range from .10 to .39. Internal consistency coefficients of both mother and father forms were found as .90. Validity studies revealed .43 correlations between YPI and Symptom Check List 90-R (for the questionnaire, see Appendix L).

2.2.4.9. Basic personality traits inventory

Basic Personality Traits Inventory (BPTI) was developed by Gençöz and Öncül (submitted manuscript) particularly for Turkish Culture to measure the basic personality traits based on the five factor model of personality (McCrae & Costa, 2003; Peabody & Goldberg, 1989). They conducted a series of studies to develop BPTI. Firstly, 100 participants wrote the adjectives that they used to describe different people. 226 adjectives were determined from those written adjectives by participants, and List of Personality Traits was produced. Secondly, the List was applied to other 510 participants to describe their own personality traits. Afterwards, the data was examined with Varimax rotated factor analysis, 45 items and 6 basic personality traits, extraversion, conscientiousness, agreeableness, neuroticism, and openness to experience, and negative valence, constituted the Basic Personality Traits Inventory. The item were rated from 1 (does not apply to me) to 5 (definitely applies to me). Lastly, BPTI were applied to 454 undergraduate students to test the psychometric properties. Internal consistency coefficient for each personality traits were found as follows: Extraversion; .89, Conscientiousness; .84, Agreeableness; .85, Neuroticism; .83, Openness to Experience; .80, and Negative Valence; .71. Test-retest reliability of 6 factors ranged from .71 to .84. For concurrent validity, correlation analyses between 6 factors of BPTI and various questionnaires developed for Turkish culture was examined and found to be satisfactory validity (see Appendix M for BPTI).

2.2.4.10. Childhood trauma questionnaire

The CTQ is a 40-item screening inventory that assesses self-reported experiences of abuse and neglect in childhood and adolescence. Original form of the scale was developed by Bernstein et al. 1994. The scale has three subtests, namely; childhood experiences of physical abuse, childhood experiences of emotional abuse, and childhood experiences of sexual abuse. Most items are phrased in objective, behavioral terms ("When I was growing up, someone tried to touch me in a sexual way or tried to make me touch them."), while others call for more subjective evaluations (e.g., "When I was growing up, I believe that I was sexually abused.") (Additional sample items are given in a previous report [Bernstein et al., 1994], and

the entire scale can be obtained from the authors). Items are rated on a 5-point Likert-type scale, with response options ranging from "Never true" to "Very often true." Instructions for the CTQ ask respondents about their "experiences growing up" and, therefore, in the case of adolescents, do not distinguish between current and past maltreatment. The CTQ requires about 10 to 15 minutes for completing. Turkish adaptation, validity and reliability studies were carried by Aslan and Alparslan (1999). The reliability of the whole scale was determined as .93. Reliability coefficients of subscales were found to range in between .74 and .83; criterion validity results indicated its correlation with BDI in between .24 and .29. For the questionnaire, see Appendix N.

2.2.4.11. Perceived social support scale (PSS)

Perceived Social Support Scale (PSS) was developed by Procidano and Heller (1983) with 2 subscales for assessing the perceived level of social support from friends (PSS-fr) and family (PSS-fa). Scales were used to measure the extent to which respondents perceive that their needs for support, information, and feedback are fulfilled by friends and by family. Each scale consists of 20 statements with three response alternatives: “Yes,” “No,” and “Do not know.” For each item, a response that is indicative of support is scored as +1. The “Do not know” responses are not scored. Thus, the scores for each scale range from 0 to 20. The PSS was adapted into Turkish by Eşkin (1993) and found to be a reliable and valid instrument. The internal consistency reliability coefficients in this study were found to be .79 for the PSS-Friends and .85 for the PSS-Family. Test-retest reliability was found as .80-.90.For the questionnaire, see Appendix O.

2.2.5. Inventory administrated to teachers

2.2.5.1. Conners teacher rating form (CTRS)

This form includes 28 items, which aim to rate classroom behavior of children assessed by teachers (Goyette CH, Conners CK, Ulrich RF, 1978). There are three subscales of the form: 8 items inattentiveness, 7 items hyperactivity and 8 items conduct problems. CTRS is translated to Turkish by Şener (Şener, Dereboy,

Dereboy, Sertcan, 1995), and the Turkish form showed adequate validity and reliability (Cronbach's alpha .95). For the questionnaire, see Appendix P.

2.3. Procedure

Prior to the study acceptance from Hacettepe University Ethical Committee was obtained. All children and parents were informed about the rationale of the study. Volunteer families were included to the study after signing the informed consent form. Among applications to the child and adolescent mental health department of Hacettepe University Child Hospital, 6-12 year old children with ADHD prediagnosis were included to the study in case they did not meet the exclusion criteria. All children, both in study group and control group, were screened for their intelligence and child mental health problems. With the aim of screening intelligence and mental health problems, Wechsler Intelligence Scale for Children - Revised (WISC-R) and Schedule for Affective Disorders and Schizophrenia for School-Age Children: Present and Lifetime Version (K-SADS-PL) were administrated to all children and K-SADS-PL was also administrated to mothers. Control Group was consisted of the children who were screened and found to have no mental health problems. In addition to the clinical interview, made for the decision of diagnosis (K-SADS-PL), a semi structured clinical interview -consisting of standard open-ended questions asked to all mothers and children- was made. Questions were prepared for the present study and they covered the discipline styles of mothers with special emphasis to the possible existence of verbal or physical abusive attitudes.

CHAPTER III

RESULTS

3.1. Descriptive Information for the Measures of the Study

Regarding descriptive characteristics of the measures, means, standard deviations, and minimum maximum ranges were presented in Table 1 for Beck Depression Inventory; State-trait Anxiety Inventory subscales, namely, State Anxiety, Trait Anxiety; Adulthood Attention Deficit Hyperactivity Disorder Inventory subscales, namely, Attention Deficit Disorder, Hyperactivity Disorder, Attention Deficit Hyperactivity Disorder Combined Type, Problems Related to Attention Deficit Hyperactivity Disorder; Basic Personality Traits Questionnaire subscales, namely, Extraversion, Conscientiousness, Agreeableness, Neuroticism, Openness to Experience, Negative Valence; The Ways of Coping Questionnaire subscales, namely, Problem-Focused Coping, Emotion-Focused Coping, Indirect Focused Coping; Young Parenting Inventory subscales, namely, Normative Parenting, Belittling/Criticizing Parenting, Emotionally Depriving Parenting, Exploitative/ Abusive Parenting, Overprotective/Anxious Parenting, Conditional/ Achievement Focused Parenting, Over Pessimistic/ Worried Parenting, Permissive/Boundless Parenting, Punitive Parenting, Restricted/Emotionally Inhibited Parenting; Childhood Traumatic Experiences Inventory subscales, namely, Physical Abuse, Emotional Abuse, Sexual Abuse; Social Support Inventory (for adults) subscales, namely, perceived social support from a significant other, from friends, from family; Recognition of Emotional Maltreatment, Survey of Standards for Discipline subscales, namely, attitudes towards physical discipline practices and verbal discipline practices; Conners teacher rating subscales, namely, Attention Deficit Disorder, Hyperactivity Disorder, Conduct Disorder; Conners Parent Rating Subscales, namely, Attention Deficit Disorder, Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder; Rosenberg Self Esteem Scale, Child Depression Inventory, Social Support Appraisals (for children) subscales, namely, perceived social support from family, from friends, from teacher.

Table 1. Descriptive Information for the Measures of the Study

Measures		**N**	**Mean**	**SD**	**Min-Max Values**
BDI		121	12.39	8.35	0-38
STAI	State anxiety (STAI-S)	121	38.17	10.71	21-68
	Trait Anxiety (STAI-T)	121	45.25	8.96	22-69
Adulthood ADHD Inventory	Maternal ADD Scores	121	7.21	5.28	0-23
	Maternal HD Scores	121	6.31	6.15	0-25
	Maternal ADHD Scores	121	23.58	14.50	6-61
	Maternal problems related to ADHD	121	37.09	23.14	1-98
Basic Personality Traits Questionnaire	Extraversion	121	30.31	6.09	13-40
	Conscientiousness	121	32.17	4.31	19-40
	Neuroticism	121	25.27	6.15	11-38
	Openness	121	21.53	3.94	8-29
	Negative valence	121	9.08	2.68	6-19
	Agreeableness	121	35.12	3.72	22-40
The Ways of Coping Questionnaire	Problem Focused Coping (PFC)	121	97.29	11.12	72-128
	Emotion Focused Coping (EFC)	121	55.49	9.43	34-85
	Indirect Coping (INDC)	121	38.49	5.92	24-51
Young Parenting Inventory (YPI)	1-***Normative***				
	Mother	118	35.17	11.91	12-67
	Father	118	36.54	13.84	13-68
	2-***Belittling/Criticizing***				
	Mother	118	16.18	8.22	9-49
	Father	118	16.26	9.57	9-53
	3-***Emotionally Depriving***				
	Mother	118	31.57	3.81	21-41
	Father	118	30.14	4.00	16-40
Young Parenting Inventory	4- ***Exploitative/Abusive Parenting***				
	Mother	118	8.29	3.58	7-28
	Father	118	9.01	4.71	7-30
	5- ***Overprotective/Anxious***				
	Mother	118	20.67	5.64	7-33
	Father	118	19.50	5.25	7-31
	6- ***Conditional/Achievement Focused***				
	Mother	118	16.64	5.16	5-30
	Father	118	17.00	5.58	5-30
	7- ***Over Pessimistic/Worried***				
	Mother	118	12.42	5.18	6-32
	Father	118	12.70	5.04	6-25
	8- ***Permissive/Boundless***				
	Mother	118	8.09	3.57	3-18
	Father	118	7.70	3.61	3-18
	9- ***Punitive***				
	Mother	118	10.75	4.25	4-24
	Father	118	10.99	5.09	4-24
	10- ***Restricted/Emotionally Inhibited***				
	Mother	118	10.23	3.39	3-17
	Father	118	10.70	3.66	3-18
Perceived Social support (for adults)	Perceived social support from significant other	121	14.99	6.57	4-28
	Perceived social support from family	121	22.08	4.74	4-28
	Perceived social support from friends	121	19.63	4.49	10-28

Table 1. *Continued*

Measures	N	Mean	SD	Min-Max Values	Measures
Survey of Standards for Discipline practices	Attitudes towards physical discipline practices	121	6.90	4.09	0-21
	Attitudes towards verbal discipline practices	121	2.94	4.86	0-41
Recognition of Emotional Abuse		121	56.02	6.39	39-72
Qualitative scores of physical abuse (mother)		118	2.41	1.83	0-3
Qualitative scores of verbal abuse (mother)		118	3.36	3.16	0-14
Childhood Traumatic Experiences	Physical Abuse that Mother Has Been Exposed to in Childhood	121	29.02	8.73	18-70
	Emotional Abused that Mother Has Been Exposed to in Childhood	121	44.12	16.51	20-87
	Sexually Abuse that Mother Has Been Exposed to in Childhood	121	5.42	1.95	5-12
Conners Teacher Rating Scale	Attention Deficit Disorder	104	15.34	3.59	9-23
	Hyperactivity Disorder	104	14.41	4.50	6-24
	Conduct Disorder	104	11.41	4.48	5-20
Conners Parent Rating Scale	Attention Deficit Disorder	121	11.29	3.36	5-18
	Hyperactivity Disorder	121	11.21	2.91	4-16
	Oppositional Defiant Disorder	121	10.66	3.46	5-19
	Conduct Disorder	121	22.11	7.59	11-41
WISC-R	Verbal Intelligence Scores	125	96.73	14.49	52-133
	Performance Intelligence Scores	125	105.96	17.58	67-154
	Total Intelligence Score	125	101.33	15.55	69-137
Social Support Appraisals (for children)	Perceived social support from friends	121	55.80	6.51	42-80
	Perceived social support from family	121	30.97	3.93	19-43
	Perceived social support teacher	121	31.34	3.74	15-40
Rosenberg self esteem scores		118	30.32	4.63	18-40
Child depression scores		118	10.14	7.67	1-54
Qualitative scores of physical abuse (child)		118	.69	.46	0-1
Qualitative scores of verbal abuse (child)		118	1.69	1.25	0-5

Note 1. BDI: Beck Depression Inventory, STAI: State-Trait Anxiety Inventory, Maternal ADD: Maternal Attention Deficit scores (Inattention scores), Maternal HD: Maternal Hyperactivity Scores, Maternal ADHD: Maternal Attention Deficit Hyperactivity Scores, Maternal problems related to ADHD: Maternal scores of problems related to Attention Deficit Hyperactivity Scores, WISC-R: Profiles of Wechsler Intelligence Scores for children revised version

3.2. Differences on Demographic Variables

In order to examine the differences of child diagnostic status (namely; control group, ADHD inattentive type, ADHD hyperactivity type, and ADHD combined type) on demographic variables One-way ANOVA was conducted. The demographic variables of the study were; parental age, paternal education, maternal education, income of the family, order of birth, number of siblings, length of breast feeding, length of bottle using, length of nipple using, gender of the child, age of the child. The analysis revealed significant main effect for ADHD on length of maternal education; $F (3, 117) = 3.81$, $p<.05$, time of breastfeeding; $F (3, 117) = 3.14$, $p <.05$,

family income; F (3, 117) = 4.84, p <.01, academic performance F (3, 117) = 11.73, p<.001, and relationships with family; F (3, 117) = 9.21, p<.001, friends; F (3, 117) = 10.49, p<.001, teacher; F (3, 117) = 12.12, p<.001. Following ANOVA post-hoc analyses were conducted by Tukey's HSD at.05 level. Results revealed that mothers of control group had significantly higher education (M = 11.81 years) compared to mothers of children in ADHD combined group (M = 8.98 years). However, ADHD inattention group (M = 9.00 years) and ADHD hyperactivity group (M = 8.45 years) did not significantly differ from each other, from the mothers of control group or the mothers of ADHD combined group on maternal education scores. Accordingly, children diagnosed with ADHD hyperactivity type (M = 18.81 months) were breast-feeded for significantly longer time than children diagnosed with ADHD combined type (M = 11 months). However, ADHD inattention group (M = 12.73) and control group (M = 10.75) did not significantly differ either from each other, or from children in hyperactivity group or ADHD combined group on breast-feeding length. Children in control group significantly differed from children diagnosed with ADHD combined type on family income F = (3, 121) = 4.131, p <.01 According to the results children in control group had families with higher income (M = 2.555 TL) than children diagnosed with ADHD combined type (M = 1.447 TL). However control group children or children in ADHD combined group did not significantly differ from children diagnosed with ADHD inattention (M = 2.053 TL) or hyperactivity type (M = 1.618 TL) on family income. Also, children diagnosed with ADHD in attention (M = 2.053 TL) and hyperactivity type (M = 1.618 TL) did not differ from each other on family income. As mentioned above diagnosis revealed significant difference on academic performance scores. Accordingly, children in control group had higher academic performance scores (M = 4.48) compared to children in ADHD inattention group (M = 3.33) and children in ADHD combined group (M = 3.10) where as children in ADHD inattention group and children in ADHD combined group did not differ from each other on academic performance scores. In addition to this, children in hyperactivity group (M = 3.72) also did not differ from children in other groups on academic performance scores. Similar pattern could be observed on the relationship scores of children with their friends and teachers. Accordingly, children in control group had better relationships with their friends (M = 4.43) and their teachers (M = 4.71) compared to children in ADHD inattention group (M = 3.62 and 3.97; for scores on relationship with friends and

teacher respectively) and children in ADHD combined group (M = 3.17 and 3.49; for scores on relationship with friends and teacher respectively) where as children in ADHD inattention group and children in ADHD combined group did not differ from each other on relationship scores. In addition to this, children in hyperactivity group (M = 3.64 and 4.18; for scores on relationship with friends and teacher respectively) also did not differ from children in other groups on their relationship scores. When the post-hoc analysis on family relationships were examined children ADHD combined group had worse relationships with their families (M = 3.32) compared to children in ADHD inattention group (M = 4.03) and children in control group (M = 4.29) where as children in ADHD inattention group and children in ADHD control group did not differ from each other on family relationship scores. In addition to this, children in hyperactivity group (M = 3.73) did not differ from children in other groups on their relationship scores.

Table 2. Diagnostic Status of the Children in the Study

Diagnosis	**n**	**Percentage (%)**
Control Group	25	20
ADD Group	30	24
HD Group	11	9
Combined Group	59	47

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group.

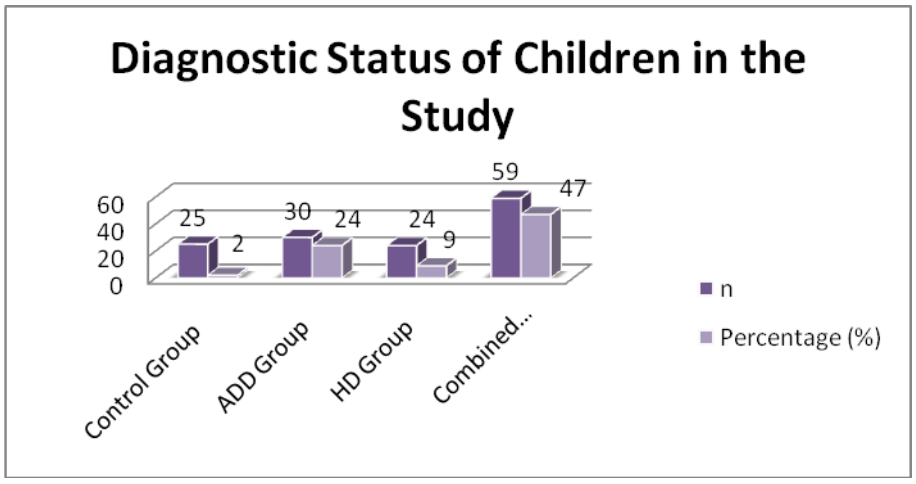

Figure 2. Diagnostic Status of Children in the Study

Table 3. Analysis of Variance for Demographic Variables

Source	df	SS	MS	F
ADHD (for income)	3	1.82	60751170.41	**4.13****
Error	121	1.78	1470508.116	
ADHD (for maternal education)	3	14.65	4.88	**4.10****
Error	121	14.02	1.19	
ADHD (breast feeding)	3	619.05	206.35	**3.23***
Error	121	7727.75	63.87	
ADHD (family relations)	3	19.04	6.35	**9.53*****
Error	121	80.59	.67	
ADHD (friendship)	3	22.07	7.36	**9.29*****
Error	121	95.73	.79	
ADHD (for relations with teacher)	3	23.08	7.69	**11.45*****
Error	121	81.35	.67	
ADHD (for academic performance)	3	30.91	10.31	**12.20*****
Error	121	102.24	.85	

Note 1. ** p <.01

Table 4. Mean Scores for Family Income

Demographic Variables	Control Group	ADD Group	HD Group	Combined Group
Income	2554,76 a	2053,67 ab	1618,18 ab	1447,07 b

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group. **Note 2.** The mean scores that do not share the same subscript on the same row are significantly different from each other, on .05 alpha level of Tukey's HSD.

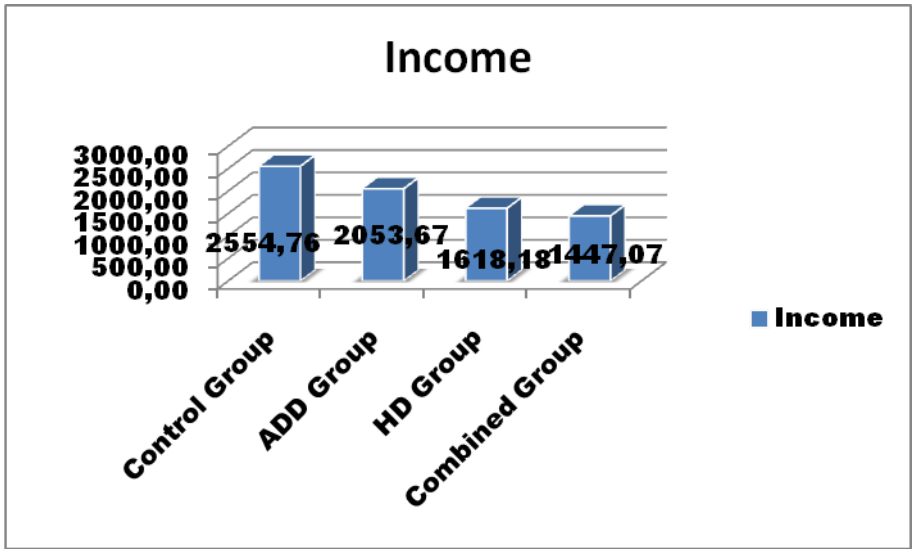

Figure 3. Mean Scores for Family Income

Table 5. Mean Scores for Demographic Variables

Demographic Variables	Control Group	ADD Group	HD Group	Combined Group
Maternal education	11.81 a	9.00 ab	8.45 ab	8.93 b
Breast feeding	12.90 ab	12.73 ab	18.82 a	10.75 b
Relationship with family	4.29 a	4.03 a	3.73 ab	3.10 b
Relationship with friends	4.43 a	3.62 b	3.63 ab	3.17 b
Relationship with teacher	4.71 a	3.97 b	4.18 ab	3.49 b
Academic performance	4.48 a	3.33 b	3.73 ab	3.10 b

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group Combined Group: Children in ADHD Combined Group. **Note 2.** The mean scores that do not share the same subscript on the same row are significantly different from each other, on .05 alpha level of Tukey's HSD.

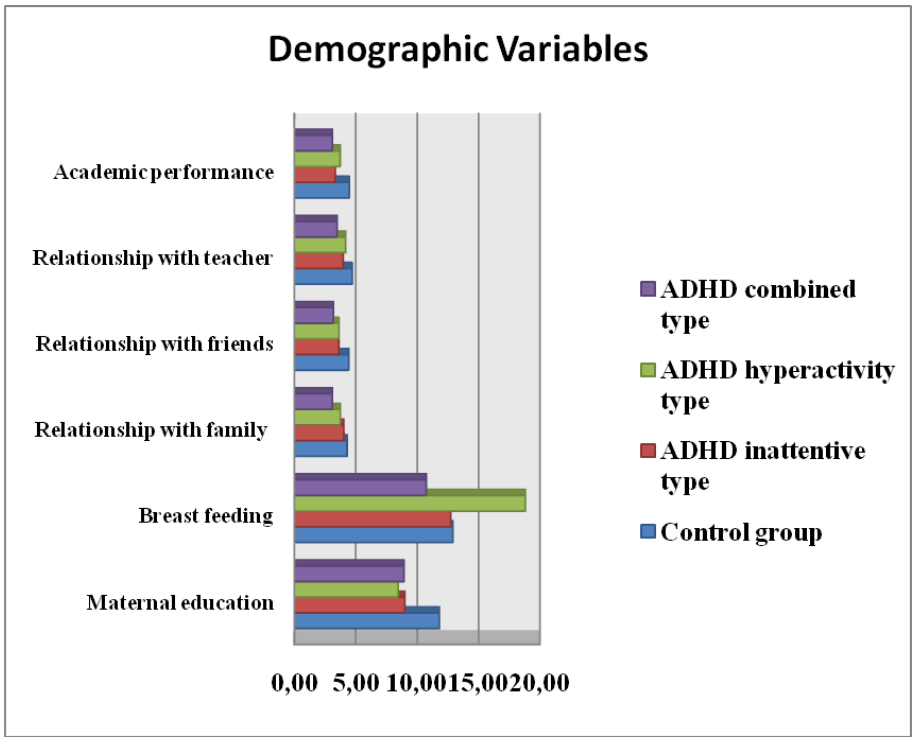

Figure 4. Mean Scores for Demographic Variables

3.3. Differences of ADHD Diagnosis on Child Characteristics

3.3.1. Differences of ADHD diagnosis on WISC-R scores of children

In order to examine the association between diagnosis (including; control group, ADHD inattentive type, ADHD hyperactivity type, ADHD combined type) and WISC-R scores of children MANOVA was conducted. The results revealed a significant main effect of diagnosis [*Multivariate F* (9, 289) = 1.42, ns, Wilks' Lambda =.90, η^2 =.04] on WISC-R scores.

3.3.2. Differences of ADHD diagnosis on child depression scores

In order to examine the differences among four groups of children (namely; control group, ADHD inattentive type, ADHD hyperactivity type, ADHD combined type) on depression scores one way ANOVA was conducted. Analysis revealed significant difference, F (3, 114) = 4.025, p<.01, ADHD diagnosis main effect on depression scores of children. The post-hoc analysis following the ANOVA conducted by Tukey's HSD at.05 significance level revealed that children in control group (M=4.95) had lower depression scores children in ADHD combined group (M=11.60). Accordingly compared to children in control group, children in ADHD combined group had significantly higher scores on Child Depression Inventory. Children with ADHD inattentive type (M=10.45) and hyperactivity type (M=11.09) did not differ on depression scores neither from each other nor from children in ADHD group or control group.

Table 6. Analysis of Variance for Depression Scores of Children

Source	**df**	**SS**	**MS**	**F**
ADHD Diagnosis of Children	3	67564.640	225.213	**4.02****
Error	114	6378.91	55.96	

Note 1. p <.01

Table 7. Mean Scores for Depression Scores of Children

	Control Group	ADD Group	HD Group	Combined Group
Child Depression Scores	4.95 a	10.45 ab	11.09 ab	11.6 b

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group.
Note 2: The mean scores that do not share the same subscript on the same row are significantly different from each other, on .05 alpha level of Tukey's HSD.

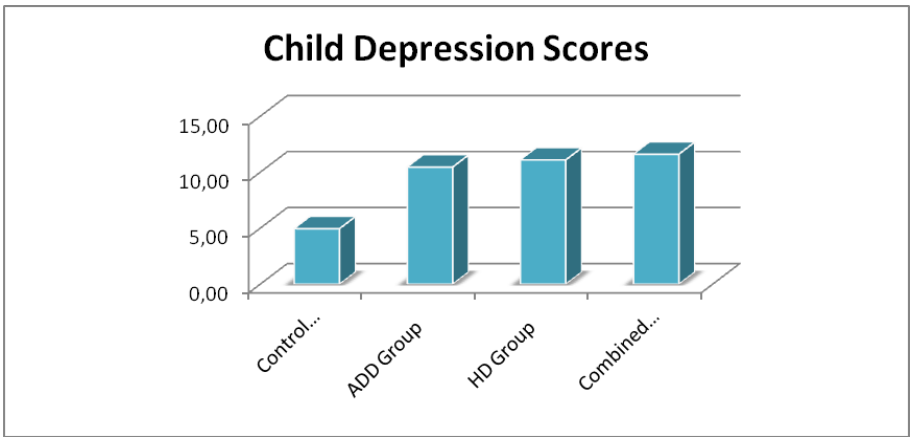

Figure 5. Mean Scores for Depression Scores of Children

3.3.3. Differences of ADHD diagnosis on Rosenberg self-esteem scores of children

In order to examine the differences among depression scores of four groups of children one-way ANOVA was conducted. Analysis revealed significant difference on Rosenberg scores of children in ADHD combined group, ADHD inattention group and ADHD hyperactivity group and control group, $F(3, 114) = 17.85$, $p<.05$. To interpret this main effect for self esteem scores, Tukey's HSD was conducted at.05 level. Post-hoc analysis revealed that children in control group (M=35.40) had significantly higher Rosenberg self esteem scores from children in ADHD inattention group (M=29.62) and children in ADHD combined group (M=28.45) however, when compared to children in hyperactivity group (M=32.81), children in control group did not have significantly different scores. Rosenberg scores of children in ADHD inattention group were also not significantly different from either children in ADHD hyperactivity group or children in ADHD combined group. Whereas children in ADHD combined group had significantly lower scores than children in ADHD hyperactivity group.

Table 8. Analysis of Variance for Rosenberg Self Esteem Scores

Source	df	SS	MS	F
ADHD Diagnosis of Children	3	802.15	267.38	**17.85*** **
Error	114	1707.61	14.98	

Note 1. *** p <.001

Table 9. Mean Scores for Rosenberg Self Esteem Scores

	Control Group	ADD Group	HD Group	Combined Group
Rosenberg Self Esteem Scores	35.40 a	29.62 bc	32.81 ab	28.45 c

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group. **Note 2.** The mean scores that do not share the same subscript on the same row are significantly different from each other, on .05 alpha level of Tukey's HSD.

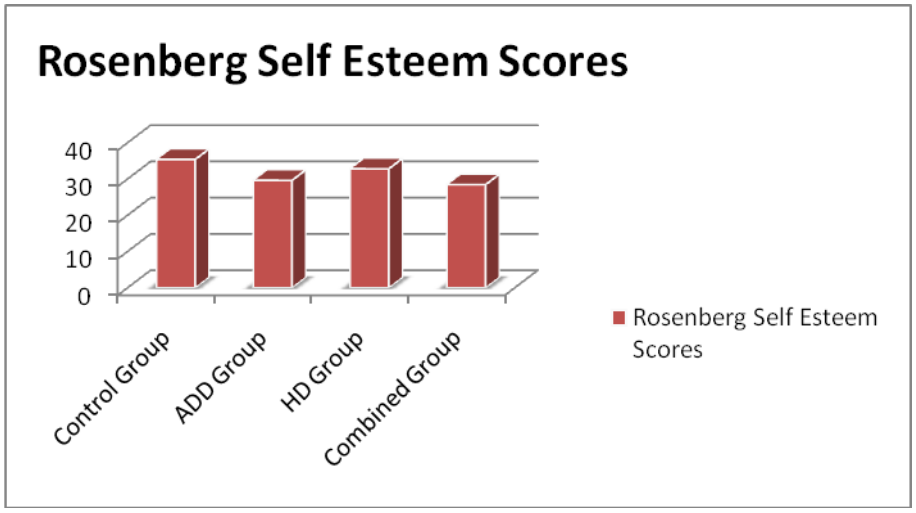

Figure 6. Mean Scores for Rosenberg Self Esteem Scores

3.3.4. The differences of ADHD diagnosis on Conners scores rated by teacher

In order to examine the differences between diagnosis (consisting of; control group, ADHD inattentive type, ADHD hyperactivity type, ADHD combined type) on teacher rated Conner's scores (namely; inattention scores, hyperactivity scores, conduct disorder scores) of children MANOVA was conducted. The results revealed a significant main effect of diagnosis [*Multivariate F* (9, 238) =, p <.001, Wilks' Lambda, .51 η^2 = .20] on Conner's scores.

Following multivariate analyses, Univariate analyses were performed for significant main effects of diagnosis with Bonferroni correction. Thus, for the Univariate

analyses, the alpha values that were lower than .17 (found by dividing alpha level by the number of subscales, i.e., .05/3 = .017 and rounded up to .02) were considered to be significant with this correction. Based on this correction, the results indicated diagnosis main effect for all Conner's scores, F (3, 100) = 15.01, 15.71, 14.35, p <.001, η^2 = .31, .32, .30, for inattention, hyperactivity, conduct disorder respectively. Thus, to interpret this main effect post-hoc analyses was conducted by Tukey's HSD at.05 alpha level. Accordingly, participants in control group (M = 11.26, 9.31, 6.37 for inattention, hyperactivity, conduct disorder scores; respectively) had significantly lower scores on all subscales of Conner's than children diagnosed with ADHD inattention type (M = 15.28, 14.20, 11.60 for inattention, hyperactivity, conduct disorder scores; respectively), hyperactivity type (M = 14.73, 16.00, 13.09 for inattention, hyperactivity, conduct disorder scores; respectively), combined type (M = 16.96, 16.14, 12.90 for inattention, hyperactivity, conduct disorder scores; respectively). However, children diagnosed with ADHD inattention type, hyperactivity, combined type did not differ from each other on Conners scores.

Table 10. The Relationship between Conner's Scores Rated by Teacher and Diagnosis of Children

	Multivariate				**Univariate**		
Source	**Wilks' Lambda**	**F**	**df**	**η^2**	**F**	**df**	**η^2**
Conners ADHD	.51	**8.54*** **	9, 300	.20	-	-	-
Conners ADD					**15.01*** **	3, 100	**.31**
Conners HD					**15.71*** **	3, 100	**.31**
Conners CD					**14.35*** **	3, 100	**.31**

Note 1. ***p <.001; Conners ADHD: Conners ADHD Parent Rating Scale, Conners ADD: Conners ADHD Parent Rating Inattention Subscale, Conners HD: Conners ADHD Parent Rating Hyperactivity Subscale, Conners CD: Conner's ADHD Parent Rating Conduct Disorder Subscale.

Table 11. Mean Scores for Conner's Scores Teacher Ratings

	Inattention Scores	Hyperactivity Scores	Conduct Disorder
Control Group	11.26 a	9.31 a	6.37 a
ADD Group	15.28 b	14.20 b	11.6 b
HD Group	14.73 b	16.00 b	13.09 b
Combined Group	16.96 b	16.14 b	12.9 b

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group Subscale.

Note 2. Inattention Scores: Scores on Conners ADHD Parent Rating Inattention Subscale, Hyperactivity Scores: Scores on Conners ADHD Parent Rating Hyperactivity Subscale, Conduct Disorder Scores: Conners ADHD Parent Rating Conduct Disorder Subscale.

Note 3. The mean scores that do not share the same subscript on the same column are significantly different from each other, on.05 alpha level of Tukey's HSD.

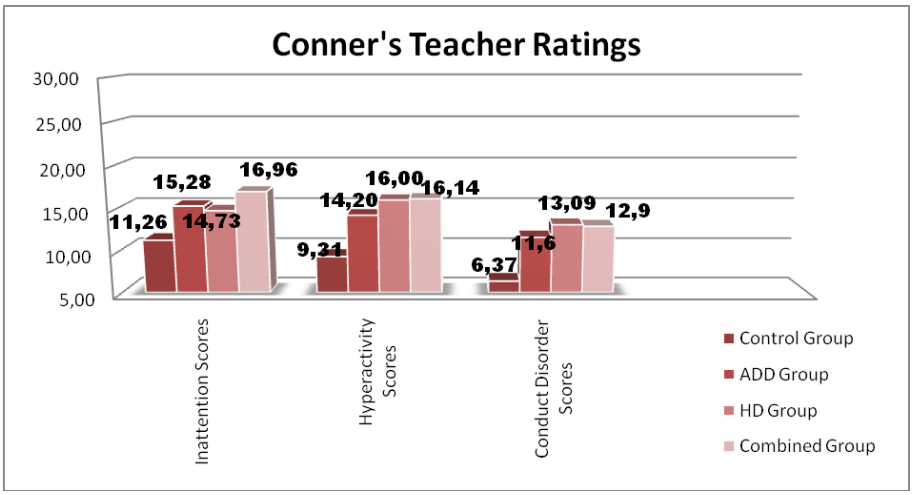

Figure 7. Mean Scores for Conner's Scores Teacher Ratings

3.3.5. The differences of ADHD diagnosis on Conners scores rated by mother

In order to examine the differences of diagnosis (consisting of; control group, ADHD inattentive type, ADHD hyperactivity type, ADHD combined type) on mother rated Conners scores (namely; inattention scores, hyperactivity scores, conduct disorder scores) of children MANOVA was conducted. The results revealed a significant main effect of diagnosis [*Multivariate F* (12, 301) = 7.44, p <.001, Wilks' Lambda = .50, η^2 = .20] on Conners scores.

Following multivariate analyses, Univariate analyses were performed for significant main effects of diagnosis with Bonferroni correction. Thus, for the univariate

analyses, the alpha values that were lower than .012 (found by dividing alpha level by the number of subscales, i.e., .05/ = .012 and rounded up to .01) were considered to be significant with this correction. Based on this correction, the results indicated diagnosis main effect for all Conners scores, F (3, 117) = 18.31, 14.31, 14.74, 13.93, p <.001, η^2 = .32, .27, .27, .26 for inattention, hyperactivity, oppositional defiant disorder and conduct disorder scores; respectively. Thus, to interpret this main effect post-hoc analyses was conducted by Tukey's HSD at .05 alpha level. Accordingly, on Conner's inattention subscale, participants in control group (M = 7.19) had significantly lower scores than children diagnosed with ADHD inattention type (M = 11.93), hyperactivity type (M = 11.91), combined type (M = 12.32). However children diagnosed with ADHD inattention type, hyperactivity, combined type did not differ from each other on Conners inattention scores.

On Conner's hyperactivity subscale, children diagnosed with ADHD inattention type (M = 9.70) and children in control group (M = 9.14) did not differ significantly from each other but they both had lower scores compared to children diagnosed with ADHD hyperactivity type (M = 12.36) or ADHD combined type (M = 12.51). However hyperactivity scores of children with ADHD hyperactivity type and ADHD combined type were also not significantly different from each other.

On Conners oppositional defiant disorder subscale participants in control group (M = 7.19) had significantly lower scores than children diagnosed with ADHD inattention type (M = 10.03), hyperactivity type (M = 11.18), combined type (M = 12.11). In addition to this children diagnosed with ADHD inattention type had also significantly lower scores than children with diagnosed with ADHD combined type. However, oppositional defiant disorder scores of children with hyperactivity type did not significantly differ from neither children diagnosed with ADHD inattention type nor children diagnosed with ADHD combined type.

On Conners conduct disorder subscale participants in control group (M = 14.85) had significantly lower scores than children diagnosed with ADHD inattention type (M = 20.50), hyperactivity type (M = 22.91), combined type (M = 25.37). In addition to this children diagnosed with ADHD inattention type had also significantly lower scores than children with diagnosed with ADHD combined type. However conduct

disorder scores of children with hyperactivity type did not significantly differ from neither diagnosed with ADHD inattention type nor diagnosed with ADHD combined type.

Table 12. The Relationship between Conner's Scores Rated by Mother and Diagnosis of Children

	Multivariate				Univariate		
Source	**Wilks' Lambda**	**F**	**df**	**η^2**	**F**	**df**	**η^2**
ADHD	.50	**7.44*****	12, 301.91	.20			
Conners ADD					**18.31*****	3, 117	.32
Conners HD					**14.31*****	3, 117	.27
Conners ODD					**14.74*****	3, 117	**.27**
Conners CD					**13.93*****	3, 117	.26

Note 1. ***p <.001, Conners ADHD: Conners ADHD Parent Rating Scale, Conners ADD: Conners ADHD Parent Rating Inattention Subscale, Conners HD: Conners ADHD Parent Rating Hyperactivity Subscale, Conners CD: Conners ADHD Parent Rating Conduct Disorder Subscale.

Table 13. Mean Scores for Conner's Scores Mother Ratings

	Inattention Scores	**Hyperactivity Scores**	**Oppositional Defiant Disorder**	**Conduct Disorder**
Control Group	7.19 a	9.14 a	7,19 a	14.85 a
ADD Group	11.93 b	9.70 b	10.03 b	20.5 b
HD Group	11.91 b	12.36 b	11.18 b	22.91 b
Combined Group	12.32 b	12.51 b	12,11 b	25.37 b

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group.
Note 2. Inattention Scores: Scores on Conners ADHD Parent Rating Inattention Subscale, Hyperactivity Scores: Scores on Conners ADHD Parent Rating Hyperactivity Subscale, Conduct Disorder Scores: Conners ADHD Parent Rating Conduct Disorder Subscale.
Note 3. The mean scores that do not share the same subscript on the same column are significantly different from each other, on .05 alpha level of Tukey's HSD.

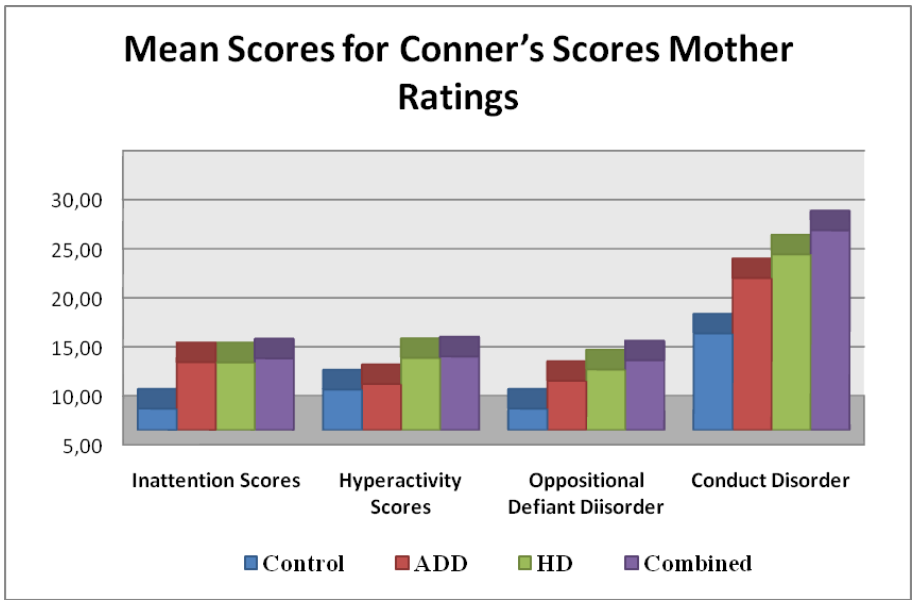

Figure 8. Mean Scores for Conner's Scores Mother Ratings

3.3.6. Differences on child social support scores according to diagnostic status

In order to examine the differences of diagnosis (consisting of; control group, ADHD inattentive type, ADHD hyperactivity type, ADHD combined type) on social support appraisals scores (namely; social support perceived from family, social support perceived from friends, social support perceived from teacher) of children MANOVA was conducted. According to the results, there was no main effect of diagnosis [*Multivariate F (*9, 272) = .74, *ns*, Wilks' Lambda = .94, η^2 = .019] on social support. Since, the *Multivariate F* was not significant Univariate analyses were not examined.

3.4. Differences of ADHD Diagnosis on Maternal Characteristics

3.4.1. Differences on maternal anxiety scores according to diagnostic status

In order to examine the differences among maternal anxiety scores of four groups (namely; control group, ADHD inattentive type, ADHD hyperactivity type, and ADHD combined type) of children one way ANOVA was conducted. There were no significant differences among maternal state anxiety scores of children in four groups F (3, 117) = 2.41, ns. Whereas ADHD revealed significant differences on maternal trait anxiety scores of mothers, F (3, 117) = 6.16, p ≤.001. The post-hoc analysis

following ANOVA, was conducted by Tukey's HSD at.05 alpha level revealed that mothers of control group received significantly lower scores on maternal trait anxiety (M=39.67) when compared to mothers of ADHD combined group (M=48.29). However, children with ADHD inattentive type (M=43.90) and hyperactivity type (M=42.91) did not differ from any groups on maternal trait anxiety scores.

Table 14. Analysis of Variance for Maternal State-Anxiety Scores

Source	df	SS	MS	F
ADHD Diagnosis of Children	3	801.51	267.17	2.41
Error	117	12954.46	110.72	

Table 15. Analysis of Variance for Maternal Trait-Anxiety Scores

Source	df	SS	MS	F
ADHD Diagnosis of Children	3	1314.04	438.01	**6.16*** **
Error	117	8324.38	71.15	

Table 16. Mean Scores for Maternal Trait-Anxiety Scores

	Control Group	ADD Group	HD Group	Combined Group
Maternal Trait Anxiety	39.67 a	43.90 ab	42.91 ab	48.29 b

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group.
Note 2: The mean scores that do not share the same subscript on the same row are significantly different from each other, on .05 alpha level of Tukey's HSD.

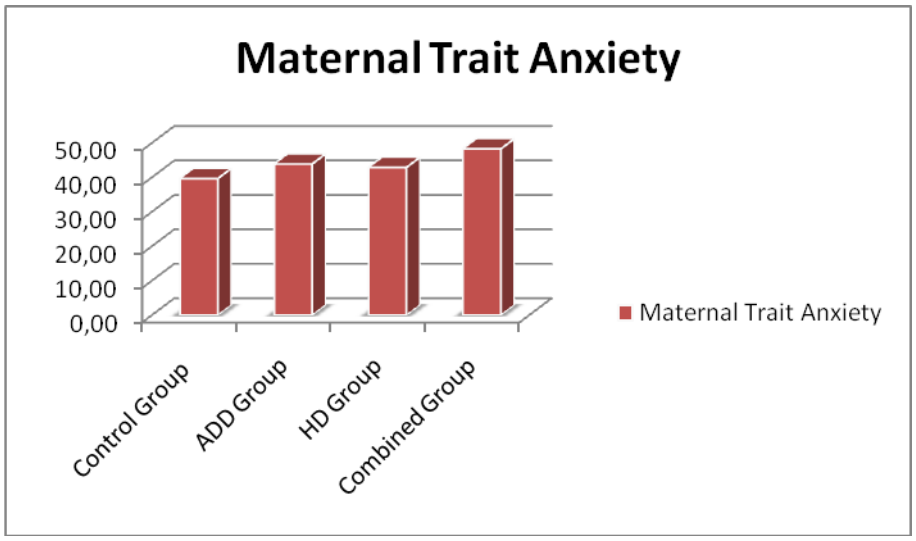

Figure 9. Mean Scores Maternal Trait-Anxiety Scores

3.4.2. Differences on maternal depression scores according to diagnostic status of children

In order to examine the differences of mothers in four groups of children (consisting of; control group, ADHD inattentive type, ADHD hyperactivity type, ADHD combined type) on depression scores, one-way ANOVA was conducted. Analysis revealed significant difference of ADHD diagnosis on maternal depression scores; F (3, 117) = 4.36, p <.01. According to the post-hoc analysis conducted by Tukey's HSD at.05 alpha level, depression scores of mothers having children in control group (M = 11.45) were significantly lower than mothers having children in ADHD combined group (M = 14.45). Mothers of children with ADHD inattentive type (M = 12.33) and hyperactivity type (M = 11.45) did not differ on depression scores neither from each other nor from mothers of children in ADHD combined group (M = 14.46) or control group (M = 7.14).

Table 17. Analysis of Variance for Maternal Depression Scores

Source	df	SS	MS	F
ADHD Diagnosis of Children	3	840.13	280.04	4.36**
Error	117	7510.61	64.28	

Note 1. **p <.01

Table 18. Mean Scores for Maternal Depression

	Control	ADD	HD	Combined
Maternal Depression	7.14 a	12,33 ab	11,45 ab	14.45 b

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group.
Note 2. The mean scores that do not share the same subscript on the same row are significantly different from each other, on .05 alpha level of Tukey's HSD.

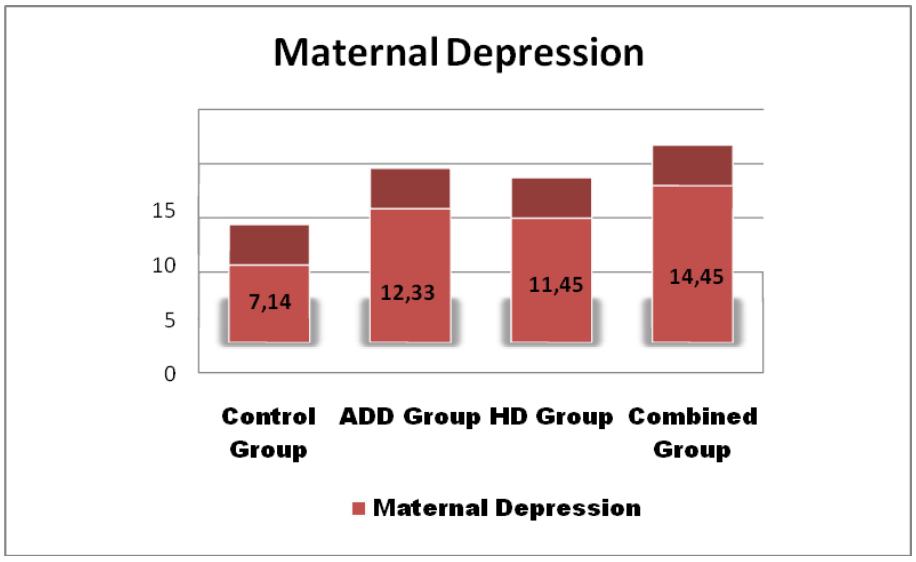

Figure 10. Mean Scores for Maternal Depression

3.4.3. Differences on maternal ADHD scores according to diagnostic status of children

In order to examine the association between child's ADHD diagnosis and maternal ADHD scores (namely; inattention scores, hyperactivity scores, ADHD scores, scores of ADHD related problems) of children MANOVA was conducted. The results revealed a significant main effect of child diagnosis [*Multivariate F* (9, 280) = 2.41, p <.05, Wilks' Lambda = .83, η^2 = .059] on ADHD scores of mothers.

Table 19. Differences on Maternal ADHD Scores According to Diagnostic Status of Children

Multivariate					**Univariate**		
Source	**Wilks' Lambda**	**F**	**df**	**η^2**	**F**	**df**	**η^2**
ADHD	.83*	2.41*	9, 280	.06			
Maternal ADD					2.88ns	3, 117	.07
Maternal HD					1,90ns	3, 117	.05
Maternal ADHD					3, 52ns	3, 117	.08
Maternal ADHD Related Problems					3, 91*	3, 117	.09

Note 1. p* <.01, Maternal ADD: Maternal Attention Deficit Hyperactivity scores for Inattention type, Maternal HD: Maternal Attention Deficit Hyperactivity scores for Hyperactivity type, Maternal ADHD: Maternal Attention Deficit Hyperactivity scores for combined type, Maternal ADHD Related Problems: Maternal scores of life problems related to Maternal Attention Deficit Hyperactivity Scores

Following multivariate analyses, Univariate analyses were performed for significant main effects of diagnosis with Bonferroni correction. Thus, for the univariate analyses, the alpha values that were lower than .012 (found by dividing alpha level by the number of subscales, i.e., .05/4 = .012 and rounded up to .01) were considered to be significant with this correction. Based on this correction, the results indicated diagnosis main effect on maternal ADHD related problems scores; $\underline{F}$ (3, 117) = 3.91, $\underline{p}$ <.01, η^2 = .09. Thus, to interpret this main effect post-hoc analyses was conducted by Tukey's HSD at .05 alpha level. Accordingly, mothers of participants in control group ($\underline{M}$ = 14.33) had significantly lower ADHD related problems scores compared to mothers of children diagnosed with ADHD combined type ($\underline{M}$ = 26.46). However, there were no significant differences on maternal ADHD related problem scores between mothers of children in ADHD inattentive group ($\underline{M}$ = 24.33) and mothers of children in ADHD hyperactivity group ($\underline{M}$ = 23.73), also ADHD inattentive group and mothers of children in ADHD hyperactivity group did not significantly differ from either children in control group or children diagnosed with ADHD combined type.

Table 20. Mean Scores of Maternal ADHD Scores According to Diagnostic Status of Children

	Maternal ADD	**Maternal HD**	**Maternal ADHD**	**Maternal ADHD Related Problems**
Control Group	4.24 a	4.57 a	23.14 a	14.33 a
ADD Group	7,47 a	5.3 a	37.1 a	24.33 ab
HD Group	7.73 a	9.27 a	40.73 a	23.73 ab
Combined Group	8.03 a	6.89 a	41.39 a	26.46 b

Note 1. Maternal ADD: Maternal Attention Deficit Hyperactivity scores for Inattention type, Maternal HD: Maternal Attention Deficit Hyperactivity scores for Hyperactivity type, Maternal ADHD: Maternal Attention Deficit Hyperactivity scores for combined type, Maternal ADHD Related Problems: Maternal scores of life problems related to Maternal Attention Deficit Hyperactivity Scores.

Note 2. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group.

Note 3. The mean scores that do not share the same subscript on the same column are significantly different from each other, on .05 alpha level of Tukey's HSD.

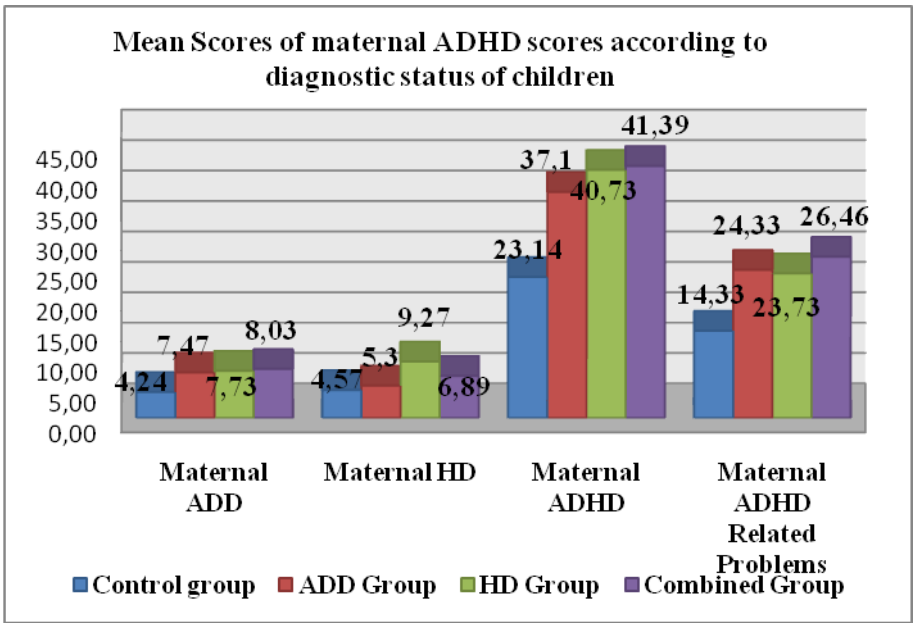

Figure 11. Mean Scores of Maternal ADHD Scores According to Diagnostic Status of Children

3.4.4. The relationship between maternal coping styles and diagnosis of children

In order to examine the association between diagnosis and maternal coping scores (namely; problem focused coping, emotion focused coping, indirect coping) of children MANOVA was conducted. According to the results, there was no main effect of diagnosis [*Multivariate F*(3, 115) = .67, *ns*, Wilks' Lambda = .95, η^2 = .017] on maternal coping scores. Since, the *Multivariate F* was not significant univariate analyses were not examined.

3.4.5. Differences on maternal recognition of emotional maltreatment (misuse) scores according to diagnostic status of children

In order to examine the differences on scores of maternal recognition about emotional abuse among the mothers of four groups of children one-way ANOVA was conducted. ADHD diagnosis (consisting of; control group, ADHD inattentive type, ADHD hyperactivity type, ADHD combined type) had no significant differences F (3, 117) = 1.99, ns on scores of maternal recognition of emotional maltreatment among the mothers groups of children in four groups (Means for children in ADHD control group, ADHD inattention group and ADHD hyperactivity group and combined group are 58.43, 56.80, 53.73, 55.19, respectively).

3.4.6. The relationship between scores of maternal approval of verbal and physical discipline towards children and diagnosis of children

In order to examine the association between diagnosis and maternal approval of verbal and physical discipline of children MANOVA was conducted. The results revealed a significant main effect of diagnosis [*Multivariate F* (6, 232) =3.99, p <.001, Wilks' Lambda = .82, η^2 = .094] on Conner's scores.

Following multivariate analyses, Univariate analyses were performed for significant main effects of diagnosis with Bonferroni correction. Thus, for the Univariate analyses, the alpha values that were lower than .025 (found by dividing alpha level by the number of subscales, i.e., .05/2 = .025 and rounded up to .03) were considered to be significant with this correction. Based on this correction, the results indicated diagnosis main effect for both maternal verbal F (3, 117) = 4.51, p <.01, η^2 = .104 and physical discipline, F (3, 117) =4.60, p <.01, η^2 = .105. Thus, to interpret this main effect post-hoc analyses was conducted by Tukey's HSD at.05 alpha level. Accordingly, participants in control group (M = 5.14) had significantly lower scores on verbal discipline compared to children diagnosed with ADHD combined group (M = 7.85). However there were no significant differences on verbal discipline scores between control group and children in ADHD inattention type (M = 5.60), children in ADHD hyperactivity group (M = 8.82). Similarly, children in ADHD combined group also did not differ from children in ADHD inattention group, children in ADHD hyperactivity group on verbal discipline scores.In addition to this, children in ADHD inattention type and children in ADHD hyperactivity did not differ from each other from each other on verbal discipline scores. Participants with ADHD hyperactivity type (M = 7.60) had significantly higher scores on physical discipline compared to children diagnosed with ADHD combined type (M = 2.98), ADHD inattention type, control group. However there were no significant differences on physical discipline scores among three groups (control group, ADHD inattention type, ADHD combined type).

Table 21. The Relationship between Scores of Survey of Standards for Discipline Practices and Diagnosis of Children

Multivariate					**Univariate**		
Source	**Wilks' Lambda**	**F**	**df**	**η^2**	**F**	**df**	**η^2**
ADHD	.82	3.99***	6, 232	.09			
Attitudes towards verbal discipline practices					4.51*	3.117	.10
Attitudes towards physical discipline practices					4.60*		.10

Note 1. ***p <.001, **p <.01, *p <.05

Table 22. Mean Scores of Survey of Standards for Discipline Practices and Diagnosis of Children

	Verbal Discipline	**Physical Discipline**
Control Group	5.14 a	1.5 a
ADD Group	5.6 ab	2.19 a
HD Group	8.8 ab	7.6 b
Combined Group	7.85 b	2.98 a

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group. **Note 2.** The mean scores that do not share the same subscript on the same column are significantly different from each other, on .05 alpha level of Tukey's HSD.

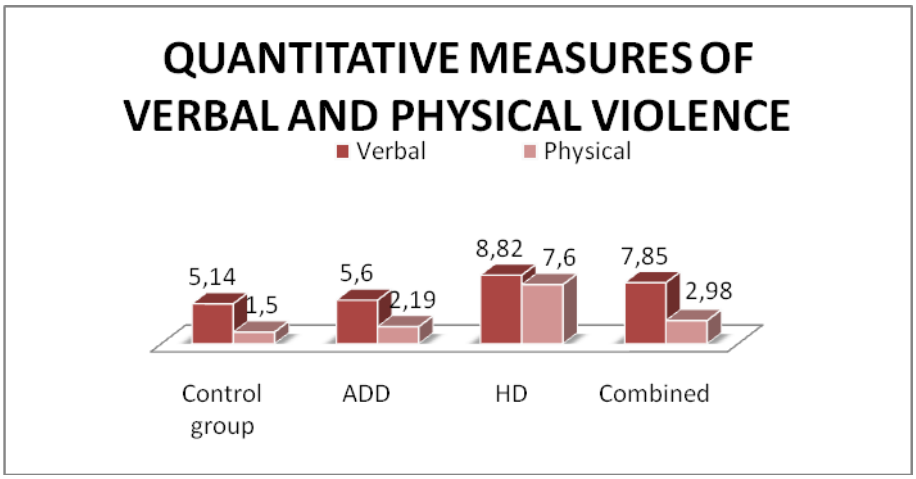

Figure 12. Mean Scores of Survey of Standards for Discipline Practices and Diagnosis of Children

3.4.7. Differences on qualitative scores of verbal and physical discipline according to diagnostic status of children

Based on the data gathered in the semi-structured interview, calculations were made to understand how frequent physical punishment and how many types of physical punishment were used by mothers. When the frequency and the number of types in physical punishment were calculated, another variable, namely the severity of physical punishment, was created from the multiplication of these two variables. However verbal discipline was indicated very frequently by mothers, whereas children could not give reliable frequency information so the severity of verbal discipline was created based on only the number of verbal discipline types. Following this procedure, quantitative analyses were conducted with these severity variables created based on the information gathered with qualitative methods.

In order to examine the differences of children's diagnostic status on qualitative scores of verbal and physical discipline One-way ANOVA were conducted. Analysis revealed significant difference of diagnostic status on verbal discipline scores of mothers; $F (3, 114) = 5.18$, $p < .01$. Accordingly, qualitative verbal discipline scores of mothers having children in control group ($M = 1.60$) were significantly lower than mothers having children in ADHD combined group ($M = 2.80$). Whereas, mothers of children with ADHD inattentive type ($M = 2.14$) and hyperactivity type ($M = 3.0$) did not differ on qualitative verbal discipline scores neither from each other nor from mothers of children in ADHD combined group or control group. According to the analysis there were significant differences among qualitative physical discipline scores of mothers; $F (3, 114) = 3.20$, $p < .05$. Accordingly, qualitative physical discipline scores of mothers having children in control group ($M = 1.40$) were significantly lower than mothers having children in ADHD combined group ($M = 4.26$). Whereas, mothers of children with ADHD inattentive type ($M = 3.39$) and hyperactivity type ($M = 3.27$) did not differ on qualitative physical discipline scores neither from each other nor from mothers of children in ADHD combined group or control group.

Table 23. Differences on Qualitative Scores of Verbal Discipline According to Diagnostic Status of Children

Source	df	SS	MS	F
ADHD Diagnosis of Children	3	139.82	46.61	5.18**
Error	114	1025.231	8.99	

Note. **p <.01.

Table 24. Differences on Qualitative Scores of Physical Discipline According to Diagnostic Status of Children

Source	df	SS	MS	F
ADHD Diagnosis of Children	3	30.87	10.096	3.20*
Error	114	360.188	3.160	

Note. **p <.05.

Table 25. Mean Scores of Qualitative Data about Verbal and Physical Discipline According to Diagnostic Status of Children

	Qualititative Verbal Discipline	Qualititative Physical Discipline
Control	1.60 a	1.40 a
ADD	2.14 ab	3.39 ab
HD	3.00 ab	3.27 ab
Combined	2.80 b	4.26 b

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group.
Note 2. The mean scores that do not share the same subscript on the same column are significantly different from each other, on .05 alpha level of Tukey's HSD.

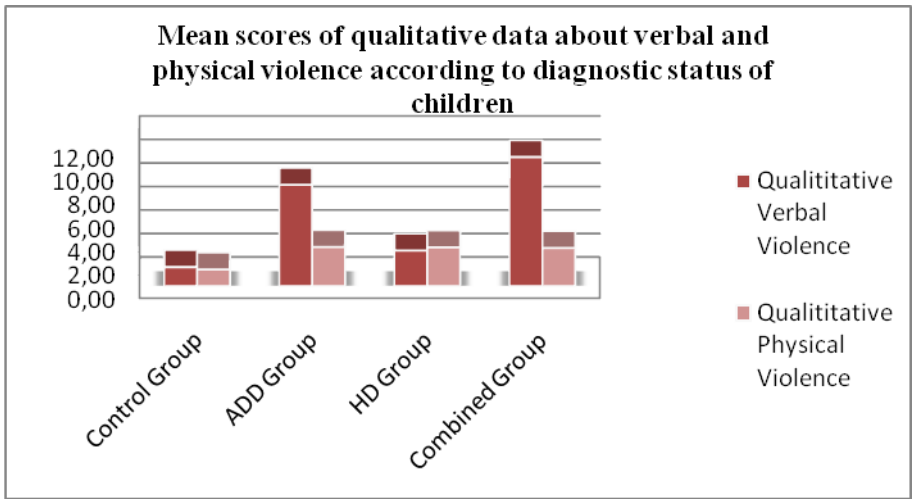

Figure 13. Mean Scores of Qualitative Data about Verbal and Physical Discipline According to Diagnostic Status of Children

3.5. Inter-correlations between groups of variables

Before the Regression Analyses, Pearson correlation analyses were carried out in order to examine the relationship between Conners scores, depression scores, Rosenberg self esteem scores of children, quantitative scores of maternal attitudes towards verbal and physical discipline, qualitative scores of maternal verbal and physical discipline towards children and other variables of the study such as; demographic variables, child and maternal characteristics, social support perception of both children and mothers, and maternal past experiences.

Considering the large sample size, among the significant correlations only those having a correlation coefficient larger than .35 were interpreted. According to the results a maternal scores on attitudes towards verbal discipline had significant positive correlations with Conner's HD (r = .41, p <.001), Conner's ODD scores (r = .49, p <.001), Conner's CD scores (r = .49, p <.001), maternal scores on attitudes towards physical discipline (r = .63***, p <.001), maternal scores on qualitative data about physical discipline (r = .36, p <.001). Thus, as maternal scores on attitudes towards verbal discipline increased Conner's HD, Conner's ODD scores, Conner's CD scores, maternal scores on attitudes towards physical discipline, maternal scores on qualitative data about physical discipline also increased.

According to the results maternal scores on both attitudes towards verbal discipline and attitudes towards physical discipline had significant negative correlations with none of the variables; however, attitudes towards physical discipline had significant positive correlations with child depression scores (r = .38, p <.001) and maternal attitudes towards verbal discipline (r = .63, p <.001). Thus, as scores on attitudes towards physical discipline increased child depression scores and maternal scores on attitudes towards verbal discipline increased.

According to the results maternal scores on qualitative data about physical discipline had significant negative correlations with none of the variables however it had positive correlations with Conner's ODD scores (r = .41, p <.001), Conner's CD scores (r = .42 p <.01), maternal scores on attitudes towards verbal discipline (r = .36, p <.001). Thus, as maternal scores on qualitative data about physical discipline

increased Conner's ODD scores, Conner's CD scores, maternal scores on attitudes towards verbal discipline also increased.

According to the results qualitative scores of verbal discipline had significant positive correlations with Conner's ADD (r = .35, p <.001). Thus, as qualitative scores of verbal discipline increased Conner's ADD scores increased also.

According to the results child depression scores had significant negative correlations with Rosenberg self esteem scores (r = -.53, p <.001) however it had positive correlations with maternal attitudes towards physical discipline (r = .38, p <.001). Thus, as child depression scores increased maternal attitudes towards physical discipline also increased however Rosenberg self esteem scores decreased.

According to the results Rosenberg self-esteem scores had significant negative correlations with child depression scores (r = -.53, p <.001), Conners ADD (r = -.40, p <.01), Conners ODD scores (r = -.40, p <.001), Conners CD scores (r = -.39, p <.001) however it had positive correlations with quality of relationship with friends (r = .39, p <.001) and with teacher (r = .41, p <.001). Thus, as Rosenberg self esteem scores increased quality of relationship with friends and with teacher increased as well, however, Conners ODD scores and Conners CD scores child depression scores decreased.

According to the results Conners ADD scores had negative correlations with quality of relationship with family (r = -.36, p <.001), with teacher (r = -.39, p <.001), with friends (r = -.40, p <.001) and academic performance (r = -.38, p <.001), Rosenberg self-esteem scores (r = -.39, p <.001); it had significant positive correlations with Conner's HD (r = .45, p <.001), Conners ODD scores (r = .55, p <.001), Conner's CD scores (r = .48, p <.01), qualitative data about verbal discipline (r = .35, p <.001). Thus, as Conners ADD scores increased Conners HD, Conners ODD scores, Conners CD scores, qualitative data about verbal discipline increased, however quality of relationship with family, with teacher, with friends and academic performance decreased.

According to the results Conners HD scores had negative correlations with quality of relationship with family (r = -.35, p <.001) and had significant positive correlations with Conners ADD (r = .45, p <.01), Conners ODD scores (r = .53, p <.001), Conners CD scores (r = .48, p <.001), attitudes towards verbal discipline (r = .41, p <.001). Thus, as Conner's ADD scores increased Conners HD, Conners ODD scores, Conners CD scores, attitudes towards verbal discipline increased, however quality of relationship with family decreased.

According to the results Conners ODD scores had negative correlations with quality of relationship with family (r = -.61, p <.001), with teacher (r = -.43, p <.001), with friends (r = -.53, p <.001), Rosenberg self-esteem scores (r = -.40, p <.001) had significant positive correlations with Conner's ADD (r = .55, p <.01), Conner's Conners HD scores (r = .53, p <.001), Conner's CD scores (r = .92, p <.001) attitudes towards verbal discipline (r = .49, p <.001), qualitative data about physical discipline (r = .41, p <.001). Thus, as Conners ODD scores increased, Conners ADD, Conners HD scores, Conners CD scores, attitudes towards verbal discipline, qualitative data about physical discipline scores increased as well, however quality of relationship with family, with teacher, with friends, Rosenberg self-esteem scores decreased.

According to the results, Conner's CD scores had negative correlations with quality of relationship with family (r = -.50, p <.001) with teacher (r = -.59, p <.001), Rosenberg self-esteem scores (r = -.39, p <.001), however it had significant positive correlations with Conner's ADD (r = .48, p <.01), Conner's HD scores (r = .48, p <.001), Conner's ODD scores (r = .92, p <.001) attitudes towards verbal discipline (r = .49, p <.001), qualitative data about physical discipline (r = .42, p <.001). Thus, as Conner's CD scores increased Conner's ADD, Conner's HD scores, Conner's CD scores, attitudes towards verbal discipline, qualitative data about physical discipline also increased, however as quality of relationship with family, with teacher, with friends, Rosenberg self esteem scores decreased, Conner's CD scores increased.

Table 26. Correlations between Demographic Variables and Main Study Variables

Variables	Gender	Child's age	Income	Maternal Education	Paternal Education	Bottle Using	Nipple Using	Breast Feeding	Walking Age	Number of Siblings
V- disp apr.	.21***	-.11	-.06	-.04	.-19*	.12	-.01	-.10	.09	.11
P -disp apr.	.08	-.12	-.04	-.12	-.17	.04	-01	.09	.27**	.11
REMS	-.09	-.09	.28**	.23**	.19*	.01	.09	-.15	.01	-.31***
P- disp prc.	.11	-.04	-.13	-.03	-.02	-.04	.05	-.08	.22*	.10
V- disp prc.	.19*	.06	-.12	-.16	-.09	-.01	-.05	-.07	.05	-.01
CDI	.16	.21*	-.15	-.18*	-.17	-.06	.04	.004	.05	.07
Self-Esteem	.08	.09	.24**	.23*	.16	.03	.01	.003	-.07	-.06
Con-ADD	.17	.09	-.08	-.21*	.02	.08	.12	.12	.10	.11
Con-HD	.18*	-.22*	-.15	-.15	-.01	.06	.10	-.12	.000	.06
Con-ODD	.26**	.10	.21*	-.20*	-.20*	.03	.05	-.02	-.10	-.01
Con-CD	.29***	.05	-.19*	-.19*	-.21*	.01	.07	.01	-.03	.11

Note 1. ***p < .001, **p < .01, *p < .05

Note 2. Con-ADD: Con-ADHD Parent Rating Inattention Subscale, Con- HD: Con- ADHD Parent Rating Hyperactivity Subscale, Con- CD: Con-ADHD Parent Rating Conduct Disorder Subscale; CDI: Scores on Child Depression Inventory; Self-esteem: Rosenberg Self-Esteem Scores.

Note 3. REMS: scores on Recognition of Emotional Maltreatment Scale; V- disp apr.: Quantitative scores of mothers on approval of verbal discipline; - disp apr.: Quantitative scores of mothers on approval of physical discipline; V- disp prc.: Qualitative scores of mothers on practicing verbal discipline; P- disp prc.: Qualitative scores of mothers on practicing physical discipline.

Table 27. Correlations between Child Characteristics and Main Study Variables

Variables	CDI	Self - Esteem	WISC-R Verb. IQ	WISC -R Perf. IQ	WISC -R Total IQ	Rel. With Family	Rel. With Teacher	Rel. With Friends	Academic Performance
V- disp apr.	.24**	-19	-.12	-.004	-.06	-.33***	-.18*	-.32***	-.11
P -disp apr.	**.38***	-.20	-.13	.002	-.06	-.17	.001	-.06	.004
REMS	-.09	.32***	.07	.09	.09	.22*	.25**	.17	.18
P- disp prc.	.15	-.24**	-.30	-.11	-.08	-.25**	-.25**	-.33***	-.18
V- disp prc.	.06	-.19	-.14	-.17	-.17	-.23*	-.18	-.26**	-.28**
CDI	**1**	**-.53*****	-.20*	.08	-.20*	-.15	-.15	-.26**	-.23*
Self-Esteem	**-.53*****	1	.23*	.14*	.21*	.33***	.41***	**.39*****	.34***
Con-ADD	-001	-.15	-.28***	-.25**	-.29***	**-.36*****	**-.39*****	**-.40*****	-.38***
Con-HD	-.08	-.03	.003	.02	.01	**-.35*****	-.17	-.20*	-.10
Con-ODD	.06	-.17	-.23*	-.23*	-.23**	**-.61*****	**-.43*****	**-.53*****	-.32***
Con-CD	.02	-.15	-.26	-.24**	-.26**	**-.50*****	**-.59*****	-.34***	-.02

Note 1. ***p < .001, **p < .01, *p < .05

Note 2. Con-ADD: Con-ADHD Parent Rating Inattention Subscale, Con- HD: Con- ADHD Parent Rating Hyperactivity Subscale, Con- CD: Con-ADHD Parent Rating Conduct Disorder Subscale; CDI: Scores on Child Depression Inventory; Self-esteem: Rosenberg Self-Esteem Scores.

Note 3. REMS: scores on Recognition of Emotional Maltreatment Scale; V- disp apr.: Quantitative scores of mothers on approval of verbal discipline; - disp apr.: Quantitative scores of mothers on approval of physical discipline; V- disp prc.: Qualitative scores of mothers on practicing verbal discipline; P- disp prc.: Qualitative scores of mothers on practicing physical discipline.

Table 28. Correlations between Social Support Perception of Both Mother and Children and Main Study Variables

Variables	Maternal Perceived SS.- *Sign. Other*	Maternal Perceived SS. *-Family*	Maternal Perceived SS. - *Friend*	Child Perception of SS *-Teacher*	Child Perception of SS. - *Family*	Child Perception of SS. - *Friend*
V- disp apr.	-.05	-.20*	-.10	-.06	.01	.06
P -disp apr.	.11	.01	.03	-.02	-.05	-01
REMS	.12	.16	.29***	-.14	.07	-.01
P- disp prc.	-.09	-.11	-.08	.04	.003	.09
V- disp prc.	-.05	-.06	-.01	.05	-.10	.12
CDI	-.08	.04	.02	-.02	-.03	-.06
Self-Esteem	-.03	.07	.21*	-.08	.07	.06
Con-ADD	-.15	-.17	-.22*	.05	-.13	-.05
Con-HD	-.05	-.04	-.18*	-.001	-.17	-.05
Con-ODD	-.18	-.23*	-.23*	-.09	-.04	-.07
Con-CD	-.21	-.23	-.25**	-.15	-.03	-.10

Note 1. REMS: scores on Recognition of Emotional Maltreatment Scale; V- disp apr.: Quantitative scores of mothers on approval of verbal discipline; - disp apr.: Quantitative scores of mothers on approval of physical discipline; V- disp prc.: Qualitative scores of mothers on practicing verbal discipline; P- disp prc.: Qualitative scores of mothers on practicing physical discipline; Maternal Perceived SS.- *Sign. Other:Maternal perception of social support from significant other;* Maternal Social Support - *Family:* Maternal perception of social support from family*;* Maternal Perceived SS. - *Friend*: Maternal perception of social support from family Child Perception of SS - *Teacher:* Child perception of social support from teacher*;* Child Perception of SS. - *Family* Child perception of social support from family; Child Perception of SS. – *Friend:* Child perception of social support from family.

Table 29. Correletions between Conners Attention Deficit Hyperactivity Parent Rating Scale and main study variables

Variables	CONNERS ADD	CONNERS HD	CONNERS ODD	CONNERSCD
V- disp apr.	.29***	**.41***	**.49***	**.49***
P -disp apr.	.20*	.16	.29***	.28**
REMS	-.11	-.11	-.25**	-.22*
P- disp prc.	.23*	.28**	**.41***	**.42***
V- disp prc.	**.35***	.22*	.28**	.23*
CDI	.20*	.04	.33***	.32***
Self-Esteem	**-.40****	-.22*	**-.40***	**-.39***
Con-ADD	1	**.45***	**.55***	**.48****
Con-HD	**.45***	1	**.53***	**.48***
Con-ODD	**.55***	**.53***	1	**.92***
Con-CD	**.48****	**.48***	**.92***	1

Note 1. ***p < .001, **p < .01, *p < .05

Note 2. Con-ADD: Con-ADHD Parent Rating Inattention Subscale, Con- HD: Con- ADHD Parent Rating Hyperactivity Subscale, Con- CD: Con-ADHD Parent Rating Conduct Disorder Subscale; CDI: Scores on Child Depression Inventory; Self-esteem: Rosenberg Self-Esteem Scores.

Note 3. REMS: scores on Recognition of Emotional Maltreatment Scale; V- disp apr.: Quantitative scores of mothers on approval of verbal discipline; - disp apr.: Quantitative scores of mothers on approval of physical discipline; V- disp prc.: Qualitative scores of mothers on practicing verbal discipline; P- disp prc.: Qualitative scores of mothers on practicing physical discipline; Maternal Perceived SS.- *Sign. Other: Maternal perception of social support from significant other;* Maternal Social Support *-Family:* Maternal perception of social support from family*;* Maternal Perceived SS. - *Friend*: Maternal perception of social support from family Child Perception of SS *-Teacher:* Child perception of social support from teacher*;* Child Perception of SS. - *Family* Child perception of social support from family; Child Perception of SS. – *Friend:* Child perception of social support from family

Table 30. Correlations between Discipline Styles Used by Mothers

Variables	V- disp apr.	P -disp apr.	REMS	P- disp prc.	V- disp prc.
V- disp apr.	1	**.63*** **	**-.19***	**.36*** **	.19*
P -disp apr.	**.63*** **	1	**-.18**	**.29** **	**.18**
REMS	-.19*	-.18	**1**	**-.25** **	**-.17**
P- disp prc.	**.36*** **	.29**	**-.25** **	**1**	**.34*** **
V- disp prc.	.19*	.18	**-.17**	**.34*** **	**1**

Note 1. ***p < .001, **p < .01, *p < .05

Note 2. REMS: scores on Recognition of Emotional Maltreatment Scale; V- disp apr.: Quantitative scores of mothers on approval of verbal discipline; - disp apr.: Quantitative scores of mothers on approval of physical discipline; V- disp prc.: Qualitative scores of mothers on practicing verbal discipline; P- disp prc.: Qualitative scores of mothers on practicing physical discipline

Table 31. Correlations between Young Parenting Inventory Mother Subscale and Main Study Variables

Variables	YA1	YA2	YA3	YA4	YA5	YA6	YA7	YA8	YA9	YA10
V- disp apr.	-.13	-.08	-.14	-.003	.02	-.13	-.03	-.03	.15	.04
P -disp apr.	-.12	-.10	-.04	-.08	.15	.08	-.05	-.02	.02	.18*
REMS	-.08	-.10	.09	.09	-.14	.01	.09	.14	-06	-.11
P- disp prc.	-.05	-.01	-.10	.16	.02	-.04	.15	-.01	.16	.04
V- disp prc.	-.07	-.07	-.03	-.14	.15	-.06	.02	.06	.04	-.01
CDI	.15	.13	-.09	.10	.06	.27**	-.07	-.002	.10	.27**
Self-Esteem	-.14	-.26**	.08	.05	-.19*	-.20*	-.14	-.07	-.13	-.16
Con-ADD	.18	.16	.04	-.03	.10	-.02	.03	.19	.21	.11
Con-HD	.12	.003	-.60	.10	.11	-.10	.14	.07	.13	.09
Con-ODD	.14	-.003	-.12	-.03	.04	-.11	.01	.06	.08	.12
Con-CD	.09	.008	-.13	.03	.03	-.09	.03	.01	.04	.15

Note 1. ***p < .001, **p < .01, *p < .05

Note 2. Con-ADD: Con-ADHD Parent Rating Inattention Subscale, Con- HD: Con- ADHD Parent Rating Hyperactivity Subscale, Con- CD: Con-ADHD Parent Rating Conduct Disorder Subscale; CDI: Scores on Child Depression Inventory; Self-esteem: Rosenberg Self-Esteem Scores.

Note 3. YA1: belittling/criticizing; YA2: emotionally depriving; YA3: exploitative/abusive parenting; YA4: overprotective/anxious; YA5: Normative conditional/achievement focused; YA6: over pessimistic/worried; YA7: over pessimistic/worried; YA8: permissive/boundless; YA9: Punitive; YA10: restricted/emotionally inhibited

Table 32. Correlations between Young Parenting Inventory Father Subscale and Main Study Variables

Variables	YB1	YB2	YB3	YB4	YB5	YB6	YB7	YB8	YB9	YB10
V- disp apr.	-.004	-.08	-.06	-.05	**-.03**	**.05**	-.03	-.05	.09	.01
P -disp apr.	-.05	-.09	-.08	-.07	.14	.14	-.01	-.04	.04	-.04
REMS	-.09	-.01	-.03	.18	-.24	-.04	**-.21***	**.08**	**.07**	**-.05**
P- disp prc.	.01	.004	-.11	.05	-.03	.02	**.16**	**.08**	**.13**	**.03**
V- disp prc.	-.05	-.09	-.07	-.12	.13	-.03	**.04**	**.06**	**.09**	**-.10**
CDI	.16	.08	-.14	.11	.05	.33***	-.06	.08	.10	.11
Self-Esteem	-.11	-.12	.03	.02	-.22	-.18	-.12	-.04	-.06	-.04
Con-ADD	.09	.08	-.03	-.03	.14	-.02	.04	.14	.14	-.01
Con-HD	.02	-.01	-.01	-.004	.03	-.10	.06	.06	.08	.09
Con-ODD	.14	-.04	-.11	-.04	.10	.000	.12	.06	.05	.004
Con-CD	.07	-.01	-.13	.01	.04	-.01	.15	-.01	.03	-.02

Note 1. ***p < .001, **p < .01,* p < .05

Note 2. YB1: belittling/criticizing; YB2: emotionally depriving; YB3: exploitative/abusive parenting; YB4: overprotective/anxious; YB5: Normative conditional/achievement focused; YB6: over pessimistic/worried; YB7: over pessimistic/worried; YB8: permissive/boundless; YB9: Punitive; YB10: restricted/emotionally inhibited.

Note 3. REMS: scores on Recognition of Emotional Maltreatment Scale; V- disp apr.: Quantitative scores of mothers on approval of verbal discipline; - disp apr.: Quantitative scores of mothers on approval of physical discipline; V- disp prc.: Qualitative scores of mothers on practicing verbal discipline; P- disp prc.: Qualitative scores of mothers on practicing physical discipline.

Table 33. Correlations between Maternal Characteristics and Main Study Variables

Variables	BDI	STAI-S	STAI-T	ADD	HD	ADHD	ADHD REL. PROB.
ADHD	**.29*** **	**.23**	**.35**	**.22***		**.25****	**.25****
V- disp apr.	**.22***	**.17**	**.18***	.16	**.18**	.21*	**.21***
P -disp apr.	.23*	**.10**	**.18***	**.13**	**.04**	.08	**.07**
REMS	-.22	**-.25****	**-.25****	**-.20**	-.05	-.12	-.11
P- disp prc.	.28**	**.18**	**.28****	.10	**.02**	.15	.20*
V- disp prc.	.12	**.13**	**.21***	.12	.14	.16	**15**
CDI	**.15**	**.08**	**.05**	**-.001**	**-.08**	.02	.06
Self-Esteem	.36***	-.22*	-23*	-.15	-.03	-.15	-.17
Con-ADD	.36***	.11	.22*	.41***	.26**	.40***	.37***
Con-HD	.19*	.13	.19*	.22*	.29*	.30***	.28**
Con-ODD	.34***	.26**	.27**	.14	.15	.24**	.28**
Con-CD	.37***	.28**	.29***	.09	.09	.20*	.24**

Note 1. ***p < .001, **p < .01, *p < .05

Note 2. Con-ADD: Con-ADHD Parent Rating Inattention Subscale, Con- HD: Con- ADHD Parent Rating Hyperactivity Subscale, Con- CD: Con-ADHD Parent Rating Conduct Disorder Subscale; CDI: Scores on Child Depression Inventory; Self-esteem: Rosenberg Self-Esteem Scores.

Note 3. REMS: scores on Recognition of Emotional Maltreatment Scale; V- disp apr.: Quantitative scores of mothers on approval of verbal discipline; - disp apr.: Quantitative scores of mothers on approval of physical discipline; V- disp prc.: Qualitative scores of mothers on practicing verbal discipline; P- disp prc.: Qualitative scores of mothers on practicing physical discipline

Note 4. BDI: Beck Depression Inventory, Maternal ADD: Maternal Attention Deficit scores (Inattention scores), Maternal HD: Maternal Hyperactivity Scores, Maternal ADHD: Maternal Attention Deficit Hyperactivity Scores, Maternal problems related to ADHD: Maternal scores of problems related to Attention Deficit Hyperactivity Scores

Table 33. *Continued*

Variables	PFC	EFC	INDC	EXTR	CONSC.	NEURT	OPN	Neg.Val	AGRB
ADHD	**-.13**	**09**	-.03	-.05	-.15	**.17**	-.11	.15	.001
V- disp apr.	.02	.25**	.03	.06	-.07	.21*	.13	.05	.13
P -disp apr.	**-.08**	**.23****	-.03	-.03	-.03	**.20***	-.04	.08	.14
REMS	**.28****	**-.20***	-.02	.02	.12	**-.25****	.08	-.17	.09
P- disp prc.	**-.20***	**.21***	.05	.11	-.05	**.16**	.02	.06	.10
V- disp prc.	**-.19***	**.03**	.02	.04	-.03	**.11**	.08	-.03	.06
CDI	-.07	.09	-.11	-.10	.08	.14	.04	.06	.02
Self-Esteem	.11	-.19*	.01	.06	.08	-.24***	.02	-.06	.11
Con-ADD	-.21*	.12	-.003	-.10	-.24**	.20*	-.03	.18*	.03
Con-HD	.07	.21*	.05	-.05	-.09	.15	-.02	.07	.13
Con-ODD	-.13	.17	.006	.002	-.07	.18	.05	.09	.09
Con-CD	-.59***	-.50***	-.61***	-.003	-.06	.20*	.10	.09	.09

Note 1. ***p < .001, **p < .01, *p < .05

Note 2. REMS: scores on Recognition of Emotional Maltreatment Scale; V- disp apr.: Quantitative scores of mothers on approval of verbal discipline; - disp apr.: Quantitative scores of mothers on approval of physical discipline; V- disp prc.: Qualitative scores of mothers on practicing verbal discipline; P- disp prc.: Qualitative scores of mothers on practicing physical discipline.

Note 3. PFC: Problem Focused Coping Style of Mother;EFC: Emotion Focused Coping Style of Mother; INDC: Indirect Coping Style of Mother; EXTR: Extraversion scores of mothers on basic personality questionnaire; NRT: Neuroticism scores of mothers on basic personality questionnaire;OPN: Openness scores of mothers on basic personality questionnaire;CONS: Conscientousness scores of mothers on basic personality questionnaire; AGRB: Agreeableness scores of mothers on basic personality questionnaire; Neg.Val.: Negative Valence scores of mothers on basic personality questionnaire.

3.6. Three Sets of Hierarchical Linear Regressions

Three sets of hierarchical regression analyses were conducted to examine the associations among the variables of the study. Hierarchical regression analyses were performed in three sets to reveal the predictors of the (i) Conners scores of children and (ii) physical and verbal discipline directed towards children (iii) psychological characteristics and symptomatology of children.

3.6.1. Variables associated with Conners scores of children

Separate hierarchical regression analyses were conducted to reveal the significant associates of Conners scores of children; namely; inattention scores, hyperactivity scores, oppositional defiant disorder and conduct disorder scores. Variables were entered into the equation in five steps. In order to control for the possible effects of demographic variables (i.e., gender, age, parental status and sibling number), they were entered (via stepwise method) into the equation in the first step. After controlling for the demographic variables, maternal factors related to the mothers past life (such as; mothers perception about her parents parenting attitudes, how much abusive her childhood was) were hierarchically entered into the equation. In the third step maternal factors related to the mothers current life (such as; mothers scores of depression, anxiety, adult ADHD, coping styles, personality characteristics, perception about her social support, about her parents parenting attitudes, and about how much abusive her childhood was) were hierarchically entered into the equation. In the fourth step social support appraisals and in the fifth step self esteem and depression scores of children were hierarchically entered into the equation. The final step was consisted of recognition of emotional maltreatment, quantitative scores of verbal and physical discipline that mothers use as discipline techniques.

3.6.2. Variables associated with scores of attitudes towards maltreatment (namely; scores of recognition of emotional maltreatment, quantitative scores of verbal and physical discipline directed to children)

Separate hierarchical regression analyses were conducted to reveal the significant associates of attitudes towards maltreatment (namely; scores of recognition of

emotional maltreatment, quantitative scores of verbal and physical discipline directed to children). Variables were entered into the equation in five steps. In order to control for the possible effects of demographic variables (i.e., gender, age, parental status and sibling number), they were entered (via stepwise method) into the equation in the first step. After controlling for the demographic variables, maternal factors related to the mothers past life (such as; mothers perception about her parents parenting attitudes, how much abusive her childhood was) were hierarchically entered into the equation. In the third step maternal factors related to the mothers current life (such as; mothers scores of depression, anxiety, adult ADHD, coping styles, personality characteristics, perception about her social support, about her parents parenting attitudes, and about how much abusive her childhood was) were hierarchically entered into the equation. In the fourth step psychological characteristics of children (namely; social support appraisals, self esteem and family relationship scores) were hierarchically entered into the equation. The fifth step was consisted of Conners scores of children. In the final step child depression was entered to the equation.

3.6.3. Variables associated with psychological characteristics of children

Separate hierarchical regression analyses were conducted to reveal the significant associates of psychological characteristics; namely; Rosenberg self-esteem scores and depression scores of children. Variables were entered into the equation in four steps. In order to control for the possible effects of demographic variables (i.e., gender, age, parental status and sibling number), they were entered (via stepwise method) into the equation in the first step. After controlling for the demographic variables, maternal factors related to the mothers past life (such as; mothers perception about her parents parenting attitudes, how much abusive her childhood was) were hierarchically entered into the equation. In the third step maternal factors related to the mothers current life (such as; mothers scores of depression, anxiety, adult ADHD, coping styles, personality characteristics, perception about her social support, about her parents parenting attitudes, and about how much abusive her childhood was) were hierarchically entered into the equation. The final step was consisted of recognition of emotional maltreatment and quantitative scores of verbal and physical discipline that mothers use as discipline techniques.

3.6.1. Variables associated with Conner's scores of children

3.6.1.1. Variables associated with Conner's ADD scores of children

Hierarchical regression analysis run for the Conner's ADD (inattention) scores of Children (see Table 34.) revealed that, among the control variables maternal education had a significant association with Conner's ADD (inattention) scores of Children [β = -.20, t (106) = -2.12, p <.05, pr = -.20] and this variable explained 4 % of the variance (F change [1, 107] = 4.48, p <.05). After controlling for this factor, among the factors of maternal past experiences; maternal perception of having a punitive mother [β = .21, t (106) = 2.30, p <.05, pr = .22] had a significant positive association with Conner's ADD (inattention) scores of Children. Maternal perception of having a punitive mother increased explained variance to 9% (F change [1, 106] = 5.28, p <.05). Among the factors of maternal current characteristics; maternal ADD (inattention) scores [β = .37, t (105) = 4.10, p <.001, pr = .36] had a significant positive association with Conner's ADD (inattention) scores of Children. Maternal ADD (inattention) scores increased explained variance to 21% (F change [1, 104] = 16.79, p <.001). Self esteem of children [β = -.32, t (104) = -3.82, p <.001, pr = -.35] had a significant negative association with Conner's ADD scores of Children. Self esteem of children increased explained variance to 31% (F change [1, 104] = 14.58, p <.05).

Totally four variables, namely maternal education status, maternal perception of having a punitive mother, maternal ADD scores and self esteem of children were found to be significantly associated with Conner's ADD (inattention) scores of Children. As maternal perception of having a punitive mother, maternal ADD scores increased Conners ADD (inattention) scores of Children also increased. However, as maternal education status and self esteem of children increased Conners ADD (inattention) scores of children decreased.

3.6.1.2. Variables associated with Conner's HD scores of children

Hierarchical regression analysis run for the Conners HD scores of children (see Table 34.) revealed that, age of saying the first word [β = -.20, t (107) = -2.06, p

<.05, pr = -.20], the length of using nipple [β = .24, t (106) = 2.48, p <.05, pr = .23] and maternal educational status [β = -.21, t (105) = -2.27, p <.05, pr = -.22] had a significant association with HD scores. Age of saying the first word explained 4 % of the variance (F change [1, 107] = 4.27, p <.05), the length of using nipple explained 9 % of the variance (F change [1, 106] = 6.16, p <.05) and maternal educational status 13 % of the variance (F change [1, 105] = 5.14, p <.05). Among the factors of maternal current characteristics, ADHD related problems [β = .27, t (104) = 3.04, p <.01, pr = .28] had a significant positive association with Conners HD scores of children and this variable explained 20 % of the variance (F change [1, 104] = 9.22, p <.01). After controlling for this factor, maternal quantitative scores on approval of verbal discipline [β = .33, t (103) = 3.88, p <.001, pr = .32] had a significant positive association with Conners HD scores of children and this variable increased explained variance to 31 % (F change [1, 103] = 15.02, p <.001).

Totally five variables, namely age of saying the first word, the length of using nipple, maternal educational status, maternal ADHD related problems, quantitative maternal approval of verbal discipline were found to be significantly associated with Conners HD scores of children factor. As the length of using nipple and maternal quantitative maternal approval of verbal discipline increased Conners HD scores of children also increased. However, as saying the first word, maternal educational status and maternal ADHD related problems increased Conners HD scores of children decreased.

3.6.1.3. Variables associated with Conner's ODD scores of children

Hierarchical regression analysis run for the Conner's ODD scores of children (see Table 34.) revealed that, among the control variables income had a significant association with Conners ODD scores of children [β = -.21, t (107) = -2.17, p <.05, pr = -.21] and it explained 4% (F change [1, 107] = 4.70, p <.05) of the variance. After controlling for this factor, among the factors of maternal current characteristics maternal depression [β = .34, t (106) = 3.63, p <.001, pr = .33] had a significant positive association with Conner's ODD scores of children and this variable increased explained variance to 15% (F change [1, 106] = 13.19, p <.001). Among the factors of psychological characteristics of children, self esteem [β = -.32, t (105)

= -3.39, p <.001, pr = -.31] had a significant negative association with Conner's ODD scores of children and this variable increased explained variance to 23% (F change [1, 105] = 11.51, p <.001). After controlling for this factor, among the factors of abusive discipline attitudes verbal discipline [β = .41, t (104) = 5.24, p <.001, pr = .40] had a significant association with Conner's ODD scores of children increased explained variance to 39 % (F change [1, 104] = 27.46, p <.001).

Totally five variables, namely family income, maternal perception of childhood sexual abuse, maternal depression scores, maternal verbal discipline and self esteem scores of children were found to be significantly associated with Conner's ODD scores of children. As maternal childhood sexual abuse, maternal ADHD related problems, maternal verbal discipline increased Conner's ODD scores of children also increased. However, as family income and self esteem scores of children increased Conner's ODD scores of children decreased.

3.6.1.4. Variables associated with Conners CD scores of children

Hierarchical regression analysis run for the Conners CD scores of children (see Table 34.) revealed that, paternal educational status had a significant association with Conners CD scores of children [β = -.19, t (107) = -2.08, p <.05, pr = -.20] and this variable explained 4 % of the variance (F change [1, 107] = 4.37, p <.05). After controlling for this factor, among the factors of maternal current characteristics maternal depression scores [β = .35, t (106) = 4.19, p <.001, pr = .38] had a significant positive association with Conners CD scores of children and this variable increased explained variance to 18 % (F change [1, 106] = 17.57, p <.001). Among the personality characteristics of mothers, openness [β = .24, t (105) = 2.67, p <.01, pr = .25] had a significant association with Conners CD scores of children. Openness increased explained variance to 23 % (F change [1, 105] = 7.15, p <.01). In the 4th step among the factors of psychological characteristics of children self esteem [β = -.27, t (104) = -3.05, p <.01, pr = -.29] had a significant negative association with Conners CD scores of children and this variable increased explained variance to 29% (F change [1, 104] = 9.31, p <.01). After controlling for this factor, among the factors of abusive discipline attitudes verbal discipline [β = .36, t (103) = 4.47, p <.001, pr =

.40] had a significant association with Conners CD scores of children increased explained variance to 41 % (F change [1, 103] = 20.00, p <.001).

Totally five variables, namely paternal educational status, maternal depression scores, openness, self esteem of children and maternal verbal discipline. As maternal depression scores and openness, maternal verbal discipline increased Conners CD scores of children increased as well. However, as paternal educational status and self esteem of the child increased Conners CD scores of children decreased.

Table 34. Variables Associated with Conners Scores of Children

	F_{change}	df	β	$t_{(within\ set)}$	R^2
Dependent Variable					
Conners Inattention (ADD) Scores					
Step 1: Control Variables					
Maternal education	4.48*	1, 107	-.20	-2.12*	.04
Step 2: Mothers Past Experiences					
Maternal perception of having a punitive mother	5.28*	1, 106	.21	2.30*	.09
Step3: Mothers Current Characteristics					
Maternal ADD Scores	16.79***	1, 105	.37	4.10***	.21
Step 4: Social Support Appraisals of Children					
-	-	-	-	-	-
Step 5: Psychological Characteristics of Children					
Rosenberg Self-Esteem Scores of Children	14.58*	1, 104	.18	2.02	.31
Depression	-	-	-	-	-

Table 34. *Continued*

	F_{change}	df	β	$t_{(within\ set)}$	R^2
Dependent Variable					
Conners Hyperactivity Scores					
Step 1: Control Variables					
Age of saying first word	4.27*	1,107	-.20	-2.06*	.04
Length of using nipple	6.16*	1, 106	.24	2.48*	.09
Maternal education	5.14*	1.105	-.21	-2.27*	.13
Step 2: Mothers Past Experiences					
-	-	-	-	-	-
Step3: Mothers Current Characteristics					
Maternal ADHD related problems	9.22**	1, 104	.27	3.04**	.20
Step 4: Social Support Appraisals of Children					
-	-	-	-	-	-
Step 5: Psychological Characteristics of Children					
Rosenberg Self-Esteem Scores of Children	-	-	-	-	-
Depression	-	-	-	-	-
Step 6: Maternal Recognition and Approval of Discipline as Discipline Styles					
Maternal approval of verbal discipline	15.02**	1, 103	.33	3.88**	.31
Dependent Variable					
Conner's ODD Scores					
Step 1: Control Variables					
Family income	4.70*	1,107	-.21	-2.17*	.04
Step 2: Maternal Past Experiences					
-	-	-	-	-	-
Step 3: Maternal Current Characteristics					
Maternal depression	13.19***	1, 106	.34	3.63***	.14
Step 4: Social Support Appraisals of Children					
Step 5: Self-esteem	11.51***	1,105	-.32	-3.39***	.23
Step 6: Maternal and Approval of Discipline as Discipline Styles					
Maternal approval of verbal discipline	27.46** *	1, 104	.41	5.24***	.37

Note 1. ***p <.001, **p <.01, *p <.05
Note 2. Conners ODD: Conners ADHD Parent Rating Oppositional Defiant Disorder Subscale

Table 34. *Continued*

	F_{change}	df	β	t (within set)	R^2
Dependent Variable					
Conduct Disorder					
Step 1: Control Variables					
Paternal educational status	4.37*	1,107	-.19	-2.09*	.04
Step 2: Mothers Past Experiences					
-	-	-	-	-	-
Step 3: Mothers Current Characteristics					
Maternal depression scores	17.57***	1, 106	.38	4.19***	.18
Maternal openness	7.15**	1,105	.24	2.67**	.23
Step 4: Social Support Appraisals of Children					
Step 5: Psychological Characteristics of Children					
Rosenberg Self-Esteem Scores of Children	9.31**	1,104	-.27	-3.05**	.29
Depression	-	-	-	-	-
Step 6: Maternal Recognition and Approval of Abuse as Discipline Styles					
Quantitative scores on maternal approval of verbal discipline	20.00***	1, 103	.36	4.47***	.41

Note 1. ***p <.001, **p <.01, *p <.05
Note 2. Conners ODD: Conners ADHD Parent Rating Oppositional Defiant Disorder Subscale

3.6.2. Variables associated with maternal recognition quantitative and qualitative scores for approval of emotional abuse, verbal and physical discipline directed to children

3.6.2.1. Variables associated with maternal recognition of emotional maltreatment

Hierarchical regression analysis run for the maternal recognition of emotional maltreatment (see Table 3.85.) revealed that, family income [β = .29, t (107) = 3.09, p <.01, pr = .29] and number of siblings [β = -.26, t (106) = -2.84, p <.01, pr = -.27] had a significant association with maternal recognition of emotional maltreatment. Family income (F change [1, 107] = 9.57, p <.01) explained 8% of the variance and number of siblings increased explained variance to 15% (F change [1, 106] = 8.09, p <.01). Among the factors of maternal current characteristics, neuroticism [β = -.25, t (105) = -2.81, p <.01, pr = -.26] had a significant association with maternal recognition of emotional maltreatment and increased explained variance to 20% (F change [1, 105] = 7.88, p <.01). In the final step among the psychological characteristics of children self esteem [β = .22, t (104) = 2.43, p <.05, pr =.23]

Totally four variables, namely family income, number of siblings, neuroticism, and self esteem of the child were found to be significantly associated with maternal recognition of emotional maltreatment factor. As family income and self esteem of the child increased maternal recognition of emotional maltreatment also increased. However, as number of siblings and neuroticism of the mothers increased, maternal recognition of emotional maltreatment decreased.

3.6.2.2. Variables associated with quantitative scores of verbal discipline

Hierarchical regression analysis run for the quantitative scores of verbal discipline (see Table 35) revealed that, none of the control variables had a significant association with quantitative scores of verbal discipline Among the factors of maternal past experiences, perception of childhood sexual abuse [β = .19, t (107) = 2.03, p <.05, pr =.21] had a significant positive association with quantitative scores of verbal discipline and this variable explained 4% of the variance (F change [1, 107] = 4.12, p <.05). After controlling for this factor, among maternal current characteristics emotional focused coping [β = .29, t (106) = 3.04, p <.01, pr = .29] had a significant positive association with quantitative scores of verbal discipline and this variable increased explained variance to 12 % (F change [1, 106] = 9.29, p <.01). Among maternal personality characteristics openness [β = .19, t (105) = 2.25, p <.05, pr =.19] and openness increased explained variance to 16% (F change [1, 105] = 5.08, p <.05). Maternal ADHD related problems [β = .23, t (104) = 2.66, p <.05, pr = .21] had a significant positive association with quantitative scores of verbal discipline and this variable increased explained variance to 21% (F change [1, 104] = 7.09, p <.01). After controlling for this factor, among the factors of psychological characteristics of children, friend relations [β = -.26, t (103) = -2.90, p <.01, pr = -.24] had a significant negative association with quantitative scores of verbal discipline increased explained variance to 27% (F change [1, 103] = 8.46, p <.01). Among Conners scores of children oppositional defiant disorder [β = .36, t (102) = 3.55, p <.001, pr = .33] and hyperactivity [β = .21, t (101) = 2.03, p <.05, pr = .20] had a significant positive association with quantitative scores of verbal discipline and conduct disorder increased explained variance to 35% (F change [1, 102] = 12.58, p <.001) hyperactivity increased explained variance to 38% (F change [1, 101] = 4.12, p <.05).

Totally seven variables, namely maternal perception of childhood sexual abuse, emotional focused coping, openness, maternal ADHD related problems, friend relations, Conner's scores of children oppositional defiant disorder and hyperactivity were found to be significantly associated with quantitative scores of verbal discipline. As maternal perception of childhood sexual abuse, emotional focused coping, openness, maternal ADHD related problems, Conners scores of children oppositional defiant disorder and hyperactivity increased, quantitative scores of verbal discipline also increased. However, as among the factors of friend relations increased quantitative scores of verbal discipline decreased.

3.6.2.3. Variables associated with quantitative scores of physical discipline

Hierarchical regression analysis run for the quantitative scores of physical discipline (see Table 30) revealed that, none of the control variables had a significant association with quantitative scores of physical discipline Among maternal current characteristics emotional focused coping [β = .25, t (107) = 2.72, p <.01, pr = .25] had a significant positive association with quantitative scores of physical discipline and this variable explained 7% of the variance (F change [1, 107] = 7.41, p <.01). Among maternal personality characteristics neuroticism [β = .20, t (106) = 2.08, p <.05, pr = .20] had a significant positive association with quantitative scores of physical discipline and neuroticism increased explained variance to 10% (F change [1, 106] = 4.33, p <.05). Among the factors of psychological characteristics of children oppositional defiant disorder [β = .23, t (105) = 2.47, p <.05, pr = .24] and depression [β = .31, t (104) = 3.39, p <.001, pr = .39] had a significant positive association with quantitative scores of physical discipline and oppositional defiant disorder increased explained variance to 15% (F change [1, 105] = 6.12, p <.001) where as depression increased explained variance to 24% (F change [1, 104] = 11.50, p <.05).

Totally four variables, namely emotional focused coping, neuroticism, Conners oppositional defiant disorder scores and child depression scores were found to be significantly associated with quantitative scores of physical discipline. As emotional focused coping, neuroticism, oppositional defiant disorder and depression increased quantitative scores of physical discipline also increased.

3.6.2.4. Variables associated with qualitative scores of verbal discipline

Hierarchical regression analysis run for the qualitative scores of verbal discipline (see Table 35) revealed that, none of the control variables had a significant association with quantitative scores of verbal discipline. Among maternal current characteristics trait anxiety [β = .22, t (100) = 2.24, p <.05, pr = .22] had a significant positive association with qualitative scores of verbal discipline and this variable increased explained variance to 5% (F change [1, 100] = 5.03, p <.05). Among maternal personality characteristics openness [β = .22, t (99) = 2.06, p <.05, pr = .20] had a significant positive association with qualitative scores of verbal discipline, this variable explained 9% of variance (F change [1, 99] = 4.26, p <.05). Among Conner's scores of children attention deficit scores of children conduct disorder [β = .30, t (98) = 3.23, p <.01, pr = .26] had a significant positive association with qualitative scores of verbal discipline increased explained variance to 18% (F change [1, 98] = 10.42, p <.05).

Totally three variables, namely maternal trait anxiety, openness, Conner's scores of attention deficit were found to be significantly associated. As maternal trait anxiety, openness, Conner's scores of attention deficit increased qualitative scores of verbal discipline also increased.

3.6.2.5. Variables associated with qualitative scores of physical discipline

Hierarchical regression analysis run for the qualitative scores of physical discipline (see Table 35) revealed that, none of the control variables had a significant association with qualitative scores of physical discipline. Among maternal past experiences perception of childhood sexual abuse [β = .25, t (100) = 2.61, p <.01, pr = .25]. Among maternal current characteristics trait anxiety [β = .28, t (99) = 2.96, p <.01, pr = .28] had a significant positive association with qualitative scores of physical discipline this variable explained 14% of variance (F change [1, 99] = 8.76, p <.01). Among maternal personality characteristics extraversion [β = .25, t (98) = 2.45, p <.01, pr = .22] had a significant positive association with qualitative scores of physical discipline this variable explained 19% of variance (F change [1, 98] = 6.02, p <.01). After controlling for this factor, among psychological characteristics of

children family relationship [β = -.27, t (97) = -2.89, p <.01, pr = -.25] and conduct disorder [β = .26, t (96) = 2.34, p <.05, pr =.23] had significant association with qualitative scores of physical discipline family relationship increased explained variance to 25% (F change [1, 97] = 8.34, p <.01) conduct defiant disorder increased explained variance to 29% (F change [1, 96] = 5.45, p <.05).

Totally four variables, namely maternal perception of childhood sexual abuse, maternal trait anxiety, extraversion, and children's family relationship, Conner's scores of conduct disorder were found to be significantly associated with qualitative scores of physical discipline. As maternal perception of childhood sexual abuse, maternal trait anxiety, extraversion, children's family relationship, Conner's scores of conduct disorder increased qualitative scores of physical discipline also increased. However, as children's family relationship increased, qualitative scores of physical discipline decreased.

Table 35. Variables Associated with Maternal Recognition and Quantitative and Qualitative Scores for Approval of Emotional Abuse, Verbal and Physical Discipline Directed to Children

	F_{change}	**df**	**β**	**t (within set)**	**R^2**
Dependent Variable					
Variables Associated with maternal REMS					
Step 1: Control Variables					
Family income	9.57**	1, 107	.29	3.09**	.08
Number of siblings	8.09**	1, 106	-.26	-2.84**	.15
Step 2: Mothers past experiences					
-	-	-	-	-	-
Step 3: Mothers current characteristics					
Neuroticism	7.88**	1, 105	-.25	-2.81**	.21
Step 4: Psychological characteristics of children					
Self esteem	5.92*	1, 104	.22	2.43*	.25
Step 5: Conners scores					
-	-	-	-	-	-
Step 6: Depression scores of children					
-	-	-	-	-	-

Note 1. ***p <.001, **p <.01, *p <.05

Table 35. *Continued*

	F_{change}	df	β	$t_{(within\ set)}$	R^2
Dependent Variable					
Variables Associated with Quantitative Scores on Maternal Approval of Verbal Discipline					
Step 1: Control Variables					
-	-	-	-	-	-
Step 2: Mothers past experiences					
Maternal perception of childhood sexual abuse	4.12*	107	.19	2.03*	.04
Step 3: Mothers current characteristics					
Maternal emotion focused coping	9.29**	106	.29	3.04**	.12
Openness	5.08*	105	.19	2.25*	.16
Maternal ADHD related problems	7.09*	104	.23	2.66*	.21
Step 4: Psychological characteristics of children					
Friend relationship	8.46**	103	-.26	-2.90**	.27
Step 5: Conners scores					
Oppositional Defiant Disorder	12.58***	102	.36	3.55***	.35
Hyperactivity	4.12*	101	.21	2.03*	.38
Step 6: Child Depression Scores	-	-	-	-	-

Note 1. ***p <.001, **p <.01, *p <.05

Dependent Variable					
Variables Associated with quantitative scores on maternal approval of physical discipline					
Step 1: Control Variables					
-	-	-	-	-	-
Step 2: Mothers past experiences					
-	-	-	-	-	-
Step 3: Mothers current characteristics					
Maternal emotion focused coping	7.41**	107	.25	2.72**	.07
Neuroticism	4.33*	106	.20	2.08*	.10
Step 4: Psychological characteristics of children					
-	-	-	-	-	-
Step 5: Conner's scores					
Oppositional defiant disorder	6.12*	105	.23	2.47*	.15
Step 6: Depression scores of children	11.50***	104	.31	3.39***	.24

Note 1. ***p <.001, **p <.01, *p <.05

Table 35. *Continued*

	F_{change}	df	β	t (within set)	R^2
Variables Associated with qualitative scores of verbal discipline					
Step 1: Control Variables					
-	-	-	-	-	-
Step 2: Mothers past experiences					
-	-	-	-	-	-
Step 3: Mothers current characteristics					
Maternal trait anxiety	5.03*	100	.22	2.24*	.05
Openness	4.26*	99	.22	2.06*	.09
Step 4: Psychological characteristics of children					
-	-	-	-	-	-
Step 5: Conner's scores					
Attention deficit disorder	10.42**	98	.30	3.23**	.18
Step 6: Depression scores of children					
-	-	-	-	-	-

Dependent Variable					
Variables Associated with qualitative scores of physical discipline					
Step 1: Control Variables					
-	-	-	-	-	-
Step 2: Mothers past experiences					
Maternal childhood sexual abuse	6.83**	100	.25	2.61**	.06
Step 3: Mothers current characteristics					
Maternal trait anxiety	8.76**	99	.27	2.96**	.12
Maternal extraversion	6.02**	98	.25	2.45**	.17
Step 4: Psychological characteristics of children					
Family relations	8.34**	97	-.27	-2.89**	.23
Step 5: Conner's scores					
Conduct disorder	5.45*	96	.25	2.34*	.29
Step 6: Depression scores of children					
-	-	-	-	-	-

3.6.3. Variables associated with psychological charactersitics and symptopathologies of children

3.6.3.1. Variables associated with self esteem scores of children

Hierarchical regression analysis run for the self esteem scores of children (see Table 36) revealed that, among demographic variables family income [β = .23, t (107) = 2.39, p <.05, pr = .31] had a significant positive association with self esteem scores of children this variable explained 5% of variance (F change [1, 107] = 5.73, p

<.05). Among maternal past experiences having a *belittling/criticizing mother* [β = -.24, t (106) = -2.66, p <.01, pr = -.24], had a significant positive association with self esteem scores and maternal perception of having a *belittling/criticizing mother* increased explained variance to 11% (F change [1, 106] = 7.07, p <.01). After controlling for this factor, among maternal current characteristics depression scores [β = -.29, t (105) = -3.06, p <.01, pr = -.27] had a significant negative association with self esteem scores of children and depression scores increased explained variance to 18% (F change [1, 105] = 9.36, p <.01). In the final step recognition of emotional maltreatment had a significant positive association with self esteem scores of children [β = .23, t (104) = 2.50, p <.05, pr = -.22] and recognition of emotional maltreatment increased explained variance to 23% (F change [1, 104] = 6.24, p <.05).

Totally four variables, namely family income, maternal perception of having a *belittling/criticizing mother*, maternal depression and recognition of emotional maltreatment were found to be significantly associated with self esteem scores of children. As family income and recognition of emotional maltreatment increased self esteem scores of children also increased. However, as maternal perception of having a *belittling/criticizing mother,* maternal depression and recognition of emotional maltreatment increased self esteem scores of children decreased.

3.6.3.2. Variables associated with depression scores of children

Hierarchical regression analysis run for the depression scores of children (see Table 36) revealed that, none of the control variables had a significant association with depression scores of children. Among maternal past characteristics having an achievement focused father [β = .33, t (100) = 3.59, p <.001, pr = .31] had a significant positive association with depression scores of children, this variable explained 11% of variance (F change [1, 100] = 12.90, p <.01). After controlling for this factor, among maternal discipline techniques quantitative scores on maternal approval of physical discipline [β = .34, t (99) = 3.96, p <.001, pr = .26] had a significant positive association with depression scores of children, this variable increased explained variance to 22% (F change [1, 99] = 15.64, p <.001).

Totally two variables, namely maternal perception of having an achievement focused father and quantitative scores on maternal approval of physical discipline were found to be significantly associated with depression scores of children. As maternal perception of having an achievement focused father and quantitative scores on maternal approval of physical discipline increased depression scores of children also increased.

Table 36. Variables Associated with Psychological Characteristics and Symptomatologies of Children

	F_{change}	df	β	$t_{(within\ set)}$	R^2
Dependent Variable					
Variables Associated with self-esteem scores of children					
Step 1: Control Variables					
Family income	5.73*	107	.23	2.39*	.05
Step 2: Mothers past experiences					
Maternal perception of having a belittling/ criticizing mother	7.07**	106	-.24	-2.66**	.11
Step 3: Mothers current characteristics					
Maternal depression	9.36**	105	-.29	-3.06**	.18
Step 4: Maternal recognition and attitudes towards discipline					
Maternal REMS	6.24*	104	.23	2.50*	.23
Dependent Variable					
Variables Associated with depression scores of children					
Step 1: Control Variables					
-	-	--	-	-	-
Step 2: Mothers past experiences					
Achievement focused father	12.90***	107	.33	3.59***	.11
Step 3: Mothers current characteristics					
-	-	-	-	-	-
Step 4: Maternal recognition and attitudes towards discipline					
Maternal approval of physical discipline	15.64***	106	.34	3.96***	.22

Note 1. ***p <.001, **p <.01, *p <.05.

3.7. Mediation Analysis

3.7.1. The mediator role of maternal attitudes towards maltreatment as discipline techniques between Conner's ODD scores of children and depression scores of children

In order to see whether Conner's ODD scores of children and depression scores of children were mediated by maternal attitudes towards discipline as discipline techniques, a hierarchical regression analysis was performed. In this analysis, depression scores of children served as the dependent variable. In the first step, Conner's scores of children (namely; inattention scores, hyperactivity scores, conduct disorder scores), in the second step maternal attitudes towards discipline as discipline techniques (verbal and physical discipline as discipline techniques and recognition of emotional maltreatment) were entered by using the stepwise method. As can be seen from Table 53, according to the Reduced Model, that is before the mediator (i.e., maternal attitudes towards physical discipline as discipline styles) was entered into the equation, among Conners scores of children only oppositional defiant disorder revealed significant association with depression scores of children (pr = . 33, t [116] = -.98; p <.001).

In the Full Model that is after the inclusion of in the second step maternal attitudes towards discipline as discipline techniques; among maternal attitudes towards discipline as discipline techniques only physical discipline revealed significant association with depression scores of children (pr = .31, t [115] = 3.52, p <.001). Compared to the first step, association between oppositional defiant disorder and depression scores of children was less but still significant (pr = .23, t [115] = 2.74, p <.01), indicating that the association between Conner's ODD scores of children and depression scores of children is maintained by maternal attitudes towards physical discipline as discipline techniques. In order to further support this argument, it also required to reveal that Conners ODD scores of children is associated with maternal attitudes towards discipline as discipline techniques of mothers. For this aim, the second regression analysis was performed where the dependent variable was maternal attitudes towards discipline as discipline techniques. Conners ODD scores of children were entered into the equation. As can be seen from Table 53 results

revealed that Conners ODD scores of children was significantly associated with maternal attitudes towards physical discipline as discipline styles (pr = .29, t [119] = 3.27, p <.001). Finally, Sobel test indicated that maternal attitudes towards physical discipline as discipline styles had 27% mediator role on the association between Conners oppositional defiant disorder scores and depression scores of children (z = 2.246, p<05). The mediator role of maternal attitudes towards physical discipline as discipline styles between Conners ODD scores of children and depression scores of children is depicted in Figure 21.

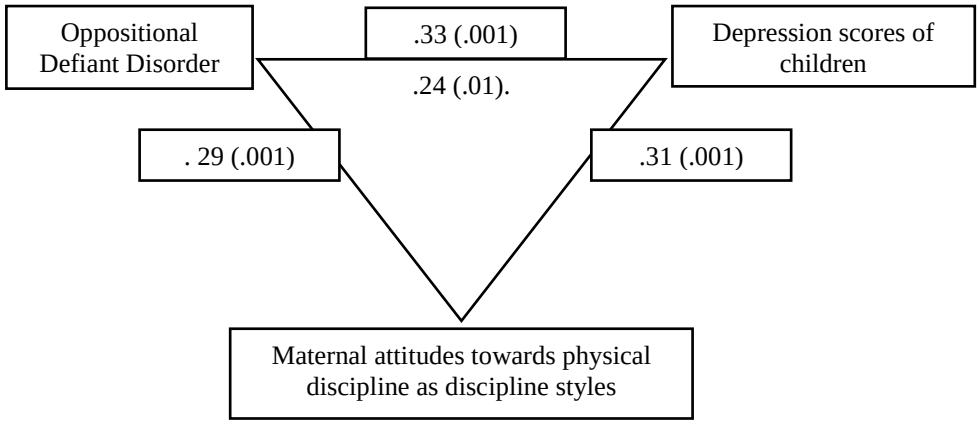

Figure 14. The Mediator Role of Maternal Attitudes towards Physical Discipline Styles between Conner's ODD Scores of Children and Depression Scores of Children

Note: Summary of mediating regression analysis for the depression scores of children including beta-weights for the model before maternal attitudes towards physical discipline as discipline techniques is included (Reduced Model) and after the inclusion of the maternal attitudes towards physical discipline as discipline techniques, which is the mediator (Full Model). The initial path between Conner's ODD scores of children and depression scores of children is indicated by beta-weight (and p value) on top of the line connecting these variables, while the beta-weight (and p value) after the depression scores of children is included as the mediator is indicated by the value directly under the path.

Table 37. The Mediator Role of Maternal Attitudes towards Maltreatment as Discipline Techniques between Conner's ODD Scores of Children and Depression Scores of Children

	$F_{for\ set}$	**t**	**df**	**Partial cor.**	**Model R^2**
First Regression Analysis					
Dependent Variable:					
Depression scores of children					
Step 1: Conner's scores					
Oppositional defiant disorder	13.80***	3.72***	1,116	.33	.11
Step 2: Maternal attitudes towards discipline as discipline techniques					
Oppositional defiant disorder	13.76 **	2.74*	1,115	.31	.19
Maternal approval of physical discipline as discipline techniques	13.76 ***	3.52***	1, 115	.31	.19
Second Regression Analysis					
Dependent Variable:					
Maternal approval of physical discipline as discipline techniques					
Oppositional defiant disorder	10.66***	3.27***	1,119	.29	.08

Note 1. ***p <.001, **p <.01, *p <.05.

3.8. Qualitative Analysis

After answering the questionnaires, in order to make a more detailed examination about the actual discipline behaviors of the mothers, all children and mothers were interviewed. In these interviews 6 standard questions, regarding the length and the quality of time spent together, the source and the type of the children's problematic behavior, and how the problems had been handled by the mother were asked to all mothers and all children. Based on these answers, child neglect and abuse were particularly detected.

3.8.1. The children's perception about who gives them directions most frequently

To investigate how much interrupted the child perceives him/her and how intrusive s/he perceives his/her parents, children were asked 'who gives orders or directions to him/her most at home'. Both groups of children, namely 47 (49%) children in study group and 14 (56%) children in control group, perceived to be mostly directed and interupted by their mothers. The rest of the children in the study group perceived that

they were directed by their fathers (22%), siblings (14%), equally by both parents (13%), or by everyone at home (2%). Among the control group, children perceived to be directed by fathers (8%), equally by both parents (12%), siblings (12%), and by no one (12%).

Table 38. The Children's Perception about Who Gives Them Directions Most Frequently

The source giving the most directions	Study Group Children, n = 95	Study Group Children, Percentage	Control Group Children, n = 25	Control Group Children, Percentage
Both Parents Equally	12	13%	3	12%
Mostly Mother	47	49%	14	56%
Mostly Father	21	22%	2	8%
Mostly Siblings	13	14%	3	12%
Everyone	2	2%	0	0%
No One	0	0%	3	12%

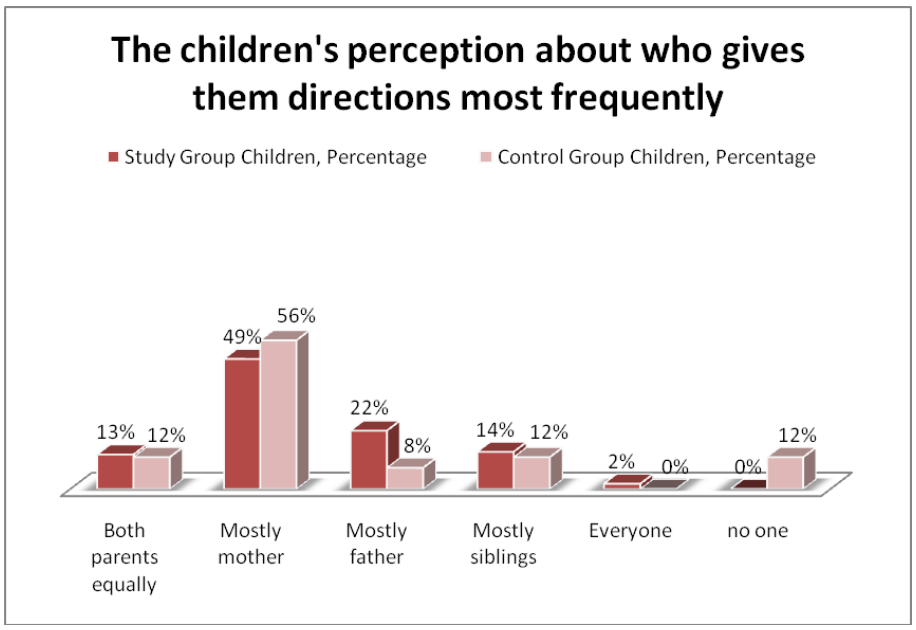

Figure 15. The Children's Perception about Who Gives Them Directions Most Frequently

3.8.2. The most problematic issues

The most problematic issues between mothers and children were asked to all four groups (mothers in the study group, mothers in the control group, children in study

group and children in control group). Issues related to academic performance and doing homework seemed to be the most frequent problems experienced by mothers and children of both study and control groups (n=48, 51%; n=9, 36%; n=57, 60%; n=10, 40%; for mothers in the study group, for mothers in the control group, children in the study group, children in the control group respectively). Two other issues that mothers of the study group experienced trouble were behavior problems of the children (n=22, 23%) and not doing things they were told to (n=31, 33%). Children in the study group complained about the restriction for watching TV and playing computer (n=24, 25%). Together with the time spent across the TV or computer, children stated that their attention deficit or their hyperactive (only the restlessness sypmtom is included) behaviors (n=24, 25%) were also among the important factors that frequently become a problem between their mothers and themselves. Eating problems, behaviors to siblings or friends, timing for playing and sleeping, were among other issues labeled by mothers and children as problem areas between them.

Table 39. The Most Problematic Issues in Parent-Child Relationships

The most problematic issues	**Study Group Mothers, n = 95**	**Study Group Children, n = 95**	**Control Group Mothers, n = 25**	**Control Group Children, n = 25**
Academic performance and doing homework	48, 51%	57, 60%	9, 36%	10, 40%
Time spent playing computer games or watching TV	7, 7%	24, 25%	1, 4%	5, 20%
Problems related to inattention and hyperactive-restless behaviors	12, 13%	24, 25%	1, 4%	4, 16%
Behavioral problems	22, 23%	4, 4%	6, 24%	0, 0%
Not doing things they are told to	31, 33%	14, 15%	8, 32%	7, 28%
Behaviors to siblings or friends	6, 6%	8, 8%	4, 16%	3, 12%
Everything	0, 0%	7, 7%	0, 0%	2 8%
Nothing	1, 1%	1, 1%	2, 8%	1, 4%
Other issues	26, 28%	39, 41%	6, 24%	13, 42%
Other issues: eating problems	7, 7%	10, 11%	1, 4%	5, 20%

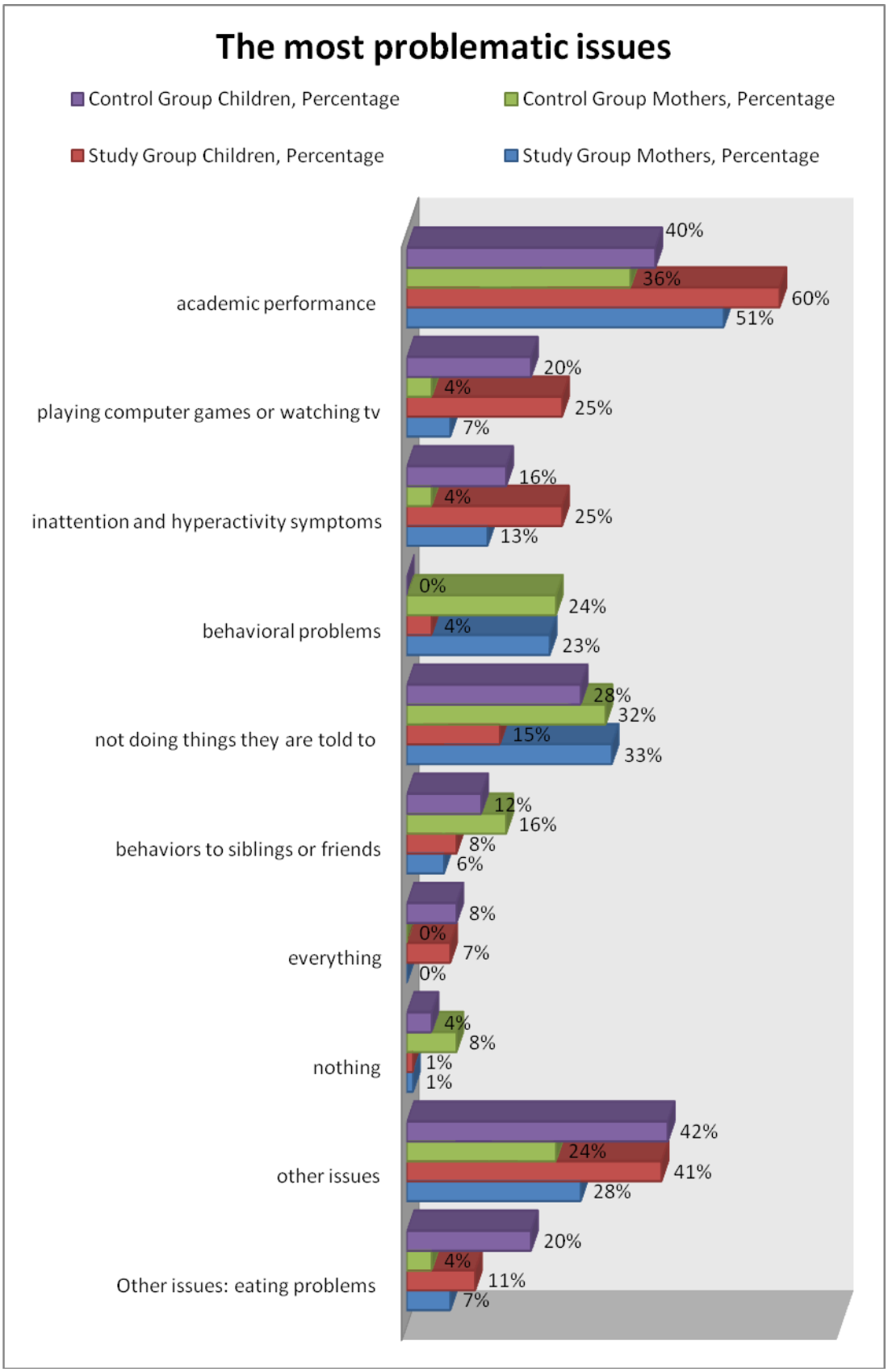

Figure 16. The Most Problematic Issues in Parent-Child Relationships

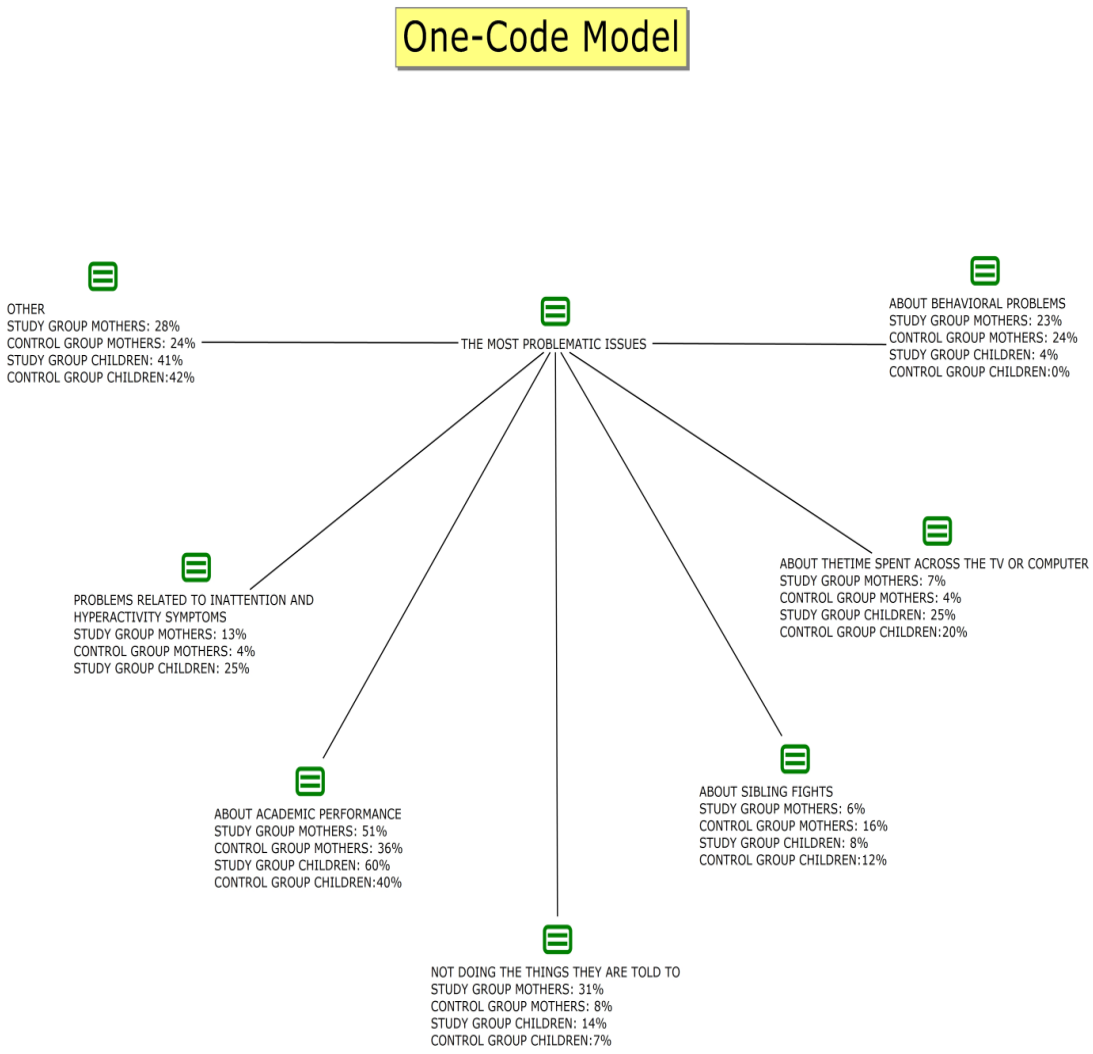

Figure 17. The Most Problematic Issues in Parent Child Relationships – *Coding Model*

3.8.3. Punishment types

When the punishment types (except for physical and verbal harm given to child) were asked 50% of mothers in the study group reported that there were no punishments in their discipline practices. Similarly 57% of the study group children approved that they were not punished when they broke rules. Among the control mothers 92% and among the control children 84% declined that there were no punishment in the discipline practices used in their family. Among the punishment types, forbidding TV and computer were the most common reported ones, by both mothers (34%) and children in the study group (21%) and by the mothers in the

control group. Whereas, children in the control group (12%) mostly reported being locked into room.

Table 40. Punishment Types

Punishment Types	Study Group Mothers, n = 95	Study Group Children, n = 95	Control Group Mothers, n = 25	Control Group Children, n = 25
not doing the things s/he wants	18, 19%	6, 6%	4, 12%	0, 0%
forbidding the child to play with his/her friends	23, 24%	12, 13%	2, 8%	1, 4%
no punishment	48, 50%	55, 57%	23, 92%	21, 84%
forbidding TV and computer	32, 34%	20, 21%	7, 28%	2, 8%
locking into a room	18, 19%	15, 16%	2, 8%	4, 12%
making the child study something	2, 2%	4, 4%	0, 0%	1, 4%
other	8, 9%	8, 8%	2, 8%	1, 4%

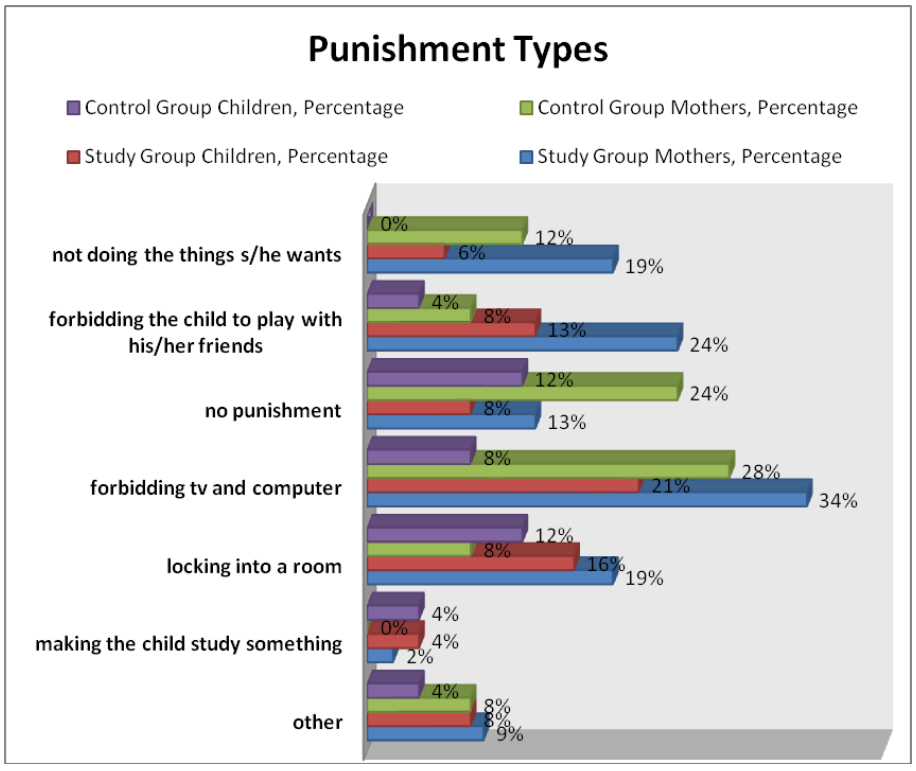

Figure 18. Punishment Types

3.8.4. Physical discipline

When physical harm was investigated, answers of 81% of the mothers and 71% of the children in the study group indicated that mothers of children with ADHD used hitting to their children as a discipline technique when they think that things are going wrong and feel that words are useless. Shaking the child, pulling hair, pulling ear, pinching the child were other types of physical harms given to the children in this group (n=19, 21%; n=7, 9%; n=3, 12; for mothers in the study group, for mothers in the control group, children in the study group, mothers in the control group, respectively). In addition to these one mother reported that she was putting pepper to the tongue of her child when s/he does something wrong and another one reported that she slitted her child's throat when she gets angry at him/her. In the control group 64% of the mothers and 36% of the children reported that hitting was used as discipline technique in their family. According to the information given by all four groups, mothers mostly preferred hitting at the face of the child and behind the child. In addition to hitting with hand, hitting with slipper was also highly common especially in the study group (n=45, 47%; n=4, 16%; n=23, 24%; n=2, 8%; for mothers in the study group, for mothers in the control group, children in the study group, mothers in the control group, children in the control group respectively). Rolling pin, stick, sweeper, jumping rope, bucket were things used for hitting children were things other than slipper. In general using something other than slipper was reported by 6% of the study group mothers, 15% of study group children, 1% of study group children. Hitting with rolling pin was reported by 4 (4%) mothers in study group, 1 (4%) mother in control group and by 7 (9%) children in study group. Five children in the study group (5%) told their mothers were using stick or sweeper while hitting him. One child reported that his mother kicked him, one child in the study group stated that his mother was hitting him with jumping rope, another one and his mother in the study group reported that bucket was also used with the aim of hitting in their house.

Table 41. Physical Discipline

Physical Discipline	Mothers of Study Group, n=95	Children in Study Group, n=95	Mothers in Control Group, n=25	Children in Control Group, n=25
Hitting	78, 81%	69, 71%	15, 60%	9, 36%
Shaking	11, 12%	3, 3%	1, 4%	0, 0%
Nipping	5, 5%	1, 1%	1, 4%	0, 0%
Pulling his/her hair	3, 3%	1, 1%	1, 4%	0, 0%
Pulling his/her ear	3, 3%	3, 3%	0, 0%	0, 0%
Other	2, 2%	0, 0%	0, 0%	0, 0%

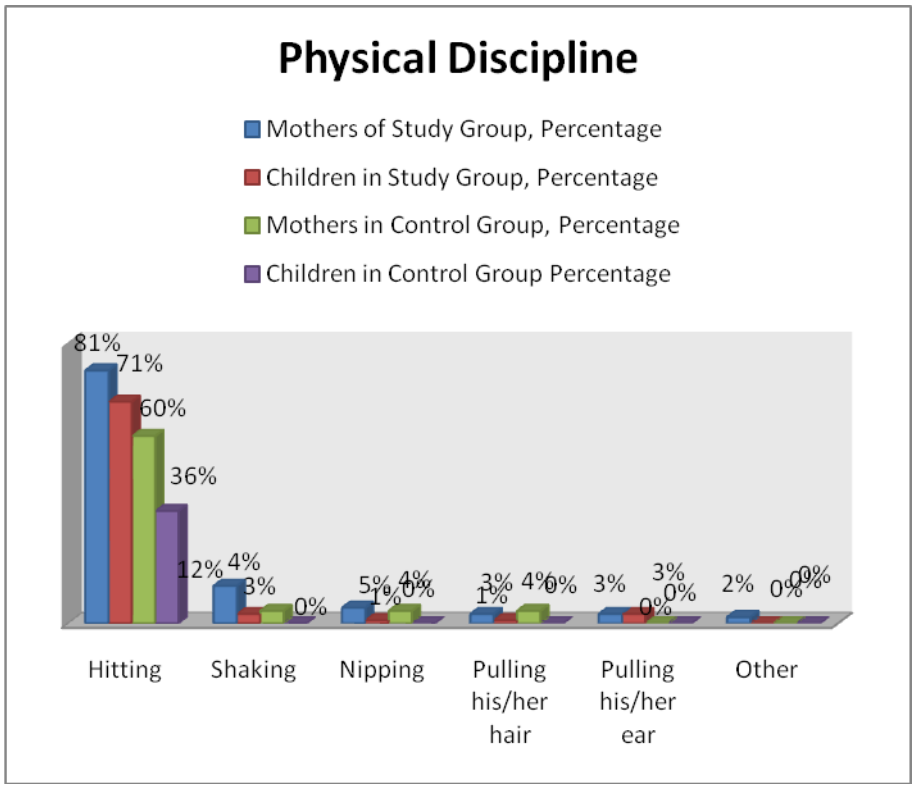

Figure 19. Physical Discipline

When the frequency of physical discipline was investigated in the study group, 15% of the mothers reported not having beaten their children, 11% submitted slapping their children once or twice in a year, 30% reported beating their children once or twice in a month, and 44% reported beating their children more than two times in a week. The frequency of physical discipline was also questioned among the mothers

of control group. According to the answers given by mothers in control group, 36% of the mothers reported not having beaten their children, 12% of these mothers used physical discipline once or twice in a year, 40% reported beating their children once or twice in a month, and 12% reported beating their children more than two times in a week. The information about frequency could be gathered only from the mothers because as expected, based on characteristics of their developmental stage, the children aged between 6-13 years had great difficulty about telling the time or the frequency of anything they have experienced or they were exposed to.

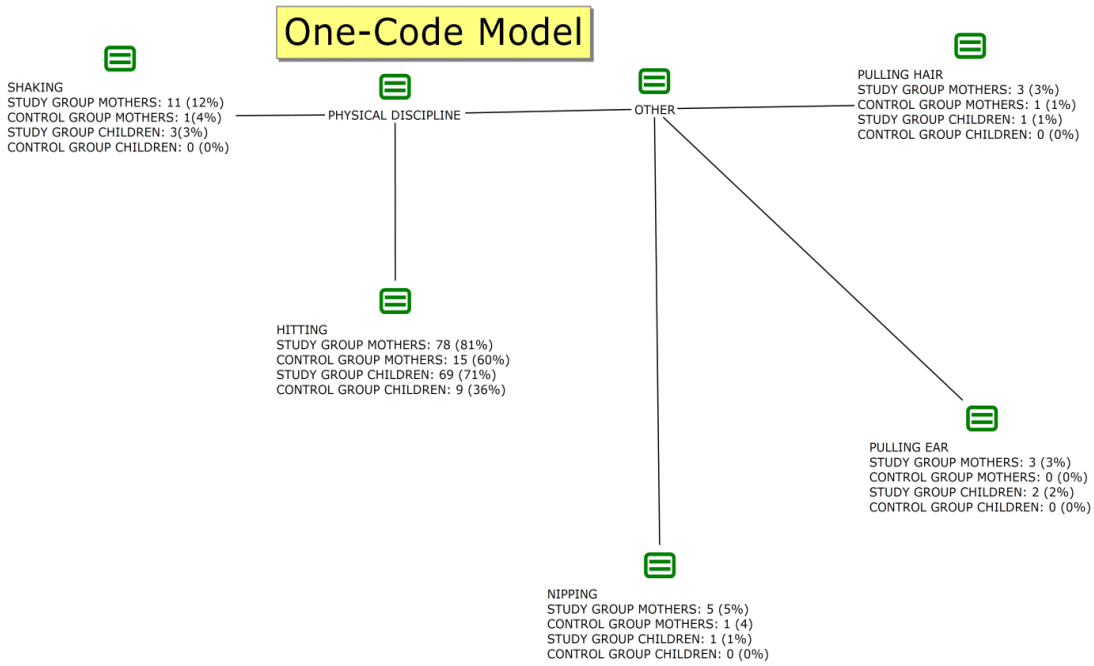

Figure 20. Physical Discipline - *Coding Model*

3.8.5. Verbal discipline

In order to learn whether there is emotional abuse or verbal discipline that can be considered as abusive in the relationship between mothers and their children, all groups were asked what the mothers tell their children when they are angry at them. When answers given by all groups were categorized 6 categories were obtained namely; cursing, refusing, comparing, threatening, and arousing pity, insulting. In the study group mothers submitted that while yelling at their children 58% of them used insulting, 56% of them used arousing pity, 46% of them used comparing, 30% of them used threatening, 25% of them used refusing, 19% of them used cursing.

Children reported that, when yelling at them, their mothers mostly insulted them (33%). According to the answers of the children, mothers also frequently used words to arouse pity (20%) and also frequently threatened (20%) them. Making comparison between the child (17%) and his/her siblings or friends and making the child feel refused (19%) were also common among the answers of children. Only five children reported that their mothers cursed at them. Similar to the children in study group, insulting was the most frequent answer when mothers in both study group and control group were asked about how they yelled at their children (59%). However, most of the children in the control group did not report being yelled at and being exposed to verbal discipline/ discipline. In this group all kinds of verbal discipline/discipline were reported by 1-5 (4%-20%) children.

Table 42. Types of Verbal Discipline

Verbal Discipline	**Study Group Mothers, Percentage**	**Study Group Children, Percentage**	**Control Group Mothers, Percentage**	**Control Group Children, Percentage**
Cursing (Beddua Etme)	19%	5%	12%	4%
Refusing (Reddetme)	25%	19%	20%	16%
Threatening (Tehdit Etme)	30%	20%	24%	8%
Accusing and Arousing Pitty (Acındırma/ Suçlama)	57%	20%	36%	20%
Making Comparison (Karşılaştırma)	47%	17%	8%	20%
Insulting (Aşağılama)	59%	33%	60%	8%

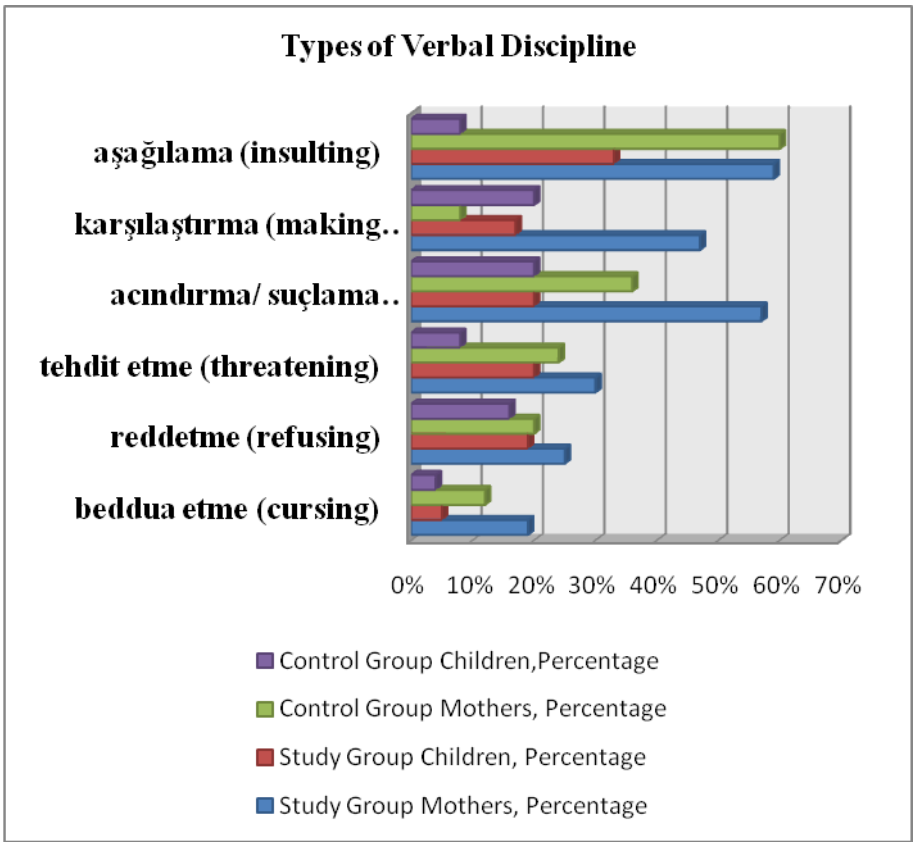

Figure 21. Types of Verbal Discipline

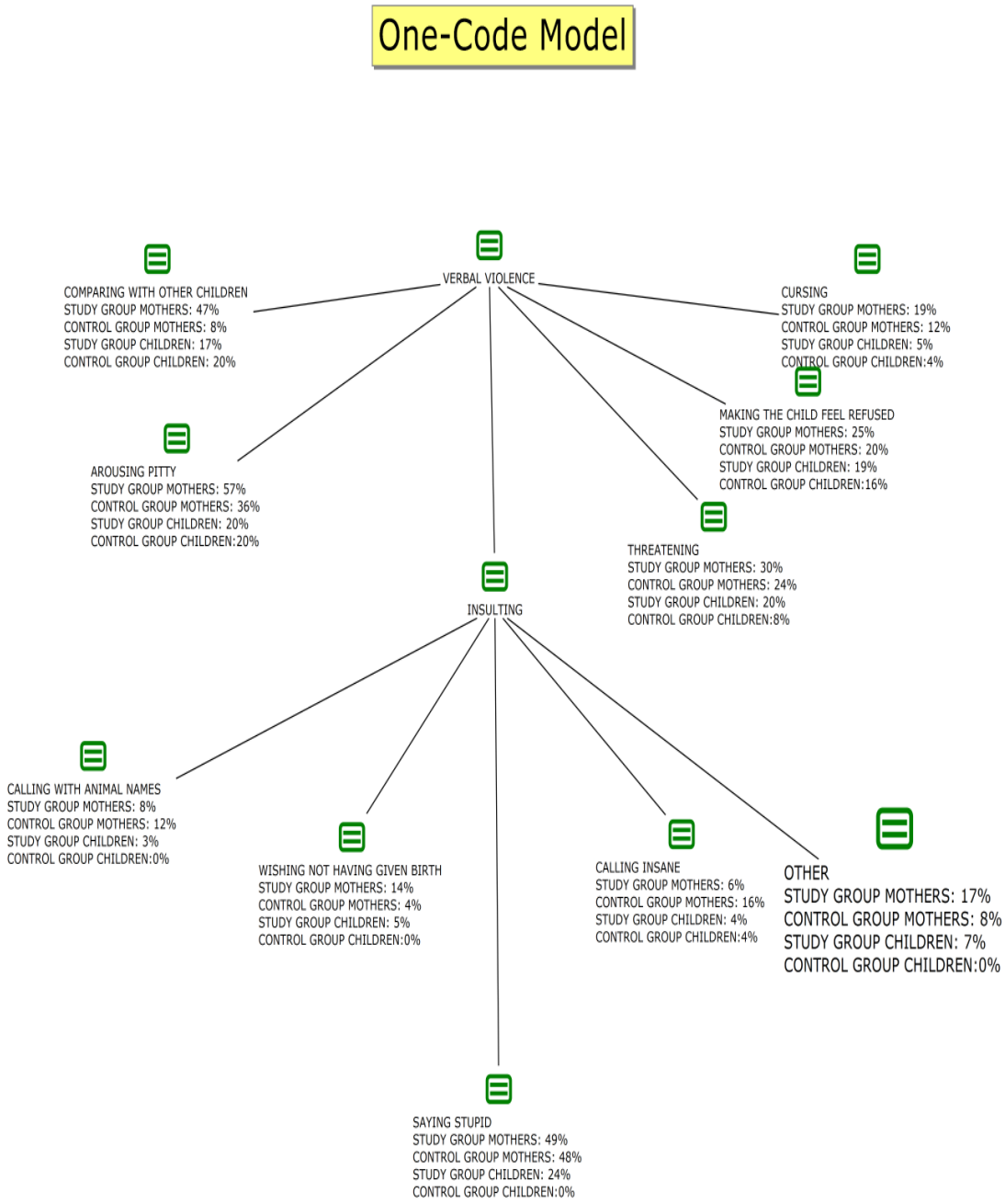

Figure 22. Types of Verbal Discipline-*Coding Model*

3.8.6. Types of insulting

When insulting was specifically investigated mothers in both groups namely; the study group (49%) and the control group (48%), and the children in the study group (24%) stated that words related to the mental capacity of the child (ex., stupid, moron) were highly used whereas none of the control group children reported to be called with these words. One child in control group (4%) reported to be called as insane (deli) and being called as insane was also reported in other groups (6%, 4%,

16%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group, respectively). Other insulting types were; wishing not having given birth to that child (doğurduğuna i1işkin pişmanlık dile getirmek; 4%, 5%, 4%, 0%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group respectively), calling the child with animal names (hayvan yakıştırması yapmak; 8%, 3%, 12%, 0%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group respectively), swearing (küfretmek; 0%, 4%, 0%, 0%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group, respectively) saying handicapped (özürlü diye seslenmek; 2%, 0%, 0%, 0%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group, respectively) dishonorable (şerefsiz demek; 2%, 0%, 0%, 0%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group, respectively) dirty (pis demek; 2%, 1%, 0%, 0%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group, respectively) abnormal (mal demek; 0%, 2%, 8%, 0%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group, respectively).

Table 43. Types of Insulting

Insulting (aşağılama)	**Study Group Mothers, Percentage**	**Study Group Children, Percentage**	**Control Group Mothers, Percentage**	**Control Group Children, Percentage**
Insulting (aşağılama)	58%	33%	60%	8%
stupid (aptal, salak) + moron (gerizekalı)	49 %	24%	48%	0%
wishing not having given birth to that child (doğurduğuna pişman olduğunu söylemek)	14%	5%	4%	0%
saying insane (deli/ manyak)	6%	4%	16%	4%
calling the child with animal names (hayvan yakıştırması)	8%	3%	12%	0%
other (diğer)	17%	7%	8%	0%
other (diğer) : swearing	0%	4%	0%	0%
other (diğer) : saying handicapped(özürlü)	2%	0%	0%	0%
other (diğer): dishonorable (şerefsiz)	2%	0%	0%	0%
other (diğer) : pis (dirty)	2%	1%	0%	0%
other (diğer): abnormal (mal)	0	2%	8%	0%

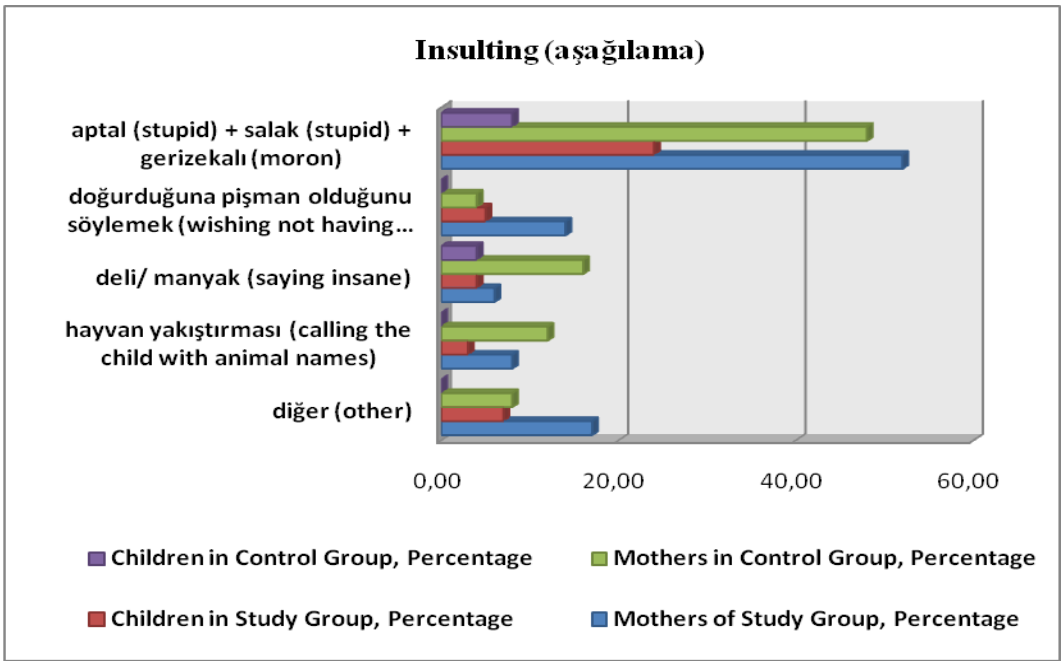

Figure 23. Types of Insulting

When the frequency of the verbal discipline/ discipline was investigated, among the control group 8 (32%, n=25), among the study group 12 (13%) reported that they have never used verbal discipline as a discipline technique. The information about frequency could be gathered only from the mothers because as expected, based on their developmental characteristics, the children aged between 6-13 years had great difficulty about telling the time or the frequency of anything they have experienced or they were exposed to.

3.8.7. The most hurtful abusive attitudes according to the children's perceptions

49 children (41 study group, 8 control group) mentioned that among two types of these abusive attitudes (verbal and physical), one of them hurt their feelings more than the other. Among 41 children in the study group 22 of them stated that they feel worse about the insulting words they hear from their mothers, 16 of them told they feel worse when their mother hit them, 3 children told both types of abusive behaviors hurt them similarly and 1 child reported not feeling hurt because of these abusive attitudes. Among the 8 children in control group, hearing insulting words was reported to be hurtful/ distressing by 5 children, being hit was perceived as most upsetting by 2 children and both types of abusive behaviors were evaluated as similar on distressing by one child.

Table 44. The Most Hurtful Abusive Attitudes according to the Children's Perceptions

The abuse type that is most hurtful/ distressing for children	Children in Study Group, n=42	Children in Study Group, Percentage	Children in Control Group, n=25	Children in Control Group, Percentage
Verbal discipline of the mother	22	52%	5	20%
Physical punishment	16	38%	2	8%
Both types equally	3	7,%	1	4%
None of them	1	2%	0	0%
Not having any abusive attitudes experience	0	0%	17	68%

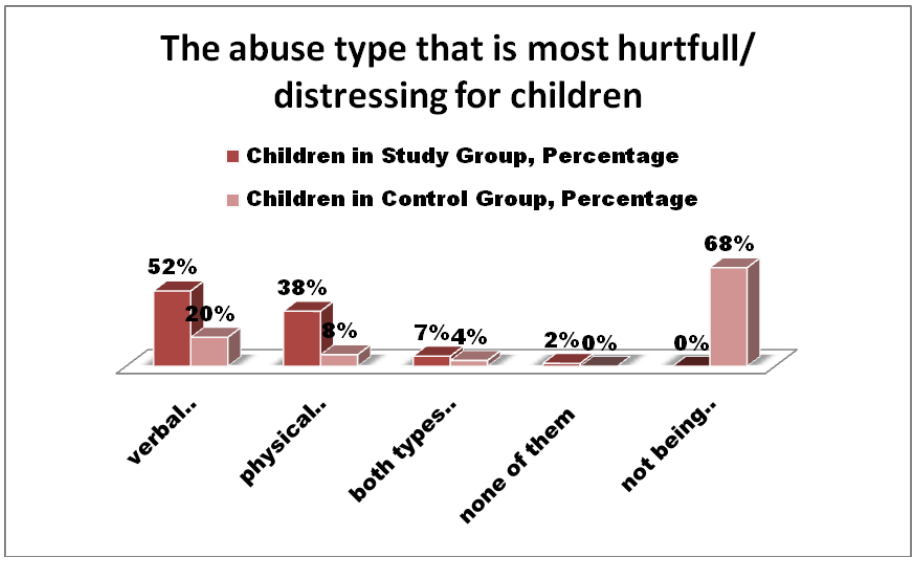

Figure 24. The Most Hurtful Abusive Attitudes according to the Children's Perceptions

3.8.8. The length and the quality of the time spent together

Mothers and children were asked how much time they spent together and whether they found it satisfying. 65 mothers (68%) in the study group and 13 (56%) mothers in the control group reported not being satisfied about the amount of the time they spare for their children. Whereas 31 mothers (32%) in the study group and 12 (44%) mothers in the control group perceived that they spent enough time with their children. When children answered the same question, 65 children (68%) in the study group and 22 (88%) children in the control group stated that their mothers spent

enough time with them. However, 30 children (32%) in the study group and 3 children (12%) in the control group expressed they do not think their mother were spending enough time with them or at least they would like their mother to be with them more.

Table 45. The Length and the Quality of the Time Spent Together

Time spent together	Study Group Mothers, Percentage	Study Group Children, Percentage	Control Group Mothers, Percentage	Control Group Children, Percentage
Enough/ satisfying	31 (32%)	64 (68%)	12 (44%)	22 (88%)
Not enough/ unsatisfying	65 (68%)	30 (32%)	13 (56%)	3 (12%)

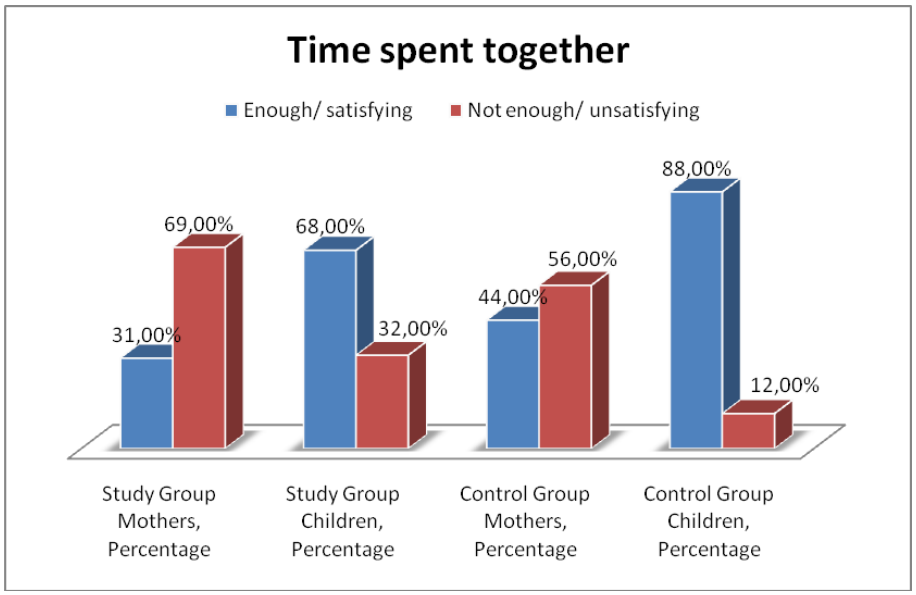

Figure 25. The Length and the Quality of the Time Spent Together

With the aim of gathering information about the quality of the time spent together all four groups were asked what they were doing together at the weekends. The most frequently reported activities by all four groups were visiting relatives (39%, 53%, 20%, 36%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group respectively), going to parks or outlet centers (39%, 37%, 48%, 36%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group respectively), studying (together, alone) (36%, 25%, 40%, 20%; for mothers in the study group, children in the study group, mothers in the control group, children in the control

group respectively), watching TV or playing computer games (31%, 20%, 28%, 24%; for mothers in the study group, children in the study group, mothers in the control group, children in the control group respectively).

In addition to these having a dinner in a restaurant, making sport together, going to picnic together, going to cinema and theatre, watching movie at home, playing game with parents, chatting all together, reading book together at the same time were among the activities that were reported as done for spending joyful time together. According to the interviews, children also frequently spent time playing with siblings or friends, helping their mothers at house-works. Never the less 14% of the mothers in study group, 20% of the children in the study group, 12% of the children in the control group stated that they were not doing anything together with their mothers/children.

Table 46. Weekend Activities of Families

Weekend activities	**Study Group Mothers, Percentage**	**Study Group Children, Percentage**	**Control Group Mothers, Percentage**	**Control Group Children, Percentage**
Nothing	14	20	0	12
Going to parks or outlet centers	39	37	48	36
Visiting relatives	39	53	20	36
Studying	36	25	40	20
Spending time by watching TV or playing computer	31	20	28	24
Other activities	66	53	76	44
Playing with siblings, friends	11	11	12	0
Picnic	9	5	12	4
Dinner outside	6	3	8	4
Sports	3	6	4	8
Reading books	7	4	12	0
Going to cinema or theatre	8	4	16	12
They spent time chatting together	20	7	32	8
Playing games together with all the family	17	3	36	0
House works	14	12	12	16

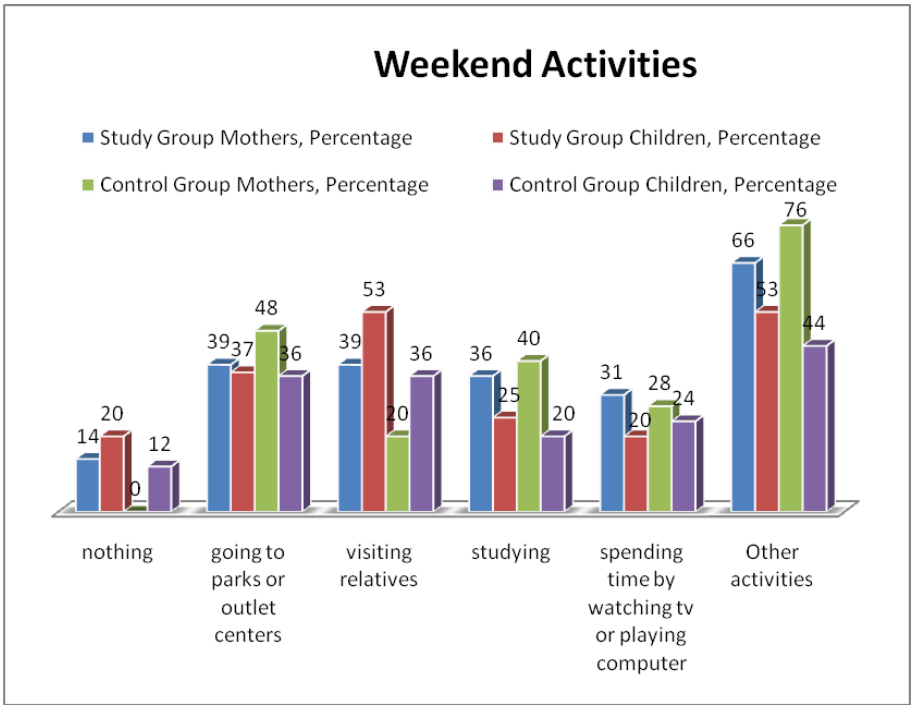

Figure 26. Weekend Activities of Families

3.8.9. Marital adjustment

In order to investigate possible marriage problems behind the mothers' attitudes towards verbal and physical child discipline, mothers were asked to describe and rate their marriage between 1-5. This hypothesis was developed while study was ongoing. For this reason it could be asked to only half of the mothers in study group. 39 mothers in study group (78%) and 21 mothers in control group (84%) expressed they were not violated by their spouses verbally or physically. 3 mothers in the study group (6%) and 3 mothers in the control group (12%) reported being verbally violated. 8 mothers in the study group and 1 mother in the control group (4%) reported being both verbally and physically abused. In the study group one of the 8 mothers who was being verbally and physically abused also reported being forced to sexual relationship. 33 mothers in the study group evaluated their marriage as 4 and 5, 17 mothers evaluated as 3 on a 5 point scale, 10 mothers evaluated less than 3. 14 mothers in the control group evaluated their marriage as 4 and, 12 mothers evaluated as 3 and 1 mother evaluated as less than 3 on a 5 point scale.

Table 47. Spouse Violation

Spouse Violation	Study Group Mothers, n = 50	Mothers of Study Group, Percentage	Control Group Mothers, n = 25	Mothers in Control Group, Percentage
No violation	39	78 %	21	84%
Only verbal violation	3	6%	3	12%
Mother and children are physically and verbally violated by father	8	16%	1	4%
There is sexual enforcement	1	2%	0	0%

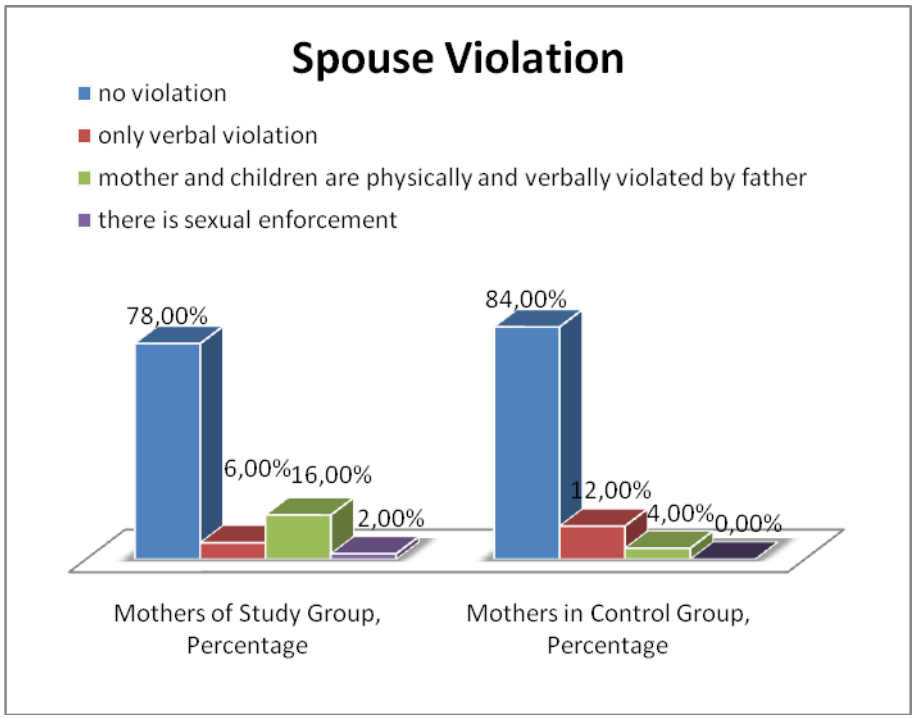

Figure 27. Spouse Violation

Table 48. Marital Adjustment Rated Over 5

Marital adjustment rated over 5	**4 & 5 (very good)**	**3 (good enough)**	**1 & 2 (not good enough)**
Mothers of Study Group, Percentage	35%	18%	11%
Mothers in Control Group, Percentage	56%	36%	4%

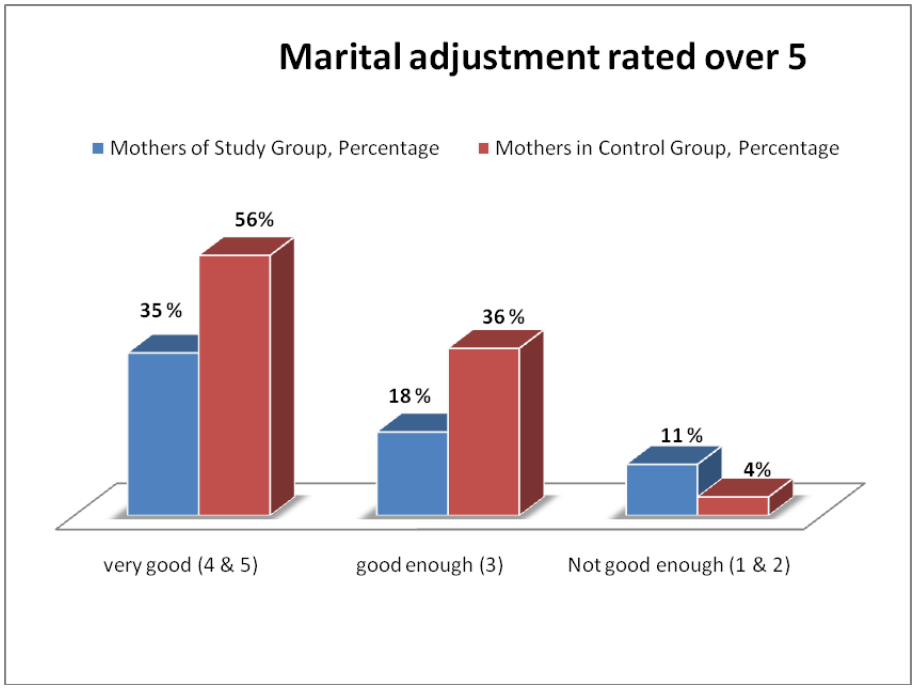

Figure 28. Marital Adjustment Rated Over 5

A FIGURE OF THE MAIN POINTS OF THE THEORY DEVELOPED AND THE RESULTS OBTAINED

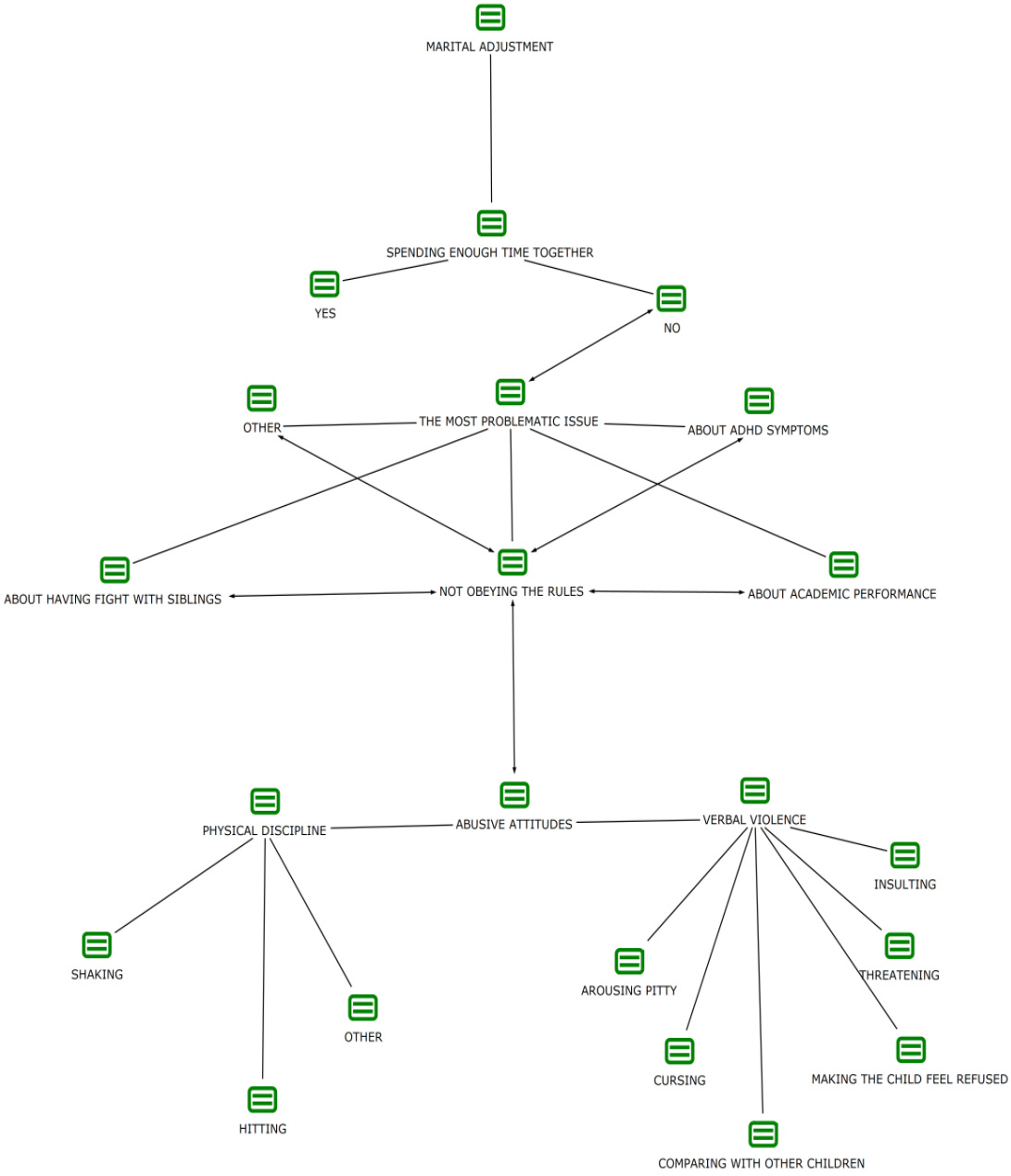

Figure 29. The Main Points of the Theory Developed and the Results Obtained – *Coding Model*

3.9. Summary Tables for Results

Table 49. Summary of the ADHD Group Differences on Demographic Variables

	Control Group	**ADD Group**	**HD Group**	**Combined Group**
Family Income	2554.76 a	2053.67 ab	1618.18 Ab	1447.07 b
Maternal Education	11.81 a	9.00 ab	8.45 Ab	8.93 b
Breast Feeding	12.90 ab	12.73 ab	18.82 A	10.75 b
Relationship with Family	4.29 a	4.03 a	3.73 Ab	3.10 b
Relationship with Teacher	4.43 a	3.62 b	3.63 Ab	3.17 b
Relationship with Friends	4.71 a	3.97 b	4.18 Ab	3.49 b
Academic Performance	4.48 a	3.33 b	3.73 Ab	3.10 b

Table 50. Summary of the ADHD Group Differences on Child and Mother Related Variables

	Control Group	ADD Group	HD Group	Combined Group
Child Related Variables				
CDI	4.95 a	10.45 ab	11.09 ab	11.6 b
Rosenberg self-esteem scores	35.40 a	29.62 bc	32.81 ab	28.45 c
Conners teacher scores For ADD, HD, CD	11.26; 9.31; 6.37 a	15.28; 14.20; 11.6 b	14.73; 16.00; 13.09 b	16.96; 16.14;12.9 b
Conners mother scores For ADD, HD, ODD, CD	7.19; 9.14; 7.19; 14.85 a	11.93; 9.70; 10.03; 20.5 b	11.91; 12.36; 11.18; 22.91 b	12.32; 12.51; 12.11; 25.37 b
Maternal Variables				
Maternal Trait Anxiety	39.67 a	43.90 ab	42.91 ab	48.29 b
Maternal BDI	7.14 a	12.33 ab	11.45 ab	14.45 b
Maternal ADHD related problems	14.33 a	24.33 ab	23.73 ab	26.46 b

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group. **Note 2.** BDI: Beck Depression Inventory, Maternal problems related to ADHD: Maternal scores of problems related to Attention Deficit Hyperactivity Scores; CDI: Scores on Child Depression Inventory; Conners teacher scores: ratings of teacher on Conners ADHD Teacher Rating Scale; Conners mother scores: Maternal ratings on Conners ADHD Parent Rating Scale, ADD/ Inattention Scores: Scores on Conners ADHD Parent Rating Inattention Subscale, Hyperactivity Scores: Scores on Conners ADHD Parent Rating Hyperactivity Subscale, Conduct Disorder Scores: Conners ADHD Parent Rating Conduct Disorder Subscale.

Table 51. Summary of the ADHD Group Differences on Discipline Attitudes and Practices

	Control Group	ADD Group	HD Group	Combined Group
Verbal discipline apr	5.14 a	5.6 ab	8.8 ab	7.85 b
Physical discipline apr	1.5 a	2.19 a	7.6 b	2.98 a
Verbal discipline prc.	1.60 a	2.14 ab	3.00 ab	2.80 b
Physical discipline prc.	1.40 a	3.39 ab	3.27 ab	4.26 b

Note 1. ADD Group: Children in ADHD Predominantly Inattentive Group, HD Group: Children in ADHD Predominantly Hyperactive Group, Combined Group: Children in ADHD Combined Group. **Note 2.** Verbal discipline apr.: Quantitative scores of mothers on approval of verbal discipline; Physical discipline apr.: Quantitative scores of mothers on approval of physical discipline; Verbal discipline prc.: Qualitative scores of mothers on practicing verbal discipline; Physical discipline prc.: Qualitative scores of mothers on practicing physical discipline

Table 52. Summary of the Predictors of Conners Scores

Conners ADD scores	**Conners HD scores**	**Conners ODD scores**	**Conners CD scores**
Maternal education (-) Maternal (+) perception of having a punitive mother Maternal ADD (+) scores Rosenberg self- (+) esteem scores Maternal BDI (+)	Age of saying the first word (-) Length of using nipple (+) Maternal education (-) Maternal ADHD related problems (+) Maternal scores on approval of verbal discipline (+)	Family income (-) Maternal BDI (+) Self esteem scores of children (-) Maternal scores on approval of verbal discipline (+)	Paternal education (-) Maternal BDI (+) Maternal openness (+) Self esteem scores of children (-) Maternal scores on approval of verbal discipline (+)

Note 1. BDI: Beck Depression Inventory, Maternal ADD: Maternal Attention Deficit scores (Inattention scores), Maternal problems related to ADHD: Maternal scores of problems related to Attention Deficit Hyperactivity Scores.

Table 53. Summary of the Predictors of Discipline Attitudes and Practices

REMS	**Verbal discipline atd.**	**Physical discipline atd.**	**Verbal discipline prc.**	**Physical discipline prc.**
Family income (+) Number of siblings Maternal neuroticism (+) Self-esteem scores of children (+)	M - perception of childhood sexual abuse (+) M- EFC (+) M- ADHD related problems (+) M - Openness (+) Child scores on friend relationship ODD scores (+) HD scores (+)	M-EFC (+) M - neuroticism (+) ODD scores (+) CDI scores (+)	M- Trait anxiety M - Openness ADD scores (+)	M - perception of childhood sexual abuse (+) M - Trait anxiety (+) M -extraversion (+) Child scores on friend relationship (-) CD scores (+)

Note 1. REMS: Maternal scores on recognition of emotional maltreatment, M- ADHD related problems: Maternal scores of problems related to Attention Deficit Hyperactivity Scores, M- EFC: Maternal scores on Emotion Focused Coping Style; M - Opennes: Maternal scores on openness dimension of basic personality traits inventory, M -extraversion Maternal scores on extraversion dimension of basic personality traits inventory; M - neuroticism: Maternal scores on neuroticism dimension of basic personality traits inventory; M- Trait anxiety: maternal scores on trait anxiety subscale of State-trait anxiety inventory.

Note 2. ADD/ Inattention Scores: Scores on Conners ADHD Parent Rating Inattention Subscale, Hyperactivity Scores: Scores on Conners ADHD Parent Rating Hyperactivity Subscale, Conduct Disorder Scores: Conners ADHD Parent Rating Conduct Disorder Subscale.

Table 54. Summary of the Predictors of Child Outcomes

Child Rosenberg self-esteem scores	**Child depression scores**
Family income (+) Maternal perception of having a belittling/ criticizing mother (-) Maternal depression scores (-) Maternal recognition of emotional maltreatment (+)	Maternal perception of having a conditioned achievement focused father (+) Maternal scores on approval of physical discipline (+)

CHAPTER IV

DISCUSSION

4.1. Outline of the Discussion

I- The sequence of discussion will be as following;

1. Features of methodology
2. Summary of the results
3. Discussion of the results

II- Summary and discussion of the results will follow the given outline;

1. Group differences and associations of child ADHD diagnosis and ADHD symptoms
    a) According to demographic characteristics,
    b) According to child characteristics
    c) According to mother characteristics
2. Precipitating and associative factors of child abusive attitudes and actual abusive disciplinary acts.
    a) Factors related to maternal characteristics
    b) Factors related to child characteristics
3. Child outcomes.

4.2. Methodological Features

This study basically aimed to investigate the approval of abusive discipline attitudes and actual discipline practices among mothers of children diagnosed with ADHD (Study Group). With this aim, two groups of children and their mothers were included into the study (namely; children with ADHD and their mothers, children having no psychiatric diagnosis and their mothers). All four groups (study group a children and their mothers, control group children and their mothers) were interviewed and then required to fill questionnaires, in order to understand the coherence between maternal attitudes towards disciplinary acts and actual discipline styles – with special emphasis on abusive practices-, and also in order to reveal the

associative or precipitating factors of abusive discipline styles. Questionnaires, administered to parents, were related to maternal childhood experiences, maternal psychological characteristics, maternal attitudes towards discipline, and parental ratings of child ADHD symptoms (Conners Parent Rating Scale). Questionnaires administered to children were related to social support perception, self-esteem and depression scores of children. Together with these questionnaires administered to children and parents, teachers were also required to fill Conners Teacher Rating Scale.

When the administration of questionnaires was completed, interviews were conducted to determine the parent child relationship on the basis of disciplinary practices. In these interviews standard open-ended questions were asked to both groups of children (namely; study group and control group) and both groups of parents (namely; study group and control group). These questions examined the amount and quality of time child and the mother spends together, the most problematic areas between parent and children, consequences of a problem occurring between parent and children, with a special emphasis on abusive disciplinary acts. These were the questions asked to both children and parent groups commonly; however, there were also questions specifically asked to mothers and questions specifically asked to children. The questions specifically asked to mothers were about their marital satisfaction and discord and possible domestic violence. One specific question was asked to children to understand their own appraisal about their mothers' discipline styles and receive self reports of their feelings when they face harsh verbal or physical disciplinary acts of their mothers. Answers given to the questionnaires of this study were analyzed with a quantitative statistic program (SPSS 18), answers given to open-ended questions asked in semi-structured interviews were analyzed through two different methodologies; quantitative and qualitative analysis. To quantitatively analyze the information gathered by qualitative methods, the information gathered about the severity of physical and verbal disciplinary acts were converted into quantitative scores (for more detail see Chapter III). Together with all other open ended questions, severities of disciplinary acts were also analyzed through qualitative strategies. Qualitative analyses were carried out with a statistical program for qualitative analyses namely; Max QDA 10.

4.3. Summary of the Results

4.3.1. Group differences and associations of child ADHD diagnosis and ADHD symptoms

4.3.1.1. Group differences and associations of child ADHD diagnosis and ADHD symptoms according to demographic characteristics

According to diagnostic status there were four groups of children in the study; Control Group (having no psychiatric diagnosis), ADD Group (ADHD Predominantly Inattentive Type), HD Group (ADHD Predominantly Hyperactive Type), and Combined Group (ADHD Combined Type). These groups differed on three demographic variables; Income, maternal education, and breastfeeding. Only Control Group and Combined Group differed from each other on income and maternal education. Specifically, children in Control Group had families with higher income and mothers with higher education compared to children in combined group. When groups were compared for the length of breast feeding results revealed that children in HD group were breast feeded longer than other three groups, all of which did not differ on length of breast feeding from each other.

4.3.1.2. Group differences and associations of child ADHD diagnosis and ADHD symptoms according to child characteristics

Differences of ADHD diagnosis were examined on seven child related factors; WISC-R scores of children, child depression scores, Rosenberg self-esteem scores, perceived social support scores, maternal rated scores of relationship with family, friends, and teacher, and maternal rated scores of academic performance. Groups did not differ on WISC-R and on social support scores. On child depression scores, only control group and combined group revealed significant difference and combined group manifested higher depressive symptoms. Combined group had the lowest self esteem scores, though this decrease on self esteem scores was significantly different from the Control and HD group but not the from ADD group. Scores of Control group on all subscales of Conners -*both parent and teacher ratings*- were significantly lower than all other three diagnosis group, however three groups with

ADHD diagnosis did not reveal significant differences on subscales of Conners. Though the children did not report difference on their social support perception, their mothers reported that while children in HD group were not different on the quality of their relationship with their family, friends and teacher, the children in combined group and ADD group had worse relationship with their friends and teachers when compared to control group. The family relationships of children in ADD group were similar to Control Group and better than the combined group. Mothers were also asked to rate the academic performance of their children. As expected control group had better academic performance than ADD and Combined Group. Interestingly, mother ratings on academic performance for children in hyperactivity group were not significantly different from the ratings of other groups.

4.3.1.3. Group differences and associations of child ADHD diagnosis and ADHD symptoms according to maternal characteristics

Differences of ADHD diagnosis were studied on three domains of maternal characteristics; maternal psychopathological symptoms, maternal personality characteristics, and maternal coping strategies. Mothers of ADD group and HD group did not differ either from each other or from the other groups on any of these domains. Similarly, mothers of children in combined and control group (according to diagnostic status) did not differ on either personality characteristics (extraversion, openness, agreeableness, conscientiousness, neuroticism, negative valence) or coping strategies (problem focused coping, emotion focused coping, indirect coping). However, mothers of combined group had higher trait anxiety, depression, and maternal ADHD related problem scores.

4.3.2. Precipitating and associative factors of child abusive attitudes and actual abusive disciplinary acts

4.3.2.1. Predictors of Conners scores

In addition to differences of diagnosis on child and maternal characteristics, factors associated with ADHD symptoms were also investigated. Accordingly, among demographic variables low maternal and paternal education, low income, saying the

first word in older ages, and using the nipple for longer times were associated with increased Conners scores. Among the child characteristics low self esteem was the only child related predictor of Conners HD and CD scores. Among maternal characteristics higher maternal ADD was associated with higher Conners ADD scores of children, higher maternal scores on depression predicted higher Conners ODD/CD symptoms. Only one maternal personality characteristics was associated with Conners scores; high maternal scores on Openness predicted higher CD symptoms. Maternal approval of verbal disciplinary practices was positively associated with all Conners HD, ODD, and CD scores.

4.3.2.2. Disciplinary attitudes and practices

Among disciplinary attitudes maternal recognition of emotional abuse did not differ according to diagnostic groups and did not predict any of the Connors scores. However, maternal awareness was detected to increase as self esteem scores of children, income of the family increased, and number of siblings or neuroticism scores of mothers decreased.

Maternal qualitative and quantitative verbal violence had a similar pattern of Manova results. Compared to control group, mothers of combined group exhibited higher approval scores on attitudes of verbal disciplinary acts and used these acts more frequently as well. Scores on approval and actual practicing of physical disciplinary acts, interestingly, manifested different results; mothers of hyperactive children showed higher approval on physical discipline than mothers of all other three groups which did not differ from each other, however, when it comes to practicing it only mothers of combined group used these styles significantly more frequent than control group. Maternal approval scores on attitudes towards verbal disciplinary acts were predicted by maternal childhood sexual abuse, emotion focused coping, openness, maternal ADHD related scores, friend relationship scores of children, Conners ODD and HD scores of children. Whereas maternal actual practices of verbal discipline scores were predicted by maternal trait anxiety, openness, and Conners ADD scores of children. Emotion focused coping style of mother, maternal neuroticism, child scores on Conners ODD and child depressive symptoms predicted maternal approval scores on physical disciplinary acts, thus, maternal perception of childhood sexual

abuse, maternal trait anxiety, extraversion as maternal personality characteristics, child scores on the quality of family relationship, and on Conners CD predicted higher frequency of maternal actual physical disciplinary practices.

In order to understand the possible outcomes of maternal disciplinary attitudes and practices on children better, verbal and physical disciplinary attitudes were investigated for their possible predictive roles. After controlling demographic factors and maternal past experiences and current characteristics, among the disciplinary attitudes higher recognition of emotional abuse predicted higher self esteem scores of children and higher maternal approval scores on physical discipline predicted higher child depression scores of children. The relationship of ODD with maternal approval of verbal and physical disciplinary acts and the relationship of ODD with child depression scores leaded to suspicion for mediator role of approval scores on physical disciplinary acts. As expected the association between ODD and depression scores of children was mediated by maternal approval scores on physical disciplinary acts.

Qualitative analysis supported results reported above and revealed that in general mothers approved using some physical and verbal disciplinary acts. However, mothers of children diagnosed with ADHD reported more problematic issues in parent child relationship, less time spent together and higher frequency of using these maladaptive styles compared to mothers of control group. Together with these children reported to be deeply affected from maternal disciplinary acts and this affect was much higher when they were exposed to verbal disciplinary acts compared to physical disciplinary acts.

4.4. Comparison of the Present Study's Results with Literature

4.4.1. Discussion of demographic factors

This study indicated that children in control group had mothers with higher education and families with higher income when compared to children in study group (children in ADHD predominantly inattentive group, ADHD predominantly hyperactive group, and ADHD combined group). In addition, these results also revealed low

parental education was associated with higher scores of Conners ADD and HD scores and low income was associated with higher Conners ODD scores. These findings are consistent with a wide a range of ADHD literature. Low income is associated with child pathologies (Pace & Mullins, 1999). As discussed in the first chapter, the prevalence of ADHD is higher in low-income populations (Barkley, 1990). There are different possible reasons of this association. Low income may cause parental distress, inadequate feeding, and stimulus deprivation. It may also cause distress on parents and both parental distress (Anastapoulos, Guevremont, Shelton, & Dupaul, 1992) and poor environmental factors are shown to be related with symptom scores of ADHD (Öktem, 1993).

Another explanation may be the heritability of ADHD. Studies investigating psychopathology among the relatives of children diagnosed with ADHD, reported that ADHD was the most common diagnosis (Faraone, Biederman, Keenan, & Tsuang, 1991; Frick et al., 1991; Nigg & Hinshaw, 1998) and adult ADHD is shown to be associated with poor outcomes such as low education, unemployment and low income (Dalteg, Lindgren, & Levander, 1999; Manuzza & Klein, 1999). However, results of this study failed to support the findings indicating shared demographic factors. Literature suggests, discipline styles of parents having lower income were harsher compared to ones having higher income (Pinderhughes, Dodge, & Bates, 2000; Portes, Dunham, & Williams, 1986). Yoon (1997) suggested that people with higher educational or income levels were more likely to perceive physical punishment as child maltreatment. The inconsistency may be related to sample, to cultural differences, or to the severity of maltreatment. Income and maternal education may have a predictive role on child maltreatment when there is no cultural approval for verbal and physical discipline, no other factors increasing parental stress or when the physical maltreatment includes physical injury. Thus, the sample of this study manifested cultural approval of maltreatment when there is no physical injury. This prediction is supported by Kırcaeli's results. Though, Kırcaeli (2005) studied with mothers having high education and high income, their results also pointed to abusive disciplinary acts. It is also possible that demographic factors may predict maltreatment through their effect on parental stress (Caliso & Milner, 1992; Coohey, 2000; Gillham et al., 1998). If this is the most realistic explanation, the inconsistency between the scores of this study and literature may stem from the sample

characteristics of this study. ADHD is known to be strongly associated with parents feelings of incompetence, parental stress (Francis & Wolfe, 2008), as the majority of the children had ADHD diagnosis in this study, as Conners scores were included in the study and as maternal psychological characteristics were among the variables in the analysis, the income might have lost the shared variance and become non-significant.

4.4.2. Child characteristics differentiating the child diagnostic status and predicting Conners scores

The results of the study revealed no significant differences on WISC-R and perceived social support scores of children. However, mother ratings of child's relationships with family, with friends, and with teacher were much lower in combined group compared to control group. Results related to the WISC-R scores were particularly consistent with literature. There are studies reporting that WISC-R did not differentiate the ADHD subtypes or ADHD from other psychiatric disorders (Evinç & Gençöz, 2007). However, those studies indicated that children having no psychiatric disorder had higher WISC-R scores. Unfortunately, this was not the case in this study. Depending on this result it may be concluded that instead of the WISC-R scores gathered on a specific subtest, comparison of the differences between the scores of the same subject on different subtests might be more helpful for the decision of diagnosis. In this study rather than depending solely on WISC-R profiles, various other sources -such as the information gathered from the parents and the teachers, clinical interviews, K-SADS- were used for the decision of diagnosis. For this reason the within WISC-R profiles were not included to the present study. Contradicting results related to social support scores of children in this study is of interest. Literature suggests children with ADHD lack of social competence, exhibit aggressive/delinquent behaviors, experience difficulty in obtaining cues related to social skills and in turn, lack social relationships and support (Barkley, Murphy, & Kwasnik, 1996; Borland & Heckman, 1996; Cunningham, Benness, Siegel, 1988; Manuzza & Klein, 1999; Nigg et al., 2002). However, ADHD diagnosis did not reveal significant differences on the perceived social support inventory of this study. Interestingly, group differences were observed on maternal rated quality scores for relationship with family, with friends, and with teacher. According to maternal

ratings, children in combined group have difficulty on all domains of relationships when compared to their peers in control group. The findings of the study are contradicting within themselves and partially with literature. One possible explanation may be related to the source which the information is taken from. The data of previous studies relevant to the social support of children with ADHD, are gathered from the mother, teacher or an observer in the research team, watching the child in school ((Barkley, Murphy, & Kwasnik, 1996; Borland & Heckman, 1996; Cunningham, Benness, Siegel, 1988; Manuzza & Klein, 1999; Nigg et al., 2002). In this study, data was gathered from the mother and from the child. Maternal report regarding the child's social interaction is consistent with literature however children reported their social support much better than expected depending on the previous findings. It is possible that children perceived their social interactions better than the actual; however it is also possible that due to the children's difficult temperament mothers develop a general negative perception of their children.

The discrepancy on the answers received from two sources, may also stem from the different ways used for measuring. Mothers were simply asked to rate their children on the basis of social interaction, however, children were administered a questionnaire to rate their perceived social support. In other words mothers rated their children's attitudes towards others whereas; children rated other people's behaviors to themselves. In addition to the slight difference in the content, depending on the developmental limitations, 6-12 year old children may have experienced difficulty in rating a five point liker type questionnaire, which requires rating items with points referring to words such as rarely, sometimes, and frequently. This group of children may be better on questionnaires in which all the choices include statements (e.g. child depression inventory) rather than abstract words.

On the depression and Conners scores; only children in control group were lower than ADHD combined group. Child self-esteem scores were also differed according to diagnosis of the child and only combined group had significant lower scores than the control group. When the ADHD literature is explored in detail, the findings seemed highly reasonable. Especially, when untreated, ADHD is frequently shown to be highly associated with a variety of negative consequences (Biederman, 1997; Erman, Turgay, Öncü, & Urdavic, 1999; Faraone, Biederman, Keenan, & Tsuang,

1991). Continuously performing under the actual capacity, being exposed to critical comments of teacher, experiencing difficulty in friendships, and receiving negative feedbacks may result in lower self-esteem and higher depression scores of children. This inference is widely supported by the ADHD literature. For example Faraone et al. (1991) have shown that cognitive impairment, depression and low self-esteem were frequently observed among girls diagnosed with ADHD (Faraone, Biederman, Keenan, & Tsuang, 1991).

Conner's scores of children were rated by two sources; namely, mothers and teachers. Both sources manifested a similar pattern on these scores. According to these results, mothers and teachers were good at differentiating the children meeting ADHD diagnosis, regardless of the subtype, from the children having no diagnosis. However; mothers and teachers failed to estimate the subtype. According to the results of regression analyses mother rated Conner's scores were predicted by child characteristics, maternal characteristics and maternal use of verbal punishment; after the demographic factors (discussed above) were controlled. Among maternal characteristics; maternal ADD predicted Conner's ADD scores and maternal depression predicted Conner's ODD and CD scores. The only personality characteristic of the mothers predicting Conner's was Openness and it revealed significant correlations with Conner's CD scores. This result will be discussed under the title of ADHD and maternal characteristics.

Among child characteristics self-esteem scores significantly predicted all Conner's scores except for Conner's HD scores. When interpreted together with the MANOVA results reported above, it may be concluded that self esteem predicted inattention scores and disruptive but not hyperactive behaviors, for this reason, children diagnosed with combined ADHD- *exhibiting both inattention and a variety of behavioral symptoms*- had lower self-esteem compared to control group and hyperactive children. There are not many studies investigating the relationship between self-esteem and subtypes of ADHD. However, academic problems were reported to be associated specifically with ADHD inattentive type, oppositional behaviors were associated with hyperactive type and disruptive behaviors were associated with ADHD combined type (Gadow, Nolan, Litcher, Carlson, Panina, Golovakha, Sprafkin, Bromet, 2000). It is possible that scoring below one’s own

capacity and the other children or being criticized by most of the significant adults surrounding the child and being isolated among peer groups is associated with lower self esteem in a bidirectional way. Consequences of these symptoms may lead to decrease on self esteem of children and lower self esteem may result in higher difficulty on tasks requiring attention and may result in higher behavioral problems.

When all characteristics of mothers and children were controlled after the demographic factors, maternal approval score on verbal discipline was a significant predictor for Conner's scores on behavioral domains (Conner's HD, Conner's ODD, Conner's CD). This result will be discussed under the title of ADHD and maternal discipline attitudes.

4.4.3. Maternal characteristics and ADHD diagnosis of children

Differences of ADHD diagnosis was investigated on six characteristics of mothers (namely; maternal depression scores, maternal state-trait anxiety scores, maternal ADHD scores, maternal personality characteristics, maternal coping styles, and maternal perception of social support). Among six characteristics maternal depression, maternal trait anxiety, and maternal ADHD related problems were differentiated according to ADHD scores of children and consistently, on entire of these domains Combined Group scored higher. In other words, children in combined group had mothers with higher scores on trait anxiety, higher depression, higher ADHD related problems. As reported above, depression scores of mothers were also found to be predictive for Conners ODD and CD scores. This reciprocal relationship between Conners scores and the higher anxiety experienced by mothers of children in Combined Group has enough support in literature. ADHD combined type is characterized by symptoms of both hyperactivity and attention deficit (APA, 1994) and shown to exhibit higher disruptive behaviors compared to predominantly in attentive or hyperactive types (Gadow et al., 2000). Similarly, both ODD and CD are defined with highly difficult temperaments such as; aggressive and negativistic behaviors towards others (APA, 1994). The association between maternal depression and disruptive behavioral symptoms of children is widely supported by literature (Evinç, 2004; Milberger, Biederman, Faraone, Murphy, & Tsuang, 1995; Nigg & Hinshaw, 1998). Compared to the child's hyperactive behaviors and cognitive

difficulties, aggressive behaviors may be more distressing for the parents (Patterson & Forgatch, 1995). Biederman et al. (Biederman, Faraone, Milberger, Jetten, Chen, Mick, Grene, & Russel, 1996) indicated that the risk for major depression was higher for ODD + CD + ADHD than for ODD + ADHD but for both conditions the risk for Major Depression was higher than for ADHD alone.

In addition to increased parenting stress, the association between depression and disruptive behaviors of children may stem from several reasons such as, common vulnerability factors (Bradley & Golden, 2001), overlapping symptoms of ADHD, poor parental modeling (Garber, Robinson, & Valentiner, 1997), poor interaction between the depressive parent and child, (Schachar, 1987) the difficulty in managing a child with ADHD, (McClearly & Ridley; 1999), possible exaggerations on self or child reports made in order to receive help and also exaggerations resulting from the possible generalized negative view that the parent caries about the child (Cummings & Davies, 1999; Lang, Pelham, & Atkeson, 1999; Pelham et al., 1997).

Group differences on maternal ADHD related problems and the predictive role of maternal ADD on Conner's ADD scores of children also seem to be consistent with the findings of previous studies. ADHD is shown to be a heritable disorder (e.g., Gilger, Pennington, & Defries, 1992; see Bradley & Golden, 2001 for a review). Parental ADHD is shown to be a great risk factor for child's psychological development. In a study comparing the children of people with and without ADHD it was found that the high-risk children exhibited more disruptive behaviors, anxiety and depression symptoms and that, together with all these, failure at school increased in follow up period (Faraone, Biederman, Mennin, Gershon, & Tsuang, 1996). Supporting the predictive role of maternal ADD on Conner's ADD scores of children, Barkley (1996), defined inattention as lack of task or goal oriented persistence. It has also been reported that, biological parents of ADHD children were observed to have difficulty at organizing their houses and managing their children (Nigg & Hinshaw, 1998). Similarly the association between Conner's CD scores and maternal ADHD related problems which include impulsive and aggressive acts has a ground in literature. It has been suggested that parental behavioral problems specifically predict behavioral problems of children (Faraone et al., 1997). Social learning theory suggests that children learn appropriate behaving by taking their

parents as models (Bandura, 1989). Based on this literature, in addition to genetic explanations, it may be suggested that inattentive people may have difficulty on the tasks of parenting, such as; helping the child learn organizing their homework, their rooms or their days, and also impulsive parents may have difficulty in providing a good model for appropriate behaviors.

Though none of the personality traits were differed according to the diagnosis of children, Openness was another maternal factor predicting Conner's CD scores of children in this study. There is not much study investigating the associations between big five personality dimensions of mothers and psychological symptoms of children. However, there are a few studies suggesting that big five personality traits are effective on parenting behaviors (Colemont, Hiel, Cornelis, 2011; Prinzie, Stams, Belsky 2009). Openness, to some extent, was linked to impulsivity (Whiteside & Lynam, 2001), which is a core dimension underlying aggression and disruptive behaviors of conduct disorder (Barratt, 1993; Hollander & Stein, 1995; see Nigg, 2001 for a comprehensive review). Both shared etiology for impulsive behavior and social learning effect (defined above) may be reasons of this relationship. However, yet, there are not enough results to draw more clear conclusions.

4.4.4. ADHD and verbal-physical discipline styles of mothers

Maternal approval scores on attitudes towards verbal disciplinary acts were predicted by maternal childhood sexual abuse, emotion focused coping, openness, maternal ADHD related scores, friend relationship scores of children, Conners ODD and HD scores of children. Whereas maternal actual practices of verbal discipline scores were predicted by maternal trait anxiety, openness, and Conners ADD scores of children. Emotion focused coping style of mother, maternal neuroticism, child scores on Conners ODD and child depressive symptoms predicted maternal approval scores on physical disciplinary acts, thus, maternal perception of childhood sexual abuse, maternal trait anxiety, extraversion as maternal personality characteristics, child scores on the quality of family relationship, and on Conners CD predicted higher frequency of maternal actual physical disciplinary practices.

In the present study maternal childhood sexual abuse was found to have predictive roles on maternal scores of both approving verbal discipline and practicing physical discipline. Though little, there is evidence that women, sexually abused in childhood, have children showing poorer functioning and higher behavioral symptomatology (Paredes, Leifer, & Kilbaneb; 2001). This relationship may be due to the problems the mother experiences - as consequences of childhood maltreatment- on various domains; such as psychopathology developed following the sexual abuse, difficulties behavioral control and in intimate relationships, attachement disorders, and higher parenting stress due to revictimization. Childhood sexual abuse has been frequently linked to negative features of adulthood life (Kendall-Tackett & Marshall, 1998). Long-term effects of childhood sexual abuse were reported as psychoticism, hostility, anxiety, somatization, phobic anxiety, depression, externalizing problems (Haj-Yahiaa & Tamish, 2001; Manly et al., 2001; Toth et al., 1992). In addition to various psychopathologies, all kinds of childhood maltreatment were indicated to predict insecure and disorganized attachment types (Cicchetti et al., 1994; Cicchetti et al., 2006; Cyr et al., 2009) relational aggression both in short (Simons & Wurtele, 2010; Vittrup & Holden, 2010) and long-terms (Teisl & Cicchetti, 2008). Similarly, series of studies suggested that sexual abuse might lead to feelings of parental incompetence (Banyard, 1997; DiLillo & Damashek, 2003; Ruscio, 2001; Zuravin & Fontanella, 1999). Childhood sexual abuse was related with emotion dysregulation and emotion dysregulation was found to mediate the relationship between childhood abusive experiences and having an aggressive relationship style, in other terms; being an abusive parent (Alink, Cicchetti, Kim, Rogosch, 2009).

Having a psychopathology, a style of aggressive relationship and having attachment problems with one's own parents may disrupt the parent-child interaction. Parenting stress was discussed above with regard to its association to approving abusive discipline styles. In addition to the possibility of having a direct relationship, past experiences of sexual abuse and parenting stress may be mediated by domestic violence as well. Childhood sexual abuse is highly associated with re-victimization, in other words being vulnerable to experience maltreatment (independent of its type) repeatedly (Arata, 2002; Messman-Moore & Long, 2003). In a study among women reporting childhood sexual abuse 28·5% reported physical, sexual, emotional, or domestic violence as adults (Mazza, Dennerstein, Garamszegi, Dudley, 2001).

Domestic violence was indicated to be associated with maternal harsh discipline practices (Edleson, 1999) either through its traumatic, stressful consequences (Claussen ve Crittenden, 1991; Fantuzzo et al., 1991; Kolko 1992; Salzinger, Feldman, Hammer, ve Rosario, 1991) or through its relationship with approval of physical violence towards others (Bower-Russa, Knutson, & Winebarger, 2001; Durrant, Broberg & Rose-Krasnor, 1999; Holden et al., 1995, Jackson et al., 1999).

The present study revealed that maternal trait anxiety was associated with maternal verbal discipline practices. Anxious people were suggested to expect more negative outcomes (Butler & Mathews, 1983). Depending on this, anxious mothers may be assumed to catastrophise the consequences of child's misbehaviors. Consistently, some researchers suggested that parents report higher probability for using abusive discipline when their children engage in a dangerous behavior such as running into a busy street, lighting matches (Catron & Masters, 1993; Socolar & Stein, 1995).

Among personality characteristics openness (Costa & McCrae, 1992) and extraversion (Eysenck & Eysenck, 1968) were shown to be associated with impulsivity and higher likelihood of risk taking behaviors. When a child misbehaves, impulsive parents may experience higher difficulty in exhibiting patience and manifesting the best disciplinary style and they may look for immediate solutions. Researches about discipline styles indicate that abusive discipline styles are effective for immediate compliance though ineffective in long-term due to the lack of internalization (Gershoff, 2002). This effectiveness in the short term may be reinforcing the abusive attitudes of parents. Results related to the neuroticism's predictive role on maltreatment are also consistent with the very limited literature. Supporting the results of the present study, neurotic mothers are shown to have negative views about their children and accordingly reported to exhibit lower warmth to their children (Prinzie, Stams, Dekovic, Reijntjes & Belsky 2009).

The present study revealed that maternal scores on emotion focused coping were associated with higher approval of verbal discipline. There is not much study investigating the association of mothers coping and parenting styles. However, limited evidence exists that when people using emotion focused coping styles meet a conflicting situation, they prefer not reacting for a long time and afterwards giving an

aggressive reaction (Wolfe & Manion, 1984), accordingly; abusive mothers were shown to be using less problem solving strategies and more emotion focused coping style than non-abusive mothers (Cantos, Neale, O'Leary, & Gaines, 1997).

ADHD group differences were observed on maternal approval and actual practicing of verbal and physical discipline. Results of approval and actual practicing of verbal discipline revealed same pattern. This is an important finding supporting the literature for the role of approval on the actual practicing of an inappropriate discipline style. The association between approval and actual practicing of maltreatment is given in detail in the first chapter. Briefly, it has been indicated that individuals who exhibit attitudes supporting maltreatment were shown to be more likely to actually use abusive attitudes in their child rearing styles (Jackson et al., 1999; Qasem, Mustafa, Kazem & Shah, 1998; Vargas, Lopez, Perez, Zuniga, Toro & Ciocca, 1995). This interpretation can particularly be generated to the results relevant to physical discipline.

Compared to control group, mothers of combined group exhibited higher approval scores on attitudes of verbal disciplinary acts and used these acts more frequently as well. Studies investigating the role of ADHD diagnosis on parents abusive attitudes suggest that in general a child having symptoms on the wide range of ADHD diagnosis are more prone to parental maltreatment (Briscoe-Smith & Hinshaw, 1996; Glod & Teicher, 1996; Endo & colleagues, 2006). However, little evidence is given about the specific symptoms or subtypes comprising greater risk for the occurrence of maltreatment. In general studies preferred not discriminating the subtypes or even if data has been gathered for each subtypes researchers tended to merge them when evaluating the maltreatment (Aliazadeh et al., 2007; Briscoe-Smith & Hinshaw, 1996; Ford et al., 2000; Wozniak et al., 1999). Ford et al. (2000) have not differentiated the subtypes of ADHD however, they compared ADHD and disruptive behavior disorders on the basis of parental maltreatment. Their results suggested that pure ADHD or ADHD comorbid with disruptive behavior disorders were all highly associated, but disruptive behavior disorders had higher association with parental maltreatment (Ford et al., 2000). As it has also been shown that ADHD combined type was highly characterized with disruptive behaviors, results of this study seems to be consistent with literature. However, Ford et al. (2000) studied solely physical

abuse. Based on the lack of studies investigating the association of emotional abuse and ADHD, the difference of this study on investigating both emotional and physical abuse according to the subtypes of ADHD; results may be considered as extended information. This interpretation is also eligible for the findings relevant to physical maltreatment.

Results revealed that mothers of hyperactive children showed higher approval on physical discipline than mothers of all other three groups, however; when it comes to practicing, only mothers of combined group used these styles significantly more frequently than control group. Because of the lack of the studies comparing subtypes on parental maltreatment, it is highly difficult to compare this result with literature. However as we have asserted before, hyperactivity was characterized with more opposing behaviors but ADHD combined type was characterized with disruptive behaviors. It has also been shown that parental stress was an important predictor of parental attitudes towards maltreatment (Aliazadeh, Kimberly, Applequist, & Coolidge, 2007; Berger, 2005; Park, 2001; MacKenzie, Nicklas, Brooks-Gunn & Waldfogel, 2011). Parenting stress might be considered as a possible mediator between the maternal perception of difficult child temperament and maternal abusive behavior. Supportive findings are present for this interpretation. Higher disruptiveness of behaviors was suggested to cause a higher risk for parental maltreatment (Ford et al., 2000; MacKenzie, Nicklas, Brooks-Gunn & Waldfogel, 2011). Researchers suggested that the occurrence of maltreatment depended on '*to what degree parent perceives the child temperament difficult'* (Bugental & Happaney, 2004).

When the most disruptive behaviors of the children and the most problematic issues were asked to mothers and children; academic problems had highest rating among all groups. Among both study and control groups; different from mothers, children reported that playing computer/ watching TV (between 16% - 25%) and other issues including eating problems (more than 40%) were reported highly. Another interesting difference between mothers and children was about the ratios of inattention and hyperactivity (only the restlessness symptom is included) related problems. When mothers and children compared on ratings of disruptive effect of this issue on parent child relationship, mothers had lower ratings than children.

Especially mothers and children in study group had highly different ratings; mothers did not perceive this issue much problematic (13%) whereas study group children had perceived the disruptiveness of this issue higher than all other groups including their mothers (25%). Following the academic problems, mothers mostly complained about their children's noncompliance about doing the things they are told to (more than 30% for both groups). Interestingly children in both groups but especially in study group reported this problem less than the mothers (15%).

When interpreted together with Manova and Regression results it may be concluded that mothers mostly perceived the academic problems and noncompliance of children had disruptive effect on parent child relationship. Noncompliance of children, which is a feature of ODD/CD, predicts the mother's approval and practicing of the physical discipline and academic problems, a feature of inattention scores, predicts verbal discipline practices of mothers despite their disapproval. As both academic problems and noncompliance are features of ADHD Combined Type it seems reasonable that ADHD combined type were more frequently exposed to abusive discipline styles.

The discrepancy between the child and mother reports about the most disruptive, problematic issue in their relationship is of interest. Actually, this may be another important factor predicting the repeated abusive discipline practices especially for children with ADHD. Mothers demand the children to show compliance on many domains however; children perceive that their mothers were annoyed specifically with the time they spent on computer and TV, and also annoyed with their inattention and hyperactive-restless behaviors. These results reveal children did not have clear ideas about their mothers concern. This is important because if the child does not understand why, exactly, his/ her mother is angry with him/her, the punishment-no matter which type- cannot bring a long-term positive behavioral change, even though the immediate compliance is obtained. When the long-term behavioral change is not obtained the possibility of the verbal and physical discipline to be repeated with increasing frequencies and severity, seems to be high. This interpretation is also consistent with literature suggesting that long term behavioral change requires internalization and the child has to perceive the parental message accurately for internalization (Gershoff, 2002; Grusec & Goodnow, 1994). Consistently a study

conducted with children, 58% of children watching corporally punishment given to a child in a video stated that the child in the video could forget why s/he was punished and also stated that s/he could show compliance due to the fear of being punished. Accordingly, verbal and physical discipline styles may not be helpful for children to perceive the parental message accurately and may not lead to internalization. Instead of these, studies indicate that reasoning may be more helpful for internalization and long-term compliance (e.g., Vittrup & Holden, 2010).

Consistently, Conners scores of children on disruptive disorders predicted both maternal approval and actual practicing of verbal discipline (ODD scores), and maternal actual practicing of physical discipline (CD). In addition to this, verbal discipline predicted the increase in ODD and CD symptoms. There seems a reciprocal relationship exists between disruptive behaviors of children and abusive discipline styles of mothers. Recent studies suggest that abusive parent perceives the intent of the child negatively and the severity of the symptoms higher than the actual (MacKenzie, Nicklass, Broks-Gunn, Waldfogel, 2011). Both emotion literature on anger and abuse literature on parenting styles have researches supporting these results (e.g., Hall & Davidson, 1996; Mash & Johnston, 1990; Wingrove & Bond, 2005). The possible link between anger and abusive parenting is discussed on the first chapter. Briefly, anger is an emotion interrupting the person's perceptions about the other, and causing misinterpretations on the intent of others, exaggeration about the event resulting in anger; itself (Wingrove & Bond, 2005). Abusive parents report higher feelings of anger (Ateah & Durrant, 2005), this, in turn, may affect their misinterpretations about the child's intent and the severity of the child's symptoms. This may cause the child to be more aggressive and out use acting out more, as a coping strategy. This assumption is consistent with the findings of MacKenzie et al. (2011), which revealed that parents negative attributions about the child behaviors result inhibitory and self regulatory problems of children (MacKenzie, Nicklass, Broks-Gunn, Waldfogel, 2011). Parental abuse may lead to aggressive behaviors of children also through the acceptance and approval that child develops as a consequence of frequent exposure to maltreatment. It has been reported that younger children and frequently spanked children show higher acceptance of hitting for conflict resolution and advocated spanking as a consequence of misbehavior (Simons & Wurtele, 2010). As a result these children prefer aggressive conflict resolution

with peers and siblings. According to Simons and Wurtele (2010) this is an explanation of intergenerational cycle. Vittrup and Holden studied (2010) obtained similar results with slight differences. These researchers suggested that children being exposed to low or high exposure to maltreatment do not exhibit acceptance however, children exposed to medium levels of maltreatment regarded the spanking as the best disciplinary technique. Similarly younger children were shown to evaluate spanking fair whereas; older children evaluated reasoning as fair and effective in the long term.

In the present study, disruptive behaviors were predicted not by spanking but verbal discipline. Though it may seem as a contradicting result to the literature, it may also be considered that recent studies on emotional abuse provide a ground for this result. According to the researches, all abuse types have similar consequences (Briere & Runtz, 1988; Johnson et al., 2001; Rich, Gingerich, & Rosen, 1997; Sackett & Saunders, 1999), because they all give harm to self, and trust to the environment (Hart & Brassard's, 1987). A child exposed to any type of maltreatment is assumed to experience difficulty in intimate relationships, developing appropriate problem solving styles in future and use aggression higher than the other children, higher risks of psychopathology (Briere & Runtz, 1988; Harmelen, Jong, Glashouwer, Spinhoven, Penninx, Elzinga, 2010; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Rich, Gingerich, & Rosen, 1997). This similarity aroused the importance of emotional abuse and evoked a debate such that emotional abuse may be the core of all types of abuse and the main reason of aversive consequences. Spertus et al. (2003) found that emotional abuse and neglect was associated with increased anxiety, depression, posttraumatic stress and physical symptoms. Kent, Waller, and Dagnan (1999) investigated the effect of all three types of abuse on eating psychopathology and indicated that their critical finding was the central predictor role of eating psychopathology was emotional abuse. Researchers suggested that the other forms of trauma may only appear to have an effect as a result of their strong correlations with emotional abuse. Harmelen et al. (2010) explains the link through the automatic negative self association. Accordingly, abused children develop dysfunctional (self-) attitudes and low self worth (Beck, 1967, 2008). Waller and Kent (2000), also suggested that child physical abuse was more easily viewed as a punishment for an act (imagined or actual), whereas child emotional abuse was

more readily interpreted as a direct attack upon the self. Consistent with quantitative results of the present study and consistent with literature, in the qualitative step of this research children were asked which discipline attitude of their mother upset them more and among the study group children 52%, among the control group 32% stated that they feel worse about the insulting words they hear from their mothers. When the verbal discipline styles of mothers were investigated in detail consistent with literature statement mostly included self attack. Insulting and accusing/ arousing pity were the most frequent reported types of verbal discipline among both groups of children with ADHD and control group.

4.4.5. Child outcomes

Conners scores were discussed as predictors and as outcomes. In addition to Conners scores Rosenberg self-esteem and child depression scores were also investigated in this study by means of both their predictive roles on Conners scores, on parental discipline attitudes and practices, their role as outcome. Interestingly though self esteem scores of control group were higher than children with ADHD inattentive type and children with combined type however similar to children with ADHD hyperactive type. Among Conners scores lower self esteem was associated with lower inattention, higher oppositional and disruptive behaviors. When all results are considered together, hyperactive-restless behavior of the children were not associated with lower self esteem since they are not observed together with inattention or severe oppositional-disruptive behaviors. The high scores received by hyperactive children on self-esteem may be related to such cultural perception as hyperactivity is an indicator of high intelligence. Among the abusive discipline attitudes of mothers, recognition of emotional abuse was predicted with high self-esteem. Similarly self esteem scores were also predicted by recognition of emotional abuse. Accordingly mothers being aware of the possible emotionally abusive effect of verbal discipline had children with higher self esteem. The self destructive effects of verbal discipline were explained in detail above. However, the interesting part of the results related to the self esteem is that; self-esteem was not predicted by attitudes and actual practices of abusive discipline styles other than recognition of emotional abuse. This finding raises a question whether there is any factor having buffering effect. Studies in literature suggest that not all the abused children necessarily develop psychological

problems and among the limited findings related to the buffering factors against abusive discipline styles amount of time that the parent spends with children and warmth of the relationship were found to decrease the possibility of both negative outcomes occurring following abusive discipline and the mothers actual practicing of abusive discipline. Children having warm relationship and spending enough time with their parents were suggested to be less inversely effected (Larzelere, 2000). In addition, the probability of practicing abusive discipline decreases when mothers have a warm parenting style and spend more time with their children (Park, 2001).
The qualitative results of the present study also supported this interpretation particularly. Accordingly, 68% of the children in study group and 88% of children in the control group reported that they perceived that their mother spent enough and satisfying time with them. On the contrary, 32% of the mothers in the study group and 44% of the children in control group found the amount and the quality of the time they spare for their children dissatisfying. To obtain more objective data, things they do together were examined. Results revealed that the most frequently reported activities by all four groups were visiting relatives, going to parks or outlet centers, studying (together, alone), watching TV or playing computer games. These activities generally lack parent child interaction and seem to support maternal perception. The results suggest that children had better perceptions about the length and the quality of the time better than the actual just like their ratings on their perceived social support. Depending on the literature given above children's positive perceptions about their mothers parenting may buffer against the abusive discipline styles they are exposed to.

However, when the predictive roles of abusive discipline styles on Conners scores and child depression scores were considered, the warm and supporting parenting was found to be buffering only for self esteem but not for externalizing or internalizing symptoms of children. This finding is consistent with Gamez-Guadix et al. (2010), suggesting that corporal punishment is a risk factor for developing antisocial acts independently from the parental warmth and supportive style (Gamez-Guadix et al., 2010).

Child depression scores were predicted by mothers' perception of having a conditional-achievement focused father and practicing physical abuse. Parenting was

shown to be intergenerationally transmitted. Social learning theory suggests that children learn appropriate behaving by taking their parents as models (Bandura, 1989), in turn parents learn parenting from their own parents (Bower-Russa, Knutson, & Winebarger, 2001). People having achievement focused fathers may be more achievement focused towards their children and this may lead to depressive symptoms of children especially if they are diagnosed with ADHD which is shown to be associated with poor academic performance (Hinshaw, 1992). Consistent with literature (e.g.; Kazdin, 1985; Kent & Waller, 2000) maternal approval of physical discipline was found to predict child depression. When evaluated all together verbal discipline styles predicted Conners scores on behavioral dimensions and physical discipline predicted child depression. The possible link between self-damaging effect of verbal discipline and aggressive relationship styles of children were given above. Whereas studies linked physical abuse to difficulties on emotional regulation (Alink, Cicchetti, Kim, Rogosch, 2009) which in turn, leads to internalizing problems of children (Teisl & Cicchetti, 2008).

As oppositional defiant disorder scores of children predicted child physical discipline and child physical discipline predicted child depression scores a possible mediation effect was investigated. The results revealed significant mediation effect of child physical discipline between oppositional defiant disorder scores and child depression scores. This result is particularly consistent with the results of Ford et al. (2000). Ford et al. (2000), suggested that children with ODD were more exposed to physical discipline and were more prone to develop PTSD. Both results indicate that children with ODD are more prone to be physically disciplined and develop internalizing problems as a consequence. Ford et al. (2000) debates whether ADHD symptoms are due to PTSD of children as a consequence of physical discipline however the present study suggests that ADHD symptoms are predicted by verbal discipline but not physical discipline, rather, physical discipline is predicted by child behavior problems. The mediation effect supports the link as such; behavioral symptoms related to externalizing problems increase the possibility and frequency of physical discipline and physical discipline leads to internalizing symptoms.

4.5. Limitations of the Study

The present study included mothers and children however fathers were not taken into study. The importance of marital satisfaction on child rearing styles was revealed by previous studies (e.g.; Edleson, 1999). However; the present study did not reveal effect of marital discord. The discrepancy may be due to the measuring method. In this study, mothers were asked to rate their marriage over a five point scale and to tell whether there is domestic violence in the marriage. It might have been more difficult to talk about their marriages face to face. Administering a questionnaire about marital satisfaction and violence could reveal more objective results. In order to better understand the association with maternal disciplinary attitudes and ADHD diagnosis of children, healthy siblings could be another control group however; Whitmore & Kramer (2002) suggested that there were no differences on the frequency and severity of the corporal punishment between children with ADHD and their siblings. Having a child with ADHD diagnosis may increase the parental stress and parents with higher stress may behave similarly to all of their children. Depending on this it may also be concluded that a healthy control group other than siblings of children with ADHD diagnosis might revealed more objective results.

4.6. The Implications of the Study

There are very few studies comparing the children with and without ADHD on the abusive discipline styles they are exposed to. In addition to comparing the mothers' attitudes the present study also examined the children's perceptions about their mothers discipline practices. Studies in literature generally have examined the association between exposure to maltreatment and ADHD regardless of the subtype. Together with comparing children diagnosed as ADHD and children having no diagnosis, the present study examined the group differences among the subtypes of ADHD. In the present study diagnosis and ADHD symptoms were studied together which is also very rare in literature. In other words, to explore and interpret the findings of the present study in detail, each of ADHD symptoms scores on Conner's were also studied.

Another important point is the variability on data gathering methods and the variability on the information sources. Data was gathered by structured and semi-structured interviews and also by questionnaires. Four different sources were used to gather information; mothers, children, teachers, and clinicians. Specifically, the information about the quality of the parent child relationship and about the discipline styles of the mother was gathered from both mother and children and the decision of diagnosis was made depending on the information taken from mother, child, and teacher. WISC-R scores and clinical interviews were also helpful for the decision of diagnosis. Another strength of the present study was examination of both attitudes and practices of discipline styles together.

The present study pointed to the cultural approval of abusive discipline styles and factors leading to the approving and practicing the abusive discipline styles are given in a cultural context. Results also showed that approval of abusive discipline styles were transferred into practice when children have difficult temperament such as ADHD. In addition to this results emphasized the bidirectional relationship between behavioral problems and abusive discipline styles. Negative consequences of abusive child rearing styles were also manifested.

Depending on these results it may be suggested that parenting programs about appropriate discipline styles must become prevalent. Families of children diagnosed with ADHD should be examined for their disciplinary attitudes and caution must be derived on the high possibility of maltreatment in this population. Particularly children with disruptive behaviors are at higher risk for physical discipline and the possible association between behavioral problems and abusive discipline styles must not be overlooked in this population. Attention must be given to the results about the verbal discipline. Contrary to the general perception, it had much higher effect on behavioral problems of the children. It should also be noticed that abusive discipline styles were also observed in control group. Even the children with ADHD were indicated to be at higher risk, it seems that public based parenting programs must be conducted frequently. These results are important for their contributions to recognizing child maltreatment and conducting preventive strategies, preventive programs for the public.

4.7. Suggestions for Future Researches

This study compared children with ADHD and their mothers to children without any psychiatric disorders and their mothers. Future research dealing with parental abusive discipline styles may include father characteristics as well. This would enhance our understanding of abusive discipline and associated factors particularly; ADHD and comorbid symptoms. Since the mothers may give biased information about their marriages in face to face interviews marital satisfaction may be measured by a questionnaire.

In this study there were two groups of children and their mothers; ADHD diagnosed children and non-diagnosed children and mothers of both groups. Future research including siblings of children diagnosed with ADHD is needed to gain a better understanding of the predictive role of parent characteristics on practicing abusive discipline styles. In addition, longitudinal studies may also enhance our knowledge about the factors affecting the abusive discipline styles and predicting the prognosis of children exposed to abusive discipline styles. Thus future studies are needed to clarify further and expand findings of the study.

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APPENDICES

APPENDIX A

DEMOGRAFİK BİLGİ FORMU

Çocuğunuzun Adı, Soyadı: Çocuğunuzun Cinsiyeti:
Çocuğunuzun Doğum Tarihi: Sizin Adınız, Soyadınız:
Yaşınız: Kaç çocuğunuz var?

Bu formu kaçıncı çocuğunuz için dolduruyorsunuz?
Ailenizin ortalama aylık gelirini belirtiniz

Annenin en son bitirdiği okul:
Annenin Medeni durumu? Evli Bekar Boşanmış Dul

Babanın en son bitirdiği okul:
Babanın Medeni durumu? Evli Bekar Boşanmış Dul

Aile yapısı: **a-** çekirdek **b-** geniş **c-** anne baba boşanmış **d-** anne baba evli ama ayrı yaşıyor **e-** diğer (açıklayınız):

Sizin anne babalarınızda ayrılık-alkol, madde kullanımı var mı, açıklayınız?

Çocuğunuz anne sütü aldı mı/ ne kadar süre? Anne sütüyle ilgili bir problem yaşandıysa belirtiniz.

Çocuğunuz biberon kullandı mı - ne kadar süre?

Çocuğunuz emzik kullandı mı - ne kadar süre?

Çocuğunuz kaç aylıkken/ yaşındayken yürüdü?

Çocuğunuz kaç aylıkken/ yaşındayken ilk kelimesini söyledi?

Aşağıdaki soruları 1 ile 5 arasında puanlayarak değerlendiriniz:

Çok kötü	**Kötü**	**Orta**	**İyi**	**Çok iyi**
1	**2**	**3**	**4**	**5**

Ders başarısı nasıldı?
Arkadaş uyumu nasıldır?
Öğretmenleriyle uyumu nasıldır?
Aile içi uyumu nasıldır?

APPENDIX B-1

Open-ended Questions for Children (Açık Uçlu Çocuk Soruları):

1- Sana evde en çok kim karışıyor?

2- Annen sana en çok hangi konularda karışır? En çok hangi konularda annenle sorun yaşarsın?

3- Annenin ihtiyaçlarını karşılağını düşünüyor musun (yiyecek, hijyen, okul… gibi ihtiyaçlar tek tek araştırılır)?

4- Annenin sana yeterince zaman ayırdığını düşünüyor musun? Annenle yaptığınız eğlenceli aktiviteler var mı? Cumartesi-Pazar neler yapıyorsunuz?

5- Bazen yetişkinler çocuklarını kontrol etmekte zorlanırlar sanırım sen de çok hareketli olabiliyor bazen kuralları zorlayabiliyorsun. Böyle durumlarda senin annen/ baban (öğretmenin?) ne yapıyor?

   5a- Evinizde cezalar var mı? Sana genelde ne tür cezalar verilir?
   5b- Annen sana kızdığı zaman neler söyler?
   5c- Annen sana çok kızdığı zaman neler yapar?

6- Annenin sana vurması mı söylediği sözler mi, hangisi daha çok incitiyor, üzüyor seni?

APPENDIX B-2

Open-ended Questions for Mothers (Açık Uçlu Anne Soruları):

1-Cumartesi pazarları ne yaparsınız? Çocuğunuza yeterince zaman ayırdığınızı onun ihtiyaçlarını karşıladığınızı düşünüyor musunuz?

2- Çocuğunuz sizi en çok hangi konularda zorluyor? En çok hangi alanlarda çocucuğunuzla problem yaşıyorsunuz?

3-Çocuklar bazen kurallara uymakta güçlük çeker ve kontrol edilmeleri zor hale gelirler. Bu nedenle bazen öfke uyandırabilirler. Böyle durumlarda siz ne yapıyorsunuz? Nasıl durduruyorsunuz? Ne tür cezalar veriyorsunuz?

4-Kontrol edemediğiniz zaman başka ne tür yöntemlere başvuruyorsunuz?

4a-Kızgınlık anında neler söylersiniz? Bazen anneler çok sinirlendiklerinde istemedikleri sözler söyleyebiyorlar sizin bu tür sözleriniz var mı? Nelerdir?

4b-Sözün bittiği yerde ne oluyor, söylediklerinizi işe yaramayınca ne oluyor?

5-Eşinizle ilişkiniz nasıldır anlatır mısınız (3-4 cümle)? Eşinizle ilişkinize 5 üzerinden puan verebilir misiniz?

6- Eşinizle aranızdaki anlaşmazlıklar genelde nasıl çözülür (sözel ve fiziksel şiddeti araştırılır) ? Bazen çiftler anlaşmazlıkları çözemediğinde birbirlerine seslerini yükseltebiliyor ya da fiziksel güçlerini kullanabiliyorlar sizin evinizde böyle şeyler oluyor mu?

APPENDIX C

ROSENBERG SELF-ESTEEM INVENTORY

Aşağıda, genel olarak kendinizle ilgili duygu ve düşüncelerinize yönelik 10 cümle verilmiştir. Lütfen her bir cümleyi dikkatlice okuyarak, sizin için ne kadar doğru olduğunu yandaki seçenekler üzerinde işaretleyiniz.

1. Kendimi en az diğer insanlar kadar değerli bulurum.	Çok Doğru ( )	Doğru ( )	Yanlış ( )	Çok Yanlış ( )
2. Bazı olumlu özelliklerimin olduğunu düşünüyorum.	Çok Doğru ( )	Doğru ( )	Yanlış ( )	Çok Yanlış ( )
3.Genelde kendimi başarısız bir kişi olarak görme eğilimindeyim.	Çok Doğru ( )	Doğru ( )	Yanlış ( )	Çok Yanlış ( )
4. Ben de diğer insanların birçoğunun yapabileceği kadar bir şeyler yapabilirim.	Çok Doğru ( )	Doğru ( )	Yanlış ( )	Çok Yanlış ( )
5. Kendimde gurur duyacak fazla bir şey bulamıyorum.	Çok Doğru ( )	Doğru ( )	Yanlış ( )	Çok Yanlış ( )
6. Kendime karsı olumlu bir tutum içindeyim.	Çok Doğru ( )	Doğru ( )	Yanlış ( )	Çok Yanlış ( )
7. Genel olarak kendimden memnunum.	Çok Doğru ( )	Doğru ( )	Yanlış ( )	Çok Yanlış ( )
8. Kendime karsı daha fazla saygı duyabilmeyi isterdim.	Çok Doğru ( )	Doğru ( )	Yanlış ( )	Çok Yanlış ( )
9. Bazen kendimin kesinlikle bir ise yaramadığını düşünüyorum.	Çok Doğru ( )	Doğru ( )	Yanlış ( )	Çok Yanlış ( )
10. Bazen kendimin hiç de yeterli bir insan olmadığını düşünüyorum.	Çok Doğru ( )	Doğru ( )	Yanlış ( )	Çok Yanlış ( )

Appendix D: Children's Depression Inventory

Asağıda gruplar halinde bazı cümleler yazılıdır. Her gruptaki cümleleri dikkatlice okuyunuz. Her grup için, bugün, dahil son iki hafta içinde size en uygun olun cümlenin yanındaki numarayı daire içine alınız.

Teşekkürler

A) 1- Kendimi arada sırada üzgün hissederim.
2- Kendimi sık sık üzgün hissederim.
3- Kendimi her zaman üzgün hissederim.

B) 1- İşlerim hiç bir zaman yolunda gitmeyecek.
2- İşlerimin yolunda gidip gitmeyeceğinden emin değilim.
3- İşlerim yolunda gidecek.

C) 1- İşlerimin çoğunu doğru yaparım.
2- İşlerimin çoğunu yanlış yaparım.
3- Hepsini yanlış yaparım.

D) 1- Birçok şeyden hoşlanırım.
2- Bazı şeylerden hoşlanırım.
3- Hiçbir şeyden hoşlanmam.

E) 1- Herzaman kötü bir çocuğum.
2- Çoğu zaman kötü bir çocuğum.
3- Arada sırada kötü bir çocuğum.

F) 1- Arada sırada başıma kötü birşeylerin geleceğini düşünürüm.
2- Sık sık başıma kötü birşeylerin geleceğinden endişelenirim.
3- Başıma çok kötü şeyler geleceğinden eminim.

G) 1- Kendimden nefret ederim.
2- Kendimi beğenmem.
3- Kendimi beğenirim.

H) 1- Bütün kötü şeyler benim hatam.
2- Kötü şeylerin bazıları benim hatam.
3- Kötü şeyler genellikle benim hatam değil.

I) 1- Kendimi öldürmeyi düşünmem.
2- Kendimi öldürmeyi düşünürüm ama yapmam.
3- Kendimi öldürmeyi düşünüyorum.

İ) 1- Hergün içimden ağlamak gelir.
2- Birçok günler içimden ağlamak gelir.
3. Arada sırada içimden ağlamak gelir.

J) 1- Herşey hergün beni sıkar.
2- Herşey sık sık beni sıkar.
3- Herşey arada sırada beni sıkar.

K) 1- İnsanlarla beraber olmaktan hoşlanırım.
2- Çoğu zaman insanlarla birlikte olmaktan hoşlanmam.
3- Hiçbir zaman insanlarla birlikte olmaktan hoşlanmam.

L) 1- Herhangi birşey hakkında karar verememem.
2- Herhangi birşey hakkında karar vermek zor gelir.
3- Herhangi birşey hakkında kolayca karar veririm.

M) 1- Güzel/yakışıklı sayılırım.
2- GüzeI/yakışıklı olmayan yanlarım var.
3- Çirkinim.

N) 1- Okul ödevlerimi yapmak için herzaman kendimi zorlarım.
2- Okul ödevlerimi yapmak için çoğu zaman kendimi zorlarım.
3- Okul ödevlerimi yapmak sorun degil.

O) 1- Her gece uyumakta zorluk çekerim.
2- Bir çok gece uyumakta zorluk çekerim.
3- Oldukça iyi uyurum.

Ö) 1- Arada sırada kendimi yorgun hissederim.
2- Bir çok gün kendimi yorgun hissederim.
3- Her zaman kendimi yorgun hissederim.

P) 1- Hemen hergün canım yemek yemek istemez.
2- Çoğu gün canım yemek yemek istemez.
3- Oldukça iyi yemek yerim.

R) 1- Ağrı ve sızılardan endişe etmem.
2- Çoğu zaman ağrı ve sızılardan endişe ederim.
3- Herzaman ağrı ve sızılardan endişe ederim.

S) 1-Kendimi yalız hissetmem.
2- Çoğu zaman kendimi yalnız hissederim.
3- Herzaman kendimi yalnız hissederim.

Ş) 1- Okuldan hiç hoşlanmam.
2- Arada sırada okuldan hoşlanırım.
3- Çoğu zaman okuldan hoşlanırım.

T) 1- Birçok arkadaşım var.
2- Birçok arkadaşım var ama daha fazla olmasını isterdim.
3- Hiç arkadaşım yok.

U) l-Okul başarım iyi.
2- Okul başarım eskisi kadar iyi değil.
3- Eskiden iyi olduğum derslerde çok başarısızım.

Ü) 1- Hiçbir zaman diğer çocuklar kadar iyi olamıyorum.
2- Eğer istersem diğer çocuklar kadar iyi olurum.
3- Diğer çocuklar kadar iyiyim.

V) 1- Kimse beni sevmez.
2- Beni seven insanların olup olmadığından emin değilim.
3- Beni seven insanların olduğundan eminim.

Y) 1- Bana söyleneni genellikle yaparım.
2- Bana söyleneni çogu zaman yaparım.
3- Bana söyleneni hiçbir zaman yapmam.

Z) 1- İnsanlarla iyi geçinirim.
2- İnsanlarla sık sık kavga ederim.
3- İnsanlarla her zaman kavga ederim.

APPENDIX E

Social Support Appraisals Scale for Children (APP)

Aşağıda çocuk ve gençlerin arkadaşları, aileleri ve öğretmenleriyle ilişkileri hakkında sorular bulunmaktadır. Aşağıdaki soruları dikkatlice okuyup, her bir soru için “her zaman”, “çoğu zaman”, “bazen”, “nadiren”, “hiçbir zaman” seçeneklerinden hangisi senin için doğruysa, o seçeneği işaretle. Lütfen hiç bir soruyu bos bırakma. Teşekkürler...

1. Bazı çocuklar arkadaşları tarafından dışlandıklarını hissederler, ama bazı çocuklar böyle hissetmezler. Sen, arkadaşların tarafından dışlandığını hisseder misin?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

2. Bazı çocuklar arkadaşları tarafından çok sevilir, ama bazı çocuklar o kadar sevilmezler. Sen, arkadaşların tarafından sevilir misin?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

3. Bazı çocukların arkadaşları onlara sataşır ya da takılır, ama bazı çocukların arkadaşları böyle yapmaz. Senin arkadaşların sana sataşır ya da takılırlar mı?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

4. Bazı çocukların arkadaşları, onlarla alay eder, ama bazı çocukların arkadaşları böyle yapmaz. Senin arkadaşların, seninle alay ederler mi?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

5. Bazı çocukların arkadaşları, onların düşüncelerini dinlemekten hoşlanırlar; ama bazı çocukların arkadaşları bundan hoşlanmaz. Arkadaşların, senin düşüncelerini dinlemekten hoşlanırlar mı?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

6. Bazı çocuklar ve arkadaşları, birbirleri için pek çok şey yaparlar; ama bazı çocuklar ve arkadaşları bunu yapmazlar. Sen ve arkadaşların birbiriniz için çok şey yapar mısınız?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

7. Bazı çocuklar kendilerini arkadaşlarına çok yakın hissederler; ama bazı çocuklar böyle hissetmez. Sen kendini arkadaşlarına çok yakın hisseder misin?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

8. Bazı çocuklar, sorunları olduğunda yardım ya da öneri almak için arkadaşlarına güvenebilir; ama bazı çocuklar arkadaşlarına güvenemez. Sen, sorunların olduğunda yardım ya da öneri almak arkadaşlarına güvenebilir misin?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

9. Bazı çocuklar arkadaşlarının, kendilerine gerçekten önem verdiği düşünürler; ama bazı çocuklar böyle düşünmezler. Sence, arkadaşların sana önem verir mi?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

10. Arkadaşları, bazı çocukların kendilerini kötü hissetmelerine neden olur; ama bazı çocukların arkadaşları bunu yapmaz. Senin arkadaşların, kendini kötü hissetmene neden olur mu?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

11. Bazı çocuklar, sorunları olduğunda yardım ya da öneri almak için ailelerine güvenebilir; ama bazı çocuklar ailelerine güvenemez. Sen, sorunların olduğunda yardım ya da öneri almak için ailene güvenebilir misin?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

12. Bazı çocuklar ve aileleri, birbirleri için pek çok şey yaparlar ama bazı çocuklar ve aileleri bunu yapmazlar. Sen ve ailen birbiriniz için çok şey yapar mısınız?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

13. Aileleri, bazı çocukların kendilerini kötü hissetmelerine neden olur; ama bazı çocukların aileleri bunu yapmaz. Senin ailen, kendini kötü hissetmene neden olur mu?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

14. Bazı çocuklar, aileleriyle çok şey paylaşırlar; ama bazı çocuklar paylaşmazlar. Sen ailenle çok şey paylaşır mısın?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

15. Bazı çocuklar, aileleriyle konuşmakta zorluk çekerler; ama bazı çocuklar zorluk çekmez. Sen, ailenle konuşmakta zorluk çeker misin?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

16. Bazı çocuklar, ihtiyaçları olduğunda, ailelerinin onların yanında olduğunu hissederler; ama bazı çocuklar böyle hissetmez. Sen, onlara ihtiyacın olduğunda, ailenin senin yanında olduğunu hisseder misin?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

17. Bazı çocuklar, aileleri tarafından dışlandıklarını hissederler; ama bazı çocuklar böyle hissetmez. Sen, ailen tarafından dışlandığını hisseder misin?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

18. Bazı aileler, çocuklarının düşüncelerini görmezden gelirler; ama bazı aileler böyle yapmaz. Ailen, senin düşüncelerini görmezden gelir mi?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

19. Bazı çocuklar aileleri içinde önemli bir yere sahiptir; ama bazı çocuklar böyle değildir. Sen, kendi ailen içinde önemli bir yere sahip misin?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

20. Bazı çocuklar, ailelerinin kendilerine gerçekten önem verdiğini düşünürler; ama bazı çocuklar, ailelerinin kendilerine gerçekten önem vermediğini düşünür. Sence, ailen sana önem verir mi?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

21. Bazı çocuklar, kendilerini ailelerinin bir parçası gibi hissederler; ama bazı çocuklar kendilerini ailelerinin bir parçası gibi hissetmezler. Sen kendini ailenin bir parçası gibi hisseder misin?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

22. Bazı çocuklar ailelerinin kendilerine kötü davrandığını düşünürler; ama bazı çocuklar böyle düşünmez. Sen, ailenin sana kötü davrandığını düşünür müsün?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

23. Bazı çocuklar, kendilerini sınıflarının bir parçası gibi hissederler; ama bazı çocuklar kendilerini sınıflarının bir parçası gibi hissetmezler. Sen kendini sınıfının bir parçası gibi hissediyor musun?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

24. Bazı çocuklar, sınıfları tarafından dışlandıklarını hissederler; ama bazı çocuklar böyle hissetmez. Sen, sınıfın tarafından dışlandığını hisseder misin?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

25. Bazı çocuklar, sınıflarında hiç kimsenin, kendilerine değer vermediğini hissederler; ama bazı çocuklar böyle hissetmez. Sen, sınıfında hiç kimsenin sana değer vermediğini hisseder misin?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

26. Bazı çocuklar, sınıf arkadaşları tarafından çok sevilir; ama bazı çocuklar o kadar sevilmez. Sen, sınıf arkadaşların tarafından çok sevilir misin?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

27. Bazı sınıflarda, çocuklar, birbirleri için pek çok şey yaparlar; ama bazı sınıflarda böyle olmaz. Senin sınıfında, çocuklar birbirleri için çok şey yaparlar mı?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

28. Bazı çocukların sınıf arkadaşları onlarla alay eder; ama bazı çocukların sınıf arkadaşları böyle yapmaz. Senin sınıf arkadaşların, seninle alay ederler mi?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

29. Bazı çocukların sınıf arkadaşları, sorunları olduğunda onlara yardım ederler; ama bazı çocukların sınıf arkadaşları etmez. Senin sınıf arkadaşların, sorunların olduğunda sana yardım ederler mi?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

30. Bazı çocukların sınıf arkadaşları, onlara sataşır ya da takılır; ama bazı çocukların sınıf arkadaşları böyle yapmaz. Senin sınıf arkadaşların sana sataşır ya da takılırlar mı?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

31. Sınıf arkadaşları, bazı çocukların kendilerini kötü hissetmelerine neden olur; ama bazı çocukların sınıf arkadaşları bunu yapmaz. Senin sınıf arkadaşların, kendini kötü hissetmene neden olur mu?

Her zaman	Çoğu zaman	Bazen	Nadiren (çok ender olarak)	Hiçbir zaman
( )	( )	( )	( )	( )

32. Bazı çocuklar kendilerini öğretmenlerine çok yakın hissederler; ama bazı çocuklar böyle hissetmez. Sen kendini öğretmenine çok yakın hisseder misin?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

33. Bazı öğretmenler, çocukların kendilerini yetersiz hissetmelerine neden olur; ama bazı öğretmenler buna neden olmaz. Senin öğretmenlerin, kendini yetersiz hissetmene neden olur mu?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

34. Bazı çocuklar, öğretmenleriyle konuşmakta zorluk çekerler; ama bazı çocuklar zorluk çekmez. Sen, öğretmenlerinle konuşmakta zorluk çeker misin?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

35. Bazı çocuklar, öğretmenlerinin kendilerine gerçekten önem verdiğini düşünürler; ama bazı çocuklar, öğretmenlerinin kendilerine gerçekten önem vermediğini düşünür. Sence, öğretmenlerin sana önem verir mi?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

36. Bazı öğretmenlerden, herhangi bir sorun hakkında rahatlıkla yardım ya da öneri istenebilir; ama bazı öğretmenlerden istenmez. Senin öğretmenlerinden, herhangi bir sorun olduğunda, rahatlıkla yardım ya da öneri istenebilir mi?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

37. Bazı çocukların öğretmenleri, onlara kötü davranır; ama bazı çocukların öğretmenleri böyle davranmaz. Senin öğretmenlerin sana karsı kötü davranır mı?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

38. Bazı öğretmenler, öğrencilerine kendilerini önemli hissettirir; ama bazı öğretmenler böyle hissettirmez. Senin öğretmenlerin, sana kendini önemli hissettirir mi?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

39. Bazı öğretmenler, öğrencilerin kendilerini kötü hissetmesine neden olur; ama bazı öğretmenler buna neden olmaz. Senin öğretmenlerin, senin kendini kötü hissetmene neden olur mu?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

40. Bazı öğretmenler, öğrencilerine özel görevler verirler; ama bazı öğretmenler bunu yapmaz. Senin öğretmenlerin, sana özel görevler verirler mi?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

41. Bazı öğretmenler, öğrencilerin kendilerini tedirgin (huzursuz) hissetmelerine neden olur; ama bazı öğretmenler buna neden olmaz. Senin öğretmenlerin, senin kendini tedirgin (huzursuz) hissetmene neden olurlar mı?

Her zaman ( )	Çoğu zaman ( )	Bazen ( )	Nadiren (çok ender olarak) ( )	Hiçbir zaman ( )

APPENDIX F

Recognition of Emotional Maltreatment Scale (REMS)

Aşağıda, çocuk eğitimi ve disiplini ile ilgili öyküler yer almaktadır. Sizden, her bir öyküde belirtilen ana ya da baba davranışını değerlendirmeniz beklenmektedir. Öyküde belirtilen ana-baba davranışının, çocuğun ruhsal gelişimi açısından yararlı sonuçlar sağlayabileceğini düşünüyorsanız "uygun" ya da "kesinlikle uygun" seçeneklerinden birini işaretleyiniz. Buna karşın, ana-baba davranışının çocuğun ruhsal gelişimi açısından işe yaramayacağını ya da çocuğa zarar verebileceğini düşünüyorsanız "uygun değil" ya da "kesinlikle uygun değil" seçeneklerinden birini işaretleyiniz.

		Kesinlikle uygun değil	Uygun değil	Uygun	Kesinlikle uygun
1	Üç yaşındaki Ayşe annesinin sözünü dinlemeyip koşunca düştü. Ağlayarak annesine sarılmak istedi. Annesi ders olsun diye Ayşe'nin kendisine sarılmasına izin vermedi ve kızgınlığını belli etti. Koltukta oturup yanlış hareketini düşünmesini söyledi.	1	2	3	4
2	Mehtap 10 yaşındaydı ve 6 yaşındaki kardeşini çok kıskanıyordu. Kardeşi onu kızdırdığında "salak şişko" diye bağırdı. Tartışma büyüyünce babaları "Benim kafam şişti. İçeriye gidin, kozunuzu orada paylaşın, kavganız bitince çıkarsınız" diyerek ikisini birden odalarına gönderdi.	1	2	3	4
3	Sekiz yaşındaki Ali top oynamaya çok düşkündü. Annes hava kararmadan eve gelmesini söylemişti. Hava karardığı halde Ali eve gelmeyince annesi çok merak etti. Eve bir saat geç gelen Ali'ye küstü, konuşmadı Daha sonra eve gelen eşine durumu anlatırken "Hak etmişti" dedi.	1	2	3	4
4	İki yaşındaki Filiz iştahsızdı ve yemek yememek için inatlaşıyordu. Annesi doğru dürüst beslenmezse hastalanacağından korkuyordu. Ağzına verilen kaşığı reddettiği zaman annesi "Yemezsen giderim bak!" dediğinde Filiz'in o lokmayı kabul ettiğini gördü.	1	2	3	4
5	Yedi yaşındaki Özge, annesi-babası ve akrabalarıyla pikniğe gittiğinde ağaca çıkan diğer çocuklara özenip kendisi de tırmanmak istedi. Babası ise, düşeceğinden korkup "düşersen bacağın kırılır, hastanede iğne yaparlar, piknikte top oynanır" diyerek izin vermedi.	1	2	3	4
6	Can iki yaşına geldiğinde yemeğini kendisi yemek istedi. Yeterince beslenemediği ve döküp saçtığı için annesi onu kendisi doyurmayı tercih etti.	1	2	3	4
7	Batuhan 8 yaşındaydı ve bahçede oynamayı çok severdi. Tuvaleti geldiğinde oyunu bırakıp tuvalete gitmek istemedi. Çişini kaçırdığında annesi pek üzerinde durmadı ve "Gelecek sefere tuvalete yetişmeye çalış" diyerek üstünü değiştirdi.	1	2	3	4

		Kesinlikle uygun değil	Uygun değil	Uygun	Kesinlikle uygun
8	On iki yaşındaki Sedat'ın dersleri iyi gitmiyordu. Babası, ders çalışmasını sağlamak için ona aileyi geçindirmek için çektiği sıkıntıları anlattı. Sonra sakince, ondan beklenen tek şeyin ders çalışmak olduğunu ve bunca özveriye layık olabilmesi için notlarını düzeltmesi gerektiğini söyledi.	1	2	3	4
9	On üç yaşındaki Merve matematik dersinde sınav notunu 2'den 4'e çıkardığında annesi pek memnun olmuş görünmedi. Annesi Merve'nin istese daha iyisini yapabileceğini biliyordu ve 4'ü yeterli görmesini istemedi. Annesine göre dersini tam öğrenmek Merve'nin göreviydi zaten.	1	2	3	4
10	Nilsu 3 yaşına basmasına rağmen, artık iyice eskimiş-yıpranmış olan bebeğini gittiği her yere taşıyordu. Babası Nilsu'nun eski-püskü bebeğini her yere taşınmasına izin verdi.	1	2	3	4
11	Mehmet, 10 yaşındaydı. Yaşıtı olan kuzeni Can çok sakin ve söz dinleyen bir çocuktu. Annesi ve babası, haşarı Mehmet'in kendilerini utandıran davranışları karşısında içlerinden "Keşke Can gibi davranabilse bazen…" diye geçirdiler. Bu duygularını Mehmet'e hiç belli etmedilerse de, bazen Can'ı ona örnek gösterdikleri oldu.	1	2	3	4
12	Babası 4 yaşındaki Fatih'e vurmazdı. Çok hareketli bir çocuk olan Fatih çok kızdırdığında onu "bacaklarını kırmak" ya da "kulaklarından tavana asmak" ile tehdit ettiği oldu ama Fatih bunları hiç ciddiye almadı.	1	2	3	4
13	Altı yaşındaki Aydın'ın annesiyle babası kavga ediyorlardı. Bir ara annesi aniden pencereyi açtı ve babasına "Daha fazla üzerime gelirsen atarım kendimi!" diye bağırdı.	1	2	3	4
14	Annesi 5 yaşındaki Selin'i doktora götürecekti. Evden çıkmadan önce onunla konuşarak, muayene sırasında sakin ve sessiz olması, hiç ağlamaması ve doktor ne derse yapması gerektiğini anlattı.	1	2	3	4
15	On iki yaşındaki Cihan araba kullanmaya çok hevesliydi. Bu konuda yetenekli olduğunu düşünen babası, yolda kimse yokken Cihan'ın arabayı kullanmasına izin verdi.	1	2	3	4
16	Annesi ve babası, 9 yaşındaki Murat'ın çekingen bir çocuk olmasına üzülüyorlardı. Arkadaşları tarafından ezilmesini istemedikleri için, eve hırpalanarak geldiğinde ona "Bir daha o çocuk sana vurursa, sen de ona vur." diyerek kendini savunmasını önerdiler.	1	2	3	4
17	Aşırı hareketli bir çocuk olan 2 yaşındaki Alper, gittiği her yerde çevresindekilerin olumsuz eleştirilerine maruz kalıyordu. Bu nedenle annesi, Alper'i uzun süre sakin kalması beklenen ortamlara götürmedi.	1	2	3	4

		Kesinlikle uygun değil	Uygun değil	Uygun	Kesinlikle uygun
18	Üç yaşındaki Sevgi'nin babası eve geldiğinde çok yorgundu. Biraz televizyon izlemek ve gazetesini okumak istiyordu. Yemekten sonra Sevgi üzerine tırmanıp oynamak istediğinde "Biraz kendini oyalamayı öğrensin. Sürekli birilerinden ilgi beklemesin." diye düşünerek onun davranışlarına tepki vermedi.	1	2	3	4
19	Anıl oldukça başarılı 7. sınıf öğrencisiydi. Bundan gurur duyan anne ve babası Anadolu Lisesine girmesini çok istiyorlardı. Okul sonrası ve hafta sonları dershaneye giden Anıl'ın evde test çözebilmesi için sınava kadar arkadaşlarıyla futbol oynamamasına karar verdiler.	1	2	3	4
20	Bartu 4 yaşındayken her şeyi abartarak anlatmayı çok severdi. Bir gün yine oynadığı maçta 30 gol attığını söylediğinde, annesi "Arkadaşlarınla ne güzel oynuyorsun" dedi ve doğruyu söylemesi için O'nu uyarmadı.	1	2	3	4
21	Seda 2 yaşındayken kardeşi doğdu. Annesi çok meşguldü ve çabuk yoruluyordu. Seda'yı sağlık kontrollerine götüremediği için aşıları eksik kaldı.	1	2	3	4
22	Tolga 13 yaşında okul başarısızlığı olan bir çocuktu. İlköğretimi bitirdiğinde ailesi parasal güçlükleri de olduğu için Tolga'nın liseye devam etmeyip bir işe girmesini sağladılar.	1	2	3	4
23	Sekiz yaşındaki Tahir'in annesi ve babası sık sık kavga ederlerdi. Bir tartışma sırasında odasına gönderilen Tahir annesine bir zarar geleceğinden korktuğu için odasından çıkıp annesiyle babasını ayırmaya çalıştı. Tartışma alevlenince babası bazen dayanamayıp annesine vurdu, sonra da özür diledi.	1	2	3	4
24	Ferah 4 yaşındayken bazen oyuna dalıp kakasını tutuyor, sonra da dayanamayıp kaçırıyordu. Çamaşır yıkamaktan bıkan annesi, Ferah kakasını kaçırdığında bir daha tekrarlamasın diye poposuna vurdu.	1	2	3	4
25	Ertan 9 yaşında, çok hareketli ve sakar bir çocuktu. Laftan sözden anlamadığı için yaramazlıklarını durdurmak amacıyla babası bir gün onu terlikle dövdü.	1	2	3	4
26	Tülay 7 yaşında, oldukça mızmız bir çocuktu. İsteklerini ağlayarak elde etmeye çalışırdı. Annesinin çabaları Tülay'ı bu huyundan vazgeçirmeye yetmemişti. Oldukça sessiz ve sabırlı bir kişi olan babası bağırdı ve Tülay ancak o zaman ağlamasını durdurabildi.	1	2	3	4

APPENDIX G
Adult ADD/ADHD DSM-IV based diagnostic screening and rating scale

Adınız, Soyadınız:
Tarih:
Yaşınız:
Cinsiyetiniz:
Halen kullandığınız ilaçlar:
Daha önce aldığınız ilaçlar:

Yukarıdaki bölümü tamamladıktan sonra, aşağıdaki cümleleri dikkatle okuyun ve şu anki durumunuzu en iyi ifade eden rakamı işaretleyin. Dikkatli ve dürüst yanıtlarınızla teşhisinizin güvenilirliği artacak ve sorunlarınızın şiddeti ve doğası hakkında temel verileri elde edeceğiz
Anlamadığınız sorular olursa size bu soru formunu veren hekime danışabilirsiniz.
Bu soru formu aynı zamanda tedavinin sonuçları ve gidişi hakkında nesnel karşılaştırma yapma olanağı sunacaktır.
İşbirliğiniz için teşekkür ederiz.

Bu formun kullanım hakları Entegratif Terapi Enstitüsü (ITI)' ne aittir. Yazarın ya da enstitünün yazılı izni olmadan kullanılamaz.

Kullanım izni için : Dr. Atilla Turgay,Clinical Director, Scarborough General Hospital ADHD Clinic, Department of Mental Health Services, 3040 Lawrence East, Scarborough, Ontario, Kanada M1P 2V5.

1.BÖLÜM

Sorun	**Sorunun şiddeti ve sıklığı**			
	Hemen hiç	Biraz ya da bazan	Sıklıkla	Çok sık
1. Ayrıntılara dikkat etmekte zorluk ya da okul, iş ve diğer etkinliklerde dikkatsizce hatalar yapma	0	1	2	3
2. Dikkat gerektiren görevler ya da işlerde dikkati sürdürme güçlüğü	0	1	2	3
3. Birisiyle yüzyüze konuşurken dinlemede güçlük çekme	0	1	2	3
4. Okul ödevlerini ya da iş yerinde verilen görevleri bitirmekte zorlanma, verilen yönergeleri izlemekte zorluk çekme (yönergeleri anlama güçlüğüne ya da inatlaşmaya bağlı değildir)	0	1	2	3
5. Görevleri ve etkinlikleri düzenleme/ organize etme güçlüğü	0	1	2	3
6. Uzun zihinsel çaba gerektiren işlerden kaçınma, bu işlerden hoşlanmama ya da bu işlere karşı isteksizlik	0	1	2	3
7. Görev ve etkinlikler için gereken eşyaları kaybetme (örneğin: oyuncak, okul ödevleri, kalem, kitap ya da araç gereç)	0	1	2	3
8. Dikkatin kolayca dağılması	0	1	2	3
9. Günlük etkinliklerde unutkanlık	0	1	2	3

Klinisyenin yanıtlayacağı bölüm
1.bölümde karşılanan kriter sayısı:
1. bölümden elde edilen DEHB puanı:

	Sorunun şiddeti ve sıklığı			
	Hemen hiç	Biraz ya da bazan	Sıklıkla	Çok sık
1. El ve ayakların kıpır kıpır olması, oturduğu yerde duramama	0	1	2	3
2. Oturulması gereken durumlarda yerinden kalkma	0	1	2	3
3. Koşuşturup durma ya da huzursuzluk hissi	0	1	2	3
4. Boş zaman faaliyetlerini sessizce yapmakta güçlük	0	1	2	3
5. Sürekli hareket halinde olma ya da sanki motor takılıymış gibi hareket etme	0	1	2	3
6. Çok konuşma	0	1	2	3
b) Dürtüsellik				
7. Sorulan soru tamamlanmadan yanıt verme	0	1	2	3
8. Sıra beklemekte zorluk çekme	0	1	2	3
9. Başkalarının işine karışma ya da konuşmalarını bölme	0	1	2	3

Klinisyenin yanıtlayacağı bölüm
2.bölümde karşılanan kriter sayısı:
2. bölümden elde edilen DEHB puanı (Aşırı hareketlilik/dürtüsellik):

1. ve 2.bölümlerde karşılanan kriter sayısı:
1.ve 2.bölümlerde elde edilen toplam DEHB puanı:

3. BÖLÜM
DEB/DEHB ile ilişkili özellikler

Sorun	Sorunun şiddeti ve sıklığı			
	Hemen hiç	Biraz ya da bazan	Sıklıkla	Çok sık
1. Hedeflerine ulaşamama ve başarısızlık hissi	0	1	2	3
2. Başlanan bir işi bitirememe ya da işe başlama güçlüğü	0	1	2	3
3. Aynı anda pek çok işle/projeyle uğraşma; bu işleri takipte ve tamamlamakta güçlük	0	1	2	3
4. Zamanı ve yeri uygun olmasa da aklına geleni o anda söyleme eğilimi	0	1	2	3
5. Sık sık büyük heyecanlar peşinde koşma	0	1	2	3
6. Sıkılmaya tahammül edememe	0	1	2	3
7. Herkez tarafından izlenen yolları ve kuralları uygulamamak	0	1	2	3
8. Sabırsızlık; engellenme eşiğinin düşük olması	0	1	2	3
9. Dürtüsellik (düşünmeden hareket etme)	0	1	2	3
10. Kendini güvensiz hissetme	0	1	2	3
11. Duygu durumda sık görülen oynamalar	0	1	2	3
12. Aniden parlama, tepki gösterme	0	1	2	3
13. Düşük benlik değeri	0	1	2	3
14. Parmaklarla tempo tutma, ayak sallama ya da ayak vurma	0	1	2	3
15. Sık sık iş değiştirme	0	1	2	3

16. Strese karşı aşırı duyarlılık, dayanamama	0	1	2	3
17. Zamanı ayarlamakta güçlük	0	1	2	3
18. Unutkanlık	0	1	2	3
19. Sözel saldırganlık	0	1	2	3
20. Fiziksel saldırganlık	0	1	2	3
21. Alkol kullanımı	0	1	2	3
22. Madde kullanımı	0	1	2	3
23. Yasal güçlük ve sorunlar	0	1	2	3
24. Çökkünlük (depresyon)	0	1	2	3
25. Kendine zarar verecek davranışlarda bulunma	0	1	2	3
26. Sebepsiz yere sinirli ve gergin olma (kaygı)	0	1	2	3
27. İşinden zevk alamama	0	1	2	3
28. Hayal kırıklığı ve cesaretsizlik hissi	0	1	2	3
29. Uzun süredir devam eden mutsuzluk hissi	0	1	2	3
30. Kapasitesiyle uyumlu bir düzeye ulaşamama	0	1	2	3

Klinisyenin yanıtlayacağı bölüm:

3.bölümde karşılanan kriter sayısı:
3. bölümden elde edilen DEHB puanı (Aşırı hareketlilik/dürtüsellik):

1. ve 2.bölümlerde karşılanan kriter sayısı + 3. bölümdeki pozitif semptom sayısı:
1., 2.ve 3. bölümlerden elde edilen toplam DEHB puanı:

APPENDIX H

CONNER'S PARENT RATING FORM

	Hiçbir Zaman	Nadiren	Sıklıkla	Her Zaman
1. Eli boş durmaz, sürekli birşeylerle oynar. (Tırnak, parmak, giysi gibi)	( )	( )	( )	( )
2. Büyüklere arsız ve küstah davranır.	( )	( )	( )	( )
3. Arkadaşlık kurmada ve sürdürmede zorlanır.	( )	( )	( )	( )
4. Çabuk heyecanlanır, ataktır.	( )	( )	( )	( )
5. Herşeye karışır ve yönetmek ister.	( )	( )	( )	( )
6. Birşeyler çiğner veya emer (parmak, giysi, örtü gibi)	( )	( )	( )	( )
7. Sık sık ve kolayca ağlar.	( )	( )	( )	( )
8. Her an sataşmaya hazırdır.	( )	( )	( )	( )
9. Hayallere dalar.	( )	( )	( )	( )
10. Zor öğrenir.	( )	( )	( )	( )
11. Kıpır kıpırdır, tez canlıdır.	( )	( )	( )	( )
12. Ürkektir (yeni durum, insan ve yerlerden)	( )	( )	( )	( )
13. Yerinde duramaz, her an harekete hazırdır.	( )	( )	( )	( )
14. Zarar verir.	( )	( )	( )	( )
15. Yalan söyler, masallar uydurur.	( )	( )	( )	( )
16. Utangaçtır.	( )	( )	( )	( )
17. Yaşıtlarından daha sık başını derde sokar.	( )	( )	( )	( )
18. Yaşıtlarından farklı konuşur (çocuksu konuşma, kekeleme, zor anlaşılma gibi)	( )	( )	( )	( )
19. Hatalarını kabullenmez, başkalarını suçlar.	( )	( )	( )	( )
20. Kavgacıdır.	( )	( )	( )	( )
21. Somurtkan ve asık suratlıdır.	( )	( )	( )	( )
22. Çalma huyu vardır.	( )	( )	( )	( )
23. Söz dinlemez ya da isteksiz ve zorla dinler.	( )	( )	( )	( )
24. Başkalarına göre endişelidir (Yalnız kalma, hastalanma, ölüm konusunda)	( )	( )	( )	( )
25. Başladığı işin sonunu getiremez.	( )	( )	( )	( )
26. Hassastır, kolay incinir.	( )	( )	( )	( )
27. Kabadayılık taslar, başkalarını rahatsız eder.	( )	( )	( )	( )
28. Tekrarlayıcı, durduramadığı hareketleri vardır.	( )	( )	( )	( )
29. Kaba ve acımasızdır.	( )	( )	( )	( )
30. Yaşına göre daha çocuksudur.	( )	( )	( )	( )
31. Dikkati kolay dağılır ya da uzun süre dikkatini toplayamaz.	( )	( )	( )	( )
32. Baş ağrıları olur.	( )	( )	( )	( )
33. Ruh halinde ani ve göze batan değişiklikler olur.	( )	( )	( )	( )
34. Kurallar ve kısıtlamalardan hoşlanmaz ve uymaz.	( )	( )	( )	( )
35. Sürekli kavga eder.	( )	( )	( )	( )
36. Kardeşleriyle iyi geçinemez.	( )	( )	( )	( )
37. Zora gelemez.	( )	( )	( )	( )
38. Diğer çocukları rahatsız eder.	( )	( )	( )	( )
39. Genelde hoşnutsuz bir çocuktur.	( )	( )	( )	( )
40. Yeme sorunları vardır (iştahsızdır, yemek sırasında sofradan sık sık kalkar)	( )	( )	( )	( )
41. Karın ağrıları olur.	( )	( )	( )	( )
42. Uyku sorunları vardır (uykuya kolay dalamaz, geceleri kalkar, çok erken uyanır)	( )	( )	( )	( )
43. Çeşitli ağrı ve sancıları olur.	( )	( )	( )	( )
44. Bulantı kusmaları olur.	( )	( )	( )	( )
45. Aile içinde daha az kayrıldığını düşünür.	( )	( )	( )	( )
46. Övünür, böbürlenir.	( )	( )	( )	( )
47. İtilip kakılmaya müsaittir.	( )	( )	( )	( )
48. Dışkılaşma sorunları vardır (sık ishaller, kabızlık ve düzensiz tuvalet alışkanlığı gibi).	( )	( )	( )	( )

APPENDIX I

Survey of Standarts for Discipline (Disiplin Stilleri Anketi)

Aşağıdaki durumlar için düşündüğünüzü anlatan bir şıkkı belirtiniz.

1. disiplin olarak kabul ediyorum.
2. disiplin olarak kabul etmiyorum,
3. disiplin olarak kabul etmiyorum. Bu davranış, çocuk istismarı olarak yetkililere bildirilmelidir.

	Disiplin olarak kabul ediyorum	Disiplin olarak kabul etmiyorum	Disiplin olarak kabul etmiyorum. Bu davranış, çocuk istismarı olarak yetkililere bildirilmelidir.
İz bırakmayacak şekilde..... vurmak	1	(2)	3

Örnek:

	Disiplin olarak kabul ediyorum	Disiplin olarak kabul etmiyorum	Disiplin olarak kabul etmiyorum. Bu davranış, çocuk istismarı olarak yetkililere bildirilmelidir.
1. Sosyal aktiviteleri yasaklamak.	1	2	3
2. İz kalmayacak şekilde poposuna kemerle birkaç kez vurmak	1	2	3
3. Aydınlık bir odada 15 dakika kapalı (kilitli) tutmak.	1	2	3
4. Vurup kemiklerini kırmak.	1	2	3
5. Yüzünde kızarıklık bırakacak şekilde tokat atmak.	1	2	3
6. İz bırakacak şekilde popoya birkaç kez kemerle vurmak.	1	2	3
7. Kızarıklık oluşturacak kadar yakmak (su veya sıcak bir cisimle),.	1	2	3
8. Popoya, iz kalmayacak şekilde birkaç kez el i!e vurmak.	1	2	3
9. Popoya, kızarıklık oluşturacak şiddette birkaç kez el ile vurmak.	1	2	3
10. Tekmelemek.	1	2	3
11. Popoya bir kaç kez belirgin kırmızılık bırakacak şekilde kemerle vurmak	1	2	3
12. Aydınlık odada 1 saat süreyle kilitli tutmak	1	2	3
13. Morluk bırakacak şekilde kemer dışında başka bir şeyle poposuna birkaç kez vurmak	1	2	3

	Disiplin olarak kabul ediyorum	Disiplin olarak kabul etmiyorum	Disiplin olarak kabul etmiyorum. Bu davranış, çocuk istismarı olarak yetkililere bildirilmelidir.
14. Kızarıklık kalmayacak şekilde yüzüne, tokat atmak.	1	2	3
15. Bilinç kaybı ve yara-bere oluşturacak şekilde kafaya vurmak.	1	2	3
16. Çocuğu bağlayarak hareketlerini kısıtlamaya çalışmak.	1	2	3
17. Aydınlık bir odada tüm gün kapalı tutmak.	1	2	3
18. Yumrukla vurmak	1	2	3
19. Sigara yakmak	1	2	3
20. Akşam yemeğini vermeden yatağa göndermek	1	2	3
21. Kolunu acıtacak şekilde sıkmak	1	2	3
22. Bereler bırakacak şekilde poposuna birkaç kez açık elle vurmak.	1	2	3
23. Çocuğu birkaç kez kollarından tutarak sarsmak.	1	2	3
24. Eline, geçici kızarıklık bırakacak şekilde birkaç kez elle vurmak.	1	2	3
25. Eline, ezikler bereler bırakacak şekilde birkaç kez elle vurmak.	1	2	3
26. Eline geçici kızarıklık bırakacak şekilde birkaç kez bir cisimle vurmak	1	2	3
27. Eline ezikler bereler bırakacak şekilde birkaç kez bir cisimle vurmak	1	2	3
28. Beş dakika köşede ayakta tutmak.	1	2	3
29. Okul sonrası aktivitelere izin vermemek.	1	2	3
30. TV seyretmesine izin vermemek	1	2	3
31. Çocuğa bağırmamak	1	2	3
32. Çocuğa lanet etmek, beddua etmek, hakaret etmek.	1	2	3
33. Karanlık odaya kilitlemek	1	2	3
34. Elinden yiyeceğini almak, yemeklerden uzak tutmak.	1	2	3
35. Bir saat boyunca eve almamak	1	2	3
36. Basit ev işleri vermek	1	2	3

	Disiplin olarak kabul ediyorum	Disiplin olarak kabul etmiyorum	Disiplin olarak kabul etmiyorum. Bu davranış, çocuk istismarı olarak yetkililere bildirilmelidir.
37. Elinden şekerini veya sevdiği bir şeyi almak	1	2	3
38. Para cezası vermek.	1	2	3
39. Bir kaç saat köşede ayakta tutmak.	1	2	3
40. Ağır ev işleri vermek.	1	2	3
41. Eline, iz bırakmayacak şekilde elle vurmak	1	2	3
42. Çocuğu duvara doğru itmek, çarpmak	1	2	3
43. Çocuğu çimdiklemek	1	2	3

APPENDIX J-1

State -Trait Anxiety Inventory-Trait Form

Aşağıda kişilerin kendilerine ait duygularını anlatmada kullandıkları bir takım ifadeler verilmiştir. Her ifadeyi dikkatlice okuyun, sonra da o anda **nasıl hissettiğinizi, ifadelerin sağ tarafındaki rakamlardan uygun olanını işaretlemek suretiyle belirtin. Doğru yada yanlış cevap yoktur. Herhangi bir ifadenin üzerinde fazla zaman sarf etmeksizin,** şu anda **nasıl hissettiğinizi gösteren cevabı işaretleyin.**

	Hiç	Biraz	Çok	Tamamiyle
1. Şu anda sakinim.	1	2	3	4
2. Kendimi emniyette hissediyorum.	1	2	3	4
3. Şu anda sinirlerim gergin.	1	2	3	4
4. Pişmanlık duygusu içindeyim.	1	2	3	4
5. Şu anda huzur içindeyim.	1	2	3	4
6. Şu anda hiç keyfim yok.	1	2	3	4
7. Başıma geleceklerden endişe ediyorum.	1	2	3	4
8. Kendimi dinlenmiş hissediyorum.	1	2	3	4
9. Şu anda kaygılıyım.	1	2	3	4
10. Kendimi rahat hissediyorum.	1	2	3	4
11. Kendime güvenim var.	1	2	3	4
12. Şu anda asabım bozuk.	1	2	3	4
13. Çok sinirliyim.	1	2	3	4
14. Sinirlerimin çok gergin olduğunu hissediyorum.	1	2	3	4
15. Kendimi rahatlamış hissediyorum.	1	2	3	4
16. Şu anda halimden memnunum.	1	2	3	4
17. Şu anda endişeliyim.	1	2	3	4
18. Heyecandan kendimi şaşkına dönmüş hissediyorum.	1	2	3	4
19. Şu anda sevinçliyim.	1	2	3	4
20. Şu anda keyfim yerinde.	1	2	3	4

APPENDIX J-2

State -Trait Anxiety Inventory-Trait Form

Aşağıda kişilerin kendilerine ait duygularını anlatmada kullandıkları bir takım ifadeler verilmiştir. Her ifadeyi dikkatlice okuyun, sonra da **genel olarak** nasıl hissettiğinizi, ifadelerin sağ tarafındaki rakamlardan uygun olanını işaretlemek suretiyle belirtin. Doğru yada yanlış cevap yoktur. Herhangi bir ifadenin üzerinde fazla zaman sarf etmeksizin, **genel olarak** nasıl hissettiğinizi gösteren cevabı işaretleyin.

	Hiç	Biraz	Çok	Tamamiyle
1. Genellikle keyfim yerindedir.	1	2	3	4
2. Genellikle çabuk yorulurum.	1	2	3	4
3. Genellikle kolay ağlarım.	1	2	3	4
4. Başkaları kadar mutlu olmak isterim.	1	2	3	4
5. Çabuk karar veremediğim için fırsatları kaçırırım.	1	2	3	4
6. Kendimi dinlenmiş hissederim.	1	2	3	4
7. Genellikle sakin, kendime hakim ve soğukkanlıyım.	1	2	3	4
8. Güçlüklerin yenemeyeceğim kadar biriktiğini hissederim.	1	2	3	4
9.Önemsiz şeyler hakkında endişelenirim.	1	2	3	4
10. Genellikle mutluyum.	1	2	3	4
11. Her şeyi ciddiye alır ve etkilenirim.	1	2	3	4
12. Genellikle kendime güvenim yoktur.	1	2	3	4
13. Genellikle kendimi emniyette hissederim.	1	2	3	4
14. Sıkıntılı ve güç durumlarla karşılaşmaktan kaçınırım.	1	2	3	4
15. Genellikle kendimi hüzünlü hissederim.	1	2	3	4
16. Genellikle hayatımdan memnunumum.	1	2	3	4
17. Olur olmaz düşünceler beni rahatsız eder.	1	2	3	4
18. Hayal kırıklıklarını öylesine ciddiye alırım ki hiç unutmam.	1	2	3	4
19. Aklı başında ve kararlı bir insanım.	1	2	3	4
20. Son zamanlarda kafama takılan konular beni tedirgin eder.	1	2	3	4

APPENDIX K

BECK DEPRESSION INVENTORY

Aşağıda kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde, bir çeşit ruh durumunu anlatmaktadır. Her maddeye o ruh durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatle okuyunuz. Son iki hafta içindeki (şu an dahil) kendi ruh durumunuzu göz önünde bulundurarak, size en uygun olan ifadeyi bulunuz. Daha sonra, o maddenin yanındaki harfi işaretleyiniz.

1. (a) Kendimi üzgün hissetmiyorum.
   (b) Kendimi üzgün hissediyorum.
   (c) Her zaman için üzgünüm ve kendimi bu duygudan kurtaramıyorum.
   (d) Öylesine üzgün ve mutsuzum ki dayanamıyorum.

2. (a) Gelecekten umutsuz değilim.
   (b) Geleceğe biraz umutsuz bakıyorum.
   (c) Gelecekten beklediğim hiçbirşey yok.
   (d) Benim için bir gelecek yok ve bu durum düzelmeyecek.

3. (a) Kendimi başarısız görmüyorum.
   (b) Çevremdeki birçok kişiden daha fazla başarısızlıklarım oldu sayılır.
   (c) Geriye dönüp baktığımda, çok fazla başarısızlığımın olduğunu görüyorum.
   (d) Kendimi tümüyle başarısız bir insan olarak görüyorum.

4. (a) Herşeyden eskisi kadar zevk alabiliyorum.
   (b) Herşeyden eskisi kadar zevk alamıyorum.
   (c) Artık hiçbirşeyden gerçek bir zevk alamıyorum.
   (d) Bana zevk veren hiçbirşey yok. Herşey çok sıkıcı.

5. (a) Kendimi suçlu hissetmiyorum.
   (b) Arada bir kendimi suçlu hissettiğim oluyor.
   (c) Kendimi çoğunlukla suçlu hissediyorum.
   (d) Kendimi her an için suçlu hissediyorum.

6. (a) Cezalandırıldığımı düşünmüyorum.
   (b) Bazı şeyler için cezalandırılabileceğimi hissediyorum.
   (c) Cezalandırılmayı bekliyorum.
   (d) Cezalandırıldığımı hissediyorum.

7. (a) Kendimden hoşnutum.
   (b) Kendimden pek hoşnut değilim.
   (c) Kendimden hiç hoşlanmıyorum.
   (d) Kendimden nefret ediyorum.

8. (a) Kendimi diğer insanlardan daha kötü görmüyorum.
   (b) Kendimi zayıfliklarım ve hatalarım için eleştiriyorum.
   (c) Kendimi hatalarım için çoğu zaman suçluyorum.
   (d) Her kötü olayda kendimi suçluyorum.

9. (a) Kendimi öldürmek gibi düşüncelerim yok.
   (b) Bazen kendimi öldürmeyi düşünüyorum, fakat bunu yapamam.
   (c) Kendimi öldürebilmeyi isterdim.
   (d) Bir firsatını bulsam kendimi öldürürdüm.

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

11. (a) Her zamankinden daha sinirli değilim.
    (b) Her zamankinden daha kolayca sinirleniyor ve kızıyorum.
    (c) Çoğu zaman sinirliyim.
    (d) Eskiden sinirlendiğim şeylere bile artık sinirlenemiyorum.

12. (a) Diğer insanlara karşı ilgimi kaybetmedim.
    (b) Eskisine göre insanlarla daha az ilgiliyim.
    (c) Diğer insanlara karşı ilgimin çoğunu kaybettim.
    (d) Diğer insanlara karşı hiç ilgim kalmadı.

13. (a) Kararlarımı eskisi kadar kolay ve rahat verebiliyorum.
    (b) Şu sıralarda kararlarımı vermeyi erteliyorum.
    (c) Kararlarımı vermekte oldukça güçlük çekiyorum.
    (d) Artık hiç karar veremiyorum.

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

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

16. (a) Eskisi kadar rahat uyuyabiliyorum.
    (b) Şu sıralarda eskisi kadar rahat uyuyamıyorum.
    (c) Eskisine göre 1 veya 2 saat erken uyanıyor ve tekrar uyumakta zorluk çekiyorum.
    (d) Eskisine göre çok erken uyanıyor ve tekrar uyuyamıyorum.

17. (a) Eskisine kıyasla daha çabuk yorulduğumu sanmıyorum.
    (b) Eskisinden daha çabuk yoruluyorum.
    (c) Şu sıralarda neredeyse herşey beni yoruyor.
    (d) Öyle yorgunum ki hiçbirşey yapamıyorum.

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

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

- Daha az yemeye çalışarak kilo kaybetmeye çalışıyor musunuz? EVET ( ) HAYIR ( )

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

21. (a) Son zamanlarda cinsel yaşantımda dikkatimi çeken birşey yok.
    (b) Eskisine oranla cinsel konularda daha az ilgiliyim.
    (c) Şu sıralarda cinsellikle pek ilgili değilim.
    (d) Artık, cinsellikle hiçbir ilgim kalmadı.

APPENDIX L

TURKISH WAYS OF COPING INVENTORY

AÇIKLAMA

Bir genç olarak çeşitli sorunlarla karşılaşıyor ve bu sorunlarla başa çıkabilmek için çeşitli duygu, düşünce ve davranışlardan yararlanıyor olabilirsiniz. Sizden istenilen karşılaştığınız sorunlarla başa çıkabilmek için neler yaptığınızı göz önünde bulundurarak, aşağıdaki maddeleri cevap kağıdı üzerinde işaretlemenizdir. Lütfen her bir maddeyi dikkatle okuyunuz ve cevap formu üzerindeki aynı maddeye ait cevap şıklarından birini daire içine alarak cevabınızı belirtiniz. Başlamadan önce örnek maddeyi incelemeniz yararlı olacaktır.

ÖRNEK:

Madde 4. İyimser olmaya çalışırım.

	Hiç uygun değil		Pek uygun değil	uygun	oldukça uygun	çok uygun
Madde 4.	1	.....	2	(3)	4	5

	Hiç uygun değil		Pek uygun değil	uygun	oldukça uygun	çok uygun
1. Aklımı kurcalayan şeylerden kurtulmak için değişik işlerle uğraşırım…	1	…….	2	…….	3	…….4
2. Bir sıkıntım olduğunu kimsenin bilmesini istemem …….	1	…….	2	…….	3	…….4
3. Bir mucize olmasını beklerim..……	1	…….	2	…….	3	…….4
4. İyimser olmaya çalışırım…….	1	…….	2	…….	3	…….4
5. “ Bunu da atlatırsam sırtım yere gelmez ” diye düşünürüm……	1	…….	2	…….	3	…….4
6. Çevremdeki insanlardan problemi çözmede bana yardımcı olmalarını beklerim…….	1	…….	2	…….	3	…….4
7. Bazı şeyleri büyütmemeye üzerinde durmamaya çalışırım…….	1	…….	2	…….	3	…….4
8. Sakin kafayla düşünmeye ve öfkelenmemeye çalışırım……..	1	…….	2	…….	3	…….4
9. Bu sıkıntılı dönem bir an önce geçsin isterim……..	1	…….	2	…….	3	…….4
10. Olayın değerlendirmesini yaparak en iyi kararı vermeye çalışırım……	1	…….	2	…….	3	…….4
11. Konuyla ilgili olarak başkalarının ne düşündüğünü anlamaya çalışırım…	1	…….	2	…….	3	…….4
12. Problemin kendiliğinden hallolacağına inanırım……	1	…….	2	…….	3	…….4
13. Ne olursa olsun kendimde direnme ve mücadele etme gücü hissederim	1	…….	2	…….	3	…….4
14. Başkalarının rahatlamama yardımcı olmalarını beklerim……..	1	…….	2	…….	3	…….4
15. Kendime karşı hoşgörülü olmaya çalışırım……..	1	…….	2	…….	3	…….4
16. Olanları unutmaya çalışırım……..	1	…….	2	…….	3	…….4
17. Telaşımı belli etmemeye ve sakin olmaya çalışırım……	1	…….	2	…….	3	…….4
18. “ Başa gelen çekilir ” diye düşünürüm……..…….….	1	…….	2	…….	3	…….4
19. Problemin ciddiyetini anlamaya çalışırım……..	1	…….	2	…….	3	…….4
20. Kendimi kapana sıkışmış gibi hissederim……..	1	…….	2	…….	3	…….4
21. Duygularımı paylaştığım kişilerin bana hak vermesini isterim……..……	1	…….	2	…….	3	…….4
22. Hayatta neyin önemli olduğunu keşfederim……..	1	…….	2	…….	3	…….4
23. “ Her işte bir hayır vardır ” diye düşünürüm……...	1	…….	2	…….	3	…….4
24. Sıkıntılı olduğumda her zamankinden fazla uyurum……..	1	…….	2	…….	3	…….4
25. İçinde bulunduğum kötü durumu kimsenin bilmesini istemem……..	1	…….	2	…….	3	…….4
26. Dua ederek Allah’tan yardım dilerim……....	1	…….	2	…….	3	…….4
27. Olayı yavaşlatmaya ve böylece kararı ertelemeye çalışırım…….	1	…….	2	…….	3	…….4
28. Olanla yetinmeye çalışırım……	1	…….	2	…….	3	…….4
29. Olanları kafama takıp sürekli düşünmekten kendimi alamam……..	1	…….	2	…….	3	…….4
30. İçimde tutmaktansa paylaşmayı tercih ederim……..	1	…….	2	…….	3	…….4
31. Mutlaka bir yol bulabileceğime inanır, bu yolda uğraşırım……..	1	…….	2	…….	3	…….4
32. Sanki bu bir sorun değilmiş gibi davranırım……	1	…….	2	…….	3	…….4
33. Olanlardan kimseye söz etmemeyi tercih ederim……..	1	…….	2	…….	3	…….4
34. “ İş olacağına varır ” diye düşünürüm……	1	…….	2	…….	3	…….4

	Hiç uygun değil	Pek uygun değil		oldukça uygun	çok uygun
35. Neler olabileceğini düşünüp ona göre davranmaya çalışırım……..	1	2	3	4	5
36. İşin içinden çıkamayınca " elimden birşey gelmiyor " der, durumu olduğu gibi kabullenirim……..	1	2	3	4	5
37. İlk anda aklıma gelen kararı uygularım……..	1	2	3	4	5
38. Ne yapacağıma karar vermeden önce arkadaşlarımın fikrini alırım……..	1	2	3	4	5
39. Herşeye yeniden başlayacak gücü bulurum……..	1	2	3	4	5
40. Problemin çözümü için adak adarım……	1	2	3	4	5
41. Olaylardan olumlu birşey çıkarmaya çalışırım……..	1	2	3	4	5
42. Kırgınlığımı belirtirsem kendimi rahatlamış hissederim……..	1	2	3	4	5
43. Alın yazısına ve bunun değişmeyeceğine inanırım……	1	2	3	4	5
44. Soruna birkaç farklı çözüm yolu ararım……	1	2	3	4	5
45. Başıma gelenlerin herkesin başına gelebilecek şeyler olduğuna inanırım					
46. " Olanları keşke değiştirebilseydim " derim……..	1	2	3	4	5
47. Aile büyüklerine danışmayı tercih ederim……	1	2	3	4	5
48. Yaşamla ilgili yeni bir inanç geliştirmeye çalışırım……..	1	2	3	4	5
49. " Herşeye rağmen elde ettiğim bir kazanç vardır " diye düşünürüm…….	1	2	3	4	5
50. Gururumu koruyup güçlü görünmeye çalışırım……	1	2	3	4	5
51. Bu işin kefaretini (bedelini) ödemeye çalışırım……..	1	2	3	4	5
52. Problemi adım adım çözmeye çalışırım……	1	2	3	4	5
53. Elimden hiç birşeyin gelmeyeceğine inanırım……..	1	2	3	4	5
54. Problemin çözümü için bir uzmana danışmanın en iyi yol olacağına inanırım……..	1	2	3	4	5
55. Problemin çözümü için hocaya okunurum……	1	2	3	4	5
56. Herşeyin istediğim gibi olmayacağına inanırım……	1	2	3	4	5
57. Bu dertten kurtulayım diye fakir fukaraya sadaka veririm……	1	2	3	4	5
58. Ne yapılacağını planlayıp ona göre davranırım……	1	2	3	4	5
59. Mücadeleden vazgeçerim……	1	2	3	4	5
60. Sorunun benden kaynaklandığını düşünürüm……..	1	2	3	4	5
61. Olaylar karşısında " kaderim buymuş " derim……	1	2	3	4	5
62. Sorunun gerçek nedenini anlayabilmek için başkalarına danışırım……..	1	2	3	4	5
63. " Keşke daha güçlü bir insan olsaydım " diye düşünürüm……	1	2	3	4	5
64. Nazarlık takarak, muska taşıyarak benzer olayların olmaması için önlemler alırım……	1	2	3	4	5
65. Ne olup bittiğini anlayabilmek için sorunu enine boyuna düşünürüm…..	1	2	3	4	5
66. " Benim suçum ne " diye düşünürüm……	1	2	3	4	5
67. " Allah'ın takdiri buymuş " diye kendimi teselli ederim……..	1	2	3	4	5
68. Temkinli olmaya ve yanlış yapmamaya çalışırım……	1	2	3	4	5
69. Bana destek olabilecek kişilerin varlığını bilmek beni rahatlatır……..	1	2	3	4	5
70. Çözüm için kendim birşeyler yapmak istemem……	1	2	3	4	5
71. " Hep benim yüzümden oldu " diye düşünürüm……..	1	2	3	4	5
72. Mutlu olmak için başka yollar ararım……	1	2	3	4	5
73. Hakkımı savunabileceğime inanırım……	1	2	3	4	5
74. Bir kişi olarak iyi yönde değiştiğimi ve olgunlaştığımı hissederim……..	1	2	3	4	5

APPENDIX M

YOUNG PARENTING INVENTORY (YPI)

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

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

Anne Baba

1. ____ ____ Beni sevdi ve bana özel birisi gibi davrandı.
2. ____ ____ Bana vaktini ayırdı ve özen gösterdi.
3. ____ ____ Bana yol gösterdi ve olumlu yönlendirdi.
4. ____ ____ Beni dinledi, anladı ve duygularımızı karşılıklı paylaştık.
5. ____ ____ Bana karşı sıcaktı ve fiziksel olarak şefkatliydi.
6. ____ ____ Ben çocukken öldü veya evi terk etti.
7. ____ ____ Dengesizdi, ne yapacağı belli olmazdı veya alkolikti.
8. ____ ____ Kardeş(ler)imi bana tercih etti.
9. ____ ____ Uzun süreler boyunca beni terk etti veya yalnız bıraktı.
10. ____ ____ Bana yalan söyledi, beni kandırdı veya bana ihanet etti.
11. ____ ____ Beni dövdü, duygusal veya cinsel olarak taciz etti.
12. ____ ____ Beni kendi amaçları için kullandı.
13. ____ ____ İnsanların canını yakmaktan hoşlanırdı.
14. ____ ____ Bir yerimi inciteceğim diye çok endişelenirdi.
15. ____ ____ Hasta olacağım diye çok endişelenirdi.
16. ____ ____ Evhamlı veya fobik/korkak bir insandı.
17. ____ ____ Beni aşırı korurdu.
18. ____ ____ Kendi kararlarıma veya yargılarıma güvenememe neden oldu
19. ____ ____ İşleri kendi başıma yapmama fırsat vermeden çoğu işimi o yaptı.
20. ____ ____ Bana hep daha çocukmuşum gibi davrandı.
21. ____ ____ Beni çok eleştirirdi.
22. ____ ____ Bana kendimi sevilmeye layık olmayan veya dışlanmış bir gibi hissettirdi.
23. ____ ____ Bana hep bende yanlış bir şey varmış gibi davrandı.
24. ____ ____ Önemli konularda kendimden utanmama neden oldu.
25. ____ ____ Okulda başarılı olmam için gereken disiplini bana kazandırmadı.
26. ____ ____ Bana salakmışım veya beceriksizmişim gibi davrandı.
27. ____ ____ Başarılı olmamı gerçekten istemedi.
28. ____ ____ Hayatta başarısız olacağıma inandı.
29. ____ ____ Benim fikrim veya isteklerim önemsizmiş gibi davrandı.
30. ____ ____ Benim ihtiyaçlarımı gözetmeden kendisi ne isterse onu yaptı.
31. ____ ____ Hayatımı o kadar çok kontrol altında tuttu ki çok az seçme özgürlüğüm oldu.
32. ____ ____ Her şey onun kurallarına uymalıydı.
33. ____ ____ Aile için kendi isteklerini feda etti.
34. ____ ____ Günlük sorumluluklarının pek çoğunu yerine getiremiyordu ve ben her zaman kendi payıma düşenden fazlasını yapmak zorunda kaldım.

Anne Baba

35. ____ ____ Hep mutsuzdu; destek ve anlayış için hep bana dayandı.
36. ____ ____ Bana güçlü olduğumu ve diğer insanlara yardım etmem gerektiğini hissettirdi.
37. ____ ____ Kendisinden beklentisi hep çok yüksekti ve bunlar için kendini çok zorlardı.
38. ____ ____ Benden her zaman en iyisini yapmamı bekledi.
39. ____ ____ Pek çok alanda mükemmeliyetçiydi; ona göre her şey olması gerektiği gibi olmalıydı.
40. ____ ____ Yaptığım hiçbir şeyin yeterli olmadığını hissetmeme sebep oldu.
41. ____ ____ Neyin doğru neyin yanlış olduğu hakkında kesin ve katı kuralları vardı.
42. ____ ____ Eğer işler düzgün ve yeterince hızlı yapılmazsa sabırsızlanırdı.
43. ____ ____ İşlerin tam ve iyi olarak yapılmasına, eğlenme veya dinlenmekten daha fazla önem verdi.
44. ____ ____ Beni pek çok konuda şımarttı veya aşırı hoşgörülü davrandı.
45. ____ ____ Diğer insanlardan daha önemli ve daha iyi olduğumu hissettirdi.
46. ____ ____ Çok talepkardı; her şeyin onun istediği gibi olmasını isterdi.
47. ____ ____ Diğer insanlara karşı sorumluluklarımın olduğunu bana öğretmedi.
48. ____ ____ Bana çok az disiplin veya terbiye verdi.
49. ____ ____ Bana çok az kural koydu veya sorumluluk verdi.
50. ____ ____ Aşırı sinirlenmeme veya kontrolümü kaybetmeme izin verirdi.
51. ____ ____ Disiplinsiz bir insandı.
52. ____ ____ Birbirimizi çok iyi anlayacak kadar yakındık.
53. ____ ____ Ondan tam olarak ayrı bir birey olduğumu hissedemedim veya bireyselliğimi yeterince yaşayamadım.
54. ____ ____ Onun çok güçlü bir insan olmasından dolayı büyürken kendi yönümü belirleyemiyordum.
55. ____ ____ İçimizden birinin uzağa gitmesi durumunda, birbirimizi üzebileceğimizi hissederdim.
56. _____ ____ Ailemizin ekonomik sorunları ile ilgili çok endişeli idi.
57. ____ ____ Küçük bir hata bile yapsam kötü sonuçların ortaya çıkacağını hissettirirdi.
58. ____ ____ Kötümser bir bakışı açısı vardı, hep en kötüsünü beklerdi.
59. ____ ____ Hayatın kötü yanları veya kötü giden şeyler üzerine odaklanırdı.
60. ____ ____ Her şey onun kontrolü altında olmalıydı.
61. ____ ____ Duygularını ifade etmekten rahatsız olurdu.
62. ____ ____ Hep düzenli ve tertipliydi; değişiklik yerine bilineni tercih ederdi.
63. ____ ____ Kızgınlığını çok nadir belli ederdi.
64. ____ ____ Kapalı birisiydi; duygularını çok nadir açardı.
65. ____ ____ Yanlış bir şey yaptığımda kızardı veya sert bir şekilde eleştirdiği olurdu.
66. ____ ____ Yanlış bir şey yaptığımda beni cezalandırdığı olurdu.
67. ____ ____ Yanlış yaptığımda bana aptal veya salak gibi kelimelerle hitap ettiği olurdu.
68. ____ ____ İşler kötü gittiğinde başkalarını suçlardı.
69. ____ ____ Sosyal statü ve görünüme önem verirdi.
70. ____ ____ Başarı ve rekabete çok önem verirdi.
71. ____ ____ Başkalarının gözünde benim davranışlarımın onu ne duruma düşüreceği ile çok ilgiliydi.
72. ____ ____ Başarılı olduğum zaman beni daha çok sever veya bana daha çok özen gösterirdi.

APPENDIX N

Basic Personality Traits Inventory (BPTI)

(Türk Kültüründe Geliştirilmiş Temel Kişilik Özellikleri Ölçeği)

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 O

Childhood Trauma Questionnaire

(Çocukluk Örselenme Yaşantıları Ölçeği)

AÇIKLAMA: Aşağıda 18 yaş öncesi çocukluk ve gençlik yaşantılarınızla ilgili cümleler vardır. Her cümleyi dikkatle okuyup, üst tarafındaki yazılar arasından sizi en iyi tanımlayanı seçerek üzerine (X) işareti koyunuz.

	Hiçbirzaman	Nadiren	Bazen	Sıklıkla	Çok sık
1. Ben çocukken, ailemde birileri bana vurur ya da beni döverdi.					
2. Ben çocukken, hiç kimse benimle ilgilenmediği için, kendi bakımımı kendimin daha iyi yaptığını hissederdim.					
3. Ben çocukken, ailemdeki kişiler birbirleriyle tartışır, kavga ederdi.					
4. Ben çocukken, ailemde benimle ilgilenen ve beni koruyan birinin olduğunu bilirdim.					
5. Ben çocukken, ailemde bana bağırıp-çağıran biri vardı.					
6. Ben çocukken, annemi yada kardeşlerimi dövülürken ya da onlara vurulurken gördüm.					
7. Ben çocukken, gereksinimim olan sevgi ve ilgiyi gördüm.					
8. Ben çocukken, ailemde kendimi önemli ya da özel hissetmemi sağlayan biri vardı.					
9. Ben çocukken, ailemde kendimi dövüşerek, ona vurarak, ya da ondan kaçarak korumak zorunda kaldığım biri vardı.					
10. Ben çocukken, ailemde, başarılı biri olmamı isteyen, bir kişinin varlığını hissederdim.					
11. Ben çocukken, değişik zamanlarda değişik kişilerin yanında yaşadım (değişik yakınlarımla ya da evlatlık verildiğim ailelerle).					
12. Ben çocukken, sevildiğimi hissederdim.					
13. Ben çocukken, annem ve babam, bana ve kardeşlerime eşit davranmaya çalışırlardı.					
14. Ben çocukken, ailemdeki kişilerden, bir doktora ya da hastaneye gitmek zorunda kalacak denli dayak yediğim oldu.					
15. Ben çocukken, ailemde, beni başımın belaya girmesinden koruyan birileri vardı.					
16. Ben çocukken, ailemdekiler, beni bir yerlerim çürüyecek ya da iz kalacak denli döverdi.					
17. Ben çocukken, bir erişkinle ya da benden en az beş yaş büyük birisiyle cinsel ilişkim oldu.					
18. Ben çocukken, kemer, sopa, oklava ya da benzeri sert cisimlerle dövülerek cezalandırıldım.					
19. Ben çocukken, ailemizin üyeleri birbirlerini gözetirlerdi.					
20. Ben çocukken, annemle babam ayrı yaşardı ya da boşanmıştı.					
21. Ben çocukken, fiziksel olarak istismar edildiğime inanıyorum.					
22. Ben çocukken, ailemdeki kişiler beni kötü etkilerden korumaya çalıştılar.					

	Hiçbirzaman	Nadiren	Bazen	Sıklıkla	Çok sık
23. Ben çocukken, evde bana bakan ve benim sorumluluğumu üstlenen bir kişi vardı.					
24. Ben çocukken, öğretmen, komşu ya da doktor gibi kişilerin dikkatini çekecek denli kötü dayak yerdim.					
25. Ben çocukken, ailemde denetimsiz davranışları olan kişiler vardı.					
26. Ben çocukken, ailemdeki kişiler beni okula devam etmem ve eğitimimi sürdürmem için yüreklendirdi.					
27. Ben çocukken, bana verilen cezalar çok katıydı.					
28. Ben çocukken, ailemdeki kişiler birbirlerine yakındılar.					
29. Ben çocukken, birisi bana cinsel amaçla dokunmayı ya da kendisine dokundurtmayı denedi.					
30. Ben çocukken, ailemdeki kişiler beni itip-kaktı.					
31. Ben çocukken, birisi, kendisiyle cinsel ilişkim olmazsa beni incitmekle ve hakkımda yalanlar söylemekle tehdit etti.					
32. Ben çocukken, çocukluğum mükemmeldi.					
33. Ben çocukken, ailemde incitilmekle korkutuldum.					
34. Ben çocukken, birisi benimle cinsel içerikli davranışlara girmeyi ya da bana cinsellikle ilgili şeyler izlettirmeyi denedi.					
35. Ben çocukken, ailemde bana güvenen biri vardı.					
36. Ben çocukken, duygusal olarak istismar edildiğime inanıyorum.					
37. Ben çocukken, ailemdeki kişiler ne yaptığımla ilgilenir gibi gözükmezler ya da ne yaptığımı bilmezlerdi.					
38. Ben çocukken, dünyadaki en iyi aileye sahiptim.					
39. Ben çocukken, cinsel olarak istismar edildiğime inanıyorum.					
40. Ben çocukken, ailem güç ve destek kaynağımdı.					

Lütfen, Arka sayfayı da doldurunuz

APPENDIX P

Perceived Social Support Scale (PSS)

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

1. Ailem ve arkadaslarım dısında olan ve ihtiyacım oldugunda yanımda olan bir insane (örnegin, flört, nisanlı, sözlü, akraba, komsu, doktor) var.

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır - bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

2. Ailem ve arkadaslarım dısında olan ve sevinç ve kederlerimi paylasabilecegim bir insane (örnegin, flört, nisanlı, sözlü, akraba, komsu, doktor) var.

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır - bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

3. Ailem (örneğin, annem, babam, esim, çocuklarım, kardeşlerim) bana gerçekten yardımcı olmaya çalısır.

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır - bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

4. İhtiyacım olan duygusal yardımı ve destegi ailemden (örnegin, annem, babam, esim, çocuklarım, kardeslerimden) alırım.

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır - bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

5. Ailem ve arkadaslarım dısında olan ve beni gerçekten rahatlatan bir insan (örnegin, flört, nisanlı, sözlü, akraba, komsu, doktor) var.

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır - bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

6. Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır – bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

7. İşler kötü gittiğinde arkadaşlarıma güvenebilirim.

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır – bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

8. Sorunlarımı ailemle (örnegin, annem, babam, esim, çocuklarım, kardeslerimle) konusabilirim..

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır – bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

9. Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır – bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

10. Ailem ve arkadaslarım dısında olan ve duygularıma önem veren bir insan (örnegin, flört, nisanlı, sözlü, akraba, komsu, doktor) var

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır – bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

11. Kararlarımı vermede ailem (örnegin, annem, babam, esim, çocuklarım, kardeslerim) bana yardımcı olmaya isteklidir

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır – bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

12. Sorunlarımı arkadaşlarımla konuşabilirim.

1 Kesinlikle Hayır	2 Çoğunlukla hayır	3 Genellikle hayır	4 Bazen hayır – bazen evet	5 Genellikle evet	6 Çoğunlukla evet	7 Kesinlikle Evet

APPENDIX R

CONNER'S TEACHER RATING FORM

Öğretmenin Adı Soyadı:
Sınıfı:
Tarih:

	Hiçbir Zaman	**Nadiren**	**Sıklıkla**	**Her Zaman**
1. Kıpır kıpırdır, yerinde duramaz.	( )	( )	( )	( )
2. Zamansız ve uyumsuz sesler çıkarır.	( )	( )	( )	( )
3. İstekleri hemen yerine getirilmelidir.	( )	( )	( )	( )
4. Bilmiş tavırları vardı. Bilgiçlik taslar.	( )	( )	( )	( )
5. Aniden parlar, ne yapacağı belli olmaz.	( )	( )	( )	( )
6. Eleştiriyi kaldıramaz.	( )	( )	( )	( )
7. Dikkati dağınıktır, uzun sürmez.	( )	( )	( )	( )
8. Diğer çocukları rahatsız eder.	( )	( )	( )	( )
9. Hayallere dalar.	( )	( )	( )	( )
10. Somurtur, surat asar.	( )	( )	( )	( )
11. Bir anı bir anını tutmaz, duyguları çabuk değişir.	( )	( )	( )	( )
12. Kavgacıdır.	( )	( )	( )	( )
13. Büyüklerin sözünden çıkmaz.	( )	( )	( )	( )
14. Hareketlidir, durmak oturmak bilmez.	( )	( )	( )	( )
15. Heyecana kapılıp, düşünmeden hareket eder.	( )	( )	( )	( )
16. Öğretmenin ilgisi hep üzerinde olsun ister.	( )	( )	( )	( )
17. Göründüğü kadarıyla arkadaş grubuna alınmıyor.	( )	( )	( )	( )
18. Göründüğü kadarıyla başka çocuklar tarafından kolaylıkla yönlendiriliyor.	( )	( )	( )	( )
19. Oyun kurallarına uymaz, mızıkçıdır.	( )	( )	( )	( )
20. Göründüğü kadarıyla liderlik özelliğinden yoksundur.	( )	( )	( )	( )
21. Başladığı işin sonunu getiremez.	( )	( )	( )	( )
22. Olduğundan daha küçükmüş gibi davranır.	( )	( )	( )	( )
23. Hatalarını Kabul etmez, suçu başkalarının üzerine atar.	( )	( )	( )	( )
24. Diğer çocuklarla iyi geçinemez.	( )	( )	( )	( )
25. Sınıf arkadaşlarıyla yardımlaşmaz.	( )	( )	( )	( )
26. Zorluklardan hemen yılar.	( )	( )	( )	( )
27. Öğretmenle işbirliğine girmez.	( )	( )	( )	( )
28. Zor öğrenir.	( )	( )	( )	( )

APPENDIX S

TURKISH SUMMARY
DEHB OLAN VE OLMAYAN ÇOCUKLARDA ÇOCUK İSTİSMARI VE SONUÇLARIYLA İLŞKİLİ ETKENLER: KARŞILAŞTIRMALI BİR ÇALIŞMA – SÖZÜN BİTTİĞİ YERDE…-

Yazın Bilgisi

Dikkat Eksikliği Hiperaktivite Bozukluğu'nun Tanımı, Sıklığı ve Etiolojisi

Dikkat Eksikliği Hiperaktivite Bozukluğu (DEHB) çocuk ruh sağlığı bölümlerinde en çok konulan tanılardan biridir (Amerikan Psikiyatrik Birliği; APA, 1994; Barkley, 1997). DEHB, gelişim düzeyine göre normal dışı olan, yapılan ödev ya da göreve dikkati odaklamada, herhangi bir şeyi yapma isteğini ertelemede güçlük ve aşırı hareketlilikle tanımlanan bir bozukluktur. Mental Bozuklukların Tanısal ve Sayımsal El Kitabı (DSM IV; APA, 1994) bu bozukluğu Dikkat Eksikliği Hiperaktivite Bozukluğu (DEHB) olarak, Hastalıklar ve Sağlık Problemlerinin İstatistiksel Sınıflandırılması (ICD 10, Dünya Sağlık Örgütü; DSÖ, 1993).

DSM-IV'e göre (APA 1994) DEHB tanı kriterini karşılamak için çocuğun dikkat ya da hiperaktivite problemlerinin 7 yaşından önce başlaması, en az 6 ay sürmesi, gelişim düzeyiyle uyumsuz olması, birden çok ortamda gözlemlenilmesi gerekmektedir. Amerikan Psikiyatri Birliği'ne göre DEHB'nun üç alt tipi bulunmaktadır: Dikkat eksikliği önde giden tip, hareketliliği önde giden tip, birleşik tip (APA 1994). APA (1994) bu bozukluğun sıklığını % 3-5, kız ve erkeklerde görülme oranını ¼ olarak bildirmiştir. Önceden sadece bir çocukluk çağı gelişimsel bozukluğu olarak tanımlanırken son yıllarda yapılan çalışmalar DEHB'nun erişkinlikte de çeşitli şekillerde sürdüğünü ortaya koymuştur (Manuzza, Klein, Bessler, Malloy, ve La Padulla, 1998). Çocuklukta DEHB tanısı alanların %50'sinde erişkinlikte de DEHB belirtlerinin olduğu bildirilmektedir (Barkley, Dupaul, Murray, 1990; Öktem, 1996). Yaşam boyu görülen DEHB'na çocuklukta ve erişkinlikte başka bozukluk ya da problemlerin eşlik ettiği bilinmektedir. Biederman (1997),

DEHB tanısı konulan çocukların %50'sinin hayatlarının bir döneminde bir ya da daha fazla eşlik eden bir bozukluk sergilediklerini ileri sürmüştür. Çocukluk döneminde karşı olma karşı gelme bozukluğu ve davranım bozukluğu DEHB'na en sık eşlik eden bozukluklar arasındadır (Anderson et al., 1987; Milberger ve ark., 1995; Volk ve ark., 2005).

Yapılan çalışmalar DEHB'nun etiolojisinde genetik (e.g.; Bradley ve Golden, 2001), biolojik-nörolojik (örn.; Swanson et.a l, 2001), çevresel ve psikolojik pek çok farklı etkenin rol oynadığını göstermiştir (Biederman, Milberger ve ark., 1995; Öktem, 1996). DEHB kısa dönemde çocukların düşük okul başarısına, arkadaş ilişkilerinde sıkıntı yaşamalarına bunalara bağlı olarak içseleştirme ve dışsallaştırma problemleri geliştirmelerine yol açabilir (Hinshaw, 1987; Jensen, Martin, ve Cantwell, 1997). Uzun dönemde ise düşük sosyo ekonomik düzey, alkol ya da sigara bağımlılığı, uyum problemleri, işsizlik, araba kazaları, yakın ilişkilerde problemler yaşanmasına neden olabilir (Borland ve Heckeman, 1996; Manuzza ve Klein 1999).

Çocuk İhmal ve İstismarı

Çocuk ihmal ve istismarı, genel olarak çocuğun optimal gelişimini engellyen, yavaşlatan fiziksel, duygusal, cinsel kötüye kullanım içeren herhangi bir eylem ya da eylemsizlik şeklinde tanımlanabilir. Çocuk ihmal ve istismarı çok geniş bir çerçeveye sahip olduğu için farklı çalışmalarda farklı biçimlerde tanımlanabilmektedir. Buna bağlı olarak çocuk ihmal ve istismarının sıklığına ilişkin bildirilen oranlar da çalışmalarda esas alınan tanımlara göre değişmektedir. Bununla birlikte 1 ila 14 yaşlar arasında 40 milyon çocuğın istismar edilmekte olduğu öngörülmektedir (Johnson, 1996).

Çocuğun duygusal ihmal ve istismarı

Duygusal ihmal ya da istismar çocuğun psikolojik gelişimini engelliyen, bastıran bir kötüye kullanım türüdür. Barrnett, Manly, ve Cicchetti (1993) duygusal olarak kötüye kullanılan bir çocuğun kendini psikolojik olarak güvenli, kabul gören, ve yaşının gerektirdiği düzeyde otonomi geliştirmek için yeterli düzeyde desteklenen biri olarak hissetmediğini bildirmektedir. Duygusal istismarın altı temel görülme

biçimi olduğu bildirilmektedir (Galser, 2002; Garbarino ve Garbarino, 1994); reddetme, aşağılama, korkutma, duygusal karşılık vermeme, ve kendi çıkarları için çocuğu kullanma.

Çocuğun cinsel istismarı

Bir erişkin ya da yaşça büyük bir çocuk tarafından yasal olarak erişkin sayılmayan bir çocukla yapılan herhangi bir cinsel eyleme cinsel istismar denilir (Green, 1996). Bu eylemler, oral-genital, genital-genital, genital-rektal, el-genital, veya el-göğüs teması, cinsel anatominin zorla gösterilmesi, pornografi izletilmesi ya da çocuğun pornografi üretiminde kullanılması şeklinde olabilir. Bu eylemler aralarında 4 yaştan az fark olan çocuklar tarafından gerçekleştirildiğinde ve işin içinde zorlama olmadığında cinsel oyun olarak adlandırılırlar (Johnson, 2001). Wurtule ve Miller-Perrin (1992) cinsel istismarın araştırmacı tarafından nasıl tanımlandığına ve hangi grupta araştırıldığına göre görülme sıklığının kadınlarda %7-62, erkeklerde %3-16 arasında değiştiğini ileri sürmüştür. Finkelhor (1994) bu oranların kadınlar için %7-36, erkekler için %3-29 olduğunu bildirmiştir.

Çocuğun fiziksel ihmal ve istismarı

Fiziksel istismar beslenme, giyim ve hijyen yetersizliği nedeni ile çocuğun fiziksel problemler yaşamasına yol açmaktır (Kaplan, Pelcovitz, Labruna, 1999). Fiziksel istismar 18 yaşının altındaki bir çocuğa kendinden büyük biri tarafından bilerek verilen fiziksel zarardır. Bu zararı verenler genelde anne-babalar ya da çocuğun bakımından sorumlu diğer kişilerdir (Kaplan, 1996). İstismarcı, çocuğa şiddet içeren fiziksel bir ceza verir ya da çocuğun fiziksel acı çekmesine yol açacak bir davranışta bulunur (Widom, 1989). Genel olarak fiziksel ihmal ve istismarın tüm kültürlerde yaygın olduğu bildirilmektedir (Hunter, Jain, Sadowski, 2000; Jones ve McCurdy, 1992) ancak diğer istismar türlerinde olduğu gibi fiziksel istismarın sıklığı da araştırmada kullanılan tanımına ve araştırmanın hangi kültürde yapıldığına göre değişmektedir. Fiziksel istismarın bir disiplin stili olarak görüldüğü kültürlerde sıklığı artmakla birlikte bu davranışların istismar olarak nitelendirilme oranı düşmektedir. Tüm bu etkenler fiziksel istismarın oranını belirlemeyi güçleştirmektedir. Amerika'da yapılan bir çaışmada fiziksel ihmal %29, istismar

%17, Hindistan'da yapılan bir çalışmada fiziksel istismar %40, Hon-Kong'da yapılan bir çalışmada ise %95 olarak bildirilmiştir. Türkiye'de bu alanda fazla çalışma bulunmamaktadır ancak bir çalışmada beş yaşın altındaki çocukların %36sının fiziksel istismara uğradığı öne sürülmüştür (Bilir, Arı, Dönmez, 1986).

Çocuğa karşı fiziksel ve duygusal kötü muamele için risk etkenleri

Çocuk ihmal ve istismarında risk etkenlerini tanımlamak çocuk ihmal ve istismarına yol açan bazı faktörlerin olabileceği düşüncesine yol açabilme ihtimali nedeni ile biraz riskli görünmektedir. Çocuk ihmal ve istismarından söz ederken hiçbir şeyin çocuk istismarının haklı ve geçerli sebebi olmayacağı kabul edilmelidir. Ancak ebeveynlere, çocuğa ya da çevreye ilişkin bazı etkenler çocuğa kötü muamele uygulanma olasılığını arttırabilir. En uygun ve etkin müdaheleyi belirlemek için çocuğa karşı kötü muamelenin altında yatan etkenleri araştırmakta fayda vardır.

İstismarcının, istismar edilenin ve istismarın gerçekleştiği ortamın özelliklerini daha iyi anlamak için araştırmacılar çeşitli kategorizasyonlar yapmışlardır. Brown ve ark. (1998) risk etkenlerini çocuk ve yetişkin özellikleri, aile işlevselliği (örn.; evlilik doyumu, aile içi şiddet), toplumsal düzey (örn.; sosyo ekonomik düzey, ailenin komşuluk ilişkileri), sosyo-kültürel düzey (örn.; kültürel olarak kabul gören çocuk yetiştirme stilleri) olarak sınıflandırmıştır. Benzer şekilde, Bronfenbrenner risk etkenlerini dört düzeyde tanımlamıştır; mikro sistem (içinde bulunulan ortam), mezosistem (ortamlar arası ilişkiler), ekzo sistem (daha geniş sosyal sistem), ve makro sistem (ideolojik ve kurumsal sistemler). Mikro sistem, çocuk, ebeveyn, aile ve içlerinde bulundukları koşulları, mezosistem mikrosistem de sayılan çocuk, aile, ebeveyn faktörlerinin birbiryle ilişkisini, ekzosistem içinde bulunulan toplumun koşullarını ve toplumsal etkenleri, makrosistem kabul edilen ideoloji ve kültürel etkenleri içerir. Belsky (1980), Bronfenbrenner'ın sınıflandırmasına ontogenik gelişimi eklemiştir. Bu kategoride ebeveynin geçmiş yaşantıları ve varolan ortama aktarımları bulunmaktadır. Genel olarak gözden geçirildiğinde risk etkenlerinin çocuk özellikleri, ebeveyn özellikleri (geçmiş ve süregiden yaşantılarını da kapsayarak), kültürel etkenler ve kültürel olarak kabul edilen disiplin tutumlarıyla ilişkili olduğu sonucuna varılabilir.

Çocukla ilişkili risk etkenleri

Çocukların bazı özellikleri duygusal ve fiziksel olarak kötü muamele görme risklerini artırmaktadır (Ammerman, 1990). Daha küçük çocukların ve erkek çocukların istismar edilme risklerinin daha yüksek olduğu bildirilmektedir (Berger, 2005; Ross, 1996; Straus, 1994). Zor mizaçlı çocukların (Frodi, 1981; O'Keefe, 1995), agresif, saldırgan davranışları olan (Baldry; 2007), gelişimsel geriliği-bozukluğu olan (Ammerman, Hersen, Van Hasselt, McGonigle, ve Lubetsky, 1989), fiziksel engeli bulunan (Goldson, 1998; Oates, 1996) çocukların daha yüksek oranda kötü muamele gördükleri bildirilmektedir. Davranış sorunları ile istismara uğrama riski arasındaki ilişki çift yönlü olarak düşünülebilinir. Davranış sorunları ve agresyon istismarı tetikleyebileceği gibi istismarın sonucu olarak da ortaya çıkabilir. Belsky'nin (1980) belirttiği gibi çocuğun özellikleri sadece ebeveynin bu yöndeki tutumuyla eşleştiği zaman istismarı yordar.

Ebeveyne ilişkin risk etkenleri

Çocuk istismarının yordayıcılarını araştıran çalışmalar ebeveyn özelliklerinin fiziksel cezalandırma ve çocuk istismarının önemli rol oynadığını göstermektedir. Daha genç ebevceynlerin (Lealman, Haigh, Phillips, Stone, ve Ord-Smith, 1985; Olds et al., 1986; Straus, 1994; Wolfe, Edwards, Manion, ve Koverola, 1988), daha düşük ebeveyn eğitiminin (Bowker et al., 1988; Margolin ve Larson, 1988; Zuravin ve DiBlasio, 1992), düşük gelirin (Bowker et al., 1988; Caliso ve Milner, 1992; Cicchetti ve Rizley, 1981; Coohey, 2000; Gillham et al., 1998; Sedlak ve Broadhurst, 1996; Straus ve Smith, 1990), ergen yaşta anne olmanın (De Pa´Ul ve Domenech, 2000), ebeveynin zihinsel ve fiziksel sağlık problemlerinin (Cicchetti ve Rizley, 1981; Margolin ve Larson, 1988), ebeveynin empati kurma becerisinin düşük olmasının (McElroy ve Rodriguez, 2008) çocuğuna karşı istismar içeren davranışlarda bulunmasını yordadığı bildirilmektedir.

Çalışmalar gözden geçirildiğinde ebeveynin yüksek öfkesi ve düşük empati yapma becerisi birbiriyle ve çocuk istismarıyla ilişkili iki etken olarak görülebilir. Empati karşıdakinin duygusunu anlama, bakış açısı alabilme, tepkiye karar verebilmeyi içeren bilişsel bir fonksiyondur (Marshall, Hudson, Jones, ve Fernandez, 1995). Öfke

ise karşıdaki kişinin duygularını ve niyetini yanlış yordamaya yol açan bir duygudur (Hall ve Davidson, 1996; van Honk, Tuiten, de Haan, Van den Hout, ve Stem, 2001; Wingrove ve Bond, 2005). İstismara yatkın ebeveynlerin çocuklarından gerçekçi olmayan ve gelişimsel düzeyleriyle uyumsuz beklentilere sahip oldukları bildirilmektedir (Azar, 1997; Azar ve Siegel, 1990). Bununla birlikte, istismara eğilimli ebeveynlerin empati yapmakta güçlük çektiği ve istedikleri yerine gelmediğinde, içinde bulunulan durumu, çocuğun niyetini ve olayın sonuçlarını doğru yorumlayamadıkları buna bağlı olarak da daha kolay ve hızlı biçimde öfkelenebildikleri ortaya konulmuştur (Hall ve Davidson, 1996; Mash ve Johnston, 1990). Sonuç olarak, ebeveynin düşük empati becerisi ve yüksek öfkesi çocuk istismarına yatkınlığını belirleyen etkenler içinde yer almaktadır (Ateah ve Durrant, 2005).

Ebeveynlerin özellikle empati yapmaya ilişkin bilişsel becerileri çocuğa karşı kötü muameleyle ilişkilendirilse de (Feshbach, 1964; Feshbach ve Feshbach, 1969; Feshbach, Feshbach, Fauvre, ve Ballard-Campbell, 1983; Mehrabian ve Epstein, 1972) ve babaların empati yapma becerilerinin annelere göre düşük olduğu bildirilse de (Perez-Albeniz ve Paul 2004), çalışmalar annelerin babalara göre daha sıklıkla fiziksel/ bedensel cezalandırmayı diğer bir deyişle fiziksel kötü muameleyi bir disiplin stili olarak kabul ettiklerini göstermektedir. Genel olarak çocukla daha fazla vakit geçirmesi, çocuğun eğitiminden ve disiplininden babalara oranla daha fazla sorumlu olması bu farkı açıklayabilecek etkenlerden biridir (Park, 2000). Çocuk istismarını yordayan ebeveyn özellikleri içinde ebeveynin depresyonu (Whipple ve Webster-Stratton, 1991), madde kullanımı, travma sonrası stres bozukluğu (TSSB; Famularo, Kinscherff, ve Fenton, 1992; Kelleher, Chaffin, Hollenberg, ve Fischer, 1994; Murphy et al., 1991; Whipple ve Webster-Stratton, 1991), yüksek ebeveynlik stresi, (Francis ve Wolfe, 2008) algılanan düşük sosyal destek yer almaktadır (Lesnik-Oberstein vb., 1995).

Disiplin ve Çocuğa Karşı Fiziksel – Duygusal Kötü Muamele

İnsanların toplum içinde uyması gereken pek çok kural bulunmaktadır. Disiplin bu kuralların başlangıçta dışsal kaynaklar tarafından çocuğa verilmesini ve zamanla çocuk tarafından içselleştirilmesini içeren bir süreçtir (Hart, DeWolf, Wozniak, ve

Burts, 1992; Michels, Pianta, ve Reeve, 1993; Smith ve Brooks-Gunn, 1997; Strassberg, Dodge, Pettit, ve Bates, 1994). Disiplinin amacı çocuğun kendini kontrol ve disiplinize etmesine yardımcı olmaktır (Howard, 1991, p. 1352). Ebeveynler çocuklarını disiplinize etmek isterken bazen fiziksel/ bedensel cezalandırma yöntemleri kullanmaktadır. Bedensel cezalandırma ebeveynin çocuğa disiplin vermek amacıyla fiziksel acı çekmesine yol açacak fakat yaralanmaya neden olmayacak şekilde fiziksel güç kullanmasıdır (Holden, 2002; American Academy of Pediatrics, Committee on Psychosocial Aspects on Child and Family Health, 1998; Straus, 2001). Öğrenme psikolojisi alanında yapılan çalışmalar genel olarak cezanın özel olarak da bedensel cezalandırmanın uzun dönemde etkili olmadığını göstermektedir (Thorndike, 1898; Vittrup ve Holden, 2010). Çalışmalar çocukların bedensel cezalandırmanın nedenini doğru yordayamadığını ya da hatırlayamadığını, üstelik bedensel ve duygusal olarak cezalandırılan çocukların, ebeveynlerini model aldıkları yaş döneminde oldukları için, ilişkilerde sorun çözme yöntemi olarak fiziksel şiddet kullanmaya başladıklarını göstermektedir (Ateah ve Durrant, 2003; Vittrup ve Holden, 2010). Sonuç olarak, bedensel ve duygusal cezalandırmanın işlevsiz, uzun dönemde etkisiz ve hem kısa hem uzun dönemde zararlı olduğu çalışmalarca ortaya konulmaktadır.

Bunlarla birlikte, disiplin ortaya çıktığı bağlam göz ardı edilerek ele alınamaz. Disiplini anlamak ve daha iyi yorumlamak için çocukla, ebeveynle, ve sosyo-kültürel koşullarla ilgili etkenlerin yeterli düzeyde bilinmesi gerekmektedir. Bir davranışın istismar olup olmadığına karar verirken kültürel etkenlerin göz önüne alınması önemlidir (Collier ve ark., 1999). Şiddet içeren bir davranış ardındaki niyete, şiddetine, kültrel olarak kabul görme oranına göre sadece bedensel- duygusal cezalandırma olarak nitelendirilebilir, çocuğa kötü muamele olarak sınıflandırlabilir ya da çocuk istismarı olarak tanımlanabilir (Elliott, Tong, ve Tan 1997). Tümü uygunsuz olan bu üç kavramın içerdiği davranış biçimleri birbiriyle ilişkilidir, dolayısıyla bu kavramlar gerçek yaşamda birbiriyle içiçedir ancak risk etkenlerini anlamak açısından teorik olarak bu ayırımı yapmak önemli görünmektedir (Whipple ve Richey, 1997).

Kültürel olarak duygusal ve bedensel cezalandırmanın kabulü çocuk istismarı açısından risk etkenidir. Çalışmalar ebevynlerin fiziksel cezanın etkinliğine

inandıklarını ve fiziksel cezayı onaylayan ebeveynlerin bunu kullanma olasılıklarının daha yüksek olduğunu göstermektedir (Jackson, Thompson, Christiansen, Colman, Wilcox ve Peterson, 1999; Qasem, Mustafa, Kazem ve Shah, 1998; Vargas, Lopez, Perez, Zuniga, Toro ve Ciocca, 1995). Bunun çocuk istismarı açısından risk oluşturduğu bilinmektedir, nitekim araştırmalar duygusal ve fiziksel cezanın zamanla daha az etkili olmaya başladığını ve etkinliğini yitirdikçe şiddetinin arttığını göstermektedir (Hemenway, Solnick, ve Carter, 1994). İstismarın kültürel olarak kabul gördüğü bir toplumda istismar içeren cezaya maruz kalmak fiziksel ve duygusal istismarı normalize etmeye ve bir disiplin stili olarak kabul etmeye dolayısıyla istismara yatkın bir ebeveyn olmaya yol açabilir, ve bu durum nesiller arası aktarımı ve kültürel kabulü destekler (Rodriguez ve Sutherland, 1999). Kültürel kabul ve nesiller arası aktarım arasındaki çift yönlü ilişki bir toplumda çocuk istimarı oranlarını yükseltebilir (Bower-Russa, Knutson, ve Winebarger, 2001; Durrant, Broberg ve Rose-Krasnor, 1999; Holden et al. 1995, Jackson et al., 1999). Yapılan çalışmalarda çocukluk istismar öyküsü istismarcı bir ebeveyn olmakla ilişkili bulunmaktadır (Buntain-Ricklefs, Kemper, Bell, ve Babonis, 1994; Graziano, Hamblen, ve Plante, 1996; Holden ve Zambarano, 1992; Jackson, et al., 1999; Rodriquez ve Sutherland, 1999; Socolar ve Stein, 1995; Straus, 1990).

Çocuk İstismarı ve DEHB

Son çalışmalar DEHB ve fiziksel istismara uğrama oranının birbiriyle ilişkili olduğunu göstermektedir (Margolin ve Gordis, 2000). Fiziksel ya da duygusal olarak istismar edilen çocukların %14 ila %46'sının DEHB tanısı aldıkları bildirilmektedir (Briscoe-Smith ve Hinshaw, 1996; Endo ve ark., 2006; Glod ve Teicher, 1996). DEHB'na yıkıcı davranış bozuklukları eşlik ettiğinde istismar riski artmaktadır (Ford et al., 2000). Ford ve ark. (2000) saf DEHB için fiziksel istismar riskinin %25 olduğunu ancak DEHB'na Karşı Olma Karşı Gelme Bozukluğu eşlik ettiğinde bu oranın %43 ila %75'e kadar çıktığını göstermişlerdir. İstismarla DEHB arasındaki bu ilişki her ikisinde de benzer sosyo-ekonomik koşulların, benzer ebeveyn özelliklerinin, benzer ebeveyn psikopatolojilerinin görülmesinden kaynaklanabilir. DEHB olan çocukların ailelerinin daha düşük sosyo-ekonomik düzeye sahip olduğu (Rutter ve Quinton, 1977) ve sosyal destek düzeylerinin daha düşük olduğu bildirilmektedir (Cunningham, Benness, ve Siegel, 1988). Buna ek olarak, düşük

sosyo-ekonomik düzeye sahip ebeveynlerin daha sert fiziksel disiplin yöntemleri kullandıkları (Portes, Dunham, ve Williams, 1986; Pinderhughes, Dodge, ve Bates, 2000), düşük sosyo-ekonomik düzey ve düşük sosyal desteğin duygusal ve fiziksel çocuk istismarı ile ilişkili olduğu gösterilmiştir (Caliso ve Milner 1992; Coohey, 2000; Gillham et al., 1998). Hem DEHB, hem çocuk istismarı yüksek ebeveynlik stresi ile ilişkili bulunmaktadır (Caliso ve Milner, 1992; Coohey, 2000; Gillham et al., 1998), dolayısı ile düşük sosyo-ekonomik düzeye ve düşük sosyal desteğe sahip olan ailelerin çocuklarında daha sıklıkla DEHB olduğu ve bu durumun ebevenlerin streslerini artırdığı, yüksek ebeveynlik stresinin de çocuk istismarı için risk etkeni olduğu ileri sürülebilir.

Psikopatoloji sıklığı da hem DEHB olan çocukların ebeveynlerinde (Rutter ve Quinton, 1977) hem de istismara yatkın olan ebeveynlerde (Whipple ve Webster-Stratton, 1991) daha yüksek görülmektedir. Diğer bir deyişle, depresyon (DEHB için: Biederman ve ark. 2004, Milberger, Biederman, Faraone, Murphy, ve Tsuang, 1995; Evinç, 2004; istismara yatkın ebeveynlik için: Whipple ve Webster-Stratton, 1991), bipolar bozukluk (DEHB için: Hirshfeld-Becker ve ark., 2006; istismara yatkın ebeveynlik için: Çengel-Kültür ve. ark., 2007), alkol bağımlılığı (DEHB için: Milberger, Biederman, Faraone, Murphy, ve Tsuang, 1995; istismara yatkın ebeveynlik için: Berger, 2005; Merrill ve ark., 1996; Whipple ve Richey 1997), antisosyal ve sınır kişilik bozuklukları (Bland ve Orn, 1986; Gordon ve ark., 1989; Susman, Trickett, Iannotti, Hollenbeck, ve Zahn-Waxler, 1985; Whipple, Fitzgerald, ve Zucker, 1995) hem DEHB olan çocukların annelerinde, hem istismara yatkın ebeveynlerde daha sık bildirilmektedir.

Çocuk İstismarının Sonuçları

İstismar edilen çocuklar duygusal ve davranışsal sorunlar açısından risk altındadır. Çocuğa karşı kötü muamelenin sonuçları kısa ya da uzun dönemde görülebilir (Kendall-Tackett ve Marshall, 1998). Çocuk istismarı bir çocuğun erişkinlikte de sürdüreceği duygusal ve davranışsal problemler geliştirmesine yol açabilecek bir stres etkenidir. İstismar edilen çocukların bazılarının olumsuz sonuçlar açısından daha zayıf bazıları daha dayanıklıdır (Luthar ve ark., 2000). Destekleyici bir çevrenin, iyi anne-baba ilişkisinin, iyi bağlanma yaşantısının varlığı koruyucu

etkenler arasında bildirilmektedir bununla birlikte bunların olmaması ise risk etkeni olarak görülmektedir (Alink, Cicchetti, Kim, ve Rogosoh, 2009; Cyr ve ark., 2009). Çocuk istismarı çocuğun kendisi, etrafındaki kişiler ve dünya hakkındaki algısını bozan ve başetme becerilerini olumsuz etkileyen bir travmatik yaşantıdır (Ehlers, Mayou, ve Bryant, 2003). Dolayısı ile kötü muamele gören çocuklar kendilerini daha değersiz, daha çaresiz, daha yetersiz hissedebilir, diğer insanları daha kızgın, daha kötü niyetli, dünyayı daha tehlikeli algılayabilir. Bunun sonucu olarak da istismar edilen çocuklar daha düşük benlik saygısı, daha yüksek öğrenilmiş çaresizlik, depresyon ve intihar eğilimi sergilemektedir (Kazdin, 1985; Kent ve Waller, 2000). İstismarın sonuçlarının istismar türünden bağımsız olduğu (Briere ve Runtz, 1988; Johnson ve ark., 2001; Rich, Gingerich, ve Rosen, 1997; Sackett ve Saunders, 1999), ve tüm istismar türlerinin, birbirleriyle benzer şekilde, sosyal ilişkiden kaçınmaya, yakın ilişkilerde güçlük çekmeye, sosyal ipuçlarını algılamada zorluk yaşamaya, agresif davranışlar sergilemeye, bilişsel alanda problemlere sahip olmaya (Margolin ve Gordis, 2000; Osofsky, 2003; Widom, 1997) yol açtığı gösterilmektedir. Bunlarla birlikte somatizasyon (Felitti, 1991; Haj-Yahiaa ve Tamish, 2001), yeme bozuklukları (Kent ve Waller, 2000), kişilik bozuklukları (Moeller, Bachmann ve Moeller, 1993; Yehuda, Spertus, ve Golier, 2001), istismarcı olma ve yeniden kurban olma davranışı (Yehuda, Spertus, ve Golier, 2001), depresyon ve kaygı bozuklukları (Çengel-Kültür, Çuhadaroğlu-Çetin, ve Gökler, 2007; Endo & colleagues, 2006; Haj-Yahia & Tamish, 2001), travma sonrası stres bozukluğu (Broman-Fulks et al. 2007) gibi uzun dönemli sonuçları olduğu bildirilmektedir.

Bu çalışmanın amacı ve hipotezler

Bu çalışmada DEHB olan ve olmayan çocukların annelerinin disiplin yöntemleri açısından birbirleriyle karşılaştırılması ve istismar içeren disiplin yöntemlerinin yordayıcıları ve sonuçlarının araştırılması hedeflenmiştir. Bu amaçlarla annelerin geçmiş yaşantıları, erişkinlikte sahip olduğu özellikler, disiplin tutumları incelenecektir. Çocukların ise davranış sorunları, benlik saygıları, depresyon belirti düzeyleri maruz kaldıkları kötü muamele ile ilişkisi açısından incelenecektir. Bu çalışmanın bir diğer hedefi yazından farklı olarak annelerin hem disiplin tutumlarının hem de uyguladıkları disiplin yöntemlerin araştırılmasıdır. Disiplin tutumları özbildirim ölçekleri ile, disiplin uygulamaları hem anne hem çocukla yapılan yarı

yapılandırılmış görüşmelerle değerlendirilecektir. Veriler hem nitel hem nicel yöntemlerle toplanacak ve hem nitel hem nicel yöntemlerle değerlendirilecektir. Yine yazından farklı olarak bu çalışmada annelerin disiplin tutumları DEHB alt tipleri de dahil edilerek, tanıyla çalışılarak, normal kontrollerle karşılaştırılarak çalışılacaktır. Tanıyla çalışmanın yanında, Conners Ebeveyn Derecelendirme formuna göre çocukların belirti şiddetinin annelerin kötü muamele/ istismar içeren disiplin davranışı ile ilişkisine bakılacaktır. Araştırmanın hipotezleri şöyledir:

1- DEHB olan çocukların anneleri istismar içeren disiplin stillerini daha yüksek oranda kabul etmekte ve daha sık kullanmaktadır. Diğer bir deyişle DEHB olan çocuklar daha sık ve şiddetli bir biçimde istismar içeren disiplin yöntemlerine maruz kalmaktadır. İstismar içeren disipline maruz kalma açısından DEHB'nun allttipleri de birbirinden farklılaşmaktadır ve davranış sorunları içeren alttiplerde annelerin daha sert, istismar içeren disiplin yöntemlerine başvurma olasılığı ve sıklığı artmaktadır.
2- Annelerin geçmiş ve şimdiki özellikleri, çocukların Conners DEHB, Karşı Olma Karşı Gelme Bozukluğu, ve Davranış Bozukluğu puanlarını yordamaktadır.
3- Annelerin geçmiş ve şimdiki özellikleri, annelerin sert ve istismar edici disiplin stillerini onaylamasını ve uygulamasını yordamaktadır.
4- Conners DEHB Karşı Olma Karşı Gelme Bozukluğu, ve Davranış Bozukluğu puanları ile çocuğa karşı kötü muamele arasında çift yönlü karşılıklı bir ilişki vardır.
5- Kötü muamele/ istismar içeren disiplin stillerine maruz kalmak çocuğun kendilik değeri ve depresyon puanlarını yordamaktadır.

Yöntem

Bu çalışmada, annelerin disiplin tutum ve uygulamalarının anlaşılması amacıyla 100 DEHB olan ve 25 herhangi bir psikopatolojisi olmayan çocuk ve annesinden bilgi toplanmıştır. Nicel analizlerde DEHB olan çocuklar kendi içlerinde üç gruba ayrılmıştır; dikkat eksikliği önde olan DEHB grubu, hiperaktivitesi önde olan DEHB grubu, birleşik tip DEHB grubu. Çocukların psikopatolojileri yarı yapılandırılmış bir görüşme türü olan Okul Çağı Çocukları İçin Duygulanım Bozuklukları ve Şizofreni Görüşme Çizelgesi (K-SADS) ile değerlendirilmiştir. Zeka düzeyleri ise

yapılandırılmış bir görüşme olan Wechsler çocuklar için zeka ölçeği (WÇÖZ) ile ölçülmüş ve tüm zeka bölümlerinde 80 altında zeka düzeyine sahip olan çocuklar ve anneleri çalışma dışında tutulmuştur. Bunlara ek olarak, nörolojik hastalığa sahip olmak da çalışmanın dışlama kriterleri arasındadır.

K-SADS ve WÇÖZ görüşmelerinin ardından tüm çocuk ve annelerle evlerindeki disiplin stillerinin, aralarındaki ilişkinin kalitesinin açık uçlu standart sorularla sorulduğu görüşmeler yapılmıştır. Anneler bu görüşmeye ek olarak disiplin konusundaki tutumlarını, ne tür davranışları disiplin olarak kabul edip etmediklerini derecelendirdikleri 'Disiplin Stilleri Anketi'ni doldurmuşlardır. Bu anketle birlikte annelere, depresyon belirtileri, kaygı belirtileri, sosyal destek algıları, kişilik özellikleri, başetme becerileri, kendi ebeveynleriyle ilgili algıları, kendi çocukluklarında uğradıkları örselenme yaşantıları, duygusal örslenmeyle ilgili farkındalıkları ve çocuklarının DEHB belirtileri hakkında bilgi toplamak için ölçekler de verilmiştir. Çocuklardan ise kendilik değeri, depresyon belirtileri, sosyal destek algılarıyla ilgili ölçekler doldurmuşlardır. Nesnel bilgi edinmek amacıyla öğretmenlerden de çocukların DEHB belirtileri hakkında ölçek doldurmaları istenmiştir. Nicel veriler SPSS 18 ile, açık uçlu sorular yolu ile toplanan nitel veriler ise MAX QDA 10 ile değerlendirilmiştir.

Sonuçlar

DEHB bileşik tip olan çocuklar ve kontrol grubu çocuklar demografik değişkenlerden ailelerinin gelir düzeyi ve anne eğitimi açısından birbirlerinden farklılaşmışlardır. DEHB bileşik alt tipi olan çocukların ailelerinin gelir düzeyi ve annelerinin eğitim düzeyi kontrol grubundaki çocukların ailelerinin gelir düzeyi ve annelerinin eğitim düzeyinden anlamlı oranda düşük çıkmıştır. Hiperaktivitesi önde olan çocukların ise tüm diğer gruplardaki çocuklardan daha uzun süre emzirildiği bulunmuştur.

Çocuk özelliklerine bakınca DEHB bileşik tipi olan çocuklar kontrol grubundaki çocuklara kıyasla anlamlı olarak daha yüksek depresyona, daha düşük kendilik değerine, daha düşük akademik başarıya, daha olumsuz aile, öğretmen ve arkadaş ilişkilerine sahip bulunmuşlardır. Hem öğretmen hem anne formlarında üç DEHB

grubunun Conners punları kendi içlerinde farklılaşmazken kontrol grubundan anlamlı oranda yüksek çıkmıştır. Diğer bir deyişle anneler ve öğretmenler sorunun hangi alanlarda olduğunu net ayırt edemese de DEHB'yla ilişkili bir sorunun varlığını yüksek oranda doğru ayırt etmişlerdir. Gruplar, zeka puanları, çocukların sosyal destek algısı açısından birbirlerinden farklılaşmamıştır.

Anne özelliklerine bakıldığında, DEHB bileşik tipi olan çocukların anneleri, kontrol grubu çocuklarının annelerinden sürekli kaygı, depresyon, ve erişkin DEHB ölçeğinde DEHB ile ilişkili sorun puanları üzerinde farklılaşmış ve hepsinde daha yüksek ortalamalara sahip bulunmuştur. Gruplar başetme becerileri ve kişilik özellikleri üzerinde farklılaşmamıştır.

Sonuçlar, DEHB bileşik tip olan çocukların annelerinin kontrol grubu annelerine kıyasla istismar içeren sözel ve fiziksel cezayı disiplin stili olarak kabul etmeye daha eğilimli olduklarını, aynı şekilde, bu çocukların daha fazla sözel ve fiziksel istismara uğradıklarını göstermiştir. Annelerin disiplin tutumlarının yordayıcılarının neler olduğu ve çocukların duygusal-davranışsal özelliklerinin annelerinin disiplin tutumlarıyla ilişkisi incelendiğinde, annenin sözel istismarı disiplin stili olarak kabul etmesinin çocuğun davranış sorunlarındaki artışı, çocuğun davranış sorunlarındaki artışın ise annenin fiziksel istismara başvurma olasılığını, sıklığını, ve bu istismar türünün şiddetini yordadağı bulunmuştur. Annenin, kendi çocukluk cinsel istismar öyküsünün, duygu odaklı başetme stilinin, kişilik özelliklerinin, istismar içeren ceza türlerini disiplin stili olarak kabul etmesini ve uygulamasını yordadığı sonucu elde edilmiştir. Bununla birlikte, bu çalışmanın sonuçlarına göre, annenin fiziksel cezayı disiplin stili olarak kabul etmesi çocuğun depresyon puanı üzerindeki artışı yordamış ve çocuğun davranış sorunları ve depresyon puanı arasında aracı değişken (mediator) işlevi görmüştür.

Tüm annelere ve çocuklara birlikte yeterince vakit geçirip geçirmedikleri ve birlikteyken neler yaptıkları sorulmuştur. Hem DEHB olan çocukların hem de kontrol grubundaki çocukların anneleri çoğunlukla çocuklarıyla geçirdikleri süreyi yetersiz ve kalitesiz bulduklarını aktarmışlardır. Bu oran DEHB olan çocukların anneleri için (%69) kontrol grubu annelerine (%56) kıyasla daha yüksek bulunmuştur. İlginç olarak çocuklar anneleriyle geçirdikleri süreden memnun

olduklarını belirtmişlerdir. Gerçekçi bir değerlendirme için ve bu sürenin ne kadar kaliteli geçirildiğinin anlaşılması için birlikte neler yaptıkları araştırılmıştır. Ders çalışma, tv izleme ve bilgisayar oynama, akrabağ ziyaretleri birlikte olunan sürede en sık yapılan aktiviteler arasında çıkmıştır. Hem annelere hem çocuklara aralarında en çok ne konuda sorun çıktığı sorulmuş ve her iki gruptaki anneler ve kontrol grubundaki çocuklar ders başarısını ve söz dinlememeyi en sorunlu alanlar olarak tanımlamıştır. DEHB olan çocuklar ise ders başarısından hemen sonraki problemli alanlar içinde hareketlilik ve dikkat problemlerini ve tv-bilgisayar başında geçirdikleri süreyi göstermişlerdir. Yine çocuklara ve annelere aralarındaki problemi nasıl çözdükleri sorulunca çalışma grubundaki annelerin %50'si, çocukların %57'si; kontrol grubunda annelerin %92'si, çocukların %84'ü evlerinde şiddet içermeyen bir ceza türü olmadığını aktarmıştır. Şiddet içeren cezalandırma yöntemleri sorgulanınca annelerin vurma, sarsma-sıkma, saç çekme, cimcikleme gibi fiziksel cezaları kullandıkları ve bu türlerin içerisinde en sık vurma-tokat atmanın görüldüğü anlaşılmıştır. DEHB olan grupta (anneler için %81, çocuklar için %71) vurma oranı kontrol gruba (anneler için %60, çocuklar için %36) göre oldukça yüksektir. Sözel şiddet türleri içerisinde ise aşağılama en sık başvurulan yöntemdir. Genel olarak, anneler, çocuklara göre aşağılamaya başvurma oranlarını daha yüksek bildirmişlerdir (DEHB grubu annelerinde %59, çocuklarında %33; kontrol grubu annelerinde %60, çocuklarında %8). Kontrol grubundan farklı olarak DEHB grubunda acındırma (DEHB grubu annelerinde %57, çocuklarında %20, kontrol grubu annelerinde %36, çocuklarında %20) ve karşılaştırma (DEHB grubu annelerinde %47, çocuklarında %17, kontrol grubu annelerinde %8, çocuklarında %20) da yüksek oranda bildirilmiştir. Çocuklara annelerinin söyledikleri sözlerin mi yoksa vurmasının mı onları daha çok incittiği sorulmuştur. Çalışma grubundaki çocukların %52'si annelerinin sözlerini, %38'i vurmasını daha incitici bulduklarını, %7'si her ikisine eşit derecede incindiklerini, %2'si hiçbirini incitici algılamadıklarını aktarmıştır. Kontrol grubunda, %68 bu tür davranışları sık yaşamadıklarını bu nedenle incinmediklerini, %20 annelerinin sözlerinin vurmasından daha incitici olduğunu, %4 her iki davranış türüne eşit incindiğini belirtmiştir.

Tartışma

Demografik özellikler üzerindeki grup farkları yazınla tutarlıdır. DEHB olan çocukların ailelerinde gelir düzeyi ve anne eğitim düzeyi yazında da düşük olarak bildirilmektedir. Ancak bu fark genelde kontrol grubu ve DEHB olan çocuklar arasında araştırılmıştır DEHB alttipleri arasında yapılan yeterli sayıda çalışma yoktur. Sonuçlar kontrol grubundaki çocukların DEHB bileşik alt tipi olan çocuklara kıyasla daha düşük depresyon ve kendilik değeri puanlarına sahip bulunmuşlardır. Yapılan çalışmalar bu bulguyu destekler niteliktedir. DEHB kısa ve uzun döenmeli pek çok olumsuz sonuç ile ilişkilendirilmektedir. Sürekli gerçek kapasitesinin altında performans sergilemek, aile, öğretmen ve arkadaşların eleştrisine maruz kalmak bir çocuğun kendine güvenini düşürebilir ve daha yüksek oranda depresif belirtilere sahip olmasına yol açabilir. Bununla tutarlı olarak Faraone ve ark. (1991) DEHB tanısı alan kızların daha yüksek depresyon ve bilişsel problemleri, daha düşük kendine güvenleri olduğunu bulmuştur. Çocukların DEHB belirti düzeyleri hem anneler, hem öğretmenleri tarafından conners üzerinde değerlendirilmiştir. Her iki kaynaktan alınan bilgi benzer örüntü sergilemektedir. Bu sonuçlara göre anneler ve öğretmenler çocukların DEHB belirtileri bulunup bulunmadığını doğru biçimde ayırt ediyorlar ancak tanı olarak hangi alt tipte olduklarını tahmin edemiyorlar.

DEHB olan çocukların annelerinin çalışmada araştırılan altı özellikleri içersinde depresyonları, sürekli kaygıları, DEHB'yla ilişkili sorunları çocukların DEHB tanısına göre farklılaşmıştır. Bütün bu alanlarda DEHB bileşik tip grubundaki çocukların anneleri daha yüksek puan almışlardır. Bununla birlikte, regresyon analizlerinde, annelerin depresyonu çocukların Conners ölçeğindeki Karşı Olma Karşı Gelme Bozukluğu ve Davranım Bozukluğu puanlarını yordamıştır. Yazına bakıldığında, DEHB bileşik tipin hem dikkat eksikliği, hem hareketliliği içerdiği bilinmektedir (APA, 1994) ve yine yazında DEHB bileşik tipe yıkıcı davranışların eşlik etme oranı daha yüksek olarak bildirilmektedir. Benzer şekilde Karşı Olma Karşı Gelme Bozukluğu ve Davranım Bozukluğu çevreye karşı agresif ve negativistik davranışlarla tanımlanmaktadır (APA, 1994). Çocukların yıkıcı davranışlarıyla annelerinin depresyonu arasındaki ilişkinin yazında desteği vardır (Evinç, 2004; Milberger, Biederman, Faraone, Murphy, ve Tsuang, 1995; Nigg ve Hinshaw, 1998). Çocukların dikkat ve hareketlilik sorunlarına kıyasla yıkıcı

davranışları ebeveyn için daha büyük bir stres etkeni olabilir (Patterson ve Forgatch, 1995). Biederman ve ark. (1995), yıkıcı davranışların DEHB'na eklendiği koşulda annenin major depresyon riskinin daha yüksek olduğunu bildirmiştir. Çocukların yıkıcı davranışları ve annelerin duygudurumu arasındaki ilişki, ortak yatkınlık etkenleri (Bradley ve Golden, 2001), olumsuz ebeveyn modeli (Garber, Robinson, ve Valentiner, 1997), depresif anneyle çocuğu arasında zayıf ilişkinin olması (Schachar, 1987), DEHB olan çocuğu idare etmenin, yönlendirmenin güçlüğü (McClearly ve Ridley; 1999), depresyondaki ebeveynin gelecek, kendisi, ve çocuğunu da içeren tüm çevresi ile ilgili genel bir olumsuz görüşünün olması ve yardım çağrısı içinde sorunların abartılarak rapor edilmesi gibi etkenlerden kaynaklanabilir (Cummings ve Davies, 1999; Lang, Pelham, ve Atkeson, 1999; Pelham ve ark., 1997). Annelerin DEHB ile ilgili sorunları DEHB bileşik tip tanısı alan çocukların annelerinde daha yüksek çıkmıştır. DEHB'nun kalıtımsal bir bozukluk olduğu (örn., Gilger, Pennington, ve Defries, 1992; gözden geçirme için; Bradley ve Golden, 2001) ve aynı zamanda ebeveynin DEHB'nun çocuğun psikolojik sorunlarına spesifik olarak da davranış problemlerine yol açabildiği gösterilmiştir (Faraone, Biederman, Mennin, Gershon, ve Tsuang, 1996).

Bununla birlikte bu çalışmadaki nitel bulgular çocuklar ve anneleri arasındaki en problemli alanın tüm grupta akademik başarı olduğunu ortaya koymuştur. İkinci sıradaki problem anne ve çocuk raporlarında farklıdır. Hem çalışma hem kontrol grubu çocukları tv-bilgisayar başında geçirdikleri süreyi ikinci sıraya koymuşlardır. Çalışma grubu, ayrıca, dikkat ve hareketlilik problemlerini de ikinci sırada değerlendirmiştir. Oysa anneler çok daha genel olarak sözlerinin çocukları tarafından dinlenmemesi, yani, çocukların annelerin söylediklerini yerine getirmemesini ikinci problem olarak değerlendirmiştir. Bu fark çalışma grubunda daha yüksektir ki, bu durum çalışma grubu çocuklarının daha yüksek istismar riski taşımasının bir açıklaması olabilir. Çalışmalar uzun dönemli olarak kurallara uyması için çocuğun disiplini içselleştirebilmesinin (Hart, DeWolf, Wozniak, ve Burts, 1992; Michels, Pianta, ve Reeve, 1993; Smith ve Brooks-Gunn, 1997; Strassberg, Dodge, Pettit, ve Bates, 1994) ve bunun için de ebeveynin mesajını doğru algılamasının gerektiğini göstermektedir (e.g., Vittrup ve Holden, 2010). Aksi koşullarda, çocuğun yanlış davranışı tekrarlama olasılığı ve bu durumun anneler tarfından çocuğun söz dinlelememesi olarak algılanıp istismara yol açma riski yüksek görünmektedir.

Sonuçlar, DEHB bileşik tip olan çocukların annelerinin kontrol grubu annelerine kıyasla istismar içeren sözel ve fiziksel cezayı disiplin stili olarak kabul etmeye daha eğilimli olduklarını, aynı şekilde, bu çocukların daha fazla sözel ve fiziksel istismara uğradıklarını göstermiştir. Önceki çalışmalarda da DEHB tanısı alan çocukların sözel ve fiziksel kötüye kullanıma maruz kalma açısından sağlıklı çocuklara kıyasla daha yüksek altında olduğu gösterilmektedir (Briscoe-Smith ve Hinshaw, 1996; Endo ve ark., 2006; Glod ve Teicher, 1996). Ancak DEHB alt tiplerini istismar oranı açısından karşılaştıran çok az sayıda çalışma vardır. Genel olarak çalışmalar istismarı araştırırken tüm DEHB alt tiplerini bir arada değerlendirme eğilimi sergilemektedir (Aliazadeh ve ark., 2007; Briscoe-Smith ve Hinshaw, 1996; Ford ve ark., 2000; Gahnizadeh ve ark., 2009; Wozniak ve ark., 1999). Bununla birlikte, artan ebeveynlik stresinin çocuğa kötü muamele için bir risk etkeni olduğuna işaret eden (Ford ve ark., 2000; MacKenzie, Nicklas, Brooks-Gunn ve Waldfogel, 2011) ve çocuk istismarının ortaya çıkma olasılığının ebeveynin çocuğu ne ölçüde zor algıladığıyla ilişkili olduğunu (Bugental ve Happaney, 2004) ortaya koyan çalışmalar bu çalışmanın sonuçlarını destekler görünmektedir. Regresyon analizlerinde annenin kendi çocukluğunda cinsel istismara uğradığına ilişkin algısı çocuklarına karşı sözel ve fiziksel istismar içeren disiplin tutumlarını yordamıştır. Yazında çocukken cinsel istismara uğrayan kişilerin erişkinlikte çeşitli olumsuz özelliklere sahip olabileceği (Kendall-Tackett ve Marshall, 1998), bağlanma bozuklukları (Cicchetti ve ark., 2006; Cyr ve ark., 2009) ve psikopatoloji geliştirebileceği (örn.; Haj-Yahiaa ve Tamish, 2001; Manly ve ark., 2001; Tooth ve ark., 1992), daha agresif olabileceği bildirilmektedir (Teisl ve Cicchetti, 2008). Bunlarla birlikte sosyal öğrenme teorisine dayanarak insanların ebeveyn olmayı kendi ebeveynlerini model alarak öğrendiği söylenebilir (Bandura, 1989; Bower-Russa, Knutson, ve Winebarger, 2001). Bu durum göz önünde tutlursa, cinsel istismarın saldırgan bir davranış olduğu ve bu istismara maruz kalan çocukların saldırgan ebeveynlik tarzını model alabileceği sonucuna varılabilir.

Bu çalışmanın bir diğer sonucuna göre, annenin fiziksel istismar içeren disiplin tutumlarını onaylaması çocukların depresyon puanlarını yordamaktadır. Bütünlük içinde değerlendirildiğinde sözel istismar içeren disiplin tutumları Conners ölçeğindeki davranış sorunlarını, fiziksel istismarın ebeveyn tarafından onaylanması

ise çocuğun depresyon puanını artırmaktadır. Sözel disipline ilişkin bu çalışmanın bulgularına bakıldığında, istismar türlerinin sonuçlarının birbiri ile benzer olduğunu, olumsuz sonuçlara yol açan temel şeyin bireyin kendilik algısının sarsılması olduğunu (Schneider, 2005) ve fiziksel istismar ceza olarak algılanabilirken sözel istismarın kendiliğe saldırı olarak algılandığını gösteren çalışmalarla tutarlı olduğu görülmektedir (Waller ve Kent. 2000). Bu sonuçlar bu çalışmada çocukların annelerinin söyledikleri sözleri vurmalarından daha incitici bulması ile de tutarlıdır. Fiziksel disiplinin ise duygu regulasyonu problemlerine yol açtığı bilinmektedir (Alink, Cicchetti, Kim, Rogosch, 2009). Fiziksel istismarın yıkıcı davranış sorunları ile çocuğun depresyon puanı arasında olası aracı değişken rolü (mediator) araştırılmış ve bulunmuştur. Yazında birebir desteği olmasa da Ford ve ark (2000), yıkıcı davranış sorunları olan çocukların daha yüksek oranda fiziksel istismara uğradıklarını ve PTSD geliştirdiklerini bulmuştur. Sonuç olarak bu çalışma ve Ford ve ark. (2000) yaptığı çalışma yıkıcı davranış sorunları olan çocukların fiziksel istismar içeren disipline maruz kalma ve sonrasında içselleştirme bozuklukları geliştirme açısından risk altında olduğunu göstermektedir.

Bu çalışma, çocukların davranış sorunları ve çocuk istismarı arasındaki ilişkiye ve bunun olası sonuçlarına dikkat çekmesi, bu ilişkide anneye ve çocuğa ilişkin bazı risk etkenlerinin rolünü göstermesi açısından önemlidir. Hem tanı hem belirtiyle, hem çocuk hem anneyle, hem nicel hem nitel yolla çalışılması araştırmanın güçlü yanları içerisindedir. Bununla birlikte çalışmaya babaların dahil edilmemiş olması bir kısıtlılıktır. Bundan sonraki çalışmalarda babaların tutumlarının da araştırılması önerilir.

CURRICULUM VITAE

PERSONAL INFORMATION

Surname, Name: Evinç, Şükran Gülin
Nationality: Turkish (TC)
Date and Place of Birth: 1978, Mersin

EDUCATION

Degree	Institution	Year of Graduation
MS	Middle East Technical University The Faculty of Social Sciences, Department of Psychology	2004
BS	Hacettepe University The Faculty of Social Sciences, Department of Psychology	2001
High School	Özel Toros Koleji, Mersin	1996

WORK EXPERIENCE

Year	Place	Enrollment
2004-Present	Hacettepe University Department of Child and Adolescent Psychiatry	Psychologist
2002-2004	Özel İlgi Özel eğitim Merkezi	Psychologist

FOREIGN LANGUAGES

Advanced English

PUBLICATIONS

I- Published Articles

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