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IMPACTS OF PARENTIFICATION DUE TO MATERNAL DEPRESSIVE SYMPTOMS ON THE PSYCHOLOGICAL SYMPTOMATOLOGY AND INTERPERSONAL RELATIONSHIP QUALITY OF THEIR YOUNG CHILDREN: PROTECTIVE ROLE OF FATHER INVOLVEMENT

SİNEM ÇELİK

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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, Last name : Sinem Çelik

Signature :

ABSTRACT

IMPACTS OF PARENTIFICATION DUE TO MATERNAL DEPRESSIVE SYMPTOMS ON THE PSYCHOLOGICAL SYMPTOMATOLOGY AND INTERPERSONAL RELATIONSHIP QUALITY OF THEIR YOUNG CHILDREN: PROTECTIVE ROLE OF FATHER INVOLVEMENT

Sinem Çelik
Master of Science, Developmental Focused Clinical Child and Adolescent Psychology
Supervisor: Assoc. Prof. Dr. Ilgın Gökler Danışman
Co-Supervisor: Assist. Prof. Dr. Yağmur Ar-Karcı
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Maternal depression/depressive symptoms have deleterious impacts on children. Although previous studies emphasized the impacts of maternal depression/depressive symptoms on child's symptomatology and interpersonal relationships, there is surprisingly no research about the role of father involvement on parentification due to maternal depressive symptoms and child's symptomatology and interpersonal relationship quality. The purpose of current study is to investigate the role of fathers on the consequences of parentification due to maternal depressive symptoms with regard to adolescents' psychological symptomatology and interpersonal relationship quality. Of 238 mother- adolescent dyads, adolescents completed Parentification Inventory (PI), Father Involvement Scale (FIS), Brief Symptom Inventory (BSI), Scales of Dimensions of Interpersonal Relationships (SDIR) and their mother completed State-Trait Depression Inventory (STDI). The results demonstrated that although maternal depressive symptoms did not significantly predict parentification

level of adolescents, it significantly predicted adolescents' psychological symptomatology and interpersonal relationship quality. In addition, while father involvement had negative significant effect on parentification level of adolescents, both father involvement and parentification and their interaction had no significant effect on the adolescents' symptomatology and interpersonal relationship quality. The current study contributed to our understanding of how maternal depressive symptoms have deleterious impacts on adolescents' symptomatology and interpersonal relationship quality. Also, it pointed out the protective role of father involvement on adolescents who might be at risk for parentification.

Keywords: Maternal Depressive Symptoms, Parentification, Father Involvement, Psychological Symptomatology, Interpersonal Relationship Quality

ÖZET

ANNENİN DEPRESİF BELİRTİLERİ KAYNAKLI EBEVEYNLEŞME DENEYİMİNİN GENÇ ÇOCUĞUNUN PSİKOLOJİK SEMPTOMATOLOJİ VE KİŞİLERARASI İLİŞKİ KALİTESİNE ETKİSİ: BABA KATILIMININ KORUYUCU ROLÜ

Sinem Çelik
Master of Science, Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi
Tez Yöneticisi: Doç. Dr. Ilgın Gökler Danışman
Ortak Tez Yöneticisi: Dr. Öğr. Üyesi Yağmur Ar-Karcı
Ocak, 2021

Ebeveyn psikopatolojilerinden biri olan anne depresyonu/depresif belirtileri hem anne hem aile hem de çocuklar üzerinde zararlı etkilere sahiptir. Önceki çalışmalar, anne depresyonu/depresif belirtilerinin çocukların psikolojik semptomatolojilerinde ve kişiler arası ilişkilerine vurgu yapsa da, şaşırtıcı şekilde, gençlerin anne depresif belirtilerinden kaynaklı ebeveynleşme deneyiminde ve onların semptomatolojilerinde ve kişiler arası ilişkiler niteliğinde baba katılımının rolünü araştıran bir çalışma bulunamamıştır. Bu çalışmanın amacı, anne depresif belirtilerinden kaynaklı ebeveynleşme deneyiminin sonuçlarından baba katılımının rolünü gençlerin psikolojik semptomatolojisini ve kişilerarası ilişkiler niteliğini dikkate alarak incelemektir. 238 anne-genç çiftinden, gençler Ebeveynleşme Envanteri (EE), Baba Katılım Ölçeği (BKÖ), Kısa Semptom Envanteri (KSE) ve Kişilerarası İlişki Boyutları Ölçeği'ni (KİBÖ); anneler ise Durumsal-Sürekli Depresyon Ölçeği'ni (D-SDEP) doldurmuştur. Sonuçlar, annenin depresif belirtilerinin gençlerin ebeveynleşme düzeylerini yordamasa da, gençlerin psikolojik semptomlarını ve kişilerarası ilişki niteliklerini

yordadığını göstermiştir. Ayrıca, baba katılımı gençlerin ebeveynleşme düzeylerini ters yönde anlamlı olarak etkilerken; baba katılımı ve annenin depresif belirtilerinin etkileşimi ebeveynleşme üzerinde anlamlı bir etkiye sahip değildir. Ayrıca, annenin depresif belirtileri, baba katılımı, ebeveynleşme ve bunların etkileşimi gençlerin psikolojik semptomları ve kişilerarası ilişki niteliklerini anlamlı bir şekilde etkilememektedir. Bu çalışma, annenin depresif belirtilerinin gençlerin psikolojik semptomları ve kişilerarası ilişki nitelikleri üzerinde nasıl zararlı etkileri olduğunu anlamamıza önemli katkılar sunmuştur. Ayrıca, ebeveynleşme riski olan gençlerde baba katılımının önemine dikkat çekmiştir.

Anahtar Kelimeler: Anne Depresif Belirtileri, Ebeveynleşme, Baba Katılımı, Psikolojik Semptom, Kişilerarası İlişki Niteliği

To myself, to my brother, to my beloved one…

To all wounded parentified children...

Let’s find a place, far from the world...

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CHAPTER 1

INTRODUCTION

"I lost my childhood."

These are the words of a woman who had to grow up with parental psychopathology (Knutsson-Medin et al., 2007). Although it might seem a personal struggle for the parent, parental psychopathology takes its toll on the whole family, and particularly on the children. Psychosocial impacts of parental mental disorders on offspring are persisting, usually displayed through infancy to adulthood (Santana et al., 2015; Velders et al., 2011; Vostanis et al., 2006). In the families with parental psychopathology, family environmental and genetic factors are of utmost importance impacting on family functioning, parenting strategies and development of children (Silberg et al., 2011; Velders et al., 2011; McKinney & Franz, 2018). Children of parents with psychological disorders are at higher risk for future psychopathology or psychological problems compared to children of psychologically healthy parents because there is a transmission of psychopathology (e.g., behavioral disorders, depression, schizophrenia, bipolar disorder) through genes or parenting styles (Elsayed et al., 2019; Santana et al., 2015; Sucksdorff et al., 2014; Vidair et al., 2012; Vostanis et al., 2006). Particularly, these children deal with internalizing (e.g., anxiety, depression) (Elsayed et al. 2019; Silberg et al., 2011) and/or externalizing problems (e.g., conduct, hyperactivity) (Silberg et al., 2011; Vostanis, et al., 2006).

One parental psychopathology usually leading to harmful impacts on family is maternal depression. Investigation of maternal depression seems to be important since even short episodes of the disorder might be distressing for families. While it may occur after birth and may last shorter in the form of postpartum depression, it may also

last longer and become chronic in some families (Bagner et al., 2010; Farías-Antúnez et al., 2018; Knutsson-Medin et al. 2007). Similar to other psychological disorders, maternal depression might exert its impact not only on mothers, but also on the whole family (Burke, 2003; Gelfand & Teti, 1990). Impairments in family functioning and role anbiguities are quite common among families with depressed mothers. Maternal depression takes its toll on children, as well. Findings suggested that children of depressed mothers are at greater risk for various psychological and social problems (e.g., attachment problems, anxiety or depressive symptoms, substance abuse, role reversal, poor social functioning and social impairments in relationship with peers) (Billings & Moos, 1983; Champion et al., 2009; Goodman et al., 1993; Goodman et al., 2011; Hammen et al., 2008; Mechling, 2015; Raposa et al., 2012). Unfortunately, impacts of such psychosocial problems might be evident through the child's life span if left untreated (Raposa et al., 2012). One important mechanism exacerbating negative impacts of maternal depression is parentification. Simply referring to reversal of parent-child roles, children of maternal depression are at greater risk for improper family role changes, which is further associated with several psychological symptoms (Champion et al., 2009; Knutsson-Medin et al., 2007; Van Parys et al., 2013; Van Parys et al., 2014). Nevertheless, existing studies focusing on debilitating impacts of maternal depression in the context parentification are one-sided, excluding presence of a healthy father. In fact, father involvement can theoretically have a shielding effect, counteracting the negative impacts of maternal depression (Lewin, et al., 2015; Vakrat et al., 2017). Nevertheless, to the authors' knowledge, there has been no detailed investigation of the buffering effect of father involvement on maternal depression in the context of parentification.

Accordingly, this thesis aimed to understand the association between maternal depression and its possible psychosocial outcomes on offspring's life by also considering impact of father involvement. Accordingly, devastating effects of maternal depression on parenting styles, offspring and family was explained in the first section. Then, parentification was conceptualized with regard to its types, risk factors, underlying mechanisms. After highlighting the parentification and its effects in the context of maternal depression, father involvement which would be a possible buffering factor in the families with maternal depression was investigated. Finally, the aim of the current study was explained with the proposed models.

1.1. Effects of Maternal Depression

The symptoms of maternal depression directly interfere with the psychosocial health of family members (Burke, 2003; Lovejoy et al., 2000). Firstly, some impairments in parenting capacity are quite common among depressed mothers (Azak et al., 2013; Wolford et al., 2019). When compared with healthy non-depressed mothers, depressed mothers tend to be worse in parenting styles which results in increased developmental, psychological and social problems (e.g., delayed language development, more anxious and depressive symptoms and impaired interpersonal relationship) on their offspring (Hammen et al., 2008; Quevedo et al., 2011; Raposa et al., 2014; Righetti-Veltema et al., 2003). Additionally, low cohesion and higher conflict among family members is another problem, frequently observed in these families (Foster et al. 2008). Particularly, lower cohesion in the family impairs child's relationship with peers (Hipwell et al., 2005). Also, dysregulation in daily chores is evident in the presence of maternal depression due to the inherent nature of depressive symptoms (e.g. low motivation, exhaustion etc.) (Aldrige, 2006; Valdez et al., 2011;

Van Parys & Rober, 2013). Since the daily chores are generally expected by the mother in patriarchal societies, dysregulation in the family can be a huge problem by varying with the severity of symptoms.

1.1.1. Parenting Capacity of Depressed Mothers

Parenting skills usually have facilitative roles for healthy development of children (England & Sim, 2009). For a healthy psychosocial development, qualities of parenting should vary and be arranged according to the child's developmental needs. For instance, being sensitive and providing consistent care are the main tasks of parenting during infancy, while monitoring and providing room for separation becomes more pronounced in adolescence (England et al., 2009). For effective parenting, age-appropriate warmth and structure is necessary to help children develop sense of security and adaptive emotion regulation strategies (Cole et al., 2004).

It is inevitable that maternal depression affects the mother's parenting skill and parenting behaviors in numerous ways (Turney, 2011; Weissman & Paykel, 1974; Weissman et al., 1972). Symptoms of depression, which are closely related with impairments in affective, cognitive and behavioral domains, negatively affect the interaction between mother-child dyads (Azak et al., 2013; Hughes et al., 2013; Lovejoy et al., 2000; Santona et al., 2015). Generally, depressed mothers experience negative affect more. For instance, they are more hostile, distressed, irritable, and emotionally unavailable when compared with non-depressed mothers (Radke-Yarrow et al., 1994). Consistently, observational studies have shown that maternal responsiveness to children's behavior is lower among depressed mother and their interaction with the children have more negative features in terms of communication and synchrony (Cohn et al. 1990; Field et al., 1990; Goodman & Brumley, 1990.)

Also, children of depressed mothers are not provided appropriate guidance in terms of social skills (Emde et al., 1986; Gelfand et al., 1986; Goodman et al., 1990).

Two main parental patterns have been consistently observed among depressed mothers. These patterns are namely parental withdrawal and parental intrusiveness (Cohn et al.,1990; Cummings & Davies, 1994; Field et al., 2009; Gelfand et al., 1990). Although they are the opposite end of a continuum, both parenting behaviors might be exhibited by the depressed mother depending on the course of the disorder. As a result, children perceive this inconsistency in parenting behaviors as stressful (Gelfand et al., 1990; Jaser et al., 2005; Palaez et al., 2008). Depressed mothers who show parental withdrawal patterns have usually flat affect, and their activity level is lower than non-depressed mothers (Bornstein et al., 2011; Field et al., 1985). They have limited awareness of their children's actions and of what is happening in the lives of children (Gelfand et al., 1990). They were also found unable to follow their children's action and protect them from possible physical dangers. To illustrate, during the interview for a study, one of the depressed mothers was not aware that her child was climbing on a television set (Gelfand et al., 1990). Additionally, depressed mothers' responsiveness is less contingent (Flykt et al., 2010). They have little conversation and communication with their children which might result in delays in the language development (Cox et al., 1987; Quevedo et al., 2011; Righetti-Veltema et al., 2003). On the other hand, depressed mothers who have intrusive behaviors overstimulate their children. They disproportionately interfere with the child's life and do not give opportunity for building autonomy (Barber, & Xia, 2013; Field et al. 2006). However, their involvement is in an unhealthy affecting the psychosocial development of children negatively. These mothers have a tendency to interact with their children in

an angry and irritable manner (Field et al., 1990; Lovejoy et al. 2000). They also criticize their children more than the nondepressed mothers (Vakrat et al., 2017).

1.1.2. Dysregulation in Daily Chores

Physical arrangements in the household of families with depressed mothers are also compromised due to the inherent nature of depression (Corman et al., 2016). Unfortunately, daily chores are usually expected to be fulfilled by mothers due to culturally imposed gender roles (Cerrato & Cifre, 2018; Fetterolf & Rudman, 2014). In these families, daily chores such as cleaning, cooking and washing are interrupted because of lack of energy and motivation that depressed mothers experience (Alridge, 2006; Valdez et al., 2011). Dysregulation in daily chores might be even worse during times of hospitalization (Van Parys et al., 2013). Not only daily chores but also physical needs of children (e.g., nutrition or clothing) are detrimentally affected by maternal depression, resulting in poor physical health (Raposa et al., 2012). Since mothers slog on cooking, baking or feeding, children of depressed mothers are at a greater risk for having less healthy diet which can result in obesity or malnutrition (Anato et al., 2020; Garg et al., 2015; McConley et al., 2011; Noonan et al., 2016). In addition, clothing of children with depressed mother can be inattentive (sloppy) with messy and unseasonable (improper) clothes.

1.1.3. Dysfunction in the Family Process

Family functioning is another important issue that is affected by maternal depression. According to Family System Theory, families have a holistic nature. Accordingly, each member of the family affects one another in the family system in terms of behaviors, feelings and relational dynamics (Minuchin, 1974). Particularly, cohesion and rigidity are the most central terms underlying the family process

(Feldman et al., 2001). In families with higher family cohesion, cooperation among family members is more evident. Family members are more involved, and parents are more willing to catch the emotional signals given by the child. Also, there is a warm atmosphere coupled with acceptance and respect towards other's autonomy. By contrast, in families with high rigidity, enmeshment is more typical. In rigid families, autonomy is not encouraged, and adults are at the focus rather than children (Minuchin, 1974).

Concerning the interactions between subsystems (e.g., marital, parental etc.), cohesion in the family is usually related to higher marital satisfaction, greater reciprocity and synchrony (Feldman et al., 2001; Keren et al., 2005; Kitzmann, 2000). On the other hand, family rigidity affects family subsystems by increasing distance and decreasing contact and touching behaviors (Feldman et al., 2003). Overall, it can be implied from these findings that while family cohesion and harmony are accentuated by parental reciprocity, family rigidity and interruption is caused by intrusive parents.

In families with maternal depression, the relationship between family members as a whole is also impaired as a consequence of maternal depression. The impairment in relationship results in poorer family cohesion, lower warmth and increased intrusiveness and conflicts among family members, which is a key feature of rigid families (Foster et al., 2008). Also, in case of maternal depression, fathers are found to be less sensitive and more intrusive (Vakrat et al., 2017) which hightens the conflicts between parents and creates double risk for children. The effects of parental conflict in families with maternal depression can be seen in child's interaction with their peers by putting their social functioning at risk. These children who are exposed to parental

conflict tend to show aggression towards their peers through physical (e.g., physical aggression) or verbal actions (e.g., denigration or gloating) during play (Hipwell et al., 2005).

In families with maternal depression, ineffective parenting, dysregulation in daily chores and dysfunction in the family process can create profound distress for the affected children. To lower the stress and maintain family functioning, the child may need support from the other family members, especially father, or assume responsibility by taking adult roles (Jurkovic, 1997; Van Parys et al., 2014). Assuming adult roles due to unfulfilled parental responsibilities results in development of parentification in such families (Minuchin et al., 1967).

1.2. Parentification

Minuchin was one of the first theorists who pointed out to the parentification experiences by coining the term "parental child" to address children who take parental roles to ensure healthy conditions in the disordered families (Minuchin et al., 1967). Later, Boszormenyi-Nagy and Spark defined 'parentification' as a process implicitly or explicitly forcing children to fulfill parental roles in the family system (1973).

In typical families, the ones who are responsible for caregiving are ideally parents and/or other adults (Katz et al., 2009). They are responsible for meeting physical and emotional needs of the children. However, caregiving responsibility can shift through role-reversals particularly in poor functioning families (Minuchin et al., 1967). In those families, children can assume the role of a caregiver and act as if they were the parents of their own parents and siblings. For instance, a child can work to support his/her family financially, or an older sister take the responsibility of caring for her younger siblings. As an another example, a young boy can give emotional

support to his mother by putting aside his grief after his parents are divorced. Also, the parentified children may not act as the parents of their own parents but they can take the role of missing parent by acting as the spouse of remaining parent. For example, after death of her mother, a girl may start to behave motherly and support her father by taking the role of her mother in terms of physical and emotional responsibilities in the family. These children whose childhood is "dead" and who behaves as an adult are called "parentified" or "parental" children. (Minuchin et al., 1967; Earley & Cushway, 2002). For parentified children, given responsibilities are mostly not suitable with their developmental needs.

In the literature, parentification is divided into two main types which are (1) instrumental and (2) emotional parentification (Jurkovic, 1997). The division is based on the nature of responsibilities that children take in the family. Although some children might exhibit both, one is usually more prevalent depending on the particular family climate.

In families where the child provides tangible support for the physical well-being of the household, *instrumental parentification* is more pronounced (Jurkovic, 1997). Because parents may not be functioning well enough to perform adult responsibilities, the child is somehow feels obliged to fulfill adult responsibilities. In those families, the parentified child may take care for one of the parents and/or siblings. Also, these children take responsibility for cleaning the house, cooking, washing dishes and clothes and/or shopping for the household (Hooper, 2007; Knutsson-Medin et al., 2007; Van Parys et al., 2014). Moreover, it is possible for the parentified child to work for earning money to contribute to the family budget. Another type of parentification is *emotional parentification* which is closely related with

feeling responsible for meeting emotional and psychological needs of the family members (Hooper, 2007). In this type, the child usually suppresses his/her needs and tries to meet the family members' emotional needs by supporting them. Accordingly, parentified child tries to make family members feel better emotionally. Sometimes, the child can be the moderator to solve family problems or be the secret keeper during times of crisis (Akün, 2017; Earley et al., 2002; Hooper, 2007).

Among types of parentification, emotional parentification is accepted to be the one with more detrimental impacts on child's well-being (Alridge, 2006). One of the reasons for that is the inconsistency between parent's exaggerated expectancies and the child's age and maturity. Another reason is that the child ignores his/her needs for the sake of parents' or siblings' well-being as a result of which his/her needs are not optimally met. Also, the other important reason is the role ambiguity among these families (Hooper, 2014). Parentified children usually behave as an adult and become the parent of the family. Shifting roles creates an ambiguity for what to do and how to feel about their identity. Additionally, in emotional parentification, the child cannot see the rewards of his/her actions regularly while rewards associated with instrumental parentification can be observed immediately (e.g. maintenance of regular functioning in the house, earning pocket money). That is, reward is not immediately accessible in emotional parentification. For example, their effort to make mother feel emotionally better may not come work all the time. Therefore, the parentified children may think that they should show more effort or find alternative ways for possible positive outcomes (Mordoch & Hall, 2008). This ambiguity might make the parentified children to feel hyper alerted all the time.

1.2.1. Risk Factors for Parentification

There are specific vulnerability factors related to family patterns or children's demographic characteristic that put the children at an increased risk of parentification experiences (Akün, 2017). Particularly, loss of a parent, parental divorce and chronic physical or psychological illnesses in the family are amongst these factors. In families with parental loss due to death, children usually assume responsibility for taking the role of the deceased parent and filling out the gap emerged in response to death (Van Parys et al., 2014). The new roles of the children might include both tangible (e.g., financial support) and emotional aspects (Lamorey, 1999). Similar to families with parental loss, parental divorce is another risk factor for the development of parentification. In those families, the child can take the parental role by emotionally or physically supporting the other parent s/he lives together (Jurkovic et al., 2001). Another risk factor is having a family member with a chronic illness or disability (Burnett et al., 2006; Champion et al., 2009; Stein et al., 2007). In the families with physical chronic illnesses (e.g., cancer and HIV/AIDS) or disabled parent/sibling, both instrumental and emotional parentification patterns are simultaneously evident (Cohen, 1998; Lamorey, 1999; Stein et al., 2007; Thastum et al., 2008). In this family pattern, the child is forced to fulfill the responsibilities of the parent since the parent have limited functionality to perform those tasks due to chronic illness and disability. In particular, s/he helps the other parent by doing household tasks and taking care of the affected parent or siblings which generally points out to the experience of instrumental parentification (Stein et al., 2007; Thastum et al., 2008). Similarly, in the families with disabled parent/siblings, the responsibilities of non-disabled children include but not limited to providing assistance to disabled family members for

preparing meals, helping her/him to eat, clothing, toileting and bathing which means these children have more age improper duties in the family system when compared with their peers (Cohen, 1998; Lamorey, 1999). Similarly, parentification is quite prevalent in the families with psychological illnesses. In the context of parental depression, bipolar disorder, and substance use (Backer et al., 2017; Burnett et al., 2006; Champion et al., 2009), existing findings indicated that there is an increase in the caregiving practices of displayed by affected children. Accordingly, they exhibit both emotional and instrumental parentification, similar to children of parents with physical chronic illnesses (Backer et al., 2017; Burnett et al., 2006; Champion et al., 2009).

The family patterns may not be the only risk factors for parentification. The other factors are related to child's demographic characteristics and his/her position in the family. In parentification process, gender and birth order of the child are considered as contributing factors. Generally, eldest children or the only children are the ones who experience parentification through care provider role more than other children (Andsager, 2015). Also, girls are more likely to become parentified (Alridge, 2006; Burnett et al., 2006; Jurkovic, 1997) and experience both emotional and instrumental parentification more frequently when compared with boys. In addition, girls are expected to calm their parents in case of conflicts between parents which might be explained by the traditional gender roles (Vuchinich et al., 1988).

As it is explained above, in families with maternal depression, parentification is a highly possible experience for children. Children with depressed mothers initially try to understand what is happening in the family system (Earley et al., 2002; Goodman et al., 2011; Mordoch & Hall, 2008). Because what is happening to mother is a kind

of taboo and not discussed among family members, these children try to find cues to make sense of maternal condition. Also, these children are sensitive in detecting behavioral signs and cues during their interaction with their parents (Pölkki et al., 2005). Through monitoring emotional cues, they make inferences about the well-being of the depressed parent to improve conditions in the household (Knutsson-Medin et al., 2007; Pölkki et al., 2005).

1.2.2. Mechanisms of Parentification in Families with Maternal Depression

In the families with maternal depression, there are particular explanatory mechanisms which might account for parentification experience of children. These mechanisms are important to understand as the path from depressed mother to parentified children would also provide psychosocial components necessary for prevention and intervention programs.

1.2.2.1. Negative Affect of Depressed Mother

Negative affect of the depressed mothers usually makes the child to feel as if s/he was responsible from the negative mood of the parent (Van Parys et al., 2013). The depressed mother may generally seem sad, aloof and angry with the feelings of helplessness and hopelessness. Then, the child tries to alleviate mother's depressed feelings through emotional parentification (Van Parys et al., 2013; Alridge, 2006). The parentified children spend considerable effort to make mother laugh, happy, and energic. The child's efforts are mainly centered around pulling the mother out of depressive state. Additionally, they avoid certain acts in order not to arouse feelings of anger, sadness and disappointment for the depressed mother (Knutsson-Medin et al., 2007). For this purpose, the child might also hide his/her true feelings not to burden mother as the mother is already in trouble (Chase, 1999; Van Parys et al, 2013).

1.2.2.2. Mother's Inability to Meet Needs of the Family Members

Mother's inability to meet needs of the family members and household is another mechanism that poses a significant risk for the parentification in families with depressed mothers. Dysregulation in daily chores because of the somatic symptoms of depression forces one in the family to make necessary arrangements at home (Knutsson-Medin et al., 2007; Van Parys et al., 2014). In the qualitative studies conducted with children of depressed parents, it was revealed that children felt responsible for completing daily household tasks as someone had to perform them (Knutsson-Medin et al., 2007; Van Parys et al., 2013; Van Parys et al., 2014).

Generally, the eldest child is the one in the family assuming responsibility (Andsager, 2015) and carrying out the tasks that are expected from mother by exhibiting instrumental parentification. For example, instead of the father or the depressed mother, the parentified child may cook and bake for the family, clean home, wash dishes and clothes, take care of younger siblings and deal with daily familial problems (Van Parys et al., 2014).

1.2.2.3. Familial Expectations about Child's Role in the Family

In the families with maternal depression, children are expected to be there when they are needed in times of crisis (Van Parys et al., 2015). Parents, grandparents or sometimes even doctors set an expectation on the children in that direction. The expectation of parents or grandparents are based mainly on enhancing well-being of the depressed mother. The roles of these children range from rescuing mother from suicide attempts to solving conflicts between parents (Van Parys et al., 2015). As it has been mentioned above, maternal depression eventually affects the quality of the relationship between spouses, as well. Like the depressed mother, the father can be

angry or withdrawn which may increase the number and severity of the marital conflicts (Vakrat et al., 2017). Sometimes, the conflicts may even include physical violence to which generally the mothers are exposed. In those times, especially daughters are drawn into conflicts to calm parents, provide closure and keep the peace (Vuchinich et al., 1988). They manage marital conflict of parents by taking the soother role and giving them emotional and physical support after conflicts. Sometimes, they may give physical care to mother who gets injured, as well. Yet, sometimes, they try to be available to mother to prevent her disastrous circumstances like suicide (Alridge & Becker, 2003; Van Parys et al., 2013; Van Parys et al., 2014).

1.2.2.4. Intergenerational Transmission of Parentification

The literature of intergenerational transmission of parentification yielded the linkage between the parenting style of parents in the family of origin and one's own parenting styles (Belsky et al., 2009, Earley et al., 2002). Similarly, it is theorized that this transition might also be observed among parentified children when they themselves become parents in their adulthood (Barnett, & Parker, 1998; Bowen, 1978; Boszormenyi-Nagy et al., 1973; Hooper, 2008; Stein et al., 2007). The adults, who themselves had been parentified in the early years of their life, show the same pattern as a parent expecting age-inappropriate tasks from their children (Byng-Hall, 1995). Although there are not sufficient findings to support this hypothesis, a few studies found the intergenerational transmission of parentification starting even from preschool ages and earlier (Macfie et al., 2008). Especially, mothers who had role reversal experiences with their own mothers are more likely to have the same relationship with their daughters (Macfie et al., 2005). Also, the parents who were parentified in their childhood want their child to help them daily chores, solve their

problems or reparent them to compensate for the parental care lacking in their own childhood (Earley at al., 2002; Schier 2014).

Overall, a process full of age-inappropriate responsibilities affects parentified children's life in certain psychosocial domains. Yet, a much-debated questions is whether parentification might also impose positive impacts on child' well-being. For the effects and outcomes, the literature is divided into two: (1) the ones who defend parentification has negative outcomes and (2) the others who claims parentification might also have silver linings.

1.2.3. Outcomes of Parentification

Unfortunately, parentified children pay a price to compensate for their parents' dysfunctionality. In that respect, related literature has approached to the outcomes of parentification differently. While some researchers insist on debilitating impacts of parentification (Andsager, 2015; Champion et al., 2009; Jelastopulu et al., 2013; Knutsson-Medin et al., 2007; Van Parys et al., 2013), some others claim that parentification experience might also have some silver linings (Godsall et al., 2004; Hooper et al., 2008; Stein et al., 2007). Still, it is the opinion of the authors that, devastating negative outcomes of maternal depression be emphasized more to protect these ignored children.

Psychological Symptomatology

It is obvious that parentified children are at risk for exhibiting both internalizing and externalizing problems (Champion et al., 2009; Chase et al., 1998; Katz et al., 2009). Generally, female parentified children tend to have more internalizing symptoms, while male counterparts show greater propensity to developing externalizing disorders. Several studies have yielded that parentified children greater

anxiety and depression symptoms when compared with non-parentified children (Andsager, 2015; Champion et al., 2009; Jelastopulu et al., 2013). Although both instrumental and emotional parentification is related to anxiety symptoms, emotional parentification was found to be more closely related with anxiety symptoms (Champion et al., 2009). Additionally, providing age-inappropriate care to parents and siblings lead to ambiguity in the self-perceptions of these children. Parentified children are in a constant flux to decide whether they are a child or an adult. They feel as if they had lost their identity because of their ambiguous roles in the family system (Jelastopulu et al., 2013). By contrast, there are some findings related to positive outcomes for self-concept and better coping skills of the parentified children (e.g. greater self-worth, greater social competence, feeling of mastery and self-esteem) (Baggett et al., 2015; Godsall et al., 2004; Stein et al., 2007). However, it should not be forgotten that there are other ways for children to display these positive self-concepts rather than a tough experience like parentification.

Relationship Aspects

As a tough and age-inappropriate experience, parentification might also impair quality of interpersonal relationships in the future for the affected children. Yet, there are limited number of studies examining the association between interpersonal relationship quality and parentification. Existing studies focus on attachment styles, quality of romantic relationship and features of interpersonal relationships (Baggett et al., 2015; Kibwea et al., 2017; Madden & Shaffer, 2016). Specifically, college woman who were parentified in their childhood, had lower levels of satisfaction in their romantic relationships and usually formed insecure attachments with their partners (Baggett et al., 2015). Researchers accounted for the participants' interpersonal

experiences through Boundary Dissolution Theory. Since their boundaries were dissoluted by their parents as children, they possibly have role conflicts and trouble to recognize other's limits and personal space. This might be why they have difficulties to maintain healthy boundaries with others which may have negative impacts on their relationship satisfaction (Collins et al., 1997; Linder & Collins, 2005; Sroufe et al., 1993). Additionally, young adults who were parentified during their childhood have less constructive communication patterns with their partners which may be mediated by their attachment-related beliefs (Madden et al., 2016). Interpersonal relationship quality of parentified children are also challenged (Hooper, 2014; Kibwea et al., 2017) since their relationship with the attachment figure was adversely affected in the early years of their life (Hooper, 2014; Kibwea et al., 2017). Nevertheless, more research is needed to elaborate the link between childhood parentification and later close relationship quality.

Parentification of children and its negative effects on child's development is an established association in the families with maternal depression. However, there might still be some protective factors operating simultaneously resulting in differential child mental health outcomes. It is quite obvious that parentified children affected by maternal depression need support and assistance to share responsibilities, and express how they feel about the duties assigned to them (Knutsson-Medin et al., 2007; Van Parys et al., 2015). Accordingly, adults with previous parentification history highlighted the importance of social support from family members or others to cope with imposed stressors. They also stressed their wish for taking professional support to manage their burden while providing care for the family (Knutsson-Medin et al., 2007). Here, father's support may be the first choice due to being one of main

caregivers, sharing similar experiences with the child and being accessible because of living arrangements. In fact, the protective role of father's presence in the families with maternal depression has been proven in the literature even when the father and child do not share the same house (Lewin et al., 2015).

1.3. Father Involvement

In general terms, father involvement refers to the emotional and material support provided by father both to the children and family. Although rates of father involvement was low in 70s and 80s, it has increased over the years indicating that fathers give more importance to spend time with their children (Cabrera & Tamis-LeMonda, 2013). However, time spent by with for their children have never been as much as the time spent by mothers. Also, some developmental psychologists remarked the importance of the quality of time spend with children and expanded the conceptualization of father involvement. According to Bornstein (2002), father involvement is not just a term that is only related to father-child interaction but it also includes father's contribution to mother's well-being. Spending time and engaging with family, supporting mother and child for the daily chores, giving emotional care and being sensitive and less intrusive are suggested to be important components of positive father involvement for both mother's and child's well-being (Laxman et al., 2015).

In families with maternal depression, father involvement might also be compromised due to mother's psychopathology and related familial factors (Paulson et al., 2006). Some studies have explained this negative condition through spillover effect (Kouros et al., 2014; Margolin et al., 1996). In particular, the crisis and conflicts centered around mother's psychopathology is related with paternal withdrawal,

insensitivity and intrusion. This situation put the affected children at double risk in terms of impairments in social-emotional growth (Vakrat et al., 2017). Yet, if fathers stay more in tuned and involved, paternal involvement can have a buffering effect on the relation between maternal depression and child's psychosocial development (Goodman et al., 2014). Although limited in number, some studies have provided support for the protective effect of paternal involvement in the context of maternal depression (Laxman et al., 2015; Lewin et al., 2015). To illustrate, in divorced families with teen mothers (Lewin et al., 2015), increase in father involvement decrease the infant's distress by buffering maternal depression's impact on children. Also, if the father is highly sensitive and less intrusive, maternal depression does not affect the family cohesion as much as in the case when father involvement is low. Yet, if father engages with the child from the early years of his/her life, it prevents mothers from possible depressive symptoms (Laxman et al., 2015). On the contrary, when the father involvement is low, fathers display less sensitivity and greater intrusiveness. In that case, the child could find little opportunities for social engagement. Also, there is poor marital quality, less cohesion, less harmony, less warmth in the family which also lead low collaboration between family members (Najman et al., 2014; Thomas, 2017; Vakrat et al., 2017).

In addition, father involvement can have buffering effects for the parentified children due to maternal depression in terms of sharing responsibilities and providing support both to the children and the mother. Yet, to the authors knowledge, there is no study in the literature focusing on the role of fathers for development of parentification in the families with maternal depression.

1.4. Aim of the Study

In the literature, there are numerous studies examining impacts of maternal depression on children's developmental, psychological and social functioning (Barber et al., 2013; Emde et al., 1986; Farías-Antúnez et al., 2018; Gelfand et al., 1986; Goodman et al., 1990; Hammen, et al., 2008; Lovejoy et al., 2000; Quevedo et al., 2011; Raposa et al., 2012; Righetti-Veltema et al., 2003). These studies proposed that maternal depression's negative effects can be evident in the family functioning, children's mental health and interpersonal relationship quality (Champion et al., 2009; Hammen et al., 2008; Hipwell et al., 2005; Van Parys et al., 2014). Besides, parentification and its psychosocial outcomes within the context of parentification was touched upon by a few studies, as well (Champion et al., 2009; Knutsson-Medin et al., 2007; Van Parys et al., 2013; Van Parys et al. 2014; Van Parys et al. 2015). So far, however, very little attention has been paid to the protective role of father involvement on the consequences of parentification due to maternal depression. Therefore, this study aimed to investigate the role of father involvement on parentification due to maternal depressive symptoms and outcomes with respect to children's psychological symptomatology and interpersonal relationship quality. Since the literature does not provide sufficient findings for the role of fathers on parentification, the study highlights the importance of protective role of father involvement on parentification due to maternal depressive symptoms for clinicians while studying with families with maternal depression/depressive symptoms and parentification.

The hypotheses of the study were formed as follows:

a) Father involvement would moderate the effects of maternal depressive symptoms on children's parentification.

b) Parentification moderated by father involvement would mediate the relationship between maternal depressive symptoms and psychological symptomatology of the children.

c) Parentification moderated by father involvement would mediate the relationship between maternal depressive symptoms and interpersonal relationship quality.

Moreover, the research questions of the study were established as below:

"What is the relationship between parentification due to maternal depressive symptoms and father involvement among adolescents?"

"Does parentification due to maternal depressive symptoms affect psychological symptomatology and interpersonal relationship quality of adolescents negatively?"

"Does father involvement have protective role on the consequences of parentification due to maternal depressive symptoms among adolescents?

The diagrams of conceptual models of the study were presented below (Figure 1 and Figure 2).

Figure 1

The predicted model 1: Father involvement would moderate the effects of relationship between maternal depressive symptoms and parentification on child's psychological symptomatology.

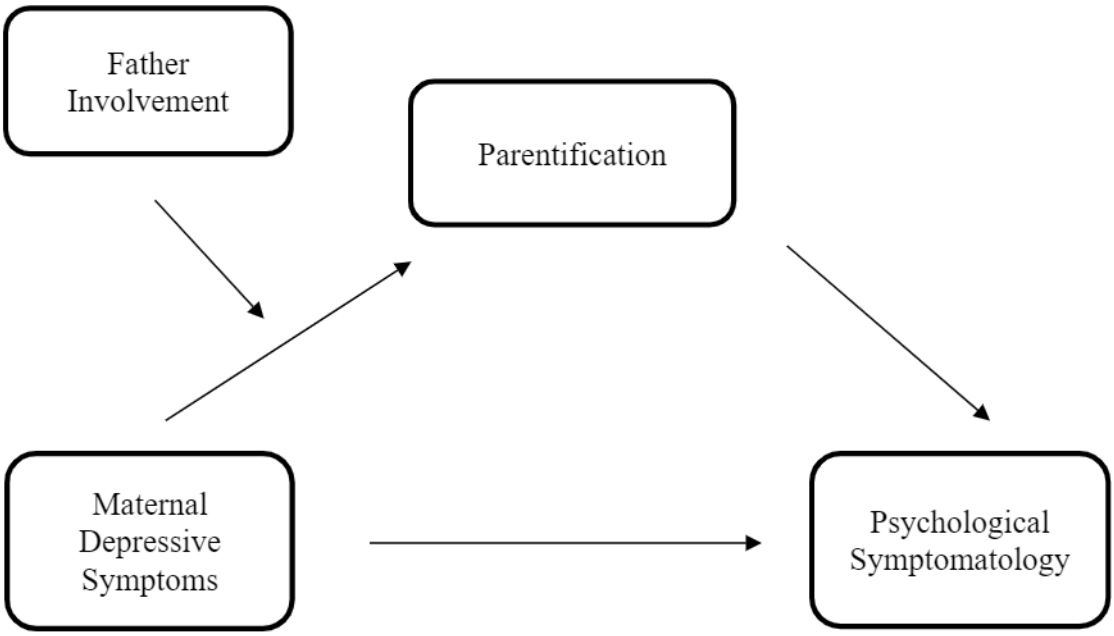
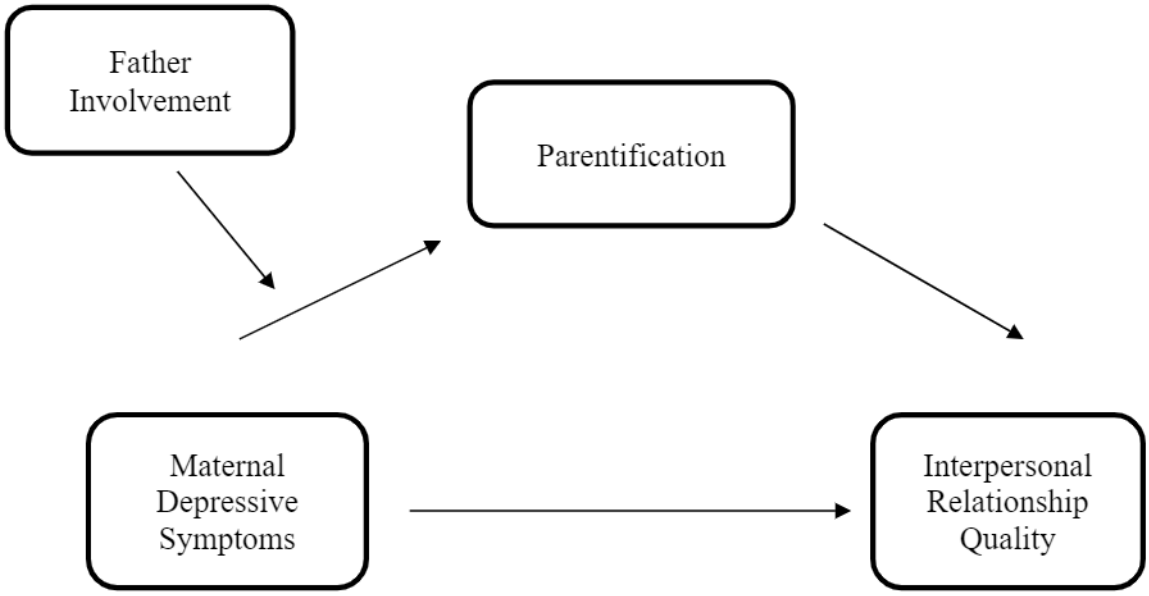


Figure 2

The predicted model 2: Father involvement would moderate the effects of relationship between maternal depressive symptoms and parentification on child's interpersonal relationship quality.



CHAPTER 2

METHOD

2.1. Participants

The initial sample consisted of 266 mother-adolescent dyads (532 participants total) who were reached through high schools and universities in Turkey. Yet, 28 participants were excluded from the obtained data due to theoretical and practical reasons (e.g. missing data, having a psychiatric diagnoses and data with extreme values). Totally, 238 mother-adolescent dyads were used for the subsequent statistical analysis. Of 238 adolescents, 95% were residing either in Ankara or İstanbul. Inclusion criteria for participation were set out as follows: (1) Being a high school or university student, (2) parents being alive and together, (3) co-residence with both parents and (4) mother agreeing to participate to the study. Demographic characteristics of the mother-adolescentdyads were presented in Table 1. Also, being 12^{th} grade student is exclusion criteria for highschool students since possibility of having higher stress due to university entrance exams.

Table 1

Demographic Characteristics of the Participants

	Mothers (n = 238)	Adolescents (n = 137)	Late Adolescents (n = 101)
Gender			
Female	238	77	63
Male		57	37
Other		3	1
Education			
Literate	2	-	-
Primary School	56	-	-
High School	70	137	-
University	98	-	101
Postgraduate	10		
SES			
Low	11	1	3
Low-to-middle	13	3	3
Middle	135	76	57
Middle-to-high	73	53	34
High	5	4	4
Age Range	33-62	14-17	18-22
Mean age (SD)	46.58(5.37)	15.32(.95)	20.80(1.23)

2.2. Materials

In the current study, Demographic Information Form, State-Trait Depression Inventory, Parentification Inventory, Father Involvement Scale, Brief Symptom Inventory and Scale of Dimensions of Interpersonal Relationships were used respectively to assess maternal depressive symptoms, parentification, father involvement, psychological symptomatology and interpersonal relationship quality.

Amongst all other scales, only State-Trait Depression Inventory was filled out by mothers. The remains were filled out by adolescents.

2.2.1. Demographic Information Form

Two separate demographic information forms were prepared both for mothers and adolescents. Both forms included questions regarding gender, age, education status, work experience, SES, and psychical/psychiatric history. Information regarding parents' marital status was obtained only from mothers (see Appendix D, E and F). Also, information regarding sibling numbers was obtained from adolescents.

2.2.2. State-Trait Depression Inventory (STDI)

The original scale was developed by Spielberger and his colleagues in an attempt to differentiate state depression from chronic depressive symptoms pertaining more to personality characteristics (2003). Because parentification is a fact that is gradually experienced over years, State-Trait Depression Inventory (STDI) was decided to be more suitable to measure mother's depressive symptoms, instead of using Beck Depression Inventory which usually aims to measure current depressive symptoms. STDI is a 4-point Likert type inventory with 20 items. The inventory has 2 subscales measuring state and trait depression levels by rating participant's current and general feelings (For State Depression: *1=Not at all, 2= A little, 3= Somewhat, 4= Very Much;* For Trait Depression: *1=Never, 2= Sometimes, 3= Often, 4= Always*). The Turkish version of STDI was adapted by Ozer and Ozer (2006). The Turkish adaptation of STDI has similar psychometric properties with the original version with a Cronbach alpha value of .82 and .83 for the subscales. For the current study, Cronbach's alpha values for state and trait domains was .85 (see Appendix G).

2.2.3. Parentification Inventory (PI)

Parentification inventory, originally developed by Hooper (2009), is a psychometric tool measuring childhood parentification experiences. It is a 5-point Likert type scale options ranging from Never to Always (*1= Never, 2= Rarely, 3= Sometimes, 4= Often, 5= Always*). Higher scores indicate greater parentification experiences in childhood. The inventory has 22 items and 3 factors which are parent-focused parentification, perceived benefits of parentification and sibling-focused parentification, respectively. The Cronbach's alpha value of the total scale was .84. Turkish adaptation of PI was performed by Köyden (2015). Turkish version of the inventory was found to be appropriate to be used for Turkish sample since it had similar psychometric properties with the original form. For the whole inventory and the factors, Cronbach's alpha values were .82, .83, .76 and .73, respectively. In the current study, Cronbach's alpha values were .75 for the whole inventory; and .80, .76 and .70 for the subdomains (see Appendix H).

2.2.4. Father Involvement Scale (FIS)

Father Involvement Scale was developed by Finley (1998) to measure children's perceptions of paternal support. The scale has 9 items which are rated on a 5-point Likert type scale from 1 to 5. Higher scores indicate higher father involvement experiences. The internal consistency coefficient value was .88 (Finley, 1998). The scale was adapted into Turkish by Kuzucu and Özdemir (2013). The internal consistency coefficient value of Turkish version was .88, while test-retest reliability correlation was .92. In the current study, internal consistency coefficient was .75 (see Appendix I).

2.2.5. Brief Symptom Inventory (BSI)

Brief Symptom Inventory is a self-report instrument which is a shortened version of SCL-90-R developed by Derogatis (1992). It is a 5-point Likert type scale with 53 items that assess psychological symptom levels of participants (0= *Not at all*, 1= *A little bit*, 2= *Moderately*, 3= *Quite a bit*, 4= *Extremely*). It has 5 subtests which are somatization, depression, anxiety, hostility, and negative self-concept. The Turkish adaptation of the inventory was performed by Şahin and Durak (1994); and its Cronbach's alpha values was .96. In the current study, the scale was used to assess the adolescents' symptomatology. The Cronbach's alpha values for the study was .95 which is similar to adaptation study (see Appendix J).

2.2.6. Scales of Dimensions of Interpersonal Relationships (SDIR)

SDIR was developed by İmamoğlu and Aydın (2009) to measure interpersonal relationship quality and its dimensions in Turkish culture. (Example items; *"I do not think others care about me", "I cannot trust others easily",* and *"Other's thought about me is very important for me to evaluate myself").* It is a 5-point Likert type scale with 53 items (*1=Strongly Disagree, 2= Disagree, 3=Neither Agree Nor Disagree, 4= Agree, 5= Strongly Agree*). There are four sub-factors which are approval dependence, empathy, trusting others, and emotional awareness. There is no total score for SDIR. Rather, scores are calculated for each domain. Particularly, the first factor, approval dependence, reflects how other's opinions, attitudes and values are important for one's relationship (İmamoğlu et al., 2009). Higher scores in this dimension indicates that one ignores oneself for the sake of others. The second factor, empathy, reflects how empathic the person in interpersonal relationships (İmamoğlu et al., 2009). Higher scores refer to one's ability to understand others' feelings and to reflect

his/her emotions simultaneously. The third factor, trusting others, reflects whether the person trusts others (İmamoğlu et al., 2009). Higher scores in this dimension indicate more trustful features of relationships. The fourth factor, emotional awareness, represents one's ability to maintain relationships depending on emotional cues (İmamoğlu et al., 2009). Higher scores means greater emotion regulation skills. The Cronbach's alpha values for the subscales ranged from .78 and .85 while test-retest reliability values were between .62 and .96. In the current study, the subscales have similar Cronbach's alpha values which were between .78 and .89 (see Appendix K).

2.3. Procedure

Initially, ethical permission was obtained from the TED University Human Research Ethics Committee (see Appendix L). Then, required permission was also obtained from Ministry of National Education for the participation of high school students (see Appendix M). For the recruitment of participants, convenience sampling was used. For most of the participants (N=199), all of the measurements were handed in hard copy format in big, closed envelopes.

For the university students, firstly, an announcement was made by course instructors in Psychology Department of TED University. Students whose ages ranged between 18-22 and who meet the inclusion criteria and were willing to participate to the study along with their mothers were guaranteed for bonus points. All of the scales were handed in hard copy format via big and enclosed envelopes. In the big closed envelope, there was another more smaller envelope in which mother's scales were placed. Mothers were requested to put filled scales into the smaller envelope again, close it for confidentiality and write a statement for informed consent. Also, students were asked to write the same statement using their handwritings so that who filled the

scales would be more easily differentiated through comparing handwritings. Completion of measures approximately lasted 30 minutes for adolescents and 10 minutes for mothers.

To collect the data from high school students, necessary permission was taken from school principals and counselors. Then, an announcement was made in the classroom and students who were willing to participate were given mother's scales along with parental informed-consent form. The scales along with the parental consent form were requested to be turned for the next day. After the scales were filled out by parents, the students were handed out survey battery in the classroom during a course period.

Although most of data were collected before the pandemic, the data collection process was interrupted by Covid-19 due to quarantines. Hence, the remaining data were collected online through distance education tools and social media announcements.

CHAPTER 3

RESULTS

In this chapter, firstly, descriptive statistics and correlation analyses of study were presented. Then, results were provided in accordance to proposed model.

3.1. Statistical Analysis

In the current study, a moderated mediation analysis was conducted via PROCESS macro v3.5 program of Hayes (2017) to investigate the role of parentification and father involvement on the effects of maternal depressive symptoms on adolescent's symptomatology and interpersonal relationship quality. Before analysis, data cleaning was done by excluding the participants with missing data, with history of psychiatric disorder or with extreem scores. Therefore, eleven participants' data were removed from the study with their dyads due to missing items; and twelve participants' data were excluded with their dyads because they had prior psychological disorder which was an exclusion criterion. Also, five participants and their dyads were excluded from the analysis due to being outlier.

3.2. Descriptive Statistics and Correlations of the Study Variables

In Table 2, means and standard deviations of the study variables and in Table 3 inter-correlations among them were presented. As shown in Table 3, maternal depressive symptoms, father involvement, symptomatology in adolescents children and interpersonal relationship domains were significantly correlated with each other.

Table 2

Means and Standard Deviations of STDI, FIS, PI, BSI, AD, EMP, TO, EA

			Mothers (N=238)		Adolescent (N=137)		Late Adolescents (N=101)	
Variables	Min.	Max.	M	SD	M	SD	M	SD
Age	-	-	46.58	5.37	15.32	.95	20.80	1.23
STDI	20	80	37.54	8.58	-	-	-	-
FIS	9	45	-	-	37.44	6.42	32.65	9.41
PI	22	110	-	-	54.18	8.70	54.78	9.43
BSI	0	212	-	-	58.47	33.14	74.64	37.01
AD	15	75	-	-	43.75	9.81	43.89	10.20
EMP	9	45	-	-	33.94	6.24	30.53	8.29
TO	15	75	-	-	47.28	8.54	46.65	8.79
EA	14	70	-	-	46.92	9.32	42.82	10.23

Note. STDI: State-Trait Depression Inventory; FIS: Father Involvement Scale; PI: Parentification Inventory; BSI: Brief Symptom Inventory; AD: Approval dependence; EMP: Empathy; TO: Trusting others; EA: Emotional awareness

Table 3

Inter-correlations among STDI, FIS, PI, BSI, AD, EMP, TO, EA

	1.	2.	3.	4.	5.	6.	7.	8.
1. STDI	*1*	*.17***	*-.07*	*.23***	*.15*	*-.15**	*-.15**	*-.15**
2. FIS		*1*	*-.30***	*.34***	*.15**	*-.24***	*-.28***	*.27***
3. PI			*1*	*-.08*	*-.04*	*.03*	*.04*	*-.02*
4. BSI				*1*	*.30***	*-.28***	*-.41***	*-.39*
5. AD					*1*	*-.14***	*-.41**	*-.35***
6. EMP						*1*	*.45***	*.61***
7. TO							*1*	*.58**
8. EA								*1*

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

STDI: State-Trait Depression Inventory; FIS: Father Involvement Scale; PI: Parentification Inventory; BSI: Brief Symptom Inventory; AD: Approval dependence; EMP: Empathy; TO: Trusting others; EA: Emotional awareness

3.3. Test of Moderated-Mediation Models

For the analysis, using model 7 in Hayes (2017), it was tested whether a-) father involvement (W) moderates the effects of maternal depressive symptoms (X) on parentification (M), b-) maternal depressive symptoms (X) affect child's symptomatology (Y) through parentification moderated by father involvement (W), c-) maternal depressive symptoms (X) affect child's interpersonal relationship quality (Y) through parentification (M) moderated by father involvement (W) by controlling gender, SES, education level, age of the adolescent and sibling order. A bias-corrected

bootstrap confidence interval based on 10.000 bootstrap samples was used for testing the significances of the index. The confidence interval for the index of conceptual model was considered as an evidence to see whether the model occured or not. The effect was accepted as statistically significant if the confidence interval did not include zero.

3.3.1. Test of Moderated-Mediation Model: Parentification Mediates the Relationship Between Maternal Depressive Symptoms and Psychological Symptomatology of Adolescents with Father Involvement Moderating the Relationship Between Maternal Depressive Symptoms and Parentification

As Hypothesis 1, it was hyptohesized that father involvement would moderate the relationship between maternal depressive symptoms and parentification. Furthermore, as Hypothesis 2, we expected that maternal depressive symptoms would predict adolescents' psychological symptomatology through parentification moderated by father involvement.

With regard to Hypothesis 1, there was no significant interaction effect of neither maternal depression nor father involvement on parentification (β= .09, SE=.16, t =.60, p > .05; 95 % CI [-.22, .41]). Also, maternal depression was not found to be significantly related to parentification (β=-.02, SE= .06, t =-.24, p > .05; 95 % CI[-.14, .11]). However, father involvement was found to have a direct effect on parentification (β=-6.61, SE= 1.46, t =-4.52, p < .05; 95 % CI [-9.50, -3.73]); which was negatively significant. That is to say, when father involvement increase, the level of parentification rated by adolescents decrease.

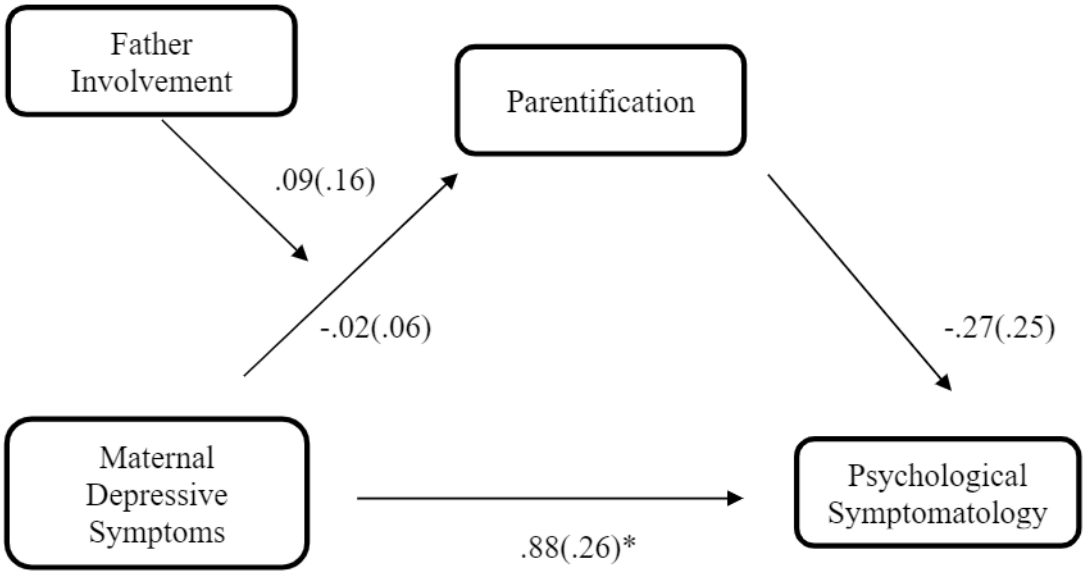
To test the Hypothesis 2, the direct effects of maternal depressive symptoms, father involvement and parentification on symptomatology as well as their interactions

were measured. The results indicated that our first moderated-mediation model (Fig. 1) explained 12% of the variance in adolescent's symptomatology ($F(7, 230) = 4.49$, $p = .0001$). The direct effect of maternal depression on child's symptomatology was positively significant ($\beta = .88$, $SE = .26$, $t = 3.37$, $p < .05$; 95 % CI [.36, 1.39]). However, there were no significant relationship between maternal depression and parentification ($\beta = -.02$, $SE = .06$, $t = -.24$, $p > .05$; 95 % CI[-.14, .11]), and parentification and adolescent's symptomatology ($\beta = -.27$, $SE = .25$, $t = -1.05$, $p > .05$; 95 % CI[-.78, .24]).

For controlling variables in the model, there was only negative significant relationship between sibling order and parentification ($\beta = -3.66$, $SE = .82$, $t = -4.44$, $p < .05$; 95 % CI [-5.29, -2.03]). When the sibling order decrease, the parentification scores increase. In other words, adolescents who are older in birth order were found to have higher parentification scores than the adolescents who were younger in birth order.

Figure 3

Moderated Mediation Model When the Psychological Symptomatology was the DV



Note. All path coefficients are unstandardized regression weights. Standard errors are in the paranthesis. * p<.05

3.3.2. Test of Moderation Model: Parentification Mediates the Relationship Between Maternal Depressive Symptoms and Interpersonal Relationship Quality of Adolescents with Father Involvement Moderating the Relationship Between Maternal Depressive Symptoms and Parentification

As Hypothesis 3, it was suggested that maternal depressive symptoms would affect adolescent's interpersonal relationship quality through parentification moderated by father involvement.

Since the Scale of Dimensions of Interpersonal Relationships does not provide a total score; the model was tested for each of the four sub-domains separately.

Firstly, for the approval dependence domain, the results demonstrated that the moderated-mediation model explained 3% of the variance in adolescents' approval dependence in interpersonal relationship. There was a significant positive direct effect between maternal depression and adolescent's approval dependence (β= .17, SE=.08, t =2.22, p < .05; 95 % CI [.01, .32]).

Secondly, for the empathy domain, the results demonstrated that our model explained 19% of the variance in adolescents' empathy in interpersonal relationship. For empathy domain, there was a negative significant effect of maternal depression on adolescents' empathy in interpersonal relationship (β= -.12, SE=.05, t =-2.25 , p < .05; 95 % CI[-.22, -.01]). In addition, empathy in interpersonal relationship were related to adolescent's age (β= 1.19, SE=.41, t =2.88, p < .05; 95 % CI[.38, 2.01], gender (β= -2.94, SE=.85 , t =-3.47, p < .05; 95 % CI[-4.61, -1.27], and education level (β= -10.16, SE=2.43 , t =-4.19 , p < .05; 95 % CI[-14.94, -5.38].

Thirdly, for the trusting others domain, the results indicated that our model explained 3% of the variance in adolescent children's trusting others in interpersonal relationship. The direct effect of maternal depression on adolescents' trusting others in their interpersonal relationship was negatively significant (β=-.14, SE=.06, t = -2.13, p < .05; 95 % CI[-.27, -.01]).

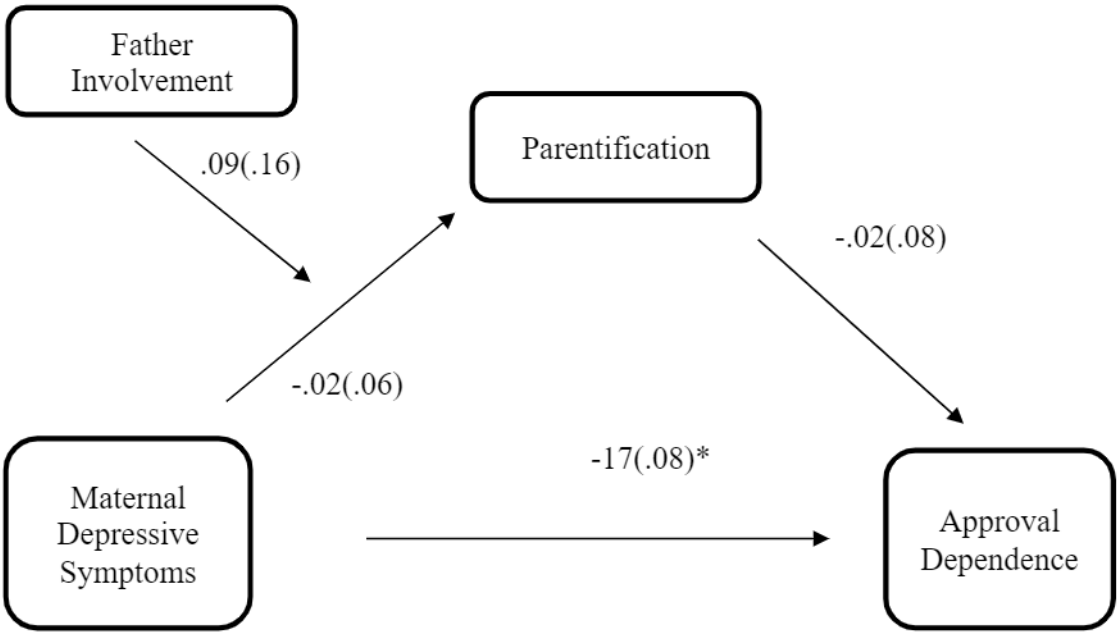
Finally, for the emotional awareness domain, the model explained 10% of the variance in adolescent children's emotional awareness in interpersonal relationship. The direct effect of maternal depression on adolescents' emotional awareness in their relationship was negatively significant (β= -.18, SE=.07, t = -2.52, p < .05; 95 % CI [-.32, -.04]).

However, for the whole model, the relationship between maternal depression and parentification was not significant (β= -.02, SE= .06, t =-.24, p > .05; 95 % CI[-.14, .11]). Also, there were no significant relationship between parentification and adolescents' approval dependence (β= -.02, SE= .08, t = -.24, p > .05; 95 % CI[-.16, .13]), or trusting others (β= .02, SE= .06, t =.37, p > .05; 95 % CI[-.10, .15]), or empathy (β=.03, SE=.09, t =.39, p > .05; 95 % CI[-.14, .20]), or emotional awareness (β=-.01, SE=.07, t =-.17, p > .05; 95 % CI[-.15, .13]) in their interpersonal relationship.

Overall, for all the domains, father involvement was found to have a negative significant direct effect on parentification (β= -6.61, SE= 1.46, t =-4.52 , p < .05; 95 % CI [-9.50, -3.73]) but the interaction effect of maternal depression and father involvement was insignificant (β= .09, SE=.16 , t =.60 , p > .05; 95 % CI [-.22, .41]).

Figure 4

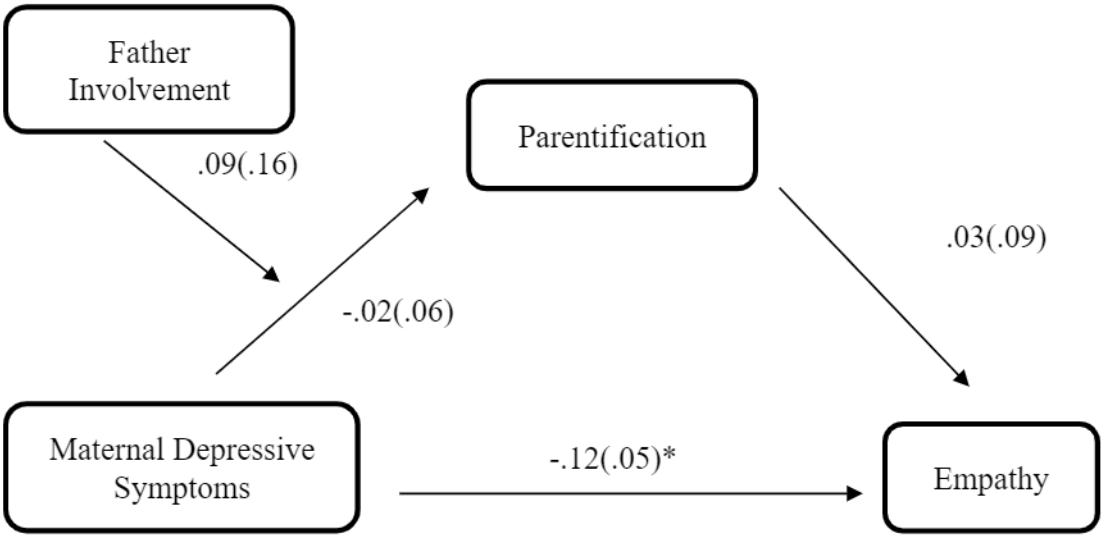
Moderated-Mediation Model When the Approval Dependence Domain was the DV



Note. All path coefficients are unstandardized regression weights. Standard errors are in the paranthesis. * p<.05

Figure 5

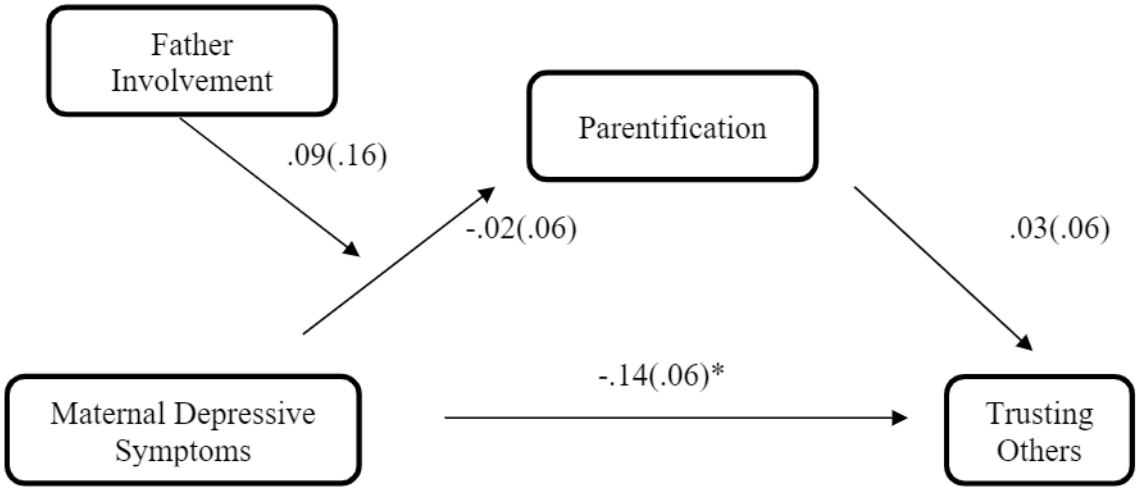
Moderated Mediation Model When the Empathy domain was the DV



Note. All path coefficients are unstandardized regression weights. Standard errors are in the paranthesis. * p<.05

Figure 6

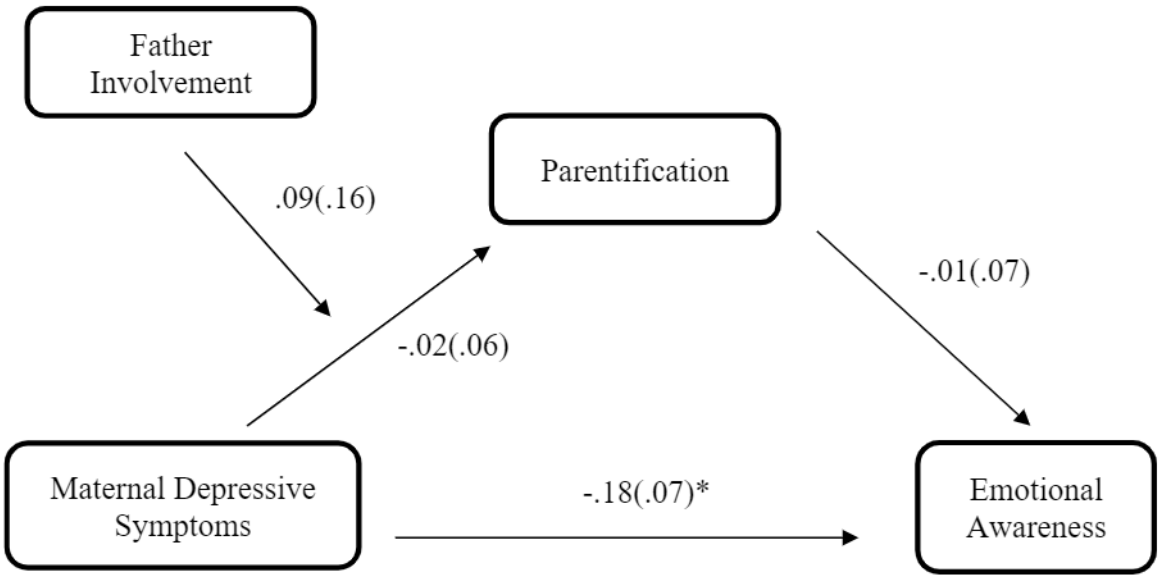
Moderated-Mediation Model When the Trusting Others Domain was the DV



Note. All path coefficients are unstandardized regression weights. Standard errors are in the paranthesis. * p<.05

Figure 7

Moderated-Mediation Model When the Emotional Awareness Domain was the DV



Note. All path coefficients are unstandardized regression weights. Standard errors are in the paranthesis. * p<.05

CHAPTER 4

DISCUSSION

The impacts of parental psychopathology (e.g., depression, bipolar disorder, schiozphrenia) on family and offspring's psychological and social development has been demonstrated by many researchers in the literature (Elsayed et al., 2019; Santana et al., 2015; Silberg et al., 2012; Sucksdorff et al., 2014; Vidair et al., 2012; Vostanis et al., 2006). Particularly, the deleterious impacts of maternal depression were pointed out by many authors by taking the children into consideration (Bagner et al., 2010; Farías-Antúnez et al., 2018; Gelfand & Teti, 1990; Knutsson-Medin et al., 2007; Lovejoy et al., 2000; Van Parys et al., 2014). Although limited in number, parentification of children with maternal depression and its hazardous impacts were reflected in the existing studies (Champion et al., 2009; Knutsson-Medin et al., 2007; Van Parys et al., 2013; Van Parys et al., 2014; Van Parys et al., 2015). However, the literature does not provide sufficient evidence regarding role of paternal involvement on the parentification experiences of children with maternal depression.

The main purpose of the study was to examine the buffering role of father involvement on the relationship between maternal depressive symptoms and child's psychological symptomatology and interpersonal relationship quality through parentification. In particular, it was investigated whether father involvement moderates the relationship between maternal depression and parentification and whether father involvement prevented the effects of maternal depression on parentification and child's psychological symptomatology or interpersonal relationship quality.

In the following sections, the results of the current study were discussed in the light of previous findings and literature. Then, clinical implications related to study findings were be provided. In the last part, limitations of the study and suggestions for future studies were also presented.

4.1. Main Findings of the Study

In the current study, it was examined whether maternal depressive symptoms are related to child's psychological symptomatology and interpersonal relationship quality. Parentification was thought as a possible underlying mechanism of this relationship because the literature points out parentification experiences of children in the families with maternal depression and its possible impacts for the children (Champion et al., 2009; Knutsson-Medin et al., 2007; Van Parys et al., 2013; Van Parys et al., 2015).

The results of the current study partially support the findings in the literature. In the current study, maternal depressive symptoms were found to be related to adolescents' psychological symptomatology which provided support to previous findings (Billings & Moos, 1983; Champion et al., 2009; Goodman et al., 2011; Hammen et al., 2008; Mechling, 2015; Raposa et al., 2012). In particular, when the maternal depressive symptoms increase, the children expressed more psychological symptomatology (i.e., depression, anxiety, somatization, negative self concept and hostility). In the literature, some authors explain its reasons as the children's concern about mother's well-being (Knutsson-Medin et al., 2007; Van Parys et al., 2013), genetic transmission (Goodman et al., 2011; Trad, 1987), family interactions (Burke, 2003), mother's parenting behaviors (Galbally & Lewis, 2017), and child's physical health affecting interactions with peers (Raposa et al., 2013).

Besides psychological symptomatology, previous studies also found that children of depressed mothers exhibited more problems in their relationship with others (Hammen et al., 2008; Kam et al., 2011; Raposa et al., 2013). In furtherance the literature, the results of the current study indicated that maternal depressive symptoms affected the interpersonal relationship quality of adolescents. Particularly, when the mothers have greater depressive symptoms, the adolescent offspring might become more dependent to others and show less emotion regulation, empathy and trust in their interpersonal relationships which are indicators of lower interpersonal relationship quality.

In the literature, it is known that close relationships may have similar elements with the early relationships established with primary caregivers (Bowlby, 1969; 1973). As the depressed mothers may be harsher than the nondepressed mothers in terms of their parenting style, the children may be exposed to more criticism, punishment and less acceptance (Gelfand et al., 1990; Lovejoy et al., 2000). Hence, the children may find out adjusting others extremely difficult, which in turn may lead to approval dependence in their relationship. In addition, among depressed mothers and their children, insecure attachment is more common than the non-depressed mothers and children dyads (Barnes & Teule, 2019; Goodman & Gotlib, 2002; Teti et al.1995). Since early attachment is a predictor of attachment in intimate relationships, trusting others less in interpersonal relationship is consistent with literature for the children of depressed mothers. Also, depressed mother's intrusiveness was found to decrease children's capacity for emotion regulation and empathy (Pratt et al., 2017).

Although the findings of the current study provide support for the deleterious impacts of maternal depression, parentification was not found as an underlying

mechanism the hypothesized relationship. As a tough experience, parentification, early in life exert significant effects on the children's life, especially for the eldest children of family (Alridge, 2006). The parentified children sometimes feel burdensome due to age-inappropriate responsibilities and exhibit depressive and anxiety symptoms (Barnett et al., 1998; Champion et al., 2009; Van Parys et al., 2015; Van Parys et al., 2013). Since they are aware of their mother's emotional states characterized by sadness, disappointment and hopelessness, they tend to hide their upsetting feelings in order not to cause extra burden (Van Parys et al., 2013). For this purpose, the parentified children try to convince the mother that they are fine. Therefore, they have to struggle with their problems on their own which may make them feel lonely (Van Parys et al., 2013; Van Parys et al., 2015). Generally, they have difficulty to share their feelings of burden and loneliness with others because they feel guilty to talk about their mother's emotional state (Knutsson-Medin et al., 2007; Van Parys et al. 2015). Therefore, they may isolate themselves from intimate relationships. Even if they do not isolate themselves, their interpersonal relationship might have aggressive, untrustful or shallow features (Hooper, 2014; Kibwea et al., 2017). They may have difficulty to share their early hazardous experiences with peers. Sometimes parents do not allow their children sharing their experiences with friends or sometimes the children may envy peers who do not struggle with parental depression (Knuttson-Medin et al., 2007; Van Parys et al. 2013).

In the families with maternal depression, support and involvement of a healthy parent, usually the father, becomes even more important to compensate for the impact of mother's unfulfilled parental responsibilities. Father involvement can comprise feeding or cooking for the children, taking responsibilities for household conditions,

playing with the children, talking over the daily hassles their children is going through or helping for the homework (Tamis-LeMonda & Cabrera, 2002). This kind of involvement can reduce the possibility of children's assuming parental role and buffer the effects of depressive symptoms (Lewin et al., 2015; Vakrat et al. 2017). However, the literature does not provide sufficient findings about the role of father involvement on parentification.

The importance of the current study was to investigate father's role in the families with maternal depression. In the current study, it was hypothesized that, father involvement could have a buffering effect by moderating the relationship between maternal depressive symptoms and parentification, which in turn may affect child's psychological symptomatology and interpersonal relationship quality. The results indicated that although father involvement did not moderate the effects of maternal depressive symptoms on parentification; when the fathers involved with their children more, the children assume parental role less. When the father involvement studies are considered, this finding is meaningful and consistent with the literature (Goodman et al., 2014; Laxman et al., 2015; Lewin et al., 2015; Vakrat et al. 2017) Also, it reflects that fathers should be engaged with their family and children more as a main caregiver so that they can assume the unfulfilled parental responsibilities of the depressed mothers and prevent the children from age-inappropriate role reversal.

The reason why the findings do not support our second and third hypotheses can be comprehensible in some point. Mostly, parentification studies were conducted with clinical groups and their children (Champion et al., 2009; Knutsson-Medin et al., 2007; Van Parys et al., 2015; Van Parys et al., 2013). In the previous studies, the mothers diagnosed with depression were the samples, and most of them were reported

to exhibit clinically significant depressive symptoms. Since depressive symptoms inherently lower the mother's energy and motivation, their children are forced intrinsically or extrinsically more to maintain family functioning by assuming parental roles. By contrast, the depression levels of the mothers in our study were not severe. Even if the mothers do not suffer from severe depressive symptoms, their maternal role and responsibilities can be affected by depressive symptoms. In turn, it can pose their children's psychological and social domains in danger. In fact, 80% of the mothers in the study have scores indicating mild symptomatology. This might explain why parentification did not mediate the relation between maternal depressive symptoms and psychological symptoms or interpersonal relationship quality of the adolescents. That is, because the maternal depressive symptoms were mostly mild, it might not interfere with mother's parental responsibilities; therefore, reducing the risk for emotional or instrumental role reversals. Since parentification emerges in case of unfulfilled parental responsibilities (Boszormenyi- Nagy et al., 1973; Engelhardt, 2012; Hooper, 2007; Minuchin et al., 1967), mild depressive symptoms may not have a triggering potential as much as moderate or severe depressive symptoms for children to take parental over the roles in the family.

One possible explanation for why maternal depressive symptoms was related to adolescents' psychological symptomatology can be identification with mother. Since the mothers are accepted as a first person for identification in child's life (Freud, 1995), the adolescents whose mother indicated higher depresive symptoms may exhibit psychological symptoms more than their peers.

In addition, culture can be regarded as an important factor that might influence the findings of the current study. In the current study, adolescents indicated higher

scores in perceived benefits of parentification and lower scores in parent focused parentification and sibling focused parentification subfactors. In Turkish culture, as a collectivistic culture, giving emotional support to parents and assuming adult roles in the family may be internalized more by the adolescents since it is promoted by previous generations. If adolescents' efforts are appreciated or admired by the parents or adult relatives, adolescents may not consider parentification as a harmful experience; thus, they may not experience negative outcomes of it (Alridge, 2006). Yet, their perception about parentification experiences may help emerging changes in hierarchy of the family. When the adolescents start to give instrumental and emotional support, they may feel as if they became independent from parents and predominated their parents which may increase their feeling of power in the family system (Hooper & Wallace, 2010). The feeling of increased power may compensate the negative outcomes of parentification.

In addition, when only parent focused and sibling focused parentification subfactors were included in the analysis by excluding perceived benefits of parentification subfactor and tested the models again, maternal depressive symptoms were found related to adolescents' psychological symptomatology and interpersonal relationship quality rather than adolescents' parentification. Although literature points out the linkage between maternal depression/depressive symptoms and parentification (Champion et al., 2009), one possible explanation for that our study's indicating no linkage for these variables, could be differences among generations. In the current study, participants were mostly born after 2000. Parents of the children who were born after 2000 are mostly known as having features of helicopter parenting. Helicopter parents are always on the alert for meeting their children's need and they show ultra

protection for their children (Howe & Strauss, 2007). In these families, the children may be more centered. In particular, the adolescents' needs, emotions, goals might be more emphasized. Their parental attitudes towards the importance and role of their children may have differences when compared with parents before 2000. Therefore, children of helicopter parents which constitutes most of the participants in the current study may experience parentification less than older generations.

Among interpersonal relationship domains, our proposed model explained lower variance in adolescents' approval dependence and trusting others domains. It should be noted that other than the variables we propose, many other mechanisms may have a role in this relationship. The possible mechanisms related to these domains can be attachment style of adolescents, their social anxiety level and early maladaptive schemas of adolescents. Although they were asked for psychiatric history or treatment, even mild level of social anxiety can have an important role on approval dependence of adolescents. Also, attachment style and early maladaptive schemas of adolescents can be the other possible mechanisms.

4.2. Clinical Implications

The present study reflected the life challenges of children whose mothers have maternal depressive symptoms by pointing possible role reversals. Since the maternal depression have detrimental impacts on the family, it should be approached in a way that include not only the mother but also whole family. In particular, because the maternal depression has an impact both on children and family functioning, other members of the family should not be disregarded during interventions.

In the parentification studies, it was demonstrated that the impacts of the tough early experiences in children's life continue into the adulthood (Knutsson-Medin et

al., 2007; Van Parys et al., 2015; Van Parys et al., 2013; Van Parys et al., 2014). In the qualitative studies, most of the parentified participants stated that they had psychological or social difficulties due to their role reversal experiences in the family. Since some of them grown up only with mothers, they remarked the importance of physical and emotional support of others to carry their responsibilities. Also, they wished that they would have a chance to take professional support by clinicians (e.g. psychiatrist or psychologist). Although there was no significant relationship between maternal depressive symptoms and parentification, the findings indicate that increasing paternal involvement would ease the life of children who are at risk to be parentified due to maternal depression/depressive symptoms. Therefore, while studying with these families, maternal depression's hazardous effect on children should not be missed out, and the fathers should be involved more in intervention programs to prevent children from deleterious impact.

4.3. Limitations and Future Directions

Our hypotheses were not confirmed by the findings of the study. Since the current study was not free of some limitations, the reason of disconfirmation might be related to these limitations.

Firstly, the current study was conducted with a non-clinical group. Therefore, the severity of depressive symptoms of mothers were lower than it was expected which probably have an impact on the children's parentification experiences. To understand the relationship effectively, the future studies may consider to test the proposed model with clinical levels of maternal depression. Because the diagnosed depressed mothers and their family get through this process intensely, the findings would be more

meaningful. In the current sample, levels of maternal depressive symptomatology is low and there is not much variance in the depression scores.

Secondly, participants were mostly from the middle and middle-to-high SES. Although previous studies with Turkish sample indicate that SES does not have significant effect on parentification (Köyden, 2015; Yıldırım, 2016), it can be a predictor of higher maternal depression and lower father involvement because it is known that maternal depression remains undiagnosed in low SES families (Abbasi et al., 2017).

Thirdly, the parentification literature mostly consists of quantitative studies, as our study. For deeply understanding of parentified children experiences, the future studies can emphasize qualitative studies, especially for their interpersonal relationship experiences. Unlike peers, they are exposed to age-inappropriate and hazardous experiences in their family; therefore, they may feel they are incomprehensible by their peers. The qualitative study can deepen understanding of their struggles.

Finally, almost 20% of data were collected during COVID-19 pandemic. Although the authors were attentive to stop collecting data during first wave, data collection in a pandemic may create biases for sample and scores. Since the data were collected online, mothers and adolescents who have internet connection and use mobile devices could participate in the study. This limitation resulted in increase in the number of participants with middle or high SES. Also, in a study investigating psychological symptomatology and interpersonal relationship quality, data collection during pandemic may create a bias for the results.

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APPENDICES

Appendix A: Inform Consent for Pre-Participation for Mothers

GÖNÜLLÜ KATILIM FORMU- ANNE

Sayın Katılımcı,

Bu araştırma, TED Üniversitesi Psikoloji Bölümü'nde Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans programında öğrenci olan Sinem Çelik tarafından, Doç. Dr. Ilgın Gökler Danışman danışmanlığında yürütülmektedir. Araştırmanın amacı ebeveynlerin psikolojik iyi oluşlarının gençlerin psikolojik sağlıkları ve kişilerarası ilişkileri üzerindeki etkilerini incelemektir. Bu kapsamda lise ve üniversite öğrencileri ve onların annelerinden bilgi toplanması amaçlanmaktadır. Bu araştırma kapsamında çocuğunuzdan bazı anket sorularına cevap vermesi istenmektedir. Bu aşamada ise annesi olarak sizden yaklaşık 10 dakika sürecek birtakım anket sorularına yanıt vermeniz beklenmektedir.

Anketlerde size yöneltilen soruların **DOĞRU ya da YANLIŞ** cevapları yoktur, bu nedenle soruları içtenlikle cevaplamanız araştırmanın sonuçları açısından önemlidir. Çalışma süresince ve sonrasında kimlik bilgileriniz çalışmada yer alan araştırmacılar dışındaki hiç kimseyle izniniz dışında paylaşılmayacaktır. Tüm katılımcılardan elde edilen bilgiler ve değerlendirmeler bir arada ele alınarak değerlendirilecektir. Bu çalışma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda ve eğitim amaçlı çevrimiçi bir ortamda paylaşılacaktır. Toplanan veriler isiminiz silinerek, bilgisayarda şifreli bir dosyada tutulacaktır.

Bu çalışmaya katılım gönüllük esasına dayalıdır. Araştırmada yer alan sorular kişisel rahatsızlık verecek nitelikte değildir. Ancak herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, nedenini açıklamaksızın araştırmadan ayrılabilirsiniz. Böyle bir durumda vermiş olduğunuz bilgilerin araştırmacı tarafından kullanılması ancak sizin onayınızla mümkün olacaktır. Bu çalışmaya katıldığınız için şimdiden teşekkür ederim.

Araştırma sürecinin sağlıklı işleyebilmesi için soruları tek başınıza ve çocuğunuzdan ayrı doldurmanız büyük önem taşımaktadır. Lütfen tüm soruları yanıtladıktan sonra anketleri zarfın içindeki küçük zarfa koyunuz ve üzerine kendi el yazınızla "Çalışmaya katılmayı kabul ediyorum." yazınız. Sonrasında ise küçük zarfı, büyük zarfın içine koyup tamamen kapatabilir ve teslim alabilmemiz için çocuğunuza teslim edebilirsiniz.

Çalışma hakkında daha fazla bilgi almak ve yanıtlanmasını istediğiniz sorularınız için araştırmayı yürüten Sinem Çelik (E-posta: sinem.celik1@tedu.edu.tr) ve Doç. Dr. Ilgın Gökler Danışman (E- posta: ilgin.danisman@tedu.edu.tr) ile iletişim kurabilirsiniz.

Teşekkürler,

Sinem Çelik, Araştırmacı
Ziya Gökalp Cad. No:48 Kolej/ Çankaya, ANKARA

Bu kısım katılımcı tarafından doldurulacaktır.

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Bu araştırma kapsamında gereken anket uygulamasında yer alacağını biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

Yukarıda yazılanları kabul ediyorum ve araştırmaya katılmak istiyorum. Evet / Hayır

Ad-Soyad (Takma isim de kullanılabilir):.....

Tarih .....

Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na (0312 585 00 05) telefon numarasından veya iaek@tedu.edu.tr eposta adresinden ulaşabilirsiniz.

Appendix B: Inform Consent for Pre-Participation for Adolescents

GÖNÜLLÜ KATILIM FORMU- GENÇ VERSİYONU

Sayın Katılımcı,

Bu araştırma, TED Üniversitesi Psikoloji Bölümü'nde Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans programında öğrenci olan Sinem Çelik tarafından, Doç. Dr. Ilgın Gökler Danışman danışmanlığında yürütülmektedir. Araştırmanın amacı ebeveyn ruh sağlığının gençlerin psikolojik belirtileri ve kişilerarası ilişkileri üzerindeki etkilerini incelemektir. Bu araştırma kapsamında hem gençlerden hem de annelerinden bazı anket sorularına yanıt vermeleri istenecektir. Bu araştırmaya katılımınız, anneniz ve sizin tarafınızdan onaylandığı ve araştırmaya annenizin de katılım onayını sağladığınız taktirde, çalışmanın katılımcısı olacaksınız. Çalışma kapsamında sizden yaklaşık 30 dakika sürecek, annenizden ise yaklaşık 10 dakika sürecek bazı anket sorularına yanıt vermeniz beklenecektir. Annelerinizin doldurması beklenen sorular size kapalı bir zarf içinde verilecektir. Araştırmanın sağlıklı ilerleyebilmesi için annenizin soruları sakin ve yalnız bir ortamda doldurması önemli olacaktır. Anket formları birbirinizden ayrı doldurmanız araştırma açısından büyük önem taşımaktadır. Son olarak, formun üzerine kendi el yazınızla "Çalışmaya katılmayı kabul ediyorum." yazıp araştırmacıya teslim etmeniz beklenmektedir.

Anketlerde size yöneltilen soruların **DOĞRU ya da YANLIŞ** cevapları yoktur, bu nedenle soruları içtenlikle cevaplamanız araştırmanın sonuçları açısından önemlidir. Çalışma süresince ve sonrasında kimlik bilgileriniz çalışma dışındaki hiç kimseyle izniniz dışında paylaşılmayacaktır. Bu çalışma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda ve eğitim amaçlı çevrimiçi bir ortamda paylaşılacaktır. Toplanan veriler isiminiz silinerek, bilgisayarda şifreli bir dosyada tutulacaktır.

Bu çalışmaya katılım gönüllük esasına dayalıdır. Araştırmada yer alan sorular kişisel rahatsızlık verecek nitelikte değildir. Ancak herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, nedenini açıklamaksızın araştırmadan ayrılabilirsiniz. Böyle bir durumda vermiş olduğunuz bilgilerin araştırmacı tarafından kullanılması ancak sizin onayınızla mümkün olacaktır. Bu çalışmaya katıldığınız için şimdiden teşekkür ederim.

Çalışma hakkında daha fazla bilgi almak ve yanıtlanmasını istediğiniz sorularınız için araştırmayı yürüten Sinem Çelik (E-posta: sinem.celik1@tedu.edu.tr) ve Doç. Dr. Ilgın Gökler Danışman (E- posta: ilgin.danisman@tedu.edu.tr) ile iletişim kurabilirsiniz.

Teşekkürler,

Sinem Çelik, Araştırmacı
Ziya Gökalp Cad. No:48 Kolej/ Çankaya, ANKARA

Bu kısım katılımcı tarafından doldurulacaktır.

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Bu araştırma kapsamında gereken anket

uygulamasında yer alacağımı biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

Yukarıda yazılanları kabul ediyorum ve araştırmaya katılmak istiyorum. Evet / Hayır

Ad-Soyad (Takma isim de kullanılabilir):.....

Tarih .....

Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na (0312 585 00 05) telefon numarasından veya iaek@tedu.edu.tr eposta adresinden ulaşabilirsiniz.

Appendix C: Parental Consent Form for Adolescents

VELİ İZİN FORMU

Sayın Veli,

Bu araştırma, TED Üniversitesi Psikoloji Bölümü'nde Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans programında öğrenci olan Sinem Çelik tarafından, Doç. Dr. Ilgın Gökler Danışman danışmanlığında yürütülmektedir. Araştırmanın amacı ebeveynlerin psikolojik iyi oluşlarının gençlerin psikolojik sağlıkları ve kişilerarası ilişkileri üzerindeki etkilerini incelemektir. Bu kapsamda lise ve üniversite öğrencileri ve onların annelerinden bilgi toplanması amaçlanmaktadır. Bu araştırma kapsamında çocuğunuzdan ve sizden bazı anket sorularına cevap vermeniz istenmektedir. Bu aşamada annesi olarak sizden yaklaşık 10 dk sürecek ve çocuğunuzdan yaklaşık 30 dk sürecek birtakım anket sorularına yanıt vermeniz beklenmektedir.

Çalışma süresince ve sonrasında kimlik bilgileriniz çalışmada yer alan araştırmacılar dışındaki hiç kimseyle izniniz dışında paylaşılmayacaktır. Tüm katılımcılardan elde edilen bilgiler ve değerlendirmeler bir arada ele alınarak değerlendirilecektir. Bu çalışma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda ve eğitim amaçlı çevrimiçi bir ortamda paylaşılacaktır. Toplanan veriler isiminiz silinerek, bilgisayarda şifreli bir dosyada tutulacaktır.

Bu çalışmaya katılım gönüllük esasına dayalıdır. İzin vermeniz dahilinde araştırmaya katılmayı kabul eden çocuğunuz anket sorularını okul idaresi izni dahilinde ders saati süresinde dolduracaktır. Araştırmada yer alan sorular kişisel rahatsızlık verecek nitelikte değildir. Ancak herhangi bir nedenden ötürü çocuğunuz, kendisini rahatsız hissetme durumunda nedenini açıklamaksızın araştırmadan ayrılabilir. Bu çalışmaya katıldığınız için şimdiden teşekkür ederim.

Çalışma hakkında daha fazla bilgi almak ve yanıtlanmasını istediğiniz sorularınız için araştırmayı yürüten Sinem Çelik (E-posta: sinem.celik1@tedu.edu.tr) ve Doç. Dr. Ilgın Gökler Danışman (E- posta: ilgin.danisman@tedu.edu.tr) ile iletişim kurabilirsiniz.

Teşekkürler,
Sinem Çelik, Araştırmacı
Ziya Gökalp Cad. No:48 Kolej/ Çankaya ANKARA

Yukarıda yazılanları kabul ediyorum ve çocuğumun araştırmaya katılmasını onaylıyorum.

Evet / Hayır

Velinin Adı-Soyadı:.....
Tarih .....
Velinin İmzası:

Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na (0312 585 00 05) telefon numarasından veya iaek@tedu.edu.tr eposta adresinden ulaşabilirsini

Appendix D: Demographic Information Form for Adolescents

DEMOGRAFİK BİLGİ FORMU- GENÇ VERSİYONU (LİSE)

Doğum Tarihi:…../……/…….

Cinsiyet: ☐ Kadın ☐ Erkek ☐ Diğer

Yaş:

Lise:

Sınıf:

1. Size uygun seçeneği lütfen işaretleyiniz.

☐ Çalışıyor ☐ Çalışmıyor

Çalışıyor iseniz;

1.a. Çalışmaya başlayalı kaç yıl oldu?

☐ 0-2 yıl ☐ 2-5 yıl ☐ 5-10 yıl

1.b. Nerede çalıştığınızı ve ne iş yaptığınızı lütfen belirtiniz

……

……

……

……

2. Hanenizde kiminle yaşıyorsunuz?

☐ Çekirdek aile ☐ Geniş aile

2.a. Geniş aile ise kimler olduğunu yazınız:

……

……

……

3. Kardeş Sayısı:

	Cinsiyet	Yaş
1.		
2.		
3.		
4.		
5.		
6		

7.		

4. Ailenizin ortalama aylık geliri:

☐ 500 TL ve altı ☐ 500 - 1000 TL

☐ 1001 – 1600 TL ☐ 1601-2500 TL

☐ 2501 – 3500 TL ☐ 3501-5000 TL

☐ 5001 TL ve üzeri

5. Lütfen ekonomik durumunuzu belirtin.

☐ Alt ☐ Ortanın altı ☐ Orta ☐ Ortanın üstü ☐ Üst

6. Yaşamınızın büyük bölümünü geçirdiğiniz yeri işaretleyiniz.

☐ Büyükşehir ☐ İl ☐ İlçe ☐ Kasaba ☐ Köy

7. Kronik bir hastalığınız var mı?

☐ Hayır ☐ Evet

7.a. Evet ise açıklar mısınız?.....

8. Şu anda tedavi gördüğünüz fiziksel ya da psikolojik/psikiyatrik rahatsızlığınız var mı?

☐ Hayır ☐ Evet

8.a. Evet ise açıklar mısınız?.....

9. Sürekli kullandığınız bir ilaç var mı?

☐ Hayır ☐ Evet

10. Daha önce psikolojik/ psikiyatrik destek aldınız mı?

☐ Hayır ☐ Evet

Appendix E: Demographic Information Form for Late Adolescents

DEMOGRAFİK BİLGİ FORMU- GENÇ VERSİYONU (ÜNİVERSİTE)

Doğum Tarihi:…../……/…….

Cinsiyet: ☐ Kadın ☐ Erkek ☐ Diğer

Yaş:

Üniversite:

Bölüm:

Sınıf:

1. Size uygun seçeneği lütfen işaretleyiniz.

☐ Çalışıyor ☐ Çalışmıyor

Çalışıyor iseniz;

1.a. Çalışmaya başlayalı kaç yıl oldu?

☐ 0-2 yıl ☐ 2-5 yıl ☐ 5-10 yıl

1.b. Nerede çalıştığınızı ve ne iş yaptığınızı lütfen belirtiniz

……

……

……

……

2. Hanenizde kiminle yaşıyorsunuz?

☐ Çekirdek aile ☐ Geniş aile

2.a. Geniş aile ise kimler olduğunu yazınız:

……

……

……

3. Kardeş Sayısı:

	Cinsiyet	Yaş
1.		
2.		
3.		
4.		
5.		

6		
7.		

4. Ailenizin ortalama aylık geliri:

☐ 500 TL ve altı ☐ 500 - 1000 TL

☐ 1001 – 1600 TL ☐ 1601-2500 TL

☐ 2501 – 3500 TL ☐ 3501-5000 TL

☐ 5001 TL ve üzeri

5. Lütfen ekonomik durumunuzu belirtin.

☐ Alt ☐ Ortanın altı ☐ Orta ☐ Ortanın üstü ☐ Üst

6. Yaşamınızın büyük bölümünü geçirdiğiniz yeri işaretleyiniz.

☐ Büyükşehir ☐ İl ☐ İlçe ☐ Kasaba ☐ Köy

7. Kronik bir hastalığınız var mı?

☐ Hayır ☐ Evet

7.a. Evet ise açıklar mısınız?.....

8. Şu anda tedavi gördüğünüz fiziksel ya da psikolojik/psikiyatrik rahatsızlığınız var mı?

☐ Hayır ☐ Evet

8.a. Evet ise açıklar mısınız?.....

9. Sürekli kullandığınız bir ilaç var mı?

☐ Hayır ☐ Evet

10. Daha önce psikolojik/ psikiyatrik destek aldınız mı?

☐ Hayır ☐ Evet

Appendix F: Demographic Information Form for Mothers

DEMOGRAFİK BİLGİ FORMU- ANNE VERSİYONU

Doğum Tarihi: …./……/…….

Yaş:

1. En son mezun olduğunuz okul:

☐Okuryazar değil ☐Okuryazar ☐ İlkokul ☐ Lise

☐ Lisans ☐ Yüksek Lisans ☐ Doktora

2. Size uygun seçeneği lütfen işaretleyiniz.

☐ Çalışıyor ☐ Çalışmıyor ☐Emekli

2.a. Çalışıyor iseniz kaç yıldır çalışıyorsunuz?

☐ 0-2 yıl ☐ 2-5 yıl ☐ 5-10 yıl ☐ 10 yıl üzeri

2.b Çalışıyor iseniz mesleği:…….

3. Lütfen aşağıdaki seçeneklerden size uygun olanı işaretleyiniz.

☐ Evli ☐ Boşanmış ☐ Eşini Kaybetmiş ☐ Diğer

Diğer ise lütfen açıklayınız:

……

4. Kaç yıllık evlisiniz?

☐ 0-2 yıl ☐ 2-5 yıl ☐ 5-10 yıl ☐ 10 yıl üzeri

5. Hanenizde kiminle yaşıyorsunuz?

☐ Çekirdek aile ☐ Geniş aile

5.a. Geniş aile ise kimler olduğunu yazınız:

……

……

……

6. Ailenizin ortalama aylık geliri:

☐ 500 TL ve altı ☐ 500 - 1000 TL

☐ 1001 – 1600 TL ☐ 1601-2500 TL

☐ 2501 – 3500 TL ☐ 3501-5000 TL

☐ 5001 TL ve üzeri

7. Lütfen ekonomik durumunuzu belirtin.

☐ Alt ☐ Ortanın altı ☐ Orta ☐ Ortanın üstü ☐ Üst

8. Yaşamınızın büyük bölümünü geçirdiğiniz yeri işaretleyiniz.

☐ Büyükşehir ☐ İl ☐ İlçe ☐ Kasaba ☐ Köy

9. Kronik bir hastalığınız var mı?

☐ Hayır ☐ Evet

9.a. Evet ise açıklar mısınız?.....

10. Şu anda tedavi gördüğünüz fiziksel ya da psikolojik/psikiyatrik rahatsızlığınız var mı?

☐ Hayır ☐ Evet

10.a. Evet ise açıklar mısınız?.....

11. Sürekli kullandığınız bir ilaç var mı?

☐ Hayır ☐ Evet

12. Daha önce psikolojik/ psikiyatrik destek aldınız mı?

☐ Hayır ☐ Evet

Appendix G: State-Trait Depression Inventory for Mothers

KENDİNİ DEĞERLENDİRME ÖLÇEĞİ (D-SDEP)

YÖNERGE: Aşağıda kişilerin kendilerine ait duygularını anlatmada kullandıkları bir takım ifadeler verilmiştir. Her ifadeyi okuyun, sonra da **şu anda** nasıl hissettiğinizi, ifadelerin sağ tarafındaki parantezlerden uygun olanını karalamak suretiyle belirtin. Doğru ya da yanlış cevap yoktur. Herhangi bir ifadenin üzerinde fazla zaman harcamadan **şimdi** nasıl hissettiğinizi gösteren cevabı işaretleyin.

ŞU ANDA,		**Hiç**	**Biraz**	**Oldukça**	**Çok**
1.	Güçlü hissediyorum.	1	2	3	4
2.	Hüzünlüyüm.	1	2	3	4
3.	Sağlıklı hissediyorum.	1	2	3	4
4.	İçim sıkılıyor.	1	2	3	4
5.	Canlı hissediyorum.	1	2	3	4
6.	Üzgün hissediyorum.	1	2	3	4
7.	Güvende hissediyorum.	1	2	3	4
8.	Karamsarım.	1	2	3	4
9.	Berbat hissediyorum.	1	2	3	4
10.	Geleceğe ümitle bakıyorum.	1	2	3	4

YÖNERGE: Aşağıda kişilerin kendilerine ait duygularını anlatmada kullandıkları bir takım ifadeler verilmiştir. Her ifadeyi okuyun, sonra da **genel** olarak nasıl hissettiğinizi, ifadelerin sağ tarafındaki parantezlerden uygun olanını karalamak suretiyle belirtin. Doğru ya da yanlış cevap yoktur. Herhangi bir ifadenin üzerinde fazla zaman harcamadan **genel** olarak nasıl hissettiğinizi gösteren cevabı işaretleyin.

GENELDE,		**Hemen Hiçbir Zaman**	**Bazen**	**Çok zaman**	**Hemen Her Zaman**
11.	Mutlu hissederim.	1	2	3	4
12.	Karamsar hissederim.	1	2	3	4
13.	Bütünlük içinde (dağılmamış) hissederim.	1	2	3	4
14.	Üzgün hissederim.	1	2	3	4
15.	Huzurlu hissederim.	1	2	3	4
16.	Neşesiz hissederim.	1	2	3	4
17.	Çökkün hissederim.	1	2	3	4
18.	Güvende hissederim.	1	2	3	4
19.	Umutsuzluk hissederim.	1	2	3	4
20.	Hayattan zevk alırım.	1	2	3	4

Appendix H: Parentification Inventory for Adolescents

EBEVEYNLEŞME ENVANTERİ

YÖNERGE: Aşağıdaki sorular siz büyürken, kendiniz ve ailenizle ilgili sahip olduğunuz düşünceleriniz, davranışlarınız ve duygularınız ile ilgilidir. Lütfen her cümleyi dikkatle okuyun. Cümlenin 1 (hiçbir zaman doğru değil) ve 5 (her zaman doğru) arasında sizin için ne kadar doğru olduğuna dayanarak bir cevap seçin. Her soruyu mümkün olduğunca doğru yanıtladığınızdan emin olun.

BU SORULARIN SİZİN BÜYÜDÜĞÜNÜZ DÖNEM HAKKINDA OLDUĞUNU UNUTMAYIN.

Yanıt Seçenekleri:
(1) Hiçbir zaman **(2)** Nadiren **(3)** Kimi zaman **(4)** Sık sık **(5)** Her zaman

	Durum	Hiçbir zaman	Nadiren	Kimi zaman	Sık sık	Her zaman
1	Üzgün olduklarında ya da duygusal zorluklar yaşadıklarında, kardeş(ler)imi rahatlatmam beklendi.	(1)	(2)	(3)	(4)	(5)
2	Anne babam sık sık diğer aile üyeleri hakkındaki sırları benimle paylaştı.	(1)	(2)	(3)	(4)	(5)
3	Benim yaşadığım yerdeki çoğu çocuk aile bütçesine katkıda bulunurdu.	(1)	(2)	(3)	(4)	(5)
4	Aile üyelerimle ilgilenmek zorunda olduğumda bile, mutlu ya da üzgün olabilecek zamana sahiptim.	(1)	(2)	(3)	(4)	(5)
5	Anne babama önemli kararlar almalarında yardım ettim.	(1)	(2)	(3)	(4)	(5)
6	Her gece kardeşlerimin yattığından emin olmak benim görevimdi.	(1)	(2)	(3)	(4)	(5)
7	Ailem tarafından takdir edildiğimi hissettim.	(1)	(2)	(3)	(4)	(5)
8	Benim yaşımdaki çoğu çocuk benimle aynı rol ve sorumluluklara sahipti.	(1)	(2)	(3)	(4)	(5)

9	Ailevi sorumluluklarım olsa da oyun ya da okul ödevleri için zamanım olurdu.	(1)	(2)	(3)	(4)	(5)
10	Çalıştım ve aile bütçesine katkıda bulundum.	(1)	(2)	(3)	(4)	(5)
11	Kardeşlerimin (kız ya da erkek) ev ödevlerini tamamlamalarına yardımcı olmaktan sorumluydum.	(1)	(2)	(3)	(4)	(5)
12	Ailemde bir anlaşmazlık olduğunda aile üyelerimin yardım istediği ilk kişiydim.	(1)	(2)	(3)	(4)	(5)
13	Kardeşlerimi disipline eden esas kişi bendim.	(1)	(2)	(3)	(4)	(5)
14	Sık sık anne babamın (ya da ailedeki bakım veren yetişkinlerin) arasındaki sorunları çözmeye yardım ettim.	(1)	(2)	(3)	(4)	(5)
15	Aile içindeki rolümden gerçekten keyif aldım.	(1)	(2)	(3)	(4)	(5)
16	Üzgün olduklarında ya da duygusal zorluklar yaşadıklarında, anne babamı rahatlatmam beklendi.	(1)	(2)	(3)	(4)	(5)
17	Haftanın çoğu günü ailenin çamaşırlarını yıkamaktan ben sorumluydum.	(1)	(2)	(3)	(4)	(5)
18	Ailem için hakem rolünü üstlendim.	(1)	(2)	(3)	(4)	(5)
19	Aile üyelerimin sırlarını paylaştığı kişi bendim.	(1)	(2)	(3)	(4)	(5)
20	Ailemizin bir takım olduğunu ve birlikte iyi çalıştığını hissettim.	(1)	(2)	(3)	(4)	(5)
21	Market alışverişinin yapılması diğer aile üyelerinden daha fazla benden talep edildi.	(1)	(2)	(3)	(4)	(5)
22	Aile üyelerim için çevirmen rolünü üstlendim.	(1)	(2)	(3)	(4)	(5)

Appendix I: Father Involvement Scale for Adolescents

BABA KATILIM ÖLÇEĞİ

Aşağıda babanızla ilişkileriniz hakkında cümleler verilmiştir. Sizden istediğimiz **çocukluk/ergenlik döneminizde babanızla yaşadığınız ilişkinizi** düşünerek, aşağıdaki cümlelerin size ne kadar uyduğunu **cümlenin yan tarafında verilen en uygun olan dereceyi (1, 2, 3, 4, 5) işaretleyerek belirtmenizdir.**

Çocukluk ve ergenlik döneminizi düşündüğünüzde;	**Hiç**				**Oldukça Çok**
Sizce babanız baba olmaktan ne kadar hoşlanıyordu?	1	2	3	4	5
Babanız sizin gereksinimlerinizi karşılamak için yeteri kadar istekli miydi?	1	2	3	4	5
Babanıza sırlarınızı paylaşabileceğiniz biri olarak güvenebileceğinizi düşünür müydünüz?	1	2	3	4	5

Çocukluk ve ergenlik döneminizi düşündüğünüzde;	**Hiçbir Zaman**				**Her Zaman**
Desteğine gereksinim duyduğunuzda babanız size bu desteği sağlar mıydı?	1	2	3	4	5
Gün içinde düşünce ve duygularınızın üzerinde babanızın varlığını ve etkisini ne kadar hissederdiniz?	1	2	3	4	5
Babanız sizinle birlikte etkinliklere katılır mıydı?	1	2	3	4	5

Çocukluk ve ergenlik döneminizi düşündüğünüzde;	**Çok Kötü**				**Çok iyi**
Babanıza duygusal olarak ne kadar yakındınız? (Babanızla olan duygusal yakınlığınızı nasıl tanımlarsınız)	1	2	3	4	5
Babanızla nasıl anlaşırdınız?	1	2	3	4	5

Çocukluk ve ergenlik döneminizi düşündüğünüzde;	**İyi Değil**				**Mükemmel**
Genel olarak babanızı nasıl değerlendirirsiniz?	1	2	3	4	5

Appendix J: Brief Symptom Inventory for Adolescents

KISA SEMPTOM ENVANTERİ (KSE)

Aşağıda insanların bazen yaşadıkları belirtilerin ve yakınmaların bir listesi verilmiştir. Listedeki her maddeyi lütfen dikkatle okuyunuz. Daha sonra sizde o belirtinin **BUGÜN DAHİL, SON BİR HAFTADIR NE KADAR VAROLDUĞUNU** yandaki bölmede uygun olan yerde işaretleyiniz. Her belirti için sadece bir yeri işaretlemeye ve hiçbir maddeyi atlamamaya özen gösteriniz. Cevaplarınızı aşağıdaki ölçeğe göre değerlendiriniz.

Bu belirtiler son bir haftadır sizde ne kadar var?

0. Hiç yok 1.Biraz var 2.Orta derecede var 3.Epey var 4.Çok fazla var

Bu belirtiler son bir haftadır sizde ne kadar var?

	Hiç				**Çok fazla**
1. İçinizdeki sinirlilik ve titreme hali	☐	☐	☐	☐	☐
2. Baygınlık, başdönmesi	☐	☐	☐	☐	☐
3. Bir başka kişinin sizin düşüncelerinizi kontrol edeceği fikri	☐	☐	☐	☐	☐
4. Başınıza gelen sıkıntılardan dolayı başkalarının suçlu olduğu duygusu	☐	☐	☐	☐	☐
5. Olayları hatırlamada güçlük	☐	☐	☐	☐	☐
6. Çok kolayca kızıp öfkelenme	☐	☐	☐	☐	☐
7. Göğüs (kalp) bölgesinde ağrılar	☐	☐	☐	☐	☐
8. Meydanlık (açık) yerlerden korkma duygusu	☐	☐	☐	☐	☐
9. Yaşamınıza son verme düşünceleri	☐	☐	☐	☐	☐
10. İnsanların çoğuna güvenilmeyeceği hissi	☐	☐	☐	☐	☐
11. İştahta bozukluklar	☐	☐	☐	☐	☐
12. Hiçbir nedeni olmayan ani korkular	☐	☐	☐	☐	☐
13. Kontrol edemediğiniz duygu patlamaları	☐	☐	☐	☐	☐
14. Başka insanlarla beraberken bile yalnızlık hissetmek	☐	☐	☐	☐	☐
15. İşleri bitirme konusunda kendini engellenmiş hissetmek	☐	☐	☐	☐	☐
16. Yalnızlık hissetmek	☐	☐	☐	☐	☐
17. Hüzünlü, kederli hissetmek	☐	☐	☐	☐	☐
18. Hiçbirşeye ilgi duymamak	☐	☐	☐	☐	☐
19. Ağlamaklı hissetmek	☐	☐	☐	☐	☐
20. Kolayca incinebilme, kırılmak	☐	☐	☐	☐	☐
21. İnsanların sizi sevmediğine, kötü davrandığına inanmak	☐	☐	☐	☐	☐
22. Kendini diğerlerinden daha aşağı görmek	☐	☐	☐	☐	☐

23. Mide bozukluğu, bulantı	□	□	□	□	□
24. Diğerlerinin sizi gözlediği ya da hakkınızda konuştuğu duygusu	□	□	□	□	□
25. Uykuya dalmada güçlük	□	□	□	□	□
26. Yaptığınız şeyleri tekrar tekrar doğru mu diye kontrol etmek	□	□	□	□	□
27. Karar vermede güçlükler	□	□	□	□	□
28. Otobüs,tren,metro gibi umumi vasıtalarla seyahatlerden korkmak	□	□	□	□	□
29. Nefes darlığı, nefessiz kalmak	□	□	□	□	□
30. Sıcak, soğuk basmaları	□	□	□	□	□
31. Sizi korkuttuğu için bazı eşya, yer ya da etkinliklerden uzak kalmaya çalışmak	□	□	□	□	□
32. Kafanızın bomboş kalması	□	□	□	□	□
33. Bedeninizin bazı bölgelerinde uyuşmalar, karıncalanmalar	□	□	□	□	□
34. Günahlarınız için cezalandırılmanız gerektiği	□	□	□	□	□
35. Gelecekle ilgili umutsuzluk duyguları	□	□	□	□	□
36. Konsantrasyonda(dikkati bir şey üzerine toplama) güçlük	□	□	□	□	□
37. Bedenin bazı bölgelerinde zayıflık, güçsüzlük hissi	□	□	□	□	□
38.Kendini gergin ve tedirgin hissetmek	□	□	□	□	□
39. Ölme ve ölüm üzerine düşünceler	□	□	□	□	□
40. Birini dövme, ona zarar verme, yaralama isteği	□	□	□	□	□
41. Bir şeyleri kırma, dökme isteği	□	□	□	□	□
42. Diğerlerinin yanındayken yanlış bir şeyler yapmamaya çalışma	□	□	□	□	□
43. Kalabalıklarda rahatsızlık duymak	□	□	□	□	□
44. Bir başka insana hiç yakınlık duymamak	□	□	□	□	□
45. Dehşet ve panik nöbetleri	□	□	□	□	□
46. Sık sık tartışmaya girmek	□	□	□	□	□
47. Yalnız bırakıldığında/kalındığında sinirlilik hissetmek	□	□	□	□	□
48. Başarılarınız için diğerlerinden yeterince takdir görmemek	□	□	□	□	□
49. Yerinde duramayacak kadar tedirgin hissetmek	□	□	□	□	□
50. Kendini değersiz görmek/değersizlik duyguları	□	□	□	□	□
51. Eğer izin verirseniz insanların sizi sömüreceği duygusu	□	□	□	□	□
52. Suçluluk duyguları	□	□	□	□	□
53. Aklınızda bir bozukluk olduğu fikri	□	□	□	□	□

Appendix K: Scale of Dimensions of Interpersonal Relationships for Adolescents

KİŞİLERARASI İLİŞKİ BOYUTLARI ÖLÇEĞİ (KİBÖ)

Aşağıdaki kendimize ve diğer insanlara yönelik algımız, bakış açımızla ilgili ifadeler bulunmaktadır. Bu ifadeleri dikkatlice okuyup, ifadenin sizi ne kadar tanımladığını düşünerek, size en uygun olanına çarpı (X) işareti koyunuz. Katkılarınız için teşekkürler…

Aşağıdaki ifadeler "SİZİ NE KADAR TANIMLIYOR?"	**Tamamen Tanımlıyor**	**Oldukça Tanımlıyor**	**Kısmen Tanımlıyor**	**Çok Az Tanımlıyor**	**Hiç Tanımlamıyor**
1. İnsanların sözünde duracağına güvenirim.					
2. Kendimi iyi hissetmediğim zaman, bana ilgi ve şefkat gösterilmesinden					
3. Kendimi kolayca kaybedip,					
4. İnsanların benim hakkımdaki düşünceleri, benim duygularımı etkiler.					
5. Kimseye kolay kolay güvenmem.					
6. Karşımdaki insana duygularımı belli					
7. Fikirlerimi söylemeden önce, başkalarının ne düşündüğünü bilmek					
8. Tartışma durumlarında konuyu					
9. Benimle ters düşen insanlardan öç almak					
10. Öfkelendiğimde ağzıma geleni söylerim.					
11. İnsanların hareketlerimi yanlış yorumlamalarından endişelenirim.					
12. Eleştirildiğim zaman doğrudan					
13. Bir kişi ile bir sorun yaşadığımda, sakin kafa ile düşünmeye,					
14. Başkalarına güvenmenin beni sıkıntıya sokacağını düşünürüm.					
15. Öfkemi kolaylıkla kontrol edebilirim.					
16. Başkasının, haklı da olsa, beni					
17. Bir başka insanın düşünce ve duygularından kolaylıkla etkilenirim.					
18. Bana dostça yaklaşılması, o kişi ile yakın ilişki kurmamı kolaylaştırır.					
19. Eğer bir insan ile geçmişte olumsuz bir yaşantım olmuş ise, o insan benim					

20. Karşımdaki insanların beni					
21. Diğer insanların hedeflerini kabul etmektense, kendi hedeflerimi kendim					
22. Sırlarımı paylaştığım insanların, sırlarımı tutacaklarına güvenirim.					
23. İnsanların beni kullandıklarını					
24. Ailemden başka hiç kimseye güvenmem.					
25. Kızdığım kişiyi kolaylıkla affedemem.					
26. Hoşuma gitmese de diğerlerini memnun edecek şekilde davranırım.					
27. Karşımdaki insanın bakış açısını					
28. Herkesin karşı çıkacağını bilsem de fikirlerimi ortaya koymaktan çekinmem.					
29. İnsanların beni önemsediklerini sanmam.					
30. Diğer insanlardan beklediğim tepkileri alamazsam, cesaretim kırılır.					
Aşağıdaki ifadeler "SİZİ NE KADAR TANIMLIYOR?"	**Tamamen Tanımlıyor**	**Oldukça Tanımlıyor**	**Kısmen Tanımlıyor**	**Çok Az Tanımlıyor**	**Hiç Tanımlamıyor**
31. İnsanların iyi niyetli olmadıklarını düşünürüm					
32. Başkalarının benim hakkımdaki düşünceleri, kendimi değerlendirmemde					
33. Karşı taraftan sevgi alamazsam kendimi					
34. Bir insanı önemsediğimi, ona ifade					
35. İhtiyacım olduğunda insanları yanımda					
36. Başkalarının önerileri, nasihatleri olmadan kendi kendime hedefler					
37. Konuşmalarım yapıcı ve olumludur.					
38. İnsanların yalan söylediklerine inanırım.					
39. Başkaları ile yakınlık kurmakta zorluk					
40. Önemsediğim kişilerin beni					
41. Önemsediğim kişilerin bana ne yapacağımı söylemesi, işimi kolaylaştırır.					
42. Olumlu duygularımı, karşımdaki kişiyle					
43. Başkalarının benim gerçek düşüncelerimi bilmelerini istemem.					
44. Diğer insanlarla yakın ilişki kurduğumda kendimi iyi hissederim.					
45. Etrafımda benden daha güçlü ya da zeki insanlar olduğunda, kolaylıkla kendime					
46. Duygularımı kontrol altında tutmak benim için oldukça zordur.					

47. Tanımadığım insanlar arasında kendimi					
48. Karşımdaki kişinin ihtiyaçlarını, göz					
49. Karşımdakini olduğu gibi kabul etmede					
50. Yeni bir ortamda bile, insanlara güvenmek gerektiğini düşünürüm.					
51. Bir iş yaparken, karşımdaki kişinin de duygularını hesaba katarım.					
52. Problemli durumlarda, başkalarını					
53. İnsanların sadece kendi çıkarları ile ilgilendiklerini düşünürüm.					