

PARENTAL ACCEPTANCE-REJECTION, SELF-ESTEEM AND
PSYCHOLOGICAL ADJUSTMENT:
CHILDREN WITH LEARNING DISABILITIES AS COMPARED TO CHILDREN
WITH INSULIN DEPENDENT DIABETES MELLITUS

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ABSTRACT

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CHILDREN WITH LEARNING DISABILITIES AS COMPARED TO
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This study aimed to investigate the psychological adjustment of children with learning disabilities (LD); to examine the group and gender differences of the psychological adjustment between children with LD and diabetes; and to investigate group differences in the way mothers experience having children with LD and diabetes in terms of their adjustment levels. In order to test the above aims, 2 (Gender) x 2 (Diagnosis) ANCOVA's were conducted to evaluate the diagnosis and gender differences on the psychological adjustment levels of children, separately. Significant diagnosis main effects were found for all of the study variables,

indicating that children with a learning disability had worse psychological adjustment compared to children with diabetes. Regression analyses were conducted in order to find out the variables associated with the symptoms of depression and anxiety for children with learning disabilities and diabetes groups, separately. Separate regression analyses were run to examine the mediator role of self-esteem between parental rejection and learned helplessness and depression in children with LD. In order to evaluate the diagnosis differences (LD, diabetes) on the psychological adjustment levels of mothers ANCOVA's were conducted. Significant diagnosis main effects were found for all of the study variables regarding mothers, indicating that mothers of children with a learning disability had worse psychological adjustment compared to mothers of children with diabetes. The results were discussed in terms of the treatment needs of children with LD, helping parents and children cope with LD, and the importance of early identification of these children for the prevention of psychosocial problems.

Keywords: psychological adjustment, learning disabilities, diabetes

ÖZ

EBEVEYN KABUL VE REDDİ, BENLİK SAYGISI VE
PSİKOLOJİK UYUM: ÖĞRENME GÜÇLÜĞÜ OLAN ÇOCUKLARLA
DİYABETİK ÇOCUKLARIN KARŞILAŞTIRILMASI

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Bu çalışmada öğrenme güçlüğü olan çocukların psikolojik uyumu; öğrenme güçlüğü ve diabetli çocukların psikolojik uyumları ile ilgili gruplar arası ve cinsiyet farklılıkları; ve bu çocukların annelerinin psikolojik uyum düzeylerinin karşılaştırılması amaçlanmıştır. Çocukların psikolojik uyum düzeylerini değerlendirmek amacıyla, 2 (Cinsiyet) x 2 (Tanı) varyans analizi uygulanmıştır. Araştırma değişkenleri ile ilgili anlamlı temel etkiler bulunmuştur. Buna göre öğrenme güçlüğü olan çocukların diabetli çocuklara göre daha fazla psikolojik uyum sorunu olduğu belirlenmiştir. Ayrıca öğrenme güçlüğü ve diabetli çocukların depresyon ve kaygı düzeylerini belirlemek amacıyla iki farklı regresyon analizi

uygulanmıştır. Benlik saygısının aile reddi ile depresyon ve öğrenilmiş çaresizlik ve depresyon arasındaki rollerini incelemek amacıyla iki farklı regresyon analizi gerçekleştirilmiştir. Annelerin psikolojik uyum düzeylerinin iki grup arası farklılıklarını görmek amacıyla tek yönlü varyans analizi uygulanmıştır. Araştırma değişkenleri Araştırılan değişkenlerle ilgili anlamlı temel etkiler bulunmuştur. Buna göre, öğrenme güçlüğü'ne sahip çocukların annelerinin diabetli annelere göre psikolojik uyumları ile ilgili daha fazla sorun yaşadıkları belirlenmiştir. Bulgular öğrenme güçlüğü olan çocukların tedavi ihtiyaçları, aile ve çocuklara öğrenme güçlüğü ile baş etme becerileri kazandırma ve bu çocuklarda ortaya çıkan psikososyal sorunları önleme amacıyla erken tanı konulmasının önemi çerçevesinde tartışılmıştır.

Anahtar Kelimeler: psikolojik uyum, öğrenme güçlüğü, diyabet

DEDICATION

To *Lara*

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CHAPTER 1

INTRODUCTION

Learning disabilities (LD) occur in 5 to 10 % of the population (Kronenberger & Dunn 2003). In Turkey, 10-20 % of school children are diagnosed with LD (Erden, Kurdođlu, Uslu, 2002). They include reading disorder (dyslexia), developmental arithmetic disorder (dyscalculia), disorders of written expression (dysgraphia), and nonverbal learning disorders. Dyslexia is the most common problem, constituting about half of all learning disabilities (Kronenberger & Dunn 2003). Learning disorders are among the most common problems that a clinician is likely to encounter (AACAP Official Action, 1998). Many of the children who are referred for evaluation due to behavioral difficulties in school or homework completion have unrecognized learning difficulties (Little, 1993; Pearl & Bryan, 1994). These children may also be referred for emotional or behavioral problems associated with these disorders. Performance anxiety, poor peer relationships, family conflicts, and decreased self-esteem are common in children with learning disorders. Some children's parents and teachers may not recognize the importance of the learning disability in the child's life in terms of emotional or behavioral problems. Usually, these problems present themselves as the child matures, and academic tasks and peer relationships become more important.

Learning disorders may often be unrecognized until children present problems such as school refusal or develop somatic symptoms such as headaches or stomachaches. If undiagnosed and untreated, these problems tend to increase until children with learning disorders dislike school, refuse to do homework, or has continuous arguments with his/her parents regarding the completion of schoolwork. Thus, these children are faced with a multitude of problems from school difficulties to problems with parents and peers. School difficulties along with constant academic failures and difficulties in peer relationships lead to different emotional problems for the child.

Recent research concerned with the effects of learning difficulties on the personal, social, and emotional development of children has shown a new direction in psychological research (Margerison, 1996). Since children with learning disabilities experience academic failure frequently, research with these children has shown interest to the extent to which these children feel about themselves. Thus, some research has shown that having a learning difficulty can adversely affect self-concept and self-esteem as well as children's adjustment (Humphrey, 2002). Research in the area of self-concept and adjustment is still inconclusive. This study aims to find out the links between parental acceptance-rejection, self-esteem, and psychological adjustment in children with learning disabilities.

1.1 The Construct of Parental Acceptance-Rejection

Parental-acceptance rejection is the warmth dimension of parenting. Parental warmth has two ends, with acceptance on one end and rejection on the other. Every

individual can be placed on some point in this continuum since everyone receives more or less warmth from their parents.

Parental love and affection is expressed in two major ways: physical and verbal. Warmth can be shown through kissing, fondling, caressing, smiling, hugging and the like physically. Expressions of verbal warmth may be saying nice things, complimenting or praising.

Rejection in parental acceptance rejection theory is defined as absence or withdrawal of acceptance (Rohner, 1986). In the theory, rejection takes three forms: hostility-aggression, indifference-neglect, and undifferentiated rejection. Hostility refers to the internal feelings of resentment and anger toward the child and it may be shown behaviorally in forms of verbal and physical aggression. Aggression refers to behaviors that are meant to hurting another person physically or psychologically.

Indifference, on the other hand, is not showing concern for the child. For example physical or psychological non-availability of the parent may be seen as emotional unresponsiveness or failing to attend the physical needs of the child.

Undifferentiated rejection refers to the child's feelings of rejection without naming parental behavior as neglect or aggression, but rather points to the child's global feelings of being unloved (Rohner, 1986).

Parental-acceptance rejection of children has been extensively studied in developmental psychology (Rohner, 1986). The Parental Acceptance Rejection Theory (PART) gives the central importance to parental acceptance (or warmth) as a factor in parent-child interaction. According to PARTheory's personality sub-theory warmth and affection from the most significant people (parents) in the child's

environment is an important psychological need of the children. If this need is unfulfilled it can lead to problems in the personality development of children.

According to parental acceptance rejection theory, the psychological adjustment of children varies directly with their experience of parental acceptance rejection. PARTheory's personality sub-theory postulates that seven personality dispositions among children vary with their experience of childhood parental rejection (Khaleque & Rohner, 2002). These dispositions are (1) hostility, aggression or problems with the management of these; (2) dependence or defensive independence; (3) impaired self-esteem; (4) impaired self-adequacy; (5) emotional unresponsiveness; (6) emotional instability, (7) negative worldview. These dispositions vary in a linear way with differing degrees of parental acceptance and rejection (Khaleque & Rohner, 2002).

Meta-analysis assessing perceived parental acceptance-rejection is associated with psychological maladjustment among children regardless of differences in gender, race, geography, language or culture (Khaleque & Rohner, 2002). Also, the association between perceived acceptance-rejection and psychological adjustment was found to be stronger among youths since youth is still a time when they can be influenced by parents love (Khaleque & Rohner, 2002). Studies attempting to identify risk factors for the development of low self-esteem have generally focused on parenting. Parenting has been implicated as a risk factor for the development of childhood low self-esteem (Rohner, 1986). Results from studies also suggest that low self-esteem is predictive of a later depressive episode.

Parental acceptance rejection has been studied with populations of disabled children, such as mental or physical handicaps (Taylor, 1998; Zafar Afaq, 2002) yet studies with children who have learning disabilities are almost non-existent.

1.2 Learned Helplessness

Another issue that has not been thoroughly studied with children who have learning disabilities is the concept of learned helplessness. Doing well at school is highly valued among parents, peers, and the society in general. Thus the negative value of academic failure cannot easily be minimized. Repeated academic failures may result in self-protective strategies, maladaptive motivational styles such as helplessness and psychological maladjustment (Valas, 2001a).

The original (Seligman, 1975) and the reformulated theory of learned helplessness (Abramson, Seligman, & Teasdale, 1978) focus on cognitive processes. The formulation of “learned helplessness” indicates that helplessness is not inherent but learned (Seligman, 1975). In the reformulated theory, cognition was refined in the form of attributions (Abramson, Seligman, & Teasdale, 1978). Most people are faced with negative stressful events that can have a major impact on the course and direction of their lives. The way people cognitively formulate explanations for negative events may shape their attributional style for future events. Learned helplessness is a reaction of giving up – a quitting response that comes from the belief that whatever you do does not matter. Attributional style is the way people usually explain why events happen. Attributional style is the modulator of learned helplessness (Seligman, 1990). It is the cognitive personality variable that reflects the usual manner in which people explain the bad events that happen to them. There

are three dimensions of interest: internality-externality, stability-instability, globality-specificity. An internal cause points to something about the self (it's me), whereas an external cause points to the environment, other people, or circumstances (it's the size of the class). A stable cause is related to a long-lasting factor (it's never going to go away), whereas an unstable cause is transient (it was a one time thing). A global cause, on the other hand, affects a wide domain of activities (it's going to affect everything I do), whereas a specific cause is circumscribed (it has no effect on my everyday life). Thus in the reformulated helplessness theory, the three dimensions of attributions of negative life events that were focused upon were: internal-external, stable-unstable, and global-specific. Internal attributions explain causes of negative events in self-referent terms, whereas external attributions assign causes to factors outside the self. Internal and external attributions may also be stable or unstable. Stable attributions explain causes of negative events in terms of permanent factors. Unstable attributions, on the other hand, explain events in terms of temporary factors. Internal and external attributions whether they are stable and unstable are divided into global and specific attributions. Global attributions explain the causes of negative events in pervasive terms and include many situations, whereas specific attributions explain events in limited, context-specific terms. For example when failure in Turkish literature lessons is explained by lack of literature ability, the cause is internal and stable; when the failure is explained by lack of effort, the cause is internal and unstable. A positive attributional style attributes negative events to external, unstable and specific causes. A negative attributional style attributes negative events to internal, stable, and global causes. When people

face frustration and failure, and also have a negative attributional style they may behave in a fatalistic and passive manner (Peterson & Barrett, 1987). The theory also proposes that there is a distinction between personal and universal helplessness (Valas, 2001a). Personal helplessness happens when a person expects that the outcome is not contingent upon a response in his/her repertoire, but in the response of a relevant other. Universal helplessness, on the other hand, happens when a person expects the outcome to be contingent on neither his nor some relevant others' response repertoire. The reformulated theory hypothesizes that in personal helplessness lowered self-esteem may occur (Abramson, Seligman, & Teasdale, 1978). The theory also hypothesizes that individuals who attribute negative events to internal, stable, and global causes are more disposed towards depression compared to those individuals who make external, unstable, and specific attributions to these events (Metalsky et al, 1982, 1987). The generality of the depressive deficits will depend on the globality, whereas the chronicity will depend on the stability of the attributions of helplessness (Abramson et al., 1978). Whether self-esteem is lowered depends on the internality of the attribution for helplessness.

1.2.1 Learned Helplessness in Children with Learning Disabilities

The ways children respond to failure are mediated by their beliefs (Dweck & Repucci, 1973). When children believe that their failures are caused by factors under their control (such as blaming their lack of effort) they tend to persist in order to master tasks, even though their initial efforts brought them failure. On the other hand, when children believe that their failures are beyond their control (such as blaming their lack of ability) they will be likely to give up quickly when faced with

difficult tasks. This response pattern has been named “learned helplessness” (Dweck & Repucci, 1973). Children with learned helplessness tend to attribute failure to external factors rather than effort, and show decreased performance following failure (Licht & Dweck, 1984). Diener and Dweck (1978, 1980) found that helpless children evaluate themselves less positively following failure, make ability attributions to failure and persist less often compared to mastery-oriented children.

Research findings have shown that past academic achievement influences the pattern of attributions. Thus, children who have a history of poor performance are more likely to attribute failure to low ability (Diener & Dweck, 1978, 1980). Past academic performance may also affect attributional patterns indirectly through the mediation of self-concept, attributing failure to lack of ability after repeated failures (Marsh, 1984). According to helplessness theory, if the failures are attributed to internal and stable factors (e.g., ability) these experiences involve expectations of independence between effort and results (Abramson et al., 1978). Thus, these expectations may give rise to symptoms of personal helplessness, leading to lowered self-esteem and increased depressive tendencies.

Students with LD may experience too much failure and set-backs in a difficult education system. The nature of the disabilities is in direct conflict with the educational process. Students with LD are likely to experience a non-contingency between response and outcome through repeated failures in spite of increased effort. Failure in this sense refers to not receiving a grade equivalent to the effort they put in. Students with LD must put in more time and energy to achieve the same results as students who do not have LD. When students with LD experience the non-

contingency between effort and performance, learned helplessness may follow.

The reformulated learned helplessness model predicts that if students with LD attribute failure to internal, stable and global causes, they may experience learned helplessness. In an academic setting, students with educational difficulties can experience differences in performance or in the amount of effort needed for similar performance compared to peers. This comparison could lead to personal helplessness which may lead to a belief that, relief from an aversive event is not within their own repertoire but is controllable by relevant others. While their classmates are succeeding, these students struggle in classes, thus, they may experience internalized helplessness. If the student's attributions for failure are stable and global the learned helplessness will transfer to other classes and situations.

The issue of learned helplessness has not been studied well with child psychiatric populations. There are a few studies on the learned helplessness response style of children with Attention-Deficit/ Hyperactivity Disorder (ADHD). Milich and Okazaki (1991) studied learned helplessness among ADHD boys and found that these boys exhibit behaviors consistent with a helpless response style when confronted with failure experiences. Yet their results also showed that ADHD boys had difficulty sustaining effort on tasks whether or not they have had exposure to insolvable problems. Thus they concluded that classification of mastery-oriented and helpless response styles may not be applicable to ADHD samples as described by Diener and Dweck (1978). In another study it was found that ADHD boys were

prone to a learned helplessness response style when faced with failure experiences (Milich et al., 1991).

Children with LD, due to the nature of their problems, experience frequent exposure to failure. In the classroom, their difficulties produce academic problems. Socially they receive negative feedback from their parents, teachers, and peers. Thus, children who experience repeated exposure to failure are at risk for developing a learned helplessness response style (Licht et al, 1985) where they attribute failure to their own lack of ability. This causal attributional style may lead to decreased effort when difficult tasks are encountered. Thus, children with a learned helplessness response style will be less likely to persist on a task after a failure experience. Their lack of persistence leads to more failure and reinforces the belief that the child has related to not being able to solve a problem and produces the behaviors that confirm this belief (Milich & Okazaki, 1991). Thus, studies examining the beliefs of learning disabled children suggest that they fit the learned helplessness response pattern (Butkowsky & Willows, 1980; Pearl, 1982; Pearl, Bryan & Donahue, 1980; Kistner, White, Haskett & Robbins, 1985). It is natural for LD children to attribute their failures to factors beyond their control after repeated school failures. Yet it has been suggested that LD children may enter into a self-perpetuating cycle since early school problems lead them to doubt their abilities and expect failures, and these beliefs and expectations may lead to less persistent attempts to achieve tasks which then increase the likelihood of continued failures (Dweck, 1975).

Although research supports that repeated failures of LD children lead them to develop helpless beliefs there could also be other explanations for the differences in the attributions of LD children and non-LD children. Children's beliefs related to their academic failures may be influenced by their experiences such as repeated failures but still they may also be related to the reasoning abilities of children (Nicholls, 1978, 1979). Thus, as the reasoning abilities of children increase through developmental changes, the information used to formulate causal attributions and the relationship between controllable and uncontrollable factors as explanations of achievement outcomes also change (Kistner et al., 1985; Nicholls, 1978, 1979).

When normally achieving children's failure attributions are investigated, it is shown that as age increases the tendency to attribute failures to insufficient effort, which is a factor within their control, increases (Frieze & Snyder, 1980). If differences between LD and normally achieving children's attributions change through cognitive maturity, then developmental changes in LD children's attributions will be similar to normally achieving children's in the long run. Yet the learned helplessness hypothesis predicts that LD children will attribute their failures to uncontrollable factors such as blaming their abilities. In a study to examine this hypothesis, it was found that LD girls were more likely than normally achieving children to attribute their failures to insufficient ability which is a factor beyond their control, regardless of age (Kistner et al., 1985). Also both younger and older girls with LD emphasized the role of effort in determining their failures less than normally achieving girls. On the other hand, for LD boys, age-related changes for their failures were found to be similar to those of normally-achieving children. Thus,

boys were more likely to attribute their failures to insufficient effort as their age increased. It was suggested that LD girls may be at greater risk for developing and maintaining “helpless” beliefs related to the cause of their failures. Developmental patterns of attributions may differ for boys and girls, thus, gender differences must also be examined when attributions of children with LD are to be examined yet very few studies have investigated this possibility. The studies with LD children and their attributions for success have shown mixed results. In a meta-analysis, it was found that LD groups attributed success to external factors such as luck and attributed failure to internal factors such as lack of ability (Kavale & Forness, 1996). On the other hand in a study about the attributions made in social situations it was found that children with LD attributed social success to both external and internal factors whereas social failure was attributed to external factors (Tur-Kaspa & Bryan, 1993). Thus, issues regarding LD children’s learned helplessness have still not been investigated thoroughly.

1.3 Psychological Adjustment

The literature shows an association between learning disability and psychological maladjustment but the direction of this relationship is not clearly established. One view is that LD is shown as a secondary reaction to a primary emotional problem (Colbert, Newman, Ney & Young, 1982; Goldstein, Paul, & SanFilippo-Cohn, 1985). According to this perspective, learning problems are a result of the child’s unconscious emotional block (Spren, 1989) or as a reaction to conflicts with teachers, unrealistic parental demands, or undiagnosed psychiatric disorders which lead to obstacles in learning (Rourke & Fuerst, 1991). In support of

this view Goldstein and colleagues (Goldstein et al., 1985), suggest that for some children with LD, depression is stable and interferes with learning by reducing cognitive capacity, which leads to poor achievement. Yet by definition, LD cannot result from serious emotional disturbance, although the two can co-occur (Hammill, 1993). Therefore, these studies that investigate the above hypothesis do not differentiate academic underachievement from LD as it is defined as a diagnosis in DSM-IV.

The alternate view points out that repeated academic failures experienced by a child with LD result in psychosocial maladjustment, including poor interpersonal relationships, internalizing and externalizing behaviors (Dyson, 2003, Greenham, 1999). As a consequence of school failure, parents, teachers, and peers express disapproval toward the child, who begins to feel helpless. This leads to further academic failure and a cycle of pressure and negative feelings that may eventually lead to social and emotional problems (Bursuck, 1989; La Greca & Stone, 1990; Valas, 2001b). Emotional factors have included internalizing problems such as depression, anxiety, low feelings of self-worth, and faulty attributions for success and failure (Greenham, 1999, Valas, 2001b). Parents and teachers who are not aware of the concept of LD, typically call these children as “lazy” or “mentally challenged” and these labels make it harder for children with LD to adjust in school (Erden, Kurdoğlu, & Uslu, 2002). Learning disability is a disorder newly recognized in Turkey. These children have academic difficulties and feel different, compared to their peers (Erden, Kurdoğlu, Uslu, 2002). These children may also experience difficulties in their relationships with their parents and teachers. Secondary

psychological problems may also arise such as depression and anxiety disorders along with problems in self-esteem. (Fristad, Topolosky, Weller, & Weller, 1992; Erden, Kurdoğlu, & Gündoğdu, 1998).

1.3.1 Self-Concept and Self-Esteem in Children with Learning Disabilities

Children with learning disabilities are at risk for social and emotional difficulties (Grolnick & Ryan, 1990; Dyson, 2003). 24 to 52 percent of children with LD are reported to have social and emotional difficulties (Bursuck, 1989; La Greca & Stone, 1990; Rock, Fessler, & Church, 1997). The social and emotional difficulties of children with LD have led to research on their social development such as global self-concept, academic self-concept and social competence yet conflicting findings have been found in these areas (Dyson, 2003; La Greca, & Stone, 1990). Several studies have shown that children with LD have a low global self-concept (Ayres, Cooley, & Dunn, 1990; Hiebert, Wong & Hunter, 1982; Kistner & Osborne, 1987; LaGreca & Stone, 1990; Rogers & Sakolfske, 1985, Valas, 2001b), yet some studies have also found no differences in self concept between children with and without LD (Bear, Juvonen & McInerney, 1993; Dyson, 2003; Grolnick & Ryan, 1990; Kistner, Haskett, White, & Robbins, 1987; Priel & Leshem, 1990; Sabornie, 1994). La Greca and Stone (1990) have found that compared to low achievers and average achievers, children with LD perceived themselves lower in global self-worth. A recent meta-analysis (Kavale & Forness, 1996) showed that around 70 % of children with LD exhibited negative global self-concept and low self-esteem. However, in general, research has produced

inconsistent results on global self-concept of children with LD and thus needs to be investigated.

Self-esteem can be defined as “a personal judgment of worthiness that is expressed in the attitudes the individual holds toward himself” (Coopersmith, 1967, p 4-5). In order to understand what constitutes self-esteem it must be understood in terms of the assumptions related to it. Firstly, the concept of self-esteem is learned (Bandura, 1977) and self-perceptions arise mainly in a social context (Coopersmith, 1967). Self perceptions tend to seek stability, consistency, and enhancement (Rogers, 1951; Maslow, 1954).

Since self-development is a social learning activity, it is not difficult to see how children with learning difficulties might suffer deficits in this area. Children with learning difficulties are at an increased risk for being teased and are less likely to be accepted by their peer group, thus this can be harmful for the developing self. Also starting from age eight, children’s self-referential statements become comparative, thus through unrealistic comparisons with their peers and maladaptive self-referential styles they may develop low levels of self-esteem (Gurney, 1988; Humphrey, 2002). In a study investigating self-esteem in dyslexia it was found that children with dyslexia attending mainstream schools had significantly lower levels of self-esteem in the areas of reading ability, writing ability, spelling ability, intelligence, English language ability, neatness, popularity, and importance than their non-learning disabled peers (Humphrey, 2002).

Researchers have become aware of the contribution of self-esteem on factors such as motivation, academic achievement, and peer relations, and how having a learning difficulty can effect these adversely (Humphrey, 2002). Children who experience problems in learning may develop maladaptive self-referential styles, in other words, they consistently refer to themselves in a negative way, and thus they also develop low levels of self-concept and self-esteem (Humphrey, 2002).

School experiences are important to psychological adjustment. Academic achievement is also an important factor in self-development. Children with learning disabilities are faced with academic failure and therefore their self-images are at risk (Valas, 2001b). Clinical observations show that children with learning difficulties who experience difficulty in most academic areas have been shown to have low levels of self-esteem compared to peers who do not have learning disabilities (Bruininks, 1978; Humphrey, 2002; Kistner & Osborne, 1987; La Greca & Stone, 1990; Rosenthal, 1973; Serafica & Harway, 1979; Thomson & Hartley, 1980). In a meta-analysis of 34 studies comparing self-reported personality characteristics of children and adolescents with and without learning disabilities, it was found that students with LD tend to self-report more negatively on factors such as self-esteem, anxiety, and locus of control compared with other students (Thompson, 1992). Other studies interested in emotional well-being in children with LD have found that both boys and girls with LD were more likely to report having skipped school without a clear reason and more likely to get into trouble in school (Svetaz, Ireland, & Blum, 2000).

Elementary school students with LD have been found to show lower self-esteem than their classmates (Kistner & Osborne, 1987; Rogers, & Saklofske, 1985). Since studies have typically compared children with LD to their healthy classmates and peers it may be natural for these children to display lower self-esteem patterns. Thus one of the aims of the present study is to compare the self-esteem patterns of LD children with that of another group of children dealing with a chronic disease (i.e., diabetes).

1.3.2 Depression

Many factors have been associated with depression such as age, sex and self-esteem. Depression has been reported to increase with age, be higher for girls than boys, and is inversely associated with self-esteem (Nolen-Hoeksema & Girgus, 1994; Nolen-Hoeksema, Girgus, & Seligman, 1992; Orvaschel, Beeferman, & Kabacoff, 1997). Attributional style, self-esteem, and helplessness have been associated with depression in elementary school-aged children (Blumberg & Izard, 1985; Haley, Fine, Marriage, Moretti & Freeman, 1985; Kaslow, Rehm, Siegel, 1984; Kaslow, Tanenbaum, Abramson, Seligman, & Peterson, 1983; Kazdin, Rodgers, & Colbus). Consistent with research indicating adolescents with LD have negative self-concepts relative to nondisabled adolescents, it may be true that adolescents with LD are also at greater risk for depression (Cohen, 1985; Dalley, Bolocofsky, Alcorn, & Baker, 1992; Heath & Wiener, 1996).

In a study examining depressive symptoms in LD, it was found that a large percentage of an urban sample of adolescents with LD rated themselves or were rated by their counselors as having clinically significant levels of depressive

symptomatology (Howard & Shick Tryon, 2002). These results are similar to those of Rodriguez and Routh (1989) who found that 61 % of their sample with LD met criteria for mild depression and 26 % met the cutoff score for severe depression. Other studies show that a depressive disorder is found in about half of the students with LD (Brumback & Staton, 1983; Heath, & Wiener, 1996; Huntington, & Bender, 1993; Palladino, Poli, Masi, & Marcheschi, 2000; Wright-Strawderman, & Watson, 1992). Some studies have found that mean depression scores for children and adolescents with LD are significantly higher than those found in both normative populations (McConaughy & Ritter, 1985; McConaughy et al., 1994; Wright-Strawderman, & Watson, 1992) and from normally-achieving controls (Rodriguez & Routh, 1989). These findings have been found to be consistent where different measures and raters were used in both clinic-referred and school-identified samples of LD (Greenham, 1999).

When self-report measures, such as the Children's Depression Inventory (CDI) and the Beck Depression Inventory (BDI) are administered to children and adolescents with LD in order to determine the severity of depressive symptoms, mean CDI or BDI scores of individuals with LD fall within the mild range of depressive symptoms between 10.6 and 15 for children (Goldstein et al., 1985; Rodriguez & Routh, 1989; Stevenson & Romney, 1984; Wright-Strawderman & Watson, 1992). In one of these studies which included a control group, the mean CDI score of 8-13 year old children with LD did not differ significantly from the mean of normally achieving children (10.6 to 8.5, respectively) (Rodriguez & Routh, 1989). The prevalence of moderate to severe depressive symptoms (BDI

scores greater than 19, CDI scores greater than 13) varies across studies (Greenham, 1999). 10 % of the normative population report scores in the moderate to severe range. In a few studies, the percentage of children with LD is significantly higher than that found in the normative population (26-36 %) (Goldstein et al., 1985; Wright-Strawderman & Watson, 1992). In some studies the percentage of children and adolescents with moderate to severe depressive symptoms was comparable to the normative population (14 % and 11 %) (Stevenson & Romney, 1984; Maag & Reid, 1994). In one study that included a control group there was no significant difference between LD and non-LD adolescents in terms of severe depression (11 %, 10 %, respectively). In another study, depression was examined in 66 children with LD compared to 69 children without LD in grades 5-8 (Heath, 1992). Children with LD were found to be at a significantly greater risk for high (clinically significant) levels of depression than were the nondisabled comparison students. In a study that examined the prevalence of LD in a sample of depressed children it was found that 7 % of children admitted to a psychiatric unit with an initial diagnosis of depression were also diagnosed with LD (Colbert et al., 1982). This percentage is similar to the rates of LD in the general population (Greenham, 1999).

In other studies mild symptoms of depression are reported for children with LD and have been associated with maladaptive attributional styles (Greenham, 1999; Rodriguez & Routh, 1989). The most widely held view of childhood depression states that children experience depression in the same way as adults (American Psychiatric Association, 1980). A consensus has emerged in the literature that depression exists in children, its symptoms picture is phenomenologically

similar to that seen in adults (such as having similar affective, cognitive, behavioral, and somatic symptoms) and there may also be some developmentally appropriate additional symptoms (such as school phobia and enuresis) (Kaslow, Rehm & Siegel, 1984).

Current theoretical models of adult depression stress social-cognitive variables as important factors in depressive symptomatology (Abramson, Seligman & Teasdale, 1978; Beck, 1972, 1976). According to Beck (1972) depressive schemas that result in a negative cognitive triad are seen as causing the depressive symptom. Depressed individuals have a negative bias in their thinking that leads them to have a negative view of themselves, their world, and the future. Thus, in this study the component of low self-esteem of the negative cognitive triad will be addressed.

Negative social experiences and individuals' interpretations of these experiences can be significant predictors of depressive symptoms (Abramson, Metalsky, & Alloy, 1989). Rejection in the context of an interpersonal relationship is often conceptualized as a significant stressor that may be associated with the development, maintenance, or relapse of depressive symptoms (Prinstein & Aikins, 2004). Yet such an association has not been studied extensively in a child psychiatric population (Gladstone & Kaslow, 1995). Rejection in the context of an interpersonal relationship such as a mother-child relationship may lead to depressive symptoms in children as well, thus this association is intended to be studied.

Cognitive vulnerability-stress models, such as the reformulated learned helplessness / hopelessness model, (Abramson et. al., 1989) suggest that the

tendency to attribute negative life events to internal, global, and stable causes is predictive of the onset, maintenance, and relapse of depressive symptoms especially when this attributional style is combined with the experience of a life stressor (Abramson et. al., 1989, Hankin, Abramson, & Siler, 2001; Nolen-Hoeksema, Girgus, & Seligman, 1992). Seligman et al., (1984) found that children between the ages of 8 and 13 who attributed bad events to internal, stable, and global causes were more likely to report depressive symptoms than children who attributed these events to external, unstable, and specific causes. In another study, it was found that compared to non-depressed children, depressed children were found to have lower self-esteem, make more depressive attributions, show negative self-evaluation, lower expectations, and a preference for punishment over reward (Kaslow, Rehm, & Siegel, 1984).

It might be expected that learning disabled children who are underachieving at school are candidates for depression. Although it has been pointed out that learning difficulties in children may lead to depression, this hypothesis has not been properly verified. In a study comparing 20 learning-disabled children with with 20 non-disabled boys in grades 3-5, it was found that learning disabled children relative to non-disabled children reported more depressive symptoms and lower expectations for future academic success (Reidy, 1985).

Thus one of the aims of the present study is to explore this hypothesis by estimating the prevalence of depression in learning disabled children. It is also the aim of this study to identify variables that distinguish children with learning

difficulties who are depressed from their non-depressed counterparts, thus enabling a further understanding of depressed children with LD.

1.3.3 Anxiety

Recently evidence has been found for increased symptoms of anxiety in children with LD by self-report ratings, and parent and teacher ratings (Greenham, 1999). Children with LD report significantly higher levels of anxiety levels compared to normative populations and normally achieving controls (Paget & Reynolds, 1984; Fisher, Allen & Kose, 1996; Rodriguez & Routh, 1989). But these scores are below clinically significant levels. In a study comparing 20 learning-disabled children with 20 non-disabled boys in grades 3-5, it was found that LD children who made more internal-stable-global attributions for failure were more likely to be anxious (Reidy, 1985).

Generally, learning disabled children may have multiple failure experiences and therefore it may be assumed that they may show higher levels of trait anxiety (Margalit & Shulman, 1986). In behavior rating scales, parents and teachers report higher levels of anxious behaviors for children and adolescents with LD as compared to normative populations and non-LD controls (McConaughy & Ritter, 1985; McConaughy et al., 1994; Maag & Reid, 1994; Rodriguez & Routh, 1989).

Some children with dyslexia respond with increased anxiety, and this is frequently associated with depression. Girls with dyslexia are much more likely to manifest anxiety and depression than boys with dyslexia (Willcutt & Pennington, 2000). Somatic complaints were also elevated in this group. This is certainly well substantiated in clinical practice; it is very common for children with dyslexia to

develop stomach-aches or other somatic symptoms, which serve to keep them out of school (Sundheim & Voeller, 2004).

Thus, there is evidence for mildly higher levels of anxiety among children and adolescents with LD in clinic-referred and school-based samples using different measures for anxiety. Some studies have found links between anxiety, maladaptive attribution styles and depression in LD (Rodriguez & Routh, 1989). There is no study in Turkey yet related to the anxiety levels of children with LD. Therefore, the anxiety levels of clinic-referred children with LD in Turkey will also be examined in the present study.

1.4 Children with LD in the Family Context

Research on children with learning disabilities has only recently started to examine psychological factors that may influence their social development. Family climate is often related to children's social and academic adjustment (Margalit & Heiman, 1986a; 1986b). Interrelations between children with learning disabilities and their families were found to be reciprocal and circular. In studies investigating the transactional-ecological model which assumes that children influence and are influenced by their environment, it was found that parents of children with LD showed lower levels of personal coherence, more feelings of anxiety, and less satisfaction with their lives in general (Margalit & Heiman, 1986a; 1986b). Learning disabilities affect family functioning and this may in return influence children's development (Dyson, 2003). In a study regarding children with learning disabilities and their families, a strong relationship between the presence of LD and family characteristics was found (Lombana, 1992). Parents of children with LD were found

to be more concerned with family organization and more anxious, and they experienced less family cohesiveness as well as less communication about family problems than parents of non-LD children (Margalit & Heiman, 1988; Morrison & Zetlin, 1992). Research has also found that families of LD children have more dependent interpersonal relationships and experience more family conflicts (Margalit & Almougy, 1991). It has been suggested by Dyson (2003) that family based psychological resources such as parental stress related with the child's disability, family relationship, family's emphasis on personal growth, and method of maintaining the family system may influence children with LD. It was suggested that parental stress is negatively associated with self-concept and positively with behavioral problems. Also positive family functioning was suggested to be related to positive development in self-concept and social competence. Thus in her study, Dyson (2003) found that some aspects of social and behavioral competence in children with LD are associated with family psychological factors. It was found that children's social competence and behavioral problems were related to their parents' stress about the child's disability. Those children with LD who were rated to have less social competence and more behavior problems had parents who showed higher levels of stress related to their children's disabilities.

Family psychological resources (family relationship, family's emphasis on personal growth, and family's maintaining of the family system) were also found to be related to global self-concept, social competence, and behavior problems in children with LD (Dyson, 2003). Thus the home environment may have different effects on children with LD. Even if self-concept is not affected by learning

disabilities, it was found that it had a negative influence on the children's social competence. This change in social competence was found to be associated with the state of parental adjustment to the child's disability. Thus, the more positive the parental adjustment, the greater the degree of social competence in children (Dyson, 2003). Thus, in this study parental adjustment to the child's disability shall be examined and the effects of this shall be observed.

1.5 Parents of Children with Learning Disabilities

Studies examining the effects of having a child with a learning disability are rare. Among families with children who have learning disabilities, a tendency toward a more rigid, and less supportive climate is reported (Margalit & Almougy, 1991). In order to compensate for their children's academic failures these families showed an increased need for the members of the family to reach personal achievements and also reported less opportunities for recreational activities (Margalit, 1982; Margalit & Heiman, 1986a; 1986b). The family climate had a tendency toward organization and control and less encouragement for free emotional expression and independence was emphasized.

Studies in family systems of children with disabilities show that some parents experience stress and emotional strains as a consequence of the care demands they are faced with (Daniels-Mohring & Lambie, 1993; Dyson, 1993; Waggoner & Wilgosh, 1990). In a study by Dyson (1996), quantitative and qualitative measures of 19 parents and 19 siblings of school-age children with learning disabilities showed that the parents of LD children experienced greater stress than did parents of nondisabled children. Furthermore, the families

experienced adaptational difficulties. Parents may also experience tension in their relationship with their LD child. It has been shown that some parents experience frustration on a daily basis as they try to help their children with completing homework and giving instructions to the child regarding household chores (Donawa, 1995). Having a child with LD may be a source of anxiety for families (Margalit & Heiman, 1986; Margalit, Raviv & Ankonina, 1992; Toro, Weissberg, Guare, & Liebenstein, 1990). In a study comparing parents of LD and non-LD children in terms of perceived stress and burden it was found that parents of LD children reported higher levels of perceived burden (Lardieri, Blacher, Swanson, 2000). Thus, compared to typical families, parents of children with LD are at risk for stress as a consequence of the care demands they face.

Since it has previously been shown that parents of LD children are prone to higher emotional dysfunctions, it was aimed to compare this population with another population which is known to have emotional difficulties due to the difficulties in the care of their child. Thus the diabetes population was chosen as a comparison group of the study variables.

1.6 Comorbidity in Learning Disorders

Any child who performs poorly in school is likely to develop a negative self-concept (Black, 1974; McKinney, 1989). It appears that a learning-disabled child is likely to manifest a pattern of increasing social and academic dysfunction as early as the first three grades (McKinney, 1989). Special education services were not noted to remediate the progressive pattern of underachievement even when these services were initiated as early as first and second grade. Scarborough (1990) suggested that

children who become dyslexic have an underlying neurocognitive condition that impedes mastery at each developmental challenge. Thus, children with dyslexia, are likely to have persistent but changing learning problems and are at increased risk of psychiatric disorders (Beitchman, & Young, 1997).

ADHD is the psychiatric disorder most often associated with LD (Kronenberger & Dunn, 2003). This is a bidirectional relationship and holds true if children with LD are examined for ADHD or children with ADHD examined for LD (Gilger, Pennington, & DeFries, 1992; Shaywitz, Fletcher, & Shaywitz, 1995; Willcutt & Pennington, 2000; Semrud-Clikeman, Biederman, Sprich-Buckminster, Lehman, Faraone, & Norman, 1992). In a study by McKinney, 29% of the children were identified with attention deficit, 14.3% with conduct problems, and withdrawn behavior was noted in 11% (1989). Depression is another frequent comorbidity of dyslexia. Thirty three percent of adolescents with dyslexia and young adults on an inpatient service were diagnosed as depressed (Cleaver & Whitman, 1998). In another study, depressed mood was markedly elevated in the poor readers (23%) compared with those who were not defined as having reading problems (9.6%) in the first and fourth grade samples, but depressed mood dropped substantially in the seventh grade subjects (Maughan, Rowe, Loeber, & Stouthamer-Loeber, 2003). The investigators explored possible factors that might explain the increased vulnerability to depression, such as a "depressogenic" family environment, the effect of other comorbid disruptive behavior disorders, or the detrimental effect of depression on learning. Although all of these factors had minor effects, the most robust effect was

the association in the first time period between low reading achievement and depression.

1.7 Children with Diabetes Mellitus

Insulin-dependent diabetes mellitus (IDDM), also known as type 1 diabetes, is a life-threatening condition and is the third most common chronic illness among young people (Northam, Todd, & Cameron, 2006). Diabetes can adversely affect psychosocial functioning, thus potentially affecting the quality of life of the child and the entire family (Delamater et al., 2001; Northam, Todd, & Cameron, 2006). Research indicates that type 1 diabetes is a risk factor for the development of psychiatric disorders in children and adolescents. Recent studies have found IDDM to be associated to an increased risk of emotional and mental disorder (Lavigne & Faier-Routman, 1992; Wilkinson, 1987). Many children develop adjustment problems after the diagnosis of diabetes (Jacobson, Hauser, Wertlieb, Woldsdorf, Orleans, & Viegra, 1986; Kovacs, Feinberg, Paulauskas, Finkelstein, Pollock, & Crouse-Novak, 1985). A study of adolescents with diabetes found that one third had psychiatric disorders, mostly being internalizing symptoms (Blanz, Rensch-Riemann, Fritz-Sigmund, & Schmidt, 1993); other studies have shown that diabetic youth have greater rates of depression (Mayou, Peveler, Davies, Mann, & Fairburn, 1991). In a study reported on 88 IDDM patients aged 8 through 14, depression was found to be the most common mental disorder, found in 24 patients (Kovacs, Mukerji, Iyengar, & Drash, 1996). Thus, there is evidence that psychological problems are increased in children with diabetes. It is known that depression, is known to be increased in children with diabetes (Northam, Todd, & Cameron,

2006). A 10-year longitudinal study found that nearly half of the study sample had a psychiatric diagnosis, the most frequent of which was depression (Kovacs, Goldston, Obrosky, & Bonar, 1997). In a longitudinal, naturalistic design, 92 children from 8 to 13 years old at onset of IDDM were followed from their initial diagnosis (Kovacs, Goldston, Obrosky, Bonar, 1997). They were repeatedly assessed and it was found that major depressive, conduct, and generalized anxiety disorders were the most prevalent problems, and major depression had a significantly higher estimated rate than each other disorder. Initial maternal psychopathology increased the risk of psychiatric disorder in the subjects, and maternal depression was a specific risk factor for depression in the subjects. Another 10- year longitudinal study found lower self-esteem among young adults with diabetes (Jacobson, Hauser, Willett, Wolfsdorf, Herman, & de Groot, 1997) and this was also reported in a review regarding children's adaptation to IDDM (Amer, 1999).

Children with chronic diseases may experience higher levels of anxiety (Vila, Nollet-Clemencon, de Blic, Mouren-Simeoni, & Scheinmann, 2000; Moussa, Alsaeid, Abdella, Refai, Al-Sheikh, & Gomez, 2005). In a study aimed to investigate the psychosocial characteristics of Kuwaiti children with type 1 diabetes as compared to healthy children without diabetes, 349 school children aged 6-18 years with type 1 diabetes, and 409 children without diabetes having comparable age, gender, and social class were examined (Moussa et al., 2005). Median scores of anxiety, depression, and total distress were significantly higher in children with diabetes, indicating worse psychological adjustment. In a study to determine the

pattern of adjustment of children with diabetes compared to children without diabetes, it was found that depression, dependency, and withdrawal were significantly higher in children with diabetes than in their peers (Grey, Cameron, Lipman, & Thurber, 1995).

In another study designed to examine self-esteem and depression in diabetic adolescent girls, one hundred nondiabetic girls aged 12-16 and 105 diabetic girls aged 12-16 were administered the Rosenberg Self-Esteem Scale and the Beck Depression Inventory. Results indicated no significant difference between diabetic and nondiabetic girls in self-esteem scores, however, diabetic girls showed significantly more depression than nondiabetic girls (Sullivan, 1978).

In a study to assess whether nonhospitalized adolescents with chronic diseases differ from their healthy peers on standardized measurements of depression, self-esteem, and life events (Seigel, Golden, Gough, Lashley, & Sacker, 1990). The study group consisted of 80 patients (20 with sickle cell disease, 40 with asthma, and 20 with diabetes). The control group consisted of 100 adolescents, matched for age and socioeconomic status, from local schools. All subjects completed a questionnaire compiled from the Beck Depression Inventory and the Rosenberg Scale of Self-Esteem. Adolescents with chronic disease had higher depression scores and lower self-esteem than their healthy age-matched controls. Depression, self-esteem, and life events did not differ significantly among the three disease groups. In another study investigating the psychological and social adjustment patterns of children and adolescents with type 1 diabetes compared with those of a control sample, it was found that children and adolescents with diabetes showed lower self-

esteem and poorer self-image than controls (Martinez Chamorro, Lastra Martinez, & Luzuriaga Tomas, 2001).

In a study in which school-age youth was assessed over the first 6 years of their insulin-dependent diabetes mellitus (IDDM) to determine self-perceived psychological adjustment it was found that after the first year of IDDM, subjects exhibited a mild increase in depressive symptoms (Kovacs, Iyengar, Goldston, Stewart, Obrosky, & Marsh, 1990). Anxiety decreased for boys but increased for girls over the duration of IDDM. Self-esteem remained stable regardless of rehospitalizations or degree of metabolic control. Adjustment of youth after IDDM onset, as reflected by levels of depression, anxiety, and self-esteem, were predictors of later adjustment. In general, it was found that children found the implications of IDDM more upsetting and the regimen more difficult with time. Girls were more upset by their illness than boys. The degree to which children were upset by the implications and management of IDDM varied as a function of their anxiety and depression. Thus, the results show that there is elevated psychiatric morbidity in samples of young people with IDDM. The morbidity reflects the high incidence of major depression in adolescence and generalized anxiety disorder in young adulthood.

In this study, the sample of diabetic children were chosen due to the reason of previous studies' findings that LD children report lower self-esteem and higher depressive and anxiety symptoms compared to their healthy peers. On the other hand, diabetic children have been found to show increased anxiety, low self-esteem and depressive symptoms more than healthy children (Swift, Seidman & Stein,

1967; Close, Davies, Price, & Goodyer, 1986). Thus, the research question in this study was whether LD children would show more psychological adjustment problems compared to children with a chronic disease, in this case diabetic children.

1.8 Parents of Children with Diabetes Mellitus

Diabetes imposes considerable demands on children and their families (Delamater, Jacobson, Anderson, Cox, Fisher, Lustman, et al. 2001). Many mothers of newly diagnosed children are at risk for adjustment problems with significant depressive symptoms observed in approximately one third of mothers (Kovacs, Finkelstein, Feinberg, Crouse-Novak, Paulauskas, & Pollock, 1985). In a study in which, mothers of children with newly diagnosed insulin-dependent diabetes mellitus (IDDM) were assessed over a period of 6 years in order to determine the psychological correlates of managing this chronic illness, it was found that both maternal depression and overall emotional distress after the 1st year of the IDDM increased with illness duration (Kovacs, Iyengar, Goldston, Obrosky, Stewart, & Marsh, 1990). Mothers' adjustment shortly after their children were diagnosed with IDDM was a strong predictor of their long-term emotional symptomatology. However, mothers' symptoms over time were not related to medical aspects of IDDM (i.e., the extent of the children's metabolic control, number of rehospitalizations, or their compliance with the medical regimen) and were also unrelated to the levels of depression or anxiety reported by their children. Mothers found it easier to cope with the IDDM the longer their children had the illness. The degree to which mothers perceived the IDDM to be bothersome or difficult to manage was associated with their overall levels of emotional distress. In a study

examining relationships of children's illness-related functional limitations and 2 maternal psychological resources, self-esteem and efficacy, to symptoms of psychological distress in children with diverse chronic illnesses, it was found that functional limitations in the child and lower resources were associated with higher maternal scores on a psychological symptom scale (Silver, Bauman, & Ireys, 1995). It was suggested that mothers experienced greater distress when their children had illness-related functional limitations and maternal efficacy was low.

In a study where differences in strategies used by mothers and fathers ($n = 60$) in coping with their child's insulin-dependent diabetes mellitus, The Ways of Coping Questionnaire (WCQ) was administered during a home interview. Results showed that both parents used planful problem solving, exercised positive reappraisal, and sought social support frequently, with mothers using more planful problem-solving strategies than fathers. Within the family, analyses showed that mothers were more likely to frequently use all the coping strategies when the child was a girl (Azar & Solomon, 2001). In a current report on pediatric diabetes it was suggested that anxiety seems to increase and to be more prevalent in girls than in boys (Schiffrin, 2001).

1.9 Aim of the Study

The literature points out that the links between parental acceptance rejection, psychological adjustment, learned helplessness, depression, anxiety, and self-esteem is not clear for children with learning disabilities. Thus, the aims of this study are:

1. To examine the mediator role of self-esteem between parental (acceptance) rejection and depression in children with LD.

2. To examine the mediator role of self-esteem between learned helplessness and depression in children with LD.
3. Since it has previously been shown that LD children are prone to higher emotional dysfunctions, it was aimed to compare this population with another population which is known to have emotional difficulties due to the chronicity of their condition. Thus the diabetes population was chosen as a comparison group of the study variables. Therefore another aim was to examine the group differences of psychological adjustment between children with LD and diabetes in terms of self-esteem, depression, anxiety, learned helplessness, and parental-acceptance-rejection in children with learning disabilities and diabetes.
4. To search for gender differences in the psychological adjustment of children with LD compared to children with diabetes.
5. To examine group differences in the way mothers experience having children with learning disabilities and diabetes in terms of their adjustment levels (depression, anxiety, family functioning, coping, problem solving abilities, parental burnout).
6. To examine group differences in the way mothers experience having children with learning disabilities and diabetes in terms of their expressed levels of parental acceptance-rejection.

CHAPTER II

METHOD

2.1 Subjects

For the study group, 102 children who were referred to the Child Psychiatry Clinic of Gazi University Hospital with ages ranging through 8-13, and with school problems were recruited for the study. In order to be accepted as a participant the children should have received a Learning Disorder (LD) diagnosis by a child psychiatrist according to the following DSM-IV criteria (American Psychiatric Association, 1994):

1. Scores on tests of reading, written skills, mathematical ability, or all are below the level expected, given the person's chronological age, measured intelligence, and age-appropriate education.
2. The deficit in criterion 1 significantly interferes with academic achievement or activities of daily life that require these skills.
3. A sensory deficit was not present.

As for the comparison group, children with diabetes were chosen. 70 children were referred from the Pediatrics Clinic of Gazi University Hospital with ages ranging through 8-13. For these children to be accepted as participants they had to have a diagnosis of Diabetes. Also no other psychiatric problem that would receive a DSM-IV diagnosis had to be present for these children, as well as those

criteria described above for LD children. Thus they were screened by a child psychiatrist and a clinical psychologist for any possible psychological problem. Children with diabetes who received a comorbid DSM-IV diagnoses was not recruited to the study and referred for help from the Child Psychiatry Clinic of the Gazi University. All the children's full scale IQ scores were assessed by the Wechsler Intelligence Scale for Children-Revised. Thus, the following inclusion criteria were used: a) there had to be no evidence of sensory deficits, retardation, emotional disturbance, or lack of educational opportunities; b) full scale IQ scores had to be above 90.

For the study group, a battery of tests as well as relevant information from the child's teachers and families was collected in order to evaluate Criterion 1. A child was diagnosed with LD if a criterion of discrepancy between expected and observed performances was noticed by teachers in scholastic measures and by a psychologist in tests. The second and third criteria were assessed on the basis of the information provided by the child's teachers and families.

Reading and writing scripts were used in order to assess reading and writing levels. For reading ability reading speed and not being able to read was taken as measures. For writing skills skipping letters, skipping words, writing backwards, mixing letters, writing without breaking words, separating phonemes, adding words, writing the whole word wrong, grammar mistakes, slow writing, and not being able to write at all dimensions were measured. These dimensions are frequently measured in studies with children with LD (Erden, Kurdođlu, & Uslu, 2002; Engel, 1997; Houck & Bilingsley, 1989; Korkmazlar, 1992; Lovett, 1987).

2.1.1 Children with LD

The children were attending grades 3 through 7. There were 34 females (33.3 %) and 68 males (66.7 %) in this group (Table 1). The ages of the children with LD ranged from 8-13 with a mean of 9.48 and standard deviation of 1.49. 37.3 % of the children ($n = 38$) were 8 years old, 17.6 % ($n = 18$) 9 years, 20.6 % ($n = 21$) 10 years, 13.7 % ($n = 14$) were 11 years, 5.9 % ($n = 6$) were 12 years and 4.9 % ($n = 5$) were 13 years old. 38.2 % ($n = 39$) of the children were attending third grade, 26.5 % ($n = 27$) fourth grade, 12.7 % ($n = 13$) fifth grade, 11.8 % ($n = 12$) sixth grade, and 10.8 % ($n = 11$) were attending seventh grade.

These children with LD diagnoses had a reading, writing, or arithmetic disorder. Among them, 5.9 % ($n = 6$) had only reading disorder, 16.7 % ($n = 17$) had only writing disorder, 2.9 % ($n = 3$) had only arithmetic disorder. The group which had a combination of these disorders constituted 74.5 % ($n = 76$) of the LD children.

The children who had no siblings at all were only 11.8 % ($n = 12$) whereas the rest 88.2 % ($n = 90$) who had at least one sibling or more. 96 % ($n = 98$) of the children were living in households with their core family, whereas only 4 % of the children were living in extended families.

Some of the children with LD had comorbid disorders. As for these disorders, 31.4 % ($n = 32$) had comorbid ADHD, 4.9 % ($n = 5$) had enuresis, 2 % ($n = 2$) had some form of speech disorder, 1 % ($n = 1$) had an epileptic disorder, and 60.8 % ($n = 62$) had no comorbid disorder.

WISC-R scores of these 102 children with LD, were as follows: the mean for the verbal IQ score (VIQ) was 86.60, with a standard deviation of 11.82; the mean for the performance IQ score (PIQ) score was 100.28, with a standard deviation of 12.04; and full IQ score's (FIQ) mean was 92.74, with a standard deviation of 10.67. In order to see the pattern of WISC-R subdivision scores, one-way repeated measures ANOVA was conducted on the 3 division scores of WISC-R. This analysis showed a significant main effect for WISC-R divisions, ($F_{2, 202} = 94.96$, $p < .001$). According to the post-hoc analyses conducted by LSD, all the subdivision scores namely, VIQ, PIQ, and FIQ scores were significantly different from each other. Thus, children with LD tend to have higher scores from PIQ than from VIQ and FIQ, moreover they also tend to have lower scores from VIQ than from FIQ.

In order to see the pattern of WISC-R subtest scores, one-way repeated measures ANOVA was conducted on the 10 subtest scores of WISC-R. This analysis showed a significant main effect for WISC-R subtests, ($F_{9, 909} = 36.77$, $p < .001$). Results of post-hoc analyses conducted by LSD are provided in Table 1. According to these results among verbal subtests, children with LD tend to obtain lowest scores from the Information subtest and highest scores from the Similarities and Comprehension subtests. As for the performance subtests, in general they tend to score higher than verbal subtests, and the highest score seems to be obtained from the Digit Symbol subtest.

2.1.2 Parents of Children with LD

a. Education

The mean age of mothers of children with LD was 37.86, SD=5.40. The mean age of fathers of children with LD was 41.29, SD=4.82. The education levels of the parents are presented in Table 2. 1.4 % of the mothers ($\underline{n} = 1$) were literate, 42.9 % ($\underline{n} = 30$) were primary school graduates, 2.9 % ($\underline{n} = 2$) were high school graduates, 30 % ($\underline{n} = 21$) were lycee graduates, 22.9 % ($\underline{n} = 16$) were university or some 2- year college graduates. On the other hand, 2.9 % ($\underline{n} = 2$) were primary school graduates, 22.9 % ($\underline{n} = 16$) were high school graduates, 47.1 % ($\underline{n} = 33$) were lycee graduates, 27.1 % ($\underline{n} = 19$) were university or some 2- year college graduates.

Table 1 WISC-R Subtest Scores of Children with Learning Disabilities ($\underline{n} = 102$)

Subtest	Mean	SD
Information	6.88 _a	2.13
Similarities	8.99 _c	4.22
Arithmetic	7.94 _b	2.78
Comprehension	9.32 _c	2.62
Digit Span	7.66 _b	2.06
Picture Completion	10.47 _{de}	2.15
Picture Arrangement	10.66 _{de}	3.61
Block Design	9.96 _{cd}	2.60
Object Assembly	10.75 _e	2.11
Digit Symbol	11.51 _f	3.10

Note. The mean scores that do not share the same subscript on the same column are significantly different from each other at .05 alpha level.

b. Job Status

Mothers of children with LD consisted highly of non-working mothers (60 %, $\underline{n} = 42$). 40 % ($\underline{n} = 28$) of the mothers were working. The working mothers were usually government employees (21.4 %, $\underline{n} = 15$), with 11.4 % ($\underline{n} = 8$) working in the private sector. 4.3 % ($\underline{n} = 3$) had a worker status and 27.1 % ($\underline{n} = 19$) were retired. Fathers were either working or retired. The working fathers were also usually government employees (77.1 %, $\underline{n} = 54$), with 15.7 % ($\underline{n} = 11$) working in the private sector, and 4.3 % ($\underline{n} = 3$) had a worker status.

Table 2 Percentages, Means, Standard Deviations and Ranges of the Sociodemeographic Variables of Children with LD (n=102)

	N (Percentage)	Mean	SD	Range
Age of children		9.48	1.49	8-13
Gender				
Female	34 (33.3 %)			
Male	68 (66.7 %)			
Education of Parents *				
Mother		3.67	1.21	
Father		4.15	1.08	
Age of Parents				
Mother		37.86	5.40	
Father		41.29	4.82	

Note. For education “1” refers to literacy, “2” to primary school graduation, “3” to high school graduation, “4” to lycee graduation, “5” to university or some college, “6” to a graduate degree or higher.

c. Economic Status

The economic status of the families of children with LD were as follows: 7.1 % of the families ($\underline{n} = 5$) were from low income families, their monthly income was 500 YTL or less, 50 % of the families ($\underline{n} = 35$) earned between 500-1000 YTL, 24.3 % of the families ($\underline{n} = 17$) had a monthly income of 1000-1500 YTL, 11.4 % ($\underline{n} = 8$) had a monthly income of 1500-2000 YTL. Only 7.1 % of the families ($\underline{n} = 5$) had a monthly income of over 2000 YTL.

2.1.3 Children with Diabetes

These children were also attending grades 3 through 7. There were 27 females (38.6 %) and 43 males (61.4 %) in this group (Table 2). The ages of the children ranged from 8-13 with a mean of 9.69 and standard deviation of 1.57. 27.1 % of the children ($\underline{n} = 19$) were 8 years old, 24.3 % ($\underline{n} = 17$) were 9 years, 27.1 % ($\underline{n} = 19$) were 10 years, 5.7 % were 11 years, 5.7 % ($\underline{n} = 4$) were 12 years and 10 % ($\underline{n} = 7$) were 13 years old. 31.4 % of the children ($\underline{n} = 22$) were attending third grade, 20 % ($\underline{n} = 14$) fourth grade, 27.1 % ($\underline{n} = 19$) fifth grade, 11.4 % ($\underline{n} = 8$) sixth grade, and 10 % ($\underline{n} = 7$) were attending seventh grade.

WISC-R scores of children were as follows: the verbal IQ score (VIQ) means were 104.34 with a standard deviation of 13.19; performance IQ score (PIQ) means were 102.96 with a standard deviation of 13.02; and full IQ score (FIQ) means were 103.99 with a standard deviation of 13.88. In order to see the pattern of WISC-R subdivision scores, one-way repeated measures ANOVA was conducted on the 3 division scores of WISC-R. This analysis showed no significant effect for WISC-R divisions, ($F [2, 138] = 2.75, p = ns$).

In order to see the pattern of WISC-R subtest scores, one-way repeated measures ANOVA was conducted on the 10 subtest scores of WISC-R. This analysis showed a significant main effect for WISC-R subtests, ($F [9, 621] = 13.62$, $p < .001$).

Means and standard deviations of all the subtests are shown in Table 3. According to these results, children with diabetes, tend to have higher scores on Similarity and Digit Symbol subtests as compared to other subtests.

Table 3 WISC-R Subtest Scores of Children with Diabetes ($n = 70$)

Subtest	Mean	SD
Information	9.73 _{ab}	1.40
Similarities	10.90 _c	1.77
Arithmetic	10.00 _{ab}	1.20
Comprehension	10.01 _{ab}	.92
Digit Span	9.56 _a	1.26
Picture Completion	10.41 _b	1.58
Picture Arrangement	9.74 _{ab}	1.41
Block Design	9.34 _a	1.21
Object Assembly	10.23 _{ab}	1.24
Digit Symbol	10.97 _c	1.86

Note. The mean scores that do not share the same subscript on the same column are significantly different from each other at .05 alpha level.

2.1.4 Parents of Children with Diabetes

a. Education

The mean age of mothers of children with diabetes was 37.09, SD = 5.23. The mean age of fathers were 40.96, SD = 3.93. The education levels of the parents are presented in Table 4. It is observed that 1.4 % ($n = 1$) of the mothers were

literate, 42.9 % ($\underline{n} = 30$) were primary school graduates, 2.9 % ($\underline{n} = 2$) were high school graduates, 30 % ($\underline{n} = 21$) were lycee graduates, and 22.9 % ($\underline{n} = 16$) were university or some 2- year college graduates. 2.9 % ($\underline{n} = 2$) of the fathers were primary school graduates, 22.9 % ($\underline{n} = 16$) were high school graduates, 47.1 % ($\underline{n} = 33$) were lycee graduates, 27.1 % ($\underline{n} = 19$) were university or some 2- year college graduates.

b. Job Status

Mothers of children with diabetes consisted highly of non-working mothers (60 %, $\underline{n} = 42$). 40 % of the mothers ($\underline{n} = 28$) were working. The working mothers were usually government employees (33.3 %, $\underline{n} = 15$), with 17.8 % ($\underline{n} = 8$) working in the private sector. 6.7 % ($\underline{n} = 3$) had a worker status and 42.2 % ($\underline{n} = 19$) were retired. Fathers were either working or retired (2.9 %, $\underline{n} = 2$). The working fathers were also usually government employees (77.1 %, $\underline{n} = 54$), with 15.7 % ($\underline{n} = 11$) working in the private sector, and 4.3 % ($\underline{n} = 3$) had a worker status.

c. Economic Status

The economic status of the families were as follows: 7.1 % of the families ($\underline{n} = 5$) were from low income families, their monthly income was 500 YTL or less, 50 % of the families ($\underline{n} = 35$) earned between 500-1000 YTL, 24.3 % of the families ($\underline{n} = 17$) had a monthly income of 1000-1500 YTL, 11.4 % ($\underline{n} = 8$) had a monthly income of 1500-2000 YTL. Only 7.1 % of the families ($\underline{n} = 5$) had a monthly income over 2000 YTL.

Table 4 Percentages, Means, Standard Deviations and Ranges of the

Sociodemographic Variables of Children with Diabetes

	N (Percentage)	Mean	SD	Range
Age of children		9.69	1.57	8-13
Gender				
Female	27 (38.6 %)			
Male	43 (61.4)			
Education of Parents *				
Mother		3.30	1.28	
Father				
	3.99	0.79		
Age of Parents				
Mother		37.09	5.23	
Father		40.96	3.93	

Note. For education “1” refers to literacy, “2” to primary school graduation, “3” to high school graduation, “4” to lycee graduation, “5” to university or some college, “6” to a graduate degree or higher.

2.1.5 Selected Subjects for Group Comparisons

In order to make comparisons between two groups, a group was selected among the children with LD to match the control group, since the study group outnumbered the control group. The selected study group was matched on the variables of age, sex, and WISC-R performance IQ (P-IQ) scores with the control group. After this selection there were 79 children with LD compared to 70 children with diabetes. A one way analysis of variance was conducted with WISC-R P-IQ scores as the dependent variable and diagnosis (LD, diabetes) as the independent variable in order to check for any confounding due to WISC-R scores of children. There was no significant difference between the mean scores, $F(1, 147) = 2.59, p > .05$. Selecting control groups matched on P-IQ of WISC scores is in accordance with the literature (Kral, Kibby, Johnson & Hynd, 2000). Means and standard

deviations for children with LD and diabetes respectively were as follows: (M = 99.59, SD = 12.45; M = 102.96, SD = 13.02).

2.2 Measures

2.2.1 Parental Acceptance-Rejection Questionnaire (PARQ) (Child Form)

The questionnaire assesses acceptance-rejection as perceived by the child.

The scale consists of 60 items measuring the 4 dimensions of PAR:

- a) Parental warmth and affection
- b) Aggression and hostility
- c) Neglect and indifference
- d) Undifferentiated rejection

PARQ is a self-report questionnaire that can be applied to children in primary school. The scores change between 4 and 1, with 4 being “almost always true”, and 1 being “almost never true”. Possible scores change between 60 and 240, higher scores indicate higher perceived rejection. The questionnaire was developed by Rohner, Saavedra, and Granum (1978). It was translated and adapted into Turkish by Erdem (1990) (see Appendix A).

The reliability studies of the child PARQ were carried out on sample of 344 children. Cronbach’s coefficient alpha ranged from .78 to .90 for the subscales and .95 for total PARQ. Test-retest reliability coefficients for the PARQ subscales ranged from .48 through .64 and .70 for the total scale (Erdem, 1990). Internal consistency in terms of Cronbach Alpha for the subscales ranged from .78 through .90 and .95 for the total scale.

2.2.2 Children's Depression Inventory

Children's depressive symptoms were assessed using the Children's Depression Inventory (CDI). The CDI is a 27 item self-report measure assessing affective, cognitive, motivational, and somatic symptoms of depression. For each item, children choose from one of three statements scored as 0 through 2, which best describe their level of depressive symptoms in the previous 2 weeks. Higher scores indicate greater levels of depressive symptoms. Possible scores range between 0 and 54. Normative data indicate a mean of 9.1 (SD = 7) for normal populations of 8 to 14-year-olds (Kovacs, 1980/1981; Smucker, Craighead, Craighead & Green, 1986). CDI was developed by Kovacs (1981) and adapted into Turkish by Öy (1990). The reliability study was conducted with 380 students and test-retest reliability coefficient was found to be .80. The criterion related validity of the CDI scores with the Childhood Depression Inventory score correlations were found as .61. The construct validity was conducted with 59 students according to DSM-III diagnostic criteria. The correct diagnosis was ratio of the CDI was reported as 84.75 % (Öy, 1990) (see Appendix B).

2.2.3 Piers-Harris Children's Self-Concept Scale

Children's self-esteem is assessed by using the Piers-Harris Children's Self-Concept Scale (Piers & Harris, 1969), which was adapted into Turkish by Çataklı and Öner (1986-1987). The scale has 80 items and 6 subtests assessing the following areas:

- a. Behavior
- b. Intellectual and School Status

- c. Physical Appearance
- d. Anxiety
- e. Popularity
- f. Happiness and Satisfaction

This is a self-report inventory. There are 80 statements, such as “I lose my temper easily”, “I am a good person” to which children respond with “Yes/No” answers for each item, which are scored as 1 or 0. Higher scores indicate positive, lower scores indicate negative thought and feelings about self. It gives a total self-concept score and 6 cluster scores.

The test-retest reliability coefficients are between .72 and .91 for primary school children and .79 and .98 for junior high school children over one to seven day intervals. Kuder Richardson reliability coefficient was found to be .87 for primary school children and .86 for junior high school children. The item total correlation coefficients range between .09 and .50 (Çataklı, 1985). The construct or criterion validity of the Turkish Piers-Harris Self-Concept Scale has been studied through comparisons the Test Anxiety Inventory and Parental Attitude Research Instrument and the research hypotheses were verified that the Piers-Harris Self-Concept Scale had construct validity (Çataklı and Öner 1986-1987) (see Appendix C).

2.2.4 Children’s Attributional Style Questionnaire (CASQ)

CASQ was developed by Seligman and his colleagues (1984). It is a forced choice instrument which contains hypothetical positive or negative events involving the child. Each event is followed by two possible explanations. The child’s explanatory style for the causes of events is conceptualized in three dimension:

global-specific, stable-unstable, internal-external. Attributing the cause of events to external, stable, and global factors indicate a helpless explanatory style. The questionnaire contains of 48 items. For each item children are asked to select one of two possible causes. A total helplessness score can be obtained from CASQ. CASQ was adapted into Turkish by Aydın (1985). The 4 week test retest reliability was found to be .83. The content validity showed that the mean ratings of the judges who rated the items of the instrument as valid and showing that the device assessed what it meant to assess was 96.1 % for all items. This gave support for the content validity of the questionnaire (see Appendix D).

2.2.5 Children's State - Trait Anxiety Scale

Children's State-Trait Anxiety Scale was developed by Spielberger (1973). It assesses state and trait anxiety of children. In this study trait anxiety test was used which is a 20 item inventory. This inventory was adapted into Turkish by Özusta (1993, 1995). This is a self-report inventory. It is scored through 1 to 3. Higher scores indicate a higher anxiety level. The test-retest reliability study was conducted with 42 female and 57 males Özusta (1993). The alpha coefficient was found to be .65 for the whole group, .48 for females and .74 for males. The cronbach alpha for the Trait Anxiety Inventory was found as .81. The criterion validity was conducted with a total of 420 students and it was found that the scale was significantly able to differentiate those groups diagnosed with anxiety disorder from groups with other psychiatric disorders and the norm group (see Appendix E).

2.2.6 The McMaster Family Assessment Device

The family assessment device was developed in order to evaluate various functions of family and to find out the problem areas in the family. This instrument's purpose is to gather information on different dimensions of the family system through the family members. The McMaster Family Assessment Device (MMFAD) was developed by Epstein, Baldwin and Bishop (1983). It was adapted into Turkish by Bulut (1990). The MMFAD has six subtests, in the Turkish version a seventh subtest has been added which assesses the family's healthy functioning in general (see Appendix F). Thus, the Turkish version of the scale has 60 items and 7 subtests assessing the following areas:

- a. Problem Solving
- b. Communication
- c. Roles
- d. Affective Responsiveness
- e. Affective Involvement
- f. Behavior Control
- g. General Functions

Problem Solving (PS) reflects the family's ability to resolve problems together, Communication (CM) refers to effectiveness, extent, clarity and directness of information exchange, Roles (RL) describes the efficacy with which family tasks are allocated and accomplished, Affective Responsiveness (AR) is the ability of family members to respond to situations with appropriate emotions, both positive and negative, Affective Involvement (AI) reflects the interest and concern that they

for each other and Behavior Control (BC) describes the standards and latitudes for behavior. General Functions (GF) gives an overall rating of family functioning.

This is a self-report inventory. It can be applied to all family members above 12 years of age. Each item is scored from 1 being “I agree completely” to 4 “I do not agree at all”. Higher scores indicate a dysfunctional family pattern.

The MMFAD was found to have cronbach alpha's between .38 through .86 for the subtests. Test-retest reliability was found to be between .62 through .90 for the MMFAD subtests in a three week interval (Bulut, 1990). Internal validity was found to be between .38 through .80 for the MMFAD subtests and .86 for the General Functions (Bulut, 1990).

The construct validity of the study was conducted with 50 families, of which half were in the divorce phase and the other half who were leading a normal marriage. The inventory was also conducted to two groups of families in which there was a psychiatric patient (n=190) and another group without any patient in the family (n=170). . All the subtests of the inventory significantly differentiated these two groups of families, separately. In order to study the concurrent validity of the inventory, MMFAD was conducted to 25 subjects who were married, along with the Marriage Life Questionnaire. The Pearson product moment correlation coefficient was found to be 0.66 which was significant ($p < .001$).

2.2.7 Turkish Ways of Coping Inventory (TWCI)

The original Ways of Coping Checklist (Folkman & Lazarus, 1980) includes 68 items with a yes-no response style. The items refer to cognitive and behavioral strategies used by people to cope with stressful situations. Yet these items did not

cover superstitious beliefs and fatalism, which Turkish people use quite often. Thus, 6 additional items representing these domains were included (Siva, 1991) so that, TWCI added up to 74 items (see Appendix G). Similar to Folkman and Lazarus (1985), who used a 4-point, Likert scale in their revised version of Ways of Coping, Siva (1991) changed the response style into 5-point Likert scale in TWCI. Three higher order factors were used as studied by Gençöz, Gençöz & Bozo (2006), namely, Emotion Focused Coping, Problem Focused Coping, and Seeking Social Support: Indirect Coping Style. The internal consistency coefficients of these factors were .88, .90, and .84, respectively as reported by Gençöz, Gençöz & Bozo (2006). Since the present study focused on children's learning disability and mothers' reactions to this situation, the mothers were asked to rate their general style of coping based on the problems they faced due to their child's learning disability.

In the same study, the criterion validity of the Problem Focused Coping factor of TWCI was shown to have a significant and negative correlation with the sociotropy, trait anxiety, submissiveness, and external locus of control scores (Gençöz, Gençöz & Bozo, 2006). This coping style also showed significant positive correlation with the autonomy measure. Emotion-Focused Coping correlated positively with the sociotropy, trait anxiety, submissiveness, and external locus of control scores; and negatively with the autonomy measure. Seeking Social Support: Indirect Coping Style factor showed significant positive correlations with the sociotropy scores and negative correlations with the autonomy scores.

2.2.8 Trait Anxiety form of State-Trait Anxiety Inventory (STAI-T)

The State-Trait Anxiety Inventory (STAI) was developed by Spielberger, Gorsuch, and Lushene (1970). STAI consists of two forms, one for state anxiety and the other for trait anxiety. Each form includes 20 items that are rated on a 4-point scale from 1 “never” to 4 “always”. In each form a separate score is formed. A higher total score in this inventory indicates higher anxiety. Turkish adaptation of this inventory was done by Öner and LeCompte (1983) (see Appendix H).

Kuder Richardson alpha coefficients for Trait Anxiety Scale were found between .83 and .87. Item remainder correlations for STAI-T ranges between .34 and .72 and test-retest reliability coefficients were found to be as .26 to .68. Various researchers supported the construct or criterion validity of the Turkish STAI such as Rüstemli (1975), Zülemyan (1979) and Kozacıoğlu (1982) (All cited in Öner & LeCompte, 1983).

2.2.9 Problem Solving Inventory

Problem Solving Inventory, Form-A (PSI-A) is a 35 item instrument developed by Heppner and Petersen (1982) to assess the individuals’ perception on his/her problem solving ability. The inventory is rated on a 6-point likert scale from 1 (always) to 6 (never). A higher total score in this inventory indicates an insufficient ability perception of problem solving. Turkish adaptation of this inventory was done by Şahin, Şahin and Heppner (1993) (see Appendix I). Score range is between 32 and 192. The reliability study for the inventory was conducted with 244 university students and the cronbach alpha reliability coefficient was found to be .88. The criterion related validity study showed that the correlation coefficient

between the total scores from the PSI and the Beck Depression Inventory was found to be .33 and .45 with the Trait Anxiety Inventory. Construct validity showed that the PSI was able to classify groups with (90 %) and without anxiety (80 %).

2.2.10 Maslach Burnout Inventory

Maslach Burnout Inventory (MBI) is a 22-item instrument developed by Maslach & Jackson (1986) to assess the three components of the burnout syndrome: emotional exhaustion, depersonalization, and lack of personal accomplishment. Items about personal feelings or attitudes in terms of how frequently these situations are experienced are marked on a 7-point scale. The MBI was adapted and translated by Ergin (1992) and the 7-point scale was converted into a 5-point scale (0 =never, 4=always) (see Appendix J). Duygun and Sezgin (2003), changed the instructions of the questionnaire which were “my recipients” to “my child” and those that were “my work” or “my job” into “the care of my child” in a sample of mothers who had mentally retarded children.

Duygun and Sezgin (2003), found two factors for the MBI with a sample of mothers of mentally retarded children, namely, emotional exhaustion and lack of personal accomplishment, both were found to have cronbach alpha's of .80. Elçi (2004), in his study with mothers of autistic children found the total alpha value of MBI to be .85.

2.2.11 Beck Depression Inventory

The Beck Depression Inventory (BDI) is a 21-item test (Beck, Steer & Garbin, 1988). The scores for each item change between 0-3. The highest score is 63. Higher scores indicate higher depressive symptomatology. The BDI was adapted

to Turkish by Hisli and scores above 17 were found to be indicating depression that needed psychiatric attention (Hisli, 1988) (see Appendix K). Beck ruled out strict adherence to cut-off points for the BDI, preferring that they be chosen according to the type of study. He suggested that total scores of less than 10 do not show depressive disorders; between 10 and 18, from mild to moderate depression; between 19 and 29 from moderate to severe; and scores of more than 30 indicate severe depression. Hisli, in her study with 259 university students found the split half reliability of the inventory to be .74. In her study for the criterion related validity Hisli (1988) found the Pearson product moment correlation coefficient to be .63 between MMPI-Depression scale and the BDI in a psychiatric patient sample. In a sample with university students, the Pearson product moment correlation coefficient was found as .50.

2.2.12 Parental Acceptance-Rejection Questionnaire (PARQ) (Mother Form)

The questionnaire assesses acceptance-rejection as perceived by the mother. The scale consists of 56 items measuring 4 dimensions of parental acceptance rejection (PAR):

- a) Parental warmth and affection
- b) Aggression and hostility
- c) Neglect and indifference
- d) Undifferentiated rejection

PARQ is a self-report questionnaire that can be applied to mothers. The scores change between 4-1, with 4 being (almost always true), and 1 being (almost never true). Scores change between 56 through 224. Higher scores indicate higher

perceived rejection. The questionnaire was developed by Rohner, Saavedra, and Granum (1978). It was translated and adapted into Turkish by Anjel (1993) (see Appendix L). The reliability studies of the child PARQ were carried out on sample of 229 mothers. Cronbach's coefficient alpha was found to be .90 for total PARQ-mother form. Test-retest reliability coefficient for the PARQ total scale was found to be .46 (Anjel, 1993). The internal consistency in terms of cronbach alpha coefficient was found to be .57 through .80 for the subscales and .89 for the total scale. The construct validity of the questionnaire was tested through factor analysis and 50 items clustered around the rejection factor.

2.2.13 Biographical Information Sheet

Demographic data related to age, gender, mother and father's education level, number of siblings, and questions related to school problems of the child and his/her family were obtained (See Appendix M).

2.3 Procedure

Each participant and their parents signed an informed consent form. Confidentiality was assured. They subsequently received a booklet containing the above questionnaires as well as a form obtaining demographic information related to age, gender, mother and father's education level, number of siblings, and questions related to specific school problems.

Children were tested in an initial session by a child psychiatrist and a clinical psychologist in order to get a possible diagnosis. In the following sessions children were administered the inventories. To minimize difficulties due to any reading difficulties, particularly for the LD group, the measures were read aloud to the

children and the children were instructed to read along. Mothers were handed the forms and instruments to fill out while their children were being assessed. Mothers were also interviewed for any recent stressful or traumatic life events in order to rule out the effects of these experiences on their emotional state. Mothers with recent stressful life events (e.g. death in the family, divorce) were not recruited to the study.

CHAPTER III

RESULTS

The results will be studied under 5 subheadings. In order to evaluate the diagnosis and gender differences on the five measures, namely self-esteem, learned helplessness, parental-rejection, depression, and anxiety levels of children, under the first subheading, separate 2 (Diagnosis) X 2 (Gender) ANCOVA will be conducted with Age taken as the covariate.

Under the second subheading, variables associated with the symptoms of depression and anxiety in children with learning disabilities and diabetes will be studied through 4 separate regression analysis.

The third subheading will include mediation analyses in order to test the mediator role of self-esteem between parental acceptance-rejection and depression symptoms and the mediator role of self-esteem between learned helplessness and depression symptoms.

The fourth subheading will be related to mother's characteristics. One-way analysis of covariance (ANCOVA) will be conducted to evaluate the diagnosis differences (LD, diabetes) on the measures of interest, namely, BDI score, TAI score, MMFAD subtest scores, PSI score, TWCI subtest scores, and PARQ-Mother Form scores. For these analyses, age of the mother will be taken as the covariate variable.

The last subheading will be related to the comparison of the psychological adjustment levels of children with pure LD and their mothers, without any comorbid disorder, and LD children having ADHD as a comorbid disorder and their mothers. In this section separate ANOVA's were conducted in order to compare children with pure LD and their mothers, without any comorbid disorder ($n = 62$) to LD children having ADHD as a comorbid disorder and their mothers ($n = 32$) on the basis of their psychological adjustment levels.

3.1 Results for Children: Comparison of the two groups

In order to examine the inter correlations among the variables, Pearson product-moment correlation coefficients were computed. As expected, there were significant correlations with the variables of total CASQ score, CDI score, TAI score, PARQ score, and Piers Harris Self-Esteem Inventory total score. Again parallel with the expectations, there were no significant correlations between groups (i.e., LD and Diabetes) and socio-demographic variables (see Table 5).

3.1.1 Psychological Adjustment

Under this section the psychological adjustment of children in terms of their self-esteem, learned helplessness, perceived parental rejection, depression, and anxiety levels will be studied. Group comparisons were conducted between 79 children with LD and 70 children with diabetes.

Table 5 Pearson Correlations of the Diagnostic Group, PARQ-Child Form, CASQ, CDI, TAI, Piers-Harris Self-Esteem Inventory and Demographic Variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12
1. Diagnosis		-.15	.05	.60**	.37**	.36**	-.37**	.56**	.08	.13	.04	.07
2. Age			-.01	-.03	.09	-.27**	.04	.02	.22**	-.08	.18*	-.08
3. Sex				-.17*	-.28**	-.08	.29**	-.06	.07	.06	.11	-.02
4. CDI					.50**	.41**	-.57**	.53**	.14	.07	.13	-.12
5. TAI						.43**	-.31**	.56**	-.31**	-.20*	-.30**	-.26**
6. PARQ							-.27**	.45**	-.18*	-.14	-.04	-.12
7. Piers-Harris SE								-.21**	-.15	-.18	-.09	.03
8. CASQ									-.11	-.13	-.10	-.14
9. Mothers' Age										.45**	.74**	.29**
10. Mother's Ed. Level											.23**	.60**
11. Father's Age												.13
12. Father's Ed. Level.												

Note. CASQ = Children's Attributional Style Questionnaire; CDI = Children's Depression Inventory; Piers-Harris SE = Piers Harris Self-Esteem Inventory; PARQ = Parental Acceptance-Rejection Questionnaire; TAI = Trait Anxiety Inventory.

** p < .01 level (2-tailed).

* p < .05 level (2-tailed).

3.1.1.1 Self Esteem

Internal reliability coefficient for the Piers-Harris Children's Self-Concept Scale was found to be .91 for this sample. Separate reliability analyses were conducted for the LD and Diabetes group, and the alpha coefficients were found to be .93 and .89, respectively.

For children with learning disorders Piers-Harris Children's Self-Concept Scale total scores ranged from 24 to 67 ($\underline{M} = 50.28$, $\underline{SD} = 9.59$). For children with diabetes, Piers-Harris Children's Self-Concept Scale total scores ranged from 37 to 69 ($\underline{M} = 57.27$, $\underline{SD} = 7.58$).

A 2 (Gender) x 2 (Diagnosis) ANCOVA was conducted to evaluate the diagnosis and gender differences on the self-esteem level of students. Thus, self-esteem scores from the Piers-Harris Children's Self-Concept Scale were taken as the dependent variable, and Diagnosis (LD, diabetes) and Gender (female, male) as the independent variables. In this analysis Age was taken as the covariate variable. The means and standard deviations for self-esteem measures as a function of the two factors are presented in Table 6. The ANCOVA indicated no significant interaction effect between Diagnosis and Gender, $\underline{F}(1, 144) = .71$, $p = ns$, partial $\eta^2 = .01$, but significant main effects for Diagnosis, $\underline{F}(1,144) = 23.80$, $p < .001$, partial $\eta^2 = .14$, and Gender $\underline{F}(1, 144) = 18.04$, $p < .001$, partial $\eta^2 = .11$. The diagnosis main effect indicated that children with a learning disability had lower self-esteem scores compared to children with diabetes. The gender main effect indicated that girls had

lower self-esteem scores compared to boys. The self-esteem levels of children according to diagnostic groups and gender are presented in Figure 1.

Table 6

Means and Standard Deviations for Self-Esteem of Children as a Function of Diagnosis and Gender

Diagnostic Group	Gender	Mean	Std. Deviation	N
Children with Diabetes	Female	52.85	6.56	27
	Male	60.05	6.88	43
	Total	57.27	7.58	70
Children with LD	Female	47.11	11.72	27
	Male	51.92	7.92	52
	Total	50.28	9.59	79
Total Group	Female	49.98	9.84	54
	Male	55.60	8.47	95
	Total	53.56	9.36	149

3.1.1.2 Learned Helplessness

Internal reliability coefficient for the Children’s Attributional Style Questionnaire (CASQ) was found to be .84 for the entire sample. Again, reliability analyses were conducted for the LD and Diabetes groups separately, and the alpha coefficients were found as .74 and .84, respectively.

For children with learning disorders CASQ scores ranged from 11 to 37 ($M = 21.99$, $SD = 5.01$). For children with diabetes, CASQ scores ranged from 5 to 22 ($M = 14.39$, $SD = 6.27$).

A 2 (Gender) x 2 (Diagnosis) ANCOVA was conducted to evaluate diagnosis and gender differences on the learned helplessness level of children. Thus, CASQ scores were taken as the dependent variable, and Diagnosis (LD, diabetes) and Gender (female, male) as the independent variables. In this analysis Age was

taken as the covariate. The means and standard deviations for learned helplessness as a function of the two factors are presented in Table 7.

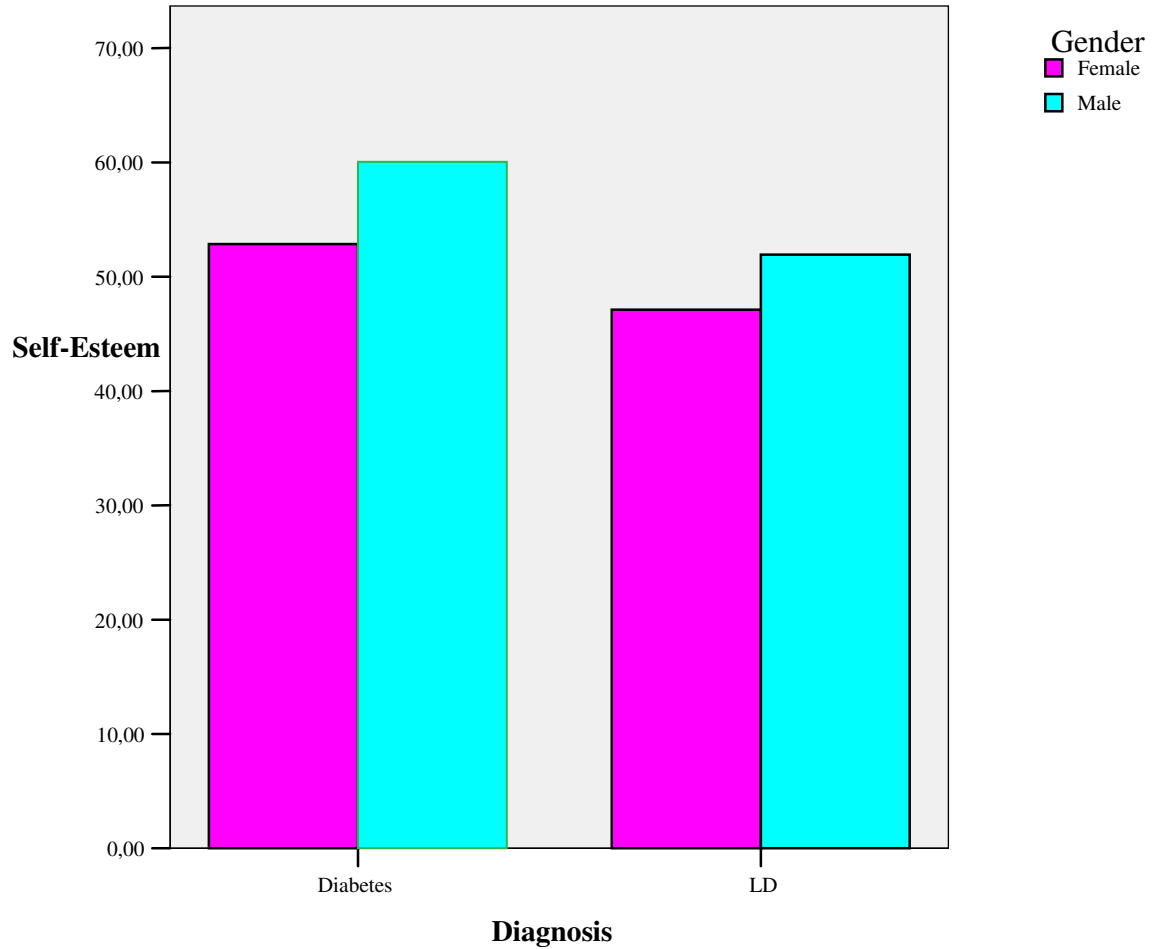


Figure 1. Self-Esteem Levels of Children by Diagnosis and Gender

**Table 7
Means and Standard Deviations for Learned Helplessness of Children as a
Function of Diagnosis and Gender**

Diagnostic Group	Gender	Mean	Std. Deviation	N
Children with LD	Female	21.19	4.80	27
	Male	22.40	5.11	52
	Total	21.99	5.01	79
Children with Diabetes	Female	16.67	3.55	27
	Male	12.95	7.16	43

	Total	14.39	6.27	70
Total Group	Female	18.93	4.76	54
	Male	18.13	7.71	95
	Total	18.42	6.78	149

The ANCOVA indicated a significant Diagnosis X Gender interaction effect, $F(1, 144) = 6.85, p < .01, \text{partial } \eta^2 = .05$, and a significant main effect for Diagnosis, $F(1, 144) = 57.77, p < .001, \text{partial } \eta^2 = .29$, however the main effect for Gender was not significant, $F(1, 144) = 1.77, p = \text{ns}, \text{partial } \eta^2 = .01$. The diagnosis main effect indicated that children with a learning disability had higher scores on learned helplessness compared to children with diabetes.

Post-hoc comparisons were conducted to evaluate the pair-wise differences among the means for the interaction effect. As can be seen from Table 8, Tukey's HSD comparisons at .05 alpha level indicated that girls with diabetes had higher levels of learned helplessness ($M = 16.67$) than boys with diabetes ($M = 12.95$). Girls with LD and boys with LD did not differ significantly on levels of learned helplessness ($M = 21.19$ and 22.40 , respectively). Boys with diabetes had the lower learned helplessness level ($M = 12.95$) than boys with LD ($M = 22.40$). Similarly, girls with LD had a significantly higher learned helplessness level ($M = 21.19$) compared to girls with diabetes ($M = 16.67$). The learned helplessness levels of children according to diagnostic groups and gender are presented in Figure 2.

Table 8
Means and Standard Deviations for Learned Helplessness of Children across Diagnostic Groups for Females and Males

Gender / Diagnostic Group	Children with LD	Children with Diabetes
Male	22.40 _a (5.11)	12.95 _c (7.16)

Female	21.19 _a (4.80)	16.67 _b (3.55)
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Note. The mean scores that do not share the same subscript on the same row or on the same column are significantly different from each other at .05 alpha level of Tukey's HSD.

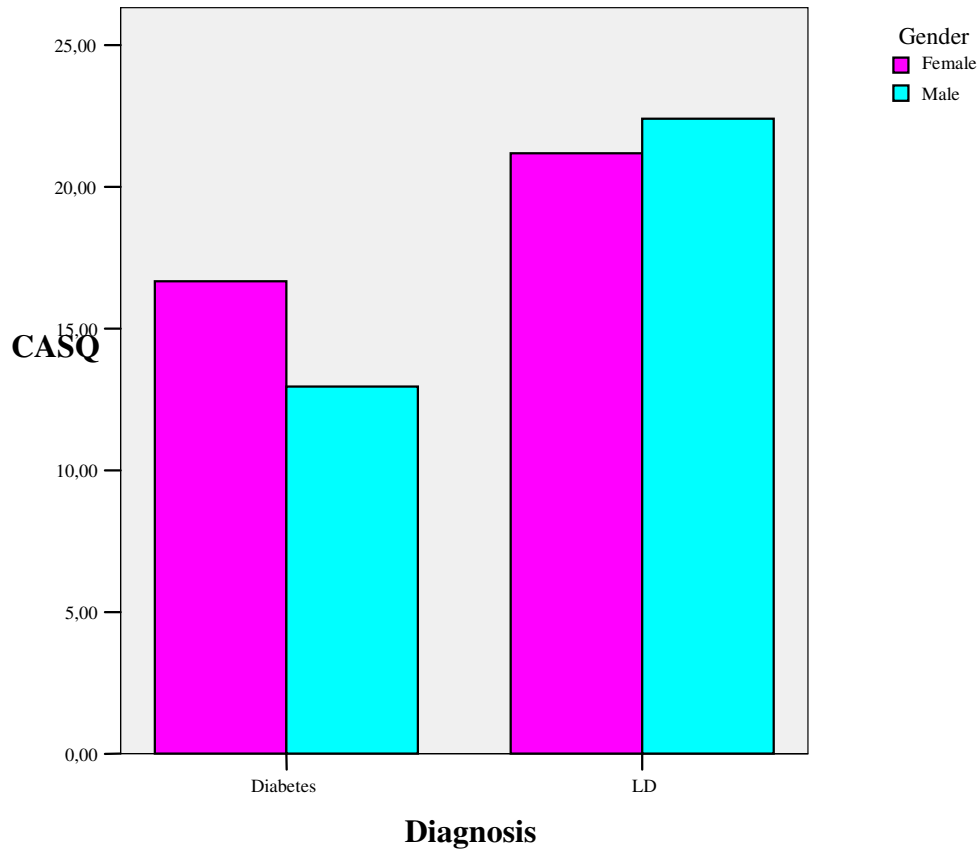


Figure 2. Learned Helplessness Levels of Children by Diagnosis and Gender

3.1.1.3 Parental Acceptance-Rejection

Internal reliability coefficient for the Parental-Acceptance Rejection Questionnaire-Child Form (PARQ-Child) was found to be .91 for this sample. For separate samples of children with LD and diabetes, coefficient alphas were found to be as .91 and .90 respectively.

For children with learning disorders PARQ-Child scores ranged from 69 to 161 ($M = 101.46$, $SD = 23.74$). For children with diabetes, PARQ-Child scores ranged from 66 to 116 ($M = 85.83$, $SD = 16.25$).

A 2 (Gender) x 2 (Diagnosis) ANCOVA was conducted to evaluate diagnosis and gender differences on the parental acceptance-rejection perception of children. Thus, PARQ-Child scores were taken as the dependent variable, and Diagnosis (LD, diabetes) and Gender (female, male) as the independent variables. In this analysis Age was taken as the covariate. The means and standard deviations for parental acceptance-rejection as a function of the two factors are presented in Table 9.

Table 9
Means and Standard Deviations for Perceived Parental Acceptance-Rejection of Children as a Function of Diagnosis and Gender

Diagnostic Group	Gender	Mean	Std. Deviation	N
Children with LD	Female	98.37	23.52	27
	Male	103.06	23.92	52
	Total	101.46	23.74	79
Children with Diabetes	Female	94.26	15.07	27
	Male	80.53	14.79	43
	Total	85.83	16.25	70
Total Group	Female	96.31	19.67	54
	Male	92.86	23.14	95
	Total	94.11	21.94	149

The ANCOVA indicated a significant Diagnosis X Gender interaction, $F(1, 144) = 7.76$, $p < .01$, partial $\eta^2 = .05$, and a significant main effect for Diagnosis, $F(1, 144) = 12.28$, $p < .001$, partial $\eta^2 = .08$, however the main effect for Gender was not significant, $F(1, 144) = 1.83$, $p = .ns$, partial $\eta^2 = .01$. The diagnosis main effect

indicated that children with a learning disability perceived higher levels of rejection from their mothers compared to children with diabetes.

Post-hoc comparisons were conducted to evaluate the pair-wise differences among the means for the interaction effect. As can be seen from Table 10, Tukey’s HSD comparisons at .05 alpha level indicated that girls with diabetes had higher levels of perceived parental rejection (\underline{M} = 94.26) than boys with diabetes (\underline{M} = 80.53). However, girls with LD and boys with LD did not differ significantly on levels of perceived parental rejection (\underline{M} = 98.37 and 103.06, respectively). Boys with LD had higher levels of perceived parental rejection (\underline{M} = 103.06) compared to boys with diabetes (\underline{M} = 80.53). Girls with LD and girls with diabetes did not differ significantly on levels perceived parental rejection (\underline{M} = 98.37 and 94.26, respectively). The perceived parental rejection levels of children according to diagnostic groups and gender are presented in Figure 3.

Table 10
Means and Standard Deviations for Perceived Parental Acceptance-Rejection of Children across Diagnostic Groups for Females and Males

Gender / Diagnostic Group	Children with LD	Children with Diabetes
Male	103.06 _a (23.92)	80.53 _b (14.79)
Female	98.37 _a (23.52)	94.26 _a (15.07)

Note. The mean scores that do not share the same subscript on the same row or on the same column are significantly different from each other at .05 alpha level of Tukey’s HSD.

In order to examine the group differences on the different subtests of parental acceptance-rejection, separate ANOVA's were conducted. Thus, PARQ-Child subtest scores (namely, parental warmth and affection, aggression and hostility, neglect and indifference, and undifferentiated rejection) were taken as the dependent variable, and Diagnosis (LD, diabetes) as the independent variables. The ANOVA for parental warmth and affection was significant $F(1,147) = 41.80, p < .001$; indicating that diabetic children perceived more warmth than LD children. The ANOVA for parental neglect and indifference was also significant $F(1,147) = 39.82, p < .001$; indicating that LD children perceived more neglect and indifference as compared to diabetic children. The ANOVA for aggression and hostility and undifferentiated rejection was not significant $F(1,147) = .09, p = ns$; $F(1,147) = 1.77, p = ns$, respectively.

3.1.1.4 Depression

For children with learning disorders CDI scores ranged from 3 to 26 ($M = 13.97, SD = 5.57$). For children with diabetes, CDI scores ranged from 3 to 15 ($M = 7, SD = 3.44$). For separate samples of children with LD and diabetes, coefficient alphas were found to be as .89 and .88 respectively.

Another set of analyses were conducted to see the magnitude of depression for LD children. The mean score for CDI was found as 13.97. In the sample of children with LD 51.9 % (41 children) may be considered mildly depressed according to the standard of Kovacs (1980/81) who suggested a cut-off score of 11 as an index of mild depression. The cut-off for severe depression suggested by

Kovacs (1980/81) is 19. In the sample of LD children 21.5 % (17 children) met this cut-off.

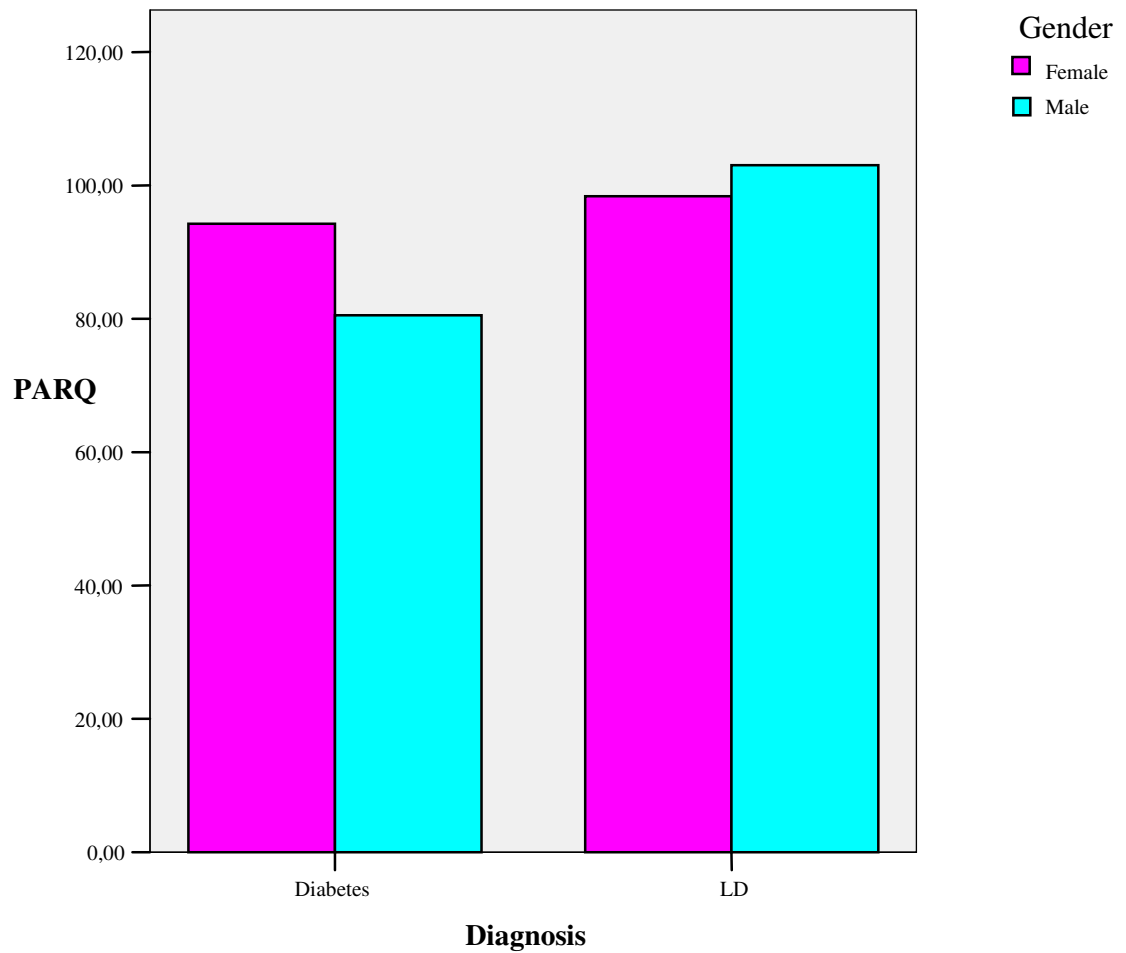


Figure 3. Perceived Parental Rejection Levels of Children by Diagnosis and Gender

A 2 (Gender) x 2 (Diagnosis) ANCOVA was conducted to evaluate diagnosis and gender differences on the depression level of children. Thus, CDI scores were taken as the dependent variable, and Diagnosis (LD, diabetes) and Gender (female, male) as the independent variables. In this analysis Age was taken as the covariate. The means and standard deviations for depression as a function of the two factors are presented in Table 11.

The ANCOVA indicated a significant Diagnosis X Gender interaction, $F(1, 144) = 4.64, p = .05, \text{partial } \eta^2 = .03$, and a significant main effect for Diagnosis, $F(1, 144) = 75.00, p < .001, \text{partial } \eta^2 = .34$, and a significant main effect for Gender $F(1, 144) = 10.01, p < .01, \text{partial } \eta^2 = .07$. The diagnosis main effect indicated that children with a learning disability had higher levels of depressive symptomatology ($M = 14.15$) compared to children with diabetes ($M = 7.41$). The gender main effect indicated that girls had higher depression levels compared to boys ($M = 12.00, M = 9.56$, respectively).

Table 11
Means and Standard Deviations for Depression Symptoms of Children as a Function of Diagnosis and Gender

Diagnostic Group	Gender	Mean	SD	N
Children with LD	Female	14.48	5.51	27
	Male	13.71	5.63	52
	Total	13.97	5.57	79
Children with Diabetes	Female	9.52	2.10	27
	Male	5.42	3.18	43
	Total	7.00	3.44	70
Total Group	Female	12.00	4.83	54
	Male	9.96	6.24	95
	Total	10.70	5.84	149

Post-hoc comparisons were conducted to evaluate the pair-wise differences among the means for the interaction effect. As can be seen from Table 12, Tukey’s HSD comparisons at .05 alpha level indicated that girls with diabetes had higher levels of depressive symptoms ($\underline{M} = 9.52$) than boys with diabetes ($\underline{M} = 5.42$). Girls with LD and boys with LD did not differ significantly on levels of depressive symptoms ($\underline{M} = 14.48$ and 13.71 , respectively). Both in LD and diabetes groups girls had higher levels of depressive symptoms ($\underline{M}s = 14.48$ and 13.71 , respectively) than boys ($\underline{M}s = 9.52$ and 5.42 , respectively). The depression levels of children according to diagnostic groups and gender are presented in Figure 4.

Table 12
Means and Standard Deviations for Depression Symptoms of Children across Diagnostic Groups for Females and Males

Gender / Diagnostic Group	Children with LD	Children with Diabetes
Male	13.71 _a (5.63)	5.42 _c (3.18)
Female	14.48 _a (5.51)	9.52 _b (2.10)

Note. The mean scores that do not share the same subscript on the same row or on the same column are significantly different from each other at .05 alpha level of Tukey’s HSD.

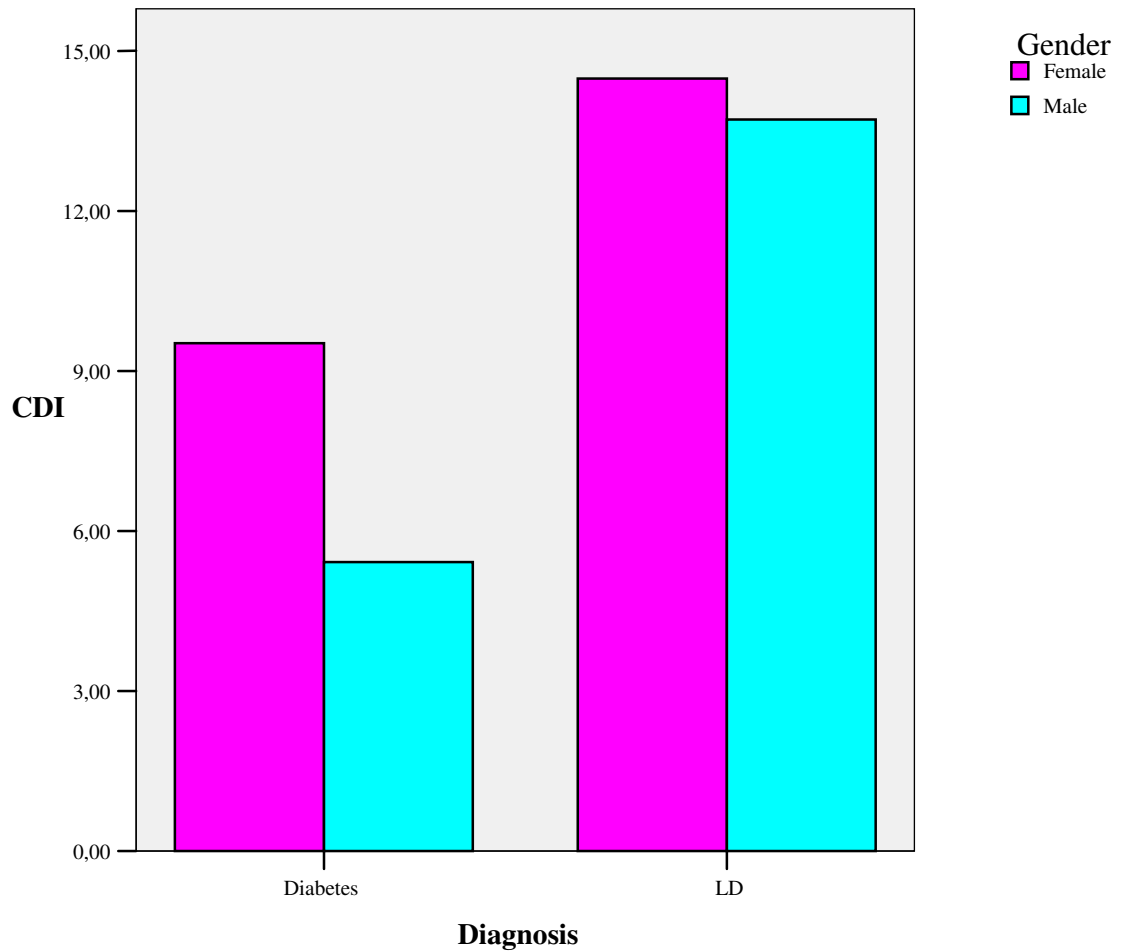


Figure 4. Depression Levels of Children by Diagnosis and Gender

3.1.1.5 Anxiety

For children with learning disorders TAI scores ranged from 23 to 51 (\underline{M} = 38.22, \underline{SD} = 6.56). For children with diabetes, TAI scores ranged from 17 to 44 (\underline{M} = 31.91, \underline{SD} = 9.39). For separate samples of children with LD and diabetes, coefficient alphas were found to be as .90 and .92 respectively.

A 2 (Gender) x 2 (Diagnosis) ANCOVA was conducted to evaluate diagnosis and gender differences on the anxiety level of students. Thus, TAI scores were taken as the dependent variable, and Diagnosis (LD, diabetes) and Gender (female, male) as the independent variables. In this analysis Age was taken as the covariate. The means and standard deviations for anxiety as a function of the two factors are presented in Table 13.

The ANCOVA indicated a significant Diagnosis X Gender interaction, $F(1, 144) = 13.32$, $p = .001$, partial $\eta^2 = .09$, a significant main effect for Diagnosis, $F(1, 144) = 20.70$, $p < .001$, partial $\eta^2 = .13$, and a significant main effect for Gender $F(1, 144) = 19.81$, $p < .001$, partial $\eta^2 = .12$. The diagnosis main effect indicated that children with a learning disability had higher levels of anxiety ($M = 38.45$) compared to children with diabetes ($M = 32.86$). The gender main effect indicated that girls had higher anxiety levels compared to boys ($M = 38.45$, $M = 32.96$, respectively).

Post-hoc comparisons were conducted to evaluate the pair-wise differences among the means for the interaction effect. As can be seen from Table 14, Tukey's HSD comparisons at .05 alpha level indicated that girls with diabetes had higher levels of anxiety symptoms ($M = 38.07$) than boys with diabetes ($M = 28.05$). Girls with LD and boys with LD did not differ significantly on levels of anxiety symptoms ($M = 38.85$ and 37.88 , respectively). Boys with LD had higher levels of anxiety symptoms ($M = 37.88$) compared to boys with diabetes ($M = 28.05$). Girls with LD and girls with diabetes did not differ significantly on levels of anxiety symptoms (M

= 38.85 and 38.07, respectively). The anxiety levels of children according to diagnostic groups and gender are presented in Figure 5.

Table 13
Means and Standard Deviations for Anxiety Levels of Children as a Function of Diagnosis and Gender

Diagnostic Group	Gender	Mean	SD	N
Children with LD	Female	38.85	6.89	27
	Male	37.88	6.43	52
	Total	38.22	6.56	79
Children with Diabetes	Female	38.07	5.59	27
	Male	28.05	9.26	43
	Total	31.91	9.39	70
Total Group	Female	38.46	6.23	54
	Male	33.43	9.22	95
	Total	35.26	8.59	149

Table 14
Means and Standard Deviations for Anxiety Levels of Children across Diagnostic Groups for Females and Males

Gender / Diagnostic Group	Children with LD	Children with Diabetes
Male	37.88 _a (6.43)	28.05 _b (9.26)
Female	38.85 _a (6.89)	38.07 _a (5.59)

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

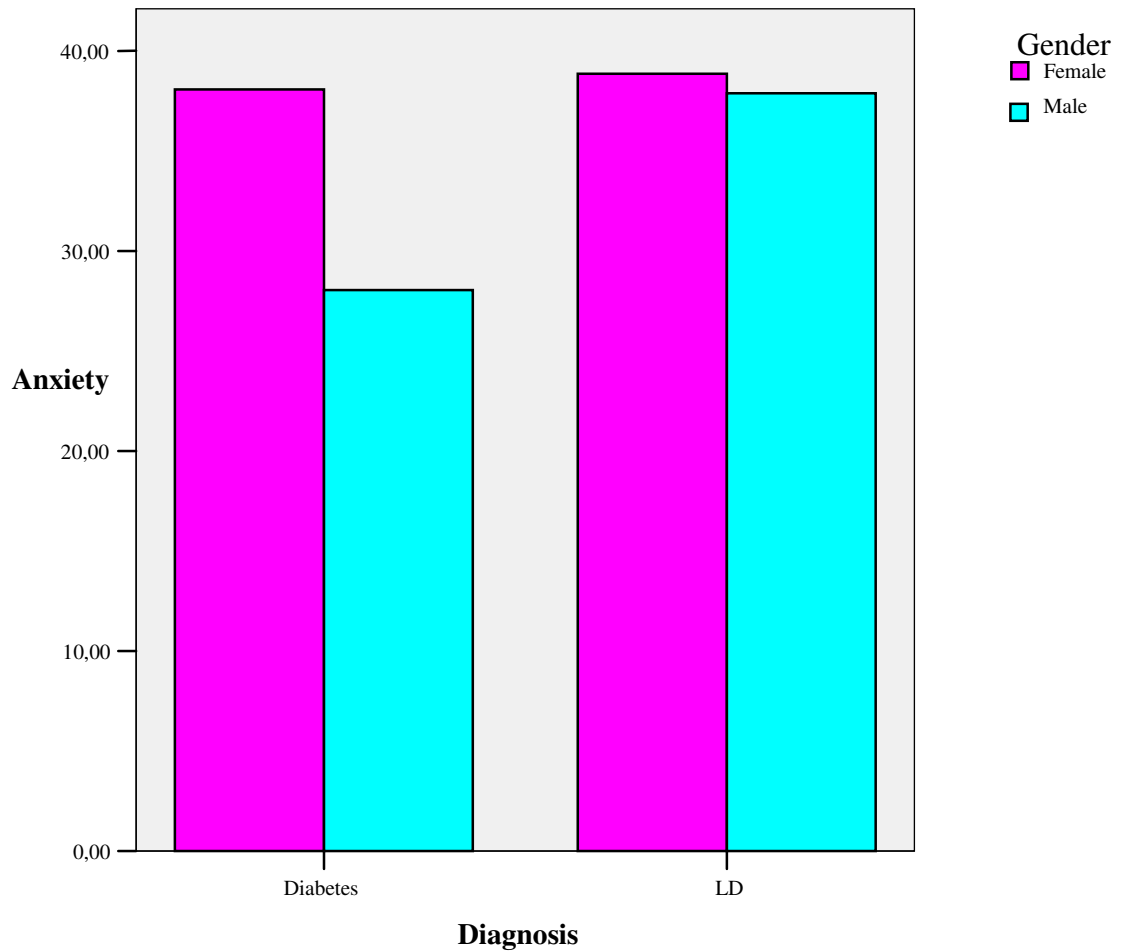


Figure 5. Anxiety Levels of Children by Diagnosis and Gender

3.2 Variables Associated with the Symptoms of Depression and Anxiety for Children with Learning Disabilities and Diabetes Groups Separately

Under this section, 4 regression analyses will be conducted in order to find out the variables associated with the symptoms of depression and anxiety for children with learning disabilities ($n = 102$) and diabetes ($n = 70$) groups separately.

Four separate multiple regression analyses were conducted to find out the

variables associated with the depression and anxiety levels of the children with LD and diabetes. For these analyses, in the first step age and gender of the child as well as variables related to the child's parents, namely, the mother's and father's ages and education levels were hierarchically entered. The second step constituted of the variables related to the child's psychological state: parental-acceptance rejection (child form) total score, Piers-Harris Children's Self-Concept Scale total score, and CASQ score. In the third step, variables related to the mother's psychological state were added to the equation: mother's depression and anxiety level as well as coping styles of the mother, namely: emotional, problem focused and indirect coping styles. All the variables were entered in stepwise fashion, thus only those variables having significant associations with the criterion variable, hierarchically entered into the equation, for each step respectively.

3.2.1 Variables Associated with the Symptoms of Depression for Children with Learning Disabilities

The criterion variable was the Children's Depression Inventory score. According to the results of this regression analysis, none of the first step variables had significant association with the children's depressive symptoms, thus these variables did not show up in the equation. Among the second step variables, only children's self esteem ($\beta = -.49$, $t [100] = -5.56$, $p < .001$; $\underline{pr} = -.49$) and parental rejection ($\beta = .21$, $t [99] = 2.44$, $p < .05$; $\underline{pr} = .24$) scores had significant associations with the depressive symptoms of children. Self esteem scores explained 24 % of the total variance ($F [1, 100] = 30.87$, $p < .001$), and parental rejection scores increased the explained variance to 28 % ($F \text{ change } [1, 99] = 5.97$, $p = .05$). After controlling

for these variables, among the third step variables, mothers' emotional coping styles ($\beta = -.25$, $t [98] = -3.01$, $p < .01$; $pr = -.29$) and depressive symptoms ($\beta = .20$, $t [97] = 2.34$, $p < .05$; $pr = .23$) entered into the equation as the third and the fifth variables, respectively. With the entrance of mothers' emotional coping styles, explained variance increased to 34 % (F change $[1, 98] = 9.05$; $p < .01$); and finally with the addition of depressive symptoms of the mothers into the equation, the explained variance increased to 38 % (F change $[1, 97] = 5.46$; $p < .05$). Thus, this regression analysis indicated that, children's low self esteem scores, and their perception of parental rejection significantly associated with children's depressive symptoms. Furthermore, after controlling for these variables that accounted for 28 % of the total variance, among mothers' characteristics utilization of lower emotional coping styles and having depressive symptoms significantly associated with children's depressive symptoms. These 4 variables that could enter into the regression equation totally explained for 38 % of the total variance (see Table 15).

Table 15 Variables Associated with the Symptoms of Depression in Children with Learning Disabilities

Predictors in set	F for set	t for with-in set	df	Partial Correlation	Model R ²
1. Piers-Harris SE	30.87***	-5.56***	1, 100	-.49	.24
2. PAR	5.97*	2.44*	1, 99	.24	.28
3. Emot. Coping	9.05**	-3.01**	1, 98	-.29	.34
4. BDI	5.46*	2.34*	1, 97	.23	.38

Note. Piers-Harris SE = Piers-Harris Children's Self-Concept Scale; PAR = Parental Acceptance-Rejection; BDI = Beck Depression Inventory; pr = Partial correlation for with-in set predictors.

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

3.2.2 Variables Associated with the Symptoms of Anxiety in Children with Learning Disabilities

The criterion variable was the Trait Anxiety Inventory score. According to the results of this regression analysis, among the first step variables, only the age of the father ($\beta = -.31$, $t [100] = -3.21$, $p < .01$; $\underline{pr} = -.31$) had a significant association with the anxiety symptoms of children. Father's age explained 9 % of the total variance ($F [1, 99] = 10.29$, $p < .01$). Among second step variables, only children's self esteem ($\beta = -.33$, $t [100] = -3.54$, $p = .001$; $\underline{pr} = -.34$) scores had significant associations with the anxiety symptoms of children. Self esteem scores increased explained variance to 20 % (F change $[1, 99] = 12.51$, $p < .001$). After controlling for these variables, among the third step variables, mothers' anxiety level ($\beta = .28$, $t [98] = 3.15$, $p < .01$; $\underline{pr} = .30$) entered into the equation. With the entrance of mothers' anxiety level, explained variance increased to 27 % (F change $[1, 98] = 9.95$; $p < .01$). Thus, this regression analysis indicated that, younger age in the father and children's low self esteem scores significantly associated with children's anxiety symptoms. Furthermore, after controlling for these variables that accounted for 20 % of the total variance, among the mother's characteristics, higher anxiety levels of mothers significantly associated with children's anxiety symptoms. These 3 variables that could enter into the regression equation totally explained for 27 % of the total variance (Table 16).

Table 16 Variables Associated with the Symptoms of Anxiety in Children with Learning Disabilities

Predictors in set	F for set	t for with-in set	df	Partial Correlation	Model R²
1. Age of the father	10.29**	-3.21**	1, 100	-.31	.9
2. Piers-Harris SE	12.51***	-3.54***	1, 99	-.34	.20
3. Mothers' anxiety level	9.95**	3.15**	1,98	.30	.27

Note. Piers-Harris SE = Piers-Harris Children's Self-Concept Scale; pr = Partial correlation for with-in set predictors.

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

3.2.3 Variables Associated with the Symptoms of Depression in Children with Diabetes

The criterion variable for this third regression analysis was the Children's Depression Inventory score. According to the results of this regression analysis, among the first step variables gender ($\beta = -.58$, $t [68] = -5.93$, $p < .001$; pr = -.58) and age ($\beta = .37$, $t [67] = 4.21$, $p < .001$; pr = .46) of the child had significant association with the diabetic children's depressive symptoms. Gender explained 34 % of the variance ($F [1, 68] = 35.16$, $p < .001$), with the addition of Age explained variance increased to 48 % ($F \text{ change } [1, 67] = 17.70$, $p < .001$). Among the second step variables, children's self esteem ($\beta = -.48$, $t [66] = -5.81$, $p < .001$; pr = -.58) and learned helplessness ($\beta = .22$, $t [65] = 2.73$, $p < .01$; pr = .32) scores had significant associations with the depressive symptoms of children. Explained variances increased to 66 and 69 % respectively with the entrance of self esteem ($F \text{ change } [1, 66] = 33.71$, $p < .001$) and learned helplessness ($F \text{ change } [1, 65] = 7.42$, $p < .01$) measures into the equation. After controlling for these variables, among the

third step variables, mothers' problem-focused ($\beta = .37$, $t [64] = 3.56$, $p < .001$; $pr = .41$), emotional ($\beta = .41$, $t [63] = 3.41$, $p < .001$; $pr = .39$), and indirect ($\beta = -.21$, $t [62] = -2.21$, $p < .05$; $pr = -.27$) coping styles entered into the regression equation. With the entrance of mothers' problem-focused coping styles, explained variance increased to 74 % (F change [1, 64] = 12.67; $p < .001$). The entrance of mothers' emotional coping styles increased explained variance to 78 % (F change [1, 63] = 11.59; $p = .001$); and finally with the addition of indirect coping style explained variance increased to 80 % (F change [1, 62] = 4.86; $p < .05$) (see Table 17).

Table 17
Variables Associated with the Symptoms of Depression in Children with Diabetes

Predictors in set	F for set	T for with-in set	df	Partial Correlation	Model R ²
1. Gender	35.16***	-5.93***	1, 68	-.58	.34
2. Age	17.70***	4.21***	1, 67	.46	.48
3. Piers-Harris SE	33.71***	-0.48***	1, 66	-.58	.66
4. CASQ	7.42**	2.73**	1, 65	.32	.69
5. Prob. Coping	12.67***	.36***	1, 64	.41	.74
6. Emot. Coping	11.59***	3.41***	1, 63	.39	.78
7. Indirect Coping	4.86*	-2.21*	1, 62	-.27	.80

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

Note. Piers-Harris SE = Piers-Harris Children's Self-Concept Scale; CASQ = Children's Attributional Style Questionnaire. pr = Partial correlation for with-in set predictors.

Thus, this regression analysis indicated that, being female and being older was significantly associated with children's depressive symptoms. Having lower self

esteem and higher learned helplessness scores also had significant associations with the depressive symptoms of children with diabetes. Depressive symptoms in diabetic children were finally significantly associated with higher problem-focused and emotional coping, and lower indirect coping styles in the mothers. These 7 variables that could enter into the regression equation totally explained for 80 % of the total variance.

3.2.4 Variables Associated with the Symptoms of Anxiety in Children with Diabetes

For the fourth regression equation the criterion variable was the Trait Anxiety Inventory score. According to the results of this regression analysis, among the first step variables, gender of the child ($\beta = -.52$, $t [68] = -5.07$, $p < .001$; $\underline{pr} = -.52$); education level of the father ($\beta = -.43$, $t [67] = -4.67$, $p < .001$; $\underline{pr} = -.50$); mother's age ($\beta = -.25$, $t [66] = -2.36$, $p < .05$; $\underline{pr} = -.28$); and finally age of the child ($\beta = .36$, $t [65] = 3.60$, $p = .001$; $\underline{pr} = .41$) had a significant association with the anxiety symptoms of diabetic children. Gender explained 27 % of the total variance $F [1, 68] = 25.69$, $p < .001$), the entrance of father's education level increased explained variance to 45 %, F change $[1, 67] = 21.80$, $p < .001$), and explained variance increased to 50 and 58 % as mother's age $F [1, 66] = 5.59$, $p < .05$), and age of the child $F [1, 65] = 12.93$, $p = .001$) entered into the equation, respectively. Among the second step variables, only parental rejection ($\beta = .74$, $t [64] = 10.31$, $p < .001$; $\underline{pr} = .79$) scores had significant associations with the anxiety symptoms of children. Parental rejection scores increased explained variance to 84 % (F change $[1, 64] = 106.38$, $p < .001$). After controlling for these variables, among the third

step variables, mothers' emotional coping styles ($\beta = .15$, $t [63] = 2.04$, $p < .05$; $pr = .25$) entered into the equation. With the entrance of mothers' emotional coping styles, explained variance increased to 85 % (F change $[1, 63] = 4.17$; $p < .05$). Thus, this regression analysis indicated that, being a female, lower education level of the father, younger age of the mother and older age in the child significantly associated with diabetic children's anxiety symptoms. Furthermore, after controlling for these variables that accounted for 58 % of the total variance, higher parental rejection scores were also found to be associated with children's anxiety symptoms. Among the mother's characteristics, higher use of emotional coping styles was significantly associated with children's anxiety symptoms. These 6 variables that could enter into the regression equation totally explained for 85 % of the total variance (see Table 18).

Table 18
Variables Associated with the Symptoms of Anxiety in Children with Diabetes

Predictors in set	F for set	t for with-in set	df	Partial Correlation	Model R ²
1. Gender	25.69***	-5.07***	1, 68	-.52	.27
2. Father's Education level	21.80***	-4.67***	1, 67	-.50	.45
3. Mother's Age	5.59*	-2.36*	1, 66	-.28	.50
4. Age of child	12.93***	3.60***	1, 65	.41	.58
5. PARQ	106.38***	10.31***	1, 64	.79	.84
6. Emotional Coping	4.17*	2.04*	1, 63	.25	.85

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

Note. PARQ = Parental Acceptance-Rejection; pr = Partial correlation for with-in set predictors.

3.3 Tests for Mediation Roles of Self-Esteem

In this section, regression analyses will be conducted to test the mediator roles of self-esteem between parental (acceptance) rejection and depression; and also between learned helplessness and depression for children with learning disabilities ($n = 102$).

3.3.1 Mediator Role of Self-Esteem between Parental Acceptance-Rejection and Depression Symptoms

It was hypothesized that self-esteem may act as a mediator between parental (acceptance) rejection and depression. The statistical procedures and criteria set by Baron and Kenny (1986) were used to assess possible mediating effects. To establish that self-esteem acts as a mediator between parental acceptance-rejection and depression, the following conditions must be met:

1. Parental-Acceptance Rejection Questionnaire-Child Form (PARQ-Child) scores must be significantly associated with depression.
2. Variations in parental acceptance-rejection must significantly account for the variations in the self-esteem variable.
3. Variations in the self-esteem measure must significantly account for the variations in depression.
4. When the effect of the self-esteem variable on depression is controlled for, the strength of the previously significant relation between parental acceptance-rejection and depression should significantly decrease.

In order to examine the accuracy of the above conditions, two regression analyses were conducted. For the first regression analysis, depression was the

dependent variable. Independent variables were entered in three steps. In the first step Gender of the child and Age were entered in order to rule out the variance accounted for by these factors. In the second step, the total parental-acceptance-rejection score was entered (this step is testing the first condition). The self-esteem score was entered in the third step (this step is testing for the third and fourth conditions).

According to the results of this regression analysis (see Table 19-A), only 1 % of the variance was explained by Age and Gender ($F [2, 99] = 0.51; p = ns$). Neither Age ($\beta = .01, t [99] = 0.10, p = ns; \underline{pr} = .01$), nor Gender ($\beta = -.10, t [99] = -1.01, p = ns; \underline{pr} = -.10$) had significant contributions to the explained variance. On the second step PAR scores increased the explained variance to 11 % $F (1, 98) = 11.04; p < .001$, thus confirming the first condition, parental rejection was found to be associated with depressive symptoms ($\beta = .33, t [98] = 3.32, p < .001; \underline{pr} = .32$). On the last step with the entrance of Self-esteem explained variance increased to 29 %, $F (1, 97) = 24.18, p < .001$, and confirming the third condition, self-esteem was found to be negatively associated with depressive symptoms ($\beta = -.48, t [97] = -4.92, p < .000; \underline{pr} = -.45$) (see Table 19-A). Additionally, on this final step, confirming the fourth condition, after controlling for self-esteem, the association of parental rejection with depression decreased ($\beta = .18, t [97] = 1.90, p = ns; \underline{pr} = .19$; cf. $\beta = .33, t [98] = 3.32, p < .001; \underline{pr} = .32$). All these findings are in line with the expectations, suggesting that the association between acceptance-rejection and depression was mediated by self-esteem.

In order to check for the second criterion stated above, and thus to be sure about the mediator role of self-esteem between parental acceptance-rejection and depression symptoms, the nature of the relationship between PAR and self-esteem level was questioned through the second regression equation. It is expected that parental rejection would be associated with low level of self-esteem. To be able to test this prediction, a second regression equation was formulated where self-esteem level was the dependent variable, Age and Gender entered in the first step as the control variables and parental-acceptance rejection score entered into the equation on the second step.

According to these results (see Table 19-B), 14 % of the variance was explained by Gender and Age $F(2, 99) = 8.33, p < .001$; in the second step explained variance increased to 23 %, $F(1, 98) = 11.47, p < .001$ with the addition of PAR score. Consistent with the expectations, parental rejection was found to be negatively associated with self-esteem scores ($\beta = -.31, t[98] = -3.39, p < .001; \beta = -.32$). Moreover, in order to test for the significance of the mediation effect, a Sobel test was conducted. The Sobel test was significant ($Z = 2.76, p < .01$), confirming that parental rejection-depression path was significantly mediated by self-esteem. Thus, as expected when the effect of the self-esteem variable on depression was controlled for, the strength of the previously significant relation between parental acceptance-rejection and depression has significantly decreased. In other words, it was found that the relation between parental acceptance-rejection and depression was mediated by self-esteem (see Figure 6).

Table 19

Mediator Role of Self-Esteem between Parental Acceptance-Rejection and Depression Symptoms

Order of entry of set	Predictors in set	F for set	t for with-in set	df	Partial Correlation	Model R ²
A. <i>Dependent Variable = CDI</i>						
1. Demographic Variables		0.51		2, 99		.01
	Age		0.10	99	.01	
	Gender		-1.01	99	-.10	
2. PAR		11.04**	3.32**	1, 98	.32	.10
3. Piers-Harris SE		24.18**	-4.92**	1, 97	-.45	.18
B. <i>Dependent Variable = Self-Esteem</i>						
1. Demographic Variables		8.33**		2, 99		.14
	Age		-3.55**	99	-.34	
	Gender		2.03*	99	.20	
2. PAR		11.47**	-3.39**	1, 98	-.32	.09

*p< .05, **p< .001

Note. CDI = Children's Depression Inventory; Piers-Harris SE = Piers-Harris Children's Self-Concept Scale; PAR = Parental Acceptance-Rejection. pr = Partial correlation for with-in set predictors.

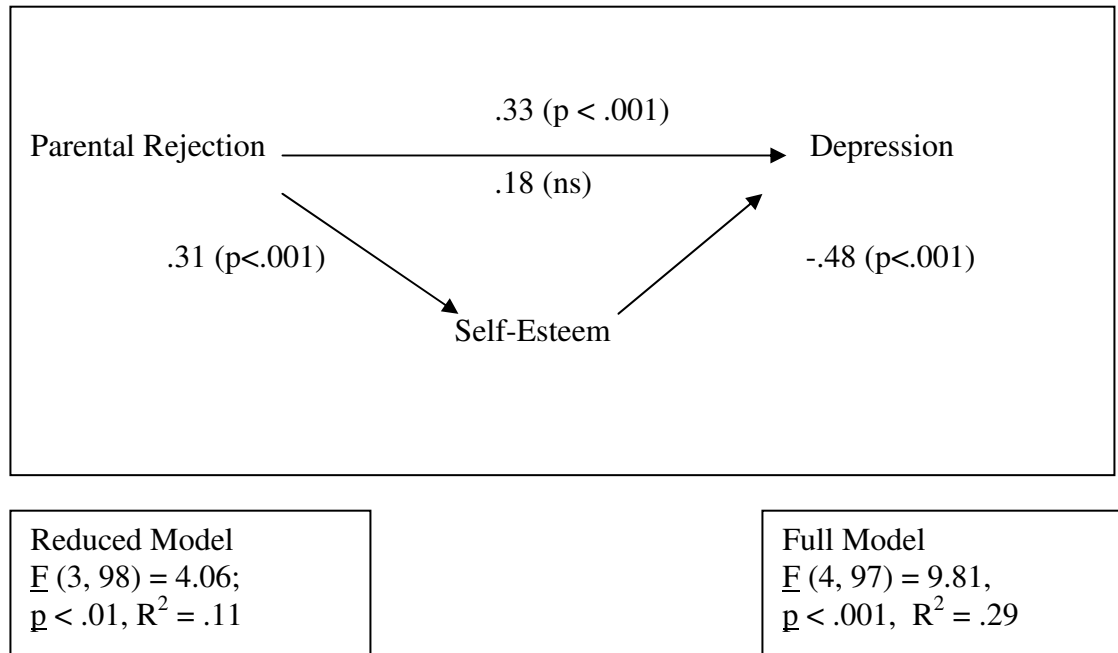


Figure 6. Parental (Acceptance) Rejection and Self-Esteem Measures Predicting Depression: Regression Analyses Testing the Mediation Hypothesis

Note. Summary of the mediating regression analysis for Depression including beta-weights, F values, and R^2 s for the model before the Self-Esteem is included (Reduced Model) and after the inclusion of the mediator: Self-Esteem (Full Model). The initial path between Parental Rejection and Depression is indicated by the beta-weight (and the p value) on the top of the line connecting these variables; whereas the beta-weight (and the p value) after self-esteem is included as the mediator is indicated by the beta-weight (and the p value) directly under the path.

3.3.2 Mediator Role of Self-Esteem between Learned Helplessness and Depression Symptoms

It was also hypothesized that self-esteem may act as a mediator between learned helplessness and depression. To establish that self-esteem acts as a mediator between learned helplessness and depression, the following conditions must be met:

1. Children's Attributional Style Questionnaire (CASQ) scores must be significantly associated with depression.
2. Variations in CASQ scores must significantly account for the variations in the self-esteem variable.
3. Variations in the self-esteem measure must significantly account for the variations in depression.
4. When the effect of the self-esteem variable on depression is controlled for, the strength of the previously significant relation between learned helplessness and depression should significantly decrease.

In order to examine the accuracy of the above conditions, two regression analyses were conducted. For the first regression analysis, depression was the dependent variable. Independent variables were entered in three steps. In the first step Gender of the child and Age were entered in order to rule out the variance accounted for by these factors. In the second step, the CASQ score was entered (this step is testing the first condition). The self-esteem score was entered in the third step (this step is testing for the third and fourth conditions).

According to the results of this regression analysis (see Table 20-A), only 1 % of the variance was explained by Age and Gender ($F [2, 99] = 0.51; p = ns$).

Neither Age ($\beta = .01$, $t [99] = 0.10$, $p = ns$; $pr = .01$), nor Gender ($\beta = -.10$, $t [99] = -1.01$, $p = ns$; $pr = -.10$) had significant contributions to the explained variance. On the second step CASQ scores increased the explained variance to 7 % $F (1, 98) = 6.13$, $p < .001$ and confirming the first condition, increased learned helplessness was found to be associated with depressive symptoms ($\beta = .25$, $t [98] = 2.48$, $p < .01$; $pr = .24$). On the last step with the entrance of Self-esteem explained variance increased to 28 %, $F (1, 97) = 27.78$, $p < .001$, and confirming the third condition, self-esteem was found to be negatively associated with depressive symptoms ($\beta = -.51$, $t [97] = -5.27$, $p < .000$; $pr = -.47$) (see Table 20-A). Additionally, on this final step, confirming the fourth condition, after controlling for self-esteem, the association of learned helplessness with depression decreased ($\beta = .13$, $t [97] = 1.39$, $p = ns$; $pr = .14$; cf. $\beta = .25$, $t [98] = 2.48$, $p < .01$; $pr = .24$). All these findings are in line with the expectations, suggesting that the association between learned helplessness and depression was mediated by self-esteem.

In order to check for the second criterion stated above, and thus to be sure about the mediator role of self-esteem between learned helplessness and depression symptoms, the nature of the relationship between CASQ and self-esteem level was questioned through the second regression equation. It is expected that learned helplessness would be associated with low level of self-esteem. To be able to test this prediction, a second regression equation was formulated where self-esteem level was the dependent variable, Age and Gender entered in the first step as the control variables and CASQ score entered into the equation on the second step.

According to these results (see Table 20-B), 14 % of the variance was explained by Gender and Age $F(2, 99) = 8.33, p < .001$; in the second step explained variance increased to 20 %, $F(1,98) = 6.47, p = .013$ with the addition of CASQ score. Consistent with the expectations, learned helplessness was found to be negatively associated with self-esteem scores ($\beta = -.23, t[98] = -2.54, p < .01; \text{pr} = -.25$).

Moreover, in order to test for the significance of the mediation effect, a Sobel test was conducted. The Sobel test was significant ($Z = 2.29, p < .05$) confirming that learned helplessness-depression path was significantly mediated by self-esteem. Thus, as expected when the effect of the self-esteem variable on depression was controlled for, the strength of the previously significant relation between learned helplessness and depression has significantly decreased. In other words, it was found that the relation between learned helplessness and depression was mediated by self-esteem (see Figure 7).

Table 20

Mediator Role of Self-Esteem between Learned Helplessness and Depression

Symptoms

Order of entry of set	Predictors in set	F for set	t for with-in set	df	Partial Correlation	Model R²
A.						
<i>Dependent Variable = CDI</i>						
1. Demographic Variables		0.51		2,99		.01
	Age		.10	99	.01	
	Gender		-.10	99	-.10	
2. CASQ		6.13*	2.48*	1, 98	.24	.06
3. Piers-Harris SE		27.78**	-5.27**	1, 97	-.47	.21
B.						
<i>Dependent Variable = Self-Esteem</i>						
1. Demographic Variables		8.33**		2, 99		.15
	Age		-3.55**	99	-.34	
	Gender		2.03*	99	.20	
2. CASQ		6.47*	-2.54*	1, 98	-.25	.05

Note. CDI = Children's Depression Inventory; CASQ = Children's Attributional Style Questionnaire; Piers-Harris SE = Piers-Harris Children's Self-Concept Scale.

pr = Partial correlation for with-in set predictors.

*p< .05, **p< .001

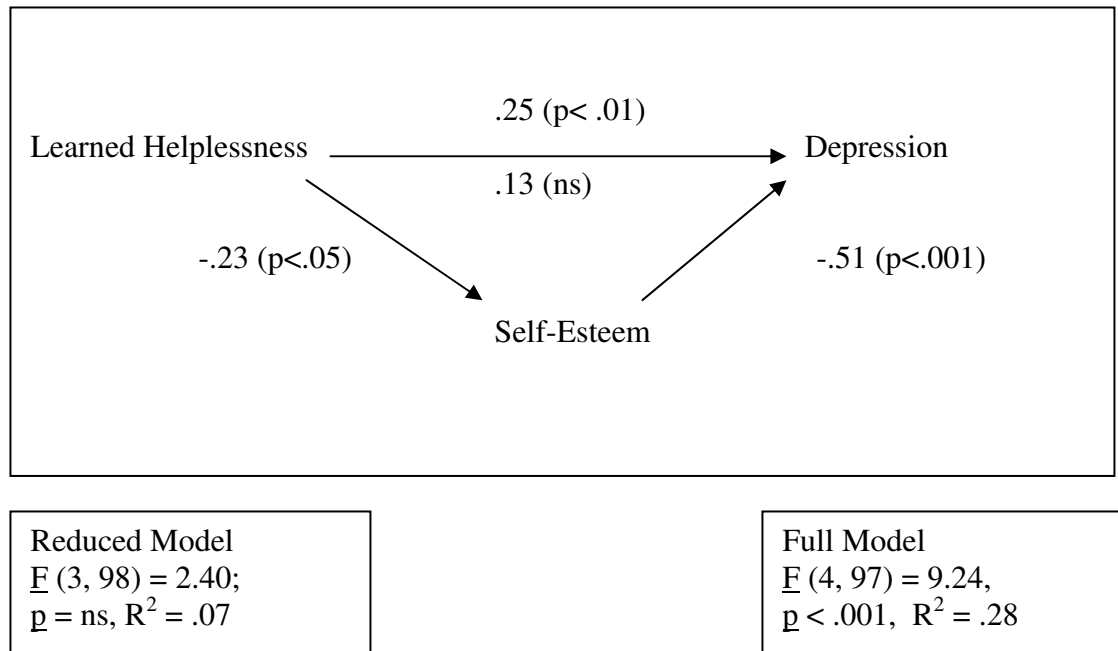


Figure 7 Learned Helplessness and Self-Esteem Measures Predicting Depression: Regression Analyses Testing the Mediation Hypothesis

Note. Summary of the mediating regression analysis for Depression including beta-weights, F values, and R^2 s for the model before the Self-Esteem is included (Reduced Model) and after the inclusion of the mediator: Self-Esteem (Full Model). The initial path between Learned Helplessness and Depression is indicated by the beta-weight (and the p value) on the top of the line connecting these variables; whereas the beta-weight (and the p value) after self-esteem is included as the mediator is indicated by the beta-weight (and the p value) directly under the path.

3.4 Results for Mothers: Comparison of the Two Groups

In order to examine the inter-correlations among the variables, Pearson product-moment correlation coefficients were computed. As expected, there were significant correlations with the study variables of total BDI score, TAI score, MMFAD subtest scores, PSI score, TWCI subtest scores, and PARQ-Mother Form scores (see Table 21). Other than these analyses, the measures received from mothers of the two groups of children, namely, LD and diabetic children were compared through one-way ANCOVA analyses. In these analyses, age of the mother was taken as the covariate variable. Comparison were conducted between the mothers of 79 children with LD and 70 diabetic children.

3.4.1 Depression

For the mothers of children with learning disorders, BDI scores ranged from 0 to 31 ($M = 13.23$, $SD = 6.82$). For the mothers of children with diabetes, BDI scores ranged from 3 to 20 ($M = 10.24$, $SD = 4.33$).

A one-way analysis of covariance (ANCOVA) was conducted to evaluate the diagnosis differences (LD, diabetes) on the depression level of mothers. Thus, BDI scores were taken as the dependent variable and Diagnosis (LD, diabetes) of the child as the independent variables. The means and standard deviations for BDI as a function of the diagnosis are presented in Table 22. The ANCOVA indicated a significant main effect for Diagnosis, $F(1, 146) = 11.47$, $p = .001$, partial $\eta^2 = .07$. The diagnosis main effect indicated that mothers of children with a learning disability had higher depression scores compared to mothers of children with diabetes (see Figure 8).

Table 21 Pearson Correlations of the Diagnostic Group, BDI score, TAI score, MBI score, MMFAD score, PSI score, TWCI scores, and PARQ-Mother Form score

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Diagnosis		.25**	.32**	.52**	.23**	.30**	-.17*	.12	.01	.09	-.32**	.15	-.09	.41**	.06	.50**
2. BDI			.49**	.29**	.35**	.41**	.31**	.39**	.38**	.36**	.14	.05	.10	.28**	.41**	.31**
3. TAI				.44**	.43**	.60**	.31**	.51**	.43**	.52**	.12	-.01	.10	.50**	.49**	.43**
4. MMFAD: PS					.53**	.55**	.27**	.19*	.26**	.64**	-.18*	-.05	.06	.52**	.34**	.56**
5. MMFAD: CM						.51**	.70**	.36**	.57**	.68**	.15	-.01	-.07	.58**	.38**	.40**
6. MMFAD: RL							.53**	.52**	.60**	.62**	.11	.20*	.16*	.57**	.57**	.56**
7. MMFAD: AR								.36**	.68**	.72**	.28**	.01	.05	.50**	.49**	.24**
8. MMFAD: AI									.45**	.49**	.24**	-.12	.26**	.41**	.60**	.27**
9. MMFAD: BC										.61**	.25**	-.07	.11	.56**	.50**	.26**
10. MMFAD: GF											.06	-.19*	.05	.51**	.61**	.41**
11. Emot. Focus Cop.												.22**	.34**	.20*	.35**	.13
12. Prob. Focus Cop.													.26**	.07	-.25**	.02
13. Indir. Cop. Style														.14	.30**	.17*
14. PSI															.49**	.56**
15. MBI																.57**
16. PARQ-total																

Note. BDI = Beck Depression Inventory, TAI = Trait Anxiety Inventory; MMFAD McMaster Family Assessment Device, PS: Problem Solving; CM: Communication; RL: Roles; AR: Affective Responsiveness; AI: Affective Involvement; BC: Behavior Control; GF: General Functions; Emot. Focus Cop. = Emotional Focused Coping; Prob. Focus Cop. = Problem Focused Coping; Indir. Cop. Style= Indirect Coping Style PSI = Problem Solving Inventory; MBI = Maslach Burnout Inventory; PARQ = Parental Acceptance-Rejection Questionnaire.

** p< .01 level (2-tailed).

* p< .05 level (2-tailed).

Table 22

Means and Standard Deviations for Depression as a Function of the Diagnosis their children received

Diagnostic Group	Mean	Std. Deviation	N
Mothers of diabetic children	10.24	4.33	70
Mothers of LD children	13.23	6.82	79
Total Group	11.83	5.96	149

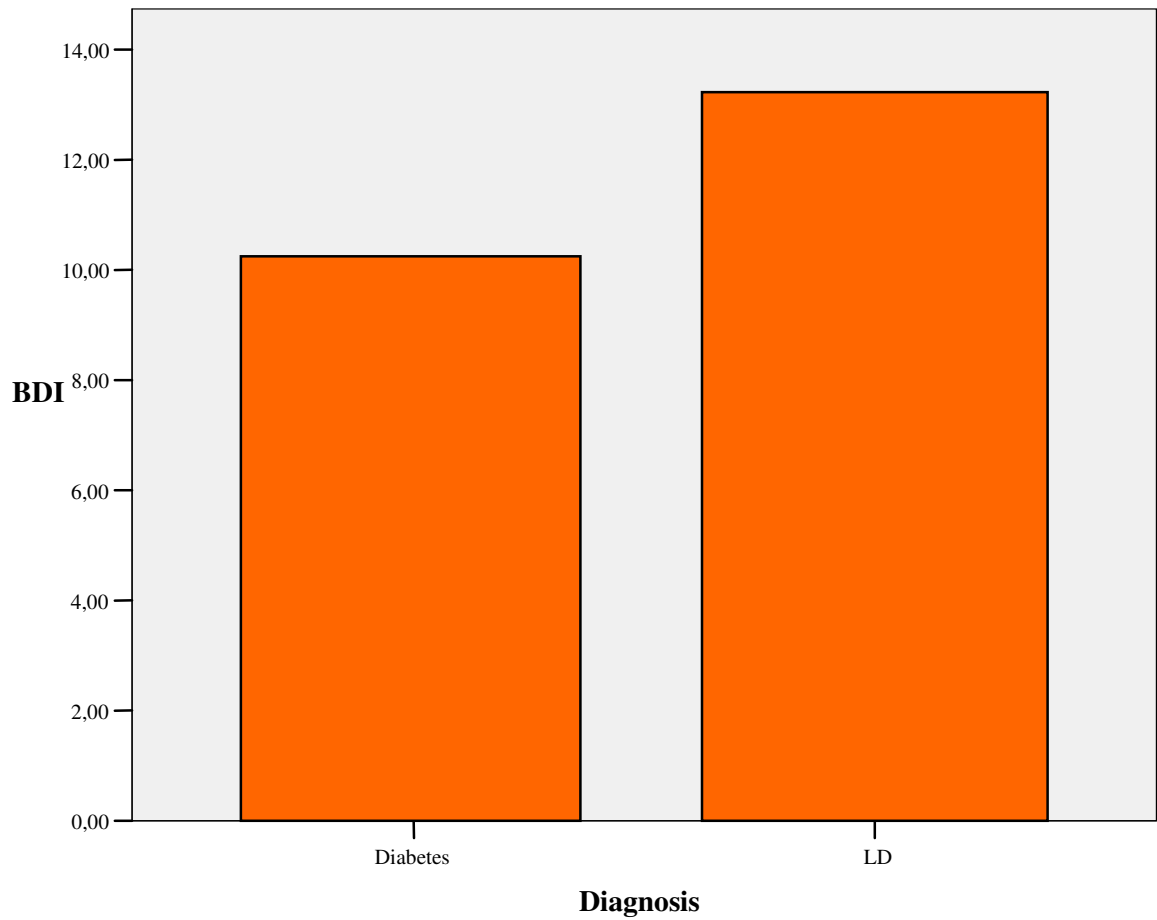


Figure 8 Depression Levels of Mothers of the Two Groups of Children

3.4.2 Anxiety

For the mothers of children with learning disorders, TAI scores ranged from 25 to 65 (M = 41.62, SD = 8.44). For the mothers of children with diabetes, TAI scores ranged from 24 to 61 (M= 36.59, SD = 6.48).

A one-way analysis of covariance (ANCOVA) was conducted to evaluate the diagnosis differences (LD, diabetes) on the anxiety level of mothers. Thus, TAI scores were taken as the dependent variable and Diagnosis (LD, diabetes) of the child as the independent variables. The means and standard deviations for TAI as a function of the diagnosis are presented in Table 23.

Table 23
Means and Standard Deviations for Anxiety as a Function of the
Diagnosis their children received

Diagnostic Group	Mean	Std. Deviation	N
Mothers of diabetic children	36.59	6.48	70
Mothers of LD children	41.62	8.44	79
Total Group	39.26	7.97	149

The ANCOVA indicated a significant main effect for Diagnosis, $F(1, 146) = 18.50$, $p < .001$, partial $\eta^2 = .11$. The diagnosis main effect indicated that mothers of children with a learning disability had higher trait anxiety scores compared to mothers of children with diabetes (see Figure 9).

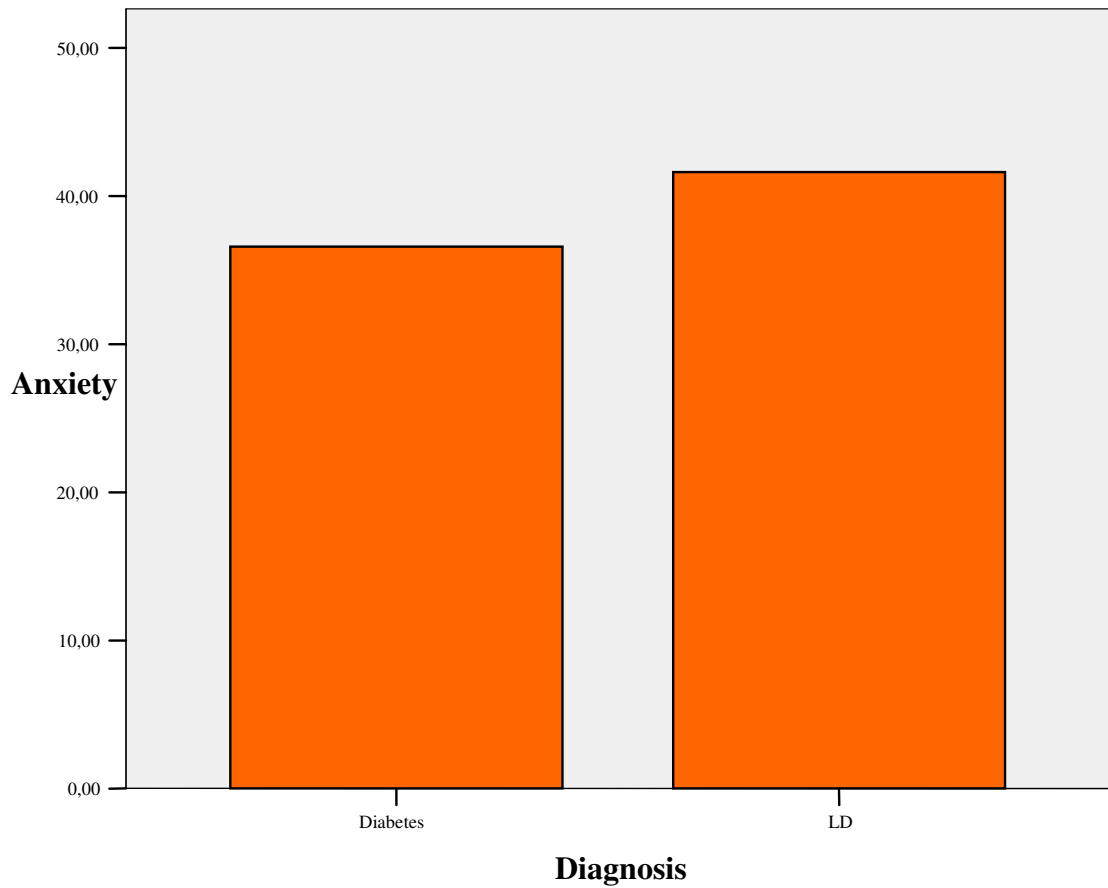


Figure 9 Anxiety Levels of Mothers of the Two Groups of Children

3.4.3 Family Functions

For the total sample, the internal reliability of the MMFAD as measured by coefficient alpha, was found to be .92. Separate reliability analyses were conducted for the LD and Diabetes group, and alpha coefficients were found to be .91 and .95, respectively. Internal reliabilities for the MMFAD subtests as measured by coefficient alphas were found to be .85, .79, .66, .70, .72, .60 and .90 for the

Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control and General Functioning subscales for this sample.

A multivariate analysis of covariance (MANCOVA) was conducted to evaluate the diagnosis differences (LD, diabetes) on the family functioning level of mothers. Thus, MMFAD subtest scores were taken as the dependent variables (Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control and General Functioning) and Diagnosis (LD, diabetes) of the child as the independent variable. For this analysis Age of the mother was the covariate variable. The means and standard deviations for MMFAD subtests as a function of the diagnosis are presented in Table 24.

Table 24

Means and Standard Deviations for Family Functioning subtests as a Function of the Diagnosis their children received

Family Functioning Subtests	Mothers of diabetic children		Mothers of LD children		Difference Between Groups
	Mean	SD	Mean	SD	
					F (1,146)
Problem Solving	1.33	.39	1.91	.55	61.41**
Communication	1.37	.40	1.56	.45	9.82*
Roles	1.74	.50	2.05	.46	16.89**
Affective Responsiveness	1.96	.74	1.74	.49	3.50
Affective Involvement	1.95	.43	2.05	.41	3.05
Behavior Control	1.83	.49	1.83	.37	.09
General Functioning	1.73	.45	1.81	.46	2.11

*p< .01, **p< .001

MANCOVA results indicated a significant Diagnosis main effect $F(7,140) = 19.67, p < .001, \text{partial } \eta^2 = .50$. Univariate analyses indicated a significant main effect for Diagnosis for the “Roles” subscale, $F(1,146) = 16.89, p < .001, \text{partial } \eta^2 = .10$; a significant main effect for Diagnosis for the “Communication” subscale, $F(1,146) = 9.82, p < .01, \text{partial } \eta^2 = .06$; a significant main effect for Diagnosis for the “Problem Solving” subscale, $F(1,146) = 61.41, p < .001, \text{partial } \eta^2 = .30$; and no significant main effects for Diagnosis for the “Affective Responsiveness”, “Affective Involvement”, “Behavioral Control” and “General Functioning” subscales. The diagnosis main effect for Roles indicated that mothers of children with a learning disability had higher problems in efficacy with which family tasks were allocated and accomplished compared to mothers of children with diabetes. The diagnosis main effect for Communication indicated that mothers of children with a learning disability had lower effectiveness and directness of information exchange in the family compared to mothers of children with diabetes. Finally, the diagnosis main effect for Problem Solving indicated that mothers of children with a learning disability had higher problems in the family’s ability to resolve problems together compared to mothers of children with diabetes.

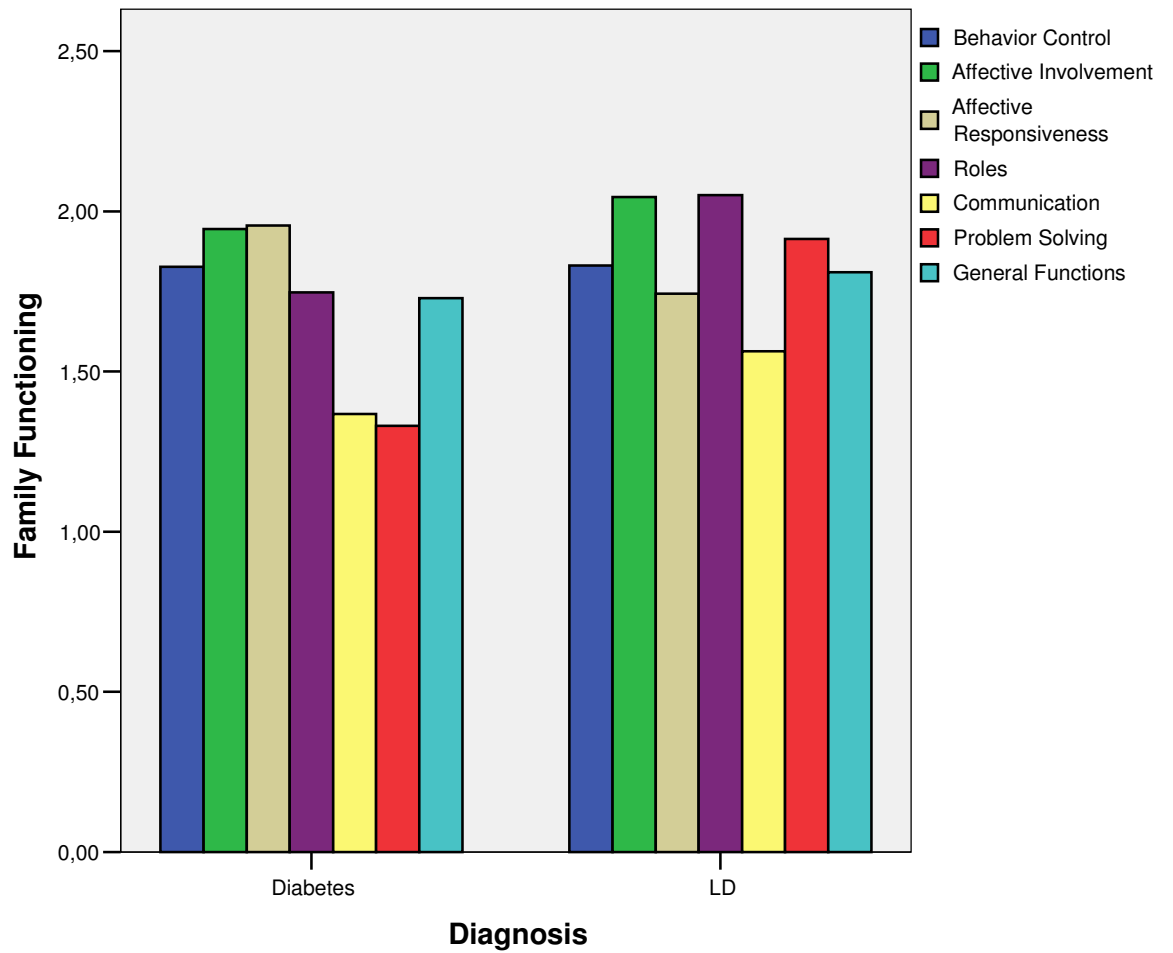


Figure 10 McMaster Family Assessment Device Subtests for the Mothers of Children of the Two Diagnostic Groups

3.4.4 Problem Solving

For the total sample, the internal reliability of the PSI as measured by coefficient alpha was found to be .87. Separate reliability analyses were conducted for the LD and Diabetes group, and alpha coefficients were found to be .85 and .87, respectively.

For the mothers of children with learning disorders PSI scores ranged from 56 to 139 ($M = 92.15$, $SD = 18.74$). For the mothers of children with diabetes, PSI scores ranged from 44 to 94 ($M = 74.76$, $SD = 20.21$).

A one-way analysis of covariance (ANCOVA) was conducted to evaluate the diagnosis differences (LD, diabetes) on the problem solving ability level of mothers. Thus, PSI scores were taken as the dependent variable and Diagnosis (LD, diabetes) of the child as the independent variable. The means and standard deviations for PSI as a function of the diagnosis are presented in Table 25. The ANCOVA indicated a significant main effect for Diagnosis, $F(1, 146) = 32.60$, $p < .001$, partial $\eta^2 = .18$. The diagnosis main effect indicated that mothers of children with a learning disability had higher perception of inability to solve problems compared to mothers of children with diabetes.

Table 25
Means and Standard Deviations for Problem Solving of Mothers as a Function of the Diagnosis their children received

Diagnostic Group	Mean	Std. Deviation	N
Mothers of diabetic children	74.76	20.21	70
Mothers of LD children	92.15	18.74	79
Total Group	83.98	21.24	149

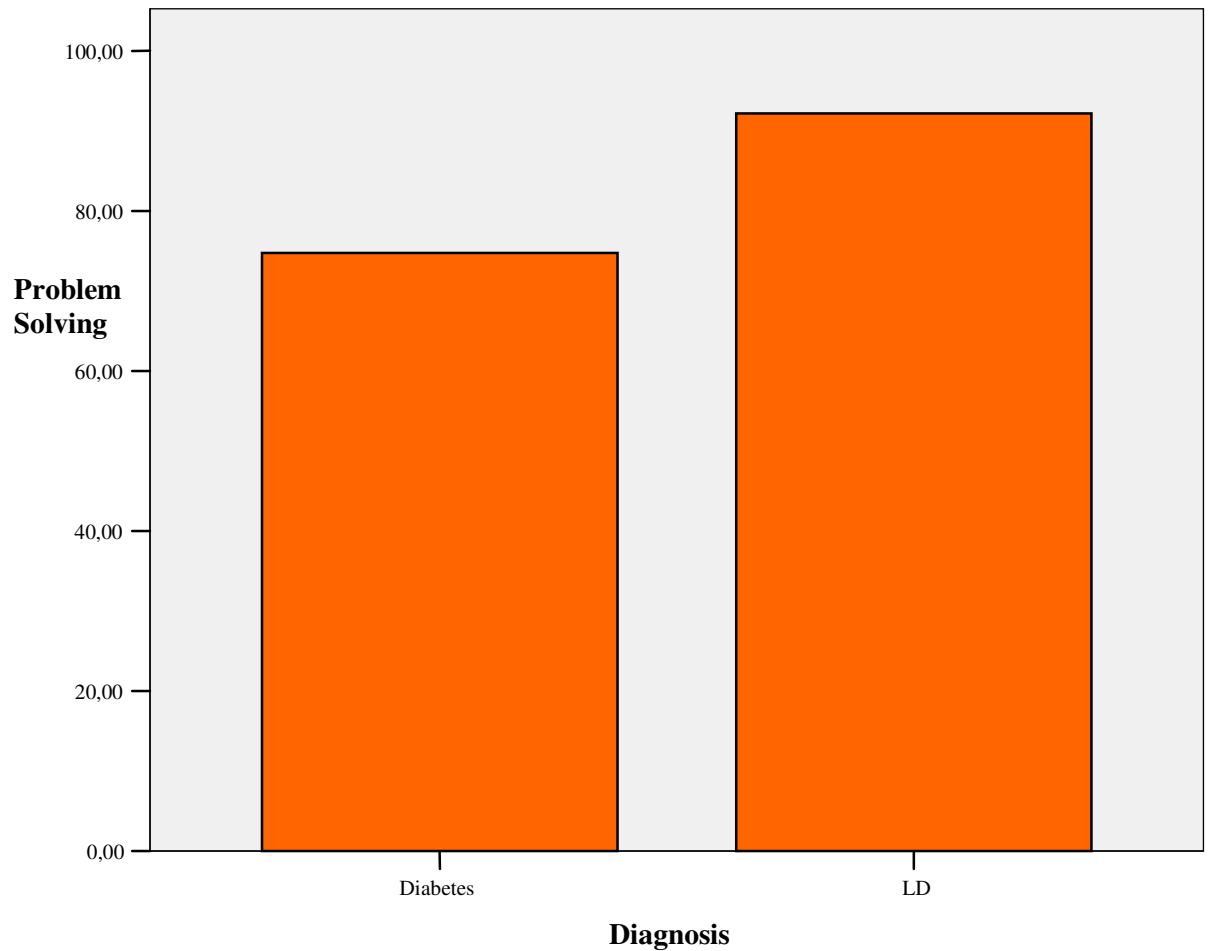


Figure 11 Problem Solving Levels for the Mothers of Children of the Two Diagnostic Groups

3.4.5 Ways of Coping

For the total sample, the internal reliability of the TWCI as measured by coefficient alpha was found to be .90. Separate reliability analyses were conducted for the LD and Diabetes group, and alpha coefficients were found to be .92 and .84, respectively. Internal reliabilities for the MMFAD subscales as measured by

coefficient alpha were found to have reliabilities of .86, .89, and .81 for Problem Focused Coping, Emotion Focused Coping, and Seeking Social Support: Indirect Coping Style for this sample. Separate reliability analyses were conducted for the LD and Diabetes group and alpha coefficients were found to be .83, .91, and .76 and .81, .89, and .80 respectively, for the Problem Focused Coping, Emotion Focused Coping, and Seeking Social Support: Indirect Coping Style subscales.

A multivariate analysis of covariance (MANCOVA) was conducted to evaluate the diagnosis differences (LD, diabetes) on the ways of coping of mothers. Thus, TWCI subtest scores were taken as the dependent variables (Emotion Focused Coping, Problem Focused Coping, and Seeking Social Support: Indirect Coping Style) and Diagnosis (LD, diabetes) of the child as the independent variable. The means and standard deviations for TWCI subtests as a function of the diagnosis are presented in Table 26. MANCOVA results indicated a significant Diagnosis main effect $F(3,144) = 8.52, p < .001, \text{partial } \eta^2 = .15$. Univariate analyses indicated a significant main effect for Diagnosis for the “Emotion Focused Coping” subscale, $F(1,146) = 16.38, p < .001, \text{partial } \eta^2 = .10$. The ANCOVA indicated no significant main effects for Diagnosis for the “Problem Solving” subscale, $F(1,146) = 2.45, p = \text{ns}, \text{partial } \eta^2 = .02$ and “Seeking Social Support: Indirect Coping Style” subscale, $F(1, 146) = 1.04, p = \text{ns}, \text{partial } \eta^2 = .01$. The diagnosis main effect for Emotion Focused Coping indicated that mothers of children with a learning disability had lower use of emotion focused coping style compared to mothers of children with diabetes.

Table 26

Means and Standard Deviations for Ways of Coping of Mothers as a Function of the Diagnosis their children received

Diagnostic Group	Mothers of diabetic children		Mothers of LD children		Difference Between Groups F (1,146)
	Mean	SD	Mean	SD	
Emotion Focused Coping	59.21	4.55	53.68	10.28	16.38*
Problem Focused Coping	87.66	12.39	90.85	9.28	2.45
Indirect Coping Style	35.47	3.32	34.80	4.28	1.04

* $p < .05$

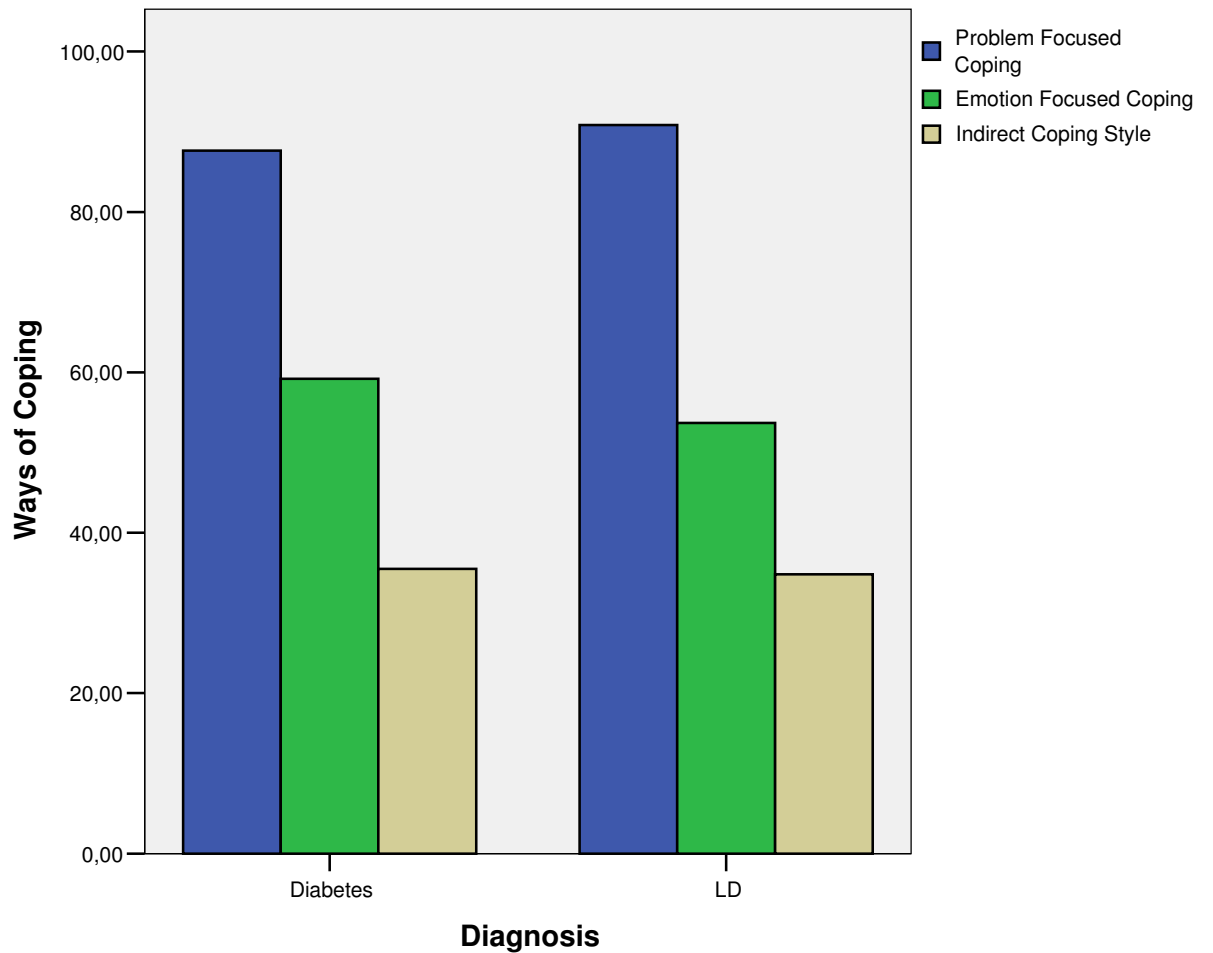


Figure 12 Ways of Coping for the Mothers of Children of the Two Diagnostic Groups

3.4.6 Parental Acceptance-Rejection

For the total sample, the internal reliability of the PARQ-Mother Form as measured by coefficient alpha was found to be .89. Separate reliability analyses were conducted for the LD and Diabetes group and alpha coefficients were found to be .89 and .86, respectively.

A one-way analysis of covariance (ANCOVA) was conducted to evaluate the diagnosis differences (LD, diabetes) on the parental acceptance-rejection as perceived by the mothers. Thus, PARQ-Mother Form total score was taken as the dependent variable and Diagnosis (LD, diabetes) of the child as the independent variable. In this analysis Age of the mother was taken as the covariate variable. The means and standard deviations for PARQ subtests as a function of the diagnosis are presented in Table 27.

Table 27
Means and Standard Deviations for Parental Rejection as perceived by mothers as a Function of the Diagnosis their children received

Diagnostic Group	Mean	Std. Deviation	N
Mothers of diabetic children	77.21	11.25	70
Mothers of LD children	92.11	14.64	79
Total Group	85.11	15.09	149

The ANCOVA indicated a significant main effect for Diagnosis for the “Parental Rejection Total score”, $F(1, 146) = 54.19, p < .001, \text{partial } \eta^2 = .27$. The diagnosis main effect on total parental rejection score indicated that mothers of children with a learning disability perceived higher levels of rejection towards their children compared to mothers of children with diabetes.

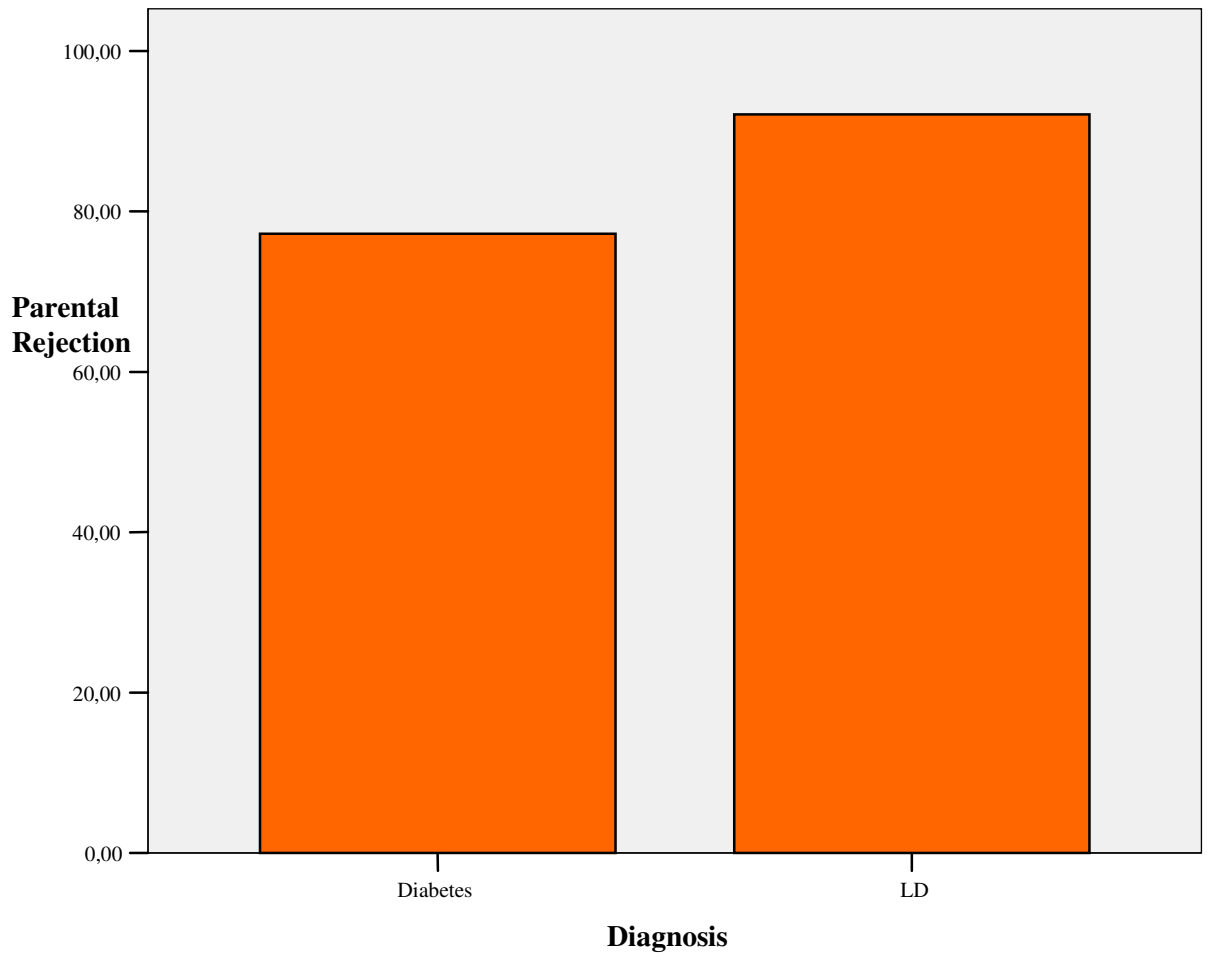


Figure 13 Parental Rejection Levels for the Mothers of Children of the Two Diagnostic Groups

3.4.7 Parental Burnout

For the total sample, the internal reliability of the MBI as measured by coefficient alpha was found to be .85. Separate reliability analyses were conducted for the LD and Diabetes group and alpha coefficients were found to be .82 and .89, respectively.

For the mothers of children with learning disorders MBI scores ranged from 5 to 44 (M = 21.28, SD = 8.80). For the mothers of children with diabetes, MBI scores ranged from 7 to 41 (M= 20.16, SD = 11.29).

A one-way analysis of covariance (ANCOVA) was conducted to evaluate the diagnosis differences (LD, diabetes) on the parental burnout level of mothers. Thus, MBI scores were taken as the dependent variable and Diagnosis (LD, diabetes) of the child as the independent variables. In this analysis Age of the mother was taken as the covariate variable. The means and standard deviations for MBI as a function of the diagnosis are presented in Table 28.

Table 28
Means and Standard Deviations for Parental Burnout Level of Mothers as a Function of the Diagnosis their children received

Diagnostic Group	Mean	Std. Deviation	N
Mothers of diabetic children	20.16	11.29	70
Mothers of LD children	21.28	8.80	79
Total Group	20.75	10.03	149

The ANCOVA indicated a significant main effect for Diagnosis, $F(1, 146) = 19.72$, $p < .001$, partial $\eta^2 = .12$. The diagnosis main effect indicated that mothers of children with a learning disability perceived higher parental burnout compared to mothers of children with diabetes.

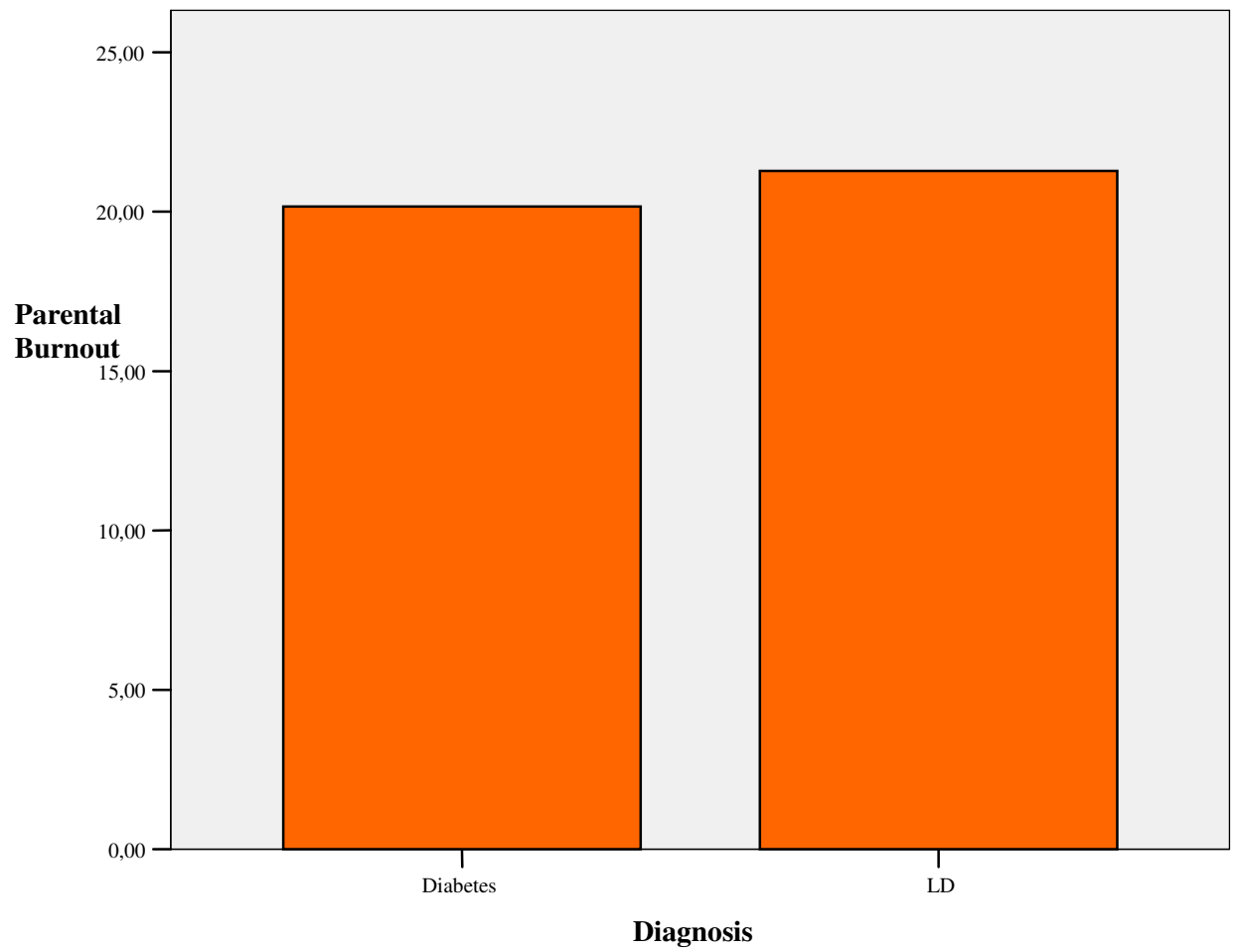


Figure 14 Parental Burnout Levels for the Mothers of Children of the Two Diagnostic Groups

3.5 Comparison of Pure LD to LD with Comorbid ADHD

In this section separate ANOVA's were conducted in order to compare children with pure LD and their mothers, without any comorbid disorder ($n = 62$) to LD children having ADHD as a comorbid disorder and their mothers ($n = 32$) on the basis of their psychological adjustment levels.

3.5.1 Comparison of Pure LD Children to LD Children with Comorbid ADHD

In order to compare the children with pure LD, that is without any comorbid disorder ($n = 62$) to LD children having ADHD as a comorbid disorder ($n = 32$), separate one-way analyses of variance analyses were conducted. These two groups were compared on the basis of their psychological adjustment levels, namely learned helplessness, parental rejection levels, depression, anxiety, and self-esteem. Thus, in these analyses, the dependent variable was the related psychological adjustment level (i.e., learned helplessness, parental rejection levels, depression, anxiety and self-esteem respectively), and the independent variable was the diagnostic group (LD vs. LD-ADHD). None of the ANOVA's were significant, indicating no significant differences between the children with LD and LD-ADHD in terms of these psychological adjustment levels.

3.5.2 Comparison of the Mothers of Pure LD Children to the Mothers of LD Children with Comorbid ADHD

In order to compare the mothers of children with pure LD, that is without any comorbid disorder ($n = 62$) to the mothers of LD children having ADHD as a comorbid disorder ($n = 32$), separate one-way analyses of variance analyses were conducted. These two groups were compared on the basis of their psychological adjustment levels, namely depression, anxiety, family functioning, problem solving, ways of coping, and parental rejection as perceived by the mother. Thus, in these analyses, the dependent variable was the related psychological adjustment level (i.e., BDI score, TAI score, MMFAD subtest scores, PSI score, TWCI subtest scores, and PARQ-Mother Form scores, respectively), and the independent variable was the diagnostic group (LD vs. LD-ADHD). None of the ANOVA's were significant, indicating no significant differences between the mothers of children with LD and LD-ADHD in terms of these psychological adjustment levels.

CHAPTER IV

DISCUSSION

This study aimed to investigate the relations between self-esteem, parental rejection, learned helplessness, anxiety and depression in children with learning disabilities. Since it has previously been shown that LD children are prone to higher emotional dysfunction it was aimed to compare this population with another population which is known to have emotional difficulties due to the chronicity of their condition. Thus the diabetes population was chosen as a comparison group of the study variables. Therefore another aim was to examine the group differences of psychological adjustment between children with LD and diabetes in terms of self-esteem, depression, anxiety, learned helplessness, and parental-acceptance-rejection. Furthermore, differences between mothers who have children with learning disabilities and those who have children with diabetes were examined in terms of their adjustment levels (i.e., depression, anxiety, family functioning, coping, problem solving abilities, parental burnout and expressed levels of parental acceptance-rejection).

4.1 Psychological Adjustment of Children with Learning Disabilities

All individuals with LD experience mildly elevated social and emotional problems and a small group of individuals with LD may experience serious psychosocial difficulties (Greenham, 1999). This study is in line with previous

findings showing psychosocial difficulties in children with LD. The female-male ratio for LD children in this study (1:2) is in line with previous studies' ratios (Kistner et al, 1985; Valas, 2001b). In a study it was found that LD males were disproportionately male, in other words it was twice the number of females (Svetaz, Ireland, Blum, 2000).

Studies have found that there is a positive developmental bias on young children's self-appraisals (Benenson & Dweck, 1986; Priel & Leshem, 1990; Stipek, 1981). Research has shown that accuracy of judgment increases with age (Benenson & Dweck, 1986), in other words children before the ages of 8 or 9 have a tendency to overrate their competence. Thus, in the analyses conducted for this study, age was taken as a covariate in order to control for possible confounding effects.

4.1.1 Self Esteem

Studies focusing on the self-esteem of children with LD are inconclusive. This study indicated that children with a learning disability have lower self-esteem scores compared to children with diabetes. This study adds to the growing literature stressing low self-concept of the LD children (Ayres, Cooley, & Dunn, 1990; Hiebert, Wong & Hunter, 1982; Kistner & Osborne, 1987; LaGreca & Stone, 1990; Rogers & Sakolfske, 1985, Valas, 2001b). This finding is also consistent with a recent meta-analysis that pointed out that around 70 % of children with LD exhibited negative global self-concept and low self-esteem (Kavale & Forness, 1996).

This study has found a low global self-concept in children with LD. It has been suggested in previous research that these children may rely upon other sources

of self-concept such as positive teacher feedback instead of their academic competence (Bear & Minke, 1996). A study by Kloomok & Cosden (1994), showed that children with LD who received higher levels of social support from parents and friends reported higher global self-worth. Thus, providing children with LD with social support may be useful intervention strategy in order to increase self-esteem of these children.

In a study, it was found that children with learning difficulties who were integrated into mainstream schooling showed low levels of self-esteem (Crozier, Rees, Morris-Beattie & Bellin, 1999). The children in this study did not receive special education; they were all in mainstream schooling. Thus, they were most probably comparing themselves with their normally-achieving peers in the classroom. This is believed to increase the probability of the low self-esteem found in these children. Previous studies have found that children with LD who are educated in segregated units had a more positive sense of self compared to those educated in mainstream schools (Crozier et al., 1999; Humphrey, 2002). Humphrey (2002) suggested that children in mainstream schooling may be making unfair comparisons between themselves and their mainstream peers. If the children in this study had been receiving education in other classes designed for their individual needs, then they might have been able obtain a more positive sense of themselves. But this brings out issues of separating children with LD from their non-LD peers. Since children in mainstream schooling develop lower levels of self-esteem, perhaps these results show that teachers in mainstream schools who work with children with LD need to take precautions in order for this not to happen. They need to work on an

environment in which the children feel secure and appreciated so that they may form higher levels of self-esteem. Teachers may emphasize the strong points in every child. Thus, this may help in developing the beliefs in children that they also have a side to themselves that is strong and can be appreciated by important others such as peers, family members or teachers. Although it is beyond the scope of this study, a previous study by Humphrey (2002), pointed out that some of the features of dyslexia-friendly schools are multi-sensory teaching programs and the use of achievement, effort, and good behavior acknowledgment in a wide range of activities. Thus, dyslexia-friendly schools may facilitate the successful education for children with LD.

The school environment has an important part in the development of self-esteem. Usually, school is the first occasion in which children act independently and compare themselves with others (Winnie, Woodlands, & Wong, 1982). Since the school environment emphasizes social comparison through the use of grades and praise, children are faced with evaluation from the time they begin school. Previous research on LD students' perceived academic competence has found that social comparison processes play an important role. LD students have been found to perceive themselves as less academically competent as they move into the next grade if they compared themselves to their classmates (Renick & Harter, 1989). On the other hand, when these children compared their abilities with LD peers in their resource room they were found to have high perceptions of their academic competence. In another study it was found that social comparison seemed to be important in the self-perceptions of mildly handicapped children (Coleman, 1983).

Coleman's (1983) study showed that those mildly handicapped adolescents who were placed in a special classroom received higher scores on the Piers-Harris Self-Concept Scale (Piers & Harris, 1969) compared to those students who were placed in regular classrooms. Thus, studies have indicated that among children with LD, difficulties in specific areas of academic performance are generalized to overall negative academic self-perception (Butkowsky & Willows, 1980; Rogers & Saklofske, 1985; Winnie et al., 1982) and self-concept (Heyman, 1990). In a study by Heyman (1990), it was found that self-perception of learning disability was related to self-esteem. It was pointed out that this finding was in line with the literature on physical disabilities suggesting that self-esteem is related to acceptance of the handicap (Heyman, 1990). Thus, Heyman (1990) suggested that having a similar perception of learning disability may increase self-esteem in LD children. The findings suggest that self-perceptions play an important role in the future behaviors of these children. It was pointed out that self-perception of LD may have an effect on academic self-concept and self-esteem, and these factors then influence academic achievement (Heyman, 1990).

Through development, children tend to use social comparison processes more frequently. Previous studies have found that LD students' perceptions of competence in regular classrooms declined with grade level (Renick & Harter, 1989). Thus, when LD students compared their competencies with those of their classmates who were normal achievers, they became aware of the discrepancy between the performance of those peers and their own. A significant linear trend in LD students' perceptions of academic competence was found to decrease across

three groups of grade level, namely grades 3-4, 5-6 and 7-8. Also since academic competence and global self-worth are related (Renick & Harter, 1989), according to the previous findings regarding the downward trend of perception of competence, age was taken as a covariate in this study.

Academic achievement and self-worth have been found to be closely linked. In a study it was found that academic competence and global self-worth were significantly correlated (Renick & Harter, 1989). This result indicates that LD children's self-esteem is closely linked with their perceptions of academic achievement. Thus many LD children may be feeling poorly about themselves due to the difference between their academic performance and that of their peers. Although the difference was not found to be significant, LD students in middle school grades were found to show a higher relationship between academic competence and global self-worth compared to students in grades 3-6.

La Greca and Stone (1990) have found that compared to low achievers and average achievers, children with LD perceived themselves lower in global self-worth. This finding indicated that lower feelings of children with LD compared to their nondisabled classmates could not be considered only to be a function of the low achievement in LD, since non-LD low achievers received significantly higher scores on global self-worth. Even when these LD children were matched with their low achieving classmates, significant differences on social and personal functioning were found. Thus, it was concluded that the lower self-worth perceptions in LD children could not be due to low achievement only but peer rejection may also have played a part (La Greca & Stone, 1990). The findings related to lower self-esteem of

LD children is in line with the previous literature findings showing lower self-esteem patterns in LD children (Ayres, Cooley, & Dunn, 1990; Hiebert, Wong & Hunter, 1982; Kistner & Osborne, 1987; LaGreca & Stone, 1990; Rogers & Sakolfske, 1985, Valas, 2001b).

In a previous study, helplessness was found to be significantly related to psychological adjustment (self-esteem and depression) (Valas, 2001a). In this study it was hypothesized that self-esteem may act as a mediator between learned helplessness and depression. Consistent with the expectations, learned helplessness was found to be negatively associated with self-esteem scores. It was also found that, the learned helplessness-depression path was significantly mediated by self-esteem. Children who show helpless behaviors do not necessarily need to show depressive symptoms. Those children who also have self-esteem problems may show depressive symptoms. This finding further indicates the importance of self-esteem in psychological adjustment and the necessity to increase these children's self-esteem. The findings indicated no significant interaction between diagnosis and gender. This is in line with previous findings in which LD children were compared with their low achieving and average achieving peers and no significant interaction differences (genderXgroup) were found (La Greca & Stone, 1990; Kistner, Haskett, White, & Robbins, 1987).

In the present study, the gender main effect indicated that girls had lower self-esteem scores compared to boys. This finding is in line with the literature where girls report more negative self-concepts than boys (Kistner, Haskett, White, & Robbins, 1987; Margalit & Ronen, 1993; Woodward & Frank, 1988; Valas, 2001a).

4.1.2. Learned Helplessness

The diagnosis main effect indicated that children with a learning disability had higher scores on learned helplessness compared to children with diabetes. The findings in this study, related to more helplessness in LD children is in line with the previous literature findings showing more helpless behaviors in LD children (Butkowsky & Willows, 1980; Pearl, 1982; Pearl, Bryan & Donahue, 1980; Kistner, White, Haskett & Robbins, 1985; Valas, 2001b). The frequent failures experienced by these children may have led to the development of beliefs of helplessness as the theories on learned helplessness suggest (Weiner, 1979). The literature points out that, those helpless children perceive past success and failures as caused by external factors, that is, events outside their control, and they use less effort in new situations compared to children who think events are under their control. Helplessness was found to be significantly related to psychological adjustment (self-esteem and depression) (Valas, 2001a).

In studies examining the beliefs of learning disabled children it has been shown that they fit a learned helpless response pattern (Butkowsky & Willows, 1980; Pearl, 1982; Pearl, Bryan, & Donahue, 1980). Since these children have repeated school failures, the tendency to attribute failures to factors beyond their control may be natural. Yet it has been pointed out in previous research that some children with LD enter into a failure cycle in which their school problems lead them to doubt their abilities and expect failures (Kistner et al, 1985). Thus these beliefs may lead to less persistent attempts to master tasks which in turn, may increase the likelihood of continued failures (Kistner et al., 1985). Although research has shown

that LD children develop learned helplessness, there may be other explanations about the attributional differences of LD and normal children. In studies by Nicholls (1978, 1979) it was found that as the reasoning abilities of children increase, the information that is used to formulate causal explanations and the relationship between controllable and uncontrollable factors for achievement outcomes change. In another study by Frieze & Snyder (1980), it was found that as normal children grow older, there is an increase in their tendencies to attribute their failure to insufficient effort. The same pattern should be expected from LD children but the learned helplessness hypothesis points out that LD children will keep on attributing their failures to uncontrollable factors (i.e., "I am unable to be successful in my lessons") if some intervention is not provided to change their beliefs (Kistner et al., 1985). In studies examining the developmental patterns of attributions for LD boys and girls it was found that LD girls were more likely to maintain maladaptive attributions compared to boys as they grow older (Kistner et al., 1985). Also LD children were less likely to attribute their failure to insufficient effort and more likely to attribute failures to insufficient ability which is a factor beyond their control, compared to normally achieving children (Kistner et al., 1985). Girls of both normally achieving and LD children attributed their failures more to insufficient ability compared to boys. The findings in this study are consistent with the literature regarding learned helplessness response patterns in LD children compared to normal controls (Kistner et al., 1985).

This study did not find a gender difference regarding learned helplessness patterns in LD children. This finding is different from previous studies which have

found boys to have increased levels of learned helplessness compared to girls (Valas, 2001a). In this study it was found that girls with diabetes had higher levels of learned helplessness as compared to boys with diabetes. This is in line with the sex difference literature of normally achieving children regarding responses to failure (Kistner et al., 1985).

There were gender effects across groups in this study. Boys with diabetes had the lowest learned helplessness level compared to boys with LD and girls with diabetes. Girls with LD had a significantly higher learned helplessness level compared to girls with diabetes. Although diabetes is a chronic disease, this study has found that those children with diabetes had lower levels of learned helplessness. This may suggest that although diabetes is a chronic disease it does not lead to the development of learned helplessness, at least not as much as children with learning disabilities.

The LD children showed learned helplessness behaviors. Since helpless children perceive past success and failures as caused by external factors, that is, events outside their control, they tend to use less effort than it will be helpful to teach these children to attribute their failures to a controllable cause of insufficient effort. Previous studies on attribution and self-control training, combined with success experiences have resulted in increased motivation and improved performance for helpless children (Dweck, 1975; Licht, Kistner, Özkaragöz, Shapiro, & Clausen, 1985; Reid & Borkowski, 1987).

4.1.3 Parental Acceptance-Rejection

Parental acceptance is necessary for the development of a positive self-concept (Rosenthal, 1973). This study showed that children with a learning disability perceived higher levels of rejection from their mothers compared to children with diabetes.

It was hypothesized that self-esteem may act as a mediator between parental (acceptance) rejection and depression. The hypothesis that parental rejection would be associated with low level of self-esteem was verified in this study. Consistent with the expectations, parental rejection was found to be negatively associated with self-esteem scores. In other words, this study showed that parental rejection-depression path was significantly mediated by self-esteem indicating that parental rejection does not directly lead to depression but it is changed by the presence of self-esteem. Studies attempting to identify risk factors for the development of low self-esteem have focused on parenting. In previous studies, parenting has been implicated as a risk factor for the development of childhood low self-esteem and results from studies also suggest that low self-esteem is predictive of a later depressive episode (Rohner, 1986).

Girls with LD and boys with LD did not differ significantly on levels of perceived parental rejection. Boys with LD had higher levels of perceived parental rejection compared to boys with diabetes. Girls with LD and girls with diabetes did not differ significantly on levels perceived parental rejection. Girls with diabetes had higher levels of perceived parental rejection than boys with diabetes.

4.1.4 Depression

In this study, the mean score for CDI for children with LD was found as 13.97. This mean is higher than the mean reported by Kovacs (M= 9.27; 1980/81). The mean found in this study is also above the cut-off score of 11 suggested by Kovacs (1980/81) as an index for mild depression. In the sample of children with LD 51.9 % (41 children) may be considered mildly depressed according to the standard of Kovacs (1980/81) who suggested a cut-off score of 11 as an index of mild depression. The cut-off for severe depression suggested by Kovacs (1980/81) is 19. In the sample of LD children 21.5 % (17 children) met this cut-off, this is higher than the 10 % of children in Kovacs' nondisabled sample. The scores found in this study are in line with previous studies finding higher depression levels in children with LD (Goldstein, Paul & Sanfilippo-Cohn, 1985). In their study of 85 LD children, Goldstein, Paul and Sanfilippo-Cohn (1985) found that 61 % (52 children) of their sample were mildly depressed according to the standard suggested by Kovacs (1980/81). In their study a similar mean of depression (M= 13.78, N=85) to the one found in this study (M= 13.97) was obtained. Again a similar finding was found for severely depressed children with LD in their sample. According to the cut-off suggested by Kovacs (1980/81) as an index for severe depression (19), they found that 26 % (21 children) of their sample met this criterion (Goldstein, Paul & Sanfilippo-Cohn, 1985). The percentage of children found to be mildly and severely depressed in this study is very similar to the percentages in the study reported by Goldstein, Paul and Sanfilippo-Cohn (1985). Thus, this study provides further

evidence that children with LD have depressive symptomatology compared to other populations.

The diagnosis main effect for depression indicated that children with a learning disability had higher levels of depressive symptomatology ($M = 14.15$) compared to children with diabetes ($M = 7.41$). This finding is in line with the literature that mean depression scores for children and adolescents with LD are significantly higher than normative populations (Goldstein, Paul & Sanfilippo-Cohn, 1985; McConaughy & Ritter, 1985; McConaughy et al., 1994; Wright-Strawderman, & Watson, 1992) and normally-achieving controls (Rodriguez & Routh, 1989). CDI scores of 11 have been previously mentioned to represent mild levels of depression (Kaslow, Rehm, & Siegel, 1984). The scores in this study were found to be in the mild range for children with LD, which is in line with current literature. Previous studies have found that mean CDI scores of children with LD were found to change through 10.6 to 15, which is a mild range (Goldstein et al., 1985; Rodriguez & Routh, 1989; Stevenson & Romney, 1984; Wright-Strawderman & Watson, 1992). In studies by Fuerst and Rourke (1993, 1995) it was found that 14 % of the parents of children with LD was mentioned that they were concerned about mild anxiety or mild depression in their children. On the other hand, 40 % of the children with LD showed profiles indicating clinically significant psychosocial disturbance. Thus, the findings in this study, related to more depressive tendencies in LD children is in line with the previous literature findings showing depressive symptoms in LD children (Brumback & Staton, 1983; Heath, & Wiener, 1996; Howard & Shick Tryon, 2002;

Huntington, & Bender, 1993; Palladino, Poli, Masi, & Marcheschi, 2000; Wright-Strawderman, & Watson, 1992; Valas, 2001b).

Using a continuous measure of depressive symptomatology, the strong negative correlation between CDI and the Piers Harris Self-Esteem Inventory in the study group is compatible with hypotheses regarding self-esteem and mood (Orvaschel, Beeferman, & Kabacoff, 1997). Thus, the greater the severity of depressive symptoms reported by these children, the lower their reports of self-concept.

Self-concept appears to provide an important area for intervention efforts as well. Improvements in self-esteem of children with LD will have beneficial effects on the overall mood of these children. Also if poor self-esteem is a precursor to mood disorder, then primary prevention strategies that target improving these children's sense of worth would reduce the prevalence of depression in children with LD.

Gender differences in this study indicated that girls had higher depression levels compared to boys. The finding that girls report higher depression scores compared to boys is in line with the previous literature on depression in children (Brage & Meredith, 1994; Valas, 2001a).

Group by gender investigations showed that girls and boys with LD did not differ significantly on levels of depressive symptoms. This finding is in line with the previous findings which did not find any gender differences in children with LD (Goldstein, Paul & Sanfilippo-Cohn, 1985). Girls with diabetes, on the other hand, had higher levels of depressive symptoms compared to boys who had the same

disease. Boys and girls with LD had higher levels of depressive symptoms compared to boys and girls with diabetes.

Thus, the above findings show that although diabetes is a chronic disease, the effects on children's moods are not as negative on these children as the effects of learning disabilities are on children diagnosed as having LD.

4.1.5 Anxiety

This study showed that children with a learning disability had higher levels of anxiety compared to children with diabetes. This finding is in line with other findings stressing the increased symptoms of anxiety in children with LD (Greenham, 1999). Children with LD report significantly higher levels of anxiety levels compared to normative populations and normally achieving controls (Paget & Reynolds, 1984; Fisher, Allen & Kose, 1996; Rodriguez & Routh, 1989). Thus, this study is in line with studies reporting higher levels of anxiety in LD children compared to their non-LD peers (Margalit & Shulman, 1986). Some studies have also reported that anxiety is related to maladaptive attributions and depression in LD children (Rodriguez & Routh, 1989). In a study by Dyson (2003), it was found that there was a significant difference between children with LD and their non-LD siblings in social competence and anxiety. Children with LD were found to have increased anxiety compared to their siblings.

The gender main effect indicated that girls had higher anxiety levels compared to boys. Studies with anxiety and gender differences show that females report significantly higher levels of anxiety compared to males (Özusta, 1993; Anderson, Williams, McGee & Silva, 1987; Bell-Dolan, Last, & Strauss, 1990;

Dong, Yang, & Ollendick 1994; Last, Hersen, Kazdin, Finkelstein & Strauss, 1987; Varol, 1990).

In this study, there was no gender differences found for children with LD on levels of anxiety symptoms, on the other hand gender differences were present for children with diabetes in that girls with diabetes had higher levels of anxiety symptoms than boys.

Boys with LD had higher levels of anxiety symptoms compared to boys with diabetes. Girls with LD and girls with diabetes did not differ significantly on levels of anxiety symptoms ($M = 38.85$ and 38.07 , respectively) yet these levels of anxiety were both high compared to previous findings of girls in the normative populations in Turkey (Özusta, 1993). In a study comparing LD children with their low and average achieving peers, it was found that LD girls reported higher anxiety levels compared to their low or average achieving peers (La Greca & Stone, 1990).

4.2 Depression and Anxiety in Children with LD and Diabetes

This study indicated that, children's low self esteem scores, and their perception of parental rejection significantly associated with children's depressive symptoms. This finding is in line with a meta-analysis assessing perceived parental acceptance-rejection which was associated with psychological maladjustment among children regardless of differences in gender, race, geography, language or culture (Khaleque & Rohner, 2002). The finding that low self-esteem is significantly associated with depressive symptoms is in line with previous studies regarding self-esteem and mood (Orvaschel, Beeferman, & Kabacoff, 1997; Rohner, 1986). Also mothers' use of lower emotional coping styles and depressive symptoms in the

mothers of these children significantly associated with children's depressive symptoms.

Another interest of research for this study was the variables associated with the symptoms of anxiety in children with learning disabilities. It was found that younger age in the father, higher anxiety in mothers' and children's low self esteem scores were significantly associated with children's anxiety symptoms. This finding is in line with the findings of a meta-analysis of 34 studies comparing self-reported personality characteristics of children and adolescents with and without LD, it was found that students with LD reported more negatively on the factors of self-esteem and anxiety compared to other students (Thompson, 1992).

In some studies, children with diabetes were shown to have increased anxiety, low self-esteem and depressive symptoms more than healthy children (Swift, Seidman & Stein, 1967; Close, Davies, Price, & Goodyer, 1986). In this study it was found that older females had more risk of depressive symptoms. Having lower self esteem and higher learned helplessness scores also had significant associations with the depressive symptoms of children with diabetes. Depressive symptoms in diabetic children were also significantly associated with higher problem-focused and emotional coping and lower indirect coping styles in the mothers.

On the other hand, anxiety symptoms were higher in older females, with lower education in the father and younger age of the mother in diabetic children. Higher parental rejection as perceived by the child was also found to be associated with children's anxiety symptoms. This finding is in line with a meta-analysis

showing perceived parental acceptance-rejection to be associated with psychological maladjustment among children (Khaleque & Rohner, 2002). Higher use of emotional coping styles by mothers was also found to be significantly associated with children's anxiety symptoms.

4.3 Psychological Adjustment of Mothers

Raising a child is not an easy task. When a child has a chronic disease like diabetes or a lifetime disorder like a learning disability, a mother's job is harder. previous studies have found that mothers of children who are diagnosed with chronic illness or psychiatric disorders, have psychological adjustment problems. In this study it was aimed to investigate the nature of these problems for mothers.

4.3.1 Depression and Anxiety

In this study it was found that mothers of children with a learning disability had higher depression and trait anxiety scores compared to mothers of children with diabetes. These findings are in line with the literature on mothers of children with disabilities. In a study on parenting stress in mothers of children with mental handicaps, it was found that mothers of these children were significantly more stressed compared mothers of non-handicapped children (Pearson & Chan, 1993). In a study with the parents of 25 dyslexic children it was found that all the parents attending the study reported experiencing a high degree of parental stress (Bull, 2003).

Pearson & Chan (1993) also found that mothers of children with mental handicaps received less emotional support from significant others compared to the control group. Mothers of these children received less social recognition and

empathy. Support from friends and colleagues were also found to be significantly lower than the control group. On the other hand, extended family members provided more support to these mothers in the study group compared to their friends or colleagues. It was concluded that family members may be more accepting of a mental handicap compared to non-family others. Although social support has not been considered in this study, the literature on social support and stress emphasizes that increased support from significant others, either buffers stress or increases the overall well-being (Cohen & Willis, 1985). In practice, fathers are reluctant to accept a diagnosis such as “mental handicap” or “learning difficulty” for their child. Thus, fathers who do not accept a diagnosis for their child will not support mothers, which may cause increased stress and anxiety in the mothers. Also the issue of stigmatization is believed to increase depression and anxiety in mothers. Families are usually reluctant to acknowledge that their child has a handicap (Pearson & Chan, 1993). Thus, the same may be true of parents of children with LD. In communications with parents, it is not uncommon for them to try to hide their child’s situation from their friends and from those teachers in the child’s extracurricular activities. Further studies with the mothers of these children should take into account the effect of support or lack of it on these mothers.

4.3.2 Family Functions

Previous studies on the family factors of children with LD indicated that these children have family problems. In this study it was found that mothers of children with a learning disability had higher problems in efficacy with which family tasks were allocated and accomplished compared to mothers of children with

diabetes. Another finding of the current study was that mothers of children with a learning disability had lower effectiveness and directness of information exchange in the family compared to mothers of children with diabetes. Also mothers of children with a learning disability had higher problems in the family's ability to resolve problems together, compared to mothers of children with diabetes.

In a study of the comparison of children with and without LD on family background it was found that children with LD lack educational stimulation at home, moreover overall family difficulties and economic difficulties were three times higher among the families of children with LD (Toro, Weissberg, Guare, & Liebenstein, 1990). In this study, mothers of LD children were having difficulties in the allocation of family tasks, communication in the family, and ability to resolve problems together as a family compared to mothers of children with diabetes. Thus, some of the problems that these children are faced in psychosocial areas may be due to the inadequacies in the home environment. Whether these familial problems are the cause or the effect of the problems of these children is beyond the scope of this study and should be assessed in further studies. Yet, the results indicate a practical need to involve the families of these children in the treatment plan. Interventions aimed at enhancing maternal psychological resources may reduce the likelihood of distress in mothers of children with chronic illness.

4.3.3 Problem Solving and Coping

In this study it was found that mothers of children with a learning disability had higher perception of inability to solve problems compared to mothers of children with diabetes. Another finding of the current study was that mothers of

children with a learning disability had lower use of emotion focused coping style compared to mothers of children with diabetes. In a study where differences in strategies used by mothers and fathers ($n = 60$) in coping with their child's insulin-dependent diabetes mellitus, The Ways of Coping Questionnaire (WCQ) was administered during a home interview. Results showed that both parents used planful problem solving, exercised positive reappraisal, and sought social support frequently, with mothers using more planful problem-solving strategies than fathers. Within the family, analyses showed that mothers were more likely to frequently use all the coping strategies when the child was a girl (Azar & Solomon, 2001). In a study of 25 dyslexic children's parents who were attending a support group, it was found that the primary reason for attending a support group was due to a feeling of not coping with their experience of raising a child with dyslexia (Bull, 2003). Ability to solve problems quickly and effectively as well as coping with problems is two important aspects of parenting. Obviously parenting a child with a disability is harder than parenting a child who has no social or academic problems in school. Thus the results of this study indicate that these parents who have children that are faced with problems in many areas of social and everyday life including school, are in need of a through counseling regarding their problem solving abilities and coping styles.

4.3.4 Parental Acceptance-Rejection and Burnout

This study showed that mothers of children with a learning disability perceived higher levels of rejection towards their children compared to mothers of children with diabetes. In a study by Ansari (2002) comparing mothers' and fathers'

rejection levels of physically and mentally handicapped children, it was found that fathers were more warm and accepting as compared to the mothers who were more rejecting. According to Ansari (2002), this rejection may be because of the perceived biological link between mothers and their children. Since mothers share more responsibility in the upbringing of children, when children have some problems, mothers may experience a sense of failure.

This study shows that parental acceptance was higher in parents of children with diabetes. This finding is in line with previous findings showing that parents show more warmth and less rejection towards their physically handicapped children compared to their children with mental retardation or their non-disabled children (Ansari, 2002). The major factor determining the attitude of the parents was the visibility or the explanation of the handicap (Ansari, 2002). When the problem was attributed to a physical illness the parents felt more comfortable and accepted the condition. Thus, children with mental handicaps were treated less warmly. In another study, it was found that tradition-based communities reported more positive attitudes toward disability compared to modernized communities (Reiter, Mari, & Rosenberg, 1986). In another study it was found that mothers of mentally handicapped children reported greater “social burden” compared to mothers of physically handicapped children (Tangri & Verma, 1992).

The findings of this study indicated that mothers of children with a learning disability perceived higher parental burnout compared to mothers of children with diabetes. In a previous study comparing parents of children with LD and non-LD it was found those parents of children with LD and who also had behavior problems

felt more stressed trying to meet the needs of their child and also try to maintain familial and personal responsibilities (Lardieri, Blacher, & Swanson, 2000). Thus, the findings in this study are consistent with the literature suggesting that parents of children with disabilities may show stress and emotional strains due to their care demands (Daniels-Mohring, & Lambie, 1993; Dyson, 1993; Waggoner, & Wilgosh, 1990).

According to the findings it is suggested that a supportive home environment in which parents are psychologically healthier and adjusted, may help improve the psychological adjustment of these children.

4.4 Implications of the Current Study

The above findings in this study have some implications for practical use. Thus, in this section these practical implications will be discussed.

4.4.1 Treatment Needs of Children with Learning Disabilities

When the treatment needs of LD children are considered a general view of multimodal treatment approach is pointed out in which education and consultation seems necessary (AACAP Official Action, 1998). In the AACAP Official Action (1998), it was pointed out that the clinician may not be involved for providing direct treatment for the LD, but if there were secondary emotional, behavioral problems or other psychiatric diagnosis, then the clinician is meant to determine interventions such as therapy, psychosocial interventions or medication as needed. It was also recommended that group or individual psychotherapy may be used for low self-esteem that results from underachievement. It was suggested that psychotherapy be tailored to the child's specific deficits. The majority of children in this study were in

need of psychotherapy due to depressive symptoms, anxiety, and self-esteem problems. As mentioned earlier these symptoms may worsen children's ability to adjust to the school environment and "fit in", thus making the above mentioned symptoms even worse. Therefore, therapy for children with internalizing symptoms is extremely important. Also improvements in self-esteem of children with LD will have beneficial effects on the overall mood of these children. Thus as mentioned earlier, primary prevention strategies that target improving these children's sense of worth may help in reducing the prevalence of depression in these children.

The goal of treatment of the child should be minimizing the difficulties and maximizing the child's potential by providing the child with problem-solving and study skills, encouragement in extracurricular activities, help with career decisions and social support (AACAP Official Action, 1998). In a study it was found that referral to appropriate support groups for children with LD would be an appropriate intervention (Falik, 1995).

In order to help the family to develop a supportive home environment, supporting the parents and consultation may be necessary. It was suggested in the AACAP Official Action (1998), that both parents and teachers should be provided with help to understand the child's problem so that they do not perceive the child as stubborn, lazy, oppositional or slow. At this stage, the clinician may have an educational and monitoring role (Forness & Kavale, 1989) in which the clinician should collaborate with the school personnel as well as educate parents and children about LD. This study has underlined the importance of educating the parents about possible parental rejection towards the child and the effect this may have on the self-

esteem, depression and anxiety levels in children. Until the diagnosis of learning disability is given to their child, parents tend to think that their child is “lazy”, “stubborn”, or “unwilling to study or go to school”. Thus, these parents are frustrated with their children and usually feelings of helplessness and anger toward their child is present. Through education of the parent these symptoms may improve, as well as the depression, anxiety and parental burnout that these parents are faced with in dealing with their learning disabled child.

4.4.2 Training Psychiatrists and Psychologists to Recognize Learning Disabilities

In Turkey, children are often sent to child psychiatry clinics and hospitals by teachers who think “there is something wrong with the child.” Since this disorder is very common in child psychiatric populations it is very important for those working with children to be able to recognize a child with a learning disability in order to give the necessary remediation for the problem. Psychiatrists receive extensive training in the diagnosis and treatment of psychiatric disorders, but in many training programs, the significant psychiatric comorbidity of learning disabilities receives minimal attention (Sundheim & Voeller, 2004). In a survey of 22 psychiatric educators, only 2 respondents felt that familiarity with communicative disorders was an essential part of residency training (Bowden, Humphrey, & Thompson, 1980). Although the presence of learning disorders has been well established since the early 1990s, the recognition and treatment of learning and the comorbid disorders still represent an area of weakness in the training of most child and adolescent psychiatrists (Sundheim & Voeller, 2004). Once the learning difficulties are

recognized in a child and the issues are worked through as part of treatment, the psychiatrist understands how a learning disability contributes to the child's clinical picture. This study sheds light for the clinicians working with these children by showing that parents and children with LD both have psychological adjustment problems. Yet in Turkey, the diagnosis of learning disability is still not well known by psychiatrists, psychologists, teachers or parents. Thus, training those clinicians working with children is an important aim in order to diagnose and treat these children as early as possible.

4.4.3 Helping Parents and Children Cope with Learning Disability

Learning disability has a significant impact on children's development. The effects of learning disabilities must be recognized by parents and teachers and measures should be taken to reduce this impact.

In order to help their child, parents need to come to terms cognitively and emotionally with the realities of their child's learning disability and associated behavioral problems. They also need to deal with learning or behavior problems that they might have themselves. Although understanding that there is something different about their child might have begun long before they started evaluation and treatment, the formal diagnostic process often heightens the need to acknowledge the child's situation from a new perspective. Some parents must face their own learning problems from a different perspective and deal with their feelings of anger, guilt and sadness. They might remember their own childhood experiences and the helplessness it brought. For other parents, who do not have a learning disorder, it can be a challenge to comprehend their child's disability and the need for intensive

intervention. Convincing that this is a real diagnosis and that effective treatment is available means that the professionals working with them need to help them confront their pain and denial in a way that helps treatment.

When they recognize that their child has a learning problem, parents may respond in different ways. Some parents minimize the problem and make the assumption that the child's learning disability will be dealt with by special education services in the school. However, although special education might stabilize academic achievement, it is unlikely that children will receive services that will remediate their skills (Mattison, Hooper, & Glassberg, 2002; Alexander & Slinger-Constant, 2004; Schatschneider, & Torgesen, 2004). Some parents of children with learning problems and significant behavioral problems assume that these problems will diminish with age. Yet this is a rare situation. Parents must decide if they have the financial and emotional resources to provide intensive remediation services to their children other than what they receive in school. Some parents respond by becoming extremely protective of their child and demand special interventions and accommodations. They might minimize the child's responsibility or demand that the child should not be required to perform to the standard of peers. But these interventions do not prepare the child for "real life," and they communicate to the child that he or she is "different" and is impaired so that special interventions are required. These kinds of reactions can initiate maladaptive behaviors that may last a lifetime. The former does not help the child develop appropriate behavioral strategies and the latter does not support the child in later success once school is finished. Both can lead to a feeling of being damaged and support in the denial of

the problem. Children must be taught how to work out their difficulties. Successful adults do not deny their difficulties, they are aware of their problems and are able to anticipate workloads and schedule adequate time and use other strategies that effectively help them to perform to the standard of their peers. Children with learning disabilities develop ways of coping with the emotional impact of these disabilities before entering school. However, once the child is in school, the child quickly becomes aware of the fact that certain tasks, which seem easy for peers, are extremely difficult. Although children might deny the problem they may also be troubled by the implications of their diagnoses and being helped may also trouble them since this may show that they are really different. The diagnosis may not have been explained clearly to them. Even if the initial explanation of the diagnosis was made clearly, it may be better to talk over this issue with the parents and child in order to help them acknowledge the diagnoses at a pace appropriate for the child and family. This may include processing the experience of the individual and other family members, the prognosis, and providing information as a necessary part of coming to terms with any diagnosis. It will not be helpful to talk about "dyslexia," "dysgraphia," or general concepts such as "learning disability". It is more helpful to the child to openly discuss the specific problem that is the result of the learning disability and emphasize the child's strengths.

Parents need to be aware of the high prevalence of learning disorders in children with behavioral disorders, and they should not attribute academic underachievement to behavioral problems. Mattison and colleagues studied a group of 8-year-old children attending a classroom for "behavioral disorders", namely,

ADHD, conduct or oppositional disorders, and depressive disorders (Mattison, Hooper, Glassberg, 2002). These children received special education services and behavioral modification programs in structured classrooms. There were 81 subjects and 52 (64.2%) met the diagnostic criteria for learning disability. Although they received special education services 61.7% of the subjects continued to meet the diagnostic criteria for LD when tested 3 years later at age 11 years. Also the Wechsler Verbal and Full Scale IQ scores of the LD children dropped significantly over that 3-year period. The authors mentioned that clinicians and special educators should not "assume that the academic performance of students with emotional-behavioral disorders is primarily related to their psychopathology and overlook the role of comorbid learning disability."

Thus, families should be assessed and provided with interventions to help them develop coping skills as soon as possible after diagnosis. Simple skills such as recognizing and treating must be taught earlier. Early diagnosis and intervention prevent problems from growing (Engel, 1997). All interventions must be designed with age-appropriate developmental capabilities and intellectual capacities in mind. Clinicians must always be aware that, in the absence of healthy coping strategies for family members and young patients with LD, the potential for psychological problems is great as put forth in the findings of this study. Dysfunctional families are far less likely to develop healthy coping strategies. Professionals who learn to observe patients' coping strategies and educate those at risk may find the outcome to be an increase of healthy coping choices.

In many cultures, as in Turkey, it is difficult for fathers to be involved because chronic diseases or disabilities are considered marks of imperfect children. Usually fathers deny the fact that there is something “wrong” with their child. They prefer to call their child as “naughty, lazy or uninterested in going to school”, they also mention that they were also like this when they were a child. Perhaps these parents were also suffering from LD as a child. Thus, the diagnosis of LD must be explained in detail to both mothers and fathers. Sometimes, mothers bring their child in secrecy, not telling the father they are going to see a doctor related to the child’s psychological difficulties. This must be avoided by the clinician. In order to help the child full collaboration from both parents is necessary. To achieve this goal, the clinician working with the family must ask both parents to be present in their meetings. Also, societal education and time are helpful ways to change these traditional beliefs.

This study has shown that parents who have children with LD may have depressive symptoms, anxiety, rejection towards their child, and ineffective coping and problem solving abilities. In order to share feelings and receive help and because unity brings strength, family members of children with LD should be encouraged to join organizations that support themselves. Previous research on the effectiveness of support groups for a broad range of conditions has shown that the functions of these groups are meeting social support, practical information, and self-advocacy needs of group participants (King, Stewart, King, & Law, 2000). Although from a cognitive-behavioral perspective, support groups may not always be encouraged due to the thought that they may reinforce the “disabled” role among

participants and may promote learned helplessness in the group members (Bull, 2003). Yet studies have found that in practice support groups may lead to an improvement in psychological and physical well-being (Subramaniam, Stewart & Smith, 1999). Previous studies have found that some of the benefits of support groups for parents may be emotional exchange, validation of experience, educational information and discussion and coping strategies (Toseland, Rossiter, Peck & Hill, 1990). In a study in which parents of dyslexic children attended a support group, participants felt that it raised their personal awareness of others experiencing the same kinds of difficulties with their children (Bull, 2003). Clinicians can educate families about the types of services specific organizations promote. These contacts can also afford families an opportunity for social support and relieve their feelings of isolation. Finally, such groups can be strong advocates for research funding and for services necessary to improve the quality of life for children with LD and their families.

4.4.4 Child Based Implications

The results of this current study add to the growing literature that suggests children with LD to have multiple problems regarding the psychosocial problems these children are faced with. In this section a number of suggestions will be presented that can be used in practice. The issues that will be presented in this section are summarized below:

1. Helpless behaviors may be an obstacle to learning therefore preventive measures such as teacher training regarding teaching LD students, providing

them with individually adapted education to reduce helplessness in order to increase academic motivation of LD children is necessary.

2. Schools need to provide dyslexia-friendly environments through providing teachers extra training regarding teaching methods for children with LD in order to provide them with a better chance to learn.
3. Since the self-esteem levels of LD children are lower than their normally-achieving peers, programs to enhance the self-esteem are necessary for children with learning difficulties.
4. The importance of early identification of LD children is important in the prevention of psychosocial problems.

The results of this study have practical implications for education of children with LD. Helplessness shows maladaptive motivational behavior. Thus, it may be an obstacle to learning. It is important to reduce helplessness and increase students academic motivation and expectation. In Turkey, the diagnosis of LD is not well-known by teachers. Yet the teacher is the most important figure for the child to be diagnosed and sent for treatment, because he/she spends the most time to observe whether the child has problems with reading, writing or arithmetic. Providing teachers with training related to LD seems rather important since it has been pointed out in previous research that teacher's perceptions of the students' motivational problems may affect teachers' attitudes, expectations and behavior towards the students (Dweck, 1975; Valas, 2001a). Thus, this may contribute in the formation of student's expectations.

Previous research has pointed out that giving individually adapted education for low achieving students may improve their achievement (Valas, 2001a). Providing LD children with individually adapted education may improve their achievement and this may reduce and prevent learned helpless attributions and improve their psychological adjustment. Thus, another way to help children increase their motivation and expectations regarding academic achievement may be to provide individually adapted education for these students so that they can achieve better in relation with their classmates. Providing individually adapted education may help to increase LD children's academic achievement, thus preventing helpless behaviors. In other words, when children are provided with this individually adapted education, they may start to achieve better, therefore they will be able to show more effort in trying to achieve, instead of thinking they can not achieve due to their inability. In Turkey, schools do not have a regulation to provide individually adapted education for children with LD yet private schools try to provide this kind of help. Whether the child is in a public or private school, parents and clinicians must work in collaboration with the child's teachers in order to provide the child with a better fitted educational program according to his/her needs. One of the most important things a teacher can do to help these children is not to give homework since it takes hours of work to finish a task that would normally be finished in 10 minutes by a normally achieving child.

As previously noted in the section of self-esteem, schools need to provide dyslexia-friendly environments. In order to achieve this, schools may need change the role of teachers and school environment to create a more accepting climate for

these children. In his study Humphrey (2002), stressed that teachers formed an important part of the LD child's environment. Teachers provide and facilitate the educational environment as well as identify and support the social, emotional, personal and educational needs of the LD child. It was pointed out those teachers in special units for students with specific learning difficulties, provided these students with a more welcoming and facilitative environment (Humphrey, 2002). These teachers in special units were more likely to have received training in teaching children with dyslexia. In light of this information, it is important that teachers in mainstream schools should receive extra training regarding teaching methods for children with LD in order to provide them with a better chance to learn.

Also, programs to enhance self-esteem may be necessary for children with learning difficulties. This may be especially important for children with LD whose self-esteem levels are low. Since self-concept and academic achievement are closely linked (Humphrey, 2004), the provision of such programs in schools seems especially important in order to increase both self-esteem and academic achievement. In a meta-analysis about school-based interventions to improve the self-concept of students with LD, it was pointed out that classroom-based interventions could provide significant positive results on the self-concept of these children (Elbaum & Vaughn, 2001). Elbaum and Vaughn, (2001), also emphasized the need to take the child as a whole, by providing academic interventions and supporting the parents. Receiving special attention and help from the child's teacher may also help improve children's self-esteem. In a study it was suggested that positive self-esteem influenced the resiliency of individuals with LD (Brooks,

1994). Thus, research on protective factors and preventative measures regarding psychosocial problems of LD children is necessary.

Lastly, the importance of early identification of these children is important in the prevention of psychosocial problems such as depressive symptoms and anxiety as well as prevention of lowered levels of self-esteem. If children with LD are diagnosed and treated as early as possible, then they may be protected against decreased self-esteem and other psychosocial problems. In a study it was found that children with LD in mainstream schools felt isolated, excluded in their schools, and half of them were regularly teased (Humphrey & Mullins, 2002). Some of this teasing was also done by teachers, calling these children “stupid, lazy or slow” (Humphrey, 2002). Thus, the humiliation that these children are faced with will diminish if they are diagnosed and treated as early as possible.

Thus, early identification, appropriate educational environment and providing children with individually adapted education and special attention to increase their motivation and expectations regarding academic achievement will help in increase academic achievement and decrease helpless behaviors by these children. Also interventions to enhance self-esteem will help these children to feel better about themselves thus providing them with the chance to reach their potentials.

4.5 Limitations and Suggestions

There may be some limitations to the generalizations of this study which should be pointed out. Only self-report measures for children’s psychological state was used. Perhaps there is a gender bias in self-report measures. It may be necessary

to investigate whether there is a tendency of girls to report in a negative direction regarding measures on depression, anxiety and self-esteem. This could be done by using different measures such as reports from teachers, parents or peers for the same variable.

It must also be noted that this study does not take into account the issue of causality. This study shows that children with LD are more likely than their non-LD peers to psychosocial problems. Yet this study does not show the causality of these psychosocial problems. Longitudinal studies may be helpful in finding the causes of these problems.

This study did not use any assessment devices about behavioral problems that the child may have had. But all families and children were assessed prior to the research and those children who were showing behavioral problems were not taken into the study in order not to confound results of the study on measures such as stress, depression and parental burnout of the mothers.

In the population of children with LD, there was only one epileptic child who was using medication for epilepsy. This child was included in the statistical analyses of total LD children. It might have been better if this child was not included in the statistical analyses due to the confounding factor of epilepsy. This may be a limitation of the current study. Further studies may include another group of children with epilepsy to see the effects of this comorbid disorder on the children's and mother's psychological adjustment level.

This study did not take into account the psychological adjustment level of the fathers of the children in the study. Thus, the effects of the father's psychological

adjustment on the adjustment of children and mothers are not known. Further studies must take psychosocial variables related to the father into consideration.

Research on protective factors and preventative measures regarding psychosocial problems of LD children is necessary.

4.6 Strengths

In Turkey studies with LD children have been very rare. Thus this study may help clinicians working with these children. A strength of this study may be the sample size. Another strength of the current study lies in having worked with the mothers of these children which has shown significant results in relation with the psychological adjustment of the children in the study. As previously noted in the above sections of this study, children with LD receive significantly worse psychological functioning levels as compared to their normally achieving peers. In order to see differences in another population whom were also diagnosed with a chronic disorder may also be considered to be a strength of this study. Children with LD seem to have deeper psychological problems than even those children with a chronic disease and the mothers of these children suffer similarly.

References

- AACAP Official Action. (1998). Practice parameters for the assessment and treatment of children and adolescents with language and learning disorders. *Journal of the American Academy of the Child Adolescent Psychiatry*, 37(10), Supplement.
- Abramson, L.Y., Seligman, M.E.P., & Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology*, 87, 49-74.
- Abramson, L.Y., Metalsky, G.I., & Alloy, L.B. (1989). Hopelessness depression: A theory based subtype of depression. *Psychological Review*, 96, 358-372.
- Alexander, A.W., & Slinger-Constant, A.M. (2004). Current status of treatment for dyslexia: Critical review. *Journal of Child Neurology*, 19, 744-758.
- Amer, K.S. (1999). Children's adaptation to insulin dependent diabetes mellitus: A critical review of the literature. *Pediatric Nursing*, 25, 627-635.
- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.
- Anderson, J.C., Williams, S., McGee, R., & Silva, P.A. (1987). DSM III disorders in preadolescent children: Prevalence in a large sample from the general population. *Archives of General Psychiatry*, 44, 69-76.
- Anjel, M. (1993). *The transliteral equivalence, reliability and validity studies of the Parental Acceptance-Rejection Questionnaire (PARQ), mother form: A tool for assessing child abuse*. Yayınlanmamış Yüksek Lisans Tezi, İstanbul: Boğaziçi Üniversitesi, Eğitim Fakültesi, Eğitim Bilimleri Bölümü.

- Ansari, Z.A. (2002). Parental Acceptance-Rejection of Disabled Children in Non-Urban Pakistan. *North American Journal of Psychology*, 4 (1), 121-129.
- Aydın, G. (1985). Sosyal başarı eğitimi ile sosyal beceri eğitiminin çocuklarda öğrenilmiş çaresizlik davranışının ortadan kaldırılmasına etkisi. Yayınlanmamış Doktora Tezi. Ankara: Hacettepe Üniversitesi, Eğitim Fakültesi, Eğitim Bilimleri Bölümü.
- Ayres, R., Cooley, E., & Dunn, C. (1990). Self-concept, attribution, and persistence in learning-disabled students. *Journal of School Psychology*, 153-163.
- Azar, R., & Solomon, C.R. (2001). Coping strategies of parents facing child diabetes mellitus. *Journal of Pediatric Nursing*, 16(6), 418-28.
- Bandura, A. (1977). Self-efficacy: towards a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.
- Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology*, 51, 1173-1182.
- Bear, G. G., Juvonen, J., & McInerney, F. (1993). Self-perceptions and peer relations of boys with and boys without learning disabilities in an integrated setting: A longitudinal study. *Learning Disability Quarterly*, 16, 127-136.
- Bear, G., & Minke, K.M. (1996). Positive bias in maintenance of self-worth among children with LD. *Learning Disability Quarterly*, 19, 23-32.
- Beck, A.T. (1972). *Depression: Causes and treatment*. Philadelphia: University of Pennsylvania Press.

- Beck, A.T. (1976). *Cognitive therapy and emotional disorders*. New York: International Universities Press.
- Beck A.T., Steer R.A., & Garbin M.G. (1988). Psychometric properties of the Beck Depression inventory: twenty- five years of evaluation. *Clinical Psychology Review*, 8, 77–100.
- Beitchman, J.H., & Young, A.R. (1997). Learning disorders with a special emphasis on reading disorders: A review of the past ten years. *Journal of the American Academy of the Child Adolescent Psychiatry*, 36, 1020-1032.
- Bell-Dolan, D.S., Last, G.C., & Strauss, C.C. (1990). Symptoms of anxiety disorders in normal children. *Journal of the American Academy of the Child Adolescent Psychiatry*, 29, 759-765.
- Benenson, J.F. & Dweck, C.S. (1986). The development of trait explanations and self-evaluations in the academic and social domains. *Child Development*, 57, 1179-1187.
- Black, F.W. (1974). Self-concept as related to achievement and age in learning disabled children. *Child Development*, 45, 1137-1140.
- Blanz, B., Rensch-Riemann, B., Fritz-Sigmund, D., & Schmidt, M. (1993). IDDM is a risk factor for adolescent psychiatric disorders. *Diabetes Care*, 16, 1579–1587.
- Blumberg, S. H., & Izard, A. E. (1985). Affective and cognitive characteristics of depression in 10- and 11- year old children. *Journal of Personality and Social Psychology*, 49, 194-202.

- Bowden, C.L., Humphrey, F.J., Thompson, M.G. (1980). Priorities in psychiatric residency training. *American Journal of Psychiatry*, 137, 1243-1246.
- Brage, D., & Meredith, W. (1994). A causal model of adolescent depression. *Journal of Psychology*, 128, 455-468.
- Bruininks, V.L. (1978). Peer status and personality characteristics of learning disabled and non-disabled students. *Journal of Learning Disabilities*, 11, 484-489.
- Brumback, R.A., & Staton, R.D. (1983). Learning disability and childhood depression. *American Journal of Orthopsychiatry*, 53, 264-281.
- Bull, L. (2003). The use of support groups by parents of children with dyslexia. *Early Child Development and Care*, 173, 341-347.
- Bulut, I. (1990). *Aile Değerlendirme Ölçeği El Kitabı*. Ankara: Özgüneliş Matbaası.
- Bursuck, W. (1989). A comparison of students with learning disabilities to low achieving and higher achieving students on three dimensions of social competence. *Journal of Learning Disabilities*, 22, 188-193.
- Butkowsky, I.S., & Willows, D.M. (1980). Cognitive-motivational characteristics of children varying in reading ability: Evidence for learned helplessness in poor readers. *Journal of Educational Psychology*, 72, 408-422.
- Cleaver, R.L., & Whitman, R.D. (1998). Right hemisphere, white-matter learning disabilities associated with depression in an adolescent and young adult psychiatric population. *Journal of Nervous and Mental Disease*, 186, 561- 565.
- Close, H., Davies, A. G., Price, D.A., & Goodyer, I.M. (1986). Emotional difficulties in diabetes mellitus. *Archives of Disease in Childhood*, 61, 337-340.

- Cohen, J. (1985). Learning disabilities and adolescence: Developmental considerations. *Adolescent Psychiatry*, 12, 177-196.
- Cohen, S., & Willis, S.T. (1985). Stress, social support and the buffering hypothesis. *Psychological Bulletin*, 98, 310-357.
- Colbert, P., Newman, B., Ney, P., & Young, J. (1982). Learning disabilities as a symptom of depression in children. *Journal of Learning Disabilities*, 15, 333-336.
- Coleman, J.M. (1983). Handicapped labels and instructional segregation: Influences on children's self-concepts versus the perceptions of others. *Learning Disability Quarterly*, 6, 3-11.
- Coopersmith, S.A. (1967). *The Antecedents of Self-Esteem*. San Fransisco: W.H. Freeman.
- Crozier, W.R., Rees, V., Morris-Beattie, A., & Bellin, W. (1999). Streaming, self-esteem, and friendships within a comprehensive school. *Educational Psychology in Practice*, 15 (2), 128-134.
- Çataklı, M. (1985). Transliteration Equivalence and Reliability of the Turkish Version of the Piers-Harris Children's Self-Concept Scale. Unpublished Master's Thesis, İstanbul. Boğaziçi Üniversitesi, Eğitim Fakültesi, Eğitim Bilimleri Bölümü.
- Çataklı, M. & Öner, N. (1986-1987). Çocuklarda Öz-Kavramı Ölçeği: Piers-Harris Ölçeğinin bir çeviri ve güvenilirlik çalışması. *Boğaziçi Üniversitesi Dergisi: Eğitim Bilimleri*, 12, 85-110.
- Çuhadaroğlu, F. (1986). Adolesanlarda benlik saygısı. Yayınlanmamış uzmanlık tezi. Hacettepe Üniveristesi, Tıp Fakültesi, Psikiyatri Bölümü, Ankara.

- Dalley, M. B. Bolocofsky, D.N., Alcorn, M.B., & Baker, C. (1992). Depressive symptomatology, attributional style, dysfunctional attitude, and social competency in adolescents with and without learning disabilities. *School Psychology Review*, 21, 444-458.
- Daniels-Mohring, D., & Lambie, R. (1993). Dysfunctional families of the student with special needs. *Focus on Exceptional Children*, 25, 1-11.
- Delamater, A. M., Jacobson, A. M., Anderson, B., Cox, D. Fisher, L., Lustman, P. et al. (2001). Psychosocial Therapies in Diabetes. *Diabetes Care*, 24, 1286–1292.
- Diabetes Epidemiology Research International Group: Secular trends in incidence of childhood IDDM in 10 countries. (1990). *Diabetes* 39, 858–864.
- Diener, C.I. & Dweck, C.S. (1978). An analysis of learned helplessness: Continuous changes in performance, strategy, and achievement cognitions following failure. *Journal of Personality and Social Psychology*, 39, 940-952.
- Donawa, W. (1995). Growing up dyslexic: A parent's view. *Journal of Learning Disabilities*, 28, 324-328.
- Dong, Q. Yang, B. & Ollendick T.H. (1994). Fears in Chinese Children and adolescent and Their Relation to Anxiety and Depression, *Journal of Child Psychology and Psychiatry*, 35 (2), 351-363.
- Duygun, T. & Sezgin, N. (2003). Zihinsel Engelli ve Sağlıklı Çocuk Annelerinde Stres Belirtileri, Stresle Başa Çıkma Tarzları ve Algılanan Sosyal Desteğin Tükenmişlik Düzeyine olan Etkisi. *Türk Psikoloji Dergisi*, 18, 37-52.

- Dweck, C.S., & Repucci, N.D. (1973). Learned Helplessness and reinforcement responsibility in children. *Journal of Personality and Social Psychology*, 25, 109-116.
- Dweck, C.S. (1975). The role of expectations and attributions in the alleviation of learned helplessness. *Journal of Personality and Social Psychology*, 31, 674-685.
- Dyson, L.L. (1993). Response to the presence of a child with disabilities: Parental stress and family functioning over time. *American Journal on Mental Retardation*, 98, 207-218.
- Dyson, L.L. (1996). The experiences of families of children with learning disabilities: parental stress, family functioning, and sibling self-concept. *Journal of Learning Disabilities*, 29 (3), 280-286.
- Dyson, L.L. (2003). Children with Learning Disabilities within the Family Context: A Comparison with Siblings in Global Self-Concept, Academic Self-Perception, and Social Competence. *Learning Disabilities Research and Practice*, 18(1), 1-9.
- Elbaum, B., & Vaughn, S. (2001). School based interventions to enhance the self-concept of students with learning disabilities: a meta-analysis. *Elementary School Journal*, 101 (3), 303-329.
- Elçi, Ö. (2004). *Predictive values of social support, coping styles and stress level in posttraumatic growth and burnout levels among the parents of children with autism*. Yayınlanmamış yüksek lisans tezi. Orta Doğu Teknik Üniversitesi, Sosyal Bilimler Enstitüsü, Ankara.

- Epstein, N.B., Baldwin, L.M., & Bishop, D.S. (1983). The McMaster Family Assessment Device. *Journal of Family and Marital Therapy*, 9(2), 171-180.
- Engel, R. (1997). Instrument for locating students with suspected learning disabilities: A quantitative approach. *International Journal of Rehabilitation Research*, 20: 169-187.
- Erdem, T. (1990). *The validity study of Turkish form of Parental-Acceptance Rejection Questionnaire*. Unpublished Master's Thesis, İstanbul. Boğaziçi Üniversitesi, Eğitim Fakültesi, Eğitim Bilimleri Bölümü.
- Erden, G., Kurdođlu, F., Gündođdu, B. (1998). Öğrenme Güçlüğü olan çocukların duygusal sorunları ve kendilik algıları. *VII. Ulusal Çocuk ve Ergen Psikiyatrisi Kongresi*, Sapanca.
- Ergin, C. (1992). Doktor ve hemşirelerde tükenmişlik ve Maslach Tükenmişlik Ölçeğinin Uyarlanması. Bayraktar, R., & Dağ, İ. (Eds.). *VII. Ulusal Psikoloji Kongresi Bilimsel Çalışmaları*, 143-154.
- Falik, L.H. (1995). Family patterns of reaction to a child with a learning disability: a mediational perspective. *Journal of Learning Disabilities*, 28, 335-341.
- Fisher, B.L., Allen, R., & Kose, G. (1996). The relationship between anxiety and problem-solving skills in children with and without learning disabilities. *Journal of Learning Disabilities*, 29, 439-446.

- Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, 21, 219-239.
- Folkman, S., & Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology*, 48, 150-170.
- Forness, S.R. & Kavale, K.A. (1989). Identification and diagnostic issues in special education: a status report for child psychiatry. *Child Psychiatry and Human Development*, 19, 279-301.
- Frieze, I.H., & Snyder, H.N. (1980). Children's beliefs about the causes of success and failure in school settings. *Journal of Educational Psychology*, 72, 186-196.
- Fristad, M.A., Topolosky, S., Weller, E.B., Weller, R.A. (1992) Depression and learning disabilities in children. *Journal of Affective Disorders*, 26, 1:53-58.
- Fuerst, D.R., & Rourke, B.P. (1993). Psychosocial functioning of children: Relations between personality subtypes and academic achievement. *Journal of Abnormal Child Psychology*, 21, 597-607.
- Fuerst, D.R., & Rourke, B.P. (1995). Psychosocial functioning of children with learning disabilities at three age levels. *Child Neuropsychology*, 1, 38-55.
- Gençöz, F., Gençöz, T., & Bozo, Ö. (2006). Hierarchical Dimensions of Coping Styles: A Study Conducted with Turkish University Students. *Social Behavior and Personality*, 34, 525-534.

- Gilger, J.W., Pennington, B.F., DeFries, J.C. (1992). A twin study of the etiology of comorbidity: Attention-deficit hyperactivity disorder and dyslexia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 343-348.
- Gladstone, T.R., & Kaslow, N.J. (1995). Depression and Attributions in children and adolescents: A meta-analytic review. *Journal of Abnormal Child Psychology*, 23, 597-606.
- Goldstein, D., Paul, G.G., & SanFilippo-Cohn, S. (1985). Depression and achievement in subgroups of children with learning disabilities. *Journal of Applied Developmental Psychology*, 6, 263-275.
- Greenham, S.L. (1999). Learning Disabilities and Psychosocial Adjustment: A critical Review. *Child Neuropsychology*, 5 (3), 171-196.
- Grey, M., Cameron, M.E., Lipman, T.H., & Thurber, F.W. (1990). Psychosocial status of children with diabetes in the first 2 years after diagnosis. *Diabetes Care*, 18 (10), 1330-1336.
- Grolnick, W.S., & Ryan, R. M. (1990). Self-perceptions, motivation, and adjustment in children with learning disabilities: A multiple comparison study. *Journal of Learning Disabilities*, 23, 177-184.
- Gurney, P. (1988). *Self-Esteem in Children with Special Education Needs*. London: Routledge.
- Haley, G. M. T., Fine, S., Marriage, K., Moretti, M. M., & Freeman, R.J. (1985). Cognitive bias and depression in psychiatrically disturbed children and adolescents. *Journal of Consulting and Clinical Psychology*, 53, 535-537.

- Hammill, D.D. (1993). A timely definition of learning disabilities. *Family & Community Health, 16*, 1-8.
- Hampson, S.E., Skinner, T.C., Hart, J., Storey, L., Gage, H., Foxcroft, D., et al. (2001). Effects of educational and psychosocial interventions for adolescents with diabetes mellitus: a systematic review. *Health Technology Assessment, 5*(10), 1-79.
- Hankin, B.L., Abramson, L.Y., & Siler, M. (2001). A prospective test of the hopelessness theory of depression in adolescence. *Cognitive Therapy and Research, 25*, 607-632.
- Heath, N.L. (1992). Domain-specific self-perceptions, achievement and depressive symptomatology in children with and without learning disabilities. Dissertation Abstracts International, 54-05A: 1678; Order No: AAINN78691.
- Heath, N.L., & Wiener, J. (1996). Depression and nonacademic self-perceptions in children with and without learning disabilities. *Learning Disability Quarterly, 19*, 34-44.
- Heppner, P. P., & Petersen, C. H. (1982). The development and implications of a personal problem solving inventory. *Journal of Counseling Psychology, 29*, 66-75.
- Heyman, W.B. (1990). The self-perception of a learning disability and its relationship to academic self-concept and self-esteem. *Journal of Learning Disabilities, 23*, 472-475.

- Hiebert, B., Wong, B., & Hunter, M. (1982). Affective influences on learning disabled adolescents. *Learning Disability Quarterly*, 5, 334-343.
- Hisli N. (1988). A study on the reliability of the Beck depression inventory. *Psikoloji Dergisi*, 6, 118-122.
- Houck, C.K., & Bilingsley, B.S. (1989). Written expression of students with and without learning disabilities: Differences across the grades. *Journal of Learning Disabilities*, 22, 9: 561-572.
- Howard, K.A. & Shick Tryon, G. (2002). Depressive symptoms in and Type of Classroom Placement for adolescents with LD. *Journal of Learning Disabilities*, 35 (2), 185-190.
- Humphrey, N. (2002). Teacher and pupil ratings of self-esteem in developmental dyslexia, *British Journal of Special education*, 29 (1), 29-36.
- Humphrey, N., & Mullins, P.M. (2002). Self-concept and self-esteem in developmental dyslexia. *Journal of Research in Special Educational Needs*, 2, 1-13.
- Huntington, D.D., & Bender, W.N. (1993). Adolescents with learning disabilities at risk? Emotional well-being, depression, suicide. *Journal of Learning Disabilities*, 26, 159-166.
- Jacobson, A., Hauser, S.T., Wertlieb, D., Woldsdorf, J., Orleans, J., Viegra, M. (1986). Psychological adjustment of children with recently diagnosed diabetes mellitus. *DiabetesCare*, 9, 323-329.

- Kaslow, N.J., Rehm, L.P. & Siegel, A. (1984). Social and cognitive correlates of depression in children: A developmental perspective. *Journal of Abnormal Child Psychology*, 12 (4), 605-620.
- Kaslow, N.J., Tanenbaum, R.L., Abramson, L.Y., Seligman, M.E.P., & Peterson, C. (1983). Problem-solving deficits and depressive symptoms among children. *Journal of Abnormal Child Psychology*, 11, 497-502.
- Kavale, K.A., & Forness, S.R. (1996). Social skills deficits and learning disabilities: A meta-analysis. *Journal of Learning Disabilities*, 29, 226-237.
- King, G., Stewart, D., King, S., & Law, M. (2000). Organisational characteristics and issues affecting longevity of self-help groups for parents of children with special needs. *Qualitative Health Research*, 10, 225-241.
- Kistner, J., White, K., Haskett, M., & Robbins, F. (1985). Development of learning-disabled and normally-achieving children's causal attributions. *Journal of Abnormal Child Psychology*, 13 (4), 639-647.
- Kistner, J., Haskett, M., White, K., & Robbins, F. (1987). Perceived competence and self-worth of LD and normally achieving students. *Learning Disability Quarterly*, 10, 237-244.
- Kistner, J.A. & Osborne, M. (1987). A longitudinal study of LD children's self-evaluations. *Learning Disability Quarterly*, 10, 258-266.
- Khaleque, A. & Rohner, R.P. (2002). Perceived parental acceptance-rejection and psychological adjustment: A meta-analysis of cross-cultural and intra-cultural studies. *Journal of Marriage and the Family*, 64 (1), 54-70.

- Kloomok, S. & Cosden, M. (1994). Self-concept in children with learning disabilities: The relationship between global self-concept, academic “discounting,” nonacademic self-concept, and perceived social support. *Learning Disability Quarterly*, 17, 140-153.
- Korkmazlar, Ü. (1992). 6-11 yaş ilkököl çocuklarında Özgöl Öğrenme Bozukluğu ve tanı yöntemleri, Doktora Tezi. İstanbul Üniversitesi, Sağlık Bilimleri Enstitüsü.
- Kovacs, M. (1981). The Children’s Depression Inventory (CDI), *Psychopharmacological Bulletin*, 21, 995-998.
- Kovacs, M. (1980/1981). Rating scales to assess depression in school aged children. *Acta Paedopsychiatry*, 46, 305-315.
- Kovacs, M., Feinberg, T.L., Paulauskas, S., Finkelstein, R., Pollock, M., & Crouse-Novak, M. (1985). Initial coping responses and psychosocial characteristics of children with insulin-dependent diabetes mellitus. *Journal of Pediatrics*, 106, 827–834.
- Kovacs, M., Finkelstein, R., Feinberg, T.L., Crouse-Novak, M., Paulauskas, S., & Pollock, M. (1985). Initial psychologic responses of parents to the diagnosis of insulin dependent diabetes mellitus in their children. *Diabetes Care*, 8, 568 – 575.
- Kovacs, M., Goldston, D., Obrosky, D., & Bonar, L. (1997). Psychiatric disorders in youths with IDDM: rates and risk factors. *Diabetes Care*, 20, 36–44.
- Kovacs, M., Iyengar, S., Goldston, D., Stewart, J., Obrosky, D.S., & Marsh, J. (1990). Psychological functioning of children with insulin-dependent diabetes mellitus: a longitudinal study. *Journal of Pediatric Psychology*, 15(5), 619-632.

- Kovacs, M., Iyengar, S., Goldston, D., Obrosky, D.S., Stewart, J., & Marsh, J. (1990). Psychological functioning among mothers of children with insulin-dependent diabetes mellitus: a longitudinal study. *Journal of Consulting and Clinical Psychology, 58*(2), 189-195.
- Kovacs, M., Mukerji, P., Iyengar, S., & Drash, A. (1996). Psychiatric disorder and metabolic control among youths with IDDM. *Diabetes Care, 19*, 318-323.
- Kral, M.C., Kibby, M.Y., Johnson, L.R. & Hynd, G.W. (2000). Behavior problems among children with ADHD and/or reading disability: effects of gender and diagnostic grouping. *Archives of Clinical Neuropsychology, 15*, 778-779.
- Kronenberger, W. G., & Dunn, D.W. (2003). Learning disorders. *Neurologic Clinics 21*:941-952.
- Lardieri, L.A., Blacher, J., & Swanson, H.L. (2000). Sibling relationships and parent stress in families of children with and without learning disabilities. *Learning Disability Quarterly, 23*, 105-116.
- Last, C.G., Hersen, M., Kazdin, A.E., Finkelstein, R., & Strauss, C.C. (1987). Comparison of DSM III separation anxiety and overanxious disorders: Demographic characteristics and patterns of comorbidity. *Journal of the American Academy of the Child Adolescent Psychiatry, 24*, 527-531.
- La Greca, A.M. & Stone, W.L. (1990). LD status and achievement: confounding variables in the study of children's social status, self-esteem and behavioral functioning. *Journal of Learning Disabilities, 23*(8), 483-490.

- Lavigne, J.V. & Faier-Routman, J. (1992). Psychological adjustment to pediatric physical disorders: a meta-analytic review. *Journal of Pediatric Psychology*, 17, 133-157.
- Licht, B. (1983). Cognitive-motivational factors that contribute to the achievement of learning disabled children. *Journal of Learning Disabilities*, 16, 483-490.
- Licht, B.G. & Dweck, C.S. (1984). Determinants of academic achievement: The interaction of children's achievement orientations and skill area. *Developmental Psychology*, 20, 628-638.
- Licht, B.G., Kistner, J. A., Ozkaragoz, T., Shapiro, S., & Clausen, L. (1985). Causal attributions of learning disabled children: Individual differences and their implications for persistence. *Journal of Educational Psychology*, 77, 208-216.
- Little, S.S. (1993). Nonverbal learning disabilities and socioemotional functioning: a review of recent literature. *Journal of Learning Disabilities*, 26, 653-665.
- Lombana, J.H. (1992). Learning disabled students and their families: Implications and strategies for counselors. *Journal of Humanistic Education and Development*, 31, 33-40.
- Lovett, M.W. (1987). A developmental approach to reading disability: Accuracy and speed criteria of normal and deficient reading skill. *Child Development*, 58: 234-260.
- Maag, J.W., & Reid, R. (1994). The phenomenology of depression among students with and without learning disabilities: More similar than different. *Learning Disabilities Research & Practice*, 9, 91-103.

- Margalit, M. (1982). Learning disabled children and their families: Strategies of extension and adaptation of family therapy. *Journal of Learning Disabilities*, 15, 594-595.
- Margalit, M., & Almougy, K. (1991). Classroom behavior and family climate in students with learning disabilities and hyperactive behavior. *Journal of Learning Disabilities*, 24, 406-412.
- Margalit M., & Heiman, T. (1986a). Family climate and anxiety in families with learning disabled boys. *Journal of the American Academy of the Child Adolescent Psychiatry*, 25, 841-846.
- Margalit M., & Heiman, T. (1986b). Learning disabled boys' anxiety parental anxiety and family climate. *Journal of Clinical Child Psychology*, 15, 218-253.
- Margalit, M., Raviv, A., & Ankonina, D.B. (1992). Coping and coherence among parents with disabled children. *Journal of Clinical Child Psychology*, 21, 202-209.
- Margalit, M., & Heiman, T. (1988). Social competence of learning disabled children: Cognitive and emotional aspects. *Exceptional Child*, 3, 179-189.
- Margalit, M., & Ronen, T. (1993). Loneliness and social competence among preadolescents and adolescents with mild mental retardation. *Mental Handicap Research*, 6, 97-111.
- Margalit, M., & Shulman, S. (1986). Autonomy perceptions and anxiety expressions of learning disabled adolescents. *Journal of Learning Disabilities*, 19, 291-293.
- Margerison, A. (1996). Self-esteem: its effect on the development and learning of children with EBD, *Support for Learning*, 11 (4), 176-180.

- Marsh, H. (1984). Relations among dimensions of self-attribution, dimensions of self-concept, and academic achievement. *Journal of Educational Psychology*, 76, 1291-1308.
- Martinez Chamorro, M.J., Lastra Martinez, I., & Luzuriaga Tomas, C. (2001). Psychosocial characteristics of children and adolescents with type 1 diabetes mellitus. *Anales Espanoles de Pediatria*, 55(5), 406-12.
- Maslach, C. & Jackson, S.E. (1986). Maslach Burnout Inventory Manual (2nd Ed.) Palo Alto, Ca: Consulting Psychologist Press.
- Maslow, A. (1954). *Motivation and Personality*. New York: Harper.
- Mattison, R., Hooper, S., Glassberg, L. (2002). Three-year course of learning disorders in special education students classified as behavioral disorder *Journal of the American Academy of Child Adolescent Psychiatry*, 41, 1454-1461.
- Maughan, B., Rowe, R., Loeber, R., & Stouthamer-Loeber, M. (2003). Reading problems and depressed mood. *Journal of Abnormal Child Psychology*. 31, 219-229.
- Mayou, R., Peveler, R., Davies, B., Mann, J., & Fairburn, C. (1991). Psychiatric morbidity in young adults with insulin-dependent diabetes mellitus. *Psychological Medicine*, 21, 639-645.
- McConaughy, S. H., & Ritter, D.R. (1985). Social competence and behavioral problems of learning disabled boys aged 6-11. *Journal of Learning Disabilities*, 18, 547-553.

- McConaughy, S.H., Mattison, R.E. & Peterson, R. L. (1994). Behavioral/emotional problems of children with serious emotional disturbances and learning problems. *School Psychology Review*, 23, 81-98.
- McKinney, J.D. (1989). Longitudinal research on the behavioral characteristics of children with learning disabilities. *Journal of Learning Disabilities*, 22, 141-150,165.
- Metalsky, G.I., Abramson, L.Y., Seligman, M.E.P., Semmel, A. & Peterson, C. (1982). Attributional styles and life events in the classroom: vulnerability and invulnerability to depressive mood reactions. *Journal of Personality and Social Psychology*, 43, 612-617.
- Metalsky, G.I., Halberstadt, L.J. & Abramson, L.Y. (1987). Vulnerability to depressive mood reactions: toward a test of the diathesis-stress and causal mediation components of the reformulated theory of depression. *Journal of Personality and Social Psychology*, 52, 386-393.
- Milich, R., & Okazaki, M. (1991). An examination of learned helplessness among attention-deficit hyperactivity disorder boys. *Journal of Abnormal Child Psychology*, 19 (5), 607-623.
- Milich, R., Carlson, C.L., Pelham, W.E., & Licht, B.G. (1991). Effects of methylphenidate on the persistence of ADHD boys following failure experiences. *Journal of Abnormal Child Psychology*, 19, 519-536.
- Morrison, G.M., & Zetlin, A. (1992). Family profiles of adaptability, cohesion, and communication for learning handicapped and nonhandicapped adolescents. *Journal of Youth and Adolescence*, 21, 225-240.

- Moussa, M.A., Alsaeid, M., Abdella, N., Refai, T.M., Al-Sheikh, N., & Gomez, J.E. (2005). *Social Science and Medicine*, 60(8), 1835-44.
- Nicholls, J.G. (1978). The development of the concepts of effort and ability, perception of academic attainment, and the understanding that difficult tasks require more ability. *Child Development*, 49, 800-814.
- Nicholls, J.G. (1979). The development of perception of own attainment and causal attribution for success and failure in reading. *Journal of Educational Psychology*, 71, 94-99.
- Nolen-Hoeksema, S., & Girgus, J.S. (1994). The emergence of gender differences in depression during adolescence. *Psychological Bulletin*, 115, 424-443.
- Nolen-Hoeksema, S., Girgus, J.S., & Seligman, M.E.P. (1992). Predictors and consequences of childhood depressive symptoms a 5-year longitudinal study. *Journal of Abnormal Child Psychology*, 101, 405-422.
- Northam, E.A., Todd, S., & Cameron, F.J. (2006). Interventions to promote optimal health outcomes in children with Type 1 diabetes-are they effective? *Diabetic Medicine*, 23(2), 113-121.
- Olsson, M.B. & Hwang, C.P. (2001). Depression in mothers and fathers of children with intellectual disability. *Journal of Intellect Disability Research*, 45(6), 535-43.
- Orvaschel, H., Beeferman, D., & Kabacoff, R. (1997). Depression, self-esteem, sex, and age in a child and adolescent clinical sample. *Journal of Clinical Child Psychology*, 26(3), 285-289.

- Öner, N., & LeCompte, A. (1983). Durumluk-sğürekli kaygı envanteri el kitabı.
İstanbul: Boğaziçi Üniversitesi Yayınları.
- Öy, B. (1990). Çocuklar için Depresyon Ölçeğinin Öğrenciler ve Çocuk Ruh Sağlığı Kliniğine Başvuran Çocuklarda Uygulanması. Çocuk Psikiyatrisi Uzmanlık Tezi. Ankara, Hacettepe Üniversitesi Tıp Fakültesi, Psikiyatri ABD.
- Özusta, Ş. (1993) *Çocuklar için Durumluk-Sürekli Envanterinin uyarlama, geçerlik ve güvenilirlik çalışması*. Yayınlanmamış yüksek lisans tezi. HÜ Sosyal Bilimler Enstitüsü, Ankara.
- Özusta, Ş. (1995) Çocuklar için Durumluk-Sürekli Kaygı Envanteri'nin uyarlama, geçerlik ve güvenilirlik çalışması. *Türk Psikoloji Dergisi*, 10: 34: 32-44.
- Paget, K.D., & Reynolds, C.R. (1984). Dimensions, levels and reliabilities on the Revised Children's Manifest Anxiety Scale with learning disabled children. *Journal of Learning Disabilities*, 17, 137-141.
- Palladino, P., Poli, P., Masi, G., & Marcheschi, M. (2000). The relation between metacognition and depressive symptoms in preadolescents with learning disabilities: Data in support of Borkowski's model. *Learning Disabilities Research and Practice*, 15 (3), 142-148.
- Panak, W.F., & Garber J. (1992). Role of aggression, rejection, and attributions in the prediction of depression in children. *Development and Psychopathology*, 4, 145-165.
- Pearl, R.A. (1982). LD children's attributions for success and failure: A replication with a labeled LD sample. *Learning Disability Quarterly*, 5, 173-176.

- Pearl, R.A., & Bryan, T. (1994). Getting caught in misconduct: conceptions of adolescents with and without learning disabilities. *Journal of Learning Disabilities, 27*, 193-197.
- Pearl, R.A., Bryan, T., & Donahue, M. (1980). Learning disabled children's attributions for success and failure. *Learning Disability Quarterly, 3*, 3-9.
- Pearson, V., & Chan, T.W.L. (1993). The relationship between parenting stress and social support in mothers of children with learning disabilities: A Chinese experience. *Social Science and Medicine, 37*(2), 267-274.
- Peterson, C., & Barrett, L.C. (1987). Explanatory style and academic performance among university freshman. *Journal of Personality and Social Psychology, 53*(3), 603-607.
- Peterson, C., & Seligman, M.E.P. (1984). Causal explanations as a risk factor for depression: Theory and evidence. *Psychological Review, 91*, 341-374.
- Piers, E.V. & Harris, D. (1969). Manual for the Piers-Harris Children's Self-Concept Scale, Nashville, Tennessee: Counselor Recordings and Tests.
- Priel, B., & Leshem, T. (1990). Self-perceptions of first- and second-grade children with learning disabilities. *Journal of Learning Disabilities, 23*, 637-642.
- Reidy, M.B. (1985). *Learned Helplessness in Children: A study of the Emotional Correlates of Attributional Style*. Unpublished Doctoral Thesis, Pennsylvania State University.
- Reiter, S., Mari, S., & Rosenberg, Y. (1986). Parental attitude toward the developmentally disabled among Arab communities in Israel: A cross-cultural study. *International Journal of Rehabilitation Research, 9*, 355-362.

- Renick, M.J., & Harter, S. (1989). Impact of social comparisons on the developing self-perceptions of learning disabled students. *Journal of Educational Psychology*, 81 (4), 631-638.
- Rock, E.E., Fessler, M.A., & Church, R.P. (1997). The concomitance of learning disabilities and emotional/behavioral disorders: A conceptual model. *Journal of Learning Disabilities*, 30, 245-263.
- Rodriguez, C.M., & Routh, D.K. (1989). Depression, anxiety and attributional style in learning disabled and non- learning disabled children. *Journal of Clinical Child Psychology*, 18, 299-304.
- Rogers, H., & Saklofske, D.H. (1985). Self-concepts, locus of control and performance expectations of learning disabled children. *Journal of Learning Disabilities*, 18, 273-279.
- Rohner, R.P. (1980). *Handbook for the study of Parental Acceptance-Rejection Center for the study of parental acceptance and rejection*. Storrs: University of Connecticut.
- Rohner, R.P. (1986). *The warmth dimension: Foundations of parental acceptance-rejection theory*. Beverly Hills CA: Sage.
- Rohner, R. P., Saavedra, J. M., & Granum, E. O. (1978). Development and validation of the parental acceptance-rejection questionnaire. *Catalog of Selected Documents in Psychology*, 8, 17-48.
- Rosenberg, Morris. (1965). *Society and the Adolescent Self-Image*. Princeton, New Jersey: Princeton University Press.

- Rosenberg, Morris. (1989). *Society and the Adolescent Self-Image*. Revised edition. Middletown, CT: Wesleyan University Press.
- Rosenthal, J. (1973). Self-esteem in children with dyslexia, *Academic Therapy*, 9, 27-39.
- Rogers, C.R. (1951). *Client-centered Therapy*. Boston: Houghton Mifflin.
- Rourke, B.P., & Fuerst, D.R. (1991). *Learning disabilities and psychosocial functioning: A neuro-psychological perspective*. New York: Guilford Press.
- Sabornie, E. (1994). Social-affective characteristics in early adolescents identified as learning disabled and nondisabled. *Learning Disability Quarterly*, 17, 268-279.
- Scarborough, H., (1990). Very early language deficits in dyslexic children. *Child Development*, 61, 1728-1743.
- Schatschneider, C., & Torgesen, J.K. (2004). Using our current understanding of dyslexia to support early identification and intervention. *Journal of Child Neurology*, 19, 759-765.
- Schiffirin, A. (2001). Psychosocial issues in pediatric diabetes. *Current Diabetes Reports*, 1(1): 33-40.
- Seigel, W.M., Golden, N.H., Gough, J.W., Lashley, M.S., & Sacker, I.M. (1990). Depression, self-esteem, and life events in adolescents with chronic diseases. *Journal of Adolescent Health Care*, 11(6), 501-4.
- Seligman, M.E.P. (1975). *Helplessness: on depression, development and death*. San Francisco, CA: Freedman.
- Seligman, M.E.P. (1990). *Learned Optimism*. New York, Pocket Books.

- Semrud-Clikeman M, Biederman J, Sprich-Buckminster S, Lehman, B.K., Faraone, S.V., Norman, D. (1992). Comorbidity between ADDH and learning disability: A review and report in a clinically referred sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 439-448.
- Serafica, F.C., & Harway, N.I. (1979). Social relations and self-esteem of children with learning disabilities. *Journal of Clinical Child Psychology*, 6, 227-233.
- Shaywitz, B.A., Fletcher, J.M., Shaywitz, S.E. (1995) Defining and classifying learning disabilities and attention-deficit/hyperactivity disorder. *Journal of Child Neurology*, 10(Suppl 1), S50-S57.
- Silver, E.J., Bauman, L.J., & Ireys, H.T. (1995). Relationships of self-esteem and efficacy to psychological distress in mothers of children with chronic physical illnesses. *Health Psychology*, 14(4):333-340.
- Siva, A. N. (1991). *İnfertilite'de stresle başetme, öğrenilmiş güçlülük ve depresyonun incelenmesi [Coping with stress, learned powerfulness, and depression among infertile people]*. Unpublished doctoral dissertation, Hacettepe University, Ankara.
- Smucker, M.R., Craighead, W.E., Craighead, L.W., & Green, B.J. (1986). Normative and reliability data for the Children's Depression Inventory. *Journal of Abnormal Child Psychology*, 14, 25-39.
- Spielberger CD (1973) Preliminary Manual for the State -Trait Anxiety Inventory for Children. Palo Alto, Consulting Psychologists Press.

- Spreen, O. (1989). The relationship between learning disability, emotional disorders, and neuropsychology; some results and observations. *Journal of Clinical and Experimental Neuropsychology*, 11, 117-140.
- Stevenson, D.T., & Romney, D.M. (1984). Depression in learning disabled children. *Journal of Learning Disabilities*, 17, 579-582.
- Stewart, S.M., Rao, U., & White, P. (2005). Depression and diabetes in children and adolescents. *Current Opinion in Pediatrics*, 17(5), 626-631.
- Subramaniam, V., Stewart, M., & Smith, J. (1999). The development and impact of a chronic pain support group: a qualitative and quantitative study. *Journal of Pain and Symptom Management*, 17, 376-383.
- Sullivan, B.J. (1978). Self-esteem and depression in adolescent diabetic girls. *Diabetes Care*, 1(1), 18-22.
- Stipek, D.J. (1981). Children's perceptions of their own and their classmates ability. *Journal of Educational Psychology*, 76, 75-84.
- Svetaz, M.V., Ireland, M., & Blum, R. (2000). Adolescents with learning disabilities: Risk and Protective factors associated with emotional well-being: Findings from the national longitudinal study of adolescent health. *Journal of Adolescent Health*, 27, 340-348.
- Swift, C.R., Seidman, F., & Stein, H. (1967). Adjustment problems in juvenile diabetes. *Psychosomatic Medicine*, 29, 555-571.
- Şahin, N., Şahin, N. H., & Heppner, P. (1993). Psychometric properties of the Problem Solving Inventory in a group of Turkish university students. *Cognitive Therapy and Research*, 17 (4), 379-396.

- Tangri, P. & Verma, P. (1992). A study of social burden felt by mothers of handicapped children. *Journal of Personality and Clinical Studies*, 6, 117-120.
- Taylor, C. (1998). Factors affecting the behavior towards people with disabilities. *The Journal of Social Psychology*. 138, 766-771.
- Thompson, P.H. Marcal, S.D., & Marcal, D.C.(1992). A meta-analysis of self-reported personality characteristics of children and adolescents with learning disabilities. *Journal of Psychoeducational Assessment*, 10, 59-64.
- Thomson, M.E. & Hartley, G.M. (1980). Self-concept in children with dyslexia. *Academic Therapy*, 26, 19-36.
- Toro, P.A., Weissberg,R.P., Guare, J., & Liebenstein, N.L. (1990). A comparison of children with and without learning disabilities on social problem-solving skill, school behavior, and family background. *Journal of Learning Disabilities*, 23, 115-120.
- Toseland, R., W., Rossiter, C.M., Peck, T., & Hill, P. (1990). Therapeutic processes in peer-led and professionally led support groups for caregivers. *International Journal of Group Psychotherapy*, 40, 279-303.
- Tur-Kaspa, H., & Bryan, T. (1993). Social attributions of students with learning disabilities. *Exceptionality*, 4, 229-243.
- Valas, H. (2001a). Learned helplessness and psychological adjustment: effects of age, gender and academic achievement. *Scandinavian Journal of Educational Research*, 45 (1), 71-90.

- Valas, H. (2001b). Learned helplessness and psychological adjustment II: effects of learning disabilities and low achievement. *Scandinavian Journal of Educational Research*, 45 (2), 101-114.
- Vila, G., Nollet-Clemencon, C., de Blic, J., Mouren-Simeoni, M.C., & Scheinmann, P. (2000). Prevalence of DSM IV anxiety and affective disorders in a pediatric population of asthmatic children and adolescents. *Journal of Affective Disorders*, 58, 223-231.
- Varol, Ş. (1990). Lise Son Sınıfı Öğrencilerinin Kaygı Düzeylerini Etkileyen Bazı Etmenler. Yayınlanmamış Yüksek Lisans Tezi, Ondokuz Mayıs Üniversitesi, Sosyal Bilimler Enstitüsü.
- Waggoner, K., & Wilgosh, L. (1990). Concerns of families of children with learning disabilities. *Journal of Learning Disabilities*, 23, 97-113.
- Weiner, B. (1979). A theory of motivation for some classroom experiences. *Journal of Educational Psychology*, 71, 3-25.
- Wilkinson, G. (1987). The influence of psychiatric, psychological and social factors on the control of insulin dependent diabetes mellitus. *Journal of Psychosomatic Medicine*, 31, 277-286.
- Willcutt, E.G., & Pennington, B.F. (2000). Comorbidity of reading disability and attention-deficit/hyperactivity disorder: Differences by gender and subtype. *Journal of Learning Disabilities*, 33, 179-191.
- Winnie, P.H., Woodlands, M.J., & Wong, B.Y.L. (1982). Comparability of self-concept among learning disabled, normal and gifted students. *Journal of Learning Disabilities*, 15, 470-475.

- Woodward, J., & Frank, B.D. (1988). Rural adolescent loneliness and coping strategies. *Adolescence*, 23, 559-565.
- Wright-Strawderman, C., & Watson, B.L. (1992). The prevalence of depressive symptoms in children with learning disabilities. *Journal of Learning Disabilities*, 25, 258-264.
- Zafar Afaq, A. (2002). Parental Acceptance-Rejection of disabled children in non-urban Pakistan. *North American Journal of Psychology*, 4(1), 121-126.

APPENDICES

Appendix A: Parental Acceptance-Rejection Questionnaire-Child Form

Aile Çocuk İlişkileri Formu

Adı Soyadı:

Sınıfı:

Cinsiyet:

Yaş:

Tarih:

Elinizdeki ölçekte anne-çocuk ilişkisini içeren ifadeler bulunmaktadır. Bu ifadelerin annenizin size olan davranışlarını uygun olup olmadığını düşünün.

Her ifadeyi okuduktan sonra o ifade annenizin size karşı davranışları konusunda ne kadar doğruysa Benim için “Hemen hemen her zaman doğru” “Bazen doğru”, “Nadiren doğru”, veya “Hiçbir zaman doğru değil” şeklinde işaretleyiniz.

Örneğin:

<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
Hemen			Hiçbir
hemen			zaman
her zaman	Bazen	Nadiren	doğru
<u>doğru</u>	<u>doğru</u>	<u>doğru</u>	<u>değil</u>

1. Annem ben hiç yokmuşum gibi davranır.

()

()

()

(X)

	<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
	Hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hiçbir zaman doğru değil
1. Annem benim hakkımda güzel şeyler söyler.	()	()	()	()
2. Annem kötü davrandığım zaman beni küçümseyerek azarlar.	()	()	()	()
3. Annem ben hiç yokmuşum gibi davranır.	()	()	()	()
4. Annem beni gerçekten sevmez.	()	()	()	()
5. Planlarımız hakkında benimle konuşur ve söyleyeceklerimi dinler.	()	()	()	()
6. Onun sözünü dinlemediğim zaman beni başkalarına şikayet eder.	()	()	()	()
7. Benimle candan ilgilenir.	()	()	()	()
8. Arkadaşlarımı eve getirmem için beni cesaretlendirir, onların hoş vakit geçirmesini sağlar.	()	()	()	()
9. Beni küçük düşürür ve benimle alay eder.	()	()	()	()
10. Onu rahatsız etmediğim sürece beni bilmezlikten gelir.	()	()	()	()
11. Kızdığı zaman bana bağırır.	()	()	()	()
12. Benim için önemli olan şeyleri ona anlatmamı kolaylaştırır.	()	()	()	()
13. Bana çok sert davranır.	()	()	()	()
14. Onun yanında olmamdan hoşlanır.	()	()	()	()

	<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
	Hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hiçbir zaman doğru değil
15. Bir şeyi iyi yaptığım zaman gurur duymamı sağlar.	()	()	()	()
16. Haketmediğim zaman bile bana vurur.	()	()	()	()
17. Benim için yapması gereken şeyleri unuttur.	()	()	()	()
18. Beni büyük bir başbelası olarak görür.	()	()	()	()
19. Beni başkalarına över.	()	()	()	()
20. Kızdığı zaman beni çok sert bir şekilde cezalandırır.	()	()	()	()
21. Benim gerekli gıdayı almam için gayret eder.	()	()	()	()
22. Benimle sıcak ve sevgi dolu bir şekilde konuşur.	()	()	()	()
23. Bana hemen hiddetlenir.	()	()	()	()
24. Benim sorularıma cevap vermemek için işi olduğunu söyler.	()	()	()	()
25. Benden hoşlanmıyor gibi görünür.	()	()	()	()
26. Hakettiğim zaman bana güzel şeyler söyler.	()	()	()	()
27. Çabuk kızar ve hiddetini benden çıkarır.	()	()	()	()
28. Arkadaşlarımla kim olduğunu merak eder.	()	()	()	()

	<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
	Hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hiçbir zaman doğru değil
29. Yaptığım şeylerle gerçekten ilgilenir.	()	()	()	()
30. Bana kırıcı şeyler söyler.	()	()	()	()
31. Yardımına ihtiyacım olduğunda beni duymazlıktan gelir.	()	()	()	()
32. Başım dertte olduğunda hatayı bende bulur.	()	()	()	()
33. Bana istenildiğimi ve ihtiyaç duyduğumu hissettirir.	()	()	()	()
34. Sinirine dokunduğumu söyler.	()	()	()	()
35. Beni çok önemser.	()	()	()	()
36. İyi davrandığım zaman benimle gurur duyduğunu söyler.	()	()	()	()
37. Beni kırmak için elinden geleni yapar.	()	()	()	()
38. Onun hatırlaması gerektiğini düşündüğüm şeyleri unuttur.	()	()	()	()
39. Kötü hareket ettiğimde artık sevilmediğimi hissettirir.	()	()	()	()
40. Yaptığım şeyin önemli olduğunu bana hissettirir.	()	()	()	()
41. Kötü davrandığım zaman beni korkutur veya tehdit eder.	()	()	()	()
42. Zamanını benimle geçirmekten hoşlanır	()	()	()	()

	<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
	Hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hiçbir zaman doğru değil
43. Üzüldüğüm veya canım sıkıldığında bana yardım etmeye çalışır.	()	()	()	()
44. Kötü davrandığım zaman arkadaşlarımla önünde beni utandırır.	()	()	()	()
45. Benden uzak kalmaya çalışır.	()	()	()	()
46. Beni şikayet eder.	()	()	()	()
47. Ne düşündüğümü merak eder ve o konuda benimle konuşmayı sever.	()	()	()	()
48. Ne yaparsam yapayım başka çocukların benden iyi olduğunu söyler.	()	()	()	()
49. Plan yaptığı zaman benim istediğim şeylere dikkat eder.	()	()	()	()
50. Önemli olduğunu düşündüğüm şeyleri onun için uygun olmasa bile yapmam izin verir.	()	()	()	()
51. Başka çocukların benden daha iyi davrandığını söyler.	()	()	()	()
52. Beni başkalarının bakımına bırakır.	()	()	()	()
53. İstenmediğimi bilmemi sağlar.	()	()	()	()
54. Yaptığım şeylerle ilgilenir.	()	()	()	()
55. Canım acıdığı zaman veya hasta olduğum zaman kendimi daha iyi hissetmem için gayret eder.	()	()	()	()
56. Kötü davrandığım zaman benden utandığını söyler.	()	()	()	()

	<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
	Hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hiçbir zaman doğru değil
57. Beni sevdiğini söyler.	()	()	()	()
58. Bana nazik ve yumuşak davranır.	()	()	()	()
59. Kötü davrandığım zaman beni utandırır ve suçlu hissettirir.	()	()	()	()
60. Beni mutlu etmeye çalışır.	()	()	()	()

Appendix B: Children's Depression Inventory

Adı Soyadı:

Cinsiyeti:

Doğum Tarihi :

Tarih:

Okul:

Sınıf:

Sevgili Öğrenciler,

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

Teşekkürler

- A) 1- Kendimi arada sırada üzgün hissedirim.
2- Kendimi sık sık üzgün hissedirim.
3- Kendimi her zaman üzgün hissedirim.
- B) 1- İşlerim hiç bir zaman yolunda gitmeyecek.
2- İşlerimin yolunda gidip gitmeyeceğinden emin değilim.
3- İşlerim yolunda gidecek.
- C) 1- İşlerimin çoğunu doğru yaparım.
2- İşlerimin çoğunu yanlış yaparım.
3- Hepsini yanlış yaparım.
- D) 1- Birçok şeyden hoşlanırım.
2- Bazı şeylerden hoşlanırım.
3- Hiçbir şeyden hoşlanmam.
- E) 1- Her zaman kötü bir çocuğum.
2- Çoğu zaman kötü bir çocuğum.
3- Arada sırada kötü bir çocuğum.
- F) 1- Arada sırada başıma kötü birşeylerin geleceğini düşünürüm.
2- Sık sık başıma kötü birşeylerin geleceğinden endişelenirim.
3- Başıma çok kötü şeyler geleceğinden eminim.
- G) 1- Kendimden nefret ederim.
2- Kendimi beğenmem.
3- Kendimi beğenirim.

- H) 1- Bütün kötü şeyler benim hatam.
2- Kötü şeylerin bazıları benim hatam.
3- Kötü şeyler genellikle benim hatam değil.
- I) 1- Kendimi öldürmeyi düşünmem.
2- Kendimi öldürmeyi düşünürüm ama yapmam.
3- Kendimi öldürmeyi düşünüyorum.
- İ) 1- Hergün içimden ağlamak gelir.
2- Birçok günler içimden ağlamak gelir.
3. Arada sırada içimden ağlamak gelir.
- J) 1- Herşey hergün beni sıkır.
2- Herşey sık sık beni sıkır.
3- Herşey arada sırada beni sıkır.
- K) 1-İnsanlarla beraber olmaktan hoşlanırım.
2- Çoğu zaman insanlarla birlikte olmaktan hoşlanmam.
3- Hiçbir zaman insanlarla birlikte olmaktan hoşlanmam.
- L) 1- Herhangi birşey hakkında karar veremem.
2- Herhangi birşey hakkında karar vermek zor gelir.
3- Herhangi birşey hakkında kolayca karar veririm.
- M) 1- Güzel/Yakışıklı sayılırım.
2- Güzel/Yakışıklı olmayan yanlarım var.
3- Çirkinim.
- N) 1- Okul ödevlerimi yapmak için her zaman kendimi zorlarım.
2- Okul ödevlerimi yapmak için çoğu zaman kendimi zorlarım.
3- Okul ödevlerimi yapmak sorun değil.
- O) 1- Her gece uyumakta zorluk çekerim.
2- Bir çok gece uyumakta zorluk çekerim.
3- Oldukça iyi uyurum.
- Ö) 1- Arada sırada kendimi yorgun hissederim.
2- Bir çok gün kendimi yorgun hissederim.
3- Her zaman kendimi yorgun hissederim.

- P) 1- Hemen hergün canım yemek yemek istemez.
2- Çoğu gün canım yemek yemek istemez.
3-Oldukça iyi yemek yerim.
- R) 1- Ağrı ve sızılardan endişe etmem.
2- Çoğu zaman ağrı ve sızılardan endişe ederim.
3- Herzaman ağrı ve sızılardan endişe ederim.
- S) 1-Kendimi yalnız hissetmem.
2- Çoğu zaman kendimi yalnız hissederim.
3- Herzaman kendimi yalnız hissederim.
- Ş) 1- Okuldan hiç hoşlanmam.
2- Arada sırada okuldan hoşlanırım.
3- Çoğu zaman okuldan hoşlanırım.
- T) 1- Birçok arkadaşım var.
2- Birçok arkadaşım var ama daha fazla olmasını isterdim.
3- Hiç arkadaşım yok.
- U) 1-Okul başarıım iyi.
2- Okul başarıım eskisi kadar iyi değil.
3- Eskiden iyi olduğum derslerde çok başarısızım.
- Ü) 1- Hiçbir zaman diğer çocuklar kadar iyi olamıyorum.
2- Eğer istersem diğer çocuklar kadar iyi olurum.
3- Diğer çocuklar kadar iyiyim.
- V) 1- Kimse beni sevmez.
2- Beni seven insanların olup olmadığından emin değilim.
3- Beni seven insanların olduğundan eminim.
- Y) 1- Bana söyleneni genellikle yaparım.
2- Bana söyleneni çoğu zaman yaparım.
3- Bana söyleneni hiçbir zaman yapmam.
- Z) 1- İnsanlarla iyi geçinirim.
2- İnsanlarla sık sık kavga ederim.
3- İnsanlarla her zaman kavga ederim.

Appendix C: Piers-Harris Self-Concept Scale

Aşağıda 80 cümle var. Bunlardan sizi tanımlayanları evet, tanımlamayanları ise hayır ile cevaplandırın. Bazı cümlelerde karar vermek zor olabilir. Yine de lütfen bütün cümleleri cevaplandırın. Aynı cümleyi hem evet hem hayır şeklinde işaretlemeyin. Unutmayın, cümledeki ifade genellikle sizi anlatıyorsa evet, genellikle sizi anlatmıyorsa hayır olarak işaretleyeceksiniz. Cümlelerin size uygun olup olmadığını en iyi siz kendiniz bilebilirsiniz. Bunun için siz kendinizi gerçekten nasıl görüyorsanız aynen öyle cevaplandırın. Cevaplarınızı işaretlerken, buradaki cümlelerin numarası ile cevap kağıdındaki numaranın aynı olmasına dikkat edin.

1. İyi resim çizerim.
2. Okul ödevlerimi bitirmem uzun sürer.
3. Ellerimi kullanmada becerikliyimdir.
4. Okulda başarılı bir öğrenciyim.
5. Aile içinde önemli bir yerim vardır.
6. Sınıf arkadaşlarım benimle alay ediyorlar.
7. Mutluyum.
8. Çoğunlukla neşesizim.
9. Akıllıyım.
10. Öğretmenler derse kaldırıncaya heyecanlanırım.
11. Dış (fiziki) görünüşüm beni rahatsız ediyor.
12. Genellikle çekingenim.
13. Arkadaş edinmekte güçlük çekiyorum.
14. Büyüdüğümde önemli bir kimse olacağım.
15. Aileme sorun yaratırım.
16. Kuvvetli sayılırım.
17. Sınavlardan önce heyecanlanırım.
18. Okulda terbiyeli, uyumlu davranırım.
19. Herkes tarafından pek sevilen biri değilim.
20. Parlak, güzel fikirlerim vardır.
21. Genellikle kendi dediklerimin olmasını isterim.
22. İstedğim bir şeyden kolaylıkla vazgeçerim.
23. Müzikte iyiyim.
24. Hep kötü şeyler yaparım.
25. Evde çoğu zaman huysuzluk ederim.
26. Sınıfta arkadaşlarım beni sayarlar.
27. Sinirli biriyim.
28. Gözlerim güzeldir.
29. Derse kalktığımda bildiklerimi sıkılmadan anlatırım.
30. Derslerde sık sık hayal kurarım.
31. (Kardeşiniz varsa) Kardeş(ler)ime sataşırım.
32. Arkadaşlarım fikirlerimi beğenir.
33. Başım sık sık belaya girer.
34. Evde büyüklerimin sözünü dinlerim.
35. Sık sık üzülür meraklanırım.

36. Ailem benden çok şey bekliyor.
37. Halimden memnunum.
38. Evde ve okulda pek çok şey dışında bırakıldığım hissine kapılıyorum.
39. Saçlarım güzeldir.
40. Çoğu zaman okul faaliyetlerine gönüllü olarak katılıyorum.
41. Şimdiki halimden daha başka olmayı isterdim.
42. Geceleri rahat uyurum.
43. Okuldan hiç hoşlanmıyorum.
44. Arkadaşlar arasında oyunlara katılmak için bir seçim yapılırken, en son seçilenlerden biriyim.
45. Sık sık hasta olurum.
46. Başkalarına karşı iyi davranmam.
47. Okul arkadaşlarım güzel fikirlerim olduğunu söylerler.
48. Mutsuzum.
49. Çok arkadaşım var.
50. Neşeliyim.
51. Pek çok şeye aklım ermez.
52. Yakışıklıyım / güzelim.
53. Hayat dolu bir insanım.
54. Sık sık kavgaya karışıyorum.
55. Erkek arkadaşlarım arasında sevilirim.
56. Arkadaşlarım bana sık sık sataşırlar.
57. Ailemi düş kırıklığına uğrattım.
58. Hoş bir yüzüm var.
59. Evde hep benle uğraşırlar.
60. Oyunlarda ve sporda başı hep ben çekerim.
61. Ne zaman bir şey yapmaya kalksam her şey ters gider.
62. Hareketlerimde hantal ve beceriksizim.
63. Oyunlarda ve sporda oynamak yerine seyredirim.
64. Öğrendiklerimi çabuk unuturum.
65. Herkesle iyi geçinirim.
66. Çabuk kızarım.
67. Kız arkadaşlarım arasında sevilirim.
68. Çok okurum.
69. Bir grupta birlikte çalışmaktansa tek başıma çalışmaktan hoşlanırım.
70. (Kardeşiniz varsa) Kardeş(ler)imi severim.
71. Vücutça güzel sayılırım.
72. Sık sık korkuya kapılıyorum.
73. Her zaman bir şeyler düşürür ve kırarım.
74. Güvenilir bir kimseyim.
75. Başkalarından farklıyım.
76. Kötü şeyler düşünürüm.
77. Kolay ağlarım.
78. İyi bir insanım.
79. İşler hep benim yüzümden ters gider.
80. Şanslı bir kimseyim.

Appendix D: Children's Attributional Style Questionnaire

Çocuklarda Öğrenilmiş Çaresizlik Ölçeği

Adı Soyadı:

Sınıfı:

Cinsiyet:

Yaş:

Tarih:

Sevgili Öğrenciler,

Elinizdeki anket öğrencilerin bazı konulardaki düşüncelerini öğrenmek için hazırlanmıştır. Anketin her sorusunda bir olay anlatılmış ve bu olay karşısında kalan bir kişinin seçebileceği a ve b harfleri ile gösterilen iki seçenek verilmiştir. Siz böyle bir olayla karşılaşırdınız bu seçeneklerden hangisini seçerdiniz? Düşününüz ve eğer a seçeneği sizin düşüncenize daha uygun ise a'yı, b seçeneği sizin düşüncenize uygun ise b'yi yuvarlak içine alınız. Unutmayın bu bir doğru-yanlış testi değildir. Önemli olan sizin gerçek düşüncenizi belirtmenizdir. Sizin düşüncenize hangi seçenek uyuyorsa onu işaretleyiniz.

Örnek

Balık tutmaya gittiniz ve hiç balık tutamadınız.

- a. Balık tutmayı bilmediğim için tutamadım.
- b. Avlandığım yerde balık az olduğu için tutamadım.

1. Bir testte en yüksek puanı aldınız.
 - a. Ben her testte başarılı olduğum için yine enyüksek puanı aldım.
 - b. Bu test benim en iyi bildiğim konuda olduğu için en yüksek puanı aldım.
2. Birkaç arkadaşınızla birlikte bir oyun oynadınız ve siz kazandınız.
 - a. Birlikte oynadığım arkadaşlar bu oyunu iyi oynayamadıkları için ben kazandım.
 - b. Bu oyunu iyi oynadığım için ben kazandım.
3. Bir arkadaşınızın evine konuk gittiniz ve çok iyi bir gün geçirdiniz.
 - a. Arkadaşım o gün bana candan ve yakın davrandığı için iyi bir gün geçirdim.
 - b. Arkadaşımın ailesindeki herkes bana candan ve yakın davrandığı için iyi bir gün geçirdim.
4. Bir grup arkadaşınızla geziye gittiniz ve çok eğlendiniz.
 - a. Ben neşeli olduğum için eğlendik.
 - b. Birlikte gittiğim arkadaşlar neşeli olduğu için eğlendik.
5. Tüm arkadaşlarınız grip oldu bir tek siz olmadınız.
 - a. Son zamanlarda sağlığım yerinde olduğum için gribe yakalanmadım.
 - b. Her zaman sağlıklı olduğum için gribe yakalanmadım.
6. Beslediğiniz bir hayvanı araba ezdi.
 - a. Ben ona iyi bakamadığım için ezildi.
 - b. Şoförler dikkatsiz olduğu için ezildi.
7. Tanıdığınız bazı çocuklar sizi sevmediklerini söylediler.
 - a. O çocuklar bana kötü davrandıkları için böyle söylemişlerdir.
 - b. Ben o çocuklara kötü davrandığım için böyle söylemişlerdir.
8. Derslerinizden çok iyi not aldınız.
 - a. Dersler kolay olduğu için iyi notlar aldım.
 - b. Çok çalıştığım için iyi notlar aldım.
9. Bir arkadaşınızla karşılaştınız ve size sevimli görüldüğünüzü söyledi.
 - a. O gün arkadaşıma herkes sevimli görüldüğü için böyle söylemiştir.
 - b. Arkadaşım her zaman başkalarına sevimli göründüklerini söylediği için bana da öyle demiştir.
10. En iyi arkadaşlarınızdan biri sizden nefret ettiğini söyledi.
 - a. O gün arkadaşımın huysuzluğu üzerinde olduğu için öyle söylemiştir.
 - b. Ben arkadaşıma o gün iyi davranmadığım için öyle söylemiştir.
11. Anlattığınız fıkraya hiç kimse gülmedi.
 - a. Ben hiç iyi fıkra anlatamadığım için hiç kimse gülmez.
 - b. Fıkrayı herkes bildiği için kimse gülmedi.
12. Öğretmeninizin derste anlattığı konuyu anlayamadınız.
 - a. O gün hiçbir şeye dikkatimi veremediğim için dersi anlayamadım.
 - b. Öğretmen anlatırken dikkatli dinlemediğim için dersi anlayamadım.

13. Öğretmeninizin uyguladığı bir testte başarısız oldunuz.
 - a. Öğretmenimiz her zaman zor testler uyguladığı için başarısız oldum.
 - b. Son birkaç haftadır öğretmenimiz zor testler uyguladığı için başarısız oldum.
14. Kilo aldınız ve oldukça şişman görünmeye başladınız.
 - a. Yemek zorunda olduğum yemekler şişmanlatıcı olduğu için şişmanladım.
 - b. Ben şişmanlatıcı yemekleri sevdiğim için şişmanladım.
15. Birisi paranızı çaldı.
 - a. Dürüst olmayan birisi paramı çalmıştır.
 - b. İnsanlar zaten dürüst değildir.
16. Yaptığınız bir şey için anne-babanız sizi ödüllendirdi.
 - a. Ben bazı şeyleri iyi yaptığım için ödüllendirildim.
 - b. Annem-babam yaptığım bazı şeyleri beğendikleri için beni ödüllendirirler.
17. Bilya oyununda tüm masketleri kazandınız.
 - a. Her şeyde şanslı olduğum için bilya oyununda da kazandım.
 - b. Oyunlarda şanslı olduğum için bilya oyununda da kazandım.
18. Denizde yüzerken neredeyse boğulacaktınız.
 - a. Her zaman dikkatsiz olduğum için az daha boğulacaktım.
 - b. Bazı günler dikkatsiz olduğum için az daha boğulacaktım.
19. Pek çok arkadaşınız sizi yaşgünü partisine çağırıyor.
 - a. Son zamanlarda arkadaşlarım beni cana yakın buldukları için yaşgünlerine çağırıyorlar.
 - b. Son zamanlarda ben arkadaşlara yakın davrandığım için yaşgünlerine çağırıyorlar.
20. Büyüklerinizden birisi size bağırdı.
 - a. İlk rastladığı insan ben olduğum için öfkesini benden çıkarmıştır.
 - b. O gün herkese bağırmıştır.
21. Bir grup arkadaşınızla bir çalışma yaptınız ve başarısız oldunuz.
 - a. O gruptaki kişilerle iyi anlaşamadığım için başarısız oldum.
 - b. Grup çalışmalarında hiçbir zaman iyi olmadığım için başarısız oldum.
22. Yeni bir arkadaş edindiniz.
 - a. İyi bir insan olduğum için arkadaş edinebilirim.
 - b. Karşılaştığım çocuklar iyi insan olduğum için arkadaş oluyorlar.
23. Ailenizdeki kişilerle iyi geçiniyorsunuz.
 - a. Ailemdeki kişilerle her zaman iyi geçinirim.
 - b. Ailemdeki kişilerle kimi zaman iyi geçinirim.
24. Çiklet satmayı denediniz ama kimse almadı.
 - a. Son zamanlarda çocuklar o kadar çok şey satıyorlar ki, artık insanlar çocuklardan birşey almak istemiyor.
 - b. İnsanlar genellikle çocuklardan birşey satın almaktan hoşlanmıyor.

25. Bir oyunda siz kazandınız.
a. Özellikle oyunlarda başarılı olmak için çok çaba gösterdiğim için ben kazandım.
b. Hemen her konuda başarılı olmak için çok çaba gösterdiğim için ben kazandım.
26. Düşük bir not aldınız.
a. Akılsız olduğum için düşük not aldım.
b. Öğretmenler düşük not veriyorlar.
27. Kapıya çarptınız ve burnunuz kanadı.
a. O anda önüme bakmadığım için kapıya çarptım.
b. Son zamanlarda çok dikkatsiz oldum.
28. Top oynarken bir hata yaptınız ve takımınız kaybetti.
a. O gün iyi oynamak için fazla uğraşmadım.
b. Top oyunlarında iyi oynamak için fazla uğraşmam.
29. Beden eğitimi dersinde ayağınızı burktunuz.
a. Son haftalarda beden eğitimi dersinde tehlikeli hareketler yaptığımız için burkuldu.
b. Son haftalarda beden eğitimi dersinde beceriksiz olduğum için burkuldu.
30. Anne-babanız sizi deniz kıyısına götürdü ve çok iyi vakit geçirdiniz.
a. O gün her şey çok güzel olduğu için iyi vakit geçirdim.
b. O gün hava güzel olduğu için iyi vakit geçirdim.
31. Sinemaya gitmek için bineceğiniz otobüs gecikti ve filmi kaçırdınız.
a. Otobüsler zamanında gelmiyor.
b. Zaten otobüsler hiçbir zaman zamanında gelmez.
32. Anneniz en sevdiğiniz yemeği pişirdi.
a. Annem her zaman beni mutlu etmek için çalışır.
b. Annem de beni mutlu etmek için çok az şey yapar.
33. Oynadığınız takım bir oyunu kaybetti.
a. Takımdaki oyuncular hiçbir zaman anlaşamadıkları için oyunu kaybettik.
b. Takımdaki oyuncular o gün anlaşamadıkları için oyunu kaybettik.
34. Ev ödevlerini çabucak bitirdiniz.
a. Son zamanlarda her şeyi çabucak yaptığım için erken bitirdim.
b. Son zamanlarda ev ödevlerimi çabucak yaptığım için erken bitirdim.
35. Öğretmeniniz bir soru sordu ve siz yanlış cevap verdiniz.
a. Bana soru sorulduğunda hep heyecanlandığım için yanlış cevap verdim.
b. Bana soru sorulduğunda o gün heyecanlandığım için yanlış cevap verdim.
36. Yanlış otobüse bindiniz ve kayboldunuz.
a. O gün çevreme dikkat etmediğim için kayboldum.
b. Genellikle çevreme dikkat etmediğim için kayboldum.

37. Lunaparka gidip çok eğlendiniz.
a. Genellikle lunaparkta çok eğlenirim.
b. Genellikle her yerde eğlenirim.
38. Sizden büyük bir çocuk sizi çok dövdü.
a. Kardeşiyle alay ettiğim için dövmüştür.
b. Kardeşi ona “Benimle alay etti” dediği için dövmüştür.
39. Yaşgününüzde istediğiniz tüm oyuncaklar armağan edildi.
a. Yakınlarım yaşgünümde hangi oyuncakları istediğimi doğru bilirler.
b. Bu yaşgünümde hangi oyuncakları istediğimi doğru bildiler.
40. Tatilde bir köye gidip çok iyi vakit geçirdiniz.
a. Köy yaşamak için güzel bir yer olduğu için iyi vakit geçirdim.
b. Köy bu mevsimde güzel olduğundan iyi vakit geçirdim.
41. Komşu çocuklar sizi yemeğe çağırdılar.
a. İnsanlar bazen nazik oluyorlar.
b. İnsanlar her zaman naziktirler.
42. Öğretmeninizin yerine bir başka öğretmen geldi ve sizden hoşlandı.
a. O gün sınıfta uslu olduğum için benden hoşlandı.
b. Sınıfta her zaman uslu olduğum için benden hoşlandı.
43. Birlikte gezdiğiniz arkadaşınız sizinle birlikte çok iyi vakit geçirdiğini söyledi.
a. Her zaman neşeli bir insan olduğum için iyi vakit geçirmiştir.
b. O gün neşeli olduğum için iyi vakit geçirmiştir.
44. Bakkal size bir şeker ikram etti.
a. O gün bakkala kibar davrandığım için bana şeker ikram etti.
b. O gün bakkalın iyiliği üzerinde olduğu için bana şeker ikram etti.
45. Gittiğiniz bir kukla tiyatrosunda kuklacı sizden yardım istedi.
a. Gözüne ilk ben iliştiğim için benden yardım istedi.
b. Benim oyunla gerçekten ilgilendiğimi anladığı için benden yardım istedi.
46. Bir arkadaşınızı sizinle birlikte sinemaya gitmek için kandırmaya çalıştınız ama gelmedi.
a. O gün canı hiçbir şey yapmak istemediği için gelmedi.
b. O gün canı sinemaya gitmek istemediği için gelmedi.
47. Uzun süredir samimi olan iki arkadaşınız birbirlerine küstüler.
a. Arkadaşlıkta geçinmek zor olduğu için küstüler.
b. Onların geçinmeleri zor olduğu için küstüler.
48. Bir çocuk klübüne üye olmaya çalıştınız ama sizi almadılar.
a. Hiçbir çocukla iyi geçinemediğim için almamışlardır.
b. O klüpteki çocuklarla iyi geçinemediğim için almamışlardır.

Appendix E: Children's Trait Anxiety Inventory

Adı Soyadı:

Tarih:

Kızların ve erkeklerin kendilerini anlattıkları bazı cümleler aşağıda verilmiştir. Her cümleyi okuyun ve hangisinin sizin için en doğru olduğuna karar verin. “Hemen hemen hiç” mi, “bazen” mi yoksa “sık sık” mı? Daha sonra sizi en doğru anlatan ifadenin önündeki parantezler arasına (X) işareti koyun. Yanlış veya doğru cevap diye bir şey yok. Herhangi bir cümle üzerinde fazla zaman geçirmeyin. Genellikle nasıl hissettiğinizi anlatan ifadeyi seçmeyi unutmayın.

1. Yanlış yapacağım diye endişelenirim. () hemen hemen hiç () bazen () sık sık
2. Ağlayacak gibi olurum. () hemen hemen hiç () bazen () sık sık
3. Kendimi mutsuz hissederim. () hemen hemen hiç () bazen () sık sık
4. Karar vermekte güçlük çekerim. () hemen hemen hiç () bazen () sık sık
5. Sorunlarımla yüz yüze gelmek bana zor gelir. () hemen hemen hiç () bazen () sık sık
6. Çok fazla endişelenirim. () hemen hemen hiç () bazen () sık sık
7. Evde sinirlerim bozulur. () hemen hemen hiç () bazen () sık sık
8. Utangacım. () hemen hemen hiç () bazen () sık sık
9. Sıkıntılıyım. () hemen hemen hiç () bazen () sık sık
10. Aklımdan engelleyemediğim önemsiz düşünceler geçer ve beni rahatsız eder. () hemen hemen hiç () bazen () sık sık
11. Okul beni endişelendirir. () hemen hemen hiç () bazen () sık sık
12. Ne yapacağıma karar vermekte zorluk çekerim. () hemen hemen hiç () bazen () sık sık
13. Kalbimin hızlı çarptığını fark ederim. () hemen hemen hiç () bazen () sık sık
14. Nedenini bilmediğim korkularım var. () hemen hemen hiç () bazen () sık sık
15. Annem-babam için endişelenirim. () hemen hemen hiç () bazen () sık sık
16. Ellerim terler. () hemen hemen hiç () bazen () sık sık
17. Kötü bir şeyler olacak diye endişelenirim. () hemen hemen hiç () bazen () sık sık
18. Geceleri uykuya dalmakta güçlük çekerim. () hemen hemen hiç () bazen () sık sık
19. Karnımda bir rahatsızlık hissederim. () hemen hemen hiç () bazen () sık sık
20. Başkalarının benim hakkımda ne düşündükleri beni endişelendirir. () hemen hemen hiç () bazen () sık sık

Appendix F: The McMaster Family Assessment Device

AİLE DEĞERLENDİRME ÖLÇEĞİ

AÇIKLAMA

İlişikte aileler hakkında 60 cümle bulunmaktadır. Lütfen her cümleyi dikkatlice okuduktan sonra, sizin ailenize ne derece uyduğuna karar veriniz. Önemli olan sizin ailenizi nasıl gördüğünüzdür.

Her cümle için 4 seçenek söz konusudur.

Aynen Katılıyorum	Eğer cümle sizin ailenize tamamen uyuyorsa işaretleyiniz.
Büyük ölçüde katılıyorum	Eğer cümle sizin ailenize çoğunlukla uyuyorsa işaretleyiniz.
Biraz katılıyorum	Eğer cümle sizin ailenize çoğunlukla uymuyorsa işaretleyiniz.
Hiç katılmıyorum	Eğer cümle sizin ailenize hiç uymuyorsa işaretleyiniz.

Her cümlenin yanında 4 seçenek için de ayrı yerler ayrılmıştır. Size uyan seçeneğe (X) işareti koyunuz. Her cümle için uzun uzun düşünmeyiniz. Mümkün olduğu kadar çabuk ve samimi cevaplar veriniz. Kararsızlığa düşerseniz, ilk aklınıza gelen doğrultusunda hareket ediniz. Lütfen her cümleyi cevapladığınızdan emin olunuz.

CÜMLELER	Aynen Katılıyorum	Büyük ölçüde katılıyorum	Biraz katılıyorum	Hiç katılmıyorum
1. Ailece ev dışında program yapmada güçlük çekeriz çünkü aramızda fikir birliği sağlayamayız.				
2. Günlük hayatımızdaki sorunların (problemlerin) hemen hepsini aile içinde hallederiz.				
3. Evde biri üzgün ise diğer aile üyeleri bunun nedenini bilir.				
4. Bizim evde kişiler kendilerine verilen her görevi düzenli bir şekilde yerine getirmezler.				
5. Evde birinin başı derde girdiğinde diğerleri de bunu fazlası ile dert ederler.				
6. Bir sıkıntı ve üzüntü ile karşılaştığımızda birbirimize destek oluruz.				
7. Ailemizde acil bir durum olsa şaşırıp kalırız.				
8. Bazen evde ihtiyacımız olan şeylerin bittiğinin farkına varmayız.				
9. Birbirimize karşı olan sevgi, şefkat gibi duygularımızı açığa vurmaktan kaçınırız.				
10. Gerektiğinde aile üyelerine görevlerini hatırlatır, kendilerine düşen işi yapmalarını sağlarız.				
11. Evde dertlerimizi, üzüntülerimizi birbirimize söylemeyiz.				
12. Sorunlarımızın çözümünde genellikle ailece aldığımız kararları uyguluyoruz.				
13. Bizim evdekiler, ancak onların hoşuna giden şey söylediğinizde sizi dinlerler.				
14. Bizim evde bir kişinin söylediklerinden ne hissettiğini anlamak pek kolay değildir.				
15. Ailemizde eşit bir görev dağılımı yoktur.				
16. Ailemiz üyeleri birbirlerine hoşgörülü davranırlar.				
17. Evde herkeze başına buyruktur.				
18. Bizim evde herkes söylemek istediklerine üstü kapalı değil de doğrudan birbirlerinin yüzüne söyler.				
19. Ailede bazılarımız duygularımız belli etmeyiz.				
20. Acil bir durumda ne yapacağımızı biliriz.				
21. Ailecek korkularımızı ve endişelerimizi birbirimizle tartışmaktan kaçınırız.				
22. Sevgi, şefkat gibi olumlu duygularımızı birbirimize belli etmekte güçlük çekeriz.				
23. Gelirimiz (ücret, maaş) ihtiyaçlarımızı karşılamaya yetmiyor.				
24. Ailemiz bir problemi çözdükten sonra bu çözümün işe yarayıp yaramadığını tartışır.				
25. Bizim ailede herkes kendini düşünür.				
26. Duygularımızı birbirimize açıkça söyleyebiliriz.				
27. Evimizde banyo ve tuvalet bir türlü temiz durmaz.				
28. Aile içinde birbirimize sevgi göstermeyiz.				
29. Evde herkes her istediğini birbirinin yüzüne söyleyebilir.				
30. Ailemizde her birimizin belirli görev ve sorumlulukları vardır.				
31. Aile içinde genellikle birbirimizle pek iyi geçinmeyiz.				

CÜMLELER	Aynen Katılıyorum	Büyük ölçüde katılıyorum	Biraz katılıyorum	Hiç katılmıyorum
32. Ailemizde sert-kötü davranışlar ancak belli durumlarda gösterilir.				
33. Ancak hepimizi ilgilendiren bir durum olduğu zaman birbirimizin işine karşınız.				
34. Aile içinde birbirimizle ilgilenmeye pek zaman bulamıyoruz.				
35. Evde genellikle söylediklerimizle söylemek istediklerimiz birbirinden farklıdır.				
36. Aile içinde birbirimize hoşgörülü davranırız.				
37. Evde birbirimize ancak sonunda kişisel bir yarar sağlayacaksa ilgi gösteririz.				
38. Ailemizde bir dert varsa kendi içimizde hallederiz.				
39. Ailemizde sevgi, şefkat gibi güzel duygular ikinci plandadır.				
40. Ev işlerinin kimler tarafından yapılacağını hep birlikte konuşarak kararlaştırırız.				
41. Ailemizde herhangi bir şeye karar vermek her zaman sorun olur.				
42. Bizim evdekiler sadece bir çıkarları olduğu zaman birbirlerine sevgi gösterirler.				
43. Evde birbirimize karşı açık sözlüyüzdür.				
44. Ailemizde hiç bir kural yoktur.				
45. Evde birinin bir şey yapması istendiğinde mutlaka takip edilmesi kendine hatırlatılması gerekir.				
46. Aile içinde herhangi bir sorunun nasıl çözüleceği hakkında kolayca karar verebiliriz.				
47. Evde kurallara uyulmadığı zaman ne olacağını bilmeyiz.				
48. Bizim evde aklınıza gelen her şey olabilir.				
49. Sevgi, şefkat gibi olumlu duygularımızı birbirimize ifade edebiliriz.				
50. Ailede her türlü problemin üstesinden gelebiliriz.				
51. Evde birbirimizle pek iyi geçinemeyiz.				
52. Sinirlenince birbirimize küseriz.				
53. Ailede bize verilen görevler pek hoşumuza gitmez çünkü genellikle umduğumuz görevler verilmez.				
54. Kötü bir niyetle olmasa da evde birbirimizin hayatına çok karşıyoruz.				
55. Ailemizde kişiler herhangi bir tehlike karşısında (yangın, kaza gibi) ne yapacaklarını bilirler çünkü böyle durumlarda ne yapılacağı aramızda konuşulmuş ve belirlenmiştir.				
56. Aile içinde birbirimize güveniriz.				
57. Ağlamak istediğimizde birbirimizden çekinmeden rahatlıkla ağlayabiliriz.				
58. İşimize (okulumuza) yetişmekte güçlük çekiyoruz.				
59. Aile içinde birisi hoşlanmadığımız bir şey yaptığında ona bunu açıkça söyleriz.				
60. Problemlerimizi çözmek için ailecek çeşitli yollar bulmaya çalışırız.				

Appendix G: Turkish Ways of Coping Inventory

Bir ebeveyn olarak çeşitli sorunlarla karşılaşıyorsunuz. Bu sorunlarla başa çıkabilmek için çeşitli duygu, düşünce ve davranışlardan yararlanıyor olabilirsiniz.

Sizden istenilen çocuğunuzun “Öğrenme Güçlüğü” ile ilgili olarak karşılaştığınız sorunlarla başa çıkabilmek için neler yaptığınızı göz önünde bulundurarak, aşağıdaki maddeleri cevap kağıdı üzerinde işaretlemenizdir. Lütfen her bir maddeyi dikkatle okuyunuz ve cevap formu üzerindeki aynı maddeye ait cevap şıklarından birini daire içine alarak cevabınızı belirtiniz. Başlamadan önce örnek maddeyi incelemeniz yararlı olacaktır.

ÖRNEK:

Madde 4. İyimser olmaya çalışırım.

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

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

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

Appendix H: Trait Anxiety Inventory

Adı Soyadı :

Cinsiyeti :

Yaşı :

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 sarfetmeksizin genel olarak nasıl hissettiğinizi gösteren cevabı işaretleyin.

	<u>Hemen hiç</u>	<u>Bazen</u>	<u>Çok</u>	<u>Hemen</u>
	<u>Bir zaman</u>		<u>Zaman</u>	<u>Her zaman</u>
1. Genellikle keyfim yerindedir.	()	()	()	()
2. Genellikle çabuk yorulurum.	()	()	()	()
3. Genellikle kolay ağlarım.	()	()	()	()
4. Başkaları kadar mutlu olmak isterim.	()	()	()	()
5. Çabuk karar vermek için fırsatları kaçıırım.	()	()	()	()
6. Kendimi dinlenmiş hissederim.	()	()	()	()
7. Genellikle sakin, kendime hakim ve soğukkanlıyım.	()	()	()	()
8. Güçlüklerin yenemeyeceğim kadar biriktiğini hissederim.	()	()	()	()
9. Önemsiz şeyler hakkında endişelenirim.	()	()	()	()
10. Genellikle mutluyum.	()	()	()	()
11. Herşeyi ciddiye alır ve etkilenirim.	()	()	()	()
12. Genellikle kendime güvenim yoktur.	()	()	()	()
13. Genellikle kendimi emniyette hissederim.	()	()	()	()
14. Sıkıntılı ve güç durumlarla karşılaşmaktan kaçınırım.	()	()	()	()
15. Genellikle kendimi hüznü hissederim.	()	()	()	()
16. Genellikle hayatımdan memnunum.	()	()	()	()
17. Olur olmaz düşünceler beni rahatsız eder.	()	()	()	()
18. Hayal kırıklığını öylesine ciddiye alırım ki hiç unutmam.	()	()	()	()
19. Akli başında ve kararlı bir insanım.	()	()	()	()
20. Son zamanlarda kafam takılan konular beni tedirgin eder.	()	()	()	()

Appendix I: Problem Solving Inventory

Bu envanterin amacı, günlük yaşantınızdaki problemlerinize (sorunlarınıza) genel olarak nasıl tepki gösterdiğinizi belirlemeye çalışmaktır. Sözü ettiğimiz bu problemler, matematik ya da fen derslerindeki alışmış olduğunuz problemlerden farklıdır. Bunlar, kendini karamsar hissetme, arkadaşlarla geçinememe, bir mesleğe yönelme konusunda yaşanan belirsizlikler ya da boşanıp boşanmama gibi karar verilmesi zor konularda ve hepimizin başına gelebilecek türden sorunlardır. Lütfen aşağıdaki maddeleri elinizden geldiüince samimiyetle ve bu tür sorunlarla karşılaştığımızda tipik olarak nasıl davrandığınızı göz önünde bulundurarak cevaplandırın. Cevaplarınızı, bu tür problemlerin nasıl çözülmesi gerektiğini düşünerek değil, böyle sorunlarla karşılaştığımızda *gerçekten* ne yaptığınızı düşünerek vermeniz gerekmektedir. Bunu yapabilmek için kolay bir yol olarak her soru için kendinize şu soruyu sorun : “ Burada sözü edilen davranışı ben ne sıklıkla yaparım ? ”

Yanıtlarınızı aşağıdaki ölçeğe göre değerlendirin:

- | | |
|--------------------------------|----------------------------------|
| 1. Her zaman böyle davranırım | 4. Arada sırada böyle davranırım |
| 2. Çoğunlukla böyle davranırım | 5. Ender olarak böyle davranırım |
| 3. Sık sık böyle davranırım | 6. Hiç bir zaman böyle davranmam |

Ne kadar sıklıkla böyle davranırsınız?

- | | | | | | | |
|--|---|---|---|---|---|---|
| 1. Bir sorunumu çözmek için kullandığım çözüm yolları başarısız ise bunların neden başarısız olduğunu araştırmam. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Zor bir sorunla karşılaştığımda ne olduğunu tam olarak belirleyebilmek için nasıl bilgi toplayacağımı uzun boylu düşünmem. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. Bir sorunumu çözmek için gösterdiğim ilk çabalar başarısız olursa o sorun ile başa çıkabileceğimden şüpheye düşerim. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. Bir sorunumu çözdükten sonra bu sorunu çözerken neyin işe yaradığını, neyin yaramadığını ayrıntılı olarak düşünmem. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. Sorunlarımı çözme konusunda genellikle yaratıcı ve etkili çözümler üretebilirim. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. Bir sorunumu çözmek için belli bir yolu denedikten sonra durur ve ortaya çıkan sonuç ile olması gerektiğini düşündüğüm sonucu karşılaştırırım | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. Bir sorunum olduğunda onu çözebilmek için başvurabileceğim yolların hepsini düşünmeye çalışırım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. Bir sorunla karşılaştığımda neler hissettiğimi anlamak için duygularımı incelerim . | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. Bir sorun kafamı karıştırdığında duygu ve düşüncelerimi somut ve açık-seçik terimlerle ifade etmeye uğraşmamam. | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. Başlangıçta çözümünü farketmesem de sorunlarımın çoğunu çözme yeteneğim vardır. | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. Karşılaştığım sorunların çoğu, çözebileceğimden daha zor ve karmaşıktır. | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. Genellikle kendimle ilgili kararları verebilirim ve bu kararlardan hoşnut olurum. | 1 | 2 | 3 | 4 | 5 | 6 |

13. Bir sorunla karşılaştığımda onu çözmek için genellikle aklıma gelen ilk yolu izlerim.	1	2	3	4	5	6
14. Bazen durup sorunlarım üzerinde düşünmek yerine gelişigüzel sürüklenip giderim.	1	2	3	4	5	6
15. Bir sorunla ilgili olası bir çözüm yolu üzerinde karar vermeye çalışırken seçeneklerimin başarı olasılığını tek tek değerlendirmem.	1	2	3	4	5	6
16. Bir sorunla karşılaştığımda başka konuya geçmeden önce durur ve o sorun üzerinde düşünürüm.	1	2	3	4	5	6
17. Genellikle aklıma gelen ilk fikir doğrultusunda hareket ederim.	1	2	3	4	5	6
18. Bir karar vermeye çalışırken her seçeneğin sonuçlarını ölçer, tartar,	1	2	3	4	5	6
19. Bir sorunumu çözmek üzere plan yaparken o planı yürütebileceğime güvenirim.	1	2	3	4	5	6
20. Belli bir çözüm planını uygulamaya koymadan önce, nasıl bir sonuç vereceğini tahmin etmeye çalışırım.	1	2	3	4	5	6
21. Bir soruna yönelik olası çözüm yollarını düşünürken çok fazla seçenek üretmem.	1	2	3	4	5	6
22. Bir sorunumu çözmeye çalışırken sıklıkla kullandığım bir yöntem ; daha önce başıma gelmiş benzer sorunları düşünmektir.	1	2	3	4	5	6
23. Yeterince zamanım olur ve çaba gösterirsem karşılaştığım sorunların çoğunu çözebileceğime inanıyorum.	1	2	3	4	5	6
24. Yeni bir durumla karşılaştığımda ortaya çıkabilecek sorunları çözebileceğime inancım vardır.	1	2	3	4	5	6
25. Bazen bir sorunu çözmek için çabaladığım halde, bir türlü esas konuya giremediğim ve gereksiz ayrıntılarla uğraştığım duygusunu yaşarım.	1	2	3	4	5	6
26. Ani kararlar verir ve sonra pişmanlık duyarım.	1	2	3	4	5	6
27. Yeni ve zor sorunları çözebilme yeteneğime güveniyorum.	1	2	3	4	5	6
28. Elimdeki seçenekleri karşılaştırırken ve karar verirken kullandığım sistematik bir yöntem vardır.	1	2	3	4	5	6
29. Bir sorunla başa çıkma yollarını düşünürken çeşitli fikirleri birleştirmeye çalışmam.	1	2	3	4	5	6
30. Bir sorunla karşılaştığımda bu sorunun çıkmasında katkısı olabilecek benim dışındaki etmenleri genellikle dikkate almam.	1	2	3	4	5	6
31. Bir konuyla karşılaştığımda ilk yaptığım şeylerden biri, durumu gözden geçirmek ve konuyla ilgili olabilecek her türlü bilgiyi dikkate almaktır.	1	2	3	4	5	6
32. Bazen duygusal olarak öylesine etkilenirim ki, sorunumla başa çıkma yollarından pek çoğunu dikkate bile almam.	1	2	3	4	5	6
33. Bir karar verdikten sonra, ortaya çıkan sonuç genellikle benim beklediğim sonuca uyar.	1	2	3	4	5	6
34. Bir sorunla karşılaştığımda, o durumla başa çıkabileceğimden genellikle pek emin değilimdir.	1	2	3	4	5	6
35. Bir sorunun farkına vardığımda, ilk yaptığım şeylerden biri, sorunun tam olarak ne olduğunu anlamaya çalışmaktır.	1	2	3	4	5	6

Appendix J: Maslach Burnout Inventory

Elinizdeki ankette anne/babaların yaşamlarındaki sıkıntılar, stresler ve yorgunlukları yansıtan ifadelere yer verilmiştir. Sizden istenen **her bir ifadenin örneklediği durumu ne kadar sıklıkla yaşadığınızı uygun yanıt aralığına (x) işareti** koyarak belirtmenizdir.

1. Çocuğumdan soğuduğumu hissediyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
2. Gün sonunda kendimi ruhen tükenmiş hissediyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
3. Sabah kalktığımda bir gün daha bu işi kaldıramayacağımı hissediyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
4. Çocuğumun ne hissettiğini hemen anlarım.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
5. Çocuğuma sanki insan değilmiş gibi davrandığımı farkediyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
6. Bütün gün çocuğumla uğraşmak için gerçekten çok yıpratıcı.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
7. Çocuğumun sorunlarına en uygun çözüm yollarını bulurum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
8. Çocuğumun bakımına yönelik olarak yaptığım işlerden tükendiğimi hissediyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
9. Yaptığım şeylerle çocuğumun yaşamına katkıda bulunduğuma inanıyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
10. Çocuğumla birlikte olmaya başladığımdan beri insanlara karşı sertleştim.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
11. Çocuğumun / çocuklarımin bakımının beni giderek katılaştırmasından korkuyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
12. Çok şeyler yapabilecek güçteyim.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
13. Çocuğumun beni kısıtladığını hissediyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
14. Çocuğumun bakımı konusunda çok fazla çalıştığımı hissediyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
15. Çocuğuma ne olduğu umurumda değil.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
16. Doğrudan doğruya çocuğumla ilgilenmek bende çok fazla stres yaratıyor.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
17. Çocuğumla aramda rahat bir hava yaratırım.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
18. Çocuğumla birlikte olduktan sonra kendimi canlanmış hissederim.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
19. Çocuğumun bakımına yönelik olarak bir çok kayda değer başarı elde ettim.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
20. Yolun sonuna geldiğimi hissediyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
21. Çocuğumla ilgili duygusal sorunlara serinkanlıkla yaklaşırım.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman
22. Çocuğumun kendisinin bazı problemlerini sanki ben yaratmışım gibi davrandığımı hissediyorum.
a. Hiçbir zaman b. Çok nadir c. Bazen d. Çoğu zaman e. Her zaman

Appendix K: Beck Depression Inventory

İsim :
Tarih:

Cinsiyeti :

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

1. (a) Kendimi üzgün hissetmiyorum.
(b) Kendimi üzgün hissediyorum.
(c) Her zaman için üzgünüm ve kendimi bu duygudan kurtaramıyorum.
(d) Öylesine üzgün ve mutsuzum ki dayanamıyorum.
2. (a) Gelecekte umutsuz değilim.
(b) Geleceğe biraz umutsuz bakıyorum.
(c) Gelecekte beklediğim hiçbir şey yok.
(d) Benim için bir gelecek yok ve bu durum düzelmeyecek.
3. (a) Kendimi başarısız görmüyorum.
(b) Çevremdeki birçok kişiden daha fazla başarısızlıklarım oldu sayılır.
(c) Geriye dönüp baktığımda, çok fazla başarısızlığımın olduğunu görüyorum.
(d) Kendimi tümüyle başarısız bir insan olarak görüyorum.
4. (a) Her şeyden eskisi kadar zevk alabiliyorum.
(b) Her şeyden eskisi kadar zevk alamıyorum.
(c) Artık hiçbir şeyden gerçek bir zevk alamıyorum.
(d) Bana zevk veren hiçbir şey yok. Herşey çok sıkıcı.
5. (a) Kendimi suçlu hissetmiyorum.
(b) Arada bir kendimi suçlu hissettiğim oluyor.
(c) Kendimi çoğunlukla suçlu hissediyorum.
(d) Kendimi her an için suçlu hissediyorum.

6. (a) Cezalandırıldığımı düşünmüyorum.
(b) Bazı şeyler için cezalandırılabilceğimi hissediyorum.
(c) Cezalandırılmayı bekliyorum.
(d) Cezalandırıldığımı hissediyorum.
7. (a) Kendimden hoşnutum.
(b) Kendimden pek hoşnut değilim.
(c) Kendimden hiç hoşlanmıyorum.
(d) Kendimden nefret ediyorum.
8. (a) Kendimi diğer insanlardan daha kötü görmüyorum.
(b) Kendimi zayıflıklarım ve hatalarım için eleştiriyorum.
(c) Kendimi hatalarım için çoğu zaman suçluyorum.
(d) Her kötü olayda kendimi suçluyorum.
9. (a) Kendimi öldürmek gibi düşüncelerim yok.
(b) Bazen kendimi öldürmeyi düşünüyorum, fakat bunu yapmam.
(c) Kendimi öldürebilmeyi isterdim.
(d) Bir fırsatını bulsam kendimi öldürürdüm.
10. (a) Her zamankinden daha fazla ağladığımı sanmıyorum.
(b) Eskisine göre şu sıralarda daha fazla ağlıyorum.
(c) Şu sıralarda her an ağlıyorum.
(d) Eskiden ağlayabilirdim, ama şu sıralarda istesem de ağlayamıyorum.
11. (a) Her zamankinden daha sinirli değilim.
(b) Her zamankinden daha kolayca sinirleniyor ve kızıyorum.
(c) Çoğu zaman sinirliyim.
(d) Eskiden sinirlendiğim şeylere bile artık sinirlenemiyorum.
12. (a) Diğer insanlara karşı ilgimi kaybetmedim.
(b) Eskisine göre insanlarla daha az ilgiliyim.
(c) Diğer insanlara karşı ilgimin çoğunu kaybettim.
(d) Diğer insanlara karşı hiç ilgim kalmadı.
13. (a) Kararlarımı eskisi kadar kolay ve rahat verebiliyorum.
(b) Şu sıralarda kararlarımı vermeyi erteliyorum.
(c) Kararlarımı vermekte oldukça güçlük çekiyorum.
(d) Artık hiç karar veremiyorum.
14. (a) Dış görünüşümün eskisinden daha kötü olduğunu sanmıyorum.
(b) Yaşlandığımı ve çekiciliğimi kaybettiğimi düşünüyor ve üzülüyorum.
(c) Dış görünüşümde artık değiştirilmesi mümkün olmayan olumsuz değişiklikler olduğunu hissediyorum.
(d) Çok çirkin olduğumu düşünüyorum.

15. (a) Eskisi kadar iyi çalışabiliyorum.
(b) Bir işe başlayabilmek için eskisine göre kendimi daha fazla zorlamam gerekiyor.
(c) Hangi iş olursa olsun, yapabilmek için kendimi çok zorluyorum.
(d) Hiçbir iş yapamıyorum.
16. (a) Eskisi kadar rahat uyuyabiliyorum.
(b) Şu sıralarda eskisi kadar rahat uyuyamıyorum.
(c) Eskisine göre 1 veya 2 saat erken uyanıyor ve tekrar uyumakta zorluk çekiyorum.
(d) Eskisine göre çok erken uyanıyor ve tekrar uyuyamıyorum.
- 17.(a) Eskisine kıyasla daha çabuk yorulduğumu sanıyorum.
(b) Eskisinden daha çabuk yoruluyorum.
(c) Şu sıralarda neredeyse her şey beni yoruyor.
(d) Öyle yorgunum ki hiç birşey yapamıyorum.
18. (a) İştahım eskisinden pek farklı değil.
(b) İştahım eskisi kadar iyi değil.
(c) Şu sıralarda iştahım epey kötü.
(d) Artık hiç iştahım yok.
19. (a) Son zamanlarda pek fazla kilo kaybettiğimi sanmıyorum.
(b) Son zamanlarda istemediğim halde üç kilodan fazla kaybettim.
(c) Son zamanlarda istemediğim halde beş kilodan fazla kaybettim.
(d) Son zamanlarda istemediğim halde yedi kilodan fazla kaybettim.
Daha az yemeye çalışarak kilo kaybetmeye çalışıyorum. Evet() Hayır()
20. (a) Sağlığım beni pek endişelendirmiyor.
(b) Son zamanlarda ağrı, sızı, mide bozukluğu, kabızlık gibi sorunlarım var.
(c) Ağrı, sızı gibi bu sıkıntılarım beni epey endişelendirdiği için başka şeyleri düşünmek zor geliyor.
(d) Bu tür sıkıntılar beni öylesine endişelendiriyor ki, artık başka hiçbir şey düşünemiyorum.
21. (a) Son zamanlarda cinsel yaşantımda dikkatimi çeken bir şey yok.
(b) Eskisine oranla cinsel konularla daha az ilgileniyorum.
(c) Şu sıralarda cinsellikle pek ilgili değilim.
(d) Artık, cinsellikle hiçbir ilgim kalmadı.

Appendix L: Parental Acceptance Rejection Questionnaire-Mother Form

Aile Çocuk İlişkileri Formu (ANNE)

Adı Soyadı:

Tarih:

Elinizdeki ölçekte annenin çocuğa karşı çeşitli davranış şekillerini içeren ifadeler verilmiştir. Her ifadeyi dikkatle okuyup, kendi davranışınıza ne derece uyduğunu düşününüz. Fazla zaman kaybetmeden ilk düşüncenizi kaydediniz. Eğer ifade sizin için **doğru** ise, hemen hemen her zaman doğru veya bazen doğru şikkını çarpılamak (x) suretiyle işaretleyiniz. İfade sizin için **doğru değil** ise, nadiren doğru veya hiçbir zaman doğru değil şikkını çarpılayarak işaretleyiniz.

Doğru ya da yanlış cevap yoktur. Soruları cevaplarken çocuğunuza karşı genelde nasıl davrandığınızı düşününüz. Soruların tamamını dürüst, samimi ve gerçekçi bir şekilde cevaplamamız önemlidir. Soruları Özgül Öğrenme Güçlüğü olan çocuğunuzla olan ilişkinizi düşünerek yanıtlayınız.

Örneğin:

<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
Hemen			Hiçbir
hemen			zaman
her zaman	Bazen	Nadiren	doğru
doğru	doğru	doğru	değil

1. Çocuğum iyi davrandığı zaman (X) () () ()
ona sarılır öperim.

Çocuğunuz iyi davrandığında hemen hemen her zaman ona sarılıp öpüyorsanız örnekte gösterildiği şekilde işaretleyiniz.

	<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
	Hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hiçbir zaman doğru değil
1. Ben çocuğum hakkında güzel şeyler söylerim.	()	()	()	()
2. Çocuğum kötü davrandığında onu küçümseyerek azarlarım.	()	()	()	()
3. Çocuğuma sanki orada yokmuş gibi davranırım.	()	()	()	()
4. Çocuğumu gerçekten sevip sevmediğimden şüphe ediyorum.	()	()	()	()
5. Günlük yaşantımızı çocuğumla tartışır ve fikrini alırım.	()	()	()	()
6. O beni dinlemediği zaman çocuğumu başkalarına şikayet ederim.	()	()	()	()
7. Çocuğumla candan ilgilenirim.	()	()	()	()
8. Çocuğumu arkadaşlarını eve getirmesi için cesaretlendiririm ve onların iyi vakit geçirmesine gayret ederim.	()	()	()	()
9. Çocuğumla alay ederim.	()	()	()	()
10. Beni rahatsız etmediği sürece çocuğumun varlığını bilmezlikten gelirim.	()	()	()	()
11. Kızgın olduğum zaman çocuğuma bağırırım.	()	()	()	()
12. Çocuğumun bana güvenip açılmasını kolaylaştırırım.	()	()	()	()
13. Çocuğuma sert davranırım.	()	()	()	()
14. Çocuğumun etrafımda olmasından hoşlanıyorum.	()	()	()	()

	<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
	Hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hiçbir zaman doğru değil
15. Çocuğum bir şeyi iyi yaptığında onun gurur duymasını sağlıyorum.	()	()	()	()
16. Haketmediği zaman bile çocuğuma vururum.	()	()	()	()
17. Çocuğum için yapmam gereken şeyleri unutuyorum.	()	()	()	()
18. Çocuğumu başkalarına överim.	()	()	()	()
19. Kızgın olduğum zaman çocuğumu cezalandırırım.	()	()	()	()
20. Çocuğumla şefkat ve sevgi dolu konuşurum.	()	()	()	()
21. Çocuğuma karşı çok sabırsızım.	()	()	()	()
22. Çocuğumun sorularına cevap veremeyecek kadar meşgulum.	()	()	()	()
23. Çocuğuma içerliyorum.	()	()	()	()
24. Çocuğumu hak ettiği zaman överim.	()	()	()	()
25. Çocuğum sinirime dokunur.	()	()	()	()
26. Çocuğumun kimlerle arkadaşlık ettiği ile ilgilenirim.	()	()	()	()
27. Çocuğumun hayatındaki olaylarla(gerçekten ilgilenirim.	()	()	()	()
28. Çocuğumla kırııcı konuşurum.	()	()	()	()
29. Çocuğum yardım istediği zaman anlamazlıktan gelirim.	()	()	()	()
30. Çocuğumun başı dertte olduğunda ona karşı anlayışsız davranırım.	()	()	()	()

	<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
	Hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hiçbir zaman doğru değil
31. Çocuğuma istenilen ve ihtiyaç duyulan bir kişi olduğunu hissettiririm.	()	()	()	()
32. Çocuğuma sinirime dokunduğunu() söylerim.	()	()	()	()
33. Çocuğuma büyük özen gösteririm.	()	()	()	()
34. Çocuğum iyi davrandığı zaman onunla gurur duyduğunu söylerim.	()	()	()	()
35. Çocuğumun kalbini kırarım.	()	()	()	()
36. Çocuğumun hatırlamamı beklediği olayları unuturum.	()	()	()	()
37. Çocuğum yanlış hareket ettiği zaman onu artık sevmediğimi hissettiririm.	()	()	()	()
38. Çocuğuma yaptığı şeyin önemli olduğunu hissettiririm.	()	()	()	()
39. Çocuğum yanlış bir şey yaptığında onu tehdit ediyorum veya korkutuyorum.	()	()	()	()
40. Çocuğumla birlikte vakit geçirmekten hoşlanırım.	()	()	()	()
41. Çocuğum üzülüşü, tasalandığı veya korktuğu zaman ona yardım etmeye çalışırım.	()	()	()	()
42. Çocuğum kötü davrandığı zaman onu oyun arkadaşlarının yanında küçük düşürürüm.	()	()	()	()
43. Çocuğumun benimle beraber olmasından kaçınırım.	()	()	()	()

	<u>Benim için Doğru</u>		<u>Benim için Doğru Değil</u>	
	Hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hiçbir zaman doğru değil
44. Çocuğumdan şikayet ederim.	()	()	()	()
45. Çocuğumun görüşlerine saygı duyarım ve açıkça söylemesi için onu cesaretlendiririm.	()	()	()	()
46. Çocuğumu olumsuz bir şekilde başka çocuklarla kıyaslarım.	()	()	()	()
47. Plan yaptığım zaman çocuğumu da göz önünde bulundururum.	()	()	()	()
48. Benim için uygun olmasa bile, çocuğumun önemli gördüğü şeyleri yapmasına izin veririm.	()	()	()	()
49. Çocuğum kötü davrandığında onu başka çocuklarla haksız bir şekilde kıyaslarım.	()	()	()	()
50. Çocuğuma istenmediğini hissettiririm.	()	()	()	()
51. Çocuğumun yaptığı şeylere ilgi duyuyorum.	()	()	()	()
52. Çocuğum kötü davrandığı zaman ondan utandığımı söylerim.	()	()	()	()
53. Çocuğuma onu sevdiğimi hissettiririm.	()	()	()	()
54. Çocuğuma nazik ve yumuşak Davranırım.	()	()	()	()
55. Çocuğum yanlış davrandığında onu utandırmaya veya suçlu hissettirmeye çalışırım.	()	()	()	()
56. Çocuğumu mutlu etmeye çalışırım.	()	()	()	()

Şimdi başa dönerek boş bıraktığınız soruları cevaplayınız.

Appendix M: Biographical Information Sheet

1. Ad soyad:.....
2. Yaşınız:.....
3. Eğitim:
 1. Okur-Yazar 4. Lise ve dengi okul mezunu
 2. İlkokul mezunu 5. Üniversite veya yüksek okul mezunu
 3. Ortaokul mezunu 6. Yüksek lisans ve Üstü
4. Evlilik durumunuzu belirtiniz
 1. Evli ve kocasıyla yaşıyor 3. Dul
 2. Boşanmış 2. Boşanmamış, ayrı yaşıyor
5. Kaç çocuğunuz var?.....
6. Aşağıda çocuklarınızın cinsiyet ve yaşını belirtiniz.
1. Çocuk: Cinsiyet Kız Erkek Yaşı:
2. Çocuk: Cinsiyet Kız Erkek Yaşı:
3. Çocuk: Cinsiyet Kız Erkek Yaşı:
4. Çocuk: Cinsiyet Kız Erkek Yaşı:
7. Aylık eve giren para miktarı ne kadardır?
 500 milyondan az 1,5 milyar – 2 milyar arası
 500 milyon-1 milyar arası 2 milyar ve üstü
 1 milyar – 1,5 milyar arası
8. İş:
 1. Çalışmıyorum
 2. Çalışıyorum
 3. Diğer (Belirtiniz).....
9. Ne tür bir işte çalışıyorsunuz?
 1. Serbest 3. İşçi
 2. Memur 4. Emekli
10. Mesleğinizi belirtiniz:.....
11. Babanın Yaşı:.....
12. Babanın eğitimi:
 1. Okur-Yazar 4. Lise ve dengi okul mezunu
 2. İlkokul mezunu 5. Üniversite veya yüksek okul mezunu
 3. Ortaokul mezunu 6. Yüksek lisans ve Üstü
12. Babanın iş durumu:
 1. Serbest 3. İşçi
 2. Memur 4. Emekli

Appendix N: Turkish Summary

Öğrenme güçlüğü toplumun % 5 ila 10'unda görülen bir bozukluktur (Kronenberger & Dunn 2003). Ülkemizde okul çağı çocuklarının % 10 - % 20'si öğrenme güçlüğü (ÖG) tanısı almaktadır Erden, Kurdoğlu, Uslu, 2002). Bu çocuklar okul sorunları ile birlikte ebeveyn ve yaşlıları ile de sorunlar yaşamaktadır. Akademik başarısızlığın yanı sıra akran ve ebeveyn ilişkilerinde de zorluklar yaşamak çocuk için farklı duygusal sorunlara yol açmaktadır. Bazı araştırmalar öğrenme güçlüğüne çocuğun benlik algısının yanı sıra uyumunu da bozduğunu göstermektedir (Humphrey, 2002). Bu araştırmanın amacı, aile kabul ve reddi, benlik saygısı ve psikolojik uyumun öğrenme güçlüğü olan çocuklardaki ilişkilerini bulmaya çalışmaktır.

Aile kabul ve reddi ebeveynliğin sıcaklık boyutu ile ilgilidir. Sıcaklığın bir ucunda kabul, diğerinde ise red kavramları vardır. Her birey bu yelpazenin bir noktasına yerleştirilebilir çünkü, herkes ebeveynlerinden az ya da çok yakınlık görür. Aile kabul ve reddi teorisine göre, çocukların psikolojik uyumu, ebeveyn kabul-reddi deneyimlerine göre değişir. Algılanan ebeveyn kabul-reddini değerlendiren meta-analizler çocuklardaki psikolojik sorunların cinsiyet, ırk, coğrafya, dil veya kültür farkı gözetmeksizin ebeveyn kabul-reddi ile ilişkili bulunmaktadır (Khaleque & Rohner, 2002). Ebeveynlik, çocuklukta düşük benlik saygısının ortaya çıkmasına yönelik olarak bir risk faktörüdür (Rohner, 1986).

Ayrıca arařtırmalar, düşük benlik saygısının daha sonraki bir depresif dönemi yordayabileceğini göstermektedir.

Okulda başarılı olmak, ebeveynler, akranlar arasında ve genel olarak toplumda oldukça fazla önem verilen bir konudur. Dolayısıyla akademik başarısızlığa atfedilen olumsuz değerler kolaylıkla küçümsenemez. Tekrarlanan akademik başarısızlıklar kendini korumaya yönelik stratejilerin gelişmesi, çaresizlik ve psikolojik uyum sorunları gibi olumsuz motivasyon tarzları gelişmesine neden olur (Valas, 2001a).

Öğrenme güçlüğü olan çocuklar sorunlarının doğası gereği sık sık başarısızlıklar yaşarlar. Sınıf içerisinde yaşadıkları zorluklar akademik problemlere neden olur. Sosyal anlamda ebeveynleri, öğretmenleri ve akranlarından olumsuz geri bildirimler alırlar. Dolayısıyla, sık sık başarısızlık yaşayan çocuklar öğrenilmiş çaresizlik tepkileri geliştirme riski taşırlar. Öğrenilmiş çaresizlik tepkisi geliştiren çocuklar ise başarısızlıklarını kendi beceriksizliklerine atfederler. Bu atıf tarzı zor görevler karşısında daha az çaba gösterilmesine neden olabilir. Dolayısıyla, öğrenilmiş çaresizlik tepki tarzı geliştirmiş olan çocuklar bir başarısızlık deneyiminden sonra bir görevi gerçekleştirmeye yönelik daha az ısrarcı olurlar. Bu da daha fazla başarısızlığa neden olur ve çocuğun problem çözemeyeceği inancını pekiştirerek bu inancın doğrulanmasına neden olan davranışları ortaya çıkartır (Milich & Okazaki, 1991).

Yazında öğrenme güçlükleri ile psikolojik sorunlar arasında ilişki bildirilmektedir ancak, bu ilişkinin yönü açık değildir. Psikolojik sorunlar arasında depresyon, kaygı, düşük benlik saygısı ve başarı ve başarısızlık ile ilgili hatalı atıflarda bulunma bildirilmektedir (Greeham, 1999; Valas, 2001b).

Öğrenme güçlüğü olan çocuklarda ayrıca sosyal ve duygusal problemler de bildirilmiştir (Grolnick & Ryan, 1990; Dyson, 2003). Bazı araştırmalarda öğrenme güçlüğü olan çocuklar için hafif depresyon semptomları bildirilmiş, bunlar hatalı atıf tarzları ile ilişkilendirilmişlerdir (Greenham, 1999; Rodriguez & Routh, 1989). Çocukluk depresyonu ile ilgili en yaygın görüş erişkinlik depresyonuna benzer olduğu yönündedir (American Psychiatric Association, 1980).

Öğrenme güçlüğü olan çocuklarda artmış kaygı düzeyleri bildirilmektedir (Greenham, 1999). Normatif örneklem grupları ve normal düzeyde başarılı olduğu bildirilen kontrol gruplarına kıyasla öğrenme güçlüğü olan çocuklarda daha fazla kaygı düzeyi bildirilmiştir (Paget & Reynolds, 1984; Fisher, Allen & Kose, 1996; Rodriguez & Routh, 1989).

Öğrenme güçlüğü olan çocukların ebeveynlerinin ÖG olmayan çocukların ebeveynlerine kıyasla aile organizasyonu ile daha fazla ilgili oldukları, daha kaygılı oldukları ve aile arasında daha az yakınlık ile daha fazla iletişim sorunu olduğu da bildirilmektedir (Margalit & Heiman, 1988; Morrison & Zetlin, 1992).

Öğrenme güçlüğü olan bir çocuğa sahip olmanın etkilerini araştıran çalışmalar oldukça azdır. Özürlü çocukların ailelerinde aile sistemine bakıldığında bazı ebeveynlerin çocuklarının bakımı ile ilgili karşı karşıya kaldıkları zorluklar nedeniyle stres ve duygusal zorlanma yaşadıkları bildirilmektedir (Daniels-Mohring & Lambie, 1993; Dyson, 1993; Waggoner & Wilgosh, 1990).

Kronik hastalığı olan çocuklar daha fazla kaygı yaşayabilmektedir (Vila, Nollet-Clemencon, de Blic, Mouren-Simeoni, & Scheinmann, 2000; Moussa, Alsaeid, Abdella, Refai, Al-Sheikh, & Gomez, 2005). Diyabet psikososyal

işlevselliği etkileyerek hem çocuğun hem de ailesinin yaşam kalitesini değiştirebilir (Delamater et al., 2001; Northam, Todd, & Cameron, 2006). Diyabetli çocukların uyumlarının diabetli olmayan çocuklarla karşılaştırıldığı bir araştırmada, diyabetli çocuklarda depresyon, bağımlılık ve geri çekilmenin akranlarına göre daha fazla bildirildiği ortaya konmuştur (Grey, Cameron, Lipman, & Thurber, 1995).

Bu araştırmada karşılaştırma grubu olarak diyabetli çocukların seçilmelerinin nedeni önceki araştırmalarda öğrenme güçlüğü olan çocuklarda sağlıklı akranlarına göre daha fazla depresyon ve kaygı semptomu ile daha düşük benlik algısı bildirilmesinden kaynaklanmaktadır. Diabetli çocuklar da sağlıklı akranlarına göre daha kaygılı ve depresif olarak bildirilmiş, benlik saygılarının daha düşük olabildiği belirlenmiştir (Swift, Seidman & Stein, 1967; Close, Davies, Price, & Goodyer, 1986). Dolayısıyla, bu çalışmadaki araştırma sorusu öğrenme güçlüğü olan çocukların kronik hastalığı olan ve normal gruplardan daha fazla sorun psikolojik uyum sorunu olduğu bildirilen bir gruba kıyasla durumlarını belirlemektir.

Yazında ebeveyn kabul-reddi, psikolojik uyum, öğrenilmiş çaresizlik , depresyon, kaygı ve benlik saygısı arasındaki ilişki, öğrenme güçlüğü olan çocuklar için açık değildir. Dolayısıyla bu araştırmanın amaçları:

1. Öğrenme güçlüğü olan çocuklarda ebeveyn kabul-reddi ile depresyon arasındaki ilişkide benlik saygısının aracı değişken olarak rolünü belirlemek.

2. Öğrenme güçlüğü olan çocuklarda öğrenilmiş çaresizlik ile depresyon arasındaki ilişkide benlik saygısının aracı değişken olarak rolünü belirlemek.
3. Öğrenme güçlüğü olan çocuklarla diyabetli çocukların benlik saygısı, depresyon, kaygı, öğrenilmiş çaresizlik, ve ebeveyn kabulü-reddi çerçevesinde psikolojik uyum düzeyleri arasındaki farklılıkları belirlemek.
4. Öğrenme güçlüğü olan çocuklar ile diyabetli çocukların psikolojik uyum düzeyinin cinsiyet açısından karşılaştırmak.
5. Öğrenme güçlüğü ve diyabetli çocuklara sahip olan iki anne grubunu psikolojik uyum düzeyleri, depresyon, kaygı, aile işlevleri, başa çıkma, problem çözme becerileri ve ebeveyn tükenmişliği açısından karşılaştırmak.
6. Öğrenme güçlüğü ve diyabetli çocuklara sahip olan iki anne grubunu algılanan ebeveyn kabulü-reddi açısından karşılaştırmak.

Araştırma grubu için Gazi Üniversitesi Hastanesi Çocuk Psikiyatri Bölümü'ne okul problemleri ile sevk edilmiş 8-13 yaş arası çocuklar seçilmiştir. Araştırmaya kabul edilebilmek için çocukların çocuk psikiyatristi tarafından değerlendirilerek Öğrenme Güçlüğü tanısı almış olmaları gerekmektedir. Kontrol grubu için Diyabet tanısı almış olan çocuklar araştırmaya katılmıştır. Gazi Üniversitesi Hastanesi Çocuk Sağlığı Bölümü tarafından Diyabet tanısı konulmuş, yaşları 8-13 arasında değişen 70 çocuk araştırmaya alınmıştır. Ayrıca, bu gruptaki çocuklar için, Öğrenme Güçlüğü olan çocukların araştırmaya katılma kriterlerinin dışında bir başka önkoşul olarak başka bir DSM-IV tanısı almamak önkoşulu belirlenmiştir. Tüm çocukların zeka bölümü katsayıları Wechsler Çocuklar için

Zeka Ölçeği-R ile değerlendirilmiştir. Dolayısıyla, araştırmaya katılma kriterleri olarak aşağıdaki kriterler kullanılmıştır: a) Hiçbir duysal bozukluk, zeka geriliği, duysal bozukluk veya eğitim yetersizliği olmamalıdır; b) Tüm puan zeka bölümü katsayıları 90'ın üzerinde olmalıdır.

Öğrenme Güçlüğü olan çocukların 34'ü kız (%33,3), 68'i erkektir (%66,7). Bu çocukların yaşları 8-13 arasında değişmekte olup, ortalaması 9,48 ve standart sapması 1,49 olarak belirlenmiştir.

Öğrenme Güçlüğü tanısı almış olan bu çocukların okuma, yazma, aritmetik alanlarından bir veya birkaçında bozuklukları vardır. Bu çocuklar arasında %5,9'unun (n=6) yalnızca okuma bozukluğu, %16,7'sinin (n=17) yalnızca yazma bozukluğu, %2,9'unun (n=3) ise yalnızca aritmetik bozukluğu olduğu belirlenmiştir. Bu tanıların birarada görüldüğü çocuklar %74,5 (n=76) olarak belirlenmiştir.

Öğrenme Güçlüğü olan 102 çocuğun WISC-R puanları şu şekildedir: Sözel bölüm zeka bölümü katsayısı ortalaması 86,60, standart sapması 11,82; performans zeka bölümü katsayısı ortalaması 100,28, standart sapması 12,04 ve toplam zeka bölümü katsayısı ortalaması 92,74, standart sapması ise 10,67 olarak belirlenmiştir.

Öğrenme Güçlüğü olan çocukların annelerinin yaş ortalaması 37,86, standart sapması 5,40 olarak belirlenmiştir. Babaların yaş ortalaması ve standart sapması ise, 41,29, 4,82'dir.

Diyabet tanısı almış olan çocukların 27'si kız (%38,6), 43'ü erkektir (%61,4). Bu çocukların yaşları 8-13 arasında değişmekte olup, ortalaması 9,69 ve standart sapması 1,57 olarak belirlenmiştir.

Diyabet tanısı almış olan 70 çocuğun WISC-R puanları şu şekildedir: Sözel bölüm zeka bölümü katsayısı ortalaması 104,34, standart sapması 13,19; performans zeka bölümü katsayısı ortalaması 102,96, standart sapması 13,02 ve toplam zeka bölümü katsayısı ortalaması 103,99, standart sapması ise 13,88 olarak belirlenmiştir.

Diyabet tanısı almış olan çocukları annelerinin yaş ortalaması 37,09, standart sapması 5,23 olarak belirlenmiştir. Babaların yaş ortalaması ve standart sapması ise, 40,96, 3,93'tür.

Bu araştırmada kullanılan ölçüm araçları çocuklar için sırasıyla şu şekildedir: Aile Kabul-Reddi Envanteri (Çocuk Formu); Piers-Harris Çocuklar için Benlik Algısı Ölçeği; Çocuklar için Öğrenilmiş Çaresizlik Ölçeği; Çocuklar için Sürekli Kaygı Ölçeği. Anneler için kullanılan ölçüm araçları ise: Aile Değerlendirme Ölçeği; Başa Çıkma Tarzları Ölçeği; Sürekli Kaygı Envanteri; Problem Çözme Envanteri; Maslach Tükenmişlik Envanteri; Beck Depresyon Envanteri; Aile Kabul-Reddi Envanteri (Anne Formu); Bigi Formu.

Çocuklar çocuk psikiyatristi tarafından değerlendirilerek tanıları konulmuştur. Daha sonraki seanslarda çocuklara test ve envanterler uygulanmıştır. Öğrenme Güçlüğü olan çocukların, okuma zorluğundan kaynaklanabilecek sorunlarını ortadan kaldırmak amacı ile ölçekler çocuklara okunmuş, çocukların da kağıt üzerinden takip etmeleri istenmiştir. Çocukları değerlendirilirken annelere kendi dolduracakları ölçekler verilmiştir. Ayrıca anneler, yakın zamanda ortaya çıkan stresli veya travmatik yaşam olaylarına yönelik olarak değerlendirilmiş, bu tür yaşantıları yakın zamanda yaşamış olan annelerin

arařtırma aısından karıřtırıcı faktörlere neden olacađı düşünülerek bu annelerin arařtırma dıřı bırakılması öngörölmüřtür.

Sonular 5 bařlık altında ele alınmıřtır: İlk alt bařlık altında 5 öleđin (Benlik Saygısı, Öđrenilmiř aresizlik, Ebeveyn Reddi, Depresyon ve Kaygı) iki grup ocuk için nasıl farklılařtıđı 2 (tanı) X 2 (cinsiyet) oklu Varyans Analizi yapılmıř, yař ortak deđiřen olarak alınmıřtır.

İkinci alt bařlık altında Öđrenme Güçlüđü ve Diyabet tanısı almıř olan ocukların Depresyon ve Kaygı semptomları ile bađlantılı deđiřkenlerin belirlenmesi için dört ayrı regresyon analizi yapılmıřtır.

Üüncü alt bařlık altında benlik saygısının Aile Kabul-Reddi ve Depresyon ile Öđrenilmiř aresizlik ve Depresyon arasındaki aracı deđiřken rolünü deđerlendirmek amacı ile iki farklı regresyon analizi gerekleřtirilmiřtir.

Dördüncü alt bařlık altında anneye özgü bilgiler deđerlendirilmiřtir. Depresyon, Kaygı, Aile Deđerlendirme alt test puanları, Problem özme Becerileri, Bařa ıkma Tarzları ve Aile Kabul-Reddi, Tükenmiřlik düzeyleri ölçümlerinin iki tanı grubu arasındaki farkları belirlemek amacı ile tek yönlü varyans analizi yapılmıřtır.

Son alt bařlık altında ise yalnızca Öđrenme Güçlüđü tanısı olan (n=62) ve Öđrenme Güçlüđü'nün yanı sıra Dikkat Eksikliđi Hiperaktivite Bozukluđu eř tanısı konulmuř olan (n=32) iki grup ocuk ve annelerinin psikolojik uyum düzeyleri karřılařtırılmıřtır. Bu bölümde iki grubun karřılařtırılması için ayrı ayrı varyans analizleri gerekleřtirilmiřtir.

İki Grup Çocuğun Karşılaştırılması

Psikolojik Uyum

Bu bölümde çocukların psikolojik uyum düzeyleri benlik saygısı, öğrenilmiş çaresizlik, algılanan ebeveyn reddi, depresyon ve kaygı düzeyleri açısından değerlendirilmiştir. Gruplar arası karşılaştırmalar Öğrenme Güçlüğü olan 79 çocuk ile Diyabet tanısı konmuş 70 çocuk arasında gerçekleştirilmiştir.

Benlik Saygısı

Tanı temel etkisi, öğrenme güçlüğü olan çocukların diyabet tanısı almış olanlara kıyasla daha düşük benlik saygısı puanları aldıklarını göstermiştir. Cinsiyet temel etkisi ise kız çocukların erkeklere göre daha düşük benlik saygısı puanları aldıklarını göstermiştir.

Öğrenilmiş Çaresizlik

Tanı temel etkisi öğrenme güçlüğü olan çocukların diyabetli çocuklara göre daha yüksek öğrenilmiş çaresizlik puanları aldığını göstermiştir. Cinsiyet X Tanı ortak etkisine göre ise diyabetli kızların erkeklere göre daha fazla öğrenilmiş çaresizlik düzeyi bildirdikleri belirlenmiştir. Öte yandan öğrenme güçlüğü olan kız ve erkeklerin öğrenilmiş çaresizlik düzeylerinin birbirinden anlamlı derecede farklı olmadığı belirlenmiştir. Diyabetli erkeklerin öğrenme güçlüğü olan erkeklerden daha düşük öğrenilmiş çaresizlik düzeyi bildirdiği belirlenmiştir. Benzer olarak, öğrenme güçlüğü olan kızların da diyabetli kızlara göre daha yüksek öğrenilmiş çaresizlik düzeyleri bildirdiği belirlenmiştir.

Ebeveyn Kabulü-Reddi

Varyans analizi sonuçlarına göre tanı temel etkisi anlamlı bulunmuştur. Buna göre öğrenme güçlüğü olan çocukların diyabetli çocuklara göre daha fazla

ebeveyn reddi algıladıkları belirlenmiştir. Cinsiyet temel etkisi anlamlı çıkmamıştır. Ancak Tanı X Cinsiyet ortak etkisi anlamlıdır. Buna göre diyabetli kız çocuklarının erkeklere göre daha fazla ebeveyn reddi bildirdiği, öğrenme güçlüğü olan kız ve erkek çocuklarının ise birbirinden anlamlı düzeyde farklı ebeveyn reddi bildirmediği ortaya çıkmıştır. Öğrenme güçlüğü olan erkek çocukların diyabetli erkek çocuklarla karşılaştırıldığında daha fazla ebeveyn reddi algıladıkları belirlenmiştir. Öğrenme güçlüğü ve diyabetli kızların arasında algılanan ebeveyn reddi açısından fark bulunmamıştır.

Depresyon

Tanı temel etkisine göre öğrenme güçlüğü olan çocukların diyabetli çocuklara göre daha fazla depresif belirtiler gösterdiği belirlenmiştir. Cinsiyet temel etkisine göre ise kızların erkek çocuklara göre daha fazla depresif belirtiler bildirdiği saptanmıştır. Cinsiyet X Tanı ortak etkisine göre Diyabetli kızların erkeklere göre daha fazla depresif semptom bildirdiği ortaya konulmuştur. Öğrenme Güçlüğü olan kız ve erkek çocukların birbirlerinden depresif semptomlar açısından anlamlı düzeyde farklılık göstermedikleri belirlenmiştir. Hem öğrenme güçlüğü hem de diyabetli gruptaki kızların erkeklere göre daha fazla depresif semptom bildirdiği ortaya konulmuştur.

Kaygı

Varyans analizi sonuçlarına göre tanı temel etkisi anlamlı bulunmuştur. Buna göre Öğrenme Güçlüğü olan çocukların Diyabetli çocuklara göre daha fazla kaygı belirtisi gösterdikleri belirlenmiştir. Cinsiyet temel etkisine göre ise kızların erkek çocuklara göre daha fazla kaygı belirtileri bildirdiği saptanmıştır. Cinsiyet X Tanı ortak etkisine göre diyabetli kızların erkeklere göre daha fazla kaygı

belirtisi bildirdiği ortaya konulmuştur. Öğrenme güçlüğü olan kız ve erkek çocukların birbirlerinden kaygı belirtileri açısından anlamlı düzeyde farklılık göstermedikleri belirlenmiştir. Öğrenme güçlüğü olan erkek çocukların diyabetli erkek çocuklara göre daha fazla depresif semptom bildirdiği ortaya konulmuştur. Öğrenme güçlüğü ve diyabetli kız çocuklarının birbirlerinden kaygı belirtileri açısından anlamlı düzeyde farklılık göstermediği belirlenmiştir.

Öğrenme Güçlüğü ve Diyabet Tanısı Konmuş olan Çocukların Depresyon ve Kaygı Belirtileri ile İlişkili Değişkenler

Bu başlık altında öğrenme güçlüğü ve diyabet tanısı konmuş olan çocukların depresyon ve kaygı belirtileri ile ilişkili olan değişkenleri bulmak amacıyla dört farklı regresyon analizi gerçekleştirilmiştir.

Belirtilen dört regresyon analizini gerçekleştirmek amacıyla ilk adımda çocuğun yaşı ve cinsiyeti ile çocuğun ailesine ilişkin değişkenler (baba ve annenin yaşları ve eğitim düzeyleri) hiyerarşik olarak girilmiştir. Regresyon analizinin ikinci adımında çocuğun psikolojik durumuna ilişkin değişkenler (Ebeveyn Kabul-Reddi toplam puanı, Piers-Harris Benlik Algısı toplam puanı, Öğrenilmiş Çaresizlik Enventeri toplam puanı) girilmiştir. Üçüncü adımda annenin psikolojik durumuna (annenin depresyon ve kaygı düzeyleri ile başa çıkma tarzları) ilişkin değişkenler analize katılmıştır.

Öğrenme Güçlüğü olan Çocuklarda Depresyon Belirtileri ile İlişkili Değişkenler

Uygulanan regresyon analizine göre düşük benlik saygısı ile algılanan ebeveyn reddinin çocuklarda görülen depresyon ile ilişkili olduğu belirlenmiştir. Ayrıca annelere ilişkin özelliklerden, annenin daha az duygusal başa çıkma tarzını

kullanması ile depresyon belirtileri çocuklarda görülen depresyon belirtileri ile ilişkili olduğu bulunmuştur.

Öğrenme Güçlüğü olan Çocuklarda Kaygı Belirtileri ile İlişkili Değişkenler

Çocuklardaki kaygı belirtileri ile düşük benlik saygısı ve babanın daha genç yaşta olması ilişkili bulunmuştur. Ayrıca annelere ilişkin özelliklerden, annenin daha kaygılı olmasının çocuklarda görülen kaygı belirtileri ile ilişkili olduğu bulunmuştur.

Diyabet olan Çocuklarda Depresyon Belirtileri ile İlişkili Değişkenler

Diyabetli çocuklarda görülen depresyon belirtilerinin kızlarda ve yaşın daha büyük olması ile ilişkili olduğu bulunmuştur. Ayrıca düşük benlik saygısı ve daha yüksek öğrenilmiş çaresizlik düzeylerinin de Diyabetli çocuklarda görülen depresyon belirtileri ile ilişkili olduğu bulunmuştur. Annelere ilişkin özelliklerden, annelerin daha fazla problem-odaklı ve duygusal başa çıkma tarzı ile daha az sosyal destek arama tarzı başa çıkma becerilerini kullanmalarının Diyabetli çocuklarda görülen depresyon belirtileri ile ilişkili olduğu bulunmuştur.

Diyabet olan Çocuklarda Kaygı Belirtileri ile İlişkili Değişkenler

Regresyon analizi sonuçlarına göre kız çocuklarında daha fazla kaygı belirtileri olduğu belirlenmiştir. Ayrıca babanın daha düşük eğitim seviyesine sahip olması, annenin daha genç olması çocuğun yaşının daha büyük olması da diyabetli çocuklarda kaygı belirtileri ile ilişkili olarak belirlenmiştir. Çocuklarda algılanan ebeveyn reddinin daha yüksek olması ve annelerde daha fazla duygusal başa çıkma tarzının kullanılması da çocuklardaki kaygı belirtileri ile ilişkili bulunmuştur.

Benlik Saygısının Aracı Değişken Olarak Rolü

Bu bölümde benlik saygısının ebeveyn kabul-reddi ile depresyon arasındaki ve öğrenilmiş çaresizlik ile depresyon arasındaki rollerini belirlemek amacıyla regresyon analizleri gerçekleştirilmiştir.

Benlik Saygısının Ebeveyn Reddi ile Depresyon Arasında Aracı Değişken Olarak Rolü

Benlik saygısının ebeveyn reddi ile depresyon arasında aracı değişken olarak rolünü değerlendirmek amacıyla iki regresyon analizi gerçekleştirilmiştir. İlk regresyon analizinde depresyon bağımlı değişken olarak alınmıştır. Bağımsız değişkenler ise üç adımda analize katılmıştır. İlk adımda çocuğun cinsiyet ve yaşı girilmiştir. İkinci adımda ise toplam ebeveyn kabul-reddi puanı girilmiştir. Üçüncü adımda ise benlik saygısı puanı analize katılmıştır. İkinci regresyon analizinde ise bağımlı değişken benlik saygısı olarak ele alınmış, çocuğun cinsiyet ve yaşı ilk adımda analize girilmiş, ikinci adımda ise ebeveyn-kabulu-reddi puanı analize girilmiştir. Bu analizlerde Baron ve Kenny'nin (1986) öngördüğü istatistiksel yöntem ve kriterler kullanılmıştır. Uygulanan analizlerin sonucunda ebeveyn kabul-reddi ile depresyon arasındaki ilişkinin aracı değişken olarak benlik saygısı tarafından anlamlı olarak değiştiği belirlenmiştir.

Benlik Saygısının Öğrenilmiş Çaresizlik ile Depresyon Arasında Aracı Değişken Olarak Rolü

Benlik saygısının öğrenilmiş çaresizlik ile depresyon arasında aracı değişken olarak rolünü değerlendirmek amacıyla iki regresyon analizi gerçekleştirilmiştir. İlk regresyon analizinde depresyon bağımlı değişken olarak alınmıştır. Bağımsız değişkenler ise üç adımda analize katılmıştır. İlk adımda

çocuğun cinsiyet ve yaşı girilmiştir. İkinci adımda ise toplam öğrenilmiş çaresizlik puanı girilmiştir. Üçüncü adımda ise benlik saygısı puanı analize katılmıştır. İkinci regresyon analizinde ise bağımlı değişken benlik saygısı olarak ele alınmış, çocuğun cinsiyet ve yaşı ilk adımda analize girilmiş, ikinci adımda ise öğrenilmiş çaresizlik puanı analize girilmiştir. Bu analizlerde Baron ve Kenny'nin (1986) öngördüğü istatistiksel yöntem ve kriterler kullanılmıştır. Uygulanan analizlerin sonucunda öğrenilmiş çaresizlik ile depresyon arasındaki ilişkinin aracı değişken olarak benlik saygısı tarafından anlamlı olarak değiştiği belirlenmiştir.

Anne Gruplarının Karşılaştırılması

Psikolojik Uyum

Bu bölümde annelerin psikolojik uyum düzeyleri Depresyon, Kaygı, Aile Değerlendirme alt test puanları, Problem Çözme Becerileri, Başa Çıkma Tarzları, Aile Kabul-Reddi, Tükenmişlik düzeylerinin iki tanı grubu arasındaki farkları belirlemek amacı ile tek yönlü varyans analizi yapılmıştır. Gruplar arası karşılaştırmalar Öğrenme Güçlüğü olan 79 çocuk ile Diyabet tanısı konmuş 70 çocuğun annesi arasında gerçekleştirilmiştir. Analizlerin tümünde annenin yaşı ortak değişken olarak alınmıştır.

Depresyon

İki tanı grubu (Öğrenme Güçlüğü, Diyabet) arasında annelerin depresyon düzeyleri arasındaki farkı belirlemek amacıyla varyans analizi uygulanmıştır. Beck Depresyon Envanteri puanları bağımlı değişken olarak ele alınmış, tanı grubu (Öğrenme Güçlüğü, Diyabet) ise bağımsız değişken olarak belirlenmiştir. Tanı temel etkisine göre öğrenme güçlüğü olan çocukların annelerinin diyabetli çocuğa sahip annelere göre daha yüksek depresyon belirtisi olduğu belirlenmiştir.

Kaygı

İki tanı grubu (Öğrenme Güçlüğü, Diyabet) arasında annelerin kaygı düzeyleri arasındaki farkı belirlemek amacıyla varyans analizi uygulanmıştır. Sürekli Kaygı puanları bağımlı değişken olarak ele alınmış, tanı grubu (Öğrenme Güçlüğü, Diyabet) ise bağımsız değişken olarak belirlenmiştir. Tanı temel etkisine göre öğrenme güçlüğü olan çocukların annelerinin diyabetli çocuğa sahip annelere göre daha yüksek sürekli kaygı seviyesi belirlenmiştir.

Aile İşlevleri

İki tanı grubu (Öğrenme Güçlüğü, Diyabet) arasında annelerin aile işlevlerini algılayışları arasındaki farkı belirlemek amacıyla çok yönlü varyans analizi uygulanmıştır. Aile Değerlendirme Ölçeği alt test puanları (Problem Çözme, İletişim, Roller, Duygusal Tepki Verebilme, Gereken İlgiyi Gösterme, Davranış Kontrolü, Genel İşlevler) bağımlı değişkenler olarak ele alınmış, tanı grubu (Öğrenme Güçlüğü, Diyabet) ise bağımsız değişken olarak belirlenmiştir. Çoklu varyans analizi tanı temel etkisinin anlamlı olduğunu ortaya koymuştur. Tek değişkenli analizlerde “Roller”, “İletişim” ve “Problem Çözme” alt test puanları için tanı temel etkisinin anlamlı olduğu ortaya çıkmıştır. “Roller” temel etkisine göre öğrenme güçlüğü olan çocukların annelerinin diyabeti olan çocukların annelerine göre ailedeki görev dağılımı ve başarılmasının etkinliği konusunda daha fazla problem yaşadıkları belirlenmiştir. “İletişim” temel etkisine göre öğrenme güçlüğü olan çocukların annelerinin diyabeti olan çocukların annelerine göre daha az bilgi alışverişi gerçekleştirebildikleri belirlenmiştir. Son olarak “Problem Çözme” temel etkisine göre öğrenme güçlüğü olan çocukların

annelerinin diyabeti olan çocukların annelerine göre ailenin birarada problem çözme becerileri ile ilgili daha fazla sorun yaşadığı ortaya konulmuştur.

Problem Çözme

İki tanı grubu (Öğrenme Güçlüğü, Diyabet) arasında annelerin problem çözme becerileri arasındaki farkı belirlemek amacıyla varyans analizi uygulanmıştır. Problem çözme puanları bağımlı değişken olarak ele alınmış, tanı grubu (Öğrenme Güçlüğü, Diyabet) ise bağımsız değişken olarak belirlenmiştir. Tanı temel etkisine göre öğrenme güçlüğü olan çocukların annelerinin diyabetli çocuğa sahip annelere göre daha fazla problemleri çözme konusunda beceriksizlik algıladıkları belirlenmiştir.

Başa Çıkma Tarzları

İki tanı grubu (Öğrenme Güçlüğü, Diyabet) arasında annelerin başa çıkma tarzları arasındaki farkı belirlemek amacıyla çok yönlü varyans analizi uygulanmıştır. Başa Çıkma Tarzları Ölçeği alt test puanları (Duygu Odaklı Başa Çıkma, Problem Odaklı Başa Çıkma, Sosyal Destek Arama Tarzı Başa Çıkma) bağımlı değişkenler olarak ele alınmış, tanı grubu (Öğrenme Güçlüğü, Diyabet) ise bağımsız değişken olarak belirlenmiştir. Çoklu varyans analizi tanı temel etkisinin anlamlı olduğunu ortaya koymuştur. Tek değişkenli analizlerde “Duygu Odaklı Başa Çıkma” tarzı için tanı temel etkisinin anlamlı olduğu ortaya çıkmıştır. Bu temel etkiye göre öğrenme güçlüğü olan çocukların annelerinin diyabeti olan çocukların annelerine göre daha az Duygu Odaklı Başa Çıkma tarzını kullandıkları belirlenmiştir.

Ebeveyn Kabul-Reddi

İki tanı grubu (Öğrenme Güçlüğü, Diyabet) arasında annelerin algılanan ebeveyn kabul-reddi arasındaki farkı belirlemek amacıyla varyans analizi uygulanmıştır. Ebeveyn Reddi puanları bağımlı değişken olarak ele alınmış, tanı grubu (Öğrenme Güçlüğü, Diyabet) ise bağımsız değişken olarak belirlenmiştir. Tanı temel etkisine göre öğrenme güçlüğü olan çocukların annelerinin diyabetli çocuğa sahip annelere göre çocuklarına yönelik daha fazla ebeveyn reddi algıladıkları belirlenmiştir.

Ebeveyn Tükenmişliği

İki tanı grubu (Öğrenme Güçlüğü, Diyabet) arasında annelerin tükenmişlik düzeyleri arasındaki farkı belirlemek amacıyla varyans analizi uygulanmıştır. Maslach Tükenmişlik Envanteri puanları bağımlı değişken olarak ele alınmış, tanı grubu (Öğrenme Güçlüğü, Diyabet) ise bağımsız değişken olarak belirlenmiştir. Tanı temel etkisine göre öğrenme güçlüğü olan çocukların annelerinin diyabetli çocuğa sahip annelere göre daha fazla tükenmişlik algıladıkları belirlenmiştir.

Öğrenme Güçlüğü ile Öğrenme Güçlüğü'ne Eşlik Eden Dikkat Eksikliği Olan Grupların Karşılaştırılması

Bu bölümde yalnızca Öğrenme Güçlüğü olan çocuklar ve anneleri (n=62), Öğrenme Güçlüğü'nün yanı sıra Dikkat Eksikliği Hiperaktivite Bozukluğu tanısı almış olan çocuklar ve anneleri (n=32), psikolojik uyum düzeyleri açısından karşılaştırılmıştır.

Çocuklar Arası Karşılaştırmalar

Yalnızca Öğrenme Güçlüğü olan çocuklar (n=62) ile Öğrenme Güçlüğü'nün yanı sıra Dikkat Eksikliği Hiperaktivite Bozukluğu tanısı almış olan

çocukları (n=32) karşılaştırmak amacı ile tek yönlü varyans analizleri uygulanmıştır. Bu iki grup öğrenilmiş çaresizlik, ebeveyn reddi, depresyon, kaygı ve benlik saygısı açısından karşılaştırılmıştır. Dolayısıyla bu analizlerde bağımlı değişken ilgili psikolojik uyum

(öğrenilmiş çaresizlik, ebeveyn reddi, depresyon, kaygı ve benlik saygısı) düzeyidir, bağımsız değişken ise tanı grubudur (Öğrenme Güçlüğü, Diyabet). Bu bölümde varyans analizlerinin hiçbiri anlamlı bulunmamıştır. Buna göre yalnızca Öğrenme Güçlüğü olan çocuklar ile Öğrenme Güçlüğü yanı sıra Dikkat Eksikliği Hiperaktivite Bozukluğu tanısı almış olan çocuklar psikolojik uyum açısından birbirlerinden anlamlı düzeyde farklı bulunmamıştır.

Anneler Arası Karşılaştırmalar

Yalnızca Öğrenme Güçlüğü olan çocukların anneleri (n=62) ile Öğrenme Güçlüğü yanı sıra Dikkat Eksikliği Hiperaktivite Bozukluğu tanısı almış olan çocukların annelerini (n=32) psikolojik uyum açısından karşılaştırmak amacı ile tek yönlü varyans analizleri uygulanmıştır. Bu iki grup Depresyon, Kaygı, Aile Değerlendirme alt test puanları, Problem Çözme Becerileri, Başa Çıkma Tarzları, Aile Kabul-Reddi ve Tükenmişlik düzeyleri açısından karşılaştırılmıştır. Dolayısıyla bu analizlerde bağımlı değişken ilgili psikolojik uyum (Depresyon, Kaygı, Aile Değerlendirme alt test puanları, Problem Çözme Becerileri, Başa Çıkma Tarzları, Aile Kabul-Reddi, Tükenmişlik) düzeyidir, bağımsız değişken ise tanı grubudur (Öğrenme Güçlüğü, Diyabet). Bu bölümde varyans analizlerinin hiçbiri anlamlı bulunmamıştır. Buna göre yalnızca Öğrenme Güçlüğü olan çocukların anneleri ile Öğrenme Güçlüğü yanı sıra Dikkat Eksikliği

Hiperaktivite Bozukluğu tanısı almış olan çocukların anneleri psikolojik uyum açısından birbirlerinden anlamlı düzeyde farklı bulunmamıştır.

Tartışma

Bu çalışmada öğrenme güçlüğü olan çocukların benlik saygısı, ebeveyn reddi, öğrenilmiş çaresizlik, depresyon ve kaygı düzeyleri açısından değerlendirilmesi hedeflenmiştir. Öğrenme güçlüğü olan çocukların normatif gruplara göre daha fazla duygusal problemler yaşadığı bilindiği için bu grubu kronik hastalıkları nedeni ile duygusal zorluklar yaşayabilen bir diğer grupla karşılaştırmak amaçlanmıştır. Dolayısıyla bir diğer amaç, öğrenme güçlüğü ve diyabet tanısı almış olan iki grup çocuk arasındaki psikolojik uyum düzeylerini benlik saygısı, ebeveyn reddi, öğrenilmiş çaresizlik, depresyon ve kaygı açısından karşılaştırmaktır. Ayrıca, öğrenme güçlüğü ve diyabet tanısı almış olan iki grup çocuğun annelerinin psikolojik uyum düzeyleri açısından karşılaştırılması amaçlanmıştır (Depresyon, Kaygı, Aile Değerlendirme alt test puanları, Problem Çözme Becerileri, Başa Çıkma Tarzları, Aile Kabul-Reddi, Tükenmişlik).

Öğrenme Güçlüğü Olan Çocukların Psikolojik Uyum Düzeyleri

Bu çalışma öğrenme güçlüğü olan çocuklarda psiko-sosyal problemler bildiren yazın bilgisi ile aynı yöndedir. Bu çalışmada öğrenme güçlüğü olan çocuklar için bildirilen düşük benlik saygısı daha önce sağlıklı çocuklarla yapılmış olan araştırma bulguları ile benzerdir. Ayrıca bu çalışmada bulunan kızların erkek çocuklara göre daha düşük benlik saygısı bildirmeleri yazın bilgisi ile uyumludur (Kistner, Haskett, White, & Robbins, 1987; Margalit & Ronen, 1993; Woodward & Frank, 1988; Valas, 2001a).

Bu arařtırmada, öğrenme güçlüğü olan çocuklarda bildirilen daha fazla çaresizlik düzeyi, öğrenme güçlüğü olan çocuklar için bildirilen çaresizlik davranıřlarının daha fazla olması daha önceki arařtırma bulguları ile uyumludur (Butkowsky & Willows, 1980; Pearl, 1982; Pearl, Bryan & Donahue, 1980; Kistner, White, Haskett & Robbins, 1985; Valas, 2001b). Öğrenilmiş Çaresizlik Teorisinin önerdiğine göre bu çocukların sık sık yaşadıkları başarısızlık deneyimleri bu çocuklarda çaresizliğe yönelik inançların gelişmesine neden olmuş olabilir.

Ebeveyn kabulü olumlu benlik algısının gelişimi açısından gerekmektedir (Rosenthal, 1973). Bu arařtırma, öğrenme güçlüğü olan çocukların diyabetli çocuklara göre daha fazla ebeveyn reddi algıladıklarını ortaya koymuştur. Bu arařtırmada benlik saygısının ebeveyn reddi ve depresyon arasınada aracı deęişken olarak rol oynaması hipotezi doğrulanmıştır. Ebeveyn reddi, beklentiler yönünde, benlik saygısı puanları ile ters yönde ilişkili olarak bulunmuştur. Diğer bir deyişle, ebeveyn reddi ile düşük benlik saygısının ilişkisine yönelik hipotez doğrulanmıştır. Bu çalışmada ebeveyn reddi ile depresyon arasında benlik saygısının aracı deęişken olarak anlamlı biçimde rol oynadığı ortaya çıkmıştır. Ebeveyn reddi direkt olarak depresyona yol açmamakta, benlik saygısının düzeyine göre deęişmektedir. Önceki çalışmalarda çocuklukta ortaya çıkan düşük benlik saygısı için ebeveynliğin önemli bir risk faktörü olduğu, düşük benlik saygısının ise, daha sonraki depresif bir dönemi yordayabileceği önerilmektedir (Rohner, 1986).

Bu çalışmada öğrenme güçlüğü olan çocuklarda, diyabetli çocuklara göre daha fazla depresif belirtiler bulunması daha önceki çalışmalarda öğrenme

güçlüğü olan çocuk ve ergenlerde normatif gruplara göre bildirilen daha yüksek depresyon düzeyleri bilgisi ile uyumludur (Goldstein, Paul & Sanfilippo-Cohn, 1985; McConaughy & Ritter, 1985; McConaughy et al., 1994; Wright-Strawderman, & Watson, 1992).

Ayrıca bu çalışmada bildirilen kız çocuklarının erkek çocuklara göre daha yüksek depresyon düzeylerine sahip oldukları bilgisi çocuklarda depresyonu araştıran yazın bilgisi ile uyumludur (Brage & Meredith, 1994; Valas, 2001a).

Bu bulgular, diyabetin, kronik bir hastalık olmasına rağmen, bu bozukluğun etkilerinin, öğrenme güçlüğünün bu çocukların duygu durumlarına olan etkileri kadar olumsuz olmadığını ortaya koymaktadır.

Bu araştırmada öğrenme güçlüğü olan çocukların diyabetli çocuklara kıyasla daha yüksek kaygı düzeyi bildirdikleri belirlenmiştir. Bu bulgu, öğrenme güçlüğü olan çocuklarda daha fazla kaygı belirtisi bildiren araştırmalar ile uyumludur (Greenham, 1999). Öğrenme güçlüğü olan çocuklar normatif gruplar ve normal düzeyde başarı gösteren kontrol gruplarına göre daha yüksek düzeyde kaygı bildirmektedirler (Paget & Reynolds, 1984; Fisher, Allen & Kose, 1996; Rodriguez & Routh, 1989). Ayrıca bu araştırmada kız çocuklarının erkeklere göre daha yüksek kaygı düzeyi bildirdikleri belirlenmiştir. Önceki çalışmalarda da benzer olarak, kız çocuklarının erkeklere göre daha yüksek düzeyde kaygı belirtileri gösterdikleri ortaya konulmuştur (Özusta, 1993; Anderson, Williams, McGee & Silva, 1987; Bell-Dolan, Last, & Strauss, 1990; Dong, Yang, & Ollendick 1994; Last, Hersen, Kazdin, Finkelstein & Strauss, 1987; Varol, 1990).

Bu araştırmada öğrenme güçlüğü olan çocuklardaki düşük benlik saygısı ve algıladıkları ebeveyn reddinin depresyon belirtileri ile ilişkili olduğu

bulunmuştur. Bu bulgu, algılanan ebeveyn reddinin psikolojik sorunlarla ilişkili olduğu bulgusunu destekleyen bir meta-analiz ile uyumludur (Khaleque & Rohner, 2002).

Bir çocuğun diyabet gibi kronik hastalığı olması veya öğrenme güçlüğü gibi yaşam boyu bir bozukluğunun olması çocuk bakımını anne açısından zorlaştıran bir faktör olabilir. Önceki araştırmalar kronik hastalıklar veya psikiyatrik bozuklukları olan çocukların annelerinde psikolojik uyum sorunları ortaya çıkabileceğini bildirmişlerdir. Bu araştırmada bu sorunların içeriği incelenmeye çalışılmıştır.

Depresyon ve Kaygı

Bu araştırmada öğrenme güçlüğü olan çocukların annelerinde diyabeti olan çocukların annelerine göre daha fazla depresyon ve sürekli kaygı düzeyi belirlenmiştir. Bu bulgular engelli çocukları olan annelere ilişkin yazın bilgileri ile uyumludur. Zihinsel engelli çocukları olan annelerin ebeveynliğe ilişkin stres düzeylerinin araştırıldığı bir çalışmada, bu annelerin engeli olmayan çocuklara sahip olan annelere kıyasla daha fazla stres düzeyi bildirdikleri belirlenmiştir (Pearson & Chan, 1993).

Aile İşlevleri

Öğrenme güçlüğü olan çocukların aileleri ile yapılan çalışmalar bu çocukların ailelerinde sorunlar olduğunu bildirmiştir. Bu araştırmada öğrenme güçlüğü olan çocukların annelerinin diyabeti olan çocukların annelerine göre ailedeki görev dağılımı ve başarılmasının etkinliği konusunda daha fazla problem yaşadıkları belirlenmiştir. “İletişim” temel etkisine göre öğrenme güçlüğü olan çocukların annelerinin diyabeti olan çocukların annelerine göre daha az bilgi

alışverişi gerçekleştirebildikleri belirlenmiştir. Son olarak “Problem Çözme” temel etkisine göre öğrenme güçlüğü olan çocukların annelerinin diyabeti olan çocukların annelerine göre ailenin birarada problem çözme becerileri ile ilgili daha fazla sorun yaşadığı ortaya konulmuştur. Dolayısıyla bu çocukların psiko-sosyal alanlarda yaşadıkları sorunların bir kısmı ev ortamının yetersizlikleri ile ilişkili olabilir. Ailevi sorunların bu çocukların yaşadığı sorunların neden ya da sonucu olup olmadığı bu araştırma bulguları ile açıklanamaz ve bu konuda daha fazla çalışmaya ihtiyaç vardır. Ancak, sonuçlar, çocukların tedavi planını uygularken ailelerini de tedavi planına katmak gerekliliğini ortaya koymaktadır. Anneye psikolojik destek sağlamaya yönelik müdahalelerin kronik veya yaşam boyu hastalığı olan çocukların annelerinin stres düzeyini azaltabileceği düşünülmektedir.

Problem Çözme ve Başa Çıkma

Öğrenme güçlüğü olan çocukların annelerinin diyabetli çocuğa sahip annelere göre daha fazla problemleri çözme konusunda beceriksizlik algıladıkları belirlenmiştir. Bu çalışmada öğrenme güçlüğü olan çocukların annelerinin diyabeti olan çocukların annelerine göre daha az Duygu Odaklı Başa Çıkma tarzını kullandıkları belirlenmiştir. Dolayısıyla bu araştırmanın sonuçları çocuklarının sosyal ve gündelik yaşamda pek çok sorunla karşı karşıya kalması durumundaki ebeveynlerin problem çözme becerileri ve başa çıkma biçimleri ile ilgili detaylı bir danışmanlığa ihtiyaçları vardır.

Ebeveyn Kabul-Reddi ve Tükenmişliği

Bu çalışmada öğrenme güçlüğü olan çocukların annelerinin diyabetli çocuğa sahip annelere göre çocuklarına yönelik daha fazla ebeveyn reddi ve

tükenmişlik algıladıkları belirlenmiştir. Fiziksel ve zihinsel engelleri olan çocuklara yönelik anne ve babanın reddini karşılaştıran bir çalışmada babaların annelere göre daha sıcak ve kabul edici olduğu bildirilmiştir (Ansari, 2002). Ansari'ye göre (2002), annelerin daha fazla reddedici olması anneler ile çocuklar arasındaki biyolojik bağlantı ile ilişkili olabilir. Anneler çocukların yetiştirilmesi ile ilgili daha fazla sorumluluk üstlendikleri için çocuklar sorunlar yaşadığında annelerin başarısızlık duygusu yaşamaları söz konusu olabilir. Ayrıca bu araştırmada öğrenme güçlüğü olan çocukların annelerinde daha fazla ebeveyn tükenmişliği bulunması, yazın bilgisinde engelli çocukların ebeveynlerinde daha fazla stres ve duygusal gerginlik bildirilmesi ile benzeşmektedir (Daniels-Mohring, & Lambie, 1993; Dyson, 1993; Waggoner, & Wilgosh, 1990).

Bu çalışmanın bulgularına göre, ebeveynlerin psikolojik olarak daha sağlıklı ve uyumlu oldukları destekleyici bir ev ortamının çocukların psikolojik uyumu açısından olumlu katkılar sağlayabileceğini göstermektedir.

Uygulamaya Yönelik Sonuçlar

Yukarıda bildirilen bulguların pratik anlamda kullanıma ilişkin bazı sonuçlarının bu bölümde incelenmesi planlanmıştır.

Öğrenme Güçlüğü Olan Çocukların Tedavi İhtiyaçları

Düşük benlik saygısına yönelik grup veya bireysel psikoterapi uygulamaları gerçekleştirilmesi ve bu terapilerin çocuğun kendine özgü zorluklarına göre uygulanması gerekmektedir. Tedavinin amacı, çocuğun zorluklarını azaltmak ve problem çözme ve çalışma becerileri, sosyal ve sportif faaliyetlerde yüreklendirme ve kariyere yönelik kararlarda yardım sağlayarak potansiyelinin en üst düzeye çıkarılması olmalıdır.

Ebeveynlerin destekleyici bir ev ortamı sağlayabilmeleri için ebeveynlere yönelik danışmanlık verilmesi gerekmektedir. Hem ebeveynler hem de öğretmenlere, çocuğu inatçı, tembel veya yavaşmış gibi algılamamaları için çocuğun sorunlarını anlamalarına yönelik yardım sağlanmalıdır. Bu çalışma ebeveyn reddinin çocuğun benlik saygısı, depresyon ve kaygı düzeylerine olası etkilerini ortaya çıkartmıştır. Dolayısıyla ebeveyn reddi ile ilgili ebeveynlere yönelik eğitim verilmesi gerekliliği bu çalışmanın önemli bir sonucudur. Öğrenme güçlüğü tanısı konulana değin ebeveynler çocuklarını tembel, inatçı veya okula gitmek ile ilgili isteksiz olarak değerlendirmektedirler. Dolayısıyla, bu ebeveynler çocuklarının bu durumu ile ilgili zorlanmış ve çocuğa yönelik çaresizlik ve öfke duyguları olabilir. Ebeveynin eğitilmesi ile birlikte, hem çaresizlik ve öfke duygularında hem de bu ebeveynlerin yaşadığı depresyon, kaygı ve tükenmişlik düzeylerinde iyileşme görülebilir.

Öğrenme Güçlüğü Olan Çocuklarla Çalışan Uzmanların Eğitilmesi

Türkiye’de çocuklar çocuk psikiyatri klinikleri ve hastanelere “bu çocukta bir sorun var” düşüncesi ile yönlendirilirler. Bu bozukluk çocuk psikiyatrik gruplarında çok yaygın olduğu için, bu gruplarla çalışan uzmanların bu çocukları tanımaları önemlidir. Psikiyatristler psikiyatrik bozuklukların tanı ve tedavisi ile ilgili oldukça yoğun eğitim almalarına rağmen öğrenme güçlükleri eğitimlerinde yeterli miktarda yer almamaktadır (Sundheim & Voeller, 2004). Dolayısıyla, alanda çalışan uzmanların bu çocuklara erken tanı koymak ve tedaviye yönlendirmek açısından eğitilmeleri büyük önem taşımaktadır.

Ebeveyn ile Çocuklara Öğrenme Güçlüğüne Yönelik Başa Çıkma Becerileri Kazandırma

Öğrenme güçlüğü'nün çocukların gelişimi üzerinde anlamlı etkileri vardır. Ebeveyn ve öğretmenler bu etkilerin azaltılmasına yönelik önlemler almalıdır. Ebeveynler çocuklarına yardım edebilmek için öğrenme güçlüğü'nü bilişsel ve duygusal olarak kabul etmelidirler. Dolayısıyla ailelere öğrenme güçlüğü tanısı konulduktan sonra değerlendirilerek başa çıkma becerilerinin kazandırılmasına yönelik müdahale gerekip gerekmediği irdelenmelidir. Bu araştırmanın bulgularında ortaya konduğu gibi aile üyeleri ve öğrenme güçlüğü olan çocukların sağlıklı başa çıkma becerileri olmadığı durumlarda psikolojik sorunların ortaya çıkma ihtimali yüksektir.

Pek çok kültürde olduğu gibi Türkiye'de de babaların bu süreçte yer alması onlara zor gelmektedir. Genellikle babalar çocukları ile ilgili bir sorun olduğunu inkar etmekte, çocuklarına tembel, yaramaz veya okula gitmek ile ilgili isteksiz olarak değerlendirmeyi tercih etmektedirler. Dolayısıyla öğrenme güçlüğü tanısının hem annelere hem de babalara detaylı biçimde açıklanması önem taşımaktadır.

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September 1998 - Today: Clinical Psychologist, Gazi University Hospital, Department of Child Psychiatry, Ankara. Conducting diagnostic interviews; planning and conducting research studies; conducting individual and group psychotherapy and family therapy; organizing seminars for medical students and families; supervising graduate and undergraduate level psychology students; giving psychometric and neuropsychological tests.

September 1997 – September 1998: Intern Psychologist, Gazi University Hospital, Department of Child Psychiatry, Ankara. Conducting research studies; attending and organizing seminars; conducting individual, group and couple psychotherapy; conducting and evaluating psychometric tests.

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1. Published Articles

İlden Koçkar A, Gençöz T. Personality, Social Support and Anxiety among Adolescents Preparing for University Entrance Examinations in Turkey. *Current Psychology*, 2004, 23 (2), 138-146.

- Güçüyener, K, Erdemođlu AK, Senol S, Serdarođlu A, Soysal S, **İlden Koçkar A.** Use of Methylphenidate for Attention-Deficit Hyperactivity Disorder in Patients With Epilepsy or Electroencephalographic Abnormalities. Journal of Child Neurology, 2003, 18 (2), 109-112.
- Kılıç B G, Irak M, **İlden Koçkar A**, Şener Ş, Karakaş S. İşaretleme Testi Türk Formu'nun 6-11 Yaş Grubu Çocuklarda Standardizasyon Çalışması. Klinik Psikiyatri, 2002, 5, 213-228.
- Kılıç B G, **İlden Koçkar A**, Irak M, Şener Ş, Karakaş S. Görsel İşitsel Sayı Dizileri Testi B Formu Kullanılarak Ölçülen Bellek Uzamının 6 – 11 Yaş Grubu Öğrencilerde Gelişimi. Psikiyatri, Psikoloji, Psikofarmakoloji Dergisi, 2002, 10 (3), 243-254.
- Kılıç B G, **İlden Koçkar A**, Irak M, Şener Ş, Karakaş S. Stroop Testi TBAG Formu'nun Türk İlkokul Çocuklarındaki Standardizasyon Bulguları. Çocuk ve Gençlik Ruh Sağlığı Dergisi 2002, 9 (2), 86-99.
- İlden Koçkar A**, Günay Kılıç B, Şener Ş. İlköğretim Öğrencilerinde Sınav Kaygısı ve Akademik Başarı. Çocuk ve Gençlik Ruh Sağlığı Dergisi, 2002, 9 (2) 100-105.
- Soysal Ş, **İlden Koçkar A**, Erdoğan E, Şenol S, Güçüyener K. Öğrenme Güçlüğü olan bir grup Hastanın WISC-R Profillerinin İncelenmesi. Klinik Psikiyatri, 2001, 4, 225-231.
- Soysal Ş, **İlden Koçkar A**, Erdoğan E, Şenol S, Güçüyener K. Dikkat Eksikliği Hiperaktivite Bozukluğu Olan Çocuklarda WISC-R Profillerinin İncelenmesi. Psikiyatri, Psikoloji, Psikofarmakoloji Dergisi, 2001, 9 (2), 205-212.
- İlden Koçkar A**, Soysal A Ş, Alparslan S, Şenol S, Buyan N. Transplantasyon Sonrası Yaşama Uyum: Grup Yaşantısı İçerisinde Üç Vakanın Değerlendirilmesi. Çocuk ve Gençlik Ruh Sağlığı Dergisi, 2000, 7(3), 182-188.
- Şener Ş, Günel N, Akçalı Z, Şenol S, **İlden Koçkar A.** Meme Kanserinin Ruhsal ve Sosyal Etkileri Üzerine Bir Çalışma. Klinik Psikiyatri Dergisi, 1999, 2:4, 254-260.
- Alparslan S, **İlden Koçkar A**, Şenol S, Maral I. Marmara Depremini Yaşayan Çocuk ve Gençlerde Ruhsal Bozukluk ve Kaygı Düzeyleri. Çocuk ve Gençlik Ruh Sağlığı Dergisi, 1999, 6(3), 135-142.

2. Master's Thesis

İlden, Z A. Roles of Personality Dispositions and Social Support on Anxiety and Academic Achievement: A Study Concerning Adolescents in their Transition Period. Middle East Technical University, Institute of Social Sciences, Unpublished Graduate Thesis, 1999.

3. Rewards

Turkish Psychiatry Association, Spring Symposium Research Prize, 2000.

Study Name: Study of the Clinical Symptomatology such as Attention Deficit Hyperactivity Disorder and Affective Disorder in Children whose parents are Diagnosed with Bipolar Affective Disorder by Genetical Determinants.

Researchers: Nurten Akarsu, Selahattin Şenol, **Aylin İlden Koçkar**, Şahnur Şener, Kıvılcım Gücüyener, Hasan Herken, Şebnem Soysal, Ali Savaş Çilli

Prof. Dr. Mualla Öztürk Child Mental Health Prize, 2002.

Study Name: Assessment of the Development of the Memory Span of 6-11 Year Old Children by Visual-Aural Digit Span-Revised Form (VADS-R)

Researchers: Birim Günay Kılıç, **Aylin İlden Koçkar**, Metehan Irak, Şahnur Şener, Sirel Karakaş

4. Papers Presented at International Congress and Symposiums

Karacan E, **İlden Koçkar A**, Gökçe E, Foto Özdemir D. Group Therapy For The Mothers Of Children With Separation Anxiety Disorder. 15th International Congress of the International Association of Group Psychotherapy. Istanbul, Turkey, 2003. Abstract Book, p. 352.

Kılıç B G, **İlden Koçkar A**, Irak M, Şener Ş, Karakaş S. The Psychometric Properties and Clinical Utility of the Turkish Form of a Cancellation Test in Children. International Congress of Child and Adolescent Psychiatry and Allied Professions. New Delhi, India, 2002. Abstract Book, p.91.

Kılıç B G, Şener Ş, **İlden Koçkar A**, Karakaş S. Information Processing in Attention Deficit Hyperactivity Disorder as Assessed by the Mini Attention Test Battery. International Congress of Child and Adolescent Psychiatry and Allied Professions, New Delhi, India, 2002. Abstract Book, p.140.

Kılıç B G, **İlden Koçkar A**, Irak M, Şener Ş, Karakaş S. Normal Neuropsychological Development in the School-Age Years: Performance on the Stroop Task in 6-11 Year Old Children. International Congress of Child and Adolescent Psychiatry and Allied Professions. New Delhi, India, 2002. Abstract Book, p.141.

Kılıç B G, **İlden Koçkar A**, Irak M, Şener Ş, Karakaş S. Digit Span Cahnges in 6-11 Year Old Children As Assessed by the Visual-Aural Digit Span Test Revised Form (VADS-R). International Congress of Child and Adolescent Psychiatry and Allied Professions. New Delhi, India, 2002. Abstract Book, p.141.

İlden Z A, Gençöz T. Predicting Anxiety in Adolescents Preparing for the University Exam. ESSOP Annual Congress of the European Society for Social Pediatrics "School Health", 1999.

Erdoğan E, **İlden Koçkar A Z**, Soysal, A Ş. WISC - R profile analysis for the differential diagnosis of ADHD children. 2 nd International Symposium on Neurophysiological and Neuropsychological Assessment of Mental and Behavioral Disorders, 1999.

İlden Koçkar Z A, Erdoğan E, Soysal A Ş, Senol S, Gücüyener K. WISC-R profile analysis for the differential diagnosis of ADHD children. The Second International Congress on Pediatrics in the Community (SIPCC), 2000.

5. Papers Presented at National Congress and Symposiums

Kılıç B G, **İlden Koçkar A**, Irak M, Şener Ş, Karakaş S. Türk İlkokul Çocuklarında Stroop Testi TBAG Formu'nun Standardizasyon Çalışması. 12. Ulusal Çocuk ve Ergen Psikiyatrisi Kongresi, Bildiri Özeti Kitabı, 2002, S. 41.

Kılıç B G, **İlden Koçkar A**, Irak M, Şener Ş, Karakaş S. Türk İlkokul Çocuklarında Görsel İşitsel Sayı Dizileri B Formu Kullanılarak Ölçülen Bellek Uzamı. IV. Ulusal Çocuk Nörolojisi Kongresi, Bildiri Özeti Kitabı, 2002, S. 173-174.

Kılıç BG, **İlden Koçkar A**, Şener Ş. Sosyal Desteğin Sınav Kaygısı ve Akademik Performans Üzerine Etkileri. 11. Ulusal Çocuk ve Ergen Psikiyatrisi Kongresi, 2001, Bildiri Özeti Kitabı, S. 47.

Soysal AŞ, **İlden Koçkar A**. Dikkat Eksikliği Hiperaktivite Bozukluğu ve Karşıt Olma Karşı Gelme Bozukluğu Olan Bir Grup Hastanın Yargılama Becerilerinin Değerlendirilmesi. 11. Ulusal Çocuk ve Ergen Psikiyatrisi Kongresi, 2001, Bildiri Özeti Kitabı, S. 33.

Şener Ş, İltar Z, Karacan, E, **İlden Koçkar A**. Bir Çocuk Psikiyatrisi Polikliniğindeki Hasta Hizmetinin Değerlendirilmesi. 11. Ulusal Çocuk ve Ergen Psikiyatrisi Kongresi, 2001, Bildiri Özeti Kitabı, S. 35.

Gücüyener K, Şenol S, Erdem A K, Serdaroğlu A, Soysal Ş, **İlden Koçkar A**, Şener Ş. Dikkat eksikliği hiperaktivite bozukluğunun tedavisinde kullanılan metilfenidatın epileptik ya da EEG düzensizliği olan hastalardaki etki ve yan etkilerinin araştırılması. II. Ulusal Çocuk Nörolojisi Kongresi, 2000.

İlden Koçkar A, Gençöz T. Akademik Başarıda Kişilik Özelliklerinin Rolü: Geçiş Dönemindeki Ergenlerle İlgili Bir Çalışma. 10. Ulusal Çocuk ve Ergen Psikiyatrisi Kongresi, 2000.

Soysal A Ş, Erdoğan E, **İlden Koçkar A**. 6 – 16 Yaşları Arasında Dikkat Eksikliği Hiperaktivite Bozukluğu Tanısıyla İzlenen Bir Grup Hastanın WISC-R Profillerinin İncelenmesi. 10. Ulusal Çocuk ve Ergen Psikiyatrisi Kongresi, 2000.

İlden Koçkar A, Soysal A Ş, Erdoğan E. 6 – 16 Yaşları Arasında Öğrenme Bozukluğu Tanısıyla İzlenen Bir Grup Hastanın WISC-R Profillerinin İncelenmesi. 10. Ulusal Çocuk ve Ergen Psikiyatrisi Kongresi, 2000.

İlden Koçkar A, Soysal A Ş, Erdoğan E. Öğrenme Bozukluğu Tanısında WISC-R'in Ayırıştırıcılığı. 11. Ulusal Psikoloji Kongresi, 2000.

Soysal A Ş, **İlden Koçkar A**, Erdoğan E. Dikkat Eksikliği Hiperaktivite Bozukluğu Olan Bir Grup Hastanın WISC-R Profillerinin İncelenmesi. 11. Ulusal Psikoloji Kongresi, 2000.

Erdoğan E, Soysal A Ş, **İlden Koçkar A**. Dikkat Eksikliği Hiperaktivite Bozukluğu ile Eş Zamanlı Görülen Bozuklukların WISC-R Profili Üzerindeki Yansımaları. 11. Ulusal Psikoloji Kongresi, 2000.

İlden Koçkar A, Soysal A Ş, Alparslan S, Şenol S, Buyan N. Transplantasyon Sonrası Yaşama Uyum: Grup İçerisinde Üç Vakanın Değerlendirilmesine İlişkin Bir Çalışma. 9. Ulusal Çocuk ve Ergen Ruh Sağlığı ve Hastalıkları Kongresi, 1999.

İlden Koçkar A, Soysal A Ş, Alparslan S, Şenol S, Buyan N. Transplantasyon Öncesi ve Sonrası Yaşama Uyum: Grup Yaşantısı İçerisinde İki Vakanın Değerlendirilmesine İlişkin Bir Çalışma. 43. Milli Pediatri Kongresi, 1999.

6. Other Publications

İlden Koçkar A. Sınav Yaklaşır: Sınav Kaygısı ile Başa Çıkma. Nane Limon Dergisi, 2004, 94-97.

İlden Koçkar A. Tırnak Yeme - Parmak Emme. Çocuk ve Aile, 2000, 3 (23), 46-47.

İlden Koçkar A, Şenol S. Görkem Büyüyor, "Çocuk ve Evcil Hayvanlar". Sürekli Tıp Eğitimi Dergisi, 2000, 9(1), 17-18.

Soysal AŞ, **İlden Koçkar A**. Görkem Pokemonlara Esir Düştü, Sürekli Tıp Eğitimi Dergisi, 2000, 9(12), 448-449.

İlden Koçkar A, Şenol S. Görkem Büyüyor, "Resim". Sürekli Tıp Eğitimi Dergisi, 1999, 8(7), 273-274.

İlden Koçkar A, Şenol S. Görkem Büyüyor, "Kardeş Kıskançlığı". Sürekli Tıp Eğitimi Dergisi, 1999, 8(10), 376-377.

İlden Koçkar A, Şenol S. Görkem Büyüyor, "Doktor Korkusu". Sürekli Tıp Eğitimi Dergisi, 1999, 8(11), 426-427.