Coping Strategies of Children with Sadness/Unhappiness and Their Relationship with Levels of Depression

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ABSTRACT

This study aimed to examine children's ideas about what to do when they are feelingdepressed/unhappy, to investigate whether there are sex and SES differences in the number and effectiveness ratings of coping strategies given by children and finally to investigate the relationship between the number and effectiveness of coping strategies given and depressive symptomatology.

Coping strategies were obtained by using a semi - structured interview which consisted of mainly five questions.

Results indicated that children in this sample had very clear ideas about "what you do when feeling depressed/unhappy", "what works best?" and also how well thet works?". Children reported coping strategies that could be grouped under nine coping categories. These were; "play", "help and comfort seeking activities", "altruistic behaviors", entertainment and aesthetics", "reactive behaviors", "avoidance", "eating", "crying", and "miscellanous". Most frequently mentioned category was play. The least frequently mentioned category was eating. The reactive type of strategies, avoidance, and altruistic behaviors seemed to be used less than play, help and comfort seeking activities and entertainment and aesthetics strategies by children in order to cope with their depressed/unhappy feelings. In response to the question "what works best?", the most frequently mentioned strategies were both play and help and comfort seeking activities strategies. Dealing with choosing the coping strategies, it was found that SES and

gender factors affect the choosing of the coping strategies. Results also pointed out that there was a strong relationship between the number of coping strategies, their effectiveness ratings and depressive symptomatology. Children who had high scores from the CDI reported less number of coping strategies and gave lower effectiveness ratings than children who had low scores from the CDI.

These results were discussed in terms of the limitations and weakness of the present study and directions for future research were suggested.

ÖZET

Bu çalışma çocukların kendilerini deprese/mutsuz hissettikleri zamanlarda, mutsuzluklarıyla başa çıkmak için neler yaptıklarını, başa çıkma yollarının sayısı ve etkililiğinin cinsiyet ve sosyo-ekonomik statü açısından anlamlı bir farklılık gösterip, göstermediğini ve son olarak da çocuklar tarafından belirtilen başa çıkma yollarının sayısı ve etkililiğinin depresif semptomatolojiyle ilişkisi olup, olmadığını araştırmayı hedeflemiştir.

Başa çıkma yolları temel olarak 5 sorudan oluşan yarı-yapılandırılmış görüşme formu aracılığıyla elde edilmiştir.

Sonuçlar örneklem kapsamındaki çocukların "kendilerini deprese/mutsuz hissettiklerinde ne/neler yapacakları", "kullandıkları başa çıkma yollarının ne kadar işlerine yaradıkları" ve "Hangisinin en çok işlerine yaradığı" konusunda açık ve net fikirlerinin olduğunu göstermiştir. Belirtilen başa çıkma yolları 9 kategori altında toplanmıştır. Bunlar, "oyun", "yardım arama aktiviteleri", "diğerkâm davranışlar", "eğlence ve estetik", "reaktif davranışlar", "kaçınma", "yeme", "ağlama" ve "diğer" şeklindedir. "Oyun"kategorisi en sıklıkla belirtilirken, "yeme" kategorisinin diğer kategorilere oranla en az sıklıkla belirtildiği saptanmıştır. Çocukların "reaktif", "kaçınma" ve "diğerkam" davranışları içeren başa çıkma yollarının, "oyun", "yardım arama aktiviteleri", "eğlence ve estetik" aktivitelerinden daha az kullandıkları görülmüştür. "En iyi hangisi işliyor?" sorusuna verilen yanıtlarda, hem "oyun" hem de "yardım arama aktiviteleri" gibi başa çıkma yollarının daha sıklıkla belirtildiği saptanmıştır. Sosyo-ekonomik statü ve cinsiyet

Sosyo-ekonomik statü ve cinsiyet faktörlerinin başa çıkma yollarının seçiminde etkili oldukları bulunmuştur. Aynı zamanda sonuçlar başa çıkma yollarının sayısı ve etkililiği ile depresif semptomatoloji arasında anlamlı bir ilişki olduğuna işaret etmiştir. Çocukluk depresyonu ölçeğinden yüksek puan alan çocukların düşük puan alanlara oranla daha az başa çıkma yollarına sahip oldukları ve bunların etkililiğinin de düşük olduğu bulunmuştur.

Yukarıda kısaca bahsedilen sonuçlar çalışmanın sınırlılıkları ve eksiklikleri çerçevesinde tartışılarak, gelecekte yapılacak çalışmalara ışık tutması amacıyla öneriler sunulmuştur.

Anahtar Sözcükler; çocukluk depresyonu, başa çıkma yolları

INTRODUCTION

Nearly everyone has experience feelings of depression or sadness. These feelings are normal reactions to events in our daily lives. We may feel sad when a close friend moves away, after a fight with a girl/boy friend or after we find that our plans will not be fulfilled. However, clinically significant depression is much less common and much more severe than the sadness or blues we have all experienced.

Clinically significant depression is considered to be an affective disturbance which is subjective . In DSM-III (APA, 1980), "depressive disorders" category is listed under the unipolar depression and bipolar depression . In unipolar depression, a depressed individual expresses a dysphoric mood which is the essential feature of major depressive episode. In major depressive episode, individuals usually describe their mood as discouraged. There is decreased activity level and psychomotor retardation. They usually complain of a loss of interest in ordinary activities, an inability to experience pleasure and a paralysis of will. Other symptoms frequently include loss of self-esteem, poor appetite and weight loss, sleep disturbances, extreme fatique, absence of sexual urges, feeling of worthlessness, and inability to concentrate or make decisions, which are not related to another physical and mental disorder, (APA, 1980). Severe cases of depression may also be accompanied by thoughts of death or even suicide attempts.

A depressive episode may occur after psychosocial stress

(e.g. divorce) or it may appear without any obvious precipitating event. It may last several days or weeks or it may be persistant and chronic. After an episode, individuals may return to their normal level of functioning. It has been estimated that in a given year 25 % of all adults may suffer from major pervasive and prolonged depressive symptoms (Silverman, Silverman and Eardley; 1984b). For adults, the chances of having a major depressive episode of clinical proportions are one in three. The incidence of major depression in women is two to three times higher than in men.

Depression seems to be manifested with behavioral, cognitive, emotional and motivational symptoms. Although the acceptance of various symptoms as characterizing depression permitted a more comprehensive operational definition of depression in adults, current classification systems provide no explanation as to how the various components of depression in adults come to be associated with each other. In other words, they provide no understanding of the linkage between behavioral, cognitive, emotional and motivational symptoms which characterizes the depressive episode.

Childhood Depression

Unlike adult depression, there is no operational definition of childhood depressive symptoms encompassing the behavioral, the cognitive, the emotional and the motivational areas because research with depressive children is still in its preliminary stage.

The manifestations of the disorder seem to differ from those

of adults. The symptoms generally depend on several factors. Data from longitudional and epidemiological studies suggests that the presence of symptoms of depression in children varies as a function of psychosocial development, cognitive integration and particularly the age of the child (Kashani and Simonds,1979; Lefkowitz and Burton, 1978).

Depression in children has only recently been accepted as a distinct clinical phenomenon. In the begining of twentieth century, researchers and clinicians became aware of depressive symptoms in children. However, they only emphasized the depressive phenomenon related to the loss of an object or separation which occurs in infancy and early childhood (Kanner, 1947; Mahler, 1961).

In the late of 1960s, based on their clinical work, clinicians noticed that children had somewhat distinct depressive symptoms as compared to adults. In the meantime, the question of whether depressive symptoms in children are the same as those of adults arised. Continuous research have shown that the manifestations of childhood depression seem to differ from those of adults. Therefore, in the middle of 1970s, three different points of view on childhood depression emerged. The first point of view is that there is no depressive phenomenon in children and even if there is such a phenomenon it is much more rarer than it is in adults and occurs in infancy and early childhood (Bowlby, 1960; Kanner, 1947; Mahler, 1961; Rie, 1966). The second idea on childhood depression is that there may be depressive features in children but it should be taken into account as masked depression (Cytryn and McKnew, 1972; Frommer,

1968; Glasser, 1967; Toolan, 1962). Finally, researchers have concluded that there is a childhood depressive phenomenon, however, its manifestations differ from those of adults. Also its manifestations show differences depending on the developmental stage of children (Carlson and Cantwell,1979; Carlson and Cantwell, 1980a; 1980b; 1982; Cytryn, 1980; Kashani, 1983; Kaslow, Rehm and Siegel, 1984; Kazdin, 1988; Kovacs, Feinberg, Crouse-Novak, Paulaskas and Finkelstein, 1984; Malmquist, 1983; McConville, Boag and Purohit, 1973; Pearce, 1977; Poznansky and Zrull, 1970).

Although the incidence and prevalence of childhood depression has not been studied adequately, nowadays it has been accepted that childhood depression is a distinct and measurable clinical entity, and can occur even as early as preschool age. Research was designed to determine certain psychosocial risk factors related to depression, such as sex, age, intellectual functioning and socio-economic-status (Myers and Weismann, 1980). Research on gender differences with the axception of by Finch et.al. (1985), showed the absence of a significant relationship between sex and depression (Aydın and Doğan,1988; Finch, Saylor and Edwards, 1985; Kashani, McGee and Clarkson, 1983; Kaslow, Rehm and Siegel, 1984; Kovacs, 1985; Myers and Weissman, 1980; Saylor, Finch and Spirito, 1984a; Saylor, Finch and Baskin, 1984b; Slotkin, 1988). Furthermore, it has been shown that sex and age were not related to depression but that there seems to be an inverse relationship between cognitive functioning and depression. Examining the relationship between socio-economic -status and depression, Lefkowitz and Tesiny (1985) found that a risk

exists for severe depression at lower and upper levels of SES. Other studies, with exception of Kashani et al., (1983) showed that there is a negative relationship between depression and SES (Aydın and Doğan, 1988; Hirschfeld and Cross, 1982; Lefkowitz and Tesiny, 1980; 1985; Öy 1991). However, there is still argument about whether SES is a risk factor to childhood depression.

More typically, the clinical manifestations of childhood depression are viewed as a characteristic mood of sadness and unhappiness, social withdrawal, loss of self-esteem (self-depriciation), poor school-work, loss of appetite and psychosomatic complains, such as headache and stomach ache (Poznansky and Zrull, 1970). If clinicians consider the child as a miniature adult and expect symptom similar to those seen in adult depression, many children will be misdiagnosed and their problems will be neglected because depression in children can also be manifested as masked depression and may appear as hyperactivity, acting out, aggression, hypochondriasis and delinquency (Cytryn and McKnew, 1972), or temper tantrums, disobediance, truancy, boredom and restlessness (Toolan,1962). More recently, Beck, Kovacs and Weissman (1975) and Seligman et. al. (1984) have added hopelessness and helplessness aspects to childhood depression.

The symptoms of childhood depression are largely ephemoral and can more parsimoniously be explained as transient developmental phenomena (Lefkowitz and Burton, 1978). Thus, data culled from epidemiological and longitudional studies (Kazdin,1988; Nowicki and Strickland, 1973; Pearce, 1977) suggests that age is an important

mitigating variable. For example, Pearce (1977) found that 33 % of children in his sample manifested insufficient appetite at age 6 but age 9 only 7.5 % of the sample showed such behavior. During development, disturbing (reactive) behavior is likely to be exhibited by almost all children but such behavior also tends to remit spontaneously overtime.

Related to the diagnosis of childhood depression, research has advanced considerably with the application of diagnostic criteria for affective disorder, specific to children and adolescents (Kazdin, 1981; Varley and Werry, 1971; van Krevelen,1981). Varley and Werry (1971) reviewed the cases of 1250 children diagnosed in a hospital for a three years period. Although they found that 7 % were diagnosed as depression, they concluded that this figure was an underestimation. Similarly, van Krevelen (1971) claimed that it is difficult to diagnose children under 10 years of age as depressed and manic because of complexity of symptoms of depression and mania. They suggested that these conditions are overlooked at that age. Manias tend to be viewed as obstreperous behavior and natural vitality tends to disguise depression. Furthermore, he argued that some childhood neurosis could be more parsimoniously interpreted as inchoate manifestations of later affective psychosis. Similarly, Malmquist (1983) stated that "the child from 5 years of age to puberty may actually comprise the most hidden group in terms of incidence". On the other hand, Sarada (1990) noted that there is a confusion about the use of the term, "depression", especially in Japan. Sarada claimed that, according to current classification systems, childhood depression as a distinct diagnosis tends to be exceedingly rare. Of the 3000 children in Japan, one case

bore the diagnosis of depression. In addition from over 10.000 cases studied at two Tokyo hospitals, he found that only a few were diagnosed as depression under the age of 15. The view that the syndrome among the children occurs with high frequency should be hardly monolithic because there is an increasing tendency to group the symptoms of minimal brain disfunction, conduct disorder and vegetative disfunctions under this syndrome .

Although the diagnosis of depression in children has shown this ambiguity and hetereogenity, the understanding of factors that contribute to childhood depression is crucial for the prevention and treatment of the syndrome. Current evidence indicates that between 27 % to 62 % of children from clinical samples, meet the criteria for depressive disorder. Many of depressive children will suffer relapses and continue to show dysfunction and that they may even make suicidal attempts (Kazdin, 1988; Kovacs et.al., 1984.). Indeed, although the rate of completed suicides are low prior to the age of 14, suicidal ideation and nonfatal suicide attempts are not uncommon in preadolescent children.Such ideation and nonfatal attempts have been noted prior to fatal suicides and more recently researchers claim that there is a strong relationship between suicides and depression with hopelessness (Kazdin, French, Unis, Esveldt-Dawson and Sherich, 1983; Beck, Kovacs, Weissman, 1975). However, the relationship between depression and suicidal ideation is unclear. There is a considerable overlap between childhood disorders, such as attention deficit disorder, hyperactivity and conduct disorder and childhood depression. Researchers have not been able to note a clear explanation

for the precipitating factors of suicidal ideation. They only claimed that, there is a substantial occurrence of depressed, nonsuicidal children as well as of suicidal but nondepressed children. Similar factors have been cited to explain both depression and suicidal ideation eventhough those factors are not mutually inclusive. It has been suggested that mainly four factors may be associated with childhood depression and suicidal intent. These factors are self-perceptions, hopelessness, coping strategies and perceptions of family environment. Research with adults (Folkman and Lazarus, 1986) has indicated differences between the coping strategies of individuals who have high and low depressive symptoms. Chaotic family environment and poor coping strategies have been posited as risk factors for depression especially for children (Sacco and Graves, 1984; Sandler, 1980).

Models of Childhood Depression

During the past decade, considerable effort has been invested in determining the primary etiological factors in childhood depression. Most reliable data has come from behavioral, cognitive and coping models. Therefore, the present study will be selectively focusing on these models.

Behavioral Models.

Behavioral models examine depression by analysing overt behavior. In this model, changes in reinforcers are taken into

consideration as the primary etiological factor in depression. Lazarus (1968) and Ferster (1973) claimed that a loss in the number of reinforcement leads to depression. The work of Lewinsohn (1974) in the area of behavioral reinforcement is based on the assumption that depressive behaviors and feelings are elicited by a low rate of response-contingent positive reinforcement. It was found that depressed individual elicited fewer positive behaviors from other people. Depressed individuals receive less positive reinforcement than nondepressed individuals. They exercise fewer social skills than nondepressed individuals and there is a relationship between depression and amount and type of behavioral activities engaged by the individuals. Mitchell and Madigan (1983) emphasized the interpersonal disturbance within this model. He views depression as a result of the loss of the ability to control interpersonal environment effectively.

Data from these explanations suggests that there are several factors which could be involved in reinforcement changes. One of these factors involves the loss of a person who previously supplied the reinforcers. Therefore, it is important to note that the types of people providing reinforcement to an individual will vary as the person grows older. In other words, this is a developmental issue. The loss of a mother does not result in the same reinforcement loss for a 6 months-old as it could for a 14 years-old teenager. The other factor is the ineffectiveness of the depressed person's own skills in obtaining reinforcement or in making reinforcers available. These factors also seem to be relavant to childhood depression. Dealing with these factors, Jacobsen, Lakey and Strauss (1983) suggested that the child's

behavior develops in respect to people's tolerance. A child may loose reinforcement if his/her behaviors become disturbing to other people. On the other hand, peer support is an important factor in getting reinforcement. Although there are some meaningful relationships between adult and childhood depression, emprical studies suggested that it is unclear whether this formulation can be extended to account for childhood depression. For example, related to peer support, Weisz and Band (1988) found that young children do not react negatively to a peer' s solicitation for support. When children seek support from adults, adults are usually more tolerant to their symptoms than they are for the symptoms of other adults, because children are normally perceived as being more dependent. Perhaps, adults may desire a child to be dependent and thus depressed children are not likely to be rejected. Dealing with socially isolated children, it was found that dispensing of punishment was not found to be related to peer rejection. Gottman stated that peer acceptance is directly related to children's own interpersonal skills. Our knowledge on the impact of peer acceptance and peer rejection is limited. Children's skills of gaining entry into a peer group may be different from those of adults. However, this difference has not been investigated yet. On the other hand, peer rejection and/or the lack of adequate interpersonal skills in childhood may be related to the emergence of depressive symptoms later on. Therefore, research should be based on different age groups and also the research should include cognitive integration at different developmental stages.

An alternative behavioral model has been developed by

Seligman and his colleagues (Abramson, Seligman and Teasdale, 1978; Seligman, et al., 1984). Seligman' s learned helplessness theory provided a link between behavioral and cognitive models of depression. Seligman's initial model was developed by studying dogs in experimental situations. Subsequently, the work has been extended to humans. He discovered that, dogs who had learned that nothing they could do would allow them to escape from electric shock, developed a sense of learned helplessness. Even when the dogs were exposed to the situations in which they could escape the shock, they did not attempt to do so. Instead, they remained inert and passive, not escaping the avoidable aversive event. They had learned to be helpless. Therefore, helplessness was assumed to be characterized by a reduction of self-initiated behaviors which would lead to positive reinforcement or avoidance of the aversive event (Seligman, 1978).

The original model due to its shortcomings was revised in order to take into account the causal attributions of individuals for the bad events (Abramson et al., 1978). The model posits that when a person is confronted with undesirable consequencies, the person looks for causal explanations and attributes to explain the reasons. In Abramson et al.' s words, people who are depressed tend to attribute negative outcomes to internal, stable and global factors. Attributions of a negative event to internal factors lead to self-depriciation. Stable attributions lead to persistance of depressive deficits overtime and attributions to global factors lead to the generalization of the deficit across situations.

Several studies examined the relationship between

attributions and learned helplessness and childhood depression (Fincham, Diener and Hokoda, 1987; Peterson, Seligman, 1984; Seligman, et al., 1984) Seligman claims that the attributional style approach may help to make a set of predictions about the emotional and behavioral development of children. He found that children possessing a depressogenic attributional style tended to view the causes of bad events as stable in time, global ineffect and internal to themselves. Finally, he concluded that depressive symptoms and attributional styles were found to be correlated positively with clinical depression and poor school achievement. Aydın (1988) examined the relationship between helpless explanatory style and popularity/unpopularity with 472 subjects from fourth and fifth grades students in different public primary schools in Ankara. She found that a significant relationship exists between helpless explanatory style and unpopularity in school. Dweck (1975) reported that attributions were effective in reducing the performance deterioration following a failure experience in a sample of fifth grades helpless children. Weisz and Band (1988) found that young children overestimate the degree of contingency between outcomes and behavior. This perception of contingency declines as children mature. However, the results of the developmental studies showed that attributional style may be nonexist in children younger than 8 years old. Similarly, Ruble and Rholes (cf.Fincham et al., 1987) reported that 5 to 6 years-old children do not regularly use their attributions and causal schema. The use of attributions emerges gradually begining from 9 th years. Therefore, it can be suggested that the helplessness associated attributional style

may play important role in the initiation of childhood depression or provide a vulnerability to it. The literature, dealing with childhood depression, showed that there is a correlation between The Children Depression Inventory (CDI) which measures symptoms of depression and Children Attributional Style Questionnaire (CASQ) which is a measure of attributional style (Seligman, Kaslow, Tanenbaum, Alloy and Abramson, 1984).

The utility of learned helplessness as a model of adult depression remains controversial not only in the view of mixed emprical findings but also in the view of continuity between mild depression and severe depression (Peterson and Seligman, 1984). The attempt to examine learned helplessness as a model of childhood depression is likely to be even more controversial given the lack of consensus regarding the existance, the diagnosis and the significance of the disorder in children (Kazdin, 1981;1988).

Cognitive Model.

Cognitive models of depression emphasized the role of negative perceptions about the self,the situation and the future in the development and maintenance of depressive symptoms (Beck, 1979). Prior research has demonstrated an association between self-reports of depressive symptoms and negative self-perceptions (Kaslow et al., 1984; Saylor, Finch, Baskin, Furey and Kelly, 1984).

According to this model, negative self-perceptions come from cognitive distortions. Cognitive distortions are thought to develop

gradually and are probably rooted in unfavourable life experiences. They lead to a tendency to overreact to events that exaggerates the negative aspects of life. The individual, then, begins to engage in a negative conceptions of the self, a negative interpretation of his life experiences and has a nihilistic view of the future. This is proposed to effect the depressed individual' s interactions with the environment and cause them to misinterpret the events. According to Beck (1979), this can be postulated to be the first link in the chain of symptoms.

The incidence of low self-esteem and poor body image in sad children suggests that the cognitive distortion model may be useful in research with children. Although the childhood depression literature is full of examples of attempts to modify children's cognitions with the goal of modifying their behavior, it is still not clear that results of these studies can be simply extrapolated to the study of childhood depression. In examining the role of developmental factors in the formation of a negative cognitive triad, there are still questions which can not be answered because the findings are only correlative (Kazdin et al.,1988). These questions are "are children capable of forming a negative cognitive triad?"; "Would a negative triad, if present in children, maintain the same relationship with emotions and behaviors as it does in adults?"

Information processing theorists proposed that young children should be as capable as adults in forming a negative cognitive triad. Although they would have more difficulty in doing so, they are capable of abstracting a theme because abstraction closely involves retrieving the past experiences from memory and comparing them with

present experiences; children seem to have this ability. However, they are inefficient retrievers and have difficulty retrieving memories spontaneously. Self-schema research of Zupan and Hammer (1984) with depressed and nondepressed children, for example, has suggested the existence of negative self-schema in childhood depression. They found that nondepressed children have positive self-schema while clinically depressed children have a negative schema. Similarly, Kazdin et al. (1983) have found that depressed inpatient children were hopeless with lowered self-esteem which supports the presence of a negative cognitive triad in depression, that is characterized by a negative view of the self, the world and the future. However, do these negative schemas play an important role in the initiation and also the maintainence of childhood depression? This question can not be easily answered from current research finding . Research has only revealed that negative schemas are absent in childhood depression between the ages of 7 to 12, leading to the conclusion that the likelihood of the formation a negative schemas in children may be considerable less likely it is for adults. Furthermore, it is not clear whether a negative cognitive triad will influence children's emotions and behaviors as it is suggested for adults.

Coping Models.

There are a number of theoretical approaches which focus on people's strategies of coping with stressful live events and depression. In the literature, this approach is referred to as Coping Models. The models deal with the way in which people's behavior can ameliorate or

maintain their depression.

What has worked in the genetic evolutionary history of human organism to promote survival is presumed to operate in the current history to promote adaptation to the contemporary environment. In other words, the mechanism of the adaptation will be utilized in coping with normal environmental stressors.

It is reasonable to argue that whether stress will result in clinically depression depends on how the individual copes with the stress and/or with its immediate psychological meaning for the individual. It is said that cognitive and behavioral therapies provide the individual with new coping skills and perceptions to deal with future stressor (Beckman and Adams, 1984; Kessler, 1985).

The simpliest design to assess the role of coping techniques involves the comparison of depressed with nondepressed individuals. Coyne, Aldwin and Lazarus (1981) have reported that depressed persons are more likely than the nondepressed to respond to stress by means of help seeking and emotional support and by means of wishful thinking. Mitchel and Hudson (1983) claimed that it may also be important to rule out the possibility of differences in the stressors. Parker and Brown (1982) have assessed people's coping responses when confronted with hypothetical stressors. Results indicated that depressed people were not discriminated by a distinctive pattern of coping responses, but showed a general reduction of faith in a broad range of coping behaviors, especially those that involve socialization and involvement in work. This reduction largely disappeared when the depression lifted. Sandler and Lakey (1982) recently compared

depressed persons who had or had not recovered from depression and reported that the two groups differed with respect to just one coping strategy; those who had been unsuccessful reported that they systematically observed their own behavior. What' s more, Pearlin and Schooler (1978) from their longitudional study have reported that job loss tends to result in depression among noncopers. Coping resources may overlap both with social support; environmental conditions and with personality variables. Mitchell and Hudson (1983) reported reliable correlations between family and environmental support and problem solving strategies, although the relationship between coping and depression was a crucial factor. Mitchell et al. (1983) and Pearlin et al. (1978) concluded that the conditions in which people lived affect the problem solving activities and coping resources.

Therefore, during the past decades, the study of coping proliferated. The paradigm that appropriate coping strategies can ameliorate the impact of life events led to several studies in this area. Rippere (1974; 1976; 1977a; 1977b; 1979; 1980a-e; 1981a-b; 1983) has explored aspects of human depressed experience. Rippere has argued that when people who are feeling depressed do thing to help themselves, they are most probably following socially transmitted behavior recipes for dealing with the common states of mind. Rippere' s studies investigated two issues; kinds of antidehressive behavior and the common stock knowledge that exists about antidepressive behaviors. Her studies took their point of view from the central concept of the contemporary sociology of knowledge which is proposed by Berger and Luckman (1967) and the early essay on "Common Sense

Knowledge of Social Structure" by Garfunkel (1962) (cf. Rippere,1980e). The term refers to accumulated experience in a society; that is transmitted from one generation to the next and is available to the individual in defining and attempting to solve problems which people encounter in everyday life. Rippere (1976) claims that the social stock of knowledge comes from typifications of all sorts of events and experiences, both social and natural and also these typifications require for major routines of everyday life.

Although Joynson has written a book-lenght defense of people' s understanding called Psychology and Common Sense and also Beck (cf. Keneally, 1989) has written favourable of people's common sense methods for solving the problems which they meet in their daily lives. Rippere' s studies have been so important because the social stock of knowledge about coping with depression did not appeared to have been previously investigated in any systematic way.

In the early studies, Rippere' s aim was essentially descriptive; to see whether the existence of a consensus opinion about the "thing to do when you are feeling depressed" could be demonstrated emprically and to find out what sorts of behaviors were regarded as coming under this heading. The method she used was simply to ask people "What' s the things to do when you are feeling depressed?". From the answers to the question, the frequency and description of strategies mentioned were analysed (Rippere, 1977a,b). The results showed that not only did people have ideas how to cope with depression but they also appeared to hold highly similar ideas about what to do. The most common strategies mentioned by people

were; see people, a friend 36 %, think of a reason for it 34 %, go for a walk 32 % (Rippere, 1977a).

Other researcher have taken their lead from Rippere' s methodology. Caro, Miralles and Rippere (1983) have investigated cultural differences with a Spanish speaking sample. They worked with fifty nonpatients Spanish adults in Valencia asked them in an open-ended interview "What' s the thing to do when you are feeling depressed?". They conducted a content analysis and also compaired their data with Rippere' s (1977b). The results showed that Spanish subjects had a lower ratio of consensual to nonconsensual items as compared to British subjects. Bayraktar (1988) in a sample of Turkish University students found that Turkish subjects had a higher ratio of consensual to nonconsensual items than Spanish subjects and British subjects.

Applying these notions of coping to the actions of children requires some alterations and additions. Children differ in their sensitivity to the environment. More responsive children may need to cope with a great number of situations than less responsive youngsters (Maccoby, 1983; cf. Compas, 1987)). Basic features of cognitive and social development are likely to effect what children experience and how they cope. Important aspects of development include self-perceptions (Harter, 1986;cf. Compas,1987), self-efficacy beliefs (Bandura, 1981), attributions of cause (Rutter, 1981), friendships (Kaplan, 1983) and parental relationship (Sandler, 1980). Not surprisingly, it appears that coping during childhood is affected both by personal and environmental factors. The degree of effective coping may

depend on the goodness of fit between the child and the environment. For example, if a child' s temperamental style does not effectively elicit care taking responses from the parents, then, a poor fit exists and the child' s coping efforts will not facilitate successful adaptation. Therefore, research investigating coping during childhood must take into account the environmental context which includes availability of resources for coping. Research and available data dealing with children's coping with depression is almost absent. There seems to be only one study which investigated behavioral strategies for coping with depression. The study was conducted by Keneally (1989), who took her lead from Rippere' s studies. Keneally (1989) investigated children' s common sense belief concerning behavior strategies for coping with depression/unhappiness. It was designed to examine the hypothesis that children may also possess a common stock knowledge concerning the "thing to do" when they are feeling depressed/unhappy. By interviewing 120 children from various ages (4-11 years-old), Keneally had two aims; both of which were essentially descriptive. The first was simply to see whether a consensus opinion also exists in children. The second aim of the study was to find out which sorts of behaviors were regarded by children as coming under this heading and to see whether these behaviors change with increased age and the final aim was to investigate with types worked best and how often they worked. She also intended to elicit some descriptive accounts of children's understanding of sadness/unhappiness and their conceptualization of depression. Keneally (1989) found that children not only had ideas about what to do when they are depressed/unhappy but also had ideas

on "what works best". Furthermore, she found that children' s repertories of antidepressive behavior increased with age. She concluded that "children appeared to have been prepared by their socialization for the possibility of feeling depressed at some time and were equipped with a repertoire of contingency plans for coping with the situation".

The present study was designed mainly to investigate the coping strategies of Turkish children and their relationship with depressive symptomatology. More specifically;

The present study was designed in order;

1-to examine the types of coping strategies given by children,

2-to examine whether Turkish children show concensuality in reporting "the thing to do when they are depressed/unhappy". Comparison of the present results with Keneally' s results, where appropriate was also planned,

3-to examine whether there are gender and socio-economic-status (SES) differences in the number of coping strategies given by fourth and fifth grades children and in the effectiveness ratings,

4-to investigate the relationship between the number and the effectiveness ratings of coping strategies and depressive symptomatology as measured by the Children Depression Inventory (CDI; Kovacs,1981).

Mainly the following two hypothesis will be tested;

1-Children possess a common stock knowledge concerning the "things to do" when they are feeling depressed.

2-There will be an inverse relationship between the CDI scores and the number of coping strategies mentioned and the effectiveness ratings provided by the children. Relatedly, children who obtain high scores from the CDI will report fewer coping strategies and will have lower effectiveness scores an compared to children who obtain low scores from the CDI.

METHOD

Pilot Study.

Subjects.

An accidental sample of 30 children between 8-12 of age, attending the fourth and fifth grades of the Seniha Isen (Sincan) public elementary school and Türk Eğitim Derneği Ankara Koleji (TED) private elementary school in Ankara, participated in this study.

Procedure.

The term depression is not commonly used in Turkey within the context of children. This pilot study has been conducted in order to find out which term children use to express their depressed feelings.

The subjects were given a list of terms and were asked, "when you are unhappy which of the following terms do you use in order to express your unhappiness?" (See Appendix A).

MAIN STUDY

Subjects.

128 elementary school students attending the fourth and fifth grades of a puplic Seniha İsen 32 girls and 32 and boys) and private (Türk Eğitim Derneği Ankara Koleji (TED); 32 girls and 32 boys) elementary schools in Ankara were selected for this study. In order to examine whether there are SES difference in the frequency and the number of antidepressive activities mentioned by the fourth and fifth grades children, two different schools were chosen; Seniha Isen in Sincan was chosen to represent low SES and TED Koleji, for high SES. Except family income, children's characteristics, which may be taken as indicators of SES; number of siblings, having a private room, fathers' education, fathers' occupation, mothers' education, mothers' occupation were obtained. Table 1 presents the characteristics of the low and high SES subjects. Family income was not included due to the unreliability of obtaining a reliable estimate in Turkey.

Table 1. Characteristic of the High and Low SES Subjects.

	Low SES Seniha İsen (%)	High SES TED (%)
number of siblings(1)	28.1	32.8
number of siblings(2)	28.1	62.5
number of siblings(3)	45.3	4.68
number of siblings(4)	11.2	-
number of siblings(5)	9.3	-
number of siblings(7)	4.6	-
has private room		100
father education(literate)	3.1	-
father education(left elementary school)	3.1	-
father education(graduated elementary school)	50	-
father education(left junior high school)	14	-
father education(reduated junior high school)	1.5	-
father education(left high school)	1.5	-
father education(graduated high school)	21.8	12.5
father education(left university)	1.5	10.9
father education(graduated univer.)	3.1	76.5
mother education(literate)	14	-
mother education(left elementary school)	12.5	-
mother education(graduated elementary school)	56.2	-
mother education(left junior high school)	6.2	-
mother education(graduated junior high school)	46	4.6
mother education(left high school)	4.6	21.8
mother education(graduated high school)	-	-
mother education(graduated university)	1.5	73.5

*(See appendix D for the occupation of father/mother)

Instrument.

The Children Depression Inventory (CDI). The CDI, developed by Kovacs (1981), is a self report inventory, consisting of 27 items modified from Beck Depression Inventory(BDI). It was designed to be used with preadolescent children. Each item consists of three statements, aranged to reflect increasing order of severity level of depression in children. The items are scored as 0-1-2, respectively. For example, "I am sad once in a while/ I am sad many times/ I am sad all the times". The scale has satisfactory internal reliability (coefficient alpha 0.86; four week test re-test reliability 0.72) (cf. Seligman, et al.,

1984). It has been validated against independent psychiatric evaluators and correlated with self-esteem and attributional style questionnaire scores associated with learned helplessness in children (Peterson, 1982).

The reliability and validity of the CDI has been recently examined in a Turkish sample by Öy (1991). By using a community sample, she studied 432 fourth and seven grades student in three different private and public elementary schools in Ankara and showed that the scale has satisfactory reliability (coefficient alpha 0.80 ; one week test retest reliability 0.77). It has been validated in the Türkish community sample by using DSM-III, (Öy. 1991). (See appendix C).

Procedure.

Initially, a group administration of the CDI was conducted. Four weeks following this administration, the students were individually administered a semi - structured interview. The questions of this interview were borrowed from Keneally's study (1989). The interview lasted between 10-20 minutes. During the interview, 5 questions were asked to the children. As the final question of the semi - structured interview, four cards were prepared to indicate the degree to which the coping strategy chosen as the best by the worked (never, sometimes, often and always). While asking the question "How often does this work?", the interviewer at the same time presented the children the four cards and asked them to choose one of them.

The questions were asked to each subject in the same order and their replies were noted by the interviewer and a judge. The first

question investigated the child' s concepts of depression. It was asked in order to help children remember a depressed/unhappy past experience and to provide a frame work of unhappy feelings. (See Appendix B).

Statistical Analysis.

Data was analyzed by the use of Statistical Package for the Social Sciences, SPSS (Nie, Hall, Jenkins, stein brenner, and Bent, 1975). Descriptive statistics and coralational analysis were used and 2x2 Anova was used in order to examine SES (low and high) and gorder (boys and girls) effects.

RESULTS

The Results of Pilot Study.

The results of the pilot study showed that 13 out of the 15 children from the lower SES (Seniha İsen) expressed their depressed/unhappy feelings by means of the word "SAD"(Üzüntü). On the other hand, all of 15 children from the higher SES (TED) expressed their depressed/unhappy feelings by means of the word "UNHAPPINESS" (Mutsuzluk). Considering these results, both of the terms "sad" and "unhappiness" were used together in the main study.

To gain experience and to find out whether children understand the translation of the questions of the semi-structured interview schedule that was used by Keneally (1989), approximately 40 children between the ages 8 - 12 from different elementary schools in Ankara were interviewed. It was noticed that Turkish children did not understand some of the questions used by Keneally in her semi-structured interview. Therefore some of these questions were modified (See Appendix B). These interviews were recorded on a cassette player. However, in the main study, the interviews could not be recorded due to practical difficulties.

Content Analysis.

The responses to the questions "What do you do when you are unhappy/sad?" and "Which one is best at making you feel better?" were assigned to the following categories by two post graduate psychology students. These categories, mainly taken from Keneally

(1989) were; "play", "help and comfort seeking activities", "altruistic strategies", "entertainment and aesthetics", "reactive behavior", "avoidance", "eating", "crying" and "miscellanous". The operational definitions provided to the judges were;

PLAY : to play with friend(s),mother, father, sister/brother and also play alone.

HELP and COMFORT SEEKING : either trying to laugh or pretending to be happy, going to father/mother/sister/brother/teacher/care taker, think of a reason for it, engaging in home activities,such as washing dishes, baking a cake and so on.

ALTRUISTIC STRATEGIES : to help someone be happy or apologizing (i.e; saying "I am sorry").

ENTERTAINMENT and AESTHETICS : This category includes various forms of behaviors dealing with entertainment activities, such as going to the cinema and watching tv and also art activities, such as drawing a picture and also caring for pets (dogs,cats,fishes).

REACTIVE BEHAVIOR : this category includes various forms of aggressive behaviors, such as slamming doors, fighting with sister/brother/friend, getting angry, ripping up posters, note-books/books, shouting as well as biting.

AVOIDANCE : going to sleep, forgeting about it or going away on their own.

EATING : to eat someting

CRYING : to cry

MISCELLANOUS : this category include unidentified responses, such as going to the house,sitting down and thinking about her/his self.

A response was operationalized as any element of behavior that could be performed independently from any other. The same response that was mentioned more than once was counted as a single behavior.

Reliability of Coding.
Interrater Reliability.

The coding was done by two separate raters. During interview the responses of the children were noted down both by the interviewer and one other rater who was a university student. After completingthe data collection, the interviews were subjected to content analysis by the two post graduate psychology students. The raters were in complete agreement in 125 out of 128 cases or 97.6 % of time. In terms of the items, they were in complete agreement in 440 out of 442 cases or 98% of time.

Qualitative and Quantitative Analyses.

Each nonrepeated response was operationally assigned to the nine categories described in the previous section by two psychologist. For example, the reply "tell my mother and play" was counted as two responses. The categories in which there was not complete agreement were "Altruistic strategies" and "Miscellanous". Total number of responses collected was 883 (mean = 6.898, sd. =4.058 and ranges = 1-16). The number of nonrepetitive responses were 442.

Frequency Strategies Given by the Sample in Different Categories.

Table 2 shows the frequency of strategies given by children in different categories. As it can be seen from table 2, the "play" and "help and comfort seeking activities" strategies were mentioned most frequently. Eating strategies were mentioned the least.

Table 2. The Frequency of Strategies Mentioned.

	Frequency	Percentage
Play	106	82.8
Help and comfort seeking	106	82
Entertainment and aesthetics	101	78.9
Crying	37	28.9
Reactive behavior	35	27.3
Avoidance	20	15.6
Altruistic behavior	18	14.1
Eating	16	12.5
Miscellanous	5	3.9

Consensuality Ratios.

The term consensuality was designed as the response (i.e; coping strategy) mentioned by more than one child. In order to obtain consensuality ratios, responses mentioned by children were subjected to frequency analysis. The analysis of the responses showed a great consensuality ratio. 91.4 per cent of the responses were mentioned by more than one child. Consensuality ratios reported by Keneally with British sample was 62,5 per cent Table 3 shows the per cent of consensual and nonconsensual items of the present study (Turkish) and of Keneally's study (British).

Table 3. Number and Percentage of Consensual and Nonconsensual Items.

	British(%)	Turkish(%)
Consensual	62.5	91.4 (431)
Nonconsentual	37.5	8.6 (11)

The Most Effective Coping Strategy Chosen by The Sample.

Children were required to give only one response to the question; " Which one is best at making you feel better? ". The most frequently mentioned strategies were "play" and "help and comfort seeking activities". In other words, the most frequently mentioned items on "What works best" were play, play with friend(s), toys, going to friend(s) and/or washing dishes, play with my computer, reading. These findings seem to support the presence of a consensus concerning the "best thing to do" when these children are feeling depressed/unhappy (table 4).

Table 4. The Frequency of Answer to the Question the "Which one is the best at making you feel better?".

	Frequency	Percentage
Play	42	32.8
Help and comfort seeking	42	32.8
Entertainment	14	10.9
Crying	14	10.9
Reactive behavior	3	2.3
Altruistic behavior	1	0.8
Avoidance	1	0.8

Children's responses to the question; "How often does this make you feel better?" is shown in table 5, as percentages in each response categoory. Keneally's results are also given in this table Dissimilar, from Keneally's five dimensions (never, not very often, sometimes, often and always) the present study used dimensions due to language difficulties (table 5).

Table 5. Percentage of Answers to the Question "How often does this make you feel better?"

	Present Study	Keneally' s Study
Never	4.2%	0%
Sometimes	7.0%	10%
Often	30.6%	30%
Always	58.8%	60%

The Results of 2x2 ANOVA for Number of Coping Strategies Mentioned, Number of Responses in Each Coping Category and CDI scores.

The responsen given by children to the question "What do you do when you are unhappy/sad?" were analysed by 2x2 ANOVA (Sex and SES) for the total number of coping strategies given and also for number of items in different categories; play, help and comfort seeking activities, altruistic behavior, entertainment and aesthetics, reactive

behavior, avoidance, eating, crying, miscellanous catepories and the effectweness ratug for the best coping response chosen, in order to examine sex and SES differences. (Kirk, 1968; and Nie, Hall, Jenkins, Steibrenner and Bent, 1975). Similarly the CDI scores were also examined by 2x2 Anova, in order to investgate SES and gender effects.

Table 6: Summary Table of 2x2 Anova Results for Number of Item Given, Effectiveness Ratings and all Coping Categories.

	Girls (mean)	Boys (mean)	F Sex	Low SES (mean)	High SES (mean)	F school
Number of item given	6.67	7.13	0.58	4.59	9.20	60.02**
Play	1.69	2.55	14.14**	1.42	2.81	37.04**
Help and comfort seeking	2.00	1.50	5.84*	1.34	2.16	15.43**
Altruistic	0.27	0.05	10.88**	0.06	0.25	8.00*
Entertainment	1.69	1.97	1.42	1.13	2.53	35.52**
Reactive behaviour	0.22	0.58	6.77**	0.20	0.59	8.06**
Avoidance	0.19	0.14	0.46	0.23	0.09	4.16*
Eating	0.13	0.13	0.00	0.00	0.25	20.66**
Crying	0.45	0.13	19.39**	0.22	0.36	3.56
Miscellanous	0.03	0.01	0.20	0.02	0.06	1.84
Effectiveness	3.06	3.31	2.33	2.94	3.05	2.45
CDI	12.27	11.30	0.95	11.73	11.83	0.92

**p<.001 *p<.05

Table 6 gives the results of the Anova analysis and the mean values for gender (boys and girls) and SES (low and high).

Total Number of Coping Strategies Given.

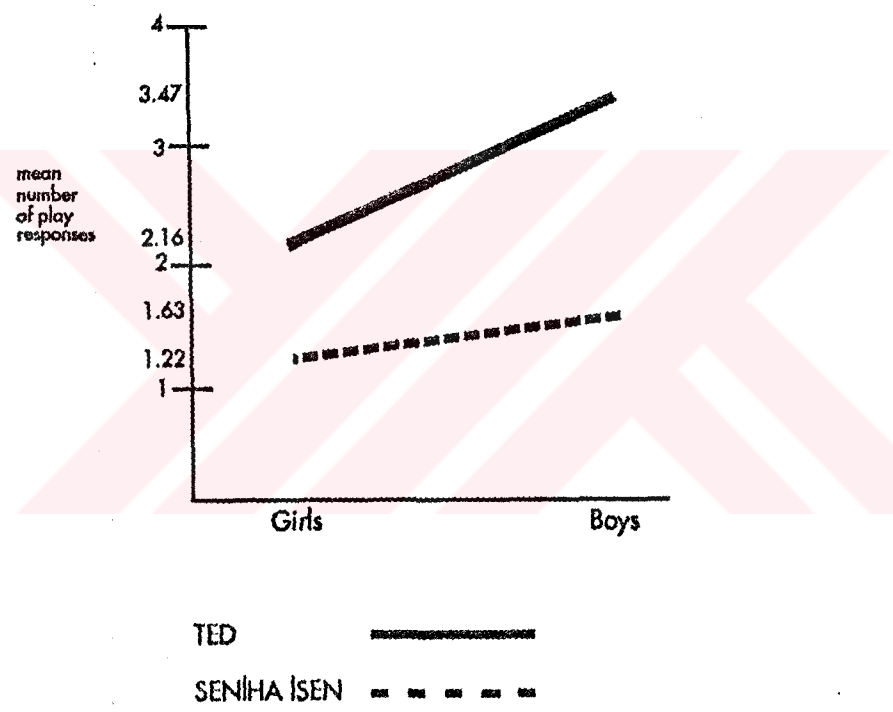
For number of coping strategies mentioned, the analysis yielded only a significant main effect for SES ($F(1,127) = 60.02$; $p < .001$). Generally, it seems that children from the higher SES mention more coping strategies than those from the lower SES.

Number of Coping Strategies Given in Different Categories.

Within the play category, the analysis yielded a significant main effect for sex ($F(1,127) = 37.04$; $p < .001$). Examining the means

presented in table 6, it seems that boys give more play related strategies compared to girls. Furthermore, there was a significant main effect for SES ($F(1,127 = 37.04$; $p < .001$). It seems that children from the lower SES gave fewer play activities than those of higher SES. The analysis also yielded sex and SES interactions for play activity (figure 1).

Figure 1: Number of Play Related Items Given by Girls and Boys From the Low and the High SES.

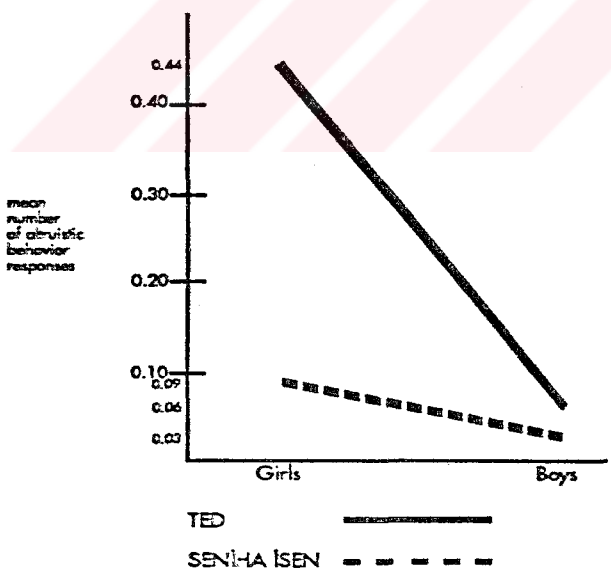


As can be seen from figure 1, although there is a slight difference between girls and boys in the Lower SES, the difference between girls and boys is only significant in the higher SES.

Within the help and comfort seeking category, a significant main effect was found for sex ($F(1,127) = 5.84$; $p<.001$) and SES ($F(1,127) = 15.43$; $p <.001$). That is, generally, girls seem to use more help and comfort seeking activities than boys. On the other hand, children from the lower SES seem to use fewer help and comfort seeking strategies than children from higher SES.

In terms of altruistic behaviors, the analysis yielded a main effect for both sex ($F(1, 127)= 10.88$; $p<.001$) and SES ($F(1, 127)= 8.00$; $p<.001$). There is also an interaction of sex and SES for altruistic behavior, ($F(1,127)= 5.55$; $p<.05$). While girls appeared to use slightly more altruistic related strategies than boys in the lower SES, the gender difference was sgnificant only in the higher SES.

Figure 2: Number of Altruistic Behavir Items Given by Girls and Boys from Lower and Higher SES Groups.



On the entertainment and aesthetics category, the analysis yielded a significant main effect of SES ($F(1, 127) = 35.82$; $p < .001$). Children from the lower SES mentioned fewer entertainment and aesthetics activities than those from the higher SES.

A significant main effect of sex ($F(1, 127) = 6.77$; $p < .05$) and SES ($F(1,127) = 8.01$; $P < .05$) was found for the reactive behavior category. Generally, boys mentioned more reactive behaviors than girls. Dealing with the main effect of SES, children from the higher SES seemed to use more reactive behaviors than those from the lower SES.

For the avoidance category, the analysis did not yield a signifcant main effect for sex but there was a significant SES effect ($F(1, 127) = 4.16$; $p < .05$). Children from the lower SES appeared to use more avoidance activities than those from the higher SES.

For the eating category, there was only a significant main effect for SES ($F(1, 127) = 20.66$; $p < .001$). Children from the higher SES seemd to give more eating strategies than those from the lower SES. Infact, children from the lower SES did not mention any eating strategies in order to cope with their depressed/unhappy feelings.

Dealing with the crying category, there was a significant main effect of sex ($F(1, 127) = 19.39$; $p < .001$). Girls, generally, appeared to use more crying strategies than boys.

At miscellanous category, the analysis did not yield any significant main effect for sex ($F(1, 127) = 0.20$; $p > .05$) and SES ($F(1, 127) = 1.84$; $p > .05$).

For the effectiveness ratings, the analysis did not yield any significant main effect for sex ($F(1, 127) = 0.76$; $p > .05$) or SES

(F (1, 127)= 0.98; p>.05).

The mean score of the CDI for the whole sample was 11.78 (s.d. = 5.58; ranges = 2-33). Taking the cut-off score of 19 (Öy, 1991), 12.5 per cent of the present sample scored above 19. Although girls scored slightly higher than boys (Girls: M = 12.27; Boys: M = 11.30), this difference was not statistically significant. 2x2 Anovas did not show a significant main effect for either sex (F (1, 127)= 0.94; p>.05) or SES (F (1, 127)= 0.009; P>.05).

Relations with Depression Scores.

To search whether there is an inverse relationships between the Children Depression Inventory scores and the number and effectiveness ratings of coping strategies as hypothesized, pearson correlation coefficients were computed. There was a high correlation between both the number of responses given and the effectiveness ratings and the CDI scores (table 7).

Table 7. The Results of the Correlational Analyses.

	Number of items	Effectiveness
mean	6.89	3.19
sd	4.05	0.90
range	1-16	1-4
r	-0.69*	-0.80*

*p < .001

After obtaining a high correlation between the number of responses given and the effectiveness ratings and the CDI scores, in order to examine whether there was a difference between children who had low and high scores from the CDI, two groups were formed by taking the subjects scoring at the top 25 per cent of the CDI score range for this sample (high CDI; (n=41) $\underline{M}$ = 18.22; sd= 4.40) and by taking those scoring at the bottom 25 pre cent of the CDI distribution (low CDI, (n=39) $\underline{M}$ = 6.20; sd= 1.90). Subsequently, the number of items given and the number of responses in each category given by the low and high CDI groups were compared by t-tests. The results are given in table 8. As can be seen from table 8, low and high CDI groups differed significantly in all comparisons except for reactive behavior, avoidance and crying categories. More specifically, the high CDI group gave less coping strategies (i.e; number of responses), gave less responses in the play, help and comfort seeking, altruistic behaviors, entertainment and aesthetics and eating categories than the low CDI group. Furthermore, the high CDI group gave lower effectiveness ratings for the "best coping response" they have chosen as compared to the low CDI group.

Table 8: The t-test Results of High and Low Depression Scores Groups.

	Low CDI Group (Mean)	High CDI Group (Mean)	T value
Number of items	10.67	3.63	10.74**
Play	3.28	1.07	7.69**
Help and comfort	2.71	0.98	7.81**
Altruistic	0.28	0.07	1.92*
Entertainmenrt	2.89	0.78	8.48**
Reactive	0.53	0.31	1.09
Avoidance	0.07	0.21	1.80
Eating	0.30	0.00	4.22**
Crying	0.35	0.31	0.39
Effectiveness	4.00	2.46	8.56**

** p<.001 * p<.05

DISCUSSION

The aims of the present study were to examine children's ideas about what to do when they are feeling depressed/unhappy, to investigate whether there are sex and SES differences in the number and effectiveness ratings of coping strategies given by children and finally to investigate the relationship between the number and effectiveness of coping strategies given and depressive symptomatology.

The results of the present stduy seemed to support the view that children have ideas about what to do when they are feeling depressed/unhappy. Furthermore, there appears to be a consensus amongst Turkish children about "what works best" for alleviating depressed/unhappy feelings. Therefore, the view that there is a canon of common sense "things to do when feeling depressed/unhappy" appears to have been met (Keneally, 1989 Rippere, 1977b) Thus, the first hypothesis of the present study seems to have been supported. The consensuality ratio found in the present study is greater than that found by Keneally (1989) in a British sample. Bayraktar (1988) in an adult Turkish sample also found a higher consensuality ratio than that found for the British sample. This difference may be related to the differences between the age ranges of the two samples. Keneally studied children distributed across seven age groups whereas the present study was conducted on a more homogeneous age group. However, this difference may also be related to cultural differences and needs to be investigated in future research.

Children in the present sample reported coping categories that could be grouped under nine coping categories. These were; "play", "help and comfort seeking activities", "altruistic behaviors",

"entertainment and aesthetics", "reactive behaviors", "avoidance", "eating", "crying", and "miscellanous", Crying strategies were reported by Turkish children more frequently than Keneally's sample. Therefore, unlike Keneally, the strategies were taken into account as a distinct coping category in the present study. Most frequently mentioned category was play. Help and comfort seeking activities strategies were mentioned in the second order, and entertainment and aesthetics strategies were mentioned in the third order by the Turkish children. The least frequently mentioned category was eating. The reactive type of strategies, avoidance and altruistic behaviors seemed to be used less than play, help and comfort seeking activities and entertainment and aesthetics strategies by Turkish children in order to cope with their depressed/unhappy feelings. In response to the question "what works best?", the most frequently mentioned strategies by Turkish children were both play and help and comfort seeking activities strategies. The least frequently mentioned strategy was altruistic behaviors strategies. Thus play and help and comfort seeking activities strategies were given most frequently and also were chosen as the best responses to reduce depressed/unhappy feelings.

These results seem to be similar to Keneally's findings. She found that play and help and comfort seeking activities strategies were chosen by the British children most frequently, (Keneally, 1989). Keneally (1989) in discussing her findings proposed that "equal proportions of ten years - old and eleven years-old children mentioned both play related strategies and help and comfort seeking activities strategies. On the other hand, nine years-old children mentioned entertainment and aesthetics strategies most frequently in order to cope with their depressed/unhappy feelings.". She added that this may be due to the socialization processes in particular circumstances.

Examining the effectiveness ratings given for the response chosen as the most effective, it seemed that "often" and "always" dimensions were mentioned by the Turkish children most frequently. The proportion of the children choosing these dimensions appears to be similar to Keneally's results. Thus, it seems that the majority of the children were able to delineate a specific coping response which they believed "often" and "always" worked. This supports the assertion that there is a common stock of knowledge on what to do when feeling depressed/unhappy and also knowledge on which strategy works best.

The investigation of the SES factor revealed that children from the higher SES seem to mention more coping strategies than children from the lower SES. The higher number of coping strategies given by children from the higher SES may be related to their living conditions; family structure, socialization processes and the appraisals made by these children or the larger variety of activities available to the children from the higher SES, such as playing with a computer, going to Atakule, playing with technic lego and so on. While eating strategies were mentioned by the higher SES children, children from the lower SES did not mention any eating strategies to cope with their depressed/unhappy feelings. On the other hand, children from the lower SES mentioned avoidance strategies more frequently than those from the higher SES, (i. e. going to sleep). Thus, it seems that although the higher SES children report more coping strategies from the majority of categories, there is a reversal of this trend for the avoidance strategies. Children from the lower SES seem to report avoidance strategies more than the higher SES children.

The present findings pointed out that there are gender differences in the types of coping strategies reported. Girls appeared to use crying, help and comfort seeking activities and altruistic strategies

more than boys whereas boys mentioned play related strategies and reactive type of strategies more than girls. The reactive type of strategies mentioned by boys included aggressive behaviors, such as fighting, getting angry, slamming doors, ripping up posters/books and biting. Thus, boys and girls seem to prefer different strategies in dealing with depressed/unhappy feelings.

Although there seems to be gender differences in the coping strategies chosen, there seems to be an interaction of gender and SES for play and altruistic behavior categories. Play related strategies do not seem to show significant gender differences in the lower SES whereas in the higher SES the gender difference is significant; boys reporting more play related strategies than girls. Dealing with the altruistic strategies, there is again only a significant difference in the higher SES; girls give more altruistic strategies than boys. Although in the lower SES, girls mentioned more altruistic strategies than boys, this difference did not reach statistical significance. Thus, it seems that boys and girls from the higher SES exhibit more differentiation in terms of the coping responses they chose whereas gender does not seem to make a strong impact for play and altruistic strategies in the lower SES.

These findings seem to support the notion that development and experience in a particular environment provides considerable scope for children to pick and choose recipes that are likely to be appropriate to and applicable in their own circumstances, (Keneally, 1989). Rippere (1980 e, 1981) has argued that when people who are feeling depressed do things to help themselves, they are most probably following socially transmitted behavior. Furthermore, it is claimed that the conditions in which people live affect their problem solving activities and coping resources, (Mitchel and Hudson, 1983; Parker and

Brown, 1982; Pearlin and Schooler, 1979). It has also been demonstrated that the cognitive depelopment, social environment and the parental relationship affects the coping resources and problem solving activities of children, (Compas, 1987; Kaplan, 1983; Sandler, 1980).

However, dealing with gender, the adaptiveness and appropriateness of traditional gender role socialization have been increasingly questioned in recent years, as advantages of gender role flexibility have become more apparent, (Katz and Boswell, 1986). Although no theory gives us a coherent account of the total process of sex-role development, cognitive development theorists, such as Kohlberg (cf. Fagot and Leinbach, 1989) and social learning theorists, such as Mishel (cf. Fagot and Leinbach, 1989) have alerted us to the importance of cognitive regularities in the child's understanding of gender and the important role of the environmental input in the formation of this understanding. Supporting these theoretical approaches, it has been demonstrated that children are surrounded by environmental input about gender from family, peers and the mass-media and that children make their own attempts to understand the world and to form categories that help them to organize their world, (Fagot and Leinbach, 1989; Fagot and Hagan, 1991; Katz and Walsh, 1991). The results of the present study seem to be partially in line with the cognitive models, and social learning theory. However, gender differences in the play and altruistic strategies categories appeared to be significant only in the higher SES. Although in the lower SES, boys and girls differed slightly in mentioning both play related and altruistic strategies, these differences were not statistically significant. This may be related to the small sample size used in the present study and future research on a larger sample may provide a

more reliable finding on the gender and SES interaction.

In order to examine the relationship between number of coping strategies, their effectiveness ratings and the depression scores, correlational analysis was conducted. Results showed that as expected, there was a strong relationship between the number of coping strategies, their effectiveness ratings and the depression scores. After obtaining these correlations children with low and high CDI scores were compared for the number of coping strategies given, number of strategies given in each category and their effectiveness ratings. The results showed that children who had high scores from the CDI reported less number of coping strategies, and gave lower effectiveness ratings than children who had low scores from the CDI. These findings support the notion that depressed children lack coping strategies or if they have some coping strategies they may be ineffective. Therefore, this finding is in line with the coping models and supports the second hypothesis of the present study. The present findings pointed out that although children show consensuality in reporting strategies to cope with depressed/unhappy feelings, SES and gender have effects on these strategies. Furthermore, there is a difference between children having high and low CDI scores, indicating that depressed children may have less and ineffective coping strategies.

However, the present study had a number of shortcomings which need to be considered in future research in order to arrive at more reliable conclusions about children's coping strategies and their relationship with depression. The present study aimed to examine Turkish children's coping strategies, their association with depression/unhappiness and gender and SES differences. However, in order to adequately answer all these questions, the sample size should have been larger. The sample should have included various age groups.

Furthermore, while interviewing the children, it would have been more reliable to use a recording instrument. In the present study, a recording instrument could not be used. Therefore, the interviewer had to ask a judge to be present during the interviews. The children's verbalization abilities may have been affected by being interviewed in the persence of two unfamiliar adults. Thus, in future research, it may be beneficial if the interviewer spends some time with the children in order to get familiar with them before administering the interview. Another shortcoming of the present study was that the CDI was administered four weeks before the interview and since the CDI is a measure of depressive symptomatology, in future research it will be more reliable to have a shorter time gap between the CDI administration and the interview.

Despite these shorcomings, a number of conclusions can be derived from the present results. The present findings showed that there is a substansial common core in the responses produced by children. Furthermore, children had very clear ideas about which behaviors worked, and how well they worked. The choice of coping strategies in children seems to depend largely on the external conditions; socialization, their own family interactions and also environmental conditions. The gender and the SES effects which may reflect different family structures and social contexts seem to support this suggestion. Finally, the number of coping strategies given by children seem to be related to depressive symptomatology.

Although there are some differences in choosing coping strategies, there appears to be some cross - cultural similarities in the strategies reported for coping with depression/unhappiness. The high consensuality ratio and the similarities in the categories mentioned by Turkish children and the British children seem to support this

suggestion. Undoubtly, the existence of a common stock of knowledge does not mean that these coping strategies will be equally effective for everybody in every situation. However, they may provide a starting point for children's effective coping.

In future research, on children's concepts of depression/unhappiness and the relationship between depression and effectiveness of children's coping strategies longitudional research may prove to be more fruitfull in elucidating the relationship between coping and depression. It may also be fruitfull to examine children from various age groups and employ objective observation procedures in children's daily lives or in laboratory settings in order to check the validity of self - reports given by children. Furthermore, future research using experimental manipulations may yield information on the causal directions between depression and coping strategies. Another line of investigation can be the training of depressed children in coping strategies and examing the effects of such a training on their level of depression. The present results pointed out that when questioned about "what to do when feeling depressed/unhappy", children seem to have answers. However, more research is needed in order to see how effective these strategies really are in coping with real life depressed/unhappy feelings and to examine whether children really do engage in these behaviors when they feel depressed/unhappy.

APPENDIX A

PİLOT ÇALIŞMANIN SORU FORMU

- "Mutsuz olduğunda mutsuzluğunu ifade etmek için aşağıdaki sözcüklerden hangisini kullanırsın?"

a- Sıkıntılı

b- Kederli

c- Mutsuz

d- Çaresiz

e- Yıkılmış

f- Üzüntülü

g- Bezgin

APPENDIX B

INTERVIEW SCHEDULE

UYGULAMADA KULLANILAN GÖRÜŞME SORULARI

1-Sana göre, mutsuz / üzüntülü olmak ne demek?

2-Mutsuz/üzüntülü olduğunda bu mutsuzluğunu/üzüntünü geçirmek için neler yaparsın?

3-(Söylediği aktiviteler tekrarlanarak) Bunlar mutsuzluğunun/üzüntünün geçmesine yardımcı oluyorlar mı?

4-En çok hangisi mutsuzluğunun/üzüntünün geçmesine yardımcı yardımcı oluyor?

5-(söylediği aktivite) Bu mutsuzluğunun/üzüntünün geçmesine herzaman mı yardımcı oluyor? Genellikle mi yardımcı oluyor? bazen mi yardımcı oluyor? Yoksa mutsuzluğunu hiç bir zaman geçirmiyor mu?(Her zaman, genellikle, bazen ve hiç bir zaman boyutları küçük kartlara yazılıp,bir yandan soru sorulurken, bu kartlarda çocuğun önüne koyulup,işaret ederek seçmesi istenmiştir) (Kartların sırası randomize edilmiştir.)

KENEALLY'S INTERVIEW SCHEDULE

1-Do you know what the word depressed means?

2-What do you do when you are depressed/unhappy/sad?

3-Does this make you feel better?

4-Which one is best at making you feel better?

5-Does this work?...

Never, not very often, sometimes, often, always (the order of these choices was randomised).

APPENDIX C
ÇOCUKLUK DEPRESYON ÖLÇEĞİ

Adı Soyadı	Tarih
Cinsiyeti	Okul
Doğum Tarihi	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 hissederim.
2) Kendimi sık sık üzgün hissederim.
3) Kendimi her zaman üzgün hissederim.

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

C. 1) İşlerimin çoğunu doğru yaparım.
2) İşlerim çoğunu yanlış yaparım.
3) Herşeyi 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 herzaman beni sıkar.
2) Herşey sık sık beni sıkar.
3) Herşey arada sırada beni sıkar.

K. 1) İnsanlarla beraber olmaktan hoşlanırım.
2) Çoğu zaman insanlarla birlikte olmaktan hoşlanmam.
3) Hiçbirz 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) Birçok gece uyumakta zorluk çekerim
3) Oldukça iyi uyurum.

Ö. 1) Arada sırada kendimi yorgun hissederim.
2) Birçok 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 zama ağrı ve sızılardan endişe ederim.
3) Her zaman ağrı ve sızılardan endişe ederim.

S. 1) Kendimi yalnız hissetmem.
2) Çoğu zaman kendimi yalnız hissederim.
3) Her zaman kendimi yalnız hissederim.

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

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

U. 1) Okul başarım iyi.
2) Okul başarım eskisi kadar iyi değil.
3) Eskiden iyi olduğum derslerden 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 seen 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 D

İKİ FARKLI SOSYOEKONOMİK DÜZEY COCUKLARININ ANNE VE BABA MESLEKLERİ

SENİHA İSEN İLKOKULU(SİNCAN)

Baba Mesleği		Anne Mesleği	
İşçi(Tarım,inşaat,fabrika	17	Evhanımı	55
Kamyon-otobüs şöför	5	Öğretmen	1
D.D.Y'da ateşçi	1	Belediye meclis üyesi	1
Elektrikçi(inşaat)	2	Devlet memuru	1
Tamirci(torna)	4	Bankada odacı	1
Terzi(kendi dük.)	2	Temizlik işçisi	1
Çaycı	2	Gündelikçi	2
Sütçü	1	Terzi	2
Bahçıvan	1		
Doğramacı	2		
İnşaat bekçisi	1		
İsportacı	1		
Tezgahtar	1		
Esnaf	5		
Kondüktor	2		
Güvenlik gör.(banka)	3		
Devlet memuru(düz)	6		
Öğretmen(ilk,lise)	2		
Hizmetli(hastane)	1		
Pazarlamacı	1		
Teknisyen	1		
İşsiz	3		

TÜRK EĞİTİM DERNEĞİ ANKARA KOLEJİ İLK KISIM

Baba Mesleği		**Anne Mesleği**	
Borsa işleriyle ilg.	6	Kuaför(sahibi)	2
Öğretim gör.(üni.)	11	Ev hanımı	30
Avukat	8	Yapımcı(TRT)	2
Özel teşebbüs	10	Öğretim gör.(üni.)	12
Noter	1	Eczacı(sahibi)	2
Savcı	1	Mimar	2
Desinatör	1	Stilist	1
Yapımcı(TRT)	2	Öğretmen	4
Adli tabib	2	Şehir plan. uzm.	2
Diş hekimi	7	Dişhekimi	4
Kuyumcu	2	Güzellik uzm.	1
Gazeteci	2	Desinatör	1
Metalurji müh.(özel şt)	1	Violonist	1
Cerrah(operatör)	3	Öğretmen(kolej)	4
Makina müh.(özel şt)	1	Sosyal hiz. uzm.	1
Doktor(çocuk uzm.)	2		
Bilgisayar programcısı	4		

*(meslekler;uluslararası meslekler sınıflandırmasına göre alınmıştır)

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