THE IMPACT OF AN EDUCATION AND SUPERVISION SUPPORT GROUP ON CAREGIVERS WORKING AT A TURKISH ORPHANAGE AND ITS RELATIONSHIP TO CHILDREN'S DEVELOPMENTAL ACHIEVEMENTS

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Eğitim ve Süpervizyon Destek Grubunun Türkiye'deki bir Çocuk Esirgeme Kurumunda Çalışan Bakıcı Anneler Üzerindeki Etkileri ve bu Etkinin Çocukların Gelişimsel Kazanımları ile İlişkisi

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Thesis Abstract

The Impact of an Education and Supervision Support Group on Caregivers Working at a Turkish Orphanage and Its Relationship to Children's Developmental Achievements

Dilşad Koloğlugil

The aim of the present study was to examine the effectiveness of an education and supervision support group for caregivers working at an orphanage in İstanbul. The group was developed to promote sensitive and responsive caregiving at the institutional setting and increase the quality of the relationship between caregivers and children. This improvement in the caregiving environment was hypothesized to lead to an improvement in children's developmental skills and a decrease in their behavioral problems. Thirty-six children between the ages of 15 – 37 months living in the Bahçelievler Children's Home, and 24 caregivers participated in the study. Eleven caregivers who attended to the 5-month-long support group composed the experimental group, and the remaining 13 caregivers who did not receive any support composed the control group. The results of the study indicated that the intervention was successfully implemented in general. Caregivers in the experimental group displayed significant decrease in the amount of psychological symptoms they reported and in their burnout levels. There were also significant improvements in their level of job satisfaction and sense of self-

efficacy. Moreover, the results showed that children’s development improved in all domains and their behavioral problems decreased. Finally, caregivers who received an education and supervision support were observed to engage in verbal communication with children and display mirroring and physical contact in their interactions with children. The implications of these findings suggest that providing caregivers with an education and supervision support creates positive changes in caregiver variables, can increase warm and socially responsive caregiving, and improves children’s developmental skills at an institutional setting.

Tez Özeti

Eğitim ve Süpervizyon Destek Grubunun Türkiye'deki bir Çocuk Esirgeme Kurumunda Çalışan Bakıcı Anneler Üzerindeki Etkileri ve bu Etkinin Çocukların Gelişimsel Kazanımları ile İlişkisi

Dilşad Koloğlugil

Bu çalışmanın amacı İstanbul'daki bir çocuk esirgeme kurumunda çalışan bakıcı annelere yönelik eğitim ve süpervizyon destek grubunun etkisini araştırmaktır. Bu destek grubu, kurum ortamında duyarlı ve çocukların ihtiyaçlarına cevap veren bir bakım yaratmak ve bakıcı anneler ile çocuklar arasındaki ilişkinin kalitesini artırmak amacıyla geliştirilmiştir. Bakım ortamında görülen bu gelişmenin, çocukların gelişimsel seviyelerinde yükselmeye ve problem davranışlarında düşüşe yol açacağı varsayılmıştır. Bahçelievler Bebek Evi'nde kalan ve yaşları 15 ila 37 ay arasında değişen 36 çocuk ile 24 bakıcı anne çalışmaya katılmışlardır. Beş ay boyunca süren destek gruplarına katılan 11 anne uygulama grubunu, hiçbir eğitim ve destek almayan 13 anne ise kontrol grubunu oluşturmuştur. Çalışmanın sonuçları yapılan müdahalenin genel olarak başarıyla yürütüldüğünü göstermektedir. Uygulama grubundaki bakıcı annelerin genel ruh sağlıklarında iyileşme ve işle ilgili tükenmişlik hislerinde düşüş olduğu bulunmuştur. Aynı zamanda bu bakıcı annelerin işlerinden duydukları tatmin yükselmiş ve öz-yeterlilikleri artmıştır. Ayrıca çocukların gelişimin her alanında ilerleme gösterdikleri ve davranışsal

problemlerinde azalma olduğu bulunmuştur. Son olarak, eğitim ve süpervizyon destek grubuna katılan bakıcı annelerin çocuklarla sözel iletişim kurdukları ve çocuklarla olan ilişkilerinde aynalama ve fiziksel temas davranışları sergiledikleri gözlemlenmiştir. Tüm bu bulgular bakıcı annelere sağlanan eğitim ve süpervizyon desteğinin bakıcı annelerde olumlu değişimlere yol açtığını, daha içten ve çocukların sosyal ihtiyaçlarına cevap veren bir bakım ortamını oluşturabileceğini ve kurumda yetişen çocukların gelişimsel becerilerini ilerlettiğini göstermektedir.

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Chapter 1: Introduction

1. 1. The Importance of Early Experiences on Later Development

Literature on child development show that researchers agree upon the impact of early relationship experiences, particularly the mother-child interaction, on the psychosocial development of children (Sroufe, 2000; Thompson, 1999; Balbernie, 2003; George & Solomon, 1999). Many studies have found the aversive influences of early maternal deprivation on the developing child, including attachment disturbances, problems with emotional regulation, and deteriorations in cognitive and psychosocial development (Frank, Klass, Earls, & Eisenberg, 1996; Thompson, 1999; Kobak, 1999; Balbernie, 2003). Although some researchers claimed these influences to be detrimental and affect an infant's development in an unchangeably negative way, most of the researchers indicated that negative experiences of early years can be ameliorated depending on the later physical and social conditions of childhood (Maclean, 2003; Thompson, 1999).

Talking about the effects of early relationship experiences on a child's later functioning requires a profound understanding of Bowlby's "attachment theory". Being dissatisfied with earlier theories, Bowlby developed attachment theory in 1950's in which he regarded the mother-infant relationship as the most important predictor of a child's future personality development (Bowlby,

1958). Attachment has been described in terms of "the dyadic regulation of infant emotion" during the first years of life (Sroufe, 2000, p. 69). During his observations with children, Bowlby (1958) realized that infants displayed intense distress when separated from their mothers, and he began to investigate the importance of this strong tie between mothers and their infants. He did not associate attachment behavior with drive or learning theories but regarded it as a kind of an instinctive / social behavior which was activated as a result of an infant's interaction with his / her environment. According to Bowlby (1969/1982), infants are innately equipped with attachment behavior and all infants who receive some kind of basic care develop attachment relationships. They are evolutionarily prone to form a close bond with their primary caregivers because during evolution, becoming attached to caregivers enhanced the chance of survival. The goal of attachment behavior is to seek protection by maintaining proximity to the attachment figure in response to real or perceived danger or threat (Gillath et al., 2005; Lyddon & Sherry, 2001). When the infant is distressed, the attachment system is activated and the infant begins to seek comfort from the mother. In other words, the infant increases his / her attachment behaviors to guarantee his / her safety (Cassidy, 1999).

As opposed to psychoanalytic theory which emphasizes the role of internal fantasies, Bowlby gave attention to the importance of an infant's actual experiences. Attachment theory is based on the idea that when primary caregivers are consistently accessible and responsive to their needs, human infants have the fundamental capacity to form a secure sense of self and world

(Bradford & Lyddon, 1994). Attachment theorists used the term "internal working models" in order to define mental representations of attachment figures, the self, and the relationship between them. According to this view, the early relationship with the attachment figure causes an infant to form internal working models for relationships which will influence interpersonal relationships throughout life (Fonagy, 1994). Bowlby (1969/1982) stated that early experiences of sensitive or insensitive care cause the formation of different relational representations depending on the accessibility and responsiveness of the caregiver. Specifically, he believed that when infants have caregivers who are constantly available to them in times of needs, they develop expectations that caregivers will be available in the future whenever needed. These infants, said to develop secure working models of relationships, seek out comfort from their caregivers with the confident expectation that they will be satisfied.

During her observations of mother-infant interactions Ainsworth (1978, as cited in Kobak, 1999) realized that having a secure attachment style increased the quality of the infant's play and exploration of the setting. She explained this interplay between the attachment and exploratory systems in terms of the "infant's using the mother as a 'secure base' from which to explore" (Kobak, 1999, p. 26). By contrast, infants with caregivers who are not responsive to their needs do not develop confident expectations regarding the availability of their caregivers. They develop insecure working models which include beliefs about others as unreliable and views of self as unworthy of care.

According to Bowlby these models allow children to anticipate the future and make plans, which in turn, shape their socio-personal patterns. Attachment theorists suggested that internal working models enable the continuity between early attachment and later psychosocial development (Thompson, 1999; Cassidy, 1999).

Ainsworth's (1978, as cited in Kobak, 1999) observations of mother-infant interactions and her laboratory procedure called "the strange situation" contributed to a deeper conceptualization of the attachment theory. In the strange situation, an infant and his / her mother are videotaped playing together in a small research room. At two key points, the mother leaves the room and the infant stays once with a stranger and once alone. Ainsworth (1978, as cited in Kobak, 1999) observed that infants reacted differently to these two separation and reunion experiences, which caused her to identify three different attachment styles: secure, avoidant, and resistant-ambivalent. Infants who have a secure relationship with their caregivers typically protest when they are separated from their caregivers and they try to attain closeness with their caregivers upon reunion. Infants with an avoidant attachment tend to ignore caregivers' departure and return, and actively avoid caregivers' attempts to regain contact. Infants with a resistant-ambivalent attachment display a mixed pattern both searching for their mothers for comfort and displaying angry resistance and rejection. Later on, the fourth attachment style was described, called disorganized / disoriented, in which the caregivers themselves are the source of fear and threat (Kobak, 1999). The caregiver may be abusive or may

himself / herself carry the burden of unresolved trauma or loss. In this kind of relationship, infants face a dilemma of having an attachment figure that is both the cause of the distress and the only source of comfort. These infants exhibit conflicted behaviors such as simultaneously reaching for and turning away from their caregivers (Sroufe, 2000; Kobak, 1999).

The security or insecurity of an infant's attachment status is mainly determined by his / her mother's availability and responsiveness, and the expectations an infant comes to develop about his / her mother will respond at times of distress depend on how his / her mother would respond to him / her in times of distress (Cassidy, 1999). Infants who find caregivers to be available in times of need develop confident expectations concerning the availability and responsiveness of their caregivers, and they form secure attachments. On the other hand, infants who lack confidence in responsiveness of their mothers develop avoidant or resistant-ambivalent attachment strategies. Avoidant infants who expect rejection from their caregivers do not express their need for proximity and turn away from their caregivers. They try to regulate their distress via other means. Infants with resistant-ambivalent relationships are uncertain about the responses of their mothers due to the inconsistent availability of them when needed. These infants were observed, in the strange situation, to be clingy to their caregivers during reunion episodes but remain distressed for unusually long periods of time (Kobak, 1999; Sroufe, 2000; Balbernie, 2003). Kobak (1999) stated that attachment theorists regarded "these strategies as ways of adapting to different levels of parental responsiveness and

provided children with a way of maintaining physical access to their attachment figures" (p. 34).

Developmental psychologists have believed in the existence of a predictive link between particular patterns of early relationship experiences and later functioning. They have argued that a secure or insecure attachment in infancy can shape many aspects of developing personality, including affect regulation, self-esteem, independence, confidence, and sociability. They found that attachment disturbances led many child and adult disorders (Gillath et al., 2005; Thompson, 1999; Berlin, Zeanah, & Lieberman, 2005), which was in line with Bowlby's (1973) argument that different attachment styles between mother and infant may have crucial long-term effects on later intimate relationships, self-understanding, and even psychopathology.

Large numbers of longitudinal studies have confirmed that there is an association between infants' attachment styles and their later interpersonal functioning. Children with secure attachment histories were found to display more effective self-regulation and fewer emotional problems, show more competent problem-solving skills, more independent and confident behaviors with teachers, and more competent interactive behaviors with peers at school age. They were judged by their teachers and observers to have higher self-esteem, to be more self-reliant, and to express more positive emotions in their interactions with others (Sroufe, 2000; Dozier, Stovall, Albus, & Bates, 2001; Balbernie, 2003). It has also been found that attachment strategies which are insecure but organized (i.e., avoidant and resistant-ambivalent attachments)

might not place children at increased risk for the development of severe disorders; however, they increased the risk of having problematic outcomes. Children with histories of resistant-ambivalent attachment were found to be easily frustrated, to seek constant contact with their teachers, not effectively deal with stressful situations, and to be unable to sustain interactions with their peers. They either had a tendency to withdraw from others or a compulsion to be dependent. A longitudinal study indicated that adolescents diagnosed with anxiety disorders were significantly more likely to have resistant attachment styles with their parents when they were infants (Sroufe, 2000; Balbernie, 2003). Those with avoidant attachment histories were shown to be aloof and disinterested in other children, and they failed to seek comfort from their teachers when distressed. Furthermore, both resistant and avoidant attachment patterns were found to be related to depression and physical illness (Sroufe, 2000). Finally, children with disorganized / disoriented attachment histories displayed the most severe disturbances in their later development. Both longitudinal and retrospective studies have found a link between disorganized attachment in infancy and severe mental health problems in adulthood, such as borderline personality disorder and dissociative experiences with disruptions in orientation and with broken emotional and cognitive functioning (Sroufe, 2000; Balbernie, 2003).

Another type of attachment disturbance seen in institutionalized or neglected / abused children is called reactive attachment disorder of infancy or early childhood (RAD). RAD is characterized by “a disruption in the

interaction between parent and child” (Tibbits-Kleber & Howell, 1985, p. 305), and is commonly associated with neglect. The diagnostic criteria for this disorder include disturbed and developmentally inappropriate social relationships prior to age five, with a history of pathogenic care (Morrison, 1995, p. 530). The general aspects of children diagnosed with RAD involve low height and weight measures, lack of social responsiveness, and behavioral problems such as aggression and withdrawal from others (Tibbits-Kleber & Howell, 1985). Two types of RAD are defined: one is the inhibited type in which children show inhibited or ambivalent and contradictory social responses, and withdraw from interpersonal interactions. The second type of RAD is the disinhibited type in which children display diffuse attachments with indiscriminate sociability and inability to form appropriate selective attachments (Morrison, 1995; Minnis, Marwick, Arthur, & McLaughlin, 2006). Minis et al. (2006) stated that the disinhibited type of RAD had developed from the theory of institutionalization, “the behavioral and intellectual sequelae of which include the ‘indiscriminate’ giving of affection and a tendency to go off with strangers” (p. 337). Tizard (1997, as cited in Maclean, 2003) described ‘indiscriminate friendliness’ as behavior that is affectionate and friendly toward all adults (including strangers) without the fear or caution characteristic of normal children.

Many studies have found RAD to be a defining characteristic of institutionalized children. Smyke, Dumitrescu, and Zeanah (2002) studied the signs of RAD in young children raised in a Romanian institution and found

significantly more signs of both types of RAD in the institutionalized group compared with a never institutionalized community group. Moreover, in their study with adopted children from Romanian institutions into the United Kingdom, O'Connor, Bredenkamp, and Rutter (1999) found a high percentage of indiscriminate behavior among these children.

Although a good deal of studies have shown the influence of early relationships on later functioning of infants, there are investigators who argue for being cautious while talking about this connection. They have claimed that the effects of early relationships may have discontinuity depending on the consistency and change in parent-child relationships in the following years. According to them, sometimes attachment in infancy predicts later psychosocial functioning, and sometimes it des not. When parent-child relationships change over time, it is unlikely that the security of the attachment will significantly predict later development of the child. Several longitudinal studies have failed to illustrate the association between infants' attachment security and behavior problems at ages 4 and 5 (Thompson, 1999). Therefore, it would be better to characterize the relationship between early experiences and later development not as in a linear causality but in a dynamic organization, and to regard attachment as the foundation of later psychosocial functioning. As Sroufe (2000) puts it:

> The special role of early experience may be understood by considering the metaphor of constructing a house. Early experience is the foundation. Of course, all other aspects of the structure are also important. However solid the foundation, a house without supporting walls or without a roof soon will be destroyed. But all rests upon the

> foundation. It provides the basis for strong supporting structures and it frames the basic outlines of the house. So it is with early experience and early self organization. They do not determine in final form the emotional capacities of the child, but they can provide the basis for healthy development (p. 73).

1. 2. Institution-Based Studies

The impacts of the early socioemotional deprivation on a developing child are clearly demonstrated by the studies of institutionalized children. Because institutional rearing often involves emotional, social, and even physical deprivation, disturbances of growth, cognitive and language development, and behavioral problems have been witnessed for more than 50 years among institution-reared children (Smyke et al., 2007; Maclean, 2003). Observations conducted at the institutions have revealed the existence of both structural problems, such as large group sizes, high caregiver-infant ratios, and instability and inconsistency of caregivers; and problems with the caregiving behaviors. Different investigators observed a similar pattern in caregivers' interaction with institutionalized-infants. Caregivers usually behave towards infants in a businesslike manner which provides infants with basic physical needs such as feeding and bathing, however does not include any signs of emotional sharing. They have limited contact with children; and they often do not talk and interact socially with them. There is low responsiveness to infants' signals, and extremely poor initiation of social interaction with infants (Muhamedrahimov, Palmov, Nikiforova, Groark, & McCall, 2004; Maclean, 2003).

All of these factors have been seen as risks to mental health development. Institution-reared children usually display developmental delays in each facet (physical, behavioral, social, and emotional). They may be malnourished and have smaller weights and heights, may exhibit internalizing and externalizing behavior problems such as withdrawal from others and aggression, may have poor peer relationships, and may have low academic achievements (Groark, Muhamedrahimov, Palmov, Nikiforova, & McCall, 2005).

Given that attachment usually develops during the second half of the first year of life, most researchers have assumed that institution-reared infants will have attachment disturbances. Attachment theory suggests that the continuity and the quality of the relationship between an infant and caregiver are identifying factors for the development of secure attachment. Discontinuity and variations in the quality of this relationship, which are the characteristics of a relationship within an institutional setting, can lead to a poor developmental progress (Ramey & Sackett, 2000). Due to the very high child to caregiver ratios, it is unlikely for an infant to establish a healthy relationship with a caregiver. Recent studies have supported this assumption through findings of indiscriminate friendliness, behavior problems, and relationship disturbances among adopted children; and they regarded these results as growing from the lack of a consistent and responsive caregiver in their first year of life (Groark et al., 2005; Marcovitch et al., 1997). Maclean (2003) stated that “Tizard has been the only researcher who examined children’s behavior toward their caregivers

within the institution context" (p. 870). Tizard and Rees (1975) talked about the difficulty of making a list of preferred adults for institution-reared infants, as opposed to for family-reared infants who have primary caregivers. They described the behaviors of 4-year-old institutionalized children toward their caregivers as very clingy but not caring deeply about anyone. They claimed that most of the institutionalized children do not have the opportunity to develop an attachment with their caregivers at the institution. These children were said to be over-friendly to strangers and markedly attention-seeking. Chisholm (1998) explained several reasons for why it might be difficult for institution-reared infants to form an attachment relationship. He stated that given the lack of a particular caregiver who readily responds to an infant's needs in a sensitive way, it was unlikely to develop an attachment. He also reported that institutionalized infants did not show proximity promoting behaviors like smiling, crying, and making eye contact that enable caregivers to have a responsive contact with infants.

Findings of adoption studies are inconsistent about whether the institutionalized infants can develop an attachment relationship with their adoptive parents (Maclean, 2003). A comprehensive review of the studies has revealed that the age of adoption is a critical factor for the quality of later attachment relationship (Marcovitch et al., 1997; Maclean, 2003; Dozier et al., 2001). However, conditions of the studies made it impossible to distinguish the effect of age at adoption from the effect of time in institution (i.e., duration of early deprivation); therefore it is not possible to know for sure whether it is the

specific age period or duration of early deprivation that determine the later attachment quality.

There are inconsistent findings in the literature about orphans' ability to form attachment relationships with their foster parents. His study with 10- to 14-year-old previously institutionalized children led Goldfarb (1943a, as cited in Maclean, 2003) to conclude that orphanage children were unable to develop attachment relationships with their foster parents. In contrast, in her study with families living in London, Tizard (1977, as cited in Maclean, 2003) found that children could form attachment relationships with their adoptive parents. The fact that the conditions of the institutions in Goldfarb's study were much worse than in the Tizard's study requires a caution while interpreting the results. The conditions of the institutions in Tizard's studies were improved in a sense that the staff-child ratio was high and there were various materials used to stimulate child development. However, the turnover rate was high and caregivers were told not to form close personal relationships with infants. Therefore, she interpreted the effects of early institutionalization stemming not only from the structural conditions of the setting but also from the poor quality of the relationship between infants and caregivers (Tizard & Rees, 1975).

Tizard and Rees (1975) studied behavioral problems of a group of 26 institutionalized children aged 4½ years old, and compared them with a group of 30 London working-class children living at home. There was another comparison group included 39 children who were adopted after spending at least 2 years in an institutional care. They found that the prevalence of behavior

problems did not differ for institutional and family-reared children. However, these two groups were reported to have different behavioral problems. While the family-reared children most frequently displayed mealtime problems, over-activity, and disobedience, institutionalized children displayed poor concentration, problems with peers, temper tantrums, and clinging. The adopted children had the lowest mean behavioral problem score, and it was significantly different from the institutionalized children. They concluded that children with a history of institutionalization could have a decrease in their problem behaviors when adopted by a family that provided them with warm and intense personal relationships. Another significant finding of the study was about the contact of the institutionalized children with their parents. It was found that children who had irregular contacts with their parents displayed higher prevalence of behavioral problems than either the children who were regularly visited or those who had no visitors (Tizard & Rees, 1975). Three years later, Tizard and Hodges (1978) reassessed these children and found no significant differences in the mean behavioral problem scores of the three groups. However, adoptive parents more often described their children as over-friendly and more often reported bad peer relationships than did natural parents.

Later in the literature, we saw more systematic studies of attachment among institutionalized children. Marcovitch et al. (1997) examined attachment in a sample of Romanian children, aged 3 to 5 years old, who were adopted to Canada. They compared 37 children who spent less than 6 months in hospitals and orphanages in the first six months of life (home group) with 19 children

who spent more than six months in institutional care (institution group). They measured the child-parent attachment using the strange situation procedure, and found a significantly lower rate of secure attachment among institution group than among home group. They also compared the CBCL scores of the two groups, and found that mean CBCL scores for both groups were within the normal range; however, the institution group received higher scores than the home group. Children in the institution group were also found to be located at the low end of the average range of the developmental measures while the home group was scored within the high average range, and the difference was statistically significant. Marcovitch et al. (1997) concluded that previously institutionalized children were able to develop attachment relationships with their adoptive parents; and the time spent in institution had an effect on later developmental and behavioral problems.

Another study which aimed at showing that institutionalized infants could develop normally, in a sense that they could form attachment relationships with their adoptive parents was conducted at a Greek orphanage by Dontas, Maratos, Fafoutis, and Karangelis (1985). They took fifteen infants, aged between 7 and 9 months old, who had been observed to already develop attachments to specific caregivers at the institution. They wanted to look at whether these infants could also form attachment relationships with their adoptive mothers within a 2-week adaptation period. The infants were observed twice, once with the favorite caregiver and once with the adoptive mother, and the intensity of the attachment to these 2 caregiver figures was assessed. The

results indicated that the infants could develop attachment relationships with their adoptive mothers. However, they were also found to explore the setting less and to show more separation anxiety in the presence of the adoptive mother than in the presence of the favorite caregiver. Dontas et al. (1985) interpreted these findings as a possible indication of a less secure attachment relationship between the infants and their adoptive mothers compared to the relationship between infants and their favorite caregivers.

Chisholm (1998) examined attachment in Romanian orphanage children and found that 66% of children adopted by 4 months of age developed secure attachments to their adoptive parents. This finding was not significantly different from the finding of a control group of nonadopted children, 58% of whom developed secure attachments. However, of the children who had spent at least 8 months in an institutional setting, only 37% were found to develop secure attachments to their adoptive parents. This group also had lower IQs, more behavior problems, higher levels of parenting stress, and showed more indiscriminately friendly behavior with strangers. All of these factors were associated with insecure attachment in previous studies (Chisholm, 1998).

From all of these studies it can be concluded that previously institutionalized children are able to develop attachment relationships with their adoptive parents, which is against Goldfarb's argument. However, the age of adoption may determine the quality of this relationship. Infants adopted at younger ages (before 8 months) showed more secure behaviors than those adopted later. Finally, Maclean (2003) questioned the appropriateness of the

attachment measures used with institutionalized children. The findings of atypical classifications of secure and insecure attachments among children with a history of institutionalization caused him to argue that the coding systems which were developed using normative samples of children were not adequate to assess attachment relationships of institutionalized children. These children were classified as clearly secure or insecure, but their strategies used in interactions were found not to fit any of the established secure or insecure patterns (p. 873). He further stated that these "coding systems were initially designed to evaluate the quality of attachment rather than the presence or absence of an attachment relationship" (p.872), which can be the case for institution-reared infants. In other words, they embody an assumption that attachment exists. Therefore, the common result that orphanage children are able to form an attachment relationship should be interpreted with caution.

Another concern while talking about the attachment relationships of institutionalized infants is the presence of more than one or two caregivers responsible for their care. In institutions, infants have to have an interaction with more than one caregiver. This fact can be problematic for the formation of an attachment relationship. Researchers have identified several criteria for the identification of attachment figures, including engagement in physical and emotional care, continuity and consistency in an infant's life, and emotional investment in the infant (Howes, 1999). They have suggested that children make a hierarchical organization of their relationship experiences, and the most salient caregiver in their relational representations (most often the primary

caregiver) becomes the most influential on their attachment qualities. This relationship also affects the security of all other attachment relationships (Cassidy, 1999; Howes, 1999).

Developmental consequences of early deprivation have also been investigated in other areas, besides attachment disturbances, such as intellectual development and academic achievement, physical development, and behavior problems. Spitz (1945a, 1945b, as cited in Maclean, 2003) and Goldfarb (1945a, 1955, as cited in Maclean, 2003) studied developmental aspects of institutionalized infants and found that they were developmentally and intellectually delayed compared to foster care groups. Improving the conditions of the institution (i.e., lower caregiver to infant ratios, increased social stimulation) was related to increase in developmental scores. Tizard and Joseph (1970) compared children who had spent first two years of their lives in high quality institutions to a sample of home-reared children, and found that the institution children's IQ scores were only slightly lower than the scores of the home-reared children and their language skills were only slightly delayed. Dennis (1973, as cited in Maclean, 2003) compared the developmental outcomes of children adopted at different ages. He found that children who were adopted before the age of 2 years old could eventually achieve normal IQ scores whereas children adapted after 2 years of age showed permanent deficits in IQ. Maclean (2003) summarized the findings of early studies and concluded that "institutionalization early in life has a negative impact on intellectual development and it is not only institutionalization but also the *length* of

institutionalization that is important" (p. 857). The same conclusion can be arrived at for the academic achievement of previously institutionalized children. Le Mare et al. (2001, as cited in Maclean, 2003) examined children adopted to Canada in terms of teachers' reports of academic performance and results of a standardized achievement test. They found that never adopted children performed best, children adopted before 2 years of age gained average scores, and those adopted after 2 years of age performed the worst. These results indicate that receiving institutional care is associated with lower IQ and academic achievement. The longer the duration of institutionalization, the greater the disturbance in these measures (Maclean, 2003).

Adoptive parents of orphanage children reported higher levels of medical problems with their children compared to parents of nonadopted children. These problems mostly include intestinal difficulties, hepatitis, and anemia (Maclean, 2003). Relevant studies also indicated that children with institutionalization experiences display more behavior problems than those without such an experience (Marcovitch et al., 1997; Fisher, Ames, Chisholm, & Savoie, 1997). The main areas of problematic behaviors were eating, attention inabilities, overactivity, social relationships, stereotyped behaviors, and indiscriminate friendliness. And again the number of behavioral problems was found to be correlated with the length of institutionalization. Especially, 'indiscriminate friendliness' was seen among previously institutionalized children, and many researchers interpreted this as a possible indication of nonattachment, rather than of one attachment style (Maclean, 2003).

1. 3. Institution-Based Intervention Programs

As a result of these observations, researchers developed intervention programs which include both the training of the caregivers and structural changes at the institutions. These programs aimed at increasing the quality of care that children received at the institutions. The improvement of the quality of the relationship between infants and caregivers was their ultimate goal because it had been found to associate with children's developmental competencies. It was observed that the higher the quality of child care, the more advanced the children's developmental skills (Ramey & Sackett, 2000).

One of these intervention studies was conducted by Groark et al. (2005) in Russian orphanages. They employed two intervention methods; one included the training of the caregivers of the 0-48-month old infants to promote sensitive and responsive caregiving, and the other included staffing and structural changes that aimed at increasing the quality of the relationship between caregivers and infants. One group received both training and structural changes interventions, the other had only the training intervention, and the last group received no intervention. The results indicated that caregivers who had received training intervention changed their behaviors toward children and became more actively engaged with them, responded to their needs when needed, and began to use toileting and diaper changing times as an opportunity for interaction. Also children showed improvements in physical growth, cognitive and language abilities, and social interactions. They further found that the impact of training becomes much more influential when it is joined with the structural

alterations at the institutions. Groark et al. (2005) concluded that training of the caregivers and making structural changes were effective in promoting sensitive and responsive caregiving behaviors, and on improving children in nearly every aspect of development.

The St. Petersburg-USA Orphanage Research Team (Muhamedrahimov et al., 2004) designed a project for the institutions in Russia. As in the study of Groark et al., (2005), their project involved two means of intervention. One is the training of the caregivers to promote socially responsive and developmentally appropriate caregiving behaviors, and the other is the structural changes to support positive relationships between children and caregivers. The training intervention provided caregivers with information on child development, and encouraged them to be affectionate, warm, and sensitively responsive while interacting with children. The structural changes included reduced group sizes, low caregiver to child ratios, enabling the stability and consistency of caregivers, and constructing a Family Hour in which children and caregivers remain in a room within their subgroups to play with each other without visitors. The aim of these interventions was to create a family-like environment that would support relationship building.

Caregivers were assessed for job satisfaction, attitudes toward children, anxiety, and depression. Children were assessed for physical, mental, language, and socio-emotional development. Results indicated that interventions were successful in promoting the desired effects. Caregivers who received training intervention improved their caregiving behaviors, reduced their anxiety,

depression, and job stress. Also children were found to be improved physically, mentally, and socio-emotionally. Muhamedrahimov et al. (2004) concluded that it was possible to create changes in institutions through intervention programs which would benefit both caregivers and children.

1. 4. Institutional Child Care in Turkey

In Turkey children in need of protection reside in Children's Homes at the institutions run by state. In Istanbul, children under the age of 6 years old stay at the Bahçelievler Children's Home which also served as the sample in the present study. In 2002, the institution's psychologist Kalkan conducted a study with children staying at the Bahçelievler Children's Home. In his report, Kalkan stated that the number of incoming children had been increasing every year while the number of caregivers had stayed the same. According to the data of 2002, for the group of children between 1 and 3 years of age, one caregiver was responsible for every 35 children. This number of caregiver could increase to 2 in some cases. Kalkan (2002) regarded the continuing increase seen every year in the caregiver-child ratio as one of the most significant problems of the institution. He argued that low caregiver-child ratio damaged the quality of the relationship between children and caregivers, which in turn had a detrimental effect on the emotional and physical development of children.

Kalkan (2002) described the behaviors of the 1 to 3 year-old children staying at the Bahçelievler Children's Home as stereotyped, numb, and withdrawn. Children were exposed to low levels of stimulation. They exhibited

self-stimulating behaviors such as rocking, hanging ad head banging. They displayed indiscriminate friendliness to the visitors who were the only source of stimulation, physical contact, and verbal interaction. It was hard for the caregivers to calm down the children after the visitors left the institution. Caregivers were observed to have difficulties while responding to the physical needs of the children such as eating, bathing, and toilet training; and not to engage in a social-emotional interaction with children. In his study, Kalkan (2002) compared the Ankara Developmental Screening Inventory scores of institutionalized children with the scores of home-reared children. He found that institutionalized children displayed a lower performance on every facet of development (cognitive-linguistic, motor, and self-care ability) than did the home-reared children.

Üstüner, Erol, & Şimşek (2005) investigated the behavioral problems of the 62 institutionalized children aged between 6 to 17 years old, using the Child Behavioral Checklist; and compared their scores with 39 children in foster care and 62 children living with their own families in Ankara. They estimated the prevalence rate of behavioral problems among family-reared children as 9.7%, among foster-cared children as 12.9%, and finally among institutionalized children as 43.5%. Institutionalized children were found to have significantly higher total problem scores than the two other groups. Total problem scores of the foster-cared children and family-reared children did not differ significantly.

Üstüner et al. (2005) stated that there were also differences in the kind of behavioral problems that most frequently seen in each group. While

disobedience, social withdrawal and somatic complaints were most frequent in the institutionalized children, attention problems and thought problems were most frequent in the foster-cared children. Because the prevalence rate of behavioral problems was highest for the institutionalized children, Üstüner et al. (2005) argued for the encouragement of foster-care in which children had the opportunity to form warm and close relationships.

Şimşek, Erol, Öztop, & Özcan (2007) replicated these results using a larger sample of orphanage children and adolescents. They gathered data from 674 children between 6 and 18 years of age who were reared in orphanages, and compared them with a nationally representative community sample of the same age reared by their own families. According to the reports of caregivers, teachers, and adolescents, the prevalence rate of total behavioral problems was found to be significantly higher in the institutionalized sample than the community sample. Institutionalized children were reported to display less internalizing but more externalizing problem behaviors than the family-reared children.

When Şimşek et al. (2007) compared the prevalence rate of each behavioral problem between the two groups, they found that social problems, thought problems, and attention problems were more frequently seen in institutional care than the community sample. They also examined the protective and risk factors associated with total behavioral problem score, and found that younger age during arrival at the institution, being in institution because of neglect or abuse, two or more changes in caregiving environments,

and recurrent physical illness were associated with an increased risk for problem behaviors. On the other hand, having a regular contact with parents or relatives, the contact of the institutional staff with school teachers, and the participation of children in school activities were related to a decrease in problem behaviors. Şimşek et al. (2007) argued for an urgent need to establish alternative modes of caring and to prepare training programs for institution staff.

At the same year, Şimşek, Erol, Öztop, & Münir (2007) published another paper reporting the behavioral problems of institutionalized children based on Teacher's Report Form. Their sample was composed of 405 children and adolescents, aged 6 to 18 years, living in eight different orphanages at different areas of Turkey. The 2280 children from the national representative sample served as the control group. Şimşek et al. (2007) found that children reared in orphanages had higher scores on all three scales of internalizing, externalizing, and total problem than did those reared in families. They also reported that the externalizing prevalence rate was higher than internalizing both in the orphanage and community sample. Moreover, they performed a regression analysis to determine the predictors of total problem score. It revealed that being younger at first admission, history of admission because of abuse, and stigmatization were risk factors for having behavioral problems. It was also found that regular contact with parents or relatives, regular relationship between classroom teachers and institution staff, perceived social

support, and competency significantly decreased the problem behavior scores of the institutionalized children.

In 2008, Şenyurt, Dinçer, Karakuş, Özdemir, and Öner prepared a report describing the behavioral problems of children, between the ages of 10 and 18, reared in Turkish orphanages. They interviewed 200 institutionalized children, 32 institution staff, and 15 school teachers, and created a general profile of the institutionalized children. The analysis of the reports of the institution staff revealed that they mostly used negative expressions when they were asked to describe the children. These negative expressions included both externalizing descriptions such as disobedience, disrespectfulness, selfishness, and aggressiveness, and internalizing descriptions such as being insecure, unhappy, and distressed. Şenyurt et al. (2008) argued that the institution staff's impression of children was predominantly negative, and this would impact the quality of the relationship between the staff and children in a negative way. Therefore, they emphasized the necessity of providing the institution staff with supervision support groups which would create positive changes in their understanding of children, and improve the quality of the relationship they formed with children.

Şenyurt et al. (2008) investigated the risk factors for behavioral problems and found that age, gender, and reason of admission were significantly associated with the problem behaviors. Younger age, being a boy, and history of admission because of divorce increased the severity of behavioral problems among the institutionalized children. When children were asked about

their future plans, majority of children who stated that they would leave the institution before the age of 18 were those who had regular contact with their parents.

Chapter 2: Statement of the Problem

2. 1. Background of the Study

As studies mentioned above indicate, the quality of the early relationship with caregivers can have long-lasting and pervasive effects on socio-emotional development of infants. The present study began with the expectation that providing caregivers with education about child development and with psychological support would create a positive change in their interactions with children, which in turn, would enhance children's development. This prediction was based on previous findings regarding the possibility of change in children's functioning despite the presence of early deprivation (Maclean, 2003; Groark et al., 2005).

The aim of the present study was to help caregivers working at the Bahçelievler Children's Home through giving support and training in developmental aspects of infants. It also aimed to help them gain insight about both their own and children's mental processes, and in this way, to improve the quality of the interaction of caregivers with children. We proposed that attendance to the education and supervision support groups would enhance caregivers' awareness about themselves and about the children. We also expected these groups to increase caregivers' self-esteem and job satisfaction, reduce their feelings of burnout related to their jobs, and improve their general

psychological health. We further proposed that the positive changes in caregivers' level of insight and coping abilities would be reflected in their caregiving behaviors and increase the quality of the relationship between caregivers and children. We expected them to show more sensitive responsiveness, acceptance, involvement and positive emotions toward children, which in turn, would promote the psychosocial development of children and decrease their behavioral problems.

This study lasted for 5 months during which 20 group sessions were held in total. The group met once a week for an hour and fifteen minutes on the same day and at the same time. The purpose of the training intervention was to inform caregivers about the developmental aspects and emotional needs of children. It helped caregivers read the nonverbal signals of children and respond to these signals effectively. The training program involved both didactic education and experiential exercises with the emphasis on caregiver-children interaction, importance of attachment relationship for development, development of autonomy in children, ways of understanding children's mental processes and reflecting it back to them, mirroring, limit setting, and positive discipline methods. Moreover, there was a special emphasis on helping caregivers express and better understand their own emotional and mental processes. Homework and experiential exercises within the groups helped caregivers gain insight about emotional and mental processes of their own and children, and internalize these abilities.

2. 2. Variables

2. 2. 1. Independent (Predictor) Variables

Caregiver Variables:

- Attending supervision groups
- Degree of involvement in the groups, as measured by the Group Participation Evaluation Scale
- Attachment status, as measured by the Relationship Scales Questionnaire (RSQ)

2. 2. 2. Dependent Variables

Caregiver Variables:

- Self efficacy, as measured by the General Self Efficacy Scale (GSE)
- Burn-out, as measured by the Maslach Burnout Inventory (MBI)
- Overall job satisfaction, as measured by the job satisfaction questions in the demographic form
- Overall mental health, as measured by the Symptom Checklist-90-Revised (SCL-90-R)
- Degree of responsiveness to children, as measured by the total Responsiveness score based on the observation checklist developed by the researcher

Child Variables:

- Overall development, as measured by the Ankara Developmental Screening Inventory
    i. Cognitive-Language
    ii. Fine Motor
    iii. Gross Motor
    iv. Social Ability-Self Care
- Overall mental health, as measured by the Child Behavior Checklist / 1 1/2 – 5 total score

2. 2. 3. Exploratory Variables

Caregiver Variables:

- Age
- Education level
- Duration at the current job
- Previous experience
- Having a child
- Attachment status, as measured by the Relationship Scales Questionnaire (RSQ)
- Overall mental health, as measured by the Symptom Checklist-90-Revised (SCL-90-R)

Child Variables:

- Age
- Gender
- Amount of time at the institute
- Contact with parents or other visitors

2. 3. Hypotheses

2. 3. 1. Hypotheses for Caregivers

There are few studies in the institution literature which have examined the role of caregivers' characteristics on the quality of their caregiving behaviors, and the existing ones are mostly interested only in caregivers' anxiety and depression (Schipper, Riksen-Walraven, & Geurts, 2007). In the present study, we expected that participating in the education and supervision support group would decrease caregivers' stress level and have a positive impact on their overall mental health. Moreover, it would decrease the feeling of burnout related to their jobs and increase their level of job satisfaction and their sense of self-efficacy.

Orphanage caregivers have been found to have higher scores on anxiety and depression scales, and this has been found to have a negative effect on their relational qualities (Muhamedrahimov et al., 2004; Schipper et al., 2007). In line with previous studies which found a decrease in anxiety and depression scores of caregivers who had participated in training groups (Muhamedrahimov

et al., 2004), we expected an improvement in the general mental health status of the caregivers who participated in the education and supervision support group. First of all, we hypothesized that their post-test SCL-90-R scores would be lower than their pre-test SCL-90-R scores. Furthermore, the post-test SCL-90-R scores of the intervention group would be significantly lower than the scores of the caregivers in the control group who did not receive any training.

Studies have reported a positive correlation between job satisfaction and quality of the caregiving behavior, and a negative correlation between job burnout and the quality of the care (Schipper et al., 2007). Early intervention programs found an increase in the level of job satisfaction of the caregivers who received training (Muhamedrahimov et al., 2004; Groark et al., 2005). As a second hypothesis we claimed that caregivers in the training group would have higher job satisfaction scores during the post-test, as measured by the questions in the demographic form, compared to their pre-test scores. Furthermore, the post-test job satisfaction scores of the experimental group were expected to be significantly higher than the scores of the control group.

Thirdly, in a parallel way, after the completion of the groups, we proposed a decrease in caregivers' burnout scores, as measured by the MBI. Moreover the post-test scores of the burnout scales were expected to be significantly lower in the intervention group compared to the scores of the control group.

Fourthly, we proposed that caregivers in the training group would show an increase in their sense of self-efficacy compared to caregivers in the non-

training group. We hypothesized an increase in their GSE scores during the post-test evaluation. Furthermore, this increase was expected to be significantly different from the scores of the control group.

Finally, we hypothesized a relationship between the caregivers' degree of involvement in the group (as measured by their scores on the Group Participation Evaluation Scale) and post-test scores of SCL-90-R, job satisfaction, burnout, and self-efficacy. First of all, we proposed that improvement in the overall mental health and decrease in the overall burnout level would be stronger for those caregivers who made better use of the groups. Therefore, we expected a negative correlation between the degree of involvement in the group and post-test SCL-90-R and burnout scores of the caregivers. Secondly, we proposed that caregivers who showed increase in job satisfaction and self-efficacy would be those who made better use of the groups. Therefore, we expected a positive correlation between the degree of involvement in the group and post-test job satisfaction and self-efficacy scores of the caregivers.

2. 3. 2. Hypotheses for Children

The positive effect of the institution-based intervention programs has been observed not only on the caregiver characteristics but also on the characteristics of the developing infants. These programs led the institutionalized children to show an improvement in all areas of development; namely, physical, mental, and psychosocial (Muhamedrahimov et al., 2004;

Groark et al., 2005; Marcovitch et al., 1997). In light of these findings, we expected an enhancement in children's cognitive, social and motor development skills. As we did not have a control group for children we tested this hypothesis through comparing their pre- and post-evaluation developmental scores with the norm group's scores provided in the Ankara Developmental Screening Inventory manual. Specifically, we hypothesized that the difference between their post-test Ankara Developmental Screening Inventory scores (ADSI) and the ADSI scores of the norm group would be smaller than the difference between their pre-test ADSI scores and the norm group's scores. In other words, the post-test ADSI scores of the children would be closer to the scores of the norm group when compared with their pre-test ADSI scores.

Secondly, we proposed a decrease in children's behavioral problems. We hypothesized that their post-test CBCL scores would be lower than their pre-test evaluation.

Finally, we explored the relative importance of age, gender, time spent at the institute and regular contact with outside visitors for the mental health and developmental levels of the children.

2. 3. 3. Exploratory Hypotheses for Caregiving Behavior

Intervention programs have revealed that participating in a training group improves caregivers' characteristics, and this improvement is reflected in their caregiving behavior. They have warmer and more sensitive relationship with the infants, readily respond to their needs, and engage in an emotional

interaction (Muhamedrahimov et al., 2004; Groark et al., 2005). In line with these findings, we wanted to have a way of exploring the direct influence of the training group on the caregiving behaviors of the caregivers and developed an observation checklist for this purpose. However, due to time limitations we could not conduct a pilot investigation on this observation method and we decided to use it only as an exploratory variable. The development of this observation system is fully described in the method section.

We hypothesized that those caregivers who made better use of the education and supervision support group would show more sensitive responsiveness in their interactions with children. We expected to find a positive relationship between the scores of the Group Participation Evaluation Scale and sensitive responsiveness of the caregivers. The relative importance of caregivers' own attachment status, degree of mental health problems, age, previous experience, and duration at the current job for their responsiveness toward the children would also be explored.

Chapter 3: Method

3. 1. Subjects

Thirty-six children between the ages of 15 – 37 months living in the Bahçelievler Children's Home, and the children's caregivers participated in this study. Caregivers work in shifts, and each caregiver spends 8 hours at the infants' home. Twelve caregivers working from 7.00 am to 3.00 pm and 12 caregivers working from 3.00 pm to 11.00 pm agreed to participate in the 5 month long education and supervision support group and were planned to compose our experimental group. One of the biggest drawbacks of this institution is that there is a high turn over rate among the caregivers due to stressful work conditions. The caregivers' work locations and shifts also change frequently. Therefore as will be described below, our targeted sample size shrank throughout the duration of the study.

Of those 24 caregivers who had agreed to participate in the study, 22 started the groups. Half of the caregivers were assigned to the supervision group that started before the beginning of their shifts (at 1.30 pm) and the other half was assigned to the group which started after their shift was over (at 3.45 pm). Because of their irregular attendance, 12 caregivers dropped out of the groups between pre- and post-test. Moreover, two of the caregivers who were attending to the groups regularly quit their jobs while the groups were going on

and therefore they were omitted from the experimental group. One more caregiver quit her job at the end of the groups but she was given the post-test measures except the observation evaluation. Shortly after the beginning of the groups, 3 more caregivers began to attend to sessions and they were given the pre- and post-test measures and were included in the experimental group. Therefore at the end of the 5 months a total of 11 caregivers who had attended at least 50% of the group sessions were taken to be the experimental group and included in the analysis.

During the pre-test evaluation, the control group consisted of 12 caregivers, 5 of which worked at night (from 11.00 pm to 7.00 am) at the same infant's home with the caregivers in the experimental group, and the remaining 7 worked with 6 to 12 months of infants at another infant's home. These 7 caregivers also worked in different shifts (3 from 7.00 am to 15.00 pm, 1 from 15.00 pm to 11.00 pm, and 3 from 11.00 pm to 7.00 am). Five of these caregivers quit their jobs between the pre- and post-test and were therefore omitted from the control group. Of those 12 caregivers who dropped out of the experimental group because of their irregular attendance, 6 were added to the control group and were given the post-test evaluations. The other 6 caregivers could not join the control group because they had quit their jobs during the time of the investigation. As a result, the final control group consisted of 13 caregivers. Ten of the caregivers in the control group did not participate in any of the group sessions. Three of them attended at most 7 sessions at the beginning of the groups. All of the caregivers were female.

3. 1. 1. Caregiver Characteristics

The average age of the 11 caregivers in the experimental group was 28.9 with a range from 20 to 42. Fifty-five percent of the caregivers had high school diplomas and 45% of them had professional high school diplomas. At the time of the pre-test evaluation, they had been employed as caregivers in Bahçelievler Children's Home for an average of 3.6 months with a range from 15 days to 10 months. Sixty-four percent of the caregivers were married with 1 to 3 children, and the remaining caregivers were single (36%). Fifty-five percent of the caregivers had children. Majority of them (45.5%) had previous job experience unrelated to the child care. Only 27.3% of the caregivers had a job experience related to child care, and 27.3% of the caregivers had no previous job experience. Most of them (63.6%) did not get any education about child development. They were responsible for an average of 5-6 infants at the institute.

Thirteen caregivers in the control group had a mean age of 26.0 years with a range from 18 to 40. Majority of the caregivers had professional high school diplomas (61.5%), 30.8% had high school diplomas and 7.7% had open-university degree. At the time of the pre-test evaluation, the amount of time working in Bahcelievler Children's Home ranged from 1 to 36 months with a mean of 8.4 months. Thirty-one percent of the caregivers were married, 7.7% were divorced and 7.7% were widowed with at most 2 children. Fifty-four percent of the caregivers were single. Only 30.8% of the caregivers had children. Majority of them (53.8%) had previous job experience related to child

care. Thirty-nine percent of them had worked in fields other than child care, and only the 7.7% had no previous job experience. Unlike the caregivers in the experimental group, most of the caregivers in the control group (84.6%) got some kind of education about child development. They were responsible for an average of 5-6 infants at the institute.

Table 1 shows the caregiver characteristics for various demographic variables. There were no significant differences between the experimental and control groups for almost all of these demographic variables. There was one exception. The number of the caregivers who got education about child development in the past was significantly higher in the control group than in the experimental group, $F(1, 23) = 7.20$, $p < .05$.

3. 1. 2. Child Characteristics

40 children were given the pre-test evaluation, however 4 of them were adopted during the time of investigation and our final sample was 36. Majority of the 36 children in our sample were boys (66.7%). Their mean age was 25.9 months with a range from 15 to 37 months. At the level of the pre-test, duration of living at the Children's Home ranged from 1 to 37 months with a mean of 16.5 months. Both parents of 47.2% of the children were alive. The percentage of children who only had living mothers was 25% and the percentage of those who only had living fathers was 8.3%. For the remaining 19.4% it was not known whether their parents were alive or not. Fifty-eight percent of the children had visitors who were mostly their mothers, and also their fathers and

Table 1
Demographic Characteristics of the Caregivers

Demographic Characteristic	Experimental Group (N = 11)	Control Group (N = 13)
Age (Years):		
M	28.9	26.0
SD	7.9	7.0
Employment in Current Job (Months):		
M	3.6	8.4
SD	2.7	9.3
Education (%):		
High School	54.5%	30.8%
Professional High School	45.5%	61.5%
Open-University Degree	-	7.7%
Marital Status (%):		
Married	63.6%	30.8%
Single	36.4%	53.8%
Divorced	-	7.7%
Widowed	-	7.7%
Have a Child (%):	54.5%	30.8%
Previous Job Experience (%):		
Related to child care	27.3%	53.8%
Unrelated to child care	45.5%	38.5%
No experience	27.3%	7.7%
Have an Education About Child Development (%):	36.4%	84.6%*

Note. * shows $p < .05$

close relatives. Those visitors met the children at the Children's Home or they could take them out for a couple of hours. Fourteen-percent of the children had

some kind of physical or mental retardation. None of the children received any rehabilitation, special training or any psychological treatment (Table 2).

Table 2
Demographic Characteristics of the Children

Demographic Characteristic	Children (N = 36)
Age (Months):	
M	25.9
SD	5.3
Time Spent at the Institution (Months):	
M	16.5
SD	9.8
Gender (%):	
Boys	66.7%
Girls	33.3%
Have a Parent (%):	
Only Mother is alive	25.0%
Only Father is alive	8.3%
Both of them are alive	47.2%
Not Known	19.4%
Have a Visitor (%):	58.3%
Have Retardation (%):	13.9%

3. 2. Measures

3. 2. 1. Measures for Caregivers

Caregivers' Demographic Form: The caregivers were asked to fill out a questionnaire that included questions about their: age, education, marital status

and the presence of any children, years of experience at the current job, and the number of children that they were responsible for at this job. In addition, the demographic form included nine questions developed by the author, measuring caregivers' satisfaction with and their level of motivation toward their jobs. These questions were answered on a 5 point Likert-scale. A sample item is, "In comparison to other occupations, how important do you think your job is?" (See Appendix B).

General Self-Efficacy Scale (GSE): The English version of GSE was developed by Matthias Jerusalem and Ralf Schwarzer to measure the sense of personal competence to deal effectively with stressful situations (Rimm & Jerusalem, 1999). It was originally developed in Germany and has been adapted to 29 different languages. The scale contains 10 items and these items produce a single factor (Basım, Korkmazyürek, & Tokat, 2007). Typical items are, "I always manage to solve difficult problems if I try hard enough" and "I am confident that I could deal efficiently with unexpected events". It is rated on a 4-point scale with possible responses of *not at all true (1), hardly true (2), moderately true (3), and exactly true (4),* yielding a total score between 10 and 40. The high validity and reliability of this scale has been demonstrated in many research projects finding internal consistencies between .75 and .91 (Rimm & Jerusalem, 1999, p.333).

The Turkish adaptation of GSE was done by Yeşilay (1996, as cited in Basım et al., 2007). In a research conducted by Tayfur (2006, as cited in Basım et al., 2007), GSE was found to be highly reliable (Cronbach alpha = .88). In

their own study, Basım et al. (2007) reported a Cronbach alpha of .83. During the factor analysis, a single factor emerged and it explained 48.76% of the total variance. They evaluated the results as an indication of the reliability and validity of the scale (See Appendix C).

Maslach Burnout Inventory (MBI): In this study, the MBI was used to assess burnout of the caregivers (Maslach, Schaufeli, & Leiter, 2001). This is a self-report scale that includes 22 items developed to measure the three subscales of human services burnout: *Emotional Exhaustion / MBI-EE* was found to be the central aspect of the burnout syndrome and refers to feelings of being emotionally exhausted and depleted of one's emotional resources. *Depersonalization / MBI-D* involves negative and overly detached responses and impersonal feelings and attitudes toward other people. *Personal Accomplishment / MBI-PA* assesses feelings of incompetence and a reduced sense of achievement in one's work (Maslach et al., 2001; Rafferty, Lemkau, Purdy, & Rudisill, 1986). Emotional exhaustion subscale involves 9 items (e.g. "I feel like I get detached to my job"), depersonalization subscale involves 5 items (e.g. "I feel I treat recipients of my service hurtfully"), and personal accomplishment subscale involves 8 items which are reversed during the analysis and informs about reduced sense of personal accomplishment (e.g. "I immediately understand how the recipients of my service are feeling"). It is rated on a 5-point Likert scale indicating the frequency of experiencing each item (0 = never, 4 = always). Three different total scores are calculated for the subscales. Possible range of scores for the subscales are 0 – 36, 0 – 20, and 0 –

32, respectively. The discriminant validity of MBI showed that burnout is a different phenomenon from other constructs such as depression and job satisfaction (Maslach et al., 2001).

The reliability and validity research of the Turkish version of MBI was conducted by Ergin (1993). Internal validity for emotional exhaustion subscale was found to be .83. This value was .65 for the depersonalization scale, and .72 for the personal accomplishment scale. Test-retest reliability was .83 for emotional exhaustion, .72 for depersonalization, and .67 for personal accomplishment. The items of emotional exhaustion and depersonalization include negative statements, and the items of personal accomplishment include positive statements. As there are no cut-off points for the subscale scores in the Turkish version, the definite conclusion that a person has burnout or not can not be arrived at. For the subjects who are experiencing burnout, the scores of MBI-EE and MBI-D are expected to be high, and the scores of MBI-PA are expected to be low (Sünter, Canbaz, Dabak, Oz, & Peksen, 2006, p. 10) (See Appendix D).

Relationship Scales Questionnaire (RSQ): The RSQ was developed by Griffin and Bartholomew in 1994 as an "indirect measure of the Bartholomew and Horowitz' four attachment prototypes" (Backstrom & Homes, 2001, p. 81). Based on the attachment theory of Bowlby, Bartholomew and Horowitz (1991) constructed a model suggesting four different adult attachment styles (secure, fearful, preoccupied, and dismissing). This questionnaire is a self-report measure made up of 30 items drawn from the paragraph descriptions of "Hazan

and Shaver´s (1987) Adult Attachment Questionnaire (AAQ), Bartholomew and Horowitz´ (1991) Relationship Questionnaire (RQ), and Collins and Read´s (1990) Adult Attachment Scale (AAS)" (Backstrom & Holmes., 2007, p. 130). 17 items are used to measure the four attachment styles (Deniz, Hamarta, & Ari, 2005). Five statements contribute to the secure and dismissing categories, and four statements contribute to the fearful and preoccupied categories. One statement is used in two different categories in a reversed direction (Sumer, 2006). Typical items are, "I find it easy to get emotionally close to others" (secure), "I find it difficult to depend on other people" (fearful), "I often worry that romantic partners don't really love me" (preoccupied), and "It is very important to me to feel independent" (dismissing). The subjects are asked to think about their emotional relationships including close relationships and romantic relationships, and to rate each item on a 7-point Likert scale, from *not at all like me (1)* to *very much like me (7).* RSQ scores for the four attachment styles are calculated by taking the average of the items representing each style. Possible range of scores for each attachment type is 1 to 7.

The test-retest reliability coefficients of the RSQ ranged from .54 to .78 (Deniz et al., 2005). Average Cronbach alpha coefficients for prototype scores varied from .41 for the secure style to .70 for the dismissing style (Griffin & Bartholomew, 1994).

The Turkish adaptation of the RSQ is developed by Sümer and Güngör (1999, as cited in Sümer, 2006). They carried out the reliability and validity studies of the scale with a Turkish sample of 123 students. As a result of the

factor analysis, the four prototypes were found to explain 69% of the total variance. Test-retest correlation coefficients ranged between .54 and .78. These findings were interpreted as a satisfactory indication of the reliability and validity of the RSQ (Çelik, 2004) (See Appendix E).

Symptom Checklist-90-Revised (SCL-90-R): This 90-item instrument was developed by Derogatis (1977, as cited in Dağ, 2000) and is used to evaluate a broad range of psychological problems and symptoms of psychopathology. It is a self-report test in which subjects are asked to rate the amount of distress they experience described in each item during the last fifteen days. It is rated on a 5-point Likert scale ranging from "none" to "extremely". It includes items such as "headache", "repetitive and unpleasant thoughts". Total score of the overall psychological distress is calculated by averaging the scores of the answered items. Possible range of scores is 0 to 4.

After the scoring of the items, 3 Global Indices are obtained: *1. Global Symptom Index / GSI* which is designed to measure overall psychological distress, *2. Positive Symptom Total / PST* which reports the number of self-reported symptoms, and *3. Positive Symptom Distress Index / PSDI* which is designed to measure the intensity of symptoms. The SCL-90-R also has 9 Primary Symptom Subscales: Somatization, Obsessive-Compulsive, interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation and Psychoticism. There are also additional subscales measuring feelings of guilt, eating disorders and problems of sleep. The SCL-

90-R can be administered by researchers who are informed about the rationalization of the self-report type of questionnaires.

Derogatis (1977, as cited in Dağ, 2000) carried out two measures of reliability and two validity studies. The Cronbach alphas for the item reliability ranged from .77 to .90 for the subscales, and for the test-retest reliability ranged from .78 to .90 for the subscales. During factor analysis, the nine scales were found to explain 53% of the total variance. Also, subscales of the SCL-90-R were found to be correlated with one another (ranging from .41 to .74) which were reported as the indication of the construct validity of the instrument. Subscales were also found to be correlated with the subscales of similar clinical instruments (MMPI) around .50.

The SCL-90-R was first translated into Turkish by psychiatrists and clinical psychologist to be used during the research of Gökler (1978, as cited in Dağ, 2000). Turkish adaptation of the instrument was conducted by Dağ in 1991 with the norm group of university students. Dağ reported a Cronbach alpha of .97 on the Global Symptom Index / GSI for item reliability. Cronbach alpha for test-retest reliability on the Global Symptom Index / GSI was .90 and ranged from .65 to .87 for the subscales. As a result of the principal components analysis, a single factor emerged which explained 68.7% of the total variance (Dağ, 2000). Dağ (2000) reported that this result is in line with other studies conducted abroad and shows that the subscales of the measure are not adequate to differentiate different symptom groups, but can be used as a whole to

measure the degree of overall psychiatric symptomatology (p. 37) (See Appendix F).

Group Participation Evaluation Scale: This scale was developed by the author to assess the degree of involvement each caregiver displayed in the group sessions. Caregivers were evaluated by the group leader on seven basic categories: empathy to children, empathy to other group members, ability to evaluate children's inner world, ability to evaluate their own inner worlds, and the degree to which they showed defensiveness, dominance, and sharing during the group sessions. Items are rated on a 5-point Likert scale ranged from *none (1)* to *very much (5)* indicating how much each caregiver showed these qualities during a particular session. The scale also includes an option called *NA (not applicable)* that the group leader could use when she could not evaluate a specific quality during a particular session. The ratings about caregivers' degree of defensiveness and dominance were combined and averaged to derive the mean of negative evaluation. The rest of the ratings were averaged and named the mean of positive evaluation. The group leader filled out a form for each participant after the 3rd, 7th, 11th, 15th, and 19th sessions (See Appendix G).

Caregiving Behavior Observation Form: This scale was developed by the author to measure the quality of the relationship between caregivers and infants. The existing caregiving observation systems are geared toward one-to-one interaction of a caregiver with an infant. However, the conditions of the institute are unique in that two caregivers generally interact with a room full of 10 to 15 infants at once, which made it very challenging for them to be

responsive and attuned to individual children. The education and supervision support group particularly aimed at exploring possibilities for keener attunement to each child even in such a chaotic environment. Therefore we wanted to come up with an observation system that would be geared toward this institute.

After a comprehensive investigation of the literature on this topic (Arnett, 1989; Oren & Ruhl, 2000; Rickel & Biasatti, 1982), the author had several visits to the institution to develop an appropriate scale for that setting. First, all the observed caregiver behaviors were listed by the author. Behaviors that were judged to fall under the similar category were represented by a single item. Moreover, other items that seemed as important components of responsive and sensitive caregiving were added. Attention was paid to write the items in easily observable, simple, behavioral terms. This scale describes 22 brief behaviors of the caregivers that they display during their interaction with infants. Sample items are, "initiates interaction with infants", "makes an eye-contact while interacting with infants", "call infants with their names", and "engages in soothing / comforting physical contact with infants". Each mother was observed for 20 minutes while interacting with a group of children. The author trained a second coder (the nurse of the institute) to use the observation form. The nurse was accepted as the second coder as she was the only person allowed by the director of the institute. The coders made a check on the observation sheet for each occurrence of the behavioral items on the form for each caregiver during the twenty-minute observation period. A total of 13

caregivers (9 in the experimental group and 4 in the control group) were observed by the second coder (the nurse). Eight of these caregivers were also observed by the first coder (the author) at the same time. In order to compute the intercoder reliability, we calculated the percentage agreement between the ratings of the two raters. The percentage agreement of the second observer to the first one was found to be 93%. For all caregivers, the codings of the second observer were used in the analysis.

For the analysis, codings of the 15 positive caregiving behavior items were combined to derive the overall responsiveness score for each caregiver. Five negative items, such as "being uninterested in interaction efforts of children", were combined to get a negative interaction score for each subject (See Appendix H).

Group Evaluation Form for the Caregivers: This form was developed by the group leader to learn about caregivers' own evaluations of the groups. It includes 12 open-ended questions, such as "do you think the support group has been useful to you?" (See Appendix I).

3. 2. 2. Measures for Children

Children's Demographic Form: The social service expert was contacted to get information about each children on the following demographic categories: gender, age, duration of living at the Children's Home, whether the parents were alive or not, and presence of any visitors that were in touch with children. In addition, the information about the presence of any physical or

mental retardation and whether children had received any special training or psychological treatment was taken from the teacher of the infant's home (See Appendix J).

Ankara Developmental Screening Inventory: The ADSI was developed by Savaşır, Sezgin, and Erol (2005) to measure the developmental aspects and abilities of the 0 – 6 years-old children in a systematic way. It should be completed by someone who has a close interaction with a child and knows her / him very well. The ADSI involves 154 items that are arranged according to several age groups. These items are designed to measure four different but related areas of development : *Cognitive-Language / GL* (65 items, e.g. "Does the child fulfill simple orders such as close the door?"), *Fine Motor / FM* (26 items, e.g. "Does the child eat using a spoon?", *Gross Motor / GM* (24 items, e.g. "Does the child walk by himself?", and *Social Ability-Self Care / SA-SC* (39 items, e.g. "Does the child take of his own shoes and socks?"). Possible responses are *Yes (1), No (0),* and *Not Known (NK)* indicating whether each item can be accomplished by the child or not (Savaşır et al., 2005, p. 1).

At the end of the evaluation, 5 different total scores are obtained. *General Development* score includes all the subscales and is calculated by the total score (e.g. number of *yes* answers) of the 154 items. It measures the general development. *Cognitive-Language* score reflects levels of verbal behaviors and complex language expressions, and abilities of simple problem solving. *Fine Motor* score measures visual-motor abilities such as eye-hand coordination. *Gross Motor* score measures balance and coordination related to

action. And finally, *Social Ability-Self Care* score reflects the abilities of self care such as eating and dressing, and also of social interaction. Total score for all of these subscales is calculated separately by adding the scores of the items that belong to each subscale (Savaşır et al., 2005).

Norm study was conducted with 860 low SES parents of children aged between 0-6 years. Savaşır et al. (2005) calculated Cronbach alpha coefficients for three different age groups: 0-12 months, 13-44 months, and 45-72 months. Cronbach alpha coefficients for the general development were estimated as .98, .97, and .88, respectively. Cronbach alpha coefficients for the subscales were also found to be high, which indicates the high internal consistency of the instrument. Test-retest reliabilities were .99, .98, and .88 for the three age groups. During the validity studies, the ADSI was found to differentiate different age groups. It was also correlated with other developmental inventories such as Denver Developmental Screening Inventory and Bayley Developmental Scale for Infants (Savaşır et al., 2005).

Child Behavior Checklist / 1 1/2 – 5: The CBCL for preschoolers was originally developed by Achenbach (1992, as cited in Erol, Kılıç, Ulusoy, Keçeci, & Şimşek, 1998) for 2- to 3-years-olds and later it was revised for use with children 18 months to 5 years old. With its versions for different age groups, the CBCL has become the most widely used questionnaire to identify child behavioral and emotional problems (van Zeijl et al., 2006). The CBCL / 1 1/2 – 5 contains 99 items plus three additional open-ended spaces that caregivers may use to include behavior problems not mentioned in the checklist. A sample

item is, “Behaves younger than his/her actual age”. Teachers or caregivers of the preschoolers are asked to rate the degree to which they believe each item on the CBCL is true for their child’s behavior within the past 2 months. It was scored on a scale from *0 (not true), 1(somewhat or sometimes true), and 2 (very true or often true)*. Standardized t-scores are used to estimate the child’s level of functioning relative to the general population (Erol et al., 1998).

The CBCL / 1 1/2 – 5 consists of three problem scales: *Internalizing* problems scale includes five syndrome subscales (Emotionally Reactive, Anxious/Depressed, Somatic Complaints, Withdrawn, Sleep Problems), *Externalizing* problems scale includes two syndrome subscales (Attention Problems and Aggressive Behavior), and *Total* problem scale includes the total score derived from all of the subscales. Achenbach and Rescorla (2000, as cited in Cai, Kaiser, & Hancock, 2004) reported high reliability scores for the *internalizing* and *externalizing* scales. The test-retest reliability ranged from .87 to .90 for the problem scales, and from .68 to .92 for the syndrome scales (p. 305). Validity has been supported by numerous studies which have found significant correlations between the CBCL and other assessments of preschool behavior problems (Shaw, Keenan, & Vondia, 1994).

The Turkish translation and adaptation of the CBCL was conducted by Erol in 1993. She reported test-retest correlation coefficients of .96, .92, and .94 for the problem scales of Internalizing, Externalizing, and Total Problem, respectively. Internal consistency coefficients were estimated as .77, .76, and

.82 for the Internalizing, Externalizing, and Total Problem scales, respectively (Erol et al., 1998, p. 27).

3. 3. Procedure

3. 3. 1. Pre-Test Phase

This study was approved by the General Management of the Social Services and Society for the Protection of Children. Before the beginning of the groups, the leader of the educational and supervision groups, the researcher (the author) and the supervisor of the project visited Bahçelievler Children's Home and met with the caregivers to introduce themselves and talk about the purpose of the project. The leader of the groups mentioned briefly the content of these group sessions and got feedback from the caregivers on how they feel about participating in such an educational and supervision group and what they would like the groups to include. The researcher informed caregivers about the details of the study and told them they will be asked to fill out a couple of questionnaires, including personal information and their attitudes toward their jobs, both at the beginning and at the end of the groups. The rule of confidentiality was explained to the caregivers and they were told that the results would be evaluated as a whole, not individually.

On a pre-decided day between the first and the second group sessions, 17 caregivers from the experimental group and all of the caregivers (12) from the control group were given the questionnaires in three different sessions. Each

caregiver attended the session that did not coincide with her working hours. The questionnaires were given together in an envelope with a subject number written on it. The questionnaire packet included an Informed Consent, Caregivers' Demographic Form, General Self-Efficacy Scale, Maslach Burnout Inventory, Relationship Scales Questionnaire, and Symptom Checklist-90-Revised. It took approximately an hour to complete the questionnaires. The remaining 5 caregivers from the experimental group were given the questionnaire packets after the second session and were asked to bring them back at the beginning of the third session. At the fourth group session, 2 new caregivers began to attend to groups and they also agreed to participate in the research and completed the questionnaires. They were given the questionnaires after the sixth session and brought them back before the seventh session. Finally, one more caregiver started to join the groups at the eleventh session and she completed the questionnaires before the thirteenth session. When these 8 caregivers completed the questionnaires, they had attended to two group sessions.

Information about children was gathered from the teacher of the infant's home and from the caregivers. CBCL forms were given to the teacher on the same day data was collected from the caregivers. She completed the CBCL forms within two weeks. During these two weeks, the researcher visited the infant's home several times to complete the ADSI forms with the caregivers. The social service expert was also interviewed to get demographic information about the children.

The group leader completed the Group Evaluation Scale during the 3rd, 7th, 11th, 15th, and 19th group sessions for each caregiver. The evaluation of the caregivers who did not attend to these sessions was done in the following session.

3. 3. 2. Post-Test Phase

One week after completion of the groups, 11 caregivers in the experimental group and 13 caregivers in the control group were given the same questionnaire packet. Only the Caregivers' Demographic Form was changed, which included only the job satisfaction questions. They were also given a group evaluation form that consisted of open-ended questions designed to evaluate which aspects of the group they found most useful and what kind of realizations they came up with regarding to themselves and their relationships with children. Nine caregivers in the experimental group and 4 caregivers in the control group were also observed for 20 minutes in a play room during a regular work hour. Their interaction with children was rated using the observation coding sheet as described above. Two caregivers in the experimental group could not be observed because one changed her shift and began to work at night, and the other had just quit her job at the time of observation. Also, eight caregivers in the control group could not be observed because they were working either at the night shift or with infants aged 6 to 12 years.

After the completion of the groups, the CBCL and ADSI forms were also filled out for each child in the children's home by their primary caregivers and the teacher at the infants' home.

Chapter 4: Results

4. 1. Results for Caregivers

As stated before, caregivers who participated in at least 50% of the group sessions, most of which were held at the second half of the groups, were included in the analysis as the experimental group. In Table 3, the descriptive statistics of the measures are presented for the caregivers in the experimental and control groups separately. Independent samples t-tests indicated that there were no statistically significant differences between the two groups on any of these measures at the pre-test (*p*s >.05). When the caregivers were measured at the post-test, changes were observed in all measures and three of them were found to be statistically significant. Post-test scores of SCL-90-R, self-efficacy and burnout (EE) were significantly different for the experimental and control groups. During the post-test evaluation, caregivers in the experimental group reported less complaint about their general mood, felt more self-efficient, and had less emotional exhaustion compared to caregivers in the control group (t (22) = -2.24, p=.03; t (22) = 2.07, p=.05 and t (22) = -2.15, p=.04, respectively).

4. 1. 1. Overall Mental Health

A repeated-measures analysis of variance (ANOVA) test was performed with the 24 participants (11 in experimental group and 13 in control group) in

Table 3
Means (standard deviations) for Caregiver Measures

Measures	Experimental Group (N=11)		Control Group (N=13)	
	Pre-test	Post-test	Pre-test	Post-test
SCL-90-R	44.72 (26.34)	21.63*[a] (17.27)	65.46 (41.02)	52.15 (42.05)
Job satisfaction	29.72 (3.92)	33.45* (3.04)	30.23 (3.60)	32.84* (3.99)
Self-efficacy	33.27 (3.66)	36.09*[a] (2.62)	32.76 (4.51)	33.38 (3.73)
Burnout (EE)	10.81 (5.81)	4.72*[a] (2.86)	10.07 (7.31)	9.46 (7.29)
Burnout (D)	3.72 (1.73)	3.09 (0.83)	4.76 (2.74)	2.76 (2.14)
Burnout (PA)	10.45 (4.98)	9.00 (3.22)	11.23 (5.59)	10.61 (3.17)

Note. * shows significant difference within group between pre-test and post-test scores ($p < .05$).
[a] shows significant difference between experimental and control groups ($p < .05$).

order to assess the effect of participating in the education and supervision support group on the general mood scores. The results showed that neither the main effect for group (F (1, 22) = 3.83, p=.06, η_p^2=.14) nor the time X group interaction (F (1, 22) =.97, p=.33, η_p^2=.042) were significant. However, the main effect for time was significant (F (1, 22) = 13.47, p<.05, η_p^2=.380). The SCL-90-R scores in the post-test phase were overall lower than in the pre-test phase. Although we could not find a significant effect for group with ANOVA,

the comparison of the pre- and post-test SCL-90-R mean scores through t-test showed a difference for the experimental and control groups. Paired samples t-tests demonstrated that post-test SCL-90-R scores of the experimental group were significantly lower than their pre-test SCL-90-R scores (t (10) = 3.55, p=.00), while there was not a significant difference between the pre- and post-test SCL-90-R scores of the control group (t (12) = 1.83, p=.09). Figure 1 shows the mean SCL-90-R scores of the groups.

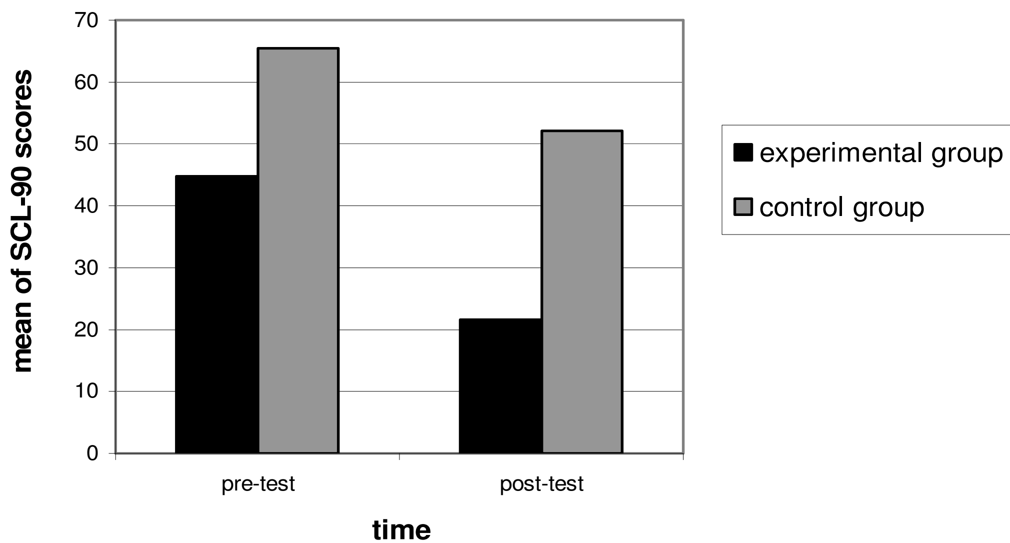

Figure 1. Mean SCL-90-R scores of the experimental and control groups for the pre- and post-test phases.

4. 1. 2. Job Satisfaction

A repeated-measures analysis of variance (ANOVA) test with Group as a between-subject factor and Time as a within-subject variable was conducted

to compare the job satisfaction scores of the experimental and control groups. It showed that the main effect for group and the time X group interaction were not significant (F (1, 22) = 0.00, p=.97, η_p^2 =.000, and F (1, 22) = .88, p=.35, η_p^2 =.039, respectively). However, the main effect for time was significant (F (1, 22) = 28.77, p<.05, η_p^2 =.567), suggesting that caregivers both in the experimental and control groups showed a significant increase in their levels of job satisfaction. According to the results of the paired samples t-tests, both for the experimental and control groups, the post-test job satisfaction scores were significantly higher than their pre-test job satisfaction scores (t (10) = 5.21, p=.00 and t (12) = 2.89, p=.01, respectively). As a result, it can be said that participating in a support group did not make a significant difference for the level of job satisfaction. Time alone made a positive impact for both groups. Figure 2 shows this increase observed in the both groups.

4. 1. 3. Burnout

Three different repeated-measures analysis of variance (ANOVA) tests were conducted for the burnout scales Emotional Exhaustion, Depersonalization and Personal Accomplishment. The main effects for group were not found to be significant in any of these analysis (F (1, 22) = 0.88, p=.35, η_p^2 =.039; F (1, 22) = 3.66, p=.06, η_p^2 =.143, and F (1, 22) = 0.61, p=.44, η_p^2 =.027, respectively). The main effect for time and time X group interaction were significant only for the Emotional Exhaustion scale (F (1, 22) = 6.88, p<.05, η_p^2 =.238 and F (1, 22) = 4.59, p<.05, η_p^2 =.173, respectively).

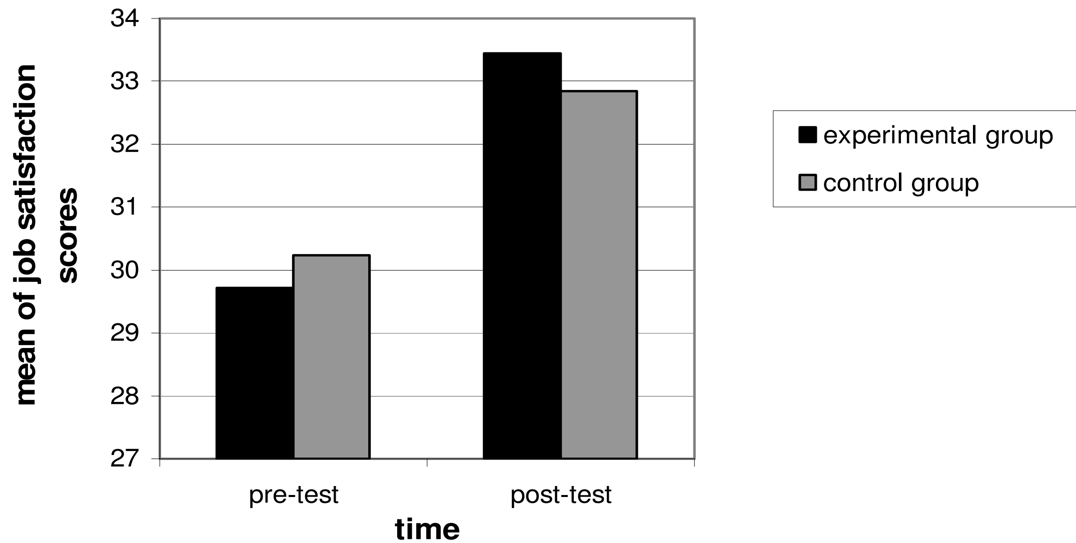

Figure 2. Mean job satisfaction scores of the experimental and control groups for the pre- and post-test phases.

That is to say while the pre- and post-test Emotional Exhaustion scores of the control group did not change significantly over time, there was a significant decrease for the experimental group (Figure 3a).

Although ANOVA did not reveal a significant effect of the Group for the burnout scales, a paired samples t-test indicated that caregivers in the experimental group reported lower level of emotional exhaustion in the post-test than in the pre-test (t (10) = 3.47, p=.00). For the caregivers in the control group, there was not a significant difference between their pre- and post-test emotional exhaustion scores (t (12) = 0.33, p=.74). Both for the experimental and control groups, there were not significant differences between the pre- and

post-test scores of the other two burnout scales. Figure 3 displays the mean scores of the burnout scales for the experimental and control groups.

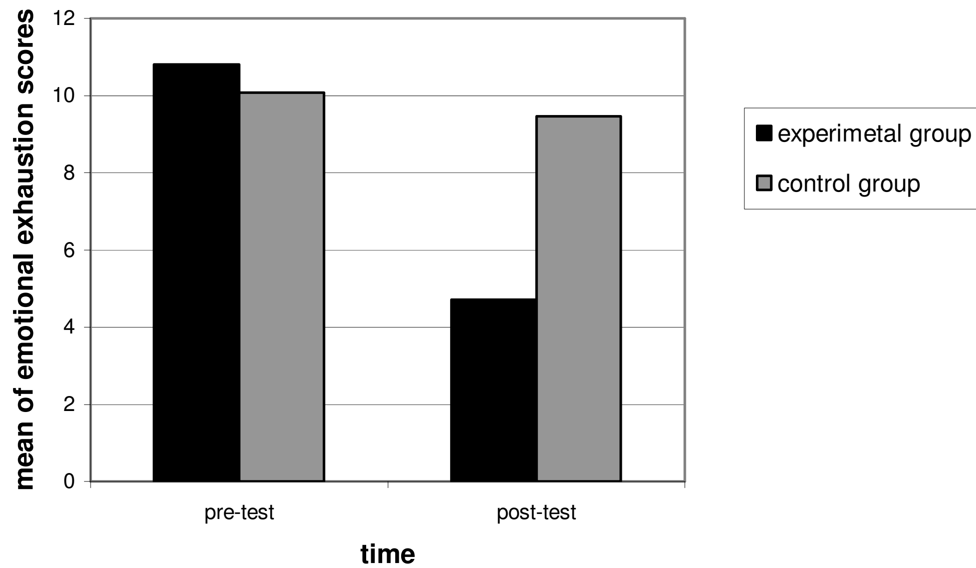

Figure 3a. Mean emotional exhaustion scores of the experimental and control groups for the pre- and post-test phases.

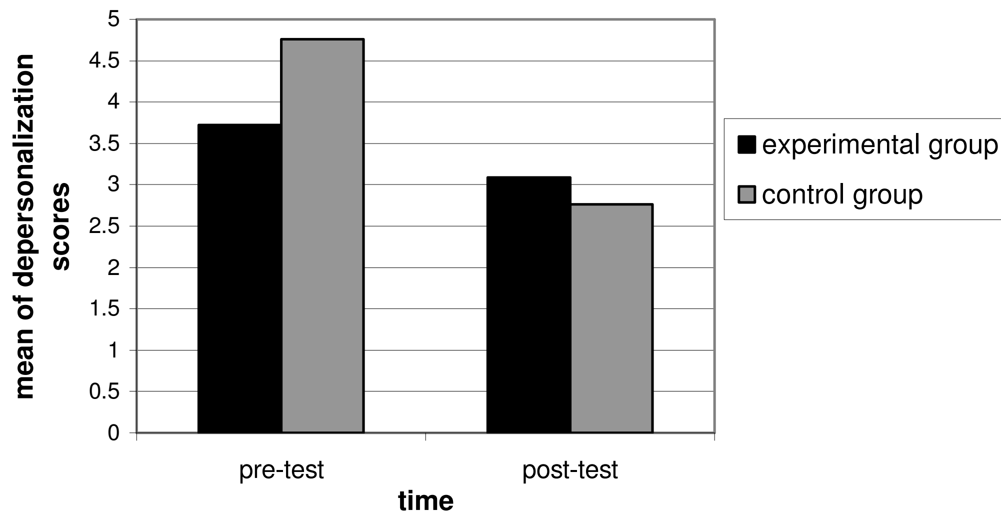

Figure 3b. Mean depersonalization scores of the experimental and control groups for the pre- and post-test phases.

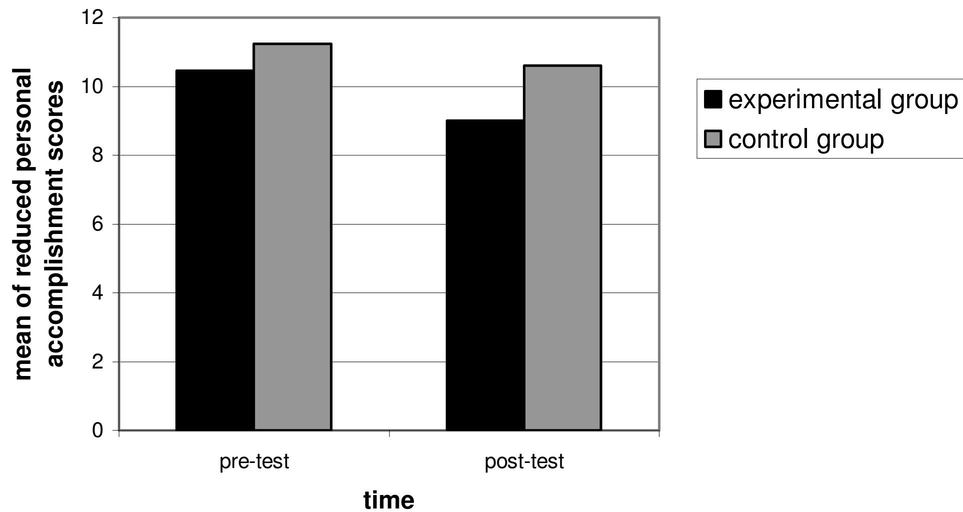

Figure 3c. Mean reduced personal accomplishment scores of the experimental and control groups for the pre- and post-test phases.

4. 1. 4. Self-Efficacy

Finally, a repeated-measures analysis of variance (ANOVA) test was performed with the self-efficacy scores. The results indicated that neither the main effect for group (F (1, 22) = 1.54, p=.22, η_p^2 =.066) nor the time X group interaction (F (1, 22) = 1.78, p=.19, η_p^2 =.075) were significant. The main effect for time was significant (F (1, 22) = 4.33, p<.05, η_p^2 =.165), indicating that there was an overall increase in self-efficacy scores of caregivers in both groups. Paired samples t-tests were performed to compare the pre- and post-test self-efficacy scores of the caregivers in the experimental and control groups separately. While there was not a significant difference between the pre- and post-test self-efficacy scores of the caregivers in the control group (t (12) = 0.53, p=.60), caregivers in the experimental group had a significant increase in their self-efficacy levels (t (10) = 2.38, p=.03) (Figure 4).

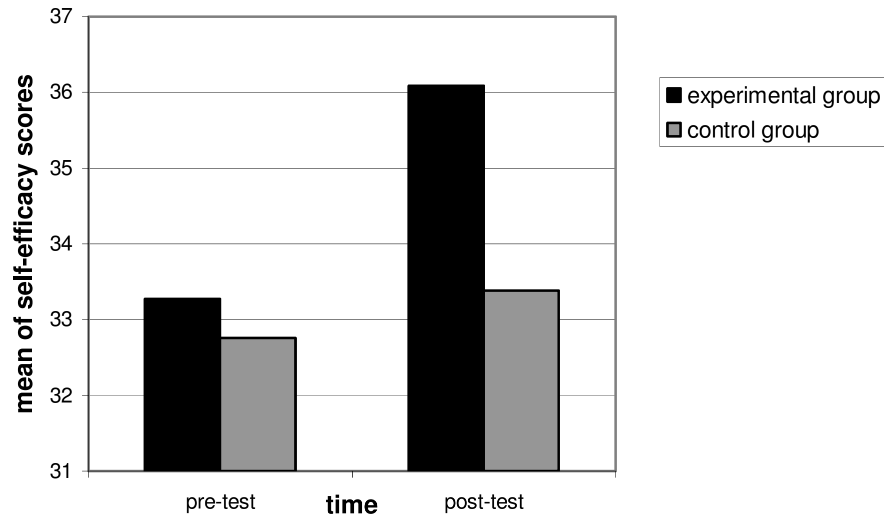

Figure 4. Mean self-efficacy scores of the experimental and control groups for the pre- and post-test phases.

4. 1. 5. Effect of involvement in the group process on caregiver variables

For the caregivers in the experimental group, we also conducted a correlational analysis to compare their post-test scores with the degree of involvement in the group. We wanted to look at whether caregivers who had lower SCL-90-R and burnout scores during the post-test were those who seemed to be the most involved in the group process. A negative correlation was observed between the post-test SCL-90-R mean scores and degree of involvement in the group, however it was not found to be statistically significant (r = -.20, p > .05). Similarly, when we compared the post-test scores of burnout scales with the degree of involvement in the group, we observed negative correlations; but they were not statistically significant (r = -.35, p= .28

for emotional exhaustion, r = -.46, p= .14 for depersonalization, and r = -.43, p= .17 for personal accomplishment).

We also expected a positive correlation between post-test scores of job satisfaction and self-efficacy and the scores of the Group Participation Evaluation Scale. As we expected, a positive correlation was observed between post-test level of job satisfaction and degree of involvement in the group, and it was almost statistically significant (r = .59, p= .055). Caregivers who reported higher levels of job satisfaction were those who were the most involved in the groups. However, for the scores of self-efficacy there was not a statistically significant relationship with the degree of involvement in the group (r = .09, p= .77).

4. 2. Results for Children

Hypotheses for children indicated that there would be an improvement in the developmental skills of children at the post-test level. We expected that at the pre-test level, the ADSI scores of the children would be lower than the norm scores, and this difference would disappear at the post-test and the children's ADSI scores would be closer to the norm scores. The ADSI manual provides t-scores only for the total score but does not provide t-scores for the 4 subscales. As the children in our sample had different ages and as their raw scores on the ADSI were expected to increase on their own with time, in order to measure the degree of their development we compared their pre-test and post-test ADSI raw scores with the norm group mean scores that were provided in the ADSI

manual using the sign-test. The sign test, which is a non-parametric procedure, conducted pairwise comparisons between the ADSI scores of the children in our sample and the respective norm scores, and determined if the two distributions differed significantly. The sign test sums all the positive and negative differences between the pairs in the two distributions and computes a z-score and a p value associated with the frequency of the positives and negatives (George and Mallery, 1999). Table 4 displays the descriptive statistics for ADSI scores of general development and subscales for the infants in our sample and norm group.

Five different sign tests, one for the general development and the others for the subscales of cognitive-language, fine-motor, gross-motor and social ability-self care were performed. All of the five sign tests supported our hypothesis. At the pre-test phase, the majority of the children's scores of general development was lower than their respective norm group scores (z= 3.71, p=.00). During the post-test phase, the children in our sample had an improvement in their developmental skills and their scores were not significantly different from the norm scores (z=.00, p=1.00).

The same result was found for the subscales of cognitive-language, fine-motor, and social ability-self care. The children's scores were significantly lower than the scores of the norm group at the pre-test level (z=-4.05, p=.00, z=-3.71, p=.00 and z=-4.17, p=.00, respectively). Only for the gross-motor ability, the two samples' scores did not differ significantly (z=-1.74, p=.08). When the

Table 4
Descriptive statistics for ADSI scores

Categories	Infants in our Sample (N=36)			Norm Group		
	M (SD)	Minimum	Maximum	M (SD)	Minimum	Maximum
General Development						
Pre-test	90.77 (18.36)*	49.0	131.0	110.38 (10.31)	80.0	127.0
Post-test	112.06 (19.61)	56.0	136.0	117.06 (7.78)	100.0	129.0
Cognitive-Language						
Pre-test	28.06 (8.72)*	12.0	48.0	38.97 (5.74)	25.0	48.0
Post-test	38.86 (9.34)	14.0	52.0	42.44 (4.66)	34.0	49.0
Fine-Motor						
Pre-test	16.19 (2.58)*	9.0	22.0	18.31 (1.33)	15.0	20.5
Post-test	19.52 (2.93)	13.0	23.0	19.20 (0.97)	17.0	21.0
Gross-Motor						
Pre-test	20.52 (2.69)	14.0	24.0	22.04 (1.06)	18.5	23.5
Post-test	22.27 (2.27)	14.0	24.0	22.63 (0.50)	21.0	23.5
Social Ability-Self Care						
Pre-test	26.00 (5.26)*	13.0	37.0	30.62 (2.48)	23.5	34.5
Post-test	31.38 (5.81)	14.0	38.0	32.11 (1.70)	28.0	35.0

Note. * shows $p < .05$

children were assessed at the post-test, the results of sign tests indicated that the significant differences for the three subscales had disappeared. Children in our sample displayed an increase in their cognitive-language, fine-motor, and social ability-self care scores and showed no more difference from the norm group of the same age (z=-1.50, p=.13; z=-.53, p=.59 and z=.00, p=1.00, respectively). Children also had an improvement in their gross-motor abilities and got higher scores than the norm group. The sign test indicated that the number of cases who had higher scores than the norm group was significantly more than the number of cases who had lower scores than the norm group (z=2.15, p=.03). To sum up, children in our sample displayed an enhancement in all areas of development and did not differ anymore from the children at the same age on all of these developmental skills. Actually, for the gross-motor skills they got higher scores compared to the norm group. It is important to note that the norm group for the ADSI comprised of children from lower SES families.

A paired sample t-test was performed to compare the pre- and post-test CBCL scores of the children. The results indicated a significant decrease of the CBCL scores. Children were found to have lower behavioral problems at the post-test level compared to the pre-test level (t (35) = 4.73, p=.00).

Finally, two separate stepwise multiple regression analyses were conducted to determine the predictors of post-test CBCL and ADSI scores. In the two analyses, we entered gender, age, amount of time at the institute, contact with parents or other visitors, and retardation as predictors of the post-test CBCL and ADSI scores. For the two measures, the only significant

predictor was found to be contact with parents or other visitors. Having a contact with parents or other visitors predicted lower CBCL scores (R^2=.13, Adjusted R^2= .11, F (1,35)= 5.36, p<.05) and higher ADSI scores (R^2=.19, Adjusted R^2= .17, F (1,35)= 8.30, p<.05) at the post-test, indicating a positive effect on children. Children who had contact with parents or other visitors displayed lower behavioral problems and had higher developmental skills than those who did not have any visitors.

4. 3. Results for Exploratory Hypotheses for Caregiving Behavior

We measured caregiving behavior with the Caregiving Behavior Observation Form describing 22 behaviors that caregivers display in their interaction with children. We formed 5 different subcategories by combining certain items, and we obtained 5 different total scores for these categories. The first category was *total responsiveness* and it included items describing caregiving behaviors such as, positive interaction, verbal communication, mirroring, and physical contact. The second category was *total negative interaction* and it included items describing caregiving behavior either unresponsive to children's needs or unrelated to child care such as talking to other caregivers. The third category was *total mirroring* and it involved items describing verbal and nonverbal mirroring. The fourth category was *total physical contact* and it included items describing physical interaction of the caregivers with infants. The final category was *emotional coping* and it

involved items describing caregivers' attempts at helping children cope with intense emotions through strategies such as diverting their attention.

Most of the caregivers in the control group were working in the night shift. Therefore, we could observe only four of them who were working during the day and as the number was very low we could not use them to compare with the caregivers in the experimental group. Therefore, we excluded the observation scores of the control group from the analysis. Table 5 displays the mean score of the experimental group for each caregiving behavior category. Caregivers were observed to engage mostly in verbal interaction with children (*M*= 6.55, *SD*= 2.9). It was followed by physical contact (*M*= 6.11, *SD*= 4.3) and mirroring (*M*= 3.22, *SD*= 3.1). They were also observed to engage in negative interaction with children (*M*= 4.0, *SD*= 2.2).

Table 5
Means (standard deviations) for Caregiver Behaviors

Categories	*M (SD)*
Total negative interaction	4.00 (2.2)
Total mirroring	3.22 (3.1)
Total physical contact	6.11 (4.3)
Emotional coping	2.55 (2.7)
Verbal interaction	6.55 (2.9)

We conducted a correlational analysis to compare the caregiving behavior scores with the scores of the Group Participation Evaluation Scale.

We expected a positive correlation between the degree of involvement in the groups and sensitive responsiveness of the caregivers. The results indicated that there were not significant relationships between the degree of involvement in the group and any of the caregiving behavior categories (ps>.05). The only correlation that was approaching significance was mirroring and it was in the expected direction. Caregivers who were observed to display more mirroring behaviors were those who were more engaged in the groups ($r = .59$, $p = .09$).

Moreover, a stepwise multiple regression analysis was conducted to determine the best predictors of sensitive responsiveness of the caregivers. We entered total responsiveness as a dependent variable, and caregivers' own attachment status, post-test scores of SCL-90-R, age, previous experience, and duration at the current job as predictor variables. The results revealed the post-test SCL-90-R scores as the only significant predictor of sensitive responsiveness. Lower SCL-90-R scores predicted higher ratings of sensitive responsiveness (R^2=.50, Adjusted R^2= .43, F (1,8)= 7.18, p<.05). Caregivers who reported lower levels of mental health problems were observed to be more sensitively responsive in their interactions with children.

Correlational analyses were also carried out to look at the relationship between degree of involvement in the groups, caregiving behaviors, caregivers' own attachment style, and their degree of mental health problems. Secure attachment was found to correlate significantly with involvement in the groups ($r = .60$, p= .05) and mirroring ($r = .65$, p= .05). Caregivers with secure attachment styles were those who made better use of the group and who were

observed to use mirroring in their interaction with children more frequently. Furthermore, significant negative correlations were found between post-test SCL-90-R scores on the one hand and total responsiveness (r =-.71, p< .05) and mirroring (r =-.79, p< .05) on the other. The correlation between post-test SCL-90-R scores and physical contact was also approaching significance in the expected direction (r = -.61, p= .08). Caregivers who reported lower levels of mental health problems were observed to be more sensitively responsive in general and to make more physical contact and mirroring in their interactions with children. Unexpectedly, caregivers with fearful attachment style were also found to display more mirroring behavior during observation (r =.70, p< .05). The correlation between fearful attachment and degree of involvement in the group was also approaching significance (r = .52, p= .09). Caregivers with fearful attachment style were also more engaged in the group process.

4. 4. Caregivers' Evaluations of the Group Process

Qualitative evaluations filled out by the caregivers showed that their general impression about the groups was positive. They thought that participating in the group sessions was useful because it enabled them to spend time with children in a more effective way. In the evaluations, the topics they stated to benefit most from were mirroring, attachment, verbal communication, and playing. Moreover, most of the caregivers emphasized the usefulness of homework and experiential exercises within the groups. They stated that the groups enabled them to understand children's behaviors and emotional

reactions easily, and to be aware of the special moments in their one-to-one interaction with children. They stated that the groups made them realize the existence of a strong bond between themselves and children, and get a lot of enjoyment from interacting with them. Caregivers also mentioned that associating certain modes of behaving toward children with theoretical perspectives helped them understand in what way a particular mode of behaving was important while interacting with children. They stated that they began to interact with children with an awareness of how their reaction would impact them. Another common theme was that the groups were useful not only for caregivers' job experiences but also for their daily lives. They said that they used the information and experience they got from the groups in their social interactions.

Chapter 5: Discussion

The purpose of the present study was to investigate the effect of participating in an education and supervision support group on caregivers and children residing in the Bahçelievler Children's Home. It provided empirical information about caregiver characteristics and the developmental status of children. It also examined the quality of the relationship between children and caregivers who participated in the support group through a direct observation of their caregiving behaviors.

5. 1. Caregiver Characteristics

The first hypothesis of the study stated that there would be an improvement in the general mental health status of the caregivers that participated in the education and supervision support group. As measured by the Symptom Checklist-90-Revised, caregivers in the experimental group displayed a significant decrease in their scores while there was not a significant difference between the pre- and post-test measures of the control group. Moreover, during pre-test evaluation the two groups did not differ significantly in their scores of mental health while during the post-test evaluation the experimental group reported significantly less complaints than did the control group. This finding supported our hypothesis that providing caregivers with

education and supervision support would decrease their overall mental health problems.

When the social-emotional atmosphere of the institutional setting and hard working conditions of the caregivers are considered, it is reasonable to expect that a support group, in which caregivers have the opportunity for sharing the difficulties that they face at work and hearing the experiences of other caregivers, will cause a general improvement in their psychological health. Our finding is similar to those of Muhamedrahimov et al. (2004) and Groark et al. (2005) which revealed a significant decrease in anxiety and depression levels of caregivers who participated in training groups.

The second hypothesis of the study was related to examining the effect of participating in an education and supervision support group on level of job satisfaction. It stated that caregivers in the experimental group would show a significant increase in their level of job satisfaction, and their post-test scores would be higher than the scores of the control group. This hypothesis was partially confirmed. An increase in the job satisfaction levels reported by the caregivers in the experimental group was observed. However, a similar increase was also observed for the control group who did not participate in the support groups. Therefore, these findings may suggest that spending more time at their jobs seems to increase caregivers' job satisfaction. The results were not consistent with previous research in this area (Muhamedrahimov et al., 2004; Groark et al., 2005) which found a difference in the job satisfaction levels of

the caregivers who received training and of those who did not receive any training.

During the study we did not have a chance to control the structural conditions of the institutional setting such as physical or procedural changes intended by the institution management, salaries of the caregivers, and group sizes. The general increase observed in the job satisfaction levels of the both groups may be related to an improvement in the working conditions of the caregivers. Findings of the previous researches (Muhamedrahimov et al., 2004; Groark et al., 2005) are compatible with this explanation. In these research designs, one group of caregivers were provided not only with training but also with structural changes while another group received neither the training nor the structural change interventions, and they revealed differences in the level of job satisfaction of the both groups. The finding of our study may indicate that caregivers' satisfaction with their jobs is mostly related to the employment practices and structural circumstances of the Children's Home. Additionally, a self-selecting bias might have also been at work as a number of caregivers quit their jobs during the process of the group. Hence, those who were very dissatisfied with their jobs might have quit their jobs on their own.

Another reason for the failure to find a difference between the experimental and control groups in their job satisfaction levels may be related to the measurement we used. We assessed the caregivers' job satisfaction levels with the questions we presented in the demographic form, which informed us about the caregivers' general attitude and level of motivation toward their jobs.

The assessment, however, may not be sensitive enough to show the difference between the two groups. A more detailed and sensitive investigation of caregivers' job satisfaction levels may help us demonstrate the impact of participating in an education and supervision support group on job satisfaction levels of the caregivers.

The third hypothesis related to caregiver variables was about the burnout level. It stated that participating in the education and supervision support group would lead to a decrease in caregivers' burnout levels. Three different analyses were conducted for the three scales of the MBI, and our hypothesis was supported only by the results of the emotional exhaustion scale. The findings revealed that caregivers, in general, did not display a significant difference between the pre- and post-test measures of their depersonalization and personal accomplishment scores. However, receiving support made a difference in emotional exhaustion scores of the caregivers. Experimental group reported significantly lower level of emotional exhaustion after the completion of the groups whereas there was not a significant difference between the pre- and post-test evaluations of the control group. Additionally, while the two groups did not differ significantly in their emotional exhaustion scores during the pre-test, there was a significant difference between the post-test emotional exhaustion scores of them. Caregivers who participated in the support groups were found to feel less emotional exhaustion related to their jobs compared to those who received no support.

These findings can be interpreted with the help of a detailed description of what each scale specifically measures. Of the three scales of MBI, the emotional exhaustion scale may be the one which reflects the burnout related to a job at an institutional setting. This scale measures the feelings of being emotionally overextended and consumed of one's emotional resources. When the working conditions of the caregivers are taken into account, it is expectable to find a decrease in the emotional exhaustion levels of the caregivers who participated in the support group. They have to show concern for a room full of 10 to 15 children at once which requires huge responsibility. During the groups they had the opportunity to express their feelings related to their jobs and learned new and more effective ways of coping with behavioral problems and negative emotional expressions of children. They also had a chance to learn different self-care strategies to cope with their emotional exhaustion. At the end of the group process they reported that they began to get enjoyment from interacting with children. Therefore, the support group which provided caregivers with alternative ways of coping while interacting with children and which enabled them to get enjoyment from this interaction can be said to strengthen their emotional resources and reduce their feelings of exhaustion related to their jobs.

For the caregivers in the experimental group, the unexpected findings of nonsignificant differences between their pre- and post-measures of the personal accomplishment and depersonalization scales can be explained again by the characteristics of their jobs or the social desirability effect. During the pre-test

evaluation, caregivers in both groups usually had a tendency to evaluate themselves positively and reported that they were successful and competent in their jobs. This general belief, among caregivers, in their success while caring for children or their reluctance to report feelings of incompetence due to fears that these results may be communicated to the director of the institution can be the explanation of the similarity between the two groups regarding their feelings of personal accomplishment related to their jobs. Finally, the depersonalization scale may be unrelated to the burnout that caregivers feel because it measures negative, overly detached, and impersonal feelings towards other people which may not be commonly seen in a job including interaction with children.

The fourth hypothesis of the study was about caregivers' sense of self-efficacy. It stated that those who participated in the education and supervision support group would show an increase in their sense of self-efficacy, and their post-evaluation scores would be significantly higher than scores of the control group. The result was consistent with our expectation. Caregivers who received support had a significant increase in their sense of self-efficacy while there was not a significant difference between the pre- and post-test evaluations of the control group. During the post-test, caregivers in the experimental group reported significantly higher levels of self-efficacy than those in the control group. Their qualitative evaluations of the groups stated that besides the achievements about child care, the groups helped caregivers realize their own capabilities and improve their social interactions in everyday life. Therefore, the

significant difference between the experimental and control groups' post-test evaluations of general self-efficacy can be explained by these personal acquisitions of the experimental group about their abilities.

Finally, we examined the effect of involvement in the group process on caregiver variables. First of all, it was hypothesized that the degree of involvement in the group would be negatively associated with the post-test SCL-90-R and burnout scores of the caregivers. We expected that caregivers who made better use of the groups would show much more improvement in their overall mental health and much more decrease in their burnout level. Results of the correlational analysis did not support our hypothesis. Negative correlations were found between the post-test SCL-90-R and burnout scores of the caregivers and degree of involvement in the groups, but they were not statistically significant. The second hypothesis related to degree of involvement in the group process was about job satisfaction and self-efficacy levels of the caregivers. It stated that caregivers who got higher scores on the Group Participation Evaluation Scale would be those who reported higher levels of job satisfaction and self-efficacy during the post-test evaluation. As in the first hypothesis, the results revealed positive but not significant correlations between the degree of involvement in the groups and job satisfaction and self-efficacy scores.

One explanation of the failure to find a significant relationship between the degree of involvement in the group process and caregiver variables may be related to our limited sample size. As a number of the original participants had

to be taken out of the final analyses due to their irregular attendance in the groups or as they quit their jobs, our final sample for this analysis only included 11 caregivers. This was in fact an overall limitation that was related to doing research at an institutional setting with many conditions that we could not control. Another explanation was related to our scale. The Group Participation Evaluation Scale was developed by the researchers without any pilot study to evaluate its reliability or validity. Hence, it may not be a sensitive evaluation of the group participation.

Furthermore, the irregularity seen in the attendance to the support groups can be another explanation for the nonsignificant findings. A good deal of drop-outs from the intervention group occurred during the study, and the caregivers who continued to join in the groups can also be interpreted as the ones who engaged in the groups. Therefore, because the experimental group was composed of caregivers who already engaged in the group process and it had small sample size, the variation in their degree of group participation was very limited.

5. 2. Child Characteristics

The existence of an association between early relationship experiences and later functioning has been confirmed by many longitudinal studies conducted by attachment theorists or developmental psychologists (Sroufe, 2000; Balbernie, 2003; Gillath et al., 2005; Berlin et al., 2005). Especially, adoption researches and studies with institutionalized children have provided a

way to see the extent to which early experiences determine later development. They have documented the unfavorable effects of the institutional care on children's personality development, and they also have showed the possibility of reducing these children's behavioral problems and improving their developmental skills through providing them with sensitive caregiving (Tizard & Rees, 1975; Marcovitch et al., 1997; Muhamedrahimov et al., 2004; Groark et al., 2005; Şimşek et al., 2007). Based on the idea that providing caregivers with an education and supervision support will improve the quality of the relationship they form with children, and this in turn, will enhance children's developmental skills; we expected that the present intervention would cause an improvement in children's developmental skills and reduce their behavioral problems.

Firstly, it was hypothesized that children would display an enhancement in their cognitive, social, and motor developmental skills, as measured by the ADSI. Findings of the study confirmed this hypothesis. Children in our sample had an improvement in all areas of development (cognitive-language, fine-motor, gross-motor, and social ability-self care) and did not differ anymore from the norm group on all of these developmental skills. These results are compatible with previous adoption studies which found significant differences between adopted and institutionally-reared children in terms of their developmental levels and the frequency of behavioral problems they had displayed (Tizard & Rees, 1975; Maclean 2003; Marcovitch et al., 1997; Üstüner et al., 2005). The findings are also consistent with the results of the

institution-based intervention program research which induced improvements in children's developmental competencies through promoting sensitive and responsive caregiving with the help of structural changes and/or training offered to the caregivers (Muhamedrahimov et al., 2004; Groark et al., 2005).

The second hypothesis related to children stated that there would be a decrease in their behavioral problems, as measured by the reports of the caregivers. The findings were in line with our expectation. Children were found to have lower behavioral problems at the post-test evaluation compared to the pre-test evaluation. As mentioned in the first hypothesis, these results are consistent with previous research documenting a decrease in behavioral problems of children who were adopted or received an intervention program (Marcovitch et al., 1997; Üstüner et al., 2005; Muhamedrahimov et al., 2004; Groark et al., 2005).

It is important to note that these results have to be interpreted with caution because we could not have a control group for children and compared their pre- and post-test CBCL or ADSI scores. Therefore, it can not be known for sure whether the decrease observed in children's behavioral problems and developmental achievements derive from the intervention we implemented or from the changing conditions of the institutional setting. About two months before we started our group intervention the 0 – 3 year-old children were moved into a new house that was constructed for them. This new, modern building offered improved facilities for the children that could have provided them with a better structure and more opportunities for stimulation.

These findings point to the effectiveness of providing caregivers with relevant education and support. Through a 20-week long intervention substantial gains were made in the quality of the relationship between children and caregivers, which also had direct influences on children. This kind of intervention programs can respond to the immediate need to improve the caring conditions of the Turkish orphanages, as argued by Şimşek et al. (2007) and Şenyurt et al. (2008).

Finally, we explored the risk and protective factors for the developmental and behavioral problems of children in institutional care. The findings of the study showed both consistency and inconsistency with the existing literature. Having a contact with parents or other visitors was identified as an important protective factor for children reared in the institutional setting. We found that children who had contact with parents or other visitors displayed lower behavioral problems and had higher developmental skills than those who did not have any visitors. This finding is consistent with the results of both Şimşek et al.'s (2007) study and Tizard and Rees' study (1975) which revealed that having a regular contact with parents or relatives was related to a decrease in problem behaviors of the institutionalized children. Unexpectedly, we could not find age, gender, and amount of time spent at the institution as predictors of the behavioral problems and developmental skills. These findings are not consistent with previous research which documented that younger age of admission (i.e. longer duration of institutionalization) and being a boy were the risk factors for the occurrence of

problem behaviors (Şimşek et al., 2007; Şenyurt et al., 2008; Marcovitch et al., 1997).

5. 3. Caregiving Behavior

Based on previous institutional research which revealed that intervention programs could promote sensitive and responsive caregiving (Muhamedrahimov et al., 2004; Groark et al., 2005), we explored the influence of the training group on the caregiving behaviors of the caregivers. It was hypothesized that caregivers who made better use of the groups, as measured by the Group Participation Evaluation Scale, would show more sensitive responsiveness in their interactions with children, as measured by the observation checklist. Because of the limitations of the institutional setting, we could not make pre-test evaluations of the caregivers' interactions with children and we could not have a control group to compare the caregiving behaviors of the intervention group with the behaviors of those who did not receive any support. Therefore, we stated our expectation as an exploratory hypothesis and examined the frequency of each caregiving behavior displayed by the caregivers. In this sense, the observation system that we have developed according to the conditions of the institutional setting can be regarded as a pilot study.

Caregivers were observed to engage mostly in verbal interaction with children. This finding is compatible with the improvement observed in children's language skills. It is also consistent with our expectation because in

the groups the importance of language development in children was emphasized and caregivers were informed about the ways of promoting language abilities of children. Caregivers were also observed to use physical contact and mirroring in their interactions with children. We expected to find positive correlations between the degree of involvement in the groups and sensitive responsiveness of the caregivers. The results of the study, however, did not confirm this expectation. Evaluations of group participation were not found to correlate significantly with the observed caregiving behaviors. The only correlation that was approaching significance was mirroring. Caregivers, who were evaluated as more engaged in the groups, were observed to display more mirroring behaviors in their interactions with children. These findings suggest that the direct influence of the education and supervision support group is mostly reflected on the mirroring behaviors of the caregivers. When we consider the fact that the importance of mirroring in children's psychosocial development and experiential exercises on this issue hold a large part in the intervention groups, this finding is also understandable. It should also be noted that a more systematic and sensitive measure of the group participation can have significant correlations with the observed caregiving behaviors. There were again important methodological limitations such as limited sample size and the limited range of scores in the Group Participation Evaluation Scale.

We also explored the variables that could be the predictors of sensitive responsiveness. Among these variables there were caregivers' own attachment status, post-test scores of SCL-90-R, age, previous job experience, and duration

at the current job. The post-test SCL-90-R scores were found to be the only significant predictor of the sensitive responsiveness. Caregivers who reported lower levels of mental health at the post-test evaluation were observed to be more sensitively responsive in their relationships with children.

Finally, we conducted correlational analyses to look at the relationship between the evaluations of group participation and caregiver variables. As we expected, caregivers with secure attachment styles were found to make better use of the groups and they were also observed to use mirroring more frequently than other caregivers in their interaction with children. Unexpectedly, we also found a significantly positive correlation between fearful attachment and the occurrence of mirroring behavior. Moreover, caregivers with fearful attachment style were rated as more engaged in the group process. These findings can be attributed to the features of the measure we used. Relationship Scales Questionnaire defines fearful attachment as an intense desire for a close relationship together with a feeling of distrust in other people. Therefore, caregivers, who were regarded as having fearful attachments, may want to establish close relationships with other caregivers in the group and with children, but at the same time they may have a fear of losing that relationship because of their lack of confidence. In order to compensate this dilemma, they may display closer mirroring in their interaction with children, and they may be more involved in the group process and seem more connected, but this sense of connection might be attached to more anxiety about separation.

5. 4. Limitations and Implications for Future Research

Conducting well-designed studies about institutionalization is challenging, especially given the limitations of the institutional settings. There are several limitations of the present study most of which are inevitable consequences of conducting a research with institutionalized children and their caregivers. First of all, we faced some complications during the data collection phase. Because of the frequent changes in caregivers' working shifts or working places, we had a difficulty in the organization of the experimental and control groups. Some of the caregivers also showed irregular attendance to the groups or some of them quit their jobs during the study, all of which left us with a small sample size. Inadequate sample size was especially evident in the failure to find the significant effect of group in the multivariate analyses. A replication of this study with a larger sample size would be important.

Secondly, we did not have a control group for children. We had to put them in total to the experimental group because all of them had a relationship with one or more caregivers who participated in the support groups. In other words, there were no children of the same age whose caregiver did not receive any support. This lack of control group led us to interpret the results of the children's hypotheses with caution. Additional research is needed to replicate the findings related to children. Furthermore, follow-up studies are recommended to see the long-term effects of the intervention program on children's developmental levels.

Another limitation of the present study is that we could not make pre-test observations of the caregiving behaviors, and instead evaluated caregivers only after the completion of the groups. As we could not compare the caregiving behaviors that caregivers displayed before the beginning and after the completion of the groups, we did not have an opportunity to assess the direct impact of participating in a support group on the sensitive responsiveness of caregivers. We also could not observe the caregivers in the control group because of their working conditions. As a result, we could only provide descriptive statistics regarding caregiving behaviors of the experimental group, and explore the correlations of them with the evaluations of group participation. Despite the absence of systematic observations of the caregiving behaviors, the observation system that we used is unique in the sense that it is developed under the conditions of an institutional setting. Therefore, the observation part of this study can be regarded as a pilot investigation, and future research can be conducted to improve this system and test its validity. Moreover, qualitative evaluations of the caregivers revealed that they remembered the experiential exercises and the homework as the most influential parts of the groups. By future intervention programs the impacts of different methods used in the training programs can be tested.

Finally, this study did not have an opportunity for controlling the structural conditions of the institutional setting. Future intervention programs including both training and structural changes which enable the stability and consistency of the caregivers and reduce the child-caregiver ratio are highly

recommended to support positive relationships between children and caregivers.

5. 5. Summary and Conclusion

Early relational experiences have been found to be significant determinants of later interpersonal functioning of children. The effects of these experiences become more influential especially for children reared at an institutional setting. Therefore, intervention programs which aim at promoting a warm and sensitive relationship between children and caregivers are of great significance. Research in this area has revealed that providing caregivers with training and making structural changes at an institutional setting improve caregivers' psychological health and make them more sensitively responsive to the physical and emotional needs of children. As a result, children show improvements in all developmental domains and reduce their behavioral problems.

In line with previous research, the general purpose of the present intervention program was to induce warm, caring, and sensitively responsive interactions between children and caregivers, and in this way to enhance children's developmental achievements. Overall, the results of the study supported these expectations. Caregivers who participated in the education and supervision support group were found to have less mental health problems and lower burnout levels. They became more satisfied with their jobs and displayed higher levels of self-efficacy. Children were also reported to exhibit lower

behavioral problems and found to improve developmentally. The findings in this study generally indicate that the investment made in the emotional needs of the caregivers is very important as it enables an improvement in children's developmental competencies.

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APPENDICES

Appendix A: Informed Consent

Bilgi ve Onay Formu

Sayın Katılımcı;

"Bakıcı annelere yönelik destekleyici grup çalışmasının bakıcı anneler ve bebekler üzerindeki etkileri" konulu yüksek lisans bitirme tezi çalışmama gönüllü katılımınızı rica ediyorum. Bu araştırmanın amacı İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencilerinden Didem ALICI tarafından yürütülecek olan 20 haftalık eğitim – süpervizyon grup çalışmasının 12 -24 aylık bebeklere bakan bakıcı anneler ve bebekler üzerindeki etkilerini değerlendirmektir.

Bu çalışmaya katılmak için grup çalışmasının başında ve sonunda çeşitli anket formları doldurmanız istenecektir. Bu işlemin yaklaşık olarak 40 dakikanızı alacağı öngörülmektedir..
Katılımcı olarak kimliğiniz gizli tutulacaktır. Ad soyad gibi kişisel bilgileriniz sadece bu onay formunun üzerinde yer alacak, bu form da diğer anketlerden ayrı bir yerde saklanacaktır. Diğer anket formlarının üzerinde sadece her katılımcıya verilen katılımcı numarası yer alacaktır. Bu araştırmadan elde edilen sonuçlar bir grup halinde ölçülecek, bireysel herhangi bir değerlendirme yapılmayacaktır. Kişisel bilgileriniz araştırmadan çıkan herhangi bir yayın ya da sunumda kullanılmayacaktır.

Araştırmaya katılımınızın size herhangi bir zarar vereceği öngörülmemektedir. Katılmak gönüllülük esasına dayanmaktadır ve istediğiniz anda anketleri doldurmaya devam etmemek hakkına sahipsiniz. Sizden ricamız eğer bu çalışmaya katılmaya gönüllü olursanız, araştırmamızın güvenirliği açısından bütün soruları olabildiğince samimi ve eksiksiz bir şekilde yanıtlamanızdır.

Bu araştırma İstanbul Bilgi Üniversitesi Klinik Psikoloji yüksek lisans öğrencilerinden Dilşad Koloğlugil'in (dilsadus@yahoo.com; 533 573 9541) yüksek lisans bitirme tezi için yürütülmektedir. Araştırmanın danışmanı İstanbul Bilgi Üniversitesi Psikoloji Bölümü öğretim üyesi Dr. Zeynep Çatay'dır (zcatay@bilgi.edu.tr; 212- 311 7616). Araştırma ile ilgili sorularınız olursa bu kişilere ulaşabilirsiniz.

Bu araştırmaya katkıda bulunduğunuz için teşekkür ederiz.

* * * *

Yukarıdaki açıklamayı okudum, belirtilenleri anladım ve bu çerçevede bu araştırma projesine katılmayı kabul ediyorum.

_________________________ _______________________ ___________

Katılımcının adı-soyadı Katılımcının imzası Tarih

_____________________ _______________________ ___________

Araştırmacının adı-soyadı Araştırmacının imzası Tarih

Appendix B: Caregivers' Demographic Form

DEMOGRAFİK BİLGİ FORMU

Katılımcı No:

1) Yaş:

2) Eğitim Durumu : a) ilkokul mezunu b) ortaokul mezunu
c) düz lise mezunu d) meslek lisesi mezunu
e) üniversite mezunu f) diğer (………………..)

3) Medeni hal : a) evli b) bekar c) dul
d) boşanmış e) birlikte yaşıyor

4) Varsa çocuklarınızın yaş ve cinsiyetlerini aşağıya yazınız

Yaş	Cinsiyet
___________	_________
___________	_________
___________	_________
____________	_________

5) Şu an bulunduğunuz işte ne kadar süredir çalışıyorsunuz?

……………………………………

6) Şu anda işinizde kaç çocuğun bakımından sorumlusunuz ve bu çocukların yaş aralığı nedir?..

Aşağıdaki sorular işinizle ilgili çeşitli değerlendirmeleri içermektedir. Lütfen bütün soruları olabildiğince samimi bir şekilde cevaplandırmaya çalışın. Her soru için size en yakın gelen seçeneği daire içine alın.

7) İşinizde kendinizi ne kadar yeterli hissediyorsunuz?

1	2	3	4	5
hiç	biraz	orta	oldukça	çok fazla

8) Yaptığınız işten ne kadar manevi tatmin duyuyorsunuz?

1	2	3	4	5
hiç	biraz	orta	oldukça	çok fazla

9) Yaptığınız işten ne kadar memnuniyet duyuyorsunuz?

1	2	3	4	5
hiç	biraz	orta	oldukça	çok fazla

10) Diğer mesleklerle kıyasladığınızda, yaptığınız işin ne kadar değerli olduğunu düşünüyorsunuz?

1	2	3	4	5
hiç	biraz	orta	fazla	çok fazla

11) Ne sıklıkta işinizden kaynaklı stres, sıkıntı, yorgunluk gibi duygular hissediyorsunuz?

1	2	3	4	5
hiçbir zaman	çok nadir	bazen	çoğunlukla	her zaman

12) Sıkıntılı olduğunuz ya da zorlandığınız zamanlarda, işinizle ilgili ne sıklıkta yardım alabiliyorsunuz?

1	2	3	4	5
hiçbir zaman	çok nadir	bazen	çoğunlukla	her zaman

13) Ne sıklıkta işinizde çok fazla çalıştığınızı hissediyorsunuz?

1	2	3	4	5
hiçbir zaman	çok nadir	bazen	çoğunlukla	her zaman

14) İleride bu işi yapmaya devam etmek istiyor musunuz? a) evet b) hayır

15) İşten ayrılmayı ne sıklıkta düşünüyorsunuz?

1	2	3	4	5
hiçbir zaman	çok nadir	bazen	çoğunlukla	her zaman

Appendix C: General Self-Efficacy Scale (GSE)

ÖZ YETERLİK ÖLÇEĞİ

Aşağıda, kişilerin sorunlar karşısında ne gibi tepkiler verdiği konusunda sorular yer almaktadır. Doğru veya yanlış cevabı olmayan bu soruları lütfen mümkün olabildiğince samimi bir şekilde cevaplamaya çalışın ve tüm soruları size en yakın gelen seçeneğe çarpı işareti (X) koyarak işaretleyiniz.

1. Yeterince uğraşırsam zor sorunları her zaman çözebilirim.

( ) 1	( ) 2	( ) 3	( ) 4
Hiç doğru değil	Pek doğru sayılmaz	Kısmen doğru	Tamamen doğru

2. Biri bana karşı çıktığında, istediğimi elde etmenin yolunu ve yordamını bulabilirim.

( ) 1	( ) 2	( ) 3	( ) 4
Hiç doğru değil	Pek doğru sayılmaz	Kısmen doğru	Tamamen doğru

3. Hedeflerime sadık kalmak ve amacıma ulaşmak benim için kolaydır.

( ) 1	( ) 2	( )3	( ) 4
Hiç doğru değil	Pek doğru sayılmaz	Kısmen doğru	Tamamen doğru

4. Beklenmedik olaylarla etkin bir biçimde başedebileceğime eminim.

( )1	( )2	( )3	( ) 4
Hiç doğru değil	Pek doğru sayılmaz	Kısmen doğru	Tamamen doğru

5. Becerikliliğim sayesinde önceden tahmin edilmeyen durumlarla başa çıkabilirim.

( )1	( )2	( )3	( )4
Hiç doğru değil	Pek doğru sayılmaz	Kısmen doğru	Tamamen doğru

6. Gerekli çabayı gösterdiğimde çoğu sorunu çözebilirim.

( )1	( )2	( )3	( )4
Hiç doğru değil	Pek doğru sayılmaz	Kısmen doğru	Tamamen doğru

7. Zorluklarla karşılaşınca sükunetimi kaybetmem, çünkü başa çıkma becerilerime güvenebilirim.

( )1	( )2	( )3	( )4
Hiç doğru değil	Pek doğru sayılmaz	Kısmen doğru	Tamamen doğru

8. Bir sorunla karşılaştığımda genellikle çeşitli çözüm yolları bulabilirim.

( )**1**	( )**2**	( )**3**	( )**4**
Hiç doğru değil	**Pek doğru sayılmaz**	**Kısmen doğru**	**Tamamen doğru**

9. Başım derde girdiğinde genellikle bir çözüm yolu düşünebilirim.

( )**1**	( )**2**	( )**3**	( )**4**
Hiç doğru değil	**Pek doğru sayılmaz**	**Kısmen doğru**	**Tamamen doğru**

10. Genellikle önüme çıkan herhangi bir sorunun üstesinden gelebilirim.

( )**1**	( )**2**	( )**3**	( )**4**
Hiç doğru değil	**Pek doğru sayılmaz**	**Kısmen doğru**	**Tamamen doğru**

Appendix D: Maslach Burnout Inventory (MBI)

Aşağıda iş ile ilgili tutumları yansıtan ifadeler yer almaktadır. Lütfen her bir ifade ile belirtilen durumu ne kadar sıklıkla yaşadığınızı belirttiniz. Size verilen bazı cümlelerde ''işim gereği karşılaştığım insanlar'' ifadesi yer almaktadır. Siz de, bu ifade ile karşılaştığınızda, kendi işiniz dolayısıyla hizmet verdiğiniz, sorunlarıyla uğraştığınız ya da işi yürütmek için muhatap olduğunuz kişileri düşününüz.

Bu soruları mümkün olabildiğince samimi bir şekilde cevaplamaya çalışın.

	Hiçbir zaman	Çok nadir	Bazen	Çoğu zaman	Her zaman
1. İşimden soğuduğumu hissediyorum.	( )	( )	( )	( )	( )
2. İş dönüşü kendimi ruhen tükenmiş hissediyorum.	( )	( )	( )	( )	( )
3. Sabah kalktığımda, bir gün daha bu işi kaldıramayacağımı hissediyorum.	( )	( )	( )	( )	( )
4. İşim gereği karşılaştığım insanların ne hissettiğini hemen anlarım.	( )	( )	( )	( )	( )
5. İşim gereği karşılaştığım bazı kişilere bazen kırıcı davrandığımı fark ediyorum.	( )	( )	( )	( )	( )
6. Bütün gün insanlarla uğraşmak benim için gerçekten çok yıpratıcı.	( )	( )	( )	( )	( )
7. İşim gereği karşılaştığım insanların sorunlarına en uygun çözüm yolları bulurum.	( )	( )	( )	( )	( )

	Hiçbir zaman	Çok nadir	Bazen	Çoğu zaman	Her zaman
8. Yaptığım işten yıldığımı düşünüyorum.	( )	( )	( )	( )	( )
9. Yaptığım iş sayesinde insanların yaşamına katkıda bulunduğuma inanıyorum.	( )	( )	( )	( )	( )
10. Bu işte çalışmaya başladığımdan beri insanlara karşı sertleştim.	( )	( )	( )	( )	( )
11. Bu işin beni giderek katılaştırmasından korkuyorum.	( )	( )	( )	( )	( )
12. Çok şeyler yapabilecek güçteyim.	( )	( )	( )	( )	( )
13. İşimin beni kısıtladığını hissediyorum.	( )	( )	( )	( )	( )
14. İşimde çok fazla çalıştığımı hissediyorum.	( )	( )	( )	( )	( )
15. İşim gereği karşılaştığım insanlara ne olduğuyla ilgilenirim.	( )	( )	( )	( )	( )
16. Doğrudan doğruya insanlarla çalışmak bende çok fazla stres yaratıyor.	( )	( )	( )	( )	( )
17. İşim gereği karşılaştığım insanlarla aramda rahat bir hava yaratırım.	( )	( )	( )	( )	( )
18. İnsanlarla yakın bir çalışmadan sonra kendimi canlanmış hissederim.	( )	( )	( )	( )	( )
19. Bu işte birçok kayda değer başarı elde ettim.	( )	( )	( )	( )	( )
20. Yolun sonuna geldiğimi hissediyorum.	( )	( )	( )	( )	( )

	Hiçbir zaman	**Çok nadir**	**Bazen**	**Çoğu zaman**	**Her zaman**
21. İşimdeki duygusal sorunlara serinkanlılıkla yaklaşırım.	( )	( )	( )	( )	( )
22. İşim gereği karşılaştığım insanların bazı problemlerini sanki ben yaratmışım gibi davrandıklarını hissederim	( )	( )	( )	( )	( )

Appendix E: Relationship Scales Questionnaire (RSQ)

İLİŞKİ ÖLÇEKLERİ ANKETİ

Aşağıda yakın duygusal ilişkilerinizde kendinizi nasıl hissettiğinize ilişkin çeşitli ifadeler yer almaktadır. Yakın duygusal ilişkilerden kastedilen arkadaşlık, dostluk, romantik ilişkiler ve benzerleridir. Lütfen her bir ifadeyi bu tür ilişkilerinizi düşünerek okuyun ve her bir ifadenin sizi ne ölçüde tanımladığını aşağıdaki 7 aralıklı ölçek üzerinde değerlendiriniz. Her bir ifade için uygun puanı ifadenin yanına yazınız.

1-------------2--------------3-------------4-------------5-------------6-------------7

Beni hiç tanımlamıyor	Beni kısmen tanımlıyor	Tamamıyla beni tanımlıyor

1. Başkalarına kolaylıkla güvenemem. ____
2. Kendimi bağımsız hissetmem benim için çok önemli. ____
3. Başkalarıyla kolaylıkla duygusal yakınlık kurarım. ____
4. Bir başka kişiyle tam anlamıyla kaynaşıp bütünleşmek isterim. ____
5. Başkalarıyla çok yakınlaşırsam incitileceğimden korkuyorum. _____
6. Başkalarıyla yakın duygusal ilişkilerim olmadığı sürece oldukça rahatım. ____
7. İhtiyacım olduğunda yardıma koşacakları konusunda başkalarına her zaman güvenebileceğimden emin değilim. ____
8. Başkalarıyla tam anlamıyla duygusal yakınlık kurmak istiyorum. _____
9. Yalnız kalmaktan korkarım. _____
10. Başkalarına rahatlıkla güvenip bağlanabilirim._____
11. Çoğu zaman, romantik ilişkide olduğum insanların beni gerçekten sevmediği konusunda endişelenirim. _____
12. Başkalarına tamamıyla güvenmekte zorlanırım. _____
13. Başkalarının bana çok yakınlaşması beni endişelendirir. _____
14. Duygusal yönden yakın ilişkilerim olsun isterim. ______
15. Başkalarının bana dayanıp bel bağlaması konusunda oldukça rahatımdır. ______
16. Başkalarının bana, benim onlara verdiğim kadar değer vermediğinden kaygılanırım. ______
17. İhtiyacınız olduğunda hiç kimseyi yanınızda bulamazsınız. ______
18. Başkalarıyla tam olarak kaynaşıp bütünleşme arzum bazen onları ürkütüp benden uzaklaştırıyor. ___
19. Kendi kendime yettiğimi hissetmem benim için çok önemli. _____
20. Birisi bana çok fazla yakınlaştığında rahatsızlık duyarım. _____
21. Romantik ilişkide olduğum insanların benimle kalmak istemeyeceklerinden korkarım. _____
22. Başkalarının bana bağlanmamalarını tercih ederim. _____
23. Terk edilmekten korkarım. ______
24. Başkalarıyla yakın olmak beni rahatsız eder. _____

25. Başkalarının bana, benim istediğim kadar yakınlaşmakta gönülsüz olduklarını düşünüyorum. _____
26. Başkalarına bağlanmamayı tercih ederim. ______
27. İhtiyacım olduğunda insanları yanımda bulacağımı biliyorum. ______
28. Başkaları beni kabul etmeyecek diye korkarım. ______
29. Romantik ilişkide olduğum insanlar, genellikle onlarla, benim kendimi rahat hissettiğimden daha yakın olmamı isterler. ______
30. Başkalarıyla yakınlaşmayı nispeten kolay bulurum. ______

Appendix F: Symptom Checklist-90-Revised (SCL-90-R)

SCL-90-R

Aşağıda zaman zaman herkeste olabilecek yakınma ve sorunların bir listesi vardır. Lütfen her birini dikkatlice okuyunuz. Sonra her bir durumun, bugün de dahil olmak üzere <u>son onbeş gün içinde</u> sizi ne ölçüde huzursuz ve tedirgin ettiğini göz önüne alarak, cevap kağıdında belirtilen tanımlamalardan (*Hiç / Çok az / Orta derecede / Oldukça fazla / İleri derecede*) uygun olanının <u>(yalnızca bir seçeneğin)</u> altındaki parantez arasına bir (X) işareti koyunuz. Düşüncenizi değiştirirseniz ilk yaptığınız işaretlemeyi tamamen silmeyi unutmayınız. Lütfen anlamadığınız bir cümleyle karşılaştığınızda uygulamacıya danışınız.

1. Baş ağrısı
2. Sinirlilik ya da içinin titremesi
3. Zihinden atamadığınız, yineleyici, hoşa gitmeyen düşünceler
4. Baygınlık veya baş dönmesi
5. Cinsel arzu ve ilginin kaybı
6. Başkaları tarafından eleştirilme duygusu
7. Herhangi bir kimsenin düşüncelerinizi kontrol edebileceği fikri
8. Sorunlarınızdan pek çoğu için başkalarının suçlanması gerektiği duygusu
9. Olayları anımsamada güçlük
10. Dikkatsizlik veya sakarlıkla ilgili endişeler
11. Kolayca gücenme, rahatsız olma hissi
12. Göğüs veya kalp bölgesinde ağrılar
13. Caddelerde veya açık alanlarda korku hissi
14. Enerjinizde azalma veya yavaşlama hali
15. Yaşamınızın sonlanması düşünceleri
16. Başka kişilerin duymadıkları sesleri duyma
17. Titreme
18. Çoğu kişiye güvenilmemesi gerektiği hissi
19. İştah azalması
20. Kolayca ağlama
21. Karşı cinsten kişilerle utangaçlık ve rahatsızlık hissi
22. Tuzağa düşürülmüş veya yakalanmış olma hissi
23. Bir neden olmaksızın aniden korkuya kapılma
24. Kontrol edilemeyen öfke patlamaları
25. Evden dışarı yalnız çıkma korkusu
26. Olanlar için kendini suçlama
27. Belin alt kısmında ağrılar
28. İşlerin yapılmasında erteleme duygusu

29. Yalnızlık hissi
30. Karamsarlık hissi
31. Herşey için çok fazla endişe duyma
32. Herşeye karşı ilgisizlik hali
33. Korku hissi
34. Duygularınızın kolayca incitilebilmesi hali
35. Diğer insanların sizin özel düşüncelerinizi bilmesi
36. Başkalarının sizi anlamadığı veya hissedemeyeceği duygusu
37. Başkalarının sizi sevmediği ya da dostça olmayan davranışlar gösterdiği hissi
38. İşlerin doğru yapıldığından emin olabilmek için çok yavaş yapma
39. Kalbin çok hızlı çarpması
40. Bulantı veya midede rahatsızlık hissi
41. Kendini başkalarından aşağı görme
42. Adale(kas) ağrıları
43. Başkalarının sizi gözlediği veya hakkınızda konuştuğu hissi
44. Uykuya dalmada güçlük
45. Yaptığınız işleri bir ya da bir kaç kez kontrol etme
46. Karar vermede güçlük
47. Otobüs, tren, metro gibi araçlarla yolculuk etme korkusu
48. Nefes almada güçlük
49. Soğuk veya sıcak basması
50. Sizi korkutan belirli uğraş, yer ve nesnelerden kaçınma durumu
51. Hiç bir şey düşünememe hali
52. Bedeninizin bazı kısımlarında uyuşma, karıncalanma olması
53. Boğazınıza bir yumru tıkanmış olma hissi
54. Gelecek konusunda ümitsizlik
55. Düşüncelerinizi bir konuya yoğunlaştırmada güçlük
56. Bedeninizin çeşitli kısımlarında zayıflık hissi
57. Gerginlik veya coşku hissi
58. Kol ve bacaklarda ağırlık hissi
59. Ölüm ya da ölme düşünceleri
60. Aşırı yemek yeme
61. İnsanlar size baktığı veya hakkınızda konuştuğu zaman rahatsızlık duyma
62. Size ait olmayan düşüncelere sahip olma
63. Bir başkasına vurmak, zarar vermek, yaralamak dürtülerinin olması
64. Sabahın erken saatlerinde uyanma
65. Yıkanma, sayma, dokunma gibi bazı hareketleri yineleme hali
66. Uykuda huzursuzluk, rahat uyuyamama
67. Bazı şeyleri kırıp dökme isteği
68. Başkalarının paylaşıp kabul etmediği inanç ve düşüncelerin olması
69. Başkalarının yanında kendini çok sıkılgan hissetme
70. Çarşı, sinema gibi kalabalık yerlerde rahatsızlık hissi
71. Herşeyin bir yük gibi görünmesi

72. Dehşet ve panik nöbetleri
73. Toplum içinde yiyip-içerken huzursuzluk hissi
74. Sık sık tartışmaya girme
75. Yalnız bırakıldığınızda sinirlilik hali
76. Başkalarının sizi başarılarınız için yeterince takdir etmediği duygusu
77. Başkalarıyla birlikte olunan durumlarda bile yalnızlık hissetme
78. Yerinizde duramayacak ölçüde huzursuzluk duyma
79. Değersizlik duygusu
80. Size kötü bir şey olacakmış duygusu
81. Bağırma ya da eşyaları fırlatma
82. Topluluk içinde bayılacağınız korkusu
83. Eğer izin verirseniz insanların sizi sömüreceği duygusu
84. Cinsiyet konusunda sizi çok rahatsız eden düşüncelerin olması
85. Günahlarınızdan dolayı cezalandırılmanız gerektiği düşüncesi
86. Korkutucu türden düşünce ve hayaller
87. Bedeninizde ciddi bir rahatsızlık olduğu düşüncesi
88. Başka bir kişiye asla yakınlık duyamama
89. Suçluluk duygusu
90. Aklınızdan bir bozukluğun olduğu düşüncesi

SCL-90-R CEVAPLAMA FORMU

	HİÇ	ÇOK AZ	ORTA DERE-CEDE	OLDUK-ÇA FAZLA	İLERİ DERE-CEDE
1.	( )	( )	( )	( )	( )
2.	( )	( )	( )	( )	( )
3.	( )	( )	( )	( )	( )
4.	( )	( )	( )	( )	( )
5.	( )	( )	( )	( )	( )
6.	( )	( )	( )	( )	( )
7.	( )	( )	( )	( )	( )
8.	( )	( )	( )	( )	( )
9.	( )	( )	( )	( )	( )
10.	( )	( )	( )	( )	( )
11.	( )	( )	( )	( )	( )
12.	( )	( )	( )	( )	( )
13.	( )	( )	( )	( )	( )
14.	( )	( )	( )	( )	( )
15.	( )	( )	( )	( )	( )
16.	( )	( )	( )	( )	( )
17.	( )	( )	( )	( )	( )
18.	( )	( )	( )	( )	( )
19.	( )	( )	( )	( )	( )
20.	( )	( )	( )	( )	( )
21.	( )	( )	( )	( )	( )
22.	( )	( )	( )	( )	( )
23.	( )	( )	( )	( )	( )
24.	( )	( )	( )	( )	( )
25.	( )	( )	( )	( )	( )
26.	( )	( )	( )	( )	( )
27.	( )	( )	( )	( )	( )
28.	( )	( )	( )	( )	( )
29.	( )	( )	( )	( )	( )
30.	( )	( )	( )	( )	( )
31.	( )	( )	( )	( )	( )
32.	( )	( )	( )	( )	( )
33.	( )	( )	( )	( )	( )
34.	( )	( )	( )	( )	( )
35.	( )	( )	( )	( )	( )
36.	( )	( )	( )	( )	( )
37.	( )	( )	( )	( )	( )
38.	( )	( )	( )	( )	( )
39.	( )	( )	( )	( )	( )
40.	( )	( )	( )	( )	( )
41.	( )	( )	( )	( )	( )
42.	( )	( )	( )	( )	( )
43.	( )	( )	( )	( )	( )
44.	( )	( )	( )	( )	( )
45.	( )	( )	( )	( )	( )
46.	( )	( )	( )	( )	( )
47.	( )	( )	( )	( )	( )
48.	( )	( )	( )	( )	( )

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89. ( ) ( ) ( ) ( ) ( )
90. ( ) ( ) ( ) ( ) ( )

Appendix G: Group Participation Evaluation Scale

13.30 / 15.30 GRUBU

Her kutuya 1-5 arası puan veriniz:	1	2	3	4	5	NA
	hiç	biraz	orta	oldukça	çok fazla	gözlemlenemiyor

Katılımcının adı	**Çocuklara empati**	**Diğer grup üyelerine empati**	**Çocukların iç dünyasını değerlendirme**	**Kendi iç dünyalarını değerlendirme**	**Ne kadar "paylaşımcı"**	**Ne kadar "baskın"**	**Ne kadar "savunmacı"**	***Kişinin kaçıncı oturumu***

Tarih :

Grubun Kaçıncı Oturumu :

Appendix H: Caregiving Behavior Observation Form

Bakıcı Annenin Kod Numarası: _______

Bakıcı Anne Davranışları Değerlendirme Gözlem Formu

Gözlemlediğiniz süre içerisinde aşağıdaki her bir davranışı gördükçe yanındaki kutulara "+" işareti koyunuz.

	1	2	3	4	5	6	7	8	9	10
1. Çocukla etkileşimi başlatır										
2. Çocuğun başlattığı etkileşime cevap verir (örn, çocuk elindeki oyuncağı anneye gösterdiğinde)										
3. Kriz durumlarında çocuğa müdahale eder (örn, çocuk ağladığında, onu yatıştırmaya çalışır)										
4. Çocuğa ismiyle seslenir										
5. Çocukla sözel iletişim kurar / konuşur										
6. Çocuğa bir durumun açıklamasını yapar (örn, "biz yemeğe sonra gideceğiz çünkü …)										
7. Çocuk için uygun kuralları ve düzenlemeleri sağlar (yönerge verir, uyarır, kural koyar)										
8. Onay verir / takdir eder										
9. Sözel aynalama yapar (çocuğun davranışını, duygusunu, vb.)										
10. Yüz ifadesini ya da hareketini aynalar										
11. Çocukla vakit geçirirken olumlu duygu ifade eder (örn, keyif alır, güler).										
12. Çocukla ilgilenirken göz kontağı kurar										
13. Çocuğu rahatlatıcı / sakinleştirici fiziksel temasta bulunur										
14. Çocuğun fiziksel temas isteğine cevap verir										
15. Çocuğun oyun kurmasına yardımcı olur										
16. Çocuğun iletişim kurma çabalarına ilgisiz kalır										
17. Çocuğa karşı olumsuz duygu ifadesinde bulunur (kızgınlık, bıkkınlık, asık yüz ifadesi, bağırarak konuşma)										

18. Çocukla iletişimi esas almayan aktivitelerde bulunur (örn, diğer bakıcı annelerle konuşma)										
19. Çocuğun ilgisini ısrarla başka yöne yönlendirir (çocuğun özerkliğini önemsemez)										
20. Çocuğun olumsuz duygusunu ortadan kaldırmak için ilgisini dağıtmaya çalışır (örn, "bak televizyonda ne var!")										
21. Çocuğun duygusunu inkar eder (örn, "yok, yok acımadı", "aaa üzülecek ne var?"										
22. Yüz ifadesi veya ses tonuyla çocuğu korkutur										

Note: *Items between 1 and 15 were used to evaluate "Total Responsiveness".

*Items numbered 16, 17, 18, 19, and 22 were used to evaluate "Total Negative Interaction".

Appendix I: Group Evaluation Form for the Caregivers

Bakıcı Anneler için Eğitim ve Süpervizyon Grup Çalışması Değerlendirme Formu

1. Bu eğitimden en çok aklınızda kalanlar neler?

2. Bu grup çalışmasının size faydası olduğunu düşünüyor musunuz? Eğer öyleyse ne açıdan?

3. Bu eğitim grubunda öğrendiklerinizden işinize yansıttıklarınız nelerdir?

4. Bu eğitimde çocuklar ile ilişkinizde neler fark ettiniz?

5. Bu eğitimde kendinizle ilgili neler öğrendiniz?

6. Bu eğitim grubunda kullanılan yöntemlerden (sunum, grup tartışması, aktiviteler, ödevler) hangilerini daha faydalı buldunuz? Neden?

7. Bu eğitimde gereksiz bulduğunuz kısımlar var mıydı?

8. Bu eğitimde daha çok üstünde durulmasını arzu ettikleriniz nelerdir?

9. Bu eğitimde size en zor gelen konular nelerdi?

10. Grup liderinin yaklaşımında size iyi gelenler...

11. Grup liderinin yaklaşımında sizi rahatsız edenler...

12. Daha çok sayıda grup oturumuna katılmanızı zorlaştıran etkenler nelerdi?

Appendix J: Children's Demographic Form

ÇOCUKLARA YÖNELİK BİLGİ FORMU

1) Adı Soyadı:

2) Cinsiyeti :

3) Doğum tarihi :

4) Ne kadar süredir yuvada bulunduğu : _____ ay

5) Anne ve/veya babası yaşıyor mu ? :
   a) hayır, ikisi de yaşamıyor.
   b) annesi yaşıyor.
   c) babası yaşıyor.
   d) evet, ikisi de yaşıyor.
   e) bilinmiyor.

6) Temasta bulunduğu herhangi bir akrabası/ziyaretçisi var mı? :
   a) Hayır
   b) Evet. Belirtiniz :

7) Fiziksel ve/veya zihinsel bir özrü var mı?
   a) Hayır
   b) Evet. Belirtiniz :

8) Şimdiye kadar herhangi bir özel rehabilitasyon eğitimi aldı mı veya psikolojik bir tedavi gördü mü? :
   a) Hayır
   b) Evet. Belirtiniz :